

**Mental Health & Recovery Board
of Erie and Ottawa Counties**

SFY 2014 Community Plan

December 13, 2013

**Ohio Mental Health and Addiction Services (OhioMHAS)
Community Plan Guidelines SFY 2014**

Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the Board area that will influence service delivery.
(NOTE: There will be an opportunity to discuss the possible effects of Medicaid expansion upon your local system in question #12.)

ECONOMIC FACTORS

Local Resources and Service Delivery

We have two separate levies, one for .3 mil and one for .7 mil. The .3 mil was last replaced on 11/3/2009 for five years and expires in 2014. The .7 mil was last replaced on 11/7/2006 for ten years and expires in 2016.

With the passage of the replacement levy in November 2009 (FY 10), levy collections—beginning in January 2011—resulted in the receipt of approximately \$290,000 in additional local revenue for FY 11. However, as evident in the table below, local revenues decreased each subsequent year due to the decline in real property values, limited new construction, and the loss of Tangible Personal Property (TPP) tax revenues. As a result, projected levy revenue for FY 14 is equivalent to the level prior to the last replacement.

Local Levy Funds

FY 10	\$3,813,955
FY11	\$4,107,071
FY12	\$4,018,730
FY13	\$3,919,093
FY14*	\$3,903,913

* projected

Impact of Loss of TPP Reimbursements

CY 2010	\$285,974
CY 2012	\$136,411
CY 2013 & Thereafter	\$61,629

The availability of local dollars allows for the provision of core alcohol/drug and mental health treatment services to persons without Medicaid or other insurance coverage at levels far exceeding state and federal allocation amounts. In addition, local funds allow for the provision of critical prevention and support services not covered under Medicaid. These include peer/self-help and Recovery support services; housing and related housing-support services for persons with Severe and Persistent Mental Illness (SPMI); vocational/employment services; Compensated Guardian Program; and all prevention, education, intervention and consultation services and programs. Finally, levy funds are also used to subsidize services to residents via a sliding payment schedule based on household income, family size and other factors.

Unemployment

Noted with brief references throughout the narrative, the data presented in the response to Question #1 is primarily from

one of the following U.S. Census Bureau sources: 2005-2007 American Community Survey (ACS); 2009 ACS 1-Year Estimates; or the 2009-2011 ACS. As necessary, other data sources are noted below.

Poverty and unemployment have well-established relationships with stressors and high-risk behaviors. Both contribute to overall community stress levels and are associated with a range of substance abuse and mental health problems. Even for those in Recovery, added stress due to the loss of employment and increased financial strain can lead to relapse.

Erie County:

According to Ranking of Ohio County Unemployment Rates (ODJFS, Office of Workforce Development), Erie County was 61st of the 88 counties at 9.3% in 2010, 55th at 8.8% in 2011, and 50th at 7.3% in 2012. Comparable rates for Ohio during that same period were 9.5%, 8.6%, and 7.2% respectively. As you can see, the rate of unemployment decreased each year, consistent with the state average. The rate relative to the rest of Ohio’s counties improved however, with a 12.5% jump in rank from 2010 to 2012. In looking at the rate by individual month, there is a slight dip during the summer months as expected due to seasonal employment opportunities through Cedar Point and related retail and restaurant businesses.

The size of a county’s labor force is also an indication of economic health. It is influenced by both the economy and the size and composition of the population. Labor force data as reported in the ODJFS Profile of Statistical and Demographic Data for Erie County (2008-2011) is as follows:

	CY 2010			CY 2009		
	County	State	U.S.	County	State	U.S.
Labor Force	42,700	5,897,600	153,889,000	43,100	5,970,200	154,142,000
Employment	38,300	5,303,000	139,064,000	38,100	5,359,000	139,877,000
Unemployment	4,400	594,500	14,825,000	5,000	611,200	14,265,000
Unemployment Rate	10.4	10.1	9.6	11.5	10.2	9.3

While there was a slight decrease in the size of the labor force between the two years shown, overall it has remained relatively stable. However, the estimated labor force according the 2009-2011 ACS for Erie County is lower at 39,095, or 62.9% of the population age sixteen or older.

Ottawa County:

According to the Ranking of Ohio County Unemployment Rates, Ottawa County was 12th of the 88 counties at 12.1% in 2010; 9th in 2011 at 11.9%; and 12th in 2012 at 9.8%. These figures range from 2.6-3.3% higher than the Ohio averages for the same period, placing the county in the top 15% of all 88 counties. As is the case in Erie County during the summer months, when you take into account the large migrant worker population living and working in the county during the summer and fall planting and harvesting seasons there is a significant dip in the rate from about May through October. As an example, the table below shows the unemployment rate by month for 2011.

Civilian Labor Force Estimates For: Ottawa County				
Year	Civilian Labor Force	Employment	Unemployment	Unemployment Rate
Jan-2011	22,200	18,100	4,000	18.2
Feb-2011	22,100	18,300	3,800	17.3
Mar-2011	21,900	18,400	3,500	16.0
Apr-2011	21,200	18,600	2,600	12.4
May-2011	20,700	18,700	2,000	9.5
Jun-2011	20,600	18,700	1,900	9.4
Jul-2011	20,600	18,700	1,900	9.2

Aug-2011	20,600	18,800	1,800	8.7
Sep-2011	20,400	18,700	1,700	8.3
Oct-2011	20,700	18,900	1,800	8.5
Nov-2011	21,300	18,800	2,400	11.4
Dec-2011	21,500	18,800	2,800	12.9
Avg-2011	21,100	18,600	2,500	11.9

Labor force information as reported in the ODJFS Ottawa County Profile (2008-2011) is as follows:

	CY 2010			CY 2009		
	County	State	U.S.	County	State	U.S.
Labor Force	20,800	5,897,600	153,889,000	21,500	5,970,200	154,142,000
Employment	17,900	5,303,000	139,064,000	18,600	5,359,000	139,877,000
Unemployment	2,900	594,500	14,825,000	2,900	611,200	14,265,000
Unemployment Rate	14.0	10.1	9.6	13.7	10.2	9.3

Income and Poverty

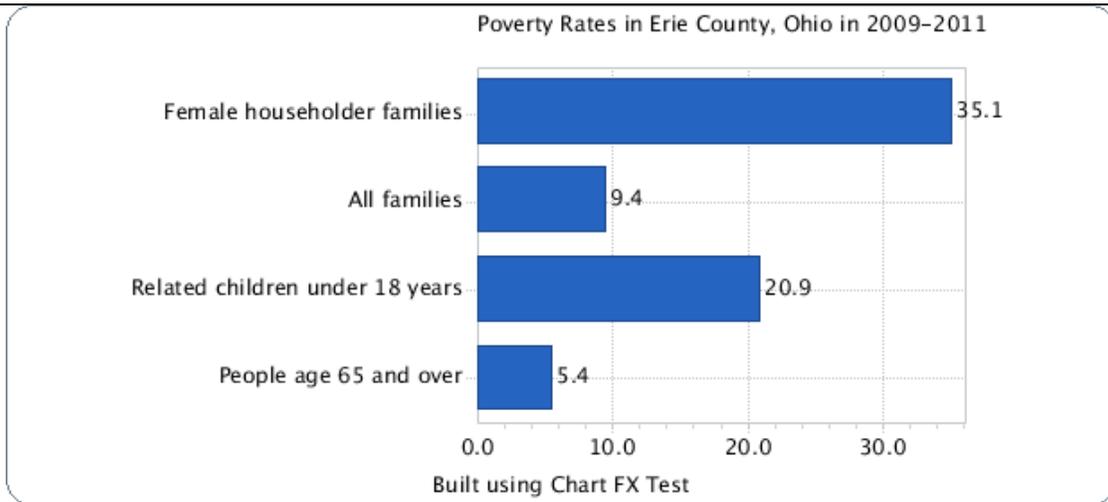
Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. According to information found in the 2013 County Health Rankings, a 1990 study found that if poverty were considered a cause of death in the US, it would rank among the top 10 causes. While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality than adults due to increased risk of accidental injury and lack of health care access. Furthermore, children’s risk of poor health and premature mortality may also increase because of the poor educational achievement associated with poverty.

Erie County:

The per capita income of a region also provides a good barometer of its economic health. According to the ODJFS Profile, over the last decade, per capita income fluctuations in Ohio have been highly correlated with employment growth or decline. The per capita income for the county in 2000 was \$36,236 and in 2009, \$28,645. Both figures are just slightly higher than the average for Ohio and slightly lower than the U.S. average. The 2009-2011 ACS estimate is \$24,846 for Erie County and \$25,020 for Ohio. Based on this data, Erie County is slightly lower than the state average.

As reported in the 2009 ODJFS Profile for Erie County, 12% of persons (2008 Census) of all ages were in poverty according to the Federal Poverty Level as issued by the U.S. Department of Health and Human Services, 16.8% of those less than eighteen years of age. That number rose to 14.6% (2009 Census) in the 2008-2011 Profile, 20.2% for those under age eighteen.

Per the American Community Survey, in 2009-2011, 14% of people (10,780 people) were in poverty. Twenty-one percent of related children under 18 (3557 children) were below the poverty level, compared with 5% of people 65 years old and over. Nine percent of all families and 35% of families with a female householder and no husband present had incomes below the poverty level.



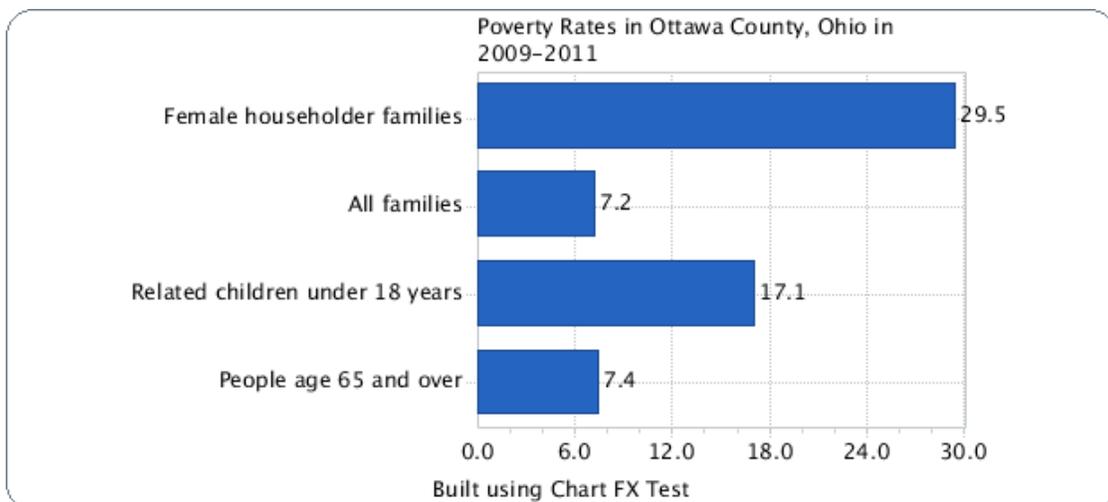
Source: U.S. Census Bureau, 2009-2011 American Community Survey

Ottawa County:

As reported in the ODJFS Profile, per capita income was \$37,094 in 2000 and \$29,105 in 2009 and as was the case with Erie County, slightly above average for the state and below that for the nation. The 2009-2011 ACS estimate is \$27,584 for Ottawa County and \$25,020 for Ohio. Based on this data as well, per capita income in Ottawa County is above the state average.

As reported in the 2009 ODJFS Profile for Ottawa County, 9% (2008 Census figures) of persons of all ages were in poverty according to the Federal Poverty Level as issued by the U.S. Department of Health and Human Services; 12.5% of those less than eighteen years of age. That number rose to 10.7% (2009 Census) in the 2008-2011 Profile, 14.9% for those under age eighteen.

Per the 2009-2011 ACS, 11% of people (4510 people) were in poverty. Seventeen percent of related children under 18 (1430 children) were below the poverty level, compared with 7% of people 65 years old and over. Seven percent of all families and 30% of families with a female householder and no husband present had incomes below the poverty level.



Source: U.S. Census Bureau, 2009-2011 American Community Survey

Health Insurance

Among the civilian non-institutionalized population in Erie County in 2009-2011 (ACS), 88% had health insurance coverage and 12% did not have health insurance coverage. For those under 18 years of age, 7% had no health insurance coverage. The civilian non-institutionalized population had both private and public health insurance, with 72% having private coverage and 32% having public coverage. According to the 2011/2012 Erie County Health Assessment, 9% of adults were without healthcare coverage, increasing to 27% of those with incomes less than \$25,000.

Among the same population in Ottawa County in 2009-2011 (ACS), 89% had health insurance coverage and 11% did not have health insurance coverage. For those under 18 years of age, 6% had no health insurance coverage. The civilian non-institutionalized population had both private and public health insurance, with 75% having private coverage and 31% having public coverage. According to the 2012 Ottawa County Health Assessment, 12% of adults were without coverage, with those adults under age 30 and those with an income level under \$25,000 most likely to be uninsured.

These figures are significant because Board funds are used to provide treatment services to the non-insured and indigent population—in this case, available as a “safety net” for approximately 9240 Erie County and 4510 Ottawa County residents.

SOCIAL AND DEMOGRAPHIC FACTORS

Population

The overall populations of both counties have remained relatively stable over the last twelve years. Using 2000 and 2010 Census figures, there was a 3.1% decrease in the total population of Erie County and a 1.1% increase in Ottawa County. Based on the most recent figures from the U.S. Census Bureau (QuickFacts), the total population of Erie Co. is estimated for 2012 at 76,398, a .9% decrease since the 2010 Census and representing a decrease of 4% over the twelve year period. For Ottawa, the total estimated population for 2012 is 41,339, a .2% decrease from 2010 and a negligible change across the twelve year period. Thus, as of the most recent data, the catchment area for our Board is comprised of 117,737 people; about 35% Ottawa Co. residents and 65% Erie Co. This is important relative to allocation of funds, as we are diligent in ensuring that all per capita and local dollars are contracted on this basis.

In terms of diversity, for people reporting one race alone 98% of Ottawa County residents were White; in Erie County, the number was 90%. As reported in the 2009-2011 ACS, in Erie Co. 9% were Black or African American with the remaining spread across the rest of the categories. Three percent of the people were Hispanic and 85% were White non-Hispanic. In Ottawa Co., 1% were Black or African American. Four percent were Hispanic and 93% were White non-Hispanic. In Ohio for this same period, 83% of people reporting one race alone were White and 12% were Black or African American. As is evident, there is very little diversity in terms of race and ethnicity in Ottawa County; only 820 people reported something other than White. While Erie Co. is comprised of a more diverse population, it still falls below that for the state. Of note however is the fact that the majority of people reporting their race as Black or African American reside in the city of Sandusky, the county seat. Using the 2009-2011 ACS figures, 85.68% of Erie Co. residents reporting their race as Black or African American live in Sandusky. Of the city of Sandusky population, 21.42% are Black or African American.

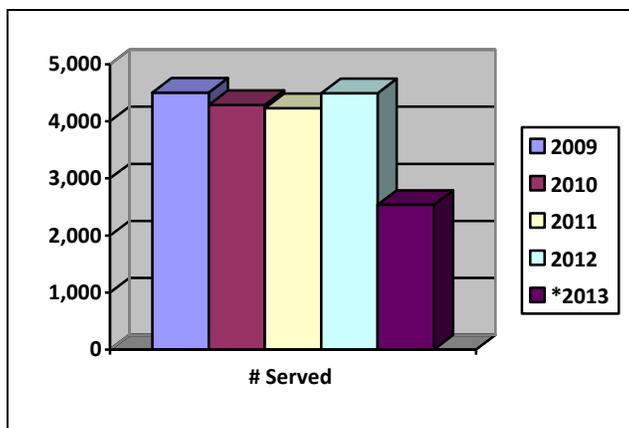
Client Characteristics

It should be noted up front that there is a disconnect in some of the data analyses presented below—not to mention a lack of continuity in looking historically at trends—as a result of the elevation of the Medicaid program to the State and Boards’ inability to access client data in the same manner. In past Community Plans, we reported on the total client population when looking at social and demographic characteristics and trend analysis. Unless there was a specific reason (i.e. looking at payer source or at changes in the proportion of children and youth with Medicaid vs. non-insured and/or indigent), client data was not viewed separately for Medicaid and Non-Medicaid. Given the timing of the last biennial Plan (due in September 2011, the beginning of the second quarter of FY 12), data was presented through FY 10, with FY 11 data provided in some cases but estimated given that the billing cycle and contract reconciliation process extended beyond the end of the fiscal year.

With the timing of this Plan, actual data for FY 11 and FY 12 is available, and data for FY 13 is available with the same limitations as presented above. There is obviously a difficulty comparing client data for FY 13 with previous years. In some cases, we were able to go back and easily pull out the data for non-Medicaid services/clients in order to look comparatively at various factors in relation to FY 13. In other cases, it was not so simple nor worth the trouble from a cost-benefit perspective given the need to look at the total population in order to continue trend analyses through FY 12, but also reconfigure past data sets and reports to pull out the Medicaid in order to have any meaningful comparison to FY 13 and beyond.

With the state budget cuts in the latter part of FY 09 and the further reduction in funding in FY 10 (totaling just under \$1.3 million for our Board area), we expected to see a decrease in numbers served in FY 10 and FY 11. We were able to increase capacity slightly in targeted areas beginning with the FY 12 contracts. Based on an unduplicated client count for paid claims for treatment services in MACSIS by fiscal year, this was indeed the case.

Number Clients Receiving Treatment Services



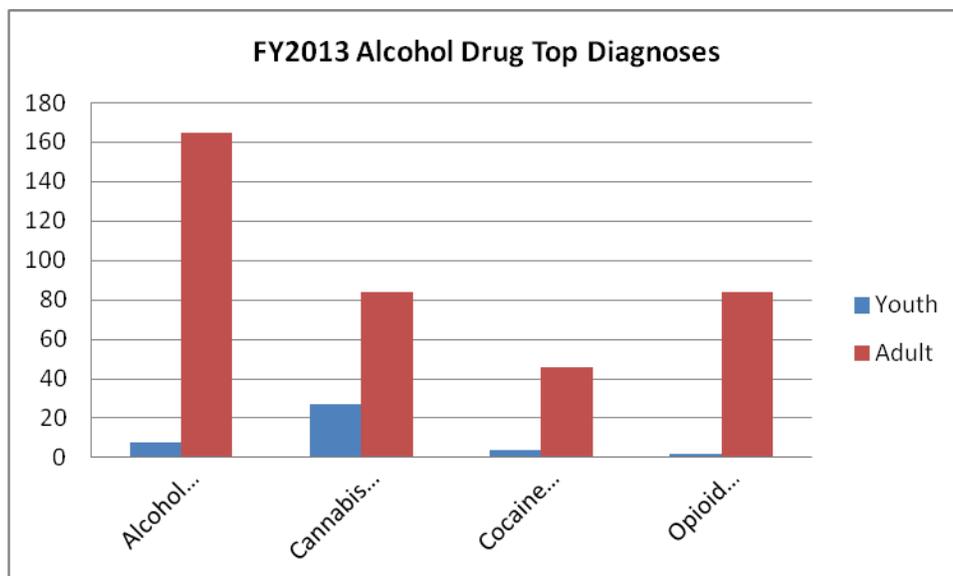
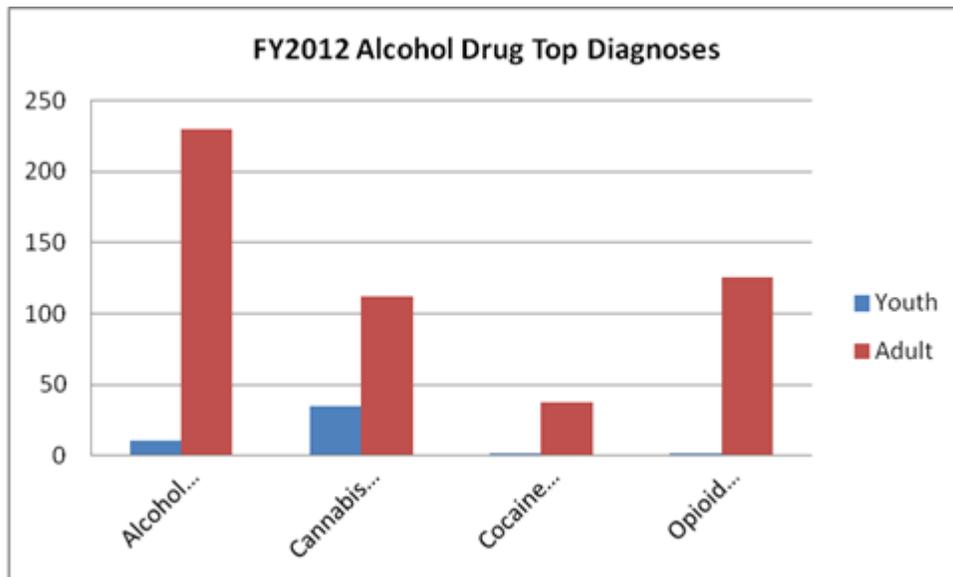
*Does not include Medicaid claims

The information below is based on data in the BH Module and reflects an unduplicated count of persons—both Erie and Ottawa County residents of all ages—receiving one or more mental health and/or alcohol/drug treatment services through the Board. It is important to note that these figures do NOT include peer/self-help or Recovery support services; supportive employment; housing and support services; and prevention, education, consultation and intervention services. These services and programs are important components of the mental health and alcohol/drug service continuum. Thus, the actual number of clients receiving services in a given fiscal year is higher than what is reflected above. Data was looked at for FY 09, FY 11 and FY 12. As described in the previous Plan, the Erie Ottawa system experienced a loss of consistent data for FY 10 as a result of the transition to the web-based BH system because our largest provider was unable to submit data until the batch process was functioning, approximately March 2010. BH data was collected by all providers on both mental health and alcohol/drug clients beginning FY 11, however the problems with the EDI upload and the BH module continued. Because of these issues along with the “loose” interpretation of so many of the fields, while we do have data it is not necessarily consistent and/or accurate across agencies in our system of care.

The general proportion of males to females served in both the youth (0-17) and adult (18-64) populations, for mental health and for alcohol/drug services, remained consistent across all three fiscal years. Of those receiving mental health treatment services, approximately 45% of adults were male and 55% female; for youth, approximately 60% are male and 40% female. For those receiving alcohol/drug treatment services, approximately 62% of adults were male, 38% female; for youth, approximately 75% were male and 25% were female. It is interesting to note that the proportion of males to females in the adult populations is almost reversed between those receiving mental health vs. alcohol/drug services.

In terms of race, we only looked at those reporting themselves as White or Black given the small numbers of clients reporting a different race category, along with the small percentage of the populations of both counties comprised by people reporting a race other than these. For adults receiving mental health services, approximately 83% were White and 14-15% Black across all three fiscal years. There was a little more variance in youth, with approximately 78-84% White and 11-15% Black. For those receiving alcohol/drug services, adults ranged from 79-84% White, 15-18% Black and youth ranged from 64-81% White and 18-24% Black.

About half of all youth and adults receiving AOD treatment in each of the three fiscal years examined identified courts or jail as the Referral Source. For adults, self-referral comprised about 20%, with the rest identified as referred by another provider (various). Self-referrals were a small proportion of youth receiving services, with the majority of those remaining reporting referral by another provider. For those receiving mental health services, a little over half of all youth and adults reported another provider (various) as the Referral Source, about a quarter reported "self" and about 10-12% reported courts or jail.



*FY 13 does not include Medicaid clients

As evident in the graphs, the majority of youth seen for treatment present with Cannabis-related diagnoses, followed by Alcohol-related. Conversely, Alcohol-related diagnoses remain the most prevalent for adults, followed by Cannabis and Opioid related ones at about the same levels. As reported in the SFY 13 Plan Update, opioid use among adults receiving service increased significantly between fiscal years 2010 and 2011, and appeared to be at the same or slightly increased level for FY 2012. FY 2013 data is included here, however because of the lack of data related to Medicaid clients (not separated out in previous years) it is difficult to know if this upward trend has actually continued. It does appear that the relative proportion among the primary diagnoses across the substances reported is about the same with the exception of cocaine. For diagnoses related to this drug, the actual number of clients is slightly higher even without taking into consideration Medicaid clients, and the relative proportion in comparison to the other top diagnosis categories increased as well.

In looking at the FY 2013 client data more in depth, the number of persons in treatment for an opioid-related drug is higher if you also take into consideration those who reported use of those substances as secondary or tertiary drugs of choice. A total of 150 clients (unduplicated count; nine of those clients had two treatment episodes) receiving treatment reported using heroin or other opiates and synthetics; of these, 113 reported opioids as primary, 24 as secondary, and 13 as tertiary. Of those reporting opioids as primary, 35 reported no use of any other substances. Our data appears to mirror that reported by Ohio Substance Abuse Monitoring Network (OSAM) in the June 2012-January 2013 Drug Abuse Trends report for the Toledo Region, except that we saw a number of persons with primary opiate and synthetic use reporting the use of cocaine (crack and/or powdered) as a secondary or tertiary substance. According to their findings, when prescription opioids are used in combination with other drugs, alcohol and sedative hypnotics (benzodiazepines) are the substances most reported. Heroin is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics, and above all else, more heroin.

The perception that heroin and other opiate use continues to rise has been shared by local providers and referral sources as well as other stakeholders in the community. One of our providers, Sandusky Artisans, offers a range of Recovery support, peer and self-help services to persons suffering from substance use disorders and mental illness. The agency hosts many 12-step and other meetings including AA, CA, NA, CoDA, Al-a-Non, Al-a-Teen, and the Family-to-Family program with about 3000 people crossing the threshold each year. As such, they are often a first point of contact for persons in the community who are struggling with substance use disorders and at the beginning of the Recovery process. They have shared they have seen a surge in opioid-addicted persons. Similarly, the local Sandusky Crime Prevention Council has identified this as one of the biggest problems in the city.

As noted in the FY 12-13 Community plan, the percentage of total number of persons receiving alcohol/drug treatment services that were also noted as SMD/SED in the BH system increased substantially between FY 08 and FY 09: more than double for the adult population and by about 30% for the youth population. These figures held steady at 09 levels for fiscal years 11-12, with approximately a quarter of the adult population and over 60% of the youth population receiving AOD treatment denoted as such. This appears consistent with some of the feedback we have received from various referral sources (i.e. specialized docket court programs) and the subsequent identification of integrated treatment for persons with co-occurring mental illness and substance use disorders as a service need. As available resources have diminished and as the Board has worked to balance funds across the various population and service priorities, an unfortunate by-product has been greater specialization among service providers and less client choice among actual agencies. While each of our treatment agencies has at least some limited capacity for the provision of both mental health and alcohol/drug services, in essence we have a primary provider for each target population in each county. In both counties, the agency serving as the primary provider of alcohol/drug treatment services to the adult population is different than those serving as the primary providers of mental health treatment services for both the general outpatient adult population as well as for adults with Serious and Persistent Mental Illness. Despite the fact that the agencies work closely to coordinate services, it can present problems for a client in the event he/she must be involved with two separate agencies in order to obtain the appropriate level of care and/or service mix or when two members of the same family are involved with different agencies during the course of service.

Children/Youth Services

As a priority population, we consistently monitor trends in service/fiscal utilization, referral patterns, and client characteristics. Based on our Continuous Quality Improvement (CQI) Planning process, funds are designated each fiscal year for prevention and treatment services for children, youth and families, along with various program and service requirements. Over the past several years, this has resulted in a richer array of programs, helped fill gaps in the service continuum, and led to increased access to care.

The numbers below reflect the total number of youth receiving alcohol/drug and mental health treatment services by Board-contract providers. They do not include Erie-Ottawa youth receiving services from out-of-county providers (primarily Medicaid), nor do they include youth receiving only prevention, education, or consultation services or those billed to non-Medicaid covered service categories such as Family Counseling and Intervention. These services—including programs such as LifeSkills or P.O.W.E.R. (school-based prevention programming), Strengthening Families, and Early Childhood Mental Health Consultation to name a few—are an important component of the continuum.

Number of Youth Served

Fiscal Year	Total # Youth	# Youth non-Medicaid	# Youth with Medicaid	% Youth with Medicaid
2008	1019	264	755	74.09%
2009	995	231	764	76.78%
2010	973	181	792	81.40%
2011	923	149	774	83.86%
2012	1031	152	879	85.26%
2013*	X	160	X	X

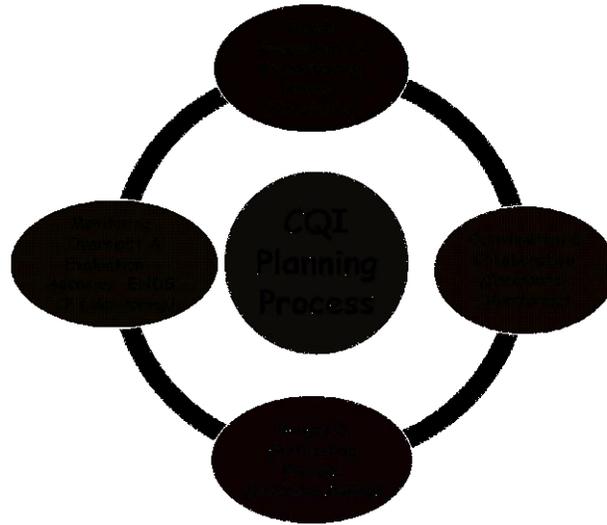
*Administration of the Medicaid program was elevated to the State beginning FY 13; as such, claims for persons covered by Medicaid no longer flow through MACSIS and the Board does not have access to that data

While there were fluctuations in the total number of youth served across the period examined, the percent of youth served with Medicaid coverage hovered around 75% for fiscal years 2008-2009 (and conversely, around 25% of the total for non-Medicaid), jumping to 81.4% in FY 10, with slight increases each year thereafter. As noted in the discussion above, a decrease in the number of non-Medicaid youth served post FY 09 was expected as a result of the significant reduction in state revenue the latter part of 09 and in FY 10-11. That is in fact evident here, although there wasn't as much a decrease in the overall number served as the percentage of youth with Medicaid increased during the same period; thus, some of the decrease in numbers can be explained by a shift in payer source.

Assessment of Need and Identification of Gaps and Disparities

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gap issues and disparities, if any. (NOTE: ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils; and, (2) outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals)

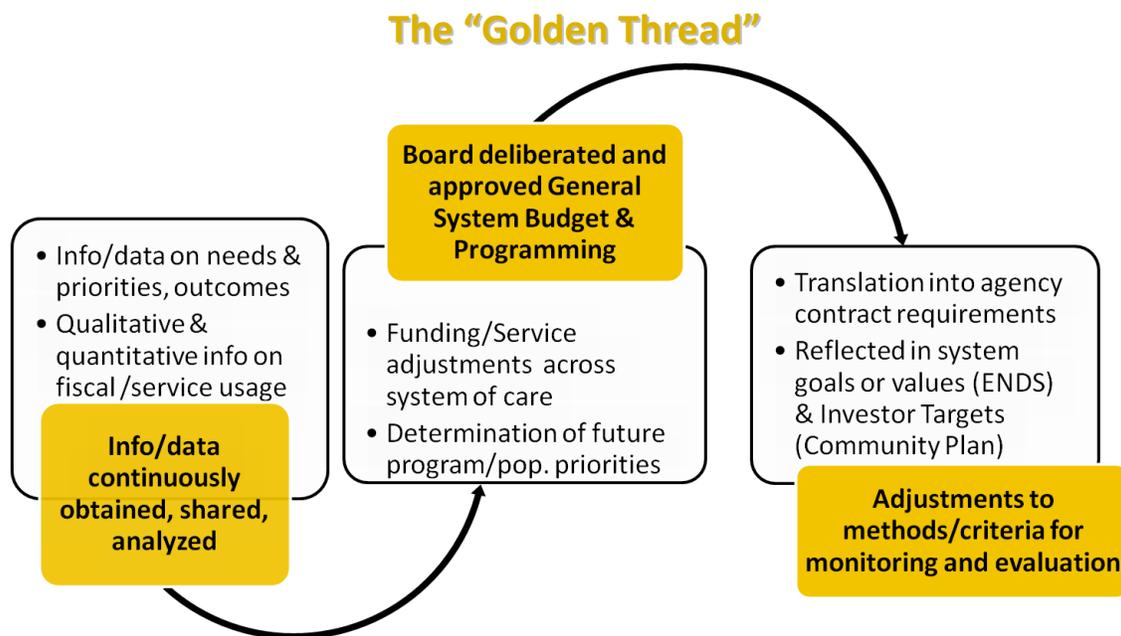
Continuous Quality Improvement (CQI) Planning



The Board employs an outcomes-based or CQI planning framework to ensure that we regularly pay attention to the conditions and constraints that define the need for mental health and alcohol and other drug prevention, treatment and support services—environmental and legislative contexts; the needs of clients, families, and community entities; specific service or program, population and other priorities; and the identification of outcomes and benefits. Activities related to needs assessment, planning, monitoring and evaluation processes occur on a daily basis, via both formal and informal mechanisms. The processes the Board uses to determine current behavioral healthcare needs and to monitor and evaluate the benefits of the system and provide information about goals or values, service and program activities, outcomes and costs are multi-faceted. Methods and criteria used range from examination of patterns of service use in the Board area—including amounts and types of services by specific client demographic and diagnostic characteristics—to reviewing cost delivered by unit of service, service pattern, client characteristics and provider agency to analyzing data on consumer outcomes. Program Reports containing qualitative and quantitative information on programming, numbers served, access and service capacity are submitted by provider agencies and reviewed in quarterly Systems Integration meetings. Progress Reports with information on key fiscal, program, reporting and administrative factors are shared quarterly with the Board of Trustees. The board works with providers and others to continuously review, refine, and amend the process and methods used in our system evaluation efforts, addressing issues such as what data or information is collected, the format and timelines for reporting, the use of data and information, and dissemination of program & service information for the system. This is an important component of the system CQI process as we work collaboratively to develop useful reporting and monitoring report formats and timelines while minimizing unnecessary administration.

Along with the qualitative and quantitative information and data obtained through the various needs assessment strategies and activities, information learned as a result of the Board’s monitoring and evaluation processes is used to inform decisions around funding priorities. In addition, the Board’s ENDS and values (priorities) as set forth in [Policy IV-A: Principles, Values and Organizational Purpose](#) of the governance policies provide direction for the determination of priorities, as do priorities and goals as defined by Ohio MHAS. The investment of resources specific to the set of values and/or relative to any individual priority area varies based on available funds and changing or emerging needs and priorities, as informed by review and analysis of quantitative and qualitative data from the various and ongoing needs assessment and evaluation processes. The goal is to balance programming and funding across system program & population priorities within the context of funding and policy constraints. Results of the various activities are integrated into the CQI planning process and inform individual service/program decisions as well as the development of and changes

to the overall continuum of care. Because they are ongoing, there is a continual reassessment of needs, programs and outcomes/benefits and how they will be used to direct the plan for the system of care.



In summary, the activities related to planning that occur on a daily basis---

- ✓ Informal and formal opportunities for community feedback
- ✓ Regular collection, analysis and use of data and other information to monitor service delivery and outcomes and inform practice
- ✓ Focused reviews and response to identified issues
- ✓ Flexibility and adjustments to system funding and/or programming in response to changing needs or other data related to efficiency and effectiveness
- ✓ Explicit and open deliberation and decision-making processes

---are regularly incorporated into the process used by the Board to determine its most important investment areas. Together, these components comprise our efforts to provide a community behavioral health care system that is responsive, flexible and outcome-oriented and is based on the changing needs of the communities and the persons experiencing mental health, alcohol and/or drug addiction problems.

STRATEGY AND METHODOLOGY

The following description summarizes the general qualitative and quantitative data sources and types, strategies, methodology, and time frames used in the needs assessment process. Because of the close relationship between many of these strategies—particularly interactions with Key Informants—and the various collaborative efforts of the Board with other systems and entities described later in the Plan, please refer to the question on collaboration as well.

In addition to formal Board-specific or board-initiated needs assessment activities, staff and trustees work in collaboration with other county and organization needs assessment and strategic planning processes. These partnerships occur in many ways including financial support, representation, and leadership. Furthermore, duplication of effort and expense is minimized, and shared investment in the process results in a more cohesive process, the determination of mutual priorities, and the development of a more comprehensive and coordinated plan or response to identified needs or gaps in resources and services. These are listed below under the heading “Collaborative Initiatives” below; note however

that data and findings from these efforts are used as part of the data surveillance process as well.

Data Surveillance

Review of multiple primary and secondary data sources concerning mental health issues; alcohol, tobacco, and other drug use; county economic indicators; crime statistics; demographic information; population and service utilization data including:

- Service and fiscal utilization data from MACSIS; client demographics and other population characteristics reported in the Behavioral Health Module
- Program/Service information (i.e. quarterly Agency Program Reports, Independent Peer Review, non-Medicaid contract conformance reviews)
- U.S. Bureau of Census data—population demographics, poverty, households, employment, education, income
- County Job and Family Service (JFS) data—child abuse and neglect cases, number of children in custody/placement, Medicaid enrollment and other statistical and demographic data from the Erie and Ottawa County Profiles
- Ohio Department of Education data—school discipline, graduation rates, student population characteristics for local school districts/buildings
- Juvenile and Adult Court data—statistics on charges/offenses; DYS commitments; and information on utilization, client characteristic and outcomes for participants in various specialized docket programs
- 2010, 2011, 2012 Ranking of Ohio County Unemployment Rates (ODJFS, Office of Workforce Development)
- Incidence, prevalence and related data on substance use and mental health issues—National Survey on Drug Use and Health (NSDUH), SAMHSA, Centers for Disease Control and Prevention (CDC)
- 2012, 2013 County Health Rankings, Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute
- Ohio Department of Health statistics
- 2010 Ohio Family Health Survey (OFHS)
- Ohio Automated Rx Reporting System (OARRS) statistics
- My Outcomes Data (for Board-contracted treatment providers)
- Ohio's Statewide Epidemiological Outcomes Workgroup (SEOW)
- Ohio Substance Abuse Monitoring Network (OSAM) Drug Abuse Trends-June 2012 and January 2013 Reports

Collaborative Initiatives

- 2008 Erie County Community Health Assessment
- 2012 Erie County Community Health Assessment
- Erie County Health Assessment-2011/2012 Children with Special Needs Health Assessment Report
- Erie County Community Health Improvement Plan (CHIP)—2013-2015
- Partners for Prevention of Erie County Coalition Strategic Plan
- 2006 Ottawa County Community Health Assessment
- 2012 Ottawa County Community Health Assessment
- O.C. FCFC Cradle to Career Mapping—county resource assessment/index
- Ottawa County Family and Children First Council Shared Plan-SFY 13 Update
- Erie County Family and Children First Council Shared Plan for SFY 13

Key Informants

Board staff consistently receives information and data on identified behavioral health service needs, implementation issues, and desired programming through regular and active involvement, coordination and collaboration with providers, service agencies, referral sources, and other community partners. This kind of interaction with Key Informants is on-going,

up-to-date, and feedback-driven so that the information exchange is always timely. It includes routine but essential interaction and coordination activities as well as opportunities designed specifically to solicit feedback on a given issue, such as targeted focus groups.

Public Forums

Public forums are hosted by the MHRB Board of Directors each year. The events, hosted in May and June, are opportunities for residents to provide input on the mental health and alcohol/drug addiction service needs of clients, of families, and of the community as part of the overall needs assessment and prioritization process. Both meetings are open to all Erie and Ottawa county residents and are held prior to the regular board meetings. Feedback from local residents and community members as well as input from community partners, referral sources and service agencies is encouraged. The date, time and location of the forums is advertised and posted in accessible community locations, on the website and/or communicated through notices or invitations. During these forums, a special effort is made to encourage consumer input from both Erie and Ottawa Counties, facilitated by the peer/self-help and Recovery support service providers with which the Board contracts.

In addition to these two “formal” venues for community input, there are opportunities for public comment at every Board meeting as incorporated into monthly meeting agendas. As is the case with the Public Forums, this time is set aside for persons to share feedback, comments or concerns.

Surveys

The Board has used surveys on many occasions as another means of collecting information on various topics related to the community behavioral healthcare system. General surveys are conducted at both the Erie and Ottawa County fairs each summer. The focus of the most recent survey was on attitudes and understanding of mental illness and addiction, and was administered with the intent of collecting information to help inform the Board’s public education and stigma reduction efforts. We have also conducted targeted surveys with stakeholder groups (i.e. child welfare, courts) on various issues and have used surveys with community agencies and organizations to identify available resources and programs currently available which address the prevention and treatment of mental illness and substance use disorders or that offer support services to persons experiencing these issues.

Focus Groups and Interviews

These tools have also been used to gather information about community needs and as part of the Board’s evaluation process.

NEEDS ASSESSMENT FINDINGS

GENERAL FINDINGS

2012 and 2013 County Health Rankings Results: While there was much useful information about a variety of health, social and economic factors and health outcomes, just a sampling is presented here. Erie County’s overall ranking in 2012 was 55th (out of Ohio’s 88 counties) and 54th in 2013; Ottawa County’s was 15th and 11th respectively.

Health Outcome/Factor	Erie 2012/2013	Ottawa 2012/2013	Ohio 2012/2013
Poor Mental Health Days (“Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”; average number)	5.9/5.0	3.8/2.4	3.8/3.8

<p>Excessive Drinking (percent of adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average)</p>	19%/20%	unreliable or missing data/same	17%/18%
<p>Inadequate Social Support (percent of adults without social/emotional support)</p> <p><i>* Social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to make healthy lifestyle choices than individuals with a strong network.</i></p>	22%/22%	11%/11%	20%/20%
<p>Children in Poverty (percent of children under age 18 living below the Federal Poverty Line-FPL)</p> <p><i>* Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors.</i></p>	24%/21%	16%/17%	23%/24%
<p>Children in Single-Parent Households (percent of all children in family households that live in a household headed male or female householder with no spouse present)</p> <p><i>* Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.</i></p>	32%/34%	28%/28%	33%/34%

Transportation Barriers

All of the county service systems are challenged by limited public transit services in both counties which impacts access to services, making engagement with and participation in services particularly difficult for clients with limited resources. Transportation issues especially present challenges for many of our clients, including those with involvement in the criminal justice system. For example, lack of transportation makes it difficult for individuals to comply with court-ordered programs and counseling, particularly in cases where the Defendant has lost his license; has little or no income; or lives outside of the county seats where many of the programs and services are located. As a result, counseling and treatment sessions are often missed, which then prompts a whole other set of consequences. The elimination of this barrier in complying would facilitate engagement in services and contribute to the successful completion of probation and other service system requirements as well as improved treatment outcomes.

Lack of Specialized Housing and Supports

In FY 13, the Board provided funding through a contract with Volunteers of America (VOA) of Greater Ohio for a total of 76 beds across the housing categories of ODMH licensed residential care and permanent supportive housing at a cost of \$734,470. In addition, the board provided funds for out-of-county residential placements for 31 clients needing a level of care or housing type not available in the Erie-Ottawa system or due to lack of capacity in the amount of \$384,438 for a total investment in housing and related supports of \$1,118,908 or 17% of the total revenue of the Board last fiscal year. \$137,268 of the out-of-county investment is the cost of a placement for just one individual with SPMI who is also a sex offender.

VOA also operates the Serenity House program, which provides supportive housing for homeless chemically dependent adults in a group living environment and scattered site apartments. Residents are expected to participate in recovery related activities such as treatment services at Bayshore Counseling and AA/NA/CA support groups. Program participants

may stay as long as 24 months, with an average length of stay around 12 months. This program is funded primarily by a Supportive Housing Program Grant from the Department of Housing and Urban Development. The funds from EOMHRB are used to pay for treatment services and case management from Bayshore Counseling and Recovery and provide valuable matching dollars for this grant which allows VOA to leverage more than \$290,000 annually. Maximum capacity at this time is approximately 30 individuals, although the number varies relative to the length of stay and mix of current program participants as these variables impact the amount of open slots in the men's and/or women's group home and the apartments.

Increasing capacity for housing and related supports and expanding the continuum of housing categories available locally have been identified priorities of the Board for several years. A critical tool for maintaining community recovery for some individuals is the ability to provide a secure residential setting. This was echoed by findings of a survey of boards about discharge barriers for individuals in the Regional Psychiatric Hospitals distributed by Ohio MHAS, in which 70% of participating boards indicated that the development of special needs secure housing alternatives would be helpful for consumers with complex needs. Currently, the only secure community options are nursing homes. Working with providers, the Boards of DD, NW Collaborative Boards, and representatives of the criminal justice system we have currently identified the following needs: 1) secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label; 2) housing options for individuals with co-occurring developmental disabilities/autism spectrum disorder and mental health/substance abuse issues that are not eligible under the DD system but who need housing; and 3) Recovery Housing.

Case Management and Service Coordination

The service definitions for case management and Community Psychiatric Supportive Treatment Services (CPST) are very specific and are based on medical necessity as are all covered treatment services. The clinical focus and the clear relationship of any activity to identified behavioral health needs on the Individual Service or Treatment Plan is very different from case management services provided from the traditional social services perspective and/or from those often allowed in or desired by other systems. For instance, transportation is not a billable case management activity; nor is attending an AA or other twelve-step meeting with a client. Yet these types of supportive services and activities are among those most often identified as needs—primarily by referral sources, and to a lesser extent, clients. We have worked in collaboration with various community partners in an attempt to address these concerns, at least for finite populations or in conjunction with specific programs—most notably specialized docket court programs—however it is consistently identified as a gap in the continuum of care.

Increased Opioid Abuse/Dependence: As noted in the previous section, we have seen an upward trend of persons in treatment with a primary opioid-related diagnosis at admission to treatment. Client reports of use of heroin, non-prescription methadone, and/or other opiates/synthetics appear to be on the rise as well, as primary, secondary or tertiary drug drugs of choice. As noted previously, local providers and referral sources have also noted a larger number of people seeking help for problems with opiate abuse/dependence. Quantitative data from a number of sources provide evidence of the impact use of heroin and prescription opiates and other synthetics is having on Erie and Ottawa Counties as well.

Findings on drug trends and availability in the Toledo region (which includes Erie and Ottawa Counties) reported in the January 2013 Ohio Substance Abuse Monitoring Network (OSAM) Drug Abuse Trend report indicate that both heroin and prescription opioids are “highly available”, rated as “10” on a scale of zero to ten with zero being “impossible” and ten being “extremely easy” to get. Echoing this, the BCI Bowling Green and Toledo Police crime labs reported that the number of powdered heroin cases they process has increased during the past six months; The BCI Bowling Green Crime Lab also reported an increase in the number of black tar heroin cases processed. Regarding prescription opioids, the BCI Bowling Green and Toledo Police crime labs reported that the number of prescription opioids cases they process has generally remained the same during the past six months; however, the Toledo Police Crime Lab reported an increase in Opana® and a decrease in OxyContin® cases processed.

As reported by OSAM and consistent with qualitative information obtained locally, study participants continued to note

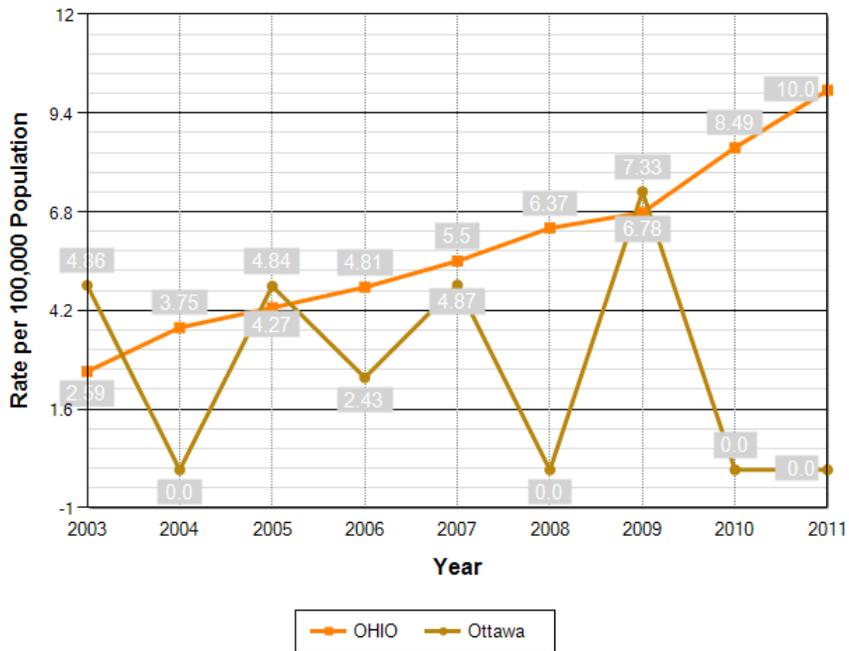
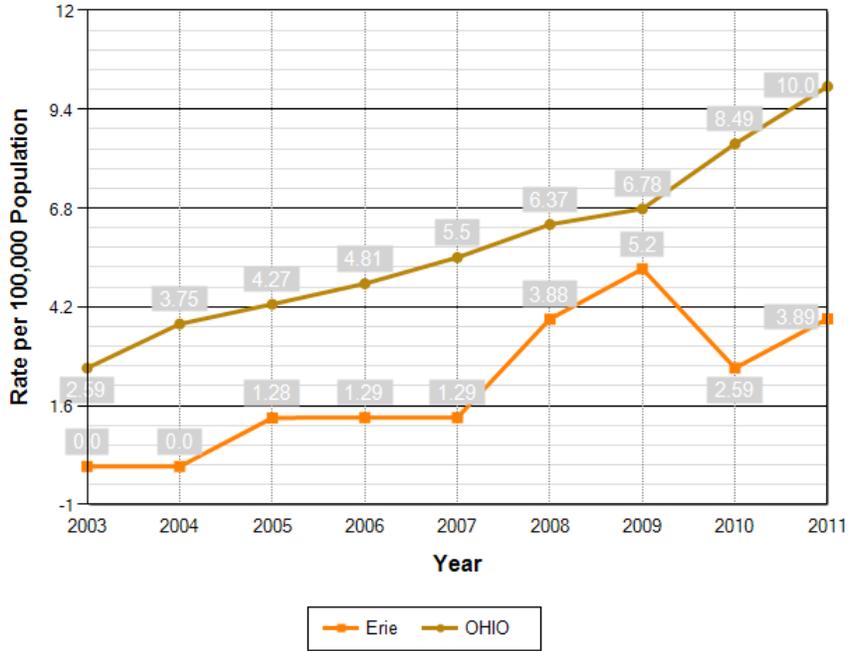
changes to the formulation of some prescription opioids aimed at making them more difficult to abuse as causing users to switch to heroin. Treatment providers noted the fact that heroin is cheaper than prescription opioids as the reason for the increase in popularity and availability of heroin. Many participants with experience using heroin report using prescription opioids first which seemingly led to heroin use; treatment providers also mentioned the glut of prescription opioids and the pill progression from prescription opioids to heroin users often undergo.

In terms of accessing these drugs, the report stated that in addition to obtaining prescription opioids on the street from dealers, participants also reported getting the drugs from emergency rooms, online, pain clinics and from Toledo and Michigan doctors. Some participants also discussed getting prescription opioids from seniors and others with chronic pain. OARRS data provided by the Ohio State Board of Pharmacy and the (former) Ohio Department of Alcohol and Drug Addiction Services contains statistics related to some of the prescription drugs dispensed to county residents. The Ohio Automated Rx Reporting System, or OARRS, is a prescription monitoring program that was established in 2006 as a tool to assist healthcare professionals in providing better treatment for patients with medical needs while quickly identifying drug seeking behaviors. Pharmacies licensed by the Ohio State Board of Pharmacy (including mail order pharmacies) are required to report to OARRS every week the prescriptions dispensed for all controlled substances, schedules II-V as well as Tramadol products (e.g. Ultram®), for all outpatients, residents in assisted living facilities, and some inmates (jails); patients excluded include hospital inpatients, residents of nursing homes, and some inmates (prisons).

Comparing OARRS statistics reported for the third quarter of 2012 and for the third quarter of 2013 for each county, the number of opiate and pain reliever doses dispensed remained relatively stable, rising about .8% in Erie County to 1,503,197 in 2013 and .5% in Ottawa to 729,690 over the period. In Erie County, the average number of doses per capita was 19.35 in 2012 and 19.50 in 2013; in Ottawa County, it was 17.53 and 17.61 respectively. The number of doses dispensed and the number of doses per capita of Depressants including Benzodiazepines remained about the same for both counties, while interestingly, the statistics reported for Stimulants increased across the reporting period. In Erie County, the number of doses dispensed increased by about 13% to 169,291 in 2013, and the number of doses per capita increased by about 13.5% from 1.94 to 2.20. In Ottawa County, there was a more modest increase of just over 4% to 91,430 doses and from 2.12 to 2.21 per capita.

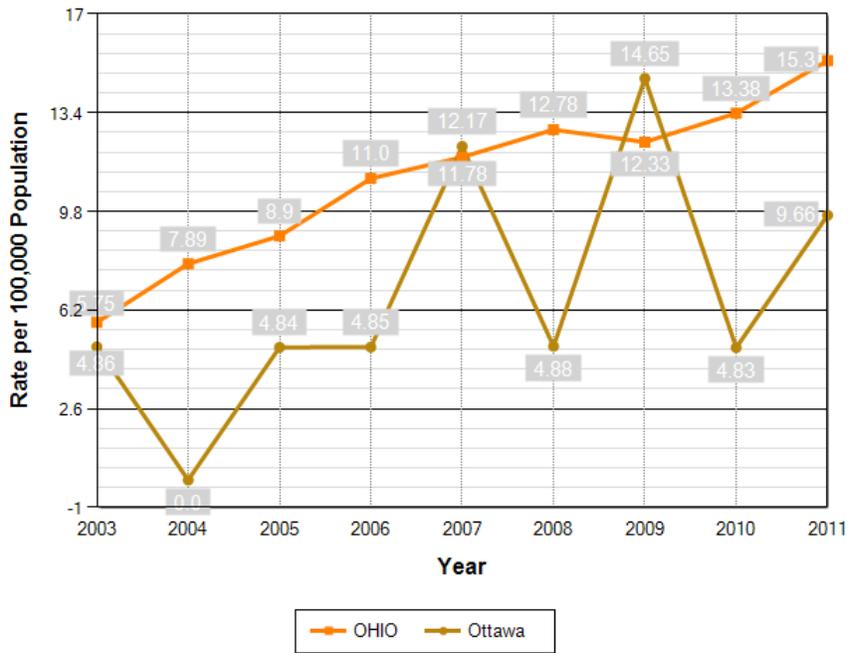
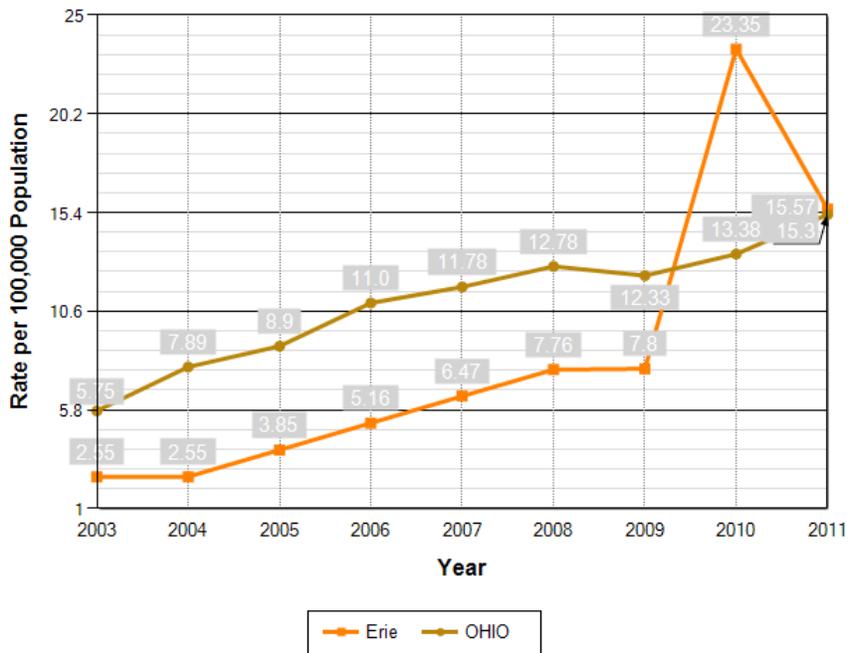
Finally, data available from the Ohio Department of Health on heroin and opiate poisonings and on the unintentional drug death rate also paint a grim picture. Unintentional drug overdose has accounted for the highest percentage of deaths in Ohio since 2007. In Erie County, there were no cases of heroin poisoning in the years 2002-2010, however the rate was 1.3 per 100,000 population in 2011. In Ottawa County, the rate per 100K was 2.43 in 2003 (much higher than the .76 rate per 100K for Ohio) and 2.41 in 2011 (Ohio rate was 3.69 per 100,000 population), but zero for the rest of the years in the period (2002-2011). Data for opioid-related poisonings is presented in the charts below. Deaths directly attributable to prescription drug use include drug psychoses, drug dependence, nondependent abuse of drugs, and polyneuropathy due to drug use. Deaths in which drugs may have been a contributing but not primary cause are not included. There is a lot of variability in the rate for Ottawa County, with sharp spikes upward—exceeding the rate for the state on several occasions. We do not know what factors contributed to this. The rate for Erie County, considerably lower than for Ohio, was more stable, steadily increasing until 2007 at which time there was a sharp upward spike in numbers for 2008 and 2009 followed by a sharp decrease in 2010.

OPIOID-RELATED POISONINGS



The graphs below show data on the unintentional drug death rate for each county. Indicator only includes deaths; illicit drug-related morbidity is not reflected. Deaths in which drugs may have been a contributing but not primary cause are not included. As apparent, there is again much more variability in Ottawa County, with sharp spikes up and down, than in Erie County, which showed a steady increase yet still below the rate for Ohio until 2009, at which time there was a sharp upward spike to almost double the rate per 100K population of the State. The rate for 2011 was back down, at 15.57, which is still slightly above the state rate of 15.3.

UNINTENTIONAL DRUG DEATH RATE



CHILDREN, YOUTH AND FAMILIES

As evidenced by the data below, several needs relative to children, youth and families were identified. While the percentage of both Erie and Ottawa youth seriously contemplating and/or attempting suicide remained stable or slightly decreased, any number is too high and the fact that 10% of youth are struggling with thoughts of suicide is troubling. Furthermore, the number of youth reporting they felt sad or hopeless almost every day for two weeks or more in a row increased in both counties to about 25%, and about 20% of youth in each county reported they have purposefully hurt

themselves by cutting, burning, scratching, hitting, biting, etc at some time in their life. Underage drinking continues to be a problem, with over half of youth between the ages of 12-18 reporting having had at least one drink in their lives. Given that the majority of youth who drink reported that a parent or someone over age 21 gave it to them or bought it for them, addressing this community problem will require a commitment to the enforcement of minimum legal age drinking laws and constant education of vendors, servers, and parents/guardians. Abuse of prescription and/or OTC medications is a problem, as 14% of youth in each county reported using medications that were not prescribed for them or taking more than prescribed to feel good or get high at sometime in their lives. Safety and violence are concerns as well, with half of youth in each county reporting they had been bullied in the past year and over a quarter reporting they had been involved in a physical fight.

There is an inherent complexity when addressing social, emotional and mental disorders in children and youth including differences in the primary mission or purpose of the many systems that work together on Youth/Family (Y/F) issues (i.e. Court's role is to respond to illegal behavior; the School's is to educate); funding issues (within and across systems) including inadequate funding levels as well as separate and restrictive eligibility, service delivery, administrative & reporting requirements; lack of comparable data and integrated information management systems; and issues related to service availability, capacity and coordination. In addition to the quantitative data presented below, other key findings and identified needs of this population from qualitative data and interactions with various community partners include:

- Need for flexible resources, possibly achieved through pooled/shared/braided funding among public and private agencies
- Sustainability of High-Fidelity Wraparound services
- Availability of non-clinical services and supports for families (i.e. in-home behavioral interventions, respite care, equine assisted therapy)
- Services for younger children with serious emotional disturbance (ages 8-11)
- Community alternatives to costly out-of-county placements in residential treatment facilities or foster homes
- Parenting Programming: education, training, mentoring, supportive services
- Timely and facilitated access to geographically feasible inpatient psychiatric hospitalization when needed

The issues around hospitalization services for youth who have been assessed to be in need have recently begun to take center stage, with Board-contract providers, Juvenile Court, the Sheriff's office and families expressing frustration about the process and the difficulties in finding and securing placements. In the past month or two in Ottawa County alone, there were three youth in need of hospitalization and the amount of time it took was excessive, tying up probation, the treatment agency and the sheriff's office staff for hours. In one case, it took two days of steady work before a placement was obtained—and that was in Youngstown (about 150 miles or a 2 ½ hour drive away)! Unfortunately, in one case the youth was placed in detention given the lack of other alternatives, despite acute behavioral health needs and the fact there was no criminal justice history. According to data collected as part of a NW Collaborative survey on psychiatric emergencies and placements, 177 Erie-Ottawa youth (ages 0-17) received emergency psychiatric services in FY 13; of these, 19 were admitted to a private hospital psychiatric unit and 2 to community-based crisis stabilization units. All of these placements were to out-of-county facilities, with the three top facilities used being Kobacher, Laurelwood and Toledo Hospitals. Crisis stabilization was provided through Rescue. The greatest challenges were noted as the length of time spent arranging for placements and the fact that hospital admission criteria varies from one facility to another.

Results of the 2010 Erie County Children (Ages Birth-11) Health Assessment:

- 27% of parents with children 6-11 years of age had an email, MySpace, or Facebook account and 43% of these same parents indicated that their child spends four (4) or more hours watching TV or playing video games on an average day after school.
- Erie County parents reported they find out about current health issues and where to get help from the following: their doctor or health care provider (68%), Sandusky Register newspaper (40%), websites (39%), neighbor or friend (30%), local radio station (22%), cable channel announcements (13%), Lorain Journal newspaper (5%), and church bulletins (3%).
- Parents discussed the following topics with their 6-11 year olds: negative effects of tobacco (80%), negative effects of alcohol (75%), negative effects of marijuana and other drugs (66%), and refusal skills (54%). 14% of parents did

not discuss any of the topics above with their 6-11 year old.

- 15% of parents reported that someone in their neighborhood has demonstrated mental health, alcohol, or addiction problems which have caused a disturbance of the neighborhood.
- 4% of parents reported that someone in their neighborhood has demonstrated mental health, alcohol, or addiction problems which have contributed to difficulty in parenting their child.
- 9% of mothers of 0-5 year olds and 13% of mothers of 6-11 year olds rated their mental and emotional health as fair or poor. No fathers reported rating their mental or emotional health as fair or poor.
- 9% of parents reported their child received mental health care or counseling in the past year
- Parents were very concerned about the following: anxiety (7%); depression (6%); substance abuse (1%); how child copes with stress (22%); bullying (9%)

Results of the Children with Special Needs Health Assessment: The *Children with Special Needs Health Assessment Report* was commissioned by the Erie County Board of Health and the Erie County Board of Developmental Disabilities and was released in January 2012. It was the first attempt to collect information from parents/guardians of children ages 0-21 identified as having Special Needs in Erie County, as identified through programs of the Board of Developmental Disabilities, Jobs & Family Services, and the Northpoint Educational Service Center. While the report contained much valuable information, of particular relevance to behavioral health were the following findings:

- Approximately 40% of parents reported their child had an emotional, developmental or behavioral problem which needed treatment or counseling
- Erie County parents reported a doctor had told them their child had ADD/ADHD (25%); Depression, anxiety, or emotional problems (15%); Behavioral health issue (15%); Developmental delay (52%); Learning disability (40%)
- Compared to other children their age, parents reported their child had difficulties with the following: Speaking, communicating, or being understood (71%); Learning, understanding, or paying attention (65%); Taking care of themselves, such as eating, dressing and bathing (54%); Making and keeping friends (39%); Coordination or moving around, such as crawling, moving arms or legs, walking, running, (33%); With behavior problems (33%); With feeling anxious or depressed (26%)
- 38% of parents reported that because of a physical, mental or emotional problem, their child has difficulty finding a program that offers any activity, such as sports, social groups, compared to other children their age
- RE: access and utilization: 2% of participants reported they had been referred to a mental health doctor but did not go, 26% were referred and went, and said they did not look or it wasn't applicable
- 55% of parents rated their mental and emotional health as excellent or very good

Erie County Health Assessment, Adult & Youth (surveyed 2011, released 2012): Findings from the 2008 health assessment were reported in the FY 12-13 Community Plan. While some new information was collected in this survey, in many cases the same questions were selected in order to look at change, trends. As applicable, that information is repeated here, with the findings from the 2011 assessment noted in red.

ERIE COUNTY YOUTH

Mental Health Related Findings:

- 22% **26%** reported they felt sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities
- 11% **10%** reported seriously contemplating suicide in the past year with 6% **6%** attempting
- 21% of youth purposefully hurt themselves by cutting, burning, scratching, hitting, biting, etc at some time in their life (**2011/2012**)

Bullying, Safety and Violence Related Findings:

- 3% stayed home from school at least one day in the previous month because they did not feel safe either at school or on their way to or from school (**2011/2012**)
- In the past year, 33% reported they had been involved in a physical fight (**2011/2012**)
- 49% **51%** reported they had been bullied in the past year

- Of those youth who were bullied: 37% **37%** were verbally bullied (teased, taunted or called you harmful names); 30% **27%** were indirectly bullied (spread mean rumors about you or kept you out of a “group”); 13% **13%** were physically bullied (you were hit, kicked, punched or people took your belongings); 12% **12%** were cyber bullied (teased, taunted or threatened by e-mail or cell phone)
- Parents discussed the following with their 12 to 17 year old in the past year: importance of education (55%), dating and relationships (53%), negative effects of alcohol (52%), negative effects of tobacco (49%), negative effects of marijuana and other drugs (46%), screen time (46%), friendships (45%), eating habits (43%), school/legal consequences of using tobacco/alcohol/other drugs (41%), bullying (39%), energy drinks (38%), refusal skills/peer pressure (37%), abstinence and how to refuse sex (36%), condom use/safer sex/STD prevention (36%), body image (35%), social media issues (34%), negative effects of misusing prescription medication (33%), anxiety/depression/suicide (30%), and birth control (25%) (**NEW**)

Alcohol/Drug Related Findings:

- 57% **48%** had at least one drink of alcohol in their life; 14% **17%** had used marijuana at least once in the past 30 days
- 11% **14%** used medications that were not prescribed for them or took more than prescribed to feel good or get high at sometime in their lives
- 44% **42%** of youth who reported drinking at sometime in their life had their first drink under the age of 12; 30% **34%** between the ages of 13 and 14; 22% **24%** between the ages of 15 and 18
- 31% **33%** of youth who drank alcohol said someone else bought it for them; 16% **31%** said a person 21 years or older gave it to them; 12% **22%** said a parent gave it to them; 7% **9%** said they took it from a store or family member; and 3% **8%** said they bought it at a store or gas station. 26% **21%** reported they got their alcohol some other way.

Perceived Risk of Drug Use (2011/2012)

How much do you think people risk harming themselves if they:	No Risk	Slight Risk	Moderate Risk	Great Risk
Smoke cigarettes	9%	13%	25%	53%
Smoke marijuana	16%	20%	17%	47%
Drinking alcohol (such as beer, wine, or hard liquor)	8%	20%	35%	37%

Degree of Disapproval of Use by Adults (2011/2012)

How do you think your parent(s) or guardian(s) would feel about you:	Would Approve	Would Not Care	Disapprove Some	Strongly Disapprove
Smoking cigarettes	1%	4%	10%	85%
Smoking marijuana	2%	3%	9%	86%
Drinking alcohol (such as beer, wine, or hard liquor)	2%	10%	24%	64%

Behaviors of Erie Youth: Current Drinkers* vs. Non-Current Drinkers (2011/2012)

Youth Behaviors	Current Drinker	Non-Current Drinker
Have been in a physical fight in the past 12 months	52%	26%
Attempted suicide in the past 12 months	14%	4%
Have smoked in the past 30 days	39%	7%

Have used marijuana in the past 30 days	50%	5%
Have had sexual intercourse	58%	15%
Participated in extracurricular activities	62%	75%

*Current Drinkers are those youth surveyed who have self-reported drinking at any time during the past 30 days

Ottawa County Health Assessments, 2006 and 2012

Findings from the 2006 health assessment were reported in the FY 12-13 Community Plan. While some new information was collected in this survey, in many cases the same questions were selected in order to look at change, trends. As applicable, that information is repeated here, with the findings from the 2012 assessment noted in red.

OTTAWA COUNTY YOUTH

Mental Health Related Findings

- 13% **10%** reported they had seriously contemplated suicide in the past year, with 6% **4%** attempting
- 21% **24%** reported they felt sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities
- Youth reported they deal with anxiety, stress, or depression in the following ways: sleeping (42%), texting someone (37%), hobbies (34%), exercising (29%), talking to a peer (26%), talking to an adult (20%), eating (19%), praying (15%), using social media (13%), breaking something (11%), shopping (9%), writing in a journal (9%), smoking/using tobacco (7%), drinking alcohol (7%), self-harm (6%), using illegal drugs (5%) (**2012**)
- 19% of youth purposefully hurt themselves by cutting, burning, scratching, hitting, biting, etc at some time in their life (**2012**)

Bullying, Safety and Violence Related Findings

- 3% **6%** stayed home from school at least one day in the previous month because they did not feel safe either at school or on their way to or from school
- In the past year, 30% **26%** reported they had been involved in a physical fight
- 50% reported they had been bullied in the past year (**2012**)
- Of those youth who were bullied: 39% were verbally bullied (teased, taunted or called you harmful names); 24% were indirectly bullied (spread mean rumors about you or kept you out of a “group”); 11% were physically bullied (you were hit, kicked, punched or people took your belongings); 15% were cyber bullied (teased, taunted or threatened by e-mail or cell phone) (**2012**)

Alcohol/Drug Related Findings

- 66% **59%** had at least one drink of alcohol in their life; 14% **9%** had used marijuana at least once in the past 30 days
- 15% **14%** used medications that were not prescribed for them or took more than prescribed to feel good or get high at sometime in their lives
- 38% **34%** of youth who reported drinking at sometime in their life had their first drink under the age of 12; 32% **30%** between the ages of 13 and 14; 21%, **36%** between the ages of 15 and 18
- 37% **34%** of youth who drank alcohol said someone else bought it for them; 30% **32%** said someone over the age of 21 gave it to them; 25% **28%** said their parents gave it to them; 11% **7%** said they took it from a store or family member; and 15% **4%** said they bought it in a store or gas station. **22%** reported they got their alcohol some other way.

ADULTS

Feedback from both community members and key stakeholders indicates timely access to services—assessment, treatment, and psychiatrist/medication—are important. Similarly, the availability of crisis intervention and hotline services, “safe-site” locations for crisis/emergency assessments, and suicide risk assessments were deemed critical. The need for detox services and residential and/or inpatient treatment for substance use disorders—especially heroin and

other opiates—has also been identified as a need by various stakeholder groups including courts, consumers, family members and coalitions or task forces such as Weed and Seed and the Sandusky Crime Prevention Council. Integrated treatment for persons with co-occurring substance use and mental health disorders continues to be identified as a gap.

Many people/community agencies expressed a lack of information about what is available and how to find out, emphasizing the need for education and public awareness. Finally, an increased need for outreach, engagement and linkage services has been identified, partly as a result of the Conestoga Program, a neighborhood-based community development initiative of which the provision of mental health and alcohol and other drug treatment services to identified individuals in the target area is a primary component. The quantitative data presented below substantiates these needs and provides additional valuable information about the scope and degree of alcohol and other drug use and related problems.

Erie County Health Assessment, Adult & Youth (surveyed 2011, released 2012): Findings from the 2008 health assessment were reported in the FY 12-13 Community Plan. While some new information was collected in this survey, in many cases the same questions were selected in order to look at change, trends. As applicable, that information is repeated here, with the findings from the 2011 assessment noted in red.

ERIE COUNTY ADULTS

Mental Health Related Findings

- 17% **18%** rated their mental health as not good on four days or more in the previous month; 11%, 8 or more days
- 11% **20%** reported poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation.
- 4% **3%** considered attempting suicide, with 1% **1%** attempting
- 67% of adults indicated they always or usually get the social and emotional support they need. 7% reported they never get the social and emotional support they need (**2011/2012**)
- Erie County adults did not use a program or service to help with depression, anxiety or emotional problems for them or a loved one ion is repeated here, with the findings from the 2011 assessment noted in red.
- for the following reasons: cost (4%), inability to find a program (3%), had not thought about it (3%), fear (2%), high co-pay/deductible (2%), stigma of seeking mental help (1%), primary care doctor did not discuss these issues (1%), primary care doctor did not refer them to a program (1%), other priorities (1%), and other reasons (2%) (**2011/2012**)

Alcohol/Drug Related Findings

- 17% **19%** were considered frequent drinkers (drank an average of three or more days per week, per CDC guidelines)
- 39% **50%** of adults who drink had five or more drinks on one occasion (binge drinking) in the past month.
- 28% **32%** drove after having alcoholic beverages
- 2% **3%** had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months
- 8% **10%** had used recreational drugs such as cocaine, methamphetamine, heroin, LSD, inhalants, Ecstasy during the past 6 months

Ottawa County Health Assessments, 2006 and 2012

Findings from the 2006 health assessment were reported in the FY 12-13 Community Plan. While some new information was collected in this survey, in many cases the same questions were selected in order to look at change, trends. As applicable, that information is repeated here, with the findings from the 2012 assessment noted in red.

OTTAWA COUNTY ADULTS

Mental Health Related Findings

- 15% **11%** had a period of two or more weeks when they felt so sad and hopeless nearly every day that they stopped

doing some usual activities

- Almost twice as many women (22%) as compared to men (13%) reported poorer mental health in the past 30 days (2006)
- 8% were diagnosed or treated for a mood disorder in the past year, 4% for an anxiety disorder, less than 1% for a psychotic disorder, and 1% for some other mental health disorder; 8% indicated they had taken medication for one or more mental health issues (2012)
- 3% 5% considered attempting suicide in the past year; 0% 1% attempting

Alcohol/Drug Related Findings

- 28% 18% of Ottawa County adults were considered frequent drinkers
- 31% 24% of those who drink were binge drinkers (5 or more drinks for males and 4 or more for females on an occasion)
- 4% 4% of those adults who drank reported driving after having too much to drink
- 8% 9% had used a medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 11% for those under 30 y.o.
- 5% 4% reported use of recreational drugs in the past 30 days
- 2% 4% used marijuana in the past 6 months

SPECIAL POPULATIONS

INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM (ADULTS AND CHILDREN)

The following list is a summary of needs identified through the various data sources, strategies and methodologies used in the needs assessment process for this target population:

- Maintenance of funding for Crisis Intervention Training
- On-site services at the Juvenile Detention Center—need for prevention, intervention, treatment services, crisis intervention & mental health/suicide screening and follow-up
- Maintenance of and/or increase in behavioral health services to inmates in the jail—assessment, individual counseling, groups; crisis/emergency services
- Issues around psychiatric medications were identified as particular concerns—the cost to jails, prescriptions/supply upon release of inmate, timeliness and notification relative to linkage with agency for Pharmacologic Management Services
- Linkage and transition to community services for persons being released from jail/prison
- Standardized jail assessment/screening form and/or protocols for following up on mental health screens conducted at intake
- Case management services—clinical definitions based on medical necessity deemed too narrow to meet needs of clients for transportation to counseling and other appointments, linkage with other community services (i.e. going to AA with client, helping client with applications for assistance/employment)

Some recurring issues related to this population group—specifically, domestic violence (DV) offenders—have been identified; many exemplify the need for protocols around court orders and coordination of who is responsible for payment of services, particularly in cases where the client is indigent. For example, often courts refer or order DV offenders to “anger management” classes, which is not always an appropriate disposition of cases. Instead, specialized DV programs, often gender-specific focusing on control issues, need to be accessed. At the same time however, declining budgets have resulted in limited capacity for specialized programming such as that for domestic violence or sex offenders, resulting in waiting lists at times. A further complication is the issue of requiring the offender to pay for at least part of the treatment, as is the current Board policy. In the past our MH professionals have stressed that requiring some payment can be an important part of therapy, because it holds them accountable as a literal and figurative investment in treatment. Judges, on the other hand, have been unhappy with this requirement if the defendant claims indigence yet have also not

provided funding in collaboration with the Board in support of the program. There is confusion as to why clients involved in the DV programs in our two agencies have a 25% co-pay while other clients receiving court-ordered treatment do not, regardless of the offense that brought them before the court. The providers have shared that the fee is often an issue for clients. Regarding the latter, the Board does have a general waiver request for client fees. These “financial hardship” cases are evaluated on a case by case basis. Based on Board approval, payment by the client can be waived or reduced and the Board will reimburse the agency.

Finally, there are ongoing concerns about access to both mental health and alcohol and other drug treatment services relative to implementation of HB 86, effective September 30, 2011, designed to divert low-level, non-violent felons from prison to community alternatives. There will be additional pressure on the system to the extent that this population needs behavioral health care—not only in terms of initial assessment and access to care but also in terms of outpatient treatment capacity, physician and medication services, and crisis intervention.

ADULTS WITH SPMI

As communicated consistently by consumers, family members and case managers/clinical staff of the treatment agencies, the sustainability of Consumer-operated and Peer/Self-Help agencies is viewed as critical for stability and maintenance of adults with SPMI in the community; as a recovery aid; for social/recreational opportunities; and social connections/friendships/support. In addition, assistance with housing—including supportive services—and medication was identified as an important need. In terms of treatment services, availability of case management, psychiatrists and pharmacological management services, and medications were identified as most important. While not services or supports provided under the public behavioral health system, the availability of community services such as the Food Bank, Disability Assistance (SSI, SSA), food stamps, Care-and-Share, WSOS, and Salvation Army were identified as a critical need.

CHILD SERVICE NEEDS RESULTING FROM FINALIZED DISPUTE RESOLUTION WITH FAMILY & CHILDREN FIRST COUNCILS

There has never been a formal dispute filed against the FCFC in either county. Per statute, both county FCFC’s have a dispute resolution process. In general, both note that the purpose of service coordination is to provide a venue for families needing services where their needs may not have been adequately addressed in traditional agency systems. Each agency system has areas of responsibility and the collaborative approach is not intended to replace or usurp the primary role of any one of these systems. Although agencies and professionals are committed to meeting the needs of the child and/or family there are times when one or more members of the team may question decisions or the process. In all instances families are encouraged to ask questions and become informed as to what is available, what their child might need, and what rights and responsibilities they have as parents. In general, potential conflicts could arise in between the family and one or more agencies, between the family and the service plan, or between/among different agencies with the service plan or with one another. If the dispute does not pertain to service coordination, parents or custodians shall use existing local agency grievance procedures to address disputes. Each agency represented on the FCFC that is providing services or funding for services that are the subject of the dispute initiated by a parent are required to continue the provision during the dispute process. There is more detail in each county FCFC’s respective service coordination plans as to the specific steps in the process, roles of respective parties and timelines.

As a matter of practice, Board staff as well as staff of provider agencies with which the Board contracts participate as necessary on Wraparound teams. Both Councils have mechanisms for initiating a process among members to negotiate funding and services outside of the local continuum of care that are necessary to meet the unique needs of the family. Both past and present, the Board has participated in shared funding arrangements for out-of-county placements in foster care or treatment settings. We also provide funds for wraparound or “other mental health services” as part of each of our treatment agency contracts; while limited, these funds are intended for use in securing needed services and supports outside the norm that are necessary for successful outcomes for a given client. This source of funds has been used in the past related to FCFC service plans for families with whom the agency is involved. The Board also maintains an “unbudgeted program” or reserve fund which can be drawn on if necessary, including for use in complying with child service needs resulting from a dispute resolution with FCFC Councils.

OUTPATIENT SERVICE NEEDS OF PERSONS CURRENTLY RECEIVING TREATMENT IN STATE REGIONAL PSYCHIATRIC HOSPITALS

For the most part, the needs of this population are similar to those described in the general “Adults” and “Adults with SPMI” sections above. This includes clinical services (treatment, pharmacologic management services) medication, case management, social/recreational and peer supports, transportation, food/clothing supports, housing and related supports and—in some cases—guardianship and/or payee services. Of course, those patients with NGRI or IST-CJ on conditional release in the community require Forensic Monitoring.

Often, most emergent needs are around stable and secure housing and medication. Case management or CPST service needs are often more intensive during and immediately after the transition to the community. Team meetings may be more frequent during these times, including involvement of the client and the guardian (including those made available through the Board’s Compensated Guardian Program) if applicable. For related information on this population, refer also to Question #9 on Inpatient Hospital Management and the description of the interaction between the local system’s utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports.

Strengths and Challenges in Addressing Needs of the Local System of Care

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. (*see definitions of “service delivery,” “planning efforts” and “business operations” in Appendix 2*).

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? (*see definition “local system strengths” in Appendix 2*).
 - a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

For the past several years, the Board has provided CFO services to the Huron County ADAMHS Board. Beginning in FY 13, they also contracted with us for MACSIS claims processing. These shared business operations provide our Board additional financial resources and collaborative knowledge sharing concerning State and local issues. The Huron County Board receives financial services, claims processing services and collaborative knowledge sharing. Furthermore, the alliance has resulted in improved efficiencies for both boards and provides a backup system for the smaller board.

Consistent with the Board value (as stated in our ENDS policy) to place a priority on establishing a stable and diversified economic base supporting local mental health and alcohol/drug services, we are active in the pursuit of additional funding through competitive application for numerous Local, State and Federal grants. These are mutual efforts involving collaboration with various community stakeholders.

The Board’s network of contract service providers is also a strength. Our service delivery system for treatment is comprised of three agencies: one that is based in Ottawa County, with offices located in several different communities and two based primarily in Erie County but that also have satellite offices in Ottawa County. There is an agency in each county that serves as the primary provider of mental health services to all adult populations and as the primary provider of both mental health and alcohol/drug treatment for children and youth. These agencies also have some funds to serve as a secondary provider for alcohol/drug treatment services for adults. The third agency serves as the primary provider of alcohol/drug treatment services for all adults, including special populations/programs, and has some funding as a secondary provider for the provision of mental health services for youth and adults and for alcohol/drug services for youth. This allows for

consumer choice for general outpatient or routine services and also facilitates access to care geographically. Additionally, prevention programming is primarily provided through two of these agencies, one in each county. All three are certified through both the (now former) Departments of Mental Health and of Alcohol and Drug Addiction Services and have national accreditation through CARF. In addition, all are stable and mature organizations, professionally managed, and financially secure. Crisis/emergency services are centralized, with our largest agency serving as the provider for the system of care. Similarly, a single agency manages the majority of the funded housing for clients with severe and persistent mental illness. The exception to this is funds for clients in out-of-county placements that are administered through “pass-through” contracts with our primary mental health providers. We also have three contract providers of peer/self-help and Recovery support services, fulfilling a valuable role in the local continuum of care.

The Erie-Ottawa MHRB is working with a variety of others around the integration of physical and behavioral healthcare, recently adding two new initiatives in partnership with Firelands Counseling & Recovery Services. Funding was provided for the program *From Cancer to Health™*, which helps people having emotional difficulties dealing with a recent cancer diagnosis. Participants learn coping skills and strategies to help manage stress and lessen the impact of physical symptoms of cancer. Research has shown the program helps people reduce stress, improve social support and communication with health care providers, and have fewer physical side effects from cancer treatments. The Board is also providing funds for lab work to monitor psychotropic medications and ensure compliance with medication protocols for indigent consumers with SPMI enrolled in the Health Home via a SAMHSA grant awarded to the agency. A Primary Care Practitioner and lab draw station were embedded onsite, making it convenient for the consumer to have everything done at once to monitor any routine health conditions and comply with psychiatrist orders to obtain blood work to monitor their psychotropic medications. The program has identified and diagnosed several very significant health care conditions that have been neglected and untreated for a long period of time because of the individual’s lack of resources. They have encountered major medical issues including serious heart problems, critically high blood pressure, untreated diabetes, breast lumps, rectal bleeding, and untreated infections of all types. Referrals were made to numerous specialists, and in two situations, the team feels there would have been a tragic outcome without immediate treatment. In addition, Emergency Room (ER) usage by program enrollees has been positively impacted, The agency examined Firelands’ ER usage for the Health Home participants for 1/12 through 5/12 before the program existed. They then compared that data with emergency room usage for those same clients from 1/13 through 5/13 (after the program began) and found that there was a 44% decrease in ER usage for the Health Home clients comparing these two time periods.

4. What are the challenges within your local system in addressing the findings of the needs assessment? (see definition of “local system challenges” in Appendix 2).
 - a. What are the current and/or potential impacts to the system as a result of those challenges?
 - b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

With the retirement of our Senior Program Consultant in April 2012, we moved to a total of five positions including the Executive Director, down from a full staff of seven. This has presented some challenges from an operational standpoint. A functional job analysis was conducted, with position descriptions revised to reflect different/additional duties. This was able to occur in part because of the reduced workload around enrollments and other business operations related to elevation of the Medicaid program and in part because the tenure and experience of remaining staff allowed the realization of efficiencies due to the streamlining of routine tasks, improvements in time management and organization, and other efforts. Still, the reduction in staff does have an impact on what new initiatives can be undertaken and/or the amount of attention that can be paid to “non-essential” but value-added activities related to planning and other Board responsibilities.

Another challenge has been around the recruitment and retention of Board members. For many years membership was stable, with most appointees serving two full terms. Between those members’ expiring terms and a variety of personal and professional issues resulting in the resignation of several of their replacements, we are left with a number of vacant

positions. Members of both staff and the Board have and are engaged in a variety of marketing and recruitment efforts in an attempt to obtain applications for consideration by the various appointing authorities. The Commissioners of both counties actively recruit potential appointees as well.

The unintended consequences of the transfer of administration of the Medicaid program to the state have resulted in some concerns as well. While Boards are no longer responsible for local match and were alleviated of the administrative tasks related to enrollment and payment of claims, the segregation of responsibility for a significant portion of the counties' population has resulted in some fragmentation of local systems of care and has made planning more difficult in many ways. Available data is limited and there is no ability to cross walk to historical data—a problem identified more in depth in Question 1. Moreover, categorizing clients by payer source (Medicaid versus non-Medicaid) tends to overlook the fact that Medicaid clients are major consumers of services that are paid for with non-Medicaid dollars such as crisis services, housing, vocational and peer support services. This makes it difficult to effectively provide coordinated care.

We have encountered some challenges relative to rules for the provision CPST service as well, both in relation to Health Homes and the service limits imposed as part of the Medicaid cost containment efforts. One of our major providers of treatment services to persons with SPMI currently has a SAMHSA grant for the establishment of health homes for the non-Medicaid population. In looking forward to statewide implementation of Health Homes for this population under the Medicaid program, they did an analysis on internal numbers using the proposed eligibility formula (which has since been revised). Based on the fact they only had access to Inpatient and ER costs for their own organization—Firelands Regional Medical Center—they ran a very conservative application of the Tier system using only the cost of CPST as criteria for inclusion across the entire seven county system where they provide services, acknowledging that some of those who do not qualify under the CPST expenditures may qualify under another cost criteria. According to that data, just over one third of the total population of adult Medicaid recipients who are SMI/SMD/SPMI would fall into Tiers 1 and 2. Applying the PM/PM rates to this population would be an increase of approximately \$335,251 over previous CPST revenues which will not cover the cost of building a system that includes the necessary supports needed for any primary care model to succeed with this population. Under the Phase I criteria the agency could have given all of the eligible individuals (especially those using the ER's for health care) quick and immediate access through the Health Home; under the Tier system however, two-thirds of the population would not qualify, many of whom need the service and the non-emergency access it provides to the medical community. Being unable to treat the lower end of the continuum pretty much eliminates the needed revenue to transform the BH system to the integrated system necessary to impact the extensive primary care needs of this population. This is unfortunate; as noted in the previous question on strengths, the results of the health home project under the SAMHSA grant have yielded surprising and impressive outcomes relative to identification of major medical issues and the reduction in use of the ER by enrollees. We are concerned that the current plan for implementation of the Medicaid Health Home will not allow agencies to provide the intensive support services at the Care Management and HH Specialist levels necessary to actually improve the health status of this population.

We have also experienced difficulties in circumstances where Erie-Ottawa residents are placed in group homes in Lucas County, which was part of the Phase I implementation of the Medicaid Health Home. Upon enrollment in the health home, case management and/or CPST billings are no longer permissible, yet the Board/contract agencies still have monitoring responsibilities and are still involved in case planning to some extent. In fact, upon placement the Board contract agencies have to sign an agreement which includes acceptance of the responsibility to pay for necessary behavioral health services not otherwise covered, lab tests or studies, and unreimbursed costs were the client to exhaust Medicaid service limits. The inability to submit claims for CM/CPST presents a hardship and impedes the ability of our agencies to provide the necessary monitoring and oversight. While the Board has devised another mechanism to reimburse the providers for these services in the interim, in essence it is a cost-shift.

A final challenge related to provision of the CPST service is related to service caps under the Medicaid system. As reported by providers, now that they are into year two of billing Medicaid through the state vs. the board they are beginning to see the effects of the caps for services. Upon implementation of the various cost containment measures, the Board considered

the feasibility of application of the same standards to non-Medicaid services for the purpose of consistency. However, as a result of the current inability of the Board and providers to easily track and monitor service provision at the individual level, the Board decided not to apply the service limits, tiered payment and prior authorization cost control measures under the community mental health Medicaid program to non-Medicaid services. The Board—like the majority of Boards across the state—also adopted a policy not to purchase and/or reimburse services delivered to Medicaid clients beyond the limits imposed under the Medicaid program as of July 1, 2011. Since presumably prior authorization is granted if medical necessity criteria are met, that adds another level to the decision as to whether another payer (the Board) would pick up additional service costs, as the issue of medical necessity is theoretically independent from payer source. We don't have a concurrent clinical review process for outpatient care or a prior authorization process relative to the non-Medicaid benefit package which further complicates things. According to providers, toward the end of FY 13 there were a number of clients that were going over the cap in CPST for whom prior authorization was requested for additional hours; however, this is a very involved process and takes a great deal of time and usually resulted in getting some hours but not enough to cover the number over the cap. The agencies did not discontinue services, providing what was needed despite the inability to submit claims. Of course, they can only provide a certain amount of non-reimbursable services before it begins to impact them financially. Similarly, there is concern about the caps on counseling since that is limited to 52 hours per year and is a combination of both individual and group hours. According to our agencies, some clients are in groups and are being seen individually as well, and 52 hours is simply not sufficient to meet the treatment needs in these cases.

5. Describe the Board's vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (*see definitions of "cultural competence" and "culturally competent system of care" in Appendix 2*).

Some general statistical data can be useful as a frame for the Board's efforts to establish a culturally competent system of care.

CITY OF SANDUSKY, ERIE COUNTY

This city has the highest prevalence of minorities in Erie County. The racial makeup of the city was 70.4% White, 22.0% African American, 0.4% Native American, 0.6% Asian, 1.1% from other races, and 5.5% from two or more races. Hispanic or Latino of any race were 4.9% of the population.

There were 11,082 households of which 29.4% had children under the age of 18 living with them, 32.9% were married couples living together, 19.7% had a female householder with no husband present, 5.2% had a male householder with no wife present, and 42.1% were non-families. 35.1% of all households were made up of individuals and 12.1% had someone living alone who was 65 years of age or older. The average household size was 2.28 and the average family size was 2.93. The median age in the city was 38.5 years. 23.9% of residents were under the age of 18; 9.3% were between the ages of 18 and 24; 24.2% were from 25 to 44; 27.7% were from 45 to 64; and 15% were 65 years of age or older. The gender makeup of the city was 47.6% male and 52.4% female.

CITY OF PORT CLINTON, OTTAWA COUNTY

This city has the highest prevalence of minorities in Ottawa County. The racial makeup of the city was 93.3% White, 2.3% African American, 0.1% Native American, 0.2% Asian, 1.8% from other races, and 2.1% from two or more races. Hispanic or Latino of any race were 7.8% of the population.

There were 2,633 households of which 27.9% had children under the age of 18 living with them, 42.2% were married couples living together, 13.9% had a female householder with no husband present, 5.2% had a male householder with no wife present, and 38.7% were non-families. 33.6% of all households were made up of individuals and 12.8% had someone living alone who was 65 years of age or older. The average household size was 2.24 and the average family size was

2.81. The median age in the city was 41.5 years. 22.1% of residents were under the age of 18; 7.8% were between the ages of 18 and 24; 24% were from 25 to 44; 28.5% were from 45 to 64; and 17.6% were 65 years of age or older. The gender makeup of the city was 47.8% male and 52.2% female. The poverty level for Port Clinton is 9.7% and for Sandusky it is 15.3% (2010 Census). For prevalence of BH problems it is 15.38/per 100 in Port Clinton vs. 18.18/per hundred in Sandusky (MHRBEO and Census data).

We note that the recently-released Erie County Health Assessment found that African-American residents repeatedly accessed important health services less frequently than Caucasian residents. By focusing on the entire population of specific geographic areas, including the Sandusky Southside Neighborhood, which has a concentrated minority population, we expect to reduce that disparity. We believe that this project can learn much from the Center for Cultural Awareness, which has a magnificent record of making service access and utilization uniform across racial and cultural boundaries.

Historically, the percentage of African Americans enrolled in treatment programs of Erie and Ottawa Counties is 19.7% of males (n=402) and 12.6% of females (n=203), or 605 divided by 3645 = 17%. But population figures from 2010 census show the % populations of African-Americans to be 8.64% in Erie, and 0.65% in Ottawa Counties. Thus, it makes sense for Erie and Ottawa Counties to focus on the two major cities of Sandusky and Port Clinton to promote culturally competent engagement for BH services.

The leadership of the Mental Health and Recovery Board of Erie and Ottawa Counties (MHRBEO) is firmly committed to the advance of cultural competence, including taking affirmative action to reduce the discrepancies between the desired goals, eloquently articulated by Ohio's State Interdepartmental Definition of cultural competence. The Board's executive director is currently the AA-EEO officer of the Board, and has held during his career similar positions with Portage County, Geauga County, Wilmington (Ohio) College, and Lake County ADAMHS Board. The MHRBEO's current Chair is a highly respected member of the African-American Community in Sandusky, in Erie County.

Policies, procedures, and contracting are in place to further this goal. Data is kept through the existing State system on race, ethnicity, gender, and age in order to keep track of our ability to meet our AA-EEO goals, which are important measurement tools to further cultural competence. This data can be pulled and analyzed at any time by our MIS staff and Executive Director to set and monitor realistic timelines for achievement of progress. Contracting includes the provision of services from the Center for Cultural Awareness to engage the local minority population and thus facilitate entry into certified treatment programs. This leadership helps act as a "Front Door" through which stigma can be reduced and therapeutic enrollment increased.

The recommended services are focused on each client's specific needs, of which cultural needs are a major factor, by the Individualized Services Plan (ISP) written for each client. In this plan, the client and family's cultural background is taken into account in determining when, how, and where services will be offered. Over time, we hope to shift more emphasis on making the ISP, and measures to support it, a key objective of the planning and funding process.

The ISP includes substantial input from the consumer, family members, other treatment and community support organizations, and client advocate if available. Much of this opportunity for input comes from the Continuous Quality Improvement (CQI) process which the Board follows, including ample opportunity for testimony in public forums, open meetings, and guest comment periods on the agenda of each Board Monthly meeting. In addition, both the MHRBEO and its contract agencies have requirements in support of cultural competence due to other legal and certification requirements. These other requirements have only gotten stricter due to the implementation of the Affordable Care Act. Agency hiring practices include outreach and recruiting efforts which encourage minority hiring in accordance with standard AA procedures. EEO success is demonstrated, at least in part, by the fact that all three major treatment agencies have directors who are by gender members of protected classes. For the Board staff itself, 2 of 3 executive positions are held by such members.

Staff training in cultural competence theory and practice is provided by the Executive Director, most recently in 2010. Topics include the background and evolution of AA-EEO necessity, monitoring data and establishing patterns of

underutilization of protected classes, developing a plan to ameliorate identified patterns, identifying points in the hiring/promotion process where such underutilization can be corrected, and means to corrected those weak points in the hiring/promotion/compensation process. Since we are also a system serving disabled persons, Americans with Disability Act (ADA) data and requirements are also discussed and analyzed.

Interacting with adults, children and families in culturally and linguistically competent ways requires training, sensitivity, and tactfulness as well as data collection to measure success of engagement. For just one example, an African-American youth in a classroom or therapeutic session may avoid eye contact, display a bored countenance, and pick up no verbal cues at first. It is easy for a naïve therapist or case manager to become irritated or frustrated at such appearance of not paying attention to what is being said. But with experience **and support from other staff members familiar with this culture**, the agency staff member learns to be patient as the client develops more trust and empathy with the services provider. It is always important for staff to be culturally sensitive to the **place and type** of services made available to the adult, child and family. For example, one agency (Bayshore Counseling Services) recently added more evening and weekend hours so that clinical staff could be more available to lower-income persons who do not have the flexibility to simply “take off from work” whenever a medical appointment is scheduled. For them, vacation and sick leave may be non-existent, so appointments during normal “business hours” can’t be accessed. Additionally, another Board agency (the Sandusky Artisans Community Support Center) offers a place which is not intimidating to the person with humble background, does not require appointments, and yet has a wide range of 12-step and Recovery Coach options with which to help a substance abuser or addict steer toward the direction of recovery.

A final particular is the need for sensitivity to the suspicion that many members of the African-American Community had towards the old State Mental Hospital system. To them, the State Hospital was a place where “unwanted” trouble-makers were sent away and locked up for years, even a lifetime, without due process or advocacy. Although such is not the case today, care givers must know that this residue of past discrimination still haunts the minds of many, especially the elderly, who have been shown in past MHRBEO Q-analysis surveys to have a peculiar dread of “being sent off to an institution somewhere” as they slip into their retirement years. As a result, the need for emergency care is clearly discussed with the client, HIPAA regulations strictly followed, and discharge progress monitored not only by the agency, but also by MHRBEO and its partners, including of course the State hospital itself.

Finally, the system of care works to reach out to the to the diverse racial, ethnic, and cultural groups in the community by all of the policies and procedures above, along with public relations and education efforts to dispel stigma, and promote Recovery. “Treatment works. People Recover” is the message, and opportunities are continually sought for speaking engagements, civic functions, and neighborhood gatherings to promote that goal, for all people and cultures in Erie and Ottawa Counties.

Priorities

6. Considering the Board’s understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board’s priorities, and add the Board’s unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.

Priorities for (enter name of Board)				
Substance Abuse & Mental Health Block Grant Priorities *Priorities Consistent OHIOMAS Strategic Plan				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): (very low numbers) this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider.
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe):): (very low numbers) this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider.
SAPT-BG: Mandatory: Parents with substance abuse disorders 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)	1. Improve timely access to services and supports to adults involved in the child welfare system in Erie County 2. Stabilization and treatment of parental	1 (a) Collaborate with Juvenile Court Judge around use of the IDAT funds for treatment services to this population where substance abuse is a contributing factor to legal charges 1(b) Through the planning committee for the family drug court, identify treatment service needs specific to this population 2 (a) In partnership with Board contract	For #1 & #2: Amount IDAT \$ Spent # Referrals from JFS # Served by IFAST MyOutcomes data for IFAST participants	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

	mental illness and/or substance use disorder to prevent removal of children from the home and/or to promote successful reunification of families when issues are present	agencies, work with caseworkers at Departments of JFS and staff at family/juvenile courts to improve identification and referrals of families in need of intensive home-based treatment (IFAST) or other services 2 (b) Provision of services—including targeted case management—to participants in the O.C. HOPE Court (Helping Our Families Excel) Family Dependency Treatment Court program		
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases				<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	1. Improve access to juvenile emergency/crisis psychiatric inpatient hospitalization and/or community residential stabilization	1 (a) Purchase 22 crisis/respite bed days through the Juvenile Crisis Hot Spot Project of the NW Collaborative to expand range of available options available 1 (b) Meet with reps of juvenile courts, treatment, and sheriffs’ office to identify issues around process 1 (c) Continue to work with NW Collaborative as follow up to Private-Public Hospital Initiative around possible regional solutions	#bed days used for crisis, transition and extended stay services # youth served through project Meeting minutes—qualitative data from 1 b & c for feedback into CQI Planning	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Specific goal not selected, however this population is a priority and is impacted directly by goals set in other priority areas such as “Integration of BH/PH Services” & “Recovery Support Services”
Priorities	Goals	Strategies	Measurement	Reason for not selecting

<p>MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*</p>	<p>1. Reduce the stigma of cancer patients seeking behavioral health treatment for the emotional toll that diagnosis and on-going cancer treatment can have upon patients</p> <p>2. Increase access to BH treatment and promote the integration of physical and behavioral health care</p> <p>3. Improve earlier identification of physical health problems and ensure compliance with psychotropic medication protocols</p>	<p>1. Maintain funding for <i>From Cancer to Health</i>, an emerging best practice approach that integrates behavioral health and cancer treatment (a pilot group was funded at the end of FY 13)</p> <p>2. Provide funding for on-site screening for mental health and substance use disorders, consultation and engagement services to youth and adults at Family Health Services of Erie County</p> <p>3. Provide funding for lab work for indigent consumers with SPMI enrolled in the non-Medicaid Health Home via a SAMHSA grant awarded to the Board contract agency</p>	<p>1. # referrals to program, # group participants, # participants identified/referred for assessment and counseling</p> <p>2. # screenings youth vs. adult and disposition as per identified Levels I-III</p> <p>3. #/type of PH conditions identified, #/type of referrals to specialists, ER use, other SAMSHA indicators as per grant</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p>MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders</p>	<p>1. Increase employment of persons with mental and/or substance use disorders who want to work</p> <p>2. Develop system capacity for peer-delivered support services</p>	<p>1 (a) Expand eligibility under the board-funded Supported Employment Preparation and Linkages Services (SEPALS) program to include adults from the MH-General Population and AOD Service Groups</p> <p>1 (b) (Depending upon outcome of VRP3 Program) Redirect local match funds and/or invest additional funds into supported employment programs targeted at persons with SMI/SPMI/AOD OR Maximize the provision of vocational rehabilitation and employment services and other supports via BH-VRP3 program</p> <p>2 (a) Work with local CCAR trained Recovery Coaches and Lorain Area Recovery Coaches network to define service delivery model for use of Recovery Coaches</p> <p>2 (b) Provide training for 4-7 Erie-Ottawa consumers as Certified Peer Supporters (CPS) through joint sponsored training with Lorain ADAS Board for the 40-hour OMHAS training through OCA</p>	<p>1. Dollars allocated, dollars spent, number clients receiving services, number clients employed, VRP3 measures/outcomes</p> <p>2. Meetings/contacts with Recovery Coaches, minutes, # people trained as CPS, # people receiving services from Recovery Coach (currently two trained; each can work with one individual at a time) or CPS</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant *Priorities Consistent OHIOMAS Strategic Plan				
Treatment: Veterans				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Individuals with disabilities				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	1. Arrest the spread of opiate addiction among residents of Erie and Ottawa Counties	1 (a) Continue to gather quantitative & qualitative on range/scope of current problem 1 (b) Work collaboratively with Weed and Seed, Sandusky Crime Prevention Council, Let's Get Real and others to explore feasibility of developing a Community Opiate Task Force to identify and pursue mutual goals 1 (c) Increase community awareness around the dangers of opiate use (i.e. promote use of drop-boxes, prevention programs)	Service utilization data (# in treatment for opioid-related drug use, diagnosis, drug of choice), OSAM & OARRS data	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Underserved racial and ethnic minorities and LGBTQ populations				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting

Treatment: Youth/young adults in transition/adolescents and young adults				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Early childhood mental health (ages 0 through 6)*				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	1. Strengthen families and parents through education, training and skill-building	1 (a) Provide funding for parenting programs—Loving Solutions, Active Parenting, Strengthening Families 1 (b) Expand continuum to include program focused on prevention of underage drinking (i.e. Parents Who Host...) 1 (c) Create opportunities for parent mentoring and support through collaboration with FCFCs 1 (d) Maintain capacity for school-based services (classroom and individual prevention services) including Life Skills	Data Surveillance/Trend Analysis (measures reported in Community Health Assessments by youth on use of alcohol in lifetime, where they got it, etc.), service utilization data, juvenile court data (i.e. charges related to underage substance use or where underage substance use was present), pre and post tests	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Promote wellness in Ohio's workforce				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage

Organizations*				__ Other (describe):
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Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Prevention: Increase community knowledge about mental and substance use disorders	1. Decrease stigma as a barrier to early intervention for emotional problems and mental	1 (a) Provide funds to train one person in Mental Health First Aid to deliver the program Erie-Ottawa Counties 1 (b) Convene a Board-Agency Public Education Steering Committee with a focus on the creation of a set of topic-specific presentations for use in community presentations to help increase understanding about the issues of mental illness and alcohol/drug abuse and dependency 1 (c) Promote the Board website as a resource in the community 1 (d) Increase the use of PSAs	#MHFA trainings, # participants, #community presentations delivered, pre-and post tests, CY 14 county fair survey focus on stigma/attitudes toward persons with MH/AOD issues

Priorities (continued)

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(1) Secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label	A critical tool for maintaining community recovery for some individuals is the ability to provide a secure residential setting. This was echoed by findings of a survey of boards about discharge barriers for individuals in the Regional Psychiatric Hospitals distributed by Ohio MHAS, in which 70% of participating boards indicated that the development of special needs secure housing alternatives would be helpful for consumers with complex needs. Currently, the only secure community options are nursing homes, and trying to establish alternative secure placement arrangements is very costly and next to impossible. The Board is currently paying nearly \$140,000 a year in expenses for housing/supervision costs for just one individual; necessary treatment costs outside of Medicaid are additional.
(2) Expansion of continuum of care available for persons with alcohol/drug disorders, especially access to Levels of Care II-IV	Currently, the only levels of care available are outpatient and limited intensive outpatient. Minimal funds are available, coordinated on behalf of the system by the Board's primary contract provider, for residents in need of services falling under Levels II-IV. Even then, the geographical location of various detox, inpatient, and community residential facilities makes coordination and engagement with local treatment providers and with the recovery community challenging. Funds would also be used to develop programming specific to those with opioid-related diagnoses; currently MAT is not available in the Board area.

(3) Recovery housing	<p>Recovery housing and related supports is an important component of the continuum of care, and is supported by SAMHSA and considered a priority domain within the context of Recovery-Oriented Systems of Care. There is very little local capacity, as the only project that currently exists is the Serenity House program, which provides supportive housing for homeless chemically dependent adults in a group living environment and scattered site apartments. Residents are expected to participate in recovery related activities such as treatment and AA/NA/CA support groups. Program participants may stay as long as 24 months, with an average length of stay around 12 months. This program is funded primarily by a Supportive Housing Program Grant from the Department of Housing and Urban Development. Funds from the Board are used to pay for treatment and for case management services for program participants and serve as a valuable source of matching dollars for the grant, allowing Volunteers of America to leverage more than \$290,000 annually. Maximum capacity at this time is approximately 30 individuals, although the number varies relative to the length of stay and mix of current program participants as these variables impact the amount of open slots in the men's and/or women's group home and the apartments. For instance, going into FY 12 the length of stay in transitional housing through Serenity House was between 18 to 24 months. Residents are taking longer to find subsidized housing and an increase in income. The number of clients served decreases as the length of stay increases.</p>
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

Collaboration

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.

Ongoing involvement, interaction, and collaboration with service and referral agencies and other community partners and stakeholders occur as part of the effort to develop and ensure an efficient and comprehensive system of mental health and alcohol/drug services and supports; maximize resources and minimize duplication of services; and improve consumer outcomes. As a result, timely and current feedback is obtained and used in many ways—from joint funding of programs or initiatives to identification of gaps in the service continuum; to enhanced communication and streamlined referral protocols.

As comprehensive accounts of the Board's processes, relationships and benefits of collaboration were provided in both the SFY 12-13 Plan and the SFY 13 Plan Supplement (the latter submitted within the two year time frame asked about in this question), a representation of various partnerships and mutual endeavors is presented below, along with any updates or new efforts.

Let's Get Real, Inc. is a recently formed information and referral community center assisting families and loved ones in their journey from addiction to recovery located in Vermilion, a city that is located partly on the east end of Erie County and partly in the west end of Lorain County. They offer information and resources about a number of treatment centers located in Lorain, Erie, Ottawa and Cuyahoga counties as well as for parents and loved ones of those struggling with addiction. The facility hosts various family support groups and self-help meetings as well. The Board has provided administrative and office support (i.e. copies, mailings) and has worked with them to coordinate a Cross-County Collaboration meeting as a forum for community members to hear about available resources and to share concerns and ask questions of a panel of professionals (including our Board E.D.) from both Erie and Lorain Counties regarding their interests and concerns as they relate to drug problems in Vermilion. Future discussions and co-coordinated activities are being planned. Let's Get Real was recently honored with an Award for Excellence for Outstanding New Program by the Erie-Ottawa Board at its annual banquet in October.

The Board is also working with the **Sandusky Crime Prevention Council**, a volunteer group of about 12 Sandusky City residents who came together to improve the city by researching and initiating various methods of involvement and cooperation between residents, law enforcement and social services with a common goal of reducing crime and thereby improving the quality of life for everyone in the community. The Board contributed financial support for and participated in one of their initial efforts, a community meeting in October of their "Clear Vision" drug awareness program. The Council convened the program as a means of providing residents with knowledge and the perspective of the current status of drug problems in the city from a number of panelists including the Board, Judges, treatment professionals, and law enforcement representatives. We have continued to participate in meetings of the Council.

An ongoing and multi-year effort of the Board has been working with the various courts to establish programs around use of the **Indigent Driver Alcohol Treatment (IDAT) Funds**. IDAT Funds are comprised primarily of a portion of each driver's license reinstatement fee for offenders convicted of drunken driving who lose their licenses. IDAT also receives money from each fine for OVI, moving violation conviction and immobilization waiver fees. The funds go directly to the respective court through the State Department, and can be used for alcohol/drug treatment for OVI offenders court-ordered into treatment and determined to be indigent. Funding may also be utilized for the continued use of an electronic monitoring device and for other criminal offenses where alcohol was a contributing factor. Per law, the local Board administers the IDAT program of the court. Through programs set up with the Sandusky and Ottawa Co. and Municipal Courts—the latter program just established the second quarter of FY 12—31 people received addiction treatment services paid through these funds, for a total of \$25,605.07. We have also been working with Vermilion Municipal Court and the Lorain ADAS Board around administering an IDAT program. Still, there are significant funds remaining that would go far in expanding capacity and addressing local emergent needs (i.e. increasing opioid drug abuse and dependence)—particularly given the

cuts in alcohol/drug allocations in FY 09 and FY 10, the fact that pre-cut levels were never restored, and the upcoming reductions in SAPT funds due to cash realignment. Based on the Annual Reports for SFY 2013, the following are balances carried over for use on or after July 1, 2013:

Erie Co. Juvenile Court	\$45,308.26
Erie Co. Municipal Court	\$24,382.43
Huron Municipal Court	\$119,349.90
Ottawa Co. Juvenile Court	\$2643.03
Ottawa Co. Municipal Court	\$110,746.71
Sandusky Municipal Court	\$190,548
Vermilion Municipal Court	\$284,519.79

Ottawa County Common Pleas Court: At the end of FY 12, as one strategy toward achievement of identified goals in the FY 12-13 Community Plan around increasing capacity in Ottawa County and working to strengthen collaboration with the various courts around diversion, post-adjudication, and re-entry services, our primary AOD treatment agency serving adults received training in “Thinking for Change” (T4C) in order to provide the program to adult probationers. The T4C program is an integrated, cognitive behavioral change program for offenders that includes cognitive restructuring, social skill development, and development of problems solving skills. More recently, staff members of the Board and provider agencies worked with the Judge and staff of the Court to develop and implement a specialized docket drug court program (DATA Program) that just began in mid-November. In order to streamline the times between program application, diagnostic assessment (DA), and acceptance into drug court, we will be expanding the role of the Board-funded Court Assessment Program currently in place for the O.C. Juvenile Court to include assessment of those individuals screened for possible inclusion in the Drug Court program. This will also have the result of standardizing the format in which the results of the DA and any treatment recommendations are presented. As with other specialized docket programs, agency staff are prepared to participate as part of the treatment team and attend weekly meetings/hearings. The Court had also requested a single, designated case manager for all persons involved in treatment and with the Court. For several reasons, that was not feasible. It was determined that the participants in the new drug court program (described above) will be the target population for designated case management services. Our contract agencies will each designate one individual who will work with program participants. While the exact role of the case managers hasn’t been determined, we will be looking at ways to provide limited flexibility for the provision of services outside of the clinical definition per certification standards. We are also looking at the viability of providing case management services to program participants who are not receiving other services from the agency, such as those who are attending the Court’s own Intensive Outpatient Program.

O.C. Detention Center: Staff of the Board, provider agencies, and Common Pleas Court also worked with representatives of the Ottawa County Detention Center around a variety of issues. We were able to collectively identify and begin implementing a few changes related to services at the Detention Center. The Board already provides funding for on-site services including crisis/emergency, assessments, counseling, and intervention/education groups. In order to move toward earlier identification of inmates with behavioral health needs, the jail agreed to provide the information on mental health and alcohol/drug history and current issues that is collected as part of the classification form at intake. The on-site clinician reviews these and attempts to engage individuals. As participation is voluntary, most inmates refuse; however, we are working with the Judge to “close the loop” relative to providing additional incentive for incarcerated individuals to voluntarily participate in treatment. We are also looking at other ways to improve communication, such as notification of incarceration by Probation to Treatment on those individuals known to be active in treatment to help alleviate issues related to no-shows and missed appointments.

NOTE: while there have been many accomplishments as a result of our collaborative efforts with the Common Pleas Court and the Juvenile Court (not addressed above) in Ottawa County, one challenge that has been identified by the Board and providers that needs to be examined is around the duplication of services in many instances. As noted in the previous Plan and Supplement, despite capacity in Ottawa County for prevention and treatment services for all populations, utilization has decreased in the past several years. While some of the factors contributing to this are known (discussed in previous Plan), it has become apparent that some of it is due to decreased referrals from the two Courts as they are providing similar programs through their own staff or via contracts with private clinicians or out-of-county providers. For instance,

Juvenile Court was awarded a grant about two years ago for the T4C program, with which they contracted for with an outside provider despite the fact that the Board contract agency had adequate program capacity and had been serving the youth referred by the Court previously (and since, after the grant funds expired). Recently, the Juvenile Court (in conjunction with Ottawa County DJFS, DD and another agency) began running their own parenting program to teach parents skills to deal with the problems of truancy, family conflict, poor grades, drug and alcohol use, delinquent behavior, running away, violence and negative peer influences. Again, this despite various parenting and other prevention programs offered through Board providers. Another example is the Intensive Outpatient Program (IOP) that the Common Pleas Court provides on-site through a contract with a provider outside the Board system, while local contract agencies struggle at times to fill groups/programs. As noted elsewhere in this Plan, we have a primary provider of adult alcohol/drug treatment services that offers a full continuum of outpatient care as well as an IOP level of care in Ottawa County. The secondary provider of services for adults also has the capacity for both levels of care.

Peer Supporters/Recovery Coaches: In FY 13, the Board supported the training of two individuals as Recovery Coaches through a CCAR training coordinated by the Lorain ADAS Board. Both are active in the Lorain Area Recovery Coaches network and meetings. As the State moves forward with BRSS-TACS and certified peer supporters (CPS), there is some concern regarding the ability of Recovery Coaches to be utilized in the community. We are hopeful that there will be a plan developed to “grandfather” those who have been trained in the CCAR model as the skills and role they offer to those new into or struggling with Recovery are valuable assets and consistent with a Recovery Oriented System of Care model. Related to this, the Board has agreed to work with the Lorain ADAS Board to bring Ohio Citizens Advocates to Lorain for a peer supporter training that would be open to persons from both counties. OCA will conduct the 40-hour (5 consecutive days) training and will provide attendees with the OMHAS’ certified peer supporter credential. We will be working with our consumer and peer support agencies to identify possible candidates for this training, and will be providing financial support.

Partners for Prevention of Erie County Coalition: Staff and trustees of the Board and provider agencies are actively involved in this coalition of agencies, youth, adults, and others dedicated to reducing the negative outcomes and impact of alcohol, tobacco, and other drug (ATOD) use and abuse in the community and upon its citizens. The Board is contributing to identified goals of reducing underage drinking and emphasizing targeted developmental assets (Search Institute) through the determination of shared priority and investment areas.

Inpatient Hospital Management

9. Describe the interaction between the local system’s utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that you expect/foresee

The Board contracts with Firelands Counseling and Recovery Services (“Firelands”) for emergency services programming for the system of care. Services are available 24/7 for youth and adults and include a crisis hotline, pre-screening, inpatient psychiatric hospitalization (for adults), and transportation service to the hospital/crisis care facility. In Ottawa County, they have an agreement with the Giving Tree (another Board provider) to provide pre-screening and face-to-face emergency assessments during normal business hours with responsibility shifting to Firelands for evenings and weekends. The Board contracts with Rescue Mental Health Services (“Rescue”) for residential crisis stabilization services for youth and adults. The Board also contributes funding for 2-1-1, a 24/7 “warm line” providing information and referral services for Health & Human Services assistance.

The hotline service is available 24 hours/7 days a week. It is located on the inpatient behavioral health unit and is staffed by designated behavior health workers who are licensed nurses and/or trained bachelor level staff. Their primary task is to provide short term telephone interventions to persons who may be experiencing a psychiatric or other emotional crisis. Hotline workers also provide information and referral services and also fulfill the role as secondary CPST staff to assist clients of the agency with ongoing support and symptom monitoring and to reinforce medication compliance. In addition,

hotline workers serve as the entry point for a face-to-face assessment provided by the behavioral health professional (BHP).

The Board provides funding for inpatient services for Erie and Ottawa County residents providing the client has been prescreened prior to inpatient admission by Firelands' staff and the client has no other source of payment that will cover inpatient psychiatric services. Furthermore, the client signs an authorization to allow Firelands Regional Medical Center or their designee to apply for benefits on their behalf. All indigent clients are required to apply for Medicaid benefits upon admission as a prerequisite to receiving Board funds; if they do not agree to sign an authorization and/or do not follow through with an application to Medicaid, the client is billed for the cost of the hospital stay. If Medicaid benefits are denied due to ineligibility, board funds can be used to the extent available. Per contractual agreement, payment for Inpatient Hospitalization Services will be made for every two admissions accompanied by a third admission provided at no charge to the Board. Firelands outpatient staff attends weekly team meetings for each psychiatrist who admits to the inpatient unit to provide continuity of care for patients who are being discharged. In cases where the individual requires more structured programming to increase success in community tenure, referrals to the PHP program can be arranged as part of the discharge plan. We also contract with Rescue Mental Health Services ("Rescue") for diversion and stabilization services via their crisis unit as part of the effort to manage inpatient admissions to the State Hospital and for the sake of additional capacity when the inpatient unit at Firelands is full. As manager of our emergency services system, Firelands is responsible for validating the referral and accuracy of invoices prior to the board executing payment to RMHS, as well as with coordination of discharge planning.

The Board and providers work with Rescue, staff of the State and Private Hospitals, the individual, and the guardian (if applicable) around length of stay and discharge planning to ensure a seamless transition to community-based services and supports. This population receives priority in terms of access to care on an outpatient basis; particularly important when limited resources are available. The Board also contracts with Managed Resources Unlimited, LLC for Quality Assurance and Utilization Reviews (QA/UR) of Erie and Ottawa County residents hospitalized at Northwest Ohio Regional Psychiatric Hospital (RPH). The consultant conducts retrospective reviews of admissions to the State hospital as well as periodic Continued Stay reviews for medical necessity to help ensure that the appropriate level of care is being provided. The Board's designated Forensic Monitors are responsible for working with hospitals to coordinate discharge planning and conditional release for forensically hospitalized adults. Among the issues addressed by forensic discharge planning are housing; re-socialization; continuation of medication and BH treatment; case management; vocational resources; and linkages to family, friends, and civic/religious organizations as appropriate.

Member Boards of the Northwest Collaborative, the RPH, and Ohio MHAS met in September as a follow-up meeting to the Public/Private State Hospital Initiative with the goal to "Define an Ideal Regional Crisis Network". Elementary data was collected from member boards related to the types of service arrangements available, the number of patients entering crisis care systems across the region, the resultant placements in the various levels of care, and information about key relationships and challenges regarding Boards' ability to meet the needs of individuals in psychiatric emergency. Data relative to emergency psychiatric services, placements and challenges relative to youth was discussed in the section on needs assessment earlier in this document. For FY 13, 1308 adults received emergency psychiatric services. Of these, 15 were involuntarily committed to a public psychiatric hospital and 270 to a private hospital psychiatric unit; 3 were voluntarily committed to a public psychiatric hospital and 370 to a private hospital psychiatric unit. Excluding public psychiatric hospital admissions, 575 of the 640 were admitted to facilities outside of the county. The three greatest challenges related to the provision of emergency psychiatric services to adults were noted as follows: 1) length of time arranging for admissions, particularly related to labs/medical clearance; 2) lack of available beds at the RPH at times; 3) lack of alternatives to Inpatient Care/capacity for crisis residential.

Emergency Psychiatric Services: Rescue and Firelands (FY 12-FY13)

	FY 12			FY 13		
	Total Cost	#Clts	Cost/ Client	Total Cost	#Clts	Cost /Client
Firelands	\$239,610	100	\$2396	\$164,037	75	\$2187
Rescue (w/o emergency transportation costs)	\$403,523	339	\$1190.33	\$331,317.05	263	\$1259.76
Rescue (with emergency transportation costs)	\$441,994	NA	\$1303.82		NA	\$1393.27

Looking at the costs of emergency psychiatric services for fiscal years 12 and 13, the Board spent a total of \$681,604 on inpatient psychiatric hospitalization, crisis stabilization, and transportation for 439 persons in crisis in FY 12 for an aggregate cost per client of \$1552.63. For FY 13, a total of \$530,467 was expended for 338 persons at an aggregate cost per client of \$1569.43. These figures do not include other components of the crisis care system such as the hotline.

In looking at admissions to NOPH and overall use of bed days compared to previous years, between FY 2012 and FY 2013 data for Erie-Ottawa was as follows:

- Total admissions increased (from 31 to 35) for a 13% increase;
- Civil admissions increased (from 23 to 26) for a 13% increase; and
- Forensic admissions increased (from 8 to 9) for a 13% increase.

Based on an unofficial FY 14 Collaborative Board Bed Day Report of October 8, 2013 comparing the three year bed day rate to FY 14 annualized based on actual bed days YTD, the average bed days per year for FY 10-12 was 2404. Based on 939 days used through 9/30/13, the annualized total for FY 14 would be 3725—1321 over the three year average! Of course, the actual fruition of this assumes the same rate of use for the remainder of the year which as we know from the past may very well not be the case. Regarding civil admissions, while we did not anticipate an increase between the two years or from the three year average, in looking historically over the past several years it is apparent that there has been a good deal of variability. The 26 admissions for FY 13 was still less than 09-10 levels.

NOPH Civil Admissions

Board	FY 09	FY10	FY11	FY12	FY13
Erie-Ottawa	28	32	24	23	26

When forensic admissions are taken into consideration, the total bed day increase is even greater as they too increased between 12 and 13. Note that some of the increase in FY 13 could be attributed to the difference in categorization of bed days by Ohio MHAS, as jail transfers began to be counted as Forensic Admissions in FY 13. Also, FY 13 was the first year of the statewide hospital utilization management partnership program between the Department and Boards, with Boards having the ability to elect participation in bed day management and discharge planning for both the civil and forensic hospital populations. As this was not a population the Board has historically had responsibility for managing, it will take time to develop the necessary relationships, services and supports to effectively impact admission and discharge of forensic patients.

NOPH Admissions SFY 2012 and SFY 2013

	2012			2013		
	Civil Adm	Forensic Adm	Total Adm	Civil Adm	Forensic* Adm	Total Adm
Erie-Ottawa	23	8	31	26	9	35

*Jail transfers began to be categorized by ODMHAS as Forensic Admissions in SFY 2013, accounting for some of the increase in this category

Discharge and Transition to Outpatient Services and Supports

The Board provides funding to both the Giving Tree and Firelands for a range of mental health outpatient services and supports. A third agency, Bayshore Counseling Services, has primary responsibility for alcohol/drug service delivery to adults and also serves as a secondary provider of mental health treatment in both counties, thereby providing at least some opportunity for consumer choice in each county. In general, outpatient treatment services include assessment, individual and group counseling, case management, individual and group community psychiatric support service, partial hospitalization, intensive outpatient, pharmacologic management services, and urinalysis. Within this service mix, there are many specialized or targeted programs as well. For example, the Partial Hospitalization Program (PHP) is an intensive level of outpatient care designed to serve as an alternative intervention to prevent hospitalization and to help persons safely and effectively transition from hospitalization into the outpatient setting. An integral component of PHP (and of the Recovery Group, which is often used as a step down program for those completing PHP) is Illness Management and Recovery (IMR), an evidence-based program that helps people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives.

The Systematic Treatment for Emotional Predictability and Problem Solving (STEPPS) Program was developed to serve persons who met criteria for Borderline Personality Disorder, but was also found to be efficacious for persons who did not meet all the criteria for BPD, but who had related BPD features. The program uses a structured skills training model from a cognitive-behavior perspective. Interventions focus on using a common language and confronting and correcting maladaptive cognitive “filters.” The STEPPS program serves adults with serious and persistent mental illness as well as those with less intensive mental health problems as well. In addition, self-help/peer support, employment/vocational and housing support services are available as well as prevention, education, consultation and intervention services. It is important to note however that capacity is limited for many of these treatment and support services and programs. Furthermore, some of the specialized programming is targeted to specific population groups.

The availability of the compensated, professional guardianship program is also an asset in our continuum of care and a valuable tool in addressing and removing some of the barriers to discharge from the RPH of clients with complex needs. The goal of the Professional Guardianship Program is to reduce hospitalization of clients and to maintain mental health stability in the least restrictive placements. Under the auspices of the system’s Housing Clinical Oversight Committee, eligibility criteria and referral protocols were developed for the guardianship program. While still in the process of being fully implemented, a brief summary of the criteria are as follows:

- Client has had more than two psychiatric hospitalizations in the proceeding twelve month period;
- Other services provided by case management have failed to stabilize client’s mental health per goals of client’s case plan;
- Clients case plan goals would benefit from the structure and authority of a legal guardian;
- The client does not have suitable family members willing to assume guardianship;
- Referring agency has initiated a preliminary case plan specifically directed toward goals associated with the assistance of the professional guardian, (i.e. what services are required of the professional guardian)

Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?

- a. Service delivery
- b. Planning efforts
- c. Business operations
- d. Process and/or quality improvement

Please provide any relevant information about your innovations that might be useful, such as: how long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

Advocacy (Optional)

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

Open Forum (Optional)

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which you believe are important for your local system to share with the Departments or other relevant Ohio Communities.

Appendix 1: Alcohol & Other Drugs Waivers

A. 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.

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this waiver is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with OhioMHAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

Appendix 2: Definitions

Business Operations: Shared Resources, QI Business Plan, Financial Challenges, Pooled funding, Efficiencies, Strategic Planning, Contracts, Personnel Policies, etc.

Cultural Competence: (Ohio's State Inter-Departmental Definition) Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

Culturally Competent System of Care: The degree to which cultural competence is implemented as evidenced by the answers to these questions:

- Is leadership committed to the cultural competence effort?
- Are policies and procedures in place to support cultural competence within the system, including policies and procedures to collect, maintain and review caseload cultural demographics for comparison to the entire community?
- Are the recommended services responsive to each adult, child and family's culture?
- Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?
- Is staff reflective of the community's racial and ethnic diversity?
- Is staff training regularly offered on the theory and practice of cultural competence?
- Are clients and families involved in developing the system's cultural competence efforts?
- Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?
- Is staff culturally sensitive to the place and type of services made available to the adult, child and family?
- Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?

Local System Strengths: Resources, knowledge and experience that is readily available to a local system of care.

Local System Challenges: Resources, knowledge and experience that is not readily available to a local system of care.

Planning Efforts: Collaborations, Grant opportunities, Leveraging Funds, Data Collection (e.g., Key Performance Indicators, Outcomes), Trainings

Service Delivery: Criminal Justice, School Based or Outreach, Crisis Services, Employment, Inpatient/Residential Services, Housing, Faith Communities, etc.