

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.)

The ADAMH Board of Franklin County's strategic plan for 2012-17 highlights a number of significant factors that will impact the business environment over the next five years. The strategic plan explores the business environment in three broad areas: consumers, provider network, and community. Both challenges and opportunities for each of these broad areas are outlined.

Over the next five years, the ADAMH Board of Franklin County envisions the consumer landscape will be impacted by the following six challenges and opportunities:

1. Changing community demographics, continuing severe economic stressors and increased complexity of consumer and family needs will challenge ADAMH to provide culturally competent services, delivered by culturally capable professionals that address the following socioeconomic and health factors:
 - Sustained levels of unemployment and associated mental health and addiction implications;
 - Increased numbers of uninsured citizens;
 - Increased poverty – more people are in more extreme poverty;
 - People exposed to trauma (neighborhood, war, etc.);
 - Children, youth and families at risk;
 - Emerging immigrants;
 - Stigma;
 - Aging population and caregivers;
 - Integration of increased numbers of ex-offenders into community;
 - Diversion from jails/prisons;
 - Increasing acuity of consumers at time of entry into system; and
 - Homelessness.
2. Increasing number of diverse healthcare plans with differing benefits (e.g. access to medications) will challenge consumers and families in meeting their expectations from multiple public payer systems.
3. A significant increase in the need for specialized treatments for individuals with dual disorders (i.e. both mental health and substance abuse) as well as an increase in the demand for intensive treatments (e.g. high use of psychiatric beds and crisis services.).
4. An expectation for health care "homes" in which mental health and substance abuse treatment is integrated with primary healthcare rather than a separate and distinct system.
5. Increased demand for more supportive housing and support services (e.g. vocational, crisis stabilization) will require the Board to determine the un-met need and the level of supports that are required within a continuum of care.
6. Increased advocacy from consumers and family members for vital services from the public system of care.

The ADAMH Board of Franklin County envisions the provider network will be impacted by the following three challenges and opportunities:

1. Capability of providers to meet the demands of consumers will be challenged by:
 - Rapidly changing reimbursements environment by multiple healthcare plans for insured & non-insured consumers;
 - Increased demand for price, quality, transparency, and performance reimbursements; and
 - Insufficient diversity in the workforce.
2. Opportunity to partner with primary healthcare providers to develop integrated systems of care that address both the mental health and substance abuse treatment and physical healthcare needs of the patient.
3. Sustainability of the current provider system (e.g. network of providers) in light of changing reimbursement structures.

Finally, the ADAMH Board of Franklin County envisions the community will be impacted by the following eight challenges and opportunities:

1. Availability of discretionary funds (resources available) is uncertain due to the:
 - Reduction in local levy funds due to slowed housing starts or de-valuation of property;
 - Uncertainty of community support of the local levy due to continued economic uncertainty;
 - Reduction of non-levy discretionary funds as a result of economic recession; and
 - Elevation of Medicaid match financing to the State of Ohio.
2. Re-definition of Board's relationship with the State's hospitalization program.
3. Increased number of consumers who are Medicaid-eligible will require the Board to:
 - Re-define its relationship with the Medicaid program; and
 - Evaluate the impact of the State's Medicaid cost-containment, including the possibility of managed care.
4. Impact of Federal Affordable Healthcare Act on the ADAMH system of care from 2014 and beyond is uncertain due to the:
 - Development of medical home models;
 - Growth in Medicaid Eligibility;
 - Development of Health Care Exchanges;
 - Employer choice to opt-in/out;
 - Continuing political/legal challenges to implementation; and
 - Health Information Technologies.
5. Changing community expectations for priority prevention and treatment services that will be available within the new business environment:
 - Integration of new models of prevention services into diverse learning environments;
 - New requirements for school-based civic service or service leadership may create opportunities for community organizations;
 - Increase of violence, crime, and deteriorating conditions in certain communities threaten the health, safety and stability of its citizens (particularly youth);
 - Loss of income, housing, jobs, and other life-threatening conditions are negatively impacting the health/stability of citizens and families;
 - Integration of new models of treatment services that incorporate peer supported environments;
 - Faith institutions are being sought by residents seeking a wide range of services (i.e., food, shelter, counseling, youth programs, safety, etc.).

6. Increased poverty – more people are in more extreme poverty.
7. Increased expectations among all funders for systems to collaborate.
8. Increased advocacy from and for consumers and family members for vital services.

The economic and demographic profile of Franklin County continues to change as a result of the growth of the county's population. According to the 2010 Census, the Franklin County total population now stands at 1,163,414 people, which is an increase of 94,436 people from the 2000 census. This equates to a population growth rate of 8.8% over the past decade.

A significant majority (1,022,640 or 87%) of the county's population lives within incorporated large urban areas with the remaining 13% (140,774) living in small incorporated townships or unincorporated rural areas. Table 1 below provides a snapshot of the dispersion and growth of the county's population within incorporated urban communities (Source: Ohio County Profiles Ohio Department of Development).

Table 1. Population of Largest Cities & change in population 2000 to 2010

Largest Places	2010 Census	2000 Census	Increase/Decrease Number/Percentage	
Columbus	770,122	702,132	67,990	+10%
Grove City	35,575	27,075	8,500	+31%
Dublin	35,367	27,087	8,280	+31%
Upper Arlington	33,771	33,686	85	+<1%
Gahanna	33,248	32,636	612	+2%
Hilliard	28,435	24,230	4,205	+17%
Westerville	28,328	29,418	-1,090	-4%
Reynoldsburg	26,157	26,388	-231	-1%
Whitehall	18,062	19,201	-1,139	-6%
Worthington	13,575	14,125	-550	-4%

Below are some selected demographics from a review of 2010 Census for Franklin County:

- Female population is 51.3% of the total population and numbers 596,915.
- Male population is 48.7% of the total population and numbers 566,499.
- The population under age 18 is 278,542 or 23.9%.
- The population age 18 & over is 884,872 or 76.1%.
- The percentage of foreign-born persons is 8.4%.
- Language other than English spoken at home (percent that is age 5+) is 10.6%.
- Percent of population (age 25+) with less than a 9th grade education is 3.2%.
- Percent of population (age 25+) with 9th to 12th grade education, no diploma, is 7.9%.
- Percent of population that are high school graduates (age 25+) is 88.6%.
- Percent of population that hold a Bachelor's Degree or higher (age 25+) is 35.1%.
- Veteran population is 75,444 or 6.5%.
- Estimated number of households is 453,580.
- Persons per household are 2.43.
- Median household income for 2009 was \$47,460.
- Percentage of population below poverty level in 2009 is 18.4%.
- Mean family size is 3.05.

- Mean family size (foreign born) is 3.59.
- Homeownership rate is 58.2%.

Table 2 below provides a breakdown of the county’s population by age and gender. The table reveals that the median age for women of 34.5 years is slightly higher than the median age of men, which is 32.3 years. The median age for both male and female is 33.4 years. It should be noted that among children and adolescents up until age 19, the male population is larger than the female population in each age group. Among the adult population 20 years and older, females outnumber males in all age groups with the exception of the 40 to 44 age group.

Table 2. Population by age and gender

Age (years)	Male	Female	Both Genders
Under 5	43,372	40,745	83,117
5 to 9	39,175	37,593	76,768
10 to 14	37,609	36,169	73,778
15 to 19	41,288	39,704	80,992
20 to 24	51,225	51,423	102,648
25 to 29	50,010	51,898	101,908
30 to 34	44,139	44,716	88,855
35 to 39	40,173	40,494	80,667
40 to 44	38,669	38,524	77,193
45 to 49	39,358	41,123	80,481
50 to 54	38,171	41,253	79,424
55 to 59	31,609	35,518	67,127
60 to 64	25,400	29,350	54,750
65 to 69	16,169	19,931	36,100
70 to 74	11,412	15,122	26,534
75 to 79	8,689	12,136	20,825
80 to 84	6,351	10,374	16,725
85 to 89	3,401	7,028	10,429
90 and over	1,279	3,814	5,093
Median age	32.3	34.5	33.4

The county’s population continues to grow more diverse. Fifty nine percent of the growth of the county’s population is attributable to new immigrants (Human Services, Page 9). To gain further perspective on the racial makeup of the county, Table 3 below provides a racial breakdown of the county population by race and ethnicity. The majority racial group of the county is white, with minorities making up approximately 28.6 % of the population. The largest minority/ethnic population is African American (21.2%), which is followed by Hispanic/Latino (4.8%) and then Asian (3.9%). Because of the way Census data is recorded, recent African immigrants (within the last decade) may be included in the African American category, which makes it difficult to ascertain the size of the recently immigrated African population.

However, we are able to gain some additional insight into the diversity of the minority populations within Franklin County by reviewing Census data from the 2012 American Community Survey (ACS). ACS data reveals that the foreign-born population as stated previously is 8.4% of the county’s population and primarily comes from the following world regions. The data provides us with a percentage estimate from each of the world regions:

- Europe – 9.9%
- Asia – 37.4%
- Africa – 30.0%

- Oceania – 0.3%
- Latin America – 21.3%
- North America – 1.2%

Table 3. Population by race and ethnicity (number and percentage)

Race/Ethnicity	Number	Percentage*
White	805,617	69.2%
African American	247,225	21.2%
Asian	44,996	3.9%
American Indian/Alaska Native	2,852	0.2%
Native Hawaiian/Pacific Islander	746	0.1%
Other	27,272	0.2%
Identified by two or more races	34,706	3.0%
Hispanic/Latino	55,718	4.8%
Non-Hispanic/Latino	1,107,696	67.3%

*Percentage will not add to 100. Hispanics may be of any race.

A review of selected social and economic characteristics of Census data for the county provides us with further insight into the challenges and opportunities for residents over the next five years. The unemployment rate steadily increased from 5.2% in 2005 to 8.3% in 2009 during the great recession. According to Census data from the 2012 ACS, the unemployment rate for Franklin County has fallen to 5.3% as the Ohio and Franklin County economies like the nation’s economy have struggled to gain traction. Although unemployment has fallen within Franklin County, poverty within Franklin County has increased to an estimated 17.9% of the county’s population.

Table 4 below provides us with selected demographic data for poverty within Franklin County using data from the U.S. Census Bureau’s 2012 American Community Survey (ACS) estimates:

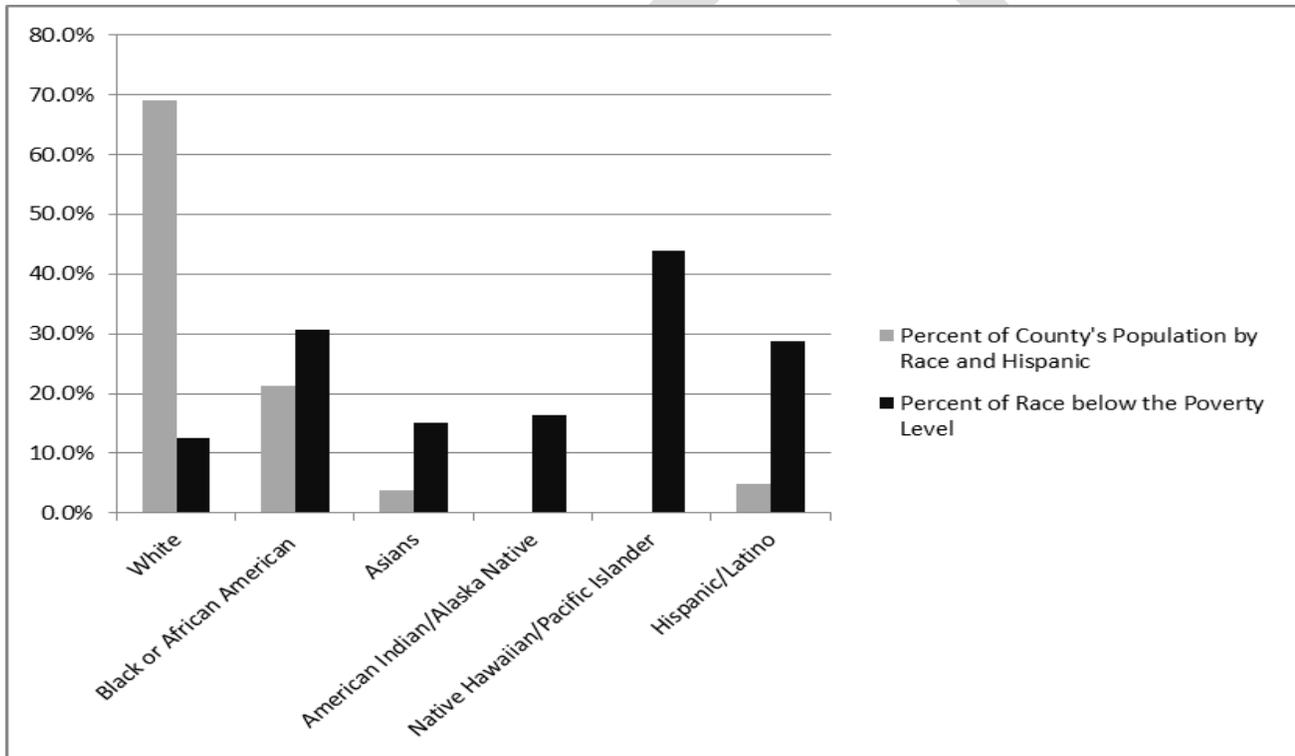
Table 4. Poverty Selected Demographics 2012 ACS Estimates

Demographic	# below poverty level	% below poverty level
Population for whom poverty is determined	209,041	17.9%
Age		
Under 18 years	70,700	25.2%
18 to 64	128,588	16.7%
65 years and over	9,753	8.1%
Gender		
Male	93,477	16.4%
Female	115,564	19.2%
Race and Hispanic/Latino		
White	103,196	12.8%
Black or African American	83,997	33.4%
American Indian/Alaska Native	N	N
Asian	6,594	13.7%
Native Hawaiian/Other Pacific Islander	N	N
Hispanic/Latino (any race)	16,284	27.5%
Educational Attainment		
Population 25 years and over	97,524	12.7%
Less than high school graduate	26,303	34.9%
High school graduate (includes GED)	32,221	16.7%
Some college, associate’s degree	26,955	12.7%
Bachelor’s degree or higher	12,045	4.2%
Employment Status (civilian labor force 16 years & over)		

Employed	48,584	8.3%
Male	19,762	6.6%
Female	28,822	10.0%
Unemployed	19,927	41.0%
Male	10,127	36.5%
Female	9,800	46.9%
Population 16 years and over	143,317	15.7%
Worked full-time year-round in the past 12 mos.	10,570	2.5%
Worked part-time or part-year in the past 12 mos.	53,799	23.4%

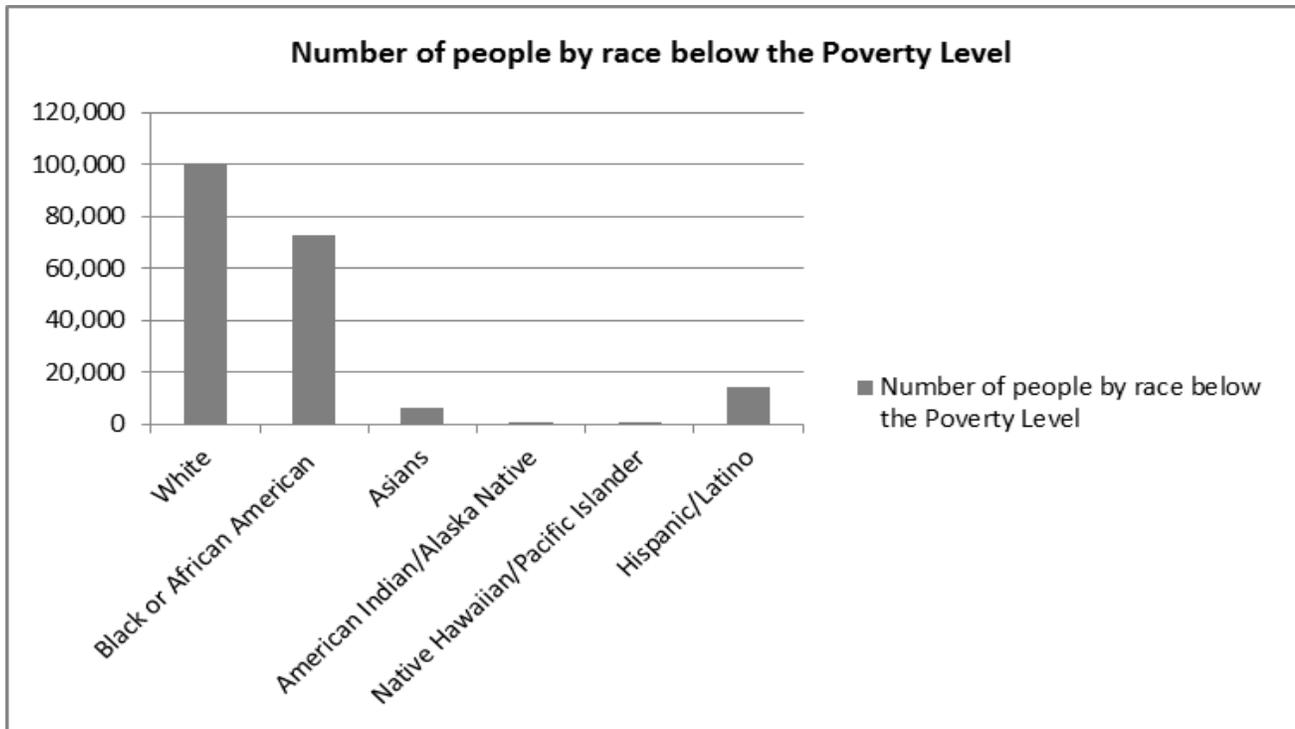
A review of the data in Table 4 reveals that one of the largest percentages of people living below the federal poverty level in Franklin County is children under the age of 18. Over twenty-five percent (25.2%) of all children in Franklin County are living in poverty. The number and percentage of women who are poor is greater than the number and percentage of men that are poor: 19.2% of females live below the federal poverty level and 16.4% of males live below the federal poverty level.

Table 5. Percentage of Population by Race and Poverty for Franklin County 2010 Census



Looking at the racial demographics of poverty for the county, we see in Table 5 above that Whites make up 69.2% of the county's population with just 12.6% of Whites living below the poverty level. Although the percentage of Whites in poverty is the lowest among the racial groups in Franklin County, Table 6 below shows that the number of Whites that are poor totals more than all of the other racial groups combined.

Table 6. Number of People by Race below the Poverty Level for Franklin County 2010 Census



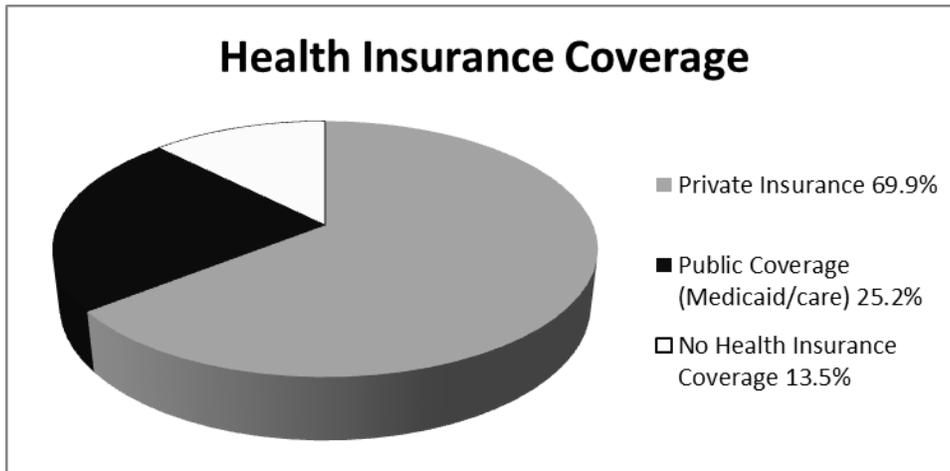
Looking at poverty among the minority groups within the county, we see that all of the minority groups have a significantly disproportionate number of people below the poverty level. The analysis below, coupled with Tables 5 and 6 above, gives us a picture of poverty levels among the racial groups and Hispanics/Latinos, as compared to their proportion of the total population:

- Blacks or African Americans make up 21.2% of the county's population with 30.6% of Blacks or African Americans being poor;
- Asians make up 3.9% of the county's population with 15.1% of Asians being poor;
- American Indian/Alaska Natives make up 0.2% of the county's population with 16.3% of American Indian/Alaska Natives being poor;
- Native Hawaiian/Pacific Islanders make up 0.1% of the county's population with 44% of Native Hawaiian/Pacific Islanders being poor; and
- Hispanic/Latinos make up 4.8% of the county's population with 28.7% of Hispanic/Latinos being poor.

When we consider other demographics such as educational attainment and employment status, we see that the group with the largest percentage of people in poverty is the group that lacks a high school diploma, with 34.9% being poor. Turning our attention to employment status, Table 4 further reveals that more people below the poverty level are employed rather than unemployed. In addition, when we look at the civilian labor force 16 years and over, we see that the largest number (53,799) of people that are below the poverty level worked part-time or part-year in the past 12 months.

While unemployment has decreased, a significant number of people remain unemployed or are working part-time, whereas we have seen a corresponding rise in the number of people living below the poverty level. Many of these people lack health insurance and many depend on government insurance programs as well as rely on public assistance programs as a means to be self-sufficient. According to the U.S. Census Bureau's American Community Survey 3-Year Estimates 2008-2010, Table 7 and Table 8 below provide us with an overview of health insurance coverage for Franklin County and income and benefits data for income other than earned income.

Table 7. Health Insurance Coverage*



*Totals do not equal 100 due to coverage changes, which would lead to being counted more than one category. Source: U. S. Census Bureau 2008-2010 American Community Survey 3-Year Estimates

To gain some perspective of the size of the population of people that have Medicaid, we utilized data from the Ohio Department of Jobs and Family Services 2009 Franklin County Profile. According to the profile there are **256,054 residents enrolled in Medicaid** in Franklin County.

Table 8 below provides a three year history of consumers served by line of business. A review of this data shows that non-Medicaid consumers receiving ADAMH funded services increased significantly in 2011 with 683 additional consumers receiving ADAMH funded services and with ADAMH expending \$1,722,627 more than what was expended in 2010. Again, in 2012, the number of non-Medicaid consumers receiving ADAMH funded services increased as well as the amount of funding expended to serve those consumers in need increased. For 2012, consumers receiving ADAMH funded services increased by an additional 115 consumers with ADAMH expending \$489,793 more than it expended in 2011 to serve non-Medicaid consumers in need. The number of Medicaid eligible consumers receiving ADAMH funded services increased in 2011, but decreased by 251 in 2012.

Table. 8. Three Year History of Consumers Served by Line of Business

Line of Business	2010 Allowed Amount	2010 Distinct Patient Count	2011 Allowed Amount	2011 Distinct Patient Count	2012 Allowed Amount	2012 Distinct Patient Count
MCD	\$12,236,855	6,701	\$11,110,875	7,000	\$11,154,872	6,749
NON	\$35,931,666	17,119	\$37,654,293	17,802	\$38,144,086	17,917
Grand Total	\$48,168,522	22,746	\$48,765,168	23,588	\$49,298,958	23,278

To gain some perspective as to the number of people that have no health insurance we utilized the 2010 Ohio Family Health Survey (OFHS). Key findings from the survey are:

- The uninsured percentage for working-age adults has increased from 15% to 18.5% from 2003/04 to 2010, for an increase of 308,645 Ohioans. Forty-six and a half percent (143,709) of this number has occurred within the past two years.
- The number of uninsured working-age adults has increased for each income category, except for people with incomes above 400% of poverty (which would be \$76,360 for a family of three).
- Employer-sponsored coverage remains the most common type of coverage for working-age adults, though this rate

of coverage has fallen by 8.9 percentage points between 2003/2004 (66.3%) and 2010 (57.4%).

- Being uninsured is the second largest insurance category (not insured) for working-age adults, followed by those enrolled in Medicaid.

To calculate the number of working-age adults (age group of 18 to 64) that do not have health insurance, we can use the uninsured percentage from the Ohio Family Health Survey of 18.5% multiplied by the number of working adults obtained from U. S. Census data (769,166). Performing the calculation, we can estimate that **142,296 working-age adults in Franklin County have no health insurance**.

The Ohio Family Health Survey also provides us with some key findings for uninsured children. Those findings are below:

- Ohio’s percent of uninsured children has declined from 5.4% to 4.6% from 2003/04 to 2010 (29,420 children).
- Ohio’s child uninsured proportion is less than ½ the national average, which exceeds 10%.
- Almost 86% of Ohio uninsured children in 2010 (108,260) live in families with incomes less than or equal to 200% of the federal poverty level, suggesting that they meet the income eligibility criteria for Medicaid.
- Ohio’s low child uninsured rate has benefited from an increase in Medicaid coverage for children due to SCHIP.
- The rate of employer sponsored insurance coverage for children has fallen by 23.4 percentage points, from 61.9% to 48.5% between 2003/04 and 2010, with almost 1/3 of this reduction happening within the past two years.
- Medicaid is the second largest source of coverage for children at 39.5%.

To calculate the number of children (age group under 18) that do not have health insurance, we can use the uninsured percentage from the Ohio Family Health Survey of 4.65% multiplied by the number of people under 18 obtained from U. S. Census data (278,542). Performing the calculation, we can estimate that **12,813 children in Franklin County have no health insurance**. As stated above, the Ohio Family Health Survey estimates that almost 86% of Ohio uninsured children live in families whose income meets the income eligibility criteria for Medicaid. We can use this estimate to calculate an approximate number of children that are Medicaid eligible that have no health insurance for Franklin County. As a result, we estimate that **11,019 uninsured children in Franklin County are Medicaid eligible**.

The Census data from 2012 ACS provides us with some additional estimates for the number of people in Franklin County that are uninsured which are as follows: 160,970 or 13.6% of the county’s total population is uninsured of which 17,772 are under 18 years of age, 141, 666 are between the ages of 18 and 64 years of age and 1,532 are estimated to be 65 years and older.

To gain a better understanding of the Medicaid and uninsured populations, a brief review of some selected socio-economic data could be most insightful. Table 9 below provides information regarding sources of income other than earnings and benefits. Depending on the size of the household(s), many of these household(s) would be living below the federal poverty level. To gain an understanding as to how impoverished these households are, the 2013 federal poverty level for family sizes of one through three is below. As stated earlier, mean family size for Franklin County is 3.05.

- A. Family Size of 1 = \$11,490;
- B. Family Size of 2 = \$15,510; and
- C. Family Size of 3 = \$19,530.

Table 9. Income other than earnings and benefits 2012 ACS

Income Source/Benefit	Number of People	Average Income/Benefit (if provided)
Social Security	100,495	\$15,681
Retirement/pension	72,935	\$24,675
Supplemental Security	22,699	\$8,759
Cash Public Assistance	17,785	\$2,789
Food Stamp/SNAP	73,236	-----

We can conclude that many of the households with Supplemental Security and Cash Public Assistance, without any other income or public assistance, will have significant and multiple barriers to self-sufficiency, which will impact their ability to seek, access and maintain mental health or AOD treatment services.

To make our analysis more meaningful in terms of who may need mental health and AOD treatment services, we also considered national prevalence rates from the report “Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings” prepared by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. The National Survey provides a prevalence rate of 20% of the U.S. adult population has any mental illness (AMI) and a prevalence rate of 5% for severe mental illness (SMI). The National Survey also reports that women aged 18 or older were more likely than men aged 18 or older to have past year AMI (23.0 vs. 16.8 percent) and SMI (6.5 vs. 3.4 percent).

In addition, the National Survey provides a prevalence rate for youth (ages 12 to 17) who had a major depressive episode (MDE) during the past year of 8.0% and a prevalence rate for youth that received treatment or counseling for problems with emotions or behavior of 12.2%. Using these prevalence rates and population data from the U.S Census Bureau, we can calculate local population prevalence estimates for both adults and youth (see Table 10 below).

Table 10. Calculation of Population Estimate for Franklin County

2010 U.S. Prevalence Rate	Population	Estimate of Local Prevalence
Adults (age 18 and over) AMI = 20%	884,872	176,974
Adults SMI = 5%	884,872	44,244
Youth (age 12 to 17) MDE = 8%	90,248	7,220
Youth Problem with Emotions/Behavior = 12.2%	90,248	11,010

The National Survey, also, provides a prevalence rate for substance dependence or abuse among adults aged 18 or older with AMI in the past year: 20.0 percent met the criteria for substance dependence or abuse. Among adults aged 18 or older with SMI in the past year, 25.2 percent also had past year substance dependence or abuse. Using these prevalence rates we can calculate population prevalence estimates for substance dependence or abuse for adults 18 and older by AMI and SMI (see Tables 11 and 12 below).

Table 11. Calculation of Population Estimate for Substance Dependence/Abuse for Adults with AMI

Estimate of Local Population Prevalence AMI	Prevalence Rate AMI with substance dependence or abuse = 20%
Adults (age 18 and over) = 176,974	35,395

Table 12. Calculation of Population Estimate for Substance Dependence/Abuse for Adults with SMI

Estimate of Local Population Prevalence SMI	Prevalence Rate SMI with substance dependence or abuse = 25.2%
Adults (age 18 and over) = 44,244	11,150

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Assessment of Need and Identification of Gaps and Disparities

- 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)

In 2010, approximately 32.2%, or 354,680 of Franklin County's population lives at or below 199% of the federally designated poverty level (<http://development.ohio.gov/research/files/s0/Franklin.pdf>). It is this population that attempts to access behavioral health services from the public sector.

The Board employs a variety of approaches in determining current and future needs for services and care in the Franklin County public care system. One such method is the utilization of co-sponsored research, surveys and reports by Universities within the state and various Government Departments of the State of Ohio. With more than 51,000 households interviewed, the Ohio Family Health Survey (OFHS) is one of the largest and most comprehensive state-

level health and insurance surveys conducted in the country. The project was managed by The Ohio State University's Ohio Colleges of Medicine Government Resource Center, and the Health Policy Institute of Ohio. The survey was conducted by Macro International. The Ohio Departments of Insurance, Job and Family Services, Health, and Mental Health, the Cleveland State University, and the Ohio Board of Regents funded the project. The current project (2008) is the third in a series of statewide health surveys, following family health surveys in 1998 and 2004.

The 2008 Ohio Family Health Survey (OFHS), Franklin county level data estimates that 26,722 children that have health insurance, have no mental health coverage (9.82%) and another 13,099 have no health or mental health coverage (4.5%). It further estimates that there are 139,193 (18.88%) adults ages 18-64 in Franklin County who are uninsured, and 183,589 (24.9%) with no mental health coverage. In addition, an estimated 44,396 adults (7.42%) with health insurance have no coverage for mental health, and another 25,786 (4.31%) insured adults have no benefits for needed prescription drugs. An estimated 146,553 (19.88%) of adults reported that they could not afford the cost of needed prescription drugs even with health insurance coverage. This is the primary population that the ADAMH Board of Franklin County has and will be serving in the foreseeable future, and given national prevalence data for mental illness and drug/alcohol addiction, we estimate that at least 11,000 children ages 0-17, and more than 55,000 adults ages 18-64 could benefit from ADAMH services.

OFHS data analyses revealed that approximately 10% of children and adults report having social, emotional, behavioral or substance abuse problems that require counseling. It was documented that with approximately 4% of adults, these mental health problems are so severe that they had resulted in at least 30 days of missed normal activities within the past year. The prevalence of the mental health challenges reported is complicated by the fact that 8.7% of children and 16.7% of adults did not have mental health coverage at the time of the survey. Furthermore, 23% of adults and 18% of parents were unsure of whether their plans included mental health coverage.

OFHS found that both adults and children experienced unmet mental health needs due to barriers including cost and no insurance coverage. Additionally, the demographic and health risks were similar for children and adults. For children, being ages 13-17 years old, male and African-American or multi-racial backgrounds were all associated with having more emotional, developmental or behavioral problems. Children from low-income families (100% below the federal poverty level), children who were obese, and those with parents with less than a high school education also had more emotional, developmental or behavioral problems.

For adults, OFHS found that males were at greatest risk for needing mental health care services; however, females were more likely to seek services. Finally, adults ages 45-64, minorities, separated couples and those with high school or less education were more likely to have 30 or more missed activity days. In general, urban counties reported higher rates of mental health challenges. To further illustrate the connection of mental health problems across generations, 92% of parents who need or receive treatment for a mental health condition also have a child/children that need or receive treatment.

Since this survey was completed, economic conditions have deteriorated causing both an increase in the numbers of families and individuals without health coverage and a reduction in available Board funding. Because of inadequate funding levels for community mental health treatment, available resources were targeted toward the most frail and vulnerable populations – SMI, SMD, and SED.

Our primary unrealized goal has been access to services by two large populations – non-SMD/SMI/SED clients and those without any healthcare coverage whatsoever. General and older adults who are not SMD/SMI have been given the lowest priority for services. Thus, this has been the group with the least access to behavioral healthcare services in the current economy. Unfortunately, this is also the population that requests services in the greatest number.

The primary barrier to serving this population has been the funding levels. ADAMH estimates that approximately 15,000 adults and older adults will seek outpatient mental health services from the public sector in SFY2013-14. Since

many Provider Agencies have many more requests for services than they can handle, many general mental health consumers will not receive services through the public sector annually. With current budget levels, we now estimate that for SFY2013-14, only 12,000 will actually receive mental health treatment.

The need for safe and affordable housing in Franklin County for consumers in the ADAMH system of care continues to be a concern. Consumers receiving ADAMH funded services increased from 17,119 people in 2010 to 17,917 people in 2012. This was an increase of 798 additional consumers. Over 10,000 people are currently on a waitlist for housing, and homelessness continues to be an issue with the Community Shelter Board (CSB) reporting 9,167 individuals having spent time in the Emergency Shelter system while 1,561 single adults were diverted from entering the emergency shelter system in fiscal year 7/1/12 to 6/30/13. For the same fiscal year, CSB reported capacity limitations for single adults prevented 51 individuals, on average, from receiving emergency shelter each night outside the overflow season.

The Board employs all standard approaches in determining current and future needs for services and care in the Franklin County public care system (focus groups, key informants, surveys, penetration rates, demographic and social indicators, etc.). The Board's 2005 Levy Plan is a ten year plan (2007-2016), which included the board's process for determining current and future treatment needs. The needs assessment process began with using national epidemiologic data on prevalence and demographic, poverty and social data to arrive at the number of people most likely to be in need of our services in Franklin County.

All planning efforts include input from key stakeholders, consumers and family members through various interviews, task forces, educational group meetings, and surveys. Our planning and needs assessment process incorporates educational stakeholder focus groups (including consumers and family members), and interviews to determine more specific service and program needs for the next three to five years. The needs assessment and planning process culminates with our annual Strategic Business Plan which lays out specific desired measurable results that are aligned to the Key Strategic Results, which are three to five year goals formulated by our Board.

As a result of these efforts, our Board of Trustees has established the following Key Strategic Results:

Access To Integrated Care: By January 2017, ADAMH will expand access to care for uninsured people through models of primary care, addiction treatment, and mental health care to help achieve identified outcomes and recovery.

Access To Quality Care & Supports: By January 2017, ADAMH will improve access to clinically appropriate and necessary treatment services and supports for children, youth, families, and individuals to help achieve identified outcomes and recovery.

Value Based Contracting: By January 2017, ADAMH will streamline service delivery to increase system efficiencies, expand access to care, and sustain clinical quality and cultural competency through value based contracting.

Community Collaboration & Engagement: By January 2017, ADAMH will increase support from Franklin County communities for the Board's mission by sustaining and expanding its collaboration and outreach with community partners.

Community Advocacy: By January 2017, ADAMH will advocate to local, state, and national elected officials and decision makers to provide increased support for community-based services and treatment for children, youth, families, and individuals.

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*).

Strong working collaborative efforts exist in Franklin County that support and provide care to priority populations in addition to investment in evidence-based models for service delivery. These efforts include:

Behavioral Health/Juvenile Justice

The ADAMH Board of Franklin County, in collaboration with Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch, and Franklin County Family and Children First Council, has developed, implemented and expanded a model to meet the treatment and support needs of youth and their families who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system.

The model moves a youth from the Franklin County Juvenile Court Pre-Sentence Investigation through a screening and assessment process that involves a care coordinator who facilitates the delivery of service throughout the program. Care coordinators engage families and provide linkage and bridging to evidenced-based treatment services including Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Multidimensional Family Therapy (MDFT).

The service delivery team includes the youth and family, probation officer, school, family defined support, treatment providers and other system representatives as necessary. This model will continue to improve intersystem communication and shared outcomes among the behavioral healthcare, juvenile justice, and child welfare systems.

Multi-systemic Therapy (MST) for juvenile offenders addresses the multidimensional nature of behavior problems in troubled youth. Treatment focuses on those factors in each youth's social ecology that are contributing to his or her antisocial behavior. The cultural context of children and their families is fundamental to the social ecological model. As a result, MST has been implemented successfully with youth and families from many different cultural backgrounds. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization. Three decades of research has shown the following positive outcomes:

- Long-term re-arrest rates reduced by 25-70%;
- Out-of-home placements reduced by 47-64%;
- Improved family functioning;
- Decreased substance use; and
- Fewer mental-health problems for serious juvenile offenders.

Functional Family Therapy (FFT) is an empirically grounded, well-documented and highly successful family intervention for at-risk youth ages 10 to 18 whose problems range from acting out to conduct disorders to alcohol and/or substance abuse. This approach focuses on the strengthening of relationships in the family by opening up communication and reframing negative behaviors by putting them within a positive relational context. FFT has been increasingly adopted in

multicultural contexts and outcome data supports the generalizability of this intervention across racial/cultural groups. Since Dr. James F. Alexander founded FFT in 1972, FFT has demonstrated positive program outcomes across a wide range of youth and communities as evidenced by:

- Significant and long-term reductions in youth re-offending and violent behavior;
- Significant effectiveness in reducing sibling entry into high-risk behaviors;
- Low drop-out and high completion rates; and
- Positive impacts on family conflict, family communication, parenting, and youth problem behavior.

The Reception Center is a joint venture between the Franklin County Court of Common Pleas Division of Domestic Relations, Juvenile Branch and the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board. The program is designed to improve intersystem collaboration and shared outcomes among the behavioral healthcare and the juvenile justice system. Based on the data, there are a significant number of juveniles currently admitted into the Franklin County Juvenile Detention Center who might be better served by community-based behavioral health treatment alternatives and existing programs and services in the community. The Reception Center Intervention will provide pre-adjudicated youth and their families with immediate access to mental health and alcohol and other drug assessment and referral to ongoing services as needed. Currently, a youth who has been charged with an offense will wait 100 to 120 days before their case is processed and court-ordered referrals for services are completed. This project intends to provide an expedited assessment and linkage to services. For youth who cannot return home safely following the youth's assessment, alternative care providers have been included in this model of care to provide safe respite. The Reception Center Intervention will also include the opportunity to refer youth to an Evening Supervision program which will provide the youth with mental health and substance use oriented group treatment in the evenings when gaps in supervision and structured activities tend to occur. The Reception Center began full implementation in September of 2013.

The Youth Crisis Stabilization Unit (YCSU) is an initiative that was implemented in 2011 and expanded in 2013 for the purpose of bolstering the crisis service continuum and providing an alternative to psychiatric inpatient hospitalization for youth 18 and under who reside in Franklin County. The YCSU provides assessment by a clinician and a psychiatrist, brief individual and family psychotherapy. The goals of the unit are to help the youth and families understand what led to the crisis event, to identify and develop healthy and adaptable coping skills to decrease future crises or need for psychiatric inpatient hospitalization and to improve commitment to ongoing mental health counseling in the community. YCSU clinicians ensure timely linkage with the appropriate level of care in the community (or re-linkage if a youth/family is already receiving services). Up to three follow-ups are available to help bridge while families wait to link.

Identification, linkage and treatment services to individuals hospitalized in State BHOs (primarily individuals without health insurance): this is inclusive of a strong, working Continuity of Care Agreement held between lead agencies, ADAMH, and the State Hospitals. Specifically trained Hospital Liaisons are unique positions within our Lead Agencies, including a primary AOD provider, that coordinate care and discharge planning for these individuals. Our network of residential Care facilities and investments in supportive Housing programs supports the discharge process for these same individuals and provides an intensive level of care needed to coordinate and ease their transition back into the community. A complementary and parallel collaboration and network of hospital liaisons exist, as well, serving individuals exiting local private psychiatric hospitals, and Netcare's Crisis Stabilization unit.

Since 2008, Franklin County has implemented and sustained a strong **Integrated Dual Disorder Treatment/Assertive Community Treatment** initiative that has created a level of care that did not previously exist. This initiative currently serves 325 of Franklin County's severely mentally ill persons with co-occurring substance use disorders.

Treatment and crisis services to the most vulnerable (i.e. SMD, SED, pregnant and IV drug users), legislatively mandated populations have been maintained in the last 3-5 years of reductions and policy change effecting services to Franklin County residents. Crisis care is inclusive of both mental health and AOD crisis care and specifically includes

24/7 crisis intervention, sub-acute detoxification, methadone/buprenorphine programming, and engagement services for homeless, publically inebriated adults.

Franklin County's primary crisis care provider, Netcare, works closely with Maryhaven our sub-acute detoxification provider to prioritize entry into these detoxification beds for individuals presenting to Netcare. This collaboration has also led to collaborative efforts on the identification of frequent users with our crisis care system and the coordination of crisis planning for these most vulnerable individuals.

Medication Assisted Treatment (MAT) is an ambulatory outpatient service for adults addicted to narcotic/opiate drugs. In addition to the administration of Methadone and Suboxone to block the cravings for opiates, clients are offered a full array of support services including medical, psychological, familial, vocational/educational, urine screening and others in order to improve their quality of life and to guide them in becoming productive members of society. **MAT** is provided at Comp Drug and at Maryhaven and assures services to uninsured adults. Comp Drug is the largest Medication Assisted Treatment provider in the State. In 2014, the ADAMH Board plans to be involved in the Vivitrol Pilot Project with four community specialty docket drug courts in Franklin County.

Specialty Dockets

Strong working relationships between our local Municipal Court, Mental Health Court, and Specialty Dockets exist in Franklin County to provide mental health and addiction treatment services to individuals participating in the Mental Health Court and the Alcohol and Drug Abuse Program specialty dockets. A specialized team exists to provide Integrated Dual Disorder Treatment series to individuals referred directly from Municipal and Common Pleas court in need of such care.

In 2013, the ADAMH Board partnered with the C.A.T.C.H (Changing Actions to Change Habits) Court to provide residential treatment to survivors of Human Trafficking. Through an RFR process, the Alvis House was awarded funds to provide safe housing and supports to women who are in the C.A.T.C.H Court program.

AOD Residential Services

In the ADAMH system, we have several residential treatment options that help consumers achieve sobriety. This higher level of care provides support, education, the 12-step process, therapy, and the opportunity to recreate their lifestyle in order to promote wellness and good health.

In the past year, the ADAMH Board of Franklin County in partnership with the Ohio Department of Mental Health and Addiction Services provided funding to the House of Hope for two Sober Houses. Sober Housing allows for consumers in our system of care to step down from Residential Care with the necessary peer supports so that the consumers can practice the skills of their recovery in the community. The consumers pay their own rent and are often times employed.

Integrated Care Models

In 2013, the ADAMH Board continued to invest resources in development of Integrated Care Models. These efforts will provide increased access to mental health and substance use services for uninsured people residing in Franklin County through an integrated primary and behavioral healthcare approach.

Services should include:

- Maximized linkage to primary healthcare provider if a patient presents first from a behavioral health need;
- Ready access for persons in primary healthcare to receive services in behavioral health;
- Referrals from providers (e.g. behavioral health to primary health or primary health to behavioral health) are exchanged and responded to in a timely manner; and
- Behavioral health providers offer psychiatric consultation to Primary Care Physician regarding medication needs.

The expansion will continue in 2014. Our goal is to ensure a co-location of behavioral health in all FQHCs in the county

as well as Integrated Care Models in other healthcare settings.

Dual Diagnosis Treatment

The ADAMH Board issued a request for results to the Franklin County System of Care to provide Integrated treatment services for individuals with co-occurring mental health and substance use disorders. Integrated treatment services coordinate substance use treatment and mental health interventions to treat the whole person more effectively, combining treatment interventions within a primary treatment relationship or service setting, ensuring that entry into any one system can provide access to all needed services.

Amethyst Inc., Maryhaven, Nationwide Children's Hospital, North Central and Southeast, Inc. were all awarded funds to provide services to clients who had either "more severe mental disorders and less severe substance use disorders" or "more severe substance use disorders and less severe mental disorders".

The awarded dual diagnosis program at Nationwide Children's Hospital is the Integrated Co-Occurring Treatment (ICT) Model. ICT is an integrated treatment approach embedded in an intensive home-based method of service delivery, which provides a comprehensive and integrated set of mental health and substance use treatments to youth with co-occurring disorders of substance use and serious emotional disturbance (SED) and their families in home, school, and community settings. The service array includes: integrated contextual assessment, individual and family counseling, skill building, crisis intervention and stabilization, service coordination, and resource and support building activities. ICT providers are on-call to the youth and families they serve 24 hours a day, 7 days a week. Caseloads are small (4 to 6 families) which allows for intensive provision of services (3 to 6 hours per week) over a 4 to 6 month period of time. ICT utilizes an eco-contextual framework which maintains that symptoms and behaviors manifest in, and are influenced by, multiple contexts including home, school, peers, and community factors. ICT believes that the formation of multiple, culturally-mindful relationships and partnerships with youth, family members, family supports, and system partners are necessary to impact meaningful change.

Prevention Services

The ADAMH Board of Franklin County and its providers offer mental health education and skill-building services to children, youth, families and individuals so they can avoid the abuse of drugs and alcohol, make positive behavior choices, and improve the well-being of our community. Services include:

- ATOD screening services, problem gambling screening services
- Coalition building services: community outreach, strategic planning, workgroup development, training
- Early intervention services: HIV, ATOD, suicide prevention, anger management, job readiness, problem gambling
- Hotline services
- Prevention education trainings referral services
- Program development technical assistance services
- School and community-based mental health services such as consultation, support groups facilitation, student assistance, parental support

Partnerships in the community include funders such as the United Way of Central Ohio, City of Columbus and the Faith community. These partnerships combine resources and expertise to prevent problem behaviors across the individual's life span in the home, school and the community.

Franklin County Urban Strategic Prevention Framework Coalition

Partners include ADAMH Providers: Columbus Public Health, UMADAOP, Community for New Direction; Community Groups and Businesses: Community Research Partners, Youth Build Franklin County, Clarity Creative Institute, Warhol & WALL ST, Ohio National Guard, The Neighborhood House.

- Goal is to reduce the use of marijuana by 18-25 year old African Americans residing in Columbus' Urban Core (zip codes 43204, 43205, 43206, 43211, 43223).

- The FCUC Usage Survey data 2012 indicate that 42% of 18-25 year olds in the urban core have used marijuana or hashish in the last 30 days. In comparison, SAMSHA estimates that in Ohio (2012) 18.5% of the population use marijuana (aged 18-26). The mean age of first use was 13.9 for marijuana according to respondents of the FCUC Usage Survey.
- The 5,880 18-25 year old African Americans residing in the urban core are more likely:
 - To listen to hip hop/rap music considered to be the “CNN for black people”⁸ (79% of the 18-25 year olds reported their favorite music is hip-hop.)⁹
 - To be unemployed or not in the labor force.

The urban core unemployment rate is 44%, which is significantly higher than the City of Columbus unemployment rate of 8% and Franklin County unemployment rate 7%.¹⁰ Facts about youth admitted to juvenile justice institution or prison include:

- In 2010, 71% of Franklin County youth admitted to juvenile justice institutions were African Americans from the urban core.¹¹
- In 2010, blacks represented 44.0% of those committed to state prison facilities from the Franklin County court system, although they comprised only 19.3% of the population of Franklin County.¹²

Facts about academic failure include:

- In 2009-10, 45% of African American males in Franklin County graduated from high school compared to 80% of the white non-Latino males (Ohio ranked 46th in the nation).¹³
- The OSU Kirwan Institute for the Study of Race and Ethnicity’s African American Male Initiative analytic review of the literature has revealed studies continue to show that teachers perceive African American males to be academically inferior, overly aggressive, lacking adequate leadership, and social skills.
- The OSU Kirwan Institute for the Study of Race and Ethnicity’s African American Male study found that structural factors contribute to the disproportionate number of black males suspended from school, including zero tolerance policies and the criminalization of male behavior.

Health disparity facts include:

- Blacks are 21.5% of the population in Franklin County. If there was an equal and fair distribution of disease, blacks would represent approximately 20% of the deaths for each cause, yet they represent:
- 63% of the homicides in Franklin County 2012;
- 52.5% of conditions originating in the perinatal period that negatively affect the health outcomes of mother and the baby including: infant mortality, low birth weight and pre term births; and
- 47.2% of HIV disease including Living with AIDS/HIV and HIV incidence.

7 Data sources include the 2011 Census and the 2006-2010 American Community Survey.

8 http://www.berkeley.edu/news/media/releases/2008/04/01_rapmusic.shtml

9 [http://fcuc.org/fcuc-reports/Needs Assessment Report SPF SIG Franklin County 2013 Individual Level FCUC 18-25 year old Usage Survey 2012](http://fcuc.org/fcuc-reports/Needs%20Assessment%20Report%20SPF%20SIG%20Franklin%20County%202013%20Individual%20Level%20FCUC%2018-25%20year%20old%20Usage%20Survey%202012)

10 [http://fcuc.org/fcuc-reports/PDF Needs Assessment Report SPF SIG Franklin County 2013 Appendix Individual Level FCUC 18-25 year old Usage Survey 2012](http://fcuc.org/fcuc-reports/PDF%20Needs%20Assessment%20Report%20SPF%20SIG%20Franklin%20County%202013%20Appendix%20Individual%20Level%20FCUC%2018-25%20year%20old%20Usage%20Survey%202012)

11 http://centralohioindicators.org/site/indicators/safety/1_PDFS/Safety%205.pdf

12 http://centralohioindicators.org/site/indicators/safety/1_PDFS/Safety%209.pdf

13 www.blackboysreport.org The Schott 50 State Report on Public Education and Black Males — 2012

Ohio After School Network

The Ohio Afterschool Network (OAN) supports children, youth, families, and communities by advocating and building capacity with a unified voice for sustainable investments in safe, healthy, and engaging afterschool experiences that promote life-long learning. In 2013, OAN distributed Quality Self-Assessment Tool (QSAT) aligned to the Quality Guidelines for Ohio’s Afterschool Programs.

Community Conversations on Mental Health

Partners include: Every Day Democracy, Franklin County Children's Services, Human Service Chamber of Franklin County, Multiethnic Advocates for Cultural Competence (MACC), Mental Health America of Franklin County, National Alliance on Mental Ill of Franklin Co. (NAMI FC & NAMI Ohio) Ohio Dept. of Mental Health and Addiction Services (ODMHAS), Suicide Prevention Foundation, The Center For Family Safety and Healing, The P.E.E.R. Center, Columbus Police Department, Wellness Management and Recovery

Goals of the deliberations are:

- Get Communities talking about mental health, to break down misperceptions and promote recovery and healthy communities;
- Find innovative solutions to mental health needs that are relevant to communities and that serve young people and young adults in particular; and
- Develop clear action steps to move forward in a way that complements existing local activities.

- a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

Integrated Dual Disorder/Assertive Community Treatment

The Franklin County Behavioral Health/Juvenile Justice initiative presents an opportunity for Franklin County ADAMH to provide assistance to other boards and/or to state departments. Oversight of the project is conducted by the BHJJ Oversight Group, which is currently comprised of representatives from ADAMH, FCCS, Juvenile Court, and Nationwide Children's Hospital, a service provider within the ADAMH system of care, and representatives from both the Ohio Department of Youth Services and the Ohio Department of Mental Health and Addiction Services.

In addition, Franklin County ADAMH participates in a statewide BHJJ workgroup that meets quarterly. Board representatives from across the state attend this meeting and are asked to share information regarding their local initiative's progress to date, lessons learned regarding clinical issues, intersystem collaboration, implementation issues, financing/sustainability, and evaluation issues.

Crisis Intervention Training (CIT)

Implements training programs to assist police officers to become more competent in working with people with mental illness by increasing their sensitivity and improving their skills. Both a Consumer and Family Panel are utilized to share their perspectives and offer strategies on ways officers should engage consumers during crises.

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*).
 - Our local system of care has been seeing the impact of the many individuals who do not fall into ADAMH's priority populations for treatment services. Persons with routine care needs that are not listed in prioritized or mandated population categories may have to wait longer for services or may not receive services at all in our system. Our local stakeholders within the court system have identified this as having a significant impact on the ability for them to refer probationers into treatment.
 - Increased numbers of individuals re-entering and newly entering Franklin County after being incarcerated continues to be an issue of great concern. Many of these individuals return to the community without any support

system and end up being diverted to our community-based crisis sites with long term care needs for which we do not have the resources to fully provide the care they need.

- An increasing number of diverse healthcare plans & benefits will challenge consumers and families in meeting their expectations from multiple public payer systems.
- A significant increase in the need for intensive and specialized treatment for individuals with dual disorders (i.e. both mental health and substance abuse disorders) and high use of psychiatric beds.
- Lack of availability of local private inpatient psychiatric beds continues to be a challenge for the Central Ohio Area.
- Services for Transitional Age Youth are fragmented. Limited access across different programs (e.g., mental health, education, vocational rehabilitation, juvenile justice, child welfare, housing) and funding mechanisms (e.g., Social Security, state and local appropriations, Medicaid, and federal block grants) further complicate this transition arena for young people with emotional and behavioral disturbances and their families. For the most part, each of these program components has entirely different eligibility requirements, and the child-serving and adult-serving programs operate under different world views. While each program may provide some essential services individually, together these programs are often impossible for young people, parents, and professionals to navigate due to the complexities and fragmentation within and between programs. Franklin County ADAMH is in the process of identifying a viable and sustainable treatment model for this population.
- We also have a challenge meeting ADAMH consumer housing needs. A continuum of housing options is needed, ranging from the most independent housing; to supportive housing that provides an on-site resident manager; to service-enriched housing with some sort of on-site services provided twenty-four hours per day; to residential treatment with intensive supports and assistance with activities of daily living to ensure a smooth transition to community-based living. In addition to needing more housing units there is the challenge to create the most efficient, cost effective system of moving people along that continuum. Although housing is considered permanent, efforts and expectations need to be made to move people out of the more intensive, higher cost settings when appropriate and on to a more independent setting to allow room for those with higher needs.
- We see challenges for the ADAMH-contracted Provider Network. Their ability to meet the demands of consumers will be challenged by a rapidly changing reimbursements environment along with increased demand for price and quality transparency and performance reimbursements.
- Another challenge for ADAMH providers is a lack of sustainability of the direct care workforce, along with an insufficient capacity for cultural competency for the increasingly diverse population of Franklin County.
 - a. What are the current and/or potential impacts to the system as a result of those challenges?
 - We anticipate an increasing lack of availability of timely AOD and mental health treatment services for individuals falling outside of our prioritized populations.
 - The lack of stable and sustainable direct care workforce translates into poor clinical relationship development as consumers experience high turnover within their primary team of individual care providers and lost productivity for the provider.
 - We have started to see challenges within our provider network regarding the tiered payment for CPST. The resulting impact is a reduction of needed intensive services when consumers exit higher levels of care and are in need of time intensive, stabilizing services within the weeks post-discharge. Coordination efforts between providers have been tested and challenged.

- The impact to the ADAMH system in not being able to move people along the continuum of housing options is that higher costs will be incurred when a consumer remains in a residential care facility because there is not space available in a supportive housing unit, a less intense service setting. In addition, wait lists will continue to grow due to a shortage of available housing units.
 - Franklin County continues to have peak crisis service delivery periods in which all local inpatient beds are full, resulting in long stays in emergency rooms at Netcare prior to an individual placement in a psychiatric bed. Diversion of crisis referrals may result during these peak periods of system crisis care acuity, further straining our local emergency rooms and law enforcement. On the youth side of the crisis continuum, Franklin County has seen a spike in the number of youth presenting to local emergency departments for behavioral health needs. This increase has continued to impact the system negatively despite expansion of the Youth Crisis Stabilization Unit (YCSU) at Nationwide Children’s Hospital.
 - We are struggling to find doctors who can prescribe Medication Assisted Treatment to clients who are addicted to Opiates. As the Opiate Epidemic continues, there is a shortage of doctors to prescribe medications due to the prescribing restrictions of Medication Assisted Treatment.
- b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

Transition Age Youth

Services for Transitional Age Youth are fragmented. Limited access across different programs (e.g., mental health, education, vocational rehabilitation, juvenile justice, child welfare, housing) and funding mechanisms (e.g., Social Security, state and local appropriations, Medicaid, and federal block grants) further complicate this transition arena for young people with emotional and behavioral disturbances and their families. For the most part, each of these program components has entirely different eligibility requirements, and the child-serving and adult-serving programs operate under different world views. While each program may provide some essential services individually, together these programs are often impossible for young people, parents, and professionals to negotiate due to the complexities and fragmentation within and between programs. Franklin County ADAMH is in the process of identifying a viable and sustainable treatment model for this population. Assistance from other boards and/or state departments would be welcomed.

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*).

Vision: To provide a wide range of culturally competent programs and services that address the unique mental health and alcohol and other drug needs of racial and cultural diverse communities.

Goal: To enhance the quality of care in Ohio’s behavioral health system and to incorporate cultural competence into systems and organizations that provide care to Ohio’s most vulnerable and at-risk populations.

Provider Network:

1. Ability of providers to meet the demands of consumers will be challenged by:
 - ◆ Insufficient cultural diversity in the workforce:
 - Increased costs of interpretation services;
 - Lack of bilingual/bicultural staff who can better related to immigrants/refugees; and
 - Assessment tool that can inform the Board about system disparities.

The ADAMH Board of Franklin County continues to build on the tenets of cultural competence, which we established in 1990 after responding to a statewide Minority Concerns Report published by the Ohio Department of Mental Health (ODMH, 1989 & 1991). That report illustrated the disparities impacting ethnic minorities in the state of Ohio (i.e., misdiagnoses, over-medication, over-hospitalization, under-utilization of community-based care, etc.). As a result, the Board used that report along with its previous work in cultural training in the late 1980s to establish a principled approach to continuously address the needs of underserved diverse populations. We clearly recognized the Sisyphean challenge of sustaining cultural competence in our system - especially since there are so many variables influencing underserved diverse populations.

Since the 2010-2011 Community Plan submission, our system experienced significant cuts to the budget. Those cuts impacted cultural competency efforts in several ways, which caused ADAMH to eliminate and modify some of its planned initiatives. Primarily, cuts eliminated cultural competence training at the system's level. This was particularly concerning since there is evidence to show cultural competence training leads to better outcomes for clients, thus reducing costs. Additionally, cuts eliminated the initial partnership between ADAMH providers and Columbus Neighborhood Health Center on the west side to provide behavioral health services to Latino/Hispanic and other Westside residents who also sought primary healthcare (Note: there now is a mental health provider housed in CNHC Westside clinic, but full integration as we planned has not occurred). Reductions also ended the board's own innovation grants to providers designed to stimulate new services, including cultural specific programs and services.

The ADAMH Board continues to find new ways of addressing cultural competency efforts during these difficult times – realizing the importance of serving all diverse communities. The Board is partnering with organizations to address the multiple needs of diverse communities. The Board plans on working with providers to identify culturally situated grants to address issues regarding disparities and related monitoring/assessment tools, professional development, interpretation and translation supports, informational/promotional material development, and other supports. The goals for 2013-14 will be built upon provider cultural competency plans submitted in 2012. As a part of the cultural competency plan development process, providers were required to conduct a comprehensive self-assessment of 11 key culturally competent standards. The Board will review provider plans and provide technical support to ensure both compliance and technical capacity to address the needs of diverse populations. These plans are built upon the overall structure of ADAMH's cultural competency initiatives outlined below.

Background:

The context for the Board's cultural competence initiatives is grounded in a model that was adopted and modified for use by our system of care. The modification of the CASSP Technical Assistance Model (Cross, 1989) extends the cultural competency basics of policy, practice, structure, and attitude to incorporate key elements that support research, outreach/engagement, training, and quality assurance. Although the Cross model provides a solid grounding for systemic praxis, it needed to be adjusted to meet the unique needs of Franklin County – particularly with our emerging populations (i.e., Somali, Latino/a, Iraqi).

Additionally, it helps support the needs of other key populations of need that include veterans, ex-offenders, LGBTQ and deaf/hard of hearing. The underpinnings of this model illustrated in the diagram below are enhanced with other elements that further define our operational use. This model will help explain the Board's current activities, strategies, successes and challenges for sustaining a culturally competent system of care. In addition, ADAMH's Board of Trustees has incorporated cultural competency into their system strategic goals in terms of treatment services, system development, funding and grant opportunities, and workforce diversity.

P.A.S.P.O.R.T.

A Cultural Competence Model for Behavioral Health



(Modification of CASSP Technical Assistant Center -Cross, 1989)
(ADAMH Board-Dixon, 2008)

Below is an overview of the Board's responsibility associated with the P.A.S.P.O.R.T. model for Franklin County:

Policy:

- a. ADAMH's Board of Trustees ensures the need for culturally competent services in their overall strategic results for the Board and system.
- b. ADAMH articulates the importance of having Board representation that reflects the population that is served in terms of race and gender.
- c. Several ADAMH Board members have expressed their personal interest in cultural competence and offered their active support and involvement.
- d. Board internal and system policies are reviewed to ensure they support cultural efforts (reviewed in 2010).

Attitude:

- a. ADAMH's CEO has been a strong advocate for cultural competency within our system – as well as through statewide associations (i.e., Board Association, MACC, local community leadership, etc.). According to research and diversity literature (Thomas, 1994), the CEO is a critical component in moving cultural competency and diversity initiatives forward and ensuring that the agency overall, and individual staff, take it seriously. Monitoring the cultural climate through self/organizational assessments is an important mechanism required

by the system's Cultural Competency Plan.

- b. ADAMH's senior leadership regularly questions issues and concerns regarding cultural competence impacting diverse populations, especially new and emerging communities such as Somalis and Hispanics.

Structure:

- a. The Board ensures that the key structural components of cultural competence are addressed/developed through the submission of provider Cultural Competency Plans (last submitted Fall 2010), Agency Service Plans (Identification of 2-3 key annual goals in off years when the full plan is not submitted), ProviderStat Reviews (Cultural Plan Issues Addressed), System Quality Indicator Monitoring, and Consumer Satisfaction reports. Full plans provide a comprehensive assessment of provider cultural competency plans over the next 2-3 years. Utilizing these monitoring and compliance methods support our efforts to improve quality and address disparities.
- b. Board and system staff reflective of the population served is monitored and discussed in the system within our ProviderStat framework. Additionally, it is important for providers to have diversity reflected on all levels of the organization.

Practice:

- a. The Board strongly supports and funds culturally competent behavioral health services and monitors funded services that target diverse communities.
- b. The Board recognizes all providers have both similarities and differences in terms of populations they serve – and must create practices that best meet the unique needs of various communities (i.e., no one cultural competency practice meets the needs of all).
- c. Up through 2008, the Board provided stimulus and innovation funds to allow providers to address the needs of diverse and emerging populations – requiring they utilize evidence-based (if they exist). We are encouraging providers to redirect existing resources and/or partner with other entities to continue to develop services unique to diverse communities when funding was cut.
- d. The Board wants to ensure that services to diverse communities are aligned with best and promising practices for optimal quality. The Board also seeks more integration with primary care – since this is an outpost for many immigrants seeking help.

Outreach:

- a. The Board is collaborating with several health and human service organizations (i.e., Columbus Public Health, United Way of Central Ohio, Multi-Ethnic Advocates, OSU College of Social Work, Access Health Columbus, Columbus Neighborhood Health Centers, etc.) to support a more comprehensive and integrated strategy for minority populations and others.
- b. The Board built and continues to sustain healthy relationships with organizations and leaders in the Latino, African American, Somali (African), Asian, Native American and other communities (i.e., newest group - Iraqis/Middle Easterners) to ensure our goals and objectives are consistent with meeting their needs. Relationships with local Imams, faith leaders, and cultural informants are helping to increase education and awareness with such populations.
- c. The Board is participating with a number of initiatives that are addressing the needs of veterans (i.e., Ohio Suicide Prevention, MACC Veteran Survey, Educational and Training Efforts, Local VA Support Initiatives).

- d. The Board supports community-based initiatives that address the needs of diverse communities such as Juneteenth, Ohio Psychological Association Cultural Symposium, Ohio Latino Mental Health Network, Somali Women and Children's Alliance and other events to name a few. Due to limited resources, ADAMH continues to serve on multiple committees, boards, and collaboratives that address the needs of diverse communities (i.e., Faith-based, Violence Prevention, Family Violence).
- e. Marketing to minority communities through print and electronic media was cut in 2009-10 because of budget reductions. ADAMH's public affairs department will seek earned minority media opportunities. Although, current plans are underway to re-initiate some targeted marketing opportunities in print and electronic media. The Board will also target marketing to communities where high numbers of individuals where English is not their primary language.

Research:

- a. It is the intent of ADAMH to work with institutions of higher education to co-create research initiatives to address issues of disparities in mental health (e.g., ADAMH completed a research project with Dr. Charles Partridge examining the effectiveness of intervention services for Somali youth at Mifflin International Middle School funded by the Columbus Foundation).
- b. The Board also lends its grant-writing expertise to MACC – realizing the importance of supporting statewide initiatives to further support local cultural competency efforts. The Board is supportive of any state initiative designed to improve care to diverse and underserved populations.
- c. During 2013-14, the Board will seek funding to develop an instrument to monitor and inform providers about disparities in services. Additionally, finding integrative service models (i.e., health / mental health) that we can consider may help address stigma that impacts various minority populations who do not access care. The Board did apply for system transformation grants from ODMH to implement mechanisms to identify, monitor, and address disparities, but was not funded.

Training:

- a. Due to the budget reductions, the Board eliminated funds for system-wide training. Culture training sessions are being provided at the individual provider level (in-service), local conferences, as well as sessions offered by MACC and United Way. We realize that our cuts will limit cultural training opportunities for system staff and board members.
- b. The Board encourages providers who are able to provide training to allow other providers to attend – and also seek other fee and free cultural training opportunities across disciplines (i.e., Columbus Public Health, Ohio Commission on Minority Health, College of Public Health). Since the 2010-11 Community Plan ADAMH has partnered with Columbus Public Health and MACC to offer free and low cost training to providers.
- c. ADAMH will explore or design possible online, computer-based cultural training options so that providers will have low cost and convenient options.

Agency Service Plans:

Agencies are required to address their annual cultural competency plans during years the full Cultural Competency Plans are not submitted. Those plans identify two or three key areas that the agency will address outside of training (e.g., translating material into foreign languages, tracking disparities, etc.) for the following service year.

A review of the Agency Service Plans (ASP) indicated that providers are clearly moving into niche cultural competence areas that we did not see with earlier reports.

ADAMH CEO David Royer understands that cultural competency is not a wholesale movement of a system, but both individualistic and collective movement through incremental shifts and patterns that are engrained into the particular consumer base providers serve. What we found was that each provider was unique – and that agency cultural initiatives varied based on provider size, population served, outcomes, and geographic region where the provider was located (e.g., providers on Westside may offer more after-school AOD prevention programming to avoid increased violence in that area).

What we have seen in recent ASP reports are providers who are moving beyond the basics of training and awareness/tolerance activities – to one where their cultural competence goals are specific to the needs of the diverse populations they are serving. This is a huge development in terms of ownership and creating provider-specific systems of continuous quality improvement.

Cultural Competency Plan:

The ADAMH Board clearly understands the importance of providing culturally competent care for the benefit of consumers, families and overall system competence. Each provider monitors overall cultural competence through the completion of their Cultural Competency Plan that targets 11 key standards (over 60 result areas) that support the P.A.S.P.O.R.T. model illustrated above. Because of the uniqueness of providers, plans range widely – as expected. Individual provider plans and service issues impacting diverse populations will be assessed and discussed during their ProviderStat sessions. The initial review of plans revealed that providers needed support in training, valid agency cultural-logical assessment/monitoring tools, recognizing disparities, interpretation supports and funding, and general technical assistance.

Cultural Competence Standards:

The eleven Cultural Competence Standards below are the key areas that are assessed in the Cultural Competency Plan providers submit every three years. They represent the detailed areas that are identified in the P.A.S.P.O.R.T. model and help guide providers when examining their levels of cultural competence.

1. Access to Services
2. Assessment
3. Case Management
4. Cross-Cultural Linguistics and Communication Support
5. Cultural Competence Planning
6. Governance
7. Human Resource Development
8. Management Information Systems
9. Prevention/Education/Outreach
10. Quality Monitoring and Improvement
11. Treatment Plan/Individual Service Plan.

Current activities, strategies, successes and challenges

Strategies:

The overall strategy for Franklin County is outlined above through the P.A.S.P.O.R.T. program. This model helps to ensure that all cultural competency areas are addressed in the system of care. One unique difference that we have providers address in their ASPs is for them to focus on two or three key improvement/result areas per year (generally outside of training itself). The reason for this is to provide focus and attention on critical niche areas of each provider.

We also recommend that providers continuously seek out best and better culturally competent practices within their mental health/behavioral health service delivery paradigm. This strategy is beginning to pay off in terms of providers sharing their expertise with other agencies in the system. Another key strategy that will emerge with serving diverse and underserved communities is finding better ways to integrate health and behavioral health services. We are

learning that integrating services will provide for a more holistic and efficient way serving underserved and diverse communities, hopefully leading to better outcomes and cost savings to multiple systems.

Current Activities (Board Focus):

The Board identified a few key cultural competence areas to focus on during the next two program years. Those areas include: Faith-Based Outreach Initiative; Community Engagement/ Relations; Grant Submissions for key Cultural Areas (i.e., Disparity Monitoring, Faith-Leaders Symposium, etc.); and system monitoring.

Faith-Based:

The Board recently established a Faith Leader Advisory Council to provide input about the kinds of challenges they are experiencing with behavioral health issues. We learned that with the downturn in the economy, there is a significant increase of behavioral health issues experienced by the faith community (i.e., domestic violence, alcohol and drug use, depression, youth and gang violence, etc.) due to lost employment, foreclosures, etc.

Community Engagement:

Designed to establish partnerships with other systems and organizations to address community-based issues related to behavioral health for improved integration, partnerships, collaborations, and communications.

- a. Service on various boards and committees to address issues related to services to various populations (i.e., Columbus Neighbor Health Center Board, Access Health Columbus Board, Franklin Co. Commissioner Multicultural Workgroup, Stonewall, Columbus Public Health Minority Affairs Advisory, Coalition Against Family Violence Community Advisory, Commission on African American Males, Multiethnic Advocates for Cultural Competence, Our Optimal Health, Ohio Latino Mental Health Network, OSU Youth Violence Initiative, etc.).

Grants:

- a. Submit grants to support cultural competence initiatives.
- b. Continue partnerships with other organizations to support better integration of services (i.e., Health/Behavioral Health). Seek future grants to address key areas identified in provider Cultural Competency Plans: Cultural-logical Assessment Tools, Training, Material Translation, and Disparity Monitoring.

Marketing:

- a. Identify earned media opportunities to help communicate behavioral health information to diverse communities (i.e., Latinos, Deaf and Hard of Hearing, Somalis, etc.).

Training:

- a. Partner with Multiethnic Advocates for Cultural Competence to plan future trainings that system providers can participate.

Current Activities (Provider/System Focused)

The following is a summary of current activities by cultural competency categories (P.A.S.P.O.R.T.) to fully understand ongoing activities unrelated to specific cultural competency goals and objectives set forth by ADAMH. The diversity of activities is enormous amongst provider agencies – and unique to their target populations.

Policy (Governance):

Each provider submits a racial/ethnic composition of their board of trustees in the ASP and is prepared to discuss board composition if it does not reflect the population served during ProviderStat reviews.

Attitude (Organization and Individual Support):

ADAMH's CEO has been a strong advocate for cultural competency within our system – as well as through statewide associations. As a result, many providers have also modelled similar leadership within their agencies and support many of the cultural competency initiatives within their organization. Several provider agencies require internal staff climate

audits, performance appraisals, diversity councils, affinity groups, and other methods to create a culturally supportive environment. In addition, some agencies have designed their waiting areas to be culturally sensitive motif through diverse artwork, magazines, artifacts and other methods to make consumers feel welcome. Most providers realize their front-desk staff must also express a level of understanding and sensitivity when working with diverse populations who seek care.

Structure (Staffing/Plan & Evaluate/Monitor/Compliance):

Providers are addressing their staff diversity based on the population they serve through ADAMH’s ProviderStat review meetings. Any variance above 10% with respect to racial / ethnic disparity must be addressed by providers. The Board continues to examine outcomes data to ensure there is consumer satisfaction based on race/ethnicity. ProviderStat is the forum to monitor compliance.

Disparities in access and Treatment Outcomes:

The Board monitors system quality indicators in terms of identifying disparities among service demographics. In particular, data is examined by race, ethnicity, age and gender to determine if significant differences exist in access and treatment domains. ADAMH will continue to address system access issues by identifying areas of concern and utilizing the ProviderStat format, clinical director meetings, and other methods to pinpoint areas of concern. Additionally, ADAMH will work with SAMHSA, Office of Minority Health, and other local and regional offices who also seek to address disparities based on access, quality, and outcomes.

Ultimately, the ADAMH board will continue to address cultural competency in all aspects of our business, as illustrated in the P.A.S.P.O.R.T. model above. More importantly, we will provide encouragement, incentives, support and offer other methods to providers to encourage their staff to identify, understand, and respect the uniqueness of culturally diverse communities in order to provide the best quality care in meeting the individual and collective needs of those who are served. Since our Consumer Satisfaction surveys indicate no statistically significant difference between minority and non-minority consumers regarding satisfaction with services, we consider this aspect of our work quite successful.

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 ADAMH Board of Franklin County

**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 (IVDU)	Increase the availability of medication assisted treatment (MAT).	Expand MAT capacity and treatment options.	Number of people receiving MAT	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE: ORC 5119.17 required priority)	100% of pregnant women seeking alcohol or other drug treatment services will have their first appointment within contractual timeframes.	Developed a Pregnant Women’s Workgroup and a tracking tool to assure that Addicted Pregnant Women are receiving timely access.	Number of women that receive timely access to treatment.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
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)	Ensure adequate services are available within the community to meet the needs of this population.	Access the need and current capacity to meet the needs of this population. Expand capacity, if needed.	Analysis of need and current capacity. Recommendations for additional capacity, if necessary.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	100% of persons infected with tuberculosis seeking alcohol or other drug treatment services will have their first appointment within contractual timeframes	Provide access to persons infected with tuberculosis.	Number of persons served.	<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): Children with Serious Emotional Disturbances (SED)	Increase accessibility of services for children with SED through a system of care approach.	Continue to develop and promote cross systems partnerships. Prioritize and increase services accessibility to young consumers and their families at risk of serious family emotional instability, loss of parental custody, child placement, court involvement, and/or academic failure due to untreated mental illness.	Number of children served with SED	<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
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Expand access to care for uninsured people through integrated models of primary care, addiction treatment, and mental health care to help achieve identified outcomes and recovery.	Continue to invest in integrated health care and dual diagnosis for consumers with SMI. Continue to develop and promote cross systems partnerships.	Number of adults with SMI receiving services	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*	Expand access to care for uninsured people through integrated models of primary care, to help achieve identified outcomes and recovery.	Fund multiple types of integrated care models. Develop a system to evaluate integrated healthcare models in order to make effective funding decisions.	Number of persons served	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	Increase certified recovery/peer support in the system.	Continue to fund AOD Recovery Coach. Fund a Consumer Resource Center to help consumers navigate the mental health system. Continue to fund the Peer Center Recovery Center. Continue to fund ex-offender mini-grant.	Number of individuals trained.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant
***Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
Treatment: Veterans	Explore possibilities to increase services to veterans.	Identify and engage with system partners to assess the need. Engage system providers to provide services to veterans. Incorporate a claims identifier within our billing system to track services provided to Veterans.	Plan to develop, track and provide services to 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	Identify need and provide additional treatment to individuals with disabilities.	Provide crisis support to individuals with both mental health and developmental disabilities.	Number of consumers served	<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*	Increase Medication Assisted Treatment slots for residents of Franklin County.	Expand MAT capacity and treatment options.	Number of consumers served	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

<p>Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*</p>	<p>Increase permanent supportive housing units for homeless persons with mental illness and/or addiction.</p>	<p>Partner with and support the development of CMHA’s Franklin Station housing proposal, which will include 25 ADAMH designated units.</p> <p>Partner with and support the development of CHN’s Hawthorn Grove housing proposal, which will include 40 ADAMH designated units.</p> <p>Partner with and support the development of VOAGO’s housing proposal, which will include 40 ADAMH designated units.</p>	<p>Number of consumers served.</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>
<p>Treatment: Underserved racial and ethnic minorities and LGBTQ populations</p>	<p>Expand services to racial and ethnic minorities and LGBTQ populations.</p>	<p>Fund LGBTQ program at North Central.</p> <p>Fund education and support groups for Somali and Latino(a) women at CPH.</p> <p>Fund outreach and treatment for Somali youth at Buckeye Ranch.</p> <p>Fund outreach and early intervention services at Columbus Public Health in partnership with Columbus Recreation and Parks (APPS Program).</p>	<p>Number of consumers served.</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>

<p>Treatment: Youth/young adults in transition/adolescents and young adults</p>	<p>Increase services to youth/young adults in transition.</p>	<p>5 housing units will be added within the ADAMH housing continuum to provide housing to transition-age youth with complementary treatment services.</p> <p>Fund outreach and early intervention services at Columbus Public Health in partnership with Columbus Recreation and Parks (APPS Program).</p> <p>Support the Franklin County Urban Coalition strategy to reduce marijuana use among 18-25 year old African Americans.</p>	<p>Number of transition age youth served.</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>
<p>Treatment: Early childhood mental health (ages 0 through 6)*</p>	<p>Maintain capacity for early childhood mental health consultation and training.</p>	<p>Continue to support early childhood educator training and coaching.</p> <p>Continue to support the ECMH and child welfare initiative at Nationwide Children's Hospital.</p>	<p>Number of educators trained or coached.</p> <p>90% of children receiving ECMH services will increase protective factors and decrease behavioral concerns, as measured by the Devereux Early Childhood Assessment (DECA).</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<p>Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure</p>	<p>Sustain the Franklin County Urban SPF Coalition so it can reduce the use of marijuana by 18-25 year olds African Americans residing in Columbus' Urban Core (zip codes 43204, 43205, 43206, 43211, 43223).</p> <p>Train ADAMH Providers and partners on the SPF.</p> <p>Develop logic models in 2014 for prevention service areas: In School Initiatives, Community Based Programs Based, Youth Led Programs.</p>	<p>Implement a media campaign focusing on the 8 dimensions of wellness to reduce risk associated with marijuana use for 18-25 year olds January - March 2014.</p> <p>Offer SPF training in Franklin County to ADAMH Provider Network and its partners by March 2014.</p> <p>Offer logic model training to ADAMH Providers and Partners coordinated by Global Trainers by July, 2014.</p>	<p>Evaluation Plan to be developed by FCUC and its SPF SIG Evaluator by March 2014</p> <p>Agency service plan will incorporate SPF elements for Prevention Services by 2015</p> <p>Logic model completed by providers for services agency offers by September 2014</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>Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*</p>	<p>Offer prevention services across life span with a focus on families with children/adolescents.</p> <p>Fund new programs that support families with children/adolescents.</p>	<p>Review prevention services to ensure prevention services are available across lifespan with a focus on families with children and adolescents.</p> <p>Implement faith family pilot program.</p>	<p>A minimum number of two programs provided in each life span domain. 80% of parents who complete the program will establish protective factors for their children.</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>Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices</p>	<p>Empower pregnant women and women of child bearing age to engage in healthy lifestyle choices.</p>	<p>Continue to support the Women's Services programs and the Pre-natal program at CAI/Project Linden.</p>	<p>Number of women that complete the program.</p> <p>The number of women that deliver a healthy baby.</p> <p>Evaluation plan for prevention programs will incorporate a question, inventory or checklist associated with healthy lifestyle choices.</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>Prevention: Promote wellness in Ohio's workforce</p>				<p>X_ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p>
<p>Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*</p>	<p>Develop strategies to reduce problem gambling and increase community awareness of problem gambling.</p>	<p>Develop a Problem Gambling SPF Plan for prevention, early Intervention and treatment services for teens and adults in 2014.</p> <p>Organize a Franklin County problem gambling workgroup to review 2013 plan and make revisions and changes based on the Community Research Partners needs assessment report 2014-2015.</p>	<p>Problem gambling plan will be submitted to the Ohio Department Mental Health and Addictive Services for review and approval in July 2014.</p> <p>Awareness strategy and treatment strategies will be implemented by June 30, 2014.</p>	<p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p>

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Board Local System Priorities (add as many rows as needed)

Priorities	Goals	Strategies	Measurement
Criminal Justice	Ensure adequate behavioral health services are available to meet the needs of individuals involved in the criminal justice system.	<p>Fund the CFRO program provided by UMADAOPFC for persons reentering the community.</p> <p>Continue to support the Behavioral Health/Juvenile Justice (BHJJ) program provided by Nationwide Children’s Hospital.</p> <p>Continue to support the Multisystemic Therapy (MST) programs provided by The Buckeye Ranch and Nationwide Children’s Hospital.</p> <p>Continue to support the Functional Family Therapy (FFT) program provided by The Buckeye Ranch.</p> <p>Continue to support the Reception Center program provided by The Village Network.</p> <p>Support the BJA Reentry Project and Taskforce.</p> <p>Partner with seven Specialty Dockets/Courts.</p>	<p>Number of people served and recidivism rate</p> <p>Number of youth served and linked to mental health programs</p> <p>Number of youth served and recidivism rate</p> <p>Number of youth served and recidivism rate</p> <p>Number of youth served and recidivism rate</p>
Human Trafficking	In partnership with CATCH Court provide supports and treatment services to women involved in Human Trafficking.	Fund a sober residence and supportive services program.	Number of women that complete the program

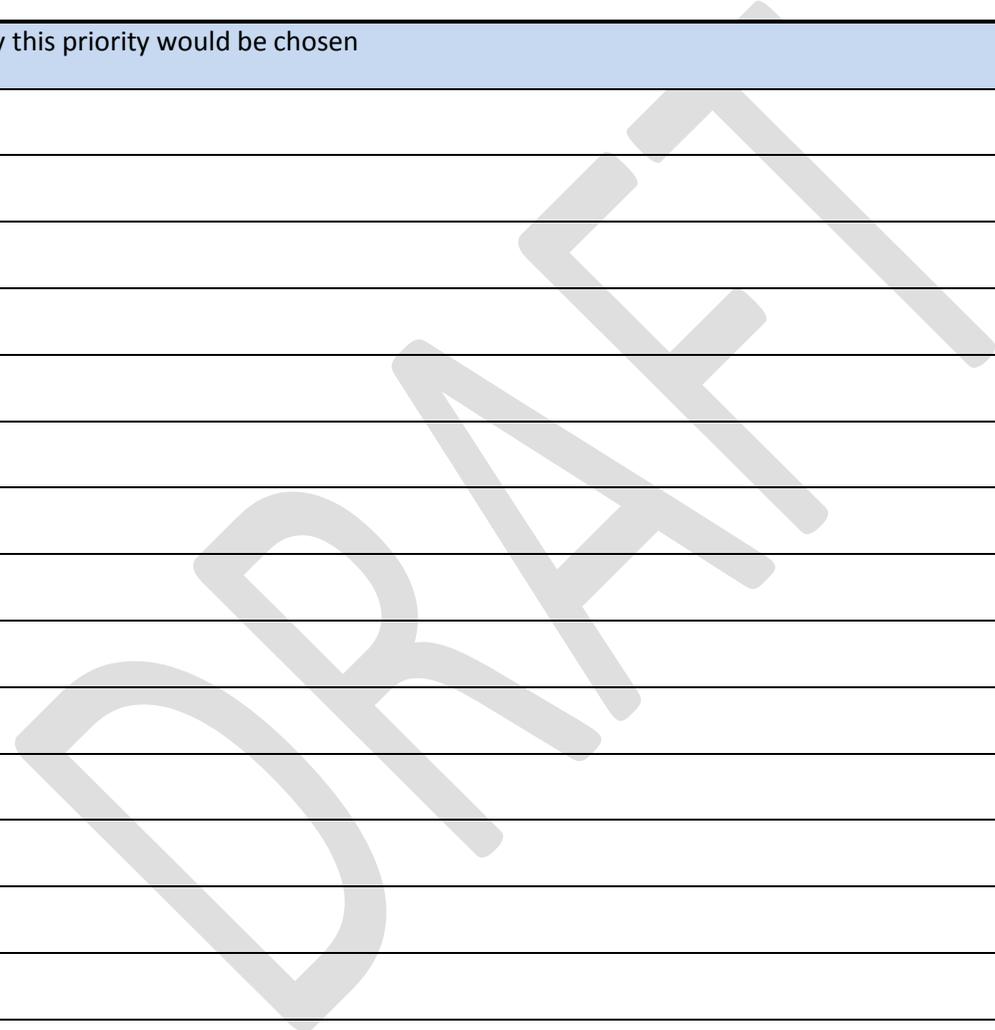
Faith-Based Outreach	Partner with the faith-based community.	Fund faith-based community-based events that promote behavioral health awareness Fund summer day camps in partnership with faith-based congregations and Children’s Defense Fund.	Number of people that attend community based events Number of youth that complete the program
HIV	Provide HIV Early Intervention Services to county residents.	Maintain funding of the Syntero HIV Program for youth, Columbus Public Health and CompDrug HIV Early Intervention programs for adults.	Number of consumers served.

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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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	



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

Faith-Based Summer Pilot Project

The ADAMH Board of Franklin County, in collaboration with Community for New Direction, The Shalom Zone, Family Missionary Baptist Church, the Earnest Hardy Center, Heart of the City Freedom School, and Children Defense Fund implemented summer day camps in four Columbus neighborhoods to increase protective factors. Over three hundred youth who live in families with alcohol or drug problems and reside in high crime areas benefited from the summer programs that help them improve academic skills, develop day-to-day coping strategies, and strengthen bonds with peers and caring adults.

Franklin County SPF Urban Coalition (FCUC)

ADAMH partnered with Community for New Directions, Columbus Public Health, The Urban Minority Alcoholism and Drug Abuse Program, to write a proposal to form the Franklin County SPF Urban Coalition which was funded by ODADAS. The Coalition utilizes the Strategic Prevention Framework, a planning process comprised of five phases to assist communities in delivering and sustaining effective substance abuse prevention. Communities assess prevention needs based on epidemiological data, build prevention capacity, implement effective community prevention programs, policies and practices and evaluate their efforts for outcomes. Integral to each step in the framework is cultural competence and sustainability. We are implementing the Strategic Prevention Framework with coalition members from Ohio National Guard, Columbus Public Schools, Community Research Partners, Neighborhood House, YouthBuild and young adults 18-25, primarily African Americans, residing in Columbus urban core neighborhoods. Implementing the Strategic Prevention Framework on a community level ultimately results in residents examining their norms around alcohol and marijuana use and choosing to engage in environmental strategies that will reduce alcohol consumption and marijuana use in the 18-25 age groups. In 2013, the FCUC worked with an evaluator to develop an overall theory of change which states: If we educate young adults about the risks associated with marijuana use, then the perception of risk associated with marijuana use will increase. If the perception of risk associated with marijuana use increases, then more 18-25 year olds will disapprove of marijuana use. If more 18-25 year olds disapprove of marijuana use, then the number of young adults using marijuana decreases. ADAMH will work jointly with the FCUC and Radio One 107.5 FM to implement the media strategy developed in 2013.

Ohio Afterschool Network

ADAMH participates on the Ohio Afterschool Network which supports children, youth, families, and communities by advocating and building capacity with a unified voice for sustainable investments in safe, healthy, and nurturing afterschool experiences. The network of over 600 (and growing) after school advocates serves as a vehicle to bring together a number of systems and stakeholders, including policymakers, educators, parents, and service providers.

The Franklin County Suicide Prevention Coalition

ADAMH participates on the Franklin County Suicide Prevention Coalition whose goal is to prevent suicide by increasing public awareness by engaging a wider base of concerned stakeholders, providing training to gatekeepers and developing public relations/media activities to educate the public at large.

Ohio Suicide Prevention Foundation (OSPF)

ADAMH participates on the Ohio Suicide Prevention Foundation (OSPF) whose purpose is to build and support a statewide infrastructure of community programming that promotes suicide prevention, works to eliminate stigma, and encourages early intervention for Ohioans that are suffering from suicidal thoughts, mental illness, and alcohol and drug addiction.

ADAPO

ADAMH participates with the Alcohol and Drug Abuse Prevention Association of Ohio (ADAPO), a membership-based association that serves as the voice of alcohol, tobacco and other drug prevention in Ohio. The association sponsors training and networking opportunities for alcohol and other drug prevention professionals.

ODADAS POPS Workgroup

ADAMH serves on the ODADAS Proving Ohio Success workgroup and hosted the Central Ohio POPS training which prepared users to navigate the new reporting system.

Behavioral Health Juvenile Justice Initiative-Youth MH Treatment

The ADAMH Board of Franklin County, in collaboration with Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch, and Franklin County Family and Children First Council, has developed, implemented and expanded a model to meet the treatment and support needs of youth and their families who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system.

The model moves a youth from the Franklin County Juvenile Court Pre-Sentence Investigation through a screening and assessment process that involves a care coordinator who facilitates the delivery of service throughout the program. Care coordinators engage families and provide linkage and bridging to evidenced-based treatment services including MST, FFT, and MDFT. The service delivery team includes the youth and family, probation officer, school, family defined support, treatment providers and other system representatives as necessary. This model will continue to improve intersystem communication and shared outcomes among the behavioral healthcare, juvenile justice, and child welfare systems.

The Reception Center is a joint venture between the Franklin County Court of Common Pleas Division of Domestic Relations, Juvenile Branch and the Franklin County Alcohol, Drug, And Mental Health (ADAMH) Board. The program is designed to improve intersystem collaboration and shared outcomes among the behavioral healthcare and the juvenile justice system. Based on the data, there are a significant number of juveniles currently admitted into the Franklin County Juvenile Detention Center who might be better served by community-based behavioral health treatment alternatives and existing programs and services in the community. The Reception Center Intervention will provide pre-adjudicated youth and their families with immediate access to mental health and alcohol and other drug assessment and referral to ongoing services as needed. Currently, a youth who has been charged with an offense will wait 100 to 120 days before their case is processed and court ordered referrals for services are completed. This project intends to provide an expedited assessment and linkage to services. For youth who cannot return home safely following the youth's assessment, alternative care providers have been included in this model of care to provide safe respite. The Reception Center Intervention will also include the opportunity to refer youth to an Evening Supervision program which will provide the youth with mental health and substance use oriented group treatment in the evenings when gaps in supervision and structured activities tend to occur. The Reception Center began full implementation in September of 2013.

Investment in System Workforce

The ADAMH Board worked with providers and The Ohio State University College of Social Work to implement an ADAMH system Master's Degree in Social Work program. The impetus behind this program was to establish ways to grow and retain the system's workforce by creating a program that was low-cost and convenient. Those who are participants in the MSW cohort will increase their employment options, while providing employers with a growing pool of master's level clinicians and administrators. This program is offered at the ADAMH Board's office at 447 East Broad Street so that students have a central location off campus to attend classes in an attempt to accommodate those that work full-time. The providers support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunities for shared internships. This is a four-year, part-time program with a minimum of 15 students, although 25 students are currently enrolled. The program began in the autumn of 2009 and classes are

held two nights weekly. Furthermore, several ADAMH staff members teach within this program at The Ohio State University. ADAMH staff members also serve as curriculum advisers to Columbus State Community College (CSCC) students enrolled in the MA/SA/DD program. CSCC is preparing students to seek employment within the ADAMH system or are directing them to enter four-year programs in social work at surrounding universities.

Collaborative Workgroups

ADAMH participates in an **Ohio Hospital Association-convened workgroup** that brings together leadership of all Franklin County local psychiatric hospitals, including Netcare and Twin Valley Behavioral Healthcare. Through the work of this group, the collaborative Hospital Bed Board became available for use by Netcare, TVBH, Ohio State University Medical Centers, Mount Carmel, and Ohio Health hospitals. The availability of this active client-exchange system has greatly improved the transfer of clients needing inpatient psychiatric hospitalization and in achieving the goal of getting the right client to the right location at the right time. Netcare began to participate in daily conference calls with the private hospitals, with the goal of getting the right client to the right location at the right time. This process includes transferring clients to/from Netcare, as well as clients shifting between the private hospitals.

Additionally ADAMH convenes a workgroup that includes representation **from three local private hospitals**, Netcare and five of our Lead agency mental health providers with the purpose to ensure timely linkage to outpatient care for individuals being discharged from these acute care settings.

ADAMH sits on the **Franklin County Re-Entry Coalition** and co-chairs the **Health/Behavioral Health/Housing subcommittee** of this larger Coalition. This participation has led to collaborative efforts on several grant proposals, improved communication and problem-solving efforts between our criminal justice and local housing partners, as well as a recent focus on our shared cross system consumers who frequently utilize ADAMH services, local homeless shelters and the Franklin County Jail.

The Franklin County BHJJ Initiative, now in its seventh year, was developed to meet the treatment and support needs of youth who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system. This model has improved intersystem communication and shared outcomes among the behavioral health, juvenile justice, and child welfare systems. This initiative was researched, designed, and will continue to be implemented by the **Cross System Initiative Committee (CSI)**, a local partnership that includes ADAMH, Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch (Juvenile Court), and Franklin County Family and Children First Council.

The development of this proposal reflects the cooperative atmosphere and willingness to work together by members of different systems with interests in the same target population. Community partners have designed a program that involves parents, schools, child welfare, behavioral health and juvenile justice systems. Collaboration partners have committed time, resources and funds to the success of the initiative.

ADAMH participates on the **Franklin County Family and Children First Financial Oversight Committee**. The goal of this collaboration is to assist system partners with increasing the access, capacity and effectiveness for the most vulnerable Franklin County youth and their families whose needs extend beyond any of youth-serving program in the community.

The Franklin County ADAMH Board and the Franklin County Children Services Board has implemented an Interagency Agreement which focuses on a commitment to work together to improve the service delivery system on behalf of children and families served by both systems. Our current projects are:

- 1) One **Functional Family Therapy (FFT)** team which seeks to address children and adolescents engaging in disruptive behaviors that are putting them at risk for out of home placement.
- 2) Two **Multisystemic Therapy Teams (MST)** targeting adolescent sex offenders and other adolescents actively engaged in the criminal justice system.
- 3) **C.A.L.L (Consultation, Assessment, Liaison, Linkage) project** is a joint venture between Franklin

County Children Services (FCCS) and the Franklin County Alcohol, Drug, And Mental Health Board (ADAMH), to implement screening, assessment and consultation so as to more effectively and efficiently identify and link youth and families involved in the local child welfare authority. Clinicians make referrals to evidence-based and emerging best practice treatment models available in the county where possible. This program is designed to improve intersystem communication and shared outcomes among the behavioral healthcare and child welfare systems.

- 4) **ECMH/CW (Early Childhood Mental Health/Child Welfare) project** is a mutual venture between Franklin County Children Services (FCCS) and the Franklin County Alcohol, Drug, And Mental Health Board (ADAMH). This initiative focuses on the partnership between child welfare and behavioral health for children ages 0-6 and their caregivers who are engaged with the child welfare system. Expected outcomes are to increase the number of children who are able to safely remain in their homes and to provide early identification for other areas of need, including childhood development. This program is designed to improve intersystem communication and shared outcomes among the behavioral healthcare and child welfare systems.

Involvement of customers and general public in the planning process

Consumer and Family involvement is an important component of the ADAMH Board's structure and operations. We seek and value input and feedback from consumers through various Board activities. This is an essential ingredient to ensure that ADAMH strives to be recovery driven in its mission of improving the well-being of our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Franklin County. The following are ways that the board seeks to engage and incorporate consumer /family input into its business operations.

Board of Trustees: ADAMH by statute must have a primary (secondary) consumer of mental health and alcohol and other drug services on its Board. The following is also incorporated in ADAMH Policies and Procedures Section 4.1.2. *The ADAMH Board, Provider Leadership Association and the Consumer and Family Advocacy Council shall collaboratively implement strategies to further the involvement of consumers and families in providing recommendations and advice on identifying needs, planning, prioritization, implementation/delivery and evaluation of mental health, alcohol and other drug addiction services.* This is done through a variety of mechanisms that ensures that all the work of the Board has consumer and family participation as sanctioned by the Board of Trustees. Besides the use of consumers, families, and the general public in the formal planning structures as shared above, the Board finds other ways to engage consumers for having their influence on our daily operations.

- a. **Coordinating Committee of the Board:** A committee of the ADAMH Board of Trustees whose purpose is to review, discuss, and recommend actions to the full board for decisions and approval. There is usually a consumer and family member who participates on this committee – to ensure that their perspectives are articulated.
- b. **ADAMH Board Strategic Business Plan:** A process that establishes the strategic direction for board and system services. The plan is evaluated annually and incorporates consumer and family input and feedback into this process. The purpose of this plan is to ensure that public resources are used in the most efficient and effective manner to serve as many consumers as possible with quality alcohol/drug and mental health treatment and prevention services. Consumers participate in the Board planning process that is under the auspices of the board of trustees.
- c. **Managing for Results System (MFR):** An outcome of the strategic business plan is the MFR system, which incorporates both the Strategic Results (i.e., longer range/overarching goals) and the Operational Results. These results drive the development of internal lines of business and guide the board annually in its operations. Consumers and Family members are involved in the review and creation of this document and participate actively with an internal process to monitor these results called ADAMH-STAT.

- d. **ADAMH-STAT:** The internal performance review platform that monitors all of the annual board results (metrics) in the MFR Performance Plan under all Lines of Business. ADAMH invites consumers to participate (i.e., ask questions / provide input) on these weekly meetings that review all board quarterly results. Consumer input in this process helps board staff understand how recipients of service perceive outcomes and results.
- e. **Consumer and Family Focus Groups:** The Board periodically seeks consumer and family input to ascertain opinions about a variety of issues regarding operations. One example is when the board sought feedback regarding the development of Provider Contract language to ensure consumer and recovery centeredness.

Below are examples of how Consumer and Family Advisory Council (CFAC) members are interwoven into assisting to improve our System of Care:

- **Crisis Intervention Training (CIT):** Implements training programs to assist police officers to become more competent in working with people with mental illness by increasing their sensitivity and improving their skills. Both a Consumer and Family Panel are utilized to share their perspectives and offer strategies on ways officers should engage consumers during crises.
- **Agency Services Plan Review (ASP):** Provides feedback from the perspective of consumers and family members on services proposed by contract agencies. The goal is to review Agency Services Plan submitted by contract agencies and offer feedback to Clinical Services in preparation for the new contract year to ensure services are consumer-centered and recovery - focused. The Board established consumer/family focus groups through CFAC to obtain feedback on the development of actual contract language.
- **Grant Development:** Over the past several years ADAMH has not only written grants to support consumers and families, but also utilizes the input of consumers and families on the development of funding grants.
- **Visual Performance Management (VPM):** ADAMH utilizes a unique process of posting visuals (i.e., pictures, artwork, and images of consumers), history timelines, performance data/metrics and other visual aides to communicate visually the mission, performance, and work of ADAMH. A consumer representative participates on this monthly workgroup.
- **Public Relations/Community Affairs:** ADAMH consistently utilizes consumer and family members in marketing / advertising campaigns and publications. Consumer and family members are also represented at community events such as recovery month and other public gatherings.
- **Advocacy:** Members of CFAC also serve as a voice to other consumers through various committees related to their work. Those include, but are not limited to: Action Committee – examines legislation that impacts consumers and establishes ways to support initiatives that they perceive as beneficial – up to and including meeting with legislators and providing formal testimony; Resource Center - members have access to an office with a computer, literature, books, documents, and other items to help them conduct business both within the board as well as within the provider network and community; Education – members plan a variety of speakers, films, document sharing, and training that helps educate other consumers/families and the community about behavioral health. Once a year there is a Saturday training day that is open to the public on a variety of mental health issues.

ADAMH values the importance of consumer and family involvement at all levels of our Board operation. It truly feels natural to have engaged consumers at the table for planning meetings, projects, key document reviews, annual provider reviews, and other key activities of the board. ADAMH also wants to ensure we value consumer input by offering them a survey to tell us how we are doing with the business of consumer involvement on workgroups and committees. We

believe this strong partnership with consumers and families ensures better outcomes for consumers system-wide and the community at-large.

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.

Identification, linkage and treatment services to individuals hospitalized in State BHOs (primarily individuals without health insurance): this is inclusive of a strong, working Continuity of Care (COC) Agreement held between lead agencies, ADAMH, and the State Hospitals. Specifically trained Hospital Liaisons are unique positions within our Lead Agencies, including a primary AOD provider, that coordinate care and discharge planning for these individuals. Our network of residential Care facilities and investments in supportive Housing programs supports the discharge process for these same individuals and provides an intensive level of care needed to coordinate and ease their transition back into the community.

A complementary and parallel collaboration and network of hospital liaisons exists as well, serving individuals exiting local private psychiatric hospitals, and Netcare's Crisis Stabilization unit.

Our existing COC Agreement is operative on a two year cycle and it governs the interaction between our system's Crisis Care provider, State BHO's and Lead Agency providers around continuity from admission, to care within the hospital as well as coordinated discharge planning. Every two years, we solicit input from Lead agency clinical leadership and Twin Valley Behavioral Healthcare regarding potential changes to the document. Each year we may make minor revisions only on an as-needed basis.

The Franklin County ADAMH System has one contract agency responsible for all pre-hospital screening services.

Assertive utilization management/discharge planning: As described above, the Board is represented at weekly utilization review meetings with hospital staff and a housing provider reviewing all patients that have been hospitalized for two weeks or longer in order to identify and then address barriers to discharge. Temporary housing subsidies have been developed by the Board and received from the federal government and these are targeted to homeless persons in the state hospital. In addition, patients who are high utilizers of inpatient services may be referred to an IDDT-ACT team in the community, all of which are demonstrating a positive effect on reducing criminal recidivism in addition to reducing homelessness, reducing use of the state hospital and crisis services and improving clinical conditions. The Board also works closely with the hospital's Forensic Review Team and the forensic monitors to ensure that hospital lengths of stay are related to clinical need and not solely an artifact of criminal justice involvement.

Community resource development: These patients are eligible to receive temporary and permanent housing subsidies that have been earmarked for state hospital patients; may be enrolled onto an IDDT-ACT team and/or be transferred from the state hospital into intensive AOD treatment if clinically appropriate and the patient expresses a desire to do so. The Board is also working with community stakeholders, including the Community Shelter Board and various components of the re-entry task force, to seek demonstration project grant funding to expand IDDT-ACT capacity to encompass high utilizers of the shelter, jail, mental health and AOD systems.

ADAMH Franklin County continues to have an assertive role in working with the state hospital and provider agencies around hospital utilization management which includes civil and forensic patients. Representatives from the Board and Community Housing Network meet weekly with TVBH staff to review every patient that has been in the state hospital for 14 days or longer in order to identify and then address barriers to community placement.

The Board has developed a program to authorize and fund placement of homeless men in the local YMCA temporarily while awaiting more permanent housing options. Franklin County received federal stimulus dollars for housing homeless individuals, as well, and all of the money was targeted to homeless patients in the state hospital. Neither TVBH, the Board nor providers restrict the use of these funds based on a patient's legal status – only clinical needs are considered.

In CY2007, the Franklin County ADAMH Board conducted an analysis of its adult, high utilizer, inpatient hospital population. We posed the following questions: Why are we experiencing an increase in demand and/or volume and what were the potential causes? Which groups or specific individuals are presenting with the highest clinical risk? Which groups of specific individuals are creating the highest financial risk? Which services and/or strategies, if employed, would potentially improve key clinical and financial indicators?

After analyzing the data, we discovered that a large percentage of individuals that were utilizing crisis and inpatient hospitals were presenting with co-occurring disorders. As a result, the IDDT/ACT teams that are mentioned throughout this plan were funded to target the specific needs of this highly vulnerable population. Results look extremely promising. Four teams were created at four large comprehensive centers.

ADAMH has not made any changes in its utilization management process in the last year, as it relates to care coordination for individuals hospitalized in State BHO's. For people hospitalized at regional campuses other than TVBH, discharge planning has been difficult. Providers find it problematic to provide the needed transportation back to Franklin County, hampering the transition out of the hospital.

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

We are continuing to plan, support, and where feasible fund providers' efforts to identify medical comorbidity among their SMD and elder consumers; to increase the utilization of mobile/community-based RNs and APNs in delivery of mental health care (e.g. ADAMH's IDDT-ACT initiative; North Central MHS's Nurse Outreach Team, Southeast's Homeless PATH Program); and increase bi-directional co-location (e.g. Southeast SAMHSA-funded primary care clinic; North Community Counseling's entire West Side practice moving into the Westside Wellness Center of the Columbus Neighborhood Health Centers; Concord's and Northwest's outreach and care coordination with elders' primary care providers.

b. Planning efforts

Beginning in January 2012, we have instituted a new work team at ADAMH dedicated to planning and system evaluation. This team has created a Resource Library for the use of all staff regarding best practices, Franklin County data, treatment and prevention models, and other mental health and alcohol and other drug issues. Also, this team will be conducting Needs Assessments and Outcome measures for our many program areas.

c. Business operations

Given the rapid and uncertain changes in service delivery and billing taking place at both the state and federal levels, we have begun the process to develop a new data system, called SHARES to collect, analyze and process consumer information and activity in our system of care. We are collaborating on this sizeable project by

forming a Council of Government with the Hamilton and Cuyahoga county boards, and intend to make it available to other Boards if they so desire.

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.

Surveying the Community and Making a Difference

Life for the ADAMH surveyors has had its ups and downs like many of us, but through recovery and perseverance Lutrecia Johnson, Shanita Henderson, and Lawrence McMutary have learned to live healthy, productive lives.

Johnson, Henderson, and McMutary all work as surveyors within the ADAMH system of care. "This job is so rewarding," said McMutary, "we work each day to improve the ADAMH system to make sure the individuals receiving services are getting the help they need."

The surveyors are a part of the Project Work program, a work program at ADAMH-funded Southeast, Inc. Project Work is a supported employment program that provides temporary employment opportunities as well as job training and placement options to people with disabilities.

"I think we give a lot of the people hope and encouragement that the ADAMH system hears their concerns and we show them that we care about their recovery," said Henderson. "I love working with people and helping people and sometimes all they need is someone to talk to when life gets hard."

"I live with bipolar disorder and struggled with a drug addiction for years," said Johnson who understands how hard life can be when you live with a mental illness. She is now five years clean and working to earn her degree in psychology. "When I started working I hadn't worked in 10 years, it was hard but it was worth it," Johnson explained.

Each year ADAMH surveyors call over 1,000 Franklin County residents who have received services within the ADAMH system of care and ask questions like: What is the best thing this agency did for you? Name one area the agency could improve.

"The work we do is very helpful," said Henderson, "sometimes people feel like they can't express themselves. When we call and survey them they feel like someone is listening and their opinions matter."

"People need to know that they are not alone," said McMutary, "I tell the people I talk to all the time that there are resources available in the system, and if you need to talk to someone who has experienced living with a mental illness or

substance use issue, then try The P.E.E.R. Center or a support group, just don't give up."

The ADAMH surveyors believe that people receiving treatment for their mental health issue or substance use disorder need hope. "If all else fails, do not give up hope," said Johnson, "If I can do it, I believe you can too."

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.