

**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.)

Portage County's population of 161,451 ranks 19th out of the 88 counties in the state, and its population had grown 6.2% from 2000 to 2010, as compared to 1.6% statewide. Economic indicators suggest that while Portage County is not the hardest hit by the downturn that still plagues Ohio, it is also not doing much better than the rest of the state. The following statistics would seem to support that assessment.

- The percent of persons below poverty level is 14.3%, slightly lower than the state's 14.8%.
- Unemployment in October 2013 was 6.7% compared to 7.5% for Ohio. Portage County shared the 6.7% rate with six other counties; 28 counties had a lower unemployment rate, and 54 counties had a higher unemployment rate, according to the Bureau of Labor Statistics, which cited a range of unemployment rates from 12% for Meigs County to 4.3% for Mercer County.
- Median household income is \$51,441 as compared to the median household income of \$48,071 for Ohio as a whole.

However, from the standpoint of available local support for the Mental Health & Recovery Board of Portage County, perhaps a more telling statistic in a discussion of the county's economic status is the decline in the value of the housing stock upon which the levy is calculated. The Board is funded locally by three ten year levies:

1. .3 mill (new in 1972, never replaced),
2. .5 mill (new in 1979, never replaced)
3. 1 mill (new in 1984, replaced in 2003, for an annual increase in levy revenue of about \$1,400,000).

Because of the drastic cuts in state funding, the Board contemplated replacing the 1 mill Levy in November 2013, as a way of raising more revenue. When the Auditor's Office calculated what the increase would be in the 1 mill levy revenue if it was replaced, the replacement, if passed, would have generated an annual increase of \$64,825. However, by replacing the levy, the annual \$134,844.90 in Personal Property Tax Loss revenue that is tied to the 1 mill Levy would have been lost. In other words, by passing a replacement levy, the Board would have *lost* \$70,000 annually. And this is true despite the addition of approximately 2,900 new homes!

In addition to the declining local revenue, Portage County has historically received less per capita from ODMH and ODADAS, with only four counties receiving less per resident. In FY2014, \$961,444 was allocated to Portage County as an attempt to redress some of this historical inequity. Portage County was receiving *\$1.89 per capita less than the average per capita rate*; thus, if all counties were receiving the average per capita rate, Portage would have received about \$305,000 more in funding a year; therefore, the \$961,444 allocation received in FY14 covered about three years' shortfall.

The allocation was welcome, but because of the uncertainty of the funding continuation (with Medicaid expansion

the additional funding that the legislature approved will most likely not continue), the notification of the amount of the allocation after the start of the fiscal year (service contract amounts are typically decided in February and March and no planning had been done for the additional funding), and because the funding has to be spent within the fiscal year, it is difficult to develop a stable service portfolio using the funds. Instead, these funds are being used for pilots and projects, including infrastructure support, where appropriate; alternatively, levy funds have been freed up to be used for projects, by using the 507 funding for services.

The extended uncertainty regarding the Federal SAPT funding was an additional hardship. Contracts need to be in place in July in order to reimburse contract agencies in a timely fashion; as a result of funding allocation delays, contracts had to be issued on a contingency basis, with multiple amendments, in order to allow payment to the agencies for programs for the first four months of the fiscal year while the issues were being decided.

Concern exists for the future of our two residential addiction treatment centers with the cuts in the Federal SAPT funds and Women's SAPT Treatment funding. Our Women's residential house was originally established using these funds as the primary funding source. With steady cuts to these funds, the Board has been supplementing the cost. Next year, with the 33% proposed cuts to the Women's SAPT funding, the Board will need to provide additional funding to prevent closure. A new men's facility was established this year as a result of extreme community pressure, despite reduced funding. This new program has not yet had the opportunity to develop non Board funding streams, and funding reductions threaten its continuation as well.

If the additional 507 funding is not maintained in FY15, with the expected \$248,339 in SAPT funding cuts, the Board will be facing an annual operating deficit of (\$582,770) with continued support of the two non medical community residential addiction treatment locations.

**Note:** Census and demographic characteristics referred to in this discussion, and the needs assessment discussion are based upon the **U.S. Census Bureau's State and County QuickFacts, last revised Thursday June 27, 2013 (projected through July 1, 2012)**. All subsequent county and state demographic information is based upon this same source. Consumer characteristics are based upon information from **the MACSIS Datamart for FY2012, extract dated July 6, 2013 for SMI statistics**.

## Assessment of Need and Identification of Gaps and Disparities

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

### **Quantitative Needs Assessment:**

**Process:** The quantitative needs assessment process looks at the demographic characteristics of the county as a whole (age, gender, race) and compares them to the demographic characteristics of the consumers in treatment (alcohol and drug addiction treatment and mental health treatment) to determine the whether there is apparent equity in the access to services.

It also looks at the service penetration rates for the same demographic groups, and compares the service penetration rate to the epidemiological prediction of the prevalence of mental health and drug and alcohol addiction to evaluate the gap in services.

The penetration rate is considered for the alcohol and drug addiction treatment and mental health treatment consumers separately to identify disparities (if they exist) between the types of services provided.

### **Summary Findings:**

The following discussion focuses on the analysis of the population in treatment first using demographic characteristics, and then looking at the severity of the illness within the population, using the MACSIS DATAMART to identify the proportion of SED/SMI within the population in treatment. Client counts and dollars spent are both used in the analysis.

#### **Summary of General Demographic Population Analysis: Age, Gender, and Race**

In summary, the total population in treatment (all those receiving Mental Health and/or AOD treatment services) is compared to the general county population to determine if services are distributed evenly amongst county residents, based on three demographic characteristics: age, gender, and race. This allows the Board to target underserved populations.

GENDER. The population in treatment closely mirrors the county population demographics when considering gender (.59% variance between the general population and the population in treatment), and the distribution of gender within the county remains virtually unchanged from FY2010 to FY2012, and equivalent to gender population distribution to the state as a whole.

RACE. The racial characteristics of the general population in Portage County is predominately white (92.20%), with the African American population (at 4.40%) and the other race category (at 3.40%) making up less than 8% of the population. Since the last biennium the race distribution within the county has changed slightly: the Other demographic category has decreased by .19%, and the white population has decreased about .07%, while the African American population has grown .26%.

The total population in treatment is appears to be showing Whites being underserved by about 4.5% which is offset by the percentage of the African American population in treatment exceeding the percentage of African Americans in the general population by 2.13% and the Other population in treatment exceeding the percentage of Other in the general population 2.35% more than the general population. This is a change from 2010, when the variance between the White proportion of the population in general, and those in treatment was only 1.75%.

AGE. However, there is considerable disparity between the age distribution in the general population and that of the population in treatment. This has been the case since 2007. There are a disproportionate number of children in treatment when compared to those in the general population. In addition, adults 65 and over receive virtually no services, and that population is growing. When the AOD and MH populations are looked at separately (below) these disparities shift somewhat: the low number of children receiving AOD treatment services is masked by the disproportionately high MH treatment services provided to children and adolescents.

#### **Summary of SED and SMI Population Analysis**

The Board is able to serve the SED/SMI clients of Portage County who have been identified in the MACSIS Datamart as being SED/SMI—in FY2012 49.33% of the consumers in treatment (2,768 consumers of the 5,611 consumers who received mental health services). Thus the Board was providing treatment services to 2,843 consumers who were not SED/SMI. However, the treatment services provided to the consumers with SED/SMI utilized 80.89% of the Board mental health match and non-Medicaid dollars, leaving very few resources available

for treatment services for others in need.

Some consumers with SED/SMI also use drug and alcohol addiction treatment services (196 consumers in FY2012). When mental health services and drug and alcohol addiction services are considered together, the percentage of the total MACSIS match and non-Medicaid expended for the SED/SMI population decreases to 68.54%.

However, since the current SED/SMI definition is partially dependent upon the frequency and type of services received by the client, the lack of funding to purchase more services may be artificially deflating the actual number of SED/SMI. This dependence on expenditure levels may also be contributing to the apparent higher incidence of severe mental illness in children that is reflected below. Children are more likely to be eligible for Medicaid, more money is thus spent on children's services, and the SED penetration rate goes up.

**Note: Tables that support the Summary above in detail are provided in the Appendix 3 at the end of this document.**

### **Qualitative Needs Assessment:**

**Review of child service needs resulting from finalized dispute resolution with FCFC:** In Portage County, there have not been any disputes regarding child service needs that required resolution.

**Outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals:** In the past two years, with one exception, all Portage County residents who received treatment at Heartland received timely and appropriate outpatient services upon discharge to the community. The one exception is an ongoing case at Heartland of an individual who is an “undocumented” immigrant who worked in the US for 30 years but does not qualify for Medicaid benefits. Due to mental health and physical health issues, he requires an assisted living residence but there are no funds to pay for this placement and his family is unable to care for him at home. The Mental Health and Recovery Board of Portage County has been actively working with Heartland staff on finding both an appropriate outpatient setting and the funds to pay for this.

### **Qualitative Needs Assessment Process for Portage County:**

A “Community Plan Survey” was developed by the Mental Health & Recovery Board of Portage County for two purposes: (1) Identify a list of priority services for mental health and addiction treatment for Portage County, and (2) Identify any unmet mental health and addiction needs in Portage County that should be addressed. Total number of responses was 169. The survey was distributed in the following manner from November 15 through December 18, 2014 to collect responses:

- Community members were invited to complete an on-line survey at [surveymonkey.com](http://surveymonkey.com). The link was publicized for several weeks on the Board’s social media sites, including Facebook. The link was also publicized in letters to the editor from the Chairman of the Mental Health and Recovery Board in several county newspapers. In addition, the link was emailed to a number of community members involved with local citizens groups. They were the National Alliance on Mental Illness Portage County and Citizens for Addiction Recovery and Education.
- Distributed to the Clinical Directors of the Board’s four contract agencies for distribution to their staff and consumers– Coleman Professional Services, Children's Advantage, Townhall II, and Family and Community Services.
- Distributed to the Executive Directors of the contract agencies for distribution to their Board members.
- Distributed to and collected from the Portage County Family and Children First Council and the Interagency Clinical

Assessment Team. At these meetings, the needs of children and families in the community are continually addressed and monitored. These two groups represent the local child-serving agencies in the county, providing a very comprehensive and in-depth assessment of current needs of families. FCFC consists of parent representatives and the following agencies: Juvenile Court, Department of Job and Family Services, public schools, Educational Service Center, MRDD, Children's Advocacy Center, County Commissioners, County Health Department, Northeast Ohio Adoption Services, Department of Youth Services, United Way, Help Me Grow, and agencies served by the Mental Health and Recovery Board of Portage County. Information from FCFC and ICAT was collected through the distribution of the Community Plan Survey in November 2013 that was also followed by a discussion of unmet needs for children and families in the county.

- Distributed to and data collected in November 2013 from the Portage County Suicide Prevention Coalition that consists of consumers, and representatives from the following organizations: mental health and AOD, Kent State University, Hiram College, Northeastern Universities College of Medicine, Agency on Aging, Veteran's Administration and Juvenile Court.
- Mental Health & Recovery Board of Portage County Board of Directors
- Current class of Leadership Portage County, class of 2014.
- Current class of police officers at the Crisis Intervention Team training in December 2013.

The results from the Board survey are as follows:

- Individuals who completed the survey identified themselves in the following manner (note that the responses total greater than 169 as more than one category could be checked):
  - Interested member of the Portage County community (N = 82)
  - Community stakeholder (e.g., school, organization involved with mental health/addiction) N = 51
  - Family member of someone who uses mental health and/or addiction services (N = 48)
  - Provider agency staff or agency board member (N = 47)
  - User of mental health and/or addiction services (N = 18)
  - Law enforcement (N = 18)
  - Mental Health & Recovery Board members (N = 7)
- Based on 169 surveys completed (89 completed online at Survey Monkey and 80 paper surveys), the following, in ranked order, are the services identified as priorities in Portage County:
  - Outpatient Counseling for adults, children and teens (N = 77)
  - Crisis Services (N = 66)
  - Detoxification Services (N = 60)
  - Outpatient addiction Services (N = 55)

- Housing for adults with mental illness where support services are provided (N = 55)
  - Case Management support services (N = 52)
  - Criminal Justice diversion programs for people with addictions/mental health problems (N = 52)
  - Residential treatment services, both mental health and addiction (N = 50)
  - Medications for people with mental illness (N = 50)
  - Early childhood mental health programs for schools and parents (N = 47)
  - Medical/physical health care services for people with mental illness and addictions (N = 46)
  - Drug/alcohol use prevention programs (N = 45)
  - Community educations about mental health and addictions (N = 41)
  - Suicide prevention programs (N = 41)
  - Employment services, including assessment, training, job coaching (N = 41)
  - Treatment using medications (e.g., Suboxone) for people with addictions (N = 24)
  - Peer support services (N = 15)
  - Other single responses included the following: Focus on the drug epidemic; Re-entry services for those involved with criminal justice system; Education and empowerment of those with mental illness; More education on mental illness and solutions to deescalate the situation; Day treatment programs; Ambulatory detox; Community education about available services; Drug addicted infants; More services in middle schools; More psychiatric providers; Transition programming for young adults; Comprehensive dual diagnosis treatment; prescreening mental health facility with longer hold time.
- Unmet mental health and addiction service needs that were identified in the survey are as follows along with the number of individuals who endorsed this same unmet need:
    - Detoxification in Portage County (N = 25) – NOTE: Portage does contract for detox services outside the county but there is a waiting list for detox and no facility in the county.
    - More Mental Health and Addiction services, including trauma, for children and adolescents and their families/parents (N = 20)
    - More Residential Treatment for people with addictions (N = 16)
    - More psychiatric and mental health/addiction services for adults (N = 11)
    - More services for families and overall community awareness (N = 10)
    - Mental Health and Drug Courts in the County for alternative sentencing rather than jail (N = 7)
    - More housing for those with mental health, addictions, criminal histories (N = 6)

- More employment services for those with mental health/addictions (N = 6)
  - Better access and linkages to services, including transportation (N = 4)
  - Peer support services (N = 2)
  - Other responses included: women’s issues for single mothers; more mental health/addiction services in the jail; identify and address social and environmental determinants; provide neuro-feedback services; less competition among agencies; more help for those with traumatic brain injuries; services for veterans; fitness classes and yoga; free medications; respite care for children; stigma reduction.
- Finally, in addition to the survey responses, a number of anecdotal comments were made during various discussions that occurred with the above groups when the survey was administered and the following observations were made:
- There has been an increase in referrals for the assessment of children and adolescents who may be identified as having Autism Spectrum Disorder or Pervasive Developmental Disorder. Defining appropriate treatment for this population has become a prominent concern. In particular, a number of adolescents are presenting with extremely aggressive and “out of control” behaviors that has resulted in the Mental Health and Recovery Board of Portage County contributing funds to pay for out-of-home residential placements for assessment, safety, and stabilization.
  - Another major need that has been identified is for services for SED youth who are turning 18 years of age. Most of these youth need to become fully integrated into the adult system with a focus on independent living skills. Many of these youth are still in high school when they turn 18, so adult services need to be focused on current school functioning as well as preparing them for the world of work. Other youth are either in the foster care network or are in residential/group home placements when they turn 18, often without a family to live with upon discharge from the foster care system or residential/group home placement.
  - Adults and adolescents who abuse or are addicted to alcohol or other drugs, especially heroin. The Portage County Department of Job and Family Services is reporting an increase in the number of children their agency must remove from homes due to addiction problems of the parents/guardians. In the current calendar year (2013), there have been 22 deaths by overdose in Portage County, most of them due to heroin overdose. That is an increase of 7 over 2012 and of over 13 from 2011. Also there is no inpatient detoxification in Portage County so the Board accesses detoxification services in two neighboring counties, Summit and Stark, through agreements with these facilities. However, there is frequently a wait of several days for these services due to high demand as these units typically run at 100% capacity. There is no consumer support group for adolescents in Portage County (such as Ala-teen) so this is also an ongoing unmet need.
  - Individuals involved in the criminal justice system (both adults and children): The Portage County mental health system has developed a close connection with the local courts and county jail that has resulted in better care for those individuals who become involved with criminal justice system and who have a mental illness. More specifically, there is a Jail diversion program that targets people with Misdemeanor offenses who can have the charges expunged from their record by following through with treatment. Also, for those individuals who do become incarcerated in the county jail, there are case managers, therapists and a psychiatrist who provide face-to-face services in the jail. The major need is to expand both programs due to an

increase in people being arrested and incarcerated, many of them for substance abuse offenses. Portage County has seen an increase in arrests for drug possession and related drug offenses (e.g., theft) that have resulted in an overcrowding situation in the county jail, particularly for women. There is no drug court in Portage County and no immediate plans to develop one in spite of more incarcerations.

- Transportation: Although there is a public transportation system in Portage County through the Portage Area Regional Transportation Authority, there are major limitations on bus routes as many of the remote communities are not serviced by the main bus lines. Consumers can contact PARTA to arrange for door-to-door transportation, but depending on where they live in the county and schedules, they often have to plan for an entire day to attend a single appointment given long wait times.
- Lack of inpatient psychiatric facilities for both adults and children in Portage County. Although Portage County is able to conduct face-to-face prescreening assessments of adults and children in crisis who may require hospitalization, all hospitalizations must occur outside the county, requiring additional time and resources and making it difficult for family members to see and be a part of ongoing psychiatric treatment while their family member is hospitalized.

#### Additional Needs Assessments:

- Portage County Maternal and Child Health Consortium for Issue Prioritization (June 2013): The Ohio Department of Health, Child and Family Services awarded the Portage County Health Department a five year grant in 2011 to fund maternal and child health programming. Key stakeholders from 35 Portage County organizations, including the Mental Health & Recovery Board of Portage County, participated in a needs assessment for children and families in the context of population-based health. Although the majority of the focus of the group was on physical health risks and needs (e.g., child immunizations, lead poisoning, cancer), one area identified was child obesity, with Portage County showing that 45.9% of the children in the age range of 11-17 are overweight as compared with the Ohio state average of 35.6%. As an aside, this issue is being currently addressed through a collaborative effort between the Portage County Health Department, Kent State University, and the Mental Health & Recovery Board of Portage County to screen children in public schools for both mental health issues as well as issues related to nutrition and obesity.
- Needs Assessment Report: Reentry Issues in Portage County Ohio, January 2011. A Report for the Portage County Reentry Coalition. The Portage County Reentry Coalition was comprised of 22 members from a variety of agencies and organizations, including Family & Community Services, Townhall II, Children's Advantage, Coleman Professional Services, Portage County Probation and Jail, Portage County Prosecutor's office, local clergy, Kent State University, Portage County Job and Family Services, Portage County Metropolitan Housing, Portage Area Regional Transportation Authority, and interested community members. The Coalition completed an assessment through 2010 on the issues and barriers confronting individuals who are returning to the community following incarceration. Major barriers that directly affect individuals returning to the community and affecting their ability to remain out of prison include difficulty obtaining employment due to their record and a lack of education and job skills, lack of affordable housing, limited transportation in the county, mental health and addiction issues, lack of family support, and untreated physical health problems.
- Needs Assessment Report (revised) July 2013 from the Portage County Substance Abuse Prevention Coalition supported by the Ohio Strategic Prevention Framework – State Incentive Grant (SPF-SIG). The Mental Health

& Recovery Board of Portage County received a SPF-SIG grant in 2010 that is focused on reducing high risk alcohol use among the 18-25 year old population, especially at Kent State University. The results from a 2012 KSU alcohol survey revealed the following issues and needs:

- 84.8% reporting having used alcohol in the past 30 days. This is a major concern since it is 22.7% higher than the national prevalence rate of 62.1% reported by NSDUH, 2009. This is also 19.2% higher than the Ohio rate of 65.6% reported by the State Epidemiological Outcomes Workgroup (SEOW) 2006-2008 and 12.4% higher than Portage County's Board area of 72.4% reported by (SEOW) from 2006-2008.
- High-risk drinking (defined as 4 or more drinks in one sitting in the past 2 weeks for women or 5 or more drinks in one sitting in the past 2 weeks for men), was engaged in by 50% of KSU students overall.

### 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 needs assessment? (*see definition "local system strengths" in Appendix 2*).

- Community Support as evidenced by the passage of three levies, including the Renewal of our largest one mill levy on November 5, 2013 by a margin of 67% for the levy to 33% against.
- Collaboration and cooperation amount local stake holders.
- Stability of local leadership at the Board and Provider level.
- Excellent network of local providers for non-Medicaid services.
- Availability of local crisis stabilization/residential unit to both keep individuals in the County rather than going to a hospital and/or as a step-down from a psychiatric (private or state) hospital.
- Availability of two coordinated 24-hour access lines.
- Cooperation and collaboration with two detoxification programs in Stark and Summit Counties for Portage residents.
- Development of a coordinated Service Coordination Team for children, as part of our Interagency Clinical Assessment Team, that provides wraparound services for children and families that helps them stay in with their families and in the community.
- Efficiencies and pooled resources in board business operations via membership in Heartland East Administrative Services Organization, a regional consortium of Boards to provide IT services.
- Availability of Electronic Health Records system to all contract agencies.
- Having access to an excellent state hospital and nearby private psychiatric hospitals.
- Good working relationships with other Heartland boards, especially through monthly meetings and sharing in joint treatment projects.

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

state departments.

- Collaborative approach to electronic health records system.
- Regional administrative services center.
- Training for both Crisis Intervention Team (CIT) and Crisis Intervention Team Education Collaboration for school personnel.

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*).

The primary local system challenge is funding. Our Mental Health & Recovery Board of Portage County since 2008 has suffered a loss of over \$2.2 million dollars to our system, most of that a cut in State funding. With a Board budget around \$6 million, these cuts have directly impacted the ability of the Board to provide necessary treatment services and mandated emergency services. In the current fiscal year 2014, our Board's state funding was increased by over \$900,000 but this funding may be reduced or cut so it is not possible to do any long range planning for services beyond one quarter at a time. Plus with the State of Ohio planning to begin the distribution of Federal funds over 6 quarters rather than 4 quarters starting in FY15, our Board needs to use a substantial portion of the additional funding (assuming it continues in FY15) to cover the reduction in Federal funds in order to maintain the current level of services. Also, some less immediately apparent repercussions are as follows:

a. What are the current and/or potential impacts to the system as a result of those challenges?

It is reducing service capacity within the local system. Some of this reduction is a direct effect of funding reductions as service clinicians have been laid off by agency providers who can no longer afford to employ them due to reduction of Board funding. But the constant reductions of funding in this segment of the health care field, and the relatively low salaries that are offered for a career professional, is having a more insidious and long term effect on the number of people who choose to become mental health or drug and alcohol treatment professionals. Other health care fields are much more lucrative, and although many health care professionals are dedicated to helping others, very few want to take an advanced degree for a profession whose future is so uncertain, when there are other health care fields with a more positive future and better promise of a good income.

It is also reducing the Board's influence in the local system of care which greatly limits the success of strategic planning. This reduction in influence is a direct result of the Board's severely limited ability to purchase services, or to contribute funds to local collaborative efforts.

Local providers who received Medicaid funding as well as non-Medicaid funding from the Boards, now perceive the Board as a minority funder. As local funding contracts decrease, providers are less and less likely to devote time to county-wide initiatives, as they struggle to survive in competition with the other providers in the county for a very limited number of dollars. This impacts the success of Board strategic planning among the providers and other human service agencies within the county.

It also limits the ability of the Board to successfully continue existing collaborations or initiate new ones. Most local collaboration requires that funding be available to pool for specific new projects as well as for the continuation of existing collaborations. Decreasing funding means that fewer Board funds can be used in collaborative efforts. This would be bad enough if it were only the mental health/drug and alcohol treatment system that had experienced cuts. However, it is not.

An existing collaboration, our local Interagency Clinical Assessment Team (ICAT), is a good example of the local deterioration of pooled funding. Residential placement of children who were involved with multiple county agencies used to be funded by four local systems: the local court system, the Developmental Disabilities Board, the Mental Health and Recovery Board, and the Portage County Department of Job and Family Services. Each funder contributed an even share of the child's placement costs, according to the child's involvement with each of them. If the child was involved with all four systems, for example, the child's placement costs were

divided equally amongst the four funders. If the child was involved with only two of the funders, those two funders covered the costs of the child's placement equally. A few years ago, the court system's funding was cut, and the courts no longer contribute to placement costs. The Board has been forced to reduce its own share of ICAT funding. Although the county has come together to work on more collaborative community alternatives and have decreased the length of most residential placements, there has been increase in the severity of certain children who put both themselves and others at risk of harm and require long term out of home placements. In the past the Board supported around 15 children in placement each month (not necessarily the same children). Currently, the Board supports three or four a month. Fewer and fewer children can be placed, with a much heavier funding burden on each collaboration partner.

The Board also has a limited ability to participate in grants for new initiatives, since most require grant funds match, and a sustainability plan. Because of limited resources, and new funding that is tenuous, this would require funding to be diverted from an existing program, and dedicated to a new one. However, the Board does consistently apply for grants.

- i. School consultation received additional funding through the state this current FY14 in collaboration with the Board of Developmental Disabilities.
  - ii. Vocational services are provided through Rehabilitation Services Commission grants: VRP3 and Recovery to Work. The match dollars are all the Vocational services which the Board purchases at this time.
  - iii. SPF-SIG grant from ODADAS, as well as the Federal Women's Special Services Grant from ODADAS for treatment and prevention.
- b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.
- Portage County is always very open to collaborating with other Boards and State Departments on joint treatment projects.
  - The Mental Health & Recovery Board of Portage County is currently developing a new strategic plan and is also examining the Board Staff organization/structure, both areas that we could use other ideas and assistance, especially as we head into more unpredictable funding.
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*).

The Mental Health and Recovery Board of Portage County has the vision that all individuals living in Portage County who are receiving any kind of mental health/substance abuse service are treated with respect and dignity at all times. Respect includes an active acceptance of each person's unique background and characteristics. When an individual and/or family comes into our system of care, we envision providers actively inquiring about the cultural qualities that they bring into any therapeutic relationship, utilizing these characteristics to develop individualized service plans that welcome and respect their diversity and uniqueness.

In order to develop policies that promote culturally effective programs and services, the Mental Health and Recovery Board of Portage County is dedicated to the mission of continuously building awareness, understanding and tolerance of all individuals' unique beliefs, values, customs, languages, abilities, traditions and cultures. To achieve this culturally competent system of care in Portage County, the Mental Health and Recovery Board of Portage County expects that its contract agencies, along with their clinical providers, will do the following:

- The top leadership in each contract agency, including the Mental Health and Recovery Board of Portage County

leadership staff and Board of Directors, will demonstrate a commitment to cultural competence and sensitivity. Coleman Professional Services, Children's Advantage, Townhall II and Family and Community Services all have demonstrated this commitment as measured by having written policies and procedures in place that address hiring staff and selecting board members that reflect the racial, ethnic and cultural makeup of our community and training staff annually on issues related to cultural sensitivity. To date, the agencies have been successful in hiring staff that closely match the population demographics. In addition, agencies typically do an annual training on a variety of topics related to the theory and practice of cultural competence. Examples include the Appalachian culture, religion and spirituality in treatment, LGBT community, economically challenged, and the deaf culture.

- When individuals and families present for services, it is expected that cultural information will be gathered at the initial intake. This will be achieved by asking people to share what cultural, racial, religious, etc., practices and identities are important to them. Of great importance, the provider doing the initial assessment, as well as subsequent sessions, must be sure to understand that a particular behavior/action may be a reflection of a cultural characteristic/practice (including but not limited to religious affiliation, sexual identity) and not perceive it as a sign of illness or pathology. The cultural information should then be used to develop a service plan that is sensitive and responsive to each adult, child and family's background, such as when and where such services will be offered. For all of our Board's contract agencies, the diagnostic assessment/intake process does ask people to share their cultural identities and backgrounds with the intent of using this information to develop an array of services that is respectful of their preferences. If a consumer's request for a particular cultural service cannot be met, such as using specific religious practices, each agency is expected to facilitate a referral to an appropriate provider either in the agency or to another organization/provider.
- Providers must interact with all people, consumers and colleagues, at all times in a manner that is culturally and linguistically competent. If an interpreter is required, including sign language, it is expected that the agency will provide one at no cost to the consumer. The consumer is also always welcome to bring along anyone of their choosing to any session to assist with language and/or cultural barriers. The Board's contract agencies appear to be meeting specific needs and requests of individuals as they arise.
- To develop our system's efforts toward cultural competence, all contract agencies gather information through client satisfaction surveys that ask for feedback about the cultural awareness of agency staff. In addition, all agency Boards along with the Mental Health and Recovery Board of Portage County have consumers on these boards who provide ongoing input about cultural issues and sensitivity.
- To reach out to diverse racial, ethnic, and cultural groups in the community, the contract agencies along with the Board participate in a wide variety of county events and informational fairs. One of the agencies implements a Minority Fair on an annual basis. Several agencies provide services at a community center in one town that is geographically isolated with a high poverty rate. Also, a variety of school-based prevention and early intervention services are provided on site to every school district in the county to provide access to services outside the agency centers. The Board and its agencies regularly accept invitations to speak to community groups, especially addressing topics related to stigma and acceptance of diversity. Finally, all of the contract agencies and the Board regularly use the media (print, radio, internet, etc.) to educate the county about mental health and substance abuse issues, especially promoting a common respect for and understanding of all people regardless of disability, mental illness, addiction, poverty, racial and ethnic and cultural differences, and sexual identity.

## 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 Mental Health & Recovery Board of Portage County**

**Substance Abuse & Mental Health Block Grant Priorities  
\*Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Increase in percent of pregnant women who complete AOD treatment	Detox treatment Outpatient AOD treatment Residential Treatment (Horizon House)	Number of drug-free births for those women who gave birth prior to discharge at Horizon House	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> 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)	Prevent loss of custody and increase family reunification for parents involved with the child welfare system due to their substance abuse	Detox treatment Outpatient AOD treatment Residential Treatment	Number of families who remain intact or are re-unified	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases				<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Increase accessibility of services for children with SED using a system of care approach	Use Family and Children First Council and Interagency Clinical Assessment Team to facilitate system access. Expand services in schools for early identification. Provide same day diagnostic assessments. Provide same day counseling services. Expand prescribers with Medicaid Expansion opportunities	Number of children served identified 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):
<b>MH-BG:</b> Mandatory (for OhioMHAS):	Maintain and possibly expand	Continue use of FIRST program for	Number of adults served who are	<input type="checkbox"/> No assessed local need

Adults with Serious Mental Illness (SMI)	accessibility to mental health services for adults with SMI	early onset psychosis. Comprehensive services, both clinical and recovery supports (housing, vocational). Provide same day diagnostic assessments. Provide same day counseling services. Increase the number of prescribers to adjust to Medicaid expansion. Transfer stable adults to primary care for medication monitoring.	identified with SMI	<input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*	Develop an integrated care system that treats both physical and mental health conditions in a coordinated manner.	Establish Health Homes in the county. Advocate for Medicaid expansion. Train agency providers to communicate regularly with medical providers. Continue to work collaboratively with local Federally Qualified Health Center and others to increase bi-lateral integration –provide behavioral health services within primary care	Number of adults with SMI who receive Ohio Medicaid Health Home services	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	Increase the availability of Certified Peer Support specialists	With our two current Peer Support specialists, continue to increase the number of consumers served. Obtain training for one more Peer Support specialist. Hire Peer Specialists in Health Homes. Offer on-line recovery resources	Number of certified Peer Support specialists trained in Portage County.	<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				
<b>Treatment:</b> Veterans	Increase the number of veterans receiving services.	Reach out to local resources serving veterans (e.g., Freedom House) and their families.	Number of veterans 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):
<b>Treatment:</b> Individuals with disabilities (hard of hearing/deaf)	Increase the number of deaf/ hard of hearing clients who receive substance	Increase of the use of or Integration of “Deaf Off of Drugs” services (i.e. using	Number of deaf/hard of hearing clients receiving services.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds

	abuse services.	telemedicine hardware.		<input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	Increase percentage of opiate addicted individuals who have a successful disposition at discharge	Use a combination of detox services outside the county, residential services in the county, and outpatient services along with MAT (if available and appropriate)	Number of individuals with opiate addictions who are successfully discharged from treatment with goals met from Horizon and Root House	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*	Increase safe and affordable housing to persons with SPMI including substance abuse disorders	Continue to work on obtaining funds to increase the number of living spaces along with appropriate staff supervision. Increase specialized housing for transitional youth and adults with criminal histories.	Number of new individuals who were homeless with mental illness and/or addiction who are placed in permanent supportive housing	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations	Enhance mental health and addiction workforce skills through cultural competence training	Contract agencies should conduct annual cultural competence training to staff	Number of agency staff members receiving training	<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
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults	Increase positive treatment outcomes for adolescents	Provide Transition to Independence Process (TIP) for agency providers and wraparound services for youth. Develop specialized housing for transitional youth. Partner with OOD for vocational and employment services	Number of youth served by TIP who were successfully treated per disposition at discharge. Number of transitional youth who achieve housing outcomes. Number of transitional youth who achieve employment outcomes.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Early childhood mental health (ages 0 through 6)*	Early mental health screening, assessment, and referral to services are common practice	Provide consultation and training to staff of child-care providers and pre-schools and consultation to families	Number of children ages 0-6 at risk of removal from school/child care who are not removed	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Adopt a public health approach (SPF) into all levels of the prevention infrastructure				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with	Increase family communication around drug use	Promote prevention activities for youth and families (e.g., Parents Who Host; school-based prevention education)	Number of children/youth and families who receive prevention services	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage

children/adolescents*				__ Other (describe):
<b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage in healthy life choices				__ No assessed local need <input checked="" type="checkbox"/> Lack of funds __ Workforce shortage __ Other (describe):
<b>Prevention:</b> Promote wellness in Ohio's workforce				__ No assessed local need <input checked="" type="checkbox"/> Lack of funds __ Workforce shortage __ Other (describe):
<b>Prevention:</b> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*	Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Local provider agency will conduct problem gambling prevention activities in the community and assess for gambling problems during Intakes	Number of people in community receiving gambling prevention activities and inclusion of gambling assessment on all Intake forms	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Crisis Services	Provide in-county 24/7 crisis services to children and adults and families to prevent suicides	Fund 24/7 Hotline with Townhall II and fund 24/7 hospital pre-screening services at Coleman	Number of individuals who are served by each 24/7 service and number hospitalized
Crisis Stabilization for adults (time limited)	Keep people out of the hospital when possible as well as provide a facility for people to safely step-down after a hospitalization	Fund a 24/7 Crisis Stabilization Unit in Portage County that is connected with the pre-screening program at Coleman to provide a seamless transition to the CSU	Number of individuals (adults) who are not hospitalized after screening and number who step-down to the CSU after hospitalization.
Housing – permanent, group home, and supportive living sites	Provide a continuum of housing options for people with mental health issues that includes permanent and independent sites, a group home, and supportive living sites with staff oversight	Assist in funding these various housing options through Coleman Professional Services for adults with mental health problems	Number of people served in each of the permanent, group home and supportive living sites
Residential Treatment for AOD (men and women)	Provide separate facilities for adult men and women who need residential treatment for their addictions	Assist in funding two AOD residential programs: Horizon house for women run by Townhall II and Root House for men run by Family & Community Services	Number of men and women served each year and number who successfully complete treatment



	could be appropriately served
(3) More outpatient services for psychiatry, therapy and CPST	Due to major state cuts and waiting lists, particularly psychiatry, we need to increase access for consumers for outpatient services that we believe will lead to a decrease in crisis situations if they are receiving adequate and timely outpatient services.
(4) More housing for adults for both MH and AOD	Portage County always has a waiting list for housing, especially if the individual needs supportive services or a group home. We are not able to meet the local needs for housing in the County.
(5) Housing for transitional age youth	Portage has NO housing for transitional age youth so this is clearly an unmet need.
(6) Recovery Housing for AOD adults	Portage has NO recovery housing for adults with addictions so this is clearly an unmet need.
(7) Crisis stabilization for adolescents (time limited)	Portage does have a CSU for adults but nothing for adolescents who may need a time-limited place to get stabilized without being hospitalized.
(8) Drug and Mental Health Courts in Portage County	Portage County does not have either Specialty Docket for a Mental Health or a Drug County. Although we do run a mental health diversion program through the Municipal Court, we would benefit by being certified as a Mental Health Court.
(9) More school-based services	The Board currently funds school-based services in the local schools for early identification and treatment for children of all ages. However, the schools continuously ask for more services but the funding is not there.
(10) Residential treatment (mental health)for adults and children in Portage County	Portage County does not have any residential facilities for either adults or children for consumers with mental health issues resulting in all consumers leaving the county for services. For children in particular, this presents additional challenges for families, particularly to be a part of regular treatment and planning for a return home and to the community.
(11) Acute detox in the County	There are NO in-county detox facilities in Portage and it would be more consumer-friendly to have a facility, especially for adults, so that care is provided closer to home.
(12) Inpatient treatment in the County for MH hospitalizations	Years ago there was an inpatient psychiatric ward at Robinson Memorial Hospital, our only county hospital. Again, having psychiatric inpatient facilities in the county would make hospitalizations more effective for consumers, particularly children and their families.
(13)	
(14)	
(15)	

## Collaboration

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.
- Family and Children First Council: The Board's Executive Director is an active member of the FCFC Council and is an active member on FCFC's Interagency Clinical Assessment Team (ICAT) that oversees consideration of children for placement in residential facilities. ICAT is comprised of all AOD and mental health agencies supported by the Board along with the Department of Job and Family Services, Juvenile Court, Board of DD and local schools. ICAT revised its procedures to match the Service Coordination procedures for the entire county.
  - Adult Courts and Jail: The Board is responsible for running the Jail Diversion Committee that oversees how consumers are diverted in the criminal system to mental health treatment. The Board works closely with Coleman Professional Services as they provide case management and psychiatric services to consumers in the jail. To date the program has successfully served 15 consumers in the past year through its diversion services.
  - Robinson Memorial Hospital: The Board meets at least quarterly with the hospital to discuss and resolve problems with how mutual consumers have been managed in their hospital, particularly those consumers who come to the Emergency Department in need of hospitalization for psychiatric problems and/or for detox services. Current discussions are focused on developing more specific procedures to benefit consumers and to reduce problems and increase safety. These efforts have been extremely productive, particularly in stopping the use of force and subsequent incarceration of consumers who present at the ED in crisis. In 2010, the number of arrests was over 70 while in 2012 the number of arrests at the hospital was 5.
  - St. Thomas Hospital/SUMMA Care and Akron General Hospital: The Board has developed formal contracts with both St. Thomas and Akron General Hospitals with Coleman Professional Services for inpatient psychiatric hospitalization. At the current time, psychiatric patients with medical issues are referred to St. Thomas for hospitalization.
  - Summit County ADM Board and Oriana House: The Board contracts with the detox facility in Summit County run by Oriana House to provide three to five day detox services for Portage County consumers and to then coordinate aftercare services in Portage County.
  - Stark County Crisis Intervention and Recovery Center: The Board contracts with this detox facility in Stark County to provide three to five day detox services for Portage County consumers and to then coordinate aftercare services in Portage County.
  - Local Police, Sheriff Department and Public Schools: The Board was instrumental in developing CIT in Portage County in 2006 and until 2009, served as the home office for CIT. The plan is to continue to be an active sponsor and supporter of CIT in collaboration and coordination with the Portage County Sheriff's Department. The Board is a member of the CIT Advisory Committee and CIT Planning Team. The Board also has taken the lead on expanding the CIT concept to include comprehensive training for the public schools, known as the Crisis Intervention Team Education Collaboration (CITEC). A pilot training was done for CITEC in August 2008 with the seventh training planned for July 2014. This training has been accepted by Kent State University, Hiram College and Ashland University for two graduate credits in education.
  - Department of Job and Family Services: The Board has strongly supported Children's Advantage (CA), Townhall II (TH), Coleman Professional Services (CPS) and Family and Community Services (FCS) in obtaining contracts to provide consumer services for DJFS. TH provides staff to conduct on-site assessments and referrals for parents with drug/alcohol problems. CPS provides after hour coverage for DJFS's child abuse reporting hot line. FCS provides Multi-

systemic Therapy, an in-home service for families involved with their agency for abuse and/or neglect.

- Portage County Schools: For over 12 years, the Board has enabled Children’s Advantage to provide on-site consultation and screening to all twelve public schools in Portage County. The Board has also co-sponsored training for educators on mandated requirements related to mental health awareness, depression and suicide, bullying, child abuse and substance abuse.
- County Health Department and Kent State University: The Board has established a contract between Children's Advantage and the Portage County Health Department, in collaboration with Kent State University in developing an integrated wellness program. This in-school program enables children/adolescents to receive both a nutrition assessment and a mental health screening at a local school district, particularly to address the issue of childhood obesity.
- Stark County and Heartland East: Multiple agencies in Stark County along with two Portage County agencies (Children's Advantage and Townhall II) are collaborating on a shared software system to implement electronic health records within each of the agencies. The collaboration enables all agencies to benefit from reduced costs in the purchase and maintenance of the EHR along with conducting shared training for billing and clinical staff members.
- Best Practices in Schizophrenia Treatment (BeST) and Coleman Professional Services and Mental Health and Recovery Board of Portage County: Portage County in 2012 received intensive training and consultation on the FIRST program, an evidenced-based practice of treating schizophrenia when it is first manifested within an individual. Coleman providers and the Executive Director of the Mental Health and Recovery Board of Portage County received training in the FIRST model.
- Rehabilitation Services Commission: The Mental Health and Recovery Board of Portage County, Coleman Professional Services and Townhall II have been actively working together to provide both vocational and treatment services to individuals struggling with issues related to substance abuse and joblessness. The program provides a combination of job assessment and training and substance abuse services.
- Summit County ADM Board: Both the Summit County and Portage County Boards work jointly on coordination of crisis care for consumers who cross county lines and management of residency disputes. This collaboration has resulted in a procedure that is being implemented between the two Boards. To date, the procedure has been working as already several situations have occurred in which potential problems have been quickly handled for the direct benefit of consumers. The Boards have continued their collaboration with a local foundation, Margaret Clark Morgan, to coordinate training and funding for consumers to develop a “speakers’ bureau” where consumers learn how to make presentations in the community and receive compensation for their efforts.

### 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.

Up until September 16, 2013, Portage County had been utilizing Heartland Behavioral Healthcare as our State Hospital. At the request of ODMHAS, the Mental Health & Recovery Board of Portage County agreed to now utilize Northcoast Behavioral Healthcare as our State Hospital. To date, the transition has gone very smoothly and for the consumers, Northcoast is actually closer to Portage County than Heartland, making for a shorter drive for family members to stay connected. Portage continues to use both Summa and Akron General for psychiatric hospitalizations when the individual has appropriate insurance and/or Medicaid or when the person has a concurrent medical condition that requires a medical hospital. Utilization rates have been holding fairly steady over

the past couple of years at the State 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:

As mentioned above, the Mental Health & Recovery Board of Portage County in collaboration with the Best Practices in Schizophrenia Treatment (BeST) Center at the Northeast Ohio Medical University and Coleman Professional Services developed the FIRST program in 2012, an evidenced-based practice of treating schizophrenia when it is first manifested within an individual. Coleman providers and the Executive Director of the Mental Health and Recovery Board of Portage County received training in the FIRST model. We believe that this early intervention program provides not only effective treatment for those experiencing the first signs of schizophrenia but it also helps the individual to be a productive member of society through education and employment and not having to be on disability.

b. Planning efforts

c. Business operations

d. Process and/or quality improvement

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

### Advocacy (Optional)

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

### Open Forum (Optional)

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

#### MACSIS Retirement—Financial Implications for Boards

The state began the creation of MACSIS in 1999 to provide claim level information on services provided to mental health and alcohol and drug consumers and the demographic information about the populations served. The MEMBER module created a unique identifier across the state, enabling an unduplicated count of clients, regardless of Medicaid eligibility or county in which the services were provided. This data was further compiled into a data warehouse which allowed access to statewide information.

The decision to discontinue MACSIS causes a substantial burden for the local Boards. Not only will the Boards have to do the research and planning for a new system (with existing staff and consultants), but they will have to do the research, planning, purchase and maintenance with local funds. The state has made it clear that there are no funds budgeted for a replacement system, but it has also been made clear that claims level data will be required from the Boards. An additional complication is the state's lack of specific guidance regarding the data that will be required, the format of the data to be required, how it is to be submitted, and whether the state will want to continue some sort of unique identifier. These issues would typically all be necessary components of a request for a proposal, and since no specific guidance has been issued, the Boards will have to make decisions about what they think the state will require, and hope that they are able to meet the requirements.

The new system will be expensive, and the expenses will be duplicative across the state, since there will be no statewide system for each board to purchase. The SHAREs program being developed by the three large metropolitan boards will be prohibitively expensive for smaller Boards to participate in, and the other system, GOSH, is not sufficiently supported for serious consideration (one individual developer). Thus local Boards will have to come up with their own alternative.

Portage County is a member of Heartland East, and so will share in a collaborative effort to develop or purchase an adjudication system, but we are very concerned about the additional expenses at a time when resources have been severely reduced. This discontinuation of MACSIS is a sizeable statewide cut to the local Boards.

## 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.

### Appendix 3—Detail supporting Quantative Analysis in Question 2

#### SPECIFIC DEMOGRAPHIC INFORMATION: AGE, GENDER, and RACE

Summary tables below compare the age, gender, and race of the general population of Portage County to those of the Portage County Board consumers (consumers of mental health services and alcohol and drug services are combined).

**AGE.** The first table compares the age distribution of the Portage County general population to the distribution of consumers by age. Two basic disparities are apparent. The percentage of children in treatment exceeds the percentage of children found in the general population by approximately 13%, and the percentage of adults age 65 and over in the general population exceeds the percentage of those same older adults in treatment by 12%; thus, it appears that children are being over-served, and older adults are being underserved. This disparity for older adults has grown 1% since FY2010.

AGE		County Population	% of Total	Consumer Count	% of Total
<b>ODMH &amp; ODADAS</b>	<b>00 - 17</b>	31,967	19.80%	2,166	33.17%
	<b>18 - 64</b>	107,365	66.50%	4,275	65.47%
	<b>65+</b>	22,119	13.70%	89	1.36%
	<b>Totals</b>	161,451	100.00%	6,530	100.00%
<b>6-Jul-13 Note: Unduplicated count of consumers is 6,451</b>					

These numbers do not indicate the amount of service each age group receives, so the table below looks at total dollars spent for MACSIS services (Board funds and Human Services Reimbursement (Medicaid) and Board funds only (non-Medicaid and Medicaid match dollars) in FY2012 for the same age groups.

DOLLARS SPENT by CONSUMER AGE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non- Medicaid	% of Total
<b>ODMH &amp; ODADAS</b>	<b>00 - 17</b>	\$4,457,117	43.73%	\$1,689,461	31.20%
	<b>18 - 64</b>	\$5,606,064	55.01%	\$3,646,605	67.35%
	<b>65+</b>	\$128,193	1.26%	\$78,541	1.45%
	<b>Totals</b>	\$10,191,374	100.00%	\$5,414,607	100.00%
<b>6-Jul-13</b>					

An examination of the dollars spent shows that the inequitable distribution remains, and is in fact more marked (~ +24%), when considering Board Cost for children. This makes sense, since it includes Medicaid, and Medicaid is far more readily available for children, and is paid at a higher rate of reimbursement. When looking at Board funds alone, the disproportionate spending remains marked for children—11.4%. However, the combination of alcohol and drug services and mental health services is masking some differences in spending for children. The table below shows mental health services by age group, and the disparity in funding by age group is even greater.

AGE		County Population	% of Total	MH Consumer Count	% of Total
ODMH	00 - 17	31,967	19.80%	2,106	37.05%
	18 - 64	107,365	66.50%	3,495	61.49%
	65+	22,119	13.70%	83	1.46%
	<b>Totals</b>	161,451	100.00%	5,684	100.00%
6-Jul-13 Note: Unduplicated count of consumers is 5,611					

DOLLARS SPENT by CONSUMER AGE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
ODMH	00 - 17	\$4,201,932	49.40%	\$1,600,870	37.58%
	18 - 64	\$4,179,996	49.14%	\$2,583,415	60.65%
	65+	\$124,804	1.47%	\$75,288	1.77%
	<b>Totals</b>	\$8,506,732	100.01%	\$4,259,573	100.00%
6-Jul-13					

In both categories (Board cost including Medicaid and Board Cost only), however, spending remains far lower (~ -12%) for the aged in the county than would seem to be warranted by the general population distribution in the county.

When the same age information is examined for consumers in AOD treatment in Portage County, it is apparent that the older adults and children and adolescents receive very few AOD services. Children, youth, and older adults are apparently underserved.

AGE		County Population	% of Total	AOD Consumer Count	% of Total
ODADAS	00 - 17	31,967	19.80%	129	10.17%
	18 - 64	107,365	66.50%	1,133	89.28%
	65+	22,119	13.70%	7	0.55%
	<b>Totals</b>	161,451	100.00%	1,269	100.00%
6-Jul-13 Note: Unduplicated count of consumers is 1,264					

DOLLARS SPENT by CONSUMER AGE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
ODADAS	00 - 17	\$255,185	15.15%	\$88,591	7.67%
	18 - 64	\$1,426,068	84.65%	\$1,063,179	92.05%
	65+	\$3,390	0.20%	\$3,254	0.28%
	<b>Totals</b>	\$1,684,643	100.00%	\$1,155,024	100.00%
6-Jul-13					

**GENDER.** The first table compares the gender distribution of the Portage County general population to the distribution of consumers by gender. The percentage of males in treatment is .59% lower than the percentage of males in the general population, and the percentage of females in treatment is .59% higher than the percentage of females in the general population.

GENDER		County Population	% of Total	Consumer Count	% of Total
ODMH & ODADAS	M	78,788	48.80%	3,110	48.21%
	F	82,663	51.20%	3,341	51.79%
	Totals	161,451	100.00%	6,451	100.00%
6-Jul-13		Note: Unduplicated count of consumers is 6,451			

The gender distribution discrepancy for Mental Health clients is 3% lower than the percentage of males in the general population, and the percentage of females in treatment 3% higher than the percentage of females in the general population.

GENDER POPULATION		County Population	% of Total	Consumer Count	% of Total
ODMH	M	78,788	48.80%	2,560	45.62%
	F	82,663	51.20%	3,051	54.38%
	Totals	161,451	100.00%	5,611	100.00%

The gender distribution discrepancy for Alcohol and Drug clients is ~10% higher than the percentage of males in the general population, and the percentage of females in treatment ~10% lower than the percentage of females in the general population.

POPULATION		County Population	% of Total	Consumer Count	% of Total
ODADAS	M	78,788	48.80%	739	58.47%
	F	82,663	51.20%	525	41.53%
	Totals	161,451	100.00%	1,264	100.00%
6-Jul-13		Note: Unduplicated count of consumers is 1,264			

Since these numbers do not indicate the amount of service each gender group receives, the table below looks at total dollars spent (Board funds and Human Services Reimbursement (Medicaid)) and Board funds only (non-Medicaid and Medicaid match dollars) in FY2012 for the same gender groups.

DOLLARS SPENT by CONSUMER GENDER		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
ODMH & ODADAS	M	\$4,955,771	48.63%	\$2,644,751	48.84%
	F	\$5,235,603	51.37%	\$2,769,846	51.16%
	Totals	\$10,191,374	100.00%	\$5,414,597	100.00%
6-Jul-13					

There is a smaller variance between the percentage of dollars spent and the percentage of the gender distribution in the general population.

DOLLARS SPENT by CONSUMER GENDER		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non- Medicaid	% of Total
ODMH	M	\$4,195,595	49.32%	\$2,099,823	49.30%
	F	\$4,311,136	50.68%	\$2,159,749	50.70%
	Totals	\$8,506,731	100.00%	\$4,259,572	100.00%
6-Jul-13					

The differences in the percentage of dollars spent on Mental Health clients and the percentage of the gender distribution in the general population remains small.

DOLLARS SPENT by CONSUMER GENDER		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non- Medicaid	% of Total
ODADAS	M	\$760,176	45.12%	\$544,928	47.18%
	F	\$924,467	54.88%	\$610,097	52.82%
	Totals	\$1,684,643	100.00%	\$1,155,025	100.00%
6-Jul-13		Note: Unduplicated count of consumers is 1,264			

The differences in the percentage of dollars spent on Alcohol and other drug clients and the percentage of the gender distribution in the general population is a little over 2%, larger than the Mental Health variance.

RACE. The first table compares the race distribution of the Portage County general population to the distribution of consumers by race. The African American race category shows a 2.13% variance between the county-wide population distribution, and the distribution within the consumers; the consumer percentage is higher. This is .37% less than in FY2010. The White race category seems to be underserved by approximately 4.5%, while the Other race category is overserved by 2.35%.

RACE		County Population	% of Total	Consumer Count	% of Total
ODMH & ODADAS	White	148,858	92.20%	5,661	87.75%
	African American	7,104	4.40%	421	6.53%
	Other*	5,489	3.40%	369	5.72%
	Totals	161,451	100.00%	6,451	100.00%
6-Jul-13		*The County "Other" category includes American Indians and Alaskan Natives (0.2%), Asian (1.5%), Other (0.21%), and two or more races (1.6%).			

The variance for the clients receiving Mental Health services is very similar to that of the combined behavioral health services in the previous table.

RACE		County Population	% of Total	Consumer Count	% of Total
ODMH	White	148,858	92.20%	4,890	87.15%
	African American	7,104	4.40%	370	6.59%
	Other*	5,489	3.40%	351	6.26%
	Totals	161,451	100.00%	5,611	100.00%
6-Jul-13					

However, the variances for the alcohol and other drug clients are much different from those of behavioral health in general. The percentage of white clients in treatment closely mirrors the percentage of the general population, and the Other category appears to be underserved, although the African American category remains about the same.

RACE		County Population	% of Total	Consumer Count	% of Total
<b>ODADAS</b>	<b>White</b>	148,858	92.20%	1,160	91.77%
	<b>African American</b>	7,104	4.40%	82	6.49%
	<b>Other*</b>	5,489	3.40%	22	1.74%
	<b>Totals</b>	161,451	100.00%	1,264	100.00%
6-Jul-13 <b>Note: Unduplicated count of consumers is 1,264</b>					

Since these numbers do not indicate the amount of service each race group receives, the table below looks at total dollars spent (Board funds and Human Services Reimbursement (Medicaid) and Board funds only (non-Medicaid and Medicaid match dollars) in FY2012 for the same Race groups. Here the variances follow a similar pattern to the table above, but are slightly higher, with the African American and Other categories apparently benefitting from the lower white category.

DOLLARS SPENT BY CONSUMER RACE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
<b>ODMH &amp; ODADAS</b>	<b>White</b>	\$8,945,205	87.77%	\$4,837,025	85.31%
	<b>African American</b>	\$743,501	7.30%	\$361,963	6.38%
	<b>Other*</b>	\$502,669	4.93%	\$471,856	8.32%
	<b>Totals</b>	\$10,191,375	100.00%	\$5,670,844	100.01%
* See note on previous table					

The variances for the clients receiving Mental Health services are very similar to that of the combined behavioral health services in the previous table.

DOLLARS SPENT by CONSUMER RACE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
<b>ODMH</b>	<b>White</b>	\$7,356,784	86.49%	\$3,737,949	87.76%
	<b>African American</b>	\$668,079	7.85%	\$319,098	7.49%
	<b>Other*</b>	\$481,868	5.66%	\$202,525	4.75%
	<b>Totals</b>	\$8,506,731	100.00%	\$4,259,572	100.00%
6-Jul-13					

However, the variances for the alcohol and other drug clients are much different from those of behavioral health in general. The percentage of white clients in treatment closely mirrors the percentage of the general population, and the Other category appears to be underserved, although the African American category remains about the same.

DOLLARS SPENT by CONSUMER RACE		Board Cost: Includes Medicaid	% of Total	Board Funds Only: Match & Non-Medicaid	% of Total
<b>ODADAS</b>	<b>White</b>	\$1,588,421	94.29%	\$1,099,076	95.16%
	<b>African American</b>	\$75,421	4.48%	\$42,864	3.71%
	<b>Other*</b>	\$20,802	1.23%	\$13,086	1.13%
	<b>Totals</b>	\$1,684,644	100.00%	\$1,155,026	100.00%

**SPECIFIC DEMOGRAPHIC RATE INFORMATION: SED/SMI**

Consumers with Serious Emotional Disturbance (SED) or Severe Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) are our major target population—the consumers who are most in need of our services. These tables utilize the MACSIS Datamart formula for categorization, and the current SED/SMI definition formula is partially dependent upon the frequency and type of services received by the client. Thus the lack of funding to purchase more services may be artificially deflating the actual number of SED/SMI. This dependence on expenditure levels may also be contributing to the apparent higher incidence of severe mental illness in children that is reflected below. Children are more likely to be eligible for Medicaid, more money is thus spent on children's services, and the SED penetration rate goes up.

The first table looks at all MACSIS spending for the Department of Mental Health for Portage County. The consumers with SED/SMI make up 49.33% of the mental health services consumers, but 84.86% of the total dollars spent (includes FFP) and 80.89% of the Board match and non-Medicaid dollars are spent in treatment for this population.

SED/SMI		Consumer Count	% of Total	Total Dollars Spent	% of Total	Match & non-Medicaid Dollars Spent	% of Total
<b>ODMH</b>	<b>SED/SMI</b>	2,768	49.33%	7,218,606	84.86%	3,445,410	80.89%
	<b>Non SED/SMI</b>	2,843	50.67%	1,288,125	15.14%	814,162	19.11%
	<b>Totals</b>	5,611	100.00%	8,506,731	100.00%	4,259,572	100.00%
<b>6-Jul-13</b>		<b>Note: Unduplicated count of consumers is 5,611</b>					

The second table looks at those clients served with ODADAS services that are also SED/SMI. Although there is a far lower proportion of consumers who suffer from SED/SMI, this population utilizes a disproportionate share of the expenditures for alcohol and other drug treatment services.

SED/SMI		Consumer Count	% of Total	Total Dollars Spent	% of Total	Match & non-Medicaid Dollars Spent	% of Total
<b>ODADAS</b>	<b>SED/SMI</b>	196	15.51%	427,630	25.38%	265,949	23.03%
	<b>Non SED/SMI</b>	1,068	84.49%	1,257,013	74.62%	889,076	76.97%
	<b>Totals</b>	1,264	100.00%	1,684,643	100.00%	1,155,025	100.00%
<b>6-Jul-13</b>		<b>Note: Unduplicated count of consumers is 1,264</b>					

The final table shows the consumers of all behavioral health services. When this combination is made, SED/SMI percentage of the consumer population drops to 43.02%, and the dollars spent percentage drops to 68.54% of MACSIS services.

SED/SMI		Consumer Count	% of Total	Total Dollars Spent	% of Total	Match & non-Medicaid Dollars Spent	% of Total	
<b>ODMH &amp; ODADAS</b>	<b>SED/SMI</b>	2,775	43.02%	7,646,236	75.03%	3,711,358	68.54%	
	<b>Non SED/SMI</b>	3,676	56.98%	2,545,138	24.97%	1,703,238	31.46%	
	<b>Totals</b>	6,451	100.00%	10,191,374	100.00%	5,414,596	100.00%	
6-Jul-13	<b>Note: Unduplicated count of consumers is 6,451</b>							

The board is apparently able to purchase treatment services for the non-SED/SMI population, which would indicate that there is sufficient capacity within the county. However, since the accumulated statistics concerning the SED/SMI category is also looking at services received as a component of the formula to categorize the clients, the availability of funding has a direct impact on the number of identified consumers with SED/SMI.