

**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.)

Tuscarawas and Carroll Counties are contiguous counties located within the east central region of the state and characterized as Appalachian. Carroll County (pop. 28,836) covers approximately 395 square miles and Tuscarawas County (pop. 92,582) covers approximately 568 square miles. The largest municipality in Carroll County is Carrollton (pop. 3,241) and in Tuscarawas County it is the city of New Philadelphia (pop. 17,288). The region is intersected by Interstate highways 77 and 70. Tuscarawas and Carroll County municipalities are within a 45 minute drive to the cities of Canton and Akron, and within a two hour drive to Columbus, Cleveland, OH and Pittsburgh, PA.

Regarding the gender composition of each county, males comprise 49.9 percent and females 50.1 percent of the population of Carroll County. The gender breakdown is similar in Tuscarawas County where 49.1 percent are males compared to 50.9 percent female. Individuals under the age of 18 represent 23.7 percent of Tuscarawas County's population and 23.1 percent of Carroll County's population. Adults 65 and older comprise 16.4 percent of Tuscarawas County's population and 15.5 percent of Carroll County's population. From a racial diversity standpoint, both counties are primarily homogenous communities with minimal racial diversity. Racial groups residing in the Counties are as follows: Caucasian (97.8% - Carroll; 96.6% - Tuscarawas) followed by Hispanic (.8% -Carroll; 1.9% Tuscarawas) and African American (.5% - Carroll; .3% -Tuscarawas). From an ethnic diversity perspective, the influence of both the Amish and Hispanic cultures is observable within the cultural, recreational and social makeup of our communities.

Unemployment, median household incomes and rates of poverty are not significantly different from other counties located in Ohio and in comparison to statewide averages. There are a significant number of churches and parishes within the two-county area and spirituality plays an important role in the lives and decision-making of many individuals and families. Churches are highly visible institutions and their sponsored activities play an important role in the social fabric of each county. Agriculture, education, government services and healthcare are the primary industries in both counties. The median family income of both counties is comparable with Carroll County slightly higher at \$42,375 and Tuscarawas County's median income at \$42,081. Only 12% of adults in Carroll County have a bachelor's degree, compared to 24.1% statewide and 27.9% nationally. This number is only slightly higher in Tuscarawas County with 14.3% of residents attaining a bachelor's degree or higher. These numbers are especially significant considering that there are six universities within 45 minutes of both counties.

Since submission of the 2013 Community Plan, significant reductions in the unemployment rates within each county have occurred. The 2011 unemployment rate in Tuscarawas County was 8.7%. In October 2013, Tuscarawas County's unemployment rate was reported at 6.4%, a decrease of 2.3%. Similarly, Carroll County's rate of unemployment dropped from 9.8% in 2011 to 7.1% in October 2013, a decrease of 2.7%. As anticipated, the development of oil and gas mining and distribution in both counties has impacted both the unemployment rate and county tax revenue, a benefit most apparent in Carroll County due to the establishment of 170 oil-producing wells. An additional \$800,000 in sales tax revenue and \$125,000 in property tax revenue was collected in calendar year 2013 in comparison to 2012. Because there are presently only three oil producing wells in Tuscarawas County, there has been a minimal impact on tax revenue.

Paradoxically, employers attempting to attract both skilled and unskilled workers are continuing to report that high

percentages of applicants are testing positive for illicit drugs. This has been a pattern since the Board was first invited to participate on a committee organized by the Tuscarawas County Chamber of Commerce to address the myriad of issues related to both a large number of available positions coupled by immediate spikes in the population. In an attempt to raise community awareness about the consequences of drug use on employability, the ADAMHS Board, Tuscarawas County Chamber of Commerce and the Employment Source (WIA agency) jointly developed an informational flyer that included a substance abuse self-assessment questionnaire. The purpose of the informational piece is to assist job applicants to make better decisions about the consequences of illicit substance abuse and to direct individuals in need of interventions to the appropriate community-based treatment agency. Our unique collaboration received positive feedback from a number of constituents partly because we were targeting individuals in the pre-employment phase of their job seeking process including making the pamphlets available at our local career and technical center- which services both Tuscarawas and Carroll Counties.

Where trends in the abuse of substances and frequency of mental illness is concerned and their potential impact on the services delivery system, no specific event or pattern occurred within the Board's service district during the current or previous biennium (i.e. closure of a pill mill; high school tragedy of some nature, suicides, etc). Rather they've evolved as a part of the culture of both counties over time. The availability of marijuana and the abuse of prescription drugs by individuals entering the publically funded treatment system continues to be an emerging issue. The emergence of powerful and overly prescribed pain relievers continues to influence the rate of addiction within Tuscarawas County and is a major concern for families, officials and our community. In Tuscarawas County, a significant decrease in the use of bath salts has been identified during the past 18 months and use of synthetic marijuana is reportedly on the rise, especially in the young adult population. In Carroll County, marijuana and alcohol remain the primary drugs of choice for both youth and adults who enter the publicly funded treatment system. In response to these emerging trends and the interest of numerous constituents to address substance abuse in each of the Counties that we serve, the ADAMHS Board created two separate and distinct anti-drug coalitions. Each Coalition has the ability to address the unique cultural features of the counties and have distinctly different purposes in terms of their focus on certain target populations and drugs of abuse.

In relation to the client demographics within our system of care, the number of new clients accessing interventions and treatment in our mental health system has remained consistent from month to month during FY 13 with a higher ratio of Medicaid to non-Medicaid eligible persons being enrolled. The average number of new enrollees in the system each month is 114, most of whom are under the age of 17 (28% of enrollees in Tuscarawas County and 35% in Carroll County) followed by the 36-50 age group in both counties (22% of enrollees in Tuscarawas County and 24% in Carroll County.) Comparing FY 13 MACSIS enrollments to FY 12, a ten percent increase is seen in the number of new consumers seeking treatment services in Tuscarawas and Carroll Counties. This increase is attributable to additional treatment resources and the addition of medication assisted treatment at a primary contract provider of the Board (Community Mental Healthcare, Inc). The ADAMHS Board and our local providers took advantage of the opportunity presented to us by the Kasich administration and initiated the integrated employment and treatment program- VRP-3. The ability to leverage federal funding with a commitment of local matching resources enabled our system to expand local treatment services while adding an entirely new outpatient level of care, medication assisted treatment, to the local intervention continuum.

### **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)

The Board utilizes a variety of methods and sources of information to determine its current behavioral health needs. These can be categorized as quantitative, qualitative and sometimes anecdotally through conversations with key stakeholders within the system (e.g. Judges, probation officer, school personnel, emergency department physicians, etc.) Our processes for conducting needs assessment activities happen at regular intervals throughout the fiscal year and on an as needed basis if an emerging trend of some type is reported to the Board or if acute event occurs for a specific individual. Our primary quantitative source of data related to establishing priorities is the Multi Agency Community Services Information System (MACSIS). Diagnoses, gender, frequency of service, Medicaid eligibility, dates of service, age and numerous other data elements are important pieces of information analyzed by the Board for purposes of contracting for community services and the potential development of additional programs. For contract services not included in the MACSIS taxonomy like crisis intervention, inpatient psychiatric and detoxification services, information is reported to the Board using a series of data collection tools that provide a greater degree of clinical and demographic data related to circumstances surrounding access to these acute episodes of care. Information contained within the assessment and pre-screening forms allow the Board and system to identify how key stakeholders become involved in the referral process and subsequently it becomes a valuable tool for identifying community needs. Our system can use these details to address service intervention/coordination issues as well as training opportunities in order to improve the delivery of services. Consumer interactions with Job and Family Services, adult protective, hospital emergency room personnel and other organizations are often described in the referral or assessment process and details of their involvement are listed on these forms. MACSIS has been particularly helpful in examining the impact of cost containment strategies associated with annual limits of certain Medicaid services and their impact on non-Medicaid resources. Additionally and since MACSIS will no longer be operational effective July 1, 2014, the ADAMHS Board will be working closely with other Boards within the Heartland Region to develop an alternative purchase of service claims processing system.

Another important source of quantitative data available to the Board and system is the Behavioral Health module used by ODADAS certified agencies. Although claims data on Board purchased substance abuse treatment services is also available via MACSIS, the BH module is a significant enhancement to this information since an entirely different set of demographic and qualitative issues can be evaluated since it is administered both at admission and discharge from service on each client enrolled. This includes, but is not limited to, the following: drug of choice; frequency of use; referral source; prior episodes of treatment; employment status and primary age of first use. RPH generated "Point of intervention" process information/tracking reports on individuals being pre-screened in our local emergency departments in advance of an admission to Heartland Behavioral Healthcare has been very useful. Since major modifications to crisis intervention services were necessitated as a result of the significant reductions of FY '09-'10, individuals are sometimes waiting in local emergency rooms for inordinate amounts of time in advance of admission to our RPH. Waiting for on-call pre-screening personnel to arrive at the ED, coupled with completion of requisite medical testing per clearance guidelines of the RPH, sometimes creates the perfect storm of delays and unintended consequences for the consumer, their families, ED staff, screening personnel, transportation, etc. To address this need the Board has attempted to purchase 23 hour observation beds from the local EDs and engages in routine conversations with RPH personnel, ED staff, crisis intervention staff and others to improve efficiencies within the admission process.

In addition to the data regarding consumer trends across the system of care, the Board began to gather data specific to contract agencies during the past year. Following the adoption of a revised set of operating policies and procedures in FY '12 (CQI), the Board initiated its first round of comprehensive, purchase of service utilization reviews on Non-Medicaid purchased services for FY '13. The review, which took into account the level of compliance required of providers to meet

JCAR and COA accreditation standards, also consisted of sub-recipient monitoring related to the SAPT Block Assurances and both a retrospective completeness of record review and fiscal management review. The surveys generally resulted in minor clarifications on service definitions as interpreted by Board staff versus provider staff and evidenced, in our opinion, a high degree of quality among the two accredited contract providers. In the case of one provider review, the Board's monitoring process revealed a number of billing and qualitative, clinical documentation inaccuracies related to purchased services which are subsequently attempting to be addressed by management staff.

The Board also uses a variety of on-going qualitative methods for determining needs of individuals with behavioral health disorders. This includes communication with a variety of constituency groups including feedback from contract providers, the populations they serve, continuous feedback from representatives of NAMI, continuous feedback from the ADAMHS Board's consumer operated service, and feedback from a variety of customers of the ADAMHS Board including the judicial system, law enforcement, health and human services, juvenile court, and initiatives developed by the Family and Children First Councils (FCFCs).

The Board remains highly involved in the operation of the FCFCs in both Tuscarawas and Carroll Counties, serving as the Administrative Agent of the Tuscarawas County Family and Children First Council since 2011 and is an active member of the Carroll County FCFC governing board and numerous subcommittees. The Board's involvement in both FCFCs provides meaningful feedback on a monthly basis from parent representatives and community partners concerning their satisfaction with contracted mental health and substance abuse services. Additionally, Board staff maintains membership on the FCFC Service Review Committees (SRC) which are subcommittees designed to provide support and oversight to the service coordination process, monitor the delivery of services and report on gaps in the continuum of care. The membership of the SRC subcommittees, comprised of administrators and providers of local child serving agencies, are charged with review of the local child/family serving system of care both on a micro and macro level and serve as the first level of response FCFC dispute resolution processes in both councils. Furthermore, in Tuscarawas County the FCFC established a mechanism for providers to report on programs that are at imminent risk of being discontinued or altered as a result of funding or staffing changes. The process gives the FCFC Advisory Committee and Governing Board the opportunity to analyze the potential impact of this gap in services, determine the ongoing necessity of the service, identify whether the service can be absorbed by another provider, or review opportunities to pursue additional funding streams to maintain necessary services in the local continuum of care.

The voices of consumers, family members and partners across the adult system of care also plays a significant role in the service delivery and planning efforts of the Board. Beginning in FY 12, the Board developed a Community Team comprised of a core group of service providers from the local prescreening agency to facilitate the discharge planning and service review of individuals hospitalized in state Regional Psychiatric Hospitals (RPH). This service review and planning process specifically targets those individuals that have experienced or been at risk of RPH readmissions. The team, which incorporates the consumer, his or her family, natural supports and other systems of care across both counties including law enforcement, probation officers, and the Department of Development Disabilities, identifies local resources that would support the individual at the lowest level of care appropriate to meet his or her needs. Information gathered through this process led to the development of programs like the Community Navigator in FY 13. Designed to help consumers with an SPMI without benefits navigate the local system of care and reduce hospital recidivism, the Community Navigator has become an essential component in the system of care.

Other sources of information utilized by the ADAMHS Board in determining priorities concern contract provider agency's internal evaluations, which are generated on an annual basis. These service plans contain a wealth of management information concerning a variety of qualitative issues about the delivery of services. In addition to addressing needs

assessment, goals and objectives, analysis of strengths, weaknesses, opportunities, and threats (SWOT), the evaluations address important patterns of use information relative to clients served. Patterns of use data is provided in conjunction with general demographic information concerning gender, types of service provided, number served by program, prior treatment episode, new clients served, time in treatment, referral source, and other important information which assists the Board to establish service and funding priorities. These evaluations are also an opportunity for providers to give the Board some insight into political, economic and other local factors which influence the provision of services. An internal mechanism for logging requests from the public on a variety of issues has also been helpful in gauging service priorities. The Board is often asked by stakeholders to assist individuals with access and care management issues which are documented and brought to the attention of provider agencies.

During the past two years, the Board has been able to meet identified community needs and expand the system of care to include funding for medication assisted treatment (Suboxone) and increase availability of housing opportunities to individuals in the BH system of care by providing administrative functions for the Shelter Plus Care program. Program development related to multi-system children, also identified as a priority, resulted in the enhancement of the service coordination mechanism to strengthen cross-system collaboration; the funding of a Board subsidized home-based family therapy program which was discontinued in FY 12 due to state allocation reductions; and through a collaboration with FCFCs and a provider agency, ongoing trauma-informed care training opportunities for providers across the system.

In alignment with Board's commitment to reducing the impact of trauma following a suicide, the Board initiated development of LOSS (Local Outreach to Suicide Survivors) teams for families that experience the suicide of a family member. Five teams were established through a unique partnership between survivors of suicide, Sheriff's Offices, Coroner's Office and local behavioral health service agencies. The teams of volunteers are available twenty-four hour per day, seven days per week and 365 day per year to respond to a suicide at the location where it occurs. Since their inception in January of 2013 in Tuscarawas County and May 2013 in Carroll County our teams have responded to the scenes where eight suicides occurred. In addition to providing emotional support for those present, the teams also offer complimentary items and a variety of informational resources. Follow-up with families also happens including attempts to connect individuals to the survivor of suicide support group hosted by the ADAMHS Board. Survivor groups are held on a monthly basis.

Needs assessment activities that occurred as a result of the funding paradigm made available with additional 505 resources for FY '13 resulted in the prioritization of telemedicine, non-clinical care coordination/navigators and services to support transitional age youth- all established within the ten Heartland regional Boards. In October 2012, the HBH Board collaborative held a two-day Transition to Independence (TIP) training to provide an evidence-based framework in working with transition age youth. Locally, a Transition Age Youth taskforce is being developed in collaboration with FCFC, Tuscarawas County Job and Family Services, and a local independent living facility operator. Additionally, through this funding opportunity three of the Boards in the Heartland region also recognized the potential impact of community navigator and are subsidizing a similar position.

In order to improve the timeliness of behavioral health interventions and improve safety issues related to serving inmates at the Tuscarawas County jail, the ADAMHS Board, via 505 Hot Spot resources from OMHAS, purchased a telemedicine suite for the jail. An additional unit was also purchased for Personal and Family Counseling Services located in New Philadelphia. The Boards two primary mental health and substance abuse services providers each have telemedicine units for the purpose of improving collaboration and intervention available to offenders either in need or requesting some level of behavioral health intervention. Telemedicine services are one component of an evolving continuum of care between

the criminal justice and mental health and addiction treatment and intervention system.

From a public and key stakeholder perspective, the lack of availability of an inpatient detoxification facility within the region is one of our most significant gaps in services. It is a helpless feeling for families to witness firsthand the physical and emotional symptoms of a loved one experiencing withdrawal symptoms. However, medically managed inpatient detoxification services are only medically necessary for individuals withdrawing from dependence on benzodiazepines and/or alcohol. The Board maintains a purchase of service agreement for a limited amount of inpatient detoxification services at Summa Health System/St. Thomas Hospital in Akron for purpose of serving this group of individuals. Rapid access to medication assisted treatment is a long-term goal of our system to assist in meeting the demand for interventions from persons addicted to opioids.

Providing safe and appropriate supportive housing for consumers also remains a gap in services. Despite planning attempts, at times the needs of consumers exceed local resource options. Due to the lack of ACFs in the communities, the consumers are sent to an out-of-county ACF when they are unable to live independently, impacting their proximity to natural supports, service providers, and the familiarity of their community.

### 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*).

The ability of the Board to fulfill its statutory responsibilities depends on the knowledge, passion and interest of those individuals directly connected to its mission, namely the volunteer Governing Board and staff of the organization. The Board takes great care to ensure that its board member recruitment practices are aligned with the primary roles and responsibilities of the Board. Perhaps even more important, however, are the community members across the two county system of care that are committed in their support of the behavioral health system. Over the past two years, motivated community members and the natural supports of the individuals involved in the behavioral health system have worked to develop programs, provide outreach and support, and provide funding to support the efforts of the ADAMHS Board.

A prime example of this commitment is the mother of a 31 year old male that passed away from an accidental heroin overdose in September 2013. Throughout his long battle with addiction, the son had extensive involvement in the BH system of care including residential treatment, MAT, the Recovery to Work program, and outpatient treatment, and was facing charges in the legal system. On numerous occasions, the mother connected with ADAMHS Board staff looking for support for both her son and her family. On September 19, the night before his planned admission to inpatient treatment, the son overdosed. The LOSS team, an on-scene survivor response made up of a suicide survivor and a professional, was dispatched to the scene by the Sheriff's department. In this response, the LOSS team happened to be comprised of a natural support of the family and the Board staff member that had been in communication with the mother.

In the son's obituary, the family made the courageous decision to acknowledge the cause of his death and offered an unexpected request of support to the Board. In an effort to raise awareness of this disease and help others in need of crucial services to stop the addiction, the family requested memorial contributions be directed to the ADAMHS Board. Over \$2,000 has been donated to the ADAMHS Board in memory of the individual. With the approval of the family, a

portion of the donations was used to fund Hidden in Plain Sight, an interactive presentation designed to alert parents to risky and dangerous behavior that adolescents may attempt to conceal in their home. This event, attended by over 100 Tuscarawas County residents, was also attended by the deceased's mother. Each time contact has been made since his death, the mother states her interest in working with the Board to increase awareness and prevention when she is further in the healing process.

The commitment of community members is also necessary to the success of the LOSS (Local Outreach to Survivors of Suicide) response. LOSS teams, which primarily focus on family support and outreach at the scene of a suicide, rely on the involvement of the community to fill the vital role of survivor on these teams. Designed to provide a connection between the grieving family, a suicide survivor and local resources, the LOSS model of "postvention as prevention" posits that the increased risk of additional suicides within a family will be impacted by immediate intervention. Research has shown that families receiving a LOSS response seek services and supports at an average of four years earlier than other survivors. The immediate connection to the family as well as the ongoing Survivors of Suicide support group, co-facilitated by a survivor, are options in the continuum of care that have been made available to the eight families that received a LOSS response in 2013.

As vital as the community member support is to the Board and its programs, service development and expansion is made possible through the partnerships with larger systems of care. During the past two years, the Board has worked diligently to build services that cross the BH system and the criminal justice system including: the implementation of telemedicine services at the local jail; a criminal justice-behavioral health team working with offenders on probation with a substance abuse diagnosis; the implementation of on-site AOD and MH clinicians at the courthouse to provide immediate assessment and referral to individuals post-sentencing, and the involvement of law enforcement with consumers and family members post-hospital discharge through the Community Team planning process. In addition to the partnership with the legal system, the Board is developing a partnership with the local Departments of Developmental Disabilities, both through housing management and shared consumers. In 2012 and 2013, the Board was approached by the DD Boards in both Tuscarawas and Carroll Counties to provide property management with a secondary goal of providing supportive housing options to dually diagnosed individuals. This partnership is developing into a cross-system organizational level analysis to determine how to improve collaboration regarding shared clients.

In alignment with OMHAS's trauma-informed care initiative, the local system of care and collaborative partners are taking steps to develop our network of care. As our focus expands to include targeted populations such as jail inmates and addicted offenders, as well as traumatized children and adults in need of services, the Board partnered with the Family and Children First Council, and Personal and Family Counseling Services (PFCS)/Guidestone Ohio to train not only local clinicians but others that work with traumatized individuals. The Board and partners were able to offer a five session training series conducted by a Dr. Benjamin Kearney, the vice president and Chief Clinical Officer of Guidestone. Dr. Kearney has conducted research on the impact of trauma and its effects on development and is considered an expert in this field. These trainings were attended by case workers from Job and Family Services, Head Start staff, clinicians, probation officers, teachers from the public school system and the DD system, COMPASS (sexual assault education and support), the Child Advocacy Center, and Big Brothers/Big Sisters. With respect to the Child Advocacy Center and development of their multi-disciplinary team, ADAMHS Board staff provided a great deal of consultation and support both in the development of the referral protocols as well as identifying local trauma-informed care treatment providers.

While strengthening system partnerships has been a priority, the Board has also built momentum with the local media. In March of 2013, the Board began a series of three educational meetings titled Bearing the Weight of a Loved One's Addiction designed to provide information and support to family members of addicted loved ones. A panel of AOD

treatment providers answered questions related to enabling behavior, treatment engagement and boundary setting to audiences of up to 50 members. The majority of attendees reported they learned of the event through coverage in the local newspaper and the radio spots on two local stations. Media support of the Board's efforts to impact addiction is continuing as the local newspaper has committed to sending a representative to the monthly Anti-Drug Coalition committee meetings.

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

4. What are the challenges within your local system in addressing the findings of the needs assessment? (*see definition of "local system challenges" in Appendix 2*).

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

Through strong collaborations with local partners and other providers outside our service area, the Board has been able to address and eliminate many challenges facing our service delivery system. In some instances, reduced yet still significant barriers continue to exist.

Being primarily rural and located within the Appalachian region of Ohio, Tuscarawas and Carroll Counties has historically had difficulty in securing adequate psychiatric coverage. This situation has only been compounded by State revenue reductions during the FY '10-'11 budget biennium. The shortage of psychiatrists and the waiting period for initial appointments began to impact the discharge process between hospitals and the local prescreening agency resulting in longer lengths of stay. The Board and local mental health provider serving individuals with severe and persistent mental illnesses, CMH, worked closely with Summa during the past four years to address this need and the Board and provider network were successful in obtaining a Health Professional Shortage Area designation for Tuscarawas and Carroll Counties in order to both attract and retain physicians and independently licensed professionals to the region. At the same time, a parallel effort was underway to implement telepsychiatry through a partnership with SUMMA psychiatrists and CMH. The ADAMHS Board and CMH assisted Summa staff in securing a grant from the Margaret Clark Morgan Foundation for the hardware and software components necessary to implement telepsychiatry within the hospital. CMH secured a grant from the Ohio University foundation to purchase telemedicine suites in Carrollton and Dover. The opportunity to use this resource reduces the wait time for psychiatric services for all mental health consumers and improves all facets related to consumer continuity of care. However, the availability of local, face-to-face psychiatric personnel remains limited.

Another significant challenge to many residents within the counties continues to be the lack of availability of safe, affordable housing opportunities for those with limited incomes. The Tuscarawas Metropolitan Housing "Housing Choice Voucher" program has been at capacity for many years and the waiting list is no longer open to new applicants. Available existing low-income housing has been greatly diminished by the influx of transient workers associated with the emerging gas and oil industry in both counties. Limited geographic opportunities create difficulties in the development of new low-income or subsidized housing projects. With these more traditional housing options wither limited or no longer available, the Board has struggled to assist consumers to find the kind of safe and appropriate housing necessary to begin or continue the treatment progress. While the local Shelter+Care grant administered by the Board continues to be successful in placing homeless consumers in safe housing at little to no cost to the participant, the lengthy waiting list and restrictive nature of the eligibility requirements make this option unattainable for many. The Board continues to explore many options for development of additional housing through resources such as the MHAS Capital process as well as other grant and funding opportunities through entities like OHFA and HUD.

- b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

A priority for the two-county area is the development of ACFs. Due to the lack of resources, often Tuscarawas and Carroll County residents in need of a higher level of care are placed at ACFs a distance from their community, impacting their ability to maintain contact with local services and, most importantly, their natural support systems. As the collaborative relationship between the Board, the local prescreening agency, and consumers have expanded over the past few years in regard to reducing hospital readmissions, the Board has become even more acutely aware of impact of this transition on consumers. The Board would welcome support from other Boards or the state department to help develop this resource locally.

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 Board and provider network are keenly aware of workforce development issues confronting our network of care, especially those related to cultural competence. In regard to race, Tuscarawas and Carroll Counties are primarily homogenous with over 95% of residents in each county indicating Caucasian as their race. However the past decade has shown a continued increase in the Hispanic population in both counties, drawn to the area from Guatemala for employment opportunities. The system of care has made a concerted effort to ensure all community residents have access to prevention and intervention resources including providing outreach through Hispanic Ministries, ensuring that written materials are available both in English and Spanish, engaging translators that are familiar with the specific dialect used by the local Hispanic population and ensuring that the treatment providers are aware of cultural norms that may impact service delivery.

While ensuring that our system is responsive to the diverse needs of racial groups, it is equally important to consider cultural differences inherent in our local residents. In addition to the Hispanic culture, the Amish culture and individuals living within a "culture of poverty" comprise the three most salient subsets accessing services within the provider system. The Board acknowledges that culturally competent providers must be aware of the norms related to racial and cultural subsets of the community, including understanding dynamics related to family hierarchy, the role of the church, gender roles, and the groups' views of "outsiders." In an effort to maintain a culturally competent system of care, the Board and Tuscarawas County Job and Family Services partnered to host a series of trainings for professionals in the BH field, child welfare system, law enforcement, and early childhood. This series of three trainings, attended by over 100 individuals, were held throughout Fiscal Year 2013 and focused on the Hispanic community, the Culture of Poverty, and the Amish community. Plans for ongoing collaborative trainings on cultural diversity will be reviewed over the next six months.

Board's involvement in both FCFC service coordination as well as the Child Advocacy Center (CAC) has shown that the number of individuals from cultural subsets in need of support or education through the BH system have increased. Existing transition age youth efforts or independent living skills programs are not necessarily relevant to the Amish culture where children quit school after the 8<sup>th</sup> grade. Similarly, the local CAC efforts to intervene with child victims of sexual abuse has brought to light what may be a cultural issue. The local partners on the CAC Multidisciplinary Team have noticed a trend in the number of Guatemalan girls under the age of 18 that have become pregnant by an adult male. Based on discussions with the local Guatemalan community, it is reported that there is a level of status believed to be gained by some adult men in this cultural group related to engaging in sexual relations with "virgins". The absence of an adequate understanding across cultures of norms, rules, and laws, both of cultural subsets and of the community as a whole, can

have momentous consequences both on the lives of individuals and the services provided. Because of this, the Board prioritizes the continuous attainment of knowledge and growth of clinician skill sets are required to better meet the changing needs of the community.

As the need increases both in and out of the mental health and drug and alcohol treatment system, discussing cultural components of intervention implementation is helpful but is not enough. An understanding of the mores and norms of a culture must occur first if we hope, as a system of care, to engage and maintain relationships.

### 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 ADAMHS Board of Tuscarawas and Carroll Counties**

**Substance Abuse & Mental Health Block Grant Priorities**

**\*Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<p><b>SAPT-BG:</b> Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)</p>	<p>Expand the use of medications (e.g. Vivitrol, Suboxone) in conjunction with outpatient levels for care for the treatment of intravenous drug users within the publicly-funded system of care.</p>	<ol style="list-style-type: none"> <li>1. Recruit or identify a physician(s) and/or a program that will manage the use of an integrated outpatient and medication-assisted substance abuse treatment program.</li> <li>2. Solicit a request for proposals from provider(s) organization inclusive of integrated medication assisted treatment and outpatient levels of care for the treatment of injecting drug user for the FY '15 budget process.</li> <li>3. Conduct annual staff in-service and Board member training related to medication assisted treatment interventions.</li> <li>4. Describe and publicize the availability of integrated medication-assisted treatment and outpatient counseling services</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase the number of individuals receiving medication assisted treatment (Board and Contract providers)</li> <li>2. Increase budgeted expenditure for the purchase of medications, pharmacological management and physician services for the FY '15-'16 timeframe (Board financials and provider budgets).</li> <li>3. Reduce the number of reported cases of Hepatitis C within Tuscarawas and Carroll Counties (Health Departments)</li> <li>4. Reduce the number of accidental overdoses related to injecting heroin users (Health Departments, Local hospital EDs and Coroner's Office)</li> <li>5. Documented in-service training for contract provider staff and ADAMHS Board (providers and Board)</li> <li>6. Board funded printed materials and other awareness strategies (ADC Coalition, Board and Provider websites) will reflect descriptions of integrated outpatient and medication-</li> </ol>	<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>

			assisted treatment options	
<b>SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)</b>	Engage and prioritize pregnant women with addiction disorders in treatment services.	<ol style="list-style-type: none"> <li>1. Provide resource material to the County Health Departments and OB providers in our catchment area offering patients confidential opportunities to seek treatment.</li> <li>2. Providers will treat this population as a priority, without regard to wait lists.</li> <li>3. Agencies will screen all female clients upon initial request for service.</li> <li>4. Agencies will provide non-covered or additional services, as needed, on a case by case basis with Board approval using Board dollars.</li> <li>5. Agency staff (ie: Community Navigator or Case Manager) will provide additional support and follow up to pregnant women in service with a substance abuse disorder.</li> </ol>	<ol style="list-style-type: none"> <li>1. Agency policies and procedures will reflect above mentioned strategies as audited by the Manager of Community Services.</li> <li>2. Agencies will monitor and report to the Board the number of treatment episodes of pregnant women with a substance abuse disorder annually.</li> <li>3. An annual review will be held with appropriate Case Managers and Community Navigators to review the volume, trends, and any other relevant information regarding pregnant women served with substance abuse disorders throughout the year.</li> </ol>	<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: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) &amp; 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)</b>	Increase substance abuse prevention protective factors in children under the age of 18 living with a parent or guardian receiving addiction recovery services within the publicly funded system of care.	<ol style="list-style-type: none"> <li>1. Ensure that all substance abuse assessment and related intake processes include a component which identifies and addresses the relationship between primary consumer and any dependent children.</li> <li>2. Encourage, when appropriate, participation in some amount of treatment by dependent</li> </ol>	<ol style="list-style-type: none"> <li>1. Board purchase of service utilization reviews processes will include a section on dependent children and non-using spouse/significant other.</li> <li>2. Awareness materials related to the impact of parental substance abuse on substance</li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

		<p>children and non-using spouse/significant other of primary consumer.</p> <ol style="list-style-type: none"> <li>3. Distribute age-appropriate awareness materials designed to address questions and inform dependent children of questions related to recovery services and behavior of primary consumer.</li> <li>4. Encourage participation in available family support groups for non-using spouse/significant other and dependent children as appropriate.</li> </ol>	abuse	
<p><b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases</p>	<p>Identify potential cases, or at risk cases, of TB or other communicable diseases and ensure referral for counseling, testing and treatment.</p>	<ol style="list-style-type: none"> <li>1. Agencies will obtain TB histories and TB risk assessments during initial intake.</li> <li>2. Agencies with partner with local health department, TB clinic or contracted physician and refer individuals for evaluation, treatment, education, management and follow-up if a possible case of TB or other communicable disease is suspected.</li> <li>3. Masks will be made available for potential cases of TB or other communicable diseases.</li> <li>4. Clients with documented cases shall provide proof of repeated screening and testing with</li> </ol>	<ol style="list-style-type: none"> <li>1. Manager of Community Services will review agency policy regarding treatment of individuals with tuberculosis and other communicable diseases during annual review.</li> <li>2. Documented education provided to staff regarding TB and other communicable diseases.</li> <li>3. Awareness materials available for clients and staff on TB and other communicable diseases.</li> </ol>	<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>

		negative results prior to readmission to the agency for service.		
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure the availability of an array of services and interventions to support children with SED and their families.	<ol style="list-style-type: none"> <li>1. Through system partnerships, ensure the ongoing availability of service coordination to support children with SED.</li> <li>2. Develop an MH/DD partnership to provide specialized services to children diagnosed with SED and a development disability.</li> <li>3. The Early Childhood Mental Health (ECMH) program will maintain a presence in day care facilities/Head Start across Tuscarawas and Carroll counties.</li> </ol>	<ol style="list-style-type: none"> <li>1. Service coordination will maintain a caseload of 20 cases with referrals across the system of care and continue to pool financial resources to maintain children in the community.</li> <li>2. A team of providers across the MH system and the DD system will be cross-trained and develop a memorandum of understanding regarding collaborative service delivery.</li> <li>3. The ECMH program will serve children in 7 day care facilities/Head Start Centers in FY 14.</li> </ol>	<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): Adults with Serious Mental Illness (SMI)	Ensure access to a continuum of services and cross-system collaboration to maintain individuals with an SMI in the least restrictive environment.	<ol style="list-style-type: none"> <li>1. Provide individualized planning opportunities utilizing a cross-system community team for individuals at risk of admission/readmission to RPH.</li> <li>2. Ensure the availability of telemedicine services for individuals with SMI in both traditional and non-traditional sites.</li> <li>3. Maintain and potentially expand existing services to ensure a continuum of care.</li> </ol>	<ol style="list-style-type: none"> <li>1. Cross-system collaboratives designed to provide support to individuals with SMI will be expanded.</li> <li>2. Individuals will have access to telemedicine services at contract agencies and non-traditional sites such as the county jail.</li> <li>3. Services such as consumer support, Central Pharmacy, and telemedicine will be maintained and potentially expanded following Medicaid expansion.</li> <li>4. Executed purchase of services agreements with OMHAS and other community-based</li> </ol>	<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
<p><b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*</p>	<p>Ensure that adults and children accessing behavioral health services within Tuscarawas and Carroll Counties are offered a coordinated set of services interventions that include both primary and mental behavioral health within the publicly funded system of care.</p>	<ol style="list-style-type: none"> <li>1. Train CPST and Supervisors within the behavioral health services system in Care Management techniques relative to integrated primary and behavioral healthcare</li> <li>2. Encourage local community mental health and addiction recovery treatment centers to become health homes or develop affiliation agreements with health homes in Ohio.</li> <li>3. Encourage providers to develop assessment tools, treatment plans and discharge planning processes which incorporate integrated care delivery and coordination.</li> </ol>	<p>providers including a designated agency agreement per ORC.</p> <ol style="list-style-type: none"> <li>1. Selected treatment plans within the ADAMHS Boards utilization review process will include the presence of both behavioral and primary care issues.</li> <li>2. Review CQI plans for the presence of integrated care planning and referral processes.</li> </ol>	<p>___ No assessed local need          ___ Lack of funds          ___ Workforce shortage          ___ Other (describe):</p>
<p><b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders</p>	<p>Reduce obstacles to recovery for individuals with mental health or substance abuse disorders residing in Tuscarawas or Carroll Counties</p>	<ol style="list-style-type: none"> <li>1. CPST and other direct services personnel demonstrate knowledge of the array of recovery supports including: transportation, child care, healthcare, parenting classes, legal resources, utility</li> </ol>	<ol style="list-style-type: none"> <li>1. CPST and relevant direct service staff training materials will include training on recovery supports.</li> <li>2. 211 informational resources will be available at provider agencies.</li> </ol>	<p>___ No assessed local need          ___ Lack of funds          ___ Workforce shortage          ___ Other (describe):</p>

		<p>assistance and social recreational resources within the service district.</p> <p>2. Ensure that new CPST/direct services personnel are trained in available recovery support resources.</p> <p>3. Utilize 211 currently available in both Tuscarawas and Carroll Counties as a referral and information service for available recovery supports.</p>		
<b>Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant</b> <b>*Priorities Consistent OHIOMAS Strategic Plan</b>				
<b>Treatment: Veterans</b>	Ensure Veterans have access to the continuum of community-based, behavioral health services and supports	<p>1. Inquire about the armed services status of persons contacting the ADAMHS Board or provider agencies and inform them on the sliding fee scale for services.</p> <p>2. Identify both VA and non-VA covered behavioral health services in both the service district and within Tuscarawas and Carroll Counties.</p> <p>3. Include VA-based behavioral health specialists on initiatives that include a cross-section of</p>	<p>1. Signed Memorandum of Understanding between Tuscarawas and Carroll Counties Veterans Services Commissions, Veterans Administration in Tuscarawas County and the ADAMHS Board which describes scope of training and exchange of information.</p> <p>2. Maintain at the ADAMHS Board printed resource materials designed specifically for Veterans and their families (e.g. Veterans Help Lines, Suicide</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>the community and which address mental health or addiction services issues (e.g. anti-drug coalitions, suicide prevention coalition)</p> <p>4. Cross-train local VA office psychiatric/behavioral health services personnel and community-based provider agency staff at least every two years during in-service training to include resource manuals, informational materials, website links, contact information.</p>	<p>Prevention lines, volunteers, etc.).</p> <p>3. Meeting minutes, membership, invitees, listserv, shall include VA-based behavioral health specialist phone number, contact names, e-mails and address.</p> <p>4. List on ADAMHS Board website a link to VA behavioral health resources within the region.</p>	
<b>Treatment:</b> Individuals with disabilities	The Behavioral Health (BH) and Developmental Disabilities (DD) systems will develop a plan to collaboratively serve shared clients.	<p>1. The BH and DD systems will participate in monthly planning meetings to impact shared service delivery.</p> <p>2. Providers in each system will receive training on dual diagnosis and the regulations guiding both the DD and MH systems.</p>	<p>1. A SWOT analysis will be completed to determine opportunities for improved service delivery and collaboration.</p> <p>2. The BH and DD systems will collaborate to organize across-system training to occur in 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>
<b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs* (see IV drug users section)				<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><b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*</p>	<p>Provide permanent, affordable and independent housing opportunities with supportive services for homeless individuals with a mental illness and/or addiction disorder.</p>	<ol style="list-style-type: none"> <li>1. Staff training with the Corporation for Supportive Housing (CSH) and the Department as available surrounding permanent supportive housing.</li> <li>2. Continue and grow our collaborations with our local Metropolitan Housing Authority, the Homeless Shelter, Domestic Violence Shelter and Halfway House, our housing not for profit- Gateway Housing and Starlight Enterprises, Inc. (SEI) for dually diagnosed clients.</li> <li>3. Active participation in the Homeless Continuum to continue receipt and administration of the Shelter + Care grant.</li> <li>4. Enlist services of the Community Navigator as needed for homeless individuals with mental health and/or substance abuse issues.</li> <li>5. Continue efforts towards a Capital Project for individuals and families in need of supportive housing due to mental illness or addiction disorders.</li> </ol>	<ol style="list-style-type: none"> <li>1. Shelter + Care funds are used to the maximum extent possible, ensuring funds are not decreased.</li> <li>2. Reduction in waiting lists for individuals in need of housing at the homeless shelter, the S + C program and SEI housing.</li> <li>3. Reduction in the annual PIT Count conducted by the Homeless Continuum as the Ohio Homelessness Report shows that nearly half of individuals who are homeless have a severe mental illness and/or chronic substance abuse disorder.</li> </ol>	<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><b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations</p>	<p>Opportunities to gather information related to racial and ethnic minorities and LGBTQ populations will be made available by the ADAMHS Board.</p>	<ol style="list-style-type: none"> <li>1. Community partners and service providers will have a central location to access resources and information</li> </ol>	<ol style="list-style-type: none"> <li>1. The ADAMHS Board website will contain links to information related to minority groups as well as the LGBTQ population</li> </ol>	<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
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults	The community will develop a more targeted and specialized approach to working with youth in transition.	<ol style="list-style-type: none"> <li>1. A task force will be created by the systems of care that serve the youth in transition population.</li> <li>2. The Board will offer educational opportunities to local systems of care to build understanding of the needs and opportunities for youth in transition.</li> </ol>	<ol style="list-style-type: none"> <li>1. In collaboration with Family and Children First Council and Job and Family Services, a Youth in Transition Taskforce will be developed.</li> <li>2. Through 505 funding and the HBH collaborative, training opportunities related to serving youth in transition will be offered in Fiscal Year 14.</li> </ol>	<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)*	The local system of care will work to equip parents and caregivers of young children with the skills to help their children develop into mentally healthy individuals, specifically targeting high-risk, high-need areas in the community.	<ol style="list-style-type: none"> <li>1. The ECMH program will work to increase knowledge, resources and skills necessary to meet the behavioral health needs of young children and their families.</li> <li>2. The ECMH program will work to build protective factors in young children.</li> </ol>	<ol style="list-style-type: none"> <li>1. Behavior management strategies and protective factor strategies will be developed in collaboration between the ECMH consultant, providers, and parents and monitored by the consultant to address site based and home based environments.</li> </ol>	<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	Enhance prevention infrastructure to strengthen community and agency based prevention initiatives.	<ol style="list-style-type: none"> <li>1. Mobilize community partners to engage in prevention activities.</li> <li>2. Educate the community regarding the prevention needs across both counties.</li> <li>3. Ensure prevention providers have access to prevention trainings that will impact their ability to provide evidence based interventions.</li> <li>4. Increase cross-system data collection efforts.</li> </ol>	<ol style="list-style-type: none"> <li>1. Expand involvement of the Anti-Drug Coalition to include development of Youth-Led prevention in both counties to extend prevention efforts to middle school and high schools students.</li> <li>2. School systems will participate in information dissemination related to community-based prevention activities to increase buy-in both at the institution level and community level.</li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

			<p>3. Documented trainings will be made available to ensure both prevention specialists and community partners have information regarding up-to-date prevention activities and opportunities.</p> <p>4. Partners in the Anti-Drug coalitions will share data that provides insight into the impact of prevention activities in their system of care.</p>	
<p><b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*</p>	<p>Adults and children will increase their understanding of the individual and collective role in prevention as well as the development substance abuse and addiction.</p>	<p>1. Informational programs designed to increase awareness and impact prevention will target youth and their parents.</p> <p>2. Youth will identify their role in the prevention efforts and begin to develop a community-wide strategy.</p>	<p>1. Hidden in Plain Sight, an interaction prevention presentation, will be completed in both Tuscarawas and Carroll Counties.</p> <p>2. The Anti-Drug Coalitions will work to develop a Youth-Led Prevention program.</p> <p>3. The Takin' It To the Schools drug prevention program will be offered to each elementary school in both counties.</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><b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage in healthy life choices</p>				<p><input checked="" 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><b>Prevention:</b> Promote wellness in Ohio's workforce</p>	<p>Raise awareness of the impact of substance abuse on applicants' ability to obtain employment.</p>	<p>1. Develop a brief self-assessment and awareness pamphlet for distribution to our Career and Technical Center, Workforce Investment Act agency (i.e Employment Source), libraries</p>	<p>1. ADAMHS Board represented on local Chamber of Commerce workplace wellness</p> <p>2. ADAMHS Board contract providers will participate in Union Hospital Workplace</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>and other area of public access to inform about workforce and substance abuse issues.</p> <ol style="list-style-type: none"> <li>2. Discuss emerging trends in the abuse of substances with local employers/constituents on a routine basis.</li> <li>3. Improve reporting of prevalence of illicit substances among local applicants referred for drug testing during hiring and interview processes.</li> </ol>	<p>wellness/drug free workplace training sessions</p>	
<p><b>Prevention:</b> Integrate Problem Gambling Prevention &amp; Screening Strategies in Community and Healthcare Organizations*</p>	<p>Behavioral Health system of care will include a targeted approach to the prevention and assessment of problem gambling.</p>	<ol style="list-style-type: none"> <li>1. Data will be gathered to determine the extent of problem gambling as a local need.</li> <li>2. Educational opportunities will be provided to increase the understanding of prevention and intervention efforts as they relate to problem gambling.</li> </ol>	<ol style="list-style-type: none"> <li>1. Problem gambling screening tools will be completed by those adults receiving services at contract provider agencies.</li> <li>2. The Board and the Anti-Drug Coalitions will collaborate to provide a training opportunity to increase understanding of problem gambling and develop local prevention efforts.</li> <li>3. The Board and the Anti-Drug Coalitions will collaborate to provide continuing education to clinicians to increase competency in the treatment of problem gambling.</li> </ol>	<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>

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

Priorities	Goals	Strategies	Measurement
Collaboration regarding individuals involved in the criminal justice system and the behavioral health system	Barriers that impacted the shared service delivery to individuals involved with the criminal justice (CJ) system and the behavioral health system will be identified and a plan to impact change will be developed.	<ol style="list-style-type: none"> <li>1. Through planning with the Tuscarawas County Jail, a telemedicine suite will be utilized to provide psychiatric services to incarcerated individuals with an SMI/SPMI.</li> <li>2. The CJ system and BH system will develop a collaborative process through which shared cases will be reviewed.</li> <li>3. The Criminal- Justice/Behavioral Health grant received by OHMAS will provide opportunities to impact barriers to collaboration and consumer recovery.</li> </ol>	<ol style="list-style-type: none"> <li>1. Incarcerated individuals with an SMI/SPMI will utilize tele-psychiatry services in collaboration with a local provider.</li> <li>2. Collaborative meetings will occur, at minimum, on a monthly basis with treatment providers and probation officers to review shared clients and develop a supportive plan.</li> <li>3. The CJ-BH grant will fund a cross-system training on Motivational Interviewing.</li> <li>4. A CJ-BH Community Navigator will complete a needs assessment on shared clients and impact barriers to successful implementation of services.</li> </ol>



	more consumers to initiate services while in a safe environment prior to returning to their homes all in a location close to their natural support system.
(3)	
(4)	
(5)	
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(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.

The Board prioritizes collaboration with consumers, families, the provider network, and other systems of care to strengthen and expand the service continuum and improve outcomes for individuals and families experiencing mental health or substance abuse issues. Collaboratives initiated during the last biennium and shared in the prior community plan included the Family and Children First Councils service coordination process; the Child Advocacy Center and associated Multi-Disciplinary Team; relationships with private psychiatric hospitals; the Anti-Drug Coalitions and the housing network and infrastructure currently being developed by the Board. Each of these partnerships and areas of focus remain a vital component in the adult and child serving systems and serve as prevention and intervention resources in our system of care.

Throughout the past two years and in response to emerging trends in behavioral healthcare, the Board has continued to emphasize collaboration among traditional and non-traditional partners including a more recent partnership with the Joint County Workforce Investment Act (WIA) agency, the Employment Source, and Tuscarawas County Chamber of Commerce. This initiative was previously discussed and started in order to raise awareness about the impact of drug abuse on obtaining employment within the oil and gas industry. An information and assessment tool was developed and made available to customers of the employment source and the local career and technical center which includes narratives designed to ease an individual's comfort with accessing the system of care.

During the past two years there has been an upward trend in the number of Individuals with a co-occurring developmental disability and mental health diagnosis receiving crisis intervention/emergency services and subsequently hospitalized at Heartland Behavioral Healthcare- the Board RPH. Structural and clinical differences between the BH and DD systems relative to our roles and responsibilities were creating misconceptions and impeding our ability to partner on high-need, high-risk individuals within the community. Additionally, the gap in the continuum of care that exists between the two systems impacts higher functioning individuals with a DD diagnosis and a SMI/SPMI that are most in need of service interventions. Many times, psychiatric hospitals will deny admission to an individual in crisis with a DD diagnosis at a moderate level of functioning. However, this same individual functions too high to be placed for stabilization at a DD Developmental Center. Historically, individuals with an MH/DD diagnosis were often seen as *either-or*, either the individual is a client BH system or in the DD system based which diagnosis is perceived as primary. Rarely were services provided across both systems of care and when they were, rarely was a shared plan developed. The opportunity to jointly serve dually diagnosed individuals prompted the MH/DD collaborative. This planning group consists of Board Directors from the DD and BH system, staff from each Board, and direct service providers working to complete a SWOT analysis which will be used to direct a cross-system approach with a common vision.

The Board identified another opportunity for developing a reciprocal relationship between the BH system and the Criminal Justice system in order to improve services for individuals served, or in need of services within both systems. In September 2013, the Board was awarded one of twelve Criminal Justice-Behavioral Health grants by OMHAS via a competitive application process. The funding will be used to build a meaningful and replicable set of interventions between the Board (funder), Community Mental Healthcare (provider) and municipal courts in Tuscarawas and Carroll Counties. The target population, individuals with court involvement and a substance abuse history, will work with a team including a probation officer, clinician and community navigator that have been training in Motivational Interviewing (MI). Funding is earmarked for wraparound supports to break down barriers to recovery. Using MI framework to guide the

collaboration, this team will meet weekly to review client progress toward the shared cross-system plan with the goal of sustained recovery and reduced legal involvement.

Collaboration of this type is not new to the system. The Board, CMH and Tuscarawas County Common Pleas Court Probation Department began monthly meeting in the past year to increase collaborative support of shared clients. Clients and natural supports are encouraged to participate in the community team process and ensure their voices are heard and to the extent possible, their needs are met.

The Recovery to Work Program has also been an opportunity to increase partnership both at the state level and the local level, including the local affiliation between Personal and Family Counseling Services, the program administrator; local referral sources including the probation system, provider agencies, and the homeless shelter, and the Board. The RtW program provides a benefit that is appealing to many different systems in that it focuses on recovery as an objective in the long-term goal of employment versus recovery as the goal in and of itself.

FY '13 was also a period of expansion and infrastructure development for programs managed by the ADAMHS Board including the Anti-Drug Coalitions and the Shelter Plus Care Program. The Board allocated Problem Gambling funding to a local prevention services agency, Personal and Family Counseling Services/Ohio Guidestone, Inc. for the purpose of hiring part-time staff to perform coordination duties on behalf of the Anti-Drug Coalitions (initiated by the ADAMHS Board with SPF-SIG resources) in both Tuscarawas and Carroll Counties. The Coalitions quickly evolved into the "go to" organizations for a number of major drug prevention awareness and intervention activities that include law enforcement, courts, schools, community providers and volunteers. A cross-section of our community is represented on each of the Coalitions and a number of individuals that participated in their start-up are still actively involved. Additionally, the Board was asked to act as administrative agent for the Shelter Plus Care program managed by the local continuum of care and in conjunction with Tuscarawas Metropolitan Housing Authority. This program, which manages \$142,000 in housing vouchers annually, assists or pays in total for rental assistance, security deposit, and utilities for 24 households a month.

In September 2013, the Board submitted two capital funding requests to MHAS for the purpose of moving a consumer operated recovery center, ACE, to a new location and to also expand an existing five bed crisis stabilization unit to ten beds. Both requests will support programs that impact a consumer's ability to achieve and maintain wellness and recovery and remain in the community. Since its creation, ACE has been evolving into a critical component within our local continuum of services for adult consumers with severe and persistent mental illnesses. Programming is directed exclusively by consumers and includes coping with daily life stressors, health and wellness services, information and referral services for housing and education on mental health treatment. ACE volunteers also provide peer support for members including employment support (e.g. mock interviews, employment-related stress reduction support). ACE staff and consumer leadership also coordinate a variety of social recreational services for members including an annual two day retreat, attendance at Kent State University's Performing Arts Center, sporting events and numerous other leisure and recreational activities. Additionally, rarely are services available in the mental health system that serve as both prevention and intervention in the way that crisis stabilization does. Often individuals are able to be diverted from hospitalization to the voluntary crisis stabilization unit. Here the individuals have access to intervention with a psychiatrist and clinician designed to decrease the level of acuity and maintain connection with their local treatment team. The crisis stabilization unit serves as a step-down option to allow consumers to transition out of a higher level of care but remain in a supportive environment. During the past year, this resource has been capacity with increasing frequency which removes the unit as an alternative to hospitalization or step-down to a lower level of care.

## 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

To meet the needs of SPMI consumers, the Board has entered into contractual relationships with SUMMA/St. Thomas in Akron and Windsor-Laurelwood in Willoughby to provide both psychiatric and inpatient detoxification services. Both types of admissions are facilitated by the Board's designated prescreening agency. Prescreening staff work closely with local emergency department personnel in order to appropriately assess, refer and transfer individuals to one of our selected inpatient service providers. The assessment process is highly individualized and a great deal of follow-up service coordination occurs within existing multi-disciplinary team processes on both a local and RPH/inpatient provider basis.

In FY '13, there was a decrease in the total number of inpatient psychiatric admissions from the Board catchment area. Admissions to both the RPH and contracted beds at private hospitals decreased from 160 admissions in FY 2011 to 143 admissions in FY 13, a drop of 11%. While the overall number of admissions to these hospitals has decreased, the number of admissions to the state RPH has increased from 24 in FY 11 to 90 in FY 13, an increase of 74%. The reason for the increase is twofold: the removal of the SCUD formula decreased the financial risk to the Board and secondly, private hospitals have often declined to accept clients that are high-risk/high-need, especially those clients that the hospital has struggled to stabilize in the past.

The decrease in admissions to psychiatric hospitals is, in part, due to the role of the Community Navigator. This position, funded originally by the Margaret Clark Morgan Foundation in FY 2013 and by the Board in FY 2014, was designed to work with individuals with a high level of vulnerability and risk in the community due to homelessness, symptom instability, substance abuse, lack of access to medical care, lack of access to healthy diet, lack of healthy supports, and/or involvement in the legal system. The target population experiences high rates of recidivism or incarceration or is at risk of such and has an inability to navigate benefits, resources and traditional services. The Navigator program was introduced with the goals decreasing lengths of stay and recidivism rates, improving communication between organizations both in and out of the system of care, increasing compliance and post-discharge follow-up rates, providing support and guidance in accessing benefits and resources, and increasing the involvement and preparedness of natural supports.

A component necessary to the success of the program was on-site communication with the clients and staff at the RPH. To ensure care was coordinated at the organizational and the individual level, the Navigator met at least weekly with clients at the RPH, contacted the social worker within one business day of admission, participated in team meetings, provided support and assistance in the level movement process, conducted needs assessment and began linkages to benefits and resources while the individual was hospitalized, and provided support, guidance and contact following discharge. The coordination continued post-discharge with both the client and the treatment providers to assure necessary appointments were kept and client needs were being met.

During the course of the grant, over 100 clients were served by the Community Navigator. The follow-up rate for post-discharge appointments increased from 64% to 95%, client readmission rates decreased from 4.8 to 1.3, and 76% of clients involved in the Navigation program stepped down to more traditional, community-based services. The Navigator actively participates in the Community Team meetings pre-and post-discharge to provide ongoing community wrap around support to clients at risk of recidivism and engages professional and natural supports in the process. Due to the Navigator's ongoing communication with the client, providers, and natural supports, she is able to gauge the client's level of functioning and encourage readmission to the local Crisis Stabilization Unit when an increase in symptom instability is

seen.

The crisis stabilization unit (CSU) is a critical component of our local continuum of care and has a positive impact on the number of psychiatric admissions, lengths of stay per episode of care and is geographically located directly across from our local hospitals emergency department- where all of our medical clearance assessments occur. The CSU is often a more appropriate and appealing option for local consumers due to its proximity to natural supports and service providers. Individuals that may balk at admission to a psychiatric hospital are more willing to consider voluntary admission to the CSU which allows the treatment team to provide intervention prior to an individual decompensating to the point where inpatient treatment becomes necessary. In the same sense, consumers are often willing to agree to a step-down from hospitalization to the CSU prior to returning to their homes, thereby decreasing their length of stay and ensuring that the individual is engaged in services necessary to support ongoing stabilization.

The development of the Medication Assisted Treatment (MAT) program at Community Mental Healthcare (CMH) has impacted the number of detox admissions across both counties. From FY 11 to FY 13, there has been a 60% decrease in admissions for detox. Through the partnership between the Board, the Recovery to Work Program and CMH, individuals that may have been admitted for detox in the past due to opiate addiction are now able to engage in the MAT/Suboxone program. In addition to providing the medical intervention, CMH requires that clients participating in the MAT program also engage in individual or group counseling to ensure that the medical intervention is accompanied by a behavioral health intervention.

Understanding that the majority of individuals that were admitted for detox during the past fiscal year were alcohol dependent, the Board requested a presentation with a representative from Alkermes, the manufacturer of Vivitrol, in order to determine whether this is a viable addition to the MAT program. The presentation, attended by representatives from the legal system, the health system, and the BH system, focused on the use of Vivitrol both as a treatment for opioid addiction and alcohol addiction. Throughout FY 14 and beyond, the Board will continue to pursue this as an option by attempting to increase stakeholder engagement.

### 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 –

Continued from previous year, the Board participated in the development the of medication assisted treatment and utilization of RtW resources to support its cost in collaboration with Community Mental Healthcare, Inc and Personal and Family Counseling Services as well as the implementation of telepsychiatry at Community Mental Healthcare, Personal and Family Counseling Services, and the Tuscarawas County Jail. The Board is working with partners on a Community Team planning process for individuals at risk of re-hospitalization as well as developing a criminal justice-behavioral health collaborative with local municipals courts utilizing Motivational Interview as a common approach. The development of the Community Navigation program has also impacted initial connection to and ongoing engagement with service delivery.

b. Planning efforts

Board staff have been actively involved in exploring numerous types of housing solutions for individuals with severe and persistent mental illness residing in the catchment area and those transitioning from more restrictive levels of care. Our emphasis includes developing knowledge of supportive housing resources, programs and services as well as landlord/tenant issues which lead to more positive housing outcomes for consumers. Our actions include comprehensive, in-depth trainings on the types and application procedures for various grant based and tax-credit housing programs, to active participation in the local housing continuum, the board continuously seeks out and evaluates any available funding opportunity that may provide relief to an ever decreasing pool of housing options. Close collaboration with our local metropolitan housing authority has lead also significantly improved our understanding of the operating procedures and protocols necessary to address the housing needs of low-income and disabled adults and transition aged youth.

c. Business operations

Over the past four years, 60% of Board staff have participated in specialized trainings in the housing field. Specifically, management and development of supportive housing have been targeted as priorities in terms of the board's expansion of housing offerings for the residents of the two county area. The Board operates all housing programs using the Housing First model, prescribing that the provision of safe, affordable housing is the necessary first step on the journey to wellness.

In that vein, the Board currently provides property management services for eight privately owned rental homes, consisting of 26 beds. The facilities provide a safe, home-like atmosphere for individuals with developmental disabilities or co-occurring developmental disabilities and mental health disorders. The Board is also actively involved in the tenant selection process which offers an available, though limited, option for high needs individuals.

This foray into housing management has now also led to additional opportunities to expand housing options in Carroll County. The Carroll County DD Board, through a side-by-side non-profit, operates 6 facilities similar to the units in Tuscarawas County. An offer has been made to the Board to assume ownership of these properties and the associated management of the facilities. This would provide a valuable housing cache in an area currently subject to skyrocketing rents and nearly non-existent available units.

In July of 2011, the board assumed the administrative role for the Tuscarawas County Shelter+Care program. With a FY2014 grant amount of over \$142,000, the board is able to provide rent, security deposit, and utility assistance to over 30 disabled and homeless individuals, over 90% of whom have a mental health or addiction diagnosis. Shelter+Care has provided a valuable tool to the mental health community by offering a second chance to many persistently mentally ill individuals who have not been successful in retaining housing in the past.

d. Process and/or quality improvement

The ADAMHS Board of Directors approved an updated set of Board policy and procedures under the guidelines of OACBHA's Culture of Quality to be initiated in FY 13. Included in this is a Board-facilitated utilization review policy that creates a framework for the evaluation of non-Medicaid expenditures by provider agencies as well as a continuous quality improvement policy designed to provide a mechanism to monitor progress in achieving

Board missions and goals and monitor provider agency compliance with federal and state block grant assurances.

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.

As indicated throughout the plan, the Community Navigator has been one of the most successful programs implemented across the system of care during the previous biennium. On a macro level, the program positively impacted readmission rates, follow-up appointments attendance, and connection to services but the true success of the program lies in the individual stories.

Recently, the Navigator engaged a female client who was experiencing worsening symptoms of depression over the past 12 months. She frequently called the crisis hotline, had been in and out of the crisis stabilization unit and had been hospitalized for suicidal ideations. She had been referred for individual counseling but was resistant to any types of treatment. Initially, she refused to allow the Navigator to see her in the community or in her home but reluctantly agreed to meet with her weekly at the office. This ultimately built a bridge with the mental health therapist who worked with the Navigator and client to create a treatment plan and begin to work on her depressive symptoms. One step in this process was beginning to build her social support system. With the help of the Navigator, she began to attend ACE clubhouse, the consumer operated organization. At the clubhouse, she began to create friendships for the first time in years. These connections increased her trust in the Navigator and her willingness to engage in services continued to grow. She remains consistent with therapist and she applied for and received appropriate Medicaid and SSDI benefits. The Navigator created a transition plan with the client as her level of need no longer warranted navigation services but the client felt she was doing well enough that she did not need a case manager. She attends group sessions to maintain stability and, while she has stayed at the CSU once this year, she was able to identify early warning signs of decompensation and sought support prior to needing hospitalized.

### 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.

With the exception of 505 "Hotspot" funding allocated initially within FY '13, the Board has not received meaningful discretionary resources via the funding formulary to support non-Medicaid service demand for mental health and addiction treatment services within the district. Primary or Core behavioral health services were rationed among non-

Medicaid recipients coupled by a corresponding loss of fundamental recovery supports and services. These include, but are not limited to, the following: Criminal Justice services collaborations/Specialty Docket Courts; Permanent Supportive Housing; Outreach, Intervention, Prevention and Education; Recovery Supports/Consumer Operated Services and Supports; and Care Coordination.

In spite the financial instability of our system during the previous three budget biennium, the ADAMHS Board has been developing our knowledge infrastructure and formalizing various collaborations with key local partners in order to expedite implementation of a more comprehensive system of recovery support services within Tuscarawas and Carroll Counties. Resources available via Medicaid expansion will be used to rapidly enhance the Core services currently being provided to Medicaid enrollees and others receiving health insurance through the Federal/State Exchange- including any other non-Federally or non-Medicaid covered services.

Several of our planned enhancements and expansions under consideration are as follows: **Criminal Justice service collaborations:** The Board is working closely with the Tuscarawas County Sheriff's Office to improve the continuum of professionally directed behavioral health services within the jail. This includes utilizing the capabilities of the recently installed telemedicine suite at the facility. The Board also intends to enhance the core services being made available via the CJ-BH grant from OMHAS by making available supports that will improve treatment outcomes for offenders charged with assault and with a substance abuse and/or behavioral health diagnosis. Additionally, adult service coordination services for individuals involved with the criminal justice system, local community corrections office and emerging specialty docket-like court interventions are also under consideration.

**Permanent Supportive Housing:** The Board will analyze creation of a system or process for making available housing vouchers or subsidies in a manner similar the Shelter Plus Care Program which the ADAMHS Board currently manages in conjunction with the Metropolitan Housing Authority and on behalf of the Homeless Continuum. There is currently a waiting list for the Shelter Plus Care Program in Tuscarawas County. Carroll County does not currently have an operational Homeless Continuum and subsequently no Shelter Plus Care vouchers. The Board has been encouraging elected officials and others in Carroll County to formally engage existing State and/or Federal Housing projects in order to make more housing options available for disabled individuals and low-income households. Anecdotally we're hearing that low income families in Carroll County are being "squeezed" out of existing rental units as Landlords are transitioning to higher paying employees within the oil and gas drilling industry. Also, the ADAMHS Board is in the process of developing an agreement with a private, not-for-profit housing organization to managed five single family/multi-family homes located in Carrollton for the purpose of making housing available for disabled adults and adults with SPMI. The Board is taking a very active role in tenant selection processes for high-risk, high-need individuals with dual disorders as a result of our supportive housing initiatives and experience.

Being cognizant, however, that some consumers are not able to live independently, either on a short-term or long-term basis, the Board is looking to develop ACFs locally. As stated in previous sections, presently individuals with SPMI that need higher levels of care are placed at ACFs a distance away, impacting the provision of services by local providers and the connection to the natural support system. The development of ACFs would allow consumers to remain in their community, maintain a connection with providers and supports, and utilize local resources, including the local team planning process, that are often more difficult to access outside the consumer's local system of care.

Medicaid Expansion will likely lead to significant improvements within the local behavioral health system's ability to provide substance abuse **Outreach, Intervention, Prevention and Education Programming education and awareness programming along with mental health stigma reduction services.** Generally, only Core behavioral health services have

received Board support in consideration of stagnant funding allocations and with the loss of Safe and Drug Free Schools and Communities Act resources a five years ago. We anticipate that resources will be available for the planning, development and implementation of evidenced-based prevention programs that will reduce risk factors associated with substance abuse. Expansion funding will also improve the effectiveness of two anti-drug Coalitions which were started by the ADAMHS Board and which operate independently in both Tuscarawas and Carroll Counties. The Board was able to allocate a portion of its Problem Gambling allocation from OMHAS to substance abuse prevention outreach services. This was carried out through development of an MOU between the ADAMHS Board and agency-based, certified prevention staff that act on behalf of each of the Coalitions. Additional financial support is likely necessary in order for the Coalitions to make a meaningful impact on their two priorities: 1) Alcohol abuse by minors; And, 2) Prescription drug abuse. Efforts to develop and implement mental health stigma reduction activities will also improve access to behavioral health services.

Key **Recovery Supports/Consumer Operated Services** available via our consumer and peer support program, ACE, will be examined for additional resource allocation through the expanded Medicaid program. Although Peer and Consumer Operated Services are not currently eligible for Medicaid reimbursement, they fulfill a critical role on behalf of clients with SPMI. Transportation, social recreational-like services, educational activities and dietary needs of clients which use our consumer operated service will all be reviewed for increased funding. Levy funding may also be an option for matching a Capital Plan request submitted to MHMAS to move the offices of ACE.

In response to the regional 505 Hotspot proposal process coupled with Ohio's emerging interest in implementing Health Homes/Integrated Care for adults with SPMI and chronic health conditions, the Heartland Collaborative identified care coordination/Navigation as one of its top four priorities around **Care Coordination**. Following an extensive amount of research on integrated care models, potential for Medicaid Expansion and determining the Boards' roles as "purchaser of services", the Heartland Boards' settled primarily on developing "Navigators" or purchasing navigation services in order to improve outcomes and transitional care issues related to hospital and community-based services. Additionally the Heartland Boards coordinated a three-day training series offered by the National Council on case to care management in order to improve the knowledge infrastructure of our local systems of care. The opportunity now exists to expand our investment in care coordination and the accompanying IS infrastructure to support the coordination of care for non-Medicaid services and to connect Medicaid enrollees to a developing set of recovery supports not reimbursed by Medicaid.

## 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.