Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Instructions SFY 2017

Enter Board Name: _____Erie-Ottawa_____

NOTE: OhioMHAS is particularly interested in update or status of the following areas: (1) Trauma informed care; (2) Prevention and/or decrease of opiate overdoses and/or deaths; and/or (3) Suicide prevention.

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: With regard to current environmental context, boards may speak to the impact of Medicaid redesign, Medicaid expansion, and new legislative requirements such as Continuum of Care.

ECONOMIC FACTORS

Local Resources and Service Delivery

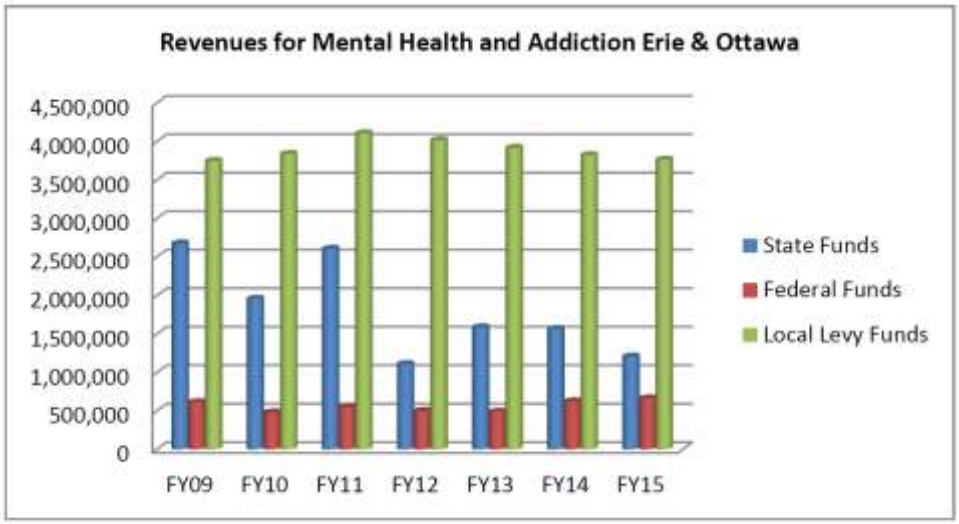
We have two separate levies, one for .3 mil and one for .7 mil. The .3 mil was replaced on 11/3/2009 for five years and expired in 2014. While the passage of the replacement levy in November 2009 (FY 10) generated approximately $290,000 in additional revenue for FY 11, the gains were eroded as a result of the decline in real property values, limited new construction, and the loss of Tangible Personal Property (TPP) tax revenues. Thus, as per the Table below, local revenue in FY 14 was equivalent to the amount pre-replacement.

Our SFY 15 budget came in at almost a $400,000 reduction in state and federal funding. This is a direct reduction to treatment and prevention services in Erie and Ottawa Counties. Thus, after deliberation on various alternatives, the Board of Trustees decided to place a five-year renewal plus an additional 0.20 mills on the ballot in November, 2014. Thanks to Erie and Ottawa County voters, the levy passed and is projected to generate approximately $740,381 in additional funds, commencing in 2015 and first due in CY 2016.

The .7 mil was last replaced on 11/7/2006 for ten years and expires in 2016. The Board is currently exploring the various options related to this levy, and will be placing it on the ballot in November.

Local Levy Funds (*FY 16 is YTD)

FY 10	$3,813,955
FY11	$4,107,071
FY12	$4,018,730
FY13	$3,919,093
FY14	$3,824,009
FY 15	$3,867,919
FY 16*	$4,133,534



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

Unemployment

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

Ohio and U.S. Employment Situation

Ohio's unemployment rate was 5.1 percent in March 2016, up from a revised 5.0 percent in February. The March unemployment rate for Ohio was equal to the March 2015 rate of 5.1 percent. The U.S. unemployment rate for March was 5.0 percent, up from 4.9 percent in February and down from 5.5 percent in March 2015.

Erie County:

According to Ranking of Ohio County Unemployment Rates (ODJFS, Office of Workforce Development) for March 2016, Erie County was 32nd in the state at 6.5%, down slightly from 6.9% in March 2015. This is an improvement over figures reported in the last Community Plan, when Erie County was ranked 55th at 8.8% in 2011, and 50th at 7.3% in 2012. Comparable rates for Ohio during that same period were 8.6%, and 7.2% respectively. As you can see, the rate of unemployment decreased each year, consistent with the state average; however, while the rates in Erie County mirrored those of Ohio in previous years, it is approximately 1.8-1.4% higher than Ohio's averages for March of 2015 and 2016 respectively. There is a slight dip in the unemployment rate during the summer months as expected due to seasonal employment opportunities through Cedar Point and related retail and restaurant businesses.

The size of a county's labor force is also an indication of economic health. It is influenced by both the economy and the size and composition of the population. Labor force data as reported in the ODJFS Profile of Statistical and Demographic Data for Erie County as of July 2013 is as follows:

	YTD CY 2013			CY 2012		
	County	State	U.S.	County	State	U.S.
Labor Force	44,400	5,821,000	157,196,000	40,600	5,748,000	154,975,000
Employment	41,400	5,397,000	145,113,000	37,700	5,335,000	142,469,000
Unemployment	3,000	425,000	12,083,000	3,000	413,000	12,506,000
Unemployment Rate	6.9	7.3	7.7	7.3	7.2	8.1

While there was a slight increase in the size of the labor force between the two years shown, overall it has remained relatively stable. For instance, in CY 2010 the labor force was 42,700 with 38,300 employed.

Ottawa County:
According to the Ranking of Ohio County Unemployment Rates, Ottawa County was 9th of the 88 counties at 11.9% in 2011 and 12th in 2012 at 9.8%. These figures range from 2.6-3.3% higher than the Ohio averages for the same period, placing the county in the top 15% of all 88 counties. In March 2016, Ottawa County was 9th highest at 8.8%, up by one-tenth of a percent from 8.7% in March 2015. As previously, these figures are higher than the state average for that period. As is the case in Erie County during the summer months, when you take into account the large migrant worker population living and working in the county during the summer and fall planting and harvesting seasons there is a significant dip in the rate from about May through October.

Labor force data as reported in the ODJFS Profile of Statistical and Demographic Data for Erie County as of July 2013 is shown below. The size of the labor force is slightly down from previous years, although overall it has remained relatively stable.

	YTD CY 2013			CY 2012		
	County	State	U.S.	County	State	U.S.
Labor Force	20,600	5,821,000	157,196,000	20,800	5,748,000	154,975,000
Employment	18,900	5,397,000	145,113,000	18,800	5,335,000	142,469,000
Unemployment	1,700	425,000	12,083,000	2,000	413,000	12,506,000
Unemployment Rate	8.0	7.3	7.7	9.8	7.2	8.1

Income and Poverty

Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. According to information found in the 2016 County Health Rankings, a 1990 study found that if poverty were considered a cause of death in the US, it would rank among the top 10 causes. While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality than adults due to increased risk of accidental injury and lack of health care access. Furthermore, children's risk of poor health and premature mortality may also increase because of the poor educational achievement associated with poverty.

Erie County:
The per capita income of a region also provides a good barometer of its economic health. According to the 2013 ODJFS Profile, over the last decade, per capita income fluctuations in Ohio have been highly correlated with employment growth or decline. The per capita income for the county in 2000 was $28,645, and in 2011 was $38,161. Both figures are just slightly higher than the average for Ohio and slightly lower than the U.S. average.

As reported in the 2009 ODJFS Profile for Erie County, 12% of persons (2008 Census) of all ages were in poverty according to the Federal Poverty Level as issued by the U.S. Department of Health and Human Services, 16.8% of those less than eighteen years of age. According to the 2013 Profile, that number rose to 12.8% (2011 Census), 21.4% for those under age

eighteen. Per the 2016 County Health Ranking, which uses the Small Area Income and Poverty Estimates (SAIPE) program for its data, 22% of children under 18 were living under poverty in Erie County, compared to 23% in Ohio.

Per the 2010-2014 American Community Survey (ACS) 5-Year Estimates, 12.7% of all people were in poverty; 18.4% of related children under 18 were below the poverty level, compared with 6.2% of people 65 years old and over. Nearly 8.5% of all families and 30.6% of families with a female householder and no husband present had incomes below the poverty level.

Ottawa County:
As reported in the ODJFS Profile, per capita income was in $29,105 in 2000 and in $39,553 in 2011. As was the case with Erie County, this was slightly above average for the state and below that for the nation.

As reported in the 2009 ODJFS Profile for Ottawa County, 9% (2008 Census figures) of persons of all ages were in poverty according to the Federal Poverty Level as issued by the U.S. Department of Health and Human Services; 12.5% of those less than eighteen years of age. According to the 2013 Profile, that number rose to 10.9% (2011 Census), 17% for those under age eighteen. Per the 2016 County Health Ranking, 16% of children under 18 were living under poverty in Ottawa County.

Per the 2010-2014 ACS, 10.3% of people were in poverty, 16% of related children under 18 and 4.8% of people 65 years old and over. Nearly 7% of all families and 28.9% of families with a female householder and no husband present had incomes below the poverty level.

Health Care Coverage/Insurance

Lack of health insurance coverage is a significant barrier to accessing needed health care. According to a November 2015 Kaiser Family Foundation report, “Uninsured people are far more likely than those with insurance to report problems getting needed medical care. Over a quarter (27%) of adults without coverage say that they went without care in the past year because of cost compared to 5% of adults with private coverage and 10% of adults with public coverage." According to Health Ranking figures, 13% of Erie County residents and 12% of Ottawa County residents had no health insurance coverage; slightly higher than the figures reported in the 2010-2014 ACS as shown below.

Among the civilian non-institutionalized population in **Erie County** in 2010-2014 (ACS), 89.4% had health insurance coverage and 10.6% did not. For those under 18 years of age, 5.3% had no health insurance coverage. The civilian non-institutionalized population had both private and public health insurance, with 71.8% having private coverage and 34.5% having public coverage. According to the 2015 Erie County Health Assessment, 7% of Erie County adults were without health care coverage. Those most likely to be uninsured were adults under the age of 30 and those with an income level under $25,000. The top reasons uninsured adults gave for being without health care coverage were loss of job or changed employers (39%), could not afford to pay the premiums (35%), and could not afford the exchange premiums (16%).

Among the same population in **Ottawa County**, 90.5% had health insurance coverage and 9.5% did not according to the ACS survey. For those under 18 years of age, 4.7% had no health insurance coverage. The civilian non-institutionalized population had both private and public health insurance, with 75.2% having private coverage and 33.2% having public coverage. According to the 2012 Ottawa County Health Assessment, 12% of adults were without coverage, with those adults under age 30 and those with an income level under $25,000 most likely to be uninsured. In 2012, the top reasons uninsured adults gave for being without health care coverage were could not afford to pay the insurance premiums (39%), lost their job or changed employers (24%), their employer does not/stopped offering coverage (17%), and they became ineligible (age or left school) (11%).

These figures are significant because Board funds are used in part to provide treatment services to the non-insured and indigent population, along with critical recovery support, prevention and education services. For FY15, over 3,350 youth and 442 adults received prevention and consultation services in Erie and Ottawa Counties, and over 240 youth and 2,200 adults received treatment services for mental health and alcohol and drug addiction problems.

Medicaid Expansion

The data below reflects actual enrollment under Medicaid expansion for Erie and Ottawa Counties and projected ranges of new enrollment for persons aged 19-64 for SFY 2015-2017 according to Ohio Medicaid data by county reported by the Health Policy Institute of Ohio in the December 2014 brief *Medicaid Enrollment Trends and Impact Analysis.* It is likely that many of those enrolling in Medicaid coverage under the new eligibility criteria were previously uninsured, and this is what contributed to the slight increases in people with public health care coverage as reported previously.

County	Actual enrollment		
	County-level enrollment (as of 10/14)	18-64 year old population by county (2013 Census)	% of 18-64 population enrolled in Medicaid extension (as of 10/14)
Erie	2,874	45,477	6.3%
Ottawa	1,026	24,280	4.2%

County	SFY 2015 Original Projection	SFY 2015 Rebased Projection	SFY 2016 Original Projection	SFY 2016 Rebased Projection	SFY 2017 Original Projection	SFY 2017 Rebased Projection
Erie	3,831	4,133	4,244	4,629	4,474	4,901
Ottawa	1,433	1,546	1,587	1,731	1,673	1,833

Impact of Expansion

While looking at fiscal considerations going into the FY 15 budgeting and contracting process, it was noted that while not as robust as anticipated, Medicaid expansion had resulted in some shifts in payer source, thus a slightly lesser amount of non-Medicaid funds were being drawn down for some populations. However, we were not seeing the gains (in terms of freed up local resources) from Medicaid expansion consistent with the timeline and projected figures prepared by MHAS. In addition, there was a significant loss of state and federal funds in FY 15 (SAPT funds, ALI 507 funds, ALI 421 Collaborative/"Hot Spot" project funds). Thus, in contracting for services in FY 15, initial adjustments were made between Service Groups and/or some were reduced with minimal impact on client services as we realigned need and capacity with revenue sources. We also used carryover funds to the extent possible in order to minimize service reductions as a result of the lost revenue. We elected not to make further reductions in agency contracts based on anticipated "savings" from Medicaid expansion prospectively, as agencies cannot budget on money that does not yet exist. However, as reimbursement for covered clinical/treatment services currently paid for by the Board from Medicaid increased, the intent was to redirect contracted funds to other Board priorities across the system of care as appropriate.

Moving into contracting for FY 16, budget assumptions included recognition of the potential for redirection of funds as Medicaid expansion continues, thereby providing reimbursement for covered clinical/treatment services currently paid for by the Board. As noted above, the FY 15 allocations had accounted for this somewhat and as of April 2015 overall agency contract utilization was slightly lower than YTD (billing through February). The largest gain was seen in the Inpatient

Hospitalization Service Group, with only about 20% of the $150,000 allocated had been drawn down. Thus, in contracting for services in FY 16, fewer funds were allocated for inpatient hospitalization as that is a service where Medicaid expansion has had a sizable impact, with more individuals eligible for coverage. Those dollars were shifted to crisis/emergency services to help support the restructured after-hours crisis program, developed in partnership with the Sandusky/Seneca/Wyandot and Huron Boards (also served by Firelands) in response to identified needs. Another crisis team was added to allow for improved response times and more thorough service provision. Also, four beds were added at Rescue, dedicated for use by individuals in the three-board area, and Firelands negotiated a contract with Glenbeigh for detoxification /inpatient services to expand appropriate placement options. All of these measures will improve outcomes for individuals in need of these services. There was no change in the general funding level for FY 16 for the provision of mental health and addiction treatment services as adequate capacity exists and there are little to no waiting lists for service. Recovery support services were increased, including funds to the local Recovery Community Center for the training and provision of services by Certified Peer Specialists and the addition of a WRAP (Wellness Recovery Action Plan) program at one of our consumer organizations. We have continued to monitor utilization of services and funds and will redirect further savings as a result of Medicaid expansion toward other identified local priorities.

Potential Impact of Medicaid Redesign

The Behavioral Health Redesign and the unknowns associated with changes occurring within the BH redesign present challenges in planning for the community service delivery system. Several issues and unanswered questions exist relative to its impact, ranging from concerns about the rates, the scope of the project, the timelines, the impact on clients, services and providers—not to mention the fact that all this is occurring concurrent with major changes to ORC 340 vis-à-vis the Continuum of Care requirements and all that goes along with that—and the transition of public mental health and addiction services to managed care in January, 2018! Further narrative on some of these concerns is summarized below.

- The State has proposed drastically reduced service rates. A 4th and not yet final iteration of rates by OhioMHAS fiscal staff at a Board Association meeting held March 18, 2016 in Westerville was handed out and discussed. At that meeting, OhioMHAS officials explained the intent of the state is to realize *zero balanced budgeting* by the Redesign. This is to be achieved using SFY14 as the base year, and substituting the new proposed rates for all Medicaid services provided in SFY14. This will allow evaluating the total costs for that fiscal year using the new rates compared with the actual SFY14 costs. However, Boards were told budget neutrality would not be modeled at the Board level and would not necessarily be applicable at the Board level, so the local impact will be unknown.

- Another concern is the layer of bureaucracy and cost that may occur when Managed Care Organizations (MCO) are retained by the state to provide authorizations of treatments sought by Medicaid recipients with mental illnesses. While managed care plans were credited with curbing medical cost inflation in the late 1980s by reducing unnecessary hospitalizations and forcing providers to discount rates, the growth of managed care plans and strategies led to consumer backlash because many managed care health plans are provided by for-profit companies and their cost-control efforts created the widespread perception that they were more interested in saving money than in providing health care. For example, in a 2004 poll by the Kaiser Family Foundation a majority of those surveyed said managed care decreased the time doctors spent with patients, made it harder for people who are sick to see specialists, and failed to produce major cost savings.

- Another concern exists around Certified Peer Supporters. Our understanding is that the training and certification authority for consumers to become peer specialists has been taken from the now non-existent Ohio Empowerment Coalition by OhioMHAS, which itself will provide a new course and certification, not available yet. Consumers previously certified by the OEC will need to take a 16-hour OhioMHAS Web-based course and an examination, neither of which have been developed yet, to attain the state's new certificate. This seems burdensome and unfair to those who have already undergone the training as per standards previously in place. In the meantime, Boards and providers are expected to have peer services in place in SFY 17, with no ability yet to have them paid by Medicaid and no real understanding of what will be involved or reimbursed.

- There are many concerns relative to data management in general and MACSIS in particular. For instance, there is a need for a crosswalk on rates and billing codes and for a definitive date as to when the new Medicaid rates and services will be implemented and what they will be so Boards know how to construct contracts with service providers for FY2017. MACSIS will not be compatible with some of the new proposed billing codes and there is reportedly no plan to convert it, yet no date has been issued as to when MACSIS will go offline. Many Boards are still using this billing system for non-Medicaid claims, which means the necessity of additional cost and time to research, purchase, train staff, and implement a new IT system. Furthermore, OhioMHAS expects each Board to purchase use of an Information Technology (IT) system designed for this purpose (with no additional funds). This step would make OhioMHAS the only State department in Ohio without its own publicly-supported Statewide Information Technology System. Beyond the impact on Boards, the issues with MACSIS and IT in general are also a problem for many providers, as electronic medical records will not use two systems effectively since it is not always possible to know which clients are Medicaid-eligible when services are provided. It would result in regional providers possibly needing to submit bills in multiple IT systems.

- Concerns exist about communication, involvement of stakeholders, quality of care and the impact on individuals served, short and long-term impacts on the system, and monitoring and oversight.

- Specific issues about the various programs and other details exist such as concerns regarding the offense exclusion list and how it may affect the pool of individuals who could provide services; changes under the Specialized Recovery Services Program; the potential ratio of recovery managers to clients (1:60); and eligibility of other Medicaid services for individuals under the 1915i waiver;

Continuum of Care Requirements

While there is clear support for the intent of the legislation, several concerns have been voiced related to timing and sustainability, issues of scope and capacity relative to various services required (i.e. how can you legislate Twelve-Step approaches, which by definition are anonymous and peer run?), and funding. Not only does this legislation earmark funds for a particular service mix and a specific population but does so at the expense of others the Board has responsibility to serve. Furthermore, the legislation really speaks to service capacity for opioid-addicted persons, so a very specific population. Locally identified needs and priorities, determined through a variety of mechanisms and processes (described in detail in Question #2), do not always align with continuum of care and other state requirements and priorities. Resource concerns (staffing and funding) can also create barriers to addressing community needs. For a board area that lacks many of the services defined as necessary in the legislation—particularly given the fact there are no new funds, but clearly an issue with flat funding or the more likely decrease in resources to local communities—this could require a significant shift in current funds from existing providers/services/populations/local priorities that could be disruptive. Plus, that potentially creates a gap in relation to necessary services to other priority populations, such as individuals with SPMI, creating or exacerbating another problem. The reality of operationalizing this could have serious unintended consequences on service availability to other populations and on the stability of the provider network in some communities.

In addition, the requirement that the majority of services be categorized as available either "within the service district" exceeds national standards (i.e., SAMHSAs National Behavioral Health Quality Framework, which provides a mechanism to examine and prioritize quality prevention, treatment and recovery elements and the dissemination of proven interventions and accessible care), exceeds the standards required of Medicaid MCOs, and is counter to the regional Board planning required by OhioMHAS the past five years that *functionally* broadened the service districts of Boards (i.e. "Hot Spot" initiatives and regional planning and funding that resulted in new service configurations such as that undertaken by the Clermont, Warren/Clinton and Brown County Boards, which developed recovery housing in one county to be used collectively). National Accessibility Standards should be able to be utilized to address local needs. Needs often times do not stop at county borders and National Accessibility Standards could support more collaboration amongst board areas.

The lack of clarity about some of the requirements—still at this late date, months before the effective date—is of concern as well. For instance, what is meant by the terms "in an integrated manner and without delay" in reference to clients' access to treatment and recovery supports in ORC 340.033? How will compliance be measured? What constitutes an application for services? How will compliance with the Essential Elements be measured—merely having the service in existence, or a certain level of capacity available, or some other factor? Availability doesn't necessarily equate to access, and compliance with the statute does not necessarily equate to positive outcomes or even address its intended result.

There are issues relative to the Waiting List Requirements as well. They add more administrative requirements to agencies with no way to recoup the costs. The goal is to ensure timely access, but it is unclear whether the reporting requirements as designed will actually get at that. There are also questions as to how the data will be interpreted and used.

At this point, there is the potential we would not meet the requirement for having Ambulatory detox services within our service district. We have been working with our providers for about two years now around adding this service, however we have found that not many providers around the state are really familiar with it, as we (nor our providers) have been successful with obtaining much guidance or technical assistance about how to proceed—even from MHAS—and it does not seem to be very cost effective for the relatively small number of clients in our two-county service district. Apparently we are not alone in this; according to Cheri Walter at the 4/15 OACBHA meeting on the Community Plan and Continuum of Care (CoC) Guidelines, 27 Boards would not meet CoC requirements based on a survey of the membership, most because of ambulatory detox (lack of physicians for MAT, lack of providers, lack of clarity about service and what it entails). We did include this in the Request for Information for the FY 17 contracts, and are still working to meet the 9/15/16 implementation date.

SOCIAL AND DEMOGRAPHIC FACTORS

Population

The overall populations of both counties have remained relatively stable over the last twelve years. Using 2000 and 2010 Census figures, there was a 3.1% decrease in the total population of Erie County and a 1.1% increase in Ottawa County. Based on the 2010-2014 ACS, the total population of Erie Co. is estimated at 76,416 and Ottawa at 41,304. Thus, as of the most recent data, the catchment area for our Board is comprised of 117,720 people; about 35% Ottawa Co. residents and 65% Erie Co. This is important relative to allocation of funds, as we are diligent in ensuring that all per capita and local dollars are contracted on this basis.

In terms of diversity, for people reporting one race alone 95.7% of Ottawa County residents were White, 1% (396 persons) were Black or African American, and the rest were spread among the remaining categories; in Erie County, the number reporting their race as White was 86.9%, and 8.1% (6221 persons) Black or African American. Of the total population, the percent in Erie County of any race reporting Hispanic or Latino was 3.7% (2839 persons), and in Ottawa County, 4.6% (1905 persons).

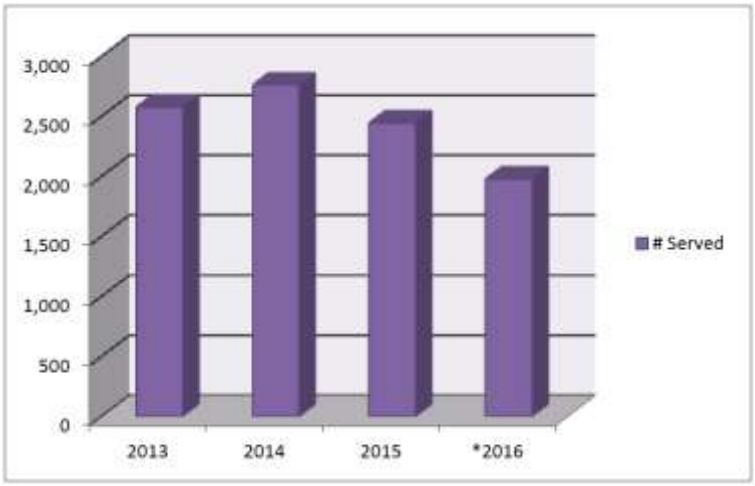
As is evident, there is very little diversity in terms of race and ethnicity in Ottawa County; only 1108 people reported something other than White. While Erie Co. is comprised of a more diverse population, it still falls below that for the state. Of note however is the fact that the majority of people reporting their race as Black or African American reside in the city of Sandusky, the county seat. Using the 2010-2014 ACS figures, 83.2 % of Erie Co. residents reporting their race as Black or African American live in Sandusky. Of the city of Sandusky population, 21.49% are Black or African American.

Client Characteristics

The information below is based on data in the BH Module and reflects an unduplicated count of persons—both Erie and Ottawa County residents of all ages—receiving one or more mental health and/or alcohol/drug treatment services through the Board. It is important to note that these figures do NOT include peer/self-help or Recovery support services; supportive

employment; housing and support services; and prevention, education, consultation and intervention services. These services and programs are important components of the mental health and alcohol/drug service continuum. Thus, the actual number of clients receiving services in a given fiscal year is higher than what is reflected below. Since these numbers do not reflect those residents in the Board service district receiving services through Medicaid, it is possible that Medicaid expansion accounts for some of the decrease seen.

Number Clients Receiving Treatment Services



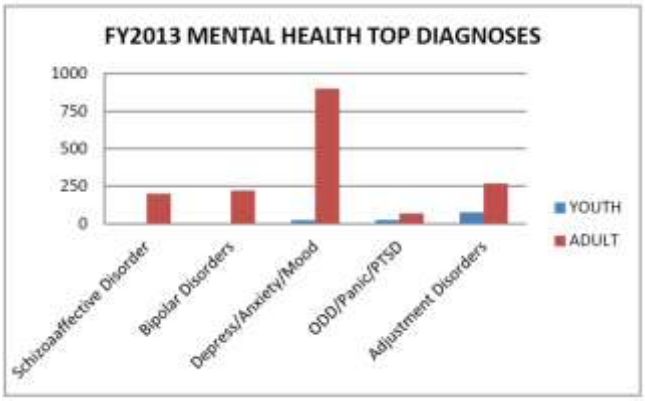
***FY 16 is YTD**

Age, Gender, Race

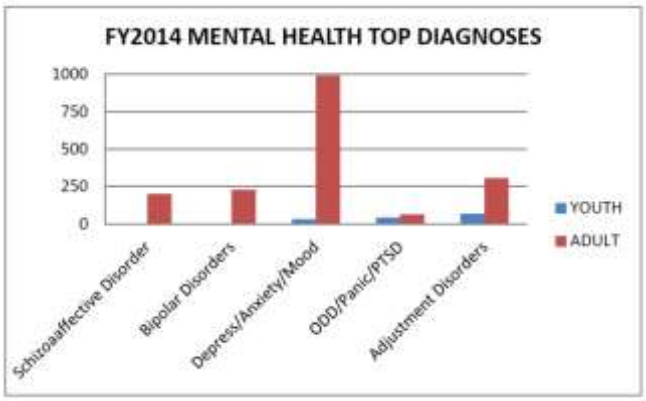
The general proportion of males to females served in the adult (18-64) populations, for mental health and for alcohol/drug services, remained consistent across all three fiscal years examined for this Plan (FY 13-15), however the proportion of males to females served rose compared to previous years. Of those receiving mental health treatment services, about 51-52% were males and 49-48% females (as opposed to 45% male and 55% female for FY 10-12). For those receiving alcohol/drug treatment services, approximately 73-78% of adults were male and 22-26% female (compared to 62% of male, 38% female in the previous period). For youth ages 0-17, the trend was actually reversed for mental health; the proportion of females receiving mental health treatment increased for the period covering fiscal years 13-15 as compared to 10-12, with approximately 51% males/49% females in FY 13, 58/42 in FY 14 and 53/47 in FY 15 vs. 60% male and 40% female historically. The proportion of males to females receiving alcohol/drug treatment services remained stable, about 75% males vs. 25% females with the exception of a slight spike in FY 14 (82% males vs. 18% females).

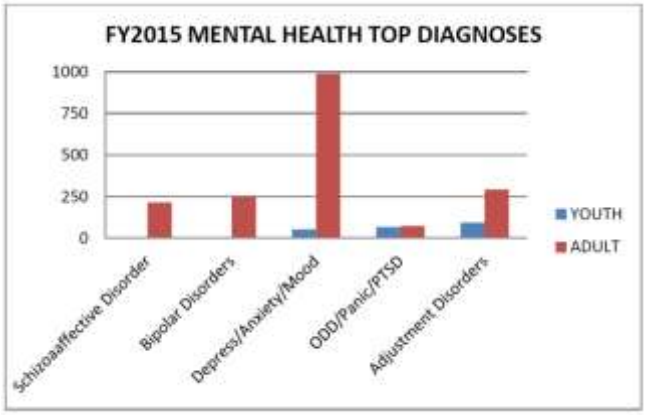
Adults ages 18-64 represented approximately 83-88% of the total population seen for mental health treatment each of the three fiscal years 91-96% for alcohol/drug. Adults age 65 and older comprised about 3-6% of the mental health population and 1-1.5% of the total alcohol/drug population presenting for services. Finally, youth were about 8-11% of the mental health population, and 3-7% of the alcohol/drug population.

In terms of race, we only looked at those reporting themselves as White or Black given the small numbers of clients reporting a different race category, along with the small percentage of the populations of both counties comprised by people reporting a race other than these. For adults 18-64 receiving mental health services, approximately 83% were White and 14-15% Black with the exception of FY 14, in which 90% reported as White and 8% Black. Otherwise, this is consistent with the previous period as well. There was a little more variance in youth, with approximately 79-87% White and 10-14% Black. For those receiving alcohol/drug services, adults ranged from 83-88% White, 11-15% Black and youth ranged from 68-78% White and 15-28% Black.

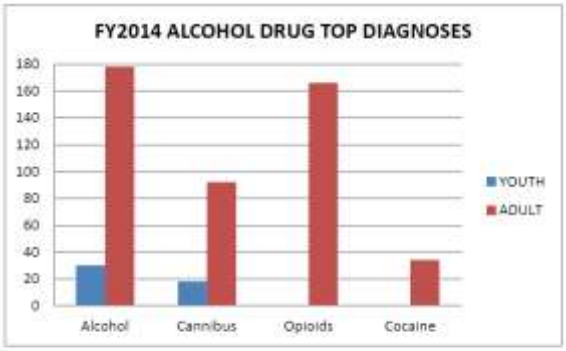


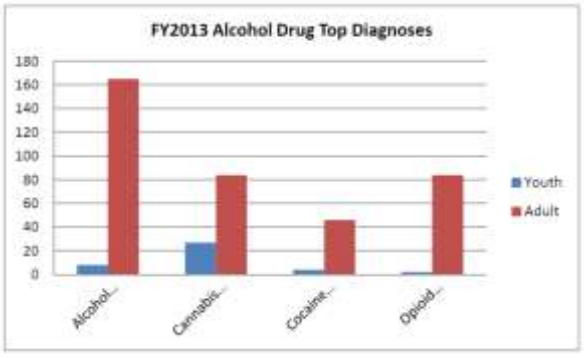
As evident in the graphs, the top mental health diagnoses over the past few fiscal years has remained stable, with the majority of adults seen for issues related to depression, anxiety and mood disorders, followed by adjustment disorders and bipolar disorder. For youth, the majority present with adjustment disorders, followed by oppositional defiant disorders and PTSD and diagnoses related to depression, anxiety and mood.

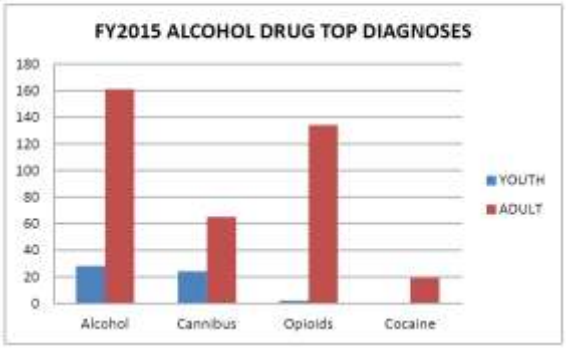




For those receiving treatment services for alcohol and drug use, there have been some shifts in both the youth and adult populations. As clear in the graphs below, the majority of youth seen for treatment in FY 13 presented with Cannabis-related diagnoses, followed by Alcohol-related. Conversely, Alcohol-related diagnoses remain the most prevalent for adults, followed by Cannabis and Opioid related ones at about the same levels. For FY 14 and 15, alcohol-related diagnoses were the highest among youth (62.5% and 51.9% respectively), followed closely by cannabis-related diagnoses. For adults, the percentage with alcohol-related diagnoses remained about the same, however the amount with opioid-related diagnoses increased while the number of cannabis and cocaine- related diagnoses decreased. In FY 13, about 22% of the total number of adults receiving an alcohol or drug treatment service had an opioid-related diagnosis vs. just over 35% in both fiscal years 14 and 15.



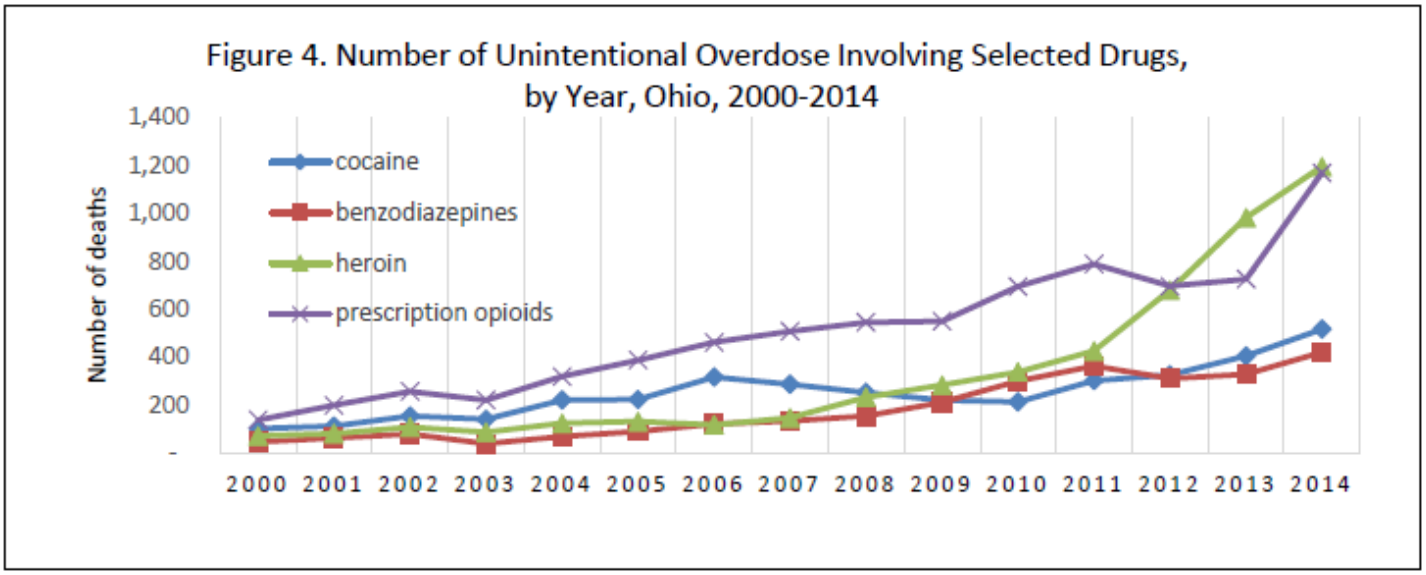




According to the Ohio Department of Health, unintentional drug overdose continued to be the leading cause of injury-related death in Ohio in 2014, ahead of motor vehicle traffic crashes – a trend which began in 2007.

Unintentional drug overdoses caused the deaths of 2,531 Ohio residents in 2014. This is the highest number of deaths on

record from drug overdose and reflects a 20 percent increase compared to 2013 when there were 2,110 drug overdose deaths. The increased illicit use of a powerful opioid called fentanyl was a significant contributor to this rise in drug overdose deaths. As seen in the chart below, opioids (prescription, heroin) are a major factor in the majority of accidental overdoses.



Updated information on the number of unintentional deaths due to overdose for Ohio residents and for Erie and Ottawa County residents is shown below. As you can see, deaths per 100,000 population spiked in Erie County in 2010 then decreased, however rose again in 2013 and 2014 and are almost back at the highest point. Both the crude and age-adjusted rates for the county are higher than that in Ohio. The rate in Ottawa County has remained more stable and is much lower, at about half that of the state.

Number of Unintentional Drug Overdose Deaths of Ohio Residents and Average Crude and Age-Adjusted Annual Death Rates Per 100,000 Population, by County, 2009-2014[1,2]

County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2009-2014 Total	Crude Rate	Age Adjusted Rate	Ratio County to State
ERIE	2	2	3	4	5	6	6	18	12	12	16	17	81	17.6	18.9	1.1
OTTAWA	2	0	2	2	5	2	6	2	4	3	4	3	22	8.9	9.1	0.5
OHIO TOTAL	658	904	1,020	1,261	2634	2699	2698	2718	2872	2985	3119	3400	11294	16.3	16.7	1.0

[1]Table includes Ohio residents who died due to unintentional drug poisoning (primary underlying cause of death X40-X44).
[2]Sources: Ohio Department of Health, Bureau of Vital Statistics; analysis by Injury Prevention Program; U.S. Census Bureau (population estimates).
*Rate suppressed if < 10 total deaths for 2009-2014.

Erie County, including both the sheriff's office and several local police forces, along with the Ottawa County Sheriff's Office,

were early adopters of using Narcan (Naloxone). After Ohio's legislature passed a law allowing law enforcement officials to carry Narcan, the Erie County Sheriff and the Health Department moved quickly in 2014 to make it available. In addition to deputies in the sheriff's office, police officers in Vermilion, Huron, Sandusky, Perkins, Bay View, Kelleys Island and Milan now carry Narcan. According to Health Department records, it has been used by law enforcement 54 times since then to revive overdose victims. In Ottawa County, the Sheriff and his deputies began carrying it in 2014 as well, and it has been used to save people's lives three times. EMS/ambulance crews also carry the life-saving drug, although we don't have that data.

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

Number of Youth Served

Fiscal Year	Total # Youth	# Youth non-Medicaid	# Youth with Medicaid	% Youth with Medicaid
2008	1019	264	755	74.09%
2009	995	231	764	76.78%
2010	973	181	792	81.40%
2011	923	149	774	83.86%
2012	1031	152	879	85.26%
2013	X	177	X	X
2014	X	205	X	X
2015	X	248	X	X
2016*	X	215	X	X

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

***FY 16 is YTD**

While there were fluctuations in the total number of youth served across the period examined, the percent of youth served with Medicaid coverage hovered around 75% for fiscal years 2008-2009 (and conversely, around 25% of the total for non-Medicaid), jumping to 81.4% in FY 10, with slight increases each year thereafter. As noted in the discussion above, a decrease in the number of non-Medicaid youth served post FY 09 was expected as a result of the significant reduction in state revenue the latter part of 09 and in FY 10-11. That is in fact evident here, although there wasn't as much a decrease in the overall number served as the percentage of youth with Medicaid increased during the same period; thus, some of the decrease in numbers can be explained by a shift in payer source. Interestingly, as the chart earlier in this section demonstrates, while the total number of individuals served decreased since F Y 13—barring a spike in FY 14—the number of youth served has actually increased. For adults, this could be explained by Medicaid expansion, as that population was less likely to be covered under traditional Medicaid programs; however, we are not sure what factors underlie the increase in the number of youth receiving non-Medicaid treatment services.

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, gaps in services and disparities, if any.
   a. Needs Assessment Methodology: Describe how the board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and consumers in assessing needs, evaluating strengths and challenges and setting priorities for treatment and prevention [ORC 340.03 (A)(1)(a)].

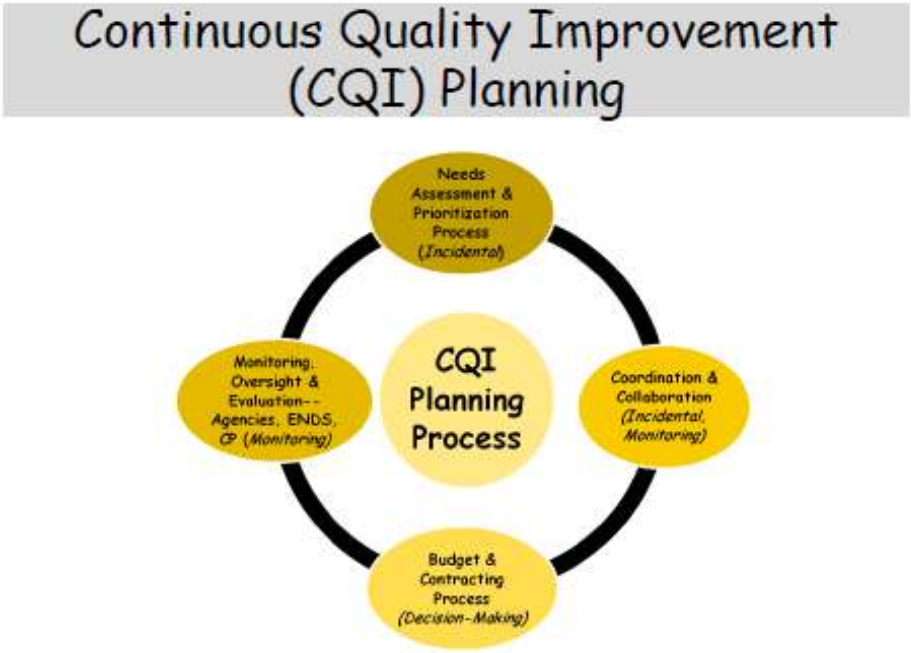
   b. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].

   c. Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].

   d. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.

   e. Needs and gaps in facilities, services and supports given the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

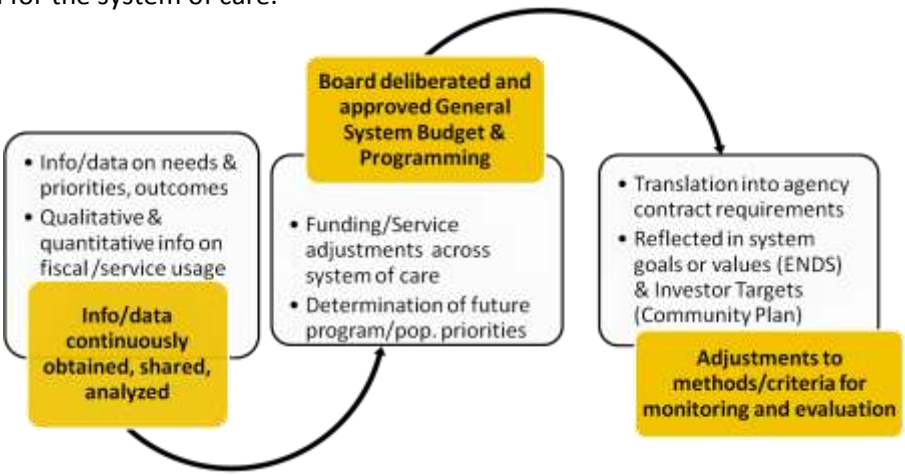
2A. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document)



NEEDS ASSESSMENT PROCESS

The Board employs an outcomes-based or CQI planning framework to ensure that we regularly pay attention to the conditions and constraints that define the need for mental health and alcohol and other drug prevention, treatment and support services—environmental and legislative contexts; the needs of clients, families, and community entities; specific service or program, population and other priorities; and the identification of outcomes and benefits. Activities related to needs assessment, planning, monitoring and evaluation processes occur on a daily basis, via both formal and informal mechanisms. Multi-faceted processes are used to determine current behavioral healthcare needs, to monitor and evaluate the benefits of the system, and to provide information about goals or values, service and program activities, outcomes, and costs. Along with the qualitative and quantitative information and data obtained through the various needs

assessment strategies and activities, information learned as a result of the Board's monitoring and evaluation processes is used to inform decisions around funding priorities. In addition, the Board's ENDS and values (priorities) as set forth in Policy IV-A: Principles, Values and Organizational Purpose of the governance policies provide direction for the determination of priorities, as do priorities and goals as defined by Ohio MHAS.
The goal is to balance programming and funding across system program & population priorities within the context of funding and policy constraints. Results of the various activities are integrated into the CQI planning process and inform individual service/program decisions as well as the development of and changes to the overall continuum of care. Because they are ongoing, there is a continual reassessment of needs, programs and outcomes/benefits and how they will be used to direct the plan for the system of care.



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

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

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

STRATEGY AND METHODOLOGIES

The Board uses a variety of qualitative and quantitative data sources and types, strategies, methodologies, and time frames in the needs assessment process. In addition to formal Board-specific or board-initiated needs assessment activities, staff and trustees work in collaboration with other county and organization needs assessment and strategic planning processes. These partnerships occur in many ways including financial support, representation, and leadership. Furthermore, duplication of effort and expense is minimized and shared investment in the process results in a more cohesive process, the determination of mutual priorities, and the development of a more comprehensive and coordinated plan or response to identified needs or gaps in resources and services. Quantitative data sources include, but are not limited to, the following:

- Service and fiscal utilization data from MACSIS; client demographics & other population characteristics reported in the Behavioral Health Module
- Program/Service information (i.e. quarterly Agency Program Reports)
- U.S. Bureau of Census data—population demographics, poverty, households,

employment, education, income

- County Job and Family Service (JFS) data
- Ohio County Unemployment Rates
- NSDUH, SAMHSA, CDC, ODH—incidence, prevalence
- County Health Rankings, Robert Wood Johnson Foundation
- 2010 Ohio Family Health Survey (OFHS)
- Ohio Automated Rx Reporting System (OARRS) statistics
- My Outcomes, Ohio's Statewide Epidemiological Outcomes Workgroup (SEOW), Ohio Substance Abuse Monitoring Network (OSAM)
- Erie & Ottawa County Community Health Assessments
- Erie County-2011/2012 Children with Special Needs Health Assessment Report
- Erie County Community Health Improvement Plan (CHIP)—2013-2015
- Partners for Prevention of Erie County Coalition Strategic Plan
- Erie & Ottawa County Family and Children First Councils Shared Plans

TOOLS/METHODS:

- Data Surveillance
- Collaborative Initiatives
- Key Informants
- Public Forums
- Surveys
- Focus Groups
- Interviews

GENERAL FINDINGS: ACCESS ISSUES, GAPS IN SERVICES AND DISPARITIES [questions 2 (b)-(e)]

Transportation Barriers—limited public transit services in both counties impact access to services, making engagement with and participation in services particularly difficult for clients with limited resources . This finding was consistent across many surveys and assessments and across many stakeholder groups.

Lack of Specialized Housing and Supports—a critical tool for maintaining community recovery for some individuals is the ability to provide a secure residential setting. Along with increasing capacity for housing and related supports and expanding the continuum of housing categories available locally for clients with SPMI, current needs include: 1) secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label; 2) housing options for individuals with co-occurring developmental disabilities/autism spectrum disorder and mental health/substance abuse issues that are not eligible under the DD system but who need housing; and 3) transitional housing alternatives for both mental health and addiction populations

Case Management and Service Coordination—service definitions for case management and Community Psychiatric Supportive Treatment Services (CPST) are very specific and are based on medical necessity as are all covered treatment services. The clinical focus is very different from case management services provided from the traditional social services perspective and/or from those often allowed in or desired by other systems. Yet these types of supportive services and activities are among those most often identified as needs—primarily by referral sources, and to a lesser extent, clients. This is particularly raised as a concern by representatives of the Criminal Justice System relative to shared clients in the specialized docket programs and those individuals on probation or parole.

Jail Services—Both the Erie and Ottawa County Jails are interested in more services, including MH and AOD groups, exploring the possibility of Telepsychiatry, and reducing some of the requirements regarding an initial face to face psychiatric assessment. Needs/gaps also exist relative to lack of capacity of civil/forensic beds at the State Hospital and lengthy admission times, and numerous/time-consuming medical clearance requirements.

Increased Capacity for Certified Peer Supporters/Recovery Coaches—we have had many requests for a CPS from various programs, community agencies and referral sources. Sometimes this is viewed as a partial solution to the issues of transportation and case management described above, and others it is in response to the recognition of the value of peer support and the desire to provide this additional service.

Ambulatory and Sub-Acute Detoxification and Residential Treatment for Persons with Substance Use Disorders—these

services do not currently exist in the Board service district, and while the Board does allocate funding to both providers of alcohol/drug treatment services to manage access and coordinate care for Erie and Ottawa residents, geographical distance and limited access to available services due to lack of capacity across the State are problematic.

Regarding Ambulatory Detox (required within the board service district), as noted in the previous section, we have been working with our providers for about two years now around adding this service, however we have found that not many providers around the state are really familiar with it, as we (nor our providers) have been successful with obtaining much guidance or technical assistance about how to proceed—even from MHAS—and it does not seem to be very cost effective for the relatively small number of clients in our two-county service district. One of the Board's providers, Bayshore Counseling Services, has been researching Ambulatory Detoxification by looking at settings, levels of care (ASAM), and patient placement according to CSAT/SAMHSA. A number of opioid withdrawal scales have been examined as well. They are looking at providing Level I-D Service: Ambulatory Detoxification Without Extended Onsite Monitoring. This level of care, appropriate for persons with mild to moderate withdrawal symptoms, offers services in an outpatient setting by trained and qualified clinicians who provide medically supervised evaluation, detoxification, and referral services according to a predetermined schedule.

Another of the Board's providers of behavioral health treatment, prevention and support services, Firelands Counseling & Recovery Services (FCRS), is a large hospital-based organization with a continuum of care that includes both outpatient and inpatient levels of care and that provides contract services to the Boards of Huron, Erie-Ottawa, Seneca-Sandusky-Wyandot, and Lorain Counties. It has explored adding Ambulatory Detoxification to the continuum of care it offers, but has found that while this service is vaguely defined, it generally is practiced by physicians utilizing the euphoric MAT of Soboxone maintenance to assist opioid-addicted individuals to achieve detoxification. FCRS has been informed by organizations that have provided Ambulatory Detox with Soboxone maintenance that this approach was found to be largely ineffective, with very poor rates of treatment follow through by individuals who used this service, and was found to be risky since Suboxone addiction is growing. Glenbeigh Drug & Alcohol Rehabilitation, an affiliate of Cleveland Clinic and a contract provider of sub-acute detoxification and residential treatment for Huron County, for example, offered this service for a short time, but discontinued it as ineffective. FCRS' physicians are utilizing the non-euphoric MAT of Vivitrol and individuals beginning Vivitrol must be detoxed from opioids to begin Vivitrol. Use of Suboxone to detox these individuals is seen as unnecessary. No doctors at Firelands will do this. We would welcome OhioMHAS to meet with the Board and its contract agencies to provide information and evidence that this service can be effective and can be done without Suboxone, and to provide general guidance regarding development of the Ambulatory Detoxification service.

Increased Opioid Abuse/Dependence—the upward trend noted in the FY 14 Community Plan has continued, with an increase in the number of persons seeking and receiving treatment services for opioid-related diagnoses. Local providers and referral sources have also noted a larger number of people seeking help for problems with opiate abuse/dependence. Quantitative data from a number of sources provide evidence of the impact use of heroin and prescription opiates and other synthetics is having on Erie an Ottawa Counties as well.

Limited Access to Medication Assisted Treatment (MAT)—Both Board-contracted treatment agencies provide some capacity for MAT in the form of Naltrexone. It is also available through the Erie County Health Department in some capacity, as well as through some of the court programs/jails. There are no Suboxone or Methadone providers. Access for persons without Medicaid is limited.

Lack of Awareness of Community Resources and How to Get Help—despite numerous efforts to the contrary, we continually receive feedback from referral sources, consumers and family members, and the general public that they do not know what services and programs are available or how to access care. There is a perception that treatment services are not available, when in fact adequate capacity exists across the continuum and outpatient services for all populations are available in both counties.

2012 vs. 2016 County Health Rankings Results: While there was much useful information about a variety of health, social

and economic factors and health outcomes, just a sampling is presented here. Erie County's overall ranking in 2012 was 55th (out of Ohio's 88 counties) and 56th in 2016; Ottawa County's was 15th and 27th respectively.

Health Outcome/Factor	Erie 2012/2016	Ottawa 2012/2016	Ohio 2012/2016
Poor Mental Health Days ("Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"; average number)	5.9/4.1	3.8/3.8	3.8/4.3
Excessive Drinking (percent of adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average)	19%/17%	unreliable or missing data/16%	17%/19%
Violent Crime (number of violent crimes reported per 100,000 population including homicide, forcible rape, robbery, and aggravated assault) ** High levels of violent crime compromise physical safety & psychological well-being. High crime rates can also deter residents from pursuing healthy behaviors. Additionally, exposure to crime and violence has been shown to increase stress.*	298/245	63/47	360/307
Children in Poverty (percent of children under age 18 living below the Federal Poverty Line-FPL) ** Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors.*	24%/22%	16%/16%	23%/23%
Children in Single-Parent Households (percent of all children in family households that live in a household headed male or female householder with no spouse present) **Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.*	32%/36%	28%/28%	33%/35%

SERVICE AND SUPPORT NEEDS DETERMINED BY BOARD RECOVERY ORIENTED SYSTEM OF CARE (ROSC) ASSESSMENTS

The Erie-Ottawa Mental Health & Recovery Board (MHRB), along with our peer boards across Ohio, is working to transition Ohio's community mental health and addiction services system into a Recovery-Oriented System of Care (ROSC). A MHRB implementation team comprised of Board and Provider Agency staff was convened to design and implement the survey process, review the results, and conduct focus groups.

Across the month of December, a large and diverse group of community stakeholders were invited to complete a self-assessment to help determine broad-based community strengths and areas of improvement within a ROSC framework. The survey, available for completion online through Survey Monkey and hard copy via pencil/paper, is a prescribed format that all systems in Ohio are using. The survey was sent to a broad and diverse set of community stakeholders identified by the MHRB implementation team. In addition, agencies asked various treatment group participants to complete the survey.

Similarly, individuals in recovery and family members attending support groups at Sandusky Artisans were offered the opportunity to complete the survey. Thus, there was no definitive number of surveys administered. 91 surveys were returned. Of these, 80 individuals answered all of the questions through the first domain; 66 through domain #2; 64 through domain #3; 63 through domain #4; and 61 through domains # 5 & 6. In comparison (of the pilot boards whose results are published), Paint Valley received 21; Stark, 41; Richland, 54; Warren-Clinton, 40; Lorain ADAS, 70; Allen-Auglaize-Hardin, 19; Lake, 77.

Two focus groups were held, one in each county, to assist us with looking at the results, determining priorities, and identifying goals. The MHRB implementation team analyzed the survey data and identified trends, strengths, and areas of improvement. Those findings and the survey data were presented to the focus groups (and Board of Trustees), which included representatives from each of the survey target areas. Additional input was garnered and incorporated into findings. A final "Report to the Community" summarizing the results and areas of consensus was prepared and widely disseminated to community stakeholders.

Key Findings

Strengths

- Multi-disciplinary teams (clinician, peer support, family members, other cross-system partners) work together with the goal of recovery
- Partnerships exist with peer support programs and recovery community organizations and with organizations that provide other resources (i.e. housing, employment services) to benefit those served
- A continuum of prevention, treatment & support services are available in the community
- Behavioral health has an identifiable presence in the community, and is seen as a key indicator in county-wide assessments and surveys
- Stages of Change models and other strength-based approaches are used by providers, criteria for successfully completing and exiting treatment are clearly communicated, and indicators of initial treatment engagement are monitored regularly

Opportunities for improvement

- Consumers, family members, referral sources & agency staff are often unaware of available services and don't know how to access them
- More community education about mental illness & addictions is needed, along with consistent strategies to decrease stigma
- Interim services and more assertive linkages (especially during transitions from jail, hospitals, and after crisis services) using peer-based recovery support staff or case managers are needed
- Lack of high intensity services locally such as detox & residential treatment for persons with addiction
- Need for additional Recovery homes and for transitional housing (for persons with mental illnesses and for those with addictions)

Some areas identified as needing improvement involve services over which the MHRB has no direct control. In these cases it is important to engage community partners to help facilitate change. These include:

- ✓ Transportation barriers
- ✓ Lack of age-appropriate, peer-run leisure activities
- ✓ Need for more proactive, consistent and integrated community response to emerging issues

CHILDREN, YOUTH AND FAMILIES

There is an inherent complexity when addressing social, emotional and mental disorders in children and youth including differences in the primary mission or purpose of the many systems that work together to serve the youth/family; funding issues (within and across systems) including inadequate funding levels as well as separate and restrictive eligibility, service delivery, administrative & reporting requirements; lack of comparable data and integrated information management systems; and issues related to service availability, capacity and coordination. **Examples of key findings and identified needs of this population from qualitative data and interactions with various community partners include but are not limited to the list below. Unless otherwise noted, data is from the latest Community Health Assessments (Erie, 2015; Ottawa, 2012).**

- Timely access to geographically feasible emergency inpatient psychiatric hospitalization services
- Availability of non-clinical services and supports for families (i.e. in-home behavioral interventions, respite care)
- Services for younger children with serious emotional disturbance (ages 8-11)
- Community alternatives to costly out-of-county placements in residential treatment facilities or foster homes
- Parenting Programming: education, training, mentoring, supportive services

> While the percentage of both Erie and Ottawa youth seriously contemplating and/or attempting suicide remained stable or slightly decreased, 10% reported struggling with thoughts of suicide. Furthermore, the number of youth reporting they felt sad or hopeless almost every day for two weeks or more in a row increased in both counties to about 25%, and about 20% of youth in each county reported they have purposefully hurt themselves by cutting, burning, scratching, hitting, biting, etc at some time in their life. These numbers were higher when only looking at females.
>
> ------Erie & Ottawa Co. Community Health Assessments

✓ Underage drinking is a problem, more so Ottawa County than Erie County. According to the 2012 Ottawa Co. Health Assessment, that more than half (59%) of all Ottawa County youth (ages 12 to 18) have had at least one drink of alcohol in their life, increasing to 81% of those ages 17 and older; per the Erie County 2015 Assessment, one-third (33%) of all Erie County youth (ages 12 to 18) had at least one drink of alcohol in their life, increasing to 53% of those ages 17 and older

Given that the majority of youth who drink reported that a parent or someone over age 21 gave it to them or bought it for them, addressing this community problem will require a commitment to the enforcement of minimum legal age drinking laws and constant education of vendors, servers, and parents/guardians

✓ Abuse of prescription and/or OTC medications is a problem, as 14% of youth in Ottawa and 6% of youth in Erie reported using medication that was not prescribed for them or taking more than prescribed to feel good or get high at sometime in their lives, increasing to 30% of those over the age of 17 in Ottawa and 13% in Erie

According to the National Institute on Drug Abuse, youth who abuse prescription medications are also more likely to report use of other drugs

✓ In 2015, 8% of all Erie County youth had used marijuana at least once in the past 30 days, increasing to 17% of those over the age of 17. In Ottawa County, 9% and 21% respectively.

✓ Safety and violence are concerns as well, with nearly half of youth in each county reporting they had been bullied in the past year (42% Erie, 50% Ottawa) and nearly a quarter reporting they had been involved in a physical fight (21% Erie, 26% Ottawa)

✓ Erie County parents discussed the following topics with their 6-11 year olds: negative effects of tobacco (80%), negative effects of alcohol (75%), negative effects of marijuana and other drugs (66%), and refusal skills (54%). 14% of parents did not discuss any of the topics above with their 6-11 year old *(Source: 2010 Erie County Children (Ages Birth-11) Health Assessment)*

✓ 60% of Erie County youth thought there was a great risk in harming themselves if they smoked one or more packs of cigarettes per day

✓ 38% of Erie County youth thought there was a great risk in smoking marijuana once or twice a week vs. 77% who reported their parents would feel it was very wrong for them to use marijuana

ADULTS

Feedback from both community members and key stakeholders indicates that timely access to services—assessment, treatment, and psychiatrist/medication—are important. Similarly, the availability of crisis intervention and hotline services, "safe-site" locations for crisis/emergency assessments, and suicide risk assessments were deemed critical. Access to detoxification services and residential treatment for substance use disorders—especially heroin and other opiates—has also been identified as a need by various stakeholder groups including courts, consumers, family members and coalitions or task forces. Many people/agencies expressed a lack of information about what resources are available in the community and how to find out, emphasizing the need for education and public awareness. Finally, an increased need for outreach, engagement and linkage services has been identified, partly as a result of the Conestoga Program, a neighborhood-based community development initiative of which the provision of mental health and alcohol and other drug treatment services to identified individuals in the target area is a primary component.

Quantitative data from a variety of sources substantiates these needs and provides additional valuable information about the scope and degree of alcohol and other drug use and mental health related problems. A sample of key findings is presented below.

OTTAWA COUNTY ADULTS (2012 Community Health Assessment)

Mental Health Related Findings

- In the past year, 11% had a period of two or more weeks when they felt so sad and hopeless nearly every day that they stopped doing some usual activities
- 8% were diagnosed or treated for a mood disorder in the past year, 4% for an anxiety disorder, less than 1% for a psychotic disorder, and 1% for some other mental health disorder; 8% indicated they had taken medication for one or more mental health issues
- 5% considered attempting suicide in the past year; 1% attempting

Alcohol/Drug Related Findings

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

ERIE COUNTY ADULTS (2013 and 2015 (in red) Community Health Assessments)

Mental Health Related Findings

- In the past year, 10% 10% of adults had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities
- 2% 3% considered attempting suicide, with less than 1% 1% attempting
- Erie County adults received the social and emotional support they needed from the following: family (79% 78%), friends (65% 68%), church (27% 28%), neighbors (12% 12%), a professional (8% 7%), internet (5%), community (5% 4%), and self-help group (1% 1%)
- 8% 6% of Erie County adults used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems. Reasons for not using such a program included: could not afford to go (4% 4%), other priorities (3% 2%), co-pay/deductible too high (2% 2%), stigma of seeking mental health services (2% 3%), fear (2% 2%),primary care doctor had not referred them to a program (2%), transportation (1% 1%), had not thought of it (1% 8%), did not know how to find a program (1% 1%), and could not get to the clinic/office (<1%). 79% 76% of adults indicated they did not need such a program.

The number of adults reporting the reason for not using a program or service to help with a mental concern because they had not thought of it rose from 1% to 8%. This suggests a need for broader education on recognizing signs and symptoms of a mental health issues and the efficacy of treatment and support services.

Alcohol/Drug and other Addiction Related Findings

- 15% 19% were considered frequent drinkers (drank an average of three or more days per week, per CDC guidelines)
- 34% 39% of adults who drink had five or more drinks on one occasion (binge drinking) in the past month.
- 6% 7% of adults reported driving after having perhaps too much to drink
- 8% 10%had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months
- 1% 3% had used recreational drugs such as cocaine, synthetic marijuana/K2, heroin, LSD, inhalants, Ecstasy, bath salts, and methamphetamines during the past 6 months
- 7% 9% of Erie County adults had used marijuana in the past 6 months

Of concern, there was an increased report of use in each category between the 2013 and 2015 surveys

Gambling

A question on gambling was included for the first time in the 2013 survey, with 49% 47%of all adults reported gambling in the past year: Lottery (40% 36%), casinos (19% 15%), at home with friends (7% 4%), at work with coworkers (6% 5%), bingo (3%), online (2% 1%), horse track (1% 1%), dog track (1% <1%), and other types of gambling (1% 2%).

African-American Population (2015 Health Assessment)

- Erie County African American adults were more likely than Whites to have rated their health status as fair or poor (37% compared to 12% of Whites)
- 9% of Erie County African American adults did not have health care coverage, compared to 6% of Whites
- 32% of African Americans have been limited in some way because of a physical, mental or emotional problem compared to 29% of Whites
- Erie County African American adults were more likely than Whites to:
  - Have used marijuana in the past 6 months (15% compared to 9% of Whites)
  - Have misused prescription drugs in the past 6 months (20% compared to 9% of Whites)
  - Be a current smoker (31% compared to 19% of Whites)
  - Have seriously considered attempting suicide (7% compared to 3% of Whites)
  - Have attempted suicide (3% compared to less than 1% of Whites)
- Erie County African American adults were less likely than Whites to:
  - Have consumed alcohol in the past 30 days (43% compared to 65% of Whites)
  - Be considered a binge drinker (9% compared to 24% of Whites)
  - Have driven after having perhaps too much to drink (5% compared to 8% of Whites)

SPECIAL POPULATIONS

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

- ✓ Jail Services—both the Erie and Ottawa County Jails are interested in more services, including MH and AOD groups, exploring the possibility of Telepsychiatry and reducing some of the requirements regarding an initial face to face psychiatric assessment
- ✓ Issues around psychiatric medications were identified as particular concerns—the cost to jails, prescriptions/supply

upon release of inmate, timeliness and notification relative to linkage with agency for Pharmacologic Management Services, issues relative to payment and type of medicine when transfer occurs to CBCFs

- ✓ Linkage and transition to community services for persons being released from jail/prison
- ✓ Issues around State Hospital Bed Availability: length of time for admission can be multiple days; numerous and time-consuming medical clearance requirements, from jail and from probate

ADULTS WITH SPMI

- ✓ Sustainability of Consumer-operated and Peer/Self-Help agencies
- ✓ Housing and related supports
- ✓ In terms of treatment services, availability of case management, psychiatrists and pharmacological management services, and medications were identified as most important

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

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

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

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

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

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

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

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development.

3. Strengths:
   a. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment?
   b. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

a) Business Operations:
For the past several years, the Huron County MHAS Board has contracted for Financial Management and MACSIS services from our board. These shared business operations provide us with additional financial resources and collaborative knowledge sharing concerning State and local issues. The Huron County Board receives financial services, claims processing services and collaborative knowledge sharing. Furthermore, the alliance has resulted in improved efficiencies for both boards and provides a backup system for the smaller board. For FY 17, the Huron County Board is interested in purchasing recovery housing stays for their residents referred for the service by its AOD treatment provider, Firelands Counseling & Recovery Services (also an Erie-Ottawa Board provider).

The Board was successful at the ballot in November 2014 for a five-year renewal plus an additional 0.20 mills, commencing in 2015 and first due in CY 2016. We have a .7 mil that was last replaced on 11/7/2006 for ten years and expires in 2016. The Board is currently exploring the various options related to this levy, and will be placing it on the ballot this November. Levy collections represented 59% of total revenue in FY 15. Having a robust levy has been and continues to be a strength that many board areas do not possess. This has enabled our behavioral health system to weather many of the recent cuts in state/federal funding and to initiate or continue programs that would not otherwise qualify for funding from other sources. It has also allowed us to provide additional funding for addiction services beyond state and federal allocations (much less robust than mental health allocations) and to continue funding for important prevention, education and Recovery support services. Finally, the levy allows for a subsidized payment schedule for Erie and Ottawa residents, based on the updated FPL.

Service Delivery: The Board's network of contract service providers is also a strength of the local system of care. We have two treatment agencies that provide both mental health and addiction services for youth and adults, and both have sites in Erie and Ottawa Counties. This allows for consumer choice for general outpatient or routine services and also facilitates access to care geographically. Additionally, prevention programming is provided through these two agencies, one primarily focused in each county. Both are certified through the (now former) Departments of Mental Health and of Alcohol and Drug Addiction Services and have national accreditation through CARF. In addition, they are stable and mature organizations, professionally managed, and financially secure. Crisis/emergency services are centralized, with our largest agency serving as the provider for the system of care. Similarly, a single agency manages the majority of the funded housing for clients with severe and persistent mental illness. The exception to this is funds for clients in out-of-county placements that are administered through "pass-through" contracts with our primary mental health providers.

We also have three providers of peer/self-help and Recovery support services, fulfilling a valuable role in the local continuum of care. We are fortunate that we were able to sustain these services and programs during the budget cuts several years back, when many areas around the state were forced to streamline services and focus on clinical and "core services" at the expense of equally important prevention and support services. Erie Shore Network is a non-profit organization that provides peer support and advocacy service for adults with Serious Mental Illness (SMI) in Erie and Ottawa Counties and strives to create, strengthen, and reinforce the mental health of its members through community actions and contributions toward the strengthening and betterment of society. Oak House Clubhouse is a non-profit organization that strives to enhance community outreach to individuals suffering from emotional or mental illness. The agency provides a variety of peer support activities, crafts, trips and a full social program for adults with mental illness in Ottawa and Erie Counties. Sandusky Artisans Recovery Community Center (SARCC) provides a range of Recovery support, peer and self-help services to persons suffering from substance use disorders and mental illness. The agency hosts many 12-step and other meetings including AA, CA, NA, CoDA, Al-a-Non, Al-a-Teen, and the Family-to-Family program. A variety of art classes are also available for children and adults of Erie and Ottawa Counties, including classes specifically for adults with Serious Mental Illness. Additional programming includes services to youth in the Juvenile Community Correction Facility, services to persons on parole transitioning back into the community, and Camp Recovery. SARCC has also been instrumental in training Certified Peer Supporters and coordinates a roster of trained individuals locally as part of the effort to expand peer services across the local continuum of care.

Vocational Rehabilitation Program- Through the OOD VRP3 program, Erie/Ottawa exceeded all deliverables for FY2015. The biggest accomplishment was successfully placing 57 individuals! The Board also provides funds in the non-Medicaid contract for vocational services for populations not included in the OOD program. The contract agency, Firelands, also started providing vocational services in the Juvenile Detention Center. They plan to add this service to the jails in the upcoming year. Below is one of the success stories:

> Alphonso is a 58 year old male from Sandusky, Ohio (Erie County) who has been in and out of prison since he was 18 years old. He was sentenced to 35 years in prison and served all of that term. Aphonso got out at 55 years old. He was homeless and did not have a job. Through the VR program, Alphonso obtained the appropriate skills needed to maintain work. Alphonso completed classes to be certified as a peer specialist and was able to obtain a job as a peer specialist working with at risk youth. Alphonso is thankful for all the VR program did for him and he likes the fact he may be able to help kids. Alphonso was able to save enough money to get an apartment and is currently saving for a car. This program has completely changed his life. Alphonso has been a peer specialist for about 5 months and absolutely loves his job and being able to share his story and help others turn their lives around.

Planning Efforts: The Board continues to build on collaboration and partnerships both within its service provider network and across systems to address the findings for our community's alcohol, tobacco and other drug use needs. The Board and providers meet regularly in CQI Planning or Systems Integration meetings to discuss and problem solve various ongoing needs in our community, to review monitoring and evaluation data for reports to the community and Board of Trustees, and in collaboration around special projects. In December 2015-January 2016, the Board and agencies worked together to administer the ROSC survey to a diverse group of community stakeholders and conducted two Focus Groups, one in each county, to gather feedback on the results and priorities. The Board also works in collaboration with many community partners and other county service systems, described in more detail in response to Question #8.

(b) We would be willing to provide assistance to Board and Department partners on any area in which it was felt we could be of assistance. We utilize our membership with the Ohio Association of County Behavioral Health Authorities (OACBHA) for peer sharing on a regular basis. Additionally we have found OACBHA to be a valuable tool when we may have a need that they will find another board in Ohio that is always willing to share their assistance

4. Challenges:
    a. What are the challenges within your local system in addressing the findings of the needs assessment,

including the Board meeting the Ohio Revised Code requirements of the Continuum of Care?

b. What are the current and/or potential impacts to the system as a result of those challenges?
c. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

Items related to the Continuum of Care were discussed under Question #2. In the last Plan we talked about the challenges of recruiting and retaining Board members. Luckily, that has changed, and for the past two years we have been at or near the full complement of Board members at eighteen. Some new challenges have arisen related to that however, specifically in regard to the influx of new members, the lack of collective tenure, and the relative inexperience on the Board of Trustees. In addition, the current Board isn't happy with the adopted Carver policy governance structure, nor with the way that financial reports have historically been prepared. As a result, a lot of time and attention at Board meetings is spent on these issues, often at the expense of scheduled agenda items related to Continuous Quality Improvement planning (i.e. results of needs assessments, priorities, outcomes, and services). Consequently, many board members are feeling a disconnect with the planning process and wish to be more involved in the detail of establishing priorities and making funding decisions about specific programs and services.

Additional challenges are:

- Transportation is a more extensive issue than can be addressed by the MH system, but impacts ability of clients to get to counseling sessions, and to employment and medical appointments. We are working with our contract agencies to provide funds for vouchers for public transportation and taxis, and with one of our consumer organizations around procurement of a van to help with transportation of its members. Exploring the use of Recovery Coaches and Peer Supporters has been proposed as a partial solution to aid in this problem as well.

- Challenges with financial projections and multi-year budgeting given major changes and shifts in focus (Hot Spot and regional vs. in service district), inability to project impact of Medicaid BH Redesign on board areas.

- Issues with civil/forensic bed capacity at the state hospital, long admission times and cumbersome medical clearance requirements are resulting in access and capacity issues for inpatient psychiatric care; this has been especially problematic relative to the jails and probate court. The state has no known contingency plan for when all state beds reach capacity.

- It would be very helpful if the state department set the vision for the community behavioral health system. We need a unified vision that includes the state department, boards, providers and managed care entities. Because the system lacks clear vision, we tend to be reactionary to all other changes including the continuum of care requirements and BH Redesign.

- The state department needs to take a leadership role around physician recruitment, training for primary care physicians (MAT) and workforce development, as local boards on their own cannot impact these issues.

- Penetration of those with mental illnesses and substance use disorders into the criminal justice system, with the jails often being used as pseudo "detox" centers; despite strides made through cross-systems collaboration, investment in jail treatment services, and programming and other diversion efforts at each point of contact we continue to see opportunities for improvement.

- Placement problems with consumers having co-morbid DD/MH who exhibit behavioral problems that include physical acting out and/or those with sex offenses continue to pose challenges to both law enforcement and local providers.

- State requirements (continuum of care, state priorities) often limit communities in setting local priorities, particularly if they are not in alignment. It takes a lot of resources (staff time, resources, planning) to implement state and legislative mandates, often for them to be reversed or terminated the next fiscal year (i.e. "Hot Spot" collaborative/regional planning vs. "in service district" requirements of Continuum of Care), and often with little value added to the local continuum of care. Boards are statutorily vested with the powers and duties to assess community behavioral health needs, set priorities and fund services and facilities in their service district; it is a challenge to meet that mandate when the state superimposes its own priorities over those that are locally derived based on analysis of needs assessment data.

5. Cultural Competency
    a. 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.

Population and client characteristics were discussed in the response to Question #2, and disparities in findings as a result of race found in the 2015 Erie County Health Assessment were presented under Question #3. As a reminder, the overall population of both counties is predominantly White. Approximately 1% in Ottawa County reported their race as Black, and 4.6% Latino; 8.1% and 3.7% respectively in Erie County. The County seats of Port Clinton in Ottawa County and Sandusky in Erie County are the most diverse.

Contracting includes the provision of services from the Center for Cultural Awareness to engage the local minority population and thus facilitate entry into certified treatment programs. This leadership helps act as a "Front Door" through which stigma can be reduced and therapeutic enrollment increased.

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

Furthering our system's efforts to focus on the individual to ensure quality service delivery, in 2011 we began using the *Partnership for Change Outcome Management System* (PCOMS), or *MyOutcomes* system. It directly involves clinicians and clients in an ongoing process of measuring and discussing both progress and the therapeutic alliance. PCOMS, a SAMSHA-recognized evidence-based practice, includes two measurements: the Outcome Rating Scale (the ORS**)** and the Session Rating Scale (the SRS). The ORS looks at how the client perceives their own "well-being" using four scales that measure: 1) individual well-being/distress; 2) interpersonal functioning specific to intimate/family relationships; 3) social functioning/distress indicating issues in school/work/friend relationships, and 4) a general overall measure. The SRS also use four scales to measure the client's perception of the session and the relationship with the therapist, often called the "alliance". Importantly, this process lets the therapist know the client's perception of several indicators of success in therapy: 1) the relational bond; 2) the degree of agreement between the therapist and client about the goals and tasks of therapy; 3) the fit between the therapist's approach and the client's expectations; and 4) how the client perceived the outcome of the session.

Agency hiring practices include outreach and recruiting efforts which encourage minority hiring in accordance with standard AA procedures. EEO success is demonstrated, at least in part, by the fact that all three major treatment agencies have directors who are by gender members of protected classes. For the Board staff itself, 2 of 3 executive positions are held by such members.

Finally, the system of care works to reach out to the to the diverse racial, ethnic, and cultural groups in the community by

all of the policies and procedures above, along with public relations and education efforts to dispel stigma, and promote Recovery. “Treatment works. People Recover” is the message, and opportunities are continually sought for speaking engagements, civic functions, and neighborhood gatherings to promote that goal, for all people and cultures in Erie and Ottawa Counties.

Priorities

Priorities for Mental Health & Recovery Board of Erie and Ottawa Counties				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)				__ No assessed local need __ Lack of funds __ Workforce shortage _X_ Other (describe): (very low numbers) this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider.
SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)				__ No assessed local need __ Lack of funds __ Workforce shortage _X_ Other (describe): (very low numbers) this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider.
SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority				__ No assessed local need __ Lack of funds __ Workforce shortage _X_ Other (describe): no specific goals/strategies selected, however

for children at risk of parental neglect/abuse due to SUDs)				this population is being served; Board/providers collaborate with Erie and Ottawa JFS', Specialized Docket Court Programs that serve this population
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				_X_ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure access to a full continuum of treatment services	• Provide funding for a full continuum of outpatient treatment services in Erie and Ottawa County • Provide 24/7 crisis services and inpatient hospitalization as needed through access to Board's emergency/crisis system • Increase on-site services at Erie Co. Detention facility to five days/week, including continuation of the Job Club began in the 4th quarter of FY 16 • Continue service provision and collaboration with Erie and Ottawa County Specialized Docket Court Programs; on-site assessment programs	Service Utilization Data (# served by program/service) Juvenile Court Data	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Ensure access to a full continuum of treatment and recovery support services, thereby: • Decreasing # days hospitalized/LOS • Improving functioning	• Provide funding for a full continuum of inpatient and outpatient treatment services including specialized programming such as Partial Hospitalization, SAMI Group, Recovery Group and STEPPS • Provide funding for housing and related supports (i.e. case management, CPST focused on	Service Utilization Data (# served by program/service) State Hospital Utilization Data; Data for Rescue and FRMC-1South MyOutcomes data	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		development of life skills), vocational services, peer support and mentoring		
MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing				_X_ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	Improve engagement of older adults into the MH/AOD system	• Creation of a senior outreach program through the formation of partnerships with key stakeholders including APS, Serving Our Seniors, and local law enforcement. • Provision of consultation to aforementioned systems and participation on Elder Abuse Prevention Task Force in both Erie and Ottawa Counties. • CPST engagement to outreach older adults in their homes or other community settings to build rapport and engage into services • Board funded therapy services if necessary to remove barriers imposed by Medicare restrictions.	Tracking of consultation hours by groups Service data for adults age 65 and older	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	• Ameliorate symptoms of incarcerated individuals with mental illnesses/SUD • Improve follow-up with treatment upon release • Reduce recidivism	• Increase MH services at Erie Co Jail to 3 days/wk and to 2 days/wk in Ottawa Co; Increase AOD services at both Erie and Ottawa Co Jails to 5 days/wk. Services include assessment, individual and group treatment. • New Liaison Position:	# services delivered in jails (assessments, individuals and group treatment services) # (unduplicated) individuals served # seen in agency after release # re-arrests/re-incarcerations	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Therapist/Case Manager will schedule appt. with client at agency prior to release, and track attendance in outpatient services; identify barriers; re-engage if necessary. • Introduction of the Job Club in the jails, a program designed to assist those coming into the community from correctional facilities by providing tools and knowledge to conduct a well-planned and thorough job search upon release.		
Integration of behavioral health and primary care services	Increase wellness and physical health of clients in the PLUS program (non-Medicaid Health Home program)	• Provide funds for physical health services such as on-site blood work, outpatient lab visits, occupational and/or physical therapy, or assistance with medication. • Provide wellness initiatives such as health cooking and smoking cessation classes, YMCA, incentives	Physical health indicators Type/cost of lab tests, physical health services # persons served #attending YMCA, cooking/smoking classes	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental or substance use disorders; (e.g. housing, employment, peer support, transportation)	• <u>Transportation</u>: Assist with removal of transportation barrier for agency clients • <u>Peer Support Services:</u> Increased capacity for Peer Support services across the local continuum of care	<u>Transportation:</u> Increase Wrap funding to treatment agencies to purchase transportation vouchers (bus passes, taxi service) to assist MH/AOD clients in accessing treatment and recovery support services. <u>Peer Support Services</u>: Increase funding to treatment agencies to pay for peer supporters to assist with outreach and engagement and to serve as part of AOD service delivery teams.	<u>Transportation:</u> Dollars spent Persons served <u>Peer Support</u>: # services provided # individuals served Qualitative description of services provided (for use in further development of our system wide peer support program)	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)				_X_ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	• Increases access to alcohol/drug residential treatment and detoxification services • Increase access to MAT in Board service district	• Increase funds to treatment agencies to coordinate access to Levels of Care II-IV and as well as linkage to outpatient and recovery support services upon discharge • Continue to explore models of Ambulatory Detoxification and local feasibility based on ASAM, NIH and ongoing discussions with MHAS in preparation for July 2017 implementation date • Support building of local detoxification facility by Erie County Health Department/Erie County Community Health Center • Increase funding for MAT for Board-funded treatment agencies to serve uninsured, underinsured and indigent populations, provided physician resources can be secured	# persons served #/type of services provided ODH data (unintended accidental overdose deaths_ County Coroner Data Use of Narcan data locally (reversed overdoses)	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Promote Trauma Informed Care approach				__ No assessed local need __ Lack of funds _X_ Workforce shortage __ Other (describe) Provider agencies and some other local systems (i.e. court, JFS) have received training on TIC and there are some discrete programs/services that have been implemented; no systemic approach has been undertaken

Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Strengthen families and parents through education, training and skill-building	• Provide funding for parenting programs—Put Parenting First, Parent Project, 1-2-3 Magic • Expand continuum to Whole Child Matters (grant program)-focused on provision of ECMH consultation services in Mills Elementary (Sandusky), Bataan Elementary (Port Clinton) and at Family Health Services (FQHC, Erie) to help at risk children ages 3-6 increase their social and emotional development. • Create opportunities for parent mentoring and support through collaboration with FCFCs • Maintain capacity for school-based services (classroom and individual prevention services) including Life Skills	Data Surveillance/Trend Analysis (measures reported in Community Health Assessments by youth on use of alcohol in lifetime, where they got it, etc.), service utilization data, juvenile court data (i.e. charges related to underage substance use or where underage substance use was present), pre and post tests	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Increase awareness of mental illness and reduce stigma	Delivery of three Mental Health First Aid (MHFA) trainings (Children and Adults sessions), to a minimum of 50 people in Erie and Ottawa Counties. MHFA is a program on SAMHSA's National Registry of Evidence Based Practices.	# of people attending/completing #/location of training sessions, type of session (children or adult)	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Suicide prevention	Increase number of persons receiving suicide prevention training in Erie and Ottawa Counties by 400% to 250 adults/youth	Expansion of Question Persuade Refer (QPR) Suicide Prevention Program **(also an NREPP program, and applicable in the category above as well)** focused educating people on the common causes of suicidal behavior and on how	# youth/adults receiving training	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		to identify/recognize the warning signs of a suicide crisis and how to question, persuade and refer someone to help.		
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations				__ No assessed local need __ Lack of funds __ Workforce shortage _X_ Other (describe): no specific goal, but Bayshore is already doing

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Ensure community awareness of available services and resources	Increase knowledge of family members, referral sources & agency staff about what services are available in the Board system, who is eligible, and how to access them	• Creation of a standardized, formal "Board System 101" training held quarterly, targeting these populations, that describes services and resources available from Board-funded agencies, who is eligible for services, and how to get help and schedule appointments. by Board and Sandusky Artisans Recovery Community Center • Obtain commitments from JFS, Probation, Contract Agencies and others to send staff to first available training upon hire; advertise to community	# of trainings held # of person attending, from what agency/sector # requesting follow up information/contact
Promote healthy neighborhoods	Increase collaborative resources and services in Sandusky's HUD identified neighborhoods, including the Southside area	• Increase involvement of local citizens through continued investment in Conestoga Program, operated by Center for Cultural Awareness • Work with MHRB, Sandusky City Commission and local planning board around focus of local HUD resources in the target area • Continue efforts to secure funding through competitive grant opportunities and/or foundation funds	• Description activities/services provided • Quantitative data (i.e. number of community meetings, number of attendees) related to each of the items

Priorities (continued)

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

Priority if resources were available	Why this priority would be chosen
(1)Construction and Operation of AOD Residential Treatment Center and Transitional Housing Unit for Women	Our current primary provider of alcohol and drug addiction outpatient services for the local system of care, Bayshore Counseling Services, is interested in adding to its current array of outpatient services. This would address an identified gap in the system of care, as currently there is no residential treatment in either Erie or Ottawa Counties. The detoxification facility that the Erie County Health Department is proposing to build will reportedly provide 8 beds for males and 8 for females, and Recovery Housing was added to the continuum of care in FY 16 for both males (Erie and Ottawa County) and females (Erie County). By adding the transitional housing beds (as opposed to Recovery Housing, which is considered permanent housing), the unit could be used as a "step down" from residential treatment if necessary while the women are involved in intensive or regular outpatient treatment services.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	

(11)	
(12)	
(13)	
(14)	

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. (Note: Highlight collaborative undertakings that support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)

As part of the effort to develop and ensure an efficient and comprehensive system of mental health and alcohol/drug services and supports; maximize resources; and improve customer outcomes, staff of the Board regularly interacts, coordinates and collaborates with provider agencies and other community partners and stakeholders. This occurs in a variety of ways, both informal and formal, via a variety of mechanisms (i.e. phone calls; board-hosted, structured meetings around a given purpose; involvement on task forces, committees). Ongoing, timely and current feedback is obtained as a result of this routine but essential interaction and coordination with Key Informants, service and referral agencies and other community stakeholders. Information gained about all aspects of the prevention and treatment service system through these interactions is regularly incorporated into the needs assessment and prioritization process via mechanisms such as Program Reports to the Board, Systems Integration meetings with contract agencies and issue-focused or follow-up meetings around various needs. It should be noted that resource limitations sometimes create barriers for collaboration with other systems; greater collaborations could occur with additional and more flexible resources.

General benefits derived from intersystem collaboration include:

- ✓ Information sharing
- ✓ Joint funding of particular programs or initiatives
- ✓ Increased understanding of the roles, barriers and opportunities relative to various systems
- ✓ Enhanced communication and streamlined referral protocols
- ✓ Consensus around community needs and priorities
- ✓ Identification of gaps in the service continuum
- ✓ Development of strategic plans to address identified community needs

<u>The following list serves as a representation of just some of the entities the board interacts with regularly and a brief description of benefits/results of the collaboration:</u>

- Family and Children First Councils (i.e. Fiscal, Executive and Clinical committees; ad hoc work groups; Wraparound; collaborative plans, shared funding contracts, competitive grant applications)
- Providers (i.e. quarterly CQI/Systems Integration meetings; joint meetings with stakeholders; agency specific issues and/or specialized meetings that are topic driven, such as Ambulatory Detox/MAT or ROSC)
- Erie Co. and Ottawa Co. Health Departments (i.e. Community Health Assessments; CHIP- Community Health Improvement Plans; Drug Free Community Task Force; maternal depression screening; Care-A-Van)
- Ottawa Co. Board of Social Concerns
- United Ways of Erie County and Ottawa County
- Consumers and General Public (Commentary at regular meetings of the Board; Public Forums; Stakeholder Surveys/Focus Groups/Interviews; Conestoga Neighborhood Meetings)
- Law Enforcement (Weed and Seed, CIT, jail programming, meetings with Ottawa and Erie Co. Sheriff's Departments)
- Court Programs/Judges:
  --Erie Co. Juvenile Drug Court & Erie Co. Family Dependency Court (i.e. monthly meetings of Oversight/Planning Committees, programming—Seven Challenges, Case Management)
  --Ottawa Co. Juvenile Court (i.e. Juvenile Court Assessment Program, specialized docket programs, juvenile hospitalizations/transport)
  -- Erie Co. Common Pleas (mental health court planning, Benchmark Drug Court Program)
  --Ottawa Co. Common Pleas (DATA Specialized Docket Court Program, MAT, Case Mgmt, psychiatric meds)
  -- Municipal Courts—various (IDAT referral/funding protocols)
- Elected Officials—local, state

- County Commissioners—semi-annual reports, special meetings (i.e. around submission of grants, levy, funding)
- Civic groups—presentations on resources, services, mental health and substance use disorders
- Erie Co. and Ottawa Co. Departments of Job and Family Services (i.e. coordination of funding streams around eligibility requirements to maximize available services and supports available to youth/families involved with child welfare system; shared funding agreements for youth in placements)

In addition, a representation of various partnerships and mutual endeavors is highlighted below.

BAYSHORE/MHRB/LOCAL SCHOOLS/FAMILY HEALTH SERVICES: Bayshore Counseling Services, along with the Board, worked with a local community health center and various local schools to garner support for submission of a grant application for funding for the addition of on-site mental health consultations services to work with children ages 0-8 years old. Fortunately, Ohio MHAS awarded a $265,387 grant, which will pay for two new mental health consultants, who will work with local teachers at three sites: At Family Health Services of Erie County, a community health center on the south campus of Firelands Regional Medical Center and two local schools (one in each county) yet to be determined. The consultant will provide help when there are factors that could affect school performance such as family poverty, a missing parent, a recent divorce or abandonment. Part of the interventions will be the reduction of stigma related to children who have emotional, developmental, environmental and sensory issues that result in labeling the child rather than the behavior. These are critical services, as preschoolers and kindergartens are expelled at a higher rate than high school students in Ohio, which is in line with the national trend. According to Dr. Valerie Alloy, who leads MHAS' early childhood mental health initiatives, during the 2012-13 academic year, nearly 4,000 out-of-school suspensions and expulsions for fighting and disruptive behaviors were reported for Ohio's kindergarteners. Disruptive behavior can be associated with childhood trauma, abuse and neglect

MHRB/PROVIDERS/ERIE COUNTY SHERIFF, COURTS, and COMMISSIONERS: Working together, the group devised the "Escorted Home Help" program, a collaboration between the CJ and BH system to help stop the revolving door into jail for persons with mental illness, which they are hoping to get funded through a grant application submitted in May under the BJA's "Stepping Up Initiative". The proposal included a request for funding for a uniformed deputy sheriff in a marked vehicle and a mental health social worker to be teamed together for community outreach. This team would work throughout the county on a daily basis to ensure that referred individuals are compliant with medications and are receiving any and all services available in an effort to prevent them from legally reoffending because of their mental illness. By nature of the team's expertise and legal authority, the individual who is non-compliant and/or is discovered to be once again in the midst of a mental health crisis could be immediately taken into custody and safely transported for medical and/or mental health treatment--thereby preventing him/her from becoming violent and/or being once again arrested and confined in the county jail to protect the community. The makeup of this team would also (hopefully) allow for the building of a trusting relationship between the mentally ill individual and a uniformed deputy sheriff, perhaps preventing a violent confrontation in the future between the individual and the police. This team together will also visit persons, on parole or probation, who otherwise would have been referred to the Erie County Jail.

ERIE COUNTY HEALTH DEPARTMENT/ERIE COUNTY COMMUNITY HEALTH CENTER/ERIE COUNTY COMMISSIONERS/MHRB: The Erie County Health Department/Erie County Community Health Center is planning to build a 16 bed (8 men, 8 women) medically supervised detoxification facility in Erie County, with an annual capacity to serve 1200 individuals with a five-day LOS. This endeavor is the culmination of a multi-year planning effort among the above partners, along with the NORTHERN OHIO RECOVERY ASSOCIATION (NORA) and many other stakeholders known as the Circle of Care, which also resulted in the establishment of the Genesis Recovery Housing project for women. It is anticipated that admissions into the detox facility will be both voluntary as well as via judicial referrals. The latter will contribute to the easing of jail over-crowding and treatment in lieu of incarceration. A capital funds request was submitted by the Board to MHAS, and the partners listed above are each being asked to contribute significant funds toward the building/renovation/operation costs. Initial meetings have also occurred among the Board and its contract providers and the Health Department around service delivery and coordination to ensure continuity of care and seamlessness of services between the two systems, as well as around evidence-based practices.

MHRB/CENTER FOR CULTURAL AWARENESS/SANDUSKY CITIZENS AND RESIDENTS OF SOUTHSIDE NEIGHBORHOOD: Center for Cultural Awareness has provided services for the Conestoga program, a neighborhood revitalization effort, in the Southside neighborhood of Sandusky since the end of FY 15. Residents have been very active, focused primarily on clean-up efforts and the drug problem in the area. Lately, the focus has been on working with the Sandusky City Commission and Planning Board in an effort to secure potential resources focused on HUD-neighborhoods, as those, in conjunction with Conestoga resources targeted at the area, could make a significant impact.

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

Inpatient Hospital Management

9. Describe the interaction between the local system's utilization of the State Hospital(s), Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that is expected or foreseen.

The Board contracts with Firelands Counseling and Recovery Services ("Firelands") for emergency services programming for the system of care. Services are available 24/7 for youth and adults and include a crisis hotline, pre-screening, inpatient psychiatric hospitalization (for adults), and transportation service to the hospital/crisis care facility. The Board contracts with Rescue Mental Health Services ("Rescue") for residential crisis stabilization services for youth and adults. The Board also contributes funding for 2-1-1, a 24/7 "warm line" providing information and referral services for Health & Human Services assistance.

The hotline service is the central focal point for the Crisis System across the Firelands service area. The program is run 24/7 and provides information and referral services. It also serves as an initial crisis screen and is able to alert local law enforcement and first responders to emergent situations with residents requiring intervention, and maintains routine contact with consumers that require additional support in the off hours.

Firelands also manages pre-screenings for admission into the State Hospital, local admissions to Firelands Regional Medical Center (1 South), and/or diversion to Rescue. The use of board funding for local admissions to FRMC (1 South) is helpful in securing a local psychiatric admission for those clients who have no other source of payment. When clients are transferred to inpatient units outside of the local area it can cause a hardship for the families and clients. Providing for placement at the local unit allows clients access to their support systems and can assist to ease the process of discharge. Still, while it is the intention of the staff to utilize and place clients seen on crisis to the psychiatric care unit at FRMC, it is at times necessary to divert clients to Rescue Mental Health Services. This is an important component of the continuum as part of the effort to manage inpatient admissions to the State Hospital and for the sake of additional capacity when the inpatient unit at Firelands is full. As manager of our emergency services system, Firelands is responsible for validating the referral and accuracy of invoices prior to the board executing payment to RMHS, as well as with coordination of discharge planning. About 385 individuals are projected to be served through Rescue in FY 17.

The most prevalent reason for diversion to Rescue would be in cases where a bed is not available at 1South. The local system has seen record numbers of admissions over the past several years (FY14 total number of admissions 1543, FY 15 total number of admissions 1542, FY 16 through April 2016 reporting 1236 admissions), a trend which continues to increase and can exceed the local capacity to manage and requires the use of outside resources. The projected number of

admissions to 1South this fiscal year is 1,648. FRMC has a limited number of "special care" beds that are single person rooms with increased capacity for monitoring and behavioral management of patients. Individuals requiring this increased level of care are sent to Rescue for diversion to private hospitals in the Toledo area when all of these specialized beds are occupied. Individuals that have not interacted well with staff and other patients when placed at 1 South are often diverted to Rescue crisis. Some issues which have resulted in diversion to Rescue include theft, bringing illegal substances on the unit, fighting with other patients, sexual, behavioral, or severe boundary issues between patients, and repeated admission to 1 South with little engagement on the unit and no follow through at discharge indicating a clinical need to try a different treatment milieu.

Prior to FY 16, FIrelands discounted one third of all admissions to 1 South per a contractual agreement with the Board. However, a crisis team was added with the primary response area being Erie & Ottawa Counties. From 7/1/15 through 4/30/16 Firelands provided 2,259 crisis intervention services to Erie and Ottawa Counties, projected to be over 3,000 by the end of this fiscal year. This addition significantly reduced wait times for all crisis calls throughout the system due to the volume of crisis that occurs in the Erie/Ottawa service area. Furthermore, increased access to healthcare coverage through the healthcare exchange and expanded Medicaid resulted in an underutilization of inpatient funds previously allocated to the service. For instance, about 68% of the total inpatient funding was used in FY14 and just under 21% of the allocation in FY 15. As of March 1, 2016 FCRS admitted 61 people from Erie or Ottawa Counties to 1 South who were indigent at the time of the admission. In an effort to conserve board monies, FCRS staff worked with the patients to complete the Medicaid application, which resulted in 52 individuals obtaining benefits for healthcare. As a result, we have been able to reduce the overall number of board pay admissions from previous fiscal years. To date, only 9 of the 61 admissions have been billed to the MHRB for FY 2016. Thus, for FY 16, continuing into the FY 17 contract, the Board will pay for all indigent inpatient admissions to 1 South for Erie and Ottawa residents.

As far as utilization of beds at the State Hospital, according to the FY 16 Collaborative Board Bed Day Report dated February 24, 2016 (based on YTD as of January 31, 2016), Erie-Ottawa's average Bed Day Per Year use for FY 12-14 was 3,021; Actual Days YTD were 1,160; Annualized for FY 16 at 1,969, which is 1,052 under the 3-year Average. Some challenges regarding State Hospital admissions, medical clearance and wait times were discussed under Question #4. State Hospital Bed availability has become a problem. Because of the lack of capacity, the length of time to admit to a State facility could be days. This has been a problem for our jails and emergency departments especially. This is true on both the civil and forensic sides. We had an individual with a Court-ordered Restoration who was transported to NOPH by the Erie County Sheriff's Department from the court room only to be turned away because there were no available forensic beds. Medical clearance has also become an issue. The amount of tests required and the length of time to obtain all of the physician orders and get the tests completed—even if the individual is in jail custody—is excessive, adding to the time it takes for admission once a bed even becomes available. This is also resulting in overtime costs for the Sheriff's Departments, as they have to keep a Deputy with the individual at all times, and is also keeping the crisis services team tied up.

The continuation of CPST coverage for physician team meetings, regular contact with discharge planners, and linkage to services immediately following discharge will help to ensure that continuity of care of is not lost between inpatient and outpatient care. In cases where the individual requires more structured programming to increase success in community tenure, referrals to the PHP program can be arranged as part of the discharge plan. The AOD case manager will continue to try to engage clients that are inpatient on one south in an attempt to engage individuals with substance abuse concerns prior to discharge.

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 is believed to benefit other Ohio communities in one or more of the following areas:
    a. Service delivery
    b. Planning efforts
    c. Business operations
    d. Process and/or quality improvement

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

    NOTE: The Board may describe Hot Spot or Community Collaborative Resources (CCR) initiatives in this section, especially those that have been sustained.

Advocacy (Optional)

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

Open Forum (Optional)

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which is believed to be important for the local system to share with the department or other relevant Ohio communities.

Community Plan 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.

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

A. HOSPITAL	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	UPID #	SERVICE	ALLOCATION

SIGNATURE PAGE

Community Plan for the Provision of Mental Health and Addiction Services SFY 2017

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds, and is in effect until OhioMHAS approves a subsequent Community Plan.

The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

_____

ADAMHS, ADAS or CMH Board Name (Please print or type)

_____ _____

ADAMHS, ADAS or CMH Board Executive Director Date

_____ _____

ADAMHS, ADAS or CMH Board Chair Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.)].

Instructions for Table 1, "SFY 2017 Community Plan Essential Services Inventory"

Attached are the SFY 17 Community Plan (ComPlan) Essential Services Inventory and some supporting files to enable the Inventory's completion.

Various service inventories have been included in the ComPlan in the past. The current Essential Services Inventory included with the 2017 ComPlan requires a new element: the listing of services for which the board does not contract. This new element is necessary due to recent changes in the Ohio Revised Code to detail the behavioral health (BH) continuum of care in each board area. The department and constituent workgroups, in pilot studies, have found this information necessary for boards to meet the Ohio Revised Code CoC requirements.

Some additional CoC information resources have been provided (Section VI) to assist in this process, but board knowledge is vitally important given the limitations of these included CoC resources. For example, the attached resources will not address BH services provided by Children Service Boards and other key providers within the local behavioral healthcare system.

Instructions for the Essential Services Inventory

The 1st file is the Services Inventory. The goal is to provide a complete listing of all BH providers in the board area. To be able to proceed, please click on the "Enable Editing" and/or the "Enable Content" buttons, if they occur on top of the spreadsheet, and enter the name of the board in the 1st row.

The spreadsheet lists the ORC required Essential Service Categories in each row. Also in each row are cells to collect information about how each category requirement can be met. The information requested includes:

- Provider Name. Also included in some Provider Name cells are prompts for descriptions of services for which there are no FIS-040 or MACSIS definitions. The prompts request that descriptions of how the Board provides for these services be put in the last column, "Board Notes". The prompts can be deleted to make room for a Provider Name.
- Mandatory individual service(s) that satisfy the ORC Essential Service Category
- Services related to the required category, but are needed to meet local BH needs, rather than the CoC mandate.
- "Yes" or "No" response indicating that the board contracts with the provider providing the service.
- Counties within the board where the provider provides the required "must be in the board area" service; or, out-of-board location when the required service is allowed to be provided outside the board area.
- Populations for which the service is intended to serve; or, for Prevention/Wellness services, the IOM Category.

Except for "Provider Name" and "Board Notes" cells, in which information is manually entered, all the other cells have a drop down menu from which services are chosen, and typed data entry cannot occur.

To use the drop down menu, click on a cell and a downward pointing arrow will appear. Click on the arrow and a drop-down list of services will appear. Click on a service and it will appear in the cell. Click on the service a 2nd time and it will erase the service entry in the cell; or highlight the unwanted service entry and click "Clear Content" from the right mouse button menu. Click on as many services as are needed for each provider cell in the row. Use the slide-bar on the right side of the drop down menu to see all available items in the list.

To add additional providers in a particular Essential Service row, highlight all cells in the row below the needed Essential Service, and click "Insert" from the right mouse button menu. All of the instructions and drop down menus for that Essential Service will be included in the "Inserted" rows.

Additional Sources of CoC Information

1. **MACSIS Data Mart Client Counts by AOD and MH services for 2015.**
   Explanation: If a required service or support is not found in a Board's budget, there may be a number of possible explanations, e.g.:
   a. Variation in how Boards account for services and supports in the budgeting process. A check of the MACSIS Data Mart may reveal budgeted services or supports that haven't been directly captured in the current budget.
   b. Required service or support is delivered by Providers serving Medicaid only clients. The Data Mart will show that the Medicaid paid service or support is being provided within the Board service area even though the Board has no contract with that Provider.

2. **OhioMHAS 2015 Housing Survey.**
   Explanation: Certain required housing categories may not be budgeted, e.g., Recovery Housing, or there may be lack of clarity between required housing categories and 040 reporting categories or specified in the Community Plan. The OhioMHAS Housing Survey brings greater clarity to classifications of housing services and environments and better track provision of those Continuum of Care (CoC) elements in Board service areas.
3. **SAMHSA 2014 National Survey of Substance Abuse treatment Services (N-SSATS), and the**

4. **SAMHSA 2014 National Mental Health Services Survey (N-MHSS).**
   Explanation: SAMHSA annually surveys AOD and MH Providers irrespective of their OhioMHAS certification status. The surveys provide a broad spectrum of information, including the existence of some AOD or MH services or supports within a Board's service district that are required essential CoC elements, but which are not found within the public behavioral health service taxonomy, or are not captured within the Board's budget. These surveys should be reviewed for existing required CoC elements delivered by Providers that are OhioMHAS certified (in network) and those Providers that are not (out of network).

Service Crosswalks between ORC Required Essential Service Category Elements and the Additional Information Sources

Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
A-Ambulatory Detox ‡		OP Detox ASAM Level I.D & II.D	
A-Sub-Acute Detox ‡		Residential Detox ASAM Level III.2-D	
A-Acute Hospital Detox		Inpatient Detox	
Intensive Outpatient Services: • A-IOP ‡ • M-Assertive Community Treatment • M-Health Homes		Intensive OP ASAM Level II.1 (9+ HRS/WK)	• Assertive Community Treatment (ACT) • Primary Physical Healthcare
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
A-Medically Assisted Treatment ‡		• Naltrexone • Vivitrol • Methadone • Suboxone • Buprenorphine (No Naltrexone)	
12 Step Approaches ‡		Clinical/therapeutic approaches Used:.. • 12 step facilitation	
Residential Treatment: A-MCR-Hospital A-BHMCR-Hospital		Hospital IP Treatment ASAM IV & III.7	

Residential Treatment ‡: A-MCR- Non-Hospital A-BHMCR-Non-Hospital	Residential Treatment Medical Community Residence	Residential Short-Term ASAM Level III.5 (High Intensity)	
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Residential Treatment ‡: A-NMR-Non-Acute A-BH-Non-Medical-Non-Acute	Residential Treatment Medical Community Residence	Residential Long-Term ASAM Level III.3 (Low Intensity)	
Recovery Housing ‡	Recovery Housing		
M-Residential Treatment	Residential Treatment-MH		24 Hour Residential (Non-Hospital)
Locate & Inform: • M-Information and Referral			MH Referral, including emergency services
M-Partial Hospitalization			Setting: Day Treatment/Partial Hospitalization
M-Inpatient Psychiatric Services (Private Hospital Only)			Inpatient Services
Recovery Supports: • M-Self-Help/Peer Support • M-Consumer Operated Service			MH Consumer Operated (Peer Support)
Recovery Supports: • M-Employment/ Vocational Services			• Supported Employment Services • MH Vocational Rehabilitation Services
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Recovery Supports: • M-Social Recreational Services			Activities Therapy
M-Crisis Intervention			MH Psychiatric Emergency (walk-in)
Wide Range of Housing Provision & Supports: • M-Residential Care	Residential Care: • Adult Care Facility/ Group Home • Residential Care Facility (Health) • Child Residential Care/Group Home		MH Supported Housing Services
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Wide Range of Housing Provision & Supports: • M-Community Residential • M-Housing Subsidy	Permanent Housing: • Permanent Supportive Housing • Community Residence • Private Apartments		MH Housing Services
Wide Range of Housing Provision & Supports: • M-Crisis Bed • M-Respite Bed	Time Limited/ Temporary: • Crisis • Respite • Temporary		

• Temporary Housing • Transitional	• Transitional		
Wide Range of Housing Provision & Supports: • M-Foster Care	Time Limited/ Temporary: • Foster		• Therapeutic Foster Care
Wide Range of Housing Provision & Supports: • AOD			• See Residential Treatment, above