

**Ohio Department of Mental Health and Addiction Services (OhioMHAS)
Community Plan Instructions SFY 2017**

Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County

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.**

Demographic factors and the evolving policy climate at the state and federal level will continue to provide challenges and opportunities for ADAMH in the provision of quality, timely and appropriate mental health and substance abuse treatment healthcare. Population growth, persistent poverty, changing community demographics, access to care, the changing role of the state government in meeting the behavioral healthcare needs of Medicaid beneficiaries, the impact of consumers utilizing marketplace health plans and ensuring access to services mandated in the Continuum of Care are all factors that will influence service delivery in the coming years. Significant insurance reform including Medicaid eligibility expansion and behavioral health redesign in Ohio, are continuing to have a material impact on the types of services ADAMH invests in for the community. As more Franklin County residents obtain insurance coverage for mental health and addiction treatment services through Medicaid expansion or the ACA marketplace, the demand for ADAMH-paid treatment services is beginning to decline. This transition is allowing ADAMH to increase investments in much needed prevention, evidence-based programs, crisis care and recovery supports (residential, vocational, intervention, etc.) that are not covered by Medicaid.

Demographic Factors

The size of the Franklin County population has grown over the past decade and is projected to increase by 14% from 2015 to 2040. In addition, Franklin County continues to become increasingly diverse, with a significant population of foreign-born persons and limited English language speakers. The number of Franklin County residents who were born outside the U.S. rose from 6% in 2000 to 9.6% in 2014 and households with limited English proficiency comprise 3% of all households in the county. These figures indicate that ADAMH must continue to strengthen and expand culturally competent contract services that are delivered by culturally-capable professionals.

The role of poverty and its impact on access to care and health insurance coverage remains a major factor in spite of the expansion of Medicaid to individuals up to 138% of the Federal Poverty Level (FPL). Persistent poverty continues to be a factor as the percentage of Franklin County residents who live below 200 percent of poverty remains at 35.4% in 2014, a figure largely unchanged since 2012. In addition, “deep” poverty (individuals at <50% FPL) also has remained steady at 8.9% during this time. The prevalence of poverty remains key as literature has strongly established the relationship between mental disorders and socioeconomic status: mental disorders lead to reduced income and employment, which entrenches poverty and in turn increases the risk of mental disorder.

Homelessness also remains a major issue for Franklin County and the ADAMH system of care. The Community Services Board 2015 Annual Homeless Assessment Report indicates 10,093 individuals and children were served in emergency shelters in Franklin County during FY15 and although this number has remained relatively stable since 2013, it continues to exceed the 7,182 served in 2010. Services for this vulnerable population remains a key priority for ADAMH as statistics from the National Alliance for Mental Illness indicate that an estimated 46% of homeless adults staying shelters live with severe mental illness and/or substance use disorders.

Access to Care and the Uninsured/Underinsured Population

As a result of the adoption of Medicaid expansion and the availability of ACA marketplace plans in Ohio, the number of Franklin County residents who are uninsured has dropped significantly, from 16% in 2013 to 9% in 2015, according to data from Enroll America. In addition, the implementation of new federal regulations relating to mental health and substance use disorder parity in Medicaid services and the continuing roll-out of Medicaid behavioral health redesign in Ohio has also extended the shift of expenses for behavioral health treatment expenses away from ADAMH, allowing the Board to increase investments in non-Medicaid taxonomy services. Despite these positive changes, some populations remain uninsured or underinsured and in need of access to quality behavioral health care. In Franklin County, minority populations (African-American and Hispanic) and younger individuals (age 18-34) continue to have higher rates of uninsurance (13%) than the rest of the county. In addition, despite having insurance through an employer or the marketplace, many non-Medicaid eligible individuals continue to be considered underinsured and have difficulty meeting the costs of care. According national data from the Commonwealth Fund, 23% of all insured adults had such high out-of-pocket costs that they are considered underinsured and 44% of adults surveyed indicated that they did not receive care due to cost concerns. ADAMH will continue to play a role in providing treatment services to these uninsured and underinsured populations in the coming year.

Policy Environment

Although Medicaid expansion in Ohio has demonstrated significant success in extending coverage to an estimated 454,000 individuals statewide (as of November 2015), the potential remains for the implementation of policy or administrative options that may reverse these trends and result in the shift of treatment expenses back to ADAMH. The implementation of cost-sharing requirements and administrative decisions regarding eligibility determination are two examples of potential policy changes that can negatively affect Medicaid enrollment with consequences for local funding of treatment services. For example, the proposed "Healthy Ohio" Medicaid waiver submitted by the Ohio Department of Medicaid to the Centers for Medicare and Medicaid Services for consideration would require premium payments by a significant portion of Medicaid enrollees. Projections indicate that adoption of this proposal in its current form could reduce enrollment by up to 15%, leaving many of these individuals to seek coverage through other means or potentially become uninsured. ADAMH continues to monitor the continuing developments surrounding the Healthy Ohio waiver, Medicaid behavioral health and disability determination redesign as well as health care reform in general in order to better serve Franklin County residents who live with mental health or substance abuse issues.

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)].

In 2014, the ADAMH Board of Franklin County selected the Health Policy Institute of Ohio (HPIO) and Community Research Partners (CRP) to conduct its most recent Needs Assessment. The report, completed in September 2014 and updated in April 2015, outlined Franklin County's trends of addiction and mental illness and pertinent behavioral healthcare needs. The Needs Assessment also projected the current and near future (next 5-7 years) need for publicly-funded behavioral healthcare treatment, support and prevention/wellness services for Franklin County residents in the greatest need for services through ADAMH's network of care.

In order to ensure that future investments are aligned with the most pressing needs in Franklin County and that ADAMH's network of providers has the capacity to efficiently deliver high-quality services to those in need, the assessment was designed to address the following general questions:

- Policy changes: Which recent state and federal policy changes are most relevant to ADAMH and how are they likely to impact the number of people needing ADAMH-funded services?
- Demographic trends: How will the demographic composition of Franklin County impact future needs for ADAMH-funded services?
- Type of need: What types of services are most needed?
- Demand: How many people will need services that are funded through ADAMH and which types of services will be in greatest demand?
- Capacity: Where are the current gaps in provider capacity now and where will they likely be in the future?

In order to address these questions, the Needs Assessment utilized the following sources of information and methodology:

- Secondary data, including compilation and analysis of demographic data from the U.S. Census Bureau, prevalence of mental illness and substance abuse/dependence from Substance Abuse and Mental Health Services Administration (SAMHSA), Medicaid enrollment data from the Ohio Department of Medicaid, and service use information from the ADAMH Board of Franklin County and Ohio Mental Health and Addiction Services (OhioMHAS)
- Policy review, including analysis of recent state and federal policy changes that impact behavioral health
- Online survey of providers, including 26 ADAMH network providers and 7 representatives from provider organizations outside the ADAMH network (total of 33 completed surveys, 38% response rate)

- Focus groups with three stakeholder groups: consumers (1 focus group), immigrant and refugee community representatives (1 focus group), and ADAMH contracted service providers (2 focus groups)
- Stakeholder interviews, including initial exploratory interviews with 5 internal stakeholders (1 group exploratory interview with ADAMH Board of Trustees members, 4 interviews with ADAMH board staff and network providers), and 8 interviews with the Chief Executive Officers or Directors of large ADAMH network providers

In developing the Needs Assessment, staff worked in collaboration with more than 33 local non-profit organizations located in neighborhoods across Franklin County that are part of the ADAMH network of care. These community experts provide quality mental health and substance abuse treatment as well as prevention and supportive services such as housing, job training and peer supports. In addition to these contract agencies, ADAMH collaborates with other organizations in the community to help meet the needs of consumers and family members.

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

Not applicable

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

Access to alcohol and other drug (AoD) services – Medication Assisted Treatment (MAT), Ambulatory Detox, Intensive Outpatient Programs (IOPs)

Access to mental health (MH) Services – Partial Hospitalization Program, additional Intensive Outpatient Programs and Peer Support

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

Not applicable

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)].

Based upon inventory of facilities, services and supports provided in Table 1, no needs or gaps in Continuum of Care mandatory services have been identified.

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)

See attached Excel document

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?

ADAMH has a critical role to play in providing support to people who are in recovery from addiction and mental illness by helping them to live in the community rather than in institutions and in helping people to improve their quality of life. In particular, housing and peer support are two types of critical support services in which ADAMH already invests that are strengths of the local system of care. These investments could be further strengthened to meet growing demands voiced by consumers and providers. ADAMH can continue to maintain an important role in partnering with providers on housing development projects to use local funds in order to match state and private capital funds. Housing assistance for behavioral health consumers relies heavily upon resources from outside the behavioral health system and ADAMH's ability to leverage these funds is critical to the success of these investments.

Peer support services are also vital to recovery and are a current asset of the ADAMH system in Franklin County that can be built upon in order to help more people engage in holistic wellness and recovery. There are a wide variety of possibilities for how peer support could be expanded further, including adding more peer support center locations and doing more to enlist the help of peers in respite and crisis settings. Given the increasingly complex range of health insurance options, there may be an opportunity to build upon existing peer support programs by training peer mentors to help consumers navigate health insurance enrollment and to connect consumers to information about existing programs and services.

Changes to Medicaid have also placed ADAMH in a strong position to focus on a more flexible portfolio of services. As Medicaid expansion and redesign, economic recovery, and continued enrollment in proceeds, ADAMH will likely have greater flexibility to invest additional local levy dollars in prevention and support services. If the need for ADAMH to pay for treatment services for the uninsured declines and other funding streams are relatively stable, then ADAMH will be in an excellent position to expand investment in the following activities:

- Universal prevention programs to reduce the prevalence of mental illness and addiction, such as school-based alcohol and other drug prevention and social-emotional learning programs.
- Early intervention programs for young people at risk of mental, emotional and behavioral disorders; parenting programs; and caregiver support.
- Partnerships with schools to improve school climate and access to care.
- Improved services for immigrants and refugees, including culturally-competent, trauma-informed services; effective interpreter/translation services; and culturally-specific Community Health Navigators to connect immigrants to care and overcome stigma that prevents individuals from seeking

treatment services.

- Leadership of collective impact strategies to bring local partners together to improve outcomes for people struggling with mental illness and addiction.
- Building bridges with other payers to invest in coordinated care for the “whole person.” ADAMH is in a prime position to be a leader, convener and facilitator to help providers navigate the changing healthcare landscape.

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

Not applicable

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?

The following threats could negatively impact ADAMH’s ability to fulfill its mission in the future:

- Erroneous belief among some in the general public that the ACA marketplace, mental health parity regulations and Medicaid expansion have fully addressed all barriers to accessing behavioral health care and that mental health and addiction services are now adequately covered for all Ohioans.
- Uncertainty about the stability of state and local funding streams. Future changes to the ACA, Medicaid program or the OhioMHAS budget could impact ADAMH revenues and/or expenditures. Furthermore, the current local property tax levy expires in 2020. Given that the levy provides nearly three-quarters of ADAMH’s revenue, failure to pass a future levy or a reduction in levy funding would negatively impact the ADAMH network.
- Our local system of care has been seeing the impact of the many individuals who do not fall into ADAMH’s priority populations for treatment services. Persons with routine care needs that are not among the prioritized or mandated population categories may have to wait longer for services or may not receive services at all in our system. Our local stakeholders within the court system have identified this as having a significant impact on the ability for them to refer individuals involved in the justice system to appropriate treatment placements.
- The need to serve increased numbers of individuals re-entering and newly entering Franklin County following a period of incarceration continues to be an area of focus. Many of these individuals return to the community without any support system and are diverted to our community-based crisis sites with long term care needs for which we do not have the resources to fully provide necessary care.
- An increasing number of diverse healthcare plans & benefits will challenge consumers and families in meeting the expectations of multiple public and private payment systems.
- A significant increase in the need for intensive and specialized treatment for individuals with dual disorders (i.e. both mental health and substance abuse disorders) and high use of psychiatric beds.
- The lack of availability of local private inpatient psychiatric beds continues to be a challenge for the central Ohio region in general.

- Services for Transitional Age Youth are fragmented. Limited access across different programs (e.g., mental health, education, vocational rehabilitation, juvenile justice, child welfare, housing) and funding mechanisms (e.g., Social Security, state and local appropriations, Medicaid, and federal block grants) further complicate this transition arena for young people with emotional and behavioral disturbances and their families. For the most part, each of these program components has entirely different eligibility requirements and the child-serving and adult-serving programs operate under different paradigms. While each program may provide some essential services individually the combined effect of this environment is that it is often impossible for young people, parents and professionals to navigate the complexities and fragmentation within and between programs. ADAMH is in the process of identifying a viable and sustainable treatment model for this population.
- We also have a challenge in meeting the housing needs of ADAMH consumers. A continuum of housing options is needed that includes the most independent housing; to supportive housing that provides an on-site resident manager, service-enriched housing with on-site services provided twenty-four hours per day, as well as residential treatment with intensive supports and assistance with activities of daily living to ensure a smooth transition to community-based living. In addition to needing more housing units there is the challenge to create the most efficient, cost effective system of moving people along that continuum. Although housing is considered permanent, efforts and expectations need to be made to move people out of the more intensive, higher cost settings when appropriate and on to a more independent setting to allow room for those with greater needs.
- The ADAMH network of care is challenged to meet the demands of consumers by an environment of changing reimbursements along with increased demand for price and quality transparency as well as the movement towards more performance-based reimbursement structures.
- Another challenge for ADAMH providers is a lack of sustainability of the direct care workforce and the need for greater cultural competency for the increasingly diverse population of Franklin County.

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

- We anticipate an increasing lack of availability for the provision of timely AoD and mental health treatment services for individuals falling outside of our prioritized populations.
- The lack of a stable and sustainable direct care workforce translates into poor clinical relationship development with consumers as they experience high turnover within their primary team of individual care providers in addition to lost productivity for the provider.
- We have started to see challenges within our provider network regarding the tiered payment for Community Psychiatric Support Treatment (CPST). The resulting impact is a reduction of needed intensive services when consumers exit from higher levels of care and are in need of time intensive, stabilizing services during post-discharge.
- The failure to move people along the continuum of housing options is that higher costs will be incurred by the ADAMH system of care when a consumer remains in a residential care facility due to the unavailability of a less intense service setting, such as a supportive housing unit. In addition, wait lists will continue to grow due to a shortage of available housing units in general.
- Franklin County continues to have peak crisis service delivery periods in which all local inpatient beds are full, resulting in long stays in emergency rooms at Netcare prior to an individual placement in a psychiatric bed. Diversion of crisis referrals may result during these peak periods of system crisis care

acuity, further straining our local emergency rooms and law enforcement. On the youth side of the crisis continuum, Franklin County has seen a spike in the number of youth presenting to local emergency departments for behavioral health needs. This increase has continued to impact the system negatively despite the expansion of the Youth Crisis Stabilization Unit (YCSU) at Nationwide Children's Hospital.

- We are struggling to find doctors who can prescribe Medication Assisted Treatment to clients in order to address the increased need to treat opiate-addicted individuals.

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

Not applicable

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.

ADAMH takes cultural competency initiatives seriously and has engaged in multiple efforts to ensure that diverse communities have access to culturally and linguistically appropriate services. ADAMH has initiated both proactive and reactive strategies based on existing and emerging diverse community needs and issues. These strategies are designed to help ensure that the unique needs of culturally diverse populations are considered in our design and implementation of mental health and substance abuse promotion, prevention, treatment, and recovery support services. Additionally, one of ADAMH's strategic initiatives, *Community Collaboration and Engagement*, was created in order to ensure that our services and supports are offered in key community outposts and in partnership with diverse community organizations in order to ensure better access to, and design of, our services. ADAMH has spent considerable time learning about Franklin County's diverse communities and identified national best practice models in order to construct programs and services that target/support immigrant, refugee, cultural and ethnic populations.

The following initiatives were implemented during the previous levy cycle and ongoing efforts are being developed to address the changing needs of our diverse service population:

- Administered a Culturally Competent Assessment Tool so providers can evaluate their organizations based on 11 key standards. This tool is the foundation for how system providers assess their own level of competence and provides ADAMH with a benchmark regarding how the network is addressing the needs of diverse clients.
- Designed system cultural competence trainings to improve administrator, clinician and line staff services to diverse communities. There has been significant emphasis on immigrant and refugee staff training to ensure that the system understands their unique needs and can provide the best possible services in convenient locations.
- Partnered with Multiethnic Advocates for Cultural Competence (MACC) to design training for system staff that focused on the needs of immigrant/refugees, veterans, LGBTQ, faith-based, Latino, Somali

and other target populations.

- Each provider is required to identify their top three priorities in the annual Agency Service Plan (ASP) for addressing cultural competence, including changes in their populations.
- Launched outreach and engagement activities to ensure that ADAMH was an active partner with key immigrant/refugee, faith and minority community leaders to ascertain the needs of their respective communities.
- Established specific marketing and educational campaigns to inform immigrant communities about how to recognize signs and symptoms of mental health and substance abuse problems and how to access help.
- Developed language specific videos, brochures, billboards, and radio spots that target immigrant and refugee communities.
- Provided mini-grant funds to several immigrant/refugee/minority-serving organizations to support community educational and awareness activities in order to reduce the stigma associated with behavioral health issues.
- Collaborated with Columbus Public Health's *Office of Minority Health* to address the needs of Franklin County's diverse communities.
- Engaged faith-based organizations to help them better support the needs of their congregations and communities they serve.

Since 2006, ADAMH learned that many faith leaders are confronted with mental health and substance abuse problems in their pastoral roles and has offered information on how to address a growing range of concerns related to behavioral health (i.e., youth suicide, domestic violence, youth and gang violence, opioids and other drugs, divorce, death, etc.). In order to further address these issues, ADAMH has engaged in the following activities:

- Met with dozens of faith leaders to learn more about their problems, needs and interests as part of our annual community ascertainment strategies.
- Offered a series of trainings for faith leaders to recognize mental health/alcohol and other drug signs and symptoms, crisis supports and referral information.
- Hosted a faith leader symposium in 2011, offering 25 sessions (serving a total of 200 attendees) taught by clinical professionals and diverse faith leaders to engage them on key behavioral health, health and alternative health topics.
- Participated in a statewide education and training initiative supported by SAMHSA.
- Trained more than 45 faith leaders in Mental Health First Aid, as well as hosted community conversations on mental health in various Franklin County communities.
- Funded a wide-range of prevention programs in collaboration with faith institutions.
- Established six faith-based camp programs on the west, near east, and north sides of Columbus.

Additional activities conducted in the previous levy cycle:

- Developed several immigrant/refugee specific services, ranging from trauma-informed care, intergenerational conflict family supports, support groups for Somali and Latino women and case management supports.

- Implemented an international middle school program to address immigrant student truancy, disciplinary problems and parent/family supports.
- Provided a translator training for those working in the system to better serve those with Limited English Proficiency (LEP).
- Monitored disparities and other key performance indicators based on race/ethnicity, age, gender, and related primary/secondary dimensions of diversity.
- Required all new system/school-based investment provider applicants to explain how they will address cultural competence in their proposed program/service delivery proposals.

Offered recruitment and training for institutions of higher education to better inform students about working in diverse communities. ADAMH engaged in several initiatives with local colleges and universities to address cultural competence, including:

- Collaborated with Columbus State Community College (CSCC) and Ohio State University (OSU) on various projects to train undergraduate and graduate students on the importance of ADAMH's work associated with cultural competence. ADAMH also engaged in student recruitment for Somalis who may be interested in CSCC mental health technology program.
- Offered field placement /practicum opportunities in our system for students interested in working with diverse communities.
- Encouraged immigrant community leaders to explore social work and other human service degree programs for members of their community.
- Worked with researchers from the Wright State University Center for Global Health and Boonshoft School of Medicine to conduct a World Health Organization survey of refugees about their quality of life in central Ohio, resulting in production of a report on the subject.
- Coordinated with OSU to offer graduate students field placement in federally qualified health centers (FQHC) that service immigrants.

Several of the aforementioned initiatives will continue during the next levy cycle. The board will build on this momentum by continuing to work with network providers and partners outside of the network to ensure the holistic needs of consumers are addressed. Since the current levy cycle is for five years, the board will move forward on existing objectives as well as address the efforts listed below:

- Continue education and outreach efforts targeting various immigrant/ethnic communities and their leaders as a strategy aimed at reducing stigma associated with mental health through Mental Health First Aid training, support for health fairs and print media.
- Target key faith leaders in communities that serve a high numbers of immigrant, refugee and ethnic populations who are also impacted by a range of social issues.
- Support minority recruitment efforts to help providers ensure their staff reflect the populations served in the community and assist in identifying potential minority board members.
- Seek support to conduct system research that examines health disparities and best practices to reach underserved communities.
- Media efforts that target minority communities to reduce stigma and build awareness.
- Provide ongoing Crisis Intervention Training (CIT) for law enforcement officers working with diverse clients

and families.

- Expand summer camp opportunities in communities where there are large immigrant and minority residents with little resources.
- Incorporate other cultural competence initiatives as identified by the Board of Trustees during the annual strategic planning retreat this fall.

Priorities

6. Considering the board’s understanding of local needs, the strengths and challenges of the local system, what has the board set as its priorities for service delivery including treatment and prevention and for populations?

Below is a table that provides federal and state priorities.

Please complete the requested information only for those federal and state priorities that are the same as the board’s priorities, and add the board’s unique priorities in the section provided. For those federal and state priorities that are not selected by the board, please check one of the reasons provided, or briefly describe the applicable reason, in the last column.

Most important, please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in the board’s response to question 2.d. in the “Assessment of Need and Identification of Gaps and Disparities” section of the Community Plan [ORC 340.03(A)(11) and 340.033].

Priorities for Alcohol, Drug and Mental Health Board of Franklin County

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) | Increase the availability of medication assisted treatment (MAT) | <ul style="list-style-type: none"> Maintained MAT capacity and treatment options at Maryhaven (80 slots) and CompDrug (65 slots) Expanded a Naloxone Education program that provides kits to family members and loved ones who are impacted by drug use Expanded detox services within the network by an additional 8 beds which will serve an additional 365 individuals per year | <ul style="list-style-type: none"> Number of people receiving MAT | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority) | 100% of pregnant women seeking alcohol or other drug treatment services will have their first appointment within contractual timeframes | <ul style="list-style-type: none"> Developed a Pregnant Women’s Workgroup, tracking tool and monthly data report to assure that services for pregnant women are prioritized and are receiving timely access Expanded detox services within the network by an additional 8 beds which will serve an additional 365 individuals per year and prioritizes pregnant women Expanded a Naloxone Education program that provides kits to family members and loved ones who are impacted by drug use | <ul style="list-style-type: none"> Percentage of women receiving timely access to treatment | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County) | Ensure adequate services are available within the community to meet the needs of this population | <ul style="list-style-type: none"> Expanded detox services within the network by an additional 8 beds to meet the needs of the community | <ul style="list-style-type: none"> Analysis of need and current capacity Recommendations for additional | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |

| Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs) | | | capacity if necessary | |
|---|---|--|--|--|
| SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.) | 100% of persons infected with tuberculosis seeking alcohol or other drug treatment services will have their first appointment within contractual timeframes | <ul style="list-style-type: none"> • Provide access to persons infected with tuberculosis • Persons with tuberculosis have access to community treatment | <ul style="list-style-type: none"> • Percentage of persons served | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |
| MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED) | Increase accessibility of services for children with SED through a system of care approach | <ul style="list-style-type: none"> • Continue to develop and promote cross-systems partnerships with agencies such as Children Services, Juvenile Court, Family and Children First Council in order to maintain a variety of intensive treatment programs with collaborative funding • Prioritize and increase service accessibility to young consumers and their families at risk of serious family emotional instability, loss of parental custody, child placement, court involvement, and/or academic failure due to untreated mental illness • Maintain school based interventions in order to help identify youth in need of mental health and/or alcohol and drug related services earlier and to help these youth and their families access care more quickly | <ul style="list-style-type: none"> • Number of children with SED that are served | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |
| MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI) | Expand access to care for uninsured people through integrated models of primary care, addiction treatment and mental health care to help achieve | <ul style="list-style-type: none"> • Continue to develop and promote cross systems partnerships. • The number of IDDT / ACT teams was increased to six with teams | <ul style="list-style-type: none"> • Number of adults with SMI receiving services | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |

| | | | | |
|---|---|--|--|--|
| | identified outcomes and recovery | <p>specific to the homeless population and the criminal justice population</p> <ul style="list-style-type: none"> • Due to the expansion of Medicaid and the availability of Federal funding for FQHCs, ADAMH funding was underutilized in the Integrated Care setting. In response ADAMH allowed providers to retain funding but gave them additional flexibility in using those funds for the uninsured | | |
| <p>MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing</p> | <p>Increase permanent housing units (along a continuum) for homeless persons with mental illness and/or addiction</p> | <ul style="list-style-type: none"> • Provided 40 new units of service enriched housing with the opening CHN's Hawthorn Grove location. On-site supportive (non-Medicaid taxonomy) services delivered by Concord Counseling • Provided 40 units of service enriched housing for ADAMH consumers by opening Van Buren Village (developed by VOA). On site supportive services (emphasis on peer-led) provided to all 100 tenants (60 previously homeless individuals not served by the ADAMH network) • Lease up will begin in the fall 2016 for CHN's new (replacement property) development, Terrance Place, which will house a total of 60 units, including 13 ADAMH designated units (remaining 47 units designated for previously homeless individuals) • In 2015, added 10 units of Recovery Housing (owned by | <ul style="list-style-type: none"> • Number of consumers served | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |

| | | | | |
|-----------------------------------|--|---|---|--|
| | | <p>House of Hope & Amethyst). Awaiting final 2017-18 Capital Bill in order to invest in one or two new recovery houses (5-10 units)</p> <ul style="list-style-type: none"> • The number of Franklin County consumers in need of housing at the time of discharge from a psychiatric acute care facility and Netcare’s Crisis Stabilization Unit presents a growing challenge for locating and securing safe and affordable housing for individuals homeless at the time of discharge • In an attempt reduce the number of individual discharged from TVBH and Netcare into homelessness, the ADAMH Board is addressing this issue by: (1) providing additional funding to Community Housing Network (CHN) through its Housing Facilitation Program to house individuals; (2) expanding Temporary Transitional Housing capacity for adults being discharged from an acute care setting; (3) training provider case managers on the process and community resources to house homeless individuals; (4) enhanced the hospital liaison program to respond to homeless discharge | | |
| MH-Treatment: Older Adults | Ensure adequate behavioral health services are available to meet the needs of older adults | <ul style="list-style-type: none"> • Fund the Senior Services program through Concord Counseling to provide support services to medically fragile older adults • Fund the Senior outreach program | <ul style="list-style-type: none"> • Number of people served | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |

| | | through Syntero to provide services to seniors with the goal of keeping them in their homes rather than institutional care | | |
|---|---|--|--|--|
| 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 | Ensure adequate behavioral health services are available to meet the needs of individuals involved in the criminal justice system | <ul style="list-style-type: none"> • Fund the CFRO program provided by UMADAOPFC for persons reentering the community • Continue to support the Behavioral Health/Juvenile Justice (BHJJ) program provided by Nationwide Children’s Hospital • Continue to support the Multi-systemic Therapy (MST) programs provided by The Buckeye Ranch and Nationwide Children’s Hospital • Continue to support the Functional Family Therapy (FFT) program provided by The Buckeye Ranch • Continue to support the Reception Center program provided by The Village Network • Support the BJA Reentry Project and Taskforce • Provide funding for the TIES Court and partnered with all seven specialty dockets to provide the Access to Success program to support its participants • Support and monitor the ATPP/ Vivitrol Project to provide MAT services while the client is in jail • Support the CHAT House for | <ul style="list-style-type: none"> • Number of people served and recidivism rate • Number of youth served and linked to mental health programs • Number of youth served and recidivism rate | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |

| | | | | |
|--|---|---|---|--|
| | | victims of human trafficking | | |
| Integration of behavioral health and primary care services | Expand access to care for uninsured people through integrated models of primary care to help achieve identified outcomes and recovery | <ul style="list-style-type: none"> • Due to the expansion of Medicaid and the availability of Federal funding for FQHCs, ADAMH funding was underutilized in the Integrated Care setting. In response ADAMH allowed providers to retain funding but gave them additional flexibility in using those funds for the uninsured | <ul style="list-style-type: none"> • Number of persons served | <ul style="list-style-type: none"> ___ 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) | Increase certified recovery/peer support in the system | <ul style="list-style-type: none"> • Continue to fund AOD Recovery Coach operating out of the Bell Center's Club Serenity • Fund a Consumer Resource Center to help consumers navigate the mental health system. • Continue to fund the Peer Center Recovery Center. • Tutorial for COVA website and RecoveryWorks program and a marketing document for the resource center has been completed • Website design completed; moving from test phase to production phase • Currently working with an AV company to get the equipment ready for offering online classes • We increased funding to the PEER Center to expand services | <ul style="list-style-type: none"> • Number of individuals trained | <ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe): |

| | | | | |
|--|--|--|--|---|
| <p>Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)</p> | <p>Expand services to racial and ethnic minorities and LGBTQ populations</p> | <ul style="list-style-type: none"> • Fund LGBTQ program at North Central • Fund education and support groups for Somali and Latino(a) women at CPH • Fund outreach and treatment for Somali youth at Buckeye Ranch • LGBTQ services were expanded in 2015 to provide services additional group and individual counseling services • Continue to fund education and support groups for Somali and Latino women at CPH and fund outreach and treatment for Somali youth at Buckeye Ranch | <ul style="list-style-type: none"> • Number of consumers served | <p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p> |
| <p>Prevention and/or decrease of opiate overdoses and/or deaths</p> | <p>Increase Medication Assisted Treatment slots for residents of Franklin County</p> | <ul style="list-style-type: none"> • Expand MAT capacity and treatment options • Maintained suboxone programs at Maryhaven and CompDrug • Support and monitor the ATPP/ Vivitrol Project to provide MAT services while the client is in jail • Expanded a Naloxone Education program at Comp Drug that provides kits to family members and loved ones who are impacted by drug use • Expanded detox services within the network by an additional 8 beds which will serve an additional 365 individuals per year | <ul style="list-style-type: none"> • Number of consumers served | <p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p> |

| | | | | |
|---------------------------------------|--|---|--|---|
| Promote Trauma Informed Care approach | Promote Trauma Informed Care within the ADAMH network of providers | <ul style="list-style-type: none"> • Support the efforts of agencies within the ADAMH network in becoming trauma informed providers • Promote the use of evidence based programs specific to the treatment of trauma within the ADAMH provider network • Continue the use of trauma screening in the Behavioral Health, Juvenile Justice program | <ul style="list-style-type: none"> • Number of consumers served | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe) |
|---------------------------------------|--|---|--|---|

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 | Offer prevention services across life span with a focus on families with children/adolescents | <ul style="list-style-type: none"> • Fund new programs that support families with children/adolescents • Review prevention services to ensure prevention services are available across lifespan with a focus on families with children and adolescents • Implement faith family pilot program • Continue prevention services across the lifespan with a focus on families with children • Continue faith-based parenting program • Support partnership with Future Ready, Children Services, Job and Family Services and United Way of Central Ohio | <ul style="list-style-type: none"> • A minimum number of two programs provided in each life span domain • The number parents who complete the program will establish protective factors for their children • The number of summer day camp youth screen on DESSA-mini | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Prevention: Increase access to evidence-based prevention | Expand evidence-based prevention activities | <ul style="list-style-type: none"> • Funded nine summer day camps in high need areas • Implemented Workforce | <ul style="list-style-type: none"> • Number of youth that complete the summer program • Number of parents who participate | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage |

| | | | | |
|--|---|---|---|---|
| | | <p>Readiness Support Program to reduce marijuana use and increase life skills</p> <ul style="list-style-type: none"> • Implement Life skills program for school age children with special needs | <p>in parent meetings</p> <ul style="list-style-type: none"> • Number of adults who complete the Workforce Readiness Support Program • Number of school age children with special needs who develop life skills | <p>___ Other (describe):</p> |
| <p>Prevention: Suicide prevention</p> | <p>In partnership with community stakeholders, develop strategies to reduce the number of suicides in Franklin County</p> | <ul style="list-style-type: none"> • Franklin County Suicide Prevention Workgroup was convened • Franklin County Suicide Prevention Brief was created • Support The Ohio State University Wexner Medical Center and Nationwide Children’s Hospital in moving the Franklin County Suicide Prevention Workgroup forward and create resource lists for suicide prevention strategies in the county • Monitor and catalog Evidence Based Practices for suicide prevention • Continue suicide hotline and support groups at North Central Mental Health • Work with provider network to develop a suicide text/IM service • Continue to support LOSS for survivors of suicide • Monitor Franklin County suicide data • Maintain Suicide Prevention Hotline • Fund Suicide Prevention coalition | <ul style="list-style-type: none"> • Participation in Franklin County collaborative meetings • Recommendations for additional actions if necessary • Number of calls received/interventions • Information dissemination to schools/community/groups and individuals on suicide prevention | <p>___ No assessed local need</p> <p>___ Lack of funds</p> <p>___ Workforce shortage</p> <p>___ Other (describe):</p> |
| <p>Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations</p> | <p>Develop strategies to reduce problem gambling and increase community awareness of problem gambling</p> | <ul style="list-style-type: none"> • Implement media campaign and launch a problem gambling website • Implement screening services for | <ul style="list-style-type: none"> • Number of hits on the website • Media campaign number of spots on paid media outlets • Number of people who referred to | <p>___ No assessed local need</p> <p>___ Lack of funds</p> <p>___ Workforce shortage</p> <p>___ Other (describe):</p> |

| | | | | |
|--|--|---|--|--|
| | | <p>problem gamblers</p> <ul style="list-style-type: none"> • Continue to support problem gambling implementation of SPF Plan • Collaboration between ADAMH and community partners to implement a county wide problem gambling and informed gambling program • Continue funding for Maryhaven to work with the families of problem gamblers to increase the number of problems seeking services | <p>early intervention or treatment services</p> <ul style="list-style-type: none"> • Number of people receiving prevention services | |
|--|--|---|--|--|

| Board Local System Priorities (add as many rows as needed) | | | |
|--|--|---|---|
| Priorities | Goals | Strategies | Measurement |
| Human Trafficking | In partnership with CATCH Court provide supports and treatment services to women involved in Human Trafficking | <ul style="list-style-type: none"> • Continue to fund a sober residence and supportive services provided by Alvis House | <ul style="list-style-type: none"> • Number of women that complete the program |
| Faith-Based Outreach | Partner with the faith-based community | <ul style="list-style-type: none"> • Fund faith-based community-based events that promote behavioral health awareness through mini grants process • Fund summer day camps in partnership with faith-based congregations and Children’s Defense Fund. • Provide Mental Health First Aid Training to faith community | <ul style="list-style-type: none"> • Number of people that attend community based events • Number of youth that complete the summer program • Number of parents who participate in parent meetings |
| HIV | Provide HIV Early Intervention Services to county residents | <ul style="list-style-type: none"> • Maintain funding of the Syntero HIV Program for youth, Columbus Public Health and CompDrug HIV Early Intervention programs for adults • Continue to support the work of Coalition for Sexual Health through our provider network | <ul style="list-style-type: none"> • Number of consumers served. • Number of HIV providers engaged in the community-based process/coalition building • Number of community meetings and events that promote maintaining sexual health in youth and adult populations |

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) NONE | N/A |

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?)

In 2014, ADAMH engaged in the following collaborative efforts with other systems representing significant accomplishments in advancing the system of care in Franklin County:

- School-Based Investments - collaborated with 14 suburban school districts to provide more than \$2.3 million for prevention, early intervention, treatment and referral services for elementary, middle, and high school students. Services range from mental health school-based services (such as suicide prevention), AOD prevention/intervention services and early detection/ screenings.
- Franklin County Guardianship Services Board – board formed to address the growing needs of county residents who are most in-need of guardianship arrangements.
- Franklin Station Integrated Care Clinic - opened the Southeast, Inc. Integrated Healthcare Center at Franklin Station, the first ever integrated care clinic at a permanent supportive housing facility in collaboration with Southeast and CMHA.
- Consumer Advocacy Funded Recovery Works - in partnership with COVA to promote self-directed recovery through a personalized approach. Consumers can seek support and empowerment through Recovery Guides and find support on their wellness journey, all through the use of technology.
- The P.E.E.R. Center (Westside Location) - Expanded peer supported services by investing in The P.E.E.R. Center's new Franklinton location.

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.

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

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

Our existing CoC Agreement is operative on a two year cycle and it governs the interaction between our system's crisis care provider, State BHOs and lead agency providers around continuity from admission, care within the hospital and coordinated discharge planning. Every two years, we solicit input from lead agency clinical leadership

and Twin Valley Behavioral Healthcare regarding potential changes to the document. Each year we may make minor revisions only on an as-needed basis. The Franklin County ADAMH System has one contract agency responsible for all pre-hospital screening services.

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

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

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

The Board has developed a program to authorize and fund placement of homeless men in the local YMCA temporarily while awaiting more permanent housing options. Franklin County received federal funds for housing homeless individuals which were targeted to homeless patients in the state hospital.

For people hospitalized at regional campuses other than TVBH, discharge planning has been difficult. Providers find it problematic to provide the needed transportation back to Franklin County, hampering the transition out of the hospital.

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

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

b. Planning efforts

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

c. Business operations

Given the rapid and uncertain changes in service delivery and billing taking place at both the state and federal levels, we are continuing development of a new data system (SHARES) to collect, analyze and process consumer information and activity in our system of care. We are collaborating on this project with the Hamilton and Cuyahoga county boards.

d. Process and/or quality improvement

Not applicable

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.

Not applicable

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.

Rhoads House Residents Find Peace and Recovery at Home

Recovery is reliant on many things, including the proper supports such as treatment, housing and job training. Sober housing offers tenants an environment free of alcohol and drugs where they may continue their recovery journey through peer and supportive services.

The House of Hope, an ADAMH provider, opened their newest recovery residence, Rhoads House, earlier this year. The three-story home houses five men who are in various stages of recovery.

For these men, the Rhoads House is helping bridge the gap in their recovery journeys. Mike Chapman, the house manager, has been in recovery since 2009 and knows the importance of sober housing. "Going into a recovery environment is essential to getting back into the real world," he said.

Chapman makes sure tenants follow the house rules and spend their time working, volunteering and attending meetings. Each resident is required to participate in a 12-step program and is responsible for their rent, food and bills. They also must attend at least four meetings a week and have a sponsor. These everyday responsibilities "help transition us back to real life," Chapman said.

The peer support model has helped numerous tenants at recovery residences, including Chapman. "We're like brothers...This program is about helping one another and it doesn't work any other way," he said.

Through housing and other supportive services, many individuals go on to lead healthy and productive lives. "I'm a strong believer in recovery," Chapman said, "It's given me a new life."

Southeast Integrated Healthcare Center at Franklin Station

In November 2014, ADAMH, Southeast, Inc. and Columbus Metropolitan Housing Authority celebrated the pre-opening of the integrated healthcare clinic at Franklin Station. On January 20, 2015, the Southeast Integrated Healthcare Center opened its doors to all Franklin County residents in need of mental and physical healthcare.

In late 2013, the ADAMH Board of Trustees approved funding for Franklin Station. ADAMH is committed to providing access to quality care for uninsured people through integrated models of primary care, addiction treatment and mental health care.

David Royer, ADAMH CEO, notes the importance of the new health center: "We know from research that it is estimated that people with mental illness die prematurely nearly twenty five years earlier than the general population. This is one of the reasons it is so very important that members of our community have access to integrated physical and mental health services," he said.

Tim Wheat, a long-time consumer who spoke at the pre-opening reception, also knows the value of integrated healthcare: "I'm here today to say primary and behavioral healthcare saved my life," he said.

Southeast will now service Franklin County residents at the center located at 524 B West Broad Street, Columbus. The healthcare facility offers residents physical and mental healthcare, substance abuse services, individual and group counseling and wellness management. Services available by appointment only and same day access may be available.

Franklin County Guardianship Board Appointed

Earlier this year, The Columbus Dispatch did an investigative piece about the current state of guardianships in Ohio. After review, it was clear that there was a need for guardians who can ensure safe, stable care for the community's most vulnerable population. Thanks to the hard work of Franklin County Probate Court Judge Robert Montgomery, the Franklin County Guardianship Services Board was created in June 2014. ADAMH is thrilled to partner with Judge Montgomery and the Board of Developmental Disabilities to bring guardianship services to those who can no longer care for themselves.

The Franklin County Guardianship Services Board is the only one of its kind in Ohio and is comprised of three people who are appointed by the Probate Judge, the Board of Developmental Disabilities and ADAMH.

"I applaud the diligent efforts and financial support of the ADAMH Board and the Developmental Disabilities Board to get the Guardianship Services Board underway. I also appreciate State Senator Jim Hughes' efforts, as he sponsored the legislation for this pilot project, which will ensure a completely different approach to the way Franklin County addresses the needs of the most vulnerable citizens through guardianships," Judge Montgomery said.

Judge Montgomery's appointee to the Board is Larry H. James, a partner at Crabbe, Brown & James, LLP, a Columbus firm where he has practiced law since 1981. He has served as an assistant city attorney Columbus and Cleveland and as public safety director for the City of Columbus. James has also served as chairman of the Ohio Elections Committee and as a board member for the Columbus Zoo and the Columbus Museum of Art. In 2012, James was honored as Humanitarian of the Year by the American Red Cross Columbus Chapter.

The Board of Developmental Disabilities appointee to the Board is William W. Wilkins of Pataskala, a self-employed consultant in the healthcare field. Wilkins has served the public as the State of Ohio's tax commissioner, director of the Department of Administration Services, director of the Office of Budget and Management and chairman of the Ohio Turnpike Commission. Wilkins has also served as chief executive officer of Ohio health/Grant Riverside and as a consultant to various healthcare organizations and associations.

ADAMH's appointee to the Board is Jane Higgins Marx, a partner at Carlile Patchen & Murphy LLP, a Columbus firm. Marx practices estate and business planning, probate, probate litigation, business succession planning and elder law. She also is a member of the Columbus Bar Association, The Ohio State Bar Association, the Columbus Foundation Professional Advisors, The Columbus Estate Planning Council, the Society of Financial Service Professionals Columbus Chapter and the Catholic Foundation Professional Advisors Group. Marx currently serves

on the board for the Legal Aid Society of Columbus.

David Royer, chief executive officer of ADAMH, is thrilled to be part of the Board: “ADAMH is proud to partner with Judge Montgomery and the Probate Court and the Board of Developmental Disabilities. ADAMH is excited to work with our partners to provide superior care, protection and support to the mentally ill and others who are unable to protect themselves. We will continue to advocate for our community’s most vulnerable population and we look forward to seeing the great work the Board will do.”

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.**

Not applicable

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 waiver 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.:

- 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.
- 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

| <u>Essential Service Category Elements</u> (‡ = ORC 340.033 Required) | <u>2015 OhioMHAS Housing Survey</u> | <u>2014 National Survey of Substance Abuse Treatment Services (N-SSATS)</u> | <u>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</u> |
|--|-------------------------------------|---|--|
| 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: <ul style="list-style-type: none"> • A-IOP ‡ • M-Assertive Community Treatment • M-Health Homes | | Intensive OP ASAM Level II.1 (9+ HRS/WK) | <ul style="list-style-type: none"> • Assertive Community Treatment (ACT) • Primary Physical Healthcare |

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|--|---|--|--|
| <u>Essential Service Category Elements</u> (‡ = ORC 340.033 Required) | <u>2015 OhioMHAS Housing Survey</u> | <u>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</u> | <u>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</u> |
| A-Medically Assisted Treatment ‡ | | <ul style="list-style-type: none"> • Naltrexone • Vivitrol • Methadone • Suboxone • Buprenorphine (No Naltrexone) | |
| 12 Step Approaches ‡ | | Clinical/therapeutic approaches Used:.. <ul style="list-style-type: none"> • 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) | |
| <u>Essential Service Category Elements</u> (‡ = ORC 340.033 Required) | <u>2015 OhioMHAS Housing Survey</u> | <u>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</u> | <u>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</u> |
| 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • M-Self-Help/Peer Support • M-Consumer Operated Service | | | MH Consumer Operated (Peer Support) |
| Recovery Supports: <ul style="list-style-type: none"> • M-Employment/Vocational Services | | | <ul style="list-style-type: none"> • Supported Employment Services • MH Vocational |

| | | | |
|---|---|---|---|
| | | | Rehabilitation Services |
| <u>Essential Service Category Elements</u> (‡ = ORC 340.033 Required) | <u>2015 OhioMHAS Housing Survey</u> | <u>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</u> | <u>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</u> |
| 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 |
| <u>Essential Service Category Elements</u> (‡ = ORC 340.033 Required) | <u>2015 OhioMHAS Housing Survey</u> | <u>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</u> | <u>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</u> |
| 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 • Temporary Housing • Transitional | Time Limited/ Temporary: • Crisis • Respite • Temporary • 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 |