Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2023-2025 Community Assessment and Plan (CAP) Template:

PLAN

Overview
This is the second of three sections in the Community Assessment and Plan (CAP) Template. The Plan section of the CAP Template will serve as the Board's 2023-2025 Community Plan and is designed to be completed by ADAMH Boards and returned to OhioMHAS every three years.

Template

Board name	ADAMH Board of Franklin County
Date	

Key

▲	Pre-populated data provided by OhioMHAS
✱	Question that all Boards are required to answer
Optional	Question that Boards may choose to answer, but are not required to answer

- ✱**Counties.** Please describe how your Community Plan applies to the area served by your Board:
  - ☐ Our Board serves one county

1. Our Board serves more than one county, and our Plan covers all counties together
2. Our Board serves more than one county, and we have developed a separate Plan for each county. *Repeat each of the sections below for each county and indicate the county.*

- **Priorities**

Use the findings from the Assessment section of the CAP to guide selection of a strategic set of priorities for your Community Plan. Briefly describe your community's priority strategies, priority populations and priority outcomes using the table below.

You will identify nine priorities total: Seven that are specific to each aspect of the continuum of care (prevention, mental health treatment, substance use disorder (SUD) treatment, Medication-Assisted Treatment (MAT), crisis services, harm reduction and recovery supports) in which one must be focused on youth, and two priorities specific to the required priority populations (pregnant women with SUD and parents with SUD with dependent children). You may also choose to identify collective impact priorities to address the social determinants of health (See table on Page 6). See the table below for additional instructions and an example.

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Instructions				
Identify a priority for each aspect of the continuum of care (each row below)	*Briefly indicate the service, program or policy change you will implement.*	*Indicate which age group(s) the strategy will be designed to reach (choose all that apply):* ✓ Children (ages 0-12) ✓ Adolescents (ages 13-17) ✓ Transition-aged youth (14-25) ✓ Adults (ages 18-64) ✓ Older adults (ages 65+) ***At least 1 strategy must be designed to***	*Indicate which group(s) the strategy will be designed to reach (choose all that apply):* ✓ People with low incomes or low educational attainment ✓ People with a disability ✓ Residents of rural areas ✓ Residents of Appalachian areas ✓ Black residents ✓ Hispanic residents	*Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.* *All indicators must be measurable, specific and have a data source. All indicators must reflect outcomes that are relevant to the selected strategy and age group.*

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
		reach youth (children, adolescents or transition-aged youth)	✓ White residents ✓ Other racial/ ethnic group (specify: ___) ✓ Older adults (ages 65+) ✓ Veterans ✓ Men ✓ Women ✓ LGBTQ+ ✓ Immigrants, refugees or English language learners ✓ People who use injection drugs (IDUs) ✓ People involved in the criminal justice system ✓ General community program ✓ Other, specify: _____	*If data are available, the indicator should be disaggregated for the selected priority population(s) and group(s) experiencing disparities.* *See the standardized indicator list for suggested outcome indicators.*
Example				
Prevention	*Universal school-based suicide awareness and*	*1. Adolescents (ages 13-17)* *2. Transition-aged youth (14-25)*	*3. Residents of rural areas*	*Youth suicide deaths. (Number of deaths due to suicide for*

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	education program in four school districts		*4. General community program*	*youth, ages 8-17, per 100,000 population.)*
Prevention	School-based suicide screenings	Children (ages 0-12) Adolescents (ages 13-17) Transition-aged youth (14-25)	1. Black residents 2. General community program 3. LGBTQ+	Youth suicide deaths (Number of deaths due to suicide for youth, ages 8-17, 100,000 population.)
Mental health treatment	Mental health counseling	Children (ages 0-12) Adolescents (ages 13-17) Transition-aged youth (14-25) Adults (ages 18-64) Older adults (ages 65+)	General community program People with low incomes or low educational attainment Immigrants, refugees or English language learners People involved in the criminal justice system Black residents Hispanic residents	Adult poor mental health days (Average number of mentally unhealthy days for adults, ages 18 and older, reported in the past 30 days.

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
			White residents	
Substance use disorder treatment	Intensive outpatient treatment	Adults (ages 18-64)	People involved in the criminal justice system General community program People who use injection drugs (IDUs) Immigrants, refugees or English language learners Black White Hispanic Other (all not included above)	Adult binge drinking. Percent of adults, ages 18 and older, who meet the criteria for binge drinking.

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Medication-Assisted Treatment (MAT)	Access to vivitrol injections.	Adults (ages 18-64) Older adults (ages 65+)	People who use injection drugs (IDUs) People involved in the criminal justice system People with low incomes or low educational attainment	Buprenorphine prescriptions per 100,000 residents.
Crisis services	Mobile crisis response and stabilization services	Children (ages 0-12) Adolescents (ages 13-17) Transition-aged youth (14-25) Adults (ages 18-64) Older adults (ages 65+)	Veterans Men Women LGBTQ+ Immigrants, refugees or English language learners People who use injection drugs (IDUs) People involved in the criminal justice system General community program	Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population.
Harm reduction	Naloxone kits and education	Adolescents (ages 13-17)	General community program	Unintentional drug overdose deaths. Number of deaths

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
		Transition-aged youth (14-25) Adults (ages 18-64) Older adults (ages 65+)	People who use injection drugs (IDUs) People with low incomes or low educational attainment	due to unintentional drug overdose, per 100,000 population (age adjusted).
Recovery supports	Peer recovery support services	Adults (ages 18-64)	People with low incomes or low educational attainment People involved in the criminal justice system	Unemployment
	Permanent supportive housing	Adults (ages 18-64)	General population, Unhoused population, People experiencing SPMI	Affordable and Available unites per 100 ELI Renters
	Transitional Housing	Transition aged youth (14-25)	General population, Population aging out of foster care	Adults who had serious thoughts of suicide in the past year
Specify: _____	Outreach and engagement services for pregnant women.	Adults (ages 18-64)	***Required: Pregnant women with SUD***	Kindergarten Readiness

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
		Adolescents (ages 13-17)		
Specify: _____	Screenings and referrals for parents with potential MH or SUD needs.	Children (ages 0-12) Adolescents (ages 13-17)	***Required: Parents with SUD with dependent children***	Children in out-of-home placements due to parental SUD

- ✱**SMART objectives**

SMART objectives are specific, measurable, achievable, realistic and time-bound. Develop at least one SMART objective for each of the priorities in table 2.

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Instructions						
Identify a SMART objective for each priority that you selected	*Fill in the relevant outcome indicator from the priorities table above*	*Identify the data source for the outcome indicator*	*Indicate the year (or other time period) the baseline data was collected*	*Enter the baseline data value for the outcome indicator*	*Indicate the year (or other time period) that you will set a target for to assess progress*	*Enter the data value for the outcome indicator that you aim to achieve, reflecting a decrease in a negative outcome or an increase in a*

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
						positive outcome
Example						
Prevention	*Youth suicide deaths. (Number of deaths due to suicide for youth, ages 8-17, per 100,000 population.)*	*ODH Vital Statistics, accessed through the Public Health Data Warehouse*	*2018*	*4.0*	*2025*	*3.0*
Prevention	Youth suicide deaths (Number of deaths due to suicide for youth, ages 8-17, 100,000 population.)	ODH Vital Statistics, accessed through the Public Health Data Warehouse	2021	10	2025	9
Mental health treatment	Adult poor mental health days (Average number of mentally unhealthy days for adults, ages 18 and older, reported in the past 30 days.)	BRFSS Data, accessed in OHMAS County Profile with information from ODH.	2016-2022	15.2%	2019-2025	13%

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Substance use disorder treatment	Adult binge drinking. Percent of adults, ages 18 and older, who meet the criteria for binge drinking.	BRFSS Data, accessed in OHMAS County Profile with information from ODH.	2016-2022	19%	2019-2025	16%
Medication-Assisted Treatment (MAT)	Buprenorphine prescriptions per 100,000 residents.	Ohio Automated Rx Reporting System, Accessed through the OARRS interactive data tool	2021	13,979	2024	15,000
Crisis services	Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population.	ODH Vital Statistics, accessed through the Public Health Data Warehouse	2020	15.1	2023	14.5
Harm reduction	Unintentional drug overdose	ODH Vital Statistics, accessed	2019	40.6	2023	37

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
	deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted).	through the Public Health Data Warehouse				
Recovery supports	Unemployment	U.S. Department of Labor, Bureau of Labor Statistics	2021	5%	2024	3.7%
	Affordable and available unites per 100 ELI renters	FY 2022 Central Ohio Regional Housing Needs Assessment	2018	31	2022	40
	Adults who had serious thoughts of suicide in past year	2016-2018 National Survey on Drug Use and Health Substate Region Estimates	2016-2018	4.95%	2020-2022	4.0%
Strategy for pregnant	Kindergarten Readiness	ODE school report card	2018-2019	76.3%	2022-2023	77.5%

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
women with SUD						
Strategy for parents with SUD with dependent children	Children in out-of-home placements due to parental SUD	ODJFS Children Services Dashboard	2022	24.78%	2025	23.5%

- **Family and Children First Councils (FCFC)**
  - Describe any child service needs resulting from finalized dispute resolution with county FCFC(s) [340.03(A)(1)(c)]
    Does not apply

  - Describe your collaboration with the county FCFC(s) to serve high-need/multi-system youth
    The ADAMH Board of Franklin County's CEO chairs the Franklin County Family and Children First Council (FCFC) and additional staff members attend the Council's oversite committee. ADAMHH supports agencies that have various relationships with FCFC, including supporting agencies that are part of pooled funding to address the needs of youth that are multi-system. ADAMH also supports agencies that provide assistance for children within the court system that FCFC oversees. In addition, ADAMH invests in funding that goes towards work with Juvenile Justice as part of a collaboration with FCFC, where children are idenitified as needing services and referrals are made.

  - Describe your collaboration with the county FCFC(s) to reduce of out-of-home placements (IFAST/MST)
    In addition to supporting agencies that work with multi-system youth through pooled funding, ADAMH invests in agencies that provide services that are working to alleviate crises before children are removed from their home. These investments also support targeting specific activities to get help for children upstream, to avoid the need for services. This funding goes towards assisting Multi-system youth, providing referrals for treatment. In addition, ADAMH participates in the MRSS advisory committee, which aims to keep children out of crisis care.

- **Hospital services.**
  - Boards are required to identify how future outpatient treatment/recovery needs are identified for private or state hospital patients who are transitioning back to the community.
    - ADAMH funds hospital liaisons at the identified lead providers to be part of discharge planning teams to link patients to the necessary treatment services and recovery supports for successful return to the community. There is a Continuity of care agreement signed by select lead providers that ADAMH funds in three adult serving hospitals.

  - Boards are required to identify what challenges, if any, are being experienced in this area. Boards are provided with a dropdown list of potential challenges to choose from.
    - Lack of access to state regional psychiatric hospital

  - Boards are required to explain how the Board is attempting to address those challenges.
    - ADAMH aims to utilize indigent dollars provided by OHMAS and other revenue sources, including levy funds, to meet service demand. We monitor length of stay and need for ongoing treatment leading to discharge and linkage to community-based treatment provider. Written that if patient exceeds specified number of days, they have to meet with ADAMH or SCCO. In addition, ADAMH worked with our local providers to place patients based on level of care assessments and response to treatment provided.