

Ohio Mental Health and Addiction Services (OhioMHAS) Community Plan Guidelines SFY 2014

Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the Board area that will influence service delivery.

Lucas County, according to population is the 6th largest county in Ohio (<http://quickfacts.census.gov> – 2012 estimated figures) with a population of approximately 438,000, and is home to Toledo, the fourth most populous city. Although the differences are not dramatic, it is notable that of the top 10 counties in size, Lucas County has the highest percentage of poverty and also the highest percentage of persons under the age 18. Of those same 10 counties (Board areas), Lucas has the second highest percentage of persons with Hispanic origin and the 9th lowest median income. According to The Bureau of Labor Statistics (<Http://BLS.gov>), as of October 2013, Lucas County's unemployment rate is 8.0% which, while an improvement since the last plan was developed over 2 years ago, is higher than the state average (7.0%), and the 2nd highest of the 10 largest metro counties. Of the 6 largest counties in Ohio, Lucas County has the lowest percentage of college graduates, and the lowest median household income. The county is below the state average in both of these categories.

Despite the economic difficulties in Lucas County, it's citizens have been very supportive of this Board's efforts to serve persons with mental illness and addiction. In November 2012, for the first time in 24 years, voters passed a new 1.0 mill levy that added to the two existing levies, totaling 1.5 mills. The new levy will generate approximately \$6,700,000 of new revenue per year, and allows the Board for the first time in recent memory to consider expansion of programs and services rather than approaching the year seeking the "best" places to cut funding. While having additional funds is a good "problem" to have, trying to get the money to the field as expeditiously as possible, while at the same time trying to assure that funds are invested wisely so as to generate positive and sustainable outcomes, proves to be one of the Board's greater challenges/opportunities for this planning cycle.

The provider network in the county continues to be relatively stable; however, the Board has been open to adding a small number of new providers with the passage of the new levy. The three largest Community Mental Health Centers in Lucas County have participated as pilots for the Medicaid Health Home project. They report that the implementation has created a significant amount of extra work; nevertheless, the Board notes that the model has been very profitable for those agencies in FY 2013. One of the dynamics that surfaced through the implementation process was the competition for licensed workers to staff the Health Homes. There were a significant number of individuals who transferred from one agency to another, and at times, it was reported to be difficult to find workers to fill open positions. The Board does not have conclusive evidence, however, to state that there is a defined shortage of professional staff in Lucas County, nor that the competition has dramatically raised existing wage structures. One of the larger CMHCs recently became certified to deliver AOD services, and the Board's two primary AOD providers are also certified for certain mental health services.

Another important environmental change has been the composition of the Lucas County Board itself. Several key members termed off in FY 2013, and a number of new members have been added in the last biennium. For the first time in many years, all 18 positions are filled. The new members are already contributing by asking insightful questions and bringing new ideas to the table.

Assessment of Need and Identification of Gaps and Disparities

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

In preparation for the FY 2014 funding cycle, MHR SB of Lucas County commenced a formal planning process that is the basis not only for FY 2014 funding, but for this biennial Community Plan as well. A formal Purchasing Plan including a strict timeline was approved by the Board at its January 2014 meeting. The plan was linked directly to the Board's Strategic Plan. Per the timeline, in February, 7 public forums were conducted by Board staff. One was an open forum where any community member had opportunity to present a brief statement of need to the Board. Subsequent forums were held for consumers, family members, prevention and treatment providers, supportive service providers, and stakeholders from the juvenile and criminal justice systems. In addition, an ad hoc workgroup was formed and met 8 times to study issues related to housing for persons with severe mental illness. The most recently completed Lucas County Health Assessment informed much of our thinking, especially as it related to enhancing prevention services.

While the forums were being conducted, Board staff was laying the framework to incorporate the forum feedback into a gaps analysis. We chose to use a document produced by SAMHSA entitled "*Description of a Good and Modern Addictions and Mental Health Service System*" as the basis for our analysis. The document listed elements that would likely be found in 11 separate defined domains in a good and modern system. Staff reviewed the document to determine which of the elements appeared to be missing or inadequate in the Lucas County system. After feedback from the forums was synthesized, the gaps called out by community members were combined with staff's observations into a final "System Gaps Analysis." The document was approved by the Board at its April 2013 meeting.

Staff then prepared a second document entitled "System-Wide Goals." The thrust of this work was to identify over-arching goals that could be measured at a community level. Five strategies were identified with proposed measurable targets that would indicate progress toward achieving the goals. This document was approved at the Board's May 2013 meeting. The System Gaps Analysis and the System-Wide Goals became the anchor of the subsequent planning and allocation process.

In a series of 3 separate releases, the Board issued Requests for Information (RFI) to the provider community, asking for creative solutions to filling identified gaps that would contribute to advance the System Wide Goals. Over the following months, 50 unique proposals were received; many of them led to funding that has already been allocated for the remainder of FY 2014 and will extend into FY 2015. To date nearly \$5.0 million dollars (annualized) has been allocated to local providers. In all cases, the decisions for current or future funding are being linked to the guiding documents (Gaps and Goals) that were created. Staff is now in the process of working with providers to agree upon measurable outcomes for each of the funded projects as well as determining what data are needed and how they will be collected and reported.

One of the needs that surfaced quickly was to ensure that non-Medicaid clients had timely access to medication and psychiatric care. Providers and corrections officials both confirmed that clients being released from the hospitals or correctional facilities were either not getting enough medication at release or were not getting to the assessment center quickly enough to engage with a doctor before their medication was gone.

A second area of need that was called out was simply an expansion of capacity, particularly for residential AOD services as well as sub-acute detox. Medication-assisted AOD treatment has also historically lacked funding and was identified as a growing need. While capacity for mental health treatment did not present as an unmet need, the need for further integration of AOD and MH services at single locations was identified.

A number of stakeholders suggested that the system should increase the involvement of peer support specialists or peer mentors; they further recommended a system-wide approach to facilitating such recovery-oriented services as WMR, WAP, WHAM, etc. Also, there appears to be need for increased support of families in navigating the system and getting support, particularly when they are new to the system.

A need to work more collaboratively with private hospitals in the county to find more efficient ways to accessing inpatient services continues to be high on the priority list, and housing also continues to rate high when consumers are surveyed regarding needs. Lucas County has a fairly well developed housing capacity for persons with mental illness, and receives support from both HUD and the Lucas County Metropolitan Housing Authority for rental support. In the Housing Workgroup, a need was identified to provide funding for renovations to existing housing units in order to preserve that valuable stock.

The needs for youth treatment are thought to be fairly well met because the population is largely covered by Medicaid. One area that continues to be cited as a gap is a long-term residential treatment option for youth and adolescents. Regarding transition-aged youth, it was noted that this population is difficult to house, particularly in group homes because they do not want to live with a group of older people.

In a number of Family Forums, family members recurrently stated a need for more information/guidance related to knowing how to access services, especially in the case where family members were having their first experience with mental illness. In almost all venues, the issue of transportation seems to be raised in some form.

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

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. (*see definitions of “service delivery,” “planning efforts” and “business operations” in Appendix 2*).

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? (*see definition “local system strengths” in Appendix 2*).

Lucas County’s service delivery system for treatment is comprised of three large community mental health centers, two well-established AOD service organizations, and centralized crisis and access services. All of these agencies have major accreditation. In addition, there are several smaller providers that deliver services for Medicaid clients, and there are some small contracts with prevention providers, advocacy agencies, criminal justice services, and consumer-operated services. A single agency manages the majority of the funded housing for clients with mental illness. All three of the CMHCs serve both adults and youth, and one has a specialized program for transition-aged youth. While restricted for the non-Medicaid population, there really aren’t any routine treatment services that are not available at least one agency.

All of the providers are mature, professionally managed, and relatively stable financially. Though the Board currently does not contract with them, the county is fortunate to have a rich network of private hospitals with psychiatric services as well as the Northwest Ohio Psychiatric Hospital. A unique arrangement with several local inpatient doctors has provided the community mental health system with excellent access to the private beds.

An important strength of the provider system is the commitment that is shared between the Board and the providers regarding integrated treatment for persons dually diagnosed with mental illness and substance abuse issues. Two of the three CMHCs are dually certified as are both of the primary AOD providers. The County's central assessment facilities are each certified to assess for both mental health and AOD, and they use a common assessment tool.

The providers have been fairly aggressive in helping qualified clients get access to benefits such as Medicaid in order for them to be able to receive the level of service they need while maximizing the resources remaining for clients that do not qualify for subsidized services.

The Board identifies the housing continuum as a strength. The primary housing agency owns over 500 units of multi-unit and scattered site apartments, many of them being purchased with capital grants from ODMH. Clients receive rental support from HUD, LMHA, and MHR SB. In addition, the County has a relatively large number of Adult Care Facilities. Through its contract housing agency, the Board funds approximately 123 placements in 40 separate ACF homes. In addition to these Board-funded projects, there are several other projects with affiliated providers also receiving HUD funding that have provided housing to mental health and AOD consumers. In addition to permanent supportive housing, the Board funds St. Paul's Community Center, a homeless shelter that provides shelter for 90 days, mental health and AOD programming, and assistance in obtaining housing. The Center also manages the Winter Crisis Program that provides over-night accommodations and two meals to homeless individuals during select winter months.

Both crisis services and assessment for non-Medicaid clients are centralized. The crisis services are a valuable resource to the community. The agency that performs them does emergency stabilization services as well as screening for hospitalization. The facility is open 24 hours a day, and also has 16 beds that are used for 3-5 day stabilization. Assessments are done at two primary locations and use a standardized assessment tool (currently SOQIC). The assessments are at no charge to consumers and referrals are made directly to network providers based on consumer choice, applicable services, and the type of insurance (if any) the client has. Whenever possible, individuals are referred to community supports or Board-sponsored education and support groups, thus reserving treatment capacity for those with the highest priority need.

Another strength of the service system is the Thomas Wernert Center. The facility is consumer-operated with funding from the Board and provides training in leadership, WMR, computer skills, and a variety of other things. This service has been mentioned frequently by consumers and other service providers as being a wonderful support for adults who are achieving recovery at various levels.

In fiscal year 2013, the Board hired 6 new people, which translates to one-third of the staff having less than one year of experience at the Board. We are excited to have new positions to focus on quality improvement and outcomes, public information, and supportive services, as well as replacements for three people who retired last year. Ten of the Board's 18 members have started their tenure on or after January 2012. MHR SB sees this infusion of new ideas and new energy as a tremendous asset and believes that our organization is prepared to

address the uncertainties of the near future as they unfold. The Executive Director has begun the process for reviewing and updating the Board's strategic plan early in 2014.

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

As resources are available or allow, the Board is willing to collaborate with other Boards or the state departments to improve efficiencies or increase capacity for prevention, treatment, or support services. Our areas of expertise include support of CIT initiatives, administration of criminal justice and reentry projects, as well as supporting business operations. We would also be willing to collaborate with ODMHAS in the further development of the "Description of a Good and Modern Addictions and Mental Health Service System."

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

As noted above, Lucas County voters approved a new 1.0 mil levy that has provided MHRSB an opportunity to consider expanding capacity and/or funding new programs and services, although the demands for those resources are already exceeding our ability to meet them. With the elevation of Medicaid to the state and the likelihood of expanded Medicaid eligibility, the Board projects that traditional treatment services will demand much less of its resources in the future. As a result, we have opportunity to center attention on supportive services, recovery-oriented programming, housing, evidence-based practices, etc. The challenge before the Board this year is to prioritize its investments in programs that actually advance the goals that have been called out by filling gaps in service. In addition, the Board wants to ensure that the programs that do get funded produce positive outcomes in consumers' lives. All new funding will be tied to specific outcomes, and in many cases, data collection and measurement will have to be developed in order to facilitate the process.

Though it has not yet proved to be problematic, the Board is concerned about the level of data to which it will have access related to persons in treatment (being funded by Medicaid). Historically, billing data (MACSIS) was the primary source of information related to persons in service, utilization, treatment patterns, high utilizers, etc. Planning without this information readily available becomes a challenge. Even in a Medicaid treatment environment, many of the recovery-oriented services, including housing, vocational, social-recreational, evidence-based programming, etc., will be funded through the Board.

Another challenge/opportunity will be to determine the proper balance between prevention/promotion, crisis intervention, treatment, and recovery supports. Historically the system has been geared toward crisis and treatment, but in the next biennium, MHRSB will likely be looking at opportunities to engage in additional AOD prevention or mental health promotion activities, particularly if they result in population-based level changes.

As identified in the last biennium, medication for non-Medicaid consumers is another resource which is challenging to preserve and/or expand. We project that Central Pharmacy line item (421) will be overspent by as much as 20% in FY 2014 for mental health medications, and even more than that for methadone. In addition, the Board has had to increase its allocations for Suboxone to treat persons with opiate addictions. With the expanded use of medication for treatment of addiction, and the increased use of a new generation of atypical antipsychotic medications (more expensive), it will be a growing challenge for MHRSB to provide resources with which to ensure that those medications are available.

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

MHR SB envisions dramatic enhancements in the continuum of care, particular in the areas of AOD prevention/MH promotion, recovery-oriented services, and expansion of the provider network. Further, the Board believes that as it scrutinizes both current and new investments, that quality improvements will be made.

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

MHR SB would be interested in learning how other boards gather information, particularly with regard to outcomes, both at a program level and at the community level. We would be very interested to know if the state department will be providing guidance/assistance, or if communities will be left to design and implement their own proprietary systems. Also, MHR SB is interested in knowing if any Boards have a brief screen that would identify problem gambling.

5. Describe the Board’s vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (see definitions of “cultural competence” and “culturally competent system of care” in Appendix 2).

The MHR SB Board and its staff embrace the concepts of respect for the diversity of our community as well as the importance of ensuring that services provided with tax payer dollars need to be sensitive to cultural influences that might affect the outcomes of those services. One of the first examples of that commitment is the intentional demographic diversity of the Board members and the staff, elements over which we have the greatest amount of control. Board policy requires that both the Board and the staff reflect the racial makeup of Lucas County, and contracted providers are challenged to maintain those demographics in their staffs and boards alike. MHR SB conducts an annual survey of all contract providers that measures the racial and gender make up of each agency’s Board as well as full and part-time staff, including consumers who are employed by the agency. The survey is broken down by job classification as well (medical staff, managerial, direct care, clerical, support, etc.).

Although the Board has not recently provided a standardized training for the system regarding cultural competence, most agencies when surveyed report providing an annual training for their staff.

According to the most recent census data, Lucas County has the second highest Hispanic population (6.4%) of all the major metropolitan Boards in Ohio. The Board has recently increased its investments with Adelante, a local prevention-certified agency that provides outreach, education, and prevention services within the Latino community for the primary purpose of improving access to services, particularly for residents whose first language is Spanish.

Priorities

6. Considering the Board's understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities, and add the Board's unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.

Priorities for Mental Health and Recovery Services Board of Lucas County

Substance Abuse & Mental Health Block Grant Priorities

***Priorities Consistent OHIOMAS Strategic Plan**

| Priorities | Goals | Strategies | Measurement | Reason for not selecting |
|--|--|---|--|--|
| SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU) | | | | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): lack of appropriate data to substantiate need. |
| SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority) | | | | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): lack of appropriate data to substantiate need. |
| SAPT-BG: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs) | Despite funding cuts from Lucas County Children Services (LCCS), maintain the Preferred Choice Program (at some level) that delivers AOD services to substance-using parents who have an open case at LCCS | Increase MHRSB funding to program while working with provider to identify issues. | Number of clients admitted to and served by program, and number of successful completions. | <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 OhioMHAS): Individuals with tuberculosis and other communicable diseases | | | | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): lack of appropriate data to substantiate need. |
| MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED) | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |

| MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI) | Persons who are not eligible for Medicaid would have the same access to mental health treatment as did those who are eligible. | Provide additional funding to community mental health centers for non-Medicaid clients. | Units of service and cost of services per client will increase; should be equivalent to same measures for Medicaid clients. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
|---|--|--|---|--|
| Priorities | Goals | Strategies | Measurement | Reason for not selecting |
| MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services* | | | | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): lack of appropriate data to substantiate need. |
| MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders | Increase the utilization of EBP recovery-oriented services such as WMR, WRAP, etc. Increase the numbers of peer support specialists and peer mentors in the community | Fund a single entity to train, promote, and assist agencies in implementing recovery-oriented programming. Fund new programs that train and emphasize use of peers in support/mentoring roles | Numbers of people who are enrolled/participating in WMR, WRAP, etc. Numbers of certified peer specialists Numbers of peer mentors | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant *Priorities Consistent OHIOMAS Strategic Plan | | | | |
| Treatment: Veterans | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Treatment: Individuals with disabilities | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs* | Increase the availability of medication-assisted treatment. | 1) Increase allocation amounts to current provider of MAT; 2) Engage new providers as appropriate; 3) Develop protocols for long-term use of MAT | 1) Numbers of clients who access MAT 2) Number of providers who provide MAT 3) Number of successful completions related to MAT | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |

| Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing* | Ensure that all OHMAS/MHR SB housing is available to house persons with SPMI. | Invest in one-time funding to preserve existing housing stock through intensive renovation. | Numbers of units that are fully renovated. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
|---|--|--|--|---|
| Treatment: Underserved racial and ethnic minorities and LGBTQ populations | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Priorities | Goals | Strategies | Measurement | Reason for not selecting |
| Treatment: Youth/young adults in transition/adolescents and young adults | Provide housing for younger populations who resist living in group homes with older clients. | Identify the number to be served and provide group home(s) that target this specific population. | Number of transition-aged youth who move into specified housing. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Treatment: Early childhood mental health (ages 0 through 6)* | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents* | Expand prevention services across the life-span to include senior-citizens who are at risk of substance-use disorders. | Fund a provider to deliver an evidence-based program that targets AOD prevention for seniors. | Number of senior citizens who receive a prevention message. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices | Provide education and prevention to empower Hispanic women of child-bearing age to make healthy life choices. | Provide an evidence-based program through a local agency the works in the Hispanic community. | Number of women in the program that deliver drug-free babies. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
| Prevention: Promote wellness in Ohio's workforce | | | | <input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |

| | | | | |
|--|---|---|--|--|
| Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations* | All assessment centers will include a screen for problem gambling in their diagnostic assessment. | Develop a screening tool to be used at the centers and fund its implementation. | Increase in number of referrals from AOD and Mental Health assessment centers. | <input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): |
|--|---|---|--|--|

| Board Local System Priorities (add as many rows as needed) | | | |
|--|--|---|---|
| Priorities | Goals | Strategies | Measurement |
| Persons with mental illness will have access to an ample supply of medication upon release from incarceration to bridge the gap between release and first appointment at community mental health center. | Persons released from Corrections Center of Northwest Ohio or the Lucas County Corrections Center who are currently being prescribe psychotropic medication will have a 30-day supply of those meds at release as well as a confirmed appointment for a diagnostic assessment. | 1) Establish CCNO and LCCC as distribution points for Central Pharmacy and provide an allocation for the purchase of meds at the correction centers. | 1) Number of clients who had medication in hand upon their release. |
| Integration of treatment for clients who have both Mental Health and AOD disorders. | All contracted agencies that provide behavioral health services will be either dually certified or will demonstrate that they have a plan in place so that clients who present for the agency's primary services will be provided their secondary service in an integrated fashion through coordination of care. | Provide additional non-Medicaid funding to certified agencies to provide both MH and AOD services. | Numbers of clients who receive both mental health and AOD services at their primary agency. |
| Improve working relationships between, MHR SB, Rescue (the pre-screener) and local private hospitals. | Clients who require screening for hospitalization will be screened and transferred to the appropriate setting within 4 hours, and clients who are transferred to hospital level of care will be transported in a single move (right place first time). | Provide an incentive payment to the pre-screening agency to improve efficiencies. | Percentage of persons screened and referred within 4 hours. Percentage of persons transferred to the right place the first time. |
| Family Navigators | Families of persons experiencing mental illness will have a readily accessible resource navigator that will guide them to services, help them know what to expect, explain options, etc. | Fund NAMI to provide a unique service in Lucas County that can educate family members and provide support through accessing needed services for their loved ones. | Numbers of persons who engage the services and who report that they are successful in getting help for their family member with mental illness. |
| | | | |

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) Increase subsidization for Adult Care Facility (ACF) placements. | ACFs have been an integral part of the housing continuum in Lucas County, particular in helping to facilitate hospital discharges or to house clients who will not do well in independent living. There is usually a waiting list for a subsidized slot in the homes because they have traditionally been very expensive and limited in number. If funds were available, MHRSB would consider expanding this recovery service. |
| (2) Develop housing for clients who are recovering from substance use or who have criminal records. | Most of the Board's resources for housing have been channeled to housing for persons with mental illness. The ad hoc workgroup chartered to review housing in Lucas County identified this group(s) as underserved populations and advocated for funding. |
| (3) Long-term residential care for SED youth, particularly for youth who are involved in more than one service system. | This has been a long-recognized need in Lucas County, and one which MHRSB would like to address if funding were available. We have taken some steps under the auspices of the ad hoc Crisis Care Committee to partner with other youth-serving agencies, but continue to run into roadblocks. |
| (4) | |
| (5) | |
| (6) | |
| (7) | |

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.

One of the primary collaborations in the past two years was with the Northwest Ohio Regional Board collaborative through the administration of the Hot Spot funds granted by ODMH. Lucas County spearheaded a technology innovation by providing County provider agencies with a computer-based video communication platform. This platform was provided to allow provider agencies to explore the value of using Telemedicine to help in the treatment of clients, use of video assessments, and to facilitate group communication. Another accomplishment was the establishment of short-term residential placements for youth at Rescue, Lucas County's crisis agency. Nine separate boards used the service in FY 2013. The collaboration leveraged Rescue's capacity and at the same time provided a service that was not available in some of the smaller communities.

In the area of homelessness, the Board has worked extensively with the Toledo Lucas County Homelessness Board through coordinated applications to HUD for Permanent Supported Housing; by participating in the implementation of a Coordinated Assessment Center operated by United Way to channel homeless individuals to either shelter or PSH; by funding 17 transitional housing beds for homeless persons with mental illness and substance issues; and by funding additional services at a local homeless shelter to expedite the process of moving clients in shelter into permanent housing. The Board's Executive Director is a member of the TLCHB, and Board staff has worked closely with TLCHB on a number of policy, implementation, and quality improvement issues.

A recent collaboration between MHRBS, OHMAS, the Lucas County Commissioners, a local treatment/prevention provider, and United Way has resulted in a gambling initiative that involves a population-based prevention program aimed at problem gambling as well as a treatment program for those who are screened with evidences of problem gambling. This initiative was formed in contemplation of problems that may arise as a result of opening a new gambling casino in the Toledo-Lucas County region, as well as the rise of internet café gambling.

Inpatient Hospital Management

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

Since OHMAS decided to take back the "risk" of managing State Hospital days, Lucas County managed to reduce the number of admissions and bed days from FY 2012 to FY 2013 for both private and public hospitals. The system's providers continue to make the reduction of hospitalization a priority as a matter of good client care. Rescue showed only a slight increase in the utilization of the Crisis Stabilization Unit from FY 12 to FY 13. There are current initiatives in place to make the relationship between Rescue and the private hospitals more efficient in terms of screening and admission; the Board has funded the three primary community mental health centers to do in-reach at the local public and private hospitals in order to expedite discharges and to facilitate linkage at the centers. It is hoped that these initiatives will favorably impact bed day utilization and recidivism. During the first months of FY 2014, there appears to be a slight increase in the utilization at Northwest Ohio Psychiatric Hospital, however, overall, the Board does not foresee an increase in the utilization at that facility or at private hospitals.

Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that **increase efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?**

a. Service delivery

b. Planning efforts

Again this year the Board has enhanced its planning efforts by establishing a formalized approach to identifying what it thinks the continuum of care should look like, what pieces of that vision are missing, and what strategies should be employed to either add to or enhance the continuum to fulfill the vision. The documents that were created during this process have been, and in the near term will continue to be the guidance to inform all decisions the Board makes regarding funding decisions. This process absorbed a tremendous amount of staff effort, but the Board believes the investment in the process will streamline future planning.

c. Business operations

d. Process and/or quality improvement

While there is yet work to be done to fully formalize the CQI process, the Board has laid the foundation with a renewed emphasis on the identification and collection of outcomes at both the programmatic level and the community level. A new staff position was added (Manager of Quality Improvement) as well as a part-time Compliance Monitor. Their roles are targeting the development of outcome-based contracts and monitoring the results of those contracts. To be developed in FY 2014 is a systematic CQI Plan that allows the Board to develop improvement plans in areas that fail to meet the stated outcomes or the Boards desired goals.

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

Advocacy (Optional)

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

None

Open Forum (Optional)

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

Probably the key external factor that impacts Lucas County as well as the other state Boards is the expansion of Medicaid. Our projections indicate that as many as 95% of our existing non-Medicaid clients will be eligible for Medicaid coverage. Coupled with this is the impact of the Affordable Care legislation. Both of these seem to be certain to have an impact, but what that is and when it will take affect are fairly uncertain. Coupled with these changes is the uncertainty of future funding through the State's 507 budget line item. That being said, this Board is proactively working with the provider network to gear up for enrolling as many clients as are eligible into Medicaid, and at the same time beginning to consider ways that the Board can invest in the continuum of care that is not treatment such as housing, recovery oriented services, evidence based practices that have non-billable components to their programs, prevention and wellness services, etc.

Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through OhioMHAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds.

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

| A. HOSPITAL | ODADAS UPID # | ALLOCATION |
|-------------|---------------|------------|
| | | |

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with OhioMHAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

| B.AGENCY | ODADAS UPID # | SERVICE | ALLOCATION |
|----------|---------------|---------|------------|
| | | | |

Appendix 2: Definitions

Business Operations: Shared Resources, QI Business Plan, Financial Challenges, Pooled funding, Efficiencies, Strategic Planning, Contracts, Personnel Policies, etc.

Cultural Competence: (Ohio's State Inter-Departmental Definition) Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

Culturally Competent System of Care: The degree to which cultural competence is implemented as evidenced by the answers to these questions:

- Is leadership committed to the cultural competence effort?
- Are policies and procedures in place to support cultural competence within the system, including policies and procedures to collect, maintain and review caseload cultural demographics for comparison to the entire community?
- Are the recommended services responsive to each adult, child and family's culture?
- Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?
- Is staff reflective of the community's racial and ethnic diversity?
- Is staff training regularly offered on the theory and practice of cultural competence?
- Are clients and families involved in developing the system's cultural competence efforts?
- Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?
- Is staff culturally sensitive to the place and type of services made available to the adult, child and family?
- Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?

Local System Strengths: Resources, knowledge and experience that is readily available to a local system of care.

Local System Challenges: Resources, knowledge and experience that is not readily available to a local system of care.

Planning Efforts: Collaborations, Grant opportunities, Leveraging Funds, Data Collection (e.g., Key Performance Indicators, Outcomes), Trainings

Service Delivery: Criminal Justice, School Based or Outreach, Crisis Services, Employment, Inpatient/Residential Services, Housing, Faith Communities, etc.