

### III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

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*Click on box to enter Board name.*

**BOARD NAME:** Ashtabula County Mental Health and Recovery Services Board

**A. Mission, Vision and Values Statements.** Please provide the Board’s mission, vision and values statements (see Appendix C for planning terms):

*Click on gray box to enter text.*

Mission Statement: To Improve the Mental Health and Drug/Alcohol Services in Ashtabula County

**B. Description of Current State.** Provide a brief narrative that describes relevant information about the Board area in response to the items below:

**1.0 Population priorities.** Please review information in Appendix E about the Board’s existing MACSIS business rules for covered benefits to service populations. To what extent are the existing business rules aligned with current population and service priorities for non-Medicaid expenditures by the Board?

*Click on gray box to enter text.*

The Ashtabula Board does not have the financial capacity to purchase the services necessary to come even close to meeting the present needs of the Non-Medicaid population seeking mental health services. This state is a direct result of our ever increasing Medicaid match obligation. During SFY 2000 the Board's total Medicaid costs were \$1,243,242.93 and in SFY 2001 it increased to \$1,716,985.84. Similarly in subsequent years the Medicaid costs of the Ashtabula Board continued to rise with Substance Abuse Medicaid comprising from around 8% to 13% of our total Medicaid costs: SFY 2002 \$2,459,787.49; SFY 2003 \$3,231,449.00; SFY 2004 \$3,823,320.79; SFY 2005 \$4,668,365.47; SFY 2006 \$6,076,676.67; SFY 2007 \$7,121,531.56. And we are on a path to experience Medicaid growth that may reach in excess of \$8,500,000 during SFY 2008.

When examining the data around this phenomena some interesting facts can be observed. First, that Ashtabula County's increase in Medicaid costs cannot be solely attributed to an increase in clients. The following data gathered from MACSIS shows that, although the rate of Medicaid growth and client increase did have a correlation at the beginning of our growth spurt, this has not held true for the past five years.

SFY	RATE of DOLLAR GROWTH	RATE of CLIENT GROWTH
2001	38.1%	35.1%
2002	43.3%	30.9%
2003	31.4%	16.8%
2004	18.3%	10.7%
2005	22.1%	4.2%
2006	30.2%	11.9%
2007	17.2%	2.2%

Furthermore, although Ashtabula County does have a higher Medicaid penetration rate than the state average, we have also seen an increase in our cost per client over the past several years. This increase has resulted in our cost per client for Mental Health Medicaid clients going from \$1,190.82 in SFY 2002 to \$2,315.91 in SFY 2007.

To place these numbers in perspective and to ascertain if the Ashtabula County data was typical for similar Boards or an anomaly, the Ashtabula County MHRS Board requested that our Heartland East ASM, the organization that processes our MACSIS claims, prepare a comparison of our statistics to the statistics of the Boards in our collaborative who were most akin to Ashtabula County in size. This comparison revealed that Ashtabula is in fact outside the norm when compared to this peer group. For the same time periods the combined peer group (Portage, Wayne-Holmes and Columbianna Counties) experienced the following cumulative rates of growth:

SFY	RATE of DOLLAR GROWTH	RATE of CLIENT GROWTH
2002	24.5%	19.4%
2003	2.6%	10.7%
2004	3.8%	4.0%
2005	6.0%	4.9%
2006	5.5%	11.4%
2007	-0.74%	2.8%

Likewise the comparison of the costs per client showed a similar trend. See information below.

In-County Medicaid Growth: Cost per Client  
 SFY 2002 to 2007 (Medicaid MH Services)  
 (created based on the MACSIS claims extract created February 9, 2008)

Board	SFY 2002	SFY 2007	Change
Ashtabula	\$ 1,190.82	\$ 2,315.91	94.5%
Peer Group	\$ 1,732.93	\$ 1,482.90	-14.4%

Thus, due to our out-of-the-norm Medicaid growth, the Board has depleted all of its cash balance and does not have all of the funds necessary to meet the Medicaid match obligation for SFY 2008. Even with the Safety Net funds assistance that this Board received from the Ohio Department of Mental Health during SFY 2006 and SFY 2007, we remain in the position of having scarce to non-existent resources available to fulfill the Board's ORC 340 obligations for Safety Net services for indigent mental health consumers who are in need of services and supports in order to maintain themselves in the community let alone the services vital to assist them in their journey toward Recovery.

Our service priorities have narrowed to those basic services required by ORC 340 which relate to hospitalization, crisis intervention and minimal outpatient maintenance of those most in need. We have worked with our crisis intervention agency to develop a triage policy where by they use their clinical judgement to determine who will have access to the limited services available as a result of a crisis intervention encounter or a hospitalization.

Consequently, our current business rules for Non-Medicaid services only allow for the elimination of a copay for the most cost prohibitive services for consumers, Community Psychiatric Support and Partial Hospitalization. And, at this time, we do not have a Non-Medicaid contract with

any agency to deliver Partial Hospitalization services. Our current service priorities for the provision of Non-Medicaid treatment services align with our business rules in that the priorities are to ensure that the consumers in the greatest need of stabilization/crisis services have access to treatment and that those in need of hospitalization at the state hospital receive follow-up care upon their return to the community. By requiring a copay for all contracted treatment services, except for Community Psychiatric Support (CPS), the Board is able to serve more clients with its limited resources. Unfortunately, since only 10.56 % (461 individuals) of the clients served in SFY 2006 and 10.64% (471 individuals) of the clients served in SFY 2007 had incomes sufficient to require that they pay a portion of their service costs, this practice has not yielded a large amount of additional funds for either Non-Medicaid services or Medicaid match. And although we have considered a change in the current business rules to require a copay for CPS, we believe the numbers tell us that this change would not significantly increase the Board's capacity to purchase more Non-Medicaid services and could do harm to the few indigent clients that we are able to serve.

**2.0 Recovery supports.** What are some notable achievements and trends for the Board in the area of Recovery supports?

**Recovery supports** are strategies and services designed to foster empowerment and quality of life for persons with severe mental illness. Best practices include culturally competent services, supported housing, supported employment, consumer operated services, and self help/peer services. Examples of programs include Wellness Management and Recovery, WRAP, Bridges, NAMI Family to Family, Clubhouse. Prevention, consultation, and education (P,C&E) programs that *target persons with severe mental illness* might also be included under the Recovery supports umbrella. An example of a P,C&E program of this nature is the Network of Care web site. P,C&E programs for the general public, however, should be discussed under that section of the outline.

**Best Practices in Recovery:** Funding source is often a difference between best practices in Recovery support and best clinical practices, with Recovery supports primarily funded as non-Medicaid-reimbursable services.

*Click on gray box to enter text.*

The Ashtabula Board in past years funded a supported employment program, a local consumer group, a local family group, peer support, various prevention programs and sponsored a WRAP and other consumer trainings. Over a three year period, these programs experienced cuts in funding in order to meet our local Medicaid match until we reached a point where, with the start of SFY 2006, these programs were no longer funded by the Board. In the last state fiscal year, the Board was able to offer consumer training due to the availability of Community Block Grant Funds awarded to us by our ODMH Area Director. We have also participated in the Network of Care project and offered some community trainings and public speaking on mental health issues such as suicide prevention, services to children and families and systems of care.

## **2.1 Recovery Supports: Housing**

**Supported Housing** is a specific program model in which a consumer lives in a house or apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing include: housing choice, functional separation of housing from service provision, affordability, integration with persons who do not

have mental illness, right to tenure, service choice, service individualization, and service availability. The Mental Health Housing Leadership Institute operated by NAMI Ohio provides consultation and training.

a. Do you offer **supported housing** service?

Click on gray box to select answer.

No	<b>2.1.a</b>
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b. If yes, do you have wait lists for **supported housing**?

Click on gray box to select answer.

	<b>2.1.b</b>
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c. With regard to **supported housing**, which of the following categories comes closest to the average wait time for most consumers? *Please select only one response category.*

Click on gray box to indicate "Yes" with an "X."

10 working days or less	Up to 1 month	1-3 mos.	4-6 mos.	7-9 mos.	10-12 mos.	More than One Year	Don't Know /NA	2.1.c
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

d. Of all consumers for whom supported housing would be an appropriate service, how many are currently waiting for **supported housing**?

Click on gray box to enter number.

0 Consumers Waiting	<b>2.1.d</b>
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The **Housing Assistance Program** (HAP) provides temporary rental subsidies and no-interest loans to assist persons with severe mental illness and their families with obtaining permanent, safe, decent and affordable rental housing until a permanent subsidy can be obtained (Section 8 voucher), or until a person's income increases sufficiently so that a rental subsidy is not needed, or until person owns their own home.

e. Do you have wait lists for HAP?

Click on gray box to select answer.

No	<b>2.1.e</b>
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f. For most consumers waiting for access to HAP in your area, which of the following categories comes closest to the average wait time? *Please select only one response category.*

Click on gray box to indicate "Yes" with an "X."

10 working days or less	Up to 1 month	1-3 mos.	4-6 mos.	7-9 mos.	10-12 mos.	More than One Year	Don't Know /NA	2.1.f
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

g. Of all consumers for whom HAP is appropriate, how many are currently waiting for access?

Click on gray box to enter number.

0 Consumers Waiting	<b>2.1.g</b>
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**Public Housing** is defined as housing subsidized by the federal government, such as but not limited to Section 8. People on HAP are likely to be on public housing wait lists, but HAP is not public housing.

**h.** For most consumers waiting for public housing in your area, which of the following categories comes closest to the average wait access time? *Please select only one response category.*

Click on gray box to indicate "Yes" with an "X".

Up to 1 year	1-2 yrs.	3-4 yrs.	5-6 yrs.	7-8 yrs.	9 yrs. or more	Don't Know /NA	2.1.h
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**i.** Of all consumers for whom public housing is appropriate, how many are currently waiting for a place to live?

Click on gray box to enter number.

UK Consumers Waiting	<b>2.1.i</b>
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The **Homeless Housing Status National Outcome Measure (NOM)** reported to SAMHSA by ODMH refers to adults, aged 18+ with severe mental illness (SMI), who have identified themselves as homeless on an administration of the Adult Consumer Survey in the Ohio Outcomes System. For SFY 2007, Ohio reported a Homeless Housing Status NOM to SAMSHA of **2,879** persons with SMI. Board level data for Ohio's SFY 2007 Homeless Housing Status NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

**j.** To what extent are the Board level data reported in Appendix B for homeless adults with SMI an accurate reflection of the number of such individuals served by the Board in SFY 2007?

Click on gray box to enter text.

According to the available BH and Outcomes data, the Board estimates that we have served at least 66 homeless adults with a mental health diagnosis during SFY 2007 or 2.8% of the adult population served. Comparatively, of the 871 individuals identified as severely mentally ill and homeless by the same BH and Outcomes data, 23 or 2.6% were homeless. And due to the fact that our BH and Outcomes data reporting by the mental health agencies has not reached 100%, we can postulate that the actual number of individuals with a mental illness that are homeless in Ashtabula County is slightly higher than 66. In contrast, the number for SFY 2007 reported by NOMS is 6. The Board has also relied on its Continuum of Care "Point in Time" survey as a comparison instrument. This survey was recently updated in January 2008. The data is in the process of being compiled.

**j.a.** If the Board does not use Outcomes data to estimate number of homeless persons with SMI, what data source does the Board use to plan for services to this population?

Click on gray box to indicate "Yes" with an "X". Indicate all that apply.

<input checked="" type="checkbox"/> Continuum of Care	<b>2.1.ja</b>
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<input type="checkbox"/>	PATH	
<input type="checkbox"/>	BH Mod (Behavioral Health Module)	
<input checked="" type="checkbox"/>	HMIS (Homeless Management Information System)	
<input type="checkbox"/>	Other, please specify:	

**j.b.** If the information in Appendix B is inaccurate, what was the number of homeless persons with SMI served by the Board in SFY 2007?

*Click on gray box to enter number.*

66 Homeless persons with SMI	<b>2.1.jb</b>
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**j.c.** Is there anything else important to know about the current state of housing strategies and services in your Board area?

*Click on gray box to enter text.*

The Board's current Shelter Plus Care program cannot meet all of the long term needs of the homeless adults with SMI. Consequently, we work closely with our Continuum of Care partners to assist these consumers in gaining access to mental health, substance abuse and community services. The Board has also seen an increase in the number of individuals who participate in the Shelter Plus Care grant program struggling to maintain treatment compliance necessary to remain on the program, putting their housing subsidy in jeopardy. If there was funding available, many Recovery supports, such as peer support services and supported employment, could be reengaged to offer consumers the opportunity to regain skills and have a greater chance of achieving Recovery.

## 2.2 Recovery supports: Employment

The **Employment Status NOM** reported to SAMSHA by ODMH refers to adults, aged 18+ with severe mental illness, who have identified themselves as employed full-time or part-time through an administration of the Adult Consumer Survey in the Ohio Outcomes System. For SFY 2007, Ohio reported an Employment Status NOM to SAMSHA of **24,068** persons with SMI. Board level data for Ohio's SFY 2007 Employment Status NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

**a.** To what extent are Board level data reported in Appendix B for employed adults with SMI an accurate reflection of the number of such individuals served by the Board in SFY 2007?

*Click on gray box to enter text.*

The Board Outcomes and/or BH data shows that the Board served 1022 adult clients identified as having a mental health diagnosis during SFY 2007 that were employed at some level. This is 40.2% of the total adult clients served. However, when isolating out the adult clients who were noted as having a severe mental illness, the Board's Outcomes and BH data revealed that 291 of the 877 SMI consumers were employed at some level or 33.2% of this population. The NOMS data states that 174 SMI consumers were employed during SFY 2007. The NOMS data is too low.

**a.a.** If the Board does not use Outcomes data to estimate the number of employed persons with SMI, what data source does the Board use to plan for services?

*Click on gray box to enter text.*

**a.b.** If the information in Appendix B is inaccurate, what was the number of full-time and part-time employed persons with SMI served by the Board in SFY 2007?

*Click on gray box to enter number.*

291 Employed persons with SMI

2.2.ab

**b.** Please describe existing activities related to helping consumers identify, determine, or achieve their employment goals. The continuum of activities may include referral to the Rehabilitation Services Commission (RSC), service planning and coordination through CPST, vocational counseling service, supported employment programs, agency employment of peer support specialists, or any other Board strategies aimed at helping consumers achieve employment goals.

*Click on gray box to enter text.*

The Board funding for a supported employment program ended at the beginning of SFY 2005. This program was eliminated due to the need to divert funds to meet the Board's increasing Medicaid match obligation. At that time the Board was forced to end funding for all supportive programs in favor of clinical services and Medicaid match. Currently, the Board offers information and training to CPST staff through venues like our Continuum of Care meetings and Family and Children First Council Cross trainings to familiarize them with community resources available to consumers that will assist them in gaining employment or employment services. There is no current plan to re-fund any employment programs as the Board has no funds available for Non Medicaid clinical, supportive or prevention services.

**3.0 Resilience supports.** What are some notable achievements and trends for the Board in the area of resilience supports?

**Resilience supports** include strategies for school success, early childhood intervention, transitional living, system of care coordination, wraparound, mentoring, family support and education, and family advocacy. Examples of programs and activities in these areas include Network for School Success, ABC, FAST, Incredible Years, Big Brothers/Big Sisters, Triple P, Family Advocates, NAMI Hand to Hand. Funding source is the major difference between best practices in Resilience support and best clinical practices, with the Resilience support primarily funded as non-Medicaid reimbursable services.

*There is overlap between Resilience Supports and Prevention, Consultation, and Education (P,C&E). Boards can discuss programs such as BB/BS, Triple P, Family Advocates, Early Childhood Screening, etc., as a Resilience Support or under the narrative for Section 10: P,C&E.*

*Click on gray box to enter text.*

SFY 2006 was the last year that the Board was able to fund various prevention programs that support resiliency in children. Prior to this change, the Board supported four after school programs scattered throughout the the county. Currently, the Board is very involved in the Family and Children First Council's Service Coordination Process. The Board Assistant Director facilitates the Service Coordination process in the county as well as coordinating the process for the ABC and FAST funds. Additionally, the Board is in the process of continuing to work with our county Starting Point to initiate a DECA program in the county. During SFY 2007 the Board used some Early Childhood Mental Health funds to sponsor a DECA training for Clinical and Child Care staff to introduce them to the process and get them ready for implemetation. During SFY 2008 the

current plan is to move toward implementing some DECA programs in various child care classrooms and provide mental health training to Help Me Grow and Child Care staff. Lastly, the Board receives funding from ODMH for the provision of mental health clinical and prevention services at a local alternative school setting.

### 3.1 Resilience supports: School Suspension and Expulsion NOM

The **School Suspension and Expulsion NOM** reported to SAMSHA by ODMH refers to children and adolescents, aged 18 or less, with serious emotional disturbance (SED), who have been identified as having been suspended or expelled from school through administration of a survey in the Ohio Outcomes System. For SFY 2007, Ohio reported a School Suspension and Expulsion NOM to SAMSHA of **8,187** persons with SED. Board level data for Ohio's SFY 2007 School Suspension and Expulsion NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

- a. To what extent Board-level data reported in Appendix B for school attendance an accurate reflection of the number of such individuals served by the Board in SFY 2007?

*Click on gray box to enter text.*

According to MACSIS data, Ashtabula County served 1,297 children during SFY 2007. Of these 1,297 children receiving services, 473 were categorized as being SED based on the criteria set down by the state in MACSIS and the Ohio Scales measures. If in fact the NOM information is correct this would mean that 34 or 7.2% of the SED youth served by Ashtabula County mental health providers during SFY 2007 were suspended or expelled sometime during the school year. This number appears to be low based on data found on the Ohio Department of Education web site. The website information indicates that during School year 2006-2007 there were many more suspensions and expulsions of students across all of the seven Ashtabula County school districts for students identified as Emotional Disturbance (previously SBH) than may reasonably be accounted for by 34 children. And with the knowledge that not all of the students identified as SED in the mental health system are categorized Emotional Disturbance in the public school system but are sometimes determined to have other disabilities or are unidentified in the school environment , we can deduce that the number of students with a Severe Emotional Disturbance suspended or expelled from school during the last school year was greater than 34.

- a.a. If the Board does not use Outcomes data to estimate school suspensions and expulsions among children and adolescents with SED served in your area, what data source does the Board use to plan for services that support school success?

*Click on gray box to enter text.*

Except through the planned services delivered through the FCFC Service Coordination process and the mental health portion of the Alternative Education program, the Board does have the funds to plan for other services. When able to plan for services for youth the Board will use data from the Outcomes measures as well as data from the Ohio Department of Education and the local and city school districts in Ashtabula County. In the past, the Board conducted extensive surveys of the school personnel to determine how best to use its treatment and prevention dollars to meet the needs of the youth in the community. However, the lack of discretionary funds has practically eliminated our ability to engage the schools and do any planning for youth beyond the interaction we

**3.1.aa**

have mentioned above. Additionally, the Board has not been engaged by a local provider or the school districts in the endeavour of expanding Partial Hospitalization units into various school buildings. At present a Medicaid only provider has approximately six PHP units in various school buildings around the county. But the lack of engagement of the Board by the agency means the Board has no information on what evidence-based practice the agency is using in the program and what the admission or discharge criteria encompass or how to measure if the program is meeting any treatment outcomes for the youth. The only direct information the Board has received is by way of the Medicaid Reviews. During these reviews, the Board found that a number of the youth served during the school year chose not to attend the program during the summer months.

**a.b.** If the information in Appendix B is inaccurate, what was the number of persons with SED served by the Board in SFY 2007 who were suspended or expelled?

*Click on gray box to enter number.*

0	<b>3.1.ab</b>
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**4. Inpatient Care**

Please complete the table below for the past two fiscal years. *See Appendix F for past Board purchased state hospital bed days and admissions. These data are included to help complete the public portion of this table.*

**a. Inpatient Care**

*Click on gray boxes to enter numbers.*

Board Purchased Inpatient Care	FY 06 Bed Days	FY 07 Bed Days	FY 06 Admissions	FY 07 Admissions	<b>4.a</b>
State Hospitals	1213	1553	107	132	
Private Psychiatric Hospitals: Adults	0	0	0	0	
Private Psychiatric Hospitals: C&A	0	0	0	0	

**b.a.** Please describe how the provision of Board purchased inpatient care occurs in your Board area. What is the nature of the relationship between the Board and private hospitals?

*Click on gray box to enter text.*

The Board looks at its history and determines the number of bed days it believes it will need over the next year. The Board has had ongoing conversations with the local private hospital but has not reached an agreement with them for any purchase of bed days.	<b>4.ba</b>
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**b.b.** Do you have a continuity of care agreement with your designated state hospital?

*Click on gray box to select answer*

No	<b>4.bb</b>
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**5. Residential Treatment Centers (RTCs).**

**a.** During SFY 2007, how many children and adolescents (C&A) from the Board area were funded for mental health services while living in a residential treatment facility?

*Click on gray box to enter number.*

10 C&A Consumers in SFY 2007	<b>5.a</b>
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**b.** How many children and adolescents from the Board area were placed in RTCs located outside of your service area in a 12-month period?

*Click on gray box to enter number.*

10C&A Consumers place out of county in SFY 07	<b>5.b</b>
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**c.** How many of the C&A consumers identified above involved Board participation in the placement decision?

*Click on gray box to enter number.*

1 Out of county placements involved the Board	<b>5.c</b>
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**d.** For SFY 2007, how would you describe the local trend in placements at Residential Treatment Centers? *Please select only one answer.*

*Click on gray box to indicate "Yes" with an "X."*

<b>Use is increasing</b>	<b>Use is about the same</b>	<b>Use is decreasing</b>	<b>5.d</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**e.** How does the Board understand the trend in RTC placements indicated above?

*Click on gray box to enter text.*

The local Children Services Board sees the need to reduce their RTC placements for both financial and best practice reasons. They have worked with the MHRS Board as they have developed their process of ensuring that youth in residential treatment are appropriate for residential treatment and receive the services in a therapeutic, outcomes driven manner. This has resulted in some reductions in those placements over the past few years; however, the placements have been around 8 to 10 for the last two years. Presently, the local Children Services Board is looking to further reduce their out-of-county and residential placements and have engaged the Board in some conversation concerning this issue through the FCFC Services Coordination Process. We have not experienced a reduction in residential placements due to the increased access to Partial Hospitalization Services in the county.	<b>5.e</b>
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**6. Crisis/Emergency Care.**

**a. 1. Access & Capacity.** For each of the following emergency services that are available in the Board area, please indicate "Yes" with an "X."

Click on gray box to indicate "Yes" with an "X."

Service Area	Service Available?	6.a.1
24/7 Hotline	<input checked="" type="checkbox"/>	
Warm Line	<input type="checkbox"/>	
<b>Adult Consumers</b>		
24/7 On-Call Staffing by Psychiatrists	<input checked="" type="checkbox"/>	
24/7 On-Call Staffing by Clinical Supervisors	<input type="checkbox"/>	
24/7 On-Call Staffing by Case Managers	<input checked="" type="checkbox"/>	
Mobile Response Team	<input checked="" type="checkbox"/>	
Crisis Care Facility	<input checked="" type="checkbox"/>	
Hospital Emergency Department with Psychiatric Staff	<input type="checkbox"/>	
Hospital contract for Crisis Observation Beds	<input type="checkbox"/>	
Respite Beds	<input type="checkbox"/>	
Transportation Service to Hospital or Crisis Care Facility	<input checked="" type="checkbox"/>	
Other (Please Specify):	<input type="checkbox"/>	
<b>Child &amp; Adolescent Consumers</b>		
24/7 On-Call Staffing by Psychiatrists	<input checked="" type="checkbox"/>	
24/7 On-Call Staffing by Clinical Supervisors	<input type="checkbox"/>	
24/7 On-Call Staffing by Case Managers	<input checked="" type="checkbox"/>	
Mobile Response Team	<input checked="" type="checkbox"/>	
Crisis Care Facility	<input type="checkbox"/>	
Hospital Emergency Department with Psychiatric Staff	<input type="checkbox"/>	
Hospital contract for Crisis Observation Beds	<input type="checkbox"/>	
Respite Beds	<input type="checkbox"/>	
Transportation Service to Hospital or Crisis Care Facility	<input type="checkbox"/>	
Other (Please Specify):		

**a.2. Crisis Bed Days.** If the Board contracts for crisis beds, please indicate utilization for Adults and Children & Adolescents in SFY 2006 and SFY 2007:

Click on gray box to enter number.

	SFY 06 Crisis Bed Days	SFY 07 Crisis Bed Days	6.a.2
Adults	70	49	
Children & Adolescents	0	0	

**b. Discuss achievements and trends** in crisis care services that have been areas of focus for the Board.

Click on gray box to enter text.

The major achievement of this Board is that we have managed to maintain any crisis services at all in the wake of our ever surmounting Medicaid costs. However, through careful planning with the crisis intervention agency and because of the Safety Net funds allocated to the Board during SFY 2006 and SFY 2007, some bare minimum of services have been

preserved, although far from even meeting the basic needs of the community. If the Board's financial condition continues to worsen and it sees no relief from the Medicaid trends described previously, we do not believe we will be able to deliver any of these services much longer.

**c. Crisis and Emergency Initiatives.** Briefly describe achievements and trends in the following areas:

**1. Police Coordination/CIT**

*Click on gray box to enter text.*

The Ashtabula County MHRB Board offered a CIT introductory training several years ago to its local and county policing authorities. We received some response and approximately 7 police officials attended the training. After the initial training, we had the opportunity to obtain additional funds from ODMH to support sending some officers to the week long training. Unfortunately, none of the police departments had the manpower available to allow release time for the training. All of our departments were experiencing cut backs and staff shortages at the time and even the offer to cover the cost of the loss of personnel for that week was not enough to make it possible for any officers to participate in this opportunity. Since this time, there has been no renewed interest in full CIT. However, our County Sheriff's Department and County Jail Administrator do utilize some trainings on mental health issues offered by the Cuyahoga County Mental Health Board due to the fact that Ashtabula County has not had the funding available to offer these trainings locally. If we had adequate funding to offer these trainings in our own county, we could enhance our relationships with the local law enforcement authorities.

**2. Disaster Preparedness**

*Click on gray box to enter text.*

The Board Assistant Director has worked with the local and county health departments and the County Emergency Management Agency on Disaster Preparedness plans. The Assistant Director has also been trained in the current state curriculum and has taken the required FEMA NIMS trainings. She has also participated in many planning meetings and two table top exercises, one regional and one local. The Board sponsored the original 2 day disaster preparedness training funded by ODMH and the Board will be receiving funds from ODMH during this state fiscal year in order to offer the current state training. The Board will continue to work with all of our partners to the best of our ability and within the means we have at our disposal.

What are your estimates of staff for the following areas?

*Click on gray box to enter number.*

	Local Disaster Response	Statewide Disaster Response	<b>6.c.2</b>
Trained	24	0	
Currently Available	6	2	

3. School Response, including prevention, consultation and education:
  - a. Universities & Colleges
  - b. Secondary and Primary Schools

*Click on gray box to enter text.*

The Board has not been asked by any local schools or the Kent State University Ashtabula Branch to participate in any disaster or emergency planning. We have been active in the planning for emergency situations with the local Emergency Management Agency and will respond to any request they would make to the best of our ability and within the resources we have available.

**7. Outpatient Services.**

**a. Intensive Care.** For each of the following services that are available in the Board area, please mark (X) under the column indicating approximately how many working days(wd) adult consumers wait for admission. The forms below allow you to report wait times for up to three providers of a service or program.

*Please use the “Snap Shot in Time” Methodology for determining Wait Times. During the month of January, ask providers to answer the following question: “Assuming the individual is not in crisis, how many days from today can you schedule an appointment for the following service?”*

**a.1. Adult Intensive Care**

*Click on gray box to indicate “Yes” with an “X.” Additional rows of wait time allow you to report known wait lengths for up to three providers of a service or program.*

Service Area	Service Available?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.a.1
ACT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PH Program Type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PH Program Type II	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Intensive Pharm. Mgt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Intensive CPST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**a.2.** Which intensive outpatient services for adults have been area(s) of focus for the Board? *If an agency uses a triage system to schedule services, please discuss the Board’s oversight role in planning and delivery of triaged services.* Discuss access, capacity, and quality improvement achievements and trends in service areas that are a current area of focus.

*Click on gray box to enter text.*

The Board has not had the financial capacity over the last several years to do any planning in regards to intensive outpatient services for adults. Presently, the Board's only Non Medicaid provider is using a triage process to admit Non Medicaid consumers to their outpatient services. This provider and the Board have worked collaboratively to develop this plan and the Board offered consultation in documentation and billing.

**a.3. Child & Adolescent Intensive Care**

Click on gray box to indicate “Yes” with an “X.” Additional rows of wait time allow you to report known wait lengths for up to three providers of a service or program.

Service Area	Service Available?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.a.3
IHBT / MST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PH Program Type I (Time limited)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PH Prgm. Type II (School-based)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
PH Prgm. Type III	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Therapeutic Pre-School (PH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Intensive CPST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Intensive Pharm. Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Functional Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**a.4. Which intensive outpatient services for children and adolescents have been area(s) of focus in the Board’s current planning? *If an agency uses a triage system to schedule services, please discuss the Board’s oversight role in planning and delivery of triaged services.*** Discuss access, capacity, and quality improvement achievements and trends in service areas that are a current are of focus.

Click on gray box to enter text.

The agency that delivers the Partial Hospitalization program is a Medicaid only agency and the Board has not been asked by the agency or the school districts for any oversight or assistance with quality or outcomes issues. The Board has had some discussions with some school personnel concerning the programs but no additional guidance has been requested. The Board did observe patterns and trends with the PHP services while conducting Medicaid reviews. However, the Medicaid only provider does not desire any assistance relative to quality improvement. Additionally, this Medicaid only agency does not provide the Board with wait time and access information so we cannot respond to this area.

**b. Routine Outpatient Care.** For each of the following services that are available in the Board area, please mark (X) under the column indicating approximately how many working days adult consumers wait for admission. The forms below allow you to report wait times for up to four providers of a service or program.

*Please use the “Snap Shot in Time” Methodology for determining Wait Times. During the month of January, ask providers to answer the following question: “Assuming the individual is not in crisis, how many days from today can you schedule an appointment for the following service?”*

**b.1. Adult Routine Outpatient Care**

*Click on gray box to indicate “Yes” with an “X.” Additional rows of wait time allow you to report known wait lengths for up to four providers of a service or program.*

Service	Service Available?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.b.1
Diagnostic Assessment -- Physician	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Diagnostic Assessment – Non-Physician	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Pharm. Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Counseling/ Psychotherapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
CPST	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**b.2.** Which routine outpatient services for adults have been area(s) of focus for the Board? *If an agency uses a triage system to schedule services, please discuss the Board’s oversight role in planning and delivery of triaged services.* Discuss access, capacity, and quality improvement achievements and trends in service areas that have been an area of focus.

*Click on gray box to enter text.*

A medicaid only provider and a contract provider of the Board provide routine outpatient services. The Medicaid only provider does not provide the Board with any information regarding access, capacity, quality improvement or waiting lists. The Board has not had the financial capacity over the last several years to do any planning in regards to routine outpatient services for adults. Presently, the Board's only Non Medicaid provider is using a triage process to admit Non Medicaid consumers to their outpatient services. Although these services are not intensive outpatient services, they are the critical care services that are needed to maintain a person with a mental illness safely in the community. These services are now only available to Non Medicaid consumers if they are in a mental health crisis, if they are recently released from the State Hospital or have a past history that

would indicate a critical need for outpatient services. The Board has left the clinical decisions as to which consumers receive the scarce resources to this provider; however, the Board and the agency have continuing communication concerning the process. This provider also sends the Board regular quality improvement reports that include wait list and utilization information.

### **b.3. Child & Adolescent Routine Outpatient Care**

*Click on gray box to indicate "Yes" with an "X." Additional rows of wait time allow you to report known wait lengths for up to four providers of a service or program.*

Click on gray box to enter text.

Service	Service Available?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.b.3
Diagnostic Assessment -- Physician	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Diagnostic Assessment – Non-Physician	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Pharm. Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Counseling/Psychotherapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
CPST	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**b.4.** Which routine outpatient services for children have been area(s) of focus for the Board? *If an agency uses a triage system to schedule services, please discuss the Board's oversight role in planning and delivery of triaged services.* Discuss access, capacity, and quality improvement achievements and trends in service areas that have been an area of focus.

Click on gray box to enter text.

There are two providers of routine services for youth and the Medicaid only provider does not supply the Board with any information. Planning has also been difficult for services for youth. The scant planning that has been done in this area has been due to the FCFC Service Coordination Planning process and the ABC and FAST funds. Youth are subject to the same triage process as adults; however, youth are less likely to have access to service issues due to the fact that they are more likely to have Medicaid coverage.

**c. Best Clinical Practices.** (See Appendix C for definition and examples.) What, if any, Best Clinical Practices for Adults and/or Children and Adolescents have been area(s) of focus for the Board? Briefly discuss achievements and trends in these areas.

Click on gray box to enter text.

In past years, the Board has offered training in Recovery, Trauma-Based treatment for youth and Suicide Prevention. Presently the Board has no funds to promote training in or implementation of evidence-based practice. However, our Non Medicaid agency does provide DBT groups. The groups have been an essential evidence-based clinical intervention for consumers and they have also moved many folks from individual counseling into groups, which has made the intervention more cost effective.

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**8. Staff Capacity & Workforce Development.**

a. How many of the following staff positions for adults were budgeted (047) in the Board area during SFY 2007?

*Click on gray boxes to enter number of FTEs.*

Pharm. Management Practitioner FTEs:*	5.00	<b>8.a</b>
CPST FTEs:	12.00	
Counselor/Therapist FTEs:	10.00	

\*Includes Advanced Nurse Practitioners with prescriptive authority.

b. How many of the following positions for child and adolescent consumers were budgeted (047) in the Board area during SFY 2007?

*Click on gray boxes to enter number of FTEs.*

Pharm. Management Practitioner FTEs:*	1.60	<b>8.b</b>
CPST FTEs:	10.00	
Counselor/Therapist FTEs:	4.00	

\*Includes Advanced Nurse Practitioners with prescriptive authority.

c. Please describe any areas of focus for the Board regarding **workforce development**. For help with framing a response on this topic, Boards are encouraged to review Appendix G: *An Action Plan for Behavior Health Workforce Development* from the Annapolis Coalition.

*Click on gray box to enter text.*

First, since the Board does not receive a courtesy copy of the 047s from its largest agency (which is a Medicaid only agency) we have no idea how many staff they have or how many are budgeted for in any given year. Consequently, the above numbers are estimates. Second, as you can see from the number of staff available (based on some hard data and some estimates taken from conversations with community partners) we do not appear to have a shortage of staff. Retention of staff in some areas seems to be an ongoing problem, especially in the area of community psychiatric support. The psychiatric staff at our Non Medicaid agency appears to be relatively stable at this time, which is very helpful to consumers in gaining some consistency in their treatment. At this time, the only role this Board may have in workforce development may be in offering training and support to staff in order to increase their knowledge base and confidence in the performance. The Board has provided clients' rights training to its contract provider. In addition, the Board provides ongoing consultation and education to staff individually or as a group in areas requested by any provider. This may help the agencies in retention and skill development of staff.

**9. Inter-system Collaboration**

a. Discuss achievements and trends in the following areas.

1. Adult Justice/Court Coordination, Recidivism and Diversion.

*Click on gray box to enter text.*

The Board currently responds promptly to requests from the adult court system. We have developed a relationship with a comfort level that allows judges, parole officers and probation officers access to the Board personnel when needed.

2. Juvenile Justice/Court Coordination, Recidivism and Diversion.

*Click on gray box to enter text.*

The Board works closely with the Juvenile Justice system through the FCFC Service Coordination process. Since the Board Assistant Director facilitates this process, we have developed a good working relationship with the Court and the probation department. This relationship has been essential in tackling many issues for youth involved with Juvenile Court. Additionally, until SFY 2005, the Board helped to fund the Juvenile Court Mediation project started through the FCFC Family Stability Program. However, with the increasing cost of Medicaid and the need to fund the critical Safety Net services, we were no longer able to assist with this program.

**b.** Have any of the following areas been a focus for the Board? Discuss achievements and trends in those areas, if applicable.

1. Jails

*Click on gray box to enter text.*

The Board has worked diligently over the last several years to build a solid working relationship with the various local jails, especially the Ashtabula County Jail. Presently, the jails feel free to contact the Board with the issues they are experiencing and we do our best to respond. This benefits the consumers and their families as we advocate on their behalf in a helpful manner within the parameters of the jail system. Additionally, the Ashtabula County Jail Administrator is the President of the MHRS Board and the recently retired County Jail Administrator is a former Board officer.

2. Detention Centers

*Click on gray box to enter text.*

Our relationship with the Juvenile Detention Center is an extension of our relationship with the Juvenile Court.

2. Homeless, Runaway & Domestic Violence shelters

*Click on gray box to enter text.*

In past years, we have funded a peer support program at the local domestic violence shelter. However, due to the financial issues of the Board, we ceased funding this program at the beginning of SFY 2006. Nevertheless, our relationship with the domestic violence shelter and the local homeless shelter continue to remain good. Both entities attend our Housing Coalition meetings and continue to be an active partner in this process.

3. Nursing Homes

*Click on gray box to enter text.*

It has been necessary to maintain a basic working relationship with as many of the local nursing homes and group homes in Ashtabula County as possible. This is in large part due to the fact that we have an out-of-county mental health agency that is working with several of our nursing facilities. This agency is providing a considerable amount of mental health services to nursing home residents, both seniors and non-seniors. At least three of the nursing homes in Ashtabula County have bariatric treatment (weight loss) programs and take residents from all over the United States and Puerto Rico. These out-of-state residents are granted Ashtabula County Medicaid and then are considered Ashtabula County residents for the purposes of billing Medicaid for their mental health services. Thus, we established the ability to dialogue with the nursing homes for purposes of establishing residency for their clients. Also, many of the local group homes, including the ICF-MRs, turn to the Board when faced with a resident that is struggling with mental health symptoms. Although we do not always have the answers, we take calls from these folks and work them to brain

storm answers to their dilemmas.

4. Prison Reentry

Click on gray box to enter text.

Prior to our extreme financial emergency the Board worked closely with the ODMH prison reentry case workers to assist in accessing services for mental health consumers returning to the community from prison. This population is a priority population for the Board. However, with the current situation in Ashtabula County, the Non Medicaid agency is left to triage these requests in the same manner they handle all requests for Non Medicaid services.

6. Physical/Mental Health Integration (Specify whether adult and/or child & adolescent.)

Click on gray box to enter text.

NA

7. Other.

NA

10. Prevention, Education & Consultation (P,C&E). Discuss achievements and trends in the following areas:

- a. Suicide Prevention
- b. Any local or state P,C&E services of relevance to the Board.

Click on gray box to enter text.

Presently, as mentioned previously, the Board is no longer financially able to fund prevention services for either adults or youth. The Board will, as long as the funding is available, continue the prevention services delivered with the Alternative Education dollars. Additionally, we will promote suicide prevention by offering community trainings and distribution of our English and Spanish language suicide prevention brochures. However, unless additional prevention funds are made available to the Board, we do not see the re-instatement of the prevention programs in the near or distant future.

11. Cultural Competency: Discuss achievements and trends in any of the following areas:

- a. Consumer satisfaction with services and staff
- b. Staff recruitment
- c. Staff training.
- d. Addressing disparities for cultural groups in access and outcomes
- e. Other

Click on gray box to enter text.

Mental Health staff, through the FCFC cross-training process, have had access to the training in cultural competency, including the culture of poverty. All of the mental health agencies have at least one clinical staff person that is bi-lingual (English/Spanish).

12. Other: Please use this area to discuss achievements and trends and other current state issues of concern to the Board.

Click on gray box to enter text.

### C. Needs Assessment.

Describe the processes the board used to determine its current needs in crisis care, clinical services, recovery, resilience, prevention, consultation and education services. Include any data sources and types, methodology, time frames, stakeholders, collaborative partners and methods of prioritizing. Examples of needs assessment processes include, but are not limited to: surveys, focus groups, expert panels, key informants, penetration rates, demographic and social indicators. The board must employ at least **one** of the above approaches and at least **one** approach that involves consumer participation.

*Click on gray box to enter text.*

#### INTRODUCTION

The Ashtabula County Mental Health and Recovery Services Board employed a logic model process to design the plan for state fiscal year 2009. We defined a process for data collection, completed an environmental scan, gaps analysis and data analysis, including examining the external factors that affect our ability to plan and postulated on the basic assumptions that would need to be in place to achieve our plans.

#### PROCESS

The Ashtabula County Mental Health and Recovery Services Board (MHRS Board) designed a process for accessing the needs of the community that would tap into a variety of different data sources and include consumers and stakeholders. The process included the following components: examination of the current service delivery and financial environment in Ashtabula County as well as an analysis of the gaps in the service delivery system; a look at the data concerning clients served and services delivered, including information found during the administration of surveys to stakeholders and consumers; incorporation of the Family and Children First Council's HB289 survey data; and prioritization of service goals for the next biennium.

#### ENVIRONMENTAL SCAN AND GAPS ANALYSIS

As mentioned in the narrative of the situation, the mental health service delivery system in Ashtabula County is currently burdened with a Medicaid match that far exceeds the county's ability to pay. This may be due in part to the human landscape of the county. According to 2004 U.S. Census Bureau data the percentage of people in Ashtabula County living at or below the poverty line is 12.7% compared to Ohio's 11.7%. Additionally, 19.6% of Ashtabula County's children are living in households that are considered at or below the poverty line. Likewise, as with the overall poverty rate, the average poverty rate for children in Ohio is 16.8% and 17.8% overall in the United States. In keeping with these numbers, according to the Ohio Department of Job and Family Services, the Medicaid penetration rate for Ashtabula County was 23.3% in SFY 2005 compared to the state-wide penetration rate of 17.8%. The number of children 5-18 covered by Medicaid in Ashtabula County for the same time period was 43.1% compared to 33.5% statewide. And indications are that the penetration has continued to rise in the subsequent years at least to the extent of the 2.7% over all increase in Medicaid case loads reported by the Ohio Department of Job and Family Services in the SFY 2006 Annual Report. Additionally, since Ashtabula County is a large but mostly rural county, we do not have an extensive system of private providers that would offer mental health services to consumers outside of our system or charitable organizations that offer mental health services to indigent consumers.

Added to these facts is the data collected through the MACSIS system on our average cost per client of \$2,315.91 in SFY 2007 up from \$1,191.82 in SFY 2002.

Consequently, Ashtabula County has experienced an expansion of our Medicaid match costs that has led to a gradual reduction of services to indigent Ashtabula County residents to the point of no longer having the capabilities to provide the basic Safety Net services most of these consumers desperately need. Due to Safety Net funds received from the Ohio Department of Mental Health (ODMH) over the last two state fiscal years, the Board has managed to maintain some emergency services but the feedback from agencies and consumers clearly shows where the gaps remain. For seriously mentally ill consumers who are not in crisis there is no longer the access to Safety Net services that maintain them in the community successfully. Likewise, for those consumers that are in crisis or reach a crisis level, we have been able to offer crisis intervention services and state hospital intervention but there are minimal to no services available to them after a crisis or a hospitalization to adequately meet their needs and assist them in remaining as crisis free as possible. Consequently, the concepts of mental health Recovery and Resiliency are not supported sufficiently for these consumers to make it a reality for them. The system is stressed and broken. And no longer does it just affect this mental health Board and the clients it serves, the urgency and tragedies of the reality of our inability to provide services and supports is being felt across systems to our community partners, who can no longer rely on us to provide services for the populations they serve.

## DATA AND ANALYSIS

### Service Information

During SFY 2007 services delivered and billed to Medicaid and those billed to Non-Medicaid differ in service type. The chart below shows the differences between what was billed to Medicaid and what was billed to Non Medicaid. (It is also important to note that not all of the services billed to Non Medicaid were actually paid.)

Medicaid				Non Medicaid			
Procedure	Units	Dollars	% of \$	Procedure	Units	Dollars	% of \$
Ind. CPS	133,339	\$2,843,666	40%	Ind.CPS	13,491	\$288,061	35%
Pharm. Mgt	6,686	\$1,401,141	19.7%	Pharm. Mgt.	1,228	\$243,778	30%
Ind. Co. 5	2,477	\$1,173,176	17%	Ind. Co.	6,762	\$139,132	17%
Partial Hosp.	9,018	\$1,052,823	15%	Crisis	420	\$64,190	8%
MH Asst	1,911	\$233,819	3%	Group Co.	2,366	\$23,336	3%
DA-Phys.	841	\$176,403	2.4%	MH Asst.	211	\$21,226	2.6%
Group Co.	11,325	\$111,110	1.6%	DA-Phys.	103	\$20,974	2.6%
Crisis Inter.	333	\$50,887	.7%	CPS Group	1,510	\$14,813	1.8%
CPS Group	4,677	\$45,847	.6%	Partial Hosp.	00	\$0.0	0%
Total		\$7,088,872				\$815,512.41	

Information from MACSIS data. Report name LA02\_Board. Run date 10/08/2007.

An examination of the service patterns between Medicaid and Non Medicaid services is distinctive in that there is a deviation in service focus after the first four services. This is most likely explained by the difference in the limited but still planned focus of services that occurs on the Non Medicaid side and services delivered solely based on client demand, referral source request or agency

determination on the Medicaid side. Still interestingly, when surveyed by the Board and asked to list service preferences based on what consumers and stakeholders believed were most helpful to Recovery for adults or Resiliency for youth, the respondents listed the top four services in the following order: Pharmacological Management/DA- Physician, Individual Counseling, Diagnostic Assessment, Community Psychiatric Support (Individual or Group). (Note: We did not include Crisis Intervention in the survey). Additionally, the preference list was the same for both children and adults.

### Population Information

During SFY 2007 the Ashtabula County MHRS Board served 2,943 adults and 1,423 Children (473 of which were SED). Based on the current available BH and Outcomes data we noted that of the clients served, 66 or 2.8% were homeless, 1022 or 40.2% were employed and 762 or 21.4% were involved with either the adult or juvenile justice system at some point during the state fiscal year.

According to information taken from BH data, consumers came to the mental health system from a wide variety of referral sources. The top ten referral sources in order from largest to smallest number of referrals made are as follows: self referral, mental health provider, other health provider, County Job and Family Services, other community referral, school, dual provider, Juvenile Court, other Criminal Justice, Municipal Court.

We also examined the aggregate population data in order to develop a clearer picture of the consumers we serve. The data collected were in the areas of age grouping, gender and race. As mentioned previously, we served 2,943 adults during SFY 2007. These adults were primarily between the ages of 18-54 with the age groups of 25-34 and 35-44 being the primary adult population served. Of the 1,423 children the largest age group served were 14-17 with 10-13 and 0-9 almost reaching 400 children in each age category.

Our gender breakdown is approximately 50% males and 50% females while the race breakdown is as follows: 87.2% White, 5.8% African-American, 4.0% Hispanic, 2.1% Unknown, 0.4% Multi-racial and 0.4% Other. In comparison we find that, according to the U.S. Census data for 2006, Ashtabula's population is 48.9% male and 51.1% female. The racial breakdown is 94.8% White, 3.4% African-American, 2.7% Hispanic and 1.2% also identifying themselves as multi-racial. Consequently, from this comparison we can infer that, despite the overall access problem that exists in Ashtabula County, African-Americans and Hispanics are receiving services in numbers slightly greater than they are seen in the overall population. This information should also lead us to ask if there is a greater need for programming and outreach to these populations due to some stressors on these communities which may be resulting in the need for services. This idea may also be supported by the SFY 2005 Ohio Department of Job and Family Services (JFS) data that states that of the 97,925 Whites in Ashtabula County 22% were Medicaid eligible while of the 3,439 African-Americans living in the county 55% were Medicaid eligible during the same time period. Similarly, of the 1,788 individuals listed as "Other" in the JFS report, 33.6% were Medicaid eligible.

### Consumer and Stakeholder Surveys

The Board also surveyed slightly over 1% of adult consumers and other stakeholders in order to gain feedback on what focus areas they believed were priorities in regards to supporting Recovery for adults and Resiliency for youth. Respondents were asked to score the various focus areas for

perceived importance in Recovery or Resiliency from 1 to 3 with 1 being the most important and 3 being the least important. Participants were told that they could have as many 1s, 2s or 3s as they wished. Once the surveys were collected, the responses were summed and the focus areas arranged in order from those with the smallest number to those with the largest. We then found the median and ascertained where to establish the groupings so we had a high priority range, a medium and a low.

At this point the prioritized focus areas showed a high priority in areas such as suicide prevention, evidenced-based and best practice skills, retaining clinical staff, inpatient hospital days and crisis bed availability and coordination with law enforcement and the court systems. Medium priority areas were school success for youth, early childhood mental health, housing, wellness and recovery skills, preparing for disasters and medication availability. Areas of low priority were services after a crisis, crisis screening for youth, continued care after a hospitalization, responding to colleges during a crisis situation, transitioning to adulthood for youth and employment services.

As mentioned in the Data and Analysis section, we also asked consumers and stakeholders to prioritize services types based on their belief as to their importance in a consumer's Recovery or Resiliency. In this section the respondents were forced to give each service category a number 1 through 6 with 1 being the service most important to Recovery or Resiliency and 6 being the least important. Once completed, the answers were tabulated and the services listed based on numbers. There was a separate list for adults and youth.

The tabulation resulted in the following service order for the top four services: Pharmacological Management/DA- Physician, Individual Counseling, Diagnostic Assessment, Community Psychiatric Support (Individual or Group). (Note: We did not include Crisis Intervention in the survey). Additionally, the preference list was the same for both children and adults.

Finally we looked at the Family and Children First Council's House Bill 289 data to give us some further information to consider. During the HB289 process the Family Council members were given a survey and asked to list areas of concern for the county and also to grade current services available in the county on a Likert Scale. The Likert Scale numbers were then translated into a mean and given an equivalent grade. The grades were A, B, C, D. When grading the current services available in the county, the members of the Family and Children First Council gave a grade of "D" or lower to the following county services: transportation services, employment services, housing programs, programs that address youth at risk and child care. Additionally, they were asked to list the areas of greatest concern to them. They listed employment opportunities, education, transportation, health care and the prevalence of risky behaviors in youth as the things that concerned them most.

## ASSUMPTIONS

1. Basic funding will be available for Ashtabula County to meet the Medicaid match obligation and plan and provide for basic Safety Net services for indigent Ashtabula County residents who need mental health services.
2. Providers will be available to deliver the services needed.
3. Services should be delivered using best practice and/or evidenced-based models.

## EXTERNAL FACTORS

1. Presently Ashtabula County has exhausted its cash balance and has no reserve funds available for cash flow purposes.
2. Ashtabula County currently does not receive enough state and local funds to meet the Medicaid match obligation and provide the basic ORC 340 Safety Net services.
3. There are indigent Ashtabula County residents in need of basic mental health Safety Net services who are going without those services due to their inability to pay and the Board's inability to purchase those services for them.
4. Ashtabula County has only two community mental health agencies certified by ODMH and our largest mental health agency is Medicaid only.
5. The Board has no control over the amount of Medicaid services delivered and billed to the Board for payment.
6. The Board does not have utilization tools for Medicaid providers that would assist in ensuring that appropriate levels of care are provided to meet the needs of the clients.

### **D. Community Plan for SFY 2009.** (Desired State)

Please refer to "Planning Terms" in Appendix C.

- 1. Planning Processes.** Describe the process utilized by the Board to determine its priorities for SFY 2009. How did the Board decide the most important areas in which to invest their resources?

*Click on gray box to enter text.*

After thorough consideration of all of the data collected, including the information as it relates to our current financial condition and realities, the Board merged the survey priorities with the ORC 340 statutory requirements and made a final selection of priorities for SFY 2009. As a result we compiled a list that address some of the high priorities expressed by consumers and the stakeholders as well as areas where the Board may be able to make an impact based on the availability of funding and the need to provide basic Safety Net services. Additionally, we understand that we must respond to the items in the plan marked with an asterisk (\*) by the Ohio Department of Mental Health.

Thus, after completion of this process and input from Board members the Board developed the following priorities:

#### High Priority

Inpatient  
Continuity of Care  
Crisis Hotline  
Adult Crisis Services  
Crisis Bed Days  
CIT/Police Coordination\*  
Suicide Prevention

#### Medium Priority

Wellness Mgt. and  
Recovery\*  
Housing  
Early Childhood Mental  
Health  
Disaster Preparedness\*

#### Low Priority

Employment\*  
Crisis at a College or Univ.\*  
Integrated Dual Diagnosis Treatment\*

**2. Recovery Supports.** Using the format below, please describe goals, strategies, and measurable objectives for SFY 2009 for housing, employment, including supported employment, and other recovery supports of relevance to the Board, such as Wellness Management and Recovery, WRAP, Bridges, Networks of Care, Peer Support Services, etc. (See Appendix C for definition of recovery supports and examples of strategies and programs.) Based on identified needs, rank priorities as high, medium or low. What systems/entities/providers/consumer groups will the board collaborate with or have discussions, and what benefits/results are expected?

Items with an asterisk (\*) must be addressed, even if this is a low priority area and planning is minimal.

*Click on gray box to indicate priority level.*

**2.a. EMPLOYMENT\***

Priority:

**Goals:** *Click on gray box to enter text.*

All Mental Health Consumers have the skills, knowledge and tools necessary to maintain employment or meaningful activity as a support for their Recovery.

**Strategies:** *Click on gray box to enter text.*

The MHRS Board will provide information to agencies on the importance of work and meaningful activities to Consumer Recovery and a listing of resources available to assist Mental Health Consumers in access employment opportunities.

**Measurable Objectives:** *Click on gray box to enter text.*

The number of Mental Health Consumers engaged in employment or meaningful activities as reflected on the Consumers Outcomes and BH instruments will increase by 2%. The Board will examine Outcomes and BH data mid year and at the end of the year to monitor effectiveness of the information dissemination.

**Discussions and/or Collaborations:** *Click on gray box to enter text.*

In the past, the MHRS Board funded a Work Readiness program through the local Goodwill office that was designed to meet the specific needs of individuals with a mental illness who had reached the point in their recovery that they were ready to re-engage in work activities. The program, inconjunction with Goodwill's already established Work Adjustment and Personal Adjustment programs, was a spring board for Consumers. Unfortunately, at the beginning of SFY 2006, the Board was forced to cease funding for the program due to the ever escalating costs of Medicaid.

Ideally, the Board would like to work with the Supported Employment Center of Excellence to establish evidence-based services in our county. However, due to the limited funding available, at this point in time, the MHRS Board would like to continue to support the importance of work and meaningful activity to MH Recovery by developing guides to resources and gathering publications from various sources to access educational materials on the importance of employment and meaningful activity to distribute to clinicians and Consumers. Barring any new funding to support development of a new program to support the work aspirations of Recovering Consumers, the Board feels education of Consumers and Providers and access of already existing services will at least keep the topic of work and meaningful activity in the forefront as a vital part of MH Recovery.

**2.b. WELLNESS MANAGEMENT & RECOVERY\***

Priority:

Goals: *Click on gray box to enter text.*

All Mental Health Consumers will have the skills, knowledge and tools to achieve Recovery or Resiliency and maintain their wellness in the community.

Strategies: *Click on gray box to enter text.*

If funding becomes available, the Board will offer training on Wellness and Recovery to both Consumers and Clinicians.

Measurable Objectives: *Click on gray box to enter text.*

25% of the MH Consumers that attend the training will report an increase in stability management 6 months after completion of the training. 25% of the MH Clinicians who attended training will report using interventions that support Recovery with their Consumers 6 months after the training.

Discussions and/or Collaborations: *Click on gray box to enter text.*

Training is an excellent tool to support change in the way Consumers and Clinicians look at MH Recovery and Wellness. However, in the past, offering Consumer training has been difficult and has not always yielded the numbers of trainees we would like. If funding would become available for training for Consumers and/or Clinicians, the Board would like to work in collaboration with a mental health agency to offer the Recovery training in a manner that is more accessible to the Consumers, such as in a peer support group setting rather than in a traditional training type format.

## 2.c. HOUSING

Priority:  Medium

Goals: *Click on gray box to enter text.*

All Mental Health Consumers have access to safety, decent, affordable housing.

Strategies: *Click on gray box to enter text.*

Board will continue to support its housing assistance program as long as funding is available and educate mental health agencies on resources available in the community through the Board's Housing Coalition.

Measurable Objectives: *Click on gray box to enter text.*

The number of consumers that report homelessness on the Outcomes or BH will decrease by 2%. The Board will examine Outcomes and BH data mid year and at the end of the year to monitor effectiveness of the strategy.

Discussions and/or Collaborations: *Click on gray box to enter text.*

The Board will continue to work with all of its housing partners through the Housing Coalition process to gain information on resources available to Consumers.

*Click on gray boxes to name Recovery Support area and indicate priority level.*

2.d. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

2.e. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

2.f. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**2.g. Other.** If you need additional space for discussion of Recovery Supports planning:

*Click on gray box to enter text.*

**3. Resilience Supports.** Using the format below, please describe goals, strategies, and measurable objectives for SFY 2009 for school success, ABC, and any other Resilience supports of relevance to the

Board, such as Transition Age Programs, Parent Advocacy, etc. (See Appendix C for definition of resilience supports and examples of strategies and programs.) Based on identified needs, rank priorities as high, medium or low. What systems/entities/providers/consumer groups will the board collaborate with or have discussions, and what benefits/results are expected?

*There is overlap between Resilience Supports and Prevention, Consultation, and Education (P,C&E). Boards can discuss programs such as BB/BS, Triple P, Family Advocates, Early Childhood Screening, etc., as a Resilience Support or under the narrative for Section 10: P,C&E.*

*Click on gray box to indicate priority level.*

### **3.a. SCHOOL SUCCESS**

Priority: Low

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

### **3.b. EARLY CHILDHOOD CARE**

Priority: Medium

Goals: *Click on gray box to enter text.*

All Ashtabula County children have the resiliency skills necessary to succeed in life.

Strategies: *Click on gray box to enter text.*

The Board will provide DECA Technical Assistance to up to 6 childcare centers and training on mental health topics.

Measurable Objectives: *Click on gray box to enter text.*

Each participating Center will see a 5% increase in the DECA resiliency skills of the youth in the DECA classroom. Data collected will be consistent with the DECA protocol. Programs receiving training will report satisfaction with the training.

Discussions and/or Collaborations: *Click on gray box to enter text.*

The Board has worked with the local childcare centers, the county Starting Point and various other community partners to educate the community on the importance of early childhood mental health. However, at the present time the Board does not have a mental health provider interested in engaging in this program and providing the mental health consultation piece needed to get this project fully engaged in the community settings. Thus we have worked with our partners and ODMH to begin the process of implementing the DECA program in some selected, trained and interested childcare centers. Additionally, we will work with the local Starting Point, Help Me Grow and a mental health provider to offer trainings on mental health topics pertinent to the subject

of Early Childhood Mental Health.

**3.c. TRANSITION AGE CARE**

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

The MHRS Board does address some transition issues for youth who are involved with the FCFC Service Coordination Team. Youth with the team at the time of their aging out of the child servicing systems are assisted with some transition planning when requested. Additionally, youth are referred to the Children Services Independent Living program, which is open to any youth in need of the service who is a resident of Ashtabula County.

*Click on gray boxes to name Recovery Support area and indicate priority level.*

**3.d. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

**3.e. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

3.f. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

3.g. **Other.** If you need additional space for discussion of Resilience Supports planning:

*Click on gray box to enter text.*

4. **Inpatient Care.** Please complete the table below to estimate planned utilization for the next year, as best you can, even though final plan for SFY 2009 use of state hospital days is not due until May 1. Note that the state hospital per diem will be fixed for SFY 2009 at \$481. (Please note Appendix F for additional state bed day utilization data.)

*Click on gray box to enter number.*

Board Purchased Inpatient Care	SFY 2009 Bed Days	SFY 09 Admissions
State Hospitals		
Private Psychiatric Hospitals: Adults	0	0
Private Hospitals: Children & Adolescents	0	0

Using the format below, please discuss goals and strategies regarding **inpatient care** in your Board area and identify anticipated discussions or initiatives with inpatient providers. Also, please describe any future goals and strategies to assess and improve **continuity of care** between inpatient and community mental health providers. Finally, please discuss any planning for patients discharged from inpatient care with serious **somatic health care** needs.

Address as many of the following questions as possible in your discussion of inpatient care, continuity of care, and somatic health care planning:

- i.** Are you developing new or modified community based services which are expected to reduce your current inpatient bed day utilization?
- ii.** If you do not have a continuity of care agreement (see Appendix J) with your local state hospital, will you be addressing this issue with them in the next year?
- iii.** Are you planning future activities to improve linkage and follow up of discharged patients from inpatient care with serious somatic health care needs to general health care services?

#### **4.a. INPATIENT CARE**

Priority: **High**

Goals: *Click on gray box to enter text.*

All indigent Mental Health Consumers have access to inpatient services when appropriate.

Strategies: *Click on gray box to enter text.*

Mental Health Consumers in crisis will have access to crisis intervention services to divert them from hospitalization when appropriate. Consumers with Medicaid or other insurance will not be admitted to the state hospital.

Measurable Objectives: *Click on gray box to enter text.*

Hospital bed days remain stable in comparison to SFY 2008 or see a reduction in utilization. Bed day utilization is monitored monthly throughout the state fiscal year.

Discussions and/or Collaborations: *Click on gray box to enter text.*

The present financial condition of the Board makes it impossible to maintain crisis and basic Safety Net services for Consumers. These essential ORC 340 services and duties are in jeopardy in Ashtabula County due to the rising Medicaid cost to the Board. Many consumers at risk cannot be seen to divert a crisis situation and an adequate level of services cannot be provided to maintain many Consumers after a hospitalization. Without continued financial support from ODMH we cannot meet the needs of the Consumers without Medicaid in Ashtabula County and successfully manage our bed day utilization. Additionally, Ashtabula County is in the process of entering into a Continuity of Care Agreement with our state hospital along with the other Boards in our area that use the same hospital in the system

#### **4.b. CONTINUITY OF CARE**

Priority: **High**

Goals: *Click on gray box to enter text.*

All SMI Consumers have access to the Safety Net services necessary to meet their needs.

Strategies: *Click on gray box to enter text.*

All Mental Health Consumers in crisis will have access to crisis intervention services to divert them from hospitalization when appropriate and receive the needed outpatient aftercare services in order to assist them in remaining safely in the community. All Consumers hospitalized or in crisis will receive appropriate aftercare.

Measurable Objectives: *Click on gray box to enter text.*

Services are still available and hospital bed days remain stable in comparison to SFY 2008 or see a reduction in utilization. Status of services and bed day utilization is monitored monthly.

Discussions and/or Collaborations: *Click on gray box to enter text.*

The present financial condition of the Board makes it impossible to maintain crisis and basic Safety Net services for Consumers. These essential ORC 340 services and duties are in jeopardy in Ashtabula County due to the rising Medicaid cost to the Board. Many consumers at risk cannot be seen to divert a crisis situation and an adequate level of services cannot be provided to maintain many Consumers after a hospitalization. Without continued financial support from ODMH we cannot meet the needs of the Consumers without Medicaid in Ashtabula County.

#### 4.c. SOMATIC HEALTH CARE

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**4.d. Other.** If you need additional space to discuss planning in the area of inpatient care, continuity of care, or somatic health care:

*Click on gray box to enter text.*

**5. Residential Treatment Centers.** Using the format below, please discuss the Board's goals and strategies to *reduce* Residential Treatment Center placements of children and adolescents in SFY 2009. Has the Board set any targets for evaluating the effectiveness of those strategies in reducing RTC placements?

#### 5.a. Residential Treatment Centers

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives or Targets: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

The Board will continue to work with our local Children Services Board (CSB) on residential treatment reduction through our relationship with CSB and through our involvement with the Family and Children First Council.

**5.b. Other.** If you need additional space to discuss planning in the area of residential treatment for children and adolescents:

*Click on gray box to enter text.*

**6. Crisis Care.** Using the format below, please discuss the Board’s plan in SFY 2009 for areas of relevance in crisis care, e.g., hotline, warm line, 24/7 staffing, mobile response, crisis facility, contract for observation beds, respite/emergency beds, transportation service, or other. *It is not necessary to discuss all listed programs and services. This is primarily a place to discuss planned expansion or contraction of capacity in crisis care services and programs. Please discuss only those areas that are a focus of current planning.*

**6.a. Adult Consumers**

*Click on gray boxes to select area of crisis care and priority level.*

**6.a.1.** Area of Adult Crisis Care: Hotline/Warmline

Priority: High

Goals: *Click on gray box to enter text.*

All Ashtabula County residents in crisis have access to a 24/7 hotline number.

Strategies: *Click on gray box to enter text.*

Maintain the current 24/7 crisis hotline.

**Measurable Objectives**

The 24/7 crisis hotline will still be available to consumers and clinicians throughout the state fiscal year. Status of the hotline service is monitored monthly.

**Discussions and/or Collaborations**

The hotline has been a vital link for clinicians and consumers during this time of decreasing availability of adequate outpatient and crisis services to meet the needs of the Non Medicaid Mental Health Consumers in Ashtabula County. Consumers who have not been able to access services are encouraged to use the hotline number in times of a stressful situation to assist in diverting them from a crisis situation. Should we lose the capacity to fund this service it would be a dramatic lose to an already shattered system of care.

**6.a.2.** Area of Adult Crisis Care: Beds

Priority: High

Goals: *Click on gray box to enter text.*

All Mental Health Consumers in crisis have access to a less restrictive setting for crisis stabilization when appropriate, to meet their needs.

Strategies: *Click on gray box to enter text.*

The Board will make available a crisis bed for MH Consumers that are in crisis but do not meet the level of care to be hospitalized.

Measurable Objectives: *Click on gray box to enter text.*

The crisis bed alternative will still be available throughout the state fiscal year. Status of the crisis bed is monitored monthly.

Discussions and/or Collaborations: *Click on gray box to enter text.*

The availability of a crisis bed option has been a vital resource to the Crisis Intervention agency and the MH consumers in meeting presenting needs. Although we have reduced the number of beds purchased, this service is desperately needed as an alternative to maintain the safety of a consumer that does not quite meet the criteria for hospitalization but is lacking the natural support systems in the community to remain safe until they can be seen by their outpatient clinicians. The crisis bed has also been important as a step down facility from the state hospital when a consumer is ready for discharge but a community placement for them will not be available for a few days. A crisis bed option helps to keep state hospital bed days down and is a less restrictive setting for consumers that need this level of care for a short period of time.

**6.a.3.** Area of Adult Crisis Care:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**6.a.3. Other.** If you need additional space to discuss planning in the area of adult crisis care:

*Click on gray box to enter text.*

## **6.b. Child & Adolescent Consumers**

*Click on gray boxes to select area of crisis care and priority level.*

**6.b.1** Area of C&A Crisis Care:

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

6.b.2. Area of C&A Crisis Care:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

6.b.3. Other. If you need additional space to discuss planning in the area of C&A crisis care:

*Click on gray box to enter text.*

6.c. Planned Crisis Bed Days. If the Board contracts for crisis beds, please indicate projected utilization for Adults and Children & Adolescents in SFY 2008 and SFY 2009:

*Click on gray box to enter number.*

	SFY 2008 Crisis Bed Days	SFY 2009 Crisis Bed Days
Adults	50	50
Children & Adolescents	0	0

6.d. Crisis Response. Using the format below, please discuss the Board’s plan for SFY 2009 in the following areas. Items with an asterisk (\*) must be addressed, even if this is a low priority area and planning is minimal.

**6.d.1. CIT/POLICE COORDINATION\***

*Click on gray box to select priority level.*

Priority: **High**

Goals: *Click on gray box to enter text.*

The Board/law enforcement relationship facilitates meeting the needs of consumers that encounter law enforcement.

Strategies: *Click on gray box to enter text.*

Maintain a working relationship with the law enforcement community by being responsive to their needs to the best of our ability.

Measurable Objectives: *Click on gray box to enter text.*

The Board will be able to resolve 70% of all concerns received in regards to law enforcement issues to everyone’s satisfaction. Calls will be recorded and results monitored throughout the state fiscal year.

Discussions and/or Collaborations: *Click on gray box to enter text.*

Without adequate funding, the Board cannot enter into any new programs or initiatives that will target offering additional services or interventions to the law enforcement community. Being responsive to them and working to resolve issues for the benefit of our MH Consumers is a high priority for this Board, but one that we cannot pursue further do to our lack of financial means. The Board has worked to improve relationships with the law enforcement community and, as mentioned previously, currently has two law enforcement representatives on the Board.

**6.d.2. DISASTER PREPAREDNESS\***

Priority: **Medium**

Goals: *Click on gray box to enter text.*

All Mental Health needs of Ashtabula County residents are met during a disaster situation.

Strategies: *Click on gray box to enter text.*

The Board will attend meetings, trainings and planning sessions for disaster preparedness throughout the state fiscal year.

Measurable Objectives: *Click on gray box to enter text.*

The Board will have a revised disaster plan and be incorporated into the local community plans before the end of state fiscal year 2009. Progress monitored by completion of tasks.

Discussions and/or Collaborations: *Click on gray box to enter text.*

Although resources are limited and are not sufficient to meet the needs of the community should a disaster situation arise, the Board will remain active with the community partners and provide whatever information and support it can both during the planning process and in the vent of a disaster.

**6.d.3. COLLEGES & UNIVERSITIES\***

Priority: **Low**

Goals: *Click on gray box to enter text.*

All Mental Health needs of Ashtabula County residents are met during a crisis on the local Kent State Campus.

Strategies: *Click on gray box to enter text.*

The Board will respond to requests for participation in disaster response planning if called upon by the university in the county.

Measurable Objectives: *Click on gray box to enter text.*

The Board will respond to requests to the best of our ability.

Discussions and/or Collaborations: *Click on gray box to enter text.*

Some of the planning for an emergency situation on the local Kent State University branch is completed through our participation with the Ashtabula County Emergency Management Agency and the subcommittee we attend on special populations. Should the EMA need assistance from the Board, we have a system in place to be contacted 24/7.

#### 6.d.4 PRIMARY & SECONDARY SCHOOLS

Priority:

Goals: *Click on gray box to enter text.*

See Above response concerning colleges and universities.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

#### 6.3.5. Other. If you need additional space to discuss Crisis Response planning:

*Click on gray box to enter text.*

**7. Outpatient Services.** Using the format below, please discuss the Board’s plan for relevant outpatient “services as usual,” e.g., Diagnostic Interview-Physician, Diagnostic Assessment, Pharmacological Management, CPST, Counseling, Partial Hospitalization. *It is not necessary to discuss all listed services. This is primarily a place to discuss planned expansion or contraction of capacity in routine outpatient services. Please discuss only those areas that are a focus of current planning.*

#### 7.a. Adult Services.

*Click on gray boxes to select service area and priority level.*

7.a.1. Area of Adult Services:

Priority:  High

Goals: *Click on gray box to enter text.*

All Mental Health Consumers will have the skills, knowledge and tools to achieve Recovery or Resiliency and maintain their wellness in the community.

Strategies: *Click on gray box to enter text.*

At this time, without substantial financial assistance from the ODMH, this Board sees further contraction of the Non Medicaid Safety Net services that are vital to the stability and Recovery of the Non Medicaid MH Consumers of Ashtabula County. The Board will continue to work with its mental health Non Medicaid provider to triage consumers and attempt to maintain the Safety Net services for those most in need.

Measurable Objectives: *Click on gray box to enter text.*

The number of consumers served by Ashtabula County providers who are Non Medicaid and diagnosed with a severe mental illness will remain static or see a slight increase in comparison to SFY 2008 numbers. Also, an analysis of the array of Non Medicaid services delivered will reflect the services vital to the stability and Safety Net needs of those most in need of intervention as outlined in ORC 340 and reflective of the data collected from consumers during the SFY 2009 planning process: Pharmacological Management, Community Psychiatric Support, Individual Counseling and Crisis Intervention

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.a.2.** Area of Adult Services:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.a.3.** Area of Adult Services:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.a.4. Other.** If you need additional space to discuss planning in the area of adult “services as usual”:

*Click on gray box to enter text.*

**7.b. Child & Adolescent Services.**

*Click on gray boxes to select service area and priority level.*

**7.b.1** Area of C&A Services:

Priority: Low

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.b.2** Area of C&A Services:

Priority:

Goals: *Click on gray box to enter text.*

Strategies *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.b.3.** Area of C&A Services:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.b.4. Other.** If you need additional space to discuss planning in the area of child & adolescent “services as usual”:

*Click on gray box to enter text.*

**7.c. Best Clinical Practices for Adults, Children & Adolescents.** What are the Board’s plans for SFY 2009 regarding Best Clinical Practices? The term “best practices” includes both promising and evidence-based practices. Examples of Best Practices include, but are not limited to: Assertive Community Treatment, Intensive Home Based Treatment, Intensive Dual Disorder Treatment (IDDT), Early Childhood Assessment, Functional Family Therapy, Treatment Foster Care, Physical/Mental Health Services Integration, Trauma-focused Community Based Treatment (TF-CBT), Dialectical Behavior Therapy (DBT), Trauma Screening and Assessment, Telemedicine, Tobacco Dependence Treatment, Older Adult care, Integrated Care for persons with MR/MI. (See definitions in Appendix C.)

Items with an asterisk (\*) must be addressed, even if this is a low priority area and planning is minimal.

**7.c.1. INTEGRATED DUAL DIAGNOSIS TREATMENT (IDDT)\***

Priority: Low

Goals: *Click on gray box to enter text.*

All Mental Health Consumers have access to IDDT when appropriate to meet their needs.

Strategies: *Click on gray box to enter text.*

The Board will explore training opportunities for clinical staff should funding be made available.

Measurable Objectives: *Click on gray box to enter text.*

If the Board receives some funds to provide training to the clinical agencies, the Board will plan and conduct training on IDDT. 80% of the clinical staff trained will demonstrate an understanding of IDDT

Discussions and/or Collaborations: *Click on gray box to enter text.*

The Board believes that the addition of an evidence-based IDDT program would improve the outcomes of the dually diagnosed adults. However, the current financial condition of this Board does not permit planning for new interventions or incentives for agencies to gain expertise in new treatment options for consumers.

Click on gray box to enter name of practice:

**7.c.2. PRACTICE:**

Priority:

Goals: Click on gray box to enter text.

Strategies: Click on gray box to enter text.

Measurable Objectives: Click on gray box to enter text.

Discussions and/or Collaborations: Click on gray box to enter text.

Click on gray box to enter name of practice:

**7.c.3. PRACTICE:**

Priority:

Goals: Click on gray box to enter text.

Strategies: Click on gray box to enter text.

Measurable Objectives: Click on gray box to enter text.

Discussions and/or Collaborations: Click on gray box to enter text.

Click on gray box to enter name of practice:

**7.c.4. PRACTICE:**

Priority:

Goals: Click on gray box to enter text.

Strategies: Click on gray box to enter text.

Measurable Objectives Click on gray box to enter text.

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter name of practice:*

**7.c.5. PRACTICE:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**7.c.6. Other.** If you need additional space for planning in the area of Best Clinical Practices:

*Click on gray box to enter text.*

**8. Staff Capacity and Workforce Development.** Using the format below, please describe the Board’s plan for workforce development in SFY 2009. For help with identification of goals, see Appendix G: **An Action Plan for Behavioral Health Workforce Development.**

*Click on gray boxes to enter workforce development area and priority level.*

**8.a.1.** Area of Workforce Development:

Priority:

Goals: *Click on gray box to enter text.*

Strategies *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray boxes to enter workforce development area and priority level.*

**8.a.2.** Area of Workforce Development:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**8.a.3. Other.** If you need additional space to discuss planning in the area of workforce development:

*Click on gray box to enter text.*

**9. Inter-system Collaboration.** Using the format below, please describe the Board's plan for SFY 2009 in the following areas.

**9.a. Adults**

**9.a.1. ADULT JUSTICE/COURT COORDINATION**

*Click on gray box to indicate priority level.*

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

Although this was a high priority area on the surveys, the Board does not have the capacity at this time to address new initiatives or services that could increase the collaboration between the Board and the Adult Judicial System. The Board does, however, have an excellent relationship with the various courts and the parole and probation officers. We respond to the best of our ability to any requests or concerns they may have and in turn we are able to contact them when a concern arises from a consumer. We will strive to continue this relationship for the benefit of the consumers we serve.

**9.a.2 ADULT RECIDIVISM**

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.a.3. ADULT DIVERSION**

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.a.4. Other.** If you need additional space to discuss planning in the area of Justice/Court Coordination, Recidivism or Diversion:

*Click on gray box to enter text.*

**9.b. Adolescents**

**9.b.1. ADOLESCENT JUSTICE/COURT COORDINATION**

*Click on gray box to indicate priority level.*

Priority:

Goals: *Click on gray box to enter text.*

No goal at this time.

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

Although this was a high priority area on the surveys, the Board does not have the capacity at this time to address new initiatives or services that could increase the collaboration between the Board and the Juvenile Justice System. The Board does, however, have an excellent relationship with the court and the probation officers. We respond to the best of our ability to any requests or concerns they may have and in turn we are able to contact them when a concern arises from a family or guardian. This relationship is enhanced by our active participation in the FCFC Service Coordination process.

**9.b.2. ADOLESCENT RECIDIVISM**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.b.3. ADOLESCENT DIVERSION**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

As mentioned in a previous section, the Board was active in planning and funding the Juvenile Court Diversion program but ceased providing this support a few years ago due to our increasing financial crisis. The Board continues to look for opportunities to assist with this program or to offer any non financial support it has available.

**9.b.4. Other.** If you need additional space to discuss planning in the area of adolescent Justice/Court Coordination, Recidivism or Diversion:

*Click on gray box to enter text.*

**9.c. Other Inter-System Collaboration.** What, if any, are the Board's plans for SFY 2009 in the following areas?

**9.c.1. JAILS**

*Click on gray box to indicate priority level.*

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.2. DETENTION CENTERS**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.3. SHELTERS (Includes Homeless, Runaway, Domestic Violence)**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.4. NURSING HOMES**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.5. PRISON RE-ENTRY**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.6. PHYSICAL & MENTAL HEALTH INTEGRATION**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to area of cross-system collaboration:*

**9.c.7. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

**9.c.8. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

*Click on gray box to enter text.*

**9.c.9. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**9.c.10. Other.** If you need additional space to discuss plans involving significant inter-system collaboration:

*Click on gray box to enter text.*

**10. Prevention, Consultation and Education (P,C&E).** What are the Board's plans for SFY 2009 in the following areas? It is not necessary to discuss all prevention programs funded by the Board. Please discuss P,C&E planning of most salience or strategic importance to your system.

**10.a. SUICIDE PREVENTION**

*Click on gray box to enter priority level.*

Priority:

Goals: *Click on gray box to enter text.*

Reduce stigma and increase help seeking behaviors.

Strategies: *Click on gray box to enter text.*

Offer suicide prevention training throughout the community and continue the distribution of the English and Spanish versions of our suicide prevention brochure.

Measurable Objectives: *Click on gray box to enter text.*

The Board will conduct at least one community training and distribute at least 1,000 brochures.

Discussions and/or Collaborations: *Click on gray box to enter text.*

In light of the statistics around suicide in Ashtabula County, the Board sees this as a high priority area; however, at this time, the Board does not have the funds to pursue additional strategies around suicide prevention and the Suicide Prevention Coalition started by the Board has not taken root in the county. Ideally, the Board would like to see an increase in the number of individuals who seek assistance in an effort to prevent suicides; however, there is minimal to no capacity at this time to serve additional Non Medicaid persons in the Ashtabula County system.

*Click on gray box to enter name of P,C&E activity:*

**10.b. OTHER:**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

The Board sees prevention services as vital to the community; however our financial condition has resulted in the elimination of all funding for any MH prevention services in the community beyond what the Alternative Education funds allow us to do at the county's alternative school setting. And at this time, due to some changes in progress at the the school administrative level, we are not sure what the plan will be for SFY 2009 in regards to the alternative school and the Alternative Education funding.

10.c. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**10.d. Other.** If you need additional space to discuss planning for prevention, consultation and education:

*Click on gray box to enter text.*

**11. Cultural Competency:** What are the Board's plans for SFY 2009 to increase cultural competence? Please discuss the areas of most salience or strategic importance to your system.

**11.a. CONSUMER SATISFACTION WITH SERVICES AND STAFF**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**11.b. STAFF RECRUITMENT**

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

### 11.c. STAFF TRAINING

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

### 11.d. ADDRESSING DISPARITIES IN ACCESS AND OUTCOMES

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

11.e. OTHER:

Priority:

Goals: *Click on gray box to enter text.*

Strategies: *Click on gray box to enter text.*

Measurable Objectives: *Click on gray box to enter text.*

Discussions and/or Collaborations: *Click on gray box to enter text.*

**11.f. Other.** If you need additional space to discuss planning in cultural competency:

*Click on gray box to enter text.*

**12. ANYTHING ELSE?** Are there are other Board plans for SFY 2009 not covered by the outline? Is there any other information pertinent to the Community Plan that the Board would like to share?

*Click on gray box and enter text.*

As mentioned in many sections of this plan, the Ashtabula MHRS Board is presently not in a position to engage in real and meaningful planning for services for the community and especially for the Non Medicaid Consumers in desparate need of mental health services. Without financial assistance to assure the capacity to purchase the basic essential Safety Net services, the county's Non Medicaid Consumers, both adults and children, will experience a continued reduction in services. The Board believes that it has an excellent knowledge of its service area, community needs and providers. The Board could more effectively plan and manage services if it had the tools to address utilization by Medicaid providers and the funds to adequately meet the Medicaid match requirements as well as provide the Safety Net services needed by those individuals who do not have Medicaid, insurance or any other means to pay.

**13. Projected Budget.** *Please refer to the following link:*

<http://www.mh.state.oh.us/cmtypolicy/planning/guidelines/2009/budget-template.xls>

Using the Board's submitted SFY 2007 FIS-040 report as a baseline and for comparison purposes, please complete the Community Plan Budget excel spreadsheet for SFY 2009 (if desired, your SFY 2007 FIS-040 may be obtained from Holly Jones at [joneshm@mh.state.oh.us](mailto:joneshm@mh.state.oh.us)). **The Excel spreadsheet must be included with the Word form template, when submitting your Community Plan electronically.** Please indicate how the Board plans to purchase services by fund source.

**14. Business Rules.** Identify any changes in the Board's business rules (See Appendix E. Business Rules for MACSIS) that will be necessary to accomplish the Board's Plan for non-Medicaid reimbursable services and services to consumers that are ineligible for Medicaid.

*Click on gray box and enter text.*

No Change.

**E. Evaluation of Plan Implementation.**

**E.1.** How does the Board plan to evaluate services, pursuant to ORC 340.03?

<http://codes.ohio.gov/orc/340.03>

*Click on gray box and enter text.*

<p>Each section of the Strategic Plan requires collaboration with consumers, family members, stakeholders, providers, and other service systems. Many of the goals will be monitored and implemented through the various documents and Board level reporting. The Board will use the following evaluation criteria to evaluate the need for facilities and mental health services, assess the mental health needs, set priorities and develop plans for the operation of facilities and community mental health services:</p> <ol style="list-style-type: none"> <li>1. Measurement and analysis of the level of community acceptance of services offered by the mental health providers and with the Board planning process. Information will be obtained through consumer surveys and agency quarterly reporting on their internal Consumer satisfaction survey results. In addition, the Board will obtain information from community stakeholders.</li> <li>2. Measurement and analysis of the patterns of service use in the Board area, including amounts and types of services by important client demographic and diagnostic characteristics and provider agencies. Information will be obtained on at least a quarterly basis from providers and the Heartland East Collaborative.</li> <li>3. Measurement and analysis of the cost of services delivered in the service district by unit of service, service pattern, client characteristics and provider agency. Information will be obtained on at least a quarterly basis from providers and the Heartland East Collaborative.</li> <li>4. Measurement and analysis of the levels of consumer outcomes achieved by clients, service patterns, client characteristics and provider agency. The Board will utilize the Data Mart and Ohio Department of Mental Health Outcomes web site to obtain information regarding consumer outcomes.</li> <li>5. Measurement and analysis of the cost-effectiveness and cost efficiency of services delivered by service pattern, client characteristic and provider agency. Information will be obtained on at least a quarterly basis from providers and the Heartland East Collaborative.</li> </ol>	E.1
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**E.2.** How does the Board plan to develop and use various databases, (e.g, MACSIS, Outcomes, Behavioral Health Module) to evaluate the effectiveness and efficiency of services?

*Click on gray box and enter text.*

<p>The Heartland East Boards have a long-standing Reports Group, a committee of Board clinical staff who convene quarterly to develop reports with the HeartlandEast database programming staff. The group has developed several reports that utilize the BH data with claims, including reports on costs per episode of care, treatment patterns within diagnostic groups and cost per client. The Heartland East Reports Group is currently focusing on the development of reporting that combines outcomes with claims data to determine cost effectiveness of services using clinically comparable client populations and providers/programs.</p>	E.2
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**E.3.** To what extent does the Board need technical assistance concerning compliance with ORC 340.03? (Guidelines for ORC 340.03 appear in Appendix D.)

*Click on gray box and enter text.*

<p>The Board plans to continue to work with the Heartland East Collaborative to obtain data</p>	E.3
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and learn effective use of the Ohio Department of Mental Health Outcome and BH data in evaluating services. It would be helpful to gain information as to how Boards can impact the use of Outcomes by its providers.	
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**Form 1**

**Board Appointment Data Sheet**

**Form 2**

**Community Board Resources**

a. Please provide the name, address, phone number, and email of the Board's Forensic Monitor:

Name	Street Address	City	Zip	Phone Number	Email
Vincent Arduin	5212 Mahoning Ave., Suite 317	Youngstown	44515	330-792-1918	NA

b. Please provide the name, address, phone number, and email of the Board's Community Linkage Contact:

Name	Street Address	City	Zip	Phone Number	Email
Miriam Walton	4817 State Road, Suite 203	Ashtabula	44004	440-992-3121	ashtabadmew@suite224.net

c. Please provide the name, address, phone number, and email of the Board's Client Rights Officer:

Name	Street Address	City	Zip	Phone Number	Email
Pat Wagner	4817 State Road, Suite 203	Ashtabula	44004	440-992-3121	ashtabadmhbd@suite224.net

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Form 3

Planned State Inpatient Bed Days

<b>BOARD NAME</b>	
<b>2009 Planned Use of State Inpatient Days</b>	
<b>Northcoast-Toledo</b>	
<b>Northcoast-Toledo</b>	
<b>Northcoast-Toledo</b>	
<b>Northcoast-Toledo</b>	
<b>Total Inpatient Days</b>	

Signed \_\_\_\_\_  
Board Executive Director

I anticipate contracts for CSN services to some degree.

- Yes
- No

Form 4

Notification of Election of Distribution – SFY 2009

The (Board) has passed a resolution making the following:

- The Board plans to elect distribution of 408 funds.
- The Board plans not to elect distribution of 408 funds

Signed:

\_\_\_\_\_  
(Name)  
Executive Director  
(Board)

Date: