

III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

Click on box to enter Board name.

BOARD NAME: Hancock County Board of Alcohol, Drug Addiction and Mental Health Services

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

The Mission for the Hancock County Board of Alcohol, Drug Addiction and Mental Health Services shall be:

“To create an environment that brings hope and improves the quality of life for persons affected by mental illness and substance abuse and promote wellness for all ages through a locally administered and publicly funded system.”

"CARING FOR OUR OWN, LED BY OUR OWN"

BOARD VALUES:

1. Mental health and substance abuse treatment works and people recover.
2. Our highest level of accountability is to the residents of Hancock County, especially those receiving mental health and/or substance abuse services.
3. The strengths and talents of peer, family and informal support services are critical in the success of one's recovery.
4. Client and family involvement is important at all levels of planning and decision making.
5. Providers are needed to deliver quality, client directed services which achieve positive results through the application of evidence-based interventions.
6. Addressing behavioral health problems requires an array of services and supports that must be coordinated across ages, cultures, agencies and other health delivery systems.
7. Data informed decisions will be used to continually seek improvements in the system.
8. Community members understand that being mentally healthy and addiction-free are essential to one's overall health and the overall health of the community.

Revised January 18, 2007

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 business rules are reviewed annually by the Board and are an accurate reflection of the current population and service priorities for non-Medicaid expenditures by the Board. A new business rule will be added for FY'09 to address out of state and out of country students at our local university.

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 communities making up Hancock County have been impacted from some of the worst flooding that has been experienced in over 100 years, first in August of 2007, then again in February 2008. Our specific response to this disaster and the pivotal role played as a community partner is described in other Sections of the Plan. Because of the tight fiscal climate, the Board of Directors adopted a set of Community Plan priorities that include sustaining current services, especially to flood survivors. Within this climate, the Board is committed to improving the lives of consumers needing services.

Achievements the Hancock County ADAMHS Board has made since in the area of Recovery Supports includes the adoption of the Board’s Strategic Plan (FY 07 – 09) which was exclusively focused on transforming our local system through the shared values of Recovery and Resiliency (R&R). These shared values focus on the implementation of these six priorities:

1. Increase customer voice
2. Strengthen engagement
3. Make system of care changes consistent with R&R
4. Adapt ADAMHS roles to R&R shared values
5. Targeted wellness promotion including selective prevention efforts

6. Focused partnerships with criminal and juvenile justice, physical health education, and child welfare

Strategies implemented since the submission of the Board’s last Strategic Plan include the creation of the Quality of Life Continuum to use as a training tool to illustrate the Board’s and agencies role in transforming the system through the shared values of Recovery and Resiliency; re-designed the Board’s CQI process to include a focus on Recovery and Resiliency measures available within the system and includes responsibilities for each of the Board’s Committees in monitoring and analyzing information relevant to each Committee’s specialty area; establishment of a dedicated position to foster and grow consumer and family supports throughout the entire adult and youth system (the Director of Advocacy and Support); development of a Board Stipend Policy and creation of a stipend account that is managed by the Director of Support and Advocacy and used to pay consumers for representation on planning committees or their participation in educational programs; and re-tooling of the agency quarterly audit process to monitor an array of recovery focused items (including baselining the number of self-declared consumers and family members serving on Boards, Committees, and/or employed by the agencies).

In addition to these strategies, the Board currently funds an array of evidence-based services, including supported employment, CIT Training, Intensive-Home-Based Services, MST, ACT/IDDT, a range of Early Childhood interventions and consultations, including the Incredible Years and Dina School, Moral Reconciliation Therapy, Cognitive Behavioral Therapy, and a range of housing developments and supports that are identified in more detail in section 2.1 of this Plan. Finally, a novel partnership was developed several years ago with a local Foundation and the University of Findlay’s Occupational Therapy Department to create OT field placements within community mental health settings and within our Peer Drop In Center.

Outstanding goals include the recruitment of “Recovery Coaches”- paid and trained persons who can mentor consumers and families using public services; the development of a Dual Recovery Anonymous Support Group; reviewing the feasibility of clinically “staging” all priority populations to match interventions with the appropriate phase of change and stage of treatment; increase the number of available hours of Peer Support; professional development conferences on Suicide, Campus Safety, and Cultural Competency and the role of spirituality; and conducting a system-wide training on best practices with respect to engagement and outreach, and the implementation of Brief Strategic Family Therapy and Aggression Replacement Training.

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.

Yes	2.1.a
-----	--------------

b. If yes, do you have wait lists for **supported housing**?

Click on gray box to select answer.

No	2.1.b
----	--------------

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 checked="" 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	2.1.d
---------------------	--------------

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	2.1.e
----	--------------

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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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	2.1.g
---------------------	--------------

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 checked="" type="checkbox"/>	<input 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.

30 Consumers Waiting	2.1.i
----------------------	--------------

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.

k. Appendix B reflects 10 persons for Hancock County. This is a fair representation of our services. Discharge to jail or a homeless shelter is not considered an acceptable plan. As a result, our system is very involved with housing.

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	2.1.ja
<input type="checkbox"/>	PATH	
<input checked="" type="checkbox"/>	BH Mod (Behavioral Health Module)	
<input 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.

10 Homeless persons with SMI	2.1.jb
------------------------------	---------------

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 is currently involved with a capital project to develop 16 units; 15 efficiency apartments and one, one bedroom apartment for an onsite apartment manager. The manager will be a peer in recovery. This housing complex will house individuals with mental illness and/or substance abuse. As a part of the local CHIP planning process, there was an agreement to include rental assistance for residents of this facility while they are awaiting a Section 8 voucher.

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 NOMS number of adults with SMI employed full or part time as provided by the ODMH is 262. This number is higher than any of the other sources of information we presently track. A recent run (1-31-08) from the Ohio Association of County Behavioral Health Authorities “Care Management Indicators” using claims data linked to Outcomes Instrument Adult Consumer A or B identified only 14 adults who were employed, however, less than 30% of the 650 adults with SMI had corresponding outcome data (the major adult provider is now showing only a 40% missing data report via the Outcomes tracking).

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.

The Board also tracks employment through its Supported Employment Program as well as fidelity to the Supported employment model (the agency averages a score of 71-73 out of a total of 75). Currently the Supported Employment program is one FTE who can work with a Peer Support Specialist and an OT graduate student. The Community Support program (serving only clients who meet the criteria for SMD) also provides projections of those employed who did not go through or use the Supported Employment program.	2.2.aa
---	---------------

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.

b. Please describe existing activities related to helping consumers identify, determine, or achieve their employment goals. The continuum of activities may include referral to 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.

As of the end of the first quarter in FY 2008, 52 individuals served through the Community Support Program are employed and another 33 individuals were currently enrolled in the Supported Employment Program. Employed persons with SMI	2.2.ab
--	---------------

the

Click on gray box to enter text.

Our two largest barriers to increasing the number of clients competitively employed is breaking what Mary Ellen Copeland identifies as learned helplessness of some clients with severe mental illness and the benefits management side of enticing individuals to become employed. Our supported employment specialist continues to provide this type of counseling to individuals. In addition, we have expanded the use of volunteering and the exploration of “meaningful activities” (one of the R&R shared values) with our clients through case management. Our partnership with the University of Findlay’s OT department was mentioned briefly. This is the fourth year of this partnership, which seeks to bring OT to the community mental health field. OT is very compatible with Recovery as both are anchored in striving to raise the quality of life of clients. OT can be a vital component within a community mental health agency desiring to raise the quality of life for its clients.

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.

Notable areas include the involvement of The University of Findlay Occupation Therapy Program with our system. This is reinforcing the need to focus on the "quality of life" vs. symptom management. The University also has initiated a pharmacy program. Outreach efforts have been made to involve them with our system as well to assist clients/families with understanding of medication management, drug interactions, side effects, etc.

The local director of Advocacy and Support has been providing technical assistance to all of our informal system supports. This has increased attendance at our local support groups; aided our

local NAMI Chapter with establishing a board of directors; and increased client participation in the system.

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.

The Board does not fully utilize the Outcomes database as we are working with agencies to get a higher than 90% compliance with outcome data submission. According to the Ohio Department of Education’s datamart, called the interactive Local Report Card (or the iLRC, which can be accessed at http://ilrc.ode.state.oh.us/Power_users.asp), the number of out of school suspensions for Hancock county schools over the 2007-2008 school year is 811 students coming primarily from the two largest schools.

- 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.

In addition to the iLRC, we have been using additional sources for information to track our impact with local schools- these include regular stakeholder contact with local school officials, the Ohio Department of Education website and agency-specific information. From the ODE website, an annual report is provided to the Board on the “grade” received by each school as provided by the education department’s evaluation, the enrollment, attendance, graduation rate, and the percentage of “economically disadvantaged” students of all nine of our county schools and Findlay City schools. Our main children’s agency (Family Resource Centers) provides a quarterly report by school that identifies the clinical and prevention/education/consultation activity occurring at each school. FRC provides a case manager to each school and there are 2-3 FTE clinicians that are school-based in the City schools and the Alternate Learning Center (the county’s SBH unit). Starting in this fiscal year (FY 08), the Board’s CQI plan identified a project to include a review and monitoring from the Outcomes DataMart those indicators consistent with the shared values of Recovery and Resiliency. For children, The Ohio Scales Functioning scale includes a rating if the youth is attending school/passing grades. The Board continues to work with the provider to see how this data can be used as a “dashboard” indicator to make sure school performance is addressed via treatment.

3.1.aa

- 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.

4. Inpatient Care

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

According to the ODE DataMart, the number of out of school suspensions for Hancock county schools over the 2007-2008 school year is 811 students.	3.1.ab
---	---------------

fiscal
state

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	4.a
State Hospitals	482	421	12	13	
Private Psychiatric Hospitals: Adults	1619	1651	330	340	
Private Psychiatric Hospitals: C&A	152	178	38	43	

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.

<p>Contract providers track all state and private hospital use. This is the information that is provided above. The Board holds no contracts with private hospitals to pay for the hospitalization of youth or adults. The Board does provide a small amount of funds to the designated adult agency, which in turn contracts with an area adult hospital. In addition, the Board has a small contract with the local psychiatrists who provide inpatient care. The contract is used to cover services provided by them, for indigent and non-Medicaid eligible clients, while on the inpatient unit.</p> <p>There is a local Inpatient Planning Committee which meets every 6-8 weeks to discuss issues related to inpatient/community care. In April of 2008, the local hospital will be opening a new, 9 bed, inpatient psychiatric unit. It is anticipated that as a result of the structural changes, the local hospital will be in a better position to admit more involuntary clients.</p>	4.ba
---	-------------

b.b. Do you have a continuity of care agreement with your designated state hospital?

Click on gray box to select answer

No	4.bb
----	-------------

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.

4 C&A Consumers in SFY 2007	5.a
-----------------------------	------------

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.

4C&A Consumers place out of county in SFY 07	5.b
--	------------

c. How many of the C&A consumers identified above involved Board participation in the placement decision?

Click on gray box to enter number.

4 Out of county placements involved the Board	5.c
---	------------

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."

Use is increasing	Use is about the same	Use is decreasing	5.d
<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.

Presently, the Board collects information on youth in out of home placements (there are no residential centers or psychiatric hospitals in our county) that are cost shared with the Family First Council. Our Goal over the next year is to develop a CQI process that more accurately tracks out-of-home placements of all youth (cross systems including residential treatment centers, foster care, respite care and inpatient care) and establishes care management strategies aimed at discharge planning.	5.e
--	------------

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"/>	
Adult Consumers		
24/7 On-Call Staffing by Psychiatrists	<input type="checkbox"/>	
24/7 On-Call Staffing by Clinical Supervisors	<input checked="" type="checkbox"/>	
24/7 On-Call Staffing by Case Managers	<input checked="" type="checkbox"/>	
Mobile Response Team	<input type="checkbox"/>	
Crisis Care Facility	<input type="checkbox"/>	
Hospital Emergency Department with Psychiatric Staff	<input checked="" 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 checked="" type="checkbox"/>	
Child & Adolescent Consumers		
24/7 On-Call Staffing by Psychiatrists	<input type="checkbox"/>	
24/7 On-Call Staffing by Clinical Supervisors	<input checked="" type="checkbox"/>	
24/7 On-Call Staffing by Case Managers	<input checked="" type="checkbox"/>	
Mobile Response Team	<input type="checkbox"/>	
Crisis Care Facility	<input type="checkbox"/>	
Hospital Emergency Department with Psychiatric Staff	<input checked="" 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):		

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	0	0	
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.

Our units of crisis intervention services and persons served (esp. adult clients) is trending upwards. The total number of units for adults went up by 188 units, while the number of units for youth remained relatively stable, with an increase of 22 units. The same is true for numbers served. 580 adults (up from 509 in FY'06) received crisis services; compared to 113 youth (up from 111 in FY'06) Total claims spent in FY 07 for this service was \$214,949,

equaling about 5% of all claims. Statewide in FY 07, Crisis Intervention claims made up over 2.8% of all claims paid through ODMH.

As a result of our CIT program, we are working with law enforcement and mental health crisis providers to develop a continuity of care planning guideline that articulates the roles and responsibilities of mental health professionals working with law enforcement in crisis situations. The guidelines will define care management in crisis situations, re-enforce CIT as a diversionary program, and identify the information to be provided by the CIT officer to the Pre-screener- and what information the pre-screener provides to the CIT officer regarding the results of pre-hospital assessments.

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 Hancock County Crisis Intervention Team (CIT) training is a community partnership among law enforcement, mental health, consumers and family members. This unique alliance began in 2001 when representatives from the mental health community and the Findlay Police Department and the Hancock County Sheriff's Office were sent to Memphis to assess the CIT program. While there, the Hancock County Team went on ride-alongs with trained Memphis CIT officers. The consensus from the Memphis visit was to develop and implement CIT as a way to provide a focused and safe approach to resolving psychiatric crisis situations that law enforcement officers face in the line of duty.

Hancock County graduated its first class of 24 officers in 2002. Additional classes were held in 2003, 2004, 2006, and 3 classes in 2007. In 2004, Findlay City Police Department (FCPD) and the Hancock County Sheriff's Office (HCSO) each had reached its first CIT training goal of having one quarter all law enforcement staff trained. This coverage allowed every shift in each of these departments to have a trained CIT officer at the ready. In 2005, the graduates of the first two CIT classes underwent a two day refresher course and in that same year, over 23 dispatchers from FCPD, HCSO and Bluffton PD were trained in handling calls involving suicide and mental illness. Over 21 Dispatchers completed refresher training in January, 2008. At our 2006 training, we included the jail administrator and 3 Hancock County corrections officers. In January and May of 2007, an intensive CIT training was adapted and provided to 20 corrections officers. In October of 2007 and February 2008 a "blended" training was conducted that included 18 corrections staff and 12 law enforcement officers.

In addition to training Hancock County law enforcement and corrections officers, law enforcement officers from Paulding and Van Wert counties, as well as McComb, Tiffin, and Urbana Ohio have attended. Presently there are 45 FPD (60% of the force), 34 HCS deputies, plus the chaplain or about (100% of the force), and 35 corrections officers (100% of the force) as well as 2 (two) University of Findlay Security Officers who have gone through the training.

Finally, the CIT Committee members have responded to presentations and requests for assistance in establishing CIT programs in these areas: Wood County, Seneca County, Tri-County (Miami, Darke, Shelby), and Logan/Champaign Counties. In addition, Committee

members presented at all three of the National CIT conferences (2005 – 2007) on the de-escalation model developed by the Committee and adapting CIT training goals to corrections settings. In 2007, consultation was provided to New Mexico in adapting the EAR model for CIT training in rural areas.

2. Disaster Preparedness

Click on gray box to enter text.

While the Board had been involved with disaster preparedness in the past, in August of 2007, a major flood occurred in Findlay, Ohio. Over 3000 structures were impacted. A local shelter was opened, where over 275 people sought shelter. Our local agencies responded by providing 24 hour coverage at the local shelter for crisis counseling as well as making outreach to clients of the agencies to ensure their safety. 135 clients in our system were directly impacted by the flood.

As soon as the command center was opened, the Executive Director was on site. While the agencies concentrated on providing direct services; the Board worked on public information and education. The Board completed and was awarded a FEMA Emergency Response Grant as well as a Regular Services Grant. The Regular Services Grant will provide for three outreach teams to continue to provide services through August of 2008. There is still a significant amount of work to be done to assist this community with recovery.

The Board has been a part of the local Long Term Recovery Committee and has authored two grants to the local Community Foundation on their behalf to hire a local coordinator and fund two case managers. Both grants have been awarded. The current caseload of the recovery committee, which is focused on returning individuals/families to safe, secure and sanitary living environments is over 100.

Outreach efforts have been, in collaboration with the Putnam County ADAMHS Board, to secure the commitment of the local newspaper to provide ongoing information related to emotional recovery to the community. In addition, a suicide prevention conference is being planned in collaboration with the Ohio Suicide Prevention Foundation for August 14, 2008. Keynoting this conference will be Michael Duffy, Director of Mental Health and Substance Abuse from Louisiana and Dr. Larry Burd, who conducted a study on social indicators following the Grand Fork Flood in North Dakota. His study revealed an increase in: depression; substance abuse; domestic violence; truancy and suicide as a result of the flood. The Board is actively focusing on these key areas, as the community has much in common with the Grand Fork area.

Prior to the flood, the Board had worked with the system to establish a Disaster Response Policy. This was very helpful during the flood as each of the parties involved were clear on their primary responsibilities. Since the flood, the Policy has been reviewed and revisions will be made in FY'09 to enhance its effectiveness.

Throughout the disaster, the Board was in regular contact with ODMH and ODADAS. Staff at ODMH were extremely helpful with navigating the FEMA process and providing support during and subsequent to the disaster.

While Hancock County had 75 individuals who completed the two day disaster response training; only 46 were available to provide assistance during the August flood. It is apparent that the need to update and maintain the list of qualified trainers needs to be a priority; as

well as the need to offer a "refresher" training. The number of trainers listed under statewide disaster response is the same for trained (as it was a state approved training). All who went through the training agreed to be contacted in the event of a state disaster, however many are likely to be unavailable. As a result, an estimate, less than those responding to a local disaster was included below.

What are your estimates of staff for the following areas?

Click on gray box to enter number.

	Local Disaster Response	Statewide Disaster Response	6.c.2
Trained	75	75	
Currently Available	46	10	

3. School Response, including prevention, consultation and education:

- a. Universities & Colleges
- b. Secondary and Primary Schools

Click on gray box to enter text.

In the area of disaster preparedness and the school systems, the Board established a task force in June of 2007 as a result of the Virginia Tech incident to determine what steps need to occur locally to address this concern. As a result of their efforts, on April 24, 2008 a state-wide conference on reducing risk in educational systems will be offered. This conference is designed to provide communities with a base understanding of the issues surrounding school violence as well as the need for close collaboration and communication.

The University of Findlay has a program titled School of Environmental and Emergency Management. One of the primary services they offer is campus/school safety and security. Staff from this program are involved with our local schools on safety and security. As a result of the planning of the statewide conference, the Board has been extended an invitation to work collaboratively with them on future projects.

Our local university has a large population of international students. The Board has been working with university staff to develop a MACSIS Business Rule that addresses the provision of needed mental health and/or substance abuse services to this population. This rule will be in place for FY'09.

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 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"/>	
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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <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’s focus area has been on ACT. Century Health provides fidelity reports to the Board on an ongoing basis which is a part of the Program Compliance Monitoring completed by the Board.

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 checked="" 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"/>	
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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <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"/>	<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"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Intensive CPST	<input checked="" 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"/>
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"/>	<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"/>	<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 Board’s focus area has been on IHBT/MST and Functional Family Therapy. Family Resource Centers provides fidelity reports to the Board on an ongoing basis which is a part of the Program Compliance monitoring completed by the Board.

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 blow 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 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"/>	
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 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"/>	
Pharm. Management	<input checked="" 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"/>	<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 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"/>	
CPST	<input checked="" 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"/>	<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.

The area of focus has been to bring clinical best practices into the system. Cognitive behavioral therapy is a fairly common thread among the practices. As a result, through BHG, a CBT certification program was sponsored and several of our providers attended and completed certification. Another area of focus has been on group therapies, in order to increase access and capacity.

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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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.

The response to this is the same as for adults.

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.

Best Clinical Practices. Identified on the following charts is a summary of the best clinical practices that are in place for the adult and youth system.

Adult Programs (Implementing agency is Century Health unless otherwise noted.)

Supported Employment Service (1 FTE) Began in FY 05. Supported employment programs assist people in finding competitive employment—community jobs paying at least minimum wage, which any person can apply for according to their choices and capabilities. Supported employment programs are staffed by employment specialists who help consumers look for jobs soon after entering the program. Extensive pre-employment assessment and training, or intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops are not required. Fifteen different measures that include caseload, integration with treatment planning,

comprehensiveness of services offered. Century has been providing this service for over three years, and is working on integrating the discipline of Occupational therapy within this program.

Housing- Implemented by L&M Housing. Housing for adults with severe mental illnesses should ensure that housing is protected while a person is in crisis. Housing programs should focus on expanding available housing stock, subsidizing to make it affordable, and providing "bridge" rentals (flexible funding that allow for down payments and/or first months rent). These elements of good housing programs are done in part through the Board's HAP dollars and Section 8 vouchers. Lisa Markel has been managing our housing stock for many years.

Assertive Community Treatment- Began in FY 2000. Assertive Community Treatment reduces the use of hospitalization by providing intensive, individualized team approaches to treatment for individuals with severe mental illness. Team consists of 2 CSP workers, clinician, doctor, nurse, and peer support specialist. Diagnostic eligibility criteria, 24/7 availability, services provided in the community, team composition, intensity of service. Century has 2 FTE case managers and access to 3 other team members. The Agency has been providing this service for over four years.

Dual Disorder Integrated Treatment- Began in FY 05. Dual Disorder Integrated Treatment (DDIT) model reduces gaps in service to persons with co-occurring disorders of substance abuse and mental illness by incorporating substance abuse services within mental health systems. Integrated substance abuse and mental illness (SAMI) services are delivered by a multidisciplinary continuous treatment team who collaborate to discuss and plan treatment, and work with consumers and caregivers to help manage their mental illness and substance abuse. Includes 17 focus areas with over 85 different measures addressing team composition, use of Stage-Wise treatment, caseload size, services offered, assessment and treatment planning. Century continues to increase its annual fidelity scores for this program. 3.7 June 07; 3.5 in 2006; 2.0 in 2004

Cognitive Behavioral Therapy- A total of 5 clinicians went through the BHG offered CBT certification program. Three of these therapists remain at the Agency. Some women's groups and sex offender groups began using the "Thinking for Change Moral Reconciliation Therapy Program and in FY 06 and in FY 07 a track specific to sex offenders was offered for those on Probation. Both approaches include a cognitive-behavioral approach. Victims of trauma also receive cognitive behavioral therapy. Both approaches are manual approaches and fidelity reviews should include adherence to the treatment approach. Our system continues to work with Adult Probation system to provide an array of evidence-based approaches.

STEPPS- Systems Training for Emotional Predictability and Problem Solving Program. The STEPPS Program is based on a systems approach to treatment of individuals with Borderline Personality Disorder(BPD) originally developed by Bartels and Crotty (1992) and subsequently been adapted and revised by Blum, St. John, and Pfohl (2002). The Program usually includes two phases- a 20-week Basic Skills group, and a one-year, twice monthly Advanced Group Program called STAIRWAYS. In this cognitive-behavioral, skills training approach, Borderline Personality Disorder (BPD) is characterized as a disorder of emotion and behavior regulation. The goal is to provide the person with BPD, other professionals treating them, and closely allied friends and family members with a common language to communicate clearly about the disorder and the skills used to manage it. The therapy is manual-based and each week specific goals are set. Century began offering this program in FY 2007.

Dialectical Behavioral Therapy- Dialectical Behavioral Therapy (DBT) is a cognitive-behavioral treatment approach with an emphasis on dialectical processes. "Dialectical" refers to the issues

involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. It usually consists of two parts: a once-weekly psychotherapy session in which a particular problematic behavior or event from the past week is explored in detail and; weekly 2.5-hour group therapy sessions in which interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills are taught. Therapists follow a detailed procedural manual. Century began offering this program in FY 2007.

Crisis Intervention Training- Coordinated by ADAMHS Bd. Began in FY 02. Specialized training for law enforcement working in crisis situations with individuals with mental illness. We began Crisis Intervention Training on an annual basis in FY 02. To date, over 70 Law Enforcement officers and 1 dozen corrections officers have graduated from the training. More formal core elements of Crisis Intervention Training are being developed. Some of these elements include role-playing, skills building, meetings with consumers and family members. Mini-Crisis Intervention Training offerings have also been provided to social service agencies.

Psycho Educational Programs- For family members and consumers. Coordinated by Alliance on Mental Illness and Focus on Friends. Bridges Training and Wellness Recovery Action Planning Training are specialized training that have curriculums and guides for the program. Twelve students attended a Bridges class in FY 06.

Tobacco Cessation Project- This Project was designed to gather information about the implementation of tobacco dependence treatment and tobacco-related policy changes at community behavioral health organizations in Ohio. Began in FY 2006. Among individuals with severe mental illness, evidence points to tobacco use as one of several preventable risk factors contributing to high rates of medical morbidity and premature deaths. New guidelines for psychiatric care highlight the connection between mental health and overall health and suggest that individuals with severe mental illness should be assessed regularly and offered treatment for tobacco dependence, in addition to other preventable risk factors (Krejci & Foulds, 2003; Newcomer, 2005). The Treatment Model includes the Change Model and The 5 A's, which is a brief, clinician-delivered smoking cessation intervention for individuals who receive care in a community behavioral health organization. The 5 A's brief intervention is designed to be used at every contact between clinical staff and clients. The intervention includes the following five components: Ask: All clients are asked if they use tobacco and have their tobacco status documented. Advise: All clinicians strongly advise every client who smokes to quit in a clear, strong and personalized manner. Assess: Once a tobacco user is identified and advised to quit, the clinician assesses the client's willingness to make a quit attempt at that time. Assist: If the client is willing to attempt quitting, interventions identified as effective like pharmacotherapy and counseling are initiated at that time. If the client is not willing to make a quit attempt at this time, motivational intervention is provided. Arrange: The client who is making a quit attempt receives a follow-up contact preferably within the first week of the quit attempt. The target population includes adolescents and adults with severe mental disorders/severe emotional disorders and/or alcohol, tobacco or other drug problems. The evaluation will focus on factors related to reduction in individual tobacco use and successful implementation of tobacco prevention programs. Seven community mental health and substance abuse service organizations including Century Health are participating in this pilot study in FY 06 and 07. The Tobacco Dependence Project is now the Tobacco Cessation Project. Deb Twining serves on the State Advisory Council and Century will be undergoing our assessment by the Coordinating Center of Excellence in April 08.

Moral Reconciliation Therapy- Cognitive-Behavioral Programming has become the preferred treatment approach for offender populations. Moral Reconciliation Therapy is one of the few that has been

consistently shown to reduce recidivism. Moral Reconciliation Therapy (MRT) is a cognitive behavioral therapy system designed by Gregory Little, Ed. D. and Kenneth Robinson, Ed. D., Correctional Counseling, Memphis, Tennessee. The Program is based on Lawrence Kohlberg's moral development theory. It also incorporates Erik Erikson's work on ego and identity development and behavioral conditioning as well as the works of Abraham Maslow, Carl Jung and Ron Smothermon. The Program was developed in 1985 and is currently used throughout forty states and also in Canada and Puerto Rico. Manual program done usually in a group format. Clients use a workbook containing exercises referred to as Steps. Moral Reconciliation Therapy Steps begin with relatively simple tasks that progressively increase in complexity and difficulty. Lower Steps are concerned with issues of honesty, trust, acceptance, and awareness. Higher Steps move toward active processes of healing damaged relationships and long-term planning. In the process the client is essentially given the opportunity to reconstruct his or her identity and personality. Century has been providing Moral Reconciliation Therapy groups to the local jail since 2006.

Youth Programs Description (Implementing Agency is Family Resource Centers unless otherwise noted).

Multi-Systemic Therapy- 3 FTE'S; 1/2 supervisor; 1/4 support). Began in FY 03 The goal of MST is to empower parents with the skills and resources needed to address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Therapist adherence measures, supervisor adherence measures, 24/7 access family change goals, case outcomes, intensity.

Wraparound- (14 FTE) Began in FY 00. Wraparound is a strategy for organizing and coordinating the design and delivery of creative services and supports when children and families have complex needs. Wraparound is not a service but the framework used to decide what services to deliver in what way, for what price, to achieve what outcome. The goal of the Wraparound process is to improve the impact of the services and support provided. Team composition, strengths-based assessments, non-traditional interventions. Five staff members are trained as Wraparound facilitators.

Home-Builders- (Homebuilders - 2 FTE'S; 1/4 supervisor) Home-Builders is an intensive family preservation program designed to avert the unnecessary placement of children into foster, group, or institutional care. The target population is children who are identified as at risk due to serious child protection, family conflict, and mental health concerns. Trained therapists work with a few families at a time performing activities that include help with material necessities (such as food, clothing, and shelter), and mental health therapy. Available 24 hours a day, the therapists provide an individualized, flexible treatment plan in the clients' homes, neighborhoods, and schools. 24/7 access family change goals, case outcomes, intensity. Family Resource Centers has been offering this program for over 3 years.

Life Skills Training- (1 FTE) A drug abuse prevention expert, Dr. Gilbert J. Botvin, has produced a training program entitled LifeSkills. LifeSkills Training (LST) has been involved in over 20 years of research on school-based drug abuse prevention in middle and high school students. LST focuses not only on prevention of substance, but associated behaviors and causes as well. LST seeks to prevent drug abuse in school-age children by addressing students' general social skills, social resistance skills, and one's personal self-management skills. Curriculum, specialized training.

Adolescent Sex Offender Treatment- (1/2 FTE) Ohio University's Sexual Offender Treatment Specialist Certification is designed to assist professionals by offering comprehensive training and seeking to reduce offender relapse risk, protect potential victims, and enhance community safety. The Program focuses on special issues and concerns that arise when working with sexual offenders in institutions or community settings and advocates offense-specific treatment that instills in sexual offenders personal responsibility, victim empathy, and relapse prevention strategy. Participants are introduced to techniques, methods, and treatment modalities aimed at helping offenders develop personal control to avoid re-offending. ABEL Assessment, participant workbooks. Family Resource Centers has been offering this program for over three years.

Parent Project- (6 community members trained as facilitators; 6 FTE at Family Resource Centers that provide direct service and coordinates the program). Parent Project is an educational program designed specifically for parents who are facing behavioral challenges with children 10-18 years of age. The curriculum consists of ten activity-based classes with parent support groups. It is an interactive approach, parent's work together to learn and incorporate efficient parenting skills into their everyday family lives. The classes teach useful techniques to deal with a variety of difficult parenting issues. Curriculum, specialized training, participant workbook. Family Resource Centers has been offering this program for over four years.

PASCET -Primary & Secondary Control Enhancement Training (3 providers trained in PASCET; 1FTE) Began in FY 05. PASCET is a structured intervention for depression to be used via outpatient for youth ages Youth ages 8-15. Treatment sessions and homework assignments are built on research findings concerning cognitive and behavioral features of depression in children and adolescents and the two-process model of perceived control and coping. Youngsters are trained to gain control of their mood by developing skills that will help them cultivate primary control (changing their environment) and secondary control (changes their internal expectations, interpretations). Program consists of 10 structured sessions with 1-4 individually tailored sessions. Home and school visits are part of the program. Adherence to manualized sessions. Occurrence of home visit, one school visit and 3 parent sessions.

Project Adventure- (Ropes Course) Began in 2003 Adventure Ropes Courses are a highly effective and unique medium for the development of individuals and teams within a fun and safe learning environment. Increases in self-esteem, team work, confidence, problem solving, creativity and communication skills are just some of the many benefits experienced by individuals and teams alike. A well facilitated Adventure Ropes Course experience helps individuals go beyond pre-conceived limitations, developing courage and strength of mind, body and character. The attainment of certain skill sets and displaying certain competencies. Two group sessions throughout the school year and 3-4 groups during the summer, each group with two to three facilitators.

Alcohol/Drug Treatment Change Company – an interactive journaling for youth and parents. Adolescent Recovery Program for Youth and parents from Hazelton FRC began out patient counseling for adolescents needing alcohol and other drug treatment in FY 06.

Certifications/Trainings- One MST therapist is completing the process to become certified in the provision of Cognitive Behavioral Therapy. One staff certified in trauma treatment (based on cognitive behavioral therapy). One staff member trained in Structured Sensory Intervention for Traumatized Children, Adolescents, and parent (SITCAP). This intervention seeks to replace trauma sensations with positive sensations; re-establishing a connectedness to the adult world which leads to a greater sense of safety and hope as a survivor.

ADEPT Curriculum- A curriculum used in the group treatment of Attention Deficit Disorder. Began implementation in FY 06.

Aggression Replacement Training- Family Resource Centers is the lead Agency- Plan to have 12 persons trained in this intervention. Aggression Replacement Training® (ART®) is an intervention designed to alter the behavior of chronically aggressive adolescents and young children, ages 12-17. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juveniles three times weekly. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. ART® has been implemented in school, delinquency, and mental health settings. Program implementation to begin in spring of FY 08.

Brief Strategic Family Therapy- Family Resource Centers is implementing Agency (2 FTE's) Brief Strategic Family Therapy (BSFT) is a family-based intervention designed to prevent and treat child and adolescent behavior problems. BSFT targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. BSFT is based on the fundamental assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently are a primary target for intervention. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. BSFT is a short-term, problem-oriented intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is 12 to 15 sessions over more than 3 months. For more severe cases, such as substance-abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in office, home, or community settings. Therapist fidelity is checked using video taped supervisory sessions with the Family Institute in Florida. Began implementation in FY 2008.

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:*	3.35	8.a
CPST FTEs:	15.20	
Counselor/Therapist FTEs:		

*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:*	1.24	8.b
CPST FTEs:	8.97	
Counselor/Therapist FTEs:	9.68	

*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.

The Board's participation in workforce development has primarily been targeted at educational opportunities. For the past several years, the Board has had a collaborative relationship with the University of Toledo Medical College. They provide four continuing education events each year at no charge. There is a local planning committee that determines the areas of education most needed. In addition to this, the Board sponsors an annual Ethics Training (and in FY'09 will begin offering Ethics in Supervision), and an annual Cultural Competency Training. The focus on education allows the local workforce to continue their educational development without the additional expense of paying conference fees and travel reimbursement. In addition, these opportunities are offered to community professionals, assisting the development of relationships throughout the behavioral health community.

For the past two years, the Board has sponsored Mental Health 101 training for staff of local social service agencies to help them gain a better understanding of the needs of persons with a mental illness. This fiscal year, Mental Health 400 training was initiated to provide advanced training for those interested (particularly domestic violence and homeless shelter staff and probation staff). Over 200 local staff have participated in these trainings.

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 is a member of the local Community Corrections Board, providing a regular opportunity to provide input to the criminal justice system and vice versa. In addition, there is a formal referral protocol between the county Adult Probation system and Century Health. A criminal justice case manager has been in place for two years and is partially funded by the Adult Probation Department. This case manager co-facilitates moral reconnection groups; relapse prevention groups; serves as a boundary spanner between the two systems and takes services to the local jail.

Annually, the adult probation department reviews every case which was not successful. Findings are shared with our system. Housing was a major issue with all the unsuccessful cases. As a result, the Board has been working closely with the Adult Probation Department on the new capital project.

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

Click on gray box to enter text.

The local children's agency, Family Resource Centers has an excellent working relationship with the Juvenile Court. The local juvenile judge is very interested in the input from the behavioral health system. The juvenile court has been very supportive of the MST program and is looking forward to

having IBFT available. The Board is currently in the process of bringing Aggression Replacement Training to the community in order to address the growing number of incidents related to aggressive acts.

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.

Mental health services are delivered to the jail upon request. The local jail administrator has been actively involved with our local CIT program and is interested in working with our system on other things that can improve services to the custodians. AA groups are offered at the jail for men and women.

2. Detention Centers

Click on gray box to enter text.

There is no local detention center in Hancock County.

2. Homeless, Runaway & Domestic Violence shelters

Click on gray box to enter text.

Staff of the homeless shelters for men and women and the domestic violence center are extended invitations to all trainings offered by the Board. Staff from these facilities helped to design the Mental Health 101 and Mental Health 400 trainings. The Domestic Violence Shelter has been involved with Aggression Replacement Training initiative.

3. Nursing Homes

Click on gray box to enter text.

There is one local nursing home with a behavioral health unit. The Board tracks the number of Hancock County residents placed in the unit, currently at 6. There are often residency issues related to this unit as well as clarifications issues as to whose responsibility it is to provide what services.

4. Prison Reentry

Click on gray box to enter text.

At the close of FY'07 a local task force was put in place to review the services provided to sex offenders. The majority of local services are provided to clients who are on adult parole from prison, with the remaining client base from the adult probation department. As a result of this groups efforts a risk assessment process was put in place and a high risk and low risk group established. There is also a group for victims.

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

Click on gray box to enter text.

The medical director of Century Health established a health screening clinic, where adult clients can have physical health screening completed a couple of times per year. This was established with the support of Jansen Pharmaceuticals as a way to address high blood pressure, diabetes education and weight control issues.

7. Other.

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.

The Hancock ADAMHS Board continues to maintain a Community Partnership, which is comprised of a Council that has representatives from agencies or organizations that have dedicated prevention education staff. The Community Partnership is responsible for overseeing general prevention/education efforts, which according to our Strategic Plan will be converted to “wellness promotion.” In addition, they are responsible for coordinating local focus groups for different segments of the community in order to receive input on current needs of the community.

Wellness efforts have been focused on improving healthy living and quality of life by being resilient and recovery focused. The suicide rate is being tracked and reported to the Board. Every suicide by a consumer goes through a case review which is a mortality review process. This information is monitored to ensure quality care.

The Board’s suicide rate is higher than the state average for youth and the elderly population. Two other focus areas are of returning veterans and flood survivors. As a result of these high risk populations, the Board submitted and was awarded a Suicide Prevention Grant that will used to distribute information to these high risk populations. In addition, these populations will be the focus of all other prevention efforts.

Conversations have been initiated with the local Veterans Administration in order to identify ways the Board can work more collaboratively with them. Greeting cards, designed by our local consumers were sent to veterans in military hospitals at Christmas. A new card has been designed and printed to be sent as a part of May is Mental Health month. The Board communicates regularly with the local military support group.

As previously described, the Board is working with the Ohio Suicide Prevention Foundation to put on a conference in August 2008, which is the anniversary date of the major flood in Findlay.

The Board has made available a toll free number for individuals needing crisis intervention and/or support. The toll free number has been publicized in school hand books for youth. Also, this toll free number is publicized on all publications put out by the Board.

The Board supports The Network of Care for Behavioral Health website. The website allows individuals to gain information on behavioral health needs. It ranges from general information to service providers.

The Board has a mascot, Paragon the Pig that encourages children to make healthy choices and to stay away from drugs and alcohol. Paragon has visited elementary schools to promote a positive message about healthy choices. Paragon’s cartoon is also in the local newspaper weekly to send a healthy message to youth. Paragon has made visits to youth events in the community promoting healthy choices.

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.

The Board conducts an annual Provider Satisfaction Survey; as well as the agency completes referral source and customer satisfaction surveys. In addition, the Board has committed to sponsoring an annual Cultural Competency training for the system, in collaboration with MACC. There is a large international community in Hancock County, especially at the local University. As previously mentioned, the Board is working to address needed behavioral health services to this population through the development of new MACSIS Business Rules.

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.

The Board established regular channels to get information about needs on its Prevention/Education programming and its Treatment Programs. For Prevention/Education Programming, the Board, through the Community Partnership, conducts annual focus groups with identified “systems” within our community (e.g., legal, education, courts, faith-based). Additional detail on this process and information is identified in the Prevention/Education section of the Community Plan in the narrative. Two recent major planning processes included the development of the Board’s Strategic Plan and its operational/allocations plan.

The planning process adopted by ADAMHS began with an orientation for the members on the concepts of Resiliency and Recovery. In addition, the Board reviewed its statutory responsibilities related to funding, planning and evaluating as well as past planning assumptions and the status of the expiring Strategic Plan. In addition, two focus groups were held with adult customers of mental health and substance abuse treatment services to gather further information on their perspectives of recovery and hear their experiences within the current system.

After the ADAMHS orientation session, the Board commissioned parallel planning committees, one with a focus on Resiliency and one with a focus on Recovery. Staff recruited content experts in each of these areas who acted as facilitators for the Planning Committees. Thelma Rist (Ohio Advocates for Mental Health) and Lisa Oswald (Adult Recovery Network) facilitated the Recovery Committee and Terri Garner (Ohio Federation for Children’s Mental Health) and Rick Shepler (Center for Innovative Practices) facilitated the Resiliency Committee. These experts spent over 16 hours in one

month with a diverse group of some fifty customers, professionals, and ADAMHS members (customers of mental health or substance abuse services and family members made up over 40% of participants on each committee). The work of each of these committees was woven into our current Strategic Plan which was identified through the Board Association as a model plan and is available for download at the OACBA site at http://www.oacba.org/programs/quality/resource_library.html under section VI: Mission and Programs.

More recently, the Board campaigned successfully for our first levy increase in over twenty years. Target issues identified as Levy enhancement areas (through the Strategic Plan and other assessments) included: Peer, Family and Informal Supports, Alcohol/Drug Capacity, Early Childhood Intervention, School-based services. The process used is explained further under the next section titled: Planning Process

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.

1. Planning Process: Special stakeholder planning groups were developed around the four topic areas of Peer, Family and Informal Supports, Alcohol/Drug Capacity, Early Childhood Intervention, and School-based services. The largest of these planning groups, the AoD committee and the Peer, Family, and Informal Supports planning committees involved more than 66 constituents, over half of whom were consumers or family members. The Board offered financial stipends for every consumer or family member wanting to be reimbursed for their time at these planning committee meetings which met over the months of November, December and January. The Committee processes included a description of the current state including a discussion on best practices in each area, a review of what the system is currently funding, a review of the gaps from best practices to what we are funding and a consensus process to identify possible strategies that were then prioritized by the members. A partial summary of the prioritized recommendations from this process include:

Substance Abuse Committee Recommendations:

1. Recovery Coach (new money; potential grant application)
2. More Moral Reconciliation Therapy trained staff (can provide with existing resources)
3. Explore Residential Treatment Center (no cost to develop business plan)
4. Continuous Education Program (at the hospital) (can complete within existing resources)
5. Develop “Contact Point” (not necessarily formal treatment) (potential linkage with existing 211 Initiative)
6. Explore relationship with seminary/faith-based initiatives (no cost to develop relationship)
7. Determine role of Focus on Friends (cost implications based on decisions that are made)
8. Review of Intensive Outpatient Program (no cost to complete the review)
9. Work with the hospital on “Detox” bed (no cost to enter into discussion with hospital; potential cost for paying for clients in need of detox with no resources)
10. Promote Pro Social Activities (can provide with existing resources)

Peer, Family, and Informal Supports Recommendations:

1. Promote the Network of Care Website (Complete within existing resources)

2. Promote a targeted “electronic presence” for youth (New money; potential grant application)
3. Review the feasibility for having a more consistent “educational presence” in our community to combat stigma. (Complete within existing resources)
4. Expand Peer, Family, and Informal supports within agency programs and across the system of care. (New money; potential grant application)
5. Provide financial support to the local National Alliance On Mental Illness

Early Intervention Recommendation:

1. Provide funds for one Early Intervention Specialist (\$32,000). This position was in place in FY '08 and was partially funded by the Community Partnership.

School Based Services Recommendations (Excluding City Schools):

1. Electronic Presence (see number 2 under Peer and Family Supports)
2. Education/Training Requests (can be filled using existing resources)
3. Need address analysis by school district to determine outsourcing request (no cost for analysis)

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.*

Increase the quality of life for consumers with severe mental disabilities through participation in the workforce.

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

Increase the number of mental health consumers served in the Supported Employment program.
Increase the number of employment related activities provided through the Supported Employment Program.

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

Both objectives will be measured against FY 07 baseline data for persons served and vocational units provided.

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

Implementing agency is Century Health. This is a low priority as there are no funds to increase services.

2.b. WELLNESS MANAGEMENT & RECOVERY*

Priority:

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

Check feasibility of working with the Wellness Management and Recovery CCOE

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

Arrange a meeting with the WMR CCOE and adult agency and Drop in Center staff to review readiness to tender an application to the CCOE for implementation of the WMR program.

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

Documentation as to if a meeting was held, an application was submitted and an implementation plan developed.

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

Work with the CCOE and possible implementing agencies Century Health and Focus on Friends

2.c. HOUSING

Priority:

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

Complete Capital Project of 16 unit complex.

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

Bid process to be completed in May; with construction to be completed by December 31, 2008.

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

Completion of construction.
Hiring of peer on-site manager.
Screening/placement of residents in facility.

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

Securing of funds through local CHIP program rental assistance until residents are eligible for a Section 8 Voucher.
Securing construction funds through Federal Home Loan Bank Application

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: **Medium**

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

Maintain services to the schools and address current concerns of bullying and the development of an electronic response system.

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

Offer programs and/or consultation related to bullying to all city and county schools.
Establish a link from all city/county school websites to the Board website.
Include behavioral health information, especially the crisis number, in all student handbooks.

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

Hits to websites; publication in handbooks; programs offered.

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

Education systems at all levels involved with aftermath of the flood; and reducing risk/safety planning for schools.

3.b. EARLY CHILDHOOD CARE

Priority: **High**

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

To provide early childhood mental health care to more families in FY 09-11. To increase the Protective Factors and decrease problematic behaviors of the children/families served.

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

To expand by an additional 75 families with young children (over FY 07 totals) early childhood mental health services.

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

Increases in numbers served will be reported to ODMH in the annual Early Childhood grant reporting. The increase in Protective Factors of those served will be measured by the most age appropriate Pre/Post Deca measurement tool; the decrease in problem behavior will be measured by the overall score of the Problem Severity Scale (Ohio Scale) for youth ages 5 to 7. Tracking of access standards built within the CQI process to assure families are being seen for a DA within 10 days of a receipt of a referral from the ECMH consultant.

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

Family Resource Centers will be the implementing agency.

3.c. TRANSITION AGE CARE

Priority: **Low**

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

No new funds to develop additional programming.

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

New capital project to house some transitional youth.

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

Number of transitional youth in board owned housing.

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

Education; homeless shelter; child protection; juvenile court and mental health have an ongoing collaborative regarding services to this population. This is an ongoing educational program targeting these youth.

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	475	30
Private Psychiatric Hospitals: Adults	2075	375
Private Hospitals: Children & Adolescents	185	45

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.*

Work with local hospital on the successful operation of their new (relocated and refurbished) inpatient unit, Orchard Hall.

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

Maintain regularly scheduled meetings with the local hospital to address issues of concern.

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

Number of admissions diverted from other private hospitals and the state hospital into local unit.
Number of involuntary admissions to local unit.

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

The Board meets with our adult agency, Century Health and representatives from the local hospital on a regular basis to address issues of concern and improve access to our residents in need of inpatient care.

4.b. CONTINUITY OF CARE

Priority: **Medium**

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

Maintain current hospital liaison position.

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

Contract persons while in the hospital to arrange outpatient services.

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

Number of clients seen following inpatient care.
Number of days from discharge to outpatient care

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

The Board is currently working with NorthCoast on a Continuity of Care Agreement via our Collaborative.

4.c. SOMATIC HEALTH CARE

Priority: **High**

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

Ensure timely appointment following inpatient care so there is no lapse in medication needs.

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

Sustain hospital liaison position.

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

Number of clients receiving med/somatic services following inpatient care.
Number of days from discharge to outpatient appointment

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

Our local medical director, Dr. Basu, has established a tremendous working relationship with the pharmaceutical companies. As a result over 100 of our clients are on an idigent drug programming. The cost savings to the Board as a result is in excess of \$225,000.

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.*

Presently, the Board collects information on youth out-of-home placements (there are no residential centers or psychiatric hospitals in our county) that are cost shared with the Family First Council. Our goal over the next year is to develop a CQI process that more accurately tracks out-of-home placements of all youth (cross systems) and establishes care management strategies aimed at discharge planning.

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

Each quarter, a review of MACSIS data on out-of-home placements will be integrated with Family First shared-cost data and inpatient care data to identify placement rates. Review of care managements targets/protocol to be developed with the contract agency that spells out our role/responsibility for out of county placements.

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

An integrated report showing total out-of-home placements and development of protocol that spell out care management responsibility and roles with designated agency.

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

Family Resource Centers will be the implementing Agency. Information is presently collected from the Family First Council on out of home placements.

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:

Priority:

Goals: Click on gray box to enter text.

Participate in local efforts of the United Way to bring 211 to Hancock County

Strategies: Click on gray box to enter text.

Attend committee meetings
Contact other Board areas with 211 system in place and identify how it works with local crisis hotline numbers as well as Board financial participation.
Provide information on how to access mini-grant dollars

Measurable Objectives

Implementation of a 211 system

Discussions and/or Collaborations

The local United Way is taking the lead on this initiative; however they are looking for funding partners.

6.a.2. 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. 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: Other

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.*

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	0	0
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: Medium

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

To train additional University of Findlay security officers in the CIT program; 2) To move into the second phase of our CIT program by developing more regular updates (refresher trainings) for all corrections, law enforcement, dispatchers and other trained responders, and strengthen the law enforcement’s ability to collect data on CIT encounters.

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

The development of an annual training calendar that meets the needs of the criminal justice collaborative. The establishment and implementation of CIT encounter data being used by Findlay Police Department and the Hancock County Sheriff’s office.

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

Implementation of an annual planning calendar. Creation of encounter sheets and the tracking of CIT data.

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

This will involve the entire Criminal Justice Collaborative (mental health, law enforcement, corrections, consumers and family members).

6.d.2. DISASTER PREPAREDNESS*

Priority: **High**

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

Update Disaster Response Policy for community.

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

Increase the number of professionals available to provide services during a time of disaster.

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

Successfully complete the implementation of the FEMA Regular Services Grant.

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

Clarify roles and responsibilities with the local Red Cross Chapter; especially in relationship to mental health staff coverage when a local shelter is opened.

6.d.3. COLLEGES & UNIVERSITIES*

Priority: **Medium**

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

Sustain and expand collaboration efforts with the local University.

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

Maintain student placements in the mental health system for occupational therapy students.
Develop a collaborative relationship with the School of Environmental and Emergency Management at The University of Findlay.
Provide access to behavioral health services for students attending the University.

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

Implement grant awarded by the local Community Foundation to expand occupational therapy field placements throughout the system.
Set up a series of meetings with the School of Environmental and Emergency Management in order to identify ways our systems can work together.
Revise current MACSIS business rules to address out of country students and out of state students without resources to pay for services.

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

The University has been an outstanding collaborator on the Reducing Risk in Educational Settings Conference. It is anticipated that this spirit of collaboration will continue.

6.d.4 PRIMARY & SECONDARY SCHOOLS

Priority: **High**

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

To reduce the incidents of aggression in one targeted middle school over the FY 09-10 school year.

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

Met with school officials at Glenwood Middle School to implement a comprehensive approach to dealing with bullying and a non-safe school environment.

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

Development and implementation of school-based based interventions at Glenwood.

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

Family Resource Centers and Glenwood Middle School.

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:

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.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:

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

To sustain all youth clinical services, especially MST and the Home-builders program

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

Provide a stable funding stream over the next two years to protect core services for SED youth.

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

MACSIS data will be used to track the units of services provided to SED and Non-SED programs.

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

Juvenile Court, Family Resource Centers and Child Protective Services

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

Priority:

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

To have Family Resource Centers become certified to provide intensive home based services; 2)

decrease the number of SED youth within the Child Welfare system who are placed in foster care; 3) To reunifying more quickly SED youth in foster care with natural or adoptive families.

Strategies *Click on gray box to enter text.*

Hire two additional FTE's to provide intensive home and community-based counseling to 100 families over a two year period. Develop referral protocol with Child Welfare to target intensive services. Implement Brief Strategic Therapy as the re-unification tool.

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

Recruit and retaining 2 FTE's that are trained in Brief Strategic Therapy. Improved clinical profile of families served will be documented via the Ohio Scales. Work with Child Welfare to track families served and outcomes related to prevention of placement and/or reunification.

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

Family Resource Centers, Family First Council and the Hancock County Department of Jobs and Family Services, Division of the Child Protective Services.

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

Priority: **High**

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

To reduce Maternal Depressive symptoms across those families seeking services and those pregnant mothers identified through outreach; 2) To increase parental awareness of emotional and psychological needs during pregnancy; 3) To establish a positive future vision for life after the baby is born.

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

To establish a Maternal Depression screening and treatment program and protocol within the local Early Intervention Community.

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

Family Resource Centers and Help Me Grow will strengthen their current collaborative efforts by implementing the Edinburgh Postnatal Depression Scale as the screening tool utilized to determine a mother's need for the program and implementing the curriculum, Promoting Maternal Mental Health During Pregnancy (developed by N-CAST, University of Washington) to expand filial and play therapy when clinically indicated.

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

Help Me Grow, Family First Council, Family Resource Centers, Early Intervention providers.

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.

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:

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.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.*

9.a.2 ADULT 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.a.3. ADULT 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.*

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.*

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.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.*

An important outcome of successful implementation of the Aggression Replacement Training is a decrease in aggressive and violent acts resulting in a reduced recidivism rate for first time offenders within the Juvenile Court system. The goal of Aggression Replacement Training is to improve the social skill competence, anger control and moral reasoning of our youth.

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

Strategies will focus on having a consultant come to Hancock County to train local professionals in Aggression Replacement Training (ART). Twelve local professional people will be trained in ART. Two members attending the training will have committed to becoming future local trainers. Following the initial training, six sessions will be offered during the first year. Conduct 6 sessions throughout the year. Project six to eight youth at each training which would calculate out to 36-48

youth being served in this program.

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

Measurable objectives will focus on the review of the evaluation forms from the local trainings. Feedback from the consultants as to maintaining fidelity to the program. Review of the rate of recidivism regarding aggressive and/or violent acts at both the city and county schools and juvenile court.

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

Review of input from the county and city school officials regarding the number of acts of aggression during school hours as well as the number of charges from the Hancock County Juvenile Court related to aggressive acts.

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.*

Since the risks of suicide and drug and alcohol use continue to increase yearly after disaster. The goal will be to increase the awareness of suicide prevention and to continue to educate the community about the risks after a natural disaster over the next four years.

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

The Board plans to organize and implement a symposium yearly for the next four years to educate and train community members and professionals.

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

Attendance at the symposium.
Monitor suicide rate of consumers and community.

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

The Board is collaborating with the Ohio Suicide Prevention Foundation. The Foundation is a resource that will be instrumental in helping locate presenters for the symposium that will be held this year. The focus of this conference will be on gate keeper training and the effects of suicide. The local hospital is also a collaborating resource. The hospital wants to train all members of their staff in suicide prevention.

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

10.b. OTHER:

Priority: High

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

Wellness promotion to reinforce resiliency and recovery in our county.

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

Promote universal mental health and addictions education and public relations within the resiliency and recovery framework through frequent and multiple outlets. Provide selective education and promotion efforts aimed at priority populations. Topics could include advance directives, health promotion addressing co-morbid health issues, and illness management and recovery issues. Incorporate customer voice within prevention, promotion and educational efforts.

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

Continued attendance at the Community Partnership Council meetings.

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

Collaboration will occur with community resources to continue to promote issues related to illness management and the recovery framework.

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 2009to 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.*

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.

In the Spring of 2007 the Board conducted a levy campaign which included an increase to our millage from 1.0 to 1.3. By a narrow margin, the levy was approved. It was projected that this money would be enough to sustain current services and provide a modest increase in some target areas including: early intervention; school based services; and peer and family supports. As a result of the levy planning committess previously described identified priorities for our system to take on.

During FY'08 the Board has been actively seeking funds from outside services to fund the priorities that were identified during the levy, as well as to address the flooding disaster that has occurred. (CHERYL IF THERE IS A WAY, I'D LIKE TO INSERT THE GRANT SPREADSHEET THAT WE HAVE HERE) This has been necessary as a result of several factors that have negatively

impacted our financial situation including: two major floods in the community, one in August of 2007 and one in February of 2008; an increase out of county Medicaid utilization; loss of the safety net funds; increased use of housing dollars for adults; match funding required for grant applications; and a set aside in the event the Federal Home Loan Grant is not awarded. In the event that the fee schedule is passed, the Board will need to have an additional \$66,000 for Medicaid match; and approximately \$100,000 in the event the agencies seek at rate at the Medicaid ceiling for non-Medicaid services. As a result, cuts will need to be made in our system to adjust to the increased expense.

Another issue the Board will need to deal with has to do with the Network of Care initiative, which is currently being funded with the Transformation Funds awarded to ODMH. In the event there are no continuation funds, given the unknown's mentioned above, it is unclear if the Board will be able to sustain this project.

In our community meetings that were referenced in this plan, there were several references to the concept of an "electronic presence". While this is an issue our Board is exploring, it is one that may be of statewide significance. So many youth are communicating electronically via email; instant messaging; text messages; websites, etc.; that the behavioral healthfield is going to need to find a way to intervene with youth in a different way...they are no longer "verbal" communicators. How will this impact the delivery of services in the future?

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). **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.

A new business rule related to billing for out of state and out of country students will need to be put in place for July 1, 2008.

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.

Over the Board's last Strategic Planning process, the Board adopted a formal CQI Plan whose process includes a review and monitoring of the systems goals and objectives set in the Strategic Plan. Our Strategic Plan was devoted to the transformation of our current system to a more recovery and resiliency oriented system. The Plan set overall context that what we do over the life of the plan next three (FY 07-09) must be directed at improving the

E.1

quality of life of those who need Board funded services. Six directional goals and three destination goals are identified in the Plan.

The Board's Quality Improvement Plan was established through policy. The purpose of the Board's Plan is to integrate information from a variety of sources to raise the quality of the county's system of behavioral health care. The Plan articulates the values and codified responsibilities related to quality improvement and identifies the structure by which the plan will be implemented. The CQI Plan includes the process by which the Board will synthesize and analyze data, as well as selecting what data will be regularly prioritized and reviewed as identified in the Strategic Plan, Board-agency contracts and the Board's Standards Manual.

Utilization review is conducted quarterly through the Profile report which provides utilization review on key services (crisis, hospital, residential) and targeted areas (AoD services to adolescents, services to seniors) as well as any external reviews conducted on the agencies (ODADAS peer reviews and satisfaction surveys). Client grievances and major incidents are also reported on through the Profile. CQI projects or special studies identified by the providers through their CQI reports are also tracked.

More comprehensive annual utilization review is conducted on services, units, and costs using trending analysis and data-drill downs to identify patterns and trends in Medicaid spending, out-of-county service activity, levy histories, and service patterns to special populations.

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.

The Board's Program Committee acts as the oversight body for Board initiated quality improvement activities and each Committee of the Board shall have data review and analysis responsibilities related to quality improvement. In addition, as part of the Board's annual allocations process, five year trending information is collected on MACSIS claims data points and targeted non-MACSIS information.

Quarterly reporting cycles are adopted for the full Board (Profile report), the Program Committee (Quality Improvement Report), and the Administrative Committee (Quarterly Management Report). The Finance Committee reviews monthly financial data of the Board and provider agencies through comparative reports. All committees review relevant annual data (e.g., Board Annual report, agency Fiscal audits, Annual strategic planning goals). In addition, opportunities are created for additional data collection, analysis, and reporting of findings through the regular meetings occurring with provider agencies and stakeholders.

The newest addition to our management of evaluation/ QI data is our participation with the Board Association's Care Management Indicators reporting warehouse. This is an online data warehouse built on existing databases including claims, MACSIS, the Outcomes and BH modules. These indicators are relevant to our framing of quality of life and include the following:

1. What % of the SMI are employed now?
2. What % of the total population is employed or a student at discharge?

E.2

<p>3. Is housing stable for child/youth? 4. Is housing stable for adults? 5. Are clients managing their symptoms better? 6. Are people abstinent at discharge? 7. Are kids succeeding in school? 8. Treated with dignity and respect? 9. How long before people get seen from DA to treatment? 10. What % of emergency psychiatric consumers receive no outpatient services within 90 days of discharge from Crisis Services? 11. How long before people get seen from crisis to treatment? 12. Time elapsed from BHMOD reported first contact date to first service? 13. At treatment end--what happened? 14. What % of kids are not in the custody of their parents? 15. Equitable Distribution of Services? 16. Safety-- reportable incidents that include a) abuse/neglect by staff and/or b) death of or caused by client/resident at county level</p> <p>It is our goal as the availability of such reports develop, to integrate information about how our system is performing on these indicators through our CQI process.</p>	
--	--

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.

	E.3
--	-----

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
Joe Kizer	2515 North Main Street	Findlay	45840	419-425-5050	Jkizer@centuryhealth.net

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
Joe Kizer	2515 North Main Street	Findlay	45840	419-425-5050	jkizer@centuryhealth.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
Paul Lilley	418 Carnahan Ave.	Findlay	45840	419-424-1985	plilley@bhg.org

Form 3

Planned State Inpatient Bed Days

BOARD NAME Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	
2009 Planned Use of State Inpatient Days	
Northcoast-Toledo	475
Northcoast-Toledo	

Northcoast-Toledo	
Northcoast-Toledo	
Total Inpatient Days	475

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 Hancock County ADAMHS Board (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:

Precia Stuby (Name)
Executive Director
Hancock County ADAMHS Board (Board)

Date: 4/25/08