# III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

*Click on box to enter Board name.*

**BOARD NAME:** Jefferson County Prevention and Recovery Board

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

*Click on gray box to enter text.*

Mission Statement

THE PURPOSE OF THE PREVENTION AND RECOVERY BOARD IS TO PLAN, COORDINATE, FUND AND EVALUATE EFFICIENT, OUTCOME DRIVEN, MENTAL HEALTH AND RECOVERY SERVICES OF THE HIGHEST QUALITY THAT ARE ACCESSIBLE TO ALL OF THE DIVERSE RESIDENTS OF JEFFERSON COUNTY.

Vision Statement

THE JEFFERSON COUNTY PREVENTION AND RECOVERY BOARD IS COMMITTED TO ENSURING THAT ANY INDIVIDUAL, FAMILY OR SYSTEM THAT NEEDS MENTAL HEALTH OR RECOVERY SERVICES CAN ACCESS THEM TROUGH A SEAMLESS, COMPREHENSIVE CONTINUUM OF CARE.

THE BOARD, IN COLLABORATION WITH ITS CONTRACT AGENCIES, WILL PROMOTE AND PROVIDE INDIVIDUALIZED QUALITY SERVICES THAT MEET THE DIVERSE NEEDS OF JEFFERSON COUNTY RESIDENTS AND THEIR FAMILIES THROUGH PREVENTION, TREATMENT AND RECOVERY PROGRAMS.

THE BOARD SHALL PROVIDE THE LEADERSHIP NECESSARY TO EFFECT QUALITY, EFFICIENT, OUTCOME DRIVEN SERVICES THROUGH ITS CONTRACT AGENCIES AND WILL ASSIST AND EMPOWER THEM TO ACQUIRE THE TOOLS, TRAINING, RESOURCES AND STAFF NECESSARY TO ENHANCE THE QUALITY OF LIFE IN OUR COMMUNITY.

**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.*

From the genesis of MACSIS, the Board chose not to complicate services and payment for services with various rules. Furthermore, the existing business rules are aligned with what should be "universal" service priorities of all Boards. This Board believes in offering the full continuum of services to appropriately-eligible persons and does not have the exclusions that many Boards do.

Therefore, persons that are non-MCD eligible, yet meeting agency low-income status, have access to the same services that those with entitlements do.

**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.*

This Board has owned properties and funded Housing CSP services long before these were the buzzwords and trends of today's system, specifically, there is a ten (10) unit apartment, and a large duplex for families that the Board has owned since the early 90s to house persons with mental illness. In July 2007, The Board opened the first rural SafeHaven (The Beacon House) in the US. This facility will offer permanent supportive housing for ten (10) people and features a drop-in center for the entire community. Under the roof of this SafeHaven, exists the housing and vocational CSP services that the Board has deemed a necessity to fund.

Moreover in 1996, this office participated in renovation and currently helps to operate a thirty (30) unit building that is classified as Single Resident Occupancy (SRO). Fifteen (15) of the units are designated for persons with a mental illness.

The drop-in center located in the SafeHaven currently offers a peer support group and is organizing a NAMI group for the area.

A prevention person position at the agency level has been supported by the Board since the 80s. This single person offers close to two-thousand (2000) units of prevention services in a year.

Due to the large population of ACF residents in the county there was a need for reliable and reputable guardianship and payee services. In FY06, the Board financially assisted a small MH provider, Family Service Association, to implement these services. To date, the Board still subsidizes this agency to maintain and to expand the guardianship program.

The Board does participate in the NETWORK OF CARE website sponsored by the TSIG grant.

**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.*

| Yes | **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** |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ | |

**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.*

| 5 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 in not needed, or until person owns their own home.

**e.** Do you have wait lists for HAP?

*Click on gray box to select answer.*

| Yes | **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** |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ | ☐ | |

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

*Click on gray box to enter number.*

| 19 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** |
|---|---|---|---|---|---|---|---|
| ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

**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.*

| 35 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.)

**k.** 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.*

| This number is relatively accurate |
|---|

**k.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.*

| | | |
|---|---|---|
| ☒ | Continuum of Care | **2.1.ka** |
| ☐ | PATH | |
| ☐ | BH Mod (Behavioral Health Module) | |
| ☒ | HMIS (Homeless Management Information System) | |
| ☐ | Other, please specify: | |

**k.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.*

| 57 Homeless persons with SMI | **2.1.kb** |
|---|---|

**k.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.*

Our area has encountered an increasing trend of homeless youth (age 18-21) that are still enrolled in high school. Two (2) such consumers have been accommodated at the SafeHaven project at present. There is a Single Room Occupancy (SRO) project operated by the local Community Action Council that has housed at least one such person for the last two (2) calendar years.

Another trend in homeless persons that this area faces is people coming from the nearby bordering states of West Virginia and Pennsylvania. These out-of-staters know there is a homeless shelter here that is reputable and clean. Likewise, they know that benefits for indigent or disabled persons are better in Ohio. Another reason for this trend is the casinos in the two nearby counties of West Virgina. People come from all areas to the casinos in hopes of winning, but often only lose the meager money they had. At this writing, there are two (2) people in the local shelter that literally became broke and subsequently homeless because they'd gambled away the only funds they had for rent and/or food.

As mentioned elsewhere in this document, Jefferson Behavioral Health System (JBHS) owns and operates three (3) ACFs. Initially there were a total of five (5) ACF homes purchased from the former for-profit operator. JBHS immediately downsized to three (3) ACFs as part of their service continuum. However at this writing, JBHS is facing a $1 million deficit for FY08 as a result of the costs associated with the ACFs. If other funding is not found to fill this gap, JBHS will be forced to again downsize the number of homes or to completely shutter the entire ACF operation. Because other housing resources are at capacity, there is nowhere to place these residents. This situation has major negative potential for the local system as well as the State System if some remedy is not found. JBHS could be bankrupted and the State Hospital could be flooded by the displaced residents.

See section 9 under "prison reentry" for an additional housing need in our area.

## 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.*

| This is a relatively accurate statistic. |
|---|

**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.*

| Demand per agency case loads. | **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.*

| Employed persons with SMI | **2.2.ab** |
|---|---|

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

*Click on gray box to enter text.*

Jefferson Behavioral Health System (JBHS) maintains an Employment Services Program that provides direct employment services ranging from job readiness and pre-vocational activities (including volunteer placements) to active job development and supported employment services. Referrals are received from all Agency units and from other in-town agencies; the vocational services are coordinated in a treatment team fashion. The vocational staff refer and coordinate services with RSC and other employment services available in the consumer's service area. The vocational unit also offers job readiness groups for those consumers who need some assistance but want to pursue employment independently. RSC assistance, community based work assessment, coaching and job shadowing are options that can assist a consumer in developing appropriate job goals.

**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.*

| With ABC funding, the Board's contract agency (JBHS) was able to provide clinical services for at-risk youth without any medical/MCD coverage that were referred to theYouth Partial-Hospitaliztion (YPH) Program and sent to the County Alternative School. To quantify, ninety-eight (98) children were served via the YPH program during FY07, and this number is only expected to increase. Additionally, the County Alternative School saw one-hundred sixty-seven (167) youth for the year.<br><br>ABC dollars also went to cover the un-reimburseable costs of necessary CPST services to kids that had private insurance. ECMH grant monies provided assessments, clincal services, and consultation with both parents and staff at all six (6) Jefferson County Head Start sites. To quantify this program, classroom assessments of two-hundred seventy-five (275) children were completed in 07.<br><br>FAST - Eighteen (18) families received mentoring in addition to such non-traditional services of transportation, recreation, tutoring, and budgeting in order to reduce out-of-home placements and foster overall resiliency in the families.<br><br>All of the above services improved functioning of families that reduced problematic behaviors. Moreover, parents were aided and equiped to increase coping skills and behavioral strategies to enhance resiliency of the family. |
|---|

### 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.*

| Board level data for attendance is somewhat inaccurate. Services were provided to six-hundred twenty-five (625) youth/children that were suspended or expelled from their home school. |
|---|

**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.*

| The Board and contract agency interact with personnel at the County Alternative School to determine students that were removed from their home school. Better efforts are underway to ensure that Outcomes data will accurately reflect this statistic. | **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.*

| 625 | **3.1.ab** |
|---|---|

## 4. Inpatient Care

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

### a. Inpatient Care

*Click on gray boxes to enter numbers.*

| Board Purchased Inpatient Care | FY 06 Bed Days | FY 07 Bed Days | FY 06 Admissions | FY 07 Admissions | **4.a** |
|---|---|---|---|---|---|
| State Hospitals | 821 | 749 | 31 | 19 | |
| Private Psychiatric Hospitals: Adults | 0 | 0 | 0 | 0 | |
| Private Psychiatric Hospitals: C&A | 0 | 0 | 0 | 0 | |

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

*Click on gray box to enter text.*

| Board staff along with JBHS CSP supervisors review past data, consider acuity of caseloads, and assess any potential environmental impacts to determine the need for State Hospital Bed Days. This data is then presented to both Board and Agency management for review. Ulitmately, the Board's Planning and Evaluation Committee analyzes the data and makes a final determination.<br><br>There is one private hospital located in Steubenville, Jefferson County. Its current capacity for behavioral health consumers is fourteen (14) beds. The Board no longer purchases beds from this facility so there is no direct planning between the Board and this hospital. Psychiatrists that admit to the local BH unit are the ultimate determination for its utilization. At the behest of the Board, the local Agency forged a contract and agreements with its psychiatrists and with others to minimize admissions to the State Hospital and instead to utlitize this local inpatient unit. This allows for maximun use of both federal and state financial resources, supplements the local economny, and keeps the consumer in a less restrictive placement and nearer to their home and family to promote recovery. | **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.*

| 32 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.*

| 19C&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.*

| 0 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** |
|---|---|---|---|
| ☒ | ☐ | ☐ | |

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

*Click on gray box to enter text.*

| Local courts and judges capriciously make decisions and choices for such placements regardless of past or present Board input. Similarly, the county CSB Office acts unilaterally in such placements.<br><br>The Board and providers have always fostered a relationship with juvenile courts and judges as well as the CSB in an effort to assist and advise the best disposition of the child but to no avail. This will be an ongoing effort. The Board is one of the leaders in the local FCFC. The Cluster Model has been reinstated which will allow for service coordination and reduction in RTC placements. | **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 | ☒ | |
| Warm Line | ☐ | |
| **Adult Consumers** | | |
| 24/7 On-Call Staffing by Psychiatrists | ☒ | |
| 24/7 On-Call Staffing by Clinical Supervisors | ☒ | |
| 24/7 On-Call Staffing by Case Managers | ☒ | |
| Mobile Response Team | ☐ | |
| Crisis Care Facility | ☐ | |
| Hospital Emergency Department with Psychiatric Staff | ☐ | |
| Hospital contract for Crisis Observation Beds | ☐ | |
| Respite Beds | ☐ | |
| Transportation Service to Hospital or Crisis Care Facility | ☐ | |
| Other (Please Specify): | ☒ | |
| **Child & Adolescent Consumers** | | |
| 24/7 On-Call Staffing by Psychiatrists | ☐ | |
| 24/7 On-Call Staffing by Clinical Supervisors | ☒ | |
| 24/7 On-Call Staffing by Case Managers | ☒ | |
| Mobile Response Team | ☐ | |
| Crisis Care Facility | ☐ | |
| Hospital Emergency Department with Psychiatric Staff | ☐ | |
| Hospital contract for Crisis Observation Beds | ☐ | |
| Respite Beds | ☐ | |
| Transportation Service to Hospital or Crisis Care Facility | ☐ | |
| 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.*

JBHS has an Intensive Supportive Services (ISS) Team that functions and looks very much like an ACT Team for Adults. Many crises are handled with immediate intervention by a worker. Likewise, this team works to prevent any consumer crises by having all team members aware of all consumer matters. As a result, local Emergency Room visits by engaged clients has literally discontinued and calls to the Agency Hotline decreased by

almost 40%.
Jefferson Behavioral Health System currently operates three (3) ACFs with sixteen (16) beds each. If space permits, a consumer can be admitted as a resident of the homes in times of crisis. This allows community placement and provides respite for the person and/or family.

**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.*

Jefferson County held its first full time CIT Academy in March 2007. Twenty (24) law-enforcement officers completed the training. The next Academy is scheduled for March 2008.

**2. Disaster Preparedness**

*Click on gray box to enter text.*

All Board Staff and several Agency staff successfully completed the training by OACBHA.

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 | 12 | 12 | |
| Currently Available | 8 | 8 | |

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

*Click on gray box to enter text.*

JBHS operates a critical incident stress de-briefing team for peers and for faculty/staff. This team has deployed throughout the county. As mentioned earlier, the agency's full-time prevention educator frequently presents at schools for health classes, attends school-preparedness rallies and fairs.

All social educators from the school districts in the county are active members of the Jefferson County Anti-Drug Abuse Coalition which is hosted by the Board. This promotes a good understanding of SAMI for the educators. The Red Flags Program was presented to all county school districts and has been implemented in most of them.

**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 Avail-able?** | **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 | ☐ | ☒ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |
| PH Program Type I | ☐ | ☒ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |
| PH Program Type II | ☐ | ☒ | ☒<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |
| Intensive Pharm. Mgt | ☐ | ☒ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |
| Intensive CPST | ☒ | ☐ | ☒<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |

**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.*

Intensive CPST is the area of focus. Please see description of ISS Team under 6.b Please see explantion of triage team under section 7.a.4.

### 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 Avail-able?** | **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 | ☐ | ☒ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | ☐<br>☐<br>☐ | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| PH Program Type I (Time limited) | ☐ | ☒ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |
| PH Prgm. Type II (School-based) | ☒ | ☐ | ☒ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |
| PH Prgm.Type III | ☐ | ☒ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |
| Therapeutic Pre-School (PH) | ☐ | ☒ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |
| Intensive CPST | ☒ | ☐ | ☒ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |
| Intensive Pharm. Management | ☒ | ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☒ ☐ ☐ | ☐ ☐ ☐ | |
| Functional Family Therapy | ☐ | ☒ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | ☐ ☐ ☐ | |

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

*Click on gray box to enter text.*

The agency (JBHS) does use a triage system designed entirely by them. The Board monitors this through review of quarterly QI reports, semi-annual Planning/Evaluation meetings, monthly meetings with Agency CEO, and at random via anecdotal reports or review of cases.

For children and adolescents the average wait for intake in Jefferson County is five (5) days. The average wait for the first clinical appointment varies due to limited after-school hours. If an after-school appointment is preferred the wait can be up to fourteen (14) business days. Otherwise, the average wait is five (5) days. Youth are typically seen every two (2) weeks for individual/family therapy and receive CPST services in the interim weeks. For youth designated as needing more intensive services, an ISS case worker makes contact 1-3 times per week with that child/family.

The wait time for Pharm Mgmt and/or a child psychiatrist is easily in excess of sixty (60) working days. However, recent utilization of a Nurse Practicioner to see both children and adults has helped to reduce that time. Any crisis situations are dealt with on a case-by-case basis via personal or phone triage.

The major provider, JBHS, does offer an Intensive Special Services (ISS) Team for kids. (See ISS definition under 6b.) Very often kids and families with immediate need or who are at-risk of outplacement are referred to this team for care.

**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 Avail-able? | 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 | ☒ | ☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☒<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | |
| Diagnostic Assessment – Non-Physician | ☒ | ☐ | ☒<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | |
| Pharm. Management | ☒ | ☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☒<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | |
| Counseling/ Psychotherapy | ☒ | ☐ | ☒<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | |
| CPST | ☒ | ☐ | ☒<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ | |

**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.*

Physician Assessment and Pharm Mgmt are areas of focus particularly as demand seems to be increasing. Please see description of triage team under 7.a 4

### 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 Avail-able? | 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 mor e | 7.b.3 |
|---|---|---|---|---|---|---|---|---|---|---|
| Diagnostic Assessment -- Physician | ☒ | ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☒ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | |
| Diagnostic Assessment – Non-Physician | ☒ | ☐ | ☒ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | |
| Pharm. Management | ☒ | ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | |
| Counseling/Psychotherapy | ☒ | ☐ | ☒ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | |
| CPST | ☒ | ☐ | ☒ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | ☐ ☐ ☐ ☐ | |

**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 largest focus has been on Pharm Mgmt. and finding strategies to decrease the wait time for the initial appointment for youth aged thirteen (13) or under. At intake, the various types of services to promote resiliency of youth and family are identified. Subsequently the many treatment options of individual counseling, CPST, Intensive Supportive Services, Youth-Partial Hospitaliaton, and Pharm Mgmt. are presented to the customers and a mutual selection is made.

**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.*

This information is adequately detailed in the above sections, specifically 2.0 and 3.1.

**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:* | 2.00 | **8.a** |
| --- | --- | --- |
| CPST FTEs: | 31.00 | |
| Counselor/Therapist FTEs: | 26.00 | |

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

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

| Pharm. Management Practitioner FTEs:* | 0.30 | **8.b** |
| --- | --- | --- |
| CPST FTEs: | 9.00 | |
| Counselor/Therapist FTEs: | 8.50 | |

*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 has always promoted and funded any supported-vocational CPST services. Our local program dovetails nicely with the goals created by the Annapolis Coalition. Specifically, consumers have always been directed to take responsibility for their own recovery and expand that recovery via the many services, such as the vocational services, funded by the Board. Similarly vocational CPST workers have strived to foster and expand supported employment with community employers while recruiting and training a viable workforce. Education and training of employers and employees is the primary goal. By promoting awareness of behavioral health issues, wellness, and recovery, workforce development for consumers can be strengthened and broadened.

**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.*

Board staff and key provider personnel have a quarterly luncheon with all judges in the county. This has been a successful format and forum for both sides to air differences and to devise solutions to smaller and often procedural issues. The larger picture is the collegial relationship fostered between the two systems; one of the immediate and ongoing results is for judges to consult with Board or provider staff about adjudication of defendants with AOD-related issues and offenses. There have been a few instances of judges asking for input regarding adjudication of adult defendants with MH-related issues and offenses. This forum has been most helpful in educating the local judicial system about mental illness and about resources in the local community. We feel it is most successful.

Additionally, a Board employee is a member of the Community Corrections Board.

JBHS sends a therapist and CPST worker to the County Jail every Friday to access any incarcerated persons that jail staff feel need MH evalution. This has helped in reducing crises in the jail and by intervening with troubled inmates.

While there is only one formal drug court (at the juvenile level) in the county, the municipal court judge of Steubenville City holds an unofficial drug court when needed. There is interest with other judges and courts to implement formalized drug courts but available funding has dried-up. At present, there is no interest (on the judges part) for a formalized mental health court. Based upon observations by providers and the Board there is not yet a great need for such a court, as judges seem to appropriately refer and/or adjudicate such cases.

See also above description about local CIT efforts that will address diversion.

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

*Click on gray box to enter text.*

See answer to 5b above.

**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.*

See above.

2. Detention Centers

*Click on gray box to enter text.*

This is not a current priority.

2. Homeless, Runaway & Domestic Violence shelters

*Click on gray box to enter text.*

Provider CPST workers interact and collaborate almost daily with staff at all homeless shelters. Additionally, on-site assessments are conducted at the local homeless shelter. By virtue of this Board's funding Housing CPST workers, homeless people with a mental illness have been a focus. The drop-in center's sole purpose is to engage any homeless individuals and is located within the Beacon House SafeHaven Project.

Our county has a well-operated domestic violence shelter for women. Personnel from this agency make appropriate referrals for their clients to all MH agencies. Additionally, the shelter personnel collaborate effectively with all service providers.

There is no runaway shelter in the county or local community.

3. Nursing Homes

*Click on gray box to enter text.*

This is not a current priority.

4. Prison Reentry

*Click on gray box to enter text.*

This is a sensitive and critical subject in our community and others these days due to the higher numbers of convicted/charged sex offenders and their subsequent return to the community. Despite the many housing options under the auspices of the Board or providers, the locations are close to schools that then limits placement of such individuals.

Additionally, the State Justice system occasionally threatens to release actively psychotic inmates.

Such occurances would put the person, the local system, and our community in danger. Efforts to stave-off such releases have been successful. The realistic response to the prision system is that our system does not have the facilities or supervision for such people, and therefore cannot adequately assist the person until he/she is relatively stable.

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

*Click on gray box to enter text.*

This is a focus in our area for both adults and children. This local system has always maintained a holistic view of the person which allows for such integration. More specifically, the local Suicide Prevention Coalition and Anti-Drug Coalition which are sponsored and hosted by the Board, promote speakers and events that integrate these areas. Also, the educator/prevention person attends all local health fairs to apprise attendees of the MH resources in the area. The Board's Executive Director is a Board member of the free health-care center which serves many of the system's consumers.

There has always been a collaboration between the MH/AOD system and local family practice MDs to promote such integration. Appropriate referrals of consumers to those doctors are made on an as-needed basis.

**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 Board was successful in helping to establish a suicide prevention coalition. Also, the Board has underwritten costs for noted suicide prevention speakers to present in the area. Likewise, the Board assists the anti-drug coalition with funding for events and speakers. Board employees chair both Coalitions.

**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.*

Consumer satisfaction with services and staff have consistenly remained in the high 90% range. Ongoing QI around any client issues or concerns assure such ratings. This statistic is inclusive of cultural competency. In the history of the agencies, there have been no problems or reports of any discordant cultural interactions.

Staff recruitment - the best and most qualified person gets the job! See immediately above. However, it is often difficult to recruit people to this economically and socially depressed area. Moreover, quality personnel can be difficult to retain, yet there are no glaring problems with employee retention.

Staff training - see above. Staff are encouraged to take advantage of any and all continuting

educational opportunities. Due to the existance of MACC; there is now more awareness and more opportunity to obtain further training. Moreover, in-house prevention staff host cultural-sensitivity training for clinical and support staff.

Minority groups are served at twice the population for Jefferson County. Therefore there are no problems for access. The satisfaction rating mentioned above included minority repsonses, so there are no problems with outcomes.

Minority groups are served at twice the population for Jefferson County. Therefore there are no problems for access. The satisfaction rating mentioned above included minority repsonses, so there are no problems with outcomes.

**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.*

AREAS OF CONCERN:

The fundamentally flawed Ohio MCD system is a big problem - no caps, any willing provider, and the match requirement from local funds are the big issues. Our Board area had a new MCD provider in FY06 and expects a new AOD MCD provider to come online in FY08. The result is loss of 408 dollars to fund the very essential non-MCD reimburseable services that promote recovery and resiliency.

The growing demands of oft-altered MACSIS system such as BH Mod and Outcomes collection continue to burden providers by increasing adminstrative costs to the detriment of clinical positions. Moreover, clients are overwhelmed by and confused from these unpersonal, data-focused efforts. Consumers want services; paperwork impedes and limits face-to-face time with a clinician.

This very document is an example of bureaucracy and a diversion of staff, clinician time and unfunded mandates imposed upon local systems. To wit, Board was asked to commit resources to attend colloquia and usurp provider resouses for the detail and information required for this one-year document. Additionally many of the NOMs and defintions herein are not consistent with other ODMH programs or Federal definitions.

ACHIEVEMENTS:

Despite the many, many taxpayer dollars that have been wasted on frivious lawsuits by the provider association, the MACSIS system, CQRT, the Network of Care, TSIG, managed care, and countless other inefficient projects by the State, somehow the local systems manage to offer quality MH care to the people who need it.

JCPRB has consistenly kept administrative costs at 6% and all revenue from the local levy are used for services. The Board has built and opened a SafeHaven project that came in on-budget as well as owning and operating other community housing that is self-sustaining.

The Board also funds a full continuum of AOD services (including residential treatment) as so many consumers are dually diagnosed.

**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.*

All provider agencies conduct a customer satisfaction survey at least once per year for an eight-week period. JBHS mails an annual key informant survey and enjoys a 25% response rate. In addition, JBHS collects very specific demographic data at the time of admission. Data from all sources and all agencies is reported to the Board at least annually.

All providers conduct bi-weekly Managers' Meetings in which specific client and/or population needs/requirements/concerns are addressed. Salient data is then communicated to the Board office on an ad-hoc basis in addition to an annual reporting. Catagorical client grievances/complaints statistics are provided to the Board quarterly.

The Board is an active member of the FCFC which launched a large-scale adolescent needs assessment. To create this assessment, data was collected on child/family issues, community focus groups arrived at core values, a pre-survey was given to indicate perception of child well-being along with a county-wide survey for grades 7-12, and there were faciltated planning sessions around indicator and goal prioritization. The result was to build supports around the state commitment of YOUTH CHOOSE HEALTHY BEHAVIORS. The two needs indentifed were 1) increasing after school activities to keep kids occupied and to avoid trouble; and 2) increase the amount of MH services for kids using the school setting as the counseling location.

**D. Community Plan for SFY 2008.** (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.*

For the Jefferson County Prevention and Recovery Board priorities have always been recovery and reaching one's full potential. As mentioned above, the Board has implemented and funded adjuncts to recovery such as housing, vocational case mgmt., payeeship and guardianship programs, and MH and AOD Prevention services. However, given that the law requires that all MCD services be matched, such planning for these extraneous priorities that ODMH espouses would quickly become useless. The intent is to maintain existing services for as long as possible even in light of some increased demand with decreased resources.

The Board intends to offer and fund a complete continuum of care/services - from all outpatient services to housing/residential needs.

**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: High

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

To maximixe customer independence, self-reliance, self-esteem, and self-determination through education and/or employment. Customers will become productive and valued members of the community through their work or service.

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

Increase the number of MH customers interested in employment by rapport building through the drop-in center and through voluteer placements.

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

Secure at least ten (10) job opportunities in the community annually for customers to work, secure at least five (5) volunteer placements annually, and complete five (5) work assessments annually.

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

Continue to maintain good working relationships with RSC, community employers, and all refering sources.

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

Priority: Low

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

Increase the number of consumers enrolled in a plan.

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

Notify all provider and consumer constituents of upcoming trainings, seminars, etc about WRAP.

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

Additional Consumers will reports having a WRAP.

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

Board will promote use of WRAP to providers and consumers at all appropriate forums.

**2.c.** HOUSING

Priority: High

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

Increase the number of MH consumers that report stable housing.

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

Continue to fund housing CPST, to provide supportive housing, as well as own housing for MH

consumers.

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

MH consumers reporting stable housing will increase by at least ten (10) percent every year.

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

Maintain good rapport with HUD.

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

**2.d.** OTHER: Housing-stock Assessment
Priority: High

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

Expand and/or re-define current housing-stock

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

Contract with Neighborhood Properties Inc. (John Hoover) to evaulate currently housing.

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

Current housing will be re-defined to house additional consumers and/or families that need housing for recovery.

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

NPI, Board, JBHS ACF operation.

*Click on gray box to enter text.*

**2.e.** OTHER: N/A
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: N/A
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 Recovery Supports planning:

*Click on gray box to enter text.*

Recovery will be negatively impacted by the cuts to state spending. Likewise, the resistance to true parity and to an unfettered Federal MCD waiver program will impede and/or arrest the recovery for consumers.

**3. Resilience Supports.** Using the format below, please describe goals, strategies, and measurable objectives for SFY 2009 for school success, ABC, and any other Resilience supports of relevance to the Board, such as Transition Age Programs, Parent Advocacy, etc. (See Appendix C for definition of resilience supports and examples of strategies and programs.) Based on identified needs, rank priorities as high, medium or low. What systems/entities/providers/consumer groups will the board collaborate with or have discussions, and what benefits/results are expected?

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

*Click on gray box to indicate priority level.*

**3.a.** SCHOOL SUCCESS

Priority: Low

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

Increase high school graduation rates.

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

Referrals will be made to all appropriate and necessary providers and services that will help the child (and family) to complete high school.

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

Graduation rate of kids involved in MH services will increase by at least three (3) percent each year.

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

Maintain working relationship with all social educators in the schools. Refer whenever necessary to CSB, alternative school, etc.

**3.b.** EARLY CHILDHOOD CARE

Priority: Medium

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

Provide services and supports that help families care for their children.

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

Kids and famililes will be screened by the ECMH program and staff. Appropriate referrals or linkage to service will be made.

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

Families will report increased confidence in parenting skills. The number of out-of-home placements will decrease at least three (3) percent.

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

Collaborate and discuss case with FCFC, CSB, ECMH program and all appropriate child-service providers.

**3.c.** TRANSITION AGE CARE
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.*

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

**3.d.** OTHER: N/A
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: N/A
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: N/A

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.*

N/A

**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 | 250 | 2 |
| Private Psychiatric Hospitals: Adults | 0 | 20 |
| Private Hospitals: Children & Adolescents | 0 | 0 |

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

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

**i.** Are you developing new or modified community based services which are expected to reduce your current inpatient bed day utilization?

**ii.** If you do not have a continuity of care agreement (see Appendix J) with your local state hospital, will you be addressing this issue with them in the next year?

**iii.** Are you planning future activities to improve linkage and follow up of discharged patients from inpatient care with serious somatic health care needs to general health care services?

**4.a.** INPATIENT CARE
Priority: High

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

To keep any needed inpatient care localized for the best continuity of care.

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

Work with local inpatient unit and local psychiatrists to meet any hospitalization needs locally instead of the State Hospital use.

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

Admissions to the State Hospital will decrease by at least five (5) percent from FY08. Local psychiatrist will report referring more people to local inpatient unit than to State Hospital.

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

Local inpatient unit and local psychiatrists will work with CPST personnel for continuity of care.

**4.b.** CONTINUITY OF CARE
Priority: High

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

Build and maintain good rapport with local inpatient unit, community providers, and Board.

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

Hold regular system-unification meetings with key personnel.

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

Client satisfaction for services will be maintained at or above the 90% level. Client outcomes will improve from previous administration and re-admission post discharge will decrease.

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

Hospital, community MH provider, and Board as well as any consumer feedback.

**4.c.** SOMATIC HEALTH CARE
Priority: High

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

Board and providers will maintain and strengthen bonds with local free healthcare clinic and with any medical providers sensitive to the MH population

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

Refer any customers to necessary medical care and have MH CPST worker designated as point-person for referrals from medical providers.

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

Referrals will be tracked and will show an increase from FY08.

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

Ongoing discussions and ad-hoc meetings as necessary with all pertinent providers, consumers, and family members.

**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.*

At this writing, the closing of Appalachian Behavioral Healthcare - Cambridge Campus was announced. For many, many years the Board and providers had a very good working relationship with the hospital staff. Furthermore, consumers that needed intensive inpatient care readily agreed and asked for treatment at this facility. Therefore, the State's decision to close the hospital will definitely have a negative impact, on inpatient care, continuity of care, and somatic health care. Cambridge had truly become a recovery focused institution that similarly respected the Appalachian culture and heritage of the patients.

The alternative State Hospital offerred to the Board was Heartland; however, this location was further in distance and likewise allied with Boards and towns that have very different priorities, values, and mores from those of our population. It appears that our Board will be permitted to admit customers to the Athens campus of Appalachian Behavioral Healthcare instead of Heartland. While this choice allows the customer a setting that acknowledges their culture, this location is almost five (5) hours by car from Jefferson County. Family involvement and even professional involvement with the patients' care will be significantly limited which has the potential to adversely affect continuity of care.

**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: High

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

Decrease the number of kids placed in residential treatment out of county.

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

Increase early screening and refer to less restrictive services. Maintain some type of ECMH care/program in the county.

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

Number of placements will be reduced from FY08.

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

Juvenile Courts, CSB, FCFC, providers, and Board will collaborate.

**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.*

N/A

**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: Beds
Priority: Medium

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

Increase access to crisis beds.

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

Develop crisis bed alternatives at local ACF and/or other ACF providers.

Measurable Objectives

Have at least one (1) bed available by the end of FY08.

Discussions and/or Collaborations

Jefferson Behavioral Health System and the Board will collaborate and plan with ACF providers.

**6.a.2.** Area of Adult Crisis Care: Other
Priority: Medium

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

Increase options for respite.

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

JBHS will create a respite bed at its ACFs and/or seek another providers.

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

Have at least one (1) bed available by the end of FY08.

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

JBHS and the Board will seek an arrangement for a respite bed.

**6.a.3.** Area of Adult Crisis Care: Hotline/Warmline
Priority: Medium

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

Increase awareness of hotline services.

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

Promote intra-agency and inter-agency communications around the hotline

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

Consumers and key informants will report knowledge and/or use of local hotline services.

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

JBHS and Board will verbally promote hotline in any appropriate setting. All printed material disseminated from JBHS will have a listing for the hotline.

**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.*

Please see 4d under "INPATIENT CARE" and section 2.1 k.c. under "RECOVERY SUPPORTS: HOUSING."

**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: Crisis Facility
Priority: Medium

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

Develop coordinated response and local (in-county) crisis care.

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

Continue collaboration and work with local CSB to establish respite/crisis beds at the County facility.

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

Prototcols in place and at least two (2) crisis beds

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

Board, providers, CSB, and local FCFC to work toward the goal.

**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: High

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

All county law enforcements agencies will have at least one (1) CIT trained officer.

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

Continue CIT Academy at local community college. Incorporate in CIT Academy areas and topics that are required by Ohio Police Officer Training Academy (OPATA).

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

Conduct one (1) CIT Academy every year. Every County law enforcement agency will report having at least one (1) trained CIT officer.

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

Board, providers, Jefferson Community College, and local law enforcement.

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

Priority: Low

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

Key Board and Agency personnel will be designated to respond to crises.

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

Personnel will complete disaster preparedness training.

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

Personnel will sucessfully complete training.

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

Board, provider, Board Association for training

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

Priority: Low

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

Ensure provider follow-up services after any crisis.

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

Provide resources of personnel and materials to college administration for use in times of crisis.

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

Monitor use of follow-up services and track outcomes.

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

Board, providers, and all interested school personnel

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

Priority: Medium

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

Provide prompt MH crisis intervention.

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

Offer resources of personnel and material to administrators at times of crisis. Activiate CISD Team.

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

Reduce any negative behaviors or outcomes following crises. Increase referrals for appropriate students. Track outcomes.

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

Board, provider, school personnel, and local law enforcement will collaborate.

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

*Click on gray box to enter text.*

With the impending budget cuts and increased demand for services, there will be few resources to address these other systems' needs. Increased demand for MCD match dollars, decreasing levy dollars, and resultant personnel cuts at the provider level will severely hinder this Board and any provider to respond timely with personnel and other resources. ODMH and state government should fund or reimburse Boards and agencies when intervention to these other systems is necessary.

**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: Pharmacological Management
Priority: High

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

Increase services for consumers and reduce wait times.

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

Nurse Practicioner will handle larger case load. Scheduling will be examined to increase efficiency and number of appointments set.

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

Number of appointment slots will increase.

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

JBHS and Board will work together to determine the various daily and seasonal consumer demands of and adjust system to better meet demands.

**7.a.2.** Area of Adult Services: CPST
Priority: High

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

Assure adequate CPST staffing in times of cutbacks, housing losses, and increased consumer demand.

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

Adequate provider workforce will be in place and caseloads will be adjusted as necessary. Use more ACT type techniques in staffing and client contact.

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

All appropriate clients needing CPST will report receiving them. Wait times will be non-existent or not longer than 48 hours after referral.

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

JBHS and Board will access demands and review case loads and scheduling. Local DJFS, CAC, and other agencies will be involved in assurring needed supports and supplies for consumers.

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

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

N/A

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.*

Given the cuts and flat funding to the MH and AOD system, Boards and providers are struggling to maintain existing services. It is unrealistic and inappropriate to expand any services until the MCD system is fixed and until adequate funding and administrative support from the State is offered.

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

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

**7.b.1** Area of C&A Services: Pharmacological Management
Priority: High

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

Increase services and reduce wait times.

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

Work with child psychiatrist to increase availability to system. Increase scheduling where

appropriate.

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

Wait times will decrease by at least two (2) weeks and number of appointments in a day will increase.

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

JBHS, Board and psychiatrist will discuss this.

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

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

N/A

Strategies *Click on gray box to enter text.*

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

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

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

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

N/A

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

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

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

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

*Click on gray box to enter text.*

See response to 7.a. above.

**7.c. Best Clinical Practices for Adults, Children & Adolescents**. What are the Board's plans for SFY 2009 regarding Best Clinical Practices? The term "best practices" includes both promising and evidence-based practices. Examples of Best Practices include, but are not limited to: Assertive Community

Treatment, Intensive Home Based Treatment, Intensive Dual Disorder Treatment (IDDT), Early Childhood Assessment, Functional Family Therapy, Treatment Foster Care, Physical/Mental Health Services Integration, Trauma-focused Community Based Treatment (TF-CBT), Dialectical Behavior Therapy (DBT), Trauma Screening and Assessment, Telemedicine, Tobacco Dependence Treatment, Older Adult care, Integrated Care for persons with MR/MI. (See definitions in Appendix C.)

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

**7.c.1.** INTEGRATED DUAL DIAGNOSIS TREATMENT (IDDT)*
Priority: Low

Goals: *Click on gray box to enter text.*
Integrate MH and AOD interventions in service contacts.

Strategies: *Click on gray box to enter text.*
Clinicians will continue to conduct adequate AOD assessment during intake and during subsequent encounters.

Measurable Objectives: *Click on gray box to enter text.*
Clinicians will report assessing AOD usage along with MH evaluation with all clients during all service contacts.

Discussions and/or Collaborations: *Click on gray box to enter text.*
Board and agency clinical leaders will ensure that staff assess for dual dysfunctionality.

*Click on gray box to enter name of practice:*
**7.c.2.** PRACTICE: Intensive Home Based Therapy
Priority: Medium

Goals: *Click on gray box to enter text.*
Increase type or cluster of services offered to family/child during service intervention.

Strategies: *Click on gray box to enter text.*
Consolidate services such as CPST, crisis, and family therapy during intervention.

Measurable Objectives: *Click on gray box to enter text.*
Clinicians will report assessing crisis and need for other services linkage during any encounter with family and child.

Discussions and/or Collaborations: *Click on gray box to enter text.*
Board and clinical leaders at provider will ensure that staff consolidates any appropriate services during the encounter.

*Click on gray box to enter name of practice:*
**7.c.3.** PRACTICE:
Priority:

Goals: *Click on gray box to enter text.*
N/A

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.*

N/A

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.*

N/A

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: Broaden concept of workforce

Priority: Medium

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

Expand role of recovering consumers and families to participate actively in recovery.

Strategies *Click on gray box to enter text.*

When available and cost-effective, train any staff and consumers about evidence based practices and techniques that promote recovery.

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

At least one (1) training of an EBP or other recovery-focused technique will be presented in the community.

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

Board, provider, CCOE, ODMH.

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

**8.a.2.** Area of Workforce Development: N/A

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.*

See response in 6.3.5

**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: Medium

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

Decrease number of adults with SMD involved with CJ system.

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

Continue to recruit officers to the local CIT Academy; continue collaborate with judges, and continue with clinician visiting jail for MH/AOD assessments.

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

Number of adults in jail with SMD will decrease and number of officers trained in CIT will increase.

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

Local PDs, justices, and MH/AOD.

**9.a.2** ADULT RECIDIVISM
Priority: Medium

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

Decrease number of SMD adults who re-enter CJ system.

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

Establish MH docket with one or more justices; increase officers trained in CIT.

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

Referrals to MH court docket will increase and number of CIT officers in county will increase.

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

Judges, probation dept., and MH system.

**9.a.3.** ADULT DIVERSION
Priority: High

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

See responses to 9.a.1.

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.*

The Safety Net of this and other systems are slowly unraveling due to persistent flat funding of the system and now due to lower, inadequate levels of funding. Diverting and preventing MH/AOD consumers is useful and appropriate at all levels, as it allows the person to receive treatment and attempt recovery; futhermore, it reduces the ignominy that one must suffer by being incarcerated due to their illness. The CJ system is already overloaded and overwhelmed, so diverting appropriate people improves the situation for a greater good. However, unless there are basic and necessary MH/AOD services available in the community, by default MH/AOD people will be funneled into the CJ system.

**9.b. Adolescents**

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

*Click on gray box to indicate priority level.*

Priority: High

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

See 9.a.1.

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: High

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

See 9.a.1.

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: High

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

See 9.a.1.

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.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.*

See 9.a.4.

**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: Medium

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

Maintain assessments at jail.

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

In the event of layoffs due to low funding, locate other funding to maintain clinician visits to jail.

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

Clinician will spend as much time at jail for assessments as in FY08.

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

Jail, MH system, and community at large.

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

Priority:

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

N/A

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: High

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

Increase access to these resources.

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

Case workers will make appropriate referrals to shelters; key stakeholders will develop strategy for care of referred persons.

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

Identify all resources in community and develop working relationship with key personnel. Referrals to shelters will be appropriate and timely.

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

Shelter personnel, volunteers, MH personnel and law enforcement to collaborate.

**9.c.4.** NURSING HOMES
Priority: High

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

Increase access to care for MH persons regardless of age.

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

MH personnel to be trained in PASAAR completement.

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

Number of adults referred to homes and/or maintained in homes increases.

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

MH personnel, Board, nursing facilities, and AAA to collaborate.

**9.c.5.** PRISON RE-ENTRY
Priority: Medium

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

Successful re-integration of persons into community life e.g. housing, employment, linkage to services.

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

Encourage CJ and prison system to connect with local system at least six (6) months prior to discharge to assess community situation vis-à-vis the person's needs.

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

People successfully re-integrate into community with appropriate housing and employment.

Recidivism is reduced. Prison will no longer unilaterally discharge person to home community.

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

Prison system, probation/parole personnel and MH/AOD system.

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

Priority: High

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

See 9.a.6.

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.*

N/A

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.*

N/A

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.*
N/A

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.*
See 6.8.5; 9.a.4; and 4.d.

**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: High

Goals: *Click on gray box to enter text.*
Increase awareness of helpline and other crisis services

Strategies: *Click on gray box to enter text.*
Suicide prevention activities and information to be disseminated at schools, public housing, health fairs, etc.

Measurable Objectives: *Click on gray box to enter text.*
Persons contemplating suicide will call the crisis hotline for help.

Discussions and/or Collaborations: *Click on gray box to enter text.*
All community partners in physical health, local housing authority, senior citizens groups, schools and MH system.

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

**10.b.** OTHER: N/A
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.c.** OTHER: N/A
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.*
See 6.8.5; 9.a.4; and 4.d.

**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: High

Goals: *Click on gray box to enter text.*
Consumer satisfaction ratings will remain in the ninety (90) percentile.

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

Board and provider staff will attend diversity trainings.

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

Personnel will attend at least one (1) cultural diversity training each year.

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

Board and Agency personnel.

**11.b**. STAFF RECRUITMENT

Priority: High

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

Maintain a professionally competent and culturally aware staff.

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

Advertise positions in periodicals that are read by people outside the local area. Encourage applicants to have some bilingual ability. Constantly review and compare pay scales to similar geographic and demographic areas.

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

All Board and agency positions will be filled within six (6) weeks of a vacancy with credentialed and qualified staff.

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

Board, providers, ODMH, OACBHA.

**11.c.** STAFF TRAINING

Priority: Medium

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

See 11a.

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

11a.

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

11a.

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

11a.

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

Priority: Medium

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

Devise quality control measures to assess culturally sensitive treatment.

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

Explore evidence based practice methods to evaluate the cultural sensitivity of services.

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

Board and agency staff to review survey results and adjust policies to continuous improvement.

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

Board, agency, MACC, ODMH

*Click on gray box to enter text.*

**11.e. OTHER:** N/A

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.*

See 6.8.5; 9.a.4; and 4.d.

**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.*

See section 12 on page 19.

**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.*

| No changes are necessary at this time. Very little non-MCD funding exists due to MCD match requirements! |
|---|

## 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.*

| Please see 12.C. and 12.D.1.<br><br>Board and agency staff review outcomes at least quarterly. Moreover, results are presented to the Planning and Evalution Committee of the Board at least semi-annually. The Board remains committed to using any evidence-based practices that fit well with this population and that are not a financial drain on other funding mandates or priorities. In review of services, there is constant mindset as to how to modify any services to achieve greater results.<br><br>The annual MCD audits allow for a good assessment of the medical necessity for all MCD-reimburseable services. A more extensive reivew of the quality of those services is sorely needed, however state rules limit that. Additionally, the Board has developed and designed an evaluation document that is an attachment to the provider contracts for services. | E.1 |
|---|---|

**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.*

| MACSIS, PCS, data mart, and OACBHA data are collected and perused by the Director and Associate Director. However, the Board cannot afford the investment of additional staff time or an additional position to review and pore over the copious amount of data for a more refined and sensitive analysis of the results. Futhermore, there is a concern that data is not complete and timely from the agency level, and consequently, funding decisions cannot be based on the results of any of this data at this time. | E.2 |
|---|---|

**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.*

| In addition to maintaining a core-level of services, implementing EBPs, being culturally competent, and maintaining the non-MCD reimbursable services that promote resilience and recovery, the Board would welcome TA on using Outcomes Data for program evaluation and CQI.<br><br>There also remains the question as to the structure of MCD reimbursement/match and to how Boards and state agencies can partner to ensure that quality issues are addressed in the MCD reimbursable MH services. | 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 |
|---|---|---|---|---|---|
| Hugh Ryan - Dist 9 | 60788 Southgate Road | Byesville | 43723 | 740.439.4136 | |

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 |
|---|---|---|---|---|---|
| Daniel P. Obertance | 500 Market St. Suite 600 | Steubenville | 43952 | 740.282.1300 | obertanced@jcprb.org |

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 |
|---|---|---|---|---|---|
| Daniel P. Obertance | 500 Market Street, Suite 600 | Steubenville | 43952 | 740.282.1300 | obertanced@jcprb.org |

Form 3

Planned State Inpatient Bed Days

| **BOARD NAME Jefferson County Prevention and Recovery Board<br>2009 Planned Use of State Inpatient Days** | |
|---|---|
| **Appalachian-Athens** | 250 |
| **Northcoast-Cleveland** | 0 |
| **Twin Valley-Columbus** | 0 |
| **Northcoast-Toledo** | 0 |
| **Total Inpatient Days** | 250 |

Signed ______________________________________________
Board Executive Director

I anticipate contracts for CSN services to some degree.

☐ Yes
☒ No

Form 4

Notification of Election of Distribution – SFY 2009

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

☒ The Board plans to elect distribution of 408 funds.

☐ The Board plans not to elect distribution of 408 funds

Signed: ________________________________

Pamela M. Petrilla, RNC, MS Ed., PCC (Name)
Executive Director
Jefferson County Prevention and Recovery Board (Board)

Date: 3/10/2008