III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

Click on box to enter Board name.

BOARD NAME: Mental Health, Drug, and Alcohol Services Board of Logan and Champaign Counties

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
Our mission is to reduce the incidence and residual effects of mental illness and substance abuse, and to responsibly steward public funds for these purposes. Under Ohio law, our board plans, funds, monitors, evaluates and contracts with service providers for a system of care for our families and neighbors seeking mental health, & drug and alcohol abstinence needs. We strive to balance quality outcomes with fiscal accountability. Our commitment is to consumers achieving independence and full participation in the social and economic life of our community. We maintain a system of care open to consumer, family, provider and citizen involvement.

VISION STATEMENT
Our vision is to build and maintain a system that promotes mental health and chemical addiction prevention & treatment that is responsible, accountable and coordinated with other systems and entities that share our mission. Our efforts are aimed at assuring quality, access to needed care, and involving consumers, families, and providers from other systems in fulfilling our mission. Our system of care is efficient and effective, and works to inform local citizens, elected officials, consumers, businesses and our fellow community service providers of recovery principles.

VALUES STATEMENT
The Board staff will operate with honesty and integrity. We value the individual and respect their viewpoint in helping them deal with day to day life. Our commitment is to increase the community's knowledge of mental health and drug and alcohol issues and to work towards the continuous improvement of mental health services available to those who need it. The Board provides the leadership to challenge the system when needed, to make change where needed through teamwork with other community agencies, and always with a positive attitude.

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

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

Click on gray box to enter text.

The existing rules are aligned with our current population and service priorities. The business rules fit our goals in that our first priority is the SMD/SED population

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.

Our two counties have a peer-run organization called Recovery Zone which is focused on consumers helping consumers. Many programs and educational trainings take place to assist the consumer in improving his or her quality of life. Currently, the Recovery Zone meets the majority of time in a central location but efforts are paying off in branching out to each county to help serve more consumers. As Recovery Zone becomes more independent, it is also becoming a vital link to assist consumers needing care that might not be available through other mainstream resource. They have started a cleaning service along with a recycling program. Within the peer support group there is a solid foundation of people trained in WRAP and even some interest in becomingWRAP trainers.

Logan and Champaign Co. were able to participate in Howie the Harp training through a grant with the ODMH. There is now a local committee meeting to design a peer driven program.
Recently, the local system was able to obtain two HUD grants providing 24 units of permanent supportive housing. Each of these tenants has supportive services to assist in their recovery process. Our local board, along with our housing vendor, continues to strive for providing permanent supportive housing for tenants of Logan and Champaign Counties. We are finding an increase in homelessness and housing needs.
The Board also has a Network of Care website.

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.

4 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.

31 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.

The Homeless Housing Status data found in Appendix B does not reflect an accurate picture of homelessness for Logan and Champaign Counties. It appears this data is based upon the Adult Consumer Survey in the Ohio Outcomes System which asks about their living situation with the three most common answers being: private residence, homeless shelter, and jails/prisons. Since March 2007, our system has served 16 single individuals with permanent housing as part of the HUD's Continuum of Care grant and each of these individuals had to be homeless according to HUD's definition. The majority of these individuals came from a shelter.

Each county has a local Continuum of Care and about a year ago, HUD required a Point-in-Time Study for each county and the results were staggering. For both counties, over 45 persons were identified as having a mental illness and being homeless. Our counties recognize that many homeless persons in rural counties involve living with family or friends in overcrowding housing. These individuals would like to live on their own but can't for various reasons.

One of the reasons a consumer may indicate their living situation as being "private residence" is because they are living with family or friends and/or we have been able to find housing for them before they take the Adult Consumer Survey. Our waiting list currently has about 25 individuals to families requesting assistance with many of these facing eviction and/or living with family and friends.

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.

26 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 local housing vendor has been chairing the local Continuum of Care meeting for both counties and beginning January 2008, a form has been developed which most agencies are using to keep track of "on-going" homelessness. This will give a more accurate picture of homelessness in our counties and we will compare this data with our next Point-in-Time Study scheduled for January 2009.

2.2 Recovery supports: Employment

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

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

Click on gray box to enter text.

The number is an accurate reflection.

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.

	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.

Clients Case Managers work with BVR to find job placements and employment opportunities. This involves thorough evaluations to look at abilities and needs of the clients. CCI has monthly meetings with BVR to collaborate services and review clients. As needed BVR staff will join in sessions with client and case manager to review progress and to increase employment opportunities. There is job coaching on site after placement and follow up.

Recovery Zone has started their own cleaning service and recycling program in conjunction with a company out of Columbus.

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.

Logan County Achievement and Trends for resilience supports

• In an effort to help more children succeed in school, Logan County has worked over the last two years to expand the implementation of the Olweus Bullying Prevention Program. Logan County identified through the Partnerships for Success planning process that children feel emotionally unsafe at school (community values survey, 2006). This risk factor threatens children's success in the classroom. The Olweus Bullying Prevention Program is a researched based program designed to reduce and prevent bully/victim problems at Elementary, Middle and Junior High Schools. It is a school-wide program with interventions at several levels. As a result of the program, researched schools have seen substantial reductions in the frequency with which students report being bullied and bullying others, students' reports of general anti-social behavior such as vandalism, fighting, theft, and truancy. In Logan County, Riverside Local Schools is currently in their third year implementing the program. Bellefontaine Intermediate School (grades 4 and 5) began implementing this year (2007-08) and Indian Lake and Benjamin Logan Elementary schools plan to

implement starting next school year (08-09). After programs are started next year at Indian Lake and Benjamin Logan, pilots will be in every school district in Logan County. Future plans include expanding the program in each district and continuing to evaluate the success for each district.

• Every child deserves a healthy start to life. This is the motto for the Logan County Help Me Grow Efforts. Help Me Grow is Ohio's birth to age three system of care. In 2005, Logan County formed the Safe Beginnings Protocol that developed a planned communication model for children services, help me grow, the local health district, and the local hospital so that children born with risk factors could be referred for supportive services. The local Health District conducts Newborn Home Visits, offered to every new parent in Logan County. Each year approximately 40% of families with a new birth take advantage of a visit. In 2007, Maternal Depression Screenings were added to the Protocol with support from the Access to Better Care Early Childhood Mental Health Initiative. Screening packets are included in 6-week OBGYN appointments for new mothers. Screenings are then forwarded to a local mental health provider for scoring and follow-up. In addition, Early Childhood mental health treatment is available for at-risk families in their homes along with parenting education with the Incredible Years parenting program, a researched based program. Ongoing Help me Grow Services for at-risk families have incorporated the Parents as Teachers curriculum, another researched based program, which offers education to parents on developmental milestones of their child each month and teach parents activities to do with their child that promote healthy development.

• Logan County has emphasized serving children and families in our local community and keeping families together whenever it is possible. Cross-system coordination of services has always been a vital part in serving families. To assist with these efforts, social service agencies offer Cross System Training where staff go to 12 various agencies and learn about the services they offer and how to access or refer. In addition, multi-need families have access to a Child and Family Team where multiple service providers work with the family to develop a service coordination plan that addresses their needs. A wraparound perspective is utilized. Currently, Logan County is exploring the use of the Ohio Community Collaboration Model for School Improvement (OCCMSI). It is hopeful that with the use of this model, the integration of prevention and intervention services conducted in schools with support from social service agency partners can be more coordinated and effective. Through this process is a linkage protocol where at-risk students can be identified early through screening for non-academic barriers to learning. Barriers are then addressed through a strengths based, cross-system team approach within the school system.

• Logan County Schools have all committed to the use of the Teen Screen program. Over the last 3-years the screening program has expanded from one school to four.

• In order to support family education, Logan County is beginning to offer the NAMI Hand to Hand Training. This training offers parents of children with mental health diagnoses information on what their diagnoses means, what resources are available, and the opportunity to meet other parents with similar needs. In addition, Logan County identified a gap in services with not having any parenting programs. The Strengthening Families Program for children ages 6 to 11 and 10-14 were implemented and continue to expand. Strengthening Families is a researched based program that has been shown to reduce the use of alcohol by 30%. Thus far, evaluation results show evidence of change for families who participated. Logan County has been able to offer non-categorical services to high risk families thanks to flexible funding through the Families and Systems Together Funding. These services allow for respite, family coaching, and service coordination for families who have children at extreme risk for placement. The non-categorical services have shown to reduce local placements and keep families safely intact.

• Logan County continues to work on expanding parent advocacy services. Parents involved with a Child and Family Team can request a Parent Advocate through the Family and Children First Council. The advocate serves as an ally for the parent at team meetings, allowing the parent to feel supported at meetings.

• In an effort to reduce substance abuse in Logan County, the community embraced prevention efforts as the way to go through the use of LifeSkills Training. The risk factor of Youth refusal skills was identified as a critical need for children in Logan County. LifeSkills Training is a researched based prevention program implemented within the school system. Logan County is currently piloting the program in several schools including, Indian Lake Elementary schools, Benjamin Logan Elementary Schools. Other sites are being explored with Bellefontaine City Schools and Riverside Local Schools. LifeSkills training has shown to be effective in reducing tobacco, alcohol, and drug abuse by as much as 87%. Some pilot schools are exploring curriculum alignment which will integrate the LifeSkills curriculum as part of students' health education.

• Bridges out of Poverty is a framework for understanding the culture of social classes in the United States. Logan County is exploring an implementation plan for educating social service agencies and the larger community. A 12-week group is also being explored where families living in poverty are paid a living wage to attend a group where they learn about social class and identify barriers, needs, and strengths to move forward in life. This effort is yet in the development phase and the county is hoping to be able to move forward with the effort.

Champaign County
Strategies for School Success in Champaign County involve monitoring early childhood immunizations, preschool attendance and kindergarten readiness assessment scores (KRA-L) upon entering kindergarten. We also monitor the percentage of children living in poverty and the numbers of children receiving health insurance through DJFS. In educating community partners on the availability of resources and various referral processes is ongoing through the Early Childhood Coordinating Committee (ECCC).

Help Me Grow is a program for Ohio's expectant parents, newborns, infants and toddlers that provides health and developmental services so that children start school healthy and ready to learn.Local programming coordinated by the Health District includes: Newborn RN Home Visits, Home Visiting Services, In Home Parenting Education, Service Coordination, Family Support Services, Multi-Disciplinary Team Evaluations. Our community agencies implementing Help Me Grow include the Champaign Health District, Champaign County MR/DD and Mercy Well Child Clinic.

All Champaign County 8th graders participated in the Search Institute Profiles of Student Life: Attitudes and Behaviors Survey, September 2005 and again in March 2007. To encourage better participation, superintendents agreed with the use of a passive consent form, which was returned to the school only if the parent did not want his/her child to participate. A total of 10% of students surveyed March of 2007, reported having 31 or more of the 40 assets. 57% reported having 20 or less.

Presentations of the survey final reports, how to use them for planning and decision making, the 40 Developmental Assets and the benefits of having assets, have been given to 4 of 5 school district superintendent's administrative teams. This data was also most recently shared at a Community Call to Action event regarding youth substance abuse. Community groups are currently scheduled

to receive this presentation. Sharing the knowledge and language of the 40 Developmental assets will hopefully create incentive for future training opportunities and the development of assets in our youth, community wide.

Champaign County has initiated the Columbia University Teen Screen Program (CTSP). The purpose of the CTSP is to identify youth who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation. While screening can take place in any number of venues, including juvenile justice facilities, shelters, and doctor's offices, the program has been primarily conducted in school settings. Our local process involves collaboration between Champaign and Logan Counties Suicide Prevention Coalition, Consolidated Care, Inc., Ben-El Child & Family Center Family Children & First Council and currently participating school districts. High school freshman health classes are being presented information to encourage more involvement in the "mental health check up". The goal of these presentations is to increase youth awareness of their Search Institute Survey statistics regarding teen depression and suicide ideation. Facilitated discussion regarding what to do if a youth or a friend is depressed or has thoughts of suicide.

The School Outreach Workers program has been established in all five school districts in Champaign county as a result of collaboration in funding, hiring and program development between with MHDAS Board and our local DJFS. It has provided a supervisor and 3 licensed outreach workers for Champaign County Schools which began January 2007. The goal of the school outreach program is to help families become more involved with their child's education, by providing support, linking and referring families to services and resources, and helping to fill gaps of the family's needs that may impede the child's learning. It will also target reducing referrals to children's services and the juvenile court by having a means of intervention with students and their families before the issues progress to needing deeper interventions. Sustainability of this program is also essential. Currently, flexible TANF dollars make up the majority of this funding source. Pending reductions of this local flexible resource is a concern to this rural community.

Community wide trainings in the Bridges Out of Poverty concept have been presented over the past few years, and will become ongoing in Champaign County. This concept is a unique and powerful tool designed specifically for social, health, and legal services professionals and is a framework for understanding poverty. It's purpose is to redesign programs to better serve the people you work with, build skills sets for management to help guide employee, upgrade training for font-line staff like receptionists, caseworkers, and managers, improve treatment outcomes in health care and behavioral health care and increase the likelihood of moving from welfare to work.

Our local Jobs & Family Services is involved in a second cycle of Getting Ahead in a Just–Getting-By World group. Individuals who are currently living in poverty, willingly have participated in a facilitated workbook experience to learn the hidden roles of class and use them to build their resources.

Champaign Co. is currently in the process of researching local capacity for implementation of the Circles Initiative. A community awareness presentation was recently held, December 17th. Next steps involve the collaboration of a conference call with Move the Mountain administrators to receive more details of this initiative. Community stakeholders are excited about this type of initiatives becoming a part or our community.

With regards to system of care coordination, Champaign County is in the process of transitioning our community to the clinically sound Wrap-a-Round process. Wrap-a-Round will create a system

of care that has been proven effective in addressing family needs and wants.

An Intersystem Diversion Team has been established as a collaborative effort for the purpose of (1) diverting unnecessary placements; (2) sharing the costs of necessary placements; (3) identifying service gaps leading to placement; and (4) monitoring out of county residential placements for appropriateness and meeting outcomes, at least every 90 days. This team is committed and meets bimonthly, consistently. The county resources of ABC funds have been allocated to the service coordination needs of our community, providing needed behavioral and non-behavioral health supports. Non Medicaid billable family supports are also included as wrap-a-round priorities. Other family supports include:

1) summer camps that were either faith-based, tutorial and instructional to enhance educational skills, or specialized in meeting the behavioral needs of youth; 2) respite for youth with intensive behavioral health needs through the use of informal supports and family - or through local foster homes if informal supports were not appropriate or could not be identified; 3) structured activities to promote parent-child bond by the purchase of bowling passes, cinema movie tickets, and YMCA memberships; 4) gas gift cards to assist in transportation expenses to and from mental health appointments; 5) youth mentoring/family coaching to provide effective role modeling and teach needed skills to youth and families; and 6) service coordination to conduct Child and Family Team meetings.

The building of infrastructure for the referral/intake process for a Child and Family Team (CFT) has been developed and quarterly trainings are given to community partners. The Diversion team is currently researching the CASII service intensity instrument and identifying a need for such an instrument in the county. This group is also in the process of reviewing system of care models and thinking about what such a model would look like for our county's needs. We look forward to plugging in our services to determine what needs we can meet locally and what needs we may look at addressing in the future. This team has also critically examined and restructured the dispute resolution process and identified protocol for future disputes.

The Mental Health, Drug and Alcohol Services Board of Logan and Champaign Counties (MHDAS), was awarded the Behavioral Health, Juvenile Justice (BHJJ) grant through the Ohio Department of Mental Health, (ODMH) and the Ohio Department of Youth Services (ODYS). This grant is part of the Access to Better Care Initiative from the State. The Champaign County BHJJ project’s goal is to increase effective services for youth involved in the court system by detecting mental health and substance abuse issues much earlier, and then linking the youth and their family to services that meet their needs as quickly as possible. The goal is to improve outcomes for the youth and enhance community safety. 158 youth from Champaign County have been referred for screenings. And 61 enrolled into the program. This project is successfully collecting diverse amounts of valuable and measurable data -- data that is being used to guide systemic decision making. The sustainability of this program is essential to council.

Family support and education activities include several parents attending Regional Family Networking meetings this past year. Parent representatives attend Council and ECCC meetings regularly. A "Hand-To-Hand" 9 week course will be offered to parents in Champaign County beginning in late February. This course covers the diagnostic process, understanding diagnoses, medications, coping skills, counseling and therapy, places to go for help, educational needs, community mandates, and family advocacy. We have been marketing this program to the schools, ministerial associations, parent groups, and mental health providers in our community.

Active Parenting Now is an acclaimed program for parents of children ages 5-12.This program offers parents effective ways to use non-violent discipline techniques that work, improve communication with children, teaches responsibility and other important values, handles problems as they come up, copes with difficult topics such as drugs, violence, and sex, defuse power struggles with your children, stimulate independence as your child grows older, and encourages your children to be their best. This program is offered by CCI through the Ohio Children's Trust Fund grant.

1-2-3-4 Parents is an acclaimed program for parents of children ages 1-4 and offers parents opportunities to learn discipline methods that work, how to prevent tantrums, how to make rules your child will follow , routines that make life easier, how to care for your child at different stages and great ways to take care of yourself. This program is also offered by CCI through the Ohio Children's Trust Fund grant.

Incredible Years is an exemplary best practice program selected as a model program by the Center for Substance Abuse prevention. This parent group helps parents to learn to manage child's behavior program ages 0-6, increase ability to set limits, learn how to praise and give positive reinforcement, learn positive communication and problem solving skills, reduce the use of criticism and negative commands, replace spanking and harsh discipline with non-violent discipline techniques and help nurture and guide children toward reaching their fullest potential. This program is offered by Ben El Child & Famiy Center. Ben-El has also recently received a community early childhood mental health grant and will provide consultation and treatment to members of the early childhood community.

DECA screening

DECA [Devearux Early Childhood Assessment] evaluates the effectiveness of individual child and program-wide intervention for children ages 2-5. Itprovides developmentally appropriate strategies to foster resilience. Effectively screens for emotional and behavioral concerns. Emphasizes a team approach among professional and family members.

DINA Classroom: Dinosaur School Program

This treatment program is delivered in 2-hour weekly small group sessions (6 children/group) lasting 20 to 22 weeks. Ideally it is offered in conjunction with the 2-hour weekly parent group sessions. The last 15 minutes of the parent group may be used to explain ways parents can foster children's learning in the Dinosaur School Program

We do provide the Children's group as a companion to the parent groups separate from the classroom but also do it onsite at Head Start and soon to be implemented at Lawn View and possibly the Discovery Center.

School Consultation/Intervention

Mental health treatment and consultation provided on site at local schools.

Provide access to mental health services within the school environment and to increase collaboration between schools and the mental health system to provide a supportive system of effective prevention, assessment and treatment of students. Students identified at risk of or pending an expulsion hearing are ordered in to school intervention services with the therapist/counselor. Treatment engagement and outcomes are weighed in determination of students' ability to remain enrolled in the school.

Crisis response services—include on site assessment, treatment planning, and safety plans. Also includes the Teen Screen program.

The DIR (Developmental, Individual-Difference, Relationship-Based)/Floortime approach provides

a comprehensive framework for understanding and treating children challenged by autism spectrum and related disorders. It focuses on helping children master the building blocks of relating, communicating and thinking.
"D" is for Developmental. Understanding where the child is developmentally is critical to planning a treatment program. The Six Developmental Milestones describes the developmental milestones that every child must master for healthy emotional and intellectual growth.
"I" is for Individual-Difference. Each child has a unique way of taking in the world - sights, sounds, touch, etc - and responding to it. Biological Challenges describes the various processing issues that make up a child's individual differences and that may be interfering with his ability to grow and learn.
"R" is for Relationship-Based. Building relationships with primary caregivers is a critical element in helping a child to return to a healthy developmental path.
Parenting/skills development and supports:
Eight week program for parents with minor-aged children diagnosed with Autism Spectrum Disorders or other pervasive developmental disabilities. Topics include an overview of the definition of ASD; the mental health approach versus the medical approach to treatment and support; disorders affecting children with ASD; specific treatments and interventions used for ASD and how to uniquely tailor these to family needs; coping skills and supports for families adjusting to the multi-dimensional needs of a child with ASD.

3.1 Resilience supports: School Suspension and Expulsion NOM

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

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

Click on gray box to enter text.

The number is accurate.

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.

N/A	**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.

	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	780	829	59	57	
Private Psychiatric Hospitals: Adults	672	730	134	135	
Private Psychiatric Hospitals: C&A	85	82	16	17	

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.

Our provider oversees all inpatient admits. Pre-hospitalization evaluations of almost all hospital admissions take place for appropriatenss of care level. There are no local private hospitals. When at all possible admssions are made at the nearest private hospital but this could still be up to 50 or 60 miles away for the client.	**4.ba**

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

Click on gray box to select answer

Yes	**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.

7 C&A Consumers in SFY 2007	**5.a**

b. How many children and adolescents from the Board area were placed in RTCs located <u>outside</u> of your service area in a 12-month period?

Click on gray box to enter number.

7C&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.

2 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.

The local commitment is to maintain kids in the community and expanding resources to keep the child in the community. Ther are times though when the right option is placement in an RTC.	**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			
Children & Adolescents			

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.

N/A

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.

About 5 years ago there was a move to bring CIT into the county but, the feedback received says, there was little interest from the community for this training. The Board, in the last 6 months, brought the sheriff's department, the police departments, and the jails to the table and found that there was an interest in CIT. The Board sent officers to trainings out side the counties and gathered their input on what was valuable in the training and what could be changed or dropped. The Board then created a committee to move forward in developing in county CIT. At the last meeting we had representatives of both sheriff's departments, both police departments, the Tri-County Regional jail, the local jails and the counties attorneys. Training will occur every 4 to 6 months until all interested officers, university security, and sheriffs are trained in CIT.

2. **Disaster Preparedness**

Click on gray box to enter text.

Board staff are members of the Disaster Preparedness groups in the counties. The Board participated in the pandemic flu exercise in Feb. 2008. The Board works with the local EMA on developing the community plan as it relates to MH services. There is a trained local team of 6, including the Board Director, with the ODMH curriculum to be available to help out in a disaster for both the community and first responders. CCI has staff trained in emergency and disaster preparedness.

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	6	1	
Currently Available	5	1	

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

Click on gray box to enter text.

Training included going into schools.

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	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Program Type I	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Program Type II	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive Pharm. Mgt	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive CPST	☒	☐	☒ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	

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.

We have an IHBT (Intensive Home Based Treatment Program) utilizing the HomeBuilders Model for treatment with at-risk families with one provider agency. Currently there are 2 FTE master's level casemanagers providing the intensive CPST services to those families whose children are at risk of removal from the home and who's problem severity scores are 30 or higher. The agency is working with the Center of Innovative Practices to improve fidelity to the standard for IHBT and are currently seeing positive results.
The quality improvement goal of better outcomes will be enhanced through the completed development of a centralized intake process under the direction of the agency psychologist. The overall goal will be to improve accuracy of diagnosis and timely referral to appropriate treatment service (correct diagnosis and service equates with better clinical outcome and shorter duration of service).

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	☒	☐	☒ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
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.

One agency is providing intensive home-based and CPST services for families with autism [and diagnoses within the spectrum] . Increasing capacity for service delivery demands through training existing staff in the DIR and ABA techniques, contracting with professional consultation for internal staff training regarding specialized treatment planning, hiring staff with expertise in necessary treatment techniques.

For one provider implementation of a direct CPST supervisor has improved service access and capacity for intensive CPST by identifying clients with clear and significant needs for such services more appropriately and timely. The agencies will move toward the use of the CASII in determining the implementation/internal referral for any/all intensive services including CPST.

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	☒	☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☒ ☐ ☐	☒ ☐ ☐ ☐	
Diagnostic Assessment – Non-Physician	☒	☐	☒ ☒ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Pharm. Management	☒	☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☒ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☒ ☐ ☐ ☐	
Counseling/ Psychotherapy	☒	☐	☒ ☐ ☐ ☐	☐ ☒ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
CPST	☒	☐	☒ ☒ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	

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.

Access has been a focus for routine outpatient services. If there is a crisis the client is seen ASAP. If it is a court ordered client they are moved to the top of the waiting list. A discharge from the hospital is seen within 3 working days with a follow up by a psychiatrist within 30 days.
Access to psychiarists is an ongoing focus for the Board and the providers, especially for Children and adolescents.

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 more	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.

One agency (CCI) has worked to improve their Child and Adolescent services. They hired the best staff from the other agency and increased the access and capacity to provide those services. The other agency has been slow to respond but is slowly building back to previous levels of services.
One agency is focusing on providing intensive home-based and CPST services for children with autism [and within the spectrum] and their families. They are ncreasing capacity for service delivery demands through training existing staff in the DIR and ABA techniques, contracting with professional consultation for internal staff training regarding specialized treatment planning, hiring staff with expertise in necessary treatment techniques.
Implementation of the direct CPST supervisor has improved service access and capacity for intensive CPST by identifying clients with clear and significant needs for such services more appropriately and timely. The agencies will move toward the use of the CASII in determining the implementation/internal referral for any/all intensive services including CPST.

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.

Training in Cognitive thearapy was offered to both local providers. Staff were involved in a year

long program to improve their cognitive therapy skills.
Community psychiatric support treatment (CPST)- Rehabilitative Approach to providing supportive services to adults, youth, and families who are identified through diagnostic assessment and treating clinicians as able to benefit from and meet the ODMH requirements for CPST services (ODMH Recovery Model).
Eye Movement Desensitization Reprocessing (EMDR)- A method of treatment used by specifically certified CCI providers to address trauma related disorders.
Dialectic Behavioral Therapy (DBT) Using Linehan's model, this program is designed to decrease self-injurious behaviors and consequent hospitalizations; increase coping skills in order to better manage negative behavior and reduce development of borderline personality disorder.
Play therapy- Designed to allow the therapist to better "connect" with the young consumer and thus facilitate a positive outcome in a shorter period of time (The Association for Play Therapy).
Active Parenting Now- Designed to develop or enhance appropriate parental ability to parent children more effectively .
Youth sex offender program -Relapse prevention treatment designed to minimize sexual re-offending. Offered currently in Logan County, Family Court has contracted with the University of Cincinnati to evaluate the program for outcomes and effectiveness (utilizes Cognitive Therapy, Stages of Change and Motivational Interviewing). There is also an Adult Sex Offender program.

Applied behavior analysis (ABA) is the applied research of behavior from a natural science perspective. It is one of four domains of behavior analysis: the philosophy of behavior analysis, basic research, applied research, and practice guided by the science. Lay terminology would call it behavioral redirection.

Incredible Years: The Incredible Years: Parents, Teachers, and Children Training Series is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 4 to 8 years). The interventions that make up this series—parent training, teacher training, and child training programs are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems.

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:*	1.05	**8.a**
CPST FTEs:	7.75	
Counselor/Therapist FTEs:	7.73	

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

Click on gray boxes to enter number of FTEs.

Pharm. Management Practitioner FTEs:*	1.34	**8.b**
CPST FTEs:	6.63	

Counselor/Therapist FTEs:	13.00	

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

Click on gray box to enter text.

Broadening the Concept of Workforce
The Board working in conjunciton with FCFC and other community groups has focused on using the Family team meetings to foster families participating in the treatment decisions. There has been a Community Call to Action to involve the community in identifying and coming up with solutions to build wellness. Over 90 people attended the first meeting.
Strengthening the Workforce
Providers are working with Wright State University, Urbana University, Dayton University, and the University of Cincinnati for internships and psychiatric time. They have also been researching working with placement agencies for psychiatrist. Provider has people from Family Practice Rural Residency program. The Board area is designated as HealthCare Professional Shortage Area. Board sets aside dollars to reimburse for tuition costs.

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.

Regular contact is made with local probation officers, about clients in the Batterer Intervention Program and Adult Sex Offender program, via telephone and with as needed meetings. Monthly written reports are also sent to keep probation officers current on client progress.

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

Click on gray box to enter text.

The Behavioral Health Juvenile Justice grant was received for both counties in collaboration with the juvenile/family courts. This project has been a successful endeavor in assessing the behavioral health needs of kids adjudicated by the courts and linking them to evidenced based treatment. Locally close to 500 kids have been screened and over 200 enrolled in treatment.
The Juvenile Sex Offender program in Logan county includes a speciality docket for one of the judges and meets once a week to review the cases. The program includes a treatment group run by a MH professional and probation officer that meets weeekly.
The Family Treatment court in Logan Co. is another speciality docket dedicated to addressing the substance abuse needs of parents of abused and neglected children. There is a dedicated case manager from the MH system assigned to these cases.

The providers and court work together in the BHJJ project. There is current programming opportunities, by court referral, for youth identified with substance use related charges to participate in a ME/CBT intervention group as a means of deferring sentencing based upon treatment engagement. Providers participate in the Community Partners meetings with Logan County Court.
.

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.

Ongoing individual and group counseling provided at the Tri-County Jail. Jail has asked that provider only be involved when requested to do evaluations. Corrections officers will be included as part of the CIT program.

2. Detention Centers

Click on gray box to enter text.

Both providers provide CPST, prevention, and individual counseling services available on site with youth incarcerated at JDC. Crisis services also available. Clinicians work with DC staff to assist with transition from incarceration and provide support back in the community.

2. Homeless, Runaway & Domestic Violence shelters

Click on gray box to enter text.

There is a Domestic Violence coalition which is led by our MH provider in the community Caring Kitchen is the homeless shelter in Urbana. Caring Kitchen works closely with our housing provider to find permanent placement for the homless. A Homeless Shelter in Logan County just recently opened in Bellefontaine. Continuum of Care works on housing for the homeless.

3. Nursing Homes

Click on gray box to enter text.

The Board is a member of the local coaltion on aging and the board director sits on the Area Agency on Aging Region 5 committee. The board has worked on a collaboration with these groups to bring some grant money into the counties to do education and screening.

CPST services for adults at the Wellington Nursing Home are available through partnership with a provider and CRSI.

4. Prison Reentry

Click on gray box to enter text.

Board has had meeting with local adult parole officers to start the conversation around local barriers for inmates trying to successfully reenter the community. The local provider participates with the ODMH Linkage program .

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

Click on gray box to enter text.

Training of local physicians occurred through a collaboration of MH and MRDD, with a CCOE grant to help physicians beter understand psychotropic medications and possible side effects. As part of the ECMH program both counties have significantly increased communication and collaboration with local medical providers to identify mothers with maternal depression and offer screening tools to address the issue. One provider has a nutrition group with parents or adults to discuss how diet effects mood and psychotropic side effects.

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 and it's local providers are actively involved in the Logan/Champaign Suicide Prevention Coalition. This coalition has been very involved in a number of activities in both communities aimed at educating the public on depression and suicide. Recently they were able to bring in Frank Campbell, LISW from Baton Rouge, LA to present to the communities the idea of LOSS Team. (Local Outreach to Suicide Survivors). This is a team of MH professionals and suicide survivors that can accompany law enforcement on the scene of a suicide to offer support and resources to the surviving family.
The Coalition has also helped to support the continued growth of TeenScreen in our local schools. The TeenScreen is an evidence based screening tool from Columbia University to detect depression and risks for suicide in youth. Both provider agencies work together to screen and provide clinical interviews to the youth in almost all our schools in the two communities.

Support services for parents/families of children with ASD

ECMH—consultation for center-based professionals to ensure engagement of children in pre-school/child care facilities in order to build resiliency and protective factors.

School Consultation: provide mental health consultation to school professionals to ensure engagement of youth in the school environment, providing support and alternatives to the classroom/IAT/IEP process addressing mental health barriers.

School Outreach Worker Program: providing casemanagement services to each school district in the two counties, targeting the elementary level students and their families. The goal of the Outreach Worker program is to improve the communication between school staff and parents and remove barriers to education so that the child is successful.

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.

While Logan and Champaign counties are not very diverse in their racial populations, there is an increasing issue of poverty that affects more and more people in the two communities. To address this there is a Bridges Out of Poverty initiative is taking place for both counties to not only to make staff aware of disparities between cultural groups but to develop trainers to provide ongoing training and updates. The program will expand into Getting Ahead classes and Circles program .

Providers track consumer satisfaction/Cultural Groups access/outcomes. One provider has 2 staff members that are proficient in Spanish and able to provide translation or services as needed to support those who have English as their second language.

CPST and IHBT services are primarily community based services to ensure in home treatment that

meets the needs of the clients with their families in their home environment.

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.

As a way of on-going monitoring and collaboration in the BHJJ grant, the Board developed a bi-monthly meeting with the Juvenile Judges from both communities, as well as local provider staff, to discuss concerns, successes and needed changes in the programs adddressing youth and their families with juvenile justice involvement and behavioral health issues. This has greatly increased the communication between the community systems.

Continuum of Care has been operating for about five years involving about 40 different agencies in each county to deal with homelessness issues. The main focus is on prevention, shelter, transitional housing, and permanent housing. The Continuum of Care meets once a month in each county and have been awarded four HUD grants in the last three years.

Providers have done ongoing training in the use of Ohio Scales in treatment planning and outcome tracking.
Providers have made significant improvement this year in their Ohio Scales compliance.

Short-term treatment: priority has been given to providing short term treatment and has included staff training, policy and procedure changes, and the restructure of quality improvement protocols within the agency. Length of Stay data has not been impacted but it is anticipated that recent efforts will show significant change in this area. Continued focus in this area remains an agency goal.

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.

Below is a list of all the various ways the Board gathers input to determine its focus.

Providers monthly give surveys to a selection of active and to all terminating/discharging clients to determine areas of needs. Information shared with Board

ECMH focus groups are held quarterly to gauge program development, outcomes, and identified barriers to services.

Board is member of Logan Co. Strategic planning committee for Logan Co. Children's Services.

Referral source satisfaction surveys are completed annually.

The Board is a member of the Continuum of Care meetings in both counties. In particular, the meetings have focused on identifying the housing needs of those with mental health and/or alcohol and drug diagnoses. As a result of this ongoing need assessments, the Continuum of Care was awarded four HUD grants. Continuum of Care consists of 20 to 30+ community organizations and stakeholders.

Regular meetings with the consumer organization, Recovery Zone, to discuss their goals for the next 3 years. ODMH staff has attended some of the meetings

Community survey of stakeholders, partners, community members, and consumers provides input on direction for Board. Survey had a 50% return rate.

Board has created a meeting with juvenile court judges, court staff, provider agencies, and other community organizations. Part of the meeting is to identify needs and solutions of the community.

Partnership for Success surveys are reviewed.

Referral Source Satisfaction surveys

Consumer Satisfaction surveys

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.

Using the input from the methods mentioned above the Board works with providers and community organizations to decide on focus. The Board survey, the Partnership for Success surveys, the judges meetings, and community input have all identified children and adolescent issues as the number 1 priority for the Board.

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: Low

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

More peer to peer support for successful employment of consumers.

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

The development of a peer coordinator of the local Howie the Harp initiative.
The use of Bridges Out of Poverty and use of Getting Ahead in a Just Getting by World.
Continued development of the CIRCLES program.

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

Peer coordinator hired and local trainings scheduled.
Number of families completing the Getting Ahead program

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

Adult parole,
housing vendor,
Local University
Employers
FCF
DJFS.

2.b. WELLNESS MANAGEMENT & RECOVERY*
Priority: High

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

Local consumer organization, Recovery Zone, to develop leadership and membership growth.
Consumer group to be more visible and accessible in local communities.
Recovery Zone developing new programming to assist consumers become more independent and less reliant upon the mental health "system."

Expand wellness groups for families of children, adults with MRDD, and other adults taking psychotropic medications.

Expansion of recovery services for those with co-occuring Substance use and MH.

Increase client awareness of potential health risk and side effects of psychotropic medications based upon nutrition/diet, life choices, and their environment.

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

Consumer organization, Recovery Zone, continue expansion in to each local community while maintaining central location.
Increase employment opportunities and experience
Develop WRAP leaders.
Recovery Zone will develop own transportation system to meet the needs of the people that are in consumer group.

Provide regularly scheduled groups for new and continuing clients taking psychotropic medications addressing potential side effects, nutritional impact on the specific disorders, life circumstances and potential impact on reactions to medications.

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

Will develop local site in communities.
Will match or exceed Board dollars given to consumer group through their employment opportunitiies.
Consumers will be responsible for overseeing transportation, van maintenance and upkeep, and will be drivers of all Recovery Zone vehicles.
Will have 2 trained WRAP leaders.
in attendance in the groups for new and continuing clients taking psychotropic medications.

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

Consumer group,
Local employers,
RA Inc., housing agent
Community groups

2.c. HOUSING
Priority: High

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

Increase Permanent Housing
Renovate housing units currently being used as permanent housing

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

Implement the HUD grants awarded to the MHDAS Board and Residential Adminstrators, Inc.
Utilize CHIP dollars from Logan and Champaign Counties for renovations
Work with local banks on homeownership

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

28 units awarded by HUD will be operating by June 2009
Renovation of 10 units from utilizing CHIP funds and will be completed June 2009
Provide homeownership to 2 consumers by working with local banks by June 2009

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

Continuum of Care
Residential Administrators, Inc.
Private Landlords
Foundations
Banks
Homeless Shelters
Local Government

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

2.d. OTHER:
Priority:

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

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

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

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

Click on gray box to enter text.
2.e. OTHER:
Priority:

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

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

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

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

Click on gray box to enter text.
2.f. OTHER:
Priority:

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

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

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

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

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

Click on gray box to enter text.

3. Resilience Supports. Using the format below, please describe goals, strategies, and measurable objectives for SFY 2009 for school success, ABC, and any other Resilience supports of relevance to the Board, such as Transition Age Programs, Parent Advocacy, etc. (See Appendix C for definition of

resilience supports and examples of strategies and programs.) Based on identified needs, rank priorities as high, medium or low. What systems/entities/providers/consumer groups will the board collaborate with or have discussions, and what benefits/results are expected?

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

Click on gray box to indicate priority level.

3.a. SCHOOL SUCCESS

Priority: High

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

Improve access to MH services and collaboration between schools and MH.

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

Assist students and their parents with barriers to academic improvement.
Coordinate and facilitate effective communication between parents and teachers to help resolve conflicts and misunderstandings.
Improve MH functioning by linking the student's family with needed resources.

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

80% of students will show improvement on their academic performance (from admission to discharge, using the Ohio Scales "Functioning" scale).
Of those students referred for behavior concerns, 80% will show improvement on their "Problem Severity" score (from admission to discharge, using the Ohio Scales Parent rating form).
80% of teachers will report improved communication with parents (from admission to discharge, using the referral form).
80% of parents will report reduced family stress (from admission to discharge, using the Ohio Scales Parent rating form).

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

Schools,
FCF,
Local providers,
DJFS
Community representatives,
Miami Valley Health Improvement Council

3.b. EARLY CHILDHOOD CARE

Priority: High

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

Early identification and treatment of at risk families and children to improve their quality of life

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

Maternal Depression Screening,
Coordination of autism services
Incredible Years Parenting Curriculum for family consultation and parenting skills development
DECA Evaluations

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

# of screenings completed for Maternal screenings and the number of mothers who are connected to treatment.

Development of a local program to meet the needs of school age children diagnosed with autism, especially in the summer months where the structured school day is not an option.

Increase parents knowledge of child's development,

Tracking of outcomes related to the DECA evaluations w/ improvement through the course of service involvement

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

ECCC,
FCFC,
Local providers
Health District,
MRDD,
Mercy Well Child,
Mary Rutan Hospital
Local physicians/pediatricians

3.c. TRANSITION AGE CARE
Priority: Low

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

To improve the successful transition to adulthood for youth with autism.

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

Development of services providing transition from pre-school to mainstreamed K (ECMH-T)
Development of services providing transition from secondary school into independent living for adolescents with ASD and their families.

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

Number of children enrolled in program;
number of successful transitions completed/facilitated;

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

Providers
Schools
MRDD Boards
FCFC

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

3.d. OTHER: Bridges Out of Poverty
Priority: High

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

Improve family's self sufficiency and move them out of the cycle of poverty

Strategies *Click on gray box to enter text.*

Bridges out of poverty training,
Getting Ahead training,
Circles program

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

5 people trained as trainers for bridges out of poverty curriculum,
completing Getting Ahead curriculum,
completing Circles 18 month cycle

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

FCF,
Residential Administrators Inc.
Continuum of Care,
Juvenile court,
JFS,
Churches,
Community volunteers

Click on gray box to enter text.

3.e. OTHER: Strengthening Families
Priority: Medium

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

Improve family communications and functioning

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

Strengthening Family program for kids 6 to 11 and 10 to 14 and their families

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

# of families participating and evaluation of family communication and functioning

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

FCFC,
Providers,
Children's Services,
Family Court,
MRDD,
DJFS

Click on gray box to enter text.

3.f. OTHER: Suicide Prevention Coalition
Priority: Medium

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

To increase community awareness of the impact of depression and suicide and the fact that treatement is available and works.

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

Community speaking engagements
Community awareness events in September for Suicide Awareness Month
Promoting use of TeenScreen in local schools
Development of local LOSS Team

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

10 Speaking engagements by members of the coalition per year
Awareness event in each county in September with media coverage
TeenScreen provided in at least 7 of the 8 school districts
Identified members of a local LOSS Team trained

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

Providers,
Schools
Community stakeholders
Law enforcement
NAMI
FCFC
Health District
Local Media

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

Click on gray box to enter text.

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

Click on gray box to enter number.

Board Purchased Inpatient Care	SFY 2009 Bed Days	SFY 09 Admissions
State Hospitals	600	41
Private Psychiatric Hospitals: Adults	274	150
Private Hospitals: Children & Adolescents	82	16

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.*

Increase local private bed day hospitalizations with the goal of reduced readmissions due to care being provided locally

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

Meet with Memorial Hospital in Marysville to discuss sending them an increased number of patients
Unite with Union Co Board to offer Memorial Hospital guaranteed bed days from boards

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

Increased Private bed days.
Decreased state bed days
Decreased readmissions

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

Union Co Board
Providers
Memorial Hospital

Providers report a poor working relationship with TVBH in Columbus and the inability to get clients admitted. The Board will be working, in conjunction with the Union County Board, to develop a relationship with the inpatient unit at the Marysville hospital to see if they can accept more of our patients. A secondary goal of this meeting will be to develop more community based services to either reduce length of stay, reduce readmissions, or even deter admissions. With the inpatient care being provided locally there can be more family involvement and more local outpatient provider involvemnt in the care. This should help to reduce readmissions and length of stay. The inpatient numbers are the current guess at what will happen . The goal would be to have the state facility inpatient days even lower than currently estimated.
The Board has identified the need for better linkage between MH and health care needs.
The Board is in the preliminary stages of developing a pilot with a local physician to provide heath

care and mental health care services to consumers at one site.

4.b. CONTINUITY OF CARE
Priority: High

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

Clients will be seen within the week of discharge and every 2 weeks for the first 3 months after discharge

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

Supervisors to work with staff and hospital on discharge date and follow up appointments

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

Track inpatient discharge and outpatient visits

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

Providers
Hospitals

4.c. SOMATIC HEALTH CARE
Priority: Low

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

Provide mental health services to individuals with co-occuring somatic isssues

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

Place mental health therapist in free clinic to provide counseling as needed

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

Therapist in clinic
# of clients seen

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

Provider
Physician
DJFS

Studies have shown that health care costs can be decreased with just one visit to a MH therapist. Many people say that there is still a stigma attached to going for mental health counseling and refuse an appointment. By putting a therapist on site in the docotr's office the visit with a therapist can occur and the patient is willing to go down the hall and see a therapist. The local Free Clinic is open 12 to 16 hours per week. The doctor is will ing to have a therapist on site and sees value to the nearby availability. The issue, as always, is how therapists time will be paid. With the current state funding issues the Board has made this a low priority. The Board will slowly move forward with this idea with the goal of having a therapist on site whens the clinic is open..

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

Click on gray box to enter text.

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

5.a. Residential Treatment Centers
Priority: Low

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

To be informed of all Residential Treatment Center admits beforehand

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

Work with court staff to include the Mental Health Board in decision making process for RT admits
Work with DJFS to sit in on meetings discussing whether client will go into Residential Treatment

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

Residential Treatment admissions will be under 7 admits

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

DJFS
Courts
Providers

There are very few Residential Treatment Center admissions. Ther have been none from Logan Co. in the past 2 years. In Champaign Co. they are either from DJFS or the court.

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

Click on gray box to enter text.

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

6.a. Adult Consumers

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

6.a.1. Area of Adult Crisis Care: Other
Priority: Low

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

Increase access for adults with MRDD to crisis services including 24/7 hotline, psychiatric on-call, and intensive CPST services as needed.

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

Secure additional adult psychiatry services
Train incumbent clinicians and future hires in treatment modalities for persons with MRDD

Measurable Objectives

Number of crisis services accessed by clients with dual, MRDD/MH diagnosis

Discussions and/or Collaborations

Both county boards of MRDD,
CRSI
Ben-El

6.a.2. Area of Adult Crisis Care:
Priority:

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

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

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

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

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

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

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

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

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

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

Click on gray box to enter text.

6.b. Child & Adolescent Consumers

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

6.b.1 Area of C&A Crisis Care: Other
Priority: High

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

Incorporate the CASII within agency protocols in order to lend consistency when ordering services and identifying treatment benchmarks.

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

Train staff in the use of the CASII
Form an internal workgroup to determine appropriate agency protocols

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

Number of staff trained
Implementation of CASII
Use as an agency protocol.

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

Providers
Juvenile Courts
Children's Services
DJFS
MRDD
Schools

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

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		
Children & Adolescents		

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.*

Train police, sheriffs, and university security in CIT

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

First incounty training in April of 2008.
Training every 4 to 6 months until all interested officers and sheriffs are trained in CIT.

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

# of officers trained

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

Both counties sheriff's departments,
All police departments,
The Tri-County Regional jail,
Local jails
Counties attorneys
Providers
University Security
NAMI

6.d.2. DISASTER PREPAREDNESS*
Priority: Low

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

To be part of teams in both counties for Disaster preparedness

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

Coordinate with local EMA's
Sit on Disaster preparedness teams
Participate in state exercises

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

Participation on teams
Attendance to meetings

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

Counties Health Districts
EMA
Police
Sheriff
Hospital
Providers

6.d.3. COLLEGES & UNIVERSITIES*
Priority: Low

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

Increase access to mental health services for college/university students
Provide early identification of high risk behaviors and mental health needs for college/university students.

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

Provide P E & C supports on site at Urbana University;
Provide intervention and treatment groups as needed on site at the college campus.
Do annual depression screenings on campus

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

Number of college student accessing services,
Number of annual depression screenings completed

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

Urbana University
Providers

6.d.4 PRIMARY & SECONDARY SCHOOLS
Priority: Low

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

Early identification and treatment of non-academic barriers to school success
Expansion of services within the school setting for children within the ASD
Increased capacity for school consultation services across the 2 county districts

Increased access to mental health services on site for school aged students.

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

Develop a school-community partnership team
Secure additional non-Medicaid funds for increased service capacity
Increase staff capacity for school-based services contingent on secured funding
Implementation of the DINA classroom program [Incredible Years Program] in local Kindergarten classrooms and Head Start programs.

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

# of school/district teams developed,
# of cases triaged
# of admissions to the program(s),
Track additional staff capacity for providing services,
Reduction of school disciplinary actions due to high risk behaviors, mental health indicators, and related issues,
Maintained school engagement for participants in the program

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

FCFC,
Schools,
Providers,
Health District,
MRDD,
Children's Services,
Faith based members,
Mary Rutan Hospital,
Community representative,
Family court
Local Schools. –in order to address desired measurable outcomes it is essential to develop a collaborative tracking and information sharing system for each participant, classroom, and school engaged in the program. This development is a primary goal for FY08 and 09.

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

Click on gray box to enter text.

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

7.a. Adult Services.

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

7.a.1. Area of Adult Services: Counseling
Priority: Low

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

One Provider will expand capacity for service delivery to adults. There will be a focus on those with MRDD

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

Provide mental health services for adults
Increase marketing to community partners for adult services
Staff development/training as needed to broaden scope of practice for professional staff regarding clients with MRDD.

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

Number of adult receiving services,
Number of staff attending training/professional development

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

Provider
CRSI,
MRDD

7.a.2. Area of Adult Services: Counseling
Priority: Medium

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

To improve client engagement and treatment outcomes

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

To work with the OSU to provide training and support in motivational interviewing techniques.

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

# of therapists trained in motivational interviewing

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

Providers
OSU
Juvenile Court

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

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

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

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

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

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

Click on gray box to enter text.

7.b. Child & Adolescent Services.

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

7.b.1 Area of C&A Services: Counseling
Priority: High

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

Provider expansion of capacity for service delivery with a focus on ASD, other early childhood, school aged youth, female teens, and substance use as a co-occuring issue with mental health.

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

Provide staff development/training opportunities for professional staff to broaden scope of practice in these targeted areas;
Develop/implement individual and group treatment structure for identified target areas;

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

Increase in number of services provided in targeted areas
Increase in number of admissions to targeted program areas
# of successful completions of targeted program areas.

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

Provider
Trainers

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

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

Strategies *Click on gray box to enter text.*

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

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

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

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

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

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

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

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

Click on gray box to enter text.

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

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

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

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

Decide is IDDT is feasible for our providers

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

Research treatment model
Evaluate cost of delivery treatment in accordance with program fidelity

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

Treatment model training is low cost
Fidelity can be maintained

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

There is a history of providers training staff in evidenced based practices and then other agencies hiring the staff away. Our counties become training centers, with no payback for the dollars invested. It also makes it almost impossible to maintain fidelity as therapists quit in the middle of

cases for their new job. It is not cost effective or efficient for providers and the Board to invest time and dollars unless there is some way to guarantee that the therapists will stay at their current job.

Click on gray box to enter name of practice:
7.c.2. PRACTICE: ECA: Early childhood assessment
Priority: Medium

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

Provide an integrated and broad array of assessment options that can be tailored to the individual needs of the child and family circumstance.

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

Expand professional development/training expertise to Early Childhood staff utilizing the best practice assessment tools.

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

Number of professional staff trained,
Number of assessments completed

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

Providers
MRDD
FCFC
Help Me Grow
Schools
DJFS/Children's Services

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

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

Build capacity for IHBT/Homebuilders Treatment model.

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

Secure staff training in the Homebuilders/IHBT model

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

Number of staff trained;
Number of programs utilizing IHBT/Homebuilders model implemented;
Number of admissions to treatment in programs using the identified treatment model.

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

Porviders
Trainers
Local stakeholders

Click on gray box to enter name of practice:

7.c.4. PRACTICE: DBT for Adolescents
Priority: Medium

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

Expand DBT services to adolescents across the Board area

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

Develop expertise and implementation of DBT individual and group counseling services for adolescents to Champaign County.

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

C & A therapists will be identified and trained on DBT for adolescents in Champaign County.
50% of adolescent clients will achieve "Improvement w/ Clinical Significance" or "Improvement w/out Clinical Significance" according to the Ohio Scales Problem Severity outcome system (from intake to termination of DBT services).

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

Providers
Trainers
New service areas will attempt to utilize Ohio Scale outcome tracking to measure progress and to compare to ODMH state-wide benchmarks.

Click on gray box to enter name of practice:
7.c.5. PRACTICE: Dual Diagnosis for C & A
Priority: Medium

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

Increase integrated MH/AoD dual diagnosis services to child and adolescent clients.

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

Develop expertise in developing and delivering integrated MH/AoD treatment plans and services from one clinician, when appropriate.

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

50% of C & A therapists will provide integrated MH/AoD services for adolescents, rather than the current method of referring to a second provider.

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

Juvenile courts,
FCFC,
child-serving systems requesting integrated services for dually diagnosed adolescents.

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: Retain MH staff

Priority: High

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

To retain highly qualified staff

Strategies *Click on gray box to enter text.*

Strengthen the workforce:

1. By retaining staff through providing opportunities for advancement
2. Continue as a state designated HPSA
3. Board offer education financial reimbursement

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

Staff retention of 80%

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

Provider

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

8.a.2. Area of Workforce Development:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

9.a. Adults

9.a.1. ADULT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority: Low

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

Improve communication between the adult justice and MH systems

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

Family Treament Court advisory team participation

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

Attendance at the Advisory Team meetings by Board and providers

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

Providers
Courts
FCFC
Schools
Children's Services
Law enforcement
Prosecutor's Office
Adult Parole

9.a.2 ADULT RECIDIVISM

Priority:

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

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

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

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

9.a.3. ADULT DIVERSION

Priority:

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

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

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

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

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

Click on gray box to enter text.

9.b. Adolescents

9.b.1. ADOLESCENT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority:

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

Maintaining a capacity for on-site screening and assessment by qualified MH staff at the Juvenile Courts in both counties.

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

Collaboratively seek sustainable funding

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

Accessing funding to continue the services

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

Juvenile Courts
Providers
Judges Meetings
BHJJ Advisory Team

9.b.2. ADOLESCENT RECIDIVISM

Priority: High

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

Reduce recidivism in BHJJ population

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

Improved tracking of treatment attendance and outcomes of youth referred through the BHJJ program.

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

reduction in # of youths who are repeat offenders

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

Providers

Courts
Parole officers

9.b.3. ADOLESCENT DIVERSION
Priority:

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

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

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

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

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

Click on gray box to enter text.

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

9.c.1. JAILS
Click on gray box to indicate priority level.
Priority: Low

Goals: *Click on gray box to enter text.*
Implement additional group activities on site at Tri-County Jail as staff capacity grows.

Strategies: *Click on gray box to enter text.*
Identify needed groups

Measurable Objectives: *Click on gray box to enter text.*
New groups implemented at jail.

Discussions and/or Collaborations: *Click on gray box to enter text.*
Jail staff
Courts
Providers

9.c.2. DETENTION CENTERS
Priority: Low

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

Strengthen transition services in order to facilitate stabilization prior to and during release from the center.

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

Collaborators to work together to identify services that will strengthen transiton and reduce readmissions

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

# of people readmitted to the detention center

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

Providers
Children's Services
Juvenile Court staff

9.c.3. SHELTERS (Includes Homeless, Runaway, Domestic Violence)
Priority: Medium

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

Community agencies will work together to provide MH services to the homeless.
Provide mental health and supportive services to individuals and families facing homelessness and/or the adjustment of life situations leading to homelessness. Facilitate successful transition in regard to mental health and family stability.

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

Connect with the Caring Kitchen to provide on-site mental health services for those entering the shelter and/or those transitioning out to the community.
Link with RA Inc.
Link with CPST services,
Provide PC&E group/public awareness activities addressing teenage runaway issues.
On-site CPST worker and or therapist; on-call/as needed services

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

Number of admissions to services,
Number of successful transitions/family stability status.

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

Local homeless shelters
Providers
Housing organization
Continuum of Care

9.c.4. NURSING HOMES
Priority: Low

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

Increase access to mental health services for those in a nursing home setting. Increase stabilization/adjustment for those facing nursing home stay/residency.

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

Provide on-site mental health services.
Scheduled group activities for residents as needed.
Referral by NH staff for initial assessment/screening at admission to the NH facility.

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

Number of admissions to the program,
Reported increased stabilization/adjustment

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

Nursing homes
Providers
CRSI,

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

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

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

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

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

9.c.6. PHYSICAL & MENTAL HEALTH INTEGRATION
Priority: Low

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

Provide mental health services to individuals with co-occuring somatic isssues

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

Place mental health therapist in free clinic to provide counseling as needed

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

Therapist in clinic
# of clients seen

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

Provider

Physician
DJFS

Studies have shown that health care costs can be decreased with just one visit to a MH therapist. Many people say that there is still a stigma attached to going for mental health counseling and refuse an appointment. By putting a therapist on site in the docotr's office the visit with a therapist can occur and the patient is willing to go down the hall and see a therapist. The local Free Clinic is open 12 to 16 hours per week. The doctor is will ing to have a therapist on site and sees value to the nearby availability. The issue, as always, is how therapists time will be paid. With the current state funding issues the Board has made this a low priority. The Board will slowly move forward with this idea with the goal of having a therapist on site whens the clinic is open..

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

9.c.7. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.8. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.9. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

10.a. SUICIDE PREVENTION

Click on gray box to enter priority level.

Priority: High

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

Development of local LOSS Team

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

Train local community members to be part of a local response team to assist law enforcement on the scene of a suicide to offer support and resources to the survivors.
.

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

LOSS Team is trained and available to law enforcement.

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

Law Enforcement
Providers
Community representatives
Hospital

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

10.b. OTHER:

Priority:

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

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

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

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

10.c. OTHER:
Priority:

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

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

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

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

.

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

Click on gray box to enter text.

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

11.a. CONSUMER SATISFACTION WITH SERVICES AND STAFF
Priority: High

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

Increase case managers and therapists cultural competency

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

To have staff training on Bridges Out of Poverty

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

# of staff that attended Bridges Out of poverty training.

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

Providers
Trainers

11.b. STAFF RECRUITMENT
Priority:

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

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

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

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

11.c. STAFF TRAINING
Priority: High

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

Bridges out of poverty training

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

Provide on site training for staff

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

Training occurred
Number of staff trained

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

Trainers
Providers

11.d. ADDRESSING DISPARITIES IN ACCESS AND OUTCOMES
Priority: High

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

Reduce wait time from call to first appointment

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

Increase staff to help reduce wait list
Develop pretreatment orientation group

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

Staff hired
orientation group started

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

Referral sources educated on what is available

Click on gray box to enter text.

11.e. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box and enter text.

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.

None at this time

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.

<table>
<tr><td>There are quarterly and annual evaluation of services. The evaluations consist of quality, performance improvement, and productivity standards and issues. Goals and focus change on as an needed basis to ensure appropriate services. Providers present both the positives and the negatives of each quarter so that issues can be discussed.

The areas currently reviewed include:

COMPLIANCE with Regulatory bodies including ODMH, ODADAS, CARF

PERFORMANCE IMPROVEMENT
client records
review and update level of care protocols
review and update length of stay protocols
chart reviews of clinical and consumer services
accessability and availability of services
Risk management
Identify top 5 diagnoses for improved focus of care

PRODUCTIVITY ADULT and YOUTH
Pharmacological Mgt.
MH assessment Physcian
MH assessment non-physician
BH counseling individual and group
Crisis intervention services
CPST group and individual
BH hotline services
Service coordination
Consultaion
Education
Prevention
IHBT

FINANCES

Client Satisfaction Surveys
Provider Satisfaction Surveys</td><td>E.1</td></tr>
</table>

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.

There are a variety of report that the Board looks at that come from data from MACSIS,	E.2

BHMOD, and Outcomes data. All the reports listed will be evaluated, updated and/or changed to become more effective tools to help in delivering the most effective treatment. Some of the data looked at includes:

What % of SMI are Employed Part-Time and Full-Time?

What % of Population is employed or Student at Discharge?

Average Number of Days from Diagnostic Assessment to first Treatment Appointment for New Clients within Board Areas

Percent of Emergency Psychiatric Consumers receiving Outpatient Services within 90 days of that Crisis Service --- Clients for whom the Crisis is their first service in 2 years

Percent of Emergency Psychiatric Consumers receiving Outpatient Services within 90 days of that Crisis Service --- Clients for whom the Crisis is NOT their first service in 2 years

For the Clients receiving Outpatient services within 90 days following a Crisis Service, what is the average number of days between that Crisis Service and their first Outpatient service? [Clients for whom the Crisis is their first service in 2 years]

For the Clients receiving Outpatient services within 90 days following a Crisis Service, what is the average number of days between that Crisis Service and their first Outpatient service? [Clients for whom the Crisis is NOT their first service in 2 years]

Time elasped (Average Days) from BHMOD reported first contact date to First Service.

Average turnaround time for claims

Service summary by provider

Service detail by provider

Service detail by diagnosis

This information gives the board a better picture of the effectiveness and efficiency on the providers. For example, looking at the service detail by provider and service detail by diagnosis the board looks at the cost per client by diagnosis. The board also uses it to identify the higher cost providers in county and also the cost for out of county providers. The next step will be to identify cost per client by therapist within a providers office. Outliers will have a higher number of visits per client for a certain diagnosis. Training can then occur to bring their treatment into line with what other therapists are doing that is effective and efficient. Another approach will be to identify which therapists are most effective with which diagnoses and to make referrals to specific therapists based on the clients diagnosis.

Monthly reports are reviewed by the Board from the MACSIS member and claims databases. These reports track timeliness of claims and other processes involved with the claims process. They also track the number of providers serving each boards residents, the quantity of each service provided and the total dollar amount of those services for the month and fiscal year.

In addition to these monthly reports, the Board looks at reports using the Behavioral Health and Outcomes databases that are produced on an as needed or requested basis. These have tracked the number of records submitted versus the number of clients served in a defined time frame. BH reports have also looked at some of the living arrangements at discharge. Outcomes reports have also gone to providers that identified clients who were treated but did not have an outcomes instrument submitted. These reports will be modified in the near future to eliminate some of the clients who do not need outcomes including crisis only and AOD service recipients.

As the level of compliance with BH and outcomes increases the Board anticipates the development and reviewing of additional reports that identify trends within and across boards that will help the Board analyze the effectiveness of some of the contracted services

from their various providers. The BH Mod will be used to provide data on various client population sub groups although at the moment this is primarily providing mostly on AoD persons. It will tell LOC at admission, who referred them in very generic terms, whether or not they had an ADA inpatient admission, diagnosis - primary & secondary, if they are with a Medicaid HMO/PPO,if they were part of a special population group (SMD./SED), if a urinalysis is requested, Primary & secondary drug code, frequency of use, date service was requested, if they are a vet, have children in legal custody of ODHS/Child servicng agency, monthly income and such. This information will be collected by the front desk & therapists and inputed by support staff. Providers will track outcomes on various levels (BHJJ, DBT for adults and adolescents, LOC for AoD, GAF scores - did they increase from the date of entry to date of termination). Supervisors can use outcomes to check on the quality of programming provided by their staff - i.e. are people getting better. Providers are working on using the open to close date to track the length of services and will use outcomes to track quality programming through the QPI process, which will be reported to the Board.	

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.

Right now we asre okay but may need some assistance in the future.	E.3

Form 1

Board Appointment Data Sheet

List all members, leaving vacant appointments blank

<table>
<tr><td colspan="3">Board Name</td><td>Date Prepared</td></tr>
<tr><td colspan="2">Board Member</td><td colspan="2" rowspan="5">Appointment: ODMH   Sex: Female   Ethnic Group: White
Officer: Chairperson   Hispanic or Latino (of any race): Yes

Representation: select all that apply:

Mental Health
☐ Consumer
☐ Family Member
☐ MH Professional
☐ Psychiatrist
☐ Other Physician

Alcohol Other Drug Addiction
☐ Consumer
☐ Family Member
☐ Professional
☐ Advocate</td></tr>
<tr><td colspan="2">Mailing Address (street, city, state, zip)</td></tr>
<tr><td>Telephone (include area code)</td><td>County of Residence</td></tr>
<tr><td colspan="2">Occupation</td></tr>
<tr><td>Term
Partial Term</td><td>Year Term Expires
2008</td></tr>
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Telephone (include area code)	County of Residence	Representation: select all that apply:
Occupation		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Term Partial Term	Year Term Expires 2008	Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate

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Board Name | Date Prepared

Board Member

Mailing Address (street, city, state, zip)

Telephone (include area code) | County of Residence

Occupation

Term: Partial Term | Year Term Expires: 2008

Appointment: ODMH | Sex: Female | Ethnic Group: White

Officer: Chairperson | Hispanic or Latino (of any race): Yes

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- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name | Date Prepared

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- ☐ Professional
- ☐ Advocate

Board Name | Date Prepared

Board Member

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☐ Professional
☐ Advocate</td></tr>
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<tr><td colspan="3">Occupation</td></tr>
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<tr><td colspan="3">Board Member</td><td rowspan="5">Appointment: ODMH
Sex: Female
Ethnic Group: White
Officer: Chairperson
Hispanic or Latino (of any race): Yes

Representation: select all that apply:

Mental Health
☐ Consumer
☐ Family Member
☐ MH Professional
☐ Psychiatrist
☐ Other Physician

Alcohol Other Drug Addiction
☐ Consumer
☐ Family Member
☐ Professional
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Board Name		Date Prepared
Board Member		Appointment: ODMH; Sex: Female; Ethnic Group: White
Mailing Address (street, city, state, zip)		Officer: Chairperson; Hispanic or Latino (of any race): Yes
Telephone (include area code)	County of Residence	Representation: select all that apply:
Occupation		Mental Health: ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Term Partial Term	Year Term Expires 2008	Alcohol Other Drug Addiction: ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate

Board Name		Date Prepared
Board Member		Appointment: ODMH; Sex: Female; Ethnic Group: White
Mailing Address (street, city, state, zip)		Officer: Chairperson; Hispanic or Latino (of any race): Yes
Telephone (include area code)	County of Residence	Representation: select all that apply:
Occupation		Mental Health: ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Term Partial Term	Year Term Expires 2008	Alcohol Other Drug Addiction: ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate

Board Name		Date Prepared
Board Member		Appointment: ODMH; Sex: Female; Ethnic Group: White
Mailing Address (street, city, state, zip)		Officer: Chairperson; Hispanic or Latino (of any race): Yes
Telephone (include area code)	County of Residence	Representation: select all that apply:
Occupation		Mental Health: ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Term Partial Term	Year Term Expires 2008	Alcohol Other Drug Addiction: ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate

Board Name			Date Prepared
Board Member			Appointment: ODMH; Sex: Female; Ethnic Group: White Officer: Chairperson; Hispanic or Latino (of any race): Yes
Mailing Address (street, city, state, zip)			Representation: select all that apply:
Telephone (include area code)	County of Residence		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Occupation			Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate
Term Partial Term		Year Term Expires 2008	

Board Name			Date Prepared
Board Member			Appointment: ODMH; Sex: Female; Ethnic Group: White Officer: Chairperson; Hispanic or Latino (of any race): Yes
Mailing Address (street, city, state, zip)			Representation: select all that apply:
Telephone (include area code)	County of Residence		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Occupation			Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate
Term Partial Term		Year Term Expires 2008	

Board Name			Date Prepared
Board Member			Appointment: ODMH; Sex: Female; Ethnic Group: White Officer: Chairperson; Hispanic or Latino (of any race): Yes
Mailing Address (street, city, state, zip)			Representation: select all that apply:
Telephone (include area code)	County of Residence		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician
Occupation			Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate
Term Partial Term		Year Term Expires 2008	

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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
Christian Oberlies	CCI PO Box 817	West Liberty	43357	937-465-8065	coberlies@ccibhp.com

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
Christian Oberlies	CCI PO Box 817	West Liberty	43357	937-465-8065	coberlies@ccibhp.com

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
Jeannie Dempster	CCI 118 Maple Avenue	Bellefontaine	43311	937-599-1975	jdempster@ccibhp.com

Form 3

Planned State Inpatient Bed Days

BOARD NAME **2009 Planned Use of State Inpatient Days**	
Northcoast-Toledo	0 at Northcoast
Northcoast-Toledo	
Northcoast-Toledo	
Northcoast-Toledo	
Total Inpatient Days	

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 Logan and Champaign (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: ______________________________
David Higgins (Name)
Executive Director
Logan and Champaign (Board)

Date: 3-11-08