III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

Click on box to enter Board name.

BOARD NAME: Tri-County Board of Recovery and Mental Health Services

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

Click on gray box to enter text.

MISSION STATEMENT: The Tri-County Board of Recovery and Mental Health Services is dedicated to planning, funding, monitoring, and evaluating substance abuse and mental health services for Darke, Miami, and Shelby Counties; working diligently to see that the services are cost-effective and of the highest possible quality; informing the community about these services; and ensuring that people have access to them.

The Board is in the midst of a strategic planning process which will include the development of vision and value statements.

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.

Our MACSIS business rules makes all medically necessary services available to adults and children/adolescents on a sliding fee scale who do not qualify for third party insurance such as Medicaid. All non-medicaid services are included except for certain services provided within the state hospital (crisis intervention, pharmacological management, individual/group counseling, and group CPST). In order to facilitate discharge planning and treatment coordination our business rules allow for phone CPST and face to face CPST at the state hospitals.

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

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

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

Click on gray box to enter text.

The Board's significant support of its consumer-operated center is a strong commitment to recovery. SafeHaven is introducing supported employment to its mix of services, which already includes WRAP and BRIDGES training. The Board's emphasis on community decision-making within the FAST $07 and ABC programs empowers resiliency within families as well.
All CMHCs have adopted the SOQIC forms (paper or electronic), which focus on and integrate recovery/resiliency issues within assessment and treatment.

The Board is just completing the information gathering phase of a broad strategic planning process which will likely extend into FY08. The information we are currently collecting will be used to shape new programs and policies as well as monitoring and evaluation procedures to ensure that services provided increase consumers' empowerment and quality of life.

The agencies within the Tri-County Board have eagerly embraced numerous recovery supports to also enhance the empowerment and quality of life for consumers. SafeHaven Inc., the local consumer operated service organziation has been in operation within Miami County since 1996; in 2000 it expanded its services into Darke and Shelby County. It currently operates sites in Miami and Darke County and has plans to open a site in Shelby County during SFY 09-10. The Miami County site serves consumers from Shelby county offering free transportation on a daily basis. SafeHaven offers the WRAP Bridges training two times per year (once at each site) to its members. Other recovery supports offered at SafeHaven include ongoing individual and group vocational training, GED classes, and the Lifestyles of Wellness group based on the Team Solutions curriculum created by the Eli Lilly and Company. The organization also offers peer support training. In 2002, SafeHaven Inc.received the Consumer Operated Service Center award from the Ohio Advocates for Mental Health. In 2006, SafeHaven Inc. received the 2006 Lilly Reintegration Social Support Award for their continued support of mental health consumers in the local communities.

Community Housing Inc., the local housing agency for mental health consumers, operates 2 gender specific supportive (congregate) houses, 4 cooperative apartments providing independent housing for 20 mental health consumers, and offers approximately 20 subsidies for independent apartments in the three counties. This continuum of housing services allows for the least restrictive placement for the mental health consumers served in the Tri-County area. The 3 local mental agencies provide monitoring and assistance to the consumers served by this agency.

NAMI of Miami Co, NAMI of Darke Co, and NAMI of Shelby Co. each facilitate an annual offering of the Family to Family curriculum. In addition to offering the curriculum, NAMI of Miami facilitates a support group for parents that is open to residents of all three counties.

In late 2006, the Tri-County Board partnered with the ODMH initiative for the Network of Care interactive website which contains information and tools for community members regarding behavioral health issues and available treatment in the local areas. To date all agencies receiving financial support from the Tri-County Board support the network of care website with updated information regarding services in the local area.

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.

20 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.

18 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.

25 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.

Per Ohio's SFY 2007 Homeless Housing Status NOM the Tri-County area served 23 adults with SMI. This number appears low when compared to the number of adults with SMI served through our homeless community outreach program, PATH. According to SFY 07 data, the PATH program completed 105 screenings for homeless adults with SMI.

When compared to the data collected through MACSIS by the Board and summarized in the Board's Executive Summary of the Quality Improvement report for FY 2007 there were 232

identified homeless adults who received mental health services in the Tri-County area. Per data collected through MACSIS and summarized in the 1st Quarter FY08 QI report there were 59 identified homeless adults who received mental health services. One possible reason for the increased numbers in the QI report is the data collected for the Board's QI report does not separate out duplicated individuals and does not track specifically which of these adults would meet criteria for having severe mental illness.

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.

105 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.

Community Housing Inc., the local housing agency for mental health consumers, operates 2 gender specific supportive (congregate) houses, 4 cooperative apartments providing independent housing for 20 mental health consumers, offers approximately 20 subsidies for independent apartments in the three counties and provides funding for approximately 12 adult care transitional facility placements. This continuum of housing services allows for the least restrictive placement for the mental health consumers served in the Tri-County area. The 3 local mental agencies provide monitoring and assistance to the consumers served by this agency.

Community Housing, Inc. is nearly every month at full capacity. With waiting lists up to a year or longer for public housing assistance, affordable, adequate, and appropriate housing continues to be a significant barrier for adults with SMI in terms of their recovery.

The Board has applied for ODMH capital grants for SFY 11-12 to purchase/renovate 4-6 existing apartment units in Shelby County as well as a capital grant for SFY 13-14 for new construction of a residential facility for the tri-county area.

The current grants applied for by the Tri-County board on behalf of contract agencies include:

1. Community Housing was awarded $121,500 through the Ohio Department of Development Homeless Assistance Grant Program. In addition, $18,000 in match funding for the Transitional Housing Program was awarded from ODMH. The 2-year program period is January 1, 2007 –

December 31, 2008.

2. Two homelessness prevention activities were funded through the Homelessness Prevention Grant: the Tri-County Transitional Housing Program and the Tri-County Homelessness Prevention/ Emergency Assistance Program. Descriptions of each follow:

2a. Tri-County Transitional Housing Program
The Transitional Housing Program provides homeless mentally ill individuals and their families with a safe living environment while supportive services assist program participants in working toward stable and permanent housing. This program is provided through the six congregate homes operated by Community Housing (the homes are owned by the Board). Each congregate home, regardless of physical location, serves the entire tri-county region and is open to residents of Miami, Darke or Shelby Counties, though site preference is given to the home county of the program participant. To meet an increasing need of the mentally ill homeless population, Community Housing recently modified the Tri-County Transitional Housing Program to serve mentally ill homeless adults with children and designated two of the six congregate homes for use by families. Each designated family home is considered one unit and offers three bedrooms that can house a family of up to 4. The remaining congregate homes serve from 3 to 4 individuals per home: 1 male home (4 beds), 1 female home (3 beds), and 2 co-ed homes (7 beds) serving both men and women. Total capacity for the Tri-County Transitional Housing Program is 16 units. Community Housing provides household furnishings and items for each home including bedding, towels, paper products, and cleaning supplies, as well as supplying each home with a telephone, telephone service and laundry facility. Residents in the independent-living homes share a common living area, kitchen and bathroom, though each resident has their own private, secured bedroom. During their stay, residents are required to receive mental health services and community support services from the local mental health center. Residential Coordinators oversee the homes and ensure that the integrity of the program is being maintained. During weekly visits, the Residential Coordinators talk with the residents and verify that treatment and supportive services are in place and that they are moving toward achieving permanent housing. To be eligible for assistance through the program, a person must be homeless, severely mentally disabled, 18 years of age or older and a resident of Darke, Miami or Shelby Counties with a household income that falls at or below 35% of the area median income. The program also serves families in which at least one adult member experiences a severe and persistent mental illness with a household income that falls at or below 35% of the area median income. All participants will be referred to the program through the local mental health center at which they are receiving treatment. Therefore, the program does not accept self-referrals.

2b. Tri-County Homelessness Prevention/Emergency Assistance Program
The Homelessness Prevention/Emergency Assistance Program provides emergency cash assistance to those in jeopardy of losing their permanent housing. The program also provides assistance to current homeless persons in need of a down payment, deposit for utilities, etc. to obtain permanent housing. The Tri-County Homelessness Prevention/Emergency Assistance Program is the only program of its kind in the tri-county area that is specific to preventing homelessness among the mentally ill population. It is anticipated that the Tri-County Homelessness Prevention/Emergency Assistance Program will provide emergency assistance to 75 SMD adults and families that are at or below 35% of the area median income and at risk of eviction or foreclosure due to the inability to pay rent or utilities. The program will also assist SMD homeless persons in shelters and transitional housing obtain permanent housing by providing them with first month's rent and security deposits to help homeless persons establish housing. Once the housing is established, supportive services provided by Community Housing will connect the individual with housing subsidy, employment,

benefits and other social service agencies. The program will provide emergency rental assistance for a maximum of three months or until temporary or permanent housing subsidy is obtained, whichever is first. The fundamental goal of the Tri-County Homelessness Prevention/Emergency Assistance Program is to provide assistance to prevent homelessness for SMD adults and families who are ineligible to receive financial assistance elsewhere. In addition to preventing homelessness, a primary goal of the emergency assistance program is to promote reunification of families and prevent families from being separated (i.e. the removal of children from the home/parents) due to eviction or foreclosure. In some cases, behavioral health services to assist in stabilizing the family will be provided through the local family stability/diversion team process and Access to Better Care funds. Community Housing will work with the Family and Children First Councils, mental health agencies and other community partners in all three counties to coordinate services and to identify families and individuals at risk and in need of this type of assistance.

3. The Tri-County Board received $122,280 from the US Department of Housing and Urban Development for a Tenant-Based Rental Assistance (TRA) Program. The TRA program provides housing and supportive services on a long-term basis for homeless severely mentally disabled (SMD) adult individuals, both male and female, in Miami County. The grant project period is 5 years commencing on July 1, 2005.

Community Housing is the lead agency responsible for administering the TRA program rental assistance and coordinating the acquisition of safe, affordable housing and supportive services for the homeless SMD clients referred to the program. The program will provide rental assistance to 5 homeless SMD adults in Miami County for five years. Eligibility criteria for the program include: homelessness, diagnosis of a severe mental disability, resident of Miami County, 18 years of age or older, current status of receiving case management services from the local mental health center, and the capability to live independently. Once placed on the program, the participant will be offered continued mental health treatment, case management, and other supportive services through the Miami County Mental Health Center, a provider agency of the Tri-County Board. Though the Tri-County Board cannot require the participants to receive mental health services through the mental health center, continuation of treatment and further care will be highly encouraged.

4. The Tri-County Board of Recovery and Mental Health Services received funds in the amount of $75,858.00 from the Ohio Department of Mental Health to work jointly with three Adult Care Facilities to improve the quality of the homes, increase community integration and service availability to the residents and to increase involvement of the Tri-County Board with local ACFs. The three homes funded through the grant, located in Piqua, Greenville and Dayton, have seen exceptional results with the grant and were able to make significant modifications to the homes due to the funding. The home renovation projects included new windows, concrete work, new heating/cooling systems, bathroom/ kitchen modifications and the purchase of new living room and bedroom furniture. The homes were also able to increase service availability and community integration by purchasing a 15-passenger van, providing transit tokens for their residents, purchasing YMCA memberships and going on outings such as baseball games, other sporting events and recreational activities.

5. The Tri-County Board of Recovery and Mental Health Services has a contract with the Darke Co. Commissioners to purchase 8 respite beds per day at the Darke Co. Home. The Respite program serves all 3 counties. It provides mental health consumers who are in need of a safe living environment a temporary residential housing alternative that provides daily structure and

supervision. While at Respite, the consumers have access to intensive community support services, outpatient therapy, medication monitoring, groups and educational sessions. The Respite program is designed to give consumers an opporutnity for mood & behavior stabilization, increase access to resources, time to find appropriate housing, establish positive social skills, and develop self sufficiency. Frequently, respite stays are arranged to either avoid pyschiatric hospitalization or as a transition from a psychiatric hospital back into the community. A stay can range from a couple of days up to a couple of months.

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.

Per Ohio's SFY 2007 Employment NOM there were 515 adults with SMI who were employed either part or full time. This appears to be an accurate reflection of the number of such individuals served by the Board in SFY 2007.

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.

SafeHaven inc., operates a consumer business, Food for Thought, which provides catering services to groups and businesses in the local community. This business employed 15 consumers in SFY 07 and earned $4300.00. SafeHaven also operates a supported employment program with one vocational specialist who works specifically with adults with SMI to assist them in finding,

obtaining, and maintaining employment.

In FY 08, SafeHaven began a new partnership and intersystem collaboration effort with Darke Co. and Miami Co. Department of Job and Family Services. The local DJFS had recognized that many of the individuals in the Work Experience Program (WEP) were not doing well to "earn" their "volunteer" work hours due to mental illness and this was negatively effecting the individuals ability to continue receiving their benefits from DJFS. The partnership between Safehaven (the consumer operated center) and DJFS allows those with verified mental illnesses to earn their mandatory "volunteer" hours at Safehaven were they learn vocational skills by doing job tasks as well as have the opportunity to learn coping skills in living with their mental illness through attending classes at Safehaven about mental illness & recovery. To date the collaboration has been very successful leading to several of the participants being hired as staff at the two Safehaven sites.

All contracted agencies make referrals to the Rehabilitation Services Commission for qualified adults with SMI who wish to seek employment. Miami Co. Mental Health Center has partnered with Eastco Enterprises to provide a vocational specialist 32 hours per week to work specifically in finding employment or job training for adults with SMI. The vocational specialist's services are paid for by BVR to Eastco Enterprises. The specialist provides job evaluations, job development and placement services. If needed, the specialist refers them for job coaching services. CPST staff at the three mental health centers have received training regarding the importance of evaluating a consumer's willingness and readiness to seek vocational training and/or employment and when appropriate adds such goals to the client's individual service plan.

Presently, Miami County Mental Health Center is beginning to research the cost and impact of adding a peer support specialist to their ACT team.

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.

Catholic Social Services (CSS) is a receipent of the ODMH early childhoold mental health intervention grant. They provide the "Incredible Years" parenting curriculum in Shelby County and Darke County in partnership with the local MRDD agencies. They are working on expanding this curriculum offering to the residents of Miami County in early 2008. A weekly parenting support group for parents of children with disabilities is offered in Shelby County but open to all residents living in the Tri-County area. CSS is hosting parenting presentations in all three counties to address "Praise and Play" and "Dealing with a Child's Challenging Behavior". DECA assessments are available for all infants and children through age 6 in partnership with the local MRDD agencies.

Through this grant, CSS has been able to establish and maintain ongoing collaboration with the local Family and Children First Councils.

The Tri-County board provides the majority of funds for youth diversion programs. All three counties have active youth diversion programs funded primarily with ABC, FAST, and local levy dollars whose mission is to reduce foster and residential placements of juveniles by providing comprehensive coordinated services within their communities. These teams have been successful at providing a variety of wraparound services including respite, in home based therapy, parental coaching, and parenting classes. Through extensive efforts to partner with other community partners (e.g. CSB, Juvenile Court, FCFC) over the past 5 years we have been able to offer a deeper and richer variety of services to at risk youth and their families.

In Darke County, the Intersystem Diversion Team (IDT)'s mission is to be a value-driven service commitment to the family to improve quality of life and reduce stressors so parents can focus on the needs of their children. It is a collaboration between Darke County Education Service Center, Health Department, Job and Family Services, Juvenile Court, Mental Health Clinic, MR/DD Board, Recovery Services, Family Health Services Inc., Gateway Youth Programs/CORSP, Greenville Schools, Family and Children First Service Coordinator, IDT Facilitator, and the parent/legal guardian. The IDT process provides: Risk Assessment; Identification of relevant resources; Development of a Family Service Plan with recommended interventions and individuals responsible;Service Coordination to team and family members; Wrap-Around support with flexible funds; and Promotion of active family participation in problem-solving. A Family Service Plan is written with the parent during the meeting. Responsibility for recommended interventions and time frames to address the recommendations are identified on the FSP. The IDT Facilitator contacts the parent when the referral is received to schedule the core team meeting; to review the consent to share information and to review parent concerns, needs, and strengths. Composition of Family Team meetings is identified at the core team meeting. Family teams include the parent, direct services and family support system. The IDT has produced the following outcomes reduced placements, increased collaboration among local service providers, increased local service to families, and increased intersystem training opportunities which has maximized use of local dollars. Flexible funds, which are pooled funds from 6 local agencies over the last 10 years, can be used to access help with wrap around services (housing, medical care, food, transportation, treatment, respite care, etc) that support children remaining with their families in intact homes. The team also has access to a residential facility, Michael's Resource Center, for up to 7 juvenile males which as lowered the need for out of county placement. IN SFY 07, the IDT team served 238 children in 98 families. Only 4 of the families involved in IDT ended in out of home placements (a total of 7 children total for the year).

In Miami County, the Family Stability team is comprised of the Family Stability coordinator and case manager, Miami Co. CSB, Juvenile Court, Miami Co. Job and Family Services, Gateway Youth Programs/CORSP, Riverside MRDD (when requested) the Health Department (when requested), and a parent/legal guardian. The goal of Family Stability is to prevent out-of-home placements. The program provides risk/needs assessment, case coordination, family support, family preservation services (respite care and therapist recommneded activities), and transporation services. The Family Stability coordinator completes an initial assessment with each family who is usually referred by family physicians, school personnel, therapists, Children Services, or Juvenile Court personnel. After the assessment, the team in conjunction with the parents/legal guardian develop an intervention plan. The Family Stability coordinator monitors the family to ensure referral to services is obtained as well as access to wrap around services including in home parental coaches, a parent advocate, parenting classes, and limited planned respite care. Depending upon the

severity of the challenges facing the youth and family, the Family Stability team will meet regularly every other week for 4 to 8 weeks to ensure all supports are being provided to the family to reduce the likelihood of a placement. In SFY07, the Family Stability team was successful in reducing out-of-home placements by 16.6%.

In Shelby County, the Diversion Assessment team is comprised of a MRDD support services assistant, Shelby Co. School & Court Liason, Intensive Children's Community Support Specialist from Shelby Co. Counseling, an outpatient therapist from Catholic Social Services, an advocate from the Gateway for Youth Program (Council on Rural Services), the Director of Special Education from Sidney Local Schools, the Chief Probation Officer from Shelby Co. Juvenile Court, the project director from the Help Me Grow program at Shelby Co. Health Department, the Shelby Co. Children Services Administrator, and the director of Family and Children First Council. The mission of the collaboration is to prevent a referral to Children's Services and keep families together by providing necessary wraparound family centered services for at risk children who without intervention would likely be removed from their home. The services include respite, in home coaching, academic tutoring, transporation, therapeutic services, parenting, and at times childcare when funding permits. In FY 07, the team served a total of 41 new families bringing the total # of families served during the fiscal year to 107.

The board funds a grant to Shelby County Educational Services Center for 1.0 FTE position in the alternative school. This position offers a variety of behavioral health services including crisis intervention and after school intervention groups for youth and their families who have been referred by juvenile court.

Our local NAMI group has sent a representative recently to become certified in NAMI Hand to Hand. The group is hopeful to offer the NAMI Hand to Hand training in SFY09 for the first time in our board are. One challenge is how to provide childcare during the training.

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.

We believe that 30 children/adolescents identified in Appendix B accurately reflects the number of SED children/adolescents who have been suspended or expelled in SFY 07 in our service area.

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.

	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	1750	1750	91	112	
Private Psychiatric Hospitals: Adults	288	292	213	301	
Private Psychiatric Hospitals: C&A			0		

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

Click on gray box to enter text.

The Tri-County Recovery and Mental Health Board purchases private psychiatric bed days for indigent clients regardless of age through a contract with UVMC Dettmer. This is a single contract that can be used in any combination between children, adolescents, and adults. We are fortunate to have a good working relationship with this one local private psychiatric hospital in our board area and therefore are able to deter many inpatient hospitalizations from the state hospital for adults as well as reduce the number of out of county placements for children and adolescents. In FY 2008, the board increased its allocation for indigent bed days from $150,000 to $175,000 but unfortunately the per diem rate went from $520 to $600 per day so we weren't able to significantly increase the number of purchased bed days for the system.	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.

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

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

Click on gray box to enter number.

105C&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.

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.

Although the number of requests has remained consistent from FY to FY such initiatives as FAST and ABC has encouraged other community partners to work in collaboration with one another within all three FCFCs in our Board area. We have seen a trend regarding increased acuity and complexity of the children we are serving. The children requiring residential treatment often are experiencing more serious symptoms with levels of functioning and more greatly impaired, necessitating longer stays. If placements continue at the current rate for FY 08 we project we will see an increase in placements by 23% (estimted total placements 128).	**5.e**

6. Crisis/Emergency Care.

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

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

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

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

Click on gray box to enter number.

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

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

Click on gray box to enter text.

The Crisis Care system is being reviewed during the current strategic planning process with the intent of addressing concerns that the consumers, families, and local community stakeholders identify. Othe crisis services delivery methodolgies will be reviewed. The lack of available new funding will greatly hamper any ability to implement a dramatically

different process.

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

1. Police Coordination/CIT

Click on gray box to enter text.

The Tri-County board has been successful in creating a diverse advisory committee for our CIT Academy. This partnership between six police departments, two sheriff departments, local community mental health agencies, county probation departments, county jails, the crisis center, the consumer operated service organization, family members, consumers, and the Board has created an unprecedneted collaborative in our Board area to best met the needs of SMI adults and SEDchildren/adolescents when they have interaction with the law enforcement community. The advisory committee has been active in developing a curriculum to meet the indivdiualized needs of the law enforcement officers serving in the three county area. To date, twenty three law enforcement officers, three sheriff deputies, three probation officers, and three professionals working in or with the criminal justice system have successfully graduated from the Academy. The Board has an upcoming academy scheduled for April 2008 and is committed to continuing this academy at least annually.

2. Disaster Preparedness

Click on gray box to enter text.

The Tri-County Board has utilized previous HRSA funding to train a core group of 33 behavioral healthcare and county government professionals in disaster response focused on behavioral healthcare needs during and following an incident. The Board has worked with its local county EMA directors to include behavioral healthcare response in each of the three county disaster mobilization plans. We do have two professionals who have completed the American Red Cross trainings in Disaster and Bio-Terrorism training.

There are barriers in deploying our professionals who are already trained. These barriers have arisen because the state-sanctioned training does not correspond to the disaster mentalh training sanctioned by the American Red Cross (which is the authority that activiates the Disaster MH response within our counties according to each county disaster plan), and neither entity recognizes or credits the training provided by the other body. We hope to partner with the local chapters of the ARC and the Miami County Mental Health Association to offer additional training to our existing pool of 33 providers as well as other interested behavioral health professionals in our service area to increase the of available disaster mental workers in FY 09.

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	33	1	

Currently Available	33	1	

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

Click on gray box to enter text.

The one local post secondary college, Edison Community College, in the 3 county area has agreed to send its director of security and one of their officers to the upcoming CIT Academy in April of 2008. This will be a starting point for the college to begin addressing behavioral health disaster response. The Board will continue to communicate regularly with the college's security team about local opportunities for training and participation in the CIT academy.

Within our Board service area there are 26 individual school districts. The Board has materials available at no cost to the schools regarding disaster planning and behavioral needs during a disaster. Due to the Board not being a direct service provider, each of the local community mental health centers have developed working partnerships with the school districts in their county. The CMHCs are contacted directly by the school districts as needs arise. The services most frequently requested are grief counseling, crisis services after a trauma, and debriefing of school personnel after a disaster.

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.

The Board contracts for intensive CPST services in 2 of the 3 counties for a total of 3.0 FTE positions. The caseloads for these positions are slightly higher than the recommneded 15 consumers per ODMH defintion. The caseloads average 20 consumers per caseload with minimum contact of 1x per week ranging up to 3-5x per week. One agency has begun utilizing their 2 intensive CPST positions almost entirely to serve the dual diagnosis population as part of a quality improvement plan.

In addition, one of the CMHCs has an ACT team. They have completed their fidelity assessment trhough the ACT CCOE as part of their ongoing quality improvement. This team serves 25 - 30 consumers and they have plans to increase this capacity 1-2 clients per month after a recommnedation from the fidelity assessment. Complete fidelity with the ACT model has been difficult for several reaons: 1) vocational services are not medicaid reimursable; 2) securing funding for a peer support specialist position; and 3) integrating substance abuse services into the team. Recently the agency was able to bring a licensed independent chemical dependency counselor to the team and will continue to train other team members on substance abuse issues.

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.

The Board's focus has been to increase the access to intensive home based treatment which creates alternatives to child placement in local and out of county systems of care. We partnered with two contract agencies in completing request for proposals for the ODMH County-Specific Intensive Home Based Treatment grant. One of the agencies, Darke County Mental Health, was chosen and began receiving funding January 2, 2007 for an 18 month period. This funding will expand these intensive outpatient servcies to 95-100 youth within 30-35 families in Darke County. In addition, the agency will become an ODMH certified provider of IHBT.

Miami County Mental Health Center has a contract with Miami Co. Children Services Board to provide in home therapy and CPST. The agency is not currently certified by ODMH to provide IHBT but is interested in further review of the new IHBT standards to determine what they would need to provide in order to be certified. At present, the agency has 1 FTE therapist and 1.375 FTE CPST through the Miami Co. CSB contract providing in home services for at risk youth and their families. In FY 07, the agency was able to provide in home therapy to 54 youth and their families.

Shelby Co. Counseling Center partners with their local Family & Children First Council to provide intensive wraparound services, specifically intensive CPST services, to at risk youth and their families. Through the local FCFC, in home parental coaching is available to at risk youth and their families. The agency also applied for the ODMH grant to establish IHBT services but were not chosen. The agency is committed to further discussion for SFY09 on how they can begin providing this therapy in collaboration with FCFC.

See response for 3.0 Resiliency Supports regarding diversion teams and their ability to provide

intensive outpatient services to the most at risk children and adolescents in our system.

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.

All of the identified services above for routine outpatient care are a focus of our Board. As part of the Board's commitment to quality improvement we require contract agencies to report quarterly: waiting list management, peer review, utilization review, major unusual incidents, client rights/grievances, client satisfaction, referral source satisfaction, and prevention satisfaction. One time per year each agency must collect information on provider satisfaction. On a quartely basis, the Board compiles this information into a quality improvement report and presents the findings to their Board of Directors and contract agency administrators. During those board meetings there are

extensive discussions regarding the challenges our area faces including but limited to the shortage of psychitric staff and the recruitment and retention of qualified behavioral health professionals.

In terms of access and capacity, the Board monitors the amount of wait time between an initial request for services and the date of the appointment; the benchark is within 7 days of request. With such a fluid movement of consumers initiating and terminating services, agencies at times have challenges in responding quickly to access and capacity demands due to availibility of staff.

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.

Please refer to response in 7.b.2

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.

Please refer to response in 3.0 re: youth/adolescent diversion teams in the 3 counties
Please refer to response in 7.a.1 re: ACT team
Please refer to response in 7.a.4 re: IHBT services

In Miami County, Miami County Mental Health Center and Riverside(the MRDD Board) have partnered to create a collaborative for adolescent and adult consumers who are dual diagnosed. The collaborative meets monthly with the consumer, family members (if appropriate), and providers from both agencies to coordinate service delivery and resolve any challenges the consumer is facing in terms of access to services.

8. Staff Capacity & Workforce Development.

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

Click on gray boxes to enter number of FTEs.

Pharm. Management Practitioner FTEs:*	2.92	**8.a**
CPST FTEs:	17.5	
Counselor/Therapist FTEs:	17.10	

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

Click on gray boxes to enter number of FTEs.

Pharm. Management Practitioner FTEs:*	0.82	**8.b**
CPST FTEs:	4.91	
Counselor/Therapist FTEs:	4.80	

*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.

Our Board applied for and was approved for HHS Mental Health Professional Shortage Area classification in October of 2005 through 2009. This allows us to qualify for J-1 visa waivers and NHSC loan repayment slots for qualified professionals (MDs, PH.Ds, and LISWs). Three of the local agencies have been approved as sites for qualified professionals. We were able to secure 1 psychiatrist under the visa waiver program and retain 2 psychologists under this program for our Board area. The agencies have been notified of the request for applications for the 2008 NHSC loan repayment cycle.

9. Inter-system Collaboration

a. Discuss achievements and trends in the following areas.

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

Click on gray box to enter text.

Board has provided training for MH and CJ personnel in system coordination and has successfully offered the CIT Academy twice. The CMHC in Shelby County has an assigned liaison staff working with the Municipal Court with both MH and AoD offenders.

Miami Co Mental Health Center currently has a contract with the Miami County Commissioners to provide mental health assessments and liason services (consulation) for court referred individuals. In FY 07, seven assessments were completed as well as 7 hours of consulation were provided.

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

Click on gray box to enter text.

The CMHC in Darke County is sharing a liaison staff with the Juvenile Court to enhance and

coordinate services. Other CMHCs provide referral and follow-up services. The CMHC in Darke County has partnered with the ODADAS-certified agency there as well as with Juvenile Probation to offer an after-school therapy program 5 days per week for both adjudicated adolescent males and females. All CMHCs collaborate to offer MH assessment services as needed to allow the court to impose conditions for treatment rather than incarceration or community control where appropriate.

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.

We have provided funding to provide on site mental health assessments and crisis services in the three county jails in our area. The Tri-County Crisis Center provides crisis mobile mental health assessments for 2 of the 3 local jails on a 24/7 basis; the third county jail chooses to contract directly with their local community mental health center for mobile mental health assessments. The Crisis Center averages 55 mobile mental health assessments per year in the jails. In addition, the Crisis Center provides four hours per week of crisis intervention services at the Miami County.

We have offered access to Central Pharmacy to all three jails for inmates known to have a history of mental illness. We have contracts with 2 or the 3 jails who utilize Central Pharmacy to provide medications to inmates who are in need of psychotropic medications. The third county jail has yet to this point utilized Central Pharmacy services although we have offered to provide access for them.

2. Detention Centers

Click on gray box to enter text.

We have offered to provide access to medication somatic services to the one juvenile detention facility in our area but they have chosen not to contract with us. Miami County Mental Health Center has one contract position for a mental health therapist at this detention service.

2. Homeless, Runaway & Domestic Violence shelters

Click on gray box to enter text.

The homeless and domestic violence shelters in our Board area work directly with our contract agencies in order to ensure their consumers have access to necessary behavioral health services. There are no runaway shelters in our tri county area.

3. Nursing Homes

Click on gray box to enter text.

Nursing homes in our Board area work directly with our contract agencies in order to ensure their consumers have access to necessary behavioral health services.

4. Prison Reentry

Click on gray box to enter text.

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

Click on gray box to enter text.

Physician private offices and local hospitals work directly with our contract agencies in order to ensure their consumers have access to necessary behavioral health services and that services are integrated to best meet the needs of the consumers.

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 has contracted with the Suicide Prevention Coalition to provide suicide prevention services to the tri-county area. The Coalition organized with a common belief and concern that not enough was being done in our local tri-county communities to bring the tragedy of suicide, particularly youth suicide, to the forefront. In keeping with the mission of the Coalition to become a foundation in which local community partners can turn to for resources focusing on the prevention of suicide, the Coalition applied for and received funds from the Ohio Department of Mental Health and the Tri-County Board of Recovery & Mental Health Services for the purchase of educational and outreach materials including various booklets on suicide prevention and depression as well as a 5-day suicide prevention curriculum for tri-county area high schools. The materials are available at the Board Office for Mental Health Professionals, teachers, clergy, law enforcement and other community partners. In addition to providing outreach materials, the Coalition also strives to promote local resources and encourage individuals to seek help when faced with difficult times or thoughts of suicide. Future projects of the Coalition include suicide prevention training for teachers and gatekeepers for the elderly population.

Please also refer to responses in section 3 "Resiliency Supports"

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

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

Click on gray box to enter text.

The Board as part of our quality improvement plan requires that all contract agencies complete quarterly consumer satisfaction surveys. The Board is committed to cultural competency and will be hosting a half day cultural competnency training for all service professionals in the late spring of 2008. Regarding staff recruitment, see answer provided in 8.c

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.

The recent announcement by Governor Strickland of the closing of Twin Valley Behavioral Health (Dayton) will cause hardships and added expense for patients, families and communities. Of particular concern is the shift of burden to local law enforcement (transport), families (travel expense and time), community mental health centers (case management), emergency rooms and private psychiatric units that are not equipped to deal with the needs of state hospital patients. Additionally, access to state hospital beds will become more difficult despite the announcement of the opening of closed units at specific hospitals. Overall, it appears that there will be a reduction of about 44 state hospital beds across the state. In 2007, 59 patients were served from Miami, Darke or

Shelby Counties. Twin Valley is approximately a 30 to 45 minute drive from anywhere in the tri-county area (Miami, Darke, Shelby). The Tri-County Board has been reassigned to the Toledo hospital which is approximately 2 ½ hours away from the tri-county area. Law enforcement officials will be required to travel the five hour round trip plus the medical clearance and crisis screening locally which will result in officers being absent a full shift from their community. In some cases off duty officers will be called (overtime) or a second officer will need to ride along for support. The added cost and time commitment threatens and creates a disincentive for the diversion process created by the tri-county CIT partnership between law enforcement and the behavioral health system. It will become easier to arrest and jail than to divert and treat. Family members will endure additional hardships in cost and time to visit and support their loved ones. Case managers will have additional unproductive travel time which increases cost and takes them away from other clients in need. Of additional concern, is that the local systems were given no opportunity for input into the decision and little time to plan for its impact.

C. Needs Assessment.

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

Click on gray box to enter text.

The Board has developed a the philosophy of continuous quality improvement to ensure performance improvement to the system in full. This philosophy is adopted from the work (i.e. Demming) and recommended practice towards Continuous Quality Improvement.

Annually, contract agencies complete consumer satisfaction and referral source satisfaction surveys which provides information to agencies as well as the Board regarding current needs, trends and patterns in the community as seen by consumers and referral agencies. In addition, the contract agencies are required to complete utilization and peer reviews, waiting list management, and prevention satisfaction surveys on a quarterly basis.

The Board has contracted with Wright State University Center for Urban and Public Affairs to conduct a strategic planning process and is in the midst of this process. The strategic planning process is to include all partners within our three county region including consumers of behavioral health services and their families, providers of services, elected officials, partner social service and County agencies such as Children Services, MR/DD Boards, Schools, Courts, Law Enforcement and others.

To date, the Center for Urban and Public Affairs has conducted quantative datat collection and analysis including nine focus group sessions held across Darke, Miami, and Shelby counties, as follows: community open forums in Darke, Miami, and Shelby counties; Family and Children First Council sessions in Darke, Miami, and Shelby counties; SafeHaven (the consumer operated service organization) in Darke and Miami counties; and a County Commissioners Joint Session in Darke, Miami, and Shelby counties.

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.

The Board has contracted with Wright State University Center for Urban and Public Affairs to conduct a strategic planning processand is in the midst of this process. The strategic planning process is to include all partners within out three county region including consumers of behavioral health services and their families, providers of services, elected officials, partner social service and County agencies such as Children Services, MR/DD Boards, Schools, Courts, Law Enforcement and others. To date the Center for Urban and Public Affairs has completed its qualitative collection of data. From the analysis of the data, there appears to be preliminary themes emerging regarding future service availibility and provision within the Board area. The eight prelimary themes are: mental health workforce development; shortages in trained behavioral health professionals including psychiatrists; shortages in infrastructure (e.g. residential treatment); system alignment including how to strength partnerships with other community stakeholders (ODJFS, law enforcement); lack of mental health services available in schools as well as overall concerns about the system being able to serve effectively the increasing number of children/families in need of services; how to combat stimga within the community; how to protect funding for core mental health services while facing rising costs of out of county placements and increasing dollars going to Medicaid match; and how to estimate the hidden costs of providing mental health services, such as the cost of police officers escorting mental health patients to hospital ERs.

Further qualitative analysis will need to occur in order to confirm the preliminary quantitative findings are supported by numerical data before goals and strategies can be developed for the Board area. At this time, the Board wishes to wait until the end of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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: Medium

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

1. Improve understanding about the vocational services available, such as BVR and county job centers, to adults with SMI in each county

2. Improve consumers knowledge about how seeking employment will affect their benefits including medicaid, food stamps, SSI/SSDI, rental subsidies

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

1. Develop and distribute an informational handout regarding available vocational resources in the tri-county area

2. Host a open forum panel discussion where consumers can hear representatives from SSA, ODJFS, Metropolitan housing speak about how employment positively impacts them

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

Consumers will report increased understanding about vocational resources available to them

Consumers will report increased knowledge about how their benefits will be effected when they obtain part or full time employment

Increase the # of adults with SMI who are employed, part time or full time, or who are enrolled in school

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

Discussion/Collaboration with RSC to ensure access

Collaboration with ODJFS, SSA, Metropolitan housing

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

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

Increase the number of consumers who understand wellness management and recovery

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

Increase the number of consumers who complete either the Bridges program, the Wellness Recovery Action Plan (WRAP), or the Eli Lilly Team Solutions program

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

Increase the number of graduates from these programs by 25% during SFY 09

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

Discussion with SafeHaven Inc., CMHCs

2.c. HOUSING
Priority: High

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

1. Increase the number of ACF subsidizes for adults with SMI who are at most risk of re-hospitalization

2. Increase the number of mental health consumers who report stable housing

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

1. Evaluate and review existing policies regarding ACF contracts and make appropriate changes to

increase total number of subsidizes available

2. Provide supportive housing for mental health consumers

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

1. Increase the # of ACF subsidizes availabe by 10%

2. Increase the number of adults with SMI in Miami, Darke, and Shelby Co. who have access to supportive housing within 30 days of referral to CHI

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

Discussions with ACF

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

2.d. OTHER: Peer Support
Priority: Low

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

Increase # of trained peer support specialists

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

Encourage the continuation of the peer support program at SafeHaven;
Evaluate what resources and means are needed to train additional peer support specialists

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

Graduation at least 1 peer support specialist per county during FY 09

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

Collaboration with cmhcs and SafeHaven

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.*

Increase knowledge base of what resilience supports are needed in order for youth with SED to graduate

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

Train behavioral health professionals and teachers on resilience supports needed to ensure youth with SED graduate

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

# of bh professionals and teachers trained

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

Collaboration with local school districts and provider agencies

3.b. EARLY CHILDHOOD CARE
Priority: High

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

Reduce mental health concerns that parents have about their young children

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

Identified families will complete appropriate training through ECMH programs provided by Catholic Social Services

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

# of families receiving Early Childhood Mental Health services in Miami, Darke, and Shelby counties

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

Collaboration with Help Me Grow, Family & Children First Council, Head Start, provider agencies, and pediatricians

3.c. TRANSITION AGE 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.*

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

3.d. OTHER: Mental Health Services in Schools

Priority: High

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

At this time, the Board recognizes the need for increased coordination and collaboration with the 26 local school districts to increase mental health services available to students but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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.*

Collaboration with cmhcs, 26 local school districts

Click on gray box to enter text.

3.e. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

3.f. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box to enter number.

Board Purchased Inpatient Care	SFY 2009 Bed Days	SFY 09 Admissions
State Hospitals	1750	115
Private Psychiatric Hospitals: Adults	292	315
Private Hospitals: Children & Adolescents		

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.*

1. Increase access to local private psychiatric hospitals to address stressors and challenges to the local system with the closing of the Dayton TVBH campus
2. To reduce the utilization of state inpatient bed days

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

1. Increase partnerships with local private psychiatric hospitals to increase capacity locally for those who require inpatient psychiatric care
2. Identify consumers who have extended length of stays defined as more than 30 consecutive days Implement regular meetings (via phone, face to face) with hospital staff, local community mental health providers, and CMHB personnel to facilitate discharge planning that is supportive of consumer's recovery and placement in a least restrictive environment

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

1. Increase # of private psychiatric beds to the local system
2. Monitor admissions to the state hospital
   Monitor program usage via admissions to program, length of stay, and discharge planning

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

1. Collaboration with psychiatric private hositals, law enforcement, families, and community mental health centers
2. Monthly meetings with CMHCs staff and state hospital to evaluate identified consumers and what services need to be in place in order to facilitate discharge

4.b. CONTINUITY OF 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.*

4.c. SOMATIC HEALTH 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.*

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: High

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

To decrease the number of children and adolescent placements in residential treatment facilities

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

Establish a multi-agency team to systematically review all children/adolescents being referred to residential placement to determine if placement is the least restrictive option available
Utilize the multi-agency team to review each child/adolescent placed in a residential facility on a minimum of a monthly basis to determine if placement continues to be the least restrictive option available

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

Number of child and adolescent residential bed days utilized in FY'09 in comparison to previous years
Monitor length of stays
Development of a multi-agency team within each county

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

Collaboration with juvenile court, children services board, FCFC, schools, MRDD, Gateway for Youth

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: Mobile Response
Priority:

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

At this time, the Board recognizes the need for increased coordination and collaboration regarding mobile response for crisis assessments but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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

Measurable Objectives

Discussions and/or Collaborations

Collaboration with CMHCs, local law enforecment, hospitals, and jail/detention centers
Collaboration with CMHCs, local law enforecment, hospitals, and jails

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

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

Increased communication to local sheriff's departments regarding the impact on their officers and crisis services in light of the Governor's recommendation to close the TVBH - Dayton Campus

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

Continue to meet regularly with law enforcement departments to strategize and problem solving issues relating to admission to state hospitals

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

Maintain a list of identified issues and suggested solutions regarding admissions to state hospitals

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

Collaboration with Tri-County Crisis Center, CMHCs, and local Sheriff's Departments

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: Mobile Response
Priority:

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

At this time, the Board recognizes the need for increased coordination and collaboration regarding mobile response for crisis assessments but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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.*

Collaboration with CMHCs, schools, parents, local law enforecment, hospitals, and detention centers

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

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box to enter number.

	SFY 2008 Crisis Bed Days	SFY 2009 Crisis Bed Days

Adults		
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.*

1. Increase availibility of CIT trained law enforcement officers in the tri-county area
2. Increase mental health professionals who are trained in the unique roles, expectations, & laws governing law enforcement

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

1. Continue funding an annual CIT training for 20+ officers
2. Host a training for behavioral health professionals addressing the laws and boundaries that law enforcement are required to operate within and how it impacts their effecitiveness when working with a person who is experiencing a mental health crisis

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

Develop a training for mental health professionals
Number of new graduates from CIT academy

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

Colloboration with local law enforecement departments and CMHCs

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

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

Key personnel on local MH Board and in local agencies will be designated as key personnel in organizing and providing behavioral health disaster relief

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

1. Key personnel will be designated as "first responders" in disaster situations
2. Key personnel will complete necessary certification either through FEMA or the American Red Cross

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

# of trained behavioral health professionals

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

Collaboration with local FEMA organizations, American Red Cross, local CMHCs

6.d.3. COLLEGES & UNIVERSITIES*

Priority: Low

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

Will increase the campus security and university personnel knowledge on how and when to access the community crisis team

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

Provide educational materials on mental health issues and resources
Provide annual training to campus security and university personnel on how and when to access community crisis team

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

Statistics on # in attendance for annual training regarding how and when to access community crisis team
Track # and type of materials requeseted by campus security and university personnel

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

Collaboration with campus security and universisty personnel

6.d.4 PRIMARY & SECONDARY SCHOOLS

Priority: Medium

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

Will provide prompt 24/7 culturally competent crisis mental health services as requested by local schools

Will increase the teachers and administrators knowledge on how and when to access the community crisis team

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

Provide educational materials on mental health issues and resources
Provide annual training to teachers and administrators on how and when to access the community crisis team

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

Statistics on # in attendance for annual training regarding how and when to access community crisis team
Track # and type of materials requeseted by campus security and university personnel
Track # of referrals for crisis services received from schools

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

Collaborative with local school districts and Tri-County Crisis Center

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: Pharmacological Management
Priority: High

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

Increase access to pharmacolgoical services for adults with SMI

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

Increase use of alternative providers such as APRNs

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

Decrease the waiting time from referral to initial appointment with psychiatrist or APRN to between 11 to 15 working days
Monitor statistics from CMHC's waiting lists for pharmacological management services

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

Discussions with CMHCs

7.a.2. Area of Adult Services: Diagnostic Assessment
Priority:

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

At this time, the Board is aware of the emerging theme from data collected during the community forums of the community's request for increased mental health services in the jails. We recognize the need for increased coordination and collaboration regarding such services but wish to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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.*

Discussions with CMHCs; local law enforcement, jails, judges

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: Pharmacological Management
Priority: High

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

Increase access to pharmacolgoical services children/adolescents with SED

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

Increase use of alternative providers such as APRNs

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

Decrease the waiting time from referral to initial appointment with psychiatrist or APRN to between 11 to 15 working days
Monitor statistics from CMHC's waiting lists for pharmacological management services

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

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

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

Increase early identification/referral of children/families with MH problems

Strategies *Click on gray box to enter text.*

Increase access to DECA assessments provided by Catholic Social Services through ECMH funding to targeted entities in all three counties such as day care providers, pre-schools, Head Start, etc.
Increase awareness of ECMH services available through the ECMH grant with Catholic Social

Services

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

Increase in number of familes referred for DECA Assessments

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

ECMH collaborative

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: Medium

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

Increase number of agency staff who are trained in the IDDT model

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

Encourage CMHCs to designate a therapist and CPST as specialists in dual diagnosis service provision

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

# of agency staff identified as specialists in dual diagnosis
# of agency staff who complete 6 hours of CEUs in dual diagnosis service provision

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

Discussions with CMHCs

Click on gray box to enter name of practice:

7.c.2. PRACTICE: Intensive Home Based Treatment
Priority: High

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

Increase the number of agencies who are certified to provide intensive home based treatment to children/adolescents and their families

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

Explore challenges and barriers for contract agencies to become certified in IBHT
Work with agency administrators in addressing identified barriers/challenges in order to become certified

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

Increase # of CMHCs that become certified by 100%

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

Discussions with CMHCs

Click on gray box to enter name of practice:

7.c.3. PRACTICE: Tobacco Dependence Treament
Priority: Medium

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

Increase access to tobacco dependence treatment for adults with SMI in all three counties

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

Offer at minimum one tobacco cessation group in each county specifically for adults with SMI per year

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

# of groups hosted per county, and systemwide
# of participants who attended the group

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

Collaboration with UVMC's Tobacco Cessation treatment program

Click on gray box to enter name of practice:

7.c.4. PRACTICE:
Priority:

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

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

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

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

Click on gray box to enter name of practice:
7.c.5. PRACTICE:
Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray boxes to enter workforce development area and priority level.
8.a.1. Area of Workforce Development: Broadening the Concept of Workforce
Priority: High

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

Significanlty expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce

Strategies *Click on gray box to enter text.*

Host trainings to local behavioral health professionals on the principles of mental health recovery
Host trainings for mental health consumers on the principles of mental health recovery

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

# of professionals and consumes who attend the trainings

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

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

8.a.2. Area of Workforce Development: Strenghtening the Workforce
Priority: High

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

Implement systematic recruitment and retention strategies at the federal, state, and local levels

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

Re-apply for active status as a HHS "Health Professional Shortage Area" (HPSA)
Advocate that all contract agencies remain active as designated agencies able to accept professionals under the "health professional shortage area" designation
Encourage contract agencies to advertise in all job postings that they qualify as an agency accepting professionals under this designation

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

# of new behavioral health professionals who serve in the tri-county area who are eligible to apply for assistance through the HPSA program
# of current behavioral health professionals who are receiving loan repayment through the HPSA program

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

Discussion/Collaboration with CMCHs

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: Medium

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

At this time, the Board recognizes the need for increased coordination and collaboration with the adult justice and court system but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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

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

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

9.a.2 ADULT RECIDIVISM
Priority:

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

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

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

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

9.a.3. ADULT DIVERSION
Priority:

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

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

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

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

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

Click on gray box to enter text.

9.b. Adolescents

9.b.1. ADOLESCENT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority: High

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

At this time, the Board recognizes the need for increased coordination and collaboration with the adolescent justice and court system but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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

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

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

9.b.2. ADOLESCENT RECIDIVISM

Priority:

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

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

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

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

9.b.3. ADOLESCENT DIVERSION

Priority:

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

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: Medium

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

At this time, the Board recognizes the need for increased coordination and collaboration with the local jails but wishes to wait until the completion of the strategic planning process before committing to what we identify as the most important areas in which to invest our limited resources.

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

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

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

9.c.2. DETENTION CENTERS
Priority:

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

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

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

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

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

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

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

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

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

9.c.4. NURSING HOMES
Priority:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.c.7. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.8. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.9. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

10.a. SUICIDE PREVENTION

Click on gray box to enter priority level.

Priority: Medium

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

Further expand the use of the curriculum "A Promise for Tomorrow" published by the Jason Foundation in the local high schools

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

Host a Train the Teacher workshop in how to use the curriculum in the classroom

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

# of teachers trained in the curriculum
# of high schools utilizing the curriculum

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

Coordination/Discussion with the Suicide Prevention Coalition and the local high schools

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:

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

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

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

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

11.b. STAFF RECRUITMENT
Priority:

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

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

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

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

11.c. STAFF TRAINING
Priority: High

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

To establish quarterly board hosted trainings that address topics vital to behavioral health professionals including but not limited to cultural competency, ethics, disaster preparedness, health officer duties

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

Develop and schedule quarterly trainings with CEUs for behavioral health professionals

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

# of trainings hosted
# of professionals who attend the trainings

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

Collaboration with contract agencies

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

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

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

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

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

Click on gray box to enter text.

11.e. OTHER:
Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box and enter text.

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.

Please refer to response provided in section C: Needs Assessment and response below in section E.2	E.1

E.2. How does the Board plan to develop and use various databases, (e.g, MACSIS, Outcomes, Behavioral Health Module) to evaluate the effectiveness and efficiency of services?

Click on gray box and enter text.

The Board is committed to the continued participation in MACSIS, Outcomes, and the Behavioral Health Module as evidenced by the requirement of all contract agencies to participate fully in these databases. As a Board, we do have concerns that using only the data gathered in the MACSIS, BH module, and Outcomes databases may not give us an accurate, complete picture of service provision due to this data only being gathered on publicly funded clients served in our system. Our Board requires that all agencies gather aggregatec data for agency and system evaluation. To date all agencies are working with an independent database company, ProComp Software, who has developed the Clinical Assessment Tracking and Tracking (CATT) database. ProComp has created custom designed quality improvement reports that meet our Board's specific needs in terms of measuring and analyzing the patterns of service use by important client demographis and diagnostic chracteristics in the Board area for both publicly funded and privately funded clients. See response in section C "Needs Assessment" and section 7.b.2 "Outpatient Services". The Board utilizes data from MACSIS to measure and analyze the cost of services as well as the cost effeciveness and cost efficiency of services. From this data we are able to isolate such factors as service delivery patterns and specific client characteristic by agency, by county, and/or by board area. This aggregate data is then used to identify trends, patterns, and service gap areas that need to be addressed in future planning efforts by the Board. The Board requires that all contract agencies complete on a yearly basis a referral source survey, a client satisfaction survey, and a prevention satisfaction survey which allows us to measure and analyze the level of community acceptance of the services offered by the provider agencies. This information is used in our Board's strategic planning process. All contract agencies are using the Consumer Outcome instruments as part of their treatment planning process & report to the Board on a quarterly basis how effective and efficient staff are at incorporating the instruments into the treatment planning process with clients. The Board has begun to work with the Outcome extracts to assist agencies in identifying clients with missing outcomes data in order to improve the agencies compliance with the 80% benchmark established by ODMH. We do not utilize the extracts for other data analysis due to our concern that historically some of the information in the database may not be accurate. We do notify agencies on a quarterly basis as to their performance against the benchmark of 80% and provide assistance and guidance on how to improve their percentage of completed outcome instruments. Historically, the Board has utilized the BH Extracts to run reports on specific indicators such as housing status, employment status, and jail recidivism rates. We have been working with contract agencies to ensure and improve the accuracy and timliness of data entry into the BH module to ensure the data drawn from the extracts accurately reflects the trends and patterns in the local communities. Through monthly tracking of central pharm utilization, billed Medicaid units, etc we inform agencies regarding where they are utilizing all the finanical resources available to them and	E.2

provide encouragement and assistance to them in how to drawdown all available financial resources. This has allowed us to create a baseline regarding the usage of central pharmacy and treatment services and allows us to monitor if usage is increasing per county and per our system which is used as part of our strategic planning process.	

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.

None at this time	E.3

Form 1

Board Appointment Data Sheet

Form 2

Community Board Resources

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

Name	Street Address	City	Zip	Phone Number	Email
Jodi Long LISW, LICDC	1100 Wayne Street, STE 4000	Troy	45373	937.335.7727 x207	longj@mdsadamhs.mh .state.oh.us

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
Jodi Long LISW, LICDC	1100 Wayne Street, STE 4000	Troy	45373	937.335.7727 x207	longj@mdsadamhs.mh. state.oh.us

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
Jodi Long LISW, LICDC	1100 Wayne Street, STE 4000	Troy	45373	937.335.7727 x207	ongj@mdsadamhs.mh.state.oh.us

Form 3

Planned State Inpatient Bed Days

BOARD NAME Tri-County Board of Recovery and Mental Health Services 2009 Planned Use of State Inpatient Days	
Northcoast-Toledo	1000
Northcoast-Toledo	
Northcoast-Toledo	
Northcoast-Toledo	
Total Inpatient Days	1000

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 Tri-County Board of Recovery and Mental Health Services (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: ___________________________________

Mark McDaniel (Name)
Executive Director
Tri-County Recovery and Mental Health Board (Board)

Date: