

III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

Click on box to enter Board name.

BOARD NAME: Paint Valley ADAMH Board

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

Click on gray box to enter text.

MISSION STATEMENT: Our mission is to meet the recovery needs of our communities by providing access to quality and integrated mental health and drug-alcohol addiction services, empowering consumers and supporting innovative and evidenced based approaches to treatment and prevention.

VISION: VALUES FOR A SYSTEM OF CARE

1. Child Centered – Services and supports are provided in the best interest of the child. Services and supports should always ensure that the child’s needs (physical, emotional, educational, and spiritual) are being met. In almost all cases services and supports should maintain and strengthen a relationship between the family of origin and the child. All components of the system of care recognize the need and value of permanent stable relationships and strive to ensure these for all children and youth.
2. Family-Focused – The child is viewed as a part of the whole family system and services and supports are based on the strengths and needs of the entire family. Children and their families have access to discussions related to their plans, an opportunity to voice their preferences and ultimately feel that they own the plan. Services and supports are designed to improve access, utilization, and satisfaction of families. Children and families have a legitimate say in all aspects of their services and supports.
3. Safety (Child, Family and Community) – Services and supports are developed to best ensure the safety of the child, family and community. Discussions and plans are based on an assessment of risk to the child, family and the community. Plans are developed to reduce these risks. For children who pose a threat to the community or family, plans reduce at risk behaviors and protect the community and family. For children whose safety is at-risk, plans reduce these risks while protecting the child.
4. Individualized – Plans and supports for children and their families are individualized by child and family teams, and supported through a system of flexible services and supports. “Individualized” services and supports are tailored to the unique situation, strengths, and needs of each child and family, and may involve existing categorical services and informal supports; modifying existing services and supports; and creating new services and supports. Flexible funding sources must be available to support individualization.
5. Cultural Competency – Services and supports reflect the unique cultural values and practices of the child and family. Cultural values including issues of ethnicity, family structures, community and spiritual preferences. Cultural competency occurs at both the individual service and system levels.

6. Direct Practice and System Persistence – When communities make a commitment to help a child or family, they embrace stability and permanence as fundamental rights. To accomplish this they create a system where services and supports are delivered with a corresponding commitment to never give up on the child or family, changing the plan instead of rejecting the child and family from services and supports. Communities recognize that needs can be complex, that change is sometimes very difficult to achieve, and commit to a mutual process of extreme persistence in the delivery of services and supports. At the system level, communities understand that overall change in a service delivery system is equally difficult to achieve, and make a commitment to persist in moving toward improved collaborative services and supports.
7. Community-based – Services and supports are provided in the home community of the child and family whenever possible. Children and families are included in the normal activities of community life. Local communities assume responsibility for all children and families and have the authority to support children and families.
8. Strength Based – Services and supports are based on identified strengths of the child/family/community. This means that strengths of the child, family and community are assessed, noted, appreciated, and reflected in the design of interventions and supports.
9. Parent/Professional Partnership – Families’ knowledge of what is needed in systems and what will work for them and other families is sought and utilized. Interactions between professionals and families are conducted in a mutual “no blame – no shame” fashion. Families fully participate in strategic planning for system of care development. Families are involved in the hiring and evaluation of staff and the evaluation and planning in all programs and the overall system of care. A wide range of and numbers of families are involved in order to get representative input.
10. Collaboration and Community Support – Collaboration between agencies, schools, community resources (e.g., service organizations, churches, and businesses) and families is the best way to build effective services and supports for individuals/families with complex needs. Wherever the needs of children and families go beyond what any one entity can provide, agencies, schools, community resources and other families work together to meet these needs. In addition, these entities engage in ongoing strategic planning to improve the system of care.
11. Social Networks and Informal Supports – People are supported through community and family social networks and informal community resources. To avoid dependency on systems, services and supports focus on building and strengthening social networks and informal community resources for children and families.
12. Outcome Based – Services and supports are outcome based with clear accountability. Plans for children and families have clear outcomes that guide services and supports to transition and completion. Families, staff, and policy makers to plan and develop systems of care use integrated outcome information as a tool.
13. Cost Effective and Cost Responsible – “Cost effective” services and supports blend formal and informal resources that are consistently reviewed to ensure responsible financial utilization. “Cost responsible,” means that local communities control the expenditure of

funds to best meet the needs of all children and families in their geographical area.

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

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

Click on gray box to enter text.

The business rules of the board were developed to assist consumers reducing the amount of out-of-pocket expense for services provided.

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.

Deaf and language interpreters are available and accessible for consumers in our service area. On a single client basis, specialized counselors are available based on disability.

The Board continues to support a continuum of housing opportunities for consumers, including residential treatment, placement in Adult Care Facilities, supervised apartments, and supervised group living. Consumers are able to move within the housing continuum based on their individual needs. As a result of strong relationships with local housing authorities, consumers quickly move up housing assistance waiting lists.

In addition to the housing assistance program, the Board provides a Flexible Community Support fund. These funds are designed to provide wraparound supports such as emergency prescriptions, utilities, rent supports, employment assistance, etc.

While the Board no longer funds supported employment as a separate service, within the community psychiatric support program, employees are encouraged to assist consumers in securing and maintaining employment. The CPST program works closely with community agencies such as BVR and Goodwill to help consumers get jobs.

The drop-in center located in Ross County has been in operation since 2000. Consumers are able to use this service on a daily basis for peer support and socialization. The Scioto Paint Valley Mental Health Center employs peer support specialists as part of ACT teams.

The Board supports the local NAMI affiliate in educating consumers and families about programs such as Wellness Management and Recovery, WRAP, Bridges, Family to Family and Advance Directives.

A functioning Network of Care Website has been in operation since May, 2007. To assist in the development of the website, consumer focus groups were conducted to provide input into the overall usefulness of the site, content and training. Extensive training was provided to administrative staff, CPST providers and consumers who in turn educated other staff, consumers and family members on how to access and utilize the program. Utilization is measured by the number of website hits.

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

Click on gray box to select answer.

<p>We do not have formal waiting lists. Consumers are able to access supported housing as soon as an opportunity suitable to their needs is available. Consumers sometimes remain in residential treatment while waiting for a bed in an Adult Care Facility or may remain in an ACF while waiting for a supervised apartment. Typical wait time for the majority of these consumers would be 1-3 months. In the case that no there are not suitable options available, the CPST is asked to explore alternatives and refer the consumer for supportive housing services again later as/if needed. The wait time for consumers for who a suitable option is not available is unknown; some consumers access alternatives and others are re-referred as there needs change, meaning these individuals could have waited more than one year for supportive housing services.</p>	2.1.b
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c. With regard to **supported housing**, which of the following categories comes closest to the average wait time for most consumers? *Please select only one response category.*

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

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

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

Click on gray box to enter number.

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

e. Do you have wait lists for HAP?

Click on gray box to select answer.

No	2.1.e
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We do not have formal waiting lists. CPST's are notified when program funds for the fiscal year are available and when funds are exhausted; therefore, waiting lists are avoided by receiving referrals only when HAP funds are available.

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

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

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

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

Click on gray box to enter number.

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

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

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

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

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

Click on gray box to enter number.

800 Consumers Waiting – estimated, no waiting list	2.1.i
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The **Homeless Housing Status National Outcome Measure (NOM)** reported to SAMHSA by ODMH refers to adults, aged 18+ with severe mental illness (SMI), who have identified themselves as homeless on an administration of the Adult Consumer Survey in the Ohio Outcomes System. For SFY 2007, Ohio reported a Homeless Housing Status NOM to SAMSHA of **2,879** persons with SMI. Board level data for Ohio's SFY 2007 Homeless Housing Status NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

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.

We believe that Appendix B is consistent with outcome data collected by the Board. However, because consumers are frequently hesitant to report homelessness, it is likely the actual number of homeless individuals served by the Board in SFY 2007 was significantly higher than the 35 reported.

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.

<input type="checkbox"/>	Continuum of Care	2.1.ka
<input type="checkbox"/>	PATH	
<input type="checkbox"/>	BH Mod (Behavioral Health Module)	
<input type="checkbox"/>	HMIS (Homeless Management Information System)	
<input type="checkbox"/>	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.

Homeless persons with SMI	2.1.kb
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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.

As a result of Medicaid match requirements, Board funding for non-Medicaid services is diminishing. It is anticipated that Medicaid match requirements will continue to increase, further reducing or perhaps eliminating the ability to support non-Medicaid programs, including supported housing. The Board will continue to provide supported housing services to the extent financially feasible.

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.

According to the latest Outcomes Missing Report (Instruments 17) Adult Consumers (A&B) shows 57.5%, Provider Adult 83.4%, Ohio Scales Youth 60.3%, Ohio Scales Parent 58.1%, and Ohio Scales Worker 76.9%, which are in line with the Statewide totals on the report. Unfortunately, with an average of 67.2% of outcomes reporting it can not be a accurate reflection of the number. On Thursday 1/24/08, an email was sent to our three providers required to report outcomes requesting a 90% reporting rate. This effort combined with monitoring Care Management report, Indicator I (What % of SMI are Employed Part-Time and Full-time) produced by The Ohio Association of County Behavioral Health Authorities should give us a more accurate reflection of SMI served by Paint Valley ADAMH Board. In addition, all SMI services are monitored by quarterly reports produced at Paint Valley ADAMH Board office. Appendix B NOM SY 20007 Employed Adults = 704 and OACBHA Care Management Reports show 737 with 2.8% of SMI employed full time with 3.1% of SMI employed Part Time. This discrepancy is probably due to the difference in reporting time. Not claim files but when outcomes were reported

- 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
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- 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
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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.

CPST providers routinely refer consumers to RSC and collaborate with RSC staff to assist consumers in meeting their vocational needs. While the Board is no longer funds supported employment, as a part of the provision of CPST services, providers assist consumers to the extent possible in securing and maintaining employment.

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.

The Alternative Education Grant made it possible to provide consultation and treatment services to adolescents in Fayette, Highland, and Pickaway Counties.

The Early Childhood Education Grant was used to expand consultation services to all Head Start Programs in the service district. The Incredible Years Program is being piloted in Pike County. All Head Start Programs are using the Devereaux Early Childhood Assessment (DECA) to measure changes in behavior during the course of the year and as part of Intervention Team Planning.

ISS - We have imbedded family preservation providers in 3 schools – Mt. Logan, Unioto, and SED classes with the Educational Service Center. ISS co-facilitated the Summer Youth Program with ABC / FAST funding. ISS has partnered with the Ross County Educational Service Center in the Roweton School to provide Mental Health and Family Preservation services for at-risk youth. ISS has continued to develop services with Juvenile Court’s IV-E program to deliver therapeutic supports in combination with Independent Living activities. These supports are designed to increase family’s capacity to keep youth in their home and build toward self-sufficiency.

NAMI supports Federation of Families through education of parents and advocates who assist parents in developing Individualized Education Plans for children with disabilities.

The Board has a history of funding mentoring services through Big Brothers/Big Sisters. This agency is planning an expansion of school-based mentoring services in two school districts. This

program will match high school students with middle or elementary school students for tutoring.

The Board has a history of collaboration and funding Family and Children First Councils (FCFC) for wraparound services. Training in the wraparound model for FCFC coordination began in FY 2001. Wraparound funding to FCFCs began in FY 2002 and has expanded with FAST funding. The Board provides support to FCFC staff to expand system of care coordination within each county. Board staff help write grants to expand system of care coordination and funding. The Board is pursuing a strategic planning process to study ways to improve access to mental health services for school age children.

3.1 Resilience supports: School Suspension and Expulsion NOM

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

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

Click on gray box to enter text.

According to the latest Outcomes Missing Report (Instruments 17) Adult Consumers (A&B) shows 57.5%, Provider Adult 83.4%, Ohio Scales Youth 60.3%, Ohio Scales Parent 58.1%, and Ohio Scales Worker 76.9%, which are in line with the Statewide totals on the report. Unfortunately, with an average of 67.2% of outcomes reporting it can not be an accurate reflection of the number. On Thursday 1/24/08, an email was sent to our three providers required to report outcomes requesting a 90% reporting rate. This effort combined with all SED services are monitored by quarterly reports produced at Paint Valley ADAMH Board office.

According to Appendix B NOMS Paint Valley ADAMH Board shows 100 Children and Adolescents.

FY 07 data at board level shows 832 SED clients served in the entire year. Units and dollars are broken down by county.

- 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
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4. Inpatient Care

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

a. Inpatient Care

Click on gray boxes to enter numbers.

Board Purchased Inpatient Care	FY 06 Bed Days	FY 07 Bed Days	FY 06 Admissions	FY 07 Admissions	4.a
State Hospitals	930	1061	60	68	
Private Psychiatric Hospitals: Adults	-0-	-0-	-0-	-0-	
Private Psychiatric Hospitals: C&A					

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

Click on gray box to enter text.

<p>Consumers in the Board’s service area are typically prescreened for psychiatric hospitalization by Scioto Paint Valley Mental Health Center. The Center determines the least restrictive, most appropriate service setting and in many cases is able to link the consumer with community services and avoid an inpatient stay.</p> <p>In some cases, consumers presents directly to a private psychiatric hospital. When this occurs, the hospital may prescreen the consumer for their inpatient psychiatric unit or hospital staff may request prescreening by the Center. If the hospital prescreens and accepts the consumer to their psychiatric unit, the Center is notified after the client’s admission for follow-up services as a part of the hospital’s discharge planning process.</p> <p>Consumers found to be in need of inpatient care are referred to private hospitals initially. Center staff providing prescreening for hospitalization may refer to 10 or more private psychiatric units prior to making a referral to a state hospital.</p> <p>Referrals for state hospitalization are made when consumers in need psychiatric hospitalization can not access a private hospital and/or when the Common Pleas Courts order consumers for forensics reasons (competency restoration, not guilty by reason of insanity, etc.).</p> <p>Mental Health Center CPST providers work closely with State Hospitals in developing discharge plans which include intensive community services. The Board supports an 18 bed residential treatment center. Frequently, inpatient care can be avoided or shortened by accessing residential treatment services. The Board</p>	4.ba
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regularly collaborates with Center staff in regard to the development of specialized community services to assure that State Hospital care is truly the least restrictive, most appropriate service setting for consumers and to minimize utilization of purchased State Hospital days.

Both the Board and the agency have good working relationships with private hospitals. We are fortunate to have a private inpatient unit located in our service area which consumers are frequently able to access. Referrals for inpatient services are also made to several private hospitals located outside the service area. Positive relationships with private hospitals have significantly reduced utilization of State Hospital care.

To assure consumer safety and immediate accessibility, the Board supports use of a local ambulance service for consumers in need of transportation to psychiatric inpatient services and/or to return to the community.

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
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5. Residential Treatment Centers (RTCs).

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

Click on gray box to enter number.

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

Click on gray box to enter number.

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

Click on gray box to enter number.

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

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

Use is increasing	Use is about the same	Use is decreasing	5.d
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<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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e. How does the Board understand the trend in RTC placements indicated above?

Click on gray box to enter text.

The Board has worked extensively with Family and Children First Councils and mental health providers to strengthen the cluster, wraparound, and coordination of services processes for children being served by various systems and for children at risk for out of home placements. There continues to be problems with staff turnover at participating agencies. Staff continually works to create a “buy in” to the cluster system both for initial referrals and in the development of plans to transition the child back home after residential placement.	5.e
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6. Crisis/Emergency Care.

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

Click on gray box to indicate “Yes” with an “X.”

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

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

Click on gray box to enter number.

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

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

Click on gray box to enter text.

The Board has maintained low usage of state hospital bed days. This is a result of quick access to the adult residential center and excellent working relationship with local private psychiatric inpatient facilities. Providers have expanded capacity to address the complex issues of persons with dual substance abuse and mental disorders. Providers have also established relationships with foster care networks in the community and uses foster care home operators to provide respite for children and adolescents that are at risk for inpatient or residential treatment. The Board has collaborated with the Family and Children First Councils with use of ADAMH Board and FAST funds to underwrite the cost of this service option.

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.

In September, 2004 the Board offered CIT training for all law enforcement agencies in the service area. Five officers became CIT graduates representing Ross and Fayette Sheriff departments as well as Greenfield and Waverly Police Departments.

One provider developed and continues to work with both the Chillicothe Police Department and the Ross County Sheriff on the Crisis Response Team as a strategy to provide law enforcement alternatives to divert youth from the Juvenile Justice System through family de-escalation and crisis management.

2. Disaster Preparedness

Click on gray box to enter text.

The Board participates in the statewide disaster preparedness trainings, All Hazards Coordinator’s Meetings, local disaster planning committees including Local Emergency Planning Commission (LEPC) and we have developed our own All Hazards Behavioral Response Team. We have previously co-sponsored a local training with area Red Cross agencies to certify mental health providers for inclusion in Red Cross disasters and our local LEPC.

What are your estimates of staff for the following areas?

Click on gray box to enter number.

	Local Disaster Response	Statewide Disaster Response	6.c.2
Trained	12	3	
Currently Available	8	2	

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

Click on gray box to enter text.

Crisis response counseling is available to area schools on an as needed basis through our Crisis Centers. Typically a school will call the ADAMH Board, the MH agency or the Crisis Center and request help for the particular situation. Staff are then dispatched to the school in response to the request. Examples may be the death of classmates or some other tragic situations that may occur in the region that would require mental health intervention.

7. Outpatient Services.

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

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

a.1. Adult Intensive Care

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

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

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.

For several years the Board's focus has been on the development of Assertive Community Treatment and Intensive Community Psychiatric Supportive Treatment. In fiscal year 2006 the mental health center implemented a block intake system. This intake system has significantly decreased no shows and wait times for diagnostic assessments. The community mental health center utilizes a triage system at block intake for prioritizing consumer entry into the service system. The triage system is designed so that persons with the highest acuity receive a higher priority for admittance into the system. The Board monitors the Center's triage system through quarterly quality assurance reporting.

a.3. Child & Adolescent Intensive Care

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

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

PH Prgm.Type III	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Therapeutic Pre-School (PH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Intensive CPST	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Intensive Pharm. Management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Functional Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

Click on gray box to enter text.

The community mental health center’s system for triaging children and adolescents operates on the same principle as applies to adults. The triage system is designed in a manner such that persons with the highest acuity receive a higher priority for admittance. The Board monitors the Center’s triage system through quarterly quality assurance reporting. The Board has strongly emphasized Intensive Community Psychiatric Supportive Treatment Service for children and adolescents. Because of program expansion, these services can generally be accessed within 1 week. The Center has collaborated with researchers at The Ohio State University School of Social Work and has worked with researchers to develop the Intensive CPST program model as an evidence-based practice. Research on the model was funded by ODMH and is listed as a promising practice in New Research in Mental Health 2004-2005 Volume 17.

In FY 2006 a Highland County provider established a partial hospitalization program for children and adolescents. Capacity is limited at the current facility to a maximum of 30 clients. Quality improvement is measured by improvement on scores from the Ohio Scales, program attendance, and court records of the participating clients.

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

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

b.1. Adult Routine Outpatient Care

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

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

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

Click on gray box to enter text.

The Board’s priority populations for treatment services are persons with SMI or those at imminent risk for self-harm. To this end, the focus has been on maintaining and improving diagnostic assessment, pharmacological management and CPST.

In fiscal year 2006 the community mental health center implemented a block intake system. This intake system has significantly decreased no shows and wait times for diagnostic assessments. The Center uses a triage scheme at block intake for prioritizing consumer entry into the service system. The triage system is designed so that persons with the highest acuity receive a higher priority for admittance into the system. The Board monitors the Center’s triage system through quarterly quality assurance reporting.

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.

b.4. Which routine outpatient services for children have been area(s) of focus for the Board? *If an agency uses a triage system to schedule services, please discuss the Board’s oversight role in planning*

and delivery of triaged services. Discuss access, capacity, and quality improvement achievements and trends in service areas that have been an area of focus.

Click on gray box to enter text.

The community mental health center uses a triage system for prioritizing entry into the service system. The same principle for triage applies to children and adolescent outpatient service as it does to outpatient services for adults. The triage system is designed so that persons with the highest acuity receive a higher priority for admittance. The Board monitors the Center’s triage system through quarterly quality assurance reporting.

A specialty provider that works with families and youth referred by the juvenile justice and child welfare systems is able to provide access to services within 10 working days. This provider’s focus is CPST, but it does contract with the community mental health center for pharmacological management services.

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.

The community mental health center expanded IDDT to consumers who meet criteria for Quadrant III. Training and fidelity testing is being provided through the SAMI CCOE.

The Center’s Criminal Justice Re-entry Program has achieved high fidelity to both the IDDT and ACT models.

The Center implemented a model of intensive home-based CPST that is being researched as a best practice. The model is an integrative approach based on strategies that have strong empirical support.

A Highland County provider uses a combination of CBT supported practices along with pharmacological management as an integrated team approach to providing treatment.

A recent needs assessment recommended that home-based family preservation services be provided in schools as a standard best practice. A specialty agency provides intensive CPST and family preservation services in two school districts in Ross County.

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

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

Click on gray boxes to enter number of FTEs.

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

*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.

Recently, four of the five counties in our region were designated as Health Professional Shortage Areas. This designation will improve contract agencies' ability to recruit and retain clinical staff members, especially psychiatrists.

The community mental health center contracted for online professional development courses in FY 2006. Since then, both the number of staff members using this option and the number of courses taken have increased rapidly. Courses available are of high quality and include passing a required post test to receive credit for a course.

9. Inter-system Collaboration

a. Discuss achievements and trends in the following areas.

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

Click on gray box to enter text.

The community mental health center has developed collaborative relationships with each of the adult courts in the service district. Local judges are ordering treatment in lieu of incarceration on a more frequent basis.

Strong collaboration is particularly evident in the Criminal Justice Re-entry SAMI IDDT/ACT program. Local judges and probation officers routinely solicit input from program providers and strongly support treatment in lieu of incarceration or other legal consequences. Recidivism for consumers served by this program is very low. The program received an ODMH Forensic Leadership Award in 2007.

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

Click on gray box to enter text.

The Scioto Paint Valley Mental Health Center has strong collaborative relationships with each of the juvenile courts in the service district. Probation officers are routinely included on Intensive CPST cases. Intensive CPST providers participate in court hearings when appropriate and offer alternatives to incarceration or residential treatment.

The partial hospitalization program in Highland County has helped reduce recidivism rates for students who are on probation for school related offences of absenteeism, tardiness, and unruly behaviors.

The Ross County Juvenile Court, Job and Family Services, and a contract provider are working

together to provide diversion, job training and placement, and mental health services to at-risk juveniles through a grant that was awarded Spring 2008.

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.

Providers visit local jails on a regular basis to assure that the mental health needs of consumers are evaluated and addressed. In Ross County, a counselor visits the jail daily to meet with inmates and offers training and consultation to law enforcement.

2. Detention Centers

Click on gray box to enter text.

The community mental health center provides assessments to the local JDC.

2. Homeless, Runaway & Domestic Violence shelters

Click on gray box to enter text.

The community mental health center provides consultation to homeless and domestic violence shelters. The Center also provides domestic violence group counseling for persons referred by the court system.

3. Nursing Homes

Click on gray box to enter text.

The community mental health center routinely provides consultation to nursing home staff and treatment services to residents.

4. Prison Reentry

Click on gray box to enter text.

The Criminal Justice Re-Entry SAMI IDDT/ACT Program has been very successful. Consumer outcomes have been positive and recidivism has been low. Local judges and probation officers strongly support the program treatment model. In addition to receiving an ODMH Forensic Leadership Award, the program also received a SAMHSA Science and Service Award in 2007.

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

Click on gray box to enter text.

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.

a. Suicide Prevention has been a priority for this Board. We are trying to develop coalitions in each county by the year 2009. We have found that we have much greater success by focusing our efforts on a single county per year to year and a half. As you can see in TABLE 1, we began developing Suicide Prevention Coalitions (SPC) in 2005:

COUNTY	YEAR	START UP GRANT
Fayette	2005-6	5,000
Pike	2005-6	5,000
Ross	2007	10,000
Pickaway	2008	7,500
Highland	2009	Planned

In addition to the initial start up grants, each county has applied for and received follow up funding that has helped to implement the strategic plans.

All four county coalitions are still active and operating. Some of the recent activities include a nationally known comedian performance/fundraising event, several gatekeeper training events, depression screenings, employee assistance, and a 5K Run in planned for 2009 in Pickaway County.

b. The community mental health center delivers targeted prevention services that are evidence-based and evaluated for effectiveness.

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.

a. As part of the community mental health center’s performance improvement plan, annual consumer satisfaction surveys are conducted on:

- Crisis Intervention Service – Mental Health and Substance Abuse
- Outpatient Counseling – Mental Health and Substance Abuse
- CPST – Mental Health and Substance Abuse
- Partial Hospitalization – Mental Health

With the exception of partial hospitalization, results are segregated the population by youth and adult.

An 85% threshold is included in agency contracts for overall satisfaction. Agencies are required to explain and/or investigate further when outcomes are below the threshold. Agencies also conduct focus reviews on negative critical feedback contained in the comment section of the client satisfaction questionnaire.

b. On an as needed basis, the community mental health center employs Spanish speaking interpreters so staff can communicate readily with Hispanic clients.

c. All mental health staff must complete annual training on cultural competence. The center has made on-line cultural competency training available to staff.

d. Selected provider agency staff are trained in American Sign Language. The agency hires ASL interpreters to better serve hearing impaired clients. The agency also contracts with a service that offers translation of more than 200 languages. Language barriers have not prevented communication with clients.

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

Click on gray box to enter text.

C. Needs Assessment.

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

Click on gray box to enter text.

Board staff routinely reviews utilization of current services. This review focuses on number of persons served, Medicaid penetration rates and service trends for persons with SMI and children who are seriously emotionally disturbed. Staff also meets periodically with a focus group of consumer and family members. The focal point of these meetings revolves around problems in crisis care, access to services appropriateness of services and enhancing consumer supports around recovery and resilience.

During Fiscal Years 2007 and 2008, board staff held focus groups and completed paper surveys with school employees, parents and students about the need for mental health services for school-age children. Focus group participants varied, but generally included teachers, principals, guidance counselors, nurses, special education personnel and school psychologists. In most focus groups, a representative from the community mental health system participated as an observer to hear firsthand accounts of the issues raised by school personnel. A total of 21 school districts participated in the employee survey and 20 districts provided key personnel to participate in focus groups. Due to the scope of the service district, the parent survey was distributed to a sample of parents with children in 3rd, 7th and 10th grades. Because the service district includes approximately 40,000 school-age children, the student survey was distributed to a sample of students in 5th, 8th and 11th grades.

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.

During fiscal years 2001 to 2007, our Board area averaged a 25% annual increase in services to Medicaid eligible persons. Prior to fiscal year 2007, the Board had substantial reserves which

enabled it to meet Medicaid match obligations. By the end of FY 2007, this fund balance was projected to fall below a three month operating reserve. This necessitated significant reductions to provider agency allocations, resulting in providers' refusal to serve consumers without a payor source. Providers did agree to protect the Board's priority populations and exempt persons identified as SMD, SED or at imminent risk of self-harm or hospitalization from this policy. In budget discussions, providers were notified that vital services to priority populations such as crisis intervention, community psychiatric support, residential services and pharmacological management must be protected. Due to a severe reduction in the fund balance, the Board was also faced with prioritizing Medicaid services over non-Medicaid services.

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

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

Click on gray box to indicate priority level.

2.a. EMPLOYMENT*

Priority:

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

Maintain close working relationship with the Ohio Rehabilitation Services Commission and the Bureau of Vocational Rehabilitation (BVR).

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

Continue open communication and periodic meetings with BVR staff to participate in agency cross-training and to discuss referral process and client access.

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

Hold at least one meeting to review ways to improve the client referral process and at least one joint training annually.

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

2.b. WELLNESS MANAGEMENT & RECOVERY*

Priority:

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

Continue to promote and encourage client and family use of the Network of Care Website.

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

Educate consumers and promote the availability of WRAP on the Network of Care website.

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

Increase the number of hits to the Paint Valley NOC website by 10% in FY 2009.

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

2.c. HOUSING

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.

2.d. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

2.e. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

2.f. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

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

Click on gray box to indicate priority level.

3.a. SCHOOL SUCCESS

Priority:

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

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

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

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

The board is nearing completion a 3-year study on ways to improve access to mental health services for school-age children.

3.b. EARLY CHILDHOOD 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.*

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:

Priority:

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

Strategies *Click on gray box to enter text.*

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

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

Click on gray box to enter text.

3.e. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

3.f. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box to enter number.

Board Purchased Inpatient Care	SFY 2009 Bed Days	SFY 09 Admissions
State Hospitals	960	960
Private Psychiatric Hospitals: Adults	-0-	-0-
Private Hospitals: Children & Adolescents	-0-	-0-

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

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

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

4.a. INPATIENT CARE

Priority:

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.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.

The Paint Valley ADAMH Board's utilization of state hospital services as a comparison is one of the lowest in the state. As a result our focus is on the maintenance of the community based system to provide the least restrictive alternatives and avoid hospitalization.

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

5.a. Residential Treatment Centers

Priority:

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

Increase collaboration among partners in each county.
Increase referrals to coordination for children removed or at risk for removal from home.

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

Regular meetings with member agencies.
Reports including out-of-county payments for services to children for board area presented at regular intervals.

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

Attendance by varied referral organizations within each county
Reduced referrals for out of county services
Increased non-ADAMH payor sources for those identified for out-of-county services

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

All referrals to RTCs are made to out-of-county providers. Current referrals are made by either the court system or children's services. We have good working relationships with these agencies but personnel turnover issues often result in poor communication and a flawed referral process. We hope that routine meetings and providing regular reports to key agency administrators will help alleviate some of these issues.

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

Click on gray box to enter text.

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

6.a. Adult Consumers

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

6.a.1. Area of Adult Crisis Care:

Priority:

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

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

Measurable Objectives

Discussions and/or Collaborations

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

Priority:

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

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

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

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

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

Priority:

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

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

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

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

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

Click on gray box to enter text.

6.b. Child & Adolescent Consumers

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

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

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.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	N/A	N/A
Children & Adolescents	N/A	N/A

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:

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

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

Discuss the benefits of CIT and/or other training with local law enforcement and take advantage of financial resources available for such training from NAMI Ohio.

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

To conduct law enforcement training in a selected county in FY 2009.

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

The community ADAMH System has developed and maintained positive working relationships with local law enforcement. These relationships will be useful in collaborating to identify and address training needs.

6.d.2. DISASTER PREPAREDNESS*

Priority:

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

Develop updated list of available and trained personnel.

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

Distribute surveys to agencies.

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

To increase our estimate of available and trained clinicians by 25%.

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

We need an annually updated list of the availability of the personnel that were previously trained and those that may have received approved training.

6.d.3. COLLEGES & UNIVERSITIES*

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.*

There are no plans to expand community crisis services specifically to local colleges or universities.

6.d.4 PRIMARY & SECONDARY SCHOOLS

Priority:

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

Complete the study to improve access to mental health services to school-age children.

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

Contract with provider to finalize strategic plan.

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

Have a strategic plan to improve access to services adopted by the ADAMH Board by the 2nd quarter of FY 2009.

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

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

Click on gray box to enter text.

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

7.a. Adult Services.

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

7.a.1. Area of Adult Services:

Priority:

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

To meet the clinical needs of patients who are most seriously mentally ill in a timely manner.

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

Due to funding cuts, the community mental health center has been forced to reduce psychiatric care access for adults. The following criteria applies in evaluating which clients have priority for access:

- Clients added to physicians’ schedules should be adults who carry diagnoses of psychosis, bipolar disorder, schizophrenia, or major depression.
- Individuals being discharged from a state hospital or the residential treatment center should be being scheduled within 2 weeks of discharge. Individuals being discharged from private hospitals should be scheduled as soon as possible but may need to wait as long as 3 or 4 weeks.
- Referrals to the psychiatrist from primary care physicians are scheduled if they meet the scheduling criteria.

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

Access to psychiatric care for adults will not exceed 60 days.

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

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

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

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

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

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

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

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

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

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

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

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

Click on gray box to enter text.

7.b. Child & Adolescent Services.

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

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

Goals: *Click on gray box to enter text.*
To meet the clinical needs of patients who are most seriously emotionally disturbed in a timely manner.

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

Due to funding cuts, the community mental health center has been forced to reduce access for children and adolescents to psychiatric care. The following are criteria and we have new service applicants

- Clients added to physicians' schedules should be children or adolescents with a diagnosis of psychoses, bipolar disorder, schizophrenia or depression.

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

Access to psychiatric care for children will not exceed 60 days.

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

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

Priority: High

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

To provide community based services for children and adolescents who have IEPs identifying them as SED and to return them to regular classroom settings as quickly as possible

Strategies *Click on gray box to enter text.*

To provide various ancillary services, i.e., medication therapy, CPST, group and individual treatment as needed in a team approach to restore highest level of functioning

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

Improved grades, decreased criminal justice involvement, improved scores on the Ohio Scales

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

The partial hospitalization program located in Highland County collaborates with all local school systems and the local ESC to determine how best to provide services for the population that is served by this program.

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

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

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

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

Priority: **High**

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

To continue the Criminal Justice SAMI IDDT/ACT Program.

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

Search for state or national grant resources to enable continuation of SAMI IDDT/ACT services for individuals returning to the community from the criminal justice system

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

Write and submit at least one grant within the next two years.

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

The Criminal Justice SAMI IDDT/ACT Re-entry Program has achieved high fidelity to both the IDDT and ACT models and been recognized on both a state (ODMH Forensic Leadership Award) and national level (SAMHSA Science and Service Award). The program has established and maintained a strong collaborative relationship with courts, probation officers, law enforcement personnel, adult parole authority, and other community stake holders.

Click on gray box to enter name of practice:

7.c.2. PRACTICE: **Intensive Home-Based CPST for at risk children and youth**

Priority: **High**

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

Seek opportunities to expand the intensive home-based CPST program.

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

Seek grant opportunities to expand the program. Take advantage of ABC funds if there is another grant cycle that includes funding for intensive home-based treatment.

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

Expand services to an additional 50 families.

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

The community mental health center is using a treatment model identified in the 2004-2005 New Research in Mental Health publication as a promising practice. Further work is in process toward advancing this promising practice to a best practice. The intensive home-based program is strongly supported by all Family and Children First Councils in the service district, including support for expansion of the program.

Click on gray box to enter name of practice:

7.c.3. PRACTICE:

Priority:

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

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

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

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

Click on gray box to enter name of practice:

7.c.4. PRACTICE:

Priority:

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

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

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

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

Click on gray box to enter name of practice:

7.c.5. PRACTICE:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

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

8.a.1. Area of Workforce Development:

Priority:

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

Strategies *Click on gray box to enter text.*

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

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

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

8.a.2. Area of Workforce Development:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

9.a. Adults

9.a.1. ADULT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority:

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

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

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

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

9.a.2 ADULT RECIDIVISM

Priority:

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

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

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

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

9.a.3. ADULT DIVERSION

Priority:

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

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

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

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

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

Click on gray box to enter text.

9.b. Adolescents

9.b.1. ADOLESCENT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority:

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

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

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

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

9.b.2. ADOLESCENT RECIDIVISM

Priority:

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

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

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

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

9.b.3. ADOLESCENT DIVERSION

Priority:

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

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:

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

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

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

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

9.c.2. DETENTION CENTERS

Priority:

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

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

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

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

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

Priority:

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

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

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

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

9.c.4. NURSING HOMES

Priority:

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

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

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

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

9.c.5. PRISON RE-ENTRY

Priority:

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

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

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

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

9.c.6. PHYSICAL & MENTAL HEALTH INTEGRATION

Priority:

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

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

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

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

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

9.c.7. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.8. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.9. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

10.a. SUICIDE PREVENTION

Click on gray box to enter priority level.

Priority:

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

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 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.*

Data from website surveys will indicate at least 70% satisfaction rating with array of services and 80% satisfaction rating with provider staff.

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

11.b. STAFF RECRUITMENT

Priority:

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

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

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

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

11.c. STAFF TRAINING

Priority:

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

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

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

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

11.d. ADDRESSING DISPARITIES IN ACCESS AND OUTCOMES

Priority:

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

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

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

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

Click on gray box to enter text.

11.e. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box and enter text.

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.

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.

Board staff routinely examine provider agency quality assurance reports to identify problem areas and evaluate consumer’s ability to access services in a timely manner. Contract agencies are required to measure client satisfaction annually. Results of client surveys are reviewed by board staff as well. Board staff will continue to monitor agency adherence to licensure and certification deadlines and plans for improvement. The Board also intends to work closely with providers to improve commitment and adherence to the Consumer Outcomes System.	E.1
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E.2. How does the Board plan to develop and use various databases, (e.g., MACSIS, Outcomes, Behavioral Health Module) to evaluate the effectiveness and efficiency of services?

Click on gray box and enter text.

The Board is developing reports that will be used to routinely evaluate services. These reports are compilations from providers and MACSIS data to retrieve not only SMD and SED data services provided by county. The Board’s Director of Information Management will compile various reports utilizing MACSIS, Outcomes, BH Mod and Care Management reports produced by The Ohio Association of County Behavioral Health Authorities.	E.2
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E.3. To what extent does the Board need technical assistance concerning compliance with ORC 340.03? (Guidelines for ORC 340.03 appear in Appendix D.)

Click on gray box and enter text.

	E.3
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Form 1

Board Appointment Data Sheet

Form 2

Community Board Resources

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

Name	Street Address	City	Zip	Phone Number	Email
Gary Kreuchauf Interim	S.R. 159	Chillicothe	45601	740-775-1260	gkreuchauf@svmhc.org

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
Bill Hicks, Supervisor	ODMH Office of Forensic Svcs, 30 E. Broad St., Suite 2435	Columbus	43215	614-644-8905	
Willa Meredith	CCI, 15802 S.R. 104	Chillicothe	45601	740-774-7080	Willa.meredith@odrc.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
D. June Frey	394 Chestnut Street	Chillicothe	45601	740-773-2283	jfrey@pvadamh.org

