Wood County ADAMHS Board

Community Plan For SFY 2010-2011

May 1, 2009

Mission Statement

MISSION STATEMENT

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The Wood County Alcohol, Drug Addiction and Mental Health Services Board accepts as its mission the following tasks:

To provide comprehensive, quality, fundamental alcohol, drug addiction and mental health services to the citizens of Wood County in a timely and effective manner regardless of their ability to pay.

To develop methods to assess and project the needs to be met by this Board in a systematic, objective manner and to assure ourselves and our fellow citizens that those needs are being addressed in a cost effective and accountable manner.

To ensure comprehensive community support systems and to encourage the development of self-help groups for Wood County citizens who suffer disabling mental illnesses, mental health disorders, alcohol or drug addiction, and for members of their families.

To reduce community indifference regarding the needs of citizens who are serviced by this Board by educating ourselves and our fellow citizens regarding those needs and the services available to meet them and by advocating with appropriate social, political, and bureaucratic entities the allocation of resources to meet those needs.

To develop strategies and procedures to improve communication among this Board and its agencies, with particular attention to setting priorities, providing evaluative feedback, clarifying expectations and enhancing cooperative relationships.

To develop strategies and procedures to evaluate the services provided on behalf of this Board.

Vision Statement

The Board does not yet have a Vision Statement, but we do have a list of Board strategic Goals:

BOARD GOALS

COMMUNITY RELATIONS
Goals: Promote client empowerment
Goal: Provider collaboration/cooperation
Goal: Promote knowledge of system of care in the community

STRATEGIC TOOLS
Goal: Increase service accountability and penetration rates
Goal: Increase access to services for alcohol, drug clients

GOVERNANCE
Goal: Board direction will be guided by its mission
Goal: Board will identify itself as “Purchaser” and will determine service expansion and resolution
Goal: Board purchasing will follow principles of recovery and resiliency
Goal: Board will encourage stakeholder collaboration

BOARD ACCOUNTABILITY
Goal: Develop a system of funding client services
Goal: Assess program results, in terms of cost/quality/and outcome

FUNDING
Goal: Maximize the utilization of State and Federal funding to meet client needs

LEVY
Goal: Develop levy plans both short and long term

PROGRAMMATIC
Goal: Increase responsiveness to consumer needs

Goal: Institute recovery based services delivered in cost effective, outcome focused manner

ACHIEVEMENT
Goal: Continually assess community need
Goal: Develop programming to meet needs

Value Statements

VALUE STATEMENTS

HONESTY
Goal: Open Communication/discussion

TEAMWORK
Goal: Engage in informal and inclusion discussion
Goal: Open to ideas that address consumer needs
Goal: Work collaboratively and be solution focused

COMMUNICATION
Goal: Open, respectful, accurate and timely communication

INTEGRITY
Goal: Act in accord with organizational principles and its values, mission and vision to formulate decisions

ACHIEVEMENT/COMPETENCY
Goal: Act with integrity
Goal: Set honest, realistic goals oriented toward the quality of the system of care

Goal: Provide public awareness of the system of care accomplishments

COMMUNITY/HELPING
Goal: Invoke the community to address consumer needs
Goal: Inform the public on relevant issues
Goal: Encourage participants/solicit input and feed back
Goal: Share accomplishments

Section I: Current Circumstances / "As-Is" State

Legal Context of the Community Plan

The Wood County ADAMHS Board is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and/or the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol, drug addiction and mental health services in its service area. Four ADAS Boards submit plans to ODADAS, four CMH Boards submit plans to ODMH, and 46 ADAMHS Boards submit their community plan to both Departments. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. This plan covers state fiscal years (SFYs) 2010 – 2011 (July 1, 2009 through June 30, 2011). The requirements for the community plan are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning.

Ohio Revised Code (ORC) 340.03 and 340.033 – Board Responsibilities

Section 340.03(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for mental health services. Among the responsibilities of the Board described in the legislation are a follows:
1) Identify community mental health needs
2) Identify services the Board intends to make available including crisis intervention services
3) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies
4) Review and evaluate the quality, effectiveness, and efficiency of services
5) Recruit and promote local financial support for mental health programs from private and public sources

Section 340.033(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for alcohol and other drug addiction services. Among the responsibilities of the Board described in the legislation are as follows:
1) Assessing service needs and evaluating the need for programs;
2) Setting priorities;
3) Developing operational plans in cooperation with other local and regional planning and development bodies;
4) Reviewing and evaluating substance abuse programs;
5) Promoting, arranging and implementing working agreements with public and private social agencies and with judicial agencies; and
6) Assuring effective services that are of high quality.

ORC Section 340.033(H) (H.B. 484)

Section 340.033(H) of the ORC requires ADAMHS and ADAS Boards to consult with county commissioners in setting priorities and developing plans for services for Public Children Services Agency (PCSA) service recipients referred for alcohol and other drug treatment. The plan must identify monies the Board and County Commissioners have available to fund the services jointly. The legislation prioritizes services, as outlined in Section 340.15 of the ORC, to parents, guardians and care givers of children involved in the child welfare system.

OAC Section 5122-29-10(B)

An section of Ohio Administrative Code (OAC) addresses the requirements of crisis intervention mental health services. According to OAC Section 5122-29-10(B), crisis intervention mental health service shall consist of the following required elements:

(1) Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by

ODMH for the crisis intervention mental health service;
(2) Provision for de-escalation, stabilization and/or resolution of the crisis;
(3) Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to: risk assessments, de-escalation techniques/suicide prevention, mental status evaluation, available community resources, and procedures for voluntary/involuntary hospitalization. Providers of crisis intervention mental health services shall also have current training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
(4) Policies and procedures that address coordination with and use of other community and emergency systems.

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop an HIV Early Intervention Investor Target and include: Butler ADAS, Eastern Miami Valley ADAMHS, Cuyahoga ADAS, Franklin ADAMHS, Hamilton ADAMHS, Lorain ADAS, Lucas ADAMHS, Mahoning ADAS, Montgomery ADAMHS, Summit ADAMHS and Stark ADAMHS Boards.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty (20) percent of federal funds be used for prevention services to reduce the risk of alcohol and other drug abuse for individuals who do not require treatment for substance abuse.

Federal Mental Health Block Grant

The federal Mental Health Block Grant (MHBG) is awarded to states to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The MHBG is also a vehicle for transforming the mental health system to support recovery and resiliency of persons with SMI and SED. Funds may also be used to conduct planning, evaluation, administration and educational activities related to the provision of services included in Ohio's MHBG Plan.

Environmental Context for the Community Plan

Board Area and Clients Served

<u>Board Area and Clients Served including recent trends such as changes in services and populations</u>

II.A.1 - Major System Accomplishments

In November, Wood County voters passed a replacement Levy by a comfortable margin. The passage of this levy will help to reverse the some of the impact of the State budget cuts we sustained so far in FY2009. However, we will not realize any increase in local levy funds until March, 2010. We anticipate receiving the full increase in levy funds (estimated to be about $600,000) until FY2011.

Since the FY2009 Community Plan, the Wood County Board system of care has achieved several notable accomplishments.

The Alcohol, Tobacco and Other Drug (ATOD) prevention services, provided by the Wood County Educational Service Center (ESC), earned national and state recognition. First this program received the Federal 2008 Substance Abuse and Mental Health Services Administration (SAMHSA) “Science and

Service Award" for "exemplary implementation of evidence based interventions important in preventing or treating mental illness or substance abuse. This was one of only 29 award winners nationwide. The second award was the ODADAS "Exemplary Program Award" for 2009. This program previously earned this award in 2006.

The same ATOD program also was able to leverage the Board's investment to obtain two Federal Grants to expand services offered and Obtaining ODADAS certification. The first grant is the "Grant to Reduce Alcohol Abuse in Secondary Schools" which totals $377,000 per year, renewable for three years. The second grant is the "School Based Drug Testing Program for Schools" for $174,587 which is renewable for three years.

Wood County's Suicide Prevention Coalition sponsored, with Board investment, the second successful annual "Walk out of Darkness" suicide prevention awareness event. This event received a great deal of media attention focused on anti-stigma messages and drew participation from throughout the county. This activity directly addresses the widespread issue of stigma as a barrier to seeking services.

The Board's program committee studied the characteristics and needs of the priority populations in Wood County over the last 6 months to better make data-based service purchasing decisions for FY2010 and FY2011. This committee has also begun education on Evidence Based Programs to address those needs in a cost effective manner.

The Board's staff has provided a System Report Card to Board members to evaluate our system by looking at data trends over time as well as comparing our performance with other Boards in Ohio. Data sources included the Board Association's Board profile data, hospital use information contained in all of the FY09 Community Plans posted on the ODMH website, MACSIS Claims DataMart, MACSIS Claims and Member extracts.

For detailed information about Wood County's socio-demographic, economic and cultural aspects please see these two web sites:

From the U.S. Census Bureau -
http://quickfacts.census.gov/qfd/states/39/39173.html

From the Ohio Department of Development -
http://www.odod.state.oh.us/research/FILES/S0/Wood.pdf

The 2007 population estimate is 125,399.
- Whites make up almost 95% of the population
- Hispanics (of any race) make up 3.3%
- Blacks make up 1.4%
- Asians make up 1%
- Total Minority population is 6.7% (8,164)

The Wood County Board ranks 30th in population among the 50 Board areas in Ohio.
Approximately 29,000 are children under age 18 (23.7%), while there are 13,160 adults 65 years of age or older (about 11%). The County's median age is 32.6 years.

Since the 2000 Census, Wood County has grown in population by 3.6% compared to Ohio's 1% growth. The projected population for 2010 is 27,020. Bowling Green is the largest population center with almost 30,000 residents. Most of the county's population lives in the northern tier of the county.
The population is relatively well educated with 10.3% holding a Master's degree or higher. About 16% hold a bachelor's degree, 20.4% have some college but no degree, and about 35% have a high school diploma. Only 11.4% have no diploma. There are two major institutions of higher learning: Bowling Green State University and Owens Community College

Median family annual income is approximately $51,000. Almost 11% of the

population is below poverty.

Of the 617 square miles of Wood County, just over 80% of useable land is cropland. Thus, Wood County has a diversity of educational and vocational aspects.

Of these Wood County Residents, 3,689 were recipients of the publicly supported behavioral health services, according to MACSIS claims data.

Charts of various client populations trends from FY2001 through FY 2008 are available, and are part of our Board-approved Community Plan, but are not pasting into this text box.

. These numbers are broken down into various requested categories.

Medicaid clients make up 48% of the total Wood County clients in MACSIS.
Men make up 51.4% of all clients (48.6% of Mental Health clients & 66.3% of AOD clients)
Youth (less than 18 years old) make up 36%
Adults (18-64) make up 62%
Seniors (65+) make up fewer than 3% and are mostly men

NOTE: the preferred term for those 65 years of age and older is "seniors." "Elders" is also accepted, instead of the term "elderly," which is seen as pejorative, implying infirmity).

Priority population data is provided in appropriate responses below.

Characteristics of Clients Receiving Substance Abuse Prevention Services

II.A.2.a - (NOTE: several charts are included in our Board-approved community plan that compares prevalence rates with consumers receiving public-supported, of ADAMHS Board supported, treatment. Also included in the plan are graphs of trend data for these treatment populations, including prevention units, AOD clients, SED youth, SMD adults and non-SED/SMD clients. These charts and graphs are part of our community plan, which truly is a living document/plan for the Board. This information has been and is being regularly consulted by Board committees, consumers, advocates, Family and Children First Council, other agency stakeholders and contract providers. Unfortunately, these graphics are not capable of being pasted into this web portal. These are available upon request and would help inform the reviewer of our ongoing planning that has occurred over the past 12 months. I have provided the text summaries of the latest data as text, but it is missing the trend data, which we have collectively found to be very informative to our planning process.)

The Board includes the general population as a priority population for prevention/education services and crisis intervention services. Many of our prevention services target the general population (universal prevention), as well as those at risk (selected services) and those with identified treatment needs (indicated services).

Wood County ADAMHS Board Priority Populations

Order of priority is from the inner circle out, with the three inner circles equal in terms of priority.

1. SED Youth
2. SMD Adults
3. AOD clients of all ages
4. The general population
5. Non-SMD/SED, Non-AOD, Non-Medicaid eligible consumers

Towards the goal of providing evidence-based ATOD prevention services to all youth, the Wood County Educational Service Center (ESC) offers prevention programs to over 18,000 students each year in 1st-12th grade in nine public school districts, a career center, four parochial schools,

detainees in the juvenile detention center, and parents and communities in Wood County. Students live in suburban and rural communities. Prevention services are available for universal, selected, and indicated populations. Several of these programs are evidence-based (e.g., Babes and Life Skills).

In 2008, the ADAMHS Board commissioned a second Wood County Youth Survey performed by Dr. Bill Ivaska, Owens Community College, updating and noting changes from the 2006 survey. This survey was administered to all Wood County youth in grades 5-12. Results showed decline in use since 2006 for: nicotine, Alcohol, marijuana, Ecstasy, LSD, narcotic painkillers, and cocaine. There was some increase use for inhalants.

This study included collaboration with Dr. Bill Donnelly, Clinical Director at Children's Resource Center, studied Substance use data with Symptom Distress measures from the Ohio Scales, which showed that there exists a significant overlap between substance use and mental health distress.

The study also looked at youth who were participants in the Life Skills prevention program and results showed a significant impact in terms of less subsequent use of substances compared with students not participating in the Life Skills program. This is consistent with the data on the effectiveness of this prevention program.

Behavioral Connections also provides indicated prevention/education program for youth referred from the local courts for substance use while driving. This is a weekend course.

For youth, but also for adults across the lifespan, the establishment of community coalitions in four communities in Wood County has ushered in greater awareness of drug abuse, provided widespread anti-stigma messages and has increased a sense of empowerment for families and communities. These coalitions include participants across the lifespan. Also, there is a Wood County Prevention Coalition that involves many social service agencies, other prevention programs and community members. This coalition meets quarterly to further inform and coordinate prevention programs throughout the county.

One of the local coalitions is the parent organization of Prevention Partners, a Perrysburg-based program that receives ODADAS funds, as a flow-through the Board. They sponsor a Teen Board and provide the Babes program. While they do not provide Life Skills, they provide a number of community and school based programs. ESC provides onsite prevention programming in Perrysburg's schools and the two organizations are collaborating on several projects.

Rural Opportunities, Inc. also receives ODADAS funding (Board flow-through funds) for prevention programs to the Hispanic youth population in the County.

There is no specific Substance Abuse prevention program targeting seniors (the preferred term for those 65 years of age and older, instead of "elderly" which is being seen as pejorative, implying infirmity).

<u>Characteristics of Clients Receiving Substance Abuse Treatment and Recovery Support Services</u>

II.A.2.b - (NOTE: several charts are included in our Board-approved community plan that compares prevalence rates with consumers receiving public-supported, of ADAMHS Board supported, treatment. Also included in the plan are graphs of trend data for these treatment populations, including prevention units, AOD clients, SED youth, SMD adults and non-SED/SMD clients. These charts and graphs are part of our community plan, which truly is a living document/plan for the Board. This information has been and is being regularly consulted by Board committees, consumers, advocates, Family and Children First Council, other agency stakeholders and contract providers. Unfortunately, these graphics are not capable of being pasted into this web portal. These are available upon request and would help inform the reviewer of our ongoing planning that has occurred

over the past 12 months. I have provided the text summaries of the latest data as text, but it is missing the trend data, which we have collectively found to be very informative to our planning process.)

Residents with substance abuse and dependency problems are priority populations for Wood County (see section II.A.2.a, above).

Based on national prevalence data, approximately 10,000 Wood County residents suffer substance abuse or dependency each year.
MACSIS Claims data indicates that 668 county residents received treatment for Substance abuse or dependency in FY08. (Chart of client trends since 2001 available on request).

Here is the client trend broken down by youth (under 18 years old) and adults for our in-county contract providers.

Age Groups: Of the 546 Adults receiving AOD treatment services in FY08, only 6 of them were 65 or older.

Despite having a Women's Residential unit, Wood County's gender breakdown reveals that almost two-thirds of clients are men (66.3%).

It should be noted that approximately 50 adults and several youth receive Integrated Dual Diagnosis services, which have been billed in MACSIS as mental health services via MACSIS guidelines, agreed to by the Departments. These individual would not show up in FY08 as AOD clients.

Wood County is concerned by the low penetration rate (overall and compared with other Board areas) for this priority population and planning will be undertaken to address this early in FY2010. It is one of the Board's Goals (see above).

Behavioral Connections is the primary provider of AOD services in Wood County, serving all age groups. In addition to outpatient services, they also provide Women's Residential services. Some Wood County residents seek and receive AOD treatment services through Allies in Mental Health, and a couple of other providers, but these services are not subsidized by, nor do these providers receive, any Board funds since we do not contract with any of other providers for AOD treatment services other than BCWC and so a small degree, CRC.

For those residents needing inpatient or residential treatment, access is available through the Women's Residential Program (Devlac Hall) of BCWC and, for men, Compass, Inc. in Toledo.

CRC is working with consultants from the Center for Innovative Practice to further implement integrated dual disorders treatment for youth according to evidence based practice guidelines.

Characteristics of Clients Receiving Mental Health Prevention, Consultation & Education (P, C&E) Services including Crisis Intervention Teams

II.A.2.c - (NOTE: several charts are included in our Board-approved community plan that compares prevalence rates with consumers receiving public-supported, of ADAMHS Board supported, treatment. Also included in the plan are graphs of trend data for these treatment populations, including prevention units, AOD clients, SED youth, SMD adults and non-SED/SMD clients. These charts and graphs are part of our community plan, which truly is a living document/plan for the Board. This information has been and is being regularly consulted by Board committees, consumers, advocates, Family and Children First Council, other agency stakeholders and contract providers. Unfortunately, these graphics are not capable of being pasted into this web portal. These are available upon request and would help inform the reviewer of our ongoing planning that has occurred over the past 12 months. I have provided the text summaries of the latest data as text, but it is missing the trend data, which we have collectively

found to be very informative to our planning process.)

Mental Health prevention services are quite varied and extensive in Wood County. For the last several years, Children's Resource Center (CRC) has provided suicide prevention services in several school districts. They use both the Red Flags educational program and the Columbia Teen Screen program (partially supported by the Garrett Lee Smith Grant). In addition to these evidence based programs, they do other educational services and presentations and provide consultation in the school setting.

The Board, with CRC, founded the Wood County Suicide Prevention Coalition in January 2005, with the help of the ODMH Incentive Grant in FY2005 and subsequent Continuation Grant in FY2007 from the Ohio Suicide Prevention Foundation. The Coalition has over 100 members of varying degrees of participation, which broadly represents the county. The Board provides up to $10,000 per annum in local levy funds to help with the Coalition's mission.

Notable achievements include: two successful Out of Darkness community walks, several presentations of the play "Eric and Elliott", a several billboard campaigns following current research, many gatekeeper trainings, and many other activities provided or overseen by relevant committees, including: Elders and Caretakers Committee, Youth Committee, Media Committee, Clinical Population Committees. Less active and newly formed committees include: clergy, veterans and Survivors of Suicide.

The activities and media campaign of the Wood County Suicide Prevention Coalition have as a major goal to inform the public of: 1) the problems of suicide, depression and other mental and substance use disorders; 2) that treatment is effective for these conditions; and 3) to encourage help-seeking via anti-stigma messages.

Training of behavioral health clinicians, other first responders and health care professionals have been provided by Behavioral Connections' (BCWC) Clinical Director, who has special training in this area, and through a collaborative training workshop with Bowling Green State University's College of Health. BCWC has provided three trainings to local professionals and interested community members on assessing and treating suicidal individuals. This one-day training teaches the clinical competencies approved by the Ohio Suicide Prevention Foundation and the National Suicide Prevention Resource Center.

Recently, with local funds collected via the Out of Darkness Walks, we were able to send several people to Survivors of Suicide Group Facilitator trainings and now have two SOS groups in operation, one a peer-provided group through a local church and the other is professionally provided.

Other critical outreach/prevention activities are provided via CRC with consultation/education provided to preschools in the county. CRC has delivered the evidence based Incredible Years programming to children and parents in both prevention and clinical settings, some of them school-based.

The Family and Child Abuse Prevention Center (FCAPC) office in Wood County provides the Sexual Abuse Prevention Program, in collaboration with CRC. This program provides a developmentally appropriate prevention/education curriculum for kindergarten and third grade school children throughout the county. A significant proportion of this programming is to promote awareness, help-seeking and coping skills.

FCAPC also offers domestic violence prevention programming and "date rape" prevention education for Junior High school students.

The Board's Education Committee is made up of a Board member, Board staff and representatives from all or our contract provider agencies and is involved in public education about our system of care, anti-stigma messages and that treatment works.

The county has a Wood County Schools Critical Incident Response Plan, which provides emergency/crisis response throughout the county. All three

contract providers are involved in responding to such crises, along with law enforcement and other First Responders, as necessary. The plan is very comprehensive and has been continually updated. The professional Crisis Team has been used on all occasions of youth suicide (along with each school, which participates in the plan as well), or other deaths that may impact the community. Appropriate community first responders are always included in the crisis response, as appropriate.

CIT program

Board Executive Director Larry Mershman met with the Wood County Sheriff in June, 2006. In August 2006, with the Sheriff's assistance, the concept of CIT presented to the Wood County Police Chiefs' Association and they endorsed a plan for implementation of this training. A curriculum group was then organized which included officers from Wood County Sheriff's Department, the Bowling Green Police, Behavioral Connections of Wood County and the ADAMHS Board. The curriculum that was developed was introduced to first Wood County CIT class in January, 2007. Our local NAMI group also provides some of the training, as well. Since there have been 7 CIT trainings and more than 135 Wood County police officials have been trained in dealing with mentally ill individuals. This has resulted in excellent communication between the law enforcement and mental health/substance abuse systems. This has facilitated resolution of crisis involving mentally ill and police in dangerous situations.

Outcomes: Board staff has been informed though members of NAMI and consumers that their interactions with a number of police over the last year has greatly improved, especially by officers wearing the CIT badge. Further, NAMI has experienced increased contacts by consumers and family members due to information provided by CIT trained officers.

Disaster Preparedness

The Board has provided disaster training for all provider agencies and coordinated a train-the-trainers for NW Ohio mental health. The CRC clinical director is a member of ODMH All-Hazards' Advisory Committee, coordination with health department and EMA, participation in disaster drills (EMA, Police and Fire, hospital, health department), local disaster preparedness committee, and pandemic flu committee. Behavioral Connections' Clinical Director and staff have also been very involved in this effort.

The Board, with appropriate parties, has developed a mental health response annex in conjunction with the Wood County Emergency Management Agency. In addition, the Board has participated in regional disaster preparedness activities.

CRC coordinates the Wood County Schools Critical Incident Response Plan, a plan for coordinated mental health response to traumatic events effecting primary and secondary schools throughout the county. This model has been presented at the 2005 and 2007 ODMH-ODADAS Disaster Preparedness Conference, Joining Forces. BGSU Counseling Center Director participates on the Wood County Mental Health Disaster Planning Committee. In conjunction with the Director of Clinical Training of the BGSU Psychology Department they helped developed the ODMH state-wide curriculum for Disaster Preparedness and they sit on the ODMH University Partners Disaster Group.

One significant problem is that virtually all mental health participation in disaster planning, preparedness and response is done without reimbursement to providers or the board. Providers and the Board are challenged to maintain training and participation.

<u>Characteristics of Clients Receiving Mental Treatment and Recovery Support Services</u>

II.A.2.d - The Board contracts with three provider agencies to provide Rehabilitation Options services (BCWC, CRC and Family Services of Northwest Ohio. Family Services provides only Diagnostic Assessment, Counseling and Pharmacological Management services, the other two provide

the full range except for adult Partial Hospitalization.

Additional non-Rehabilitation Services are provided by CRC and BCWC (see list in appendices).

The Board has prioritized Severely Emotionally Disturbed (SED) youth and Severely Mentally Disabled (SMD) adult clients, consistent with Departmental and National mandates/priorities.

(NOTE: several charts are included in our Board-approved community plan that compares prevalence rates with consumers receiving public-supported, of ADAMHS Board supported, treatment. Also included in the plan are graphs of trend data for these treatment populations, including prevention units, AOD clients, SED youth, SMD adults and non-SED/SMD clients. These charts and graphs are part of our community plan, which truly is a living document/plan for the Board. This information has been and is being regularly consulted by Board committees, consumers, advocates, Family and Children First Council, other agency stakeholders and contract providers. Unfortunately, these graphics are not capable of being pasted into this web portal. These are available upon request and would help inform the reviewer of our ongoing planning that has occurred over the past 12 months. I have provided the text summaries of the latest data as text, but it is missing the trend data, which we have collectively found to be very informative to our planning process.)

For SED, the following information is provided:

Prevalence rates indicate that approximately 3000 Wood County youth suffer from a serious emotional disorder (SED) each year. in FY2008, the ADAMHS system (based on MACSIS Claims and Member data) provided services to 821 SED youth in need of public support.

Below is the trend data from MACSIS Claims Datamart:

On a per capita basis, Wood County ranks 15th in SED penetration among the 50 Board areas.

The total number of youth clients subsidized by the Wood County Board in FY08 was 1,283. This is

Medicaid breakdown:
    Number of Medicaid clients was 857 of the 1283 total youth clients (almost 67%)
    Number of Medicaid SED clients was 554 of 821 total SED clients (67.5%)

Gender breakdown;
    533 of the total number of youth clients were female (about 42%)
    Of the total SED population of 821, 328 were female (about 40%)

CRC is the primary provider for children's services. They provide Intensive Home Based services, school-based services in five school districts and consultation to all other schools. CRC provides a small residential unit, which has greatly reduced the need for hospitalization and out of home/county placements. Their collaboration with many other agencies in providing outreach, treatment services is robust. They have excellent relations with our county school districts and jointly provide services for youth identified as educationally disabled and SED, via the PATH program with ESC. As an example of their outreach and collaboration efforts for SED kids, they work with the Juvenile Detention Center, the Wood County Courts, and ESC in providing services to youth detained in the Detention Center.

Resiliency/Recovery Support for Youth

CRC has actively used ABC funding to support early child mental health screening and consultation, as well as to support consultation to Wood County Schools' classroom for emotionally disturbed youth.

FAST funds are used to support respite care and the development of social and leisure skills for youth at risk of out-of-home placement, and also to support service learning projects for these youth.

CRC has delivered Incredible Years programming to children and parents in both prevention and clinical settings, some of them school-based.

CRC co-chairs the Wood County multi-agency cluster for service coordination; the cluster assisted our local NAMI office in the implementation of Hand-to-Hand trainings at CRC. The Hand-to-Hand classes prepare families with knowledge and practical tips to help provide a resilient family environment.

CRC also provides education and consultation to all area nursery schools on behavioral problem prevention and correction, as well as strategies that promote resilience.

Adult SMD Services/Population

Most recent prevalence rates suggest that approximately 7,600 Wood County residents (out of 94,500 adults) suffer a serious mental illness (SMD). 834 residents received public-supported (ADAMHS Board) treatment. This is approximately 11% of the total estimated need.

1,859 Wood County adults received publicly supported treatment.

Data Sources for both charts (which are not presented here as we could not paste them into this web based system) are from MACSIS Claims Extracts and Claims DataMart. The Wood County Board does not yet have its own definition of SMD, and thus uses the ODMH MACSIS algorithm for determination of this designation. The only exception for us is that we do see clients with Borderline Personality Disorder without a qualifying Axis I diagnosis to be SMD. Fourteen clients met this condition in FY08. (Source: local MACSIS Claims extract report for Borderline Diagnosis and listing all other concurrent diagnoses by UCI. Count of UCIs with non-qualifying diagnosis for SMD according to ODMH algorithm).

The total number of Adults aged 18-64 who received public (Board) subsidy in FY08 was 1913.

Number of Medicaid clients was 816 (43%)
Number of Female adult clients was 1,101 (58%)

Total number of SMD clients was 823 (43%)

Number of Medicaid SMD clients was 418 (51%)
Number of Female SMD clients was 514 (62.5%)

The Total number of Adults aged 65+ in FY08 was 95

Number of Medicaid senior clients was 39 (41%)
Number of Female senior clients was 61 (64%)

The total number of SMD seniors was 40 in FY08 (42%)

Number of Medicaid SMD senior clients was 22 (55%)
Number of Female SMD senior clients was 28 (70%)

Adult Services are primarily provided by BCWC, with Family Services playing the critical Recovery-oriented role of providing a choice for consumers wanting services from another provider. Both agencies provide services for SMD and non-SMD clients.

Family Services provides Diagnostic Assessment, Group and Individual Counseling and Pharmacological Management, and periodically as needed,

Community Psychiatric Support. BCWC offers the complete array of Rehabilitation Options Services, except for Partial Hospitalization (PH). PH is not offered as the agency's internal quality improvement process has identified intensive outpatient counseling as more cost-effective. Some of these intensive outpatient groups utilize Dialectical Behavioral Therapy (an evidence based service) for clients with Borderline Personality Disorder. Motivational Interviewing (an evidence based service) is provided for adults with dual diagnoses of mental illness and substance abuse disorder.

Recovery supports for Adults with Severe Mental Illness

In the Spring of 2007, the Board began providing funding for the local county-wide chapter of NAMI to obtain an independent office and hire an executive director. Since that time, many programs have expanded through NAMI operations. Membership has also increased significantly. The number of Family-to-Family trainings has continued to increase in our county. Membership has increased significantly from a year ago, along with donations. Resources offered include a growing lending library, a newsletter and informative brochures. NAMI is continuing to offer Hand-to-Hand classes. This development occurred via collaboration with our primary children's provider (Children's Resource Center) and NAMI. The achievements thus far have exceeded lofty expectation.

NAMI is also doing much more for consumers, as well as continuing to support family members. They enabled a consumer to start our first consumer peer support group. They also secured AmeriCorps grants to provide for two part-time consumer support persons, who will be learning more about providing peer mentoring and advocacy. This is also a first for our county.

NAMI helped start, and supports, a separate NAMI chapter for college students at Bowling Green State University. (NOTE: the Board does not provide funds for the university chapter).

Recovery Advocacy Committee: Board staff assisted a small group of consumers and community advocates to form a Recovery Advocacy Committee in December, 2007. They have written mission, vision, values and strategic goals. They encouraged others' Recovery by helping with anti-stigma campaigns, exploring new avenues for employment and consumer education. Towards this end, this group and NAMI have worked hard to secure funding to provide the first WRAP training in the county held in May, 2008. Since then, one consumer has been trained to be a WRAP peer mentor and currently provides this service. This past Fall, the RAC brought Thelma Rist to provide a public presentation as well as consultation to the committee. The RAC implemented a survey to assist with community planning for adults with SMI.

Employment: Employment services are provided to 40 or fewer clients annually in recent years. The Board, consumers and the primary adult mental health provider agency (Behavioral Connections) agree that we can and should target improving employment services and employment as an outcome for consumers. Consumers have requested the formation of a committee explore ways to improve employment opportunities for consumers. Plans are for a committee to include a number of stakeholders. (It should be noted that several years ago, the Board had Dr. Judith Cook come and present on best practices in employment services, and Supported Employment in particular. The information she provided is still available to us to assist with this new goal.)

The Board is providing approximately $200,000 for employment services in FY2009. We hope to purchase and implement the evidence-based Supported Employment services for clients, per the ODMH strategic goals in the future, perhaps as early as FY 2010. BCWC recently indicated they intend to pursue this as part of the planning process for the Community Plan. We are considering a RSC grant to enable our system of care to accomplish this.

(Note: MACSIS reports only 4 clients receiving employment services, but

services were provided to 38 clients in FY 2007 and FY08. The Board and provider agencies are studying the discrepancies between agency reports and MACSIS for non-Medicaid claims).

The Connection Center (a professionally-operated psychosocial/employment services center for clients of Behavioral Connection). Board staff worked with NAMI, consumers and Behavioral Connections staff to develop a consumer drop-in center with professional psychosocial rehabilitation services ten years ago. Clients participate with other community members on the advisory board of the center. The center has provided support for consumers in their Recovery. The Board provides approximately $150,000 for these services in the current fiscal year.

The Board is aware that this center does not meet the usual standards for a true drop-in center or for a clubhouse model. At this time, the Connection Center is not open to consumers who do not receive services from Behavioral Connections. Further, it is not a consumer-operated program, but has started employing consumers this fiscal year. Despite this, consumers continue to benefit by learning about, and receiving support for, their Recovery. The results of a recent client satisfaction survey indicate overall high satisfaction with the programs at the Connection Center. However, there is somewhat less satisfaction on a number of items (more client direction), but this is seen as a sign of growing autonomy and progress in Recovery. The Connections Center staff is working with clients to provide more consumer-desired programming, such as beginning a Wellness program. There has also been an expansion of vocational placement opportunities for consumers this fiscal year.

Housing: In the few last years, the Wood Village committee and Behavioral Connections have obtained HUD housing grants for independent living. This has enabled us to reduce some of our capacity for supported housing by enabling consumers to move into a less restrictive living situation, but with more intensive services provided, Community Psychiatric Support Treatment (CPST) in particular.

We have only recently been informed of a potential need for supportive housing for consumers with SPMI who are being released from jail. This issue will be studied in the next few months

II.A.2.e Mental Health Crisis Care Services

Question	Available In SFY 09?	Planned For SFY 10?
Community Resources & Coordination		
24/7 Hotline	Yes	Yes
24/7 Warmline	Yes	Yes
Police Coordination/CIT	Yes	Yes
Disaster Preparedness	Yes	Yes
School Response	Yes	Yes
Respite Beds for Adults	No	No
Respite Beds for Children & Adolescents (C&A)	Yes	Yes
Face-to-Face Capacity for Adult Consumers		
24/7 On-Call Psychiatric Consultation	Yes	Yes
24/7 On-Call Staffing by Clinical Supervisors	Yes	Yes
24/7 On-Call Staffing by Case Managers	Yes	Yes
Mobile Response Team	No	No
Central Location Capacity for Adult Consumers		
Crisis Care Facility	No	No
Hospital Emergency Department	Yes	Yes
Hospital contract for Crisis Observation Beds	Yes	Yes
Transportation Service to Hospital or Crisis Care Facility	Yes	Yes
Face-to-Face Capacity for C&A Consumers		
24/7 On-Call Psychiatric Consultation	Yes	Yes
24/7 On-Call Staffing by Clinical Supervisors	Yes	Yes
24/7 On-Call Staffing by Case Managers	Yes	Yes

Question	Available In SFY 09?	Planned For SFY 10?
Mobile Response Team	No	No
Central Location Capacity for C&A Consumers		
Crisis Care Facility	Yes	Yes
Hospital Emergency Department	Yes	Yes
Hospital contract for Crisis Observation Beds	No	No
Transportation Service to Hospital or Crisis Care Facility	Yes	Yes

Community Resources & Coordination - Other

At this time, we do not have specific respite bed capacity for Adults. This has not been a problem that we are aware of. We will work with our adult providers, the MR/DD system to look into costs for developing adult respite beds in the next year.

Face-to-Face Capacity for Adult Consumers - Other

While we state that we do not have Mobile Response teams, we do have a Critical Incident protocol which requires on-site clinicians for community crisis situations. Health Officers have, and will, respond to crisis situations on location as needed, usually with law enforcement as the situation demands. So we do not see a gap in service, although we do not have a designated mobile response team for all situations. However, our on-site (mobile?) crisis response has been lauded by county law enforcement agencies when such was needed. This has included suicidal individuals and those with severe psychotic symptoms at all hours, in remote locations.

Central Location Capacity for Adult Consumers - Other

Face-to-Face Capacity for C&A Consumers - Other

While we state that we do not have Mobile Response teams, we do have a Critical Incident protocol which requires on-site clinicians for community crisis situations. Health Officers have, and will, respond to crisis situations on location as needed, usually with law enforcement as the situation demands. So we do not see a gap in service, although we do not have a designated mobile response team for all situations. However, our on-site (mobile?) crisis response has been lauded by county law enforcement agencies when such was needed. This has included suicidal individuals and those with severe psychotic symptoms at all hours, in remote locations.

Central Location Capacity for C&A Consumers - Other

While we do not have a contract for hospital observation beds, on the rare occasions when these have been needed, we have been able to obtain this service through several appropriate area hospitals.

Board plans to address any gaps in the crisis care services indicated by ORC 5122-29-10(B):

II.A.2.d.i - II.A.2.e. MENTAL HEALTH CRISIS CARE SERVICES
Service Area
Available in SFY 2009? Planned for SFY 2010-2011?
Community Resources & Coordination
24/7 Hotline
Yes Yes
24/7 Warmline
Yes Yes
Police Coordination/CIT
Yes Yes
Disaster Preparedness
Yes Yes
School Response
Yes Yes
Respite Beds for Adults No
No
Respite Beds for Children & Adolescents (C&A) No
No
Other (Please specify in text box, below:)
Face-to-Face Capacity for Adult Consumers

24/7 On-Call Psychiatric Consultation
Yes Yes
24/7 On-Call Staffing by Clinical Supervisors
Yes Yes
24/7 On-Call Staffing by Case Managers
Yes Yes
Mobile Response Team No
No
Other (Please specify in text box, below:)
Central Location Capacity for Adult Consumers
Crisis Care Facility* No
No
Hospital Emergency Department*
Yes Yes
Hospital contract for Crisis Observation Beds*
Yes Yes
Transportation Service to Hospital or Crisis Care Facility
Yes Yes
Other (Please specify in text box, below:)
Face-to-Face Capacity for C&A Consumers
24/7 On-Call Psychiatric Consultation
Yes Yes
24/7 On-Call Staffing by Clinical Supervisors
Yes Yes
24/7 On-Call Staffing by Case Managers
Yes Yes
Mobile Response Team No
No
Other (Please specify in text box, below:)
Central Location Capacity for C&A Consumers

II.A.2.e.(continued) Response Needed from ADAMHS, CMH Boards for Table where "Other" was identified

NA

Identification and prioritization of training needs for personnel providing crisis intervention services and how the Board plans to address those needs in SFY 2010-11.

II.A.2.d.ii - The Board and contract provider agencies providing Crisis Intervention services are well-aware of the requirements of ORC 5122-29-10(B) and we consistently follow these requirements. Psychiatrists do not take an on-call rotation, but are available via phone from on-the-scene clinicians for consultation, and if necessary, direct contact.

Health Officers are selected by contract agency Clinical Directors, based on training and experience. Health Officer training follows rigorous curriculum. The curriculum that has been in place for a number of years is still active and meets the requirements of Code. The Health officers have received training in cultural sensitivity and training for both AOD and Mental Health issues.

Health Officers are presented to the Board's Program Committee, which reviews statutory requirements, training curriculum, basis of personnel selection and approves this for full Board action. The full Board approves a resolution affirming the Health Officers annually.

Capacity to Provide Services

Access to Services

Access to Alcohol and Drug Prevention and Treatment Services

II.B.1.a - The Board does not know why our penetration rate for substance abusing and dependent clients is so low. From client complaints reaching the Board, fees for assessment have been implicated.

We understand that there is no waiting list for these services. The Board will be studying this in FY2010.

In recent planning meetings with our local JFS Director and management team, we understand that substance abuse is a major barrier to employment for most of those served via their various programs. They have also identified substance abuse/dependence as a major factor with cases of domestic violence/child abuse.

We understand that a contract with JFS was not fulfilled by a Behavioral Health provider, which could have resulted in reduced referrals for these services.

This issue will be a top priority for improvement in FY2010.

Access to Mental Health Prevention, Recovery Support, and Treatment Services

II.B.1.b - For youth clients, CRC has recently undergone some physical re-arranging and staffing that should improve access to services.

BCWC has stated that there is less than a 5 working day waiting list to receive an assessment and BCWC has two weekly walk-in assessment clinics where clients can come to either a north county or south county site and receive an assessment on the spot. This is a waiting list for Employment Services. It does take several weeks to get an appointment with a psychiatrist.

The still-new and fledgling Recovery Advocacy Committee and Wood County NAMI will be looking to implement additional recovery and resiliency supports in Wood County in FY2010, thereby increasing access to these services. Specifically, training and outreach will occur in different locations in the county. The Board will work with these two groups to implement greater consumer advocacy, wellness training (WRAP) as well as other trainings. The intension is to see expansion of consumer support groups which have grown this year.

Workforce Development and Cultural Competence

II.B.2.a - At this time, we are not in any working relationship with the Departments to attract, retain or develop qualified direct service staff. With contract provider agencies, we have not been working with them in a direct relationship to address such. We are aware of the shortage of psychiatrists in Wood County. BCWC has handled this shortage by revamping their Pharmacological treatment services and utilizing a Nurse Practitioner to the extent possible. Child psychiatrists are also difficult to attract, but CRC has developed a relationship with two child psychiatrists that has enabled them to meet the needs.

Currently, given the Board area’s alcohol/drug utilization the available workforce seems adequate. The reputation of the School based onsite project has attracted young professionals interested in establishing a career in the prevention field.

For most adult-oriented clinicians, there appears not to be a shortage. In part this is due to the closing of a large behavioral health agency in Lucas County.

The board provided funding to CRC for specific training of personnel in the field of dual diagnosis. This training has also been available to other agencies within Wood County as part of a larger effort of collaboration. The training is modeled after a best practice approach through the Center for Innovative Practice and will be completed over a one year time period. In addition to having specific individuals more competently prepared to deal with clients in the dual disorder area, their goal is to have all staff more competently prepared to service the whole child in treatment.

BCWC, Family Services and CRC have numerous independently and

dependently licensed treatment staff. All of the dependently licensed staff are supervised by independently licensed managers.

All upper level clinical managers at BCWC have independent licenses and many MH treatment staff members have independent licenses, or at least dependent ones. Staff who work with chemically dependent individuals either have licenses or some type of substance abuse certification.

BCWC assures a high standard of work force development by evaluating new employees at 90 and 180 days and ongoing employees annually. The evaluation process requires the development of a training plan for each employee that addresses obtaining/maintaining appropriate licensure, and acceptable job performance. Each employee has an individual training plan geared specifically towards the employee's circumstances. The agency provides an all-staff training day each year; contracts with Netsmart to provide on-line trainings and tests; and each staff who provides clinical services has a clinical supervisor. Part of every employees training package is a cultural competence unit.

The threats to having adequate direct service staff for priority populations come from two sources. State budget cuts have been passed on to providers in accordance with our contract and this has resulted in the elimination of CPST clinicians. The second source has to do with our local Board-Provider contract, which will expire at the end of FY2010. This contract prevents the Board from making service purchase decisions (expansions and reductions) based upon its priorities.

II.B.2.b.1 - Part of Wood County's providers' success in maintaining a culturally diverse is due to the diverse population of graduates from local and nearby universities.

For BCWC, part of every employees training package is a cultural competence unit. The other treatment providers have stated that they employ culturally diverse clinicians at a minimum that matches the local population representation. All providers state they provide training in cultural competency on a regular basis.   All providers state that interpretive services are employed as needed for providing services for the dear and hard of hearing population.

Also, Family Services provides services for abusers, many of which are ex-offenders. For their sexual abuse offenders program, all participants are offenders. Family Services uses the Duluth Treatment Model, an evidence based practice

II.B.2.b.2 - The treatment providers have stated that they employ culturally diverse clinicians at a minimum that matches the local population representation. All providers state they provide training in cultural competency on a regular basis. All providers employ interpretive services are employed as needed for providing services for the deaf and hard of hearing population.

II.B.2.b.3 - The treatment providers have stated that they employ culturally diverse clinicians at a minimum that matches the local population representation. All providers state they provide training in cultural competency on a regular basis. Recently, we have made inroads in terms of providing services to the Arab-American population.

II.B.2.b.4 - The treatment providers have stated that they employ culturally diverse clinicians at a minimum that matches the local population representation. All providers state they provide training in cultural competency on a regular basis.

Capital Improvements

II.B.3.a - At this time, we have no plans for capital expansion.

Financial Status

Impact of reduction in services.

II.B.4.a - We have already witnessed reductions in services to our SMD population, with reduction in CPST workforce resulting in significant increase in clinician-to-client ratios. We fear that other Recovery supportive services may also become reduced. This would result in higher rates of hospitalization, crisis intervention, legal/criminal justice issues.

The other area of cuts would likely come in the broad area of prevention. For youth, this would mean elimination of adjunctive therapy. Also there could be severe reductions for substance abuse prevention and suicide prevention. Of course the evidence is clear, this is problematic because without prevention services to prevent the problem, we end up serving the client later in life when the issues are more severe and more costly. High risk populations in partial hospitalization and Treatment Foster Care will be placed at greater risk as we reduce these services.

We do not have firm estimates of what would be further reduced/eliminated with an additional ten percent cut for treatment services, as we do not purchase services on a fee-for-service method.

A 10% cut in ATOD prevention services would in turn demand a reduction in prevention staffing. Approximately 4000 potential customers would not receive services. The program is governed by research that indicates that prevention early and often is the best way to inoculate youth and prepare them for compromising situations long before they occur. Evidence-based best practice programs often dictate that multiple years of the program implementation build upon one another and yield the best long term results. A reduction would force us to compromise fidelity in some cases.

Factors contributing to the costs of services.

II.B.4.b - Health insurance costs have been a major factor in increasing costs. Low-to-below average billable unit production has also contributed to high unit rates. Certainly staff turnover hurts in many ways, not just financial.

What cost-saving measures and operational efficiencies.

II.B.4.c - The Board and the contract providers have cut administrative costs where we can this year. Agencies have reduced hours of non-clinical staff, reduced or eliminated programs and services in the areas considered as non priority population and sadly we have reduced our efforts in collaboration that are uncompensated care.

The greatest operational efficiency for the Wood County ATOD Prevention Program is the fact that the administrative costs for the Program Director is only a .4 FTE. Additionally, the program overhead is further reduced by no rent costs for the use of the building and a modest 4.41 % indirect cost rate to manage the program. Presently the Prevention Program operates with a unit rate of $53.11 which is considerably lower than state averages of $60-90 per unit depending on location and prevention domains.

Other budgetary planning efforts.

II.B.4.d - The Board is currently considering adoption of a Board staff recommended transformation plan for Wood County. This plan is meant to use current purchasing technology to: improve fiscal accountability, increase high priority population penetration rates (Substance abuse and SMD in particular), reduce costly hospitalization and improve service quality and outcome. The plan calls for moving from a grant funded method of purchasing services to a fee-for-service methodology, with the service incentives and improved accountability such will bring. The plan also calls for increased implementation of evidence based programs with the accountability of independent fidelity measures.

Our service purchasing discretion is currently limited by Board-Provider contract, but the contract ends with the close of FY2010. We are proposing using FY2010 to prepare for the implementation of this transition plan in FY 2011. The Board will be voting on this issue in the near future.

Tables 1 and 2: Portfolio of Providers

Section II: Capacity Development

Access to Services

As mentioned in II.B.4.d., above, the Board Staff proposed “Transition Plan” is designed to provide incentive to increase access to services. If the plan is approved by the Board, we intend to study the ways to ensure that fiscal issues are not a barrier to accessing services, perhaps by insuring that providers do not incur bad debt for Diagnostic Assessment services.

Recently we have met with the Wood County Jobs and Family Services to look at ways to increase collaboration and referrals to the Behavioral Health system. We are looking to implement Supported Employment for FY2010 and JFS is ready to be a major referral source of mentally ill clients for this service. Thus, we think this will also reduce stigma and other barriers for these people to receive treatment services as well.

Workforce Development and Cultural Competence

We are not certain what our weaknesses are for cultural competency, given our input above. However, we once again would like to request dialogue with the Departments about assessing our system and providing consultation regarding this very important area. We look forward to your assistance.

Capacity Development Targets

C.1 - ODADAS Capacity Targets adopted by the Wood County ADAMHS Board:

- Reduce stigma (eg., advocacy efforts).
- Addiction is recognized as a legitimate health care issue with an appropriate and necessary continuum of care that includes prevention/intervention and treatment and recovery services.
- An accessible, effective, seamless prevention/ intervention, treatment and recovery services continuum from childhood through adult.
- A highly effective workforce for the AOD system.
- Increase diversity of revenue sources to support Ohio's Alcohol and other drug system (e.g., apply for foundation and SAMHSA discretionary grants).
- Increase the use of “evidenced-based” policies, practices, strategies and programs in the AOD system.
- Increase the use of data within the AOD system to make informed decisions about planning and investment.

C.2 - ODMH Capacity Development Targets adopted by the Board:

- Reduce the stigma of seeking care.
- Maintain access to services to all age, ethnic, racial and gender categories.
- Improve cultural competence of mental health system.
- Maintain access to services in rural areas.
- Maintain/increase access to ACT, IDDT and Supported Employment, service enriched housing, peer support, CPST and WMR.
- Decrease nursing facility admissions and increase consumer choice consistent with Olmstead recommendations and Unified Long Term Care Budget.
- Adult and family of youth consumers report that they are satisfied with the quality of their care and participate in treatment planning.
- Increase hiring of peers.
- Increase training in EBP’s.
- Increase access to web-based training systems..
- Increase the availability of school-based mental health services.
- Increase availability of trauma-informed care.
- Increase use of best practices:
  - Wellness Management and Recovery;
  - ACT
  - IDDT;
  - Supported Employment;
  -
  - CIT;
  - Intensive Home-Based Treatment (IHBT).

- Increase diversity of funding sources as reported in FIS-040 (August).
- Evaluation of services will be planned.

Section III: Prevention Services

Prevention Needs

Needs Assessment Methodology

A.1 - 1. Needs assessments: The Board has contracted with independent consultants over the years to perform various needs assessments. As the Board has found trend data to be invaluable over a single "snap-shot" in time, we list the needs assessments that we continue to refer to. Each of these assessments involved consumer and family input. Here are the following assessments:

a. 1998 - County-wide assessment of youth and families in collaboration with Wood County's Family and Children First Council. Performed by BGSU Psychology Department and involved a representative sampling of the county, by school district. Focus on behavioral health, health and social service needs.

b. 2003 - Stakeholder survey and key informant interviews by BGSU Psychology Department to determine the perceived behavioral health issues facing adults, families and youth.

c. 2004 - Stratified sampling telephone survey by Funk, Lutke, Skunda regarding top behavioral health concerns in Wood County.

d. 2004, 2006 and 2008 – ADAMHS Board Youth Survey. Youth problem incidence survey in all Wood County schools, by Dr. Bill Ivaska, Owens Community College. Survey targets substance use and mental health concerns. This is a standard survey used in other counties, which provides the opportunity for comparisons. Survey was administered to 9,824 Wood County students in grades 5 through 12 in all public districts in Wood County including Eastwood, Elmwood, Lake, North Baltimore, Northwood, Ostego, Penta Career Center, Bowling Green and Rossford. This survey assessed alcohol, tobacco, and other drug use as well as other youth risk behaviors. Results/key findings were shared with each district listed above. Findings from the 2008 Survey were discussed above in section II.A.2.a.

f. 2005 – System Assessment and Design project, performed by Health Care Solutions (Alicia Smith, with assistance from Steve Wood). This was a very comprehensive look at our system of care. This approach studies local, state and national data about priority populations, their needs and the systems' strengths and weaknesses in meeting those needs. This very thorough and comprehensive project took over five months to complete. There were 23 major recommendations made in the final report. This work resulted in our ongoing system design (system transformation) project as mentioned in section A, above.

g. 2007 - Stratified sampling telephone survey by Funk, Lutke, Skunda; regarding top behavioral health concerns in Wood County and levy marketing survey.

h. Late Spring 2008 – The Wood County Health Department completed a county-wide needs assessment study that includes substantial data about the behavioral health needs in the county. The Health Assessment Survey was conducted by the Wood County Health Partners. It was administered to 503 adults over the age of 19 and 374 adolescents ages 15 to 18 years old to assess physical and mental community health and risk behaviors.
This data will be used in conjunction with the other data and is expected to assist the Board in developing a strategic plan to achieve the Board's Goals in FY2010 and beyond. This report can be found on the web at http://www.co.wood.oh.us/healthdepartment/CHA%20Report.htm.

i. Ongoing discussions and planning with community partners of the Wood County Family and Children's First Council, the Recovery Advocacy Committee, the Wood County Prevention Coalition and the Wood County Suicide Prevention Coalition and with regular meetings with our provider agencies, including the Wood County NAMI office. The Executive Director frequently meets with all

school superintendents at their regular meetings.

j. Invited participation in the first national Planning Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities (also referred to as the Asbury Summit”). This information has been discussed with the Wood County Council on Aging and planning has begun to address the burgeoning preventive and treatment issues for the growing senior population. Initial planning partners will include Bowling Green State University’s College of Health and the Wood County Health Department. The preliminary results indicate systems need to quickly work to implement evidence based programming in interdisciplinary settings and methods.

k. In response to the necessity of seeking new funding sources, a planning effort has begun with the Wood County Health Department will include other members of the Family and Children First Council, to prepare a cross-systems data warehouse to assist with collaborative grant writing. This is a new project and is focused on prevention needs at the outset.

l. Ongoing data analysis of prevention related data across data sources, such as suicide deaths, substance use reports and ongoing provider reports.

Needs Assessment Findings

A.2.a - Despite the relative strength of prevention programming in Wood County, the demonstrated cost-effectiveness of prevention programming and improved collaboration of prevention programs; we see a number of area of unmet prevention needs in all areas of prevention currently being provided. Recent documents indicating State cuts for prevention programs exacerbate this situation. Thus, we see current needs being met and outcomes achieved for AOD prevention, but there is more to do.

According to the Wood County ADAMHS Youth Survey, alcohol consumption rates indicate that both annual and monthly use has declined since 2004 and has either declined or held steady since 2006. Binge drinking declined in all grades except grade 11. Since 2004, both annual and monthly marijuana use trends dropped in all grades. In Wood County, 27.7 percent of seniors smoke marijuana, compared to 31.7 percent nationally. Rates of nicotine use by 12th graders declined from 27% use in 2004 to 18% use in 2008. Rates of use of other drugs such as cough medicine, narcotic painkillers, LSD, and methylphenidate have also declined from in 2004 to 2008.

Based on this, it seems clear that the current efforts of the Wood County Educational Service Center’s ATOD program have resulted in reduced use across different types of substances. Are these needs being met? Yes. However, despite the excellent progress that has been made, it is important to remain mindful of the need for additional ATOD prevention activities, particularly at the level of indicated prevention.

Data from the Problem Severity subscale of the Ohio Scales (from the 2008 Youth Survey) indicate that 10.6% of Wood County youth report significant mental health problems and 20% of Wood County youth report “moderate” mental health problems. Survey results also suggest that Youth who report more mental health problems are more likely to engage in substance use across a broad variety of substances, and are much more likely to think about suicide or make a suicide attempt.

Students in Career Based Intervention (CBI) represent a group of youth at particularly high risk for engaging in current or future substance use and abuse. Currently there is minimal ATOD prevention education in the CBI classrooms for these high risk students. Should funding become available we should plan to expand our prevention services into these classrooms. Besides providing universal education, onsite WCESC Prevention Specialists would be able to provide targeted indicated prevention education that could decrease the amount of substances already being used. Also since these youth are already at high risk for developing substance use problems, as well as co-occurring depression, the onsite WCESC Prevention Specialist would be available on a consistent basis to provide screening, referrals and support. This is an area where we are not meeting the need of students for AOD

prevention programming.

The Wood County System Assessment and Design Report highlighted the strong prevention services in Wood County, but noted the goal of improving the coordination and collaboration of the various programs. Since that 2006 report, there has been significant improvement in such collaboration and cross-training, alluded to above. To address this, WCESC Prevention Specialists have been trained in screening for suicide and other mental health problems in the students they serve. By updating this training they would be better able to identify and refer students experiencing both substance use and mental health problems.

A.2.b - Despite the relative strength of prevention programming in Wood County, the demonstrated cost-effectiveness of prevention programming and improved collaboration of prevention programs; we see a number of area of unmet prevention needs in all areas of prevention currently being provided. Recent documents indicating State cuts for prevention programs exacerbate this situation. Thus, we see current needs being met and outcomes achieved for AOD prevention, but there is more to do.

Local statistics over the past several years indicated the spike in suicide in Wood County, particularly for youth. That trend seems to have been reversed to a degree. We have suicide prevention in the schools as mentioned above. We think we are meeting the needs, but that more needs to be done for school-aged youth.

According to the Wood County Health Assessment, one-fifth (20%) of Wood County youth talked to no one when they were dealing with feelings of depression or suicide. Use of the evidence based Teen Screen may be in jeopardy due to decreased funding for Wood County. This ongoing need needs more resources. Mental health services (prevention and treatment) are not in every school, yet.

While we have begun to address the needs of juvenile detention residents with collaborative efforts (substance abuse and mental health interventions), there is much more to be done.

Data provided at the national Asbury Summit indicates the need for doing much more prevention/education for our senior residents. So, in planning meetings with the Wood Council on Aging, via joint work for suicide prevention, there have been greater planning efforts to address suicide prevention for high risk males, but also to do more for outreach to those who are isolated in our county. In addition, the evidence based program "PERLS" will be implemented in the next year. At this time, no ADAMHS Board funds will be necessary. The need for further collaboration and planning across systems has been noted as critical.

The apparent loss of State funding for the Incredible Years programming in Wood County due to state funding cuts will leave another area of unmet needs.

Prevention Priorities

Method for Determining Prevention Priorities

B.1 - We think this has been answered in A.2.a&b above. We have studied the needs assessments listed above, discussed needed prevention programming via Family and Children First Council and the Wood County Prevention Coalition and the Wood County Suicide Prevention Coalition. We have had discussions with school administrators, Judges, Law Enforcement (via CIT trainings and discussions) and ongoing dialogue with our contract providers.

Prevention programs were discussed at the Board's Program Committee meetings when discussing prevention needs for priority populations (including the general population) and evidence based programming.

This will be an ongoing discussion with all stakeholders and the Board for the next year. In order to deal with the fiscal threats from state funding reductions, there is tension between treatment and prevention priorities and stakeholders. We have begun a study of all our the prevention programs

funded in terms of priority (suicide risk, ATOD, SMD/SED indicated prevention, etc.), cost (statewide comparative unit rates via MACSIS unit rate by service, shared funding streams, etc.), quality (evidence based prevention services) and outcome (see Ivaska school survey above, participation rate trends, etc).

Grouping of Priorities (High, Medium and Low)

B.2.a - High:
1) To continue to decrease childhood/underage drinking and increase early intervention programming, we will expand selected (i.e., Insight) and indicated (i.e., Teen Intervene; Problem Id and Referral) prevention strategies to include youth in CBI programming.

2) To increase suicide prevention and increase depression screenings, we will update training for ATOD prevention specialists on suicide and depression screening and education.

3) We will continue to choose and implement evidence based methodologies and continue to implement these with fidelity.

4) Youth led prevention through the development of teen institute and junior teen institute we will continue to develop peer-based leaders in our districts and communities

Medium:
1) To continue to decrease childhood/underage drinking, we will continue implementing the evidence based prevention strategies currently in place that have been successful at decreasing and preventing substance use at a 1) universal (i.e., Stand; All Stars; BABES; Prime for Life; Class Action; Life Skills; Parents who Host Lose the Most Campaign; Red Ribbon Campaign; Teen Institute), 2) selected (i.e., Insight; Parent Project), and 3) indicated (i.e., Teen Intervene; Problem Id and Referral) level with Wood County youth, their families, and the community at a whole.

2) To continue to decrease rates of Fetal Alcohol Spectrum Disorder, we will continue to develop the Fetal Alcohol Spectrum Disorder Task Force.
3) To continue to strengthen the community's resolve for decreasing underage substance use, suicide, and depression, decrease the stigma surrounding both substance use and mental illness, and create solid communication links and partnerships to ensure no youth slips through the cracks, we will continue to build strong and lasting community coalitions.
Low: none

B.2.b - HIGH
Suicide Prevention – This next year we will maintain school-based programming, but expand outreach to veterans and seniors.

Depression Screenings, include Maternal Depression Screenings

Early Intervention programs – assuming the funding is available to continue these.

School-based mental health services/programs – we hope to maintain current services given the economic/funding situation

Stigma Reduction activities – has been a priority and will continue to be so.

Family-to-Family – will expand to the more populous northern part of the county to provide support and improve referrals for treatment services.

Hand-to-Hand – plan to expand into other areas of the county in the next two fiscal years.

Crisis Intervention Training (CIT) – to bring the number of law enforcement officers training from the current 135 to 300 in the next two fiscal years. Currently working to improve the training.

MEDIUM
General Community Presentations – especially for suicide prevention.

Implications of Identified Priorities to Other Systems

B.3 - As mentioned above, we are constantly working with other systems to improve mutual understanding, cooperation and collaboration. This has been facilitated by the various prevention coalitions which provides opportunity for mutual problem solving. This has included the Wood County Council on Aging, several law enforcement agencies, Wood County Prosecutor's office, Wood County Health Department, County School districts, and consumers.

State funding cuts may jeopardize these ongoing collaborations. Areas at risk would be early childhood prevention and early intervention programming (such as the Parent Project)and cutting back on suicide prevention programming in the schools, as mentioned above. The implications are known according to research: significantly increased treatment costs in the future along with reduced outreach and referrals to current treatment systems and more suffering and death.

Prevention Investor Targets

C.1 - The 9 Investor targets that the Board will pursue in collaboration with our contract providers and other stakeholders are:

1. Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm
2. Programs that increase the number of customers who perceive ATOD use as harmful
3. Programs that increase the number of customers who experience positive family management
4. Programs that increase the number of customers who demonstrate school bonding and educational commitment
5. Programs that increase social connectedness
6. Programs that promote mental health and wellness
7. Programs that decrease the number of persons at risk of developing mental health problems and/or at risk for suicide
8. Programs that increase the number of persons that receive mental health screenings, assessments or referrals to services
9. Programs that increase recovery, resiliency and protective factors

Section IV: Treatment and Recovery Support Services

Treatment and Recovery Support Needs

Needs Assessment Methodology.

A.1 - 1. Board data processes: Given the Board's new duties and increasing responsibilities with the state implementation of MACSIS, changes in federal and state law and other ODMH backed Behavioral Health management initiatives, the Board contracted with Superior Consulting to assess the needs and capabilities required by these changes. Based upon the recommendations of the consultant, the Board decided to upgrade its information technology and to implement MACSIS on its own. Although the Board did not implement all of the additional staff recommended, Board staff has made steady progress in our data capturing, analysis and reporting abilities.

a. We have utilized the programming capabilities of our outsourced MIS expertise, McEwen and Company. Reports have been developed to gather data from the MACSIS Member and Claims extracts. Our basic reports include the variables found in the MACSIS DataMart. This allows us to look at priority populations, by age and gender. We have developed several reports from this analysis alone.

b. MACSIS Claims DataMart and ODMH Outcomes DataMart. We have only recently begun to realize the value of the Outcomes DataMart. Related to these resources, we think when ODMH begins requiring the submission of the MACSIS Behavioral Health Module; this will assist us, and all Boards, even more.

c. As mentioned above, we have developed a Hospitalization Utilization Management database in Microsoft Access. Hospital Liaison staff enter data fields in MS Excel spreadsheets, which are imported into the database for reporting. We are looking to expand this use in the near future, tying it in with MACSIS claims extracts to determine any unmet needs in those discharged from the hospital.

d. Agency monthly and Year-end reporting. We use this information to assist with monitoring services for capacity issues and, in conjunction with the MACSIS-based data, to look for emerging utilization trends that might signal changes in service patterns and needs.

e. Board staff designed spreadsheets to capture data from a variety of sources to assist us in better monitoring and looking for changing trends and possible unmet needs. These "Service Inventory" spreadsheets allow staff to produce charts and graphs that are quickly understood and utilized for decision-making by Board members.

2. Interpersonal Processes: We need to be able to work collaboratively to address the data we are presented with and to gather experiential data.

a. Hospital Utilization Management Team consists of Board and BC staff and the functions were mentioned above. This is where the Team members meet for shared learning and mutual problem-solving.

b. Recently, Board staff has been meeting regularly with the Recovery Advocacy Committee, a small group of consumers. This provides Board staff with a better understanding of the needs of those active in their Recovery.

c. Board staff meets with providers to discuss various topics and consumer needs, as needed.

3. Processes involved with determining current needs:

a. Our current planning is driven by the client needs and assessment of our system to meet those needs in a cost-effective manner, i.e., taking into consideration: our resources, costs of services, quality of services and expected and actual outcomes. The bulk of this data comes from the System Assessment and Design (SAD) project analyses and recommendations and our own

analyses mentioned above. The SAD report not only analyzed current data and functioning, but compared it with an "Ideal" system of care. The Board's Goals are based upon this information. Board staff has updated many of the analyses from the SAD report. Our planning is in line with the Board Goals, knowing that they were adopted to address our needs in a number of areas.

Please note that the findings and subsequent twenty-three recommendations of the System Assessment and Design study were complex and may require significant system re-design and transformation. Board Goals (see above) were adopted to guide this complex and major work. The ongoing work to develop an implementation plan has been met with some debate and progress has been gradual. The Board Goals implementation plan will include many of the ODMH system transformation priorities. We see these priorities as being very congruent with the SAD report recommendations and our Board Goals.

b. Clinical Services: For all rehabilitation option services, we have used our Service Inventory data to analyze various trend lines (for client trends, service utilization and cost). The charts and tables from the Service Inventory workbooks are provided to Board members each fiscal year during our annual allocations process.

c. Recovery & Resilience: We have gathered information from Columbiana County, who we consider experts in this area, as well as from ODMH and NAMI. We have begun discussions about our system's recovery needs with consumers who have formed the Recovery Advocacy Committee. We have disseminated, collected and analyzed a Consumer Survey of 86 SMD consumers. We have discussed the needs of Recovery and Resilience with NAMI members who are aware of the needs from a family and parent perspective. And we have used information from various mental health journals. We do hold to the importance of consumer and family driven and choice as essential to supporting recovery and resiliency. Consumer input was also provided at public forums on the Community Plan.

d. For prevention, education and consultation services: We have relied upon the current best or evidence-based practices and experts' consultation. As an example, for the various suicide prevention activities we have discussed problems and issues with five recognized national leaders for advice and direction.

Findings of the Needs Assessment

A.2.a - Our own data for hospitalization use indicates a slowly increasing trend of admissions, a very gradual trend of increasing bed days, a high degree of hospitalized patients who are not known to our system and slightly increasing recidivism. Compared with other Board areas, our hospital use is relatively high.

Hospitalization needs are met through Northcoast Behavioral Health Systems, ProMedica Hospitals and in the community via pharmacological management, intensive case management, and intensive outpatient therapy. Improvement in getting appointments with clinicians for recently discharged clients is aimed to reducing recidivism.

Unmet needs based on research and other Boards' experience would be to have more effective and evidence-based, intensive programming such as ACT, IDDT and Supported Employment implemented in Wood County. While we offer IDDT, we would like to see improved Fidelity measures and witness a return to the significant effectiveness of this program when it more closely met the evidence based model.

We plan to explore ways of improving our outreach to residents with severe mental illness, improve access to services and to see improvement in our penetration rate for this priority population. We think this will reduce the number of those unknown to our system of care who are hospitalized.

A.2.b - For SED youth, we are working with contract agencies to provide evidence based dual diagnosed treatment. Consultation with the Center for Innovative Practice has been ongoing and expected to continue into FY2010.

We are already in discussion with clinical supervisors to discuss evidence

based programming for SED youth. This will be a focus of ongoing planning through FY2010 for FY2011 and beyond.

Unmet Needs:
Greater access to CPST and Pharmacological Management have been mentioned by consumers.
More effective employment services (Supported Employment) have been identified via data research, consultation with other Boards and from consumer input.
More intensive and coordinated care (ACT), based on research and consumer input.

A.2.c - At this time, no services are provided by the Families and Children's First Council. CRC has actively used ABC funding to support early child mental health screening and consultation, as well as to support consultation to Wood County Schools' classroom for emotionally disturbed youth. FAST funds are used to support respite care and the development of social and leisure skills for youth at risk of out-of-home placement, and also to support service learning projects for these youth. This has helped to meet the needs of at risk SED youth.

No unmet needs.

A.2.d - As mentioned above, our system now offers integrated services for SED/SA youth and SA/MI adults. We recognize that we are not meeting the needs of the county given our low penetration rate for all AOD clients and for Adult SMD clients. Consultation with the Center for Innovative Practices is open for all Wood County provider to address the needs of the dual diagnosed. In consultation with the local jail and NAMI, there are concerns for incarcerated adults with both substance abuse and mental illness. We intend to pursue planning with relevant stakeholders about this population.

A.2.e - In general, we believe the needs of this population are being met. Wood County has numerous other options for this population than that offered in our system of care. As the impact of the economic downturn becomes chronic, we wonder if this population will be in more need.

Given our need to prioritize diminishing state resources, this population may wind up receiving less publicly-supported services in the near future.

A.2.f - As mentioned above, we know that we do not serve nearly the need in terms of numbers of clients. We also know that compared to the other 49 Board areas, we rank in the bottom 5 for penetration rates for adults. As mentioned above, this is be a primary area of study for quality improvement in FY2010.

Treatment and Recovery Support Priorities

Method for Determining Treatment Priorities

B.1 - Utilizing our data reports, we know where we are not meeting needs. We have proposed a broad transition plan to impact all of these needs (see above). The process has involved, in addition to all the above mentioned processes, Board Committee meetings structured to education Board members about our priority populations and best practices, a System Data Report Card presented individually to Board members and a Board Retreat, where these issues were discussed with the help of an outside facilitator.

We are currently bound by our current Board-Provider contract for FY2010, but we propose this a transition year, with changes coming in FY2011.

Grouping of Priorities (High, Medium and Low)

B.2 - HIGH – Those services provided to promote Recovery to our priority populations as mentioned above. These would include all of the Rehabilitation Options services we currently provide, for both AOD and Mental Health clients. We would hope to prioritize evidence based services in FY2010 and especially in FY2011. For SMD, we also prioritize employment services, if we can have this provided as the evidence based service, "Supported Employment." While we have a number of new independent housing

options, we may need to plan for expansion of supported living services.

We would also see Prevention services as a high priority, given the tremendous cost-benefit of these services over the long run. In particular, Suicide prevention and ATOD prevention are of highest priority.

Medium – Services provided to the non-SMD/non-SED populations.

Low- out of county residents (which we now subsidize with our Grant funding methodology).

Implications of Identified Priorities to Other Systems

B.3 - The implications to other systems are being experienced now in Wood County, due to our low AOD penetration rate. We are seeing this in the justice arena and at Jobs and Family Services.

We are also concerned for Nursing homes and county jail use by Adults with SMD, perhaps undiagnosed.

We think we can do much better and our transition plan is geared toward system quality improvement.

Treatment and Recovery Support Investor Targets

Treatment and Recovery Support Investor Targets

C.1 - As already mentioned, we have targeted our priority populations and we wish to achieve the following goals:

1. Increased penetration (number of clients) for SMD, SED and especially AOD clients.
    a. Increased incentive to see more prioritized populations via fee-for-service service purchasing
    b. Reduction of Stigma
    c. Expansion of funding streams via collaborative efforts
2. Reduction in the use of hospitalization by helping consumers keep from deteriorating to that point.
3. Increased Quality of Care with greater implementation of evidence based services (listed above) and the improved Fidelity measures for currently offered evidence based services.
4. Increased accountability for public funds.
5 Expand prioritized prevention, education and consultation services (as listed above). Namely, ATOD and Suicide Prevention.
6 Growth of Recovery-oriented and Supportive programming.
7 Resiliency building for individuals, families and local communities

For AOD services:
- Number of customers who are abstinent at the completion of the program.
- Number of customers who are gainfully employed at the completion of the program.
- Number of customers who incur no new arrests at the completion of the program.
- Number of customers who live in safe, stable, permanent housing at the completion of the program.

For Mental Health Services:
- Number of consumers reporting positively about their quality of life.
- Increase competitive employment.
- Decrease school suspensions & expulsions.
- Decrease criminal and juvenile justice involvement.

ORC 340.033(H) (HB 484) Investor Target

C.2 - In meetings with our local JFS, we determined that the implementation of Supported Employment would be a tremendous help in getting those with AOD and/or mental health diagnoses into jobs and treatment. We are particularly interested in targeting outreach through such programming to those re-

entering society who had been in jail.

Investor Target

Greater number of clients with substance abuse issues getting AOD assessments and referred for treatment.
Greater number of clients abstaining from substance use.
Greater number of clients referred from JFS with mental health diagnoses and needing employment services.

HIV Early Intervention Investor Target

C.3 - NA

Section V: Collaboration

Continuity of Care Agreements

A - Wood County's 24 hour, Crisis response center, Hotline and primary information and referral source is The Link. Through the Link, Health Officers provide 24-hour crisis intervention services, including hospital pre-screening. All Health Officers are trained consistent with ODMH guidelines and receive that designation. The 35 designated Health Officers are trained on the Continuity of Care Agreement, annually.

The Board provides for a Hospital Liaison position who works with the Director of Emergency Services at BCWC and the Clinical Director to determine appropriate levels of care upon discharge from a hospital. This system is overseen on a monthly basis by the Board-BCWC Hospital Utilization Management Committee. Mutual problem-solving regarding access to care, admissions, discharges, billing and data analysis occurs during this process. As needed, and in compliance with HIPPA regulations, other community stakeholders are invited to participate in our Hospital Management meetings, e.g., law enforcement personnel.

Services available include supported living, CPST, Pharmacological Management, Counseling, Intensive CPST, Employment Services and Drop-in Center services.

Benefits/Results Derived from Collaborative Relationships

B - Collaboration Benefits/Results

Wood County Jobs and Family Services Planning Committee Input to the System Assessment and Design Report, Alcohol and Drug
Prevalence Survey.
Service Plan HB 484

Family and Children First Council Input: Alcohol and Drug Prevalence Survey and S.A.D Report, Endorsed Alcohol
and Drug Services at
Juvenile Detention,

Wood County Juvenile Court Planning meetings with court to contract for provider services at
juvenile detention
center

Municipal Courts Input into SAD Report, collaboration on treatment issues for mutual clients

Bowling Green Police Department Input into SAD Report, Joined Community, Intervention Team and Community Coalition

Wood County Sheriff's Department Input into SAD Report and Alcohol and Drug Prevalence Study.
Collaboration between
onsite ATOD and DARE

Bowling Green City Government Input into SAD. Reviewed Alcohol and Drug Prevalence results, member of
Community Coalition

Wood County Prevention Coalition Setup Quarterly meetings of all prevention providers/networking/education
or evidence based
programming

Wood County Cluster Inpatient SAD Report and Prevalence Study support greater outpatient success

Clients/Customers Customers' satisfaction surveys, focus groups, WRAP trainings, started a
Recovery Advocacy

Committee, promoting empowerment, Community Plan survey input

Community Coalition for Youth and Families Input SAD Report/ Alcohol and Drug Prevalence study support T.I/Red Ribbon. Community involvement

North Baltimore Community Coalition Review of Alcohol and Drug Prevalence Survey gives rise to develop of coalition

East Wood Community Coalition Input into SAD Report/ Alcohol and Drug Prevalence study support for parent project

Wood County Job and Family Services Advisory Board Service Planning HB. 484

Wood County Prosecutors Office Input on SAD Report/ Alcohol and Drug Prevalence Survey, Support for Parent Project and Youth Olympics

Parent Project Board Outreach and services to families

Contract Provider Input rise SAD Report/ Alcohol and Drug prevalence Survey. Service development and provision

School Superintendents Service planning for ATOD onsite project, Parent Project. Input into SAD Report and Alcohol and Drug Prevalence Survey.

W.B.G.U./T.V. Produced "Community Cares" Service

Wood County Council on Aging Planning for mental health promotion and suicide prevention, planning for treatment of seniors with mental illness.

Wood County Health Department Planning for suicide prevention for post-partum depressed, planning for data warehouse project to support community grant writing & needs assessment

Wood County Jobs & Family Services Collaboration on planning for Supported Employment services for mutual clients, consultation on PCSA functions

Consultation with county commissioners regarding services for individuals involved in the child welfare system

C - The Board consultation with County Commissioner is conducted primarily through the Family and Children's First Council Board and subcommittees. The County Administrator is consulted on this matter. Program planning and cost sharing is developed through our local Jobs and Family Services.

Involvement of customers and the general public in the planning for service provision

D - Customers have been involved Discussions at the consumer Recovery Advocacy Committee, consumer members of NAMI, Consumers on the Connections' Center Advisory Board and through the 86 SMD responses to a community plan survey.

Section VI: Evaluation

Board's Approach to Evaluating the Effectiveness and Efficiency of Services in the Overall System of Care

A - 1. Board staff monitor utilization data and trends as a measure of Utilization Review, using various sources (MACSIS Claims and Member extracts, MACSIS DataMart, agency reports, agency and Board financial reports), which we gather into our service inventory tools.
We have recently developed the capability to utilized reporting tools with our data warehouse which will enable us to turn reports around more quickly.

2. We are now utilizing the Outcomes DataMart see how we are doing, especially compared with other Board areas and the state averages. We are close to implementing statistical analyses of our Outcomes Extracts to look at those improving and those not, so we can work with provider agencies on quality improvement. However, given the ODMH decision to revise outcomes measures, we fear much historical data will be rendered useless for trend analyses over time.

3. We have started using the OACBHA Care Management Indicators to monitor for quality in services (e.g., access to services).

4. We monitor client complaints to the Board.

5. We update, report on and monitor Hospital use and cost trends.

6. We now meet with consumers on a regular basis and provide for an avenue of consumer input about the quality of services provided.

Collaboration with the Agencies in Evaluating Services.

B - We have just recently begun discussing ways the Board and the provider agencies could work together to evaluate services. This would include analysis of outcomes measures and developing cost-effectiveness analyses.

Currently the Board shares trend analysis for each service provided by a provider with our Board and the provider. These "service inventory" worksheets have several charts and graphs which has facilitated data-based dialogue and mutual problem-solving. We also share our system data report cards, which have also focused on quality improvement as well as resource and service expansion.

Services or Programs Having the Highest Priority for the Evaluation of Effectiveness and/or Efficiency

C - Evidence based services, especially ACT vs. Intensive CPST and soon, Supported Employment. Currently, we have a program that may not be meeting sufficient fidelity standards and we wish to know if these services are still as effective. We want to build evaluation procedures for programs targeting dual diagnosed clients.

Using the Results from the Evaluation of Programs/Services

D - Currently the Board shares trend analyses for each service provided by a provider with our Board and the provider. These "service inventory" worksheets have several charts and graphs which has facilitated data-based dialogue and mutual problem-solving. We also share our system data report cards, which have also focused on quality improvement as well as resource and service expansion.

The importance of using county trend data combined with comparisons with other boards in terms of penetration rates, hospital utilization, service utilization, unit costs, has helped to inform our board of the need for our system to become much more cost-effective. This information has assisted in our current system-wide planning for a transition to increased accountability (via a fee-for-service purchasing methodology), increased penetration rates (working with stakeholders in terms of services needed and perceived barriers to accessing services, incentives via fee-for-service purchasing methodology), improved quality (moving to more evidence based programs and services) and better system outcomes (quality of life measures, hospitalization rates, penetration rates,

etc.).

A Report Card of our system of care was developed which has sparked renewed interest in quality improvement for the Wood County system of care.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services

E - The overall strategy is not different, but the measurement tools are. See the ODMH Ohio Scales vs. the Adult Consumer Outcomes Tools.

Section VII: Ohio Department of Alcohol and Drug Addiction Services Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through ODADAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds.

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.

Agency	UPID	Allocation	Services

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with ODADAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided.

Agency	UPID	Allocation	Services

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level	e. Evidence-Based Practice (EBP)	f. Number of Sites	g. Located outside of board area	h. Funding Source		i. MACSIS UPI
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)	ODADAS	Medicaid Only	
Prevention										
Information Dissemination	WCESC ATOD Prevention Program	Prom Promise	High school seniors	Universal		9	No	No	No	11192
	WCESC ATOD Prevention Program	Red Ribbon Week	Wood Community Community	Universal		9	No	Yes	No	11192
	WCESC ATOD Prevention Program	Parents Who Host Lose The Most	Wood County Community	Universal		9	No	Yes	No	11192
Alternatives	WCESC ATOD Prevention Program	Community Learning Center After School Programs	Grades 1-8	Universal		9	No	Yes	No	11192
	WCESC ATOD Prevention Program	Teen dances and retreats	Grades 7-12	Universal		9	No	Yes	No	11192
	WCESC ATOD Prevention Program	Teen Institute	Grades 9-12	Universal		9	No	Yes	No	11192
Education	Behavioral Connections of Wood County	Weekend Education Program - DIP	First time DUI offenders, court ordered & same for youth under 18 years	Indicated		1	No	No	No	1436
	WCESC ATOD Prevention Program	Parent Project	Parents of selected population;	Selected	Parent Project	14	No	Yes	No	11192
	WCESC ATOD Prevention Program	All Stars	Grades 6-8	Universal	All Stars	14	No	Yes	No	11192
	WCESC ATOD Prevention Program	BABES	Grades K-4	Universal	BABES	14	No	Yes	No	11192
	WCESC ATOD Prevention Program	Class Action	Grades 9-12	Universal	Class Action	9	No	Yes	No	11192
	WCESC ATOD Prevention Program	Insight	Selected population (grades 6-12)	Selected	Insight	13	No	Yes	No	11192
	WCESC ATOD Prevention Program	Life Skills	Grades 3-12	Universal	Life Skills	14	No	Yes	No	11192
	WCESC ATOD Prevention Program	STAND	Grades 9-12	Universal	STAND	14	No	Yes	No	11192

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level	e. Evidence-Based Practice (EBP)	f. Number of Sites	g. Located outside of board area	h. Funding Source		i. MACSIS UPI
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)	ODADAS	Medicaid Only	
	WCESC ATOD Prevention Program	Teen Intervene	Indicated population (grades 9-12)	Indicated	Teen Intervene	9	No	Yes	No	11192
Community-Based Process	WCESC ATOD Prevention Program	Development of community-based coalitions	Wood County community organizations	Universal		9	No	Yes	No	11192
	WCESC ATOD Prevention Program	Teacher in-service presentations	Teachers of grades k-12	Universal		9	No	Yes	No	11192
Environmental	WCESC ATOD Prevention Program	Collaboration with local law enforcement agencies to reduce access to alcohol	WC Community and Law Enforcement agencies	Universal		14	No	Yes	No	11192
	WCESC ATOD Prevention Program	Education about alcohol advertising aimed at youth	Grades 6-12, parents, and WC Community	Universal		14	No	Yes	No	11192
Problem Identification and Referral	WCESC ATOD Prevention Program	Problem identification and referral	all school aged youth	Indicated		9	No	Yes	No	11192
Pre-Treatment (Level 0.5)										
Pre-Treatment										
Outpatient (Level 1)										
Outpatient	Behavioral Connections of Wood County	Phase 1 outpatient	Substance Abusers, not dependent		Motivational interviewing	2	No	Yes	No	1436
Intensive Outpatient	Behavioral Connections of Wood County	Phase 2-3	Sugstance Dependent		motivational interviewing	2	No	Yes	No	1436
Day Treatment										
Community Residential (Level 2)										

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level	e. Evidence-Based Practice (EBP)	f. Number of Sites	g. Located outside of board area	h. Funding Source		i. MACSIS UPI
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)	ODADAS	Medicaid Only	
Non-Medical	Behavioral Connections of Wood County	Devlac 1	Women who are Substance Dependent		motivational interviewing	1	No	Yes	No	3060
Medical										
Subacute (Level 3)										
Ambulatory Detoxification										
23 Hour Observation Bed										
Sub-Acute Detoxification										
Acute Hospital Detoxification (Level 4)										
Acute Detoxification										

Promising, Best, or Evidence-Based Practice	Provider Name	MACSIS UPI	Number of Sites	Program Name	Funding Source (Check all that apply as funding source for practice)				Est. Number Served in SFY 09	Est. Number Planned for in SFY 10
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)		
Integrated Dual Diagnosis Treatment (IDDT)	Behavioral Connections	10348	10348		Yes	Yes	Yes	No	45	50
Assertive Community Treatment (ACT)										
Intensive Home-based Treatment (IHBT)										
Multi-Systemic Therapy (MST)										
Functional Family Therapy (FFT)										
Supported Employment										
Supported Housing	Behavioral Connections	10348	2		No	Yes	Yes	No	15	15
Wellness Management & Recovery (WMR)										
Crisis Intervention Training (CIT)	Behavioral Connections, NAMI	10348	1	CIT	No	No	Yes	No	50	60
Therapeutic Foster Care	Children's Resource Center	10295	2	Therapeutic Foster Care	No	No	Yes	No	1	0
Therapeutic Pre-School										
Transition Age Services										
Integrated Physical/Mental Health Services										
Older Adult Services	Behavioral Connections	10348	2	Geriatric CPST	Yes	Yes	Yes	No	75	100
Sexual Offender Services	Children's Resource Center	10295	1	Sexual offenders counseling	Yes	Yes	Yes	No	8	8
	Family Services	10350	1	Sexual Offender Therapy	Yes	Yes	Yes	No	10	10
Consumer Operated Service										
Clubhouse										
Peer Support Services	Wood County NAMI	0	1	Consumer Support	No	No	Yes	No	4	10

Promising, Best, or Evidence-Based Practice	Provider Name	MACSIS UPI	Number of Sites	Program Name	Funding Source (Check all that apply as funding source for practice)				Est. Number Served in SFY 09	Est. Number Planned for in SFY 10
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)		
MI/MR Specialized Services										
Consumer/Family Psycho-Education	Wood County NAMI	0	2	Family-to-Family	No	No	Yes	No	60	75
	Wood County NAMI	0	1	Hand-to-Hand	No	No	Yes	No	10	20