

Community Plan SFY 2017

**Mental Health and Recovery Services Board of Lucas County**

**NOTE:** OhioMHAS is particularly interested in update or status of the following areas: (1) Trauma informed care; (2) Prevention and/or decrease of opiate overdoses and/or deaths; and/or (3) Suicide prevention.

**Environmental Context of the Plan/Current Status**

**1. Describe the economic, social, and demographic factors in the board area that will influence service delivery.**

Lucas County, according to population is the 6<sup>th</sup> largest county in Ohio (<http://quickfacts.census.gov> – 2015 estimated figures) with a population of approximately 434,000; a decline of 1.8% from the 2010 census. It is home to Toledo, the fourth most populous city. Of the top 10 counties by population, Lucas County continues to have the highest percentage of poverty. Of those same 10 counties, Lucas is number 9 in median household income, per capita income, and persons with health insurance. Lucas has the second highest percentage of persons with Hispanic origin at nearly twice the state average. According to The Bureau of Labor Statistics (<Http://BLS.gov>), as of March 2016, Lucas County’s unemployment rate is 5.4%. That is a significant improvement over the 8.0% that was reported in the planning process in 2014, and is only slightly higher than the state average. Those numbers do not take into account a steadily declining number of people in the workforce in Lucas County.

Despite the economic difficulties in Lucas County, its citizens have been very supportive of this Board’s efforts to serve persons with mental illness and addiction. In November 2012, for the first time in 24 years, voters passed a new 1.0 mill levy that added to the two existing levies, totaling 1.5 mills. The new levy has afforded the Mental Health and Recovery Services Board the opportunity to expand services in the county; since the passage of the levy, the Board has funded over 40 new or expanded programs within the provider network, including contracting with a number of new agencies for the first time.

The provider network in the county continues to be financially strong, but several environmental changes have affected the Board’s relationships with them. The largest providers are expanding into other counties, forming relationships with local hospital systems, or expanding facilities and services within Lucas County. As noted above, we now have contractual relationships with several smaller agencies in the county, and we have been working with a for-profit agency to provide certain services. The elevation and expansion of Medicaid has also affected relationships with the providers and changed the Board’s focus as MHRSB funding now constitutes only 8% of treatment services in Lucas county. As providers and the provider network continue to grow, competition for licensed workers and psychiatrists continues to be a challenge we face.

With respect to the new Continuum of Care requirements, the only service that the County does not have is ambulatory detox for opiates. While the Board desires to have that service in place in Lucas County and has solicited providers through an RFI process, none have expressed willingness to provide the service at a rate that approximates the Medicaid allowable rate.

Once again, communities are being thrust into the unknown, this time with the Medicaid redesign. Changes to the billing procedures will certainly require cost and effort on the part of the providers, but it will also be burdensome to the Boards as OMHAS has indicated that it will not maintain a centralized billing system. MHRSB will be required

to invest a significant amount of resource if it wants to be able to process billings for services that are not covered by Medicaid. An even more dramatic impact will be felt when the state moves to managed care. At this moment, it is difficult to guess what effect it will have on the levels of service that Medicaid clients will receive or the outcomes of that service. The Board has been working to assure that all Lucas County residents have equitable levels of service, and these changes make it probable that clients who do not have Medicaid or private insurance will be disadvantaged, which is unacceptable to MHR SB. The Board is considering alternative methodologies to fund services to the non-Medicaid population such as value based purchasing.

## Assessment of Need and Identification of Gaps and Disparities

### 2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gaps in services and disparities, if any.

In preparation for the FY 2015 and FY 2016 funding cycles, MHR SB of Lucas County commenced its formal planning process. Both years included a formal Purchasing Plan including a strict timeline approved by the Board in January 2015 and January 2016. Each year's plan was linked directly to the Board's Strategic Plan. In addition, two community workgroups led by the MHR SB emerged: 1) Access to Treatment Workgroup: met over a 13-month period to discuss and debate how to improve accessibility to mental health and addiction treatment services for the residents of Lucas County; and 2) Diversity Workgroup: met over a 13-month period to recommend strategies that will lead to the elimination of the disparities in Lucas County by increasing diversity and expanding inclusion throughout the continuum of care. Finally, substantive data-collection projects were administered in an effort to capture the many voices of the community throughout both years; those efforts are detailed herein.

#### **African American Forum (2014) and Hispanic Leadership Breakfast (2015)**

At two scheduled events, one designated as the Second Annual African American Forum on Mental Health (2014) and the other a Hispanic Leadership Breakfast (2015), MHR SB asked to have attendees complete a brief survey on paper. Its intent was primarily to learn if African Americans and Hispanic Americans have different priorities than the general population concerning mental health. When asked to whom they would go for advice, respondents overwhelmingly chose a CMHC or a PCP. When asked what would influence their choice of provider, personal recommendation and experience of the provider were the overwhelming responses. Very few said that gender of the clinician or race of the clinician would influence their decision. When asked why respondents thought that people would not seek treatment, the overwhelming response was stigma.

#### **Stakeholder Forum (Early 2015)**

Community members were encouraged to speak at a forum at the McMaster Center in February 2015. The participants that addressed the Board were contract providers, professionals representing the Hispanic/Latino Community, professionals representing stakeholder interests (DD, human trafficking, private psychiatry, and property management), and consumers of mental health services. The overwhelming number of comments had to do with increased attention to serving persons with limited English proficiency. The most frequent suggestion was to increase the number of Spanish-speaking MH workers in the system.

#### **Youth Task Force Survey (Spring 2015)**

The Youth Task Force, an assembly of mental health providers, juvenile justice professionals, and other stakeholders who work with youth, was issued a paper survey at a scheduled meeting in spring 2015. When asked

what was the greatest problem youth faced with MH issues, most indicated parents with MH/AOD issues and/or violence in the home. They reported that the greatest unmet needs are MH screening in schools and AOD mentors for youth. The majority indicated that 90+ day residential treatment centers are needed.

#### **Lucas County Pain Medication/Heroin Survey (Spring 2015)**

In early 2015, MHR SB and the Lucas County Health Department promulgated a survey designed to identify community attitudes toward opiate/heroin usage in the county. It was administered on paper and electronically. There were 4,032 respondents. 50% said that they had been negatively affected in some way by heroin/opiates; 47% said they had family members or friends who were affected. Most respondents indicated awareness of the problem in the community with opiate/heroin use/abuse. A significant majority expressed support for spending money on solving drug-related problems: Prevention (89% favorable); treatment (87% favorable); monitoring prescribers (76% favorable); MAT (65% favorable); law enforcement (64% favorable); syringe exchange programs (54% favorable). 90% of respondents identified that they know that pain medications can lead to heroin use and addiction, but 57% said they don't know where to call for resources.

#### **Heroin Opiate Summit (Summer 2015)**

In mid-2015, MHR SB convened a summit to learn about, identify, and problem-solve the issues in Lucas County. In attendance were treatment providers, prevention providers, clinicians, law enforcement, government employees, community members, family members, and consumers. The Law Enforcement/First Responder Subgroup recommended getting defendants into structured environment and mental health services; supplying police departments with Narcan and training them on administering it; and giving assessments upon being taken into custody. The Medical Subgroup recommended education for survivors and users; implementing the Dawn Project; reducing the rate of babies born addicted to illicit drugs; influencing hospitals/doctors not to "over-treat"; increasing the number of MAT prescribers; and implementing a needle exchange program. The Prevention Subgroup recommended increasing the awareness of the permanent drug drop boxes; information dissemination to parents; and working with senior centers for safe storage and disposal. The Treatment and Recovery Subgroup recommended 24/7 access; and increased communication on harm reduction, under 18 programs, sober hangouts, standard referral/intake processes, and access to Naloxone.

#### **Family Parent Survey (Summer 2015)**

MHR SB collaborated with Lucas County Family Council to conduct a survey of parents throughout the county to learn their needs related to mental health and addiction services. There were 537 respondents. When asked as family members what their greatest needs are in relation to their children's mental health and/or addiction issues, 28% responded education, 25% responded quicker access in crisis, and 17% identified parent support groups as a need. When asked how people with MH or AOD issues can be better served in the community, themes included accessibility (location, available services, clinicians); specific services such as outreach, peer support, and family support; and education/awareness (MH/AOD, anti-stigma, resources available, community education).

#### **Lucas County NAMI Surveys (FY 2015)**

Lucas County NAMI administered feedback surveys to its program participants, volunteers, and support groups in FY 2015. There were 131 families, teens/young adults, and consumers that submitted responses to the various NAMI surveys. When asked to share any challenges that families have faced recently or gaps that respondents have found while in the course of their or their family member's treatment, the following themes emerged: need for awareness (of illnesses and the continuum of care) and need for greater system navigation for families or consumers. Teens/young adults as well as adult consumers specified need for help with the MH system

(accessibility, knowledge, affordability, awareness) and more social/environmental opportunities (employment, recreation, life skills classes).

### **Stakeholder Forum (Early 2016)**

Community members spoke at a forum at the McMaster Center in February 2016. The participants that addressed the Board were contract providers, faith-based community, advocates in recovery from opiate/heroin addiction, and consumers of mental health services. Work force development was mentioned several times; in particular was an emphasis on training and hiring more peer supporters, but also in the context of a shortage of psychiatrists and certified prevention specialists. There were a number of comments calling for increased prevention efforts, specifically for more “universal” efforts for youth regarding drugs and alcohol and for a campaign to prevent FASD in newborn children. Education and stigma reduction are often mentioned together, and several presenters highlighted this as an area that continues to present opportunities.

- a. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].

MHR SB staff actively participates in the Service Coordination Mechanism as part of the Lucas County Family and Children First Council. In FY 2015 and FY 2016, there were no disputes requiring resolution.

- b. Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].

Discharge planning is defined within the Continuity of Care Agreement with NOPH and community mental health centers. Additionally, MHR SB participates in the Hospital Utilization Management Committee to discuss community trends, barriers, and opportunities. The most prevalent issue is housing at discharge.

- c. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.

The Ohio Association of Community Behavioral Health Authorities (OACBHA) designed a survey that was to be administered by all Boards to various community stakeholders. MHR SB promulgated the survey electronically to a wide variety of stakeholders, and 246 providers, consumers, criminal justice staff, health workers, family members, and MHR SB Board members and staff responded. Results indicated that it was generally unknown if interim services were available for people on waiting lists or who are not ready for treatment, and questions dealing with the availability of prevention and treatment services generally scored high while questions relating to access showed a slightly lower score.

- d. Needs and gaps in facilities, services and supports given the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

MHR SB staff met to complete a gaps analysis regarding treatment and support services for all levels of opioid and co-occurring substance use disorders in Lucas County’s continuum of care. While there may be capacity issues, particularly in the areas of suboxone administration and sub-acute detoxification, It was determined that there are gaps for all populations with respect to ambulatory detoxification, peer mentoring, and residential treatment services. Additionally, there are gaps in sub-acute detoxification, medication assisted treatment services, and 12-step approaches for juveniles.

- 2A. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document)

## Strengths and Challenges in Addressing Needs of the Local System of Care

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development.

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment?

Lucas County's service treatment system is continually growing. Harbor, the CMHC with the largest budget, affiliated with ProMedica, which strengthens its organizational capacity. Zepf, another large CMHC, merged with Compass, a major AOD provider, and has added new facilities and programs, including a wellness center and recovery housing, as it expands in the community. Unison has partnered with Mercy St. Charles Behavioral Health Institute to provide mental health intensive out-patient and partial hospitalization, and New Concepts has grown to the point that it now serves the largest number of the Board's non-Medicaid AOD clients. In addition to these well-established agencies, during the past year the Board has expanded treatment capacity by contracting for the first time in years with UMADAOP, Family Service of Northwest Ohio, and Lutheran Social Services. All but one of these agencies are fully accredited and all but one are dually certified to serve mental health and AOD clients. Between these agencies there is a robust continuum to serve children, transition aged youth and adults. MHR SB funds a 16-bed crisis service center which is a great asset to the community, and though the Board currently does not contract with them, the county is fortunate to have a rich network of private hospitals with psychiatric services as well as the Northwest Ohio Psychiatric Hospital which is incorporated into the local system of care.

In addition to a strong treatment system, Lucas County benefits from a number of support providers that contribute to a recovery oriented system of care. The Thomas Wernert Center (TWC) is a Consumer Operated Service (COS) that offers not only training in leadership, skill building and utilization of recovery tools, it also provides tremendous opportunities for socialization through weekly programming and special events. In FY 2017, MHR SB will be partnering with OMHAS (through a capital grant) to nearly double the size of the center which will enable TWC to serve more people and expand the types of programming it offers to become an even more valuable community resource. Funded agencies such as NAMI (education and support) and ABLE (assistance with benefits) also play a key role in the spectrum of recovery supports.

Lucas County identifies the housing continuum as a strong point of the system of care. Much of the housing stock is owned/managed by a single board-contracted provider, Neighborhood Properties. Many of the properties were funded in part with capital grants from OMHAS (then ODMH) and the agency currently has approximately 500 units that are available exclusively to persons with mental illness. MHR SB has recently invested a significant amount of local resources to "modernize" a number of the units so that they will continue to be a community resource. Clients receive rental support from HUD, LMHA, and MHR SB. In addition there are currently 92 licensed Adult Care facilities in Lucas County; through its contract agency NPI, the Board funds 123 placements for persons with mental illness in approximately 40 of those homes. In the past two years, the county has benefitted from the addition of about 120 recovery housing beds to support persons in their recovery from drugs and alcohol. MHR SB also has a contractual relationship with St. Paul's Community Center, a shelter for homeless individuals that provides shelter while assisting clients to move to permanent supportive housing. St. Paul's also manages the Winter Crisis Program that provides over-night accommodations and two meals to homeless individuals during select winter months.

MHR SB has increased its efforts in prevention programs and services, in particular to address the prevention of addiction to alcohol and other drugs (AOD), problem gambling and the promotion of mental health. The MHR SB places a strong emphasis on prevention services for individuals at various stages across the lifespan, from early childhood through late adulthood. Funded programs target specific population based problems and behaviors that are determined by local data and current mental, emotional and behavioral issues and trends in Lucas County. All

of the MHRSB prevention programs are evidence-based and include either education or environmental strategies (CSAP Strategies) and more than one prevention service delivery strategy. Additionally, MHRSB is heavily invested in Mental Health First Aid training.

Though difficult to quantify, the collegial relationships MHRSB enjoys with variety of stakeholders and providers is a strength in Lucas County. Over the past two years the Board has put together at least 3 major groups that convened on a regular basis; the Behavioral Health Criminal Justice Workgroup that met to look for ways to divert clients with mental illness from incarceration through the Sequential Intercept Model, the Access to Treatment Workgroup that looked at ways to ensure that all clients would get the treatment they need on a timely basis, and the Diversity and Inclusion Workgroup that studied to identify areas in which there was disparity, and worked to formulate policy statements for adoption by the Board. We believe these demonstrations of community engagement will help clarify the findings of the needs assessments as well addressing their resolution.

**Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.**

MHRSB's Information Systems department has developed an interactive scheduling system that allows staff at the Recovery Helpline to schedule appointments to clients at 8 participating agencies. Providers assign open slots (dates and times), define their insurance panels, identify the types of services available (MH or AOD) and indicate the locations at which the service is offered. MHRSB would be willing to share information regarding the system.

**4. What are the challenges within your local system in addressing the findings of the needs assessment, including the Board meeting the Ohio Revised Code requirements of the Continuum of Care?**

The volatility of Medicaid administration continues to challenge the system's ability to plan effectively. With the elevation of Medicaid, it was easier to plan for Board spending, but there arose a "disconnect" between the agencies providing services for Medicaid clients and the Board who is tasked to plan for services in the entire community. With the expansion of Medicaid, the "disconnect" grew even larger, but the Board now has more money with which to contract for specialized treatment, support, and prevention services. Adding and monitoring those services placed additional administrative burden on the Board's staff. With the pilot of Medicaid Health Homes in Lucas County (4 agencies) there were new demands placed on the system, particularly in the area of human resources as qualified clinicians were recruited to provide these services, often leaving a void in the positions and/or agencies from which they came, frequently resulting in a loss of treatment capacity for all populations. Medicaid redesign now presents what could be the most difficult challenge yet with the advent of a new billing system and managed care.

A shortage of prescribers who are willing to work in the public system has presented a challenge. Recently MHRSB funded an agency to open a Behavioral Health Urgent Care center, but it has not been able to open on schedule because of the inability to hire staff with prescribing authority.

As mentioned earlier, we have solicited proposals for the provision of ambulatory detox for opiates, but we are not finding providers that can or will deliver the service at the rates prescribed by Medicaid.

**a. What are the current and/or potential impacts to the system as a result of those challenges?**

With respect to Medicaid redesign, MHR SB's goal has been to ensure that all clients receive the advantage of the same benefit package. Since Medicaid's package is outside of the Board's control, we will try to ensure that at a minimum, non-Medicaid clients are able to access the same level of service. It seems impossible to measure that impact however because we are uncertain as to what Medicaid benefits will look like, especially as we move into managed care. The Board will stay true to its goal and will look for ways to keep the service levels equitable.

**b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.**

MHR SB would be interested in learning how other Boards gather information, particularly with regard to outcomes, both at a program level and at the community level. We would be very interested to know if OhioMHAS will be providing guidance/assistance (e.g. the Behavioral Health Information System), or if communities will be left to design and implement their own proprietary systems.

**5. Cultural Competency**

**a. Describe the board's vision to establish a culturally competent system of care in the board area and how the board is working to achieve that vision.**

The Mental Health and Recovery Services Board (MHR SB) and staff have made significant progress in its response to the changing demographics in the county and the current data available regarding behavioral health inequities among its underserved populations. The MHR SB envisions that diversity, inclusion and health equity and the provision of culturally & linguistically appropriate care will become:

- The key strategic priority to reduce health care inequities throughout our MHR SB system.
- Part of a sustainable organizational effort that is carried out in a strategic and intentional process with an appropriate infrastructure and measures.
- A model in addressing health inequity through diversity and inclusion activities and in the provision of culturally and linguistically appropriate services.
- A culture throughout the MHR SB of Lucas County system of care.

In February 2015 the Board commissioned a work group of 32 representatives from a cross section of the community including the system's credentialed behavioral health professionals, faith leaders, local law enforcement, Advocates for Basic Legal Equality, health care systems, the community organizations that uniquely serve the community's underserved populations and others, to review available research and study strategies with the expected goal of a recommended plan of action. It was the vision of the Board of Trustees that a plan of action would be developed to guide the organization forward towards reducing behavioral health disparities among its consumer base. The Diversity Workgroup presented its report, Diversity and Inclusion, Moving Forward: Reducing Health Inequities through a Culturally Responsive System of Care, to the Board of Trustees for action. The report, which contains 24 strategic recommendations that serve as actions to be undertaken that will move the system towards a more culturally responsive system of care, was approved by the Board in March 2016. The recommendations included in the report are well aligned with the revised National Standards for Culturally and Linguistically Appropriate Services (CLAS) and include the development of an office and, hiring a Manager of

Inclusion and Health Equity. The Manager has begun the work of helping the board towards achieving its vision and also serves on the Ohio Mental Health and Addiction Services Disparities and Cultural Competence (DACC) Advisory Committee, supporting the effort to eliminate disparities and achieve health equity through its four key objectives. These key state objectives serve as an additional touchstone and a resource for best practice approaches for the board. It is hoped that OhioMHAS will come forth with a “vision” for a culturally competent system of care to guide Boards and communities in their efforts to ensure that all citizens are equitably included in the behavioral healthcare system.

### Priorities

6. Considering the board’s understanding of local needs, the strengths and challenges of the local system, what has the board set as its priorities for service delivery including treatment and prevention and for populations?

Below is a table that provides federal and state priorities.

Please complete the requested information only for those federal and state priorities that are the same as the board’s priorities, and add the board’s unique priorities in the section provided. For those federal and state priorities that are not selected by the board, please check one of the reasons provided, or briefly describe the applicable reason, in the last column.

Most important, please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in the board’s response to question 2.d. in the “Assessment of Need and Identification of Gaps and Disparities” section of the Community Plan [ORC 340.03(A)(11) and 340.033].

**Priorities for Mental Health and Recovery Services Board of Lucas County**

**Substance Abuse & Mental Health Block Grant Priorities**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe local planning efforts did not substantiate additional need.
<b>SAPT-BG:</b> Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): local planning efforts did not substantiate additional need.
<b>SAPT-BG:</b> Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Parents would not lose permanent custody of their children as a result of their SUD.	MHR SB continues to fund a program that primarily targets substance-using parents. Further, MRHSB doubled its capacity for case management for the Family Drug Court which is a primary referral source for the program.	Number of clients served by the program, and number of clients successfully completing the program.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): lack of appropriate data to substantiate local need.
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): meeting assessed local need.

<b>MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)</b>	Persons who are not eligible for Medicaid will have access to the same benefits as do those who are eligible.	Align non-Medicaid benefit plan with new Medicaid billing rules and/or managed care plans.	Cost per client of non-Medicaid client will approximate the cost of serving a Medicaid client.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing</b>	Reduce the numbers of SPMI clients who are waiting for permanent supporting housing.	Extend the life of existing housing stock by funding agency to modernize units. Provide funding for private market leasing to expand available housing.	Numbers of SPMI clients on waiting list for permanent supportive housing will be reduced.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-Treatment: Older Adults</b>				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): local planning efforts did not substantiate additional need.
<b>Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant</b>				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system – in jails, prisons, courts, assisted outpatient treatment	Decrease the penetration of individuals with MH/SUD into the criminal justice system.	Screen all clients for MH/SUD at booking. Link all appropriate offenders to outpatient services at release and provide them with medication or a prescription. Create specialized services for CJ population such as ACT Teams Administer Gain SS at booking in jail to facilitate diversion and linkage	Number of people who have appointments with CMHC upon release. Number of people who have medication upon release. Number of people who have been seen in jail/prison that recidivate.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe)
Integration of behavioral health and primary care services				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Recovery support services for individuals with mental or substance use disorders; (e.g. housing, employment, peer support, transportation)	Increase opportunities for socialization and training for peer supporters.	Double the capacity (building project of the existing COS.) Funding for formal training leading to certification as peer supporter. Establish Peer Run Respite Center	Number of people participating in Wernert Center activities. Number of people certified as Peer Supporters. Numbers of people who use the center and are not hospitalized.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)	Reduce health care inequities throughout the MHR SB system and become more culturally responsive.	Maintain the Inclusion Council and implement the recommendations of the FY 2016 Diversity Workgroup.	Number of recommendations implemented.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Reduce the number of overdoses that result in death. Create greater awareness of the risks associated with the misuse of heroin and opiates.	Partner with the Lucas County Health Department to distribute Narcan kits. Expand social marketing campaign targeting adolescents. Convene prevention providers to address heroin/opiate strategies.	Numbers of deaths resulting from opiate overdoses.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe)
Promote Trauma Informed Care approach				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): local planning efforts appear consistent with community need.
<b>Prevention Priorities</b>				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Address unique prevention/education needs of all ages; priority is on age of onset for children/adolescents.	Formulation of a comprehensive prevention plan.	Plan is completed and published.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Increase access to evidence-based prevention				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Suicide prevention	Educate the community to the danger signs of suicide ideation.	Expand investment in Suicide Coalition. Continue to invest in Mental Health First Aid.	Number of presentations in schools. Number of persons trained in MH First Aid	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage

				__ Other (describe):
<b>Prevention:</b> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations				__ No assessed local need __ Lack of funds __ Workforce shortage <input checked="" type="checkbox"/> Other (describe): local planning efforts did not substantiate additional need.

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Access to care: information.	All people in the community will know how and where to get help for opiate addiction as well as general help for MH and SUD.	Fund the Recovery Helpline in collaboration with 211; 24 hour operation to provide information and or referral; Integrated scheduling software for appointments; community based advertising campaign to heighten awareness.	Numbers of people calling for information. Number of appointments scheduled within 48 hours of call.
Access to care: urgent	Establish a Behavioral Health Urgent Care Center with extended hours to provide immediate access.	Develop and fund the Urgent Center to be located at Rescue Mental Health Services.	Numbers of people who use the Urgent Care Center instead of going to the ER.
Reduce the impact of opiate/heroin use in our community.	Expand the availability of Medication Assisted treatment for opiate/heroin abuse. Decrease the incidences of babies born with neonatal abstinence syndrome.	Provide injectable Vivitrol in jail followed by linkage to outpatient treatment. Provide case management and support for pregnant women who are addicted to opiates by connecting them to Medication Assisted Treatment (Methadone).	Number of people involved in CJ system who leave jail on Vivitrol. Number of babies born free of NAS

Priorities (continued)

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(1) Increase access to evidence-based prevention across the life span	MHRSB recognizes that the need for treatment could be reduced/minimized if there were adequate prevention efforts that resulted in abstinence or delayed onset.
(2) Integration of behavioral health and primary care services	Currently Medicaid Health Homes are providing access to these services for Medicaid eligible clients; if funds were avail MHRSB would seek to make the same services available to non-Medicaid clients.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	

**8. Describe the board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years. (Note: Highlight collaborative undertakings that support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)**

Perhaps driven by the heroin/opiate epidemic, collaboration has increased dramatically in this community. The County Commissioners, Sheriff, local providers and MRHSB have been involved in the planning and formation of a special law-enforcement team that reaches out to persons who have overdosed. They have access to emergency services (including naloxone and inpatient detox), recovery housing, case management, education, information, and treatment. MHRHSB and the Lucas County Health Department formed a collaboration whereby MHRHSB agreed to fund Naloxone kits and the LCHD agreed to be the distribution channel for anyone wanting Naloxone as a means of preventing death from overdose.

A survey administered by MRHSB and the Lucas County Health Department indicated that a majority of the people in Lucas County did not know where to find help for opiate users. Hearing that there were similar problems in Hancock and Wood Counties, MHRHSB collaborated with those two county boards to develop a "Helpline" that anyone in those counties could access by calling an easily recognizable number (211) and reaching a centralized triage agency (United Way) that would divert calls for AOD and/or MH issues to a call center. The Boards joined together in joint effort to develop and fund a marketing campaign that would get the word to residents of the 3 counties that they could call either for information and or help. As part of the initiative, MHRHSB developed a scheduling software system to be administered by the Recovery Helpline. Eight local providers agreed to input available time slots and accept appointments scheduled directly from the Helpline with the goal of having clients seen within 48 hours.

As part of an effort to minimize the population in the Lucas County Jail, MHRHSB has collaborated with the Lucas County Commissioners and the Sheriff to provide screening at booking and linkage prior to release. Funding was provided by a BHCJ grant from OMHAS. From the Behavioral Health standpoint, the project tries to identify clients who would benefit from treatment and to connect those individuals to resources so that they will not be arrested prior to their next hearing, and that they will attend all hearings for which they The Board has also worked with the Municipal Courts to look for ways to provide information regarding offenders who would be better served by treatment rather than incarceration.

In the last biennium, MHRHSB partnered with Four-County ADAMHS Board to fund a prevention project in Swanton. This is a village whose boundaries cross over Lucas and Fulton Counties. The Swanton Area Community Coalition had recently had a federal prevention grant that expired, and the two Boards collaborated to help the agency address some infrastructure issues and then provided funding in order for them to provide programming in that community.

In FY 2016, MHRHSB collaborated with other child-serving systems such as Juvenile Court, Child Welfare, and a local provider (Zepf), as well as the Lucas County Commissioners, the City of Toledo, The United Way, and local foundations (i.e., Toledo Community Foundation, The Andersons, and Stranahan Supporting Organization) to fund and implement an Emergency Youth Shelter. Having the shelter up and running positions the county to apply for

federal funding through the Family and Youth Services Bureau. This is the first time that Lucas County has had a shelter for youth since 2009.

MHR SB staff participates in the Lucas County Trauma Coalition. The coalition works together to educate the community on trauma, identify gaps and barriers to trauma informed and trauma-specific services, and to increase collaboration among larger systems. Staff also leads a collaboration of community mental health providers in a Disaster Work Group that developed a Behavioral Health Disaster Response Plan and meets regularly to coordinate to train responders and consider the activation protocols for deployment of the response team. Staff also participates in the Lucas County Integrated Healthcare Steering Committee.

## Inpatient Hospital Management

### **9. Describe the interaction between the local system's utilization of the State Hospital(s), Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that is expected or foreseen.**

Since the state's decision to take back the financial responsibility for inpatient stays at the state hospital, MHR SB and its contract agencies have worked hard to minimize utilization at Northwest Ohio Psychiatric Hospital. Civil days are currently about 30% lower than the 3-year average. Forensic days, which are not directly under the Board or providers' control, are higher than the average for the same time period.

MHR SB employs different strategies to try to minimize the utilization of hospital bed days, public and private. The HUM (Hospital Utilization Management) Committee meets every other month. The meetings are collaborative in nature, and representatives meet to discuss, from a clinical perspective, specific issues and frequently specific cases in order to facilitate discharge when possible, or to problem solve difficult cases/clients. The Committee consists of representatives from the adult psychiatric units from the hospital systems (Mercy Behavioral Health Institute, ProMedica, Northwest Ohio Psychiatric Hospital, and Arrowhead Behavioral Health), the three largest community mental health agencies in our county (Harbor, Unison, and Zepf), Rescue, Inc. (crisis services and pre-screening), Neighborhood Properties (housing), and the Mental Health and Recovery Services Board. Each agency/hospital has opportunity to discuss their current census or any trends they are experiencing. The HUM meeting has provided our system of care with a mechanism to communicate with each other and to enhance continuity of care. Agencies are given the opportunity to report out any new services that are available and to monitor existing services.

Two years ago, the Board funded Harbor, Unison, and Zepf to provide hospital engagement services. These grant funds allowed the CMHCs to provide services in the hospital without having to worry about billing through Medicaid or other POS funders. Agency representatives serve clients, either new or existing, by providing assessments that enable them to open cases and/or book appointments at the agency before the client is discharged. The goal is to ensure that agency clients are seen by a prescriber within 7 days of discharge. This opportunity to engage with patients before they are discharged helps to improve compliance and reduce re-admission back into the hospital. The hospitals are cooperative, and the parties utilize the HUM meeting as a way to discuss and problem solve any issues that may come up in this program.

A third "tool" MHR SB uses to manage hospital utilization is another meeting the Board facilitates known as the Prescreening of Involuntary Commitments meeting. This group also meets every other month, and is attended by many of the same entities; however, its representation is more administrative. Hospitals, CMHCs, the Board and Probate Court meet to consider efficiencies in the prescreening for involuntary commitment process, hospital admissions, continuity of care, etc. The group has also done some work around the topic of civil outpatient commitment.

### Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that is believed to benefit other Ohio communities in one or more of the following areas:

a. Service delivery

**Community Mini-Grants:** in an effort to foster broader community involvement, and to incorporate ideas coming from grass-roots community agencies, MHRSB funded 17 agencies (from a pool of 39 applicants) in the amount of \$77,764 for a wide range of proposals that were consistent with and contributed to the Board's mission. The applications were not open to agencies that were certified mental health/AOD providers, and the maximum amount of a mini-grant was \$5,000. It is the Board's plan to increase these allocations to \$100,000 in FY 2017.

b. Planning efforts

c. Business operations

d. Process and/or quality improvement

Please provide any relevant information about your innovations that might be useful, such as: How long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

**NOTE:** The Board may describe Hot Spot or Community Collaborative Resources (CCR) initiatives in this section, especially those that have been sustained.

### Advocacy (Optional)

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

### Open Forum (Optional)

**12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which is believed to be important for the local system to share with the department or other relevant Ohio communities.**

The limitations imposed by the IMD Exclusion rule (16 – beds) continue to hamper efforts to expand inpatient detox and residential services. Local hospitals have not recognized the need to provide acute detox in their settings; the Northwest Ohio Hospital Council has begun to facilitate discussions with the Board and its member hospitals to problem solve. This will not, however, address the capacity issues for sub-acute detox created by the IMD Exclusion.

## Community Plan Appendix 1: Alcohol & Other Drugs Waivers

### A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through OhioMHAS 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.

To request a waiver, please complete this form providing a brief explanation of services to be provided and a justification. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this waiver is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	UPID #	ALLOCATION

### 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 OhioMHAS 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.

B.AGENCY	UPID #	SERVICE	ALLOCATION

SIGNATURE PAGE

Community Plan for the Provision of  
Mental Health and Addiction Services  
SFY 2017

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Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds, and is in effect until OhioMHAS approves a subsequent Community Plan.

The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

\_\_\_\_\_  
ADAMHS, ADAS or CMH Board Name (Please print or type)

\_\_\_\_\_  
ADAMHS, ADAS or CMH Board Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
ADAMHS, ADAS or CMH Board Chair

\_\_\_\_\_  
Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.)].

