

The Franklin County Board of ADAMHS

Community Plan For SFY 2010-2011

April 13, 2009

Mission Statement

Our mission is to improve the well-being of our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Franklin County.

Vision Statement

Citizens in need of care will receive the most progressive and effective mental health and addiction treatment services available. The unique cultural and individual needs of each client will guide how the services are provided, but treatment will always be provided in a timely manner. ADAMH's commitment to these goals establishes its role as a vital partner in Franklin County's health care network and will help to de-stigmatize mental illness.

Value Statements

We believe that the following are important in accomplishing our mission and fulfilling our vision:

1. Listening - to our clients and their families needs
2. Collaborating - with other systems of care in the community
3. Educating - thereby erasing the stigma of mental illness and addiction
4. Stewardship - of resources entrusted to our care
5. Creativity - look for new and better ways to solve problems and ways to serve
6. Respect - assign value to the cultural, educational, or cognitive perspectives offered by others
7. Humility - willingness to learn from our mistakes
8. Compassion - remember that we exist to help others in need
9. Diversity - recognizing uniqueness in everyone we serve

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

Legal Context of the Community Plan

The Franklin County Board of ADAMHS 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 as 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

Board Area and Clients Served including recent trends such as changes in services and populations

II.A.1 - The Alcohol, Drug and Mental Health Board of Franklin County (ADAMH) is fortunate to have the full continuum of services available in our county. These services are funded by Medicaid, but are also augmented by a local property tax levy, local, state and federal private and public grants.

In the fall of 2005, the ADAMH Board of Franklin County passed a local property tax levy. A Levy Factbook was developed outlining current and projected long-term behavioral healthcare needs of our community. The Fact Book also outlined specific services that would be enhanced or created targeting high need population groups. Some of those services included, but were not limited to the following:

- Outpatient evidenced-based trauma treatment for adults
- Evidence based primary health and behavioral health care integration

- programming targeting older adults.
- Community-based youth crisis team.
 - Transition-age youth programming. Partnership with Franklin County Children Services targeting children with SMI that are emancipating from the child welfare system.
 - Outpatient treatment services and prevention/early intervention services targeting youth and adults and the unique behavioral health care needs of the emerging Somali population
 - Evidenced based mental health services in school settings targeting high risk youth.
 - A Consumer Operated Center was created.
 - Additional supported employment programming targeting the SMI population was enhanced.

The ADAMH Board also sets aside a pool of dollars that providers can request to fund behavioral health care innovations. This provides a vehicle to infuse new innovations into the system that can be replicated by others after initial implementation and evaluation is completed.

In response to the recent loss of state revenues, growth in inpatient hospitalization and higher than projected increases in Medicaid match commitments, the ADAMH Board, in partnership with the Provider Leadership Association (PLA) worked in concert to develop a mutually acceptable response to this unprecedented loss in revenues. The recommended reductions outlined in the latest board action presented to our Board of Trustees on March 24, 2009 were developed utilizing a hybrid funding reduction model that included a 90% across the board cut, a 5% credit for historical provision on behalf of the SMD and/or SED population and 5% performance indexing.

This is in addition to the \$3,115,466 total reductions that were instituted by the Board of Trustees in both October, 2008 and January, 2009. The first two rounds of reductions included both pass-thru cuts from the Ohio Department of Alcohol and Drug Addiction Services and Board designated reductions. The ADAMH Board's administrative budget was also reduced by \$1,013,391 during that time period and was reduced again by an additional \$88,300 in March, 2009.

All of the twenty-six providers impacted by the recommended reductions in the March, 2009 board action provide some level of services on behalf of persons in need of mental health treatment, prevention, or advocacy. Due to the fact that the state imposed funding reductions emanated from the Ohio Department of Mental Health, it was determined that this round will primarily impact the mental health service delivery system.

The following service delivery and fiscal strategic objectives guided the development of the reduction recommendations:

- Maintain services to the most vulnerable, legislatively mandated populations.
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence in community.
- Crisis services maintained at current level.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services to meet the diverse needs of Franklin County.
- Leverage investments where initiatives are consistent with ADAMH priorities.
- Reduction of spending at both the ADAMH Board and service level while maintaining the pledge that 95% of all revenues support the services provided by provider agencies.
- Maintain pledge that levy will last until 2016.

OUTCOMES: The funding reduction action resulted in the following outcomes:

- Service delivery system remains intact with full compliment of providers, but some services and programs will be reduced.
- Current geographical presence in the county is maintained.
- Crisis services are maintained at the current level.
- Services are maintained to the most vulnerable, legislatively mandated

populations.

- Services purchased from providers that demonstrated the best quality, most effective and cost effective use of non-Medicaid funds. Maintained pledge that 95% of all revenues are at the service level.

In response to the reductions, each provider is required to submit a short-form narrative template covering the programmatic and budgetary impacts of the cuts and the efficiencies employed to minimize service disruptions. The Board staff will review and approve these submissions.

Characteristics of Clients Receiving Substance Abuse Prevention Services

II.A.2.a - The primary populations of AOD/Mental Health Prevention are school aged youth in Franklin County attending urban and suburban schools. The adults are primarily the parents or care givers of the school age youth in school based services or adults enrolled in AOD or HIV/AIDS interventions services

Characteristics of Clients Receiving Substance Abuse Treatment and Recovery Support Services

II.A.2.b - Our data is showing trends in persons with co-occurring disorders in need of higher intensity services which include both mental health crisis and inpatient care as well as detoxification and medically assisted alcohol and other drug treatment intervention (e.g., methadone, buprenorphine).

We are also experiencing an increased number of persons, many of them in their early 20's, abusing heroin and other opiates.

As a result of these trends, the Board has allocated additional dollars to augment medically assisted alcohol and other drug treatment and have also created four IDDT/ACT teams to respond to the needs of persons with co-occurring disorders.

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

II.A.2.c - School age youth residing in urban and suburban areas attending school are the primary target populations in this category.

The Board contracts with NetCare Corporation to support the 24/7 crisis needs of all age groups in the community. NetCare has CISM teams in place to respond when there is a critical incident in the community. The services are primarily geared toward first responders, but are also available to persons experiencing a traumatic incident first hand that are in need of a specialized intervention.

NetCare receives funds to provide specialized mobile crisis outreach on behalf of older adults, children and adolescents, probate pre-screening for adults and children and provides training to CIT officers in the community as well.

Characteristics of Clients Receiving Mental Treatment and Recovery Support Services

II.A.2.d - Respite Beds: ADAMH supports two 24 hour accessible crisis respite beds for children between the ages of 6 and 17 and that reside in Franklin County. ADAMH also supports planned respite beds for any youth served by an ADAMH contract provider.

Social/Recreational Service: School aged youth residing in urban areas in Franklin County attending summer day camps, after-school programs offered by AOD and Mental Health provider usually housed in churches and recreation or community centers.

Consumer operated service called -youth led prevention-School-aged youth-high school students in residing in urban and suburban areas participating in programs offered by AOD prevention providers; serving as small group facilitators, workshop presenters, tutors, drug free role models in teen

leadership programs or as big brother, big sisters in mentoring programs. Franklin County has three Consumer Operated service organizations, all supported by ADAMH. Partners In Active Living (Partners) has been operating for over 8 years, serving adults with severe and persistent mental illness. Many of these adults are associated with the local mental health system, but are not connected to an adequate peer support network apart from Partners. They offer a range of Recovery Support Services including a Warm Line, Employment Readiness, Peer Support, Social/Recreational opportunities, WMR (Bridges, Wrap, Educational Classes), art and exercise

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 | Yes | Yes |
| Respite Beds for Children & Adolescents (C&A) | No | No |
| 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 | Yes | Yes |
| Hospital Emergency Department | No | No |
| Hospital contract for Crisis Observation Beds | No | No |
| 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 |
| Mobile Response Team | Yes | Yes |
| Central Location Capacity for C&A Consumers | | |
| Crisis Care Facility | Yes | Yes |
| Hospital Emergency Department | Yes | Yes |
| Hospital contract for Crisis Observation Beds | Yes | Yes |
| Transportation Service to Hospital or Crisis Care Facility | No | No |

Community Resources & Coordination - Other

Face-to-Face Capacity for Adult Consumers - Other

Central Location Capacity for Adult Consumers - Other

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

Central Location Capacity for C&A Consumers - Other

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

II.A.2.d.i - Due to the recent funding reductions from the state department, higher than anticipated Medicaid growth and higher than projected inpatient hospitalization costs, our Board has had to reduce its

provider allocations by over \$4 million dollars in the last 6 months. As a result of data analysis and needs assessment the Board made the decision to hold harmless all crisis-related services and programs from any of the reductions. This included our two community based 24/7 crisis sites operated by NetCare available to all populations, child and adolescent crisis beds operated by Buckeye Ranch, detoxification services provided by Maryhaven and medically assisted alcohol and other drug treatment provided by CompDrug and Maryhaven (e.g., methadone).

The ADAMH Board in Franklin County contracts with a housing development and management company to provide housing for our consumers. Community Housing Network (CHN) provides approximately 1200 units of housing for ADAMH consumers. The majority of these units are for consumers who can live independently in the community; however there are also permanent supportive housing units for consumers who require a more service enriched environment in order to meet their needs. Supportive services can range from front door management that protect consumers from predatory behavior from persons in the community to full time trained and licensed mental health staff on site. There are also units that have a resident manager who is trained to work with people in crisis and assist them in accessing the help needed.

This Board also provides 101 units (beds) of residential treatment. These facilities are a combination of larger group homes with 24 hour professional care and smaller homes with as few as 5 beds also with 24 hour professional care.

At this time there are no plans to provide for respite beds in this community. There are 14 crisis stabilization beds attached to our crisis center. There has been discussion of this need but no available funds.

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 - CIT has trained of 14 different municipalities in the last 5 years: 7 different municipalities over the course of 3 trainings in 2008. During 2008 there were also 4 Franklin County Sheriff's Officers trained and four college campus Peace Officers. These training sessions will continue to be provided with in-kind provider clinical staff and coordinated by the Mental Health Court Coordinator in partnership with the Columbus Police Department.

Capacity to Provide Services

Access to Services

Access to Alcohol and Drug Prevention and Treatment Services

II.B.1.a - AOD Treatment:

Our board areas' alcohol and other drug treatment providers have been severely impacted by the recent budget cuts. Some of our major alcohol and other drug treatment providers which include, but are not limited to Maryhaven and House of Hope, received substantial budget cuts from both the City of Columbus and the Central Ohio United Way. As the board has to restrict care to non-mandated, priority populations that we are legally mandated to serve, some populations, although in great need, may not fall into prioritized categories. We are very vigilant about looking for alternative funding sources for ex-offenders and veterans and have been able to hold some of those programs harmless at this point in time. The increased numbers of individuals re-entering the community after being incarcerated continues to be an issue of concern. Many of these individuals return to the community without any support system and end up being diverted to our community-based crisis sites.

AOD Prevention:

Our board area's alcohol and other drug prevention providers were severely impacted by the recent budget crisis. Many of our prevention providers count on United Way, City of Columbus, ODADAS pass-thrus and other funding to operate. These agencies received disproportionate

reductions from all of these funding sources, which will impact their ability to continue serving the same number of children and families. School Age youth/school based prevention- limited access to services during the school day due to emphasis on academic improvement and test scores.

School Age Youth//School Based Services - limited access to services at charter schools in Franklin County

School Age Youth/ Limited access to services during out of school time: summer, after-school, school breaks

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

II.B.1.b - Our Board area's mental health prevention programming may potentially receive significant reductions as a result of the last round of budget reductions. As this plan is finalized, providers will be providing funding reduction recommendations to the Board for review and approval. Several of the programs eligible for potential reductions are mental health prevention services that either provide school-based mental health services or community based prevention and early intervention services. The outcomes of these reductions will not be finalized until mid-May, 2009. Specific areas of potential impact follow:

i.

School Age youth/school based prevention- Limited access to services during the school day due to emphasis on academic improvement and test scores.

School Age Youth//School Based Services -Limited access to services at charter schools in Franklin County

School Age Youth/ Limited access to services during out of school time: summer, after-school, school breaks

Workforce Development and Cultural Competence

II.B.2.a - At the present time, waiting times for entry into general adult mental health services is quite long. This is not only the lowest priority level for treatment, but also the group with the largest numbers. As of early December, the ADAMH System of Care had billed for services to almost 12,000 general adults in 2008. At a time in our economy when the need for treatment services to the general adult population is growing, funding reductions make it difficult to even maintain our current level of services.

With the passage of a levy in the fall of 2005 and subsequent expansion of our consumer run services, access to Peer-developed Recovery Support Services are good.

The context for the Board's cultural competence initiatives is grounded in a model that was adopted and modified for use in our system of care.

The modification of the CASSP Technical Assistance Model (Cross, 1989) extends the basics of policy, practice, structure, and attitude to incorporate key elements that support research, outreach/engagement, training, and quality assurance. Although the Cross model provides a solid grounding for systemic praxis, it needed to be adjusted to meet the unique needs of Franklin County - particularly with our emerging populations (i.e., Somali and Latino/a). The underpinnings of this model captured in the diagram below are enhanced with other elements that further define our operational use. This model will help explain the Board's current activities, strategies, successes and challenges for sustaining a culturally competent system of care. In addition, ADAMH's Board of Trustees has incorporated cultural competency into their system strategic goals in terms of treatment services, system development, and workforce diversity.

Below is an overview of the Board's responsibility associated with the P.A.S.P.O.R.T. model for Franklin County:

A.Policy

a. ADAMH's Board of Trustees ensures the need for culturally competent services in their overall strategic results for the Board and system.
b. ADAMH articulates the importance of having board representation that reflects the population that is served in terms of race and gender.
c. Several ADAMH Board members have expressed their personal interest in cultural competence and offered their support and involvement.

B. Attitude

a. ADAMH's CEO has been a strong advocate for cultural competency within our system - as well as through statewide associations (i.e., Board Association, MACC, local leadership, etc.). According to research and diversity literature (Thomas, 1994) the CEO is a critical component in moving cultural competency initiatives forward and ensuring that the agency overall, and individual staff, take it seriously. Monitoring the cultural climate through self/organizational assessments is an important mechanism required by the Board's Cultural Competency Plan.

C. Structure

a. The Board ensures that the key structural components of cultural competence are addressed/developed through the submission of provider Cultural Competency Plans (11 Standards), Agency Service Plans (Identification of 2-3 key annual goals), ProviderStat Reviews, System Quality Indicator Monitoring, and Consumer Satisfaction reports.

Utilizing these monitoring and compliance methods support our efforts to improve quality and reduce disparities.

b. Board and system staff reflective of the population served is monitored and discussed in the system within our ProviderStat framework.

D. Practice

a. The Board strongly supports and funds culturally competent behavioral health services and procedural guidelines for funded services that target diverse communities.

b. Up through 2008, the Board provided stimulus and innovation funds to allow providers to address the needs of diverse and emerging populations - requiring they utilize evidence-based (if they exist). We are encouraging providers to redirect existing resources and/or partner with other entities to continue to develop services unique to diverse communities since cutting funding to new initiatives.

c. The Board wants to ensure that services to diverse communities are aligned with best and promising practices for optimal quality.

E. Outreach

a. The Board is collaborating with several health and human service organizations (i.e., Columbus Public Health, United Way of Central Ohio, Multi-Ethnic Advocates, OSU College of Social Work, etc.) to support a more comprehensive and integrated strategy for minority populations.

b. The Board built and continues to sustain healthy relationships with organizations and leaders in the Latino, African American, Somali, Asian, Native and other communities to ensure our goals and objectives are consistent with meeting their needs.

c. The Board supports community-based initiatives that address the needs of diverse communities such as Juneteenth, Ohio Psychological Association Cultural Symposium, and Just for Today event to name a few.

d. Marketing to minority communities through print and electronic media is a priority with nearly 40% of the current budget dedicated to addressing this population. Television, radio, print, brochures, presentations, and other methods have been used to ensure there is adequate outreach and engagement.

F. Research

a. It is the intent of ADAMH to work with institutions of higher education to co-create research initiatives to address issues of disparities in mental health. Drs. Lonnie Snowden (U.C. Berkley - College of Public Health) and Dr. Carla Curtis (Ohio State - College of Social Work) are both interested in working with ADAMH to help secure funds and conduct research to address disparities in Franklin County and Ohio. Note: The Board currently has a concept proposal submitted to ODMH to secure initial funds to initiate this disparity project. This initial support will help leverage other funding to ensure this project's success.

b. The Board also lends its grant writing expertise to MACC - realizing the importance of supporting statewide initiatives to further support local efforts. The Board is supportive of any state initiative designed

to improve care to diverse and underserved populations.

G. Training

a. Due to the budget reductions, the Board eliminated funds for system training. Culture training sessions are being provided at the individual provider level (in-service), local conferences, as well as sessions offered by MACC and United Way. We realize that our cuts will limit cultural training opportunities for system staff and board members.

b. The Board encourages providers who are able to provide training to allow other providers to attend - and also seek other fee and free cultural training opportunities across disciplines (i.e., Columbus Public Health, Ohio Commission on Minority Health, College of Public Health).

II.B.2.b.1 - The ADAMH Board of Trustees has included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers." To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care would be to increase the number of masters level clinicians available to provide billable care and supervision.

The ADAMH Board is working with providers and The Ohio State College of Social Work to finalize implementation of an ADAMH system Master's Degree in Social Work Program. This program will be provided at the ADAMH Board's office at 447 East Broad Street so that students will have a central location off campus to attend classes in an attempt to accommodate those that work full time. The providers will support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunities for shared internships.

This will be a four-year, part-time program with a minimum of 15 students. Classes will be held two nights weekly and the program is scheduled to begin Fall, 2009.

Strategies: The overall strategy for Franklin County is outlined above through the P.A.S.P.O.R.T. program. This model helps to ensure that all cultural competency areas are addressed in the system of care. One unique difference that we have providers address in their ASPs is for them to focus on two or three key improvement/result areas per year (generally outside of training itself). The reason for this is to provide focus and attention on critical niche areas of each provider.

Providers reflected significant growth in their cultural competence development areas reflected in their 2009 ASPs. They introduce important strategies that will support their specific organizational needs and developed specialty areas in cultural competence that targeted specific populations they serve. We also recommend that providers continuously seek out best and better culturally competent practices within their mental health/behavioral health service delivery paradigm.

This strategy is beginning to pay off in terms of providers sharing their expertise with other agencies in the system.

Current Activities: Based on review of the 2009 Agency Service Plans submitted by mental health (behavioral) providers, the following is a summary of current activities that are adding to their existing levels of cultural competency. Due the volume of activities slated for 2009 by providers, the following is a summary by cultural competency categories (P.A.S.P.O.R.T.). The diversity of activities is enormous amongst provider agencies - and unique to their target populations.

Policy (Governance): Each provider submits a breakdown of their board's racial diversity in their ASP and is prepared to discuss if their board does not reflect the population served during ProviderStat sessions.

ADAMH also expresses the importance of cultural competency by having the language as a part of the Board's overall strategic results.

Attitude (Organization and Individual Support): ADAMH's CEO has been a strong advocate for cultural competency within our system - as well as through statewide associations. As a result, many providers have also model similar leadership within their agencies and support many of the cultural competency initiatives within their organization through racial and ethnic dialogs. Several provider agencies require internal staff climate audits, performance appraisals, diversity councils, affinity groups, and other methods to create supportive environment. It will be important that key questions around cultural sensitivity are asked when new employees are hired into the organization. In addition, some agencies have designed their waiting areas to be culturally sensitive through having diverse artwork, magazines, artifacts and other methods to make consumers feel welcome. Most providers realize their front-desk staff must also express a level of understanding and sensitivity when working with diverse populations who seek care.

Structure (Staffing/Plan&Eval./Monitor/Compliance): Providers are addressing their staff diversity based on the population they serve through ADAMH's ProviderStat review meetings. Any variance above 10% with respect to racial / ethnic disparity is addressed by providers. Overall the system is representative of the population that is served. The next step in our system is to work with providers to ensure that this representation is reflected on all levels of the organization (i.e., clerical/technical to senior leadership). Some providers are using the cultural competency standards as a way to examine all aspects of their operations (i.e., monitoring and compliance regarding services to diverse populations). The Board's efforts around disparity reduction will require providers to be more aware of their data beyond what we analyze with respect to outcomes and satisfaction.

Practice (Programs/Services/Procedures): There are several unique programs in place that target cultural uniqueness and unicity. Prevention and treatment programs / services that target African Americans, Somalis (e.g. Rosemont, Columbus Area, Southeast), Latinos (e,g, North Community), Gays and Lesbians (e.g. North Central), those persons homeless, and other special populations. Each agency continues to develop their cultural uniqueness based on the populations they serve. More specifics are captured under the current activities sections below.

Outreach (Relationship Development / Marketing): Most mental health agencies who serve diverse populations have established relationships with faith-based institutions, community organizations, and other entities that represent diverse racial and ethnic populations and cultures. In addition, mental health providers have developed their brochures and other marketing materials in Spanish and Somali. Many agencies display artifacts, art, reading materials that reflect the diverse populations they serve. The Board's development of a Somali video will also be well marketed within the system to help address stigma and improve access to services.

Research: Some providers have used their experiences working with diverse communities to develop or refine how they assess their organization's cultural competence. In addition some have used their own research and data analysis to rethink how they administer services. Rosemont recently completed work to further examine the outcome data (Dr. Partridge OSU College of Human Ecology) of their involvement with the Mifflin International Welcome Center Somali student population. Reports are positive and reflect the needs of the students and their families (extended). We expect other providers to enhance research efforts in the near future.

Training (Learning): The cancellation of the Maryhaven/ADAMH Training Academy, due to budget reductions, has limited one key learning option for some providers in 2009. Many providers already had multiple cultural competency learning options targeted - but this particularly impacts smaller organizations. Providers are utilizing the following ways to ensure their staff/ organizations are moving toward cultural competence.

1.Methods and Learning/Training Options used by providers:

- a.Cultural Competency Monograph Learning
- b.E-Learning Training Options / Computer-based Instruction Modules
- c.Video / DVD Training
- d.Live Training for all levels of Staff & Board (some recorded for later viewing)
- e.Cultural Affinity Groups / Cultural Competency & Diversity Committee
- f.Racial Justice Dialog Groups
- g.Partnerships with local Emerging Population Groups (i.e., LEON, Somali Community Association, Ohio Latino Mental Health Network, Asian Community Services, Ohio Hispanic Coalition, etc.) to provide speakers and learning options.
- h.Internal and External Resource Centers (including MACC)
- i.Required Reading Distributions (i.e., best practice/research/trade)
- j.Internal & External Cultural Consultants & Informants
- k.Conferences, Seminars, Workshops, Learning Communities
- 2.Topics & Events / Populations (Selected Diversity of Training & Events Participated):
- a.Holistic Services (i.e., Body, Mind, Spirit)
- b.Street & Gang Culture
- c.Kwanzaa / Juneteenth / Latino & Asian Festivals / UNCF, etc.
- d.Refugees & Immigrants
- e.Journey through Appalachian Culture
- f.Sign Language
- g.GLBT Youth
- h.Life in a Wheelchair
- i.Marketing to Diverse Communities
- j.Spanish & Somali Culture / Language Classes
- k.Culture of Poverty
- l.Special populations: GLBT / Deaf and Hearing Impaired / Those who are homeless / Islamic Community
- m.African American, African (i.e., Somali/Ghanaian, etc.), Appalachian, Asian/East Indian, Latino/a, Turkish, Russian.

Successes

The ADAMH Board is proud of our system transformation beyond cultural awareness and sensitivity training to one that is beginning to address substantive needs of diverse communities through service design, delivery, and outcomes. The CEO and Board understand the importance of this work even more during this current economic downturn. Many of the successes are noted above through the volume of work within this system around cultural competency - and under each population area. Below are some key successes that should be noted:

- 1.Providers developing niche' cultural competency areas to be used as best practices/ field experts. Wide array of culturally competent services are continued to be offered.
- 2.Plans to launch a project to address system racial/ethnic disparities in mental health (i.e., reduce disparities in care, design disparities model, and ultimately improve care/cut costs).
- 3.Programs, services, and relationship development with the Somali community.
- 4.Collaborative work with the Ohio Latino Mental Health Network.
- 5.Local collaborations with other health and human service systems (i.e., MACC, Col. Public Health, Our Optimal Health, Employed Latino Health Project, etc.).
- 6.Individual provider technical support through ADAMH, as requested.

Challenges

- 1.Limitations created by the budget reductions - how do you sustain momentum in key areas. The budget cuts also impacts new innovative initiatives proposed by providers.
- 2.Developing a system for addressing racial/ethnic disparities and how this can translate into not only better/accurate care, but also produce savings to be reinvested in more care.
- 3.Ensuring that staff diversity is utilized to tap the talents, skills, ideas, solutions, strategies, of 100% of the workforce - whereby no one is advantaged or disadvantaged in the process. In essence, using/enhancing the power of diversity beyond the achievement of people

in positions to address problems from a variety of perspectives - utilizing TQM

II.B.2.b.2 - The ADAMH Board of Trustees has included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers." To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care would be to increase the number of masters level clinicians available to provide billable care and supervision.

The ADAMH Board is working with providers and The Ohio State College of Social Work to finalize implementation of an ADAMH system Master's Degree in Social Work Program. This program will be provided at the ADAMH Board's office at 447 East Broad Street so that students will have a central location off campus to attend classes in an attempt to accommodate those that work full time. The providers will support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunities for shared internships.

This will be a four-year, part-time program with a minimum of 15 students. Classes will be held two nights weekly and the program is scheduled to begin Fall, 2009.

ADAMH's alcohol and other drug providers are astute at working with their niche' populations - many of which are quite unique and diverse.

Many AOD providers are engaging a wide range of treatment options for diverse populations in Franklin County. Our Board continues to advocate with AOD treatment providers to identify best cultural practices to implement when working with diverse communities - or utilizing general systems theory to redesign existing programs and services to meet the dynamic needs of those served. One unique area we noted in review of the 2009 ASPs was that many AOD Tx. providers are learning about populations they aren't currently serving, but anticipate serving such as the Latino and Somali populations. This demonstrates forward thinking and keeping opportunities open to all underserved populations.

Strategies: The strategies the Board encourages are generally outlined in the PASPORT model above. Many substance abuse treatment providers have constructed their own theories, methods and applications to continuously improve their levels of cultural competence. The Board monitors their programs, and reviews customer outcomes and satisfaction data - but supports providers in becoming content area experts. One key component the Board utilizes is the expertise of the network service provider staff that are knowledgeable about culturally appropriate treatment methods and response to the changing needs of these communities. Network Service staff typically keep an argus-eye on programs and services that are alien to the traditions, customs, beliefs, and practices of culturally diverse groups. As a result of this watchfulness - providers receive candid feedback about services that are not fulfilling a culturally appropriate paradigm.

Current Activities:

AOD providers are working with local communities to ensure they use a multi-disciplinary treatment approach that engages social determinants that influence success in treatment. Many provider ASPs indicate their relationships with local churches, community-based organizations, housing networks, criminal justice supports, and other human services to ensure a more holistic and collective strategy for supporting treatment and recovery. One unique aspect about AOD treatment providers is that they are encouraged to think outside the box in order to move beyond compliance in order to establish creative and innovative methods that optimize recovery. The importance of a comprehensive restoration includes a cultural understanding within the community itself in order to support those in recovery and re-entry. The current activities section under mental health encompasses much of what AOD providers have been actively doing in addition to mental health providers.

Below are some specific examples of what AOD Tx. providers are doing around cultural competency:

1. Racial and ethnicity clinical staff discussions for both staff and clients in a women's residential facility.
2. Focus on the culture of recovery and re-entry to better understand the dynamics of the needs of this population.
3. Translating AOD brochures and service descriptions in Spanish and Somali languages by several AOD providers.
4. Establishing Cultural Competency Committees to examine customer demographics, satisfaction surveys, trends in service provision, and learning for both board and staff.
5. Utilization of an Africentric TC to help clients understand their commitment to treatment for themselves and the communities to which they reside and must return.
6. Appalachian-centric and gender specific programs that utilize an Africentric treatment construct to work with persons with addictions from diverse communities.
7. Bi-lingual staff who are able to function as outreach workers, translate, market, referral and serve as internal cultural informants.

Successes

- Mandates that support provider efforts to remain engaged in enhancing their cultural capability.
- Executive leadership at the state level that supports cultural competence efforts in alcohol, drug and mental health.
- Addressing the needs of a constantly shifting community - gang activity, crime, economic shifts, unemployment, youth culture, and other factors that impact providers and making sure there is flexibility in how programs and services evolve with those changes.
- Providers with designated leadership staff to head cultural diversity and competency committees - providing the context to ensure universal support.

Challenges

- Informing and educating the community about the recovery and re-entry process so that society is more understanding of the needs of individuals returning to the community - in order to be successful once they complete their programs. This means that supports in employment, housing, religious institutions, education, and others that play a vital role in helping persons re-integrate and be a contributing member of society. Strategies for stigma reduction.
- Time and ability to identify substance abuse grant funds to create new initiatives since ADAMH's innovation funds are no longer available.

II.B.2.b.3 - The ADAMH Board of Trustees has included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers." To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care would be to increase the number of masters level clinicians available to provide billable care and supervision.

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This will be a four-year, part-time program with a minimum of 15 students. Classes will be held two nights weekly and the program is scheduled to begin Fall, 2009.

Many mental health prevention, early intervention, education, and advocacy programs clearly understand the importance of cultural competence. These providers (services) are seeking members from diverse communities to be a part of support groups, parent networks, advocacy efforts, marketing strategies, and increased outreach for hiring diverse staff.

Strategies: Mental Health prevention, consultation, and education programs are providing unique services to African Americans, youth, Somalis, Latino/as, consumers, and the general community about mental health. Since many of these programs target specific groups - the array of services is large.

Current Activities: There are several youth oriented mental health prevention initiatives. Below are some highlighted programs (many others exist) that should be noted to demonstrate the diversity within our system:

1. Mifflin International Middle School Project (Rosemont) that is working with Somali youth and their families to reduce conduct that inhibits school success for both the perpetrators and victims. The goal is to reduce truancy, fighting, outbursts, poor grades and ultimate withdraw from class. This program is meeting with great success both within the school and outreach with families.
2. The MECCA (Multiethnic Eastside Center of Columbus Area) is another youth program working with African American youth to support their efforts to be successful in the classroom and community.
3. Latino youth and family based educational services "Incredible Years" at St. Vincent is one example of outreach to a community with limited English proficiency.
4. Several providers are extending their service strategies to work with Somalis and Latinos to address their unique needs.

Successes

1. Uniqueness of the prevention, consultation, and education programs lends itself well to serving diverse communities.
2. PCE providers are excellent resources for information about the particular needs of diverse communities - having well established relations with smaller communities that always to seek out supports from larger comprehensive centers.
3. NAMI is specifically providing outreach and supports to minority communities to ensure they have a stronger and more represented voice at the table.

Challenges

1. Obviously funding cuts will impact these providers ability to grow and expand.
2. Truly tapping the communities of color to be involved will be an ongoing challenge based on the perception some of these education and advocacy agencies have as being "middle class."

II.B.2.b.4 - The ADAMH Board of Trustees has included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers." To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care would be to increase the number of masters level clinicians available to provide billable care and supervision.

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This will be a four-year, part-time program with a minimum of 15 students. Classes will be held two nights weekly and the program is

scheduled to begin Fall, 2009.

Substance abuse prevention providers offer a range of services to many diverse populations and communities in Franklin County. These are the agencies who serve specialty populations that provide services to youth, young adults and families. Many are located in areas where there are diverse communities who can easily access their services. Somalis, European, Eastern Europeans, Latinos/as, African Americans, Asians, Ghanaians, Nigerians, Native Americans, and other groups are specifically targeted to receive AOD prevention services.

Strategies: In the common parlance among certain prevention providers, the term "prevention is treatment," is evident in that many persons in these targeted minority communities will not seek formal treatment services due to stigma, denial, or other priorities that will deter someone from seeking additional supports. It is the goal of many of these programs to help educate these populations about the problems caused by substance use and abuse - but more importantly arm them with information about their collective responsibility to overcome the challenges they face. Issues such as educational success, community and nation building, self-esteem, collective work and responsibility, creativity, spirituality (not religiosity), eldership, family and extended family supports, and other positive community attributes are used to counter the negative consequences within their communities surrounded around crime, drug abuse, violence, poor quality food and health care, etc.

Current Activities: There are dozens of culturally unique programs to feature, but only a couple should provide you with the scope of what is going on.

- Directions for Youth is developing special marketing to target Somali and Latino youth to take advantage of their services. They also hired indigenous bi-lingual staff to assist with serving these populations.
- Prevention Council Red Ribbon offers school-aged youth information from experts about drug abuse prevention. Prizes, contests, and other give-a-ways keep this event kid-centered and fun.
- The UMADAOPFC program is continuing to work with youth through its after-school program. Students are developing personal books that reflect learning they acquire through field experiences.

Successes

- The ability of these providers to still continue to offer key services to needy populations - during tough economic times.

Challenges

- Proliferation of alcohol marketing (i.e., billboards, magazines, movies, etc.) in the near east side of Columbus that socializes and conditions people to believe certain behaviors are acceptable and "glamorized." The challenge is to create opportunities from the policy to grassroots level to counter this enormous propagation of alcohol marketing in the African American community.
- Due to funding cuts, many programs and services are targeting youth have been reduced. The number of hours, units delivered, activities, and other aspects of these programs had to be changed to adjust for the loss of funds. Some providers have found ways to adjust their operations to ensure those most in need are still reached.

Capital Improvements

II.B.3.a - Many agencies in the ADAMH system have submitted requests for assistance with capital projects. Not all have been addressed. There have been requests for new entrances to buildings, additional housing (of all kinds), and renovation activities and new construction that would serve ADAMH consumers. When state agencies announce available capital funding ADAMH responds rapidly to inform its contract agencies and to turn requests in to ODMH or ODADAS. Additionally, ADAMH supports provider organizations with letters of support for funding proposals that they send to federal and foundational grant sources.

Financial Status

Impact of reduction in services.

II.B.4.a - Reductions are in process, and each provider will be submitting information on reduced funding impacts. We are also awaiting the "planning numbers" and allocations from the State -ODMH.

Factors contributing to the costs of services.

II.B.4.b - Administrative cost of collecting and submitting consumer outcomes, consumer satisfaction, and the technology for data warehouse and management systems. Staff turnover remains high, and certainly contributes to training and retraining costs.

What cost-saving measures and operational efficiencies.

II.B.4.c - ODMH is now in the process of retooling the Outcomes system for greater efficiencies and reduced costs. We continue to address the workforce development issues related to staff turnover and recruitment/retention strategies. The board stopped doing Medicaid Reviews beginning in CY 2009, which reduced annual visits to 33 providers for records review which required from 2 to 5 days of onsite work.

Other budgetary planning efforts.

II.B.4.d - We are preparing for any additional funding reductions that will certainly effect our ten year Levy Plan and budget.

Tables 1 and 2: Portfolio of Providers

Section II: Capacity Development

Access to Services

As outlined in Section II, describing the current environment, our local Board area, as well as the whole State of Ohio has been responding to the unexpected and unprecedented economic downturn. Our Board has been working very closely with our Provider Leadership Association (PLA) and our Consumer and Family Advisory Committee (CFAC) to develop strategies that minimize service disruption to the greatest degree possible in a time of financial crisis. We plan to work with both entities to develop a plan of action to respond to the emerging needs of our community with much more limited and often unstable or unpredictable resources. A planning process is in place to develop revised strategies attached to our provider contract, agency services planning and budgeting for the CY2010-2011 contract cycle. This planning will take place during the spring and summer of CY2009 and the results of that planning will be enacted on January 1, 2010.

Workforce Development and Cultural Competence

The ADAMH Board of Trustees has included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral health care professionals who seek to deliver clinically and culturally appropriate services to consumers." To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care would be to increase the number of masters level clinicians available to provide billable care and supervision. The ADAMH Board is working with providers and The Ohio State College of Social Work to finalize implementation of an ADAMH system Master's Degree in Social Work Program. This program will be provided at the ADAMH Board's office at 447 East Broad Street so that students will have a central location off campus to attend classes in an attempt to accommodate those that work full time. The providers will support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunities for shared internships. This will be a four-year, part-time program with a minimum of 15 students. Classes will be held two nights weekly and the program is scheduled to begin Fall, 2009.

The Board plans to continue to make cultural competence a priority for 2010 and 2011. We will continue to work with our provider partners, other systems (i.e., United Way, Public Health, etc.), state departments, and other organizations and entities (i.e., MACC, Ohio Latino Mental Health Network, Somali leaders, etc.) that are serious about cultural competence to lead change in our system/s of care. It is our Board's intent to ensure that we are providing the overall direction and support in order for individual provider agencies to maximize their cultural capability and to closely monitor that consumers and families are benefiting from these efforts.

Here are some of the key plans for SFY 2010-11:

1. Develop a framework for addressing racial and ethnic disparities in mental health. Current work with national experts Drs. Lonnie Snowden (U.C. Berkley - College of Public Health) and Carla Curtis (Ohio State University - College of Social Work) will lead to the development of a model to assist ADAMH locally - and the state ultimately with ways to identify/measure, analyze (system or socially situated), recommend solutions, track metrics and ultimately experience reductions in disparities. According to Dr. Snowden - this seminal effort will be important for addressing mental health disparities nationally. ADAMH is currently waiting on a start-up grant from ODMH- (Transformation Funds) that will assist in this work - and then ultimately targeting federal grants to fully develop this protocol statewide.
2. Require that all providers submit a full Cultural Competency Plan during SFY 2010 that will allow them to articulate how well they are doing in each of the 11 Cultural Competence Standards. These will be reviewed in early CY 2010 and feedback given.
3. Focus on addressing stigma within minority communities by developing videos and other media efforts to provide accurate information about the system.

The Board will continue to use 40% of its marketing resources to target minority communities through radio, newspapers, church presentations, billboards, television, community fairs, sponsorships, co-sponsorships, and other ways that we have an opportunity to better inform these publics. 4. Focusing on the impact, if any, on current budget reductions will have on culturally specific services and geographic access - to insure that those diverse groups historically underserved will not be adversely impacted. The Board will monitor any changes with outcomes impacting minority communities.

What are the Board's plans for SFY 2010 and 2011 to identify, increase and assess cultural competence in the following areas: Consumer satisfaction with services and staff, staff recruitment, staff training, and addressing disparities in access and treatment outcomes.

Consumer Satisfaction:

ADAMH's consumer satisfaction assessment process captures demographic data to ensure that the opinions of diverse populations about services are captured.

In addition, the Board is host to the Consumer, Family, and Minority Council - which specifically targets a diverse mix of consumers and families to participate in discussions, activities, and input about services. In addition, the Board requires that there is consumer / family involvement and input on all committees and work groups that examine operational and policy matters.

Staff Recruitment:

The Board will continue its monthly mailing of resumes received from ethnic minority candidates interested in system employment (since early 1990s).

Since there is an increase in emerging populations such as Somalis and Hispanics/Latinos - the Board began a special effort to provide information in Somali and Latino newspapers, radio, and other communication networks to attract a diverse pool of candidates for opportunities that become available.

Staff Training:

The Board recently cut funds to the system training institute. As a result - ADAMH's work with MACC will support their quarterly and annual conference cultural training offerings. We are encouraging providers to continue offering in-service cultural competence training for staff - as well as seeking other methods (described earlier) of enhancing their knowledge.

Other systems such as United Way, Columbus Public Health, Ohio State University, Ohio Commission on Minority Health - provide trainings periodically. There is also computer-based instruction, webinars, and trade learning communities that offer opportunities for developing cultural competency skills within respective disciplines.

Disparities in Access & Treatment Outcomes

It is important to note that ADAMH regularly monitors System Quality Indicators for variances in these data. The SQI pivot table data (race/ethnicity/gender) also provides information about accessing initial services, follow-up post emergency service, and other components to ensure that outliers are captured. It will be important to construct a more scientific process for examining disparities - based on the literature, which is why we are in discussions with Drs. Snowden and Curtis (stated earlier) to help the board and system better understand this problem and how to create a structure for addressing it.

Capacity Development Targets

C.1 - The ADAMH Board of Franklin County strongly believes in the process of treatment and prevention services. The ADAMH Board has adopted the slogan: "Treatment works. Recovery happens." In 2008 the ADAMH Board introduced its first Annual Recovery Month Kick off, in conjunction with the Annual National Recovery Month Celebration. The goal is to bring together people with substance abuse disorders, their families, and treatment/prevention providers to share testimonies and empower others to take the necessary steps toward recovery.

In addition, the Board made available special funding to encourage and support capacity expansion services for clients receiving medically assisted opiate treatment to two of our service providers.

The Board has initiated collaboration between the State BHO and Maryhaven to make available assessment and possible treatment services to clients discharged from with a primary AOD diagnosis.

ODADAS Capacity Targets:

- Reduce stigma (eg., advocacy efforts).-Aimee and Asama'
- The ADAMH Board's Strategic Results include a result targeted at reducing stigma. By January 2010, an additional 15% of Franklin County residents will demonstrate accurate knowledge of mental illness and other behavioral health disorders as evidenced by the Community Behavioral Health Survey.
 - o Annual Meeting
 - o Annual Recovery Month Event
 - o Paid Advertising Efforts
 - o Proactive and Reactive Media Relations
 - o Involvement in Community Events
 - o Community Presentations about ADAMH
 - o Attend Community Meetings in behalf of ADAMH consumers, like COTA
 - o Printed Materials and Publications including e-newsletters, brochures, fact cards, etc.
- Increase diversity of revenue sources to support Ohio's Alcohol and other drug system (e.g., apply for foundation and SAMHSA discretionary grants).-Joe F.
- Increase the use of "evidenced-based" policies, practices, strategies and programs in the AOD system.(Nettie, Stephanie (IDDT/ACT)
- Increase the use of data within the AOD system to make informed decisions about planning and investment.(JER-ProviderStat)

ODMH Capacity Development Targets:

- Reduce the stigma of seeking care.-Aimee-Public Affairs
- The ADAMH Board's Strategic Results include a result targeted at reducing stigma. By January 2010, an additional 15% of Franklin County residents will demonstrate accurate knowledge of mental illness and other behavioral health disorders as evidenced by the Community Behavioral Health Survey. The specific tactics used to communicate anti-stigma messages include:
 - o Paid Advertising Efforts
 - o Proactive and Reactive Media Relations
 - o Involvement in Community Events
 - o Community Presentations about ADAMH
 - o Printed Materials and Publications including e-newsletters, brochures, fact cards, etc.
- Provide mental health and other physical health services in an integrated manner. (NorthCentral's Nurses Program-Pam)
- Maintain/increase access to ACT, IDDT and Supported Employment, service enriched housing, peer support, CPST and WMR. (Stephanie and Pam)
- Increase use of best practices: (Stephanie and Pam)
 - o Wellness Management and Recovery;
 - o IDDT;
 - o Supported Employment;
 - o CIT;
 - o Intensive Home-Based Treatment (IHBT).
- Increase diversity of funding sources as reported in FIS-040 (August).
- Evaluation of services will be planned.
- Under development: Cost-effectiveness of EBP services.

C.2 - The Mental Health school based services use the Social Development Model and or curriculum's recommended by Ohio State Center for Learning Excellence (CLEX) Alternative Education & Mental Health projects or ODMH recommend interventions. AOD/Prevention Providers are encouraged to seek training in the Evidenced Based Models or update their skills annually. In 2008 ADAMH publishes a quarterly prevention e-newsletter which highlights evidenced based models, available training opportunities in Franklin County. In 2008 the ADAMH Board funded three provider agencies to re-structure and create an IDDT/ACT Team each within their organizations. We are targeting our System's High Risk clients, primarily individuals with high State Hospital bed day utilization, in hopes to address the intensive and co-occurring

treatment needs of these individuals and ultimately reduce our inpatient bed days at our State Hospitals. We are contracting with both the Ohio SAMI CCOE and the Ohio Coordinating Center for ACT to provide the consultation and training for this initiative and to assist and coordinate the implementation process so that each agency is providing treatment services based on the Evidenced-based Practice models of each respectively. Early in 2009 an additional provider agency contracted with the ADAMH Board to provide a fourth team for this initiative. In total the project will have capacity to serve 325 consumers.

In 2008 the ADAMH Board received grant award dollars from the Ohio Rehabilitation Services Commission to provide Supported Employment Vocational Services for our High Risk SMD population in Franklin County through ORSC's Pathways II initiative. Our accepted and awarded proposal and now implemented Supported Employment initiative is a three Board Area collaboration with Delaware/Morrow and Fairfield County Boards. Our Lead vocational provider, Center of Vocational Alternatives, is embedding trained Vocational Counselors in four provider agencies also implementing IDDT/ACT Evidenced-based practices. These vocational counselors will additionally work with a second identified Community Treatment Team in each organization to ensure both a large enough referral base as well as to more closely adhere to the fidelity of the Supported Employment model. A majority of consumers served by this project will have co-occurring disorders, impacting our identified High Risk population. Divergent from previous models of vocational services to the SMD population in this state, we are hopeful that the positive outcomes that research has provided of the EBP of Supported Employment will be fully realized here in Franklin County. The initiative is still in the first six months of implementation at this time and we continue to work closely with the Supported Employment CCOE, provider agencies and the Bureau of Vocational Rehabilitation to realign how we think about the vocational needs of our High Risk adult population.

Consumer Operated Services: ADAMH's largest single-program replacement levy investment (\$566,500) was the creation of the PEER Center (Peers Enriching Each others' Recovery). The Center has been in operation since January 1, 2007 and is open from 7 a.m. to 11 p.m. every day, including holidays. The Center provides peer support and mentoring, educational and creative opportunities, a computer lab, and social activities that assist persons in their recovery. Since opening, the PEER Center has welcomed 1,549 visitors.

During 2008, 452 consumers became "Associates" -- taking a more active role and made a greater leadership investment in the PEER Center. Ninety-two percent (92%) report positive results related to their quality of life, meaningful activities and day-to-day functioning, reduction of symptoms and problems, and/or overall empowerment. Eighty-three percent (83%) of the Associates are SMD with the remainder being identified as Criminal Justice System-Involved or General Adult/Older Adult.

Wellness Management and Recovery (WMR): WMR is an Emerging Best Practice.

Southeast, Inc., headquartered in Franklin County, is the home of the state-wide Coordinating Center of Excellence (CCOE) for WMR and is an original implementation site the practice. Southeast is in contract with the ADAMH Board of Lorain, Ohio, the fiscal agent for the project. The CCOE is using two previous evidence based practices (OMAP and IMR) to create a new product for consumer education with a greater focus on wellness, rather than disease management. This concept aligns with the recovery movement. The CCOE has overall responsibility for product development, dissemination to other providers in the state (including consumer groups), and the development of research and fidelity scales for this emerging practice. The recovery outcomes for consumers who have graduated from WMR to date have increased, according to Wes Bullock, Ph.D., of the University of Toledo. Findings from the Recovery Scale used by Dr. Bullock show significant increases in persons who complete the program. ADAMH funds Southeast at approximately \$64 K per year. The Southeast goal for the number of consumers who participate in the WMR program for the coming year is 80. This project employs peers and other staff members who are working as a team to initiate pilot sites for WMR across Ohio.

Residential Care: ADAMH funds a variety of non-crisis residential care (not including independent, service enriched or supportive housing) for approximately 175 unduplicated clients with SMI and/or SAMI. The current annual "per diem" costs for the 15 programs is \$5.2 M, with an additional \$1.2 M in "unbundled" service costs. In the coming year, ADAMH will initiate

more extensive utilization review in coordination with its provider network, so as to increase opportunities for client recovery, movement to less restrictive levels of care, and placement options for individuals requiring step-down supports from Regional Psychiatric Hospitals.

Prevention-Evidenced Based Practices

In 2006 ADAMH Board of Franklin County required AOD/MH prevention providers to use evidenced based practices, programs and strategies identified by research to improve outcomes and to include them in their ASP/PTO & Budget Packet 2008. Recommended websites were the SAMSHA Evidenced Based Model Registry and Ohio State Center for Learning Excellence Alternative Education & Mental Health Projects Evidenced Based Program Searchable Data base. The AOD/ Mental Health Providers identified the evidenced based models or curriculum's on the Agency Service Plan/Performance Target Outline and reported their outcomes using the TARGETrak 2006-present or ODADAS Web Based Reporting Services 2008 -present. Most AOD prevention providers use Life Skills, Asset Development or Risk and Protective Factors Evidenced Based Models or curriculum's recommended by these models.

The Board funded three new programs targeting the older adult population that focus on the integration of primary health care and behavioral health care in community-based health care settings. Concord Counseling, Maryhaven and Northwest Counseling received additional allocations to expand and create programming in primary health care settings in partnership with primary health care providers. The older adult population was targeted due to the mistrust this population has related to behavioral health care interventions and providers. Wellness Management and Recovery (WMR): WMR is an Emerging Best Practice. Southeast, Inc., headquartered in Franklin County, is the home of the state-wide Coordinating Center of Excellence (CCOE) for WMR and is an original implementation site the practice. Southeast is in contract with the ADAMH Board of Lorain, Ohio, the fiscal agent for the project. The CCOE is using two previous evidence based practices (OMAP and IMR) to create a new product for consumer education with a greater focus on wellness, rather than disease management. This concept aligns with the recovery movement.

The CCOE has overall responsibility for product development, dissemination to other providers in the state (including consumer groups), and the development of research and fidelity scales for this emerging practice. The recovery outcomes for consumers who have graduated from WMR to date have increased, according to Wes Bullock, Ph.D., of the University of Toledo.

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In 2008 the ADAMH Board funded three provider agencies to re-structure and create an IDDT/ACT Team each within their organizations. We are targeting our System's High Risk clients, primarily individuals with high State Hospital bed day utilization, in hopes to address the intensive and co-occurring treatment needs of these individuals and ultimately reduce our inpatient bed days at our State Hospitals. We are contracting with both the Ohio SAMI CCOE and the Ohio Coordinating Center for ACT to provide the consultation and training for this initiative and to assist and coordinate the implementation process so that each agency is providing treatment services based on the Evidenced-based Practice models of each respectively. Early in 2009 an additional provider agency contracted with the ADAMH Board to provide a fourth team for this initiative. In total the project will have capacity to serve 325 consumers.

In 2008 the ADAMH Board received grant award dollars from the Ohio Rehabilitation Services Commission to provide Supported Employment Vocational Services for our High Risk SMD population in Franklin County through ORSC's Pathways II initiative. Our accepted and awarded proposal and now implemented Supported Employment initiative is a three Board Area collaboration with Delaware/Morrow and Fairfield County Boards. Our Lead vocational provider, Center of Vocational Alternatives, is embedding trained Vocational Counselors in four provider agencies also implementing IDDT/ACT Evidenced-based practices. These vocational counselors will additionally work with a second identified Community Treatment Team in each organization to ensure both a large enough referral base as well as to more closely adhere to the fidelity Community Plan · The Franklin County Board of ADAMHS · Created 6/18/2009 10:01:20

of the Supported Employment model. A majority of consumers served by this project will have co-occurring disorders, impacting our identified High Risk population. Divergent from previous models of vocational services to the SMD population in this state, we are hopeful that the positive outcomes that research has provided of the EBP of Supported Employment will be fully realized here in Franklin County. The initiative is still in the first six months of implementation at this time and we continue to work closely with the Supported Employment CCOE, provider agencies and the Bureau of Vocational Rehabilitation to realign how we think about the vocational needs of our High Risk adult population.

- o Wellness Management and Recovery;
- o IDDT; see previous documentation on IDDT/ACT Initiative and cut/paste here
- o Supported Employment; see previous documentation on IDDT/ACT Initiative and cut/paste here
- o CIT; CIT has trained of 14 different municipalities in the last 5 years: 7 different municipalities over the course of 3 trainings in 2008. During 2008 there were also 4 Franklin County Sheriff's Officers trained and four college campus Peace Officers.
- o Intensive Home-Based Treatment (IHBT).

It is our Board's goal to maintain the following at the current funding levels after three rounds of allocation reductions which were instituted in October, 2008, January, 2009 and March, 2009 totaling \$5 million:

- Maintain services to the most vulnerable, legislatively mandated populations.
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence in community.
- Crisis services maintained at current level.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services to meet the diverse needs of Franklin County.
- Leverage investments where initiatives are consistent with ADAMH priorities.
- Reduction of spending at both the ADAMH Board and service level while maintaining the pledge that 95% of all revenues support the services provided by provider agencies.
- Maintain pledge that levy will last until 2016.

Diversity of Funding Sources: (Increase diversity of revenue sources to support Ohio's Alcohol and other drug system (e.g., apply for foundation and SAMHSA discretionary grants))

The ADAMH Board of Franklin County has identified private/public funding as one of its lines of business. Our current strategic result target is: "ADAMH will supplement the system's tax-supported budget by 4% from new funding sources to fund strategic priorities & innovations to care for mental health and alcohol/other drug treatment consumers."

The purpose of the program is to provide grant seeking and technical assistance to the ADAMH system to supplement the tax-supported budget through new funding sources. Priority AOD areas which guide staff work include re-entry services, recovery services, and school prevention. Recent funding has been received by such entities as SAMHSA's Center for Substance Abuse Treatment, the U.S. Department of Justice's Bureau of Justice Assistance, and the U.S. Department of Labor.

The Board has instituted a fairly aggressive grant making component which focuses on increasing revenue from other private and public sources. These funds are allocation to the providers for the delivery of services versus our administrative budget. The areas of particular focus for this year in our grant making efforts are the following:

- Re-Entry (AOD, MH and Juvenile Justice)
- Recovery-Employment (AOD and MH)
- Cultural Competency
- Housing
- Specialty Dockets
- School Prevention (AOD, MH)
- Workforce Development

Section III: Prevention Services

Prevention Needs

Needs Assessment Methodology

A.1 - The Board employs both qualitative and quantitative approaches in determining current and

future needs for services and care in the Franklin County public care system.

The Board's 2005 Levy Plan is a ten year plan through 2016 which includes the board's process for determining current and future prevention needs. All planning efforts include input from key stakeholders, consumers and family members through various interviews, task forces, educational group meetings, and surveys. The needs assessment process begins with using national epidemiologic data on prevalence and demographic, poverty and social data to arrive at a "targeted" number of people most likely to be in need of our services in Franklin County. The needs assessment and planning process culminates with our annual Strategic Business Plan which lays out specific desired measurable results and strategic goals. The Strategic Business Plan also includes several Key Strategic Results which are three to five year goals formulated by our Board which includes a Prevention Line of Business.

The purpose of the Prevention Services Program Line of Business was to provide Alcohol and Drug and Mental Health education and skill building services to youth and adults, so they avoided the abuse of drugs and alcohol made positive behavior choices and improved the well being of our community.

The Prevention Services Program consisted of services that are evidence-based prevention model development; prevention program development and oversight; prevention outcomes analysis and reporting.

The data sources available to the Board was US Census Data 2000 Franklin County, ProviderStat Data and PPAAUS Survey. The US Census 2000 Franklin County provided household data which summarized by categories. The ADAMH Board's policy and practice was to conduct Provider Stat sessions with all of its treatment and prevention providers a minimum of one time per year. The ProviderStat sessions was a sub-recipient monitoring function using a data driven and multi-disciplinary tool that focused on each contract agency provider's business and clinical/programmatic operations. The sessions was facilitated by the provider's lead network manager and all pertinent ADAMH Board senior staff or designees was also active contributors and participants. The Primary Prevention, Awareness, Attitude and Use Survey (PPAAUS) PPAAUS is designed to measure student attitudes and reported use of alcohol, tobacco and other drugs and provide information on violence and safety issues. Sixth through twelfth graders in the 16 public school districts and 36 non-publics in Franklin County completed the latest survey in the fall of 2006. Each data source described the people of Franklin County and our network providers' customers which was useful in determining current alcohol and drug and mental prevention, consultation and education needs.

Needs Assessment Findings

A.2.a - The Prevention Line of Business uses US Census Data Franklin County to arrive at the number of adults (Out of School Population 18 years to 70 years) and the number of youth (School Age Youth) most likely to be in need of services. The Board projects the number of youth and the number of adults that can be served in the ADAMH System of Care using provider projections and historical service data..

For 2010 the number of youth (197,875) and number of adults (417,103) most likely in need of service will remain the same. The number of youth (60,835) and the number of adults (39,634) who receive prevention services in the ADAMH system of Care will be reduced due to budget cuts; percentage yet to be determined.

"need for prevention services..." It is always been our contention that prevention services (both Mental Health and Alcohol and other drug) should be offered to any resident, regardless of ability to pay, and is primarily targeted to all school age youth, and their parents/guardians represented by the (estimated) almost 50% of adults. thus, we use the term Need to be

synonymous with the number of people, "...who could benefit from Mental Health and/or Alcohol and other Drug prevention services..." The actual service numbers you see reported in the plan are those that can be supported by the target track data, and are not reflective of many efforts and programs which actually reach many more individuals every year. Programs such as Red Ribbon campaigns and "information dissemination" to the masses are not clearly defined in terms of results or measurable impact, as are the programs which are measured by the Target Track, or now...ODADAS Web-Based system.

A.2.b - Addressed in A.2.a (above)

Prevention Priorities

Method for Determining Prevention Priorities

B.1 - The Board's planning process began with a ten year Levy Plan 2005-2015 and included a Needs Assessment of public sector behavioral health needs and current trends and service patterns. With the success of the Levy, the Board invested additional funding, and updated the Needs Assessment in addition to completing focused stakeholder interviews and focus groups for the purpose of determining priority service needs for the next three years. The results of the planning process were the Board's Request for Results (RFR) process for 2007 -2010 which funded three prevention programs. Key goals and strategies for 2007-2010 are contained in the Strategic Business Plan for 2007 and any revisions, are contained in the Board's Strategic Business Plan 2008. In anticipation of the budget cuts, the Board identified service delivery strategic Investment Objectives which includes prioritizes prevention and treatment services for 2010-2011.

Grouping of Priorities (High, Medium and Low)

B.2.a - Alcohol and Other Drug Prevention (ADAMHS, ADAS)

- a. RFR Prevention Programs-Suburban Schools-High
- b. Prevention Programs for legislatively mandated populations-High
- c. Prevention Programs that demonstrate the best quality, most cost effective use of funds which maintain culturally competent services and a geographical presence in the county-Medium
- d. Prevention Programs-with non direct service supports-low

B.2.b - Mental Health Prevention, Consultation and Education (PC&E) (ADAMHS, CMH)

- a. RFR Prevention Programs-Suburban Schools-High
- b. Prevention Programs for legislatively mandated populations-High
- c. Prevention Programs that demonstrate best quality, most cost effective use of funds while providing culturally competent services and maintain a geographical presence in the county-Medium
- d. Prevention Programs with non direct service supports-Low

Implications of Identified Priorities to Other Systems

B.3 - The RFR Prevention Programs may add referrals to the behavioral health entities that provide treatment services to youth and families.

Prevention Investor Targets

C.1 - INVESTOR
TARGETS

1. Increase the number of customers who perceive AOD use as harmful and non-use as the norm. (ODADAS)
2. Increase the number of customers who have positive family management and communication. (ODADAS)
3. Increase the number of customers who demonstrate school bonding and educational commitment. (ODADAS) (ODMH)
4. Decrease in the number of HIV/ AIDS/STD/TB and Hepatitis C infection and an increase in those with HIV/AIDS/STD/TB/HEPC receiving treatment. ADAMH
5. Increase the number of customers who improve their quality of life and

live in a safe environment. ADAMH

6. Increase the number of customers who adopt a drug-free workplace policy
ADAMH

7. Decrease criminal justice involvement ADAMH

8. Increased access to services (services capacity) ADAMH

9. Increase retention in prevention programs ADAMH

Section IV: Treatment and Recovery Support Services

Treatment and Recovery Support Needs

Needs Assessment Methodology.

A.1 - The Board employs all of the typical approaches in determining current and future needs for services and care in the Franklin County public care system (focus groups, key informants, surveys, penetration rates, demographic and social indicators, etc.). The Board's 2005 Levy Plan is a ten year plan through 2016 which includes the board's process for determining current and future treatment needs. The needs assessment process begins with using national epidemiologic data on prevalence and demographic, poverty and social data to arrive at a "targeted" number of people most likely to be in need of our services in Franklin County. The ten-year Levy Plan summarizes the treatment needs and priorities for services over the ten year span of 2007 to 2016. All planning efforts include input from key stakeholders, consumers and family members through various interviews, task forces, educational group meetings, and surveys.

The next step in the planning and needs assessment process incorporates educational stakeholder focus groups (including consumers and family members), and interviews to determine more specific service and program needs for the next three to five years. In previous Community Plans we included several Board documents which explain our needs assessment, planning and allocations processes entitled "Request for Results," and resulting Board Action of August, 2006. It includes a description and input from stakeholders and focus groups (including consumers and family members) conducted in 2006 for the RFR process and decisions. This RFR process continues today and will drive our funding process in 2009 and beyond.

The needs assessment and planning process culminates with our annual Strategic Business Plan which lays out specific desired measurable results and strategic goals. The Strategic Business Plan also includes several Key Strategic Results which are three to five year goals formulated by our Board. The 2009 Plan (Calendar Year, thus first six months of SFY 2010) is summarized as follows:

The major issues affecting individuals attempting to access our network for services are summarized in the Board's Strategic Business Plan for 2009 in the Business Environment section, and are as follows:

Consumer:

1. Changing community demographics will challenge ADAMH to provide culturally competent services delivered by culturally capable professionals that address the following socioeconomic factors:

- Poverty;
- Children and families at risk;
- Emerging immigrants;
- Stigma;
- Aging population;
- Integration of ex-offenders into community.

2. Better informed and more empowered consumers will challenge ADAMH's ability to meet their expectations from the public system of care.

Providers:

Ability of providers to meet the changing demands of consumers is challenged by:

- A shortage of qualified professionals;
- A lack of continuity of workforce due to high turnover;
- An insufficient cultural diversity in the workforce.

Funding:

1. External pressures on discretionary funds (resources available) due to:

- Limited parity in insurance coverage for behavioral healthcare;
- Political environment/fiscal policy;
- Rising costs of doing business.

2. Discretionary revenues are expected to rise which will challenge ADAMH's ability to allocate limited resources to unlimited demands.

Findings of the Needs Assessment

A.2.a - Since March of 2008 there have been 101 people hospitalized at regional campuses other than TVBH. Though discharge planning has been problematic, transportation back to Franklin County from out of district regional hospital has proven to be a significant burden for providers due the time commitment involved in transporting clients. During the summer of 2008 we allocated funding specifically for transportation for consumers hospitalized in out of region hospitals. Through an allocation through TVBH-Community Support Network a contract was made with a private securities company to provide transportation with 24 hours of notice. This program has allowed for more timely discharges because case managers are forced to juggle already full schedules in addition to loss of revenues for providers due to lost productivity associated with the driving distance.

A.2.b - The Board has continued to partner with Franklin County Children Services, Family and Children First Council and Juvenile Court to identify and serve youth with intensive needs using pooled funding. We now have five MST teams and one MST-PSB team. In 2008 this partnership established a FFT Team which further builds our county's capacity to serve families with more severe needs.

A.2.c - The Board and FCFC have been working to standardize criteria for care coordination which has included the capacity to utilize multiple funding recourses. FCFC in partnership with the Board review the utilization of all FAST expenditures to assure appropriateness.

A.2.d - In CY2007, the Franklin County ADAMH Board conducted an analysis of its adult, high utilizer, inpatient hospital population. We posed the following questions:

Why are we experiencing an increase in demand and/or volume and what ther the potential causes?

Which groups or specific individuals are presenting with the highest clinical risk?

Which groups of specific individuals are creating the highest financial risk?

Which services and/or strategies, if employed, would potentially improve key clinical and financial indicators?

What we found after analyzing the data was that a large percentage of individuals that were utilizing crisis and inpatient hospitals were presenting with co-occurring disorders. As a result, the IDDT/ACT teams that are mentioned throughout this plan were funded to target the specific needs of this highly vulnerable population. Early results look extremely promising. Four teams were created at four large comprehensive centers.

A.2.e - ADAMH estimates that approximately 15,000 adults and older adults will seek outpatient mental health services from the public sector in SFY2010-11. Since many Provider Agencies have many more requests for services than they can handle, about 1000 persons will not receive services through the public sector annually. With current budget cuts going into effect, we now estimate that for SFY2010-11, only 12,000 will actually receive mental health treatment.

A.2.f - The Board is in year two of a SAMHSA grant implementing Adolescent Community Reinforcement Approach/Assertive Continuing Care (A-CRA/ACC) which is an evidenced based model for youth who are abusing substances. This model is being used by two contract providers with the evaluation portion provided by The Ohio State University College of Social Work. Once completed we will have the capacity within our county to train and continue the implementation of this model. This is an area in which the county needs more expertise and resources to serve this population effectively.

Treatment and Recovery Support Priorities

Method for Determining Treatment Priorities

B.1 - The Board's planning process begins with a ten year Levy Plan 2005-2015 (attached for more information) and includes a Needs Assessment of public sector behavioral health needs and current trends and service patterns. With the success of the Levy, the Board was able to invest additional funding, and updated the Needs Assessment in addition to completing focused stakeholder interviews and focus groups for the purpose of determining priority service needs for the next three years. The results of the planning process are contained in the attached documents which supported the Board's Request for Results (RFR) process for 2007 and beyond. Key goals and strategies for the next three years (2007-2010) are contained in the Strategic Business Plan for 2008 and 2009.

Our Board action (August, 2006) allocates \$2,150,000 to 15 different priority programs and will serve an additional 9,500 consumers in 2007 and beyond. The programs represent the top priorities for new funding at this time. They include Treatment and Prevention programs. Also included in this action is a list of other programs and allocations that are "on-hold" for future action.

Unfortunately, the Board had to reduce funding by more than \$4 million dollars since July, 2008, which has made it necessary to adjust the original ten year plan for treatment and prevention priorities.

The ADAMH Board of Franklin County has prioritized the following service delivery strategic investment objectives;

- Maintain services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services that meet the diverse needs of Franklin County.
- Leverage investments where initiatives are consistent with ADAMH priorities.

Given these priorities, the Board's current investments in both prevention and treatment services have been developed with these strategic investment objectives in mind. Allocation reductions, increases and realignments have been instituted with these core service strategies as our overarching guide. Our most recent local allocation reductions resulted in the following impact on our system of care:

- Service system remained intact with full complement of providers, but some services and programs were reduced.
 - Current geographical presence was maintained.
 - Crisis services maintained at current levels (e.g., 24/7 crisis services intact, detoxification services intact, methadone/buprenorphine programs intact, engagement services for homeless, publicly inebriated adults intact).
 - Service reductions focused on non-direct service supports, areas of low performance and future innovation programs that would have been funded with system innovation funds supported by local levy.
 - Maintained services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
 - Maintained pledge that 95% of all revenues are at the service level by reducing both Board administrative and provider allocations simultaneously.
- As noted above, our community is extremely fortunate to have been able to maintain a full complement of services targeting individuals in need of behavioral health care interventions even after extensive budgetary reductions were instituted in the past 12 month period. This ability is largely due to our local levy and the acquisition of some large federal, state and local grants which we have aggressively pursued. We will be faced with more comprehensive system restructuring should there be additional reductions to our local behavioral health care budget from the state. We have attempted to keep our system of care intact to the greatest degree possible, but understand that adjustments will have to be made as we respond to deeper cuts. Other drivers impacting our budget include the increase in state hospital utilization, Medicaid match requirements and reductions from other funding sources historically utilized to augment our system provider's budgets (e.g., United Way, City of Columbus).

Grouping of Priorities (High, Medium and Low)

B.2 - We are currently readjusting priorities and funding due to severe State MH reductions, and cannot adequately respond to this item at this time.

Please see previous (2008-2009) community plans for priorities. We will forward any and all priorities and funding reductions at a later date. The ADAMH Board of Franklin County has prioritized the following service delivery strategic investment objectives;

- Maintain services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence.
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- Service reductions focused on non-direct service supports, areas of low performance and future innovation programs that would have been funded with system innovation funds supported by local levy.
- Maintained services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Maintained pledge that 95% of all revenues are at the service level by reducing both Board administrative and provider allocations simultaneously. As noted above, our community is extremely fortunate to have been able to maintain a full compliment of services targeting individuals in need of behavioral health care interventions even after extensive budgetary reductions were instituted in the past 12 month period. This ability is largely due to our local levy and the acquisition of some large federal, state and local grants which we have aggressively pursued. We will be faced with more comprehensive system restructuring should there be additional reductions to our local behavioral health care budget from the state. We have attempted to keep our system of care intact to the greatest degree possible, but understand that adjustments will have to be made as we respond to deeper cuts. Other drivers impacting our budget include the increase in state hospital utilization, Medicaid match requirements and reductions from other funding sources historically utilized to augment our system provider's budgets (e.g., United Way, City of Columbus).

Implications of Identified Priorities to Other Systems

B.3 - Persons with routine care needs that are not listed in prioritized or mandated population categories may have to wait longer for services or may not receive services at all in our system.

The ADAMH Board of Franklin County has prioritized the following service delivery strategic investment objectives;

- Maintain services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services that meet the diverse needs of Franklin County.

- Leverage investments where initiatives are consistent with ADAMH priorities.
- Given these priorities, the Board's current investments in both prevention and treatment services have been developed with these strategic investment objectives in mind. Allocation reductions, increases and realignments have been instituted with these core service strategies as our overarching guide. Our most recent local allocation reductions resulted in the following impact on our system of care:
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 - Service reductions focused on non-direct service supports, areas of low performance and future innovation programs that would have been funded with system innovation funds supported by local levy.
 - Maintained services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
 - Maintained pledge that 95% of all revenues are at the service level by reducing both Board administrative and provider allocations simultaneously.
- As noted above, our community is extremely fortunate to have been able to maintain a full compliment of services targeting individuals in need of behavioral health care interventions even after extensive budgetary reductions were instituted in the past 12 month period. This ability is largely due to our local levy and the acquisition of some large federal, state and local grants which we have aggressively pursued. We will be faced with more comprehensive system restructuring should there be additional reductions to our local behavioral health care budget from the state. We have attempted to keep our system of care intact to the greatest degree possible, but understand that adjustments will have to be made as we respond to deeper cuts. Other drivers impacting our budget include the increase in state hospital utilization, Medicaid match requirements and reductions from other funding sources historically utilized to augment our system provider's budgets (e.g., United Way, City of Columbus).

Treatment and Recovery Support Investor Targets

Treatment and Recovery Support Investor Targets

C.1 - Access to housing for individuals being discharged from BHO's will be targeted for SFY2010-2011. Do date, there have been 51 people in state hospitals assessed not to meet the criteria for Continued Stay but have remained hospitalized. Reasons that have delayed their discharges ranges from lacking funds for deposits and utilities, past criminal charges disqualify them for Federal Housing Programs, or a back log in supportive housing options. These 51 individuals account for 734 bed days at a cost to the system of \$353,054. Working with providers and local housing authorities to maximize housing options will continue to be a focus for clinical care in the upcoming years.

ORC 340.033(H) (HB 484) Investor Target

C.2 - The Franklin County ADAMH Board's investor target if the following:

Increase the number of customers who improve their quality of life and live in a safe environment.

HIV Early Intervention Investor Target

C.3 - The Franklin County ADAMH Board's investor target is the following:

Decrease in the number of HIV/AIDS/STD/TB and Hepatitis C infection and an increase in those with HIV/AIDS/STDS/TB/HEPC receiving treatments.

We focus on education and testing focused on persons who are actively engaged in alcohol and other drug treatment as a high risk area.

Section V: Collaboration

Continuity of Care Agreements

A - During the past year quarterly trainings were conducted at TVBH for new case managers. These trainings are designed to orient new CSPT Workers to the hospital to foster greater collaboration between hospital and community staff. Trainings include: treatment team participation, documenting in hospital charts, hospital resources, and safety. Trainings averaged about 15 new case managers per session. It is the intention of both ADAMH and TVBH to continue this training event.

Benefits/Results Derived from Collaborative Relationships

B - ADAMH CEO and SCCO meet monthly with representatives from the private psychiatric hospitals, state hospital, Netcare and Maryhaven to discuss coordination of emergency services and address timely access to inpatient beds. A daily telephone call was initiated between Netcare and all county inpatient providers (including TVBH) to facilitate transfers between facilities into inpatient beds. The telephone call is being updated from a phone call to a secure website, a real time "bed board", to insure the right patient gets to the right bed in a timely manner.

The Private Hospital Liaison Program was developed to meet the needs of consumers discharged from private psychiatric units and in need follow up care, often involving case management services as well psychiatric care. Social Workers from private hospital units refer to lead SMD Providers on a rotating basis with the expectation that a case manager will make contact with the clients to both enroll for services as well as take part in discharge planning. For several years ADAMH has contracted with The Ohio State University Neuropsychiatric Unit for the provision of inpatient treatment for consumers experiencing a psychiatric crisis who have co-occurring medical conditions that can not be treated at TVBH.

| Collaborative Partners Population | Programming | Target |
|------------------------------------------------------------------------------------------------|----------------------------------|-------------|
| Juvenile Court, Child Welfare, TX Provide Children | Family Drug Court | Parents and |
| Court of Common Pleas, TX Providers Criminal Justice | Adult Drug Court | Adults- |
| Job & Family Services, TX Providers Eligible Adults | TANF Outreach | TANF |
| School Systems-Urban, Rural, Suburban Children/Adolescents | School-based Prevention | |
| Private Business Entities Workplace | BASA Coalition | Drug Free |
| Common Pleas, Municipal & Juvenile Courts & Adults | Assessment/Linkage | Adolescents |
| Neighborhood Health Centers, TX Providers Family & Children First Council Children/Adolescents | Assessment/Brief Therapy Various | Adults |
| Children's Hospital, Schools, Pediatricians Children/Adolescents | Suicide Prevention | |

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

C - The Franklin County ADAMH Board and the Franklin County Children Services Board just recently signed an Interagency Agreement which focuses on a commitment to work together to improve the service delivery system on behalf of children and families served by both systems. The following new programs were jointly funded by both entities in CY2007:

-An enhanced Transition-Age Youth Team for children with behavioral health care needs who are aging out/transitioning out of the child welfare system.

-Two Multi-Systemic Therapy Teams (MST) which are targeting adolescent sex offenders and other children actively engaged in the criminal justice system.

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

D - The Franklin County ADAMH Board has an active Consumer and Family Advisory Council (CFAC) that actively participate in the Board's planning activities throughout the year. Most recently, a member of the CFAC became a member of the ADAMH Board of Directors. Other planning activities and monitoring that CFAC members actively participate in are the following:

- Levy Plan review and input
- Needs Assessment Review
- Strategic Business Plan input and planning retreat
- Stakeholder/Focus Group input on needs and priorities
- Request for Results - review of all provider proposals
- Agency Service Plan review
- ProviderStat Monitoring
- ADAMHStat Monitoring
- Contract Provider Contract Review and Recommendations

The Board is committed to continuing to work with the CFAC to engage their membership in planning activities where their input can have an impact on improving the quality of the service delivery system from a consumer/family member perspective.

Two family members have been invited to participate in an ADAMH sponsored monthly meeting titled "Youth Problem Solving" with the intention of gaining their insight for future prioritization and planning.

The mission and vision statement of CFAC (Consumer and Family Advocacy Council) demonstrates the groups commitment in ensuring ADAMH system of care is represented by consumer and family input. Mission statement: Promotes education, support, empowerment, and activism of consumers and families within the mental health and addiction recovery services of Franklin County.

Vision Statement: The Consumer and Family Advocacy Council believes that it is the right of Franklin County residents requiring mental health and/or addiction recovery services to receive appropriate, accessible, and timely care.

The ADAMH Board incorporates consumers and family members in the internal workgroups/committees in order to shape and define our work here at the Board Level. Agency Services Plans are submitted by the agencies and consumer and family members evaluate the plans and provide feedback prior to the implementation of the plan. The Board schedules a staff strategic planning retreat at the end of every year and consumer and family members are highly involved in that process by which every line of business is reviewed and plans are developed for the upcoming year. Additionally, the ADAMH Board provides significant administrative support to the CFAC, including training grants, meeting space & logistics and data base management support for their on-going advocacy work.

Section VI: Evaluation

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

A - The Franklin County ADAMH Board has an extensive and comprehensive sub recipient monitoring process which provides oversight for the expenditure of over \$140 million in Federal, State and local funds for the purpose of providing needed treatment and prevention services to people in need of mental health and alcohol and drug services. These processes are summarized below and include:

1. Provider STAT reviews—Each agency is reviewed in a face-to-face meeting once a year, using a comprehensive report that includes fiscal, planning and service data and client outcomes based upon provider data that covers the current year and previous two years performance. The data reports include the following key components for contract performance:

a. System Quality Improvement (SQI) Indicators—Consists of 15 measurable indicators of client access, appropriateness (process measures) and client outcomes, using provider submitted data from our data warehouse, including claims data, behavioral health data, and client outcomes, all required by contract. Providers are assessed and compared to system averages and set thresholds for performance.

b. Consumer Satisfaction—The Board assesses each provider's consumer satisfaction through the employment of consumer interviewers who assess a representative sample of more than 2,500 consumers from all treatment providers on an annual basis using the CSQ-8 item survey in a telephone interview. Results are scored for each provider and compared to system averages by population served and benchmarked to national studies of behavioral health consumers.

c. Fiscal Key Performance Indicators—Audit firms performs a ratio analysis for each contract service provider. These ratio analysis are applied to six objectives; 1) Current Ratio, 2) Debt to Equity Ratio, 3) Administrative Cost to Expenses, 4) Revenue to Expenses, 5) Fund Balance Reserve, 6) Percent of Funding From ADAMH Board. The Board has entitled these analyses -Fiscal Key Performance Indicators and uses them to monitor Providers' financial performance—in Provider STAT reviews.

d. Agency Service Planning commitments—Each provider submits annual service plans which include service commitments and budgets that are assessed for actual to budget performance.

e. Compliance with Outcomes (80% threshold level)and Behavioral Health data (70% threshold for intake and closure) submission is also measured and part of the performance index for monitoring, quality improvement and evaluation.

Collaboration with the Agencies in Evaluating Services.

B - The SQI indicators and Client Outcome data are also monitored throughout the year on a quarterly basis and feedback reports are provided to each contract agency for quality improvement purposes. Quarterly meetings are held with evaluation and quality improvement representatives (staff) from each provider for the purpose of ongoing monitoring and quality improvement using the data reports mentioned above. The providers also receive quarterly updates on outcomes compliance.

In addition, we produce "benchmarking reports" which "mirror" the Statewide Outcomes reports from ODMH to compare Franklin County system results with the Statewide data, and each provider receives a report which compares their consumer outcomes data to the County and State reports.

The quarterly meetings are held with provider evaluation and quality improvement staff by major populations served (SMI Adults, General MH Adults, AOD Adults, and Children and Adolescents), and the sessions are used for troubleshooting, questions and answers, and communications regarding using data for treatment planning and quality improvement.

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

C - The Board's priorities for services are by major population groups, MH SMI Adults, MH SED Children & Adolescents, AOD Adults, and all other MH and AOD populations. The SQI measures, Outcomes and Consumer Satisfaction data/information is broken out by these major populations for performance indexing, scoring and feedback to each provider for quality improvement purposes. The Board promotes and emphasizes "best practice" programs and services, and allocates dollars to these programs, such as those addressed in various previous sections of this plan. We are beginning to evaluate certain programs using the SQI, Outcomes and Consumer Satisfaction data in order to compare program methodologies and achievement of recovery for consumers. In this way, we can confirm the research for best practices through practical application of the recovery measures and direct our resources to the most efficient and effective programs and services.

Using the Results from the Evaluation of Programs/Services

D - As noted above, the primary purpose of the extensive evaluation and results monitoring system is to inform the system, providers and our Board for the purposes of feedback for quality improvement and treatment planning. We are also beginning to use the performance data to index the system of providers as one factor in funding decisions. The ODADAS performance management system is utilized for Prevention services in order to determine program and provider performance for those programs and services. The information is also used in a similar fashion as treatment outcomes and indicators, for quality improvement and program planning.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services

E - The Board uses similar strategies for evaluation of Child & Adolescent services, however, the outcome instruments (Ohio Scales) are specifically designed for this population. We also use many of the same Access and "process" or Appropriateness measures to assess both adult and child & adolescent services, but some are also different by population. Consumer Satisfaction using the CSQ-8 is also used for all populations, but we survey both the youth and their parents, so that strategy is different in a sense.

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 |
|------------------------------------------------|------------------|-------------------------------------|----------------------|------------------------------------|----------------------------------|--------------------|----------------------------------|-------------------|---------------|---------------|
| | | | | | | | | ODADAS | Medicaid Only | |
| | | | | (Universal, Selected or Indicated) | (List the EBP name) | | (Check the box if yes) | | | |
| Prevention | | | | | | | | | | |
| Information Dissemination | | | | | | | | | | |
| Alternatives Education | | | | | | | | | | |
| Community-Based Process | | | | | | | | | | |
| Environmental | | | | | | | | | | |
| Problem Identification and Referral | | | | | | | | | | |
| Pre-Treatment (Level 0.5) | | | | | | | | | | |
| Pre-Treatment | | | | | | | | | | |
| Outpatient (Level 1) | | | | | | | | | | |
| Outpatient | | | | | | | | | | |
| Intensive Outpatient | | | | | | | | | | |
| Day Treatment | | | | | | | | | | |
| Community Residential (Level 2) | | | | | | | | | | |
| Non-Medical | | | | | | | | | | |
| 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) | | | | | | | | | | |
| Assertive Community Treatment (ACT) | | | | | | | | | | |
| Intensive Home-based Treatment (IHBT) | | | | | | | | | | |
| Multi-Systemic Therapy (MST) | | | | | | | | | | |
| Functional Family Therapy (FFT) | | | | | | | | | | |
| Supported Employment | | | | | | | | | | |
| Supported Housing | | | | | | | | | | |
| Wellness Management & Recovery (WMR) | | | | | | | | | | |
| Crisis Intervention Training (CIT) | | | | | | | | | | |
| Therapeutic Foster Care | | | | | | | | | | |
| Therapeutic Pre-School | | | | | | | | | | |
| Transition Age Services | | | | | | | | | | |
| Integrated Physical/Mental Health Services | | | | | | | | | | |
| Older Adult Services | | | | | | | | | | |
| Sexual Offender Services | | | | | | | | | | |
| Consumer Operated Service | | | | | | | | | | |
| Clubhouse | | | | | | | | | | |
| Peer Support Services | | | | | | | | | | |
| MI/MR Specialized Services | | | | | | | | | | |
| Consumer/Family Psycho-Education | | | | | | | | | | |