Contents of the SFY 2009 ODMH
ADAMH Board of Franklin County Community Plan:

A. Board Mission & Vision Statement
B. Description of Current State
    a. Key program by program status per ODMH
C. Needs Assessment and Planning processes
        i. Levy Plan 2005-2016
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D. Community Plan for SFY09
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F. Appendices (Not included here – available upon request)

1. Levy Plan 2005-2016 and Key System Results 2005-2006
    i. Executive Summary and Needs Assessment – Levy Plan 2005
    ii. Key System Evaluation Results CY 2005-2006

2. Post-Levy Planning and Educational Focus Group Results 2006 Trends and Patterns

3. Needs Assessment Update and Planning Priorities – April 2006
    i. Franklin County Trends – Population, Demographics and Social Indicators
    ii. New Levy Priority Funding Capacity Expansion – CY 2007 and 2008

4. Requests for Results (RFR) Funding Process and Recommendations – August, 2006
    i. RFR Overview and Process
    ii. Funding Recommendations and Board Action (Approved – August 22, 2006)

5. ADAMH Board of Franklin County – 2008 Business Plan

III. COMMUNITY PLAN TEMPLATE

FOR COMPLETING THE SFY 2009 COMMUNITY PLAN

Click on box to enter Board name.

BOARD NAME: Alcohol, Drug and Mental Health Board of Franklin County

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

Click on gray box to enter text.

MISSION STATEMENT

We exist to improve the well being of our community by reducing the incidence of mental health problems and the abuse of alcohol and other drugs.

VISION STATEMENT

The vision of the Franklin County Commissioners' organization is to become the best Managed County in the nation by achieving results for our customers and improving the quality of life for the people of Franklin County.

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

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

Click on gray box to enter text.

The 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.

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

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

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

Click on gray box to enter text.

After the passage of its local property tax levy in 2005, the ADAMH Board conducted an exhaustive planning process which included numerous focus groups with a variety of stakeholders. The focus groups also included consumer and family members. Overwelmingly, one of the highest priorities that was recommended by a large number of participants in all of the focus groups was the need to create an additional peer operated center in Franklin County to support the social, emotional and vocational needs of persons with severe and persistent mental illness.

The Consumer Operated Center was the Boards largest new levy investment, totaling $500,000 per year. Columbus Area, Inc. was awarded the contract, with the stipulation that they transition the program to a stand alone, self-supporting organization soley run by consumer in 3 years. Columbus Area agreed to incubate the program and then transition it to a separate 501c-3.

The new Consumer Operated Center is one of 3 peer operated programs available to persons with SMI in Franklin County. The last report from the Center indicated that they had served 790 unique individuals from January 1, 2007 thru February 22, 2008.

Another area of recovery-based services that the Board has been focusing on are peer delivered services provided by peer specialists. The Center for Vocational Services (COVA) has been funded with local levy dollars to create a peer specialist model program and has recently hired 2 peer specialists to provide services on behalf of their peers. Forensic Peer Specialists have also been hired in the ADAMH system as the result of the successful acquisition of a federal Bureau of Justice Services grant. The model for the Forensic Peer Specialists employed as part of this program were modeled after the "Howie the Harp" program in Harlem, New York. ODMH's Office of Forensic Services provided two rounds of funding in the last two years that have allowed various

local forensic peer specialists and other professionals to go on two site visits to the "Howie the Harp" program.

All of our contract agencies are requried to submit a narrative response to the following questions in their annual Agency Services Plan (ASP):

ASP Section A: Executive Summary Narrative (CY2008)
Consumer-Informed and Peer/Alumi Delivered Services

a.Describe how the strategies outlined in the CY2007 Agency Services Plan have increased your ability to provide consumer-informed and peer/alumi-delivered services, include quantifiable results.

b. Provide three specific strategies you will employ in CY2008 to increase your organization's ability to focus on recovery and resiliency. Please include at least one plan to increase consumer and family involvement in the planning, evaluating and delivering of services. Indentify quantifiable goals and the associated measurement tools.

c. Describe how your organization provides information on self-help resources for your clientele and their family members. List the resources you share with both the consumers and their families.

In addition to the information above, each contract agency is required to submit the number of staff and board members who self-identify themselves as consumers or family members. This information is reviewed and discussed at the provider's annual ProviderStat session.

2.1 Recovery Supports: Housing

Supported Housing is a specific program model in which a consumer lives in a house or apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing include: housing choice, functional separation of housing from service provision, affordability, and integration with persons who do not have mental illness, right to tenure, service choice, service individualization, and service availability. The Mental Health Housing Leadership Institute operated by NAMI Ohio provides consultation and training.

a. Do you offer **supported housing** service?

Click on gray box to select answer.

Yes	**2.1.a**

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

Click on gray box to select answer.

Yes	**2.1.b**

c. With regard to **supported housing**, which of the following categories comes closest to the average wait time for most consumers? *Please select only one response category.*

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

10	**Up to 1**	**1-3 mos.**	**4-6 mos.**	**7-9 mos.**	**10-12**	**More**	**Don't**	**2.1.c**

working days or less	month				mos.	than One Year	Know /NA	
☐	☐	☐	☐	☐	☐	☒	☐	

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

Click on gray box to enter number.

800 Consumers Waiting	**2.1.d**

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

e. Do you have wait lists for HAP?

Click on gray box to select answer.

Yes	**2.1.e**

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

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

10 working days or less	Up to 1 month	1-3 mos.	4-6 mos.	7-9 mos.	10-12 mos.	More than One Year	Don't Know /NA	2.1.f
☐	☐	☐	☐	☐	☐	☒	☐	

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

Click on gray box to enter number.

100 Consumers Waiting	**2.1.g**

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

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

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

Up to 1 year	1-2 yrs.	3-4 yrs.	5-6 yrs.	7-8 yrs.	9 yrs. or more	Don't Know /NA	2.1.h

☐	☐	☐	☒	☐	☐	☐	

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

Click on gray box to enter number.

4000 Consumers Waiting	**2.1.i**

The **Homeless Housing Status National Outcome Measure (NOM)** reported to SAMHSA by ODMH refers to adults, aged 18+ with severe mental illness (SMI), who have identified themselves as homeless on an administration of the Adult Consumer Survey in the Ohio Outcomes System. For SFY 2007, Ohio reported a Homeless Housing Status NOM to SAMSHA of **2,879** persons with SMI. Board level data for Ohio's SFY 2007 Homeless Housing Status NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

k. To what extent are the Board level data reported in Appendix B for homeless adults with SMI an accurate reflection of the number of such individuals served by the Board in SFY 2007?

Click on gray box to enter text.

513 This number is low based on our reports from the PATH program and our collaboration with the Community Shelter Board. Numbers are closer to 600. We accounted for 466 homeless adults in our Outcomes data for the SFY 2007 time period. Outcomes data is not the best source for determining number of homeless individuals with SMI or any mental illness or substance abuse issues, as there are many homeless individuals that are served by our system without having a formal case open, and outcomes forms completed. These individuals are often served through outreach and prevention type services, and refuse to engage in the system, even though that is the goal of such services.

k.a. If the Board does not use Outcomes data to estimate number of homeless persons with SMI, what data source does the Board use to plan for services to this population?

Click on gray box to indicate "Yes" with an "X.". Indicate all that apply.

☒	Continuum of Care	**2.1.ka**
☒	PATH	
☐	BH Mod (Behavioral Health Module)	
☒	HMIS (Homeless Management Information System)	
☐	Other, please specify:	

k.b. If the information in Appendix B is inaccurate, what was the number of homeless persons with SMI served by the Board in SFY 2007?

Click on gray box to enter number.

566 Homeless persons with SMI	**2.1.kb**

k.c. Is there anything else important to know about the current state of housing strategies and services in your Board area?

Click on gray box to enter text.

Currently the ADAMH Board of Franklin County is experiencing a rise in number of consumers who are being held in the state BHO beyond approval for discharge because of a lack of appropriate housing. The ADAMH system has over 1000 units of housing as provided by our contractor, CHN, but that is not enough to serve our need. We find that most of the consumers who leave the hospital are placed in housing as housing settings. Many of those persons fail and enter back into the crisis cycle. ADAMH is currently looking at other resources in the community to meet the needs of ADAMH consumers including "step down" housing for consumers as they continue in recovery.

We (ADAMH) are extrememly proud of our supported housing programs and find them to be both cost effective and a crucial part of recovery for some. One of the major difficulties this board faces is funding for the services connected with supportive housing. Medicaid can only go so far in supporting 24/7 care availability Once that funding issue is resolved we have noticed a dramatic decrease in the monies spent on treatment and crisis/hospital care per person.

There has been an increase in the total number of homeless individuals and families in Franklin County over the last 5 years. Most homeless persons are able to re-establish a home within a short period of time. Those who remain homeless or experience multiple episodes of homelessness are almost always persons in need of behavioral health care.

2.2 Recovery supports: Employment

The **Employment Status NOM** reported to SAMSHA by ODMH refers to adults, aged 18+ with severe mental illness, who have identified themselves as employed full-time or part-time through an administration of the Adult Consumer Survey in the Ohio Outcomes System. For SFY 2007, Ohio reported an Employment Status NOM to SAMSHA of **24,068** persons with SMI. Board level data for Ohio's SFY 2007 Employment Status NOM is found in Appendix B. (Syntax for calculation of this NOM can be obtained from the Community Plan website.)

a. To what extent are Board level data reported in Appendix B for employed adults with SMI an accurate reflection of the number of such individuals served by the Board in SFY 2007?

Click on gray box to enter text.

We found the data to accurately reflect our information, as we too use outcomes data to estimate these numbers. We have "benchmarked" the ODMH outcomes reports for the last two years, and feed this information back to each provider, so they can compare their outcomes data with the Franklin County system, and Statewide data for quality improvement purposes. We also use the outcomes data in our System Quality Improvement (SQI) Indicators which are a set of quality indicators of performance for all contract treatment providers. Many of these indicators are directly responsive to the various NOMS measures. We use a scoring system and comparison to system averages and our Desired Targets for feedback and quality improvement purposes. You can find a complete overview of the SQI system on our website. The discrepancies in our data versus the ODMH number is mostly due to the fact that we run our data and reports for our system exclusive of Out of County clients, for the purpose of system averages and comparisons of providers in the County. We have begun to look at the outcomes for clients served in other coutnies and paid by our Medicaid/levy match dollars, but recognize that we have no authority or control with regard to affecting change in out of county providers.

a.a. If the Board does not use Outcomes data to estimate the number of employed persons with SMI, what data source does the Board use to plan for services?

Click on gray box to enter text.

See above. This Board has been using outcomes and other measurable data (Claims, BH, Consumer Satisfaction) for planning and quality improvement purposes for over ten years (our outcomes system and instruments for SMD adults predates the ODMH outcomes system by five years). Please note the following for 2.2.ab below: * ODMH asks for SMI employment data, and not All Adults, yet Appendix B data is for both populations. We arrived at 2,345 persons with full or part time employment for all adults for the same time period. We break out the SMD and other adult populations for our providers when "benchmarking" this data locally.	**2.2.aa**

a.b. If the information in Appendix B is inaccurate, what was the number of full-time and part-time employed persons with SMI served by the Board in SFY 2007?

Click on gray box to enter number.

2345 Employed persons with SMI	**2.2.ab**

b. Please describe existing activities related to helping consumers identify, determine, or achieve their employment goals. The continuum of activities may include referral to the Rehabilitation Services Commission (RSC), service planning and coordination through CPST, vocational counseling service, supported employment programs, agency employment of peer support specialists, or any other Board strategies aimed at helping consumers achieve employment goals.

Click on gray box to enter text.

A full range of employment readiness, employment and job maintenance activities are provided within the Franklin County mental health system of care, through lead agency service planning, linkage and CPST coordination of care activities, and Peer Support specialist activities. Collectively, these services include: linkage and referral to RSC, vocational counseling, psycho-social and pre-vocational programming, a vocational "Clubhouse" offering vocational and pre-vocational activities, follow-along services, benefits consultation (a key component of the Supported Employment evidenced-based practice model), group rehabilitation readiness programming, fully staffed drop-in resource center availability, Supported Employment Transition programming (providing transitional, sheltered employment for participants with rehabilitation support, teaching employment skills and subsequent placement into fully integrated competitive community employment), and direct consumer vocational opportunities staffed by employment specialists which offer employment to any consumer who desires to work. COVA currently employs a full-time vocational specialist who is placed within a local mental health center to provide direct vocational services to their existing SMD population, very closely following the Supported Employment model.

Recent ADAMH strategies targeted to assist consumers in achieving their employment goals include several new initiatives. In 2007 grant funding was awarded to COVA to add curriculum, individual and group services to their existing Transitional programming allowing consumers to transition into community employment from their existing supported employment janitorial service. In 2008, a Wellness Management & Recovery (WMR) CCOE pilot site was initiated through COVA, (training both staff and peers in wellness and recovery activities), with the curriculum becoming an integrated part of their Careers For the Future training and Supported Employment Transition group curriculum. In 2007 COVA became a key provider of employment

services to the newly funded Peer Operated Drop-In Center (Peer Center) sponsored by Columbus Area Mental Health Center, providing rehabilitation readiness groups, benefit consultations and vocational outreach services. Efforts are currently underway at COVA to develop a Careers For the Future Alumni group. In the coming year, COVA will be hiring positions, funded locally, deemed "Employment Peer Specialists" intended to co-facilitate Rehabilitation Readiness groups, assist in the Computer Resource Center, and provide one-on-one peer support. ADAMH, in collaboration with the Ohio Department of Rehabilitation and Corrections (ODRC) and the Ohio Department of Mental Health (ODMH), was awarded a Prison Re-Entry Grant through the Bureau of Justice Assistance. ADAMH will continue its work with two of its lead agencies to implement and begin treatment services from this grant within our system of care in the coming months. The services outlined in the grant focus on successful community transition from incarceration, including the provision of individual and group employment readiness activities within institutions; development of Personal Transition Plans; the teaching of job readiness skills; individual job development and job search activities in the community; and follow along support post job start. Southeast, Inc. has a Community Living Specialist Program which allows for the education and training of consumers to become "Community Living Specialists"

3.0 Resilience supports. What are some notable achievements and trends for the Board in the area of resilience supports?

Resilience supports include strategies for school success, early childhood intervention, transitional living, system of care coordination, wraparound, mentoring, family support and education, and family advocacy. Examples of programs and activities in these areas include Network for School Success, ABC, FAST, Incredible Years, Big Brothers/Big Sisters, Triple P, Family Advocates, NAMI Hand to Hand. Funding source is the major difference between best practices in Resilience support and best clinical practices, with the Resilience support primarily funded as non-Medicaid reimbursable services.

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

Click on gray box to enter text.

P,C&E -The Board currently utilizes the Rensselerville Outcomes Model for its provider prevention services outcomes reporting.

In CY2007, Northwest Counseling Center, Children Hospital Behavior Health, Northwest Counseling Center reported serving 4,762 youth and adults and also reported that 4434 youth and adults gained protective factors/developmental assets.

The Social Development Strategy was utilized in these programs which focus on protective factores. Protective factors are conditions that buffer youth from the exposure to risk by reducing impact or changing youth response to risks

Northwest Counseling's Mentoring Program reported securing mentors for 18 youth and reported that 15 improved in one asset area.

Rosemont-Mifflin School Project work with Somali population using Asset Deveopment model focus on Commitment to Learning: Youth are actively engaged in learning at school, hands homework in on time, engages in reading; Cultural Competence-making transition to new cultural

and retaining and valuing their hertiage. The goal is to develop positive experiences and personal qualities that young people need to grow up healthy, caring, and responsible.

St. Vincent Family Center's Kids Group, NorthCentral, Nationwide Children's Hospital, Columbus Area reported enrolling 727 in school-based mental health programming and 652 achieved projected outcomes. These providers utilized Asset Development, Positive Action or Life Skills curriculum.

The Board in partnership with Frankin County Family and Children First Council continue to support the development of the Incredible Years program and use of the DECA screening with St. Vincent Family Center.

The Board and FCMRDD established a partnership to expand the Incredible Years to the MRDD Child Development Center. Within the partnership of clinicians works with MRDD staff to provide Incredible Years groups for children and parents, as well as training for staff. In addition, the clincian will screen and refer youth in need of behavioral health treatment to a community provider. St. Vincent Family Center in the provider working the with ADAMH/MRDD partnership.

3.1 Resilience supports: School Suspension and Expulsion NOM

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

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

Click on gray box to enter text.

We measured number of children and adolescents with any school suspensions in the last 90 days, based upon all Worker Form assessments received during SFY 2007. We found 1,275 kids (or 13.5%) with one or more days of suspension in the last 90 days, out of 9,447 total clients represented by a Worker Form in SFY 2007. We also measured this for all children and adolescents, and not just SED youth. We have not routinely broken out SED youth from non-SED youth for outcomes and SQI/benchmarking reporting and monitoring.

a.a. If the Board does not use Outcomes data to estimate school suspensions and expulsions among children and adolescents with SED served in your area, what data source does the Board use to plan for services that support school success?

Click on gray box to enter text.

We do not use the "negative" indicator of school suspensions, but we have measured increase or improvement in "attending school and getting good grades" as part of our Consumer Stat – Managing for Results process for 2006. We now use the System Quality Improvement (SQI) Indicators which are contained in the Appendices as well as	**3.1.aa**

on our Board website under Outcomes and SQI process. We look for improvement in key outcome and other indicators over time in treatment. Please note that the number below also represents youth served out of county as well (53 individuals). When we look at outcomes and any comparative data for Franklin County, we use only in county provider/client data in order to assess our system, as we have no control or authority for services provided by Out of County Medicaid providers.	

a.b. If the information in Appendix B is inaccurate, what was the number of persons with SED served by the Board in SFY 2007 who were suspended or expelled?

Click on gray box to enter number.

1275	**3.1.ab**

4. Inpatient Care

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

a. Inpatient Care

Click on gray boxes to enter numbers.

Board Purchased Inpatient Care	FY 06 Bed Days	FY 07 Bed Days	FY 06 Admissions	FY 07 Admissions	**4.a**
State Hospitals	25810	24415	818	911	
Private Psychiatric Hospitals: Adults	113	155	18	44	
Private Psychiatric Hospitals: C&A	98	251	11	36	

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

Click on gray box to enter text.

Annually, the Board purchases a best educated estimate of bed days from the State of Ohio, projecting what we will utilize in the coming year. This estimate takes into account current trends in local crisis services, trends in outpatient community service delivery, access to private inpatient psychiatric beds and county population growth. ADAMH currently has a contract with the OSU hospital system totaling $500,000, that allows for the inpatient psychiatric hopsitalization of consumers with co-occuring medical conditions, who would be more appropriately treated in a inpatient setting with ready access to medical care. Consumers are assessed through one lead agency (Netcare) , which if assessed to require an inpatient psychiatric level of care, will make all attempts to hospitalize consumers that have a payor source (Medicaid, Medicare or other third party insurance) within the private hopsital system. If these attempts are unsuccessful, the consumer will be admitted to our local BHO. In 2006 Franklin County experienced 35% of admissions to State BHO's as being Medicaid eligible. Franklin County has	**4.ba**

a disproportiontely low number of private hospital beds: 13.3 per 100,000. In 2007, a workgoup was developed including Netcare, ADAMH representation, local private hopsital management, and TVBH to look at ways to ensure timely consumer access to local inpatient care, public or private, and a more seamlesss transition from inpatient care to outpatient community services at time of discharge.	

b.b. Do you have a continuity of care agreement with your designated state hospital?

Click on gray box to select answer

Yes	**4.bb**

5. **Residential Treatment Centers (RTCs).**

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

Click on gray box to enter number.

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

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

Click on gray box to enter number.

276C&A Consumers place out of county in SFY 07	**5.b**

c. How many of the C&A consumers identified above involved Board participation in the placement decision?

Click on gray box to enter number.

0 Out of county placements involved the Board	**5.c**

d. For SFY 2007, how would you describe the local trend in placements at Residential Treatment Centers? *Please select only one answer.*

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

Use is increasing	**Use is about the same**	**Use is decreasing**	**5.d**
☐	☒	☐	

e. How does the Board understand the trend in RTC placements indicated above?

Click on gray box to enter text.

The trend in placement is consistent with previous years. However, ADAMH Board of Franklin County and Franklin County Children Services entered into a partnership during 2007 to develop and Integrated System of Care which will focus on youth going into residential placements. The initative was conceptualized and some framework created in 2007 and a Director for this new initiative was hired and began	**5.e**

working on 1/2/08. This partnership will directly involve the Board with the placement of youth, specifically those who go outside of Franklin County for treatment services.	

6. Crisis/Emergency Care.

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

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

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

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

Click on gray box to enter number.

	SFY 06 Crisis Bed Days	SFY 07 Crisis Bed Days	6.a.2
Adults	10676	12532	

Children & Adolescents	116	195	

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

Click on gray box to enter text.

In 2007, Franklin County experienced a significant increase in utilization of its crisis services, primarily a result of a decrease in access to private and state hospital beds, county population growth and the increasing acuity of consumers, particularly those with co-occurring substance use disorders. This prompted two large community provider Summit meetings (in Novemeber and December 2007) targeted to identify workable strategies to address the significant utilization of crisis services and inpatient psychiatric beds in Franklin County. A Crisis Bed expansion grant, a Summit identified strategy, was recently approved by ADAMH to address issues of overcrowding and delayed access to timely hospital access at Netcare. Additionaly, the local Hospital workgroup was developed to proactively deal with these issues.

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

1. Police Coordination/CIT

Click on gray box to enter text.

The Franklin County ADAMH Board coordinates the Crisis Intervention Training for Franklin County. 260 officers have been trained to date:
174 of those officers are from the Columbus Police Department,
1 officer from the Grandview Heights P.D.
6 officers from the Hilliard P.D.
2 officers from the Reynoldsburg P.D.
11 officers from the Columbus Regional Port Authority P.D.
4 officers from the Westerville P.D.
5 officers from the Clinton Township P.D. (including their Chief)
14 deputies from the Franklin County Sheriff's Office
1 officer from the Mifflin Township P.D.
3 officers (state police officer) from Twin Valley Behavioral Healthcare
2 officers (state police officer) from Ohio Department of MR/DD
Colleges/Universities
6 officers from the Columbus State Community College P.D.
11 officers from the Ohio State University P.D..

2. Disaster Preparedness

Click on gray box to enter text.

Franklin County has developed a System All-Hazards Plan, which has been submitted to the Franklin County Emergency Management & Homeland Security Office, and have coordinated plans with the American Red Cross of Central Ohio, Columbus Metropolitan Medical Response System, Regional Metropolitan Medical Response System, and our Contract Providers. We have provided clinician trainings on the provision of services in the aftermath of a disaster. In addition, we have required our contract Providers to submit a copy of their internal All-Hazards Plans and to identify those clinicians who would be

available to participate in a Behavioral Health Response to a local disaster. We have developed and printed a brochure for use with disaster victims. Franklin County ADAMH has an internal plan, currently under an update review.

What are your estimates of staff for the following areas?

Click on gray box to enter number.

	Local Disaster Response	Statewide Disaster Response	**6.c.2**
Trained	60	60	
Currently Available	100	0	

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

Click on gray box to enter text.

Secondary and Primary school systems within Franklin County have their own, well-integrated disaster response system which includes shelter-in-place; available counselors, etc. In addition, Franklin County Children's Services is available to assist, if needed. ADAMH is considered as a resource only after the schools' own systems and Children's Services. Local Universities and Colleges have not included ADAMH in their disaster plans, having coordinated with their own resources and other local entities.

7. Outpatient Services.

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

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

a.1. Adult Intensive Care

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

Service Area	**Service Avail-able?**	**Don't Know /NA**	**Up to 10 wd**	**11 to 15 wd**	**16 to 20 wd**	**21 to 30 wd**	**31 to 60 wd**	**61 to 90 wd**	**91 wd or more**	**7.a.1**
ACT	☒	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	

PH Program Type I	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Program Type II	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive Pharm. Mgt	☒	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive CPST	☒	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	

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

Click on gray box to enter text.

Franklin County consumers currently have access to ACT-like services through several of its lead community mental health centers, with a ODMH funded Forensic ACT team located at Southeast, Inc. These ACT-like teams are providing intensive CPST services, typically with reduced caseloads and wrap-around services, however the extent to which these organizations have been able to fully implement ACT has been limited, mostly due to financial constraints. It is the intent of the ADAMH Board in 2008, to provide supplemental funding, and training and consultation dollars to create ACT teams within our system of care that align closely with the ACT model of treatment. This will not only increase the prevalence of ACT CPST services, but will also allow for intensive Pharm Mgt to be more fully realized. ADAMH, within their agency contracts, currently requires its providers to effectively respond to the emergent and urgent clinical needs of current clients, recognizing the nature of mental and addictive disorders, persons' intensity of clinical need may fluctuate, necessitating different provider response times and intensity. This is an emerging priority for ADAMH as we have continued to see the increase in hospital bed day and crisis service utilization.
Persons with emergent needs shall be assisted within three (3) hours by the Provider. Emergent indicates a need for immediate intervention due to the presence of factors that may place the person at imminent risk of harm to self, harm to others, or serious and acute deterioration in functioning. A person with emergent needs, if clinically indicated following the intervention, may require a prioritized referral into a more restrictive treatment environment.

Persons with urgent needs shall be served within three (3) days (72 hours) where appropriate ODMH– and/or ODADAS–certified services can be made available.
Urgent indicates a need for expedited treatment due to the presence of factors that could place the person at risk of harm to self, harm to others, or serious and acute deterioration in functioning. The person is not exhibiting such symptoms at present; however these risks could increase without expedited access to treatment.

ADAMH asks that providers make every effort to provide timely access to services for persons with routine treatment needs. Persons who are not identified as having emergent or urgent needs may be placed on waiting lists. Persons on wait lists will be made aware of the

potential length of time they may have to wait for treatment, an agency contact name and number, what to do if needs become urgent, and alternative services or supports that may be available.

ADAMH tracks the following system quality indicators on their lead SMI prrovider organizations: BHO discharge with 30 or more days community LOS, treatment service delivered within 7 days of discharge from BHO, and service by lead agency within 3 days of discharge from a crisis service. Despite an increase in demand, the first two of these indicators have been met within the last year. These indicators will continue to be monitored in coming years to ensure timely access to intensive outpatient care, and in an effort to continue to identify gaps in treatment services.

a.3. Child & Adolescent Intensive Care

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

Service Area	Service Avail-able?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.a.3
IHBT / MST	☒	☐	☒ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Program Type I (Time limited)	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Prgm. Type II (School-based)	☒	☒	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
PH Prgm.Type III	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Therapeutic Pre-School (PH)	☒	☒	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive CPST	☒	☒	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Intensive Pharm. Management	☒	☒	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Functional Family Therapy	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	

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

Click on gray box to enter text.

During 2007 the Board in partnership with Franklin County Children Services, Family and Children First Council and Juvenile Court were able to build capacity for 5 traditional MST teams and 1 MST-PST team. The capacity was built using ADAMH, FCCS, FCFC and Juvenile Court funding.

MST is the only intensive services that the Board has involvement in manageing access. When MST capacity was created, the systems involved also established criteria for referrals and a gatekeeping function was established with all referrals being screened for appropriateness by the clinicians located onsite at Juvenile Court and Children Services, then sent to FCFC for disemination to the MST provider. FFT is being developed in 2008, again in partnership with ADAMH and FCCS.

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

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

b.1. Adult Routine Outpatient Care

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

Service	Service Avail-able?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.b.1
Diagnostic Assessment -- Physician	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Diagnostic Assessment – Non-Physician	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Pharm. Management	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Counseling/ Psychotherapy	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
CPST	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	

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

Click on gray box to enter text.

100% of providers will deliver a face–to–face treatment service within an average of 13 days after their initial assessment. ADAMH currently requests its contract agencies to deliver services to

persons with routine needs in 13 days, with the understanding that with increasing local demand for services, those individuals presenting with emergent and urgent needs take priority.
Providers make every effort to provide timely access to services for persons with routine treatment needs. Persons who are not identified as having emergent or urgent may be placed on waiting lists. Persons on wait lists will be made aware of the potential length of time they may have to wait for treatment, an agency contact name and number, what to do if needs become urgent, and alternative services or supports that may be available.

No identified factors that would suggest the person is currently exhibiting or at risk of exhibiting harm to self, harm to others, or serious and acute deterioration in functioning, such that more immediate access to treatment would be warranted.

b.3. Child & Adolescent Routine Outpatient Care

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

Click on gray box to enter text.

Service	Service Avail-able?	Don't Know /NA	Up to 10 wd	11 to 15 wd	16 to 20 wd	21 to 30 wd	31 to 60 wd	61 to 90 wd	91 wd or more	7.b.3
Diagnostic Assessment -- Physician	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Diagnostic Assessment – Non-Physician	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Pharm. Management	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Counseling/Psychotherapy	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
CPST	☒	☒	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	

b.4. Which routine outpatient services for children have been area(s) of focus for the Board? ***If an agency uses a triage system to schedule services, please discuss the Board's oversight role in planning and delivery of triaged services***. Discuss access, capacity, and quality improvement achievements and trends in service areas that have been an area of focus.
Click on gray box to enter text.

100% of providers will deliver a face–to–face treatment service within an average of 13 days after their initial assessment. ADAMH currently requests its contract agencies to deliver services to persons with routine needs in 13 days, with the understanding that with increasing local demand for services, those individuals presenting with emergent and urgent needs take priority.
Providers make every effort to provide timely access to services for persons with routine treatment needs. Persons who are not identified as having emergent or urgent may be placed on waiting lists. Persons on wait lists will be made aware of the potential length of time they may have to wait for treatment, an agency contact name and number, what to do if needs become urgent, and alternative services or supports that may be available.

No identified factors that would suggest the person is currently exhibiting or at risk of exhibiting harm to self, harm to others, or serious and acute deterioration in functioning, such that more immediate access to treatment would be warranted.

c. Best Clinical Practices. (See Appendix C for definition and examples.) What, if any, Best Clinical Practices for Adults and/or Children and Adolescents have been area(s) of focus for the Board? Briefly discuss achievements and trends in these areas.

Click on gray box to enter text.

Currently a Forensic ACT Team, funded through ODMH is operational at Southeast, Inc. Several of our provider organizations have integrated various areas of both the IDDT and ACT models within their organizations, with Southeast, Inc. having close involvement with the Ohio SAMI CCOE. As a result of our provider driven strategy prioritization process, ADAMH has identified the need to more fully implement both ACT and IDDT into our system of care. In the coming year, the Board expects to further this effort and provide support, training and implementation funding to awarded providers to fully embed these evidenced based practices into the organizational structures of these agencies. ADAMH has funded an MR/DD specialist at Netcare to ensure that crisis services address the specific needs of those challenged with mental retardation/developmental disabilites.

Additionally, ADAMH contracts with Nisonger Center, an OSU Hospital based assessment service, to provide thorough assessment and treatment reccommendations for indivuduals challenged with both disorders. Motivational Interviewing has been widely adapted within the treatment framework of many of both our mental health, and substance abuse provider organizations. Dublin Counseling Center, Northwest Counseling Services and Southeast, Inc. were locally funded to provide trauma-informed care in the agency environment, EMDR, DBT, CBT are all utilized within the context of treatment for this population. Specialized services to the Older Adult population are provided through Concord Counseling services, with SeniorLink designed to address the mental health needs of the growing 60+ population by offering services in a familiar environment, the primary care physician's office. The program targets older adults with limited resources who are residing in Franklin County, with intent to encourage the PCP to feel comfortable and competent in prescribing, thus strengthening system psychiatric resources. At the same time, the PCP office staff receive information regarding mental health needs and the older adult which will aid them in identifying older adults in need of mental health services.

8. Staff Capacity & Workforce Development.

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

Click on gray boxes to enter number of FTEs.

Pharm. Management Practitioner FTEs:*	65.70	**8.a**
CPST FTEs:	164.00	
Counselor/Therapist FTEs:	340.	

*Includes Advanced Nurse Practitioners with prescriptive authority.

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

Click on gray boxes to enter number of FTEs.

Pharm. Management Practitioner FTEs:*	0.00	**8.b**
CPST FTEs:		
Counselor/Therapist FTEs:		

*Includes Advanced Nurse Practitioners with prescriptive authority.

c. Please describe any areas of focus for the Board regarding **workforce development**. For help with framing a response on this topic, Boards are encouraged to review Appendix G: *An Action Plan for Behavior Health Workforce Development* from the Annapolis Coalition.

Click on gray box to enter text.

Please see Section 8 Staff Capacity and Workforce Development later on in this plan for this information. **Please note that data provided above in Section 8.a: the FTE's are for the entire system, as we cannot adequately break out this data by adults and child and adolescent populations. The 047 budget forms does not include such reporting. FTE's are also broken out by provider in our Appendix A. attached to this plan.

9. Inter-system Collaboration

a. Discuss achievements and trends in the following areas.

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

Click on gray box to enter text.

Franklin County has a fully operational Mental Health Court within our local Municipal Court. ADAMH recently funded a specialty justice services team through Southeast, Inc. designed to provide intensive, IDDT serivces to clients with co-occurring substance use disorders that have repeated involvement with the legal system in both the Common Pleas and Municipal Court system.

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

Click on gray box to enter text.

Franklin County BHJJ project continues to meet with success within the Franklin County Juvenile Court. This county also used all ABC funds to support the BHJJ project at the Court. In our project, youth are screened, assessed, receive care coordination and linked with treatment, in an effort to prevent youth from going into placement within a residential treatment setting or DYS. Due to the success of the project, in 2007 the Franklin County Juvenile Court, developed plans to replicate the model throughout the entire court. That change begain in late 2007 and will continue into 2008.

b. Have any of the following areas been a focus for the Board? Discuss achievements and trends in those areas, if applicable.

1. Jails

Click on gray box to enter text.

In the last year, a secure web based server was developed to bring efficiency in communication between Netcare, our primary lead MHC's and the County Jail. This is intended to help with release notifications and to ensure the timely exchange of pertinent clincial information between these entities. More work is needed to incorporate the use of this server and to make it a regular part of routine daily practice.

2. Detention Centers

Click on gray box to enter text.

The Board and Franklin County Juvenile Court worked together to expand the BHJJ project will also include all youth entering the Detention Center.

2. Homeless, Runaway & Domestic Violence shelters

Click on gray box to enter text.

The Franklin County Board approved $43,633 in additional funding to CHOICES For Victims Of Domestic Violence for the placement of a licensed social worker/therapist at the Center for Child and Family Advocacy (CCFA) to provide integrated behavioral health services to domestic violence victims that present at the CCFA.

3. Nursing Homes

Click on gray box to enter text.

The following language was placed into our existing Continuity of Care agreement to ensure that individuals in long term placement were not hospitalized without the ability to return to their former residence. In the case of long term care (nursing home or MR/DD client residing in a group home) clients who are referred to a pre-screening agency for admission, the pre-screening agency will contact the managed care director of the Hospital to obtain approval to refer the client for admission. A letter stating that the nursing home agrees to take the client back if discharged within 90 days will accompany the client for the pre-screening assessment and the pre-screening agency will send the letter to the Hospital with the rest of the admission documents. A letter from the operator of the MR/DD group home agreeing to take the client back will accompany the client to the pre-screening assessment.

4. Prison Reentry

Click on gray box to enter text.

This year, the ADAMH Board, in collaboration with the Ohio Department of Rehabilitation and Corrections (ODRC) and the Ohio Department of Mental Health (ODMH), applied for a competitive Prison Re-Entry Grant through the Bureau of Justice Assistance. The grant was awarded to ODRC, who will in turn award it to the local ADAMH Board. The services outlined in the grant focus on the successful transition into the community from incarceration for persons with mental illness. This grant was awarded as a result of sucessful collaboration of multiple community and State provider organizations. COVA and Columbus Area, Inc. are the providers that were chosen through a competetive process to implement the program.

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

Click on gray box to enter text.

During calendar year 2007, the Board awarded new levy funds to Concord Counseling Services, Northwest Counseling Services, and Maryhaven to provide different models of integrated behavioral health and primary health care services for Older Adults. The models are as follows:

1. Placement of behavioral health therapists at a neighborhood medical clinic so that services can be rendered at the time of a medical service.
2. Development of relationships with targeted primary care physicians and work with them in consultation, therapy at their offices, or accepting referrals.
3. Collaborate with Gerlach Center, providing behavioral health consultation, therapy at the setting or accepting referrals of Older Adults.

Several new ADAMH initiatives were developed with the intent of improving behavioral healthcare professional's ability to partner with primary healthcare settings that serve older adults in an attempt to better integrate medical and mental health care for the general SMD adult population. Concord Counseling Services collaborate with and encourage the PCP to feel comfortable and competent in prescribing, thus strengthening system psychiatric resources. At the same time, the PCP office staff will receive information regarding mental health needs and the consumer, which will aid them in identifying needed mental health services. Additionally, a highly specialized treatment team, primarily staffed with nurses, was established through North Central Mental Health Center to serve SMD clients who present with both severe medical and psychiatric risk factors and other related high needs. These are individuals who present with serious medical problems and co-morbid cognitive or mood disorders which interfere with their ability to address basic self-care skills. ADAMH routinely tracks the percentage of consumers that are linked to primary care, and shares this information with providers to encourage its importance in overral treatment.

10. Prevention, Education & Consultation (P,C&E). *Discuss achievements and trends in the following areas:*

- **a.** Suicide Prevention
- **b.** Any local or state P,C&E services of relevance to the Board.

Click on gray box to enter text.

North Central has one of the few volunteer operated Suicide Prevention Hotlines in the country. Many of the new volunteers are recruited by current or former volunteers. In 2007, the Franklin County Suicide Prevention Coalition received increased funding using levy dollars. In CY2007 an additional 1282 individuals received education about suicide prevention through the Franklin County Suicide Prevention Coalition and 74 additional suicide survivors received outreach packets to assist in their grieving and recovery process.

In CY2007 the Franklin County Suicide Prevention Hotline responded to 7,268 calls and 5005 callers agreed to a plan of action or an intervention.

The Franklin County ADAMH Board utilizes the Rensselaerville Outcomes Framework as its reporting mechanism for all of its prevention programs, both mental health and alcohol and other drug providers submit outcomes information in this framework to the Board. The overall results for CY2007 were the following:

• More than 56,665 youth received prevention services in CY2007 and 52,417 (92%) reported increased awareness or positive behavior change after participating in the program.

• More than 45,425 adults received prevention services in CY2007 and 37,164 (81%) reported increased awareness or positive behavior change as a result of participating in the program.

The ADAMH Board also funded three prevention/early intervention programs with new local levy funds to target children at risk for dropping out of school due to poor attendance, disciplinary actions, and failing grades at the Westerville City Schools, Hilliard, Hamilton Local, Canal Winchester, Reynoldsburg, Grandview City and Southwestern City Schools. 758 children and adolescents were served in CY2007 by these new programs.

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

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

Click on gray box to enter text.

a.The Board uses the Consumer Satisfaction Questionnaire (CSQ-8) and employs 8 to 12 consumer surveyors annually, to conduct telephone surveys of more than 2,500 consumers in a representative sampling methodology (all populations and treatment providers). Results are scored and feedback is provided to all providers for quality improvement purposes in an annual report. Providers are asked to respond to the results and any apparent disparities through the Provider Stat individual meetings

annually, in addition to other System Quality Indicators and consumer outcomes results. The individual survey also includes open ended comments from consumers regarding strengths and areas for improvement in services and are fed back to providers in an aggregate and anonymous process to protect individual consumer confidentiality. Satisfaction has remained high over the past ten years of surveys, and there have not been any significant disparities of responses/results for different races and gender. Please see the latest report of outcomes and consumer satisfaction results by race and gender which is used for discussion and attention to disparities for quality improvement purposes (Appendix H). Also included here is an example of a provider report used to feedback results of annual consumer satisfaction.

b. Staff Recruitment: The provider system generally reflects the diversity found within the consumer poulation. Providers are aware that the Board recognizes that staff demographics reflective of the population served is important and will monitor and provide feedback in areas of concern as a part of its quality improvement process. A 2007 review of the eight lead provider agency staff in the system reflects the diversity of the consumer population served (e.g., Consumers - White=56.5% / Black=38.2% / Other 2.3% / Unknown 3.0%; Staff - White=61% / Black 35% / Other 3%). Lead providers serve approximately 76% of consumers in the system. This diversity is a result of the Board's ongoing minority recruitment and retention efforts.

Emerging Populations: The county is experiencing an increase in the Somali and Latino populations. As a result, the system is serving more Somalis and Latinos/Hispanics. Over the past few years the Board has increased programs and services targeting these populations. To better understand and service Somalis and Latinos, staff from these populations have been hired at several of our provider agencies. As these populations increase, the Board will continue to develop strategies to increase the number of staff representing these populations. For example, in 2007 the Board hosted a Somali open house with Columbus State to establish an interest in Somalis entering the mental health technologies program - ultimately finding employment in our system. This is just one aspect of the Board's strategic goal regarding recruitment and retention of system staff. The Board is interested in having members of emerging populations hired within the system.

c. Staff Training: Since the last community plan, the Board itself has offered a number of cultural trainings for system staff. Training over the past couple of years has focused on working with the Somali and Latino/Hispanic populations. The Board also piloted two Spanish and one Somali language classes for those who work directly with those populations. The goal was to provide interested workers with some basic language skills to establish better relations/communications with Latinos and Somalis – thus adding value to the use of official interpreters. In 2006, the ADAMH System Training Institute at Maryhaven was created as the main entity for providing systemwide training, including cultural competency. A wide range of trainings are coordinated to address cultural competency skills and managing diversity. To maximize costs associated with cultural competency training, the board establish an agreement with United Way of Central Ohio to host joint system training. For example, on 2/14/08, United Way is hosting a CEO and board member training with Dr. James Mason (behavioral health clinician) to learn more about cultural competency from a leadership and governing perspective. At least two other events will be coordinated across systems to maximize learning opportunities. Finally, some providers have articulated that training needs to be delivered in shorter time durations and through various mediums - due to time constraints associated with productivity and out of office time. The Training Institute is exploring the uses of technology (i.e., computer-based instruction; computer-based video) as ways to best deliver learning to system employees.

d. Addressing Disparities for Cultural Groups: Over the past couple of years the Board started a more intensive review of demographic indicators in services and outcomes. The Board's internal ConsumerStat process is one forum where discussions around differential outcomes for minority populations is discussed. It was determined that there was a plethora of data that existed - and determining where to focus our efforts would need to occur. As a result, the Board convened an internal workgroup in 2007 to prioritize strategies to address racial, ethnic, gender, and age disparities. The group recommended the development of short and long term goals and strategies to address disparities (discussed in SFY 2009 section below). Beyond the specific short and longer term strategies, the Board's business analytics area samples a number of staff requested data sets to determine if race, gender, or age disparities exist. For example, it was determined that a majority of the high utilizers of inpatient hospital services are African American males. The etiology of these high utilizers is presently being explored by a systemwide team of clinical and administrative staff. Further analysis of the African American phenomena is also being determined as a step to address this issue. In addition, the Board understands that there are several factors that impact disparities. To understand disparities more holistically, the Board is collaborating with Columbus Health, MACC, OSU College of Social Work and others to explore.

e. Other: The Board has strategically shifted its cultural competency efforts from just a monitoring and compliance strategy to a praxis. The Board wants to apply its learning around cultural competency to implement programs and services that target specific needs of diverse communities. This shift means the Board will implement goals and objectives that are geared to impact the lives of culturally diverse individuals. The development of a Latino program on the westside of Columbus or increasing marketing to emerging populations to reduce stigma are just some of the efforts being implemented to address the needs of diverse communities (details in the goal and strategy section below 11e). The Board is also collaborating with several other organizations and systems to maximize efforts in cultural competency. For example, the Board and United Way of Central Ohio decided to co-host several cultural competency trainings since several providers are jointly funded and their needs are related. The Board is also working closely with Multi-Ethnic Advocates for Cultural Competency (MACC) to lead and champion issues of cultural competency statewide.

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

Click on gray box to enter text.

ADAMH is a MH Board Representative on the steering committee of the Older Ohioans Behavioral Health Network.

C. Needs Assessment.

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

Click on gray box to enter text.

The Board employs all of the above 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 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 sevices in Franklin County (see Appendix C.1 - Levy Plan - Executive Summary of the Needs Assessement process). 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 memebers through various interviews, task forces, educational group meetings, and surveys.

Appendix D. summarizes our next step in the planning and needs assessment process, and 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. Please see the documents contained in Appendices D.,E. and F., 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 (see D. 1. Below). The 2008 Plan (Calendar Year, thus first six months of SFY 2009) 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 2008 (complete Plan in Appendix G.) 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.

D. Community Plan for SFY 2008. (Desired State)
Please refer to "Planning Terms" in Appendix C.

1. Planning Processes. Describe the process utilized by the Board to determine its priorities for SFY 2009. How did the Board decide the most important areas in which to invest their resources?

Click on gray box to enter text.

The planning process is described above in Appendix C. Needs Assessment and will continue in 2009 through the Request for Results process as detailed in Appendix D. through F. and above. Also attached is Appendix A. which was submitted with our ODADAS Community Plan and details the "Current State" of the system in 2007. The Board will continue the expanded funding to priority needs programs in calendar year 2009 based upon the results of the needs assessment and planning activities over the past two years.

The 2008 Strategic Business Plan includes the following 3 to 5 year Strategic (desired) Results determined by the Board from our Needs Assessment and Planning efforts:
1. By January 2010, the ADAMH system of care will be viewed as the 'Employer of Choice' among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers, as evidenced by:
10% reduction in turnover among clinicians, caseworkers and psychiatrists;
Creative recruitment strategies, which will be used by ADAMH and may be used by Providers, which focus on increasing the 2006 levels of professionals that are representative of the racial/ethnic characteristics of the consumer population served;
The provision of system continuing education and training opportunities related to culturally competent and capable care;
Partnerships among universities and post–secondary learning institutions to create an increased supply of future healthcare professionals who choose to work for the ADAMH system of care.
2. By January 2010, expand the system of care in a culturally and clinically competent manner for children and families at risk as evidenced by:
10% increase in number of schools that offer prevention screening and referral services;
10% increase in targeted schools that offer prevention services utilizing evidence–based models;
5% increase in the number of contract prevention programs that actively work with faith communities to reach out to targeted populations in need.
3. By January 2010, ADAMH will seek to ensure timely access to clinically and culturally appropriate care so that every individual seeking help will achieve identified outcomes and recovery as evidenced by the following indicators:
Decrease the linkage time from assessment to first face–to–face treatment contact from 15.9 days to 13 days.
Increase by 5% the total number of persons served in the system of care.
4. By January 2010, ADAMH will supplement the system's tax–supported budget by 4% from new funding sources to fund strategic priorities and innovations to care for mental health and alcohol/ other drug consumers.
5. 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.
6. By January 2010, ADAMH will contract for prevention and treatment services with providers that utilize evidence–based and science–based protocols applied consistently to diverse populations, therefore promoting a healthier community at large.
The Business Plan also includes many Program Results that are updated and changed annually in order to support and achieve the longer range Strategic Results above. Please see the attached plan in Appendix G. for details.

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

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

Click on gray box to indicate priority level.
2.a. EMPLOYMENT*
Priority: Medium

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

18% of adults with severe mental illness receiving treatment will report improvement or stability in their status as full–time, part–time or supported employees or as students.

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

Joint meetings of SMI providers' Clinical & Evaluation Leaders

ADAMH System Innovation Funding for consumer Tenant Employment -- (Stages of Change based pre-employment training & on-the job training for 200 tenants)

System Innovation Funding for Peer Employment Specialists (Train & hire 5 or 6 peers and expand hours of service availability to all consumers)

ADAMH awarded DOJ PRI Grant matched with local levy dollars-team to be implemented in 2008

2008 efforts to foster Supported Employment EBP at Leads, including work with Supported Employment CCOE

2008 employment services data analysis – service volume & cost, count & profile of clients and correlation to outcomes

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

Generate consistent standardized readily-available Employment Results Reports

Monitor via joint meetings of SMI providers' Clinical & Evaluation Leader

COVA to train & hire 5 or 6 peer specialists and expand hours of service availability to all consumers

PRI team to be implemented in 2008

Schedule explaoratory meetings with COVA, Lead agencies and SE CCOE for 2008 efforts to foster Supported Employment EBP at Leads

Complete 2008 employment services data analysis – service volume & cost, count & profile of clients and correlation to outcomes

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

Exploratory discussions with Lead SMD provider agencies, COVA, Supported Employment CCOE

2.b. WELLNESS MANAGEMENT & RECOVERY*

Priority: Medium

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

Expand presence of WMR within Franklin County System of Care

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

Encourage educational/informational opportunities between lead provider agencies and WMR CCOE

Support providers in training additional staff to become WMR trainiers, support both SECMHC and COVA in efforts at furthering development of WMR CCOE presence within system

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

Agenda item for lead mental health provider clinical director's meeting in 2008 implementing agencies to share sucesses and challenges

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

WMR CCOE, COVA, SECMHC and other lead SMI provider agencies

2.c. HOUSING

Priority: High

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

ADAMH's goal for housing is to assist consumers in the journey of recovery by providing safe, decent, affordable housing along a structured continuum so that consumers are supported as needed in the community.

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

Operationalize the Strategic Housing Plan completed mid 2007.

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

92% of consumers who are provided affordable housing by CHN will maintain the same residence for at least 12 months.
90% of the 286 Shelter plus Care vouchers awarded to CHN will be utilized by ADAMH system consumers

95% of designated affordable housing units will pass the Fire and Life Safety inspections on the first inspection.
50 additional units of housing will be in development either through rent subsidies or new construction by December 2008.

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

Collaborations with service providers, consumers and family members were an important element in structuring the housing plan.

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

2.d. OTHER: Transitional "step down" housing/Peer Support Services
Priority: High

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

Our goal is to have housing available to meet the housing needs of consumers as they progress through recovery. Fully implement consumer run drop-in center within the ADAMH system

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

Develop specific housing for consumers being discharged from the hospital who need specialized supports to continue in recovery.

ADAMH Request for Results funding for consumer operated PEER Center

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

Add/develop 10 units of transitional/step down housing.

The provider of the new Consumer Operated Services Center will meet 90% of its consumer & service delivery commitments and demonstrate that 40% of consumers who participate in the Center for at least 6 months will be mostly or very satisfied with the amount of meaningful activity in their life.

Monitor weekly and quarterly; send letter of concern if program is behind and conduct sight visit and/or provide technical assistance

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

This goal was the major focus of communication between the Board, state BHO and providers in the last 2 months of 2007. /Columbus Area Mental Health Center, ADAMH, feedback from Lead agencies

Click on gray box to enter text.

2.e. OTHER:
Priority:

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

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

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

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

Click on gray box to enter text.
2.f. OTHER:
Priority:

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

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

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

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

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

Click on gray box to enter text.

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

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

Click on gray box to indicate priority level.
3.a. SCHOOL SUCCESS
Priority: High

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

In CY2008 the ADAMH Board will partner with the Franklin County Educational Council and its 17 member school districts to create a more comprehensive, coordinated system of care for children experiencing academic barriers as a result of unmet behavioral health care needs.

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

In CY2008 the ADAMH Board will partner with the Franklin County Educational Council to apply for grants to fund a more integrated system to identify and treat children in need of behavioral health

care interventions in its 17 member school districts.

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

A minimum of 3 grants will be submitted to improve the integration of behavioral health care services in Franklin County school districts.

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

Educational Council, ADAMH Board, representatives from 17 school districts, children and parents

3.b. EARLY CHILDHOOD CARE

Priority: Medium

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

Demonstrate that 70% of children in the Early Childhood Mental Health Program who receive mental health consultation services for at least 3 months will show an increase in at least one protective factor and a decrease in behavioral concerns.

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

12 Incredible Years small groups wil be conducted during the year.
18 classroom consultations will be conducted during the year.

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

Demonstrate that 70% of children in the Early Childhood Mental Health Program who receive mental health consultation services for at least 3 months will show an increase in at least one protective factor and a decrease in behavioral concerns.

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

St. Vincent's Family Center, Franklin County Board of MR/DD, ADAMH Board

3.c. TRANSITION AGE CARE

Priority: High

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

Improve day to day functioning and reduction of symptoms/problems for youth involved in the transition team for youth in foster care

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

Partnership with Franklin County Children Services to continue the TRAC team for transition age youth aging out of the foster care system. FCCS to expand funding on this model in 2008

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

90% of children and adolescents involved with the TRAC program will show improvement in the following measures of recovery: day to day functioning and reduction of symptoms/problems.

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

Ongoing meeting with the management team which includes ADAMH, FCCS and the provider.

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

3.d. OTHER:

Priority: High

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

The ADAMH Board has a Strategic Goal that 95% of its prevention programs that offer targeted school prevention services will utilize evidence based models.

Strategies *Click on gray box to enter text.*

Annual Agency Services Plans (ASP) includes section where providers are required to submit the evidence based models they utilize in their prevention programs for review and approval by the Board.

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

95% of Prevention Providers will offer targeted school prevention services utlizing evidenced based models

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

Prevention Services Providers. ADAMH Board

Click on gray box to enter text.

3.e. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

3.f. OTHER:

Priority:

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box to enter number.

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

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

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

i. Are you developing new or modified community based services which are expected to reduce your current inpatient bed day utilization?

ii. If you do not have a continuity of care agreement (see Appendix J) with your local state hospital, will you be addressing this issue with them in the next year?

iii. Are you planning future activities to improve linkage and follow up of discharged patients from inpatient care with serious somatic health care needs to general health care services?

4.a. INPATIENT CARE
Priority: High

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

To be determined (TBD) by May 1, 2008

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

Find and develop temporary housing units to be utilized by clients placed on Continued Stay Denial

Find, implement and monitor IDDT/ACT treatment teams within Franklin County System

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

Determine contract award, develop admission and discharge criteria, develop monitoring process

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

Lead SMD provider agencies, YMCA, additional community agencies, TVBH

4.b. CONTINUITY OF CARE

Priority: High

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

90% of consumers assigned to community contract service provider and discharged from TVBH will receive a service from their community contract agency within 7 days following discharge.

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

Provide data and feedback to Lead providers, continued development and revision of Continuity of Care agreement

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

Goal currently being acheived

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

Lead provider agencies, TVBH, ADAMH

4.c. SOMATIC HEALTH CARE

Priority: Medium

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

Percentage of consumers connected to primary care at time of discharge from State Hospital as compared to system average

Encourage stronger care coordination of SMD consumers with primary health care

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

Incorporate data into 2008 Provider STAT

Monitor recent initiatives with Lead provider agencies of newly developed treatment team targeting SMD clients with co-occuring medical disorders

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

Further refine and develop Provider STAT template

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

Providers, TVBH

4.d. Other. If you need additional space to discuss planning in the area of inpatient care, continuity of care, or somatic health care:

Click on gray box to enter text.

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

5.a. Residential Treatment Centers
Priority: High

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

5% reduction in the number of youth that are placed in a residential treatment center outside of Franklin County

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

In partnership with Franklin County Children Services, protocals are being developed to drive the placement of youth and to ensure placement is based on the need for an epidosode of care vs. a place to reside.

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

5% reduction in the number of youth that our placed in a residential treatment center outside of Franklin County

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

Integrated System of Care initiative in partnership with Franklin County Children Services.

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

Click on gray box to enter text.

The local Board's focused efforts are to create evidence-based programming that is community based whenever possible versus a residential or institutional level of care.

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

6.a. Adult Consumers

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

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

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

Expand crisis care continuum to allow for more timely access to crisis care

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

Fund staffing for 8 additional crisis "holdover" beds at Netcare

Measurable Objectives

80% consumers assessed to return to community, 20% referred to inpatient LOC

Discussions and/or Collaborations

Lead provider Summit strategy planning meetings

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

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

90% of linked adults with severe mental illness will experience less than 3 crisis episodes at Netcare in 2007.

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

IDDT/ACT implementation within Franklin County system

Revise/review existing Continuity of Care agreement with lead providers

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

IDDT/ACT RFR development

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

Clinical Director's meetings, Ohio SAMI CCOE, ACT Center, ADAMH

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

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

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

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

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

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

Click on gray box to enter text.

6.b. Child & Adolescent Consumers

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

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

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

90% of children and adolescents will be discharged to a less restrictive setting following successful crisis intervention

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

Continuation of the Youth Crisis Team with Netcare and Children's Hospital

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

same as above

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

Ongoing management of youth crisis issues with the Youth Crisis Management Team, which includes representatives for ADAMH, Netcare, Children's Hospital, OSU Hospital and the Buckeye Ranch.

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

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

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

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

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

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

Click on gray box to enter text.

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

Click on gray box to enter number.

	SFY 2008 Crisis Bed Days	SFY 2009 Crisis Bed Days
Adults	29200	29,200
Children & Adolescents	487	487

6.d. Crisis Response. Using the format below, please discuss the Board's plan for SFY 2009 in the following areas. Items with an asterisk (*) must be addressed, even if this is a low priority area and planning is minimal.

6.d.1. CIT/POLICE COORDINATION*

Click on gray box to select priority level.
Priority: High

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

Increase the number of officers trained in Franklin County by 20% within the year.

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

Franklin County ADAMH will work with the Columbus Police Department and the 23 other municipalities to provide sufficient notice and opportunity to attend the CIT.

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

On average there are 18 officers per training. Using baseline data from the previous sessions the Franklin County ADAMH will coordinate 3 Crisis Intervention Training sessions for Franklin County with a total of 55 officers being trained total.

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

Currently Franklin County ADAMH works closely with the Columbus Police Department in the coordination and facilitation of training. The National Alliance for The Mentally Ill, NAMI, Franklin County office has just joined the steering committee and will provide some financial support. There are a few municipalities that have not participated in the CIT. During the next year the Franklin County ADAMH Board will provide education and information to those juristictions in an effort to increase participation.

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

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

Franklin County intends to continue disaster clinician training and coordinating plans with other local and regional entities. In addition we plan to target Continuity of Operations plans both internally and with our contract agencies.

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

1. An internal group is currently working to update ADAMH's disaster plan, focusing on Continuity of Operations capability.

2. We are in contact with our Provider Leadership Association to begin engaging our contract agencies in a similar process, focusing on continuity of business in the event of a community disaster that significantly shrinks agencies from being able to conduct treatment and prevention services, billing through MACSIS as usual.

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

ADAMH will complete 100% of the tasks needed to ensure that there are appropriate plans in place for disaster mitigation and continuity of internal operations in the event of a community disaster.

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

At the present time, our work with contract agencies will be voluntary on their part. We are recommending and encouraging this work, but are not mandating it.

6.d.3. COLLEGES & UNIVERSITIES*

Priority: High

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

Please see Section 8 Discussions and Collaborations under each Goal area.

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

Please see Section 8

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

Please see Section 8

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

Please see Section 8

6.d.4 PRIMARY & SECONDARY SCHOOLS

Priority: High

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

Please see Section 8 Discussions and Collaborations under each Goal area

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

Please see Section 8

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

Please see Section 8

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

Please see Section 8

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

Click on gray box to enter text.

7. Outpatient Services.

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

7.a. Adult Services.

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

7.a.1. Area of Adult Services:
Priority: Medium

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

General Adult care is focused on improving outcomes for consumers

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

Track and compile paired responses on Consumer Form A for General Adults. Calculate the percentage of consumers who remain stable at an acceptable level, or improve.

Meet with General Adult providers quarterly to share QI techniques and ensure compliance with consumer outcome performance.

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

80% of Adults and Older Adults receiving Mental Health treatment show improvement or stability in at least one of the following measures of recovery:
symptoms/problems (reduction of)
quality of life.

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

Routine, general adult care is seen in our system as the lowest priority population, although they are the greatest in number. Agencies struggle to meet the need in all service categories (assessment, counseling, pharmacy management, etc.). ADAMH does not have plans to expand capacity for general care

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

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

Improve consumer outcomes for adults with a history of trauma.

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

Cognitive Behavioral Therapy and/or Eye Movement Desensitization Response in specialized behavioral health programs for PTSD. One of these programs targets the large immigrant Somali

population in Franklin County.

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

90% of client count and unit goals will be met and 75% of Adults treated will report a decrease in symptoms.

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

Somali Community, Federally Qualified Health Centers, Providers

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

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

Improve consumer outcomes for Older Adults by integrating behavioral health services with physical health care.

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

1. Place behavioral health therapists at a neighborhood medical clinic so that services can be rendered at the time of a medical service.
2. Develop relationships with targeted primary care physicians and work with them in consultation, therapy at their offices, or accepting referrals.
3. Collaborate with Gerlach Center, providing behavioral health consultation, therapy at the setting or accepting referrals of Older Adults.

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

90% of client count and unit goals will be met and 75% of Older Adults treated will report a decrease in symptoms

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

COAAA, Franklin County Office on Aging, Adult Protective Services

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

Click on gray box to enter text.

7.b. Child & Adolescent Services.

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

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

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

60% of children and adolescents receiving treatment will show improvement or stability in tow of the following measures of recovery: functioning, reduction of symptoms/problems and life satisfaction

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

Care received within the community behavioral health system of care.

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

same as above

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

Youth Problem Solving group with includes ADAMH leadership and all C&A providers.

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

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

Strategies *Click on gray box to enter text.*

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

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

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

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

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

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

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

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

Click on gray box to enter text.

7.c. Best Clinical Practices for Adults, Children & Adolescents. What are the Board's plans for SFY 2009 regarding Best Clinical Practices? The term "best practices" includes both promising and evidence-based practices. Examples of Best Practices include, but are not limited to: Assertive Community Treatment, Intensive Home Based Treatment, Intensive Dual Disorder Treatment (IDDT), Early Childhood Assessment, Functional Family Therapy, Treatment Foster Care, Physical/Mental Health Services Integration, Trauma-focused Community Based Treatment (TF-CBT), Dialectical Behavior

Therapy (DBT), Trauma Screening and Assessment, Telemedicine, Tobacco Dependence Treatment, Older Adult care, Integrated Care for persons with MR/MI. (See definitions in Appendix C.)

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

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

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

Decrease State Hospital bed day use

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

Fund and implement three IDDT teams in Franklin County System of Care

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

Complete RFR process, award providers, begin implementation process

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

Lead provider agencies, SAMI CCOE, ACT Center, ADAMH, Criminal Justice

Click on gray box to enter name of practice:
7.c.2. PRACTICE: ACT/Integration of physical and behavioral healthcare for older adults
Priority: High

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

Improve consumer outcomes for Older Adults by integrating behavioral health services with physical health care.

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

Place behavioral health therapists at a neighborhood medical clinic so that services can be rendered at the time of a medical service.

Develop relationships with targeted primary care physicians and work with them in consultation, therapy at their offices, or accepting referrals.

Collaborate with Gerlach Center, providing behavioral health consultation, therapy at the setting or accepting referrals of Older Adults.

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

90% of client count and unit goals will be met and 75% of Older Adults treated will report a decrease in symptoms.

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

Lead provider agencies, SAMI CCOE, ACT Center, ADAMH, Criminal Justice

Click on gray box to enter name of practice:
7.c.3. PRACTICE: Specialized treatment for recent or past trauma
Priority: High

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

Improve consumer outcomes for adults with a history of trauma.

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

Cognitive Behavioral Therapy and/or Eye Movement Desensitization Response in specialized behavioral health programs for PTSD. One of these targets the large immigrant Somali population in Franklin County.

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

90% of client count and unit goals will be met and 75% of Adults treated will report a decrease in symptoms.

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

Dublin Counseling, Northwest Counseling and Southeast, Inc.

Click on gray box to enter name of practice:

7.c.4. PRACTICE:

Priority: High

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

To provide evidence based prevention model development, prevention program development and over sight and prevention outcomes analysis and reporting.

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

ADAMAH providers staff and volunteers will receive training in evidenced based practices offer programs that used evidenced based practices so that youth and adults will achieve their milestones resulting in positive behavior change.

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

ADAMAH providers staff and volnteers will receive training in evidenced based pracitices so the impact of school based programs can measured in community wide surveys.

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

Education Council: Safe and Drug Free Schools Consortium

The Primary Prevention Awareness, Attitude & Use Survey (PPAAUS)

The Safe and Drug-Free Schools Consortium has administered the Primary Prevention, Awareness, Attitude and Use Survey (PPAAUS) seven times since 1988. The purpose of PPAAUS is to:

- Provide information that can be used to guide prevention and intervention programs
- Track changes over time in use of alcohol, tobacco, other drugs
- Identify some of the correlates and predictors of drug and alcohol use
- Identify areas of problem behaviors and safety concerns

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. The survey has been administered since 1988. The collobarting partners are Education Council, ADAMH, United Way of Franklin County, columbus Medical Association, US Dept SAMHSA-CSAP

Click on gray box to enter name of practice:

7.c.5. PRACTICE:
Priority: High

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

To provide evidence based prevention model development, prevention program development and over sight and prevention outcomes analysis and reporting.

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

ADAMH providers staff and volnteers will receive training in evidenced based pracitices so the impact of school based programs can measured in community wide surveys.

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

95% of prevention providers will offer targeted school prevention services utilizing evidenced-based models.
75% of participants will report a decrease in psychological distress.

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

Prevention providers

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

Click on gray box to enter text.

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

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

8.a.1. Area of Workforce Development: Turnover of ADAMH System of Care
Priority: High

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

Reduce turnover among clinicians, caseworkers, and psychiatrists by 10%, by 2010.

Strategies *Click on gray box to enter text.*

Collect and review direct service staff turnover data from providers through the ASP reporting process

Dialogue with provider leadership to develop strategies that increase the numbers of direct service staff entering the mental health field and decrease the number of individuals leaving the field.

Monitor agencies with high turnover through ProviderStat process

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

Identify problems associated with agency recruitment strategies and provide feedback to providers.

Monitor agency recruitment and retention strategies in 2008 through ProviderStat process

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

Beginning in 2007, the ADAMH Board began collecting data from providers, as part of the ASP reporting process. Agencies were asked to calculate turnover among direct service staff using the following formula: The number of all voluntary and involuntary separations for the year divided by average monthly employment for the year. In 2007, agencies report there are about 3663 FTE's in the ADAMH system, with 587 being in direct care, giving the average turnover among direct service staff system wide at about 16%. The ADAMH Board plans to use this data, as a baseline to help determine the best strategies to address turnover going forward.

John Glen School of Public Affairs
L2000+ Leadership Academy
L2000+ Leadership Academy is a certificate program of the John Glenn School for current and emerging leaders in mental health and addiction services agencies. The vision of L2000+ is to create a leadership institute of excellence for leaders in the field by:

- Offering innovative, individualized and diverse learning opportunities
- Creating an ongoing learning community and growth across professional boundaries
- Developing the skills needed to meet and exceed the needs and expectations of customers, and
- Building capacity to improve quality, cost effectiveness and access

L2000+ was created based on a needs assessment conducted to determine the viability of creating a leadership development initiative in Central Ohio. The four-month study produced overwhelming consensus in support of creating such an initiative. The sixty plus behavioral health care leaders who participated in the assessment were able to identify the challenges facing the next generation of behavioral healthcare leaders and the knowledge, skills and attitudes required of leaders to face these challenges. These findings guided curriculum development for the L2000+ Leadership Academy.2007 – 2008 Public Forums

Friday, November 2, 2007
Public Forum: Cultural Competency – Dr. Edwin
Nichols, Director, Nichols & Associates
8:30 am – 12:00 noon

Friday, January 11, 2008
Public Forum: Bridges Out of Poverty – Phil DeVol
Aha! Process Inc.
8:30 am – 3:30 pm

Friday, February 8, 2008
Public Forum: Strategic Planning – Dr. Sharon
Clifford, Bowling Green OH
8:30 am – 3:30 pm

Friday, April 4, 2008
Public Forum: National Picture for Behavioral Healthcare – Linda Rosenberg, President and CEO, National Council for Community Behavioral Healthcare
8:30 am – 12:00 noon

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

8.a.2. Area of Workforce Development: Recruitment and Retention of Direct Service Staff
Priority: High

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

Develop recruitment strategies that may be used by providers that focus on increasing the levels of professionals that are representative of the racial/ethnic characteristics of the consumer population served.

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

Compare agency specific strategies outlined in the CY2007 ASP have increased the provider's ability to recruit and retain essential direct services staff to determine if strategies have been effective.

Determine if strategies employed in CY 2008 to strengthen your agency's ability to focus on the recruitment and retention of direct service staff have been effective

Compare agency turnover rate over previous year to determine if strategies have been effective.

Target bilingual marketing campaign in key areas around the State of Ohio to bi-lingual workers interested in working in the ADAMH system.

Circulate minority resumes to providers on a monthly basis.

Work with OSU and possibly Franklin University to offer profesional development programs for social workers and case managers.

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

Increase the number of bilingual staff within the system as monitored through ASP and ProviderStat
Increase the likelihood of hiring more minorities into direct service positions in the ADAMH system.

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

The ADAMH Board will continue its monthly circulation of minority resumes background who may be interested in working in the system. In addition, ADAMH's 2008 marketing campaign will target specific areas in the state with the goal of attracting ethnic minorities into the Central Ohio area to work in the ADAMH system. ADAMH will utilize newspapers and radio to outreach to Latino is the Lorain, and Toledo areas. ADAMH will also evaluate the impact of resumes submitted through our website and evaluating whether we will continue these efforts indefinitely.

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

Click on gray box to enter text.

University and post-secondary partnerships

Priority: High

Goal: Partner with universities and post-secondary learning institutions to crate an increased supply of future healthcare professionals who choose to work for the ADAMH system of care

Strategies:

Develop an agreement with OSU College of Social Work to introduce a MSW cohort for system staff wanting to pursue a MSW.

Participate in a research study with Franklin University to provide input on how best to restructure their Master's in Human Services degree to make it more attractive to agency staff interested in pursuing a master's degree in social work administration

Measurable Objectives:

In the fall of 2008, introduce an intensive, week-end MSW program through OSU, designed specifically for ADAMH system staff who wish to pursue a Master's in Social Work.

Discussions and/or Collaborations:

Talks have begun with the OSU Department of Social Work to introduce a cohort of undergraduate social work students from the ADAMH system into their MSW program. This is designed to be an intensive week-end program, with two MSW supervised internships. Complete details have yet to be completed, but preliminary approval has been obtained with OSU.

ADAMH also intends to work with Franklin University once their Master's in Human Services program is revamped in order to provide professional development opportunities to system staff with an interest in social work administration.

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

9.a. Adults

9.a.1. ADULT JUSTICE/COURT COORDINATION
Click on gray box to indicate priority level.
Priority: High

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

The provider of the new Probation Behavioral Health Services Team will meet 90% of its consumer & service delivery commitments and demonstrate that 60% of the persons served by the Team with at least six months of treatment will abide by the law sufficiently to avoid incarceration and/or new criminal justice involvement.

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

Continue to support development and to monitor newly funded Probation Team

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

90% of its consumer and service delivery commitments will demonstrate that 60% of persons served within the new team avoid incarceration and/or new criminal justice involvement.

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

Mental Health Court, ADAMH, SECMHC

9.a.2 ADULT RECIDIVISM
Priority: High

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

Continue to support the Mental Health Court and Southeast's Specialty Probation Team.

We are also working the the City Attorney's Office, local providers, municipal court probation and judges, health department and others to develop a program specifically targeting women who have been arrested multiple times for prostitution who are in need of behavioral and primary health interventions.

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

Actively persue grants that focus on adult recidivism on behalf of Franklin County residents in need of alternative programming to meet their unique treatment and criminal justice intervention needs.

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

Successfully acquire grant funds to continue and enhance current adult programs focusing on recidivism

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

Criminal justice authorities, providers

9.a.3. ADULT DIVERSION

Priority: High

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

See 9.a.2

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

See 9.a.2

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

See 9.a.2

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

See 9.a.2

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

Click on gray box to enter text.

Will involve criminal justice personnel in development of new IDDT/ACT initiative with a focus of encouraging their involvement on each teams Steering Committee. ADAMHs continued ongoing collaborative efforts already functional and in place with Mental Health Court.

The ADAMH Board has prioritized re-entry and criminal justice diversion programs as priority grant seeking areas of concern. Therefore our Grants Coordinator is researching potential grant opportunities daily for consideration.

9.b. Adolescents

9.b.1. ADOLESCENT JUSTICE/COURT COORDINATION

Click on gray box to indicate priority level.

Priority: High

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

Support the creation of a Juvenile Court Care Coordination Unit to reduce the number of children involved in the criminal justice system.

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

Fund 2 behavioral health care Care Coordinators who will join the newly formed Care Coordination Unit at the Franklin County Juvenile Court.

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

Hire 2 full time Care Coordinators by May 31, 2008.
Improve the coordination of care recevied by children and their families invovled in multiple systems.

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

Franklin County Juvenile Domestic Relations Court, Franklin County Children and Family First Council, C&A providers

9.b.2. ADOLESCENT RECIDIVISM

Priority: High

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

See 9.b.1

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

See 9.b.1

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

See 9.b.1

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

See 9.b.1

9.b.3. ADOLESCENT DIVERSION

Priority: High

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

See 9.b.1

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

See 9.b.1

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

See 9.b.1

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

See 9.b.1

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

Click on gray box to enter text.

The Franklin County ADAMH Board works very closely with the Franklin County Juvenile and Domestic Relations Court to develop strategies that result in improved access to care for children who need special interventions to divert them from the criminal justice system.

9.c. Other Inter-System Collaboration. What, if any, are the Board's plans for SFY 2009 in the following areas?

9.c.1. JAILS

Click on gray box to indicate priority level.

Priority: Medium

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

Create fluid and effective exchange process of consumer clinical information via secure web-based server

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

Meetings with local Jail administrator, local crisis provider

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

A fully functional web-based server is in place and utilized by all parties to improve communication on behalf of consumers.

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

Franklin County Jail, Municipal Court Judges and key personnel, providers

9.c.2. DETENTION CENTERS

Priority: Low

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

The Board has not prioritized Detention Centers in CY2009. Our local Juvenile Detention Center has not historically wanted to provide an excessive amount of treatment in the facility. Our providers are available to provide 24/7 crisis intervention as needed.

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

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

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

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

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

Our ongoing work and prioritization of the homeless population is documented in earlier sections focusing on housing, hospitalization and adults with severe and persistent mental illness. Homeless individuals and families in need of behavioral health services will remain a priority in CY2009. We are working closely with our providers to ensure that Shelter Plus Care vouchers and other benefits related to housing are utilized efficiently in this community.

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

See above

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

See above

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

See above

9.c.4. NURSING HOMES
Priority:

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

We do not currently have nursing homes prioritized in our CY2009 plan.

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

See above

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

See above

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

See above

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

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

Seek and actively submit grant applications that support the increase in capacity in the ADAMH System of care to provide services on behalf of persons with severe and persistent mental illness to safely transition back to their home communities.

We have several initiatives that were started in CY2007 that were highlighted in previous sections.

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

Actively pursue grant opportunties to enhance the system's ability to provide adequate services on

behalf of persons with severe and persistent mental health issues who are re-entering the community from prison.

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

Successful acquisition of additional funds from grant applications that result in added capacity for tartget population.

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

Local, state and federal funding bodies, providers, local criminal justice authorities

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

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

Continue to support improved consumer outcomes for Older Adults by integrating behavioral health services with physical health care.

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

Support the following integration models:
Therapists placed at a neighborhood medical clinic
Therapists working in conjunction with targeted physician private practices
Therapists collaborating with a large older adult physical services center

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

90% of client count and unit goals will be met and 75% of Older Adults treated will report a decrease in symptoms.

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

These evidence-based practices are projects begun in calendar year 2007 as a result of the availability of new levy dollars.

Click on gray box to area of cross-system collaboration:
9.c.7. OTHER:
Priority:

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

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

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

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

Click on gray box to enter text.
9.c.8. OTHER:

Priority:

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

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

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

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

Click on gray box to enter text.

9.c.9. OTHER:
Priority:

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

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

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

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

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

Click on gray box to enter text.

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

10.a. SUICIDE PREVENTION
Click on gray box to enter priority level.
Priority: High

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

The Board considers suicide prevention a high priority and works closely with the State Suicide Prevention Foundation and local providers to increase educational opportunities and supportive services for persons of all ages in need of education or intervention related to depression and suicide.

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

Actively pursue additional funds through grant applications to enhance suicide prevention programming available to Franklin County residents.

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

Increased # of teen screen sites in local schools and primary health care offices.

Increased # of persons receiving education focusing on the early identification of signs of depression and suicide risk.

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

State Suicide Prevention Foundation, Franklin County Suicide Prevention Coalition

Click on gray box to enter name of P,C&E activity:

10.b. OTHER:

Priority:

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

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

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

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

10.c. OTHER:

Priority:

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

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

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

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

.

10.d. Other. If you need additional space to discuss planning for prevention, consultation and education:

Click on gray box to enter text.

The ADAMH Board is actively pursuing grants and other opportunties in partnership with the Educational Council to enhance the capacity of behavioral health care services available to students and families in our community.

11. Cultural Competency: What are the Board's plans for SFY 2009to increase cultural competence? Please discuss the areas of most salience or strategic importance to your system.

11.a. CONSUMER SATISFACTION WITH SERVICES AND STAFF
Priority: Medium

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

Measure and monitor Consumer Satisfaction with all providers to ensure demographic and cultural "responsiveness" in outcomes and consumer satisfaction, and identify and address any disparities that may exist.

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

The Board uses the Consumer Satisfaction Questionnaire (CSQ-8) and employs 8 to 12 consumer surveyors annually, to conduct telephone surveys of more than 2,500 consumers in a representative sampling methodology (all populations and treatment providers). Results are scored and feedback provided to all providers for quality improvement purposes in an annual report. Providers are asked to respond to the results and any apparent disparities through the Provider Stat individual meetings annually, in addition to other System Quality Indicators and consumer outcomes results. The individual survey also includes open ended comments from consumers regarding strengths and areas for improvement in services and are fed back to providers in an aggregate and anonymous process to protect individual consumer confidentiality.

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

Consumer satisfaction is scored and providers receive a report comparing their satisfaction scores by population (SMD adults, General MH adults, AOD Adults, and Children, Adolescents and Parents) to the system average as well as a minimum and desired score. Results are also reported back by race and gender for the purpose of assessing any disparities that may exist.

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

Please see the latest report of outcomes and consumer satisfaction results by race and gender which is used for discussion and attention to disparities for quality improvement purposes (Appendix H). Also included here is an example of a provider report used to feedback results of annual consumer satisfaction.

11.b. STAFF RECRUITMENT
Priority: Medium

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

1) Ensure that staff and board are reflective of the population served for achieving diversity, particularly as it relates to primary dimensions.

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

1) Minority recruitment and emerging population outreach.
2) Monitoring and feedback of minority recruitment.
3) Technical assistance and consultation regarding minority recruitment for providers.

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

1) a. Monthly minority resume circulation to provider agencies (12 year initiative).
b. Development of Somali and Latino specific intervention and treatment programs that require the hiring of members from the indigenous population (2008 will fund one Latino/Hispanic Intervention/Treatment Program).
c. A two-month marketing campaign pilot to attract bi-lingual workers (i.e., Spanish-English) to work in Franklin County ADAMH system.
d. Postings of job opportunities in minority media outlets (listed in discussion section); earmarking portion of website for those interested in hiring diverse employees.
2) a. Review Agency Service Plans to determine staff demographic information reflects consumer demographic ratios.
b. Address diversity of staff issues and concerns at each agency's ProviderStat review session (one per year).
c. Produce annual aggregate data review sheet on lead provider staff, board, and consumer demographics to determine improvement.
3) a. Providers that request support will get advice or feedback on increasing staff representation on all levels.
b. Providers that indicate on their ASP or Cultural Competency Plan that staff diversity is sought - will get written feedback about their strategies.
c. Provide consultation during site visits regarding recruitment and retention of diverse staff and board members.

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

The board supports the recommendation(s) that provider staff should be reflective of the population that is served. As a result, the Board monitors both staff and board representation for each provider through Agency Service Plans (ASPs). Overall, the ADAMH system staff is reflective of the population served. The Board will continue to monitor agency specific demographic / BH data to ensure this trend continues by provider. The Board also encourages the importance of having staff represented on all levels of provider organizations (i.e., executive/official, professional, administrative, technical, and support). Those providers required to submit the federal EEO-100 (staff by classification) forms are requested to include those with their ASP submissions each year. Additionally, the Board hosts an annual ProviderStat session with each agency. During this session, if the provider’s staff/board are under-represented with any racial/ethnic population, they are asked to explain this disparity and what strategies they will employ to increase representation, if appropriate. ProviderStat sessions will be held CY 2008.

In 2007, the Board initiated an effort to help identify Latinos/Hispanics and Somalis interested in system employment opportunities. As a result, there have been several persons hired in the system to support providers who are serving those emerging populations. More recently (as of January 20, 2008), the Board launched a two-month bi-lingual (Spanish-English) staff recruitment marketing (i.e., Latino radio/print) campaign in key areas around the state. This pilot project is designed attract bi-lingual workers that can provide an array of supports – and in particular translation/interpretation services.

The Board is collaborating with Ohio State University College of Social Work and Columbus State Community College to discuss the increase of minorities entering their respective programs. The goal is to increase minority representation in their academic programs, which will provide a more diverse applicant pool post-graduation.

Collaborative Organizations for Staff Recruitment: Somali Link Newspaper; RadioSol 1550 a.m.; WCPX-TV 48 Latino; African Community Relief Association; La Voz Statewide Newspaper; Columbus Post; Columbus Call and Post; Columbus Communicator; L.E.O.N.; Ohio Hispanic Coalition; etc.

11.c. STAFF TRAINING
Priority: Medium

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

1) Ensure that regular and good quality cultural competency training is provided systemwide through the Training Institute.
2) Collaborate with other organizations/systems to provide cultural training, thus maximizing resources.
3) Identify and share best and promising practice information with critical others.

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

1) a. Serve as advisors on the ADAMH System Training Institute at Maryhaven from the perspective of cultural competency, clinical and administrative training - based on annual survey.
b. Help identify cultural competency learning opportunities based on the needs of our providers.
c. Review feedback obtained from training evaluations to determine the effectiveness of training.
2) a. Establish partnerships with other organizations and systems to ensure that related cultural training can be co-sponsored or hosted to benefit overall objectives of culturally competent systems.
3) a. Participate on various advisory and task committees associated with cultural competency to identify what culturally situated programs and services are most effective.
b. Once identified, share information with providers, cultural competency/diversity lead staff, and Board leadership to consider similar options for development.

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

1) a. Review all proposed trainings to ensure that there are distinct cultural trainings and that other clinical and administrative trainings are addressing these issues, if appropriate.
b. Determine and monitor the number of cultural competency trainings that are being offered each year; and provide suggestions if more targeted trainings should occur.
c. Determine if the trainer or facilitator for each cultural training is the most appropriate by reviewing their credentials, asking others who used this trainer, or sampling the training itself for determining future use of this person.
2) a. Established agreement with United Way of Central Ohio to collaborate on at least 2-3 cultural competency trainings during CY09.
b. As chair of MACC's statewide advisory and planning team, coordinate local events that are meeting the cultural needs of those areas served.
c. Seek opportunities with other systems to allow cross sharing of cultural training opportunties for staff.
3) a. Through the collaboration with MACC, other systems/organizations, online resources, and communication with academic and field experts, identify best and better practices that are impacting the access, treatment, and outcomes of diverse communities. Once obtained, share this information

through ADAMH's internal e-newsletter, personal communication to providers, and feature at training forums.

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

The Board encourages regular and ongoing cultural competency training for each provider. Some providers have elected to participate at system level training sessions. Others provide in-house cultural training by utilizing the expertise of internal staff or external facilitators.

The Board asked providers to identify on their ASPs the top 2-3 cultural initiatives they sought during the next CY08. Many providers listed training as one of those priorities - without much detail beyond the type. The Board in response requested that providers determine how those trainings will impact the organization, programs or behaviors, thus impacting the quality of results for clients.

Finally, the Board participates with many organizations in order to enhance cultural competency. These collaborations are designed to maximize training opportunities for staff; provide better inter-systems understanding of cultural competency standards and application; and finally, establishes a broad framework for learning from multiple disciplines.

Collaborative Organizations for Staff Training: Maryhaven as coordintor of Training Institute; United Way of Central Ohio; Columbus Health Dept.; Working Latino Health Project (AccessHealth); MACC Statewide Advisory and Planning Team; and others.

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

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

1) Develop short and long term strategies for addressing disparities in access, service utilization, and outcomes.
2) Collaborate with other organizations to better understand disparity constructs.

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

1) a. Short-term strategies are to monitor key SQI data and Consumer Satisfaction to determine if disparities exist by race, gender, and age.
b. Short-term strategy is to continuously sample data sets through our business analytics (i.e., selects data by business issue or special requests from staff) area and determine if disparities exist through race, age, and gender.
c. Long-term strategies will be to better understand globally situated disparities (i.e., misdiagnosis, over-hospitalization, under-utilization of community based care, over-medication, greater severity of diagnoses, etc.) from national experts and establish local approaches to address.

2) The Board plans include working with MACC, Columbus Health Dept., United Way, OSU College of Social Work, and others to better understand a more universally situated approach to understanding disparities. The behavioral healthcare community must understand how behavioral health disparities are influenced by social and environmental indicators/factors. Partnering with these providers through collaborative efforts can allow space for this dialog to occur.

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

1) a. Monitor three SQI indicators through ConsumerStat sessions each quarter that could impact

race, gender, and age. Identify any disparities and provide feedback to provider agencies.
b. Based on existing knowledge about population trends, target key data sets (e.g., hospitalization, diagnose, medication, etc.) to see if race, gender or age disparities exist.
c. In collaboration with MACC's annual conference, coordinate with national experts in health/behavioral health disparities to determine ways to appropriately identify, assess, and address disparities. Drs. Lonnie Snowden (U.C. Berkley) and Howard Neighbors (U of Mich.) have been contacted and have agreed to participate in MACC's annual training conference. Dr. Snowden already indicated his interest in providing additional assistance prior to the actual conference in 9/08.

2) Serve on advisory committees that have as one of their objectives the goal of address disparities in health and behavioral health in their respective areas. Learning from these opportunities can provide the foundation/platform for constructing ADAMH's strategy for improving service delivery to underserved populations.

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

Once the framework for indentifying and prioritizing key disparities, the Board will share those findings with the appropriate staff to conduct further analysis and develop strategies to address. An important goal will be to contract with national experts in the area of behavioral and health disparities to establish a framework to address the more globally situated disparities identified by ODMH's racial and ethnic report in the late 80s and early 90s. A comprehensive approach must be taken to fully understand the underlying causes of these issues and how to solve them collectively.

Outcomes: The board reviews outcome data of various funded initiatives, such as the Mifflin Somali School-based program and the Trauma Services at Southeast. This information is reviewed during ConsumerStat sessions and if further inquiry is required, it is addressed during agency ProviderStat sessions. The Board also applied and received a grant from the Columbus Foundation to provide an independent evaluation (Ohio Scales) of the Somali program to determine its effectiveness. As the board develops new cultural initiatives, such as the future Latino focused service program, it will monitor outcome and satisfaction data each quarter upon implementation.

Click on gray box to enter text.

11.e. OTHER: Marketing Strategies

Priority: Medium

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

To implement three key marketing strategies during CY08 to provide information, education, and opportunities to minority communities about mental health services.

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

1) Establish two-month pilot recruitment marketing strategy to attract bi-lingual workers to central Ohio.
2) Development of one Somali video to help inform and educate members of the community about mental health services.
3) Visit 6-8 key African American churches to provide church leadership (designated others) with information about ADAMH system services and referral information.

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

1) Implement key recruitment messages in statewide Latino newspapers and local radio/TV to attract bi-lingual workers into our system.

2) Collaborate with Somali leaders and other behavioral healthcare entities/professionals to develop one 15-20 minutes video in the Somali language to inform them about accessing mental health services.
3) Each month visit one African American church to identify issues, share information and provide supports to those who are being impacted by individuals with behavioral healthcare challenges.

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

The Board continues its outreach and engagement efforts with minority populations. In CY 2008, the Board will release a Request for Results for the development of a Latino focused service program on the westside of Columbus. In addition, the Board has researched and discovered that minority populations are less aware of services and also reluctant to seek out behavioral health services because of stigma. ADAMH is intiating a major public affairs outreach advertising campaign to help inform and educate Latinos/Hispanics (in Spanish), Somali (in Somali), and African Americans about behavioral health services. Radio, television, billboards, and even the production of a Somali video will be developed to help educate these populations in order to reduce stigma and increase access. The Board is partnering with local ethnic group organizations (leaders) and religious institutions to co-create strategies to conduct better outreach.

The Board is collaborating with other organizations like MACC (Multi-Ethnic Advocates), Columbus Health Department, United Way, Our Optimal Health, and others to work collectively with emerging populations. These joint efforts are designed to improve existing services – and establish a less fragmented support system for diverse clients.

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

Click on gray box to enter text.

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

Click on gray box and enter text.

13. Projected Budget. *Please refer to the following link:*
http://www.mh.state.oh.us/cmtypolicy/planning/guidelines/2009/budget-template.xls
Using the Board's submitted SFY 2007 FIS-040 report as a baseline and for comparison purposes, please complete the Community Plan Budget excel spreadsheet for SFY 2009 (if desired, your SFY 2007 FIS-040 may be obtained from Holly Jones at joneshm@mh.state.oh.us). **The Excel spreadsheet must be included with the Word form template, when submitting your Community Plan electronically.** Please indicate how the Board plans to purchase services by fund source.

14. Business Rules. Identify any changes in the Board's business rules (See Appendix E. Business Rules for MACSIS) that will be necessary to accomplish the Board's Plan for non-Medicaid reimbursable services and services to consumers that are ineligible for Medicaid.

Click on gray box and enter text.

Coinsurance on all non-medicaid except crisis intervention and CPSTMonthly copay on residential treatment, community residence, foster care, and subsidized housing ranging from $0 - 550 in $35 increments.

E. Evaluation of Plan Implementation.

E.1. How does the Board plan to evaluate services, pursuant to ORC 340.03? http://codes.ohio.gov/orc/340.03

Click on gray box and enter text.

The Board has been evaluating services through several means and methods over the past ten years, in accordance with ORC 340.03. The methods and processes are detailed in our Appendices and referred to in our Planning and Needs Assessment sections as well. These include our System Quality Improvement (SQI) Plan, Strategic Business Plan and Managing for Results process, Consumer Outcomes and Satisfaction processes, Provider Stat (in-depth, annual face-to-face reviews of each of the 35 or more prevention and treatment providers). The SQI process consists of a set of 15 measurable indicators of access, appropriateness/quality, fiscal efficiency, and outcomes using data from our data warehouse of Claims, BH data, and Consumer Outcomes (including compliance measures), and was implemented over 4 years ago with quarterly reports to each provider comparing them to peers and system averages for performance and quality improvement purposes. Our Consumer Satisfaction process has been in place for over ten years and now assesses satisfaction for a representative sample of more than 2,500 consumers from all treatment providers on an annual basis using the CSQ-8, using paid consumers who interview consumers by telephone. All of these processes and results are fed back to providers and benchmarked to Statewide data as well as our County system averages, and peer population groups of providers such as SMI adult providers, AOD providers, other MH adult, and Child and Adolescent Providers. Each process also included vetting with participation of consumers and family members, who also are invited and attend our planning and review meetings. The annual Provider Stat meetings and reviews bring together all of this data and results for a comprehensive assessment of a provider's services and relative successes/areas for improvement. Please see our Appendices as well as our Outcomes website for more information. http://www.adamhfranklin.org/accountability/outcomesSQIC.php	E.1

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

Click on gray box and enter text.

We have our own data warehouse and have been utilizing specific measures of Outcomes (including Consumer Satisfaction), BH data, claims and PCS data for evaluating the effectiveness and efficiency of services. In addition to our own SQI and consumer outcomes measures, we have been benchmarking each ODMH outcomes report since # 11 and feeding back a report for each provider and the Franklin County system as compared to Statewide results for provider and system quality improvement. Our SQI reports are in the form of a quarterly "Report Card" and compare the current state to the last two year's annual results for provider quality monitoring and improvement. It should be noted that we address each of the Evaluation Criteria listed in the ODMH's guidelines for evaluation, through our Provider Stat and SQI Reporting processes to monitor the performance and QI of our system of providers. In addition, our Consumer Satisfaction Surveys utilize paid consumers to	E.2

interview other consumers, and all of our planning and evaluation meetings, both internally and externally, include consumer and family members interested in attending. We work closely with our Consumer and Family Advisory Council, often presenting our evaluation and planning products and obtaining input and advice. We also conduct an annual Provider Satisfaction Survey and have five years of continuing increased satisfaction from our providers with the "business relationship" between service providers and the Board.	

E.3. To what extent does the Board need technical assistance concerning compliance with ORC 340.03? (Guidelines for ORC 340.03 appear in Appendix D.)

Click on gray box and enter text.

None needed, but always received if asked for from Dee Roth, Jim Healy and others.	E.3

Form 2

Community Board Resources

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

Name	Street Address	City	Zip	Phone Number	Email
Ed Desmond, Supervisior of Two Forensic Monitors Lois Van Barringer-Forensic Monitor Margot Gray-Forensic Monitor	3595 Sullivant Ave.	Columbus	Ohio	752-0333 ext. 5700	desmonde@mh.state.oh.us

b. Please provide the name, address, phone number, and email of the Board's Community Linkage Contact:

Name	Street Address	City	Zip	Phone Number	Email
Stephanie Patrick	447 E.Broad Street	Columbus	43015	222-3758	spatrick@adamh.co.franklin.oh.us

c. Please provide the name, address, phone number, and email of the Board's Client Rights Officer:

Name	Street Address	City	Zip	Phone Number	Email
Phil Hedden	447 East Broad Street	Columbus	43215	614 224-1057	phedden@adamh.co.franklin.oh.us