Ohio Mental Health and Addiction Services (OhioMHAS)

Community Plan Update for SFY 2015

Needs Assessment Update

1. Please update the needs assessment submitted with the SFY 2014 Community Plan, as required by ORC 340.03, with any new information that significantly affects the Board's priorities, goal or strategies. New needs assessment information is of particular interest and importance to the Department regarding: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils (ORC § 340.03(A)(1)(c); (2) outpatient service needs of persons receiving treatment in state Regional Psychiatric Hospitals (ORC § 340.03(A)(1)(c); and (3) consequences of opiate use, e.g., overdoses and/or deaths. If the needs assessment section submitted with the SFY 2014 Community Plan is current , please indicate as such.

Board's Needs Assessment Update Response:

The various and mulit-faceted mechanisms employed by the Board to evaluate behavioral healthcare needs and provide information about goals or values, service and program activities, outcomes, and costs were described in the SFY 14 Community Plan. For the most part, the information submitted with that Plan is current, however listed below are some findings from the 2013 Erie County Community Health Assessment (published after the submission of the FY 14 Plan) and the county profiles prepared by ODH, as well as information related to health care coverage and opiate use.

2013 ERIE COUNTY COMMUNITY HEALTH ASSESSMENT

Erie County Youth

Mental Health Related Findings:

Similar to findings of the 2008 and 2011 assessments, one out of four youth reported they felt sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities. Thirteen percent of youth—up from 10% in the last survey-- reported seriously contemplating suicide in the past year.

A question on self-harm was asked for the first time in the 2011 survey: then, as in the 2013 one, 21% of youth purposefully hurt themselves by cutting, burning, scratching, hitting, biting, etc. at some time in their life. This is significant as a new study found that teenagers who harm themselves are more likely to develop substance use problems later in life, compared with their peers who do not engage in self-harm. Nearly 5,000 16-year-olds were asked whether they had ever hurt themselves on purpose in any way, such as by cutting themselves or taking too many pills. They were also asked if they had ever seriously wanted to kill themselves. The study found about 19 percent of the teens had a history of self-harm, and most had not sought professional help. The teens were followed for five years. Those who had a history of self-harm without suicidal intent were more likely to develop mental health problems, including depression and anxiety, and were more likely to harm themselves and to develop substance use problems (*BMJ* 2014;349:g5954).

Bullying, Safety and Violence Related Findings:
Findings were similar to the past two surveys for questions related to bullying, with about half of youth reporting they had been bullied in the past year. Of significance, 21% of youth reported they had been involved in a physical fight as opposed to 33% in the previous survey (the first time the question was asked). Likewise, fewer youth who are current drinkers (use in the past 30 days) and who are non-current drinkers reported being in a physical fight in the past 12 months, from 52 to 36% and 26 to 18% respectively. Youth who were bullied also reported a decrease in physical forms (hit, kicked, punched, or people took your belongings), from 13% to 10%.

Parenting, Family Related Findings:
Interestingly, there were some significant changes in the topics discussed with their youth as reported by parents. This question was first asked as part of the 2011 assessment, and was focused on 12-17 year olds; for the 2013 survey, parents were asked about topics discussed with their 10-17 year olds. It is unclear if this contributed to the variance. The results are shown below, with those from the latest survey in blue font. While the percentages of those who spoke on drug and alcohol related topics remained about the same, there was a decrease in those who discussed anxiety, depression and suicide with their youth.

Parents discussed the following with their 12 to 17 (10-17 in 2013)year old in the past year: importance of education (55% 84), dating and relationships (53% 66), negative effects of alcohol (52% 52), negative effects of tobacco (49% 49), negative effects of marijuana and other drugs (46% 54), screen time (46% 71), friendships (45% 80), eating habits (43% 71), school/legal consequences of using tobacco/alcohol/other drugs (41% 34), bullying (39% 64), energy drinks (38% 33), refusal skills/peer pressure (37% 44), abstinence and how to refuse sex (36% 46), condom use/safer sex/STD prevention (36% 37), body image (35% 50), social media issues (34% 44), negative effects of misusing prescription medication (33% 33), anxiety/depression/suicide (30% 24), and birth control (25% 31)

Alcohol/Drug Related Findings:
As reported in the 2013 survey, fewer youth are reporting use of alcohol at any time in their life than in the past two surveys, and of those who reported drinking at some time in their life, the age at which they had their first drink was later. Similarly, there was a decrease in the number of youth who reported smoking marijuana in the past 30 days, and a significant drop in the number of youth reporting misuse of prescription medications. The data is reported below, with findings from the 2008 survey in black, the 2011 in red, and the 2013 in blue.

- 57% 48% 37% had at least one drink of alcohol in their life; 14% 17% 11% had used marijuana at least once in the past 30 days
- 11% 14% 6% used medications that were not prescribed for them or took more than prescribed to feel good or get high at some time in their lives
- 44% 42% 34% of youth who reported drinking at some time in their life had their first drink under the age of 12; 30% 34% 26% between the ages of 13 and 14; 22% 24% 39% between the ages of 15 and 18

The perceived risk of alcohol and drug use by youth was asked about in the 2011 survey and repeated in the 2013 survey (data in blue), in part as a response to the recent legalization of medicinal and/or recreational use of marijuana in several states and the increased debate about the issue in Ohio. Although it is unclear if this is the reason for a change in the figures, the number of youth who view no risk of harm by smoking marijuana increased slightly, while the number who view it as a great risk decreased by 7%. At the same time, those who perceive a great risk of harm from cigarettes and alcohol both increased.

Perceived Risk of Drug Use

How much do you think people risk harming themselves if they:	No Risk	Slight Risk	Moderate Risk	Great Risk
Smoke cigarettes	9% 9	13% 9	25% 23	53% 59
Smoke marijuana	16% 19	20% 19	17% 21	47% 40
Drinking alcohol (such as beer, wine, or hard liquor)	8% 7	20% 19	35% 21	37% 40

Erie County Adults

Mental Health Related Findings

As in the last survey, about 18% of adults in the 2013 survey rated their mental health as not good on four days or more in the previous month; however, there was an increase from 11 to 20% in those who reported poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation.

Gambling

A question on gambling was included for the first time in the 2013 survey, with 49% of all adults reported gambling in the past year: Lottery (40%), casinos (19%), at home with friends (7%), at work with coworkers (6%), online (2%), horse track (1%), dog track (1%), and other types of gambling (1%).

Alcohol/Drug Related Findings

As reported in the 2013 survey, fewer adults were considered frequent drinkers than in the last two surveys. Of those who drink, fewer reported having five or more on one occasion in the past month (binge drinking). Of concern, and the opposite of what was seen in the youth data, there was an increase in the number of adults reporting misuse of prescription medication, from 3 to 8%. There was a decrease in the number reporting use of recreational drugs such as heroin during the past six months, from 10% in 2001 to 1% in 2013. The data is reported below, with findings from the 2008 survey in black, the 2011 in red, and the 2013 in blue.

- 17% 19% 15 were considered frequent drinkers (drank an average of three or more days per week, per CDC guidelines)
- 39% 50% 34 of adults who drink had five or more drinks on one occasion (binge drinking) in the past month.
- 28% 32% 32 drove after having alcoholic beverages
- 2% 3% 8 had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months
- 8% 10% 1% had used recreational drugs such as cocaine, methamphetamine, heroin, LSD, inhalants, Ecstasy during the past 6 months

In Erie and Ottawa Counties, adult males account for 62% of those receiving alcohol/drug treatment services funded through the Board.

Criminal Justice Related Findings

- Opiate possession charges (i.e., Rx opioid and heroin) per 10,000 persons by county: 2012 Erie 5.8; Ottawa .8; 2011 Erie 1.2; Ottawa 2.4
- All drugs (drug possession charges per 10,000 persons by county): 2012 Erie 56.3; Ottawa 52.3; 2011 Erie 13.8; Ottawa 22.7
- Per Ottawa County Common Pleas Court: For the first half of 2014, 29% OC defendants were indicted for drug related charges. Many offenders charged with other offenses such as theft, burglary and breaking and entering were motivated by addiction.

OPIOID –RELATED DATA

- Consistent with previous years, Alcohol-related diagnoses remain primary for adults; opiates are recognized as an acute need, not a high volume one.
- In FY 13, individuals reporting use of opioids—heroin, non-prescription methadone, and other opiates/synthetics—represented about 18.5% of all treatment admissions; in FY 14, 7.9%; in FY 15 to date (7/1/14-11/24/14), 6.2%.
- Based on diagnosis, in FY 14 a total of 218 individuals out of 2760 total seen for treatment had a primary or secondary opiate-related abuse or dependence diagnosis: 21/40 youth, or 52.5% and 197/2720 adults, or 7.2%. In FY 15 YTD, a total of 64 out of 1040: 1/9 youth, or 11%, and 63/1031 adults, or 6.1%.
- Emergency room discharge rates for persons diagnosed with opiate (i.e., heroin or Rx opioid) abuse, dependence or poisoning per 10,000 persons by county of patient residence: Five-year Weighted Average from 2008 to 2012--Ohio 14.0; Erie 12.1; Ottawa 8.0; from 2004-2008-- Ohio 8.1; Erie 6.8; Ottawa 5.0
- Naloxone administration rates in 2012 per 10,000 persons: Ohio 9.17; Erie 8.8; Ottawa 13.3
- MAT doses per 100 people for drugs like buprenorphine, Suboxone® and Subutex®, OARRS - Doses per 100 people in 2013: Erie 132.6; Ottawa 92.6; in 2010: Erie 63.5; Ottawa 33.0. Note: the range for 2013 was 16.3 to 711.7
- Number of unintentional drug overdose deaths and average crude and age-adjusted annual death rates per 100,000, by county, **2007-2012**: Erie 59/12.8/13.2 respectively; Ottawa 22/8.9/8.4.

Of note: the data from Ohio's Automated Rx Reporting System on Prescription Opioid Doses per Capita adapted by Ohio MHAS from the State Board of Pharmacy was inconsistent with that included in the Board's FY 2014 Community Plan, using OARRS reports disseminated by ODADAS. The MHAS data showed a much higher per capita rate, Erie 76.5; Ottawa 63.6 for 2013 vs. the much lower figures of 19.50 and 17.61 reported previously. We are not sure of the reason for the discrepancy.

One provider located in Erie County, Sandusky Artisans, offers a range of recovery support, peer and self-help services to persons suffering from substance abuse disorders and mental illness. The agency hosts many 12-step and other meetings including AA, CA, NA, CoDA, Al-a-Non, Al-a-Teen, SOLACE, and the Family-to-Family program with about 3,000 people crossing their threshold each year. They are often a first point of contact for persons in the community who are struggling with substance abuse disorders and at the beginning of the recovery process. They report a surge in opioid-addicted persons utilizing their services.

HEALTH CARE COVERAGE

There are still a significant number of adults without health care coverage. According to the 2011 Erie County Health Assessment, 9% of adults were without healthcare coverage, increasing to 27% of those with incomes less than $25,000; in 2013, this increased to 16% and 41% respectively. Based on the population estimate of the U.S. Census Bureau for Erie County for 2013, this equates to 9,599 adults (age 18 and older) without health care coverage. This figure is three times the estimated number of uninsured reported in the table below.

The top reasons uninsured adults gave for being without health insurance coverage were: Couldn't afford premiums (39%); Lost job or changed employers (35%); Became ineligible (14%); Employer does not/stopped offering coverage (13%); and Became part time or temporary employee (12%). Note that the total doesn't equal 100 because respondents could select more than one reason.

As reported in the Erie County profile prepared by the Ohio Department of Health, 87.2% of persons aged 0-64 have health insurance. The rate for adults (aged 18-64) is 84.5% and for children (aged under 19) is 94.5%. In Ottawa County, 87.6% of persons aged 0-64 have health insurance, with the rates for adults and children at 85.3% and 94.1% respectively.

Ohio Health Insurance Marketplace Open Enrollment Period 1 Take-Up Rate

	Marketplace Plans Purchased	Uninsured 2012	Take Up Rate	Remaining Uninsured 2014
Erie County	894	3,833	23.32%	2939
Ottawa County	418	1,938	21.57%	1520

Medicaid

According to ODJFS, in Erie County in 2013 there were 12,858 enrollees in Medicaid, 17% of the total population-2322 Aged, Blind and Disabled and 10,536 Children and Families. This represents a 15% increase since 2006. In Ottawa County, 12% of the population, or 5074 individuals were enrolled in Medicaid-1022 Aged, Blind and Disabled and 4052 Children and Families. This was a 6% increase from 2006. Based on the October 2014 Medicaid Expenditures and Eligibles Report, 17922 Erie County residents and 6835 Ottawa County residents were enrolled in Medicaid for some type of benefit; this includes the two categories above, the expansion population, and those with other types of benefits such as CHIP or Family Planning.

According to the Department of Medicaid (September report), 2733 Erie County residents and 955 Ottawa County are enrolled in Medicaid under expansion.

Current Status of SFY 2014 Community Plan Priorities

2. Please list the Block Grant, State and Board priorities identified in the SFY 2014 Community Plan, briefly describe progress in achieving the related goals and strategies, and indicate in the last column if the Priority is Continued, Modified, or Discontinued for SFY 2015. If the SFY 2014 Community Plan addressed (1) trauma informed care; (2) prevention and/or decrease of opiate overdoses and/or deaths; and/or (3) suicide prevention, OhioMHAS is particularly interested in an update or status report of these areas.

(NOTE: This section only applies to previously submitted SFY 2014 priorities. Any <u>new</u> priorities are to be listed in item #3 if applicable). Please add as many rows in the matrix below as are necessary.

PRIORITIES, GOALS AND STRATEGIES ARE CUT AND PASTED FROM THE SFY 2014 COMMUNITY PLAN					
Priority	Goal	Strategy	Progress	Barriers/Need for TA?	Priority Continued, Modified, or Discontinued in SFY 2015?
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)			Did not select in FY 14 due to very low numbers: this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider.		N/A
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)			Did not select in FY 14 due to very low numbers: this population is monitored as part of our capacity management system; in the event there is a waiting list for services, they are either moved to the front of the list and offered interim services or referred/linked to other provider		N/A
SAPT-BG: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15	1. Improve timely access to services and supports to adults involved in the child welfare system in Erie County	1 (a) Collaborate with Juvenile Court Judge around use of the IDAT funds for treatment services to this population where substance abuse is a contributing factor to legal charges	1 (a) IDAT funds were not used; balance from $45,308.26 at end of FY 13 to $45,521.22 at end of FY 14. 1 (a) The Matrix Model for Teens and Young Adults program was identified as a good fit to	1(a) The IDAT fund does not show significant growth from year to year, thus there is not familiarity with the requirements/process in the court; also, many of the youth are covered by Medicaid or other insurance, thus not meeting the indigent criteria	All Continued

required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	2. Stabilization and treatment of parental mental illness and/or substance use disorder to prevent removal of children from the home and/or to promote successful reunification of families when issues are present	1(b) Through the planning committee for the family drug court, identify treatment service needs specific to this population 2 (a) In partnership with Board contract agencies, work with caseworkers at Departments of JFS and staff at family/juvenile courts to improve identification and referrals of families in need of intensive home-based treatment (IFAST) or other services 2 (b) Provision of services—including targeted case management –to participants in the O.C. HOPE Court (Helping Our Families Excel) Family Dependency Treatment Court program	address the needs of this population. Firelands is working with the Court around training and implementation. If feasible, this may be added to the program continuum in the second half of FY 15. 1 (a) & (b) FCRS is considering approaching the Erie County Court of Common Pleas Juvenile Division to explore the interest of the court in providing an onsite assessment program similar to that in Ottawa Co. Past discussions have centered on the difficulty of engaging families and having consistent follow-up for youth referred to treatment. On-site assessment would increase the number of youth/families referrals for services in both the AoD and Mental Health programs. 2 (a) Staff of treatment agencies have worked closely with JFS caseworkers to facilitate assessment and referral, and actively participate as part of child and family teams with JFS and via Wraparound. 2(b) Service capacity was maintained in FY 14 and FY 15, and program requirements incorporated into the non-Medicaid contracts with providers. In response to the Court's request, **PREP** (Personal Responsibility Education Program) - was added to the continuum and is currently	2 (a & b) The Giving Tree, the Board's primary provider of mental health and alcohol/drug treatment and prevention services in Ottawa County, was acquired by Firelands (the Board's primary provider in Erie County) in December 2013. As a result, at the agency level the second half of FY 14 was focused on transition—staffing and administration, EMR, relationships with stakeholders and referral agencies— along with maintenance of programming as per contract. FY 15 contract negotiated around board requirements for carry-over programming in Ottawa County as well as programming mix across counties by what is now one larger primary Board contract provider. 2 (a) Data on referral sources (i.e. JFS) available via MACSIS not very useful considering majority of youth covered by Medicaid. Elected not to have agency track separately.	

			offered at the Student Achievement Program (SAP), an alternative education program for court-involved youth with behavioral health problems. PREP is a harm-reduction based curriculum specifically targeted at 14 to 19 year olds in the juvenile justice and/or foster care systems that discusses risk-behaviors that may lead to sex/unprotected sex (including AoD use), abstinence, financial literacy, STD's, and healthy relationships. In addition, Firelands has offered the 7 Challenges program in Erie County for several years, and now that they also serve Ottawa Co. will provide it there in the event enough adolescent clients present for a group.		
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	1. Improve access to juvenile emergency/crisis psychiatric inpatient hospitalization and/or community residential stabilization	1 (a) Purchase 22 crisis/respite bed days through the Juvenile Crisis Hot Spot Project of the NW Collaborative to expand range of available options available 1 (b) Meet with reps of juvenile courts, treatment, and sheriffs' office to identify issues around process 1 (c) Continue to work with NW Collaborative as follow up to Private-Public Hospital Initiative around possible regional solutions	1 (a) <u>FY 2014 Hot Spot Funding for Juvenile Crisis Project</u>: $7,700 (Jan-June); <u>Total FY 2014 Juvenile Crisis Spending</u>: $4,200 ($3,500 transferred to another Hot Spot initiative) <u>Adolescents Served</u>: 3 (Unduplicated) <u>Number of Bed Days</u>: 12 1 (b) Availability of this option led to improvement in process including a reduction in wait times (and thus sheriff/agency/court staff time) and made some difficult admissions easier to reach disposition.	1 (a) Project continued in FY 15- <u>Total Hot Spot Funding</u>: $10,500; <u>Total Hot Spot Expense</u> (through October): $10,500; <u>Adolescents Served</u>: 6 (Unduplicated); <u>Number of Bed Days</u>: 30 As the value of the program has been substantiated, we will allocate additional dollars available through collaborative for purchase of more bed days or purchase additional capacity out of Board funds. 1 (c) Change in use of 507 funds from allocation to boards for use in	All continued

			1 (c) Through re-vamped 507 funds for FY 15, partnered with SSW and Huron Boards, Firelands, and Rescue for development of crisis stabilization unit and possible detox services; still in planning stages, with next multi-partner meeting to occur in early December	communities to fund locally identified priorities to state control for regionally developed projects focused on crisis and residential services was problematic in terms of timing (large and complex projects, and funds still not fully to field as approach halfway point of FY 15), planning, and sustainability—particularly given that they are not even in the MHAS budget for FY 16-17	
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)			Specific goal not selected, however this population is a priority and is impacted directly by goals set in other priority areas such as "Integration of BH/PH Services" & "Recovery Support Services"		N/A
MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*****	1. Reduce the stigma of cancer patients seeking behavioral health treatment for the emotional toll that diagnosis and on-going cancer treatment can have upon patients 2. Increase access to BH treatment and promote the integration of physical and behavioral health care	1. Maintain funding for *From Cancer to Health*, an emerging best practice approach that integrates behavioral health and cancer treatment (a pilot group was funded at the end of FY 13) 2. Provide funding for on-site screening for mental health and substance use disorders, consultation and engagement services to youth and adults at Family Health Services of Erie County	1. Groups held Qs 1, 3 and 4 in FY 14 (therapist on maternity leave in Q2)-30 individuals served. At the end of Q1, four individuals had been referred for on-going services from the group to address symptoms of depression. Additionally, one individual was referred to individual rather than group given the severity of the depression and the complicating medical factors. Therapist completed STAR certification, ORP's flagship product and the gold-standard in cancer rehab for hospitals and cancer centers that offer multidisciplinary survivorship care. The STAR Program includes a packaged set	1.Need to ensure that data is being reported for the following for FY 15 (may need to amend quarterly Program Report submitted by the agency): # referrals to program, # group participants, # participants identified/referred for assessment and counseling 2. Areas of concern related to scheduling and follow up contact due to inaccurate phone numbers given by patients or disconnections at the time of follow up calls. Also high numbers of late cancellations reporting that they would call to reschedule and did not follow up for	All Continued

	3. Improve earlier identification of physical health problems and ensure compliance with psychotropic medication protocols	3. Provide funding for lab work for indigent consumers with SPMI enrolled in the non-Medicaid Health Home via a SAMHSA grant awarded to the Board contract agency	of training and protocols that are evidence-based medicine. Funding continued with additional capacity for FY 15. 2. Program has been offered for approximately three years. The steady numbers of referrals from each quarter suggest that this service is still needed to assist with removing stigma for mental health services from those using primary care for mental health needs. *See table at end of this chart. 3. Reimbursements for service are far below the $30K cap, as the agency has diligently worked to bill all other fund sources first; primary expenditures are for lab and Rx for those with no source of funds. Additional services have included things such as x-ray, podiatry, ophthalmology, vascular, splint, and ENT referral.	consultation services. Many duplicate referrals were noted from previous consultations and it appears that some of the referrals may already be engaged with services with FCRS. Firelands received an SBIRT grant through MHAS. Agency will assess continued need for this program in FY 15 as SBIRT is implemented, given that Family Health Services is one of the sites. 3.Need to ensure that data/information requested in contract is included on quarterly Program Reports (i.e. #/type of PH conditions identified, #/type of referrals to specialists, ER use)	
MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	1. Increase employment of persons with mental and/or substance use disorders who want to work 2. Develop system capacity for peer-delivered support services	1 (a) Expand eligibility under the board-funded Supported Employment Preparation and Linkages Services (SEPALS) program to include adults from the MH-General Population and AOD Service Groups 1 (b) (**Depending upon outcome of VRP3 Program**) Redirect local match funds and/or invest additional funds into supported employment programs	1 (a) Achieved-eligibility requirements expanded and built into Board requirements in non-Medicaid contract 1 (b) **SEPALS**: 92 individuals received services in FY 14, with 22 placed and/or working. Ave days to placement ranged from 71-83; average wage range from $8.00-8.47, with range from $7.95 to $14.00. **Summer Youth Work Experience:** teaches transitional youth vocational skills and appropriate work	Approx. Q4 of FY 14, Firelands Vocational Rehabilitation (VR) program was revised and integrated to incorporate the continuum of VR programs offered by the Giving Tree (acquired by Firelands in December 2013) in order to streamline referrals and prevent confusion. While (most importantly) seamless at the consumer end, this did present some challenges with tracking and reporting. Agencies report on the VRP3	All continued; Strategies for #2 modified for FY 15 as follows: a) Establish Sandusky Artisans Recovery Community Center as local clearinghouse for info on CPS/Recovery

		targeted at persons with SMI/SPMI/AOD **OR** Maximize the provision of vocational rehabilitation and employment services and other supports via BH-VRP3 program 2 (a) Work with local CCAR trained Recovery Coaches and Lorain Area Recovery Coaches network to define service delivery model for use of Recovery Coaches 2 (b) Provide training for 4-7 Erie-Ottawa consumers as Certified Peer Supporters (CPS) through joint sponsored training with Lorain ADAS Board for the 40-hour OMHAS training through OCA	behaviors, with the outcome to prepare the individual for permanent competitive integrated employment and independence. This year's program has nine (9) students working for a variety of employers **VRP3:** Applications: 166 Eligible/Delayed: 154 Service: 104 Closed-Rehab: 32 Of total, "Most Significantly Disabled" approximately 80% and "Significantly Disabled" 20%, Also benefitting Erie/Ottawa consumers, Firelands Counseling and Recovery Services was selected by OhioMHAS as a partner in the *Transforming Lives through Supported Employment* grant, which aims to modernize, enhance, and increase availability and quality of Individual Placement and Support (IPS) services. 2 (b) Four Erie-Ottawa residents were trained via joint training with Lorain ADAS and CMH Boards 1/13/14-1/17/14; Board contract agency Sandusky Artisans conducted a second training early in FY 15, in which 13 individuals (8 Erie-Ottawa residents) completed the training. A third session was conducted at the end of November 2014; 10/14 were	program as part of their quarterly Program reports (on the SFY), and complete more detailed reports for OOD (on the FFY). Trying to reconcile the numbers here was confusing, so the data was taken only from the caseworker tracking reports for the period 10/1/13 through 9/30/14. However one of the caseworkers covers Erie and Huron Counties (who did not participate in '15), however the number of Huron Co. participants is relatively low. For example, only 3 of the "Closed-Rehab" (competitively employed over 90 days) figure were for Huron. Finally, there was some staff turnover at one of the Board agencies in FY14. The uncertainty about funding for and continuation of the VRP3 program complicated this, as the agency hesitated to fill the positions until the issue was resolved. Upon filling the vacancies, both individuals had to complete the mandatory training and rebuild caseloads.	Coaches b) Work with contract agencies and referral sources to create opportunities for employment of CPS/Recovery Coaches c) Implement WRAP (Wellness Recovery Action Plan)program in Erie Shore Network

			Erie-Ottawa residents.		
Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	1. Arrest the spread of opiate addiction among residents of Erie and Ottawa Counties	1 (a) Continue to gather quantitative & qualitative data on range/scope of current problem 1 (b) Work collaboratively with Weed and Seed, Sandusky Crime Prevention Council, Let's Get Real and others to explore feasibility of developing a Community Opiate Task Force to identify and pursue mutual goals 1 (c) Increase community awareness around the dangers of opiate use (i.e. promote use of drop-boxes, prevention programs)	1 (a) Update on heroin epidemic and opioid-related activities based on these goals and strategies given to Board April 2014; ongoing data surveillance of many quantitative sources (see updated info under question #1) (b) The Board has been involved in the Circle of Care meetings (comprised of a variety of stakeholders including treatment, JFS, law enforcement, courts, etc.), co-chaired by the Erie County Health Commissioner and a County Commissioner. In Ottawa Co., the issue of opioids has been dealt with in the context of regular community planning and was also addressed by the Judge-led team that participated in the Judicial Symposium on Opiate Addiction last spring. The feasibility of moving forward with a formal Task Force in Ottawa Co. still needs to be explored. 1 (c) **Generation Rx** added to prevention continuum for FY 15. This initiative began at The Ohio State University College of Pharmacy in 2007 as a program to enhance medication safety and combat the increasing misuse and abuse of prescription drugs. Educational offerings will be based on strategies included in prevention toolkit to provide	1 (b) In the latter half of CY 2013, a behavioral health/addictions workgroup was initiated by the Erie Co. Health Commissioner. Initially the focus was on integrated PH/BH healthcare; however in late January 2014 the focus shifted to the heroin epidemic—primarily on the treatment continuum and even more specifically on detox and inpatient/residential services. The timing was coincidental with the Community Plan approved by the Board 12/10/13, with these goals/strategies. The Board considered several options in relation to that group, including transitioning it to a formal Opiate Task Force with broadened focus to include the prevention and community awareness efforts; establishing a separate coalition, recognizing that many of the same participants would be part of both; and/or establishing a separate Task Force with the workgroup functioning as a committee under the Task Force, focused on the treatment continuum. Because of the genesis of that group under the leadership of others than the Board, it was determined it would be too confusing and somewhat duplicative to engage in any of the above approaches; as such, board staff	All continued, except that 1 (b) will occur in Erie Co. via Circle of Care group vs. Opiate Task Force

			community presentations geared towards adolescents, college age students, adults and seniors. Also, a SOLACE (Surviving Our Loss And Continuing Every Day) support group that seeks to help build awareness about the substance abuse crisis, particularly prescription drug/opiate abuse and heroin, was formed in October, 2014.	continue to participate in the Circle of Care.	
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents *****	1. Strengthen families and parents through education, training and skill-building	1 (a) Provide funding for parenting programs—Loving Solutions, Active Parenting, Strengthening Families 1 (b) Expand continuum to include program focused on prevention of underage drinking (i.e. Parents Who Host…) 1 (c) Create opportunities for parent mentoring and support through collaboration with FCFCs 1 (d) Maintain capacity for school-based services (classroom and individual prevention services) including Life Skills	Data Surveillance/Trend Analysis-data from Erie Co. Community Health Assessment reported under question #1 1 (a) Over one hundred individuals participated in parenting programs; contract agency participated in Sandusky City schools Parent Summit 1 (b) Already incorporated into school-based prevention programming 1 (c) Agency staff worked with Wraparound and participated on child & family teams 1 (d) Evidence-based programming such as *Rachel's Challenge*, a leadership program; *The Leader in Me*, a Student Assistance program; and *A Promise for Tomorrow* and Question Persuade Refer (*QPR)*. suicide prevention programs, were added to the mix, along with LifeSkills and Power. Over 3700 students received school-based prevention services.	1 (a) Several evidence-based parenting/family programs added to the continuum in response to stakeholder/referral source requests are struggling with referrals (i.e. Parent Project, Loving Solutions, Strengthening Families); the feasibility of continuing these will be examined through the remainder of FY 15 1 (c) Instability in both Erie and Ottawa FCFCs because of loss of coordinators 1 (d) Amount of school day closures due to inclement weather last year impacted programming, resulting in lower numbers than projected in some cases; also challenging for agencies in regard to staffing and productivity. Vacancies in staff positions also occurred as a result of the acquisition of The Giving Tree by Firelands.	All continued except 1 (b), expansion of the continuum to include specific programs targeting underage drinking, as it is already being addressed

Prevention: Increase community knowledge about mental and substance use disorders	1. Decrease stigma as a barrier to early intervention for emotional problems and mental	1 (a) Provide funds to train one person in Mental Health First Aid to deliver the program Erie-Ottawa Counties 1 (b) Convene a Board-Agency Public Education Steering Committee with a focus on the creation of a set of topic-specific presentations for use in community presentations to help increase understanding about the issues of mental illness and alcohol/drug abuse and dependency 1 (c) Promote the Board website as a resource in the community 1 (d) Increase the use of PSAs	1 (a) One individual was trained in May via OACBHA. A program was delivered in Ottawa County to 14 people. Two programs will be offered in Erie County during the remainder of FY 15. 1 (b)Not done 1 (c) Website was included on all resource/PR materials prepared to educate the community about the levy, and displayed prominently on all of the giveaways handed out 1 (d) Used in conjunction with promotion of the levy, however not as a general practice as intended here	1 (b) This was not completed yet due to staffing and time constraints, and the need to focus on other priorities 1 (d) Again, staff and time constraints negatively impact the ability to engage in consistent and organized community education efforts.	All continued, except that strategy 1 (a) modified to "deliver two MHFA trainings in Erie-Ottawa Counties by June 30th, 2014"

Family Health Services-Screening Data

	Adults	Children	Consultation session outcomes	Adults	Children
Attended	38	10	Level 1: no needs	1	0
No Show	40	12	Level 2: treatment not indicated	0	0
Unable to Schedule	54	7	Level 3: referral to treatment	37	10
# Consultation Sessions provided	39	17	Of # referred: Agreed/Disagreed	37/0	10/0

The table below reflects priorities from the FY 14 Community Plan that were noted but not selected due to resource limitations. Because of funding opportunities that emerged as part of the MBR, the Board worked in collaboration with agencies/organizations in both Erie and Ottawa County around the development of recovery housing (#3 below). A brief description of activities is noted below; however a new priority for FY 15 around recovery housing was added to question #3 as well.

Also, while lack of resources is still an issue, there was a little progress relative to expansion of the continuum of care. Again, a brief description of activities is included below.

From FY 14 Plan: Identified priorities not selected due to resource limitations:

Priority if resources were available	Why this priority would be chosen
(1) Secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label	A critical tool for maintaining community recovery for some individuals is the ability to provide a secure residential setting. This was echoed by findings of a survey of boards about discharge barriers for individuals in the Regional Psychiatric Hospitals distributed by Ohio MHAS, in which 70% of participating boards indicated that the development of special needs secure housing alternatives would be helpful for consumers with complex needs. Currently, the only secure community options are nursing homes, and trying to establish alternative secure placement arrangements is very costly and next to impossible. The Board is currently paying nearly $140,000 a year in expenses for housing/supervision costs for just one individual; necessary treatment costs outside of Medicaid are additional.
(2) Expansion of continuum of care available for persons with alcohol/drug disorders, especially access to Levels of Care II-IV	Currently, the only levels of care available are outpatient and limited intensive outpatient. Minimal funds are available, coordinated on behalf of the system by the Board's primary contract provider, for residents in need of services falling under Levels II-IV. Even then, the geographical location of various detox, inpatient, and community residential facilities makes coordination and engagement with local treatment providers and with the recovery community challenging. Funds would also be used to develop programming specific to those with opioid-related diagnoses; currently MAT is not available in the Board area. **First, due to changes in the provider network for FY 15, existing dollars available for purchase of Level II-IV services were split between both agencies providing adult alcohol/drug addiction services rather than vested in one agency. This will facilitate access and will enhance seamlessness for the client. Additional funds were added to the "Inpatient Management" service groups as well.** **Second, in response to identified gaps in the continuum of care as well as to anticipated requirements as a result of the "continuum of care" language for opiate clients passed as part of the MBR, the Board sought information from current providers around the desire/ability/capacity to provide Medication Assisted Treatment (MAT) and ambulatory detox services. One of the Board-contract providers is currently assessing options relative to the provision of these services; the other has expressed interest in providing medication assisted treatment services, as well as exploring the possibility of ambulatory detoxification services to Erie and Ottawa County residents. Through a collaborative effort with the Erie County Adult Probation Department, the agency will be offering Vivitrol to a selected group of individuals with heroin/opiate addiction, and plans to expand the medication assisted services to other clients of the agency as well. Their psychiatrist is open and willing to provide these services, and discussions have begun with the Erie County Health Department around contracting with the nursing staff to provide injections.**
(3) Recovery housing	Recovery housing and related supports is an important component of the continuum of care, and is supported by SAMHSA and considered a priority domain within the context of Recovery-Oriented Systems of Care. There is very little

	local capacity, as the only project that currently exists is the Serenity House program, which provides supportive housing for homeless chemically dependent adults in a group living environment and scattered site apartments. Residents are expected to participate in recovery related activities such as treatment and AA/NA/CA support groups. Program participants may stay as long as 24 months, with an average length of stay around 12 months. This program is funded primarily by a Supportive Housing Program Grant from the Department of Housing and Urban Development. Funds from the Board are used to pay for treatment and for case management services for program participants and serve as a valuable source of matching dollars for the grant, allowing Volunteers of America to leverage more than $290,000 annually. Maximum capacity at this time is approximately 30 individuals, although the number varies relative to the length of stay and mix of current program participants as these variables impact the amount of open slots in the men's and/or women's group home and the apartments. For instance, going into FY 12 the length of stay in transitional housing through Serenity House was between 18 to 24 months. Residents are taking longer to find subsidized housing and an increase in income. The number of clients served decreases as the length of stay increases. **Two local entities, working in partnership with the Erie-Ottawa MHRB, were awarded grants by the Ohio Department of Mental Health and Addictions Services (OhioMHAS) for the development of recovery housing. In Erie County, Volunteers of America received a total of $165,000 in capital funds and operational support to transition an existing property in Sandusky into a Level II facility providing housing for four adult males. In Ottawa County, The Lighthouse Sober Living was awarded $107,604 for the purpose and renovation of a facility that will also initially house four adult males. The Board has committed match funds to each of these projects**. **As one outcome of the Circle of Care initiative described above, a proposal was submitted to OhioMHAS in December for funds to support a sober living community to be called Genesis by the Lake. The proposed project will provide recovery housing to adult females, age 18 and older, with a diagnosis of alcohol abuse and/or addiction; who have finished the beginning phases of their Individualized Treatment Plans; who have either graduated from traditional Recovery Housing or are living at home or in a neighborhood that puts them at risk for using drugs and/or alcohol; and who are ready to begin the next phase of their community reintegration. If funded, this will meet a long-standing identified need and—along with the awards received for the projects noted above—provide at least some capacity for housing and supports for both the male and female adult populations in Erie and Ottawa Counties.**

New Priorities for SFY 2015 (if applicable)

3. Please add <u>new</u> Block Grant, State or Board priorities for SFY 2015 that were not reflected in the previous Community Plan for SFY 2014.[The Department is especially interested in new priorities related to: (1) trauma informed care; (2) prevention and decrease of opiate overdoses and/or deaths; (3) suicide prevention; and/or (4) Recovery Oriented Systems of Care (ROSC)]. Please add the priority to the matrix below and complete the appropriate cells. If no new priorities are planned, please state that the Board is not adding new priorities beyond those identified in item 2 above.

In general, as part of the FY 15 General System Program/Budget approved by the Board in conjunction with the FY 15 agency allocations, the following list of priorities to be addressed as funds become available was generated. The first four bullets mirror those included in the FY 14 Community Plan and listed and

addressed above. The restoration of service capacity for prevention programming and the expansion of peer and consumer-operated services are addressed in the last question ("Open Forum"). The latter was also addressed above in the form of modified goals/strategies for FY 15. Additional Board investment into vocational rehab and employment services occurred in conjunction with the VRP3 program (operating on a FFY) since Huron County elected not to continue with the contract. The Board made up the majority of the difference in match funds, and realized additional capacity as program staff were now dedicated to Erie-Ottawa exclusively. Additional priority areas and goals around recovery housing and Recovery Oriented Systems of Care (ROSC) are addressed below.

ADDITIONAL PRIORITIES-TO BE ADDRESSED AS FUNDS BECOME AVAILABLE:

- Alternatives for expansion of Serenity House programming and other Recovery Housing-currently applying for capital funds for group home setting; also exploring cost and other factors for expansion of scattered site apartments for individuals
- Secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label
- Further expansion of continuum of care available for persons with alcohol/drug disorders, (Currently, the only levels of care available are outpatient and limited intensive outpatient. Minimal funds are available for residents in need of services falling under Levels II-IV. Even then, the geographical location and lack of capacity statewide of various detox, inpatient, and community residential facilities makes coordination and engagement with local treatment providers and with the recovery community challenging)
- Development of programming specific to those with opioid-related diagnoses; currently medication-assisted treatment (MAT) is not available in the Board area
- Restoration of service capacity for evidence-based, primary prevention programming
- Expansion of capacity for vocational rehab and employment services
- Expansion of peer and consumer-operated support services, Recovery-oriented system of care

Priorities	Goals	Strategies	Measurement
MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	1. Provide stable and sober housing to individuals with alcohol and addiction problems.	1 (a) Provide fiscal support to VOA and The Lighthouse to match capital funds and/or for operating expenses relative to the establishment of Level II Recovery Residences in Erie and Ottawa Counties respectively. 1 (b) Work in collaboration with each project to establish and implement required policies and procedures. 1 (c) Work in collaboration with each project to establish linkages to behavioral health providers and around the role of Certified Peer Supporters/Recovery Coaches.	1 (a) Approved, itemized budgets, Board consent agenda 1 (b) Policies and procedures around administration, operation, quality and outcomes for each residence 1(c) Program descriptions, programming requirements (in Attachment 1) in Board contracts, MOU's and/or affiliation agreements

MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	1. Ensure that individuals and families affected by mental illness and/or addiction have access to a high quality, Recovery-Oriented System of Care (ROSC).	1 (a) Formal adoption of value/priority by Governing Board. 1 (b) Presentation on "Recovery is Beautiful" initiative by OACBHA to Governing Board, treatment agencies and guests at December board meeting. 1 (c) Present/discuss initiative with stakeholders as part of scheduled meetings the first quarter of FY 15 1 (d) Obtain T.A. and/or guidance from OACBHA Implementation Workgroup and "early adopter" Boards re: development of implementation plan	1 (a) Board meeting minutes, amended governance policy IV-A 1 (b) Board meeting minutes, attendance roster 1 (c) Meeting notes, qualitative feedback/information 1 (d) Draft implementation plan, incorporation of tasks into FY 16 General System Program/Budget
Treatment: Underserved racial and ethnic minorities and LGBTQ populations	1. Improve access to and utilization of BH services for high-minority population in CDBG focus area of South Sandusky neighborhood via Conestoga Program by 20% of persons and units of service from baseline to be calculated.	1 (a) Establishment of monthly Conestoga meeting in local church for regular communication 1 (b) Reduce stigma and fear of involuntary hospitalization which historically has been a major concern of residents in African-American Community through awareness and education 1 (c) Engage population in determination of need for CD and BH services 1 (d) Facilitate service access/utilization through the provision of home-based services, linkage through CCA	1 (a) Number residents attending and qualitative description on CCA quarterly Program Report 1(b) Survey data on attitudes/stigma, CCA data 1 (c) Analysis of data collected from residents via survey and other mechanisms in spring of 2014; Focus group in Q3 of FY 15 1 (d) Service and population data in targeted area via MACSIS, quantitative/qualitative data on CCA's quarterly Program Report

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

If the SFY 2014 strengths and challenges section is current, please indicate as such; otherwise, please include updates.

The section in the FY 14 Plan is current with three exceptions:

1) the issues related to CPST limits and Medicaid cost containment efforts and to Erie-Ottawa residents residing in group homes in Lucas County and enrolled in the Medicaid Health Home do not seem to be problematic at this time

2) while the provider network is still a strength, there were some key changes in the local system of care as a result of the acquisition of The Giving Tree in

Ottawa County (the Board's primary provider of adult and youth mental health services, youth alcohol/drug services, and prevention) by Firelands Counseling & Recovery Services (the Board's primary of the same population/ treatment service mix in Erie County, along with providing crisis/emergency services for the system as well as inpatient psychiatric hospitalization) in December 2013. Rather than three agencies, there are now two; that impacts consumer choice and shifted the primary-secondary agency paradigm. The latter half of FY 2014 was focused on transition both within the agency, such as staffing turnover, EMR, policies and procedures, familiarity with existing programs and services offered, and in the community, such as examination and renegotiation of various inter-system programs and MOU's, relationship-building with community gatekeepers and referral sources, changes in the continuum of care and specific services offered.

3) Mention was made in previous plans of the challenges related to the multitude of providers in Ottawa County and the Board and contract-providers' ability to respond to community needs and to create specialized programming in response to requests of the Juvenile and Common Pleas Courts. This issue continues to present some difficulties. For example, both Courts have asked that we provide the Thinking for Change program for adolescents and adults, and have requested that they be gender specific as well as separated by the risk level assigned to offenders. Attempting to do this efficiently is difficult on its own, but their preference is that both Board-providers in Ottawa County have this capacity—and both Courts are working with additional private and/or Medicaid only providers around these same programs as well. Our providers have been willing to meet the identified needs, including obtaining the training and staffing for these groups; however, the fact that the Courts are coordinating with so many different providers results in low group size, inconsistent referrals, and lost productivity. In the past, the agencies have included non-criminal justice involved persons in these cognitive-behavioral groups as clinically appropriate, however there was push-back from the Courts relative to the standards imposed on them. A similar problem with capacity vs. demand exists with the intensive outpatient level of care for alcohol/drug treatment. There are also numerous specialized docket programs in Ottawa County—five or six among the various Courts, which is quite robust for a county of that size. The Board and contract-agencies also work in collaboration with the Courts on these important and beneficial programs, but the amount of "un-billable" time for agencies to send staff to the many team meetings and court hearings is becoming problematic. The $3.5M allocated to Courts as part of the last MBR to support certified specialized docket programs that target participants with drug addiction or dependency was a positive move and hopefully will result in the intended outcome of increased capacity, however this remains to be seen as the funds could also be used to defray a portion of the payroll costs associated with existing court personnel. And either way, it did nothing to help with the challenges facing providers, as community funding to Boards was reduced via the loss of SAPT funds, 507 funds, and Hot Spot funds.

Collaboration

If the SFY 2014 collaboration section is current, please indicate as such; otherwise, please include updates.

As depicted in the SFY 2014 Plan, ongoing involvement, interaction, and collaboration with service and referral agencies and other community partners and stakeholders occur as part of the effort to develop and ensure and efficient and comprehensive system of mental health and alcohol/drug services and supports; maximize resources and minimize duplication of services; and improve consumer outcomes. The partnerships and mutual endeavors described then remain current, and those listed below represent new accomplishments achieved through collaborative efforts with other systems, consumers and/or the

general public.

The Board collaborated with the **Lighthouse Sober Living** in Ottawa County and with **Volunteers of America of Greater Ohio** in Erie County around the submission of two separate grant applications for Recovery Housing, which were awarded by OhioMHAS. Both projects are Level II recovery residences and will initially provide housing for up to four adult males each. The Board has committed funds to each project for a three-year period and will continue to work in partnership with these organizations to bring the projects to fruition.

The Board worked with the **Sandusky Artisans Recovery Community Center** around the organization of the first annual Recovery walk, held in September 2014, and a "Celebrating Recovery" conference (in conjunction with the Ohio Empowerment Coalition) in October. Along with staff and financial support, the E.D. of the MHRB presented at each event.

Staff of the Board and treatment agencies have continued to work with the **Ottawa County Common Pleas Court** around the relatively new specialized docket court program. We are also working to identify and define the eventual role of Certified Peer Supporters relative to drug court participants, and also in relation to the residents of the sober house that is being developed. A monthly probation meeting was established (first one scheduled for December, 2014) in order to address some of the identified issues around communication and to provide a venue for discussion of mutual clients in order to ensure seamless and effective care.

In Erie County, the Board has been participating in the **"Circle of Care",** a task force of sorts comprised of representatives from a variety of county agencies including courts, law enforcement, JFS, commissioners, health department, treatment and recovery support service providers and others focused on addressing the "heroin epidemic" through a coordinated community response and the establishment of inpatient and detox services and recovery support services. The group is working on the design of an evidence-based system of care that will address local/regional needs and that may serve as a blueprint for other underserved locations in Ohio.

Inpatient Hospital Management

If the SFY 2014 inpatient hospital management section is current, please indicate as such; otherwise, please include updates.

INPATIENT PSYCHIATRIC HOSPITALIZATION

Looking at the costs of emergency psychiatric services for fiscal years 13 and 14, the Board spent a total of $530,467 on inpatient psychiatric hospitalization, crisis stabilization, and transportation for 338 persons in crisis in FY 13 for an aggregate cost per client of $1569.43. For FY 14, a total of $514,724 was expended for 322 persons at an aggregate cost per client of $1598.52. These figures do not include other components of the crisis care system such as the hotline. Nor do

they include the Hot Spot funds or clients served through the Juvenile Crisis Project referenced in question #2.

The chart below displays the total costs, number of clients served, and cost per client for Firelands Counseling & Recovery Services and Rescue Mental Health Services, the two agencies with which the Board contracts for these services.

	FY 13			FY 14		
	Total Cost	# Clts	Cost/Client	Total Cost	# Clts	Cost/Client
Firelands	$164,037	75	$2187	$151,951	63	$2412
Rescue (w/o emergency transportation costs)	$331,317.05	263	$1259.76	$325,722	259	$1258
Rescue (with emergency transportation costs)	$366,430	NA	$1393.27	$362,773	NA	$1400.67

Based on an unofficial FY 14 Collaborative Board Bed Day Report of October 8, 2013 comparing the three year bed day rate to FY 14 annualized based on actual bed days YTD, the average bed days per year for FY 10-12 was 2404. Based on 939 days used through 9/30/13, the annualized total for FY 14 would be 3725—1321 over the three year average. Based on this same report for FY 15 of November 24, 2014, the average three year bed day rate for FY 11-13 was 2424. Based on 1309 days used through 10/31/14, the annualized total would be 3884—1461 days over the three year average. While the latter assumes the same rate of use for the remainder of the year, which as we know from the past may very well not be the case, it still appears that the trend is slightly increasing.

Working through the Northwest Collaborative Hot Spot Funding, the Erie-Ottawa, Sandusky-Seneca-Wyandot, and Huron County Boards requested a proposal from Firelands Counseling & Recovery Services (a contract provider serving all six counties) for the development of a Crisis Stabilization Unit (CSU), independently or in conjunction with Rescue Mental Health Services so that access to psychiatric hospital beds in Toledo's private hospitals may continue. The role of a CSU located within this six-county region would be for it to provide stabilization and treatment services to persons who are in psychiatric crises. It would be expected that many of these individuals with mental illnesses and/or addictions could be treated in the CSU and returned to the community without inpatient admissions to the state psychiatric hospital. The more quickly individuals receive treatment, as opposed to being "held" without treatment, the less likely their conditions will worsen. As part of the planning efforts, several options around a CSU as well as around the development of other services to fill existing gaps in care were explored, with the following four remaining under consideration:

1) dedication of space at Rescue's Toledo facility exclusively for residents of the six counties, allowing them to keep more of our referrals if clinically appropriate rather than sending them on to inpatient.

2) provision of funding/space in one of the three board's service areas to locate a CSU

3) tentative plans of Rescue for the provision of detox services
4) possibility of telepsychiatry, especially in our hard to serve areas

A meeting of representatives from Firelands and Rescue and all three boards is planned for December 15th for further discussion.

Innovative Initiatives (Optional)

If the SFY 2014 innovative initiatives section is current, please indicate as such; otherwise, please include updates.

SFY 2014 section is current.

Advocacy (Optional)

If the SFY 2014 advocacy section is current, please indicate as such; otherwise, please include updates.

SFY 2014 section is current.

Open Forum (Optional)

If the SFY 2014 open forum section is current, please indicate as such; otherwise, please provide updates, including plans in SFY 2015 of redirecting resources resulting from Medicaid expansion.

1. Challenges related to the shift in 507 funds from board allocations to MHAS' budget and allocation to the Collaboratives for crisis/residential projects was mentioned in a previous section of this Plan. In many cases, this resulted in a reduction in capacity or a disruption of services and programs supported through 507 funds in FY 14. Plus, the late timing of these allocations, lengthy review and approval process, delay in getting funds to the field for actual expenditure, and the nature of the services targeted by these funds—"bricks and mortar" projects, large-scale, and new (as in didn't exist previously)—pose problems related to development and implementation as well as sustainability. This is further compounded by the announcement that this funding stream will not be part of the MHAS budget at all in SFY 16-17, raising even more questions about the viability and sustainability of these "hot spot" projects.

2. The loss of ~$116,422 in federal SAPT (block grant) treatment and prevention dollars as a result of adjustments by MHAS to realign disbursements with receipt of funds, coupled with the loss of ~$183,578 in ALI 507 funds (redirected from local communities through Boards to MHAS for funding of state and regional priorities as part of MBR) and ~$133,568 in ALI 421 Collaborative/"Hot Spot" project funds for FY 15 resulted in a significant loss of revenue. This translated into a need to reduce the amount contracted for prevention, treatment and recovery support services. At the same time, the availability of additional resources as a result of Medicaid expansion did not happen on the scale or within the timeframe projected by the State. Even during the last quarter of FY 14, providers reported seeing little difference in the number of persons with Medicaid coverage, and there was no decrease in utilization of the FY 14 non-Medicaid contracts—as a matter of fact, in many cases the amount of treatment services provided exceeded allocated funds. Given that, after consultation

with contract agencies, the Board elected not to make even further reductions in treatment service groups based on anticipated "savings" from Medicaid expansion prospectively, as agencies cannot budget on money that does not yet exist. However, as reimbursement for treatment services from Medicaid increases, contracted funds will be redirected to other Board priorities across the system of care.

The Board regularly monitors fund utilization by Service Group (SG), creating monthly reports for the agencies. When warranted, and consistent with locally identified population/service priorities, adjustments among SG's are sometimes made in order to respond to changing needs and/or increased demand for services. As noted above, despite the authorization of Medicaid expansion in January of last year, we did not see a decrease in utilization of funds for clinical services in the latter half of the FY 14 contracts as would be expected had a greater proportion of individuals formerly covered under the Board subsidy become eligible for insurance under the Medicaid program. We are just beginning to realize how Medicaid expansion is impacting our total revenue picture. Firelands, our largest provider, reports that a greater percentage of their patients are now enrolled in Medicaid. This will result in a decrease in the agency's ability to utilize POS funds, and thus a savings for the Board. As an example, the Board has purchased inpatient psychiatric services from Firelands for several years. In the past, the need surpassed the amount of funds allocated for this service, resulting in capped funds and eventually the negotiation of a payment agreement whereby Firelands provides one "free" stay for every two stays reimbursed by the Board. For FY 14, the agency utilized approximately $137,000 of the $200,000 set aside for In Patient stays. For FY 15, the rate of utilization is even lower as more clients are on Medicaid; from July to date, only 6 persons have presented as indigent and some of these may be eligible for Medicaid (see also previous question on Inpatient Hospital Management for more information on crisis/emergency and inpatient services). Still, in looking at both the FY 15 non-Medicaid contract utilization compared to FY 14 for the same time period and at the percentage utilized YTD vs. the contract period, there does not seem to be a significant decrease across the various treatment Service Groups. Given that, and considering the loss of state and federal funds for FY 15, the amount of resources currently available for redirection at this time is minimal. Per the Board's approved General System Program/Budget for FY 15, and to the extent funds are available, the restoration of service capacity for prevention and/or wellness programming and the expansion of peer and consumer-operated services are priorities (see also narrative at the end of question #2 and in #3 regarding additional identified priorities).

In addition, similar to the case regarding lack of sustainability of the 507 funding stream, the uncertainty over the reauthorization of Medicaid expansion presents additional challenges in terms of revenue projection and sustainability of any new funding initiative, as revenue from these sources is neither predictable nor stable. Although the Board's policy relative to values and organizational purpose includes the principle that ***"****Erie-Ottawa will have a community behavioral health care system that is responsive, flexible and outcome-oriented and is based on the changing needs of the communities and the persons experiencing mental health, alcohol and/or drug addiction problems",* the reality is that it takes time, staff, training and other resources to launch new programs, shift focus to different populations, and to build service capacity. Flexibility in funding needs to be balanced with respect for local system stability and development (i.e. from a strategic, long-term or multi-year planning perspective), as well as infrastructure/staffing realities.

Finally, we have several concerns about the "continuum of care" and requirements for boards of alcohol, drug addiction, and mental health services regarding the provision of a full spectrum of treatment services for opioid addiction in their service districts, including a provision for Ohio MHAS to withhold all state funds if a board fails to do so. We were surprised to find no questions in the FY 15 Community Plan regarding this issue, which would have provided valuable information to MHAS in terms of existing capacity for the various services as well as anticipated problems across the state in regard to boards' abilities to meet the requirements, the resultant impact on the current service continuum, and in regard to other statutorily defined and locally identified priorities. Additional issues include concerns about timing and sustainability, and whether and/or what scope and capacity has been considered in regard to the various services

required under the spectrum (i.e. blank # of residential treatment slots per some measure of total population; blank number of recovery residence beds—for males? Females? Both?). As we understand it, not only does this provision earmark funds for a particular service mix and a specific population but does so at the expense of others the Board has responsibility to serve. As reported in the response to question #1, persons presenting for treatment with opioid-related diagnoses represented only 7.9% of total alcohol/drug admissions in FY 14 and 6.2% in FY 15 to date (7/1/14-11/24/14). And this does not take into consideration the ratio of persons receiving services for mental health issues in comparison.

Since state funds are now primarily bundled into ALI 421 Continuum of Care, there really is no separation as to what alcohol/drug and mental health services can be funded (vs. the former many discrete line items such as 408, 505 and such). Furthermore, the legislation really speaks to service capacity for opioid-addicted persons, so a very specific population within the alcohol/drug population. For a board area that lacks many of the services defined as necessary in the legislation—particularly given the fact there are no new funds, but clearly an issue with flat funding or the more likely decrease in resources to local communities—this could require a significant shift in current funds from existing providers/services/populations/local priorities. Given the unknowns and the fact that FY 16 non-Medicaid contracts will be negotiated in the next couple of months, that could be disruptive. Plus, it potentially creates a gap in relation to necessary services to other priority populations, such as individuals with SPMI, creating or exacerbating another problem. The reality of operationalizing this could have serious unintended consequences on service availability to other populations and on the stability of the provider network in some communities.

SIGNATURE PAGE

Community Plan for the Provision of Mental Health and Addiction Services SFY 2015

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

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

_____

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

_____ _____

ADAMHS, ADAS or CMH Board Executive Director Date

_____ _____

ADAMHS, ADAS or CMH Board Chair Date

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