Ohio Department of Mental Health and Addiction Services (OhioMHAS)
2023-2025 Community Assessment and Plan (CAP) Template:

PLAN

Overview
This is the second of three sections in the Community Assessment and Plan (CAP) Template. The Plan section of the CAP Template will serve as the Board's 2023-2025 Community Plan and is designed to be completed by ADAMH Boards and returned to OhioMHAS every three years.

Template

Board name	Mental Health and Recovery for Licking and Knox Counties
Date	

Key

▲	Pre-populated data provided by OhioMHAS
✱	Question that all Boards are required to answer
Optional	Question that Boards may choose to answer, but are not required to answer

1. ✱**Counties.** Please describe how your Community Plan applies to the area served by your Board:
   - ☐ Our Board serves one county
   - ☐ **Our Board serves more than one county, and our Plan covers all counties together**
   - ☐ Our Board serves more than one county, and we have developed a separate Plan for each county. *Repeat each of the sections below for each county and indicate the county.*

2. ✱**Priorities**

Use the findings from the Assessment section of the CAP to guide selection of a strategic set of priorities for your Community Plan. Briefly describe your community's priority strategies, priority populations and priority outcomes using the table below.

You will identify nine priorities total: Seven that are specific to each aspect of the continuum of care (prevention, mental health treatment, substance use disorder (SUD) treatment, Medication-Assisted Treatment (MAT), crisis services, harm reduction and recovery supports) in which one must be focused on youth, and two priorities specific to the required priority populations (pregnant women with SUD and parents with SUD with dependent children). You may also choose to identify collective impact priorities to address the social determinants of health (See table on Page 6). See the table below for additional instructions and an example.

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Instructions				
Identify a priority for each aspect of the continuum of care (each row below)	*Briefly indicate the service, program or policy change you will implement.*	*Indicate which age group(s) the strategy will be designed to reach (choose all that apply):* ☐ Children (ages 0-12) ☐ Adolescents (ages 13-17) ☐ Transition-aged youth (14-25) ☐ Adults (ages 18-64) ☐ Older adults (ages 65+) ***At least 1 strategy must be designed to***	*Indicate which group(s) the strategy will be designed to reach (choose all that apply):* ☐ People with low incomes or low educational attainment ☐ People with a disability ☐ Residents of rural areas ☐ Residents of Appalachian areas ☐ Black residents ☐ Hispanic residents	*Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.* *All indicators must be measurable, specific and have a data source. All indicators must reflect outcomes that are relevant to the selected strategy and age group.*

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
		reach youth (children, adolescents or transition-aged youth)	☐ White residents ☐ Other racial/ ethnic group (specify: ___) ☐ Older adults (ages 65+) ☐ Veterans ☐ Men ☐ Women ☐ LGBTQ+ ☐ Immigrants, refugees or English language learners ☐ People who use injection drugs (IDUs) ☐ People involved in the criminal justice system ☐ General community program ☐ Other, specify: _____	*If data are available, the indicator should be disaggregated for the selected priority population(s) and group(s) experiencing disparities.* *See the standardized indicator list for suggested outcome indicators.*
Example				
Prevention	*Universal school-based suicide awareness and*	✓ *Adolescents (ages 13-17)* ✓ *Transition-aged youth (14-25)*	✓ *Residents of rural areas*	*Youth suicide deaths. (Number of deaths due to suicide for*

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	education program in four school districts		✓ *General community program*	*youth, ages 8-17, per 100,000 population.)*
Prevention	**Family Supports & Other Community Universal Prevention Strategies** To improve overall community mental health by increasing the availability of inclusive, culturally competent and trauma-informed evidenced based family supports & other universal community prevention strategies that foster resiliency and support recovery, promote protective factors, develop greater public awareness, and decrease stigma. The SAMHSA Strategic Prevention Framework (SPF) will be used to	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women • Veterans	Decrease number of poor mental health days per month for adults Licking County – 5.2 poor mental health days per month Knox County – 5.3 poor mental health days per month

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	maintain established local coalitions and partnerships and develop new ones.			
Mental health treatment	**The Public Behavioral Health Workforce** Developing infrastructure and strategies to stabilize and increase workforce recruitment and retention necessary for the provision of effective service delivery including improved access to care and addressing unmet mental health treatment needs	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women • Veterans	Increased ration of population to workers Licking County: 1 provider per 700 = 254 workers Knox County 1 provider per 440 = 139 workers
Substance use disorder treatment	**The Public Behavioral Health Workforce** Developing infrastructure and strategies to stabilize and increase workforce recruitment and retention necessary for the provision of effective	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs)	Increased ration of population to workers Licking County: 1 provider per 700 = 254 workers Knox County 1 provider per 440 = 139 workers

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	service delivery including improved access to care and addressing unmet addiction treatment needs and low retention rates.		• People involved in the criminal justice system • Women • Veterans	
Medication-Assisted Treatment (MAT)	**Evidenced-based Comprehensive Medication Assisted Treatment Services** Promote and develop access to programs that provide SAMHSA evidenced-based Medication Assisted Treatment (MAT) practices that focus on a comprehensive "whole-person' recovery approach in combination with the use of approved medication to treat alcohol and opioid addiction, counseling and behavioral therapies, access to other resources leading to improved	• Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women • Veterans	Unintentional overdose deaths (Number of deaths due to unintentional overdose deaths, ages 14 – 65+, per 100,000 population) <u>Licking County</u> 19 per 100,000 population = 31 <u>Knox County</u> 11 per 100,000 population = 6

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	functioning and life skills, and integration with primary care.			
Crisis services	**Crisis Continuum of Care** Expansion of behavioral health crisis continuum of care including a 24/7 crisis stabilization center, additional BH urgent care units, community navigators, and enhanced mobile crisis response for diversion to appropriate levels of care	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women • Veterans	80% of persons receiving a service on the crisis continuum will be diverted from jail, emergency departments, and other higher levels of care (when appropriate) to other community-based services
Harm reduction	**SUD Community – based Nurse** A full time SUD nurse to provide health education and support to high-risk SUD populations including pregnant women in community-based settings. Services	• Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs)	Unintentional overdose deaths (Number of deaths due to unintentional overdose deaths, ages 14 – 65+, per 100,000 population)

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
	include health education, infectious disease screening, overdose prevention services including naloxone education and distribution and support of other harm reduction strategies, wound care, and linkage to medical and behavioral health care services.		• People involved in the criminal justice system • Women • Veterans	
Recovery supports	**Permanent Supportive Housing Project & Other Housing Planning** Participation in community homelessness/housing planning including the development of a housing project addressing needs of people challenged with mental health and/or addiction issues along with housing challenges.	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64) • Older adults (ages 65+)	• People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women • Veterans	75% of persons receiving services in the network of care will reside in transitional or permanent housing, including scattered site transitional, adult care facilities, recovery housing, permanent supported housing or independent housing with a lease or ownership

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Specify: **Substance Use Disorder Treatment** **Pregnant Women with SUD**	**SUD Community – based Nurse** A full time SUD nurse to provide health education and support to high-risk SUD populations including pregnant women in community-based settings. Services include health education, infectious disease screening, overdose prevention services including naloxone education and distribution and support of other harm reduction strategies, wound care, and linkage to medical and behavioral health care services.	• Transitional-aged youth (aged 14 - 25) • Adults (ages 18 - 64)	***Required: Pregnant women with SUD*** • People with low incomes or low educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women	Number of substance exposed infants (County JFS Reports) Licking County: 21 Knox County: 6
Specify: **Substance Use Disorder Treatment**	**County JFS/CS SUD Family Services –** Provides SUD/MH care coordination to unserved & underserved parents	• Children (ages 0 – 12) • Transitional-aged youth (aged 14 - 25)	***Required: Parents with SUD with dependent children*** • People with low incomes or low	• Number of JFS families served and engaged in care

Continuum of care	Strategy	Age group	Priority populations and groups experiencing disparities	Outcome indicator
Parents with Substance Use Disorder with Dependent Children	who have lost or at risk of losing custody of their children (ages 0 - 17) due to their addiction. Offers advocacy, outreach and engagement with ongoing services including primary and behavioral health care and other recovery supports. Based on the OhioMHAS OhioSTART Model	• Adults (ages 18 - 64) • Older adults (ages 65+)	educational attainment • Residents of rural area • People who use injection drugs (IDUs) • People involved in the criminal justice system • Women	• Number of JFS families served retaining custody Licking County: 110 children in custody due to parental substance use Knox County – 49 children in custody due to parental substance use

3. ***SMART objectives**

SMART objectives are specific, measurable, achievable, realistic and time-bound. Develop at least one SMART objective for each of the priorities in table 2.

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Instructions						
Identify a SMART objective for each priority that you selected	*Fill in the relevant outcome indicator from the priorities table above*	*Identify the data source for the outcome indicator*	*Indicate the year (or other time period) the baseline data was collected*	*Enter the baseline data value for the outcome indicator*	*Indicate the year (or other time period) that you will set a target for to assess progress*	*Enter the data value for the outcome indicator that you aim to achieve, reflecting a*

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
						decrease in a negative outcome or an increase in a positive outcome
Example						
Prevention	*Youth suicide deaths. (Number of deaths due to suicide for youth, ages 8-17, per 100,000 population.)*	*ODH Vital Statistics, accessed through the Public Health Data Warehouse*	*2018*	*4.0*	*2025*	*3.0*
Prevention	Decrease number of poor mental health days per month for adults	County Health Rankings & Road Maps, University of Wisconsin Population Health Institute	2021	Licking County – 5.2 poor mental health days per month Knox County – 5.3 poor mental health days per month	2025	Decrease number of poor mental health days per month for adults Licking County – 2.5 poor mental health days per month Knox County – 2.5 poor mental health

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
						days per month
Mental health treatment	Increased ration of population to workers	County Health Rankings & Road Maps, University of Wisconsin Population Health Institute	2021	Licking County: 1 provider per 700 = 254 workers Knox County 1 provider per 440 = 139 workers	2025	Increased ratio of population to workers Licking County: 1 provider per 350 = 508 workers Knox County 1 provider per 220 = 277 workers
Substance use disorder treatment	Increased ration of population to workers	County Health Rankings & Road Maps, University of Wisconsin Population Health Institute	2021	Licking County: 1 provider per 700 = 254 workers Knox County 1 provider per 440 = 139 workers	2025	Increased ratio of population to workers Licking County: 1 provider per 700 = 254 workers Knox County 1 provider per 440 = 139 workers
Medication-Assisted Treatment (MAT)	Unintentional overdose deaths	ODH, Bureau of Vital Statistics, Violence &	2021	Licking County 38 per 100,000 population = 63	2025	Licking County 19 per 100,000 population = 31

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
	(Number of deaths due to unintentional overdose deaths, ages 14 – 65+, per 100,000 population)	Injury Program, Alcohol and other Drug Indicators, Behavioral Health Data (BHDG)		Knox County 23.3 per 100,000 population = 13		Knox County 11 per 100,000 population = 6
Crisis services	80% of persons receiving a service on the crisis continuum will be diverted from jail, emergency departments, and other higher levels of care (when appropriate) to other community-based services	SFY2022 MHR Board Outcome Measures and Performance Targets Report	2022	Baseline under development. Data only collected for two BH urgent care units by BHP for part of SFY22. Of the 898 persons receiving a BH urgent care service, 893 or 99% were diverted to other community-based services.	2025	80% of persons receiving a service on the crisis continuum will be diverted from jail, emergency departments, and other higher levels of care (when appropriate) to other community-based services
Harm reduction	Unintentional overdose deaths	ODH, Bureau of Vital Statistics,	2021	Licking County	2025	Decrease number of unintentional

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
	(Number of deaths due to unintentional overdose deaths, ages 14 – 65+, per 100,000 population)	Violence & Injury Program, Alcohol and other Drug Indicators, Behavioral Health Data (BHDG)		38 per 100,000 population = 63 <u>Knox County</u> 23.3 per 100,000 population = 13		overdose deaths <u>Licking County</u> 19 per 100,000 population = 31 <u>Knox County</u> 11 per 100,000 population = 6
Recovery supports	75% of persons receiving services in the network of care will reside in transitional or permanent housing, including scattered site transitional, adult care facilities, recovery housing, permanent supported housing or independent	SFY2022 MHR Board Outcome Measures and Performance Targets Report	2022	Baseline under development. The Main Place was the only MHR provider to collect data. Out of 818 unduplicated persons served in SFY22, The Main Place was only able to gather housing information for 380 people. That entire group reported	2025	75% of persons receiving services in the network of care will reside in transitional or permanent housing, including scattered site transitional, adult care facilities, recovery housing, permanent supported housing or independent housing with a

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
	housing with a lease or ownership			residing in either transitional or permanent housing.		lease or ownership
Strategy for pregnant women with SUD	Number of substance exposed infants (County JFS Reports)	County JFS Reports	2021	Licking County: 21 Knox County: 6	2025	Decrease number of substance exposed infants (County JFS Reports) Licking County: 10 Knox County: 3
Strategy for parents with SUD with dependent children	• Number of JFS families served and engaged in care • Number of JFS families served retaining custody	SOR Reports County JFS/CS Reports	2022 – program results 2021 – County JFS Reports	Knox County – 10 families served Program delayed in Licking County due to workforce	2025	Decrease number of children in custody due to parents substance use • Number of JFS families served and engaged in care • Number of JFS families served

Continuum of care	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
						retaining custody Licking County: 55 children in custody due to parental substance use Knox County – 24 children in custody due to parental substance use

4. **Optional: SMART objectives for priority populations and groups experiencing disparities**

To monitor progress toward achieving equity, you can develop SMART objectives using disaggregated data (if available for your community).

Priority population or group experiencing disparities	Outcome indicator	Data source	Baseline year	Baseline	Target year	Target
Instructions						
Indicate the priority population or group experiencing disparities	*Fill in the relevant outcome indicator from the priorities table above*	*Identify the data source for the outcome indicator*	*Indicate the year (or other time period) the baseline data was collected*	*Enter the baseline data value for the outcome indicator*	*Indicate the year (or other time period) that you will set a target for to assess progress*	*Enter the data value for the outcome indicator that you aim to achieve, reflecting a decrease in or*

						elimination of a disparity
Example						
Males	*Youth suicide deaths among males. (Number of deaths due to suicide for males, ages 8-17, per 100,000 population.)*	*ODH Vital Statistics, accessed through the Public Health Data Warehouse*	*2018*	*6.0*	*2025*	*3.0*

Optional: Collective impact to address social determinants of health	**Strategy**	**Key partners**	**Priority populations and groups experiencing disparities**	**Outcome indicator**
Instructions				
Indicate the system (sector other than behavioral health or health care)	*Briefly indicate the service, program, campaign, policy change or initiative you will implement.*	*List the primary organizations involved in implementing this strategy*	*Indicate which group(s) the strategy will be designed to reach (choose all that apply):* ☐ People with low incomes or low educational attainment ☐ People with a disability ☐ Residents of rural areas	*Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.* *All indicators must be measurable, specific and have a data source. All indicators*

			☐ Residents of Appalachian areas ☐ Black residents ☐ Hispanic residents ☐ White residents ☐ Other racial/ ethnic group (specify: ___) ☐ Older adults (ages 65+) ☐ Veterans ☐ Men ☐ Women ☐ LGBTQ+ ☐ Immigrants, refugees or English language learners ☐ Pregnant women with SUD ☐ Parents with SUD with dependent children ☐ People who use injection drugs (IDUs) ☐ People involved in the criminal justice system ☐ General community program Other, specify: _____	*must reflect outcomes that are relevant to the selected strategy.*

Examples				
Housing	*Buckeye County Affordable Housing Initiative (advocacy and planning)*	*Buckeye County Housing Alliance, Legal Aid, YWCA, Children's Hospital Medical-Legal Partnership, United Way*	✓ *People with low incomes or low educational attainment* ✓ *People with a disability*	*Affordable and available housing units (very low income). Number of affordable and available units per 100 renters with income below 50% of Area Median Income (very low income)*
K-12 schools	*Buckeye County Healthy Learners Collaborative (attendance interventions for chronically absent students and school-based health centers)*	*Educational service center, one large urban school district, chamber of commerce, corporate foundations, health systems*	✓ *Black students* ✓ *Hispanic students* ✓ *Students with a disability* ✓ *Economically disadvantaged students*	*Chronic absenteeism (K-12 students). Percent of students, grades K-12, who are chronically absent*
[Open ended]	[Open ended]	[Open ended]	[priority population check boxes]	[Open ended]
[Open ended]	[Open ended]	[Open ended]	[priority population check boxes]	[Open ended]

5. **Family and Children First Councils (FCFC)**
   - ☐ Describe any child service needs resulting from finalized dispute resolution with county FCFC(s) [340.03(A)(1)(c)]
   - ☐ Describe your collaboration with the county FCFC(s) to serve high-need/multi-system youth
   - ☐ Describe your collaboration with the county FCFC(s) to reduce of out-of-home placements (IFAST/MST)

Family and Children First Councils & **Collaborations**

High need/multi-system youth: MHR participates with other key partners including job and family services, children's services, boards of developmental disabilities, and juvenile courts as a pooled funder to serve high-need/multi-system youth (MYS). Pooled Funders contribute funding and other resources to high-fidelity family teams that plan for multi-system youth to support them remaining in the community. Pooled funding also provides access to residential treatment for youth in need of that level of care whose family has no means to pay for that service. MHR provides funds to support JFS/CS staff as high-fidelity family team facilitators and other funds directed at in-home supports including respite, consultation and planning, and home-based intensive treatment. MHR staff participate on a number of related MYS planning groups in both counties that develop plans for families of high-risk children and youth. These include an early childhood clinical committee (ages 0 -5), a children and youth clinical committee (ages 6 – 17), the Engage Committee (young adults ages 18 – 24).

Reducing Out-of-Home Placements: In addition to participation in pooled funding and local multi-system high-fidelity family teams and other home supports, MHR recognizes and supports the efforts of Family First prevention interventions in both counties. This includes The Village Network and National **Youth Advocacy Program (NYAP) who will be providing both counties with FFT and MST respectfully.** MHR has also developed with county JFS/CS family SUD services providing SUD/MH care coordination to unserved and underserved parents wo have lost or are at risk of losing custody of their children (ages 0 – 17) due to their addiction. The program offers advocacy, outreach, and engagement with ongoing services including primary and behavioral health care and other recovery supports.

6. **Hospital services.**
   - ☐ Boards are required to identify how future outpatient treatment/recovery needs are identified for private or state hospital patients who are transitioning back to the community.
   - ☐ Boards are required to identify what challenges, if any, are being experienced in this area. Boards are provided with a dropdown list of potential challenges to choose from.
   - ☐ Boards are required to explain how the Board is attempting to address those challenges.

Hospital Services

Care Management for private or state hospital patients transitioning into the community: Behavioral Healthcare Partners of Central Ohio (BHP) operates as the front door for individuals involved with a provider and those new to the system that are in need of care management and coordination of services following discharge from a private or state hospital. Care management and service coordination includes continuation of prescribed medications, assessment of treatment needs, and assistance with other supports needed at discharge including emergency housing. Discharge coordination may be requested 24/7 though Pathways 211 that operates as the gateway into the local network of care. In addition, BHP

operates behavioral health urgent care units in both counties that offer same day services including medication and nursing services, diagnostic assessment, care management and referral, and brief counseling.

Challenges

- Lack of board capacity to staff a transition-planning liaison – MHR does not have a dedicated transition-planning liaison on staff or offers funding to a provider for this position. This function is incorporated in care management services offered by BHP and supported by the MHR Clinical Director.
- Lack of communication/cooperation from private psychiatric hospital(s) – While many private facilities have worked collaboratively with us in the discharge of patients, at times they may not provide notice of discharge especially if we had no participation in the admission. In many instances, this is due to HIPAA and client choice. Licking Memorial Hospital has the capacity to admit directly to Shepherd Hill or other private hospitals if a person has Medicaid or third party insurance. We may not find out about a discharge until after the patient has returned to the community and is in need of services. At that point, we have the capacity to offer services in a timely manner.
- Lack of access to private psychiatric hospitals – Access to private psychiatric hospital adult beds has greatly improved with the introduction of OhioMHAS TVBH diversion funding. However, there continues to be admissions issues for more challenging cases especially for individuals labeled as exhibiting 'behavioral issues.' This is particularly problematic for children and youth in need for inpatient care. Many of these cases are 'boarded' in emergency departments as they have been determine at risk to self or others and not appropriate to return home or discharged into the community.
- To address the above issues, BHP has initiated the development of a 24/7 crisis stabilization center for children and adults and their families residing in the board's service district. The center will include crisis assessment and safety planning, psychiatric and nursing services, 23-hour observation, short-term crisis residential treatment, family support, and care management. BHP plans to serve individuals presenting with mental health and/or SUD crises. Both area hospitals, Licking Memorial Health Systems (LMH) and Knox Community Hospital, are part of the planning efforts. The center will be built on land donated by LMH.

7. **Optional: Data collection and progress report plan.** Briefly describe plans to evaluate progress on the SMART objectives described above. OhioMHAS encourages Boards to develop a plan that includes data sources, data collection methods, partners involved in evaluation, a data collection timeline and a plan for sharing and using evaluation results.
8. **Optional: Link to the Board's strategic plan.** Insert link(s) to your Board's most recent strategic plan, impact report or other documents that are relevant to your plan.

9. **Optional: Link to other community plans.** Insert link(s) to any local or regional community improvement plans that are relevant to your Board, such as a local health department Community Health Improvement Plan (CHIP) or hospital Community Health Needs Assessment- Implementation Strategy (CHNA-IS).