2015 Levy Fact Book

Presented to the
Franklin County Board of Commissioners
and the
Human Services Levy Review Committee

ADAMH

Alcohol, Drug and Mental Health Board of Franklin County

Treatment Works. Recovery Happens.

adamhfranklin.org

Table of Contents

List of Acronyms

As with any industry or organization, the ADAMH system of care uses several acronyms to describe diagnoses, populations and organizations. Below are a few of the acronyms included in this fact book:

ADAMH: Alcohol, Drug and Mental Health Board of Franklin County

AMI - Any Mental Illness

AOD: Alcohol and Other Drugs

ED: Emergency Department

MAT: Medication Assisted Treatment

MH: Mental Health

OMHAS: Ohio Department of Mental Health and Addiction Services

SAMHSA: Substance Abuse and Mental Health Services Administration

SPMI: Severe and Persistent Mental Illness

See ***Appendix One - List of Acronyms*** for a complete listing of acronyms used in this book.

EXECUTIVE SUMMARY

> "...the programs that ADAMH provides are helping people restore their lives."
>
> ~Aaron J.

The Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County is requesting that the Franklin County Board of Commissioners place a 2.2 mill renewal with a 0.5 mill increase property tax levy for a ten-year period on the November 3, 2015 general election ballot. This is the first time in 24 years that a request for new millage has been made in an effort to maintain the current safety net of services while also addressing the significant unmet behavioral healthcare needs in our community.

The vision statement of ADAMH states:

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

ADAMH actively pursues the actualization of the vision statement, which is evidenced in the aggressive strategic results set by the board of trustees every five years, as well as the operational metrics identified to meet those strategic results in the yearly Managing For Results (MFR) performance plan. ADAMH has effectively managed the levy resources entrusted to us by the taxpayers during the last 10-year levy cycle, amid the most significant divergence in forecasted versus actual planning assumptions in recent history. Below is a summary that highlights these divergences.

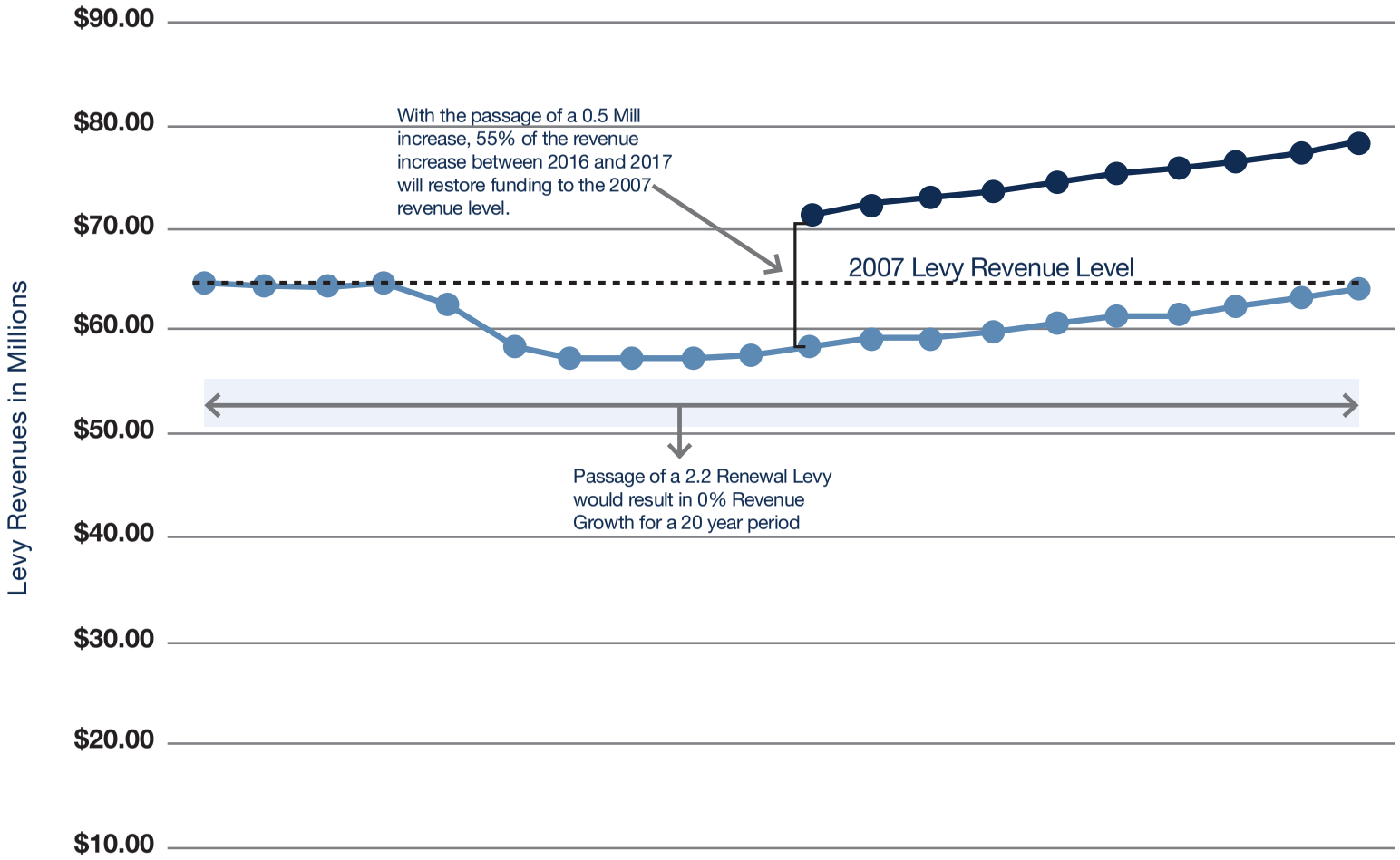
ADAMH is currently operating with a 10-year, 2.2 mill replacement levy that began collections in 2007. The levy passed on November 8, 2005 by a 62.8 percent margin and generated $57.4 million in revenue in 2014. Note that the current collection amount of $57.4 million is $7 million LESS than the actual amount of levy revenues collected in 2007 (amounts not adjusted for inflation). This is a direct result of the devaluation of property values that began during the recession and still remain and the accelerated phase-out of the Tangible Personal Property Tax (TPP), see *Levy Revenue Future* chart (page 2).

ADAMH is requesting that the Franklin County Board of Commissioners place a 2.2 mill renewal with a 0.5 mill increase property tax levy for a ten-year period on the November 3, 2015 general election ballot.

Levy Revenue Future

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Levy Collections Current & Future Levy Cycles



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
2.2 Renewal	$64.40	$64.14	$64.28	$65.04	$62.92	$58.55	$57.73	$57.39	$57.57	$58.14	$58.52	$59.10	$59.68	$60.26	$60.85	$61.45	$62.06	$62.67	$63.28	$63.90
2.2 Renewal +0.5 New											$71.58	$72.29	$73.00	$73.72	$74.45	$75.18	$75.92	$76.67	$77.43	$78.19

It is estimated that the requested 2.2 mill renewal with a 0.5 mill increase property tax levy will generate $71.6 million annually and will cost the owner of a $100,000 house $84.88 annually. This is a net increase of $17.50 per $100,000 valuation.

The lack of expected growth in property values during the current levy cycle requires the use of ADAMH's $52 million budget stabilization reserve from the current levy cycle to finance the system into the next levy cycle. Regardless of the levy type requested, replacement or renewal, it is worth noting that a 10-year levy with no additional millage is not sustainable beyond five years without substantial reductions to community investments.

Medicaid expansion and healthcare reform benefit ADAMH consumers as another payer source, but it is just one component piece of a system of care. ADAMH is responsible, under Section 340 of the Ohio Revised Code (APPENDIX 2 and 3), to provide a full continuum of care that is necessary to move Franklin County residents into recovery and maintain that recovery throughout their lives.

During the five-year period from 2009 to 2013, the ADAMH network served 70,700 consumers, 50 percent of whom were new to the system, demonstrating the relatively short-term dependency on ADAMH services while also demonstrating the ongoing demand for new consumer services.

Calendar Year	2009	2010	2011	2012	2013	Five Year Total
All Consumers	26,992	22,746	23,588	23,297	23,595	70,700
New Consumers	8,176	6,469	7,234	6,760	6,684	35,323

Overall, the penetration rate analysis finds that there are likely a significant number of Franklin County residents who are not getting the help they need.

This analysis is based on the number of residents who received at least one service. It does not address the adequacy of the services received. For this reason, these penetration rate estimates may actually overestimate the extent to which people are getting the help they need (See *Need and Service Levels* section in this fact book for further information about penetration rates, page 13).

With regards to children, the penetration rate implies there is a significant number of youth receiving treatment in Franklin County, it is important to recognize the penetration rate does not include youth who were in need of mental health services but could not obtain care because of long wait times or lack of capacity to provide care (refer to *Youth Mental Health System Challenges* on page 56 of this fact book).

The additional $14 million per year in levy collections from a renewal and small increase of 0.5 mills will allow ADAMH to continue its current service levels, maintain system stability and provide a modest (5%) increase in services for consumers to address the increasing demand for community services not covered by Medicaid or other forms of insurance.

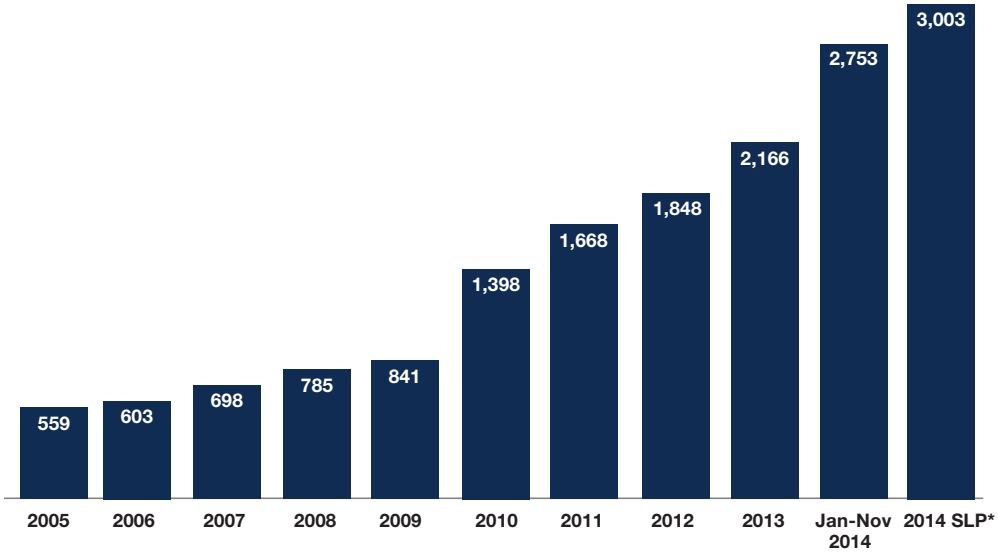
The amount requested will provide a $5.1 million annual **increase** to community investments for the following existing and new community needs:

- **Youth Crisis Care –** During the last few years, ADAMH has been able to implement additional youth crisis programs; however, the demand still exceeds the available services. The Youth Crisis Services Unit (YCSU) at Nationwide Children's Hospital (NCH) continually reports waitlists for youth and families and Netcare regularly goes on divert because there is not capacity to safely care for the number of people seeking services. Furthermore, between 2012 and 2014, there were one to four youth each day in Franklin County hospitals and Psychiatric Emergency Services locations awaiting placement in a mental health bed within the community.

  According to the Governor's introduced biennial budget, the current State Hotspot Funds, which currently assist in funding one crisis bed in Franklin County, will be eliminated. While it is still early in the legislative budget process, if funding is not renewed by the state, ADAMH's current ability to provide five crisis beds, will be in jeopardy. The loss of one crisis bed equates to approximately 121 Franklin County youth who will not have access to a crisis stabilization bed.

A renewal levy with an increase will allow ADAMH to continue working with network providers, like Nationwide Children's Hospital on expanding vital crisis care services.

NCH Psychiatric Emergency Department Visits by Year



Source: Nationwide Children's Hospital
*Straight Line Projection

- **Adult Emergency and Crisis Psychiatric Services** – Since 2008, our community has experienced a chronic issue of patients waiting extended periods for a psychiatric bed in hospital emergency departments (EDs), hospital med-surge/ICU beds, and community crisis intervention facilities. The average length of stay of mental health patients in the EDs waiting for the next level of care placement during 2013-2014 was 20.5 hours. Generally, people without insurance wait twice as long for a psychiatric bed than people with health insurance. The current community protocol developed by the Franklin County Mental Health Bed Board (bed board) to triage the patients with the most acute needs to the scarce in-patient resource is:

  1. Patients waiting the longest for placement in a psychiatric bed are placed in the next available bed, regardless of the facility in which the patient is waiting.

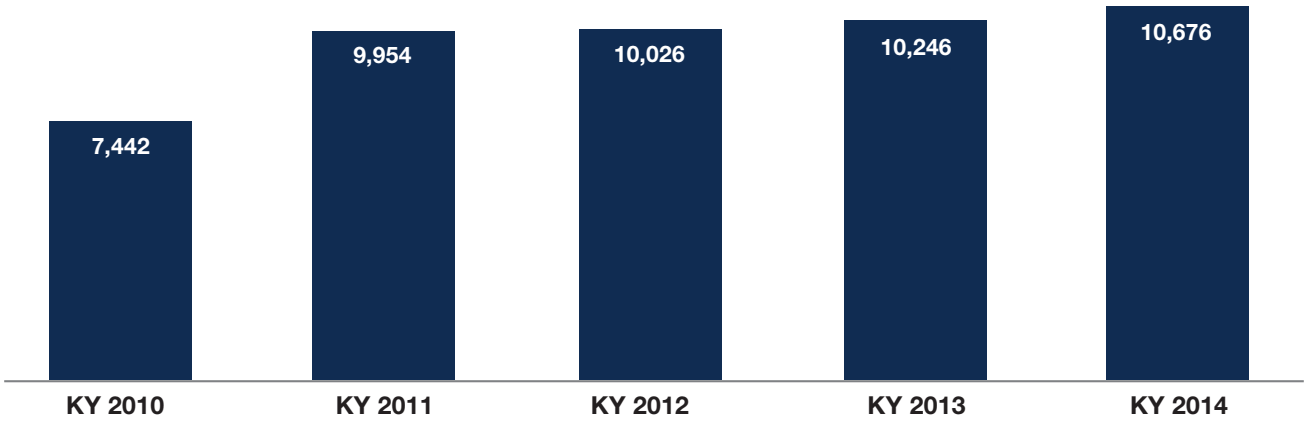
  2. Daily conference calls (365 days a year) are held to place patients into available psych beds and communication takes place throughout the day when a new bed becomes open.

  Due to the significant influx of psychiatric patients in hospital EDs, the bed board group has implemented a "surge" protocol. According to protocol, EDs reaching an unsafe level of mental health patients can declare "surge status." While on surge, patients from that hospital's ED are placed into available psychiatric beds before all others, until the ED returns to a safer environment.

  As a result of this significant community concern, a community task force was created in 2014, chaired by the Central Ohio Hospital Council (COHC); the Central Ohio Trauma System (COTS) and ADAMH. This task force was financially supported by the Columbus Foundation and ADAMH to answer the question: "What is the optimal and doable psychiatric crisis and emergency services system needed in Franklin County?"

A renewal levy with an increase will allow ADAMH to implement agreed upon re-design recommendations from the Community Psychiatric Crisis/Emergency Services Task Force, expected in fall 2015.

Number of Adult Patients in Netcare/EDs Waiting on an Impatient Psychiatric Bed



Source: Central Ohio Hospital Council

- **Permanent Supportive Housing –** The demand for safe and affordable housing in Franklin County continues to be a concern for individuals that are mentally ill and/or dually diagnosed or currently homeless. There are approximately 3,000 individuals, who likely qualify as consumers in the ADAMH system of care, on a waitlist for housing. It is believed that this number considerably understates the issue. In addition to the waitlist referenced, the Community Shelter Board's 2013 Annual Homeless Assessment Report identified 9,809 individuals and children that were served in emergency shelters in Franklin County, a seven percent increase compared to the previous year. Too many individuals discharged from an acute setting have been discharged to a shelter or ended up on the street.

  A renewal levy with an increase will allow ADAMH to increase transitional housing services to address the increased rate of adults being discharged to a shelter or the street from an acute setting (i.e. hospital) and add 25 additional units of Permanent Supportive Housing per year, over the next ten years.

- **Heroin/Opiate and Alcohol and Other Drug (AOD) Addiction Treatment -** The expanded use of new designer drugs and combinations of alcohol and other drugs will continue to grow and challenge the system of care as individuals respond to these drugs differently. Adjusting treatment regimens to meet the changing complexion of the problem will continue to be a challenge. The opiate epidemic continues to be on the rise and since 2009 the number of opiate diagnoses have increased by 64 percent. This opiate epidemic has hit all areas of Franklin County and has provided numerous challenges to suburbs, younger adults and to our system as a whole. The following chart indicates the number of adults who were diagnosed with an opiate use disorder within the ADAMH system.

Number of ADAMH Consumers Diagnosed with an Opiate Disorder Since 2009

Year	2009	2010	2011	2012	2013
# of ADAMH Consumers Diagnosed with an Opiate Disorder	2,398	2,560	3,186	3,277	3,939

Source: ADAMH Claims Data

Routinely, ADAMH's limited detox services are at full capacity, which greatly impacts other crisis care system partners (i.e. Netcare, EDs and local law enforcement). Maryhaven, the largest provider of detox services in Franklin County, reports that they are only able to take phone call screenings for the first 25 people who call in each day. After the 25th call, detox capacity is reached. The phone line opens at 8 a.m. and typically the screenings are completed within 10-15 minutes. As a result, people seeking detox services at local EDs and Netcare causes a backlog while waiting for acute treatment. In 2012, ADAMH expanded Maryhaven's detox by two additional beds, but the demand for this service continues to grow and far exceeds current capacity.

Expanding Medication Assisted Treatment (MAT) options for opiate addiction in our community allows the average length of stay (ALOS) at detox to be reduced so that patients can be stabilized and discharged to treatment in the community. MAT allows for individuals who struggle with opiate dependence to be stable in the community with the help of medication.

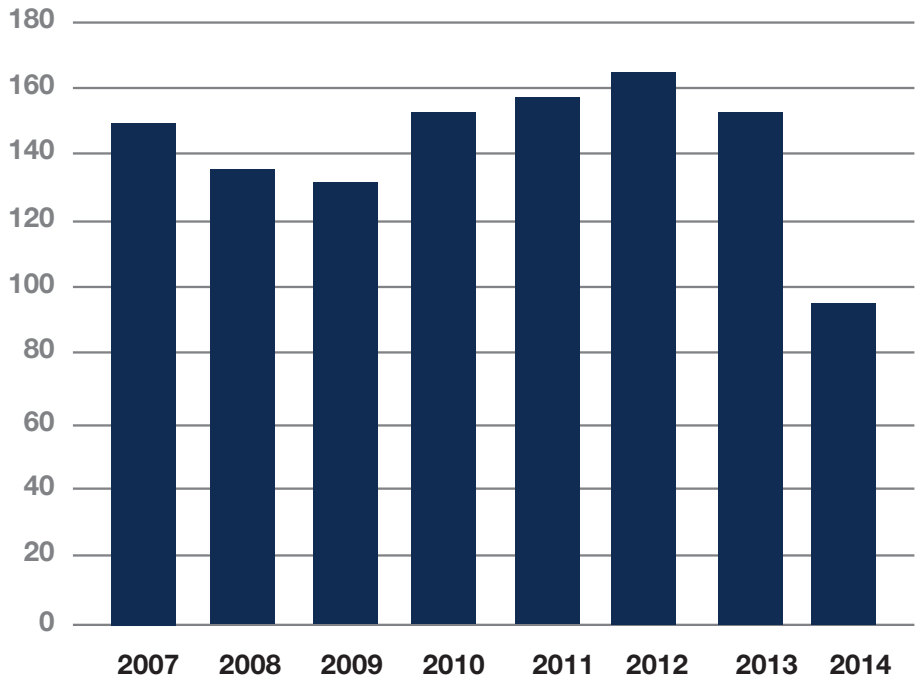
A renewal levy with an increase will allow ADAMH to expand treatment options for MAT and expand new strategies that divert persons with substance abuse disorders from the criminal justice system and into appropriate treatment opportunities (e.g. Family Drug Court, Adult Drug Court, jail) or re-entering from the Department of Rehabilitation and Corrections.

- **Adult Suicide Prevention –** According to the Ohio Suicide Prevention website, Franklin County has a suicide rate of 11.7 per every 100,000 persons and is higher than the national average of 11.5 per every 100,000 persons. Franklin County ranks 38 out of 88 Ohio counties with one being the county with the highest suicide rate. From 2007 to 2013, the average number of adult suicides per year in the county was 153.

  Of the suicides in Franklin County, 79.1 percent are male and the 85 and older age group had the highest suicide rate. What we know is that males, seniors 85 and older, veterans and some refugee communities are areas of concern for being at higher-risk for suicide.

A renewal with levy with an increase will allow ADAMH to develop and expand evidence-based suicide prevention programs for all adults with a focus on outreach to targeted populations.

Number of Franklin County Adult Suicides by Year



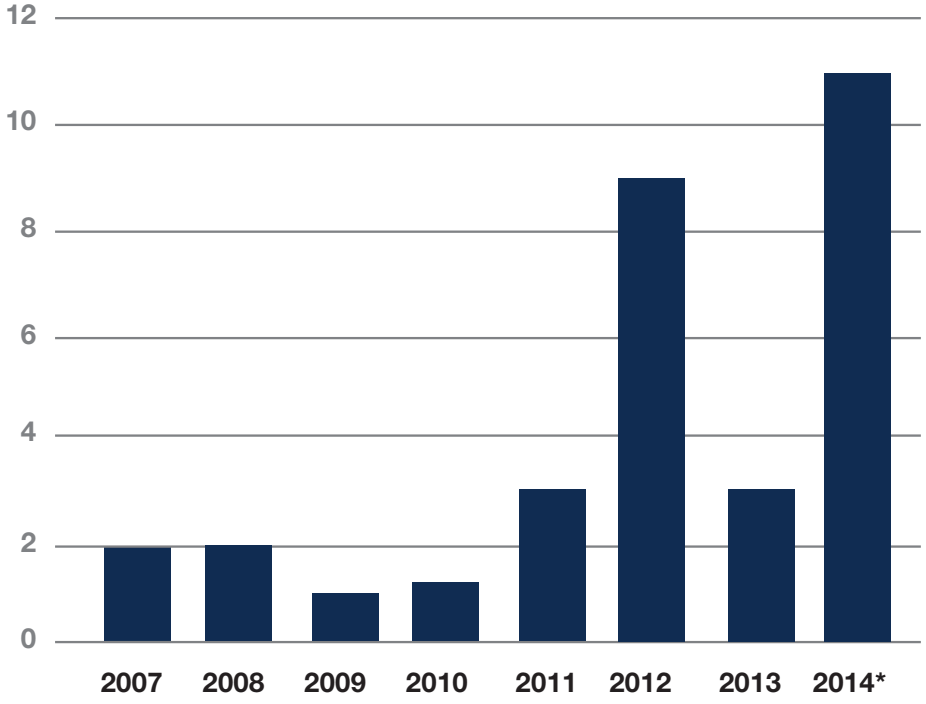
Source: The Columbus Dispatch online edition, September 21, 2014
*Through September 18, 2014

- **Youth Suicide Prevention –** From 2009 to 2014, the Franklin County youth suicide rate has significantly increased. Research indicates that 80 to 90 percent of people who commit suicide have an underlying mental illness and/or drug and alcohol addiction. The state of Ohio responded to these statistics with Anielski's Law, which mandates schools provide suicide awareness training to school personnel. There is still an unmet need for educating parents, youth and communities on recognizing the signs of suicide. One in seven Ohio youth ages 15 to 24 have seriously considered suicide and one in 11 have attempted it. Additional services and evidence-based practices to address depression and suicidal behaviors are desperately needed.

  A Nationwide Children's Hospital report reinforces this urgent need because the Franklin County youth suicide rate exceeds the national average, "additional and more effective safety nets for high risk youth in Franklin County are needed."

A renewal levy with an increase will allow ADAMH to continue working with Franklin County school districts and mental health providers to expand programming and implement more evidence-based suicide prevention programs in additional school buildings.

Number of Franklin County Juvenile Suicides by Year



Source: The Columbus Dispatch online edition, September 21, 2014
*Through September 18, 2014

- **Re-entry Services -** Recently, the Counsel of State Governments Justice Center conducted a review of the interaction between individuals with severe and persistent mental illness and the Franklin County criminal justice system. The preliminary findings of this report indicate that 6,100 ADAMH consumers were booked into the Franklin County jail in 2010. ADAMH consumers stayed an average of 32 days in jail versus 17 days for the general population. ADAMH consumers are also more likely than the general population to be homeless upon their release from jail. It is notable that these numbers are lower than the national averages, but still require a fresh review of how to best address these findings. A report will be issued by early summer with a host of recommendations.

A renewal levy with an increase will allow ADAMH to work with the county jail to establish a liaison program to facilitate linkages and expand community-based services and supports.

While the ADAMH system of care has effectively managed the levy resources entrusted to us for the past 10 years, the current resources will not sustain the current safety net and meet the emerging behavioral healthcare needs of Franklin County. If we simply continue to 'stay the course' and seek a 10-year, 2.2 mill renewal, there will be dramatic reductions to the community behavioral healthcare system in spite of research and trends that indicate emerging needs in our community that are not being met. This situation will only worsen during the next 10 years as Franklin County continues to grow.

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Calendar Years 2022 - 2026 Required Cuts Based on a 10-Year Renewal

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
10-Yr 2.2 Mill Renewal	$67,674,519	$57,557,395	$46,524,470	$34,551,717	$21,614,570	$7,687,917	($7,253,916)	($23,237,177)	($40,288,694)	($58,435,897)
10-Yr 2.2 Mill Renewal with at 0.5 Mill Increase	$75,867,809	$73,979,334	$71,209,837	$67,534,691	$62,928,703	$57,366,106	$50,820,547	$43,265,074	$34,672,123	$25,013,502
5-Yr Renewal then 5-Yr Renewal w/ Cuts	$67,674,519	$57,557,395	$46,524,470	$34,551,717	$21,614,570	$22,679,896	$23,029,881	$22,644,275	$21,502,365	$19,582,963

Note: 10-Year 2.2 Mill Renewal with 0.5 Mill Increase option includes $5.1 million annual increase in community investments.

There is a significant demand for increased adult and youth crisis services, hospitalization services as well as expanded community-based treatment services for the re-entry community. The increased rates of homelessness among adults and families with mental illness and co-occurring addictions require both treatment services, as well as supportive housing in order for individuals to fully recover. Suicide is claiming the lives of more and more adults and children in our community and there is a need to do more about this public health crisis. The opiate and heroin usage is increasing at alarming rates in Franklin County and there is a need for additional strategies to fight this epidemic. With a modest increase, ADAMH will be able to continue its current service levels, maintain system stability and meet the growing needs of our community.

Contact Information:

David A. Royer, Chief Executive Officer
(614) 222-3760
droyer@adamhfranklin.org

OVERVIEW OF THE ALCOHOL, DRUG AND MENTAL HEALTH (ADAMH) BOARD

One in four people will suffer from a mental illness at some point in their lifetime. It could be anyone – me, you, your family member, a close friend or a neighbor. Because mental illness and substance abuse problems can affect anyone, the services funded by ADAMH are important to our entire community.

ADAMH funds services for residents of our community to help them live healthy, productive lives. We do not provide direct service, but instead contract with more than 33 local non-profit organizations located in neighborhoods across Franklin County. These community experts provide quality mental health and substance abuse treatment and prevention services and supportive services like housing, job training and peer supports (support from individuals with similar experiences). The services are provided on a sliding fee scale, meaning that any Franklin County resident can receive needed services and be charged on the basis of income and circumstance.

ADAMH funds programs in our community that change people's lives every day like an elementary school student learning about making good choices and saying no to drugs in a summer camp program, a suburban high school student struggling with an addiction to pain killers, a college student who discovers he has schizophrenia, an adult with a persistent mental illness in need of job training and an older adult dealing with depression.

The ADAMH Board of Trustees is made up of 18 citizen volunteers who provide leadership and direction in forming policy and allocating funds. All are volunteers and come from various walks of life. Board members must be residents of Franklin County and interested in mental health or substance abuse programs. Ten members are appointed by the Franklin County Board of Commissioners and eight by the Ohio Department of Mental Health and Addiction Services (OMHAS).

Over 71% of the ADAMH system's resources come from a single property tax levy approved by voters. The remainder comes from state, federal and grant funding sources. It should be noted that the last time ADAMH asked for any new millage was 24 years ago.

We are requesting a 2.2 mill renewal with a 0.5 mill increase property tax levy for a ten-year period be placed on the November 3, 2015 ballot to both maintain our current level of service and also create or expand programs to address urgent, unmet community needs for: adult and youth crisis care; housing; heroin and opiate addiction; youth and adult suicide prevention and re-entry programs. We believe it is also important for our system to provide prevention services as well as supportive services like housing, job training and peer supports and integrated healthcare services.

> With a modest increase, ADAMH will be able to continue its current service levels, maintain system stability and meet the growing needs of our community.

Mission

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

Vision

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

Core Values

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

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

Collaborations

As emphasized in our Core Values, working in collaboration is essential to meeting the needs of our community. It is especially important since ADAMH does not provide direct service, but we contract with more than 33 local non-profit organizations located in neighborhoods across Franklin County. These community experts provide quality mental health and substance abuse treatment and prevention services and supportive services like housing, job training and peer supports.

2015 ADAMH Providers			
AFRICENTRIC PERSONAL DEVELOPMENT SHOP	COMMUNITY HOUSING NETWORK (CHN)	NAMI FRANKLIN COUNTY	THE P.E.E.R. CENTER
ALVIS HOUSE	COMPDRUG	NATIONAL CHURCH RESIDENCES (NCR)	SCHOTTENSTEIN CHABAD HOUSE
AMETHYST	CONCORD COUNSELING SERVICES	NATIONWIDE CHILDREN'S HOSPITAL (NCH)	SOUTHEAST, INC.
BUCKEYE RANCH	DIRECTIONS FOR YOUTH & FAMILIES	NEIGHBORHOOD HOUSE, INC.	ST. VINCENT FAMILY CENTERS
CHOICES FOR VICTIMS OF DOMESTIC VIOLENCE	HOUSE OF HOPE	NETCARE CORPORATION	SYNTERO
COLUMBUS AREA INTEGRATED HEALTH SERVICES INC.	HUCKLEBERRY HOUSE	NORTH CENTRAL MENTAL HEALTH SERVICES	THE VILLAGE NETWORK
COLUMBUS PUBLIC HEALTH	MARYHAVEN	NORTH COMMUNITY COUNSELING SERVICES	TWIN VALLEY BEHAVIORAL HEALTHCARE - COMMUNITY SUPPORT NETWORK
COLUMBUS URBAN LEAGUE	MENTAL HEALTH AMERICA OF FRANKLIN COUNTY	OHIO STATE UNIVERSITY - TBI NETWORK	UMADAOP OF FRANKLIN COUNTY
COMMUNITY FOR NEW DIRECTION			

In addition to our contract agencies, ADAMH collaborates with other organizations in the community to help meet the needs of our consumers and family members. We often work with our community partners on joint-initiatives to better serve our most in-need residents. This work is above and beyond the work we do through our contract providers. We also work with other community organizations on our projects through specialty contracts. For example, we have a specialty contract with the Franklin County Common Pleas Court for the drug court, a specialty docket for non-violent fourth and fifth felony offenders. The program connects offenders to mandatory treatment for substance abuse and/or co-occurring disorders. Below is a more detailed list of agencies we collaborate with across the city, county and state.

COMMUNITY PARTNERS	RELATIONSHIP
Columbus Metropolitan Housing Authority	Community Partner
Columbus Neighborhood Health Centers	Community Partner
Columbus Police Department	Community Partner
Columbus State Community College	Community Partner
Franklin County Children Services	Community Partner
Franklin County Job and Family Services	Community Partner
Franklin County Court of Common Pleas - Division of Domestic Relations & Juvenile Branch	Community Partner
Franklin County Municipal Courts	Community Partner
Franklin County Reentry Coalition (Formerly Task Force)	Community Partner
Franklin County Urban Coalition	Community Partner
Multiethnic Advocates for Cultural Competence	Community Partner
NAMI Ohio	Community Partner
Ohio Department of Education	Community Partner
Ohio Department of Health	Community Partner
Rebuilding Lives Funder Collaborative	Community Partner
United Way of Central Ohio	Community Partner
Ohio Department of Mental Health & Addiction Services	Funder
Central Ohio Area Agency on Aging	Speciality Contractor
Center for Evidence Based Practices	Speciality Contractor
Community Shelter Board	Speciality Contractor
Educational Service Center	Speciality Contractor
Franklin County Common Pleas Drug Court	Speciality Contractor
Franklin County Family and Children First Council	Speciality Contractor
Franklin County Probate Court	Speciality Contractor
HandsOn Central Ohio	Speciality Contractor
Legal Aid Society of Columbus	Speciality Contractor
Learn4Life	Speciality Contractor
NiSonger	Speciality Contractor
OSU Harding Hospital	Speciality Contractor
OSU Psychiatric Resident	Speciality Contractor

Federal and State Mandates

As authorized by the Ohio Revised Code 340.01 (APPENDIX 2) and 340.03 (APPENDIX 3), ADAMH is making a difference in our community by restoring and improving people's lives through mental health and substance abuse services. ADAMH meets these state mandates by:

- Planning services and programs based on the needs of our community;
- Funding mental health and substance abuse treatment, prevention and recovery support services; and
- Evaluating the quality and effectiveness of the services delivered in our system.

ADAMH Staffing

ADAMH currently employs 47 staff (APPENDIX 4: Table of Organization Chart). Since 2007, the board has continued to decrease the number of staff employed. Below is a table that lists the changes in staffing over the past eight years.

2007 - 2014 Staffing Changes

Year	# of Employees
2007	57
2008	57
2009	53
2010	48
2011	46
2012	47
2013	44
2014	47

To further explain the decrease in staffing, below is a breakdown of some of the positions that have been eliminated:

- Administrative Assistant-Planning Team
- Business System Analyst
- Claims Examiner II
- Claims Examiner II
- Director of Claims Reporting
- Director of Inter Systems
- Director of Quality
- Facilities Coordinator
- Facilities Evaluator
- Mental Health Court Coordinator
- Quality Improvement Specialist

It is important to note that in 2010, the ADAMH Board of Trustees had to pass along some major reductions in funding to our contract agencies. We made a commitment to ADAMH contract agencies that we would also make cuts to our own internal administrative costs to share in the burden. In turn, four employees were laid off.

NEEDS AND SERVICE LEVELS

Overall Community Need

In 2013, ADAMH selected the Health Policy Institute of Ohio and Community Research Partners to conduct *Preparing for the Future: 2014 ADAMH Needs Assessment*, that produced policy-relevant and action-driven information. It is important to note that much of the information included in the levy fact book as it relates to need is pulled directly from this document and hereafter will be referred to as the 2014 Needs Assessment.

2014 Needs Assessment:

1. Outlined Franklin County's trends of addiction and mental illness and pertinent behavioral healthcare needs, and
2. Projected current and near future (next 5-7 years) need for publicly-funded behavioral healthcare treatment, support and prevention/wellness services for uninsured Franklin County residents.

Prevalence of Mental Illness and Substance Abuse/Dependence Conditions

Prevalence refers to the percent of a population who are affected by a condition in a given period of time. Prevalence of behavioral health conditions is typically estimated based on surveys of random samples of the population. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey of Drug Use and Health (NSDUH) is a widely-used source of prevalence data. NSDUH data is reported at the national, state and sub-state level. Within Ohio, NSDUH prevalence estimates are available for larger counties, including Franklin County. This ability to estimate prevalence rates specifically for Franklin County is a major strength of this data source.

There are, however, several limitations to the NSDUH data source as it pertains to this county-level needs assessment. First, SAMHSA only reports the county-level data for certain age groups (18+ and 12+), although estimates for additional age group categories are reported for the national and state-level data. Second, the NSDUH does not provide prevalence estimates for children under age 12. Finally, the county-level data is not reported by race/ethnicity.

The following chart, *Estimated Prevalence of Mental Illness and Substance Abuse in Franklin County* (page 14), displays the best-available prevalence rates. Almost one-quarter of the adult population (24.10% among ages 18+) is estimated to have experienced Any Mental Illness (AMI) in the past year. A smaller proportion, 6.48%, is estimated to have experienced Serious Mental Illness (SMI) in the past year. Dependence or Abuse of Illicit Drugs or Alcohol was estimated to affect 10.88% of Franklin County residents, reported for ages 12+.

County-level prevalence estimates for children are more difficult to obtain. SAMHSA does, however, report state-level NSDUH data for the prevalence of Past-Year Major Depressive Episodes (MDE) for adolescents aged 12-17; 8.9% of Ohio youth were estimated to have experienced an MDE within the past year. An additional source, the Institute of Medicine's (IOM) 2009 report Preventing Mental, Emotional, and Behavioral Disorders Among Young People, provides a general estimate for the percent of young people affected by behavioral health disorders in the U.S. This IOM report estimates that 17 percent of young people have one or more mental, emotional or behavioral disorders, which include unipolar, anxiety, ADHD, disruptive behavior disorders and substance abuse disorders.

"When you do the right things,... you get your life back. I am so blessed to be alive."

– Timothy W.

Estimated Prevalence of Mental Illness and Substance Abuse in Franklin County

Indicator	Age	Prevalence Rate Estimate (percent of population)[1]	Total number of Franklin County residents in age group	Estimated number of Franklin County residents with condition	Year of prevalence rate estimate	Geography of prevalence rate estimate	Source
Adults/ adults and adolescents							
Serious Mental Illness in Past Year (SMI)	**18+**	**6.48%**	910,702	**59,013**	2008, 2009, 2010 (annual average)	Franklin County	SAMHSA: National Survey on Drug use and Health (NSDUH)- Sub-state level
Any Mental Illness in Past Year (AMI)	**18+**	**24.10%**	910,702	**219,479**	2008, 2009, 2010 (annual average)	Franklin County	
Dependence or Abuse of Illicit Drugs or Alcohol in Past Year	**12+**	**10.88%**	993,203	**108,060**	2008, 2009, 2010 (annual average)	Franklin County	
Serious Mental Illness in Past Year (SMI)	**18-25**	**4.10%**	135,672	**5,563**	2012	US	SAMHSA: Results from 2012 NSDUH: Mental Health Findings (national)
Serious Mental Illness in Past Year (SMI)[2]	**26-49**	**5.20%**	438,948	**22,825**	2012	US	
Serious Mental Illness in Past Year (SMI)[2]	**50+**	**3.00%**	336,082	**10,082**	2012	US	
Any Mental Illness in Past Year (AMI)	**18-25**	**19.60%**	135,672	**26,592**	2012	US	
Any Mental Illness in Past Year (AMI)[2]	**26-49**	**21.20%**	438,948	**93,057**	2012	US	
Any Mental Illness in Past Year (AMI)[2]	**50+**	**15.80%**	336,082	**53,101**	2012	US	
Co-occuring disorders							
Among adults with AMI in past year, percent with substance dependance or abuse in past year	**18+**	**19.20%**	910,702	**174,855**	2012	US	SAMHSA: Results from 2012 NSDUH: Mental Health Findings (national)
Among adults with SMI in past year, percent with substance dependance or abuse in past year[2]	**18+**	**27.30%**	910,702	**248,622**	2012	US	
Children							
Past-Year Major Depressive Episode (MDE)[2]	**12-17**	**8.90%**	82,501	**7,343**	2011-2012	Ohio	SAMHSA: Behavioral Health Barometer: Ohio 2013, data from NSDUH
Young people with one or more mental, emotional, and behavioral disorder (includes: unipolar, anxiety, ADHD, disruptive behavior disorders, and substance abuse disorders)	**0-17**	**17.00%**	284,835	**48,422**	meta-analysis reported in 2009	US	Institute of Medicine (IOM)- Preventing mental, emotional, and behavioral disorders among young people (2009)

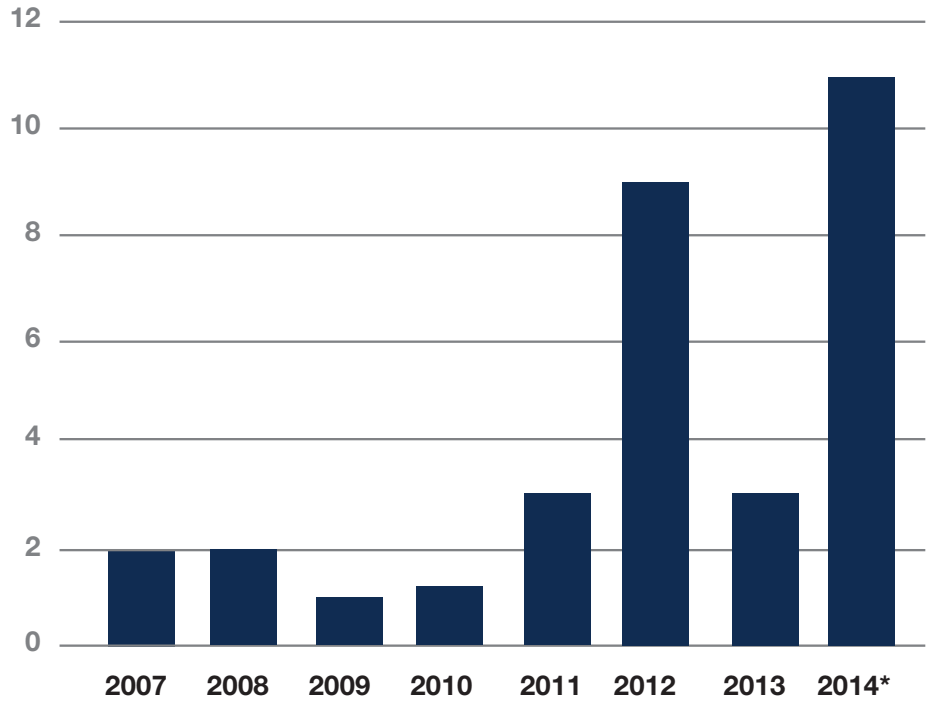
Source for population size: U.S. Census Bureau, American Community Survey, 1-year estimates, 2012

1. The prevalence rates in larger geographies may not be representative of Franklin County. Prevalence rates for the population as a whole may also not be representative of population subsets (e.g., low-income population prevalence is higher for some indicators).
2. We do not have penetration rate information for these indicators.

Prevalence of Suicide

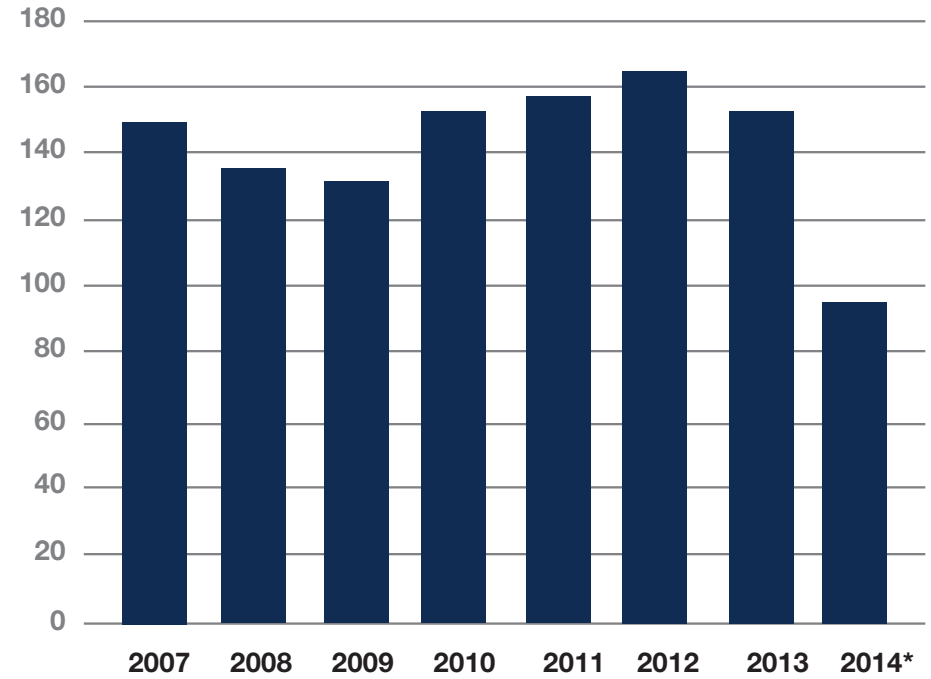
Suicide is a growing public health concern in our community. According to the Ohio Suicide Prevention website, Franklin County has a suicide rate of 11.7 per every 100,000 persons, which is slightly higher than the national average.

Number of Franklin County Juvenile Suicides by Year



Source: The Columbus Dispatch online edition, September 21, 2014
*Through September 18, 2014

Number of Franklin County Adult Suicides by Year



Source: The Columbus Dispatch online edition, September 21, 2014
*Through September 18, 2014

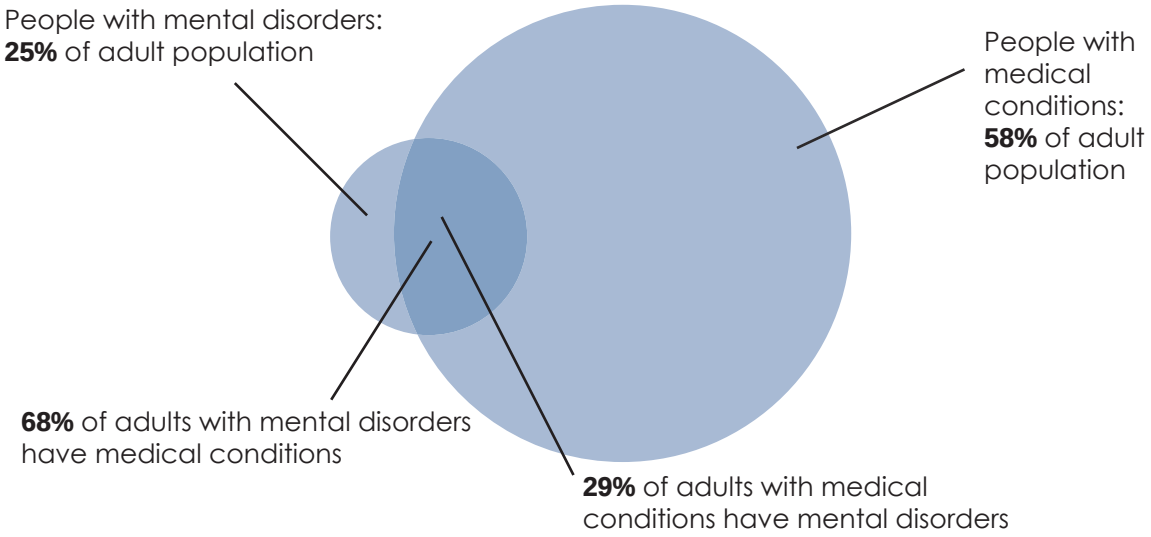
Prevalence of Co-Occurring Disorders

The terms "co-occurring disorders," "co-morbidity" and "dual diagnosis" refer to two disorders or illnesses occurring at the same time for the same person. According to the NSDUH, 19.2% of adults with AMI in the past year also had substance dependence or abuse in the past year. This estimate rises to 27.3% for the percent of adults with SMI in the past year who also had substance dependence or abuse in the past year (*Estimated Prevalence of Mental Illness and Substance Abuse in Franklin County,* page 14).

Prevalence of Co-Morbidity with Medical/Physical Health Conditions

People with behavioral health conditions are also more likely to suffer from medical/physical health problems. As displayed in the figure below, *Percentages of People with Mental Disorders and/or Medical Conditions, 2001-2003*, a national epidemiological survey found a great deal of overlap between the number of adults who have "medical conditions" (such as diabetes, asthma and cardiovascular disease) and those who have "mental disorders," including depression, anxiety disorders, schizophrenia and bipolar disorder. This study found that 68% of adults with mental illness conditions also have at least one physical health condition.

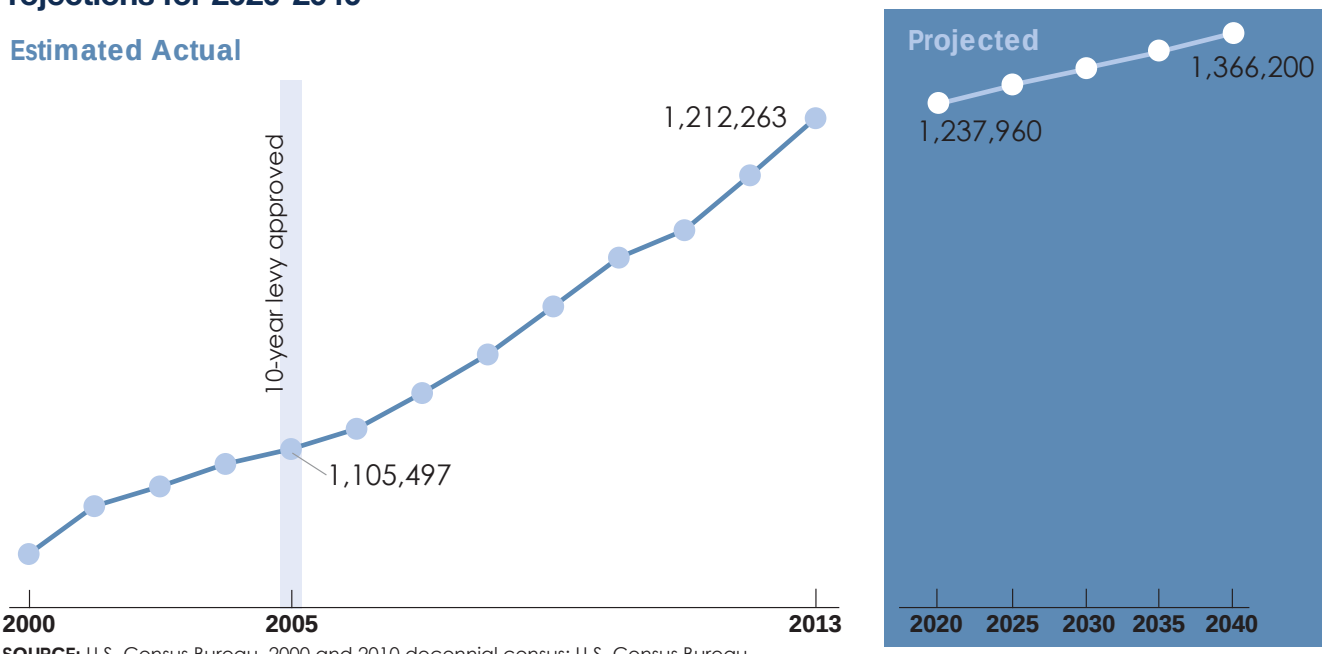
Percentages of People with Mental Disorders and/or Medical Conditions, 2001-2003



Source: Adapted from the National Co-morbidity Survey Replication, 2001-2003 (3, 83), as reported in *Mental Disorders and Medical Co-morbidity,* Robert Wood Johnson Foundation. Research and Synthesis Report No. 21. Feb. 2011.

As the population grows, we expect the needs for mental health to continue to grow. According to the 2014 Needs Assessment, Franklin County's population size has grown steadily from 2000 to 2013. By 2013, Franklin County was home to an estimated 1,212,263 people, making it the second largest county in Ohio. According to projections from the Ohio Development Services Agency, Franklin County's population will continue to grow, reaching an estimated 1,366,200 residents in 2040.

Estimated Population Change of Franklin County: Estimated Actual 2000-2012 and Projections for 2020-2040



SOURCE: U.S. Census Bureau, 2000 and 2010 decennial census; U.S. Census Bureau, intercensal estimates of resident population for counties of Ohio: April 1, 2000 to July 1, 2010; and annual estimates of the resident population, April 1, 2010 to July 1, 2013

Source: Ohio County Population Projections, Ohio Development Services Agency (ODSA), 2013
Note: The ODSA used the 2010 Census the baseline for projecting future population growth.

Size and Composition of the Overall County Population

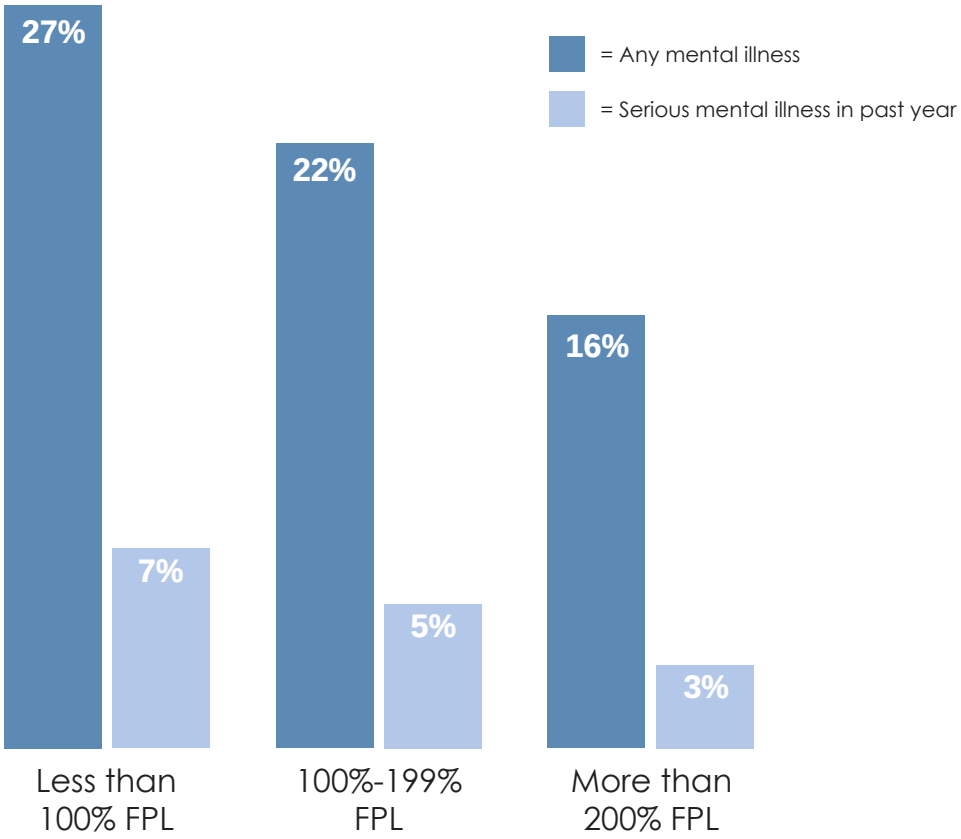
The size of the Franklin County population has grown over the past decade and is projected to continue growing in the coming years. In addition, Franklin County is becoming increasingly diverse and is slightly younger than other Ohio counties.

Differences in prevalence of adult mental illness by gender, race/ethnicity, and poverty level

Women are slightly more likely than men to report that they have a diagnosable mental illness; 22% of women ages 18+ in the U.S. in 2012 and 14.9% of men reported AMI within the past year. Similarly, 4.9% of women and 3.2% of men reported SMI. Among the four most common racial/ethnic groups in Franklin County, white and Black/African-American adults in the U.S. report similar rates of mental illness; 19.3% of whites and 18.6% of Blacks/ African Americans had reported AMI in 2012, while Hispanics/Latinos (16.3%) and Asians (13.9%) reported somewhat lower prevalence (U.S. data). Among these groups, there was very little variability for the prevalence of SMI.

People living in poverty are much more likely than those living above the Federal Poverty Line (FPL) to experience mental illness. According to 2012 U.S. data, 26.8% of those living below the FPL experienced AMI within the past year, compared to only 15.6% of those with incomes of 200% FPL or higher. Similarly, 7.2% of those below 100% FPL experienced SMI, compared to just 3% of those at 200% FPL or higher (see *Prevalence of Mental Illness by Poverty Level*, page 18).

Prevalence of Mental Illness by Poverty Level, 2012 (U.S.)



Source: Results from the 2012 National Survey on Drug Use and Health: Mental health detailed tables

Differences in prevalence of substance dependence or abuse by gender and race/ethnicity

Men are more likely than women to report substance dependence or abuse; 11.5% of males aged 12+ in the U.S. and 5.7% of females reported substance dependence or abuse in the past year (illicit drugs or alcohol). Among the four most common racial/ethnic groups in Franklin County, white (8.7%), Black/African American (8.9%), and Hispanic/Latino (8.8%) residents reported similar levels of dependence/abuse (U.S. data; illicit drugs or alcohol). The prevalence of dependence/abuse in the U.S. was lower for Asians (3.2%).

Current Consumer Demographics

During the five-year period from 2009 to 2013, ADAMH contract agencies served 70,700 consumers with treatment services. Fifty percent of consumers being served were 'new' to the ADAMH system of care, demonstrating the relatively short-term dependency on services while also demonstrating the ongoing demand for new consumer service (Note: This does not include prevention).

The total number of consumers has been consistent over this five-year period as well as the proportion of mental health consumers to addiction consumers, men to women, Medicaid to uninsured and age group distributions. It is worth noting that many ADAMH consumers (17%) receive both mental health and addiction services, known as dual diagnosis consumers.

ADAMH Current Consumer Demographics

Calendar Year	2009	2010	2011	2012	2013	Five Year Total
All Consumers	26,992	22,746	23,588	23,297	23,595	70,700
New Consumers	8,176	6,469	7,234	6,760	6,684	35,323
Addiction Services	9,364	7,625	7,911	7,363	7,528	26,186
Mental Health Services	20,761	17,718	18,541	18,743	19,108	56,668
Female Consumers	11,671	10,021	10,293	10,166	10,132	30,622
Male Consumers	15,315	12,717	13,288	13,120	13,450	40,050
Gender Unknown	6	8	7	11	13	28
Medicaid ADAMH Consumers	6,690	6,701	7,000	6,751	6,235	20,898
Uninsured ADAMH Consumers	21,453	17,119	17,802	17,936	18,658	56,767
Age 0 to 5	106	112	276	240	216	805
Age 6 to 11	876	679	804	789	779	3,117
Age 12 to 14	1,148	976	1,048	1,111	1,109	4,334
Age 15 to 17	1,978	1,747	1,758	1,692	1,708	7,048
Age 18 to 59	21,491	18,127	18,407	18,105	18,370	54,140
Age 60 +	1,756	1,380	1,602	1,653	1,745	4,479
Asian	146	122	138	144	151	447
Black/African American	9,998	8,811	9,030	8,667	8,596	25,639
Multi-Racial	386	371	384	379	375	1,135
Native American/Alaska Native	70	64	62	66	71	205
Native Hawaiian/Other Pacific Islander	39	29	20	16	27	81
Unknown	772	653	797	780	871	2,691
White	15,581	12,696	13,157	13,245	13,505	40,503

Service Level by Agency

Of ADAMH's contract agencies, 26 provide treatment services. In 2013, they provided treatment to 23,591 consumers (*number reflects unduplicated consumer count). As the county's crisis center and system front door, Netcare served the largest number consumers with 8,107. Southeast, Inc. is one of the county's largest comprehensive mental health centers serving 4,013 consumers. Maryhaven is the largest comprehensive alcohol and other addiction treatment centers in the county, which served 2,527. NCH is one of the largest child and adolescent treatment providers serving 1,574 consumers.

2013 Treatment Service Level by Agency

Provider	Consumers Served
AMETHYST	255
BUCKEYE RANCH	305
NATIONWIDE CHILDREN'S HOSPITAL (NCH)	1,574
CHOICES	106
COLUMBUS HEALTH DEPARTMENT	734
COLUMBUS AREA	1,708
COMMUNITY HOUSING NETWORK (CHN)	1,020
COMPDRUG	733
CONCORD	780
COVA	589
DIRECTIONS FOR YOUTH & FAMILIES	464
HOUSE OF HOPE	516
HUCKLEBERRY HOUSE	465
MARYHAVEN	2,527
NATIONAL CHURCH RESIDENCES	125
NEIGHBORHOOD HOUSE	205
NETCARE CORPORATION	8,107
NORTH CENTRAL MENTAL HEALTH	1,968
NORTH COMMUNITY COUNSELING	950
THE P.E.E.R. CENTER	1,362
SOUTHEAST, INC	4,013
ST. VINCENT FAMILY CENTER	190
SYNTERO	1,288
OSU - TBI NETWORK	127
TWIN VALLEY BEHAVIORAL HOSPITAL	199
THE VILLAGE NETWORK	212
GRAND TOTAL	23.591*

Prevention Service Overview by Year

Description	2009	2010	2011	2012	2013	Five Year Total
# of Adults who receive prevention services	17,391	23,226	24,682	21,063	23,661	110,023
*Environmental Prevention - Adult Populations					12,270	12,270
# of Children and Adolescents who receive prevention services	34,070	13,558	15,407	16,215	19,600	98,850
*Environmental Prevention - Youth populations					19,555	19,555

Definition: Environmental prevention strategies focus on creating system-level change. They emphasize a broad approach to prevention, associating substance use behavior with not only personal characteristics, but also with environmental influences such as the rules and regulations of social institutions; media messages; and accessibility of alcohol, tobacco and illicit drugs.

Referral and Access to the System

If a resident is experiencing an active mental health crisis, they can contact Netcare 24 hours a day, seven days a week at (614) 276-CARE (2273) or toll free at 1-888-276-2273.

If someone is seeking a referral or linkage to service, there are two options. They can contact Netcare Access and request an assessment. Netcare will provide a referral to an ADAMH-funded agency OR the individual can contact any ADAMH-funded provider directly. A complete list of providers is located in the ADAMH directory and on our website at adamhfranklin.org. If a person does not have access to the internet and needs a copy of the directory, ADAMH will mail one. Anyone can contact the ADAMH Public Affairs Assistant at (614) 222-3728 to request a copy of the directory or stop by ADAMH at 447 East Broad Street and ask the front desk for one.

If someone is using the shelter system and in need of behavioral health services, they can ask to see a shelter advocate, conveniently located at the shelter, to access a navigator for treatment. Single men and women in need of shelter should call 1-888-474-3587, as the front door to the shelter system, managed by the Community Shelter Board (CSB).

Average Length of Stay (ALOS)

For purposes of this exercise, ADAMH defines an episode of care based on both Medicaid and non-Medicaid paid services. A gap in service (service type) of 120 days or more indicates the end of an episode. Consumer counts are computed-based on the year that an episode ended, i.e., 28,061 consumers had an outpatient episode end during 2009 (refer to *Average Length of Stay* chart, page 23).

The full taxonomy of services (non-prevention) that ADAMH contracts for was grouped into five different “service types.” Crisis services include all of those services provided by Netcare as the county’s primary front door for crisis care. The high volume of consumers coupled with the low ALOS reflects the goal of Netcare services to quickly stabilize and transition the consumer into the most appropriate and least restrictive level of care.

Outpatient services are grouped by all of the typical Medicaid and non-Medicaid covered treatment services. Some of the most commonly delivered services in this category include community psychiatric support therapy (CPST), pharmacological management, individual and group counseling and assessment. The ALOS for this group of services has been relatively consistent over the five years in this sample.

Residential services include those programs where treatment is delivered in a residential setting. These services are typically provided for the system's most acutely in need of care including the severely mentally disabled (SMD) and chronically addicted. This type of care is not designed to necessarily be long-term as is reflected by the relatively brief three-month length of stay. Transitioning these consumers from residential care to an outpatient level of care is a primary goal of the program. Often times it is the provision of housing and community supports that allows for this successful transition.

Supports include a wide range of services and although included in this exercise for informational purposes, this category's average length of stay carries less significance than the other service types. Community supports include, transportation, vocational services, peer supports, family counseling, child care and education.

Housing represents the different types of housing provided by Community Housing Network (CHN) including subsidized housing, and to a lesser degree, temporary housing. CHN provides safe, affordable rental housing linked to support services and rent subsidies for consumers in the ADAMH system of care. A critical part of CHN's mission is connecting consumers to services that support their mental health, recovery from addiction and return to employment.

If we examine the significant number of new consumers who enter the system each year in combination with the ALOS data, the need for ADAMH funding to support services along the entire continuum of care becomes clear. Consumers are effectively transitioned along the continuum of care, as clinically necessary. As their recovery progresses, consumers are wrapped with ADAMH-funded support services and receive follow-up care to continue the recovery process.

Average Length of Stay (ALOS)

Service Type	Crisis		Outpatient		Residential		Supports		Housing	
	Count	ALOS	Count	ALOS	Count	ALOS	Count	ALOS	Count	ALOS
2009	10,508	1	28,061	155	531	95	11,396	47	491	612
2010	9,645	1	25,496	177	534	101	10,082	48	434	547
2011	9,213	1	26,029	165	540	83	11,052	47	624	697
2012	8,663	2	27,249	190	603	96	10,493	54	1,259 (1)*	744
2013	7,992	2	27,299	179	609	91	10,775	62	446	540

*In 2012, there was a planned change in the methodology used to count the number of consumers receiving housing services. This methodological change created a one-year anomaly in the number of episodes that ended in 2012.

Consumer Independence Strategies

It is important to note that recovery occurs via many pathways. According to the 2006 article in the *Psychiatric Rehabilitation Journal*, recovery is person-driven. Self-determination and self-direction are critical for an individual to be empowered to recover. Traditional treatment services such as outpatient counseling, medication management, group counseling and intensive outpatient treatment are only part of what most individuals need to recover and achieve wellness.

According to one of SAMSHA's strategic initiatives, *Recovery Support,* the goal of recovery is exemplified through a life that includes:

***Health**—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;*
***Home**—A stable and safe place to live that supports recovery;*
***Purpose**—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and*
***Community**—Relationships and social networks that provide support, friendship, love, and hope.*

These elements—health, home, purpose, and community—are central to recovery from mental and substance use disorders. An individual's ability to have a successful, satisfying, and healthy life integrated in a community is fostered through the availability of and appropriate use of prevention, health, clinical treatment (including residential treatment if needed), and recovery support services that are culturally appropriate, and directed by persons in recovery (and family members as appropriate). Recovery is also supported by getting and maintaining, as needed, accessible, affordable housing with supportive services; mainstream jobs that pay a living wage; and accessible educational opportunities. Finally, to support recovery, communities should welcome everyone, regardless of condition or disabilities, as full, participating members in every facet of American life.

To recover, people need good health. Research reveals the startling fact that individuals with the most serious mental illnesses and co-occurring disorders die at age 53, on average. They die from treatable medical conditions caused by modifiable risk factors, including smoking, obesity, high blood pressure, and substance use.

To recover, people need a safe, stable place to live. The number of people experiencing homelessness on any given night in the United States is estimated at more than 643,000. Due to the current economic downturn, this number may increase. Approximately 63 percent are individuals, and 37 percent are adults with children. Although Federal, State, and Territorial policies have been successful in beginning to reduce the number of individuals and veterans who are chronically homeless, the number of families that are homeless at any time during a year has increased about 30 percent since 2007.

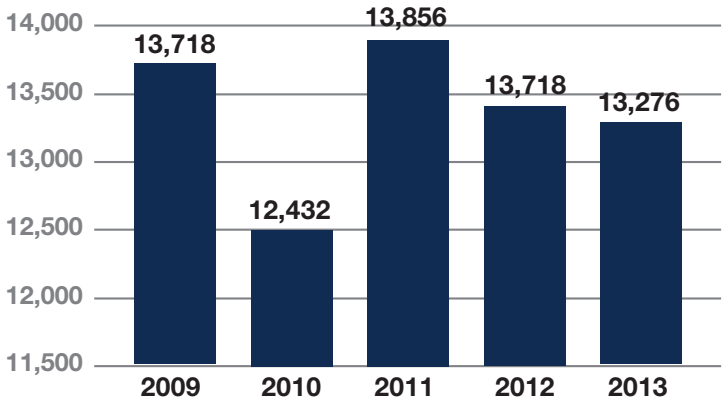
To recover, people need meaningful work and the ability to enhance their skills through education. Employment by its very nature helps integrate individuals in society and acknowledges their ability to contribute. In 2009, unemployed adults were classified with substance dependence or abuse at a higher rate (16.6 percent) than were full- or part-time employed adults (9.6 percent and 11.2 percent, respectively). The income employment produces enables people to improve their living situation, reducing exposure to violence and other stressors that may adversely affect behavioral health.

To recover, individuals need to be full, participating members of their communities. Individuals with behavioral health conditions do not recover in isolation—they recover in families and community. However, living in the community is necessary but not sufficient for individuals with behavioral health disorders to be included fully in society.

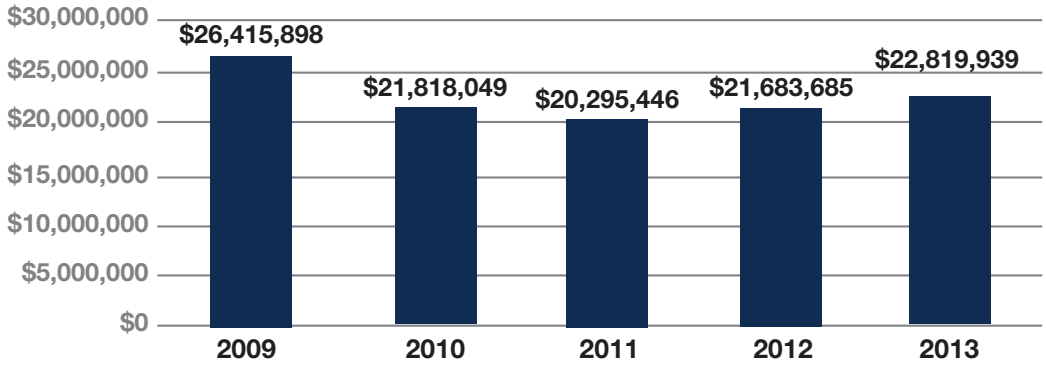
As observers have noted, insufficient natural structures exist in the community to involve persons with mental and substance use disorder in shared social activities, either with peers or with members of the community at large. Mutual support groups play a critical role for many, but there is still an unmet need. A person with a behavioral health condition is as capable of living a full life integrated in a community as anyone else.

Because ADAMH understands that many of the services needed to assist in consumer independence are not covered by Medicaid, we have continued to invest over $113 million during the past five years on supportive services. With the elevation and expansion of Medicaid and the passage of the Affordable Care Act, ADAMH has been able to use local levy resources for an array of support services offered to the consumers and in some cases, family members in our system of care.

Recovery Support Services - Consumers Served



Recovery Support Services - Dollars Spent



Levels of Service

Wait time metrics, such as the average number of days consumers wait for a first or second appointment, can be a valuable way to assess system capacity. ADAMH network providers do not currently collect and compile wait time data in a consistent way that allows for apples-to-apples comparisons across providers or with best-practice benchmarks. It is therefore difficult to pinpoint specific gaps or "bottlenecks" in the accessibility of the existing behavioral health system.

What we know is on average in 2013, only 48 percent of ADAMH consumers discharged from TVBH received psychiatric services within 14 days. In 2013, only 62 percent of consumers discharged from TVBH received an outpatient treatment service within 7 days.

According to survey responses and focus group discussions for the 2014 Needs Assessment:

> *Several providers and consumers were referred to waiting lists or long wait times for behavioral health services and for housing programs. The three largest adult mental health providers, the largest child mental health provider, and the two largest alcohol and other drug treatment providers were asked to provide information about waiting lists and wait times. Among these six providers, only one reported that they maintain an official waiting list.*
>
> *Some providers have adopted new intake procedures that allow for same-day and walk-in visits for first appointments, thereby reducing their use of waiting lists. Others reported that they typically have several consumers waiting for admission into specific programs, although they do not report these numbers as a formal wait list.*
>
> *These providers were asked if they tracked access metrics such as "average number of days consumers wait for a first appointment," "percent of consumers who wait less than/more than 14 days for a first appointment," or other wait time measures. One provider was able to report the average number of days consumers wait for a first appointment for specific service lines. Another provider reported the average number of days for the "third next available appointment." Other organizations shared more anecdotal information about typical wait times.*

Estimated Future Demand for Services

The number of people without insurance in Franklin County is a key driver of demand for ADAMH-funded treatment and support services. Furthermore, the number of Franklin County residents who have insurance (including Medicaid) but still struggle to afford needed services—particularly support services—is also an important driver of demand.

The *Uninsured and Medicaid Enrollment Data Research Questions and Sources* chart, pages 27-29, lists the key questions facing ADAMH regarding the number of residents who continue to be uninsured, including questions about the number of residents who have enrolled in Medicaid via the expansion and the number who have enrolled in the health insurance marketplace. For some of these questions, county-level data is currently available.

For other questions, however, data is not yet available; ADAMH should continue to monitor these research questions as new data become available. The key findings thus far are:

- Although the exact impact of Medicaid expansion and other aspects of the ACA on uninsured rates are not yet known, researchers have projected that the number of non-elderly uninsured people in the city of Columbus will drop 61% from 137,241 prior to the ACA to 54,108 by 2016.
- A significant number of Franklin County residents—67,721—are projected to be newly-eligible for Medicaid in 2014 via the Medicaid expansion.
- Enrollment in Medicaid began December 2013 for coverage starting January 2014. As of July 2014, 42% of the projected number of expansion enrollees has actually enrolled in Medicaid in Franklin County. This enrollment rate is below the statewide enrollment rate of 67% and below the enrollment rates for other comparable large Ohio counties.
- OMHAS estimates that through the first three quarters of calendar 2014, $3.7 million in Medicaid services have been paid on behalf of consumers who would have otherwise had their Medicaid-eligible services paid for by ADAMH. Previous estimates made by the Kasich administration estimated that over $9 million annually would be made available to Franklin County as a result of expansion.

Uninsured and Medicaid Enrollment Data Research Questions and Sources

Research question	Recommended data source *Best available data as of 7/31/14 Underlining indicates hyperlink to source*	Data value	Notes on data limitations and alternative sources
Medicaid expansion			
1. What is the projected number of FC residents eligible for Medicaid expansion?	US Census Small Area Health Insurance Estimate for 2012 (Number of uninsured Ohioans 18-64 years below 138% FPL, by county)	**67,721 eligible** Franklin County Ages 18-64	Data reported in a 7/21/14 e-mail message from the Ohio State Director of Enroll America cites 75,862 Medicaid eligible individuals in Franklin County based on the same 2012 US Census data. The 75,862 number includes ages 0-64, rather than ages 18-64. Alternative projections of the number of FC residents eligible for Medicaid expansion include: • HPIO Medicaid expansion study projection for FC in 2015: 65,655. The sources for this projection were the OSU Impact of Medicaid Expansion on Ohio Model using the 2012 Ohio Medicaid Assessment Survey (OMAS) and data from Milliman's 2011 Medicaid expansion report. • Office of Health Transformation (OHT) projection for FC: 69,663. (From county map updated December 2013. The source for this projection was the 2010 US Census Small Area Health Insurance Estimates.
2. How many FC residents have actually enrolled in Medicaid via the expansion as of June 30, 2014?	Ohio Department of Medicaid, ODM Eligible Clients, July 2014 Medicaid Manged Care Program Membership Report	**28,668 enrolled** Franklin County Ages 18-64	This report from the Ohio Department of Medicaid provides "Medicaid eligible" data by month and by county. It is a point-in-time report and is generated on the last day of the month providing totals for the current month only. Similar data reported by Enroll America or other sources may differ slightly due to when the reports are run.
3. What proportion of the projected number of Medicaid-expansion eligible FC residents have actually enrolled in Medicaid as of June 2014 and how does that enrollment rate compare to Ohio overall and to other large counties?	Calculated using rows 1 and 2 above. US Census Small Area Health Insurance Estimate for 2012 and Ohio Department of Medicaid, ODM Eligible Clients, July 2014 Medicaid Manged Care Program Membership Report	Franklin County: **42.3% enrolled** (28,668/67,721) Hamilton County: 78.4% (28,463/ 36,327) Montgomery County: 67.7% (18,569/ 27,413) Summit County: 75.5% (17,487/ 23,174) Ohio: 66.8% (339,369/ 507,837)	In the initial months of open enrollment, HealthCare.gov was unable to automatically transfer Medicaid applications to states. As a result, many Ohioans who thought they had applied for Medicaid through HealthCare.gov (245,700 in Ohio as of April 2014), did not have their applications transferred for final Medicaid eligibility determinations. When the applications were transferred to Ohio, the sudden influx of cases to county Job and Family Services agencies resulted in a backlog of applications waiting to be processed, especially in larger counties. (Source: Ohio Office of Health Transformation, "Ohio Benefits Update," 4/30/14) For this reason, it is possible that Franklin County's enrollment numbers may significantly increase within the next few months. Similar data reported by Enroll America or other sources may differ slightly due to when the reports are run. Cuyahoga County (56,644/59,415; 95.34%) is not included as a valid comparison for Franklin County. Cuyahoga County's enrollment rate is an outlier because it includes 26,000 individuals who were bulk converted in April 2014 from "early enrollment" status through MetroHealth hospital in Cleveland (part of the MetroHealthcare Plus Medicaid waiver demonstration program) to "newly eligible" status under Ohio's expanded Medicaid program.

Uninsured and Medicaid Enrollment Data Research Questions and Sources (cont.)

4. How many of the FC residents newly enrolled in Medicaid due to expansion were previously uninsured?	Not currently available	NA	
Research question	**Recommended data source**	**Data value**	**Notes on data limitations and alternative sources**
Non-expansion Medicaid			
5. How many FC residents were covered by Medicaid prior to implementation of the ACA (in 2012 or 2013)?	Ohio Department of Job and Family Services, Ohio Medical Assistance Eligibles, June 2013 Medicaid Expenditures and Eligibles Report	**264,534** Franklin County All ages	
6. How many FC residents were previously-eligible but not enrolled in Medicaid? (referred to as the "welcome mat" or "woodwork effect" group)	Not currently available	NA	
Health insurance marketplace			
7. What was the projected number of FC residents eligible for coverage through the marketplace?	Ohio data: Kaiser Marketplace Enrollment as a Share of the Potential Marketplace Population	**812,000 Ohioans** As of 4/19/14	Not currently available at the county level.
8. How many FC residents have actually enrolled in marketplace plans during the 2014 enrollment period?	Ohio data: Profile of ACA coverage expansion enrollment for Medicaid/CHIP and the health insurance marketplace (Through 3/31/14, including special enrollment period activity through 4/19/14)	**154,668 Ohioans** selected a marketplace plan Subsidized: 131,515 Unsubsidized: 23,153	Not currently available at the county level.
	Columbus data: Robert Wood Johnson Foundation (RWJF) and Urban Institute, The ACA and America's Cities: Fewer Uninsured and More Federal Dollars Table 12. Nonelderly population of Columbus by type of insurance/ insurance status with ACA, 2016	**40,661 Columbus residents enrolled** 2016 post-ACA non-group exchange coverage	The RWJF/Urban study used the Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) to estimate the effects of the ACA. "The model uses ACS data from 2009, 2010, and 2011 to obtain representative samples of state populations and their pre-ACA implementation insurance coverage." This study included several large US cities, including Columbus, but did not provide county-level data.

Uninsured and Medicaid Enrollment Data Research Questions and Sources (cont.)

9. What proportion of the projected number of marketplace-eligible FC residents have actually enrolled in a marketplace plan and how does that enrollment rate compare to Ohio overall and to other large counties?	Ohio data: Kaiser Marketplace Enrollment as a Share of the Potential Marketplace Population	**19%** of the potential marketplace population in Ohio have selected a plan (as of 4/19/14)	Not currently available at the county level.
Research question	**Recommended data source**	**Data value**	**Notes on data limitations and alternative sources**
10. How many of the FC residents newly enrolled in Marketplace plans were previously uninsured?	US data: Kaiser, Survey of Non-Group Health Insurance Enrollees	**57%** of Americans who purchased health insurance through the marketplace had been uninsured just prior to obtaining coverage	Not currently available at the county or state level.
Uninsured			
11. How many people were uninsured in FC prior to implementation of the ACA?	US Census Bureau, ACS one-year estimates, 2012	**17,722** Franklin County Ages 0-17 **141,666** Franklin County Ages 18-64	

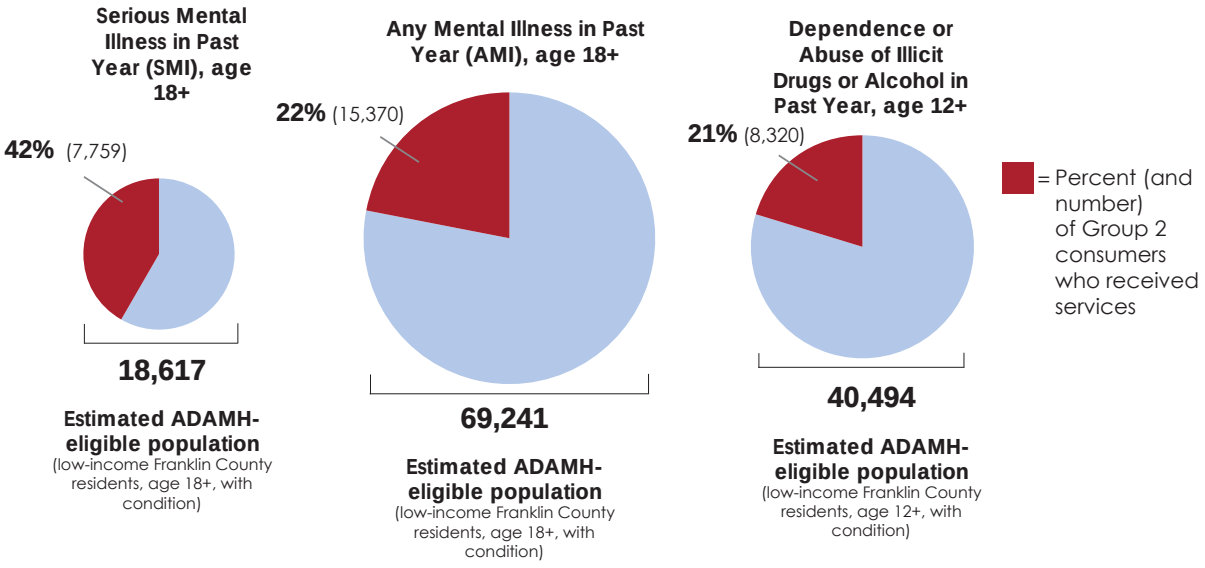
The 2014 Needs Assessment also estimated the penetration rate, the percent of individuals who are in need of services who actually received services.

Penetration rate of ADAMH-paid services

The three figures; Estimated Penetration of ADAMH-Funded Services Among the ADAMH-Elibigle Population (Low-Income Franklin County Residents with Relevant Condition 2012 (pie and data charts), and the Estimated Penetration Rates for Medicaid-Paid and ADAMH-Paid Behavioral Health Services (Group 1 and 2) Among the ADAMH-Eligible Populations) highlight the penetration rate for ADAMH-paid services for three conditions/age groups for which county-level prevalence data (denominator) was available:

- *Serious Mental Illness (SMI), age 18+*
- *Any Mental Illness (AMI), age 18+*
- *Dependence or Abuse of Illicit Drugs or Alcohol, age 12+*

Estimated Penetration of ADAMH-Funded Services Among the ADAMH-Eligible Population (Low-Income Franklin County Residents with Relevant Condition), 2012 (Pie Chart)



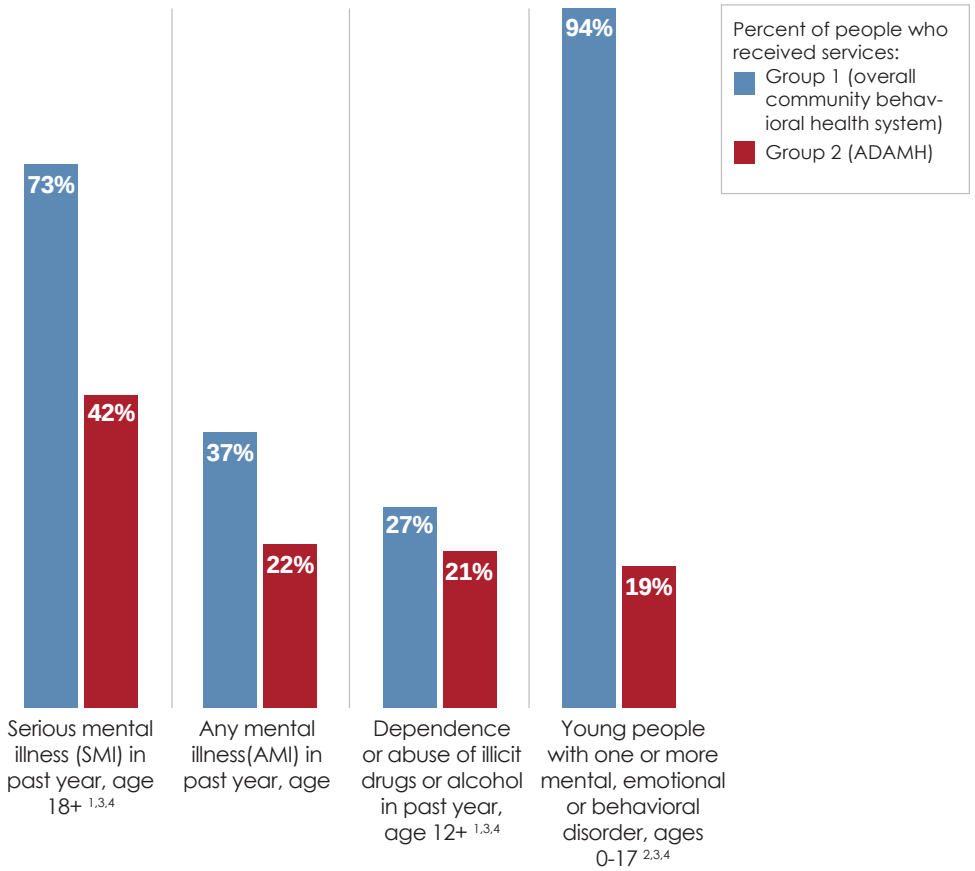
Estimated Penetration of ADAMH-Funded Services Among the ADAMH-Eligible Population (Low-Income Franklin County Residents with Relevant Condition), 2012 (Data Chart)

	Prevalence				Estimated population numbers, by indicator age group		Estimated ADAMH-eligible population			Group 2: Received at least one ADAMH paid service	
										Number Served	Penetration Rate
Indicator	Age	Prevalence Rate Estimate (percent of population)[1]	Year of prevalence rate estimate	Geography of prevalence rate estimate	Estimated total number of Franklin County residents[2]	Estimated number of low-income Franklin County residents (<200% FPL)[2]	Estimated number of Franklin County residents with condition	Estimated percentage of residents with condition who are low-income (<200% FPL)	Estimated ADAMH-eligible population (low-income Franklin County residents with condition)	OMHAS reported total number Franklin County residents served in 2012 (ADAMH Only & ADAMH/ Medicaid)[3] (MH and/ or AOD services depending on prevalence indicator)	Estimated percentage of ADAMH-eligible population with condition who received at least one ADAMH service in 2012
Serious Mental Illness in Past Year (SMI)	18+	6.48%	2008, 2009, 2010 (annual average)	Franklin County	910,702	287,306	59,013	31.55%	18,617	**7,759**	**41.68%**
Any Mental Illness in Past Year (AMI)	18+	24.10%	2008, 2009, 2010 (annual average)	Franklin County	910,702	287,306	219,479	31.55%	69,241	**15,370**	**22.20%**
Dependence or Abuse of Illicit Drugs or Alcohol in Past Year	12+	10.88%	2008, 2009, 2010 (annual average)	Franklin County	993,203	372,184	108,060	37.47%	40,494	**8,320**	**20.55%**
Appendix B spreadsheet column	B	C	D	E	F	G	H	I	J	M	N

Sources

1. SAMHSA: National Surveys on Drug use and Health (NSDUH)- Sub-state level, 2008, 2009, 2010 (annual average)
2. U.S. Census Bureau, American Community Survey, 1-year estimates, 2012.
3. Ohio Mental Health and Addiction Services. Aggregate number of Franklin County consumers who received behavioral health services in county (individuals unduplicated with each year)

Estimated Penetration for Medicaid-Paid and ADAMH-Paid Behavioral Health Services (Groups 1 and 2) Among the ADAMH-Eligible Population



1. **Source for prevalence estimates for Franklin County:** SAMHSA: National Surveys on Drug use and Health (NSDUH)- Sub-state level, 2008, 2009, 2010 (annual average)
2. **Source for prevalence estimates:** Institute of Medicine, Preventing Mental, Emotional and Behavioral Disorders Among Young People, 2009. Note: This is national prevalence data, not Franklin County.
3. **Source for population size:** U.S. Census Bureau, American Community Survey, 1-year estimates, 2012.
4. **Source for number of consumers receiving services:** Ohio Mental Health and Addiction Services. Aggregate number of Franklin County consumers who received behavioral health services in county (individuals unduplicated with each

Mental illness. *Meeting the needs of adults with SMI is a primary state statutory requirement for ADAMH. These results show that ADAMH-paid services were more likely to reach those with SMI (42% penetration rate) than those with AMI (22% penetration rate). However, fewer than half of those with SMI in Franklin County received an ADAMH-paid service in 2012. When those with SMI who only received Medicaid-paid services only are added to the calculation (see Group 1 results in the above figure), the penetration rate is 73 percent. This means that the overall community behavioral health system reached almost three-quarters of the estimated low-income SMI population in 2012.*

Dependence or abuse of illicit drugs or alcohol. *Penetration rates for those with Dependence or Abuse of Illicit Drugs or Alcohol (ages 12+) were lower than the penetration rates for those with mental illness, indicating that there are many people in Franklin County who are not getting needed alcohol and drug treatment services. Only 21% of the estimated number of Franklin County residents with an AOD condition received an ADAMH-paid service in 2012. When those who only received Medicaid-paid services are added to the calculation (see Group 1 results in the above figure), the penetration rate is still only 27%, meaning that the overall community behavioral health system is not reaching almost three-quarters of those in need.*

Overall, this penetration rate analysis finds that there are likely a significant number of Franklin County residents who are not getting the help they need.

Children. *County-level prevalence data for children ages 0-17 with mental, emotional or behavioral disorders comparable to the adult prevalence data were not available. Using a national prevalence estimate from the Institutes of Medicine (IOM), however, it was possible to calculate approximate penetration rates. The key finding from this analysis is that the overall community behavioral health system appears to be reaching most children in need of care (94% received at least one service in 2012). The ADAMH network, by contrast, only reached 19% of the estimated number of children needing behavioral health services. The high number of Medicaid-paid services is the key driver of this higher penetration rate for children, reflecting the historically strong role of Medicaid in covering children.*

While the penetration rate for children implies there is a significant number of youth receiving treatment in Franklin County, it is important to recognize the penetration rate does **NOT i**nclude youth who were in need of mental health services but could not obtain care because of long wait times or lack of capacity to provide care. Given the dramatic increase of youth in crisis, one can deduce the overall need for mental health treatment services is not currently being met.

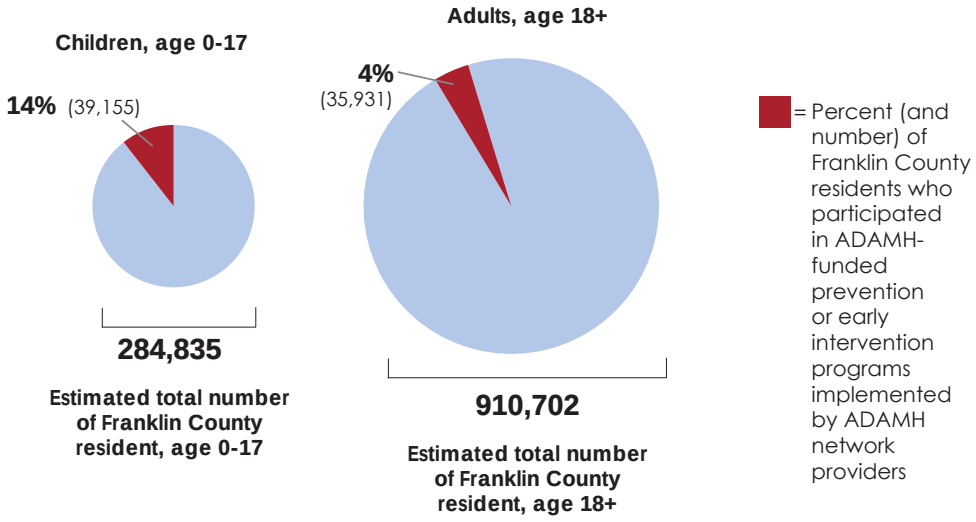
Overall, this penetration rate analysis finds that there are likely a significant number of Franklin County residents who are not getting the help they need. *Adults and those with alcohol or other drug dependence/abuse, in particular, appear to be facing significant unmet needs.*

Furthermore, this analysis is based on the number of residents who received at least one service. It does not address the adequacy of the services received. For this reason, these penetration rate estimates may actually overestimate the extent to which people are getting the help they need.

Penetration of ADAMH-funded prevention programs
Unlike treatment and support services which are for people who are experiencing mental illness or addiction, prevention programs are directed toward the overall community or to groups in the community, such as children in K-12 schools.

The following chart, Estimated Penetration of ADAMH-Funded Prevention and Early Intervention Programs (2013), displays the percent of Franklin County residents who participated in ADAMH-funded prevention or early intervention programs implemented by ADAMH network providers in 2013. More children were reached (14%) compared to adults (4%). These penetration rates are quite low, although challenges with tracking the number of prevention program participants may be a limitation. These results indicate that there are significant opportunities to increase the numbers served by prevention programs in Franklin County.

Estimated Penetration of ADAMH-Funded Prevention and Early Intervention Programs, 2013 Youth Psychiatric Emergency Department Visits by Year



Source for population size by age group: U.S. Census Bureau, American Community Survey, 1-year estimates, 2012.
Source for number of consumers receiving services: ADAMH
Note: Low-income is defined as income less than 200 percent FPL

Future Services Needed by Type

As part of the 2014 Needs Assessment process, the following conclusions were identified in response to the question "Given recent policy changes, what are likely to be the greatest areas of need over the next 5-7 years?:"

Treatment services
Unmet need may continue for some treatment services that are not adequately covered by insurance or are in very short supply, such as:

- *Psychiatry*
- *Culturally-relevant services and trauma-informed care*
- *Intensive services such as Assertive Community Treatment (ACT), Intensive Home-Based Treatment (IHBT), and Multi-Systemic Therapy (MST)*
- *Medication-Assisted Therapy for addiction*
- *Acute intensive services such as peer-based crisis, 23-hour crisis stabilization, and 24/7 crisis hotline.*

Prevention, wellness and recovery supports
Many of the services needed to support wellness and recovery are not covered by insurance. Even if Ohio is able to reach near-universal insurance coverage, a payer source will still be needed for the following activities:

- *Universal prevention programs to reduce the prevalence of mental illness and addiction, such as school-based alcohol and other drug prevention, and social-emotional learning programs.*
- *Early intervention programs for young people at risk of mental, emotional and behavioral disorders; parenting programs; and caregiver support.*
- *Recovery supports that help people to live in the community rather than in institutions, including a continuum of housing options and vocational services (including supported employment, permanent supported housing, therapeutic housing, therapeutic mentoring, respite and supported education).*
- *Recovery supports that help people to improve their quality of life, such as peer support and wellness programs (including recovery support coaching, recovery support center services, supports for self-directed care and continuing care for substance use disorders).*

A 10-Year, 2.2 mill renewal with a 0.5 mill increase property tax levy will maintain both our current level of service and also create new programs to address some of these urgent, unmet community needs. Some programmatic areas include:

- Adult Emergency and Crisis Psychiatric Services
- Youth Crisis Services
- Permanent Supportive Housing
- Heroin/Opiate and AOD Addiction Treatment
- Adult Suicide Prevention
- Youth Suicide Prevention

Below is additional detail about each of these program areas. In addition, please see *ADAMH Adult Services* and *ADAMH Youth Services* charts which highlight our current portfolio of work that will be maintained throughout the next levy cycle (pages 44-49).

Adult Emergency and Crisis Psychiatric Services

Since 2008, the average length of stay for mental health patients in the emergency departments (EDs) waiting for the next level of care placement has been a chronic issue. During 2013-2014, the average time a patient waited for a psychiatric bed was 20.5 hours. ADAMH claims data reflects that 8,867 distinct individuals sought crisis services at Netcare in KY 2013. Netcare's own utilization reports indicate 12,976 total episodes of adult's presenting for crisis care in KY 2013, showing the scope of the need.

As a result of this growing concern, the Franklin County Mental Health Bed Board (bed board) was formed. It is comprised of Franklin County's three adult hospital systems (Mount Carmel Health, OhioHealth and the OSU Wexner Medical Center), Netcare, Twin Valley Behavioral Healthcare, Ohio Hospital for Psychiatry and Dublin Springs. The group follows patterns and daily status of "boarding" mental health patients waiting in EDs or Netcare for the next level of care.

The current community protocol developed by the bed board is:

1. Patients waiting the longest for placement in a psychiatric bed are placed in the next available bed, regardless of the facility in which the patient is waiting and regardless of the facility in which the bed becomes open; and
2. Daily conference calls (365 days a year) are held to place patients into available psych beds, and communication takes place throughout the day when a new bed becomes open. Over the past two years, the volume of patients in Franklin County needing inpatient psychiatric care has skyrocketed.

A review of the data collected by the bed board from May of 2009 through September of 2014 reveals a 5.9 percent annual growth in the number of individuals presenting in an emergency setting who were placed on the bed board to await an inpatient psychiatric bed. While this does not specifically address the total number of people who present in crisis, which is considerably higher as many are able to be appropriately treated in a lower level of care and therefore never make it on to the bed board, it does approximate the increasing trend of individuals presenting in psychiatric crisis.

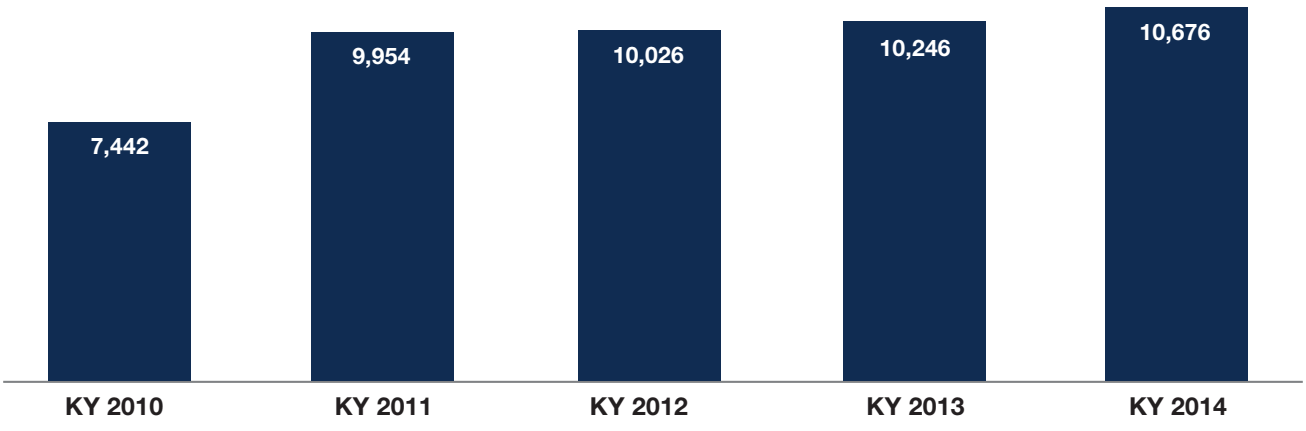
In FY2014, Netcare performed 10,744 evaluations on adults in psychiatric crisis and only 28.2% were placed on the bed board for an inpatient bed indicating that the true number who present to crisis centers in Franklin County is much higher than those that the bed board captures. One possible contributing factor to this increase is the expansion of Medicaid. A January 2014 Science report (*Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment*) found that among new Medicaid beneficiaries in Oregon, use of EDs increased by 40 percent. As Medicaid expansion continues in Franklin County, ADAMH anticipates a continued rise of those seeking crisis care.

ADAMH invested in crisis stabilization beds to address the growing number of individuals who present in crisis. These units provide treatment to individuals who require short-term management of their psychiatric emergency in a structured setting but do not require the level of intensity provided by an inpatient psychiatric unit; for example, the 2014 investment in OSU's Crisis Assessment Linkage and Management (CALM) unit. The CALM unit is an eight-bed psychiatric observation unit designed to move patients in crisis promptly from triage to treatment; avoiding lengthy and often counter-therapeutic ED stays while preserving actual inpatient psychiatric beds for those who are most in need of that level of service.

Strategies to Address Unmet Need

1. ADAMH will work with cross system partners to create the Franklin County Psychiatric Crisis and Emergency Services System Assessment.
   - ADAMH approved $75,000 to help fund a collaboration with The Central Ohio Hospital Council (COHC) and the Central Ohio Trauma System (COTS) with the support of the Columbus Foundation to answer the question: "What is the optimal and doable psychiatric crisis and emergency services system needed in Franklin County?"
2. ADAMH recently expanded the total number of beds available to treat voluntary individuals in psychiatric crisis. The beds provide specialized crisis assessment service with active treatment including individual psychotherapy, medication evaluation, and group therapy. They address short-term issues that destabilized the person while rallying social and clinical supports needed to ensure success in the community.

Number of Adult Patients in Netcare/EDs Waiting on an Impatient Psychiatric Bed



Source: Central Ohio Hospital Council

Youth Crisis Services

In 2013, Netcare responded to 1,221 episodes of crisis for youth ages 0-17. While the number of crisis episodes at Netcare has remained relatively the same from 2007 to 2013, the number of days needed to diffuse these crises has steadily increased. In 2007, the number of days utilized for crisis services were approximately 1,500, and over the course of the years, the number rose to about 2,000 by 2013.

Additionally, Nationwide Children's Hospital (NCH) reports an increase in the amount of youth presenting in its ED in need of psychiatric care. Even as early as 2010, NCH reported an 84 percent increase in the number of patients accessing its ED in need of primary psychiatric care from previous years, see *NCH Psychiatric Emergency Department Visits by Year* chart below. This number does not include youth with a primary medical concern who also received a psychiatric consultation as well. During the same time period, NCH's Crisis Team also reported a 91 percent increase in the number of youth in the community needing crisis intervention.

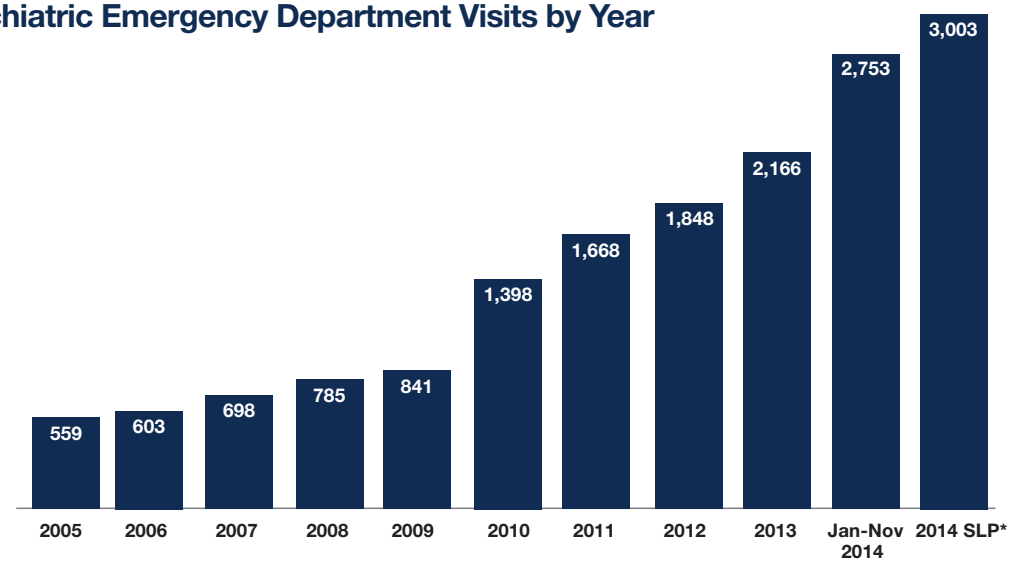
Furthermore, other hospital systems such as OSU has also seen high numbers of youth presenting in their EDs who require psychiatric care. OSU reports that, on average, 1,200 youth per year enter its ED due to psychiatric concerns.

In addition to the number of youth requiring crisis intervention, Franklin County hospital systems are faced with high numbers of youth who are held over in these facilities awaiting placement in a mental health community bed. Between 2012 and 2013, Netcare, OSU, OhioHealth and Mount Caramel Hospitals cared for 2,171 youth until a bed became available. As high as this number is, it does not include the patients at NCH who also resided in the hospital awaiting a community mental health bed.

In response to this dramatic increase in the number of youth requiring crisis care, ADAMH funded the Youth Crisis Stabilization Unit (YCSU) at NCH, behavioral health evaluations in the NCH ED and the CALM Unit at OSU. ADAMH also continued its funding to Netcare for Crisis Assessment/Intervention services and youth psychiatric inpatient hospitalization. The YCSU and the CALM Unit both aim to diffuse crisis situations, stabilize the youth and family and if possible, prevent inpatient hospitalization. However, both often have waitlists of youth needing services.

As the number of youth in crisis in Franklin County increases, additional resources and programming are necessary to meet this need. Over the last few years, ADAMH has been able to implement additional youth crisis programs. However, the demand still exceeds the available services. The YCSU continually reports waitlists for youth and families and Netcare also has had to go on divert because they did not have the capacity to safely care for the number of people seeking services. Furthermore, between 2012 and 2014, there were one to four youth each day in Franklin County hospitals, including OhioHealth, Mount Carmel and OSU, and Psychiatric Emergency Services locations such as Netcare awaiting placement in a mental health bed within the community.

NCH Psychiatric Emergency Department Visits by Year



Source: Nationwide Children's Hospital
*Straight Line Projection

Youth crisis beds are partially funded by state hotspot funds. If state funds are reduced, Franklin County's ability to provide these needed beds will be reduced. These reductions will further limit Franklin County's ability to serve youth in crisis. The loss of one crisis bed equates to approximately 121 Franklin County youth who will not have access to the crisis stabilization beds. In the midst of a growing number of youth who require such access and the uncertainty of state dollars, ADAMH funds will be vital in making sure crisis beds are available to the community to meet the demand.

Strategies to Address Unmet Need

1. ADAMH will ensure adequate services are available within the community to meet the needs of this population by expanding youth crisis intervention services.
2. ADAMH will continue to assess the need and current capacity and explore evidence-based practices that are directed at this population to find innovative treatment options for the community.
3. ADAMH will continue to promote and develop cross systems partnerships as we address this matter.

Permanent Supportive Housing

The ADAMH mental health housing portfolio includes 972 units of housing including transitional housing and residential care facilities (see *ADAMH Mental Health and AOD Housing Continuum chart*, page 38). Most of the units are owned and managed by Community Housing Network (CHN). Other housing owners are National Church Residences and Columbus Metropolitan Housing Authority. In general, the units are located in areas of Franklin County where housing is affordable; there is access to public transportation, stores and employment opportunities; and are within reasonable distances to service providers. The ADAMH AOD housing portfolio also includes 304 units of housing including residential housing and levels II & III recovery residences.

To meet the needs of the current consumers receiving ADAMH services, ADAMH would need to triple its current housing portfolio. Although this would be unrealistic, it is important to understand the magnitude of the problem.

Studies show that supportive housing programs reduce cost to the community and improve outcomes for the consumer. Several studies have indicated cost savings of between $21,000 and $29,000 per person, per year.

- A study done by the Massachusetts' Home and Healthy for Good Program showed the community cost of individuals one year prior to entering supportive housing was $33,190. After one year in the program, the total per person costs for the same services fell to $8,603.
- ADAMH conducted an analysis in 2011 with two 24/7 Supportive Housing programs (Briggsdale & Southpoint) to evaluate the cost for the period of up to two years prior to moving into supportive housing compared to the period while they were in housing. The average treatment costs per person, per year decreased from an average of $34,986 before move-in to $14,028 after move-in, a 60% reduction.
- According to the 2010-2011 NSDUH, longitudinal studies of peer-run recovery homes have shown that after 24 months, when compared to individuals who returned to their communities of origin after treatment, peer-run housing residents had significantly better outcomes, including: decreased substance use, decreased rates of incarceration and increased income (Jason et al., 2007a; Jason et al., 2006). In addition to the positive recovery outcomes indicated by research, studies attempting to calculate the economic costs and benefits of establishing recovery homes have overwhelmingly found that the benefits far outweigh the costs. For example, researchers have documented cost savings of $29,000 per person, when comparing residency in a peer-run recovery home to returning to a community without recovery supports. This factors in the cost of substance use, illegal activity and incarceration that might occur (Lo Sasso et al., 2012).

ADAMH Mental Health and AOD Housing Continuum

HOUSING CONTINUUM							
RESIDENTIAL CARE FACILITIES		24/7 SUPPORTED HOUSING		SERVICE ENRICHED HOUSING		INDEPENDENT HOUSING	
MENTAL HEALTH HOUSING							
RESIDENTIAL CARE	**Beds**	**SUPPORTIVE**	**Units**	**SERVICE ENRICHED**	**Units**	**INDEPENDENT**	**Units**
#1 Courtright	5	Briggsdale	10	Dogwood	40	Scattered Sites	627
#2 E. 4th St.	5	Southpoint	34	E Broad St	33		
#4 20th St.	5	Inglewood	15				
#5 Kellner	5	Commons at Buckingham	23				
Denbeigh	4	Commons at Third	15	*Future Development*			
Honeytree	4	Commons at Grant	14	*Hawthorn Grove (2015)*	40		
Sharon/Waters	4	Commons at Livingston	3				
Woodsfield	4	Franklin Station	25				
York/Bob Fay	4	Safe Haven	13				
Kendall	11	Wilson	8				
Redmond	15						
Carpenter	8			*Transitional Housing*			
Norwich	11	*Future Development*		YMCA	15		
Fowler (Dual Diagnosis)	10	*Van Buren Village (2015)*	40	YWCA	2		
TOTAL	**95**	**TOTAL**	**200**	**TOTAL**	**130**	**TOTAL**	**627**
ALCOHOL & OTHER DRUG (AOD) HOUSING							
LEVEL IV	**Beds**	**LEVEL III**	**Units**	**LEVEL II**	**Units**	**LEVEL I**	**Units**
Maryhaven Detox	24	Amethyst	140	House of Hope	26		
Maryhaven Womens	34	Alvis House	15	(Recovery Residences)			
Dan Cannon Hall	20						
Bell ATC	16			*Future Development*			
Bell ReEntry	9			*Rhoads House (2015)*	5		
House of Hope Dennison	16			*Belmar House (2015)*	5		
TOTAL	**119**	**TOTAL**	**155**	**TOTAL**	**36**		

The need for safe and affordable housing in Franklin County continues to be a concern. Currently, there are approximately 3,000 individuals, who likely qualify as consumers in the ADAMH system of care, on multiple waitlists for subsidized housing. It is believed that this number is considerably understated as evidenced by the following:

- Columbus Metropolitan Housing Authority (CMHA) reports there are 1,403 applicants on a waitlist for a Home Choice Voucher (HCV). This waitlist has been closed since 2008.
- CHN is a not-for-profit corporation whose mission is to provide safe affordable rental housing and linkage to supportive services for people with disabilities and other special needs such as homelessness. CHN currently has 1,412 individuals on their waitlist.
- The Unified Supportive Housing System (USHS) is a collaborative effort between CSB, Columbus Metropolitan Housing Authority and ADAMH created to provide a single point of entry to access permanent supportive housing for disabled, homeless and other at-risk individual and families with children. Currently, USHS has 60 applications on file for individuals waiting on an apartment.

In addition to the above waitlist, CSB's 2013 Annual Homeless Assessment Report identified 9,809 individuals and children were served in emergency shelters in Franklin County, a seven percent increase compared to the previous year.

Recovery Housing, also known as sober housing, is for individuals who desire to live in an environment that is free from the use of alcohol and other drugs. In 2013, an environmental scan was conducted of Recovery Housing in the state of Ohio. The purpose of the environmental scan was to document current status, needs, opportunities and challenges for expanding recovery housing approaches throughout Ohio. Inventories of recovery housing providers are informal at best and often non-existent, creating challenges in making referrals and monitoring program quality. Stakeholders at one program described this need as "almost limitless, there's a need for ten times the amount of housing than we have."

Strategies to Address the Unmet Need

Emphasis will be placed on the development of housing models appropriate for: individuals discharged from residential care facilities that need extra supportive services; individuals being discharged from the State Psychiatric Hospital that need temporary housing to prevent them from entering the shelter system and; individuals with a history of AOD addictions who desire to live in an abstinence-based, sobriety-focused environment.

ADAMH's goal is to add 250 units of Permanent Supportive Housing (PSH) by the year 2026 by acquiring an average of 25 additional units per year over the next ten years, but typically includes a combination of private and public funding. In addition, rental subsidies (vouchers), as well as service and operation funding will be necessary to ensure safe, affordable housing to meet the needs of the individual.

- PSH: provides access both to affordable housing and to a flexible and comprehensive array of supportive services designed to help tenants to achieve and sustain housing stability and to move toward recovery. PSH is an evidence-based practice for people with mental illnesses and is typically defined by the following features:
  - Tenant households execute leases (or sub-lease) agreements with the same rights and responsibilities as other households renting housing in the community.
  - Supportive services are readily available to tenants, are designed to promote housing stability and include access to crisis services 24 hours a day, seven days a week.
  - Supportive services are flexible and individualized, adjusted to meet the tenants' evolving needs and preferences.

ADAMH's goal is to add 30 transitional beds to its housing portfolio by the year 2026. The cost to provide subsidies for these beds would be $1,800,000.

- Transitional Housing: A short term setting that can include room, board, and personal care. A non-permanent setting that provides support needed for residents to return to their previous housing setting; to move into a more permanent housing setting, or a break from current housing. Treatment and/or services are part of facility rules. This is NOT a permanent housing environment. Program Rules include length of stay.

ADAMH's goal is to add 50 recovery residence beds by the year 2026. The capital cost for these houses would be $3,000,000.

- Recovery Residences: An alcohol- and drug-free living environment with peer support and other addiction recovery aids, including employment assistance. Room and board, and various levels of services based on the level of care needed are included. Program rules may be applicable. Treatment services are billed separately, if applicable.

Opiate/Heroin and Alcohol and Other Drug (AOD) Addiction Treatment

In 2012, ADAMH had a 21 percent (8,320) penetration rate to adults with dependence or abuse of illicit drugs or alcohol who were ADAMH-eligible, while an additional 27 percent (3,674) of eligible adults with AMI with substance dependence or abuse (Co-Occurring Disorders) were served in the same time period.

According to OMHAS, an estimated 108,060 people with Dependence or Abuse of Illicit Drugs or Alcohol live in Franklin County and 40,494 are ADAMH-eligible in 2013.

The opiate and heroin epidemic has continued to be on the rise and since 2009, the number of opiate diagnoses have increased by 64 percent. This epidemic has hit all areas of Franklin County and has provided numerous challenges to our suburbs, younger adults and to our system as a whole. The chart below includes the number of Franklin County consumers who have been diagnosed with an opiate use disorder since 2009.

Number ADAMH Consumers Diagnosed with an Opiate Disorder Since 2009

Year	2009	2010	2011	2012	2013
# of ADAMH Consumers Diagnosed with an Opiate Disorder	2,398	2,560	3,186	3,277	3,939

Source: ADAMH Claims Data

Due to the diverse needs of the adult AOD treatment consumer base, the demand for specialized services that meet consumers' unique and complicated needs will continue to challenge contract agencies.

A full continuum of services is available for adults in need of AOD treatment in Franklin County through the following programs:

- **Engagement Center:** The Engagement Center is a shelter for individuals who are inebriated and unable to self-care. In 2014, a total of 901 individuals stayed at the Engagement Center. Frequent users are determined to be individuals who have stayed at the Engagement Center 100 or more days in the calendar year. In 2014, four percent of the individuals who stayed at the Engagement Center were frequent users and utilized 29 percent of the resources (money and available beds) available.
- **Sub-Acute Detoxification:** Sub-Acute detoxification (Detox) is located at Maryhaven's main campus. ADAMH purchases 24 beds that serve approximately 1,095 people a year. Detox serves those who are considered to be too sick or at-risk of a dangerous withdrawal from illicit drugs or alcohol and are in need of medical monitoring. The average length of stay is between 7-10 days.
- **Medical Residential:** Dan Cannon Hall is located at Maryhaven and is a short-term adult residential program that provides counseling, case management and linkage to services post treatment. In 2013, 405 men and women were served at Dan Cannon and 83 percent of these individuals successfully completed treatment. The average length of stay is approximately 20 days.
- **Non-Medical Residential:** House of Hope, Maryhaven and Columbus Area Integrated Health Services Inc.'s Bell Center provide AOD Residential programs that provide long-term services that includes counseling, vocational services and community linkage. The average length of stay is between 3-12 months.
- **Medication Assisted Treatment:** In Franklin County, Maryhaven and CompDrug provide Medication Assisted Treatment (MAT) by using Methadone and Suboxone to help combat the recent opiate epidemic. Approximately 800 men and women per year are treated in our Franklin County community.
- **Intensive Outpatient Treatment (IOP):** Five contract agencies provide intensive outpatient services to the community. In this level of care, men and women attend treatment for a minimum of eight hours per week with services provided at least three days per week.
- **Sober Housing:** Sober Housing, also known as Recovery Housing, is a service provided for individuals who have completed the non-medical residential level of care who seek housing post-treatment. Typically, the residents establish their own rules of the house and provide support to each other as they work their skills in order to maintain recovery. The residents pay their own rent and are expected to maintain employment until they feel comfortable to live independently in the community.
- **Non-Intensive Treatment (General Counseling):** Several contract agencies provide general counseling to the residents of Franklin County.

The population continues to grow in Franklin County. The expanded use of new designer drugs and combinations of alcohol and drugs will continue to grow and challenge the system as individuals respond to these drugs differently. Adjusting treatment regimens to meet the changing complexion of the problem will continue to be a challenge in this area.

We are noticing an emerging trend of the detox units, which are currently running at full capacity and at times, impacting the crisis care system (Netcare, local emergency rooms and local law enforcement). The staff at the detox unit at Maryhaven reports that they are only able to take phone call screenings to the first 25 people who call in each day. After the 25th call, they are unable to accept any more phone calls because they are at full capacity. The phone line opens at 8 a.m. and typically the screenings are completed within 10-15 minutes.

As a result, people seeking detox at the local EDs and Netcare which causes a backlog of people waiting for acute treatment. To help address this issue, there is a Memorandum of Understanding between Netcare and Maryhaven to assure that one person per day in need of detox presenting at Netcare will be admitted to the Maryhaven detox facility.

In 2012, ADAMH expanded Maryhaven's detox by two additional beds which created additional capacity for Franklin County residents. However, the demand for detox services continues to grow.

Expanding MAT options in our community allows the average length of stay at detox to be reduced so patients can be stabilized and discharged to treatment in the community. MAT allows for individuals who struggle with opiate dependence to be stable in the community without long-term medical monitoring.

Strategies to Address Unmet Need

1. ADAMH will expand treatment options for Medication Assisted Treatment (MAT).
2. ADAMH will increase the availability of strategies that divert persons with substance abuse disorders from the criminal justice system and into appropriate treatment opportunities (i.e., Family Drug Court, Adult Drug Court, jail).
3. ADAMH will increase services and treatment options for those struggling with dual disorders (mental health and substance use disorders).
4. ADAMH will increase the early intervention programs that focus on decreasing risk behaviors and emphasize family involvement, peer support and co-occurring disorders.
5. ADAMH will increase the services to the individuals entering the Criminal Justice System or re-entering from the Department of Rehabilitation and Corrections.

Adult Suicide Prevention

According to the Ohio Suicide Prevention website, every 18 minutes, someone in the United States will complete suicide. More than 30,000 people will die by suicide in this country each year, and an estimated half a million people will attempt and survive suicide. Suicide occurs among people of every racial, ethnic, religious and income group. Each suicide has a profound and lasting effect on the surviving family members.
In Franklin County, the suicide rate is 11.7 per every 100,000 persons and is higher than the national average of 11.5 per every 100,000 persons. Franklin County ranks 38th out of 88th of Ohio counties, with one being the county with the highest suicide rate. From 2007 to 2013, the average number of adult suicides per year in the county was 153.

Of the suicides in Franklin County, 79.1 percent are male and the 85 and older age group had the highest suicide rate. What we know is that males, seniors 85 and older, veterans, and some refugee communities are areas of concern for being at higher-risk for suicide.

ADAMH funds several suicide prevention services targeting adults. Most of the adult suicide prevention services are offered by North Central Mental Health Services (NCMHS). In 2007, NCMHS Suicide Prevention Services became a member of the National Suicide Prevention Lifeline Network, a SAMHSA-sponsored initiative for a toll-free national number where calls are automatically routed to a network crisis center located closest to the caller's area code. The 24-hour crisis intervention phone services range from assessing suicide risk to referrals. NCMHS also operates three hotlines, 24-hours-day, 365 days a year: suicide prevention hotline; teen hotline and senior hotline. The suicide prevention hotline offer supports for those at-risk for suicide. The teen hotline provides peer counseling for those who are lonely, depressed, or having other problems. The senior hotline is available for older adults and caregivers and volunteers address issues related to aging. NCMHS also offers a Suicide Attempter Outreach program targeting at-risk individuals involved in Columbus Police Department with hotline information mailers. Other programs include a speaker's bureau, survivors of suicide support, depression support group, and specific outreach services for OSU students and veterans.

Strategies to Address Unmet Need

1. ADAMH and the Franklin County Suicide Prevention Coalition will continue to meet to develop efforts to better educate the public about the risks of suicide. Outreach efforts by the coalition through public relations/media activities, mailings, and social media will be employed.
2. ADAMH and service partners will continue to review and analyze the data obtained to determine trends and patterns of suicide attempts and completions to launch efforts to reduce risk factors and establish protective factors.
3. ADAMH will work with local partners and national organizations to develop marketing platforms (i.e., social media, mailings, target populations speakers bureau, etc.) designed to reach out to emerging at-risk groups in Franklin County.
4. ADAMH will guide its main provider of adult suicide prevention activities to offer services to new entities that have not traditionally focused on suicide, but can influence prevention efforts (e.g., federally qualified health centers, consumer-focused websites, faith-based locations, etc.).

Youth Suicide Prevention

From 2009 to 2014, the Franklin County youth suicide rate has significantly increased. Research indicates that eighty to ninety percent of people who die by suicide have an underlying mental illness and/or drug and alcohol addiction. The state of Ohio responded to these statistics with Anielski's law, which mandates schools to provide suicide awareness training to school personnel. However, there is still a need for educating parents, youth and communities on recognizing the signs of suicide as well. Additionally, because one in seven Ohio youth ages 15-24 have seriously considered suicide and 1 in 11 have attempted it, additional services and evidence-based practices to address depression and suicidal behaviors are desperately needed. A Nationwide Children's Hospital report reiterates this notion in its statement that because the Franklin County youth suicide rate exceeds the national average, "additional and more effective safety nets for high risk youth in Franklin County are needed."

Between 2007 and 2011, the number of youth suicides in Franklin County ranged from one to three. This number tripled in 2012. In 2013, the rate declined to previous rates, however in 2014 there was again a sharp increase in the number of youth suicides. By mid-September 2014, 11 youth under the age of 18 completed suicide. Although only nine months into the year, the 2014 percent of youth suicide had already reached a record high. The rate doubled from five percent in 2012 to ten percent by September 2014.

ADAMH funds several youth programs aimed at suicide prevention. These programs are delivered in settings including NCH, mental health agencies and within several Franklin County school districts. At NCH, services are used to support youth and families at the YCSU and include additional monitoring and supervision of suicidal patients and consultations with behavioral health professionals in the ED for youth who present with a mental and/or behavioral health concern. Mental health agencies provide youth suicide hotlines, referrals and ongoing treatment services. Programming in the schools provide: students, faculty and parents with information on recognizing signs of depression and suicide; youth screenings for depression and suicidal thoughts; and follow up with mental health providers for youth who are identified as being at risk.

Strategies to Address Unmet Need

1. ADAMH will continue to analyze this issue through internal workgroups and participation in collaborative meetings with other community stakeholders such as the Child Fatality Review Board, to further examine this matter and make recommendations for the improvement of services.
2. ADAMH will continue to work closely with Franklin County school districts and mental health providers to expand programming and to implement more evidence based suicide prevention programs into additional school buildings.
3. ADAMH will participate in Commissioner Paula Brooks' State Task Force on youth suicide.

ADAMH Adult Services

Service Type Adults	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
Crisis Care	In 2014, 12,976 adult crisis presentations were reported at Netcare. In 2013-2014, the average length of stay of mental health patients in emergency departments waiting for psychiatric care was 20.5 hours.	Patients waiting the longest for placement in a psychiatric bed are placed in the next available bed, regardless of the facility in which the patient is waiting and regardless of the facility in which the bed becomes open, via the Franklin County Mental Health Bed Board (collaboration between Mt. Carmel Health, OhioHealth, OSU Wexner Center, Netcare, TVBH, Ohio Hospital for Psychiatry and Dublin Springs.) Daily bed board conference calls place patients into available psych beds, and communication takes place throughout the day when a new bed becomes open. Over the past two years, the volume of patients in Franklin County needing inpatient psychiatric care has skyrocketed. In 2014, ADAMH expanded treatment for adults in crisis by funding additional crisis stabilization beds. Provides specialized crisis assessment service with active treatment including individual psychotherapy, medication evaluation, and group therapy.	• Work with cross-system partners via Franklin County Psychiatric Crisis and Emergency Services System Assessment Task Force to finalize recommendations for the future system design of psychiatric crisis and emergency services in Franklin County. • Implement the agreed upon recommendations for the ADAMH public system to support future system design.
Housing / Homelessness	In 2014, approx. 3,000 individuals, who likely qualify as consumers in the ADAMH system of care, are on a waitlist for housing.	As identified in the 2014 ADAMH Needs Assessment, housing will continue to be a growing need for consumers in the ADAMH system over the next five to seven years. In the qualitative research, consumers who struggle with mental health or addiction issues identified housing as a major unmet need. ADAMH current supports 1276 units of housing along a continuum (both mental health and AOD Recovery). Columbus Metropolitan Housing Authority (CMHA) reports 1,403 applicants on a waitlist for a Home Choice Voucher (HCV). This waitlist has been closed since 2008. CHN reports 1,412 individuals on their waitlist. The Unified Supportive Housing System reports 60 applications on a wait list for next available apartment. USHS is a collaborative effort between The Community Shelter Board, Columbus Metropolitan Housing Authority, and ADAMH created to provide a single point of entry to access permanent supportive housing for disabled, homeless and other at risk individual and families with children.	• Add 250 units of Permanent Supportive Housing by 2026, by acquiring an average of 25 additional units, per year over the next ten years. • Add 30 transitional beds by 2026. • Add 50 recovery residence beds by 2026.
Opiate & Other Drug Addictions	The opiate and heroin epidemic has continued to be on the rise and since 2009, resulting in an increase of 64 percent. In 2012, there was an estimated 21 percent penetration rate for ADAMH-eligible adults; and an estimated 27 percent penetration rate for adults with co-occurring disorders (AMI & AOD).	Sub-Acute Detoxification (Detox) is located at Maryhaven's main campus. ADAMH purchases 24 beds that serve approximately 1,095 people a year. Average length of stay is between 7-10 days. Since 2012, ADAMH added the use of Suboxone (a Medication Assisted Treatment) to help combat the recent opiate epidemic. Approximately 800 men and women per year are treated. Medical Residential is located at Maryhaven and is a short-term inpatient program. In 2013, 405 men and women were served. Average length of stay is 20 days. Non-Medical Residential is located at House of Hope, Maryhaven and Columbus Area's Bell Center and provides counseling, community linkage and vocational services. In 2014, 250 men and women were served. Average length of stay is 3 months. Intensive Outpatient Treatment (IOP) is located at five contract providers and provides a minimum of eight hours of treatment at least three days, per week to men and women. In 2014, 329 men and women were served. Average length of stay is approximately 3 months. In 2014, served more than 900 adults in the Engagement Center, a shelter for individuals inebriated and unable to self-care.	• Expand treatment capacity for Medication Assisted Treatment. • Increase the availability programs that divert persons with substance abuse disorders from the criminal justice system into appropriate treatment opportunities (e.g. Family Drug Court, Adult Drug Court, jail). • Increase treatment capacity for those struggling with co-occurring disorders (AMI & AOD). • Increase early intervention programs that focus on decreasing risk behaviors and emphasize family involvement, peer support, and co-occurring disorders. • Increase services to individuals entering the Criminal Justice System or re-entering from the Department of Rehabilitation and Corrections.

ADAMH Adult Services (cont.)

Service Type Adults	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
Adult Suicide	In Franklin County, the suicide rate is 11.7 per every 100,000 persons and is higher than the national average of 11.5 per every 100,000 persons. From 2007 to 2013, the average number of adult suicides per year in the county was 153. Of the suicides in Franklin County, 79.1 percent are male and the 85 and older age group had the highest suicide rate.	ADAMH currently invests in several suicide prevention services targeting adults, mostly offered by North Central Mental Health Services (NCMHS). NCMHS operates three hotlines, 24-hours-day, 365 days a year: suicide prevention hotline; teen hotline and senior hotline. The suicide prevention hotline offer supports for those at-risk for suicide. The teen hotline provides peer counseling for those who are lonely, depressed, or having other problems. The senior hotline is available for older adults and caregivers and volunteers address issues related to aging. NCMHS also offers a Suicide Attempter Outreach program targeting at-risk individuals involved in Columbus Police Department with hotline information mailers. Other programs include a speaker's bureau, survivors of suicide support, depression support group, and specific outreach services for OSU students and veterans.	• Develop efforts to better educate the public about the risks of suicide, including emerging at-risk groups in Franklin County. • Increase adult suicide prevention activities at new locations (e.g., federally qualified health centers, consumer-focused websites, faith-based locations, etc.).
Prevention (Adult) Promotion and prevention are a part of the Behavioral Health Continuum of Care Prevention Model and delivered prior to the onset of a problem.	In 2011, Franklin County had the second highest number of deaths directly attributed to prescription drug use (13.49, per 100,000 people). In a 2012 survey, 42 percent of African American young adults (18-25) reported using marijuana or hashish in the past 30 days (18.5 per 100,000 people in Ohio).	AOD/MH Education Support Groups offered to help adults cope with life challenges: Anger Management Program, Lifestyle AOD Risk Reduction Program and warm line. ADAMH is currently investing in several initiatives that are designed to address behavioral health risk and protective factors associated with community-based problems such as problem gambling and urban youth drug use.	• Make mental health promotion and drug and alcohol prevention services, early intervention and recovery supports available to adults. • Address emerging immigrant populations' needs for culturally appropriate services that address their transition into a new culture and norms for AOD use and mental health problems. • Address risk and protective factors especially those shared by substance abuse and mental Illness for suburban and urban population and emphasize the use of culturally appropriate evidence-based programs. • Invest in cost effective prevention approaches that are science-driven and facilitate attitude and behavior change for the individual, community and the society.
Employment & Vocational There is a strong statistical correlation between poverty, mental health and substance abuse. Employment is crucial for persons with severe and persistent mental illness to escape the cycle of poverty.	According to the 2012 Census, 26.8 percent of those living below the federal poverty level experienced any mental illness in the past year, compared to 15.6 percent of those with incomes of 200 percent or higher of federal poverty level.	ADAMH currently funds a variety of employment and vocational programs through ADAMH contract agencies. In 2013, served more than 2000 adults with employment/vocational support services.	• Increase supported employment programs and opportunities. • Expand vocational supports for programs targeted at transitional-age youth (age 18-23). • Educate ADAMH consumers on the benefits of work and the impact that it will have on their benefits.

ADAMH Adult Services (cont.)

Service Type Adults	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
IDDT/ACT Teams ADAMH has invested in the evidence-based practice known as Assertive Community Treatment (ACT) coupled with a change-focused model called Integrated Dual Diagnosis Treatment (IDDT) since 2008.	Admission criteria for placement on an IDDT/ ACT team may include a high rate of inpatient hospitalization or crisis intervention, or high outpatient costs and / or residential care facility. The 2014 estimated penetration rate is 38 percent.	From 2008-2014, IDDT/ACT teams have collectively served 532 consumers and have reduced hospitalizations, increased housing stability and decreased recidivism into the criminal justice system. ADAMH has created five IDDT/ACT teams and supports; including one specialized in the criminal justice population, to address the most in-need.	• Continue to invest in treatment teams and support services for people with SMI. • Increase the availability of IDDT/ACT teams to serve the adults eligible for those intensive services. • Expand outreach to the homeless adults living in shelters and on the streets who meet IDDT/ ACT criteria.
Re-entry / Criminal Justice ADAMH currently invests in initiatives to support jail and prison re-entry for those returning to Franklin County as well as in specialty court dockets.	The Counsel of State Governments Justice Center conducted a review of the interaction between individuals with severe and persistent mental illness and the Franklin County criminal justice system. The preliminary findings of this report indicate that 6,100 ADAMH consumers were booked into the Franklin County jail in 2010. ADAMH consumers also stayed an average of 32 days in jail versus 17 days for the general population.	ADAMH funds eight specialty dockets through the court system. Prison reentry services, including residential treatment services and specialized case management teams, serve over 300 individuals a year.	• Establish a behavioral health (BH) screening for all individuals booked into the jail to identity MH or AOD concerns immediately. • Develop and implement a means of sharing information between the ADAMH system and the county jail system that will allow the rapid identification of ADAMH consumers, provide the jail with provider linkage information, or in the case of no linkage facilitate, a rapid linkage to appropriate providers. • Establish a liaison program within the county jail system to facilitate linkages to community-based services. • Increase permanent supportive housing for this population. • Give providers the ability to bill criminal justice supports such as jail in-reach and providing support at hearings. • Develop and implement the Sequential Intercept Model in Franklin County.
Integrated Care	A recent SAMSHA study indicates that those diagnosed with a major mental illness will die from 7-24 years earlier than those without such disorders. Substance abuse disorders are also associated with increased mortality rates.	ADAMH currently funds six integrated health care initiatives with four ADAMH contract agencies. Prevention, early detection, and treatment of both behavioral health and physical health needs must be addressed in order to achieve overall wellness. The integrated health care model also recognizes that services must extend beyond the traditional care systems and address individual's social needs, such as housing, employment, and social supports.	• Provide screening and assessment of all Integrated Health Care (IHC) participants to determine clinical need. • Expand outreach and engagement of those with a behavioral health care need, to keep them engaged in services with both providers. • Provide wellness activities / groups such as smoking cessation, yoga, education groups on the connection between chronic illnesses and mental health concerns. • Expand IHC services to include education and prevention activities with youth. • Continue community outreach and system navigation to reduce the stigma of receiving behavioral health services.
Mental Health	In 2012, ADAMH estimated a 42 percent (7,759) penetration rate to adults with Serious Mental Illness (SMI) who were ADAMH-eligible.	Ongoing ADAMH-funded mental health treatment to adults is available throughout Franklin County. Person-centered services range from outpatient therapy and case management to intensive outpatient residential treatment. Psychiatric medication assistance is combined along the continuum of service options. Population growth is estimated to rise 14 percent from 2015 to 2040, thus increasing the need for more services. In addition, as of July 2014, Franklin county enrollment in Medicaid is lower than other urban areas in Ohio, leaving more people uninsured regardless of the resource.	• Expand access to the uninsured through integrated models of primary care, addiction treatment and mental health care to help achieve identified outcomes and recovery. • Add new treatment teams to address needs of specialized populations (e.g. immigrants/ refugees, homeless, criminal justice) for SMI adults. • Increase access to supportive housing. • Increase the number of Peer Support Specialists working in traditional contract agencies & supported housing locations. • Expand peer support services by openingtwo new locations on north & south sides of Franklin County, with an emphasis on serving immigrant populations on the north side location.

ADAMH Adult Services (cont.)

Service Type Adults	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
Dual Diagnosis Penetration rates for ADAMH-paid services indicate that there is likely a significant number of Franklin County residents not getting the help they need, which compared to the serious mental illness (SMI) population, dually diagnosed individuals received far less.	In 2012, just 27 percent of people with alcohol or other drug dependence/ abuse (AOD) as a co-occurring disorder to mental illness received a service from the community behavioral health system.	In 2014 we invested over $910,665 in services between three providers (Maryhaven, North Central Mental Health, and Southeast, Inc.) with a total capacity of 420, specifically in programs for those with mental health and substance abuse disorders. Collectively, that capacity was exceeded, totaling 721 individuals who were treated in these programs in 2014.	• Expand suboxone services to existing contract agencies of medication assisted treatment, while providing continued funds for agencies who offer supportive services to the AOD dually diagnosed. • Increase certified recovery/peer supports in the ADAMH system.

ADAMH Youth Services

Service Type Youth	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
Crisis Care	In 2013, Netcare reported 2000 days utilized for crisis services for youth ages 0-17 (up from approx. 1,500 days in 2007). Between 2012 and 2014, one to four youth each day in Franklin County hospitals and Psychiatric Emergency Services locations are awaiting placement in a mental health bed within the community. As early as 2010, Nationwide Children's Hospital reported an 84 percent increase from previous years in the number of patients accessing its ED in need of primary psychiatric care; during the same time frame, a 91 percent increase in the number of youth needing crisis intervention services.	ADAMH funded the YCSU at Nationwide Children's Hospital (NCH) and the CALM Unit at OSU to diffuse crisis situations, stabilize youth and family and, if possible, prevent inpatient hospitalization. However, both have waitlists for youth needing services. The demand still exceeds available service capacity. ADAMH continues to fund behavioral health evaluations in NCH's ED and crisis assessment and intervention services at Netcare.	• Expand youth crisis intervention services. • Continue to assess the need and current capacity and explore evidence-based practices directed at this population to find innovative treatment options to meet the community need.
Youth Suicide	From 2009 to 2014, the Franklin County youth suicide rate has significantly increased. Research indicates that eighty to ninety percent of people who commit suicide have an underlying mental illness and/or drug and alcohol addiction. By mid-September 2014, 11 youth under the age of 18 completed suicide, a record high.	ADAMH funds several youth programs aimed at suicide prevention at NCH, mental health agencies and in collaboration with several Franklin County school districts.	• Expand programming and implement more evidence-based suicide prevention programs into additional school buildings in Franklin County school districts. • Participate in Commissioner Paula Brooks' State Task Force on youth suicide.
Prevention & Early Intervention	Since 2009, emerging drug trends have shifted to prescription drug abuse and marijuana use (Ohio Youth Risk Survey, 2013). Urban youth reside in communities where 95 percent of the convenience stores or gas stations had marijuana paraphernalia at cash registers/point of sale. According to the Ohio Youth Risk Survey, 20.1 percent of the youth surveyed reported using marijuana in the past 30 days and 12.8 percent reported using prescription painkillers without a doctor's prescription.	Youth promotion and prevention are a part of the Behavioral Health Model of Continuum of Care Prevention and delivered prior to the onset of a problem and programs are available to everyone, and targeted programs are for those particularly at risk. ADAMH continues to fund several programs that support early childhood education teachers and parents in learning the skills to effectively assist children ages 0-6 to boost social emotional development. ADAMH funds 15 school districts in Franklin County to provide mental health and drug and alcohol prevention, early intervention and treatment to its students. ADAMH invests in prevention and early intervention services to provide alcohol, drug, and mental health education and skill-building services to youth and their families so they can avoid the use or abuse of alcohol and other drug and make positive behavior choices. The ADAMH faith-based component served youth living in neighborhoods with high crime rates, low school achievement scores and parental alcoholism rates higher than the national level. ADAMH is currently investing in behavioral health services that address community-based problems associated with urban youth drug use and sexually transmitted diseases.	School-Based Prevention: • Expand mental health and drug and alcohol prevention services available to students. • Continue to promote and emphasize the use of evidence-based programs to increase suicide prevention in the schools. Community-Based Prevention: • Continue to make mental health promotion and drug and alcohol prevention services available to youth including youth-led prevention. • Continue to make mental health promotion and drug and alcohol prevention services available to youth from diverse ethnic backgrounds. • Continue to address risk and protective factors for urban populations especially those shared by substance abuse and mental Illness and emphasize the use of culturally appropriate evidence based programs. • Continue to invest in cost effective prevention approaches that are science-driven for issues like problem gambling and urban drug use.

ADAMH Youth Services (cont.)

Service Type Youth	Prevalance	Current Status	Strategies to Address Need in New Levy Cycle
Alcohol & Other Drug Treatment	Only 21 percent of the estimated number of Franklin County residents with an AOD condition received an ADAMH-paid service in 2012. According to the Ohio Department of Health 2013, Youth Risk Behavior Survey, 38 percent of Ohio high school students reported having at least one drink of alcohol on one or more of the past thirty days (at the time of the survey). In the same survey, 21 percent of Ohio high school students reported that they have recently used marijuana in the past thirty days.	ADAMH collaborated with the Franklin County school districts and community mental health contract agencies to provide mental health, drug and alcohol prevention programs in the schools. In 2012, ADAMH began funding NCH to implement a dual diagnosis program that serves children who are struggling with both addiction issues and mental health issues. ADAMH funds the Buckeye Ranch to coordinate a drug and alcohol program entitled Family Alcohol and other Drug Collaborative Team (FACT). ADAMH collaborated with FCCS to help fund Multidimensional Family Therapy (MFT), an evidence-based substance abuse program for youth and their families.	• Increase the utilization of evidence-based service delivery strategies (e.g., designer drug interventions, coexisting disorder treatment). • Expand programs that prioritize parents/ guardians/caregivers involvement. • Expand intervention programs that specifically target issues such as peer pressure and limit testing. • Increase aftercare programming, especially focused on the first year after an acute episode of treatment. • Increase the utilization of models of care that enable families to stay intact while the adolescent receives alcohol and other drug treatment and other therapies (e. g., Adolescent Drug Court Specialty Docket). • Implement a single treatment plan for children who are in multiple systems, leveraging resources from all appropriate agencies. • Increase utilization of state-of-the-art treatment practices and protocols recommended by SAMHSA that focus on diversion of adolescents from the criminal justice system into appropriate alcohol and other treatment options.
Mental Health	In the last 10 years, NCH Reports, "The NCH ED experienced an 84 percent increase in primary psychiatric presentations between 2005 and 2010." In 2013, of the Franklin County youth seeking treatment, 94 percent received mental health services that were covered by Medicaid and 19 percent of those youth also received ADAMH services. However, it is important to recognize that while it would appear to be significant, it does not include youth who were in need of mental health services but could not obtain care because of long wait times or capacity of the system to provide care. Given the dramatic increase in youth in crisis in the community, one can predict the need for mental health treatment services to be high.	ADAMH offers a full continuum of services for Franklin County youth, including assessment, consultation, early childhood mental health, outpatient mental health, deaf services programs, transitional-age youth living supports, intensive community-based programs, partial hospitalization programs, crisis hotlines, respite care, crisis residential and stabilization and inpatient hospitalization. ADAMH also collaborates with other youth agencies in the community to expand mental health services to these populations of youth and to make intensive community-based programs available in order to promote youth safely remaining in their homes with their families.	• Continue to develop and promote cross system partnerships as well as prioritize and increase service accessibility to young consumers and their families at risk of serious family emotional instability, loss of parental custody, child placement, court involvement, and/or academic failure due to untreated mental illness. • Continue its focus on providing evidence-based practices, increasing family involvement and emphasizing early detection of mental illness in youth.

This page was intentionally left blank.

CURRENT LEVY CYCLE

Although there have been many unexpected changes in our business environment, ADAMH has achieved many accomplishments and cost efficiencies. Below is a snapshot of our 2013 and 2014 accomplishments. To see all of our accomplishments from this levy cycle, please refer to the appendix (APPENDIX 5: Timeline of Accomplishments).

Timeline of Accomplishments

Year	Initiative	Description
2013	Integrated Care System Investments	Identified, evaluated and used three models of integrated healthcare (co-location; facilitated referrals; joint staffing) to solicit competitive proposals for new integrated care investments.
2013	At-Risk Youth Engagement & Counseling	Provided engagement and counseling supports for at-risk students during evening hours at targeted recreation centers and summer festivals as part of the city of Columbus Mayor's Application for Pride, Purpose, and Success and Columbus Public Health.
2013	At-Risk Youth/Faith Based Investments	Partnered with the Children's Defense Fund Freedom School program, through the Shalom Zone on the west and near east sides, allowing at-risk students an opportunity to sustain academic learning and socialization in safe and drug-free locations. Collaborated with two summer-based faith programs that target at-risk youth on the south and north sides, offering leadership resiliency, social and emotional development. Includes year-round parenting support program on Southside.
2013	Collaboration with Legal Aid Society of Columbus	Launched new investment to ensure ADAMH consumers have quality legal assistance for issues like appealing benefits, domestic/family, evictions etc.
2013	Supportive Housing and Transitional Housing	Added 91 units of permanent supportive housing at Inglewood (CHN), Franklin Station (CMHA), CHAT House (Alvis House), Recovery Houses (House of Hope) and two units of transitional housing added at YWCA for homeless women with no income being discharged from TVBH.
2013	ADAMH System Orientation	Developed ADAMH System Orientation for new employees of any Franklin County organization that interfaces with customers that may need mental health or AOD services through the ADAMH system of care, in response to community partners' request.
2013	The Power of Art Program	Community-based murals featured in Columbus, Westerville and Dublin that convey messages of hope, unity and diversity and reduce the stigma associated with mental health and substance abuse issues.
2013 and 2014	School-Based Investments	Collaborated with 14 suburban school districts to provide more than $2.3 million for prevention, early intervention, treatment and referral services for elementary, middle, and high school students. Services range from mental health school-based services (e.g., suicide prevention, etc.); AOD prevention/intervention services; and early detection/ screenings.
2014	Franklin County Guardianship Services Board	Formed to address the growing needs of county residents who are most in-need of guardianships.
2014	Franklin Station Integrated Care Clinic	Opened the Southeast, Inc. Integrated Healthcare Center at Franklin Station, the first-ever integrated care clinic at a permanent supportive housing facility in collaboration with Southeast and CMHA.
2014	Consumer Advocacy	Funded RecoveryWorks in partnership with COVA to promote self-directed recovery through a personalized approach. Consumers can seek support and empowerment through Recovery Guides and find support on their wellness journey, all through the use of technology.
2014	The P.E.E.R. Center – Westside Location	Expanded peer supported services by investing in The P.E.E.R. Center's new Franklinton location.

Major Cost Efficiency Initiatives

System-Wide Cost Efficiencies

While ADAMH maintains a network of over 33 diverse contract agencies throughout the community, we also understand the need to encourage provider collaboration and at times consolidation in order to take advantage of economies of scale. During the current levy cycle ADAMH has fostered four provider consolidations and numerous collaborations to this effect, including Columbus Area and Project Linden, Syntero with Northwest Counseling and Dublin Counseling, Southeast Inc. with COVA and the Buckeye Ranch with Rosemont. In each of these instances, programs and services in the communities where the programs are located continued without disruption to those in need. In fact, additional service dollars were directed from provider administration to program services.

ADAMH has also consolidated program funding to gain efficiencies in administration and program delivery. Perhaps the most illustrative example of this involves Community for New Direction. This provider currently manages 11 different community intervention and prevention programs in conjunction with ADAMH. These programs were once spread out over five different contract agencies. The ability of ADAMH to work with one provider has increased our focus on the programs and services, including the quality of those services, while reducing administrative costs.

Over the past several years, ADAMH focused on ensuring that the most appropriate consumers were placed in Residential Care Facilities (RCFs) due to the high cost. A tool was developed for determining both the level-of-care provided by a facility and level-of-care needed for the individual consumer. A consumer scoring form was developed and completed at time of admission and at six-month intervals for the purpose of determining continued stay. Consumers whose score below the 50th percentile should be considered for a less intensive setting such as independent or supportive housing. After two years of administering the admission form, more than 90 percent of the residents are in the appropriate level of care, turnover is within the expected average length of stay, and consumers' functionality on a whole is showing improvement.

A financial analysis was done on the RCFs in 2011. The analysis resulted in a reduction of RCF expenses of $409,257. In 2012 and each subsequent year, $409,257 was repurposed from the RCF allowing the savings to go to other programs serving the needs of ADAMH consumers. In addition, standard occupancy rates were established for all RCFs providing uniformity throughout all programs.

As ADAMH reviewed data of some of the most acute consumers, we realized that 9 percent of these consumers represented 41 percent of the hospitalization costs and 44 percent of those individuals also had a co-occurring substance use disorder. The data also found those same consumers to be high utilizers of crisis services. In an effort to ensure quality care, a review of evidence-based practices was conducted, with a goal of finding a treatment model that would provide a high level of treatment and support services to the individuals while creating a reduction in the cost of care. Subsequently, it was determined that the IDDT/ACT (Integrated Dual-Disorder and Assertive Community Treatment) model was the best intervention for stabilizing the consumers and reducing costs of care.

Research indicates the model reduces: relapse of substance abuse and mental illness; hospitalization; arrest / incarceration; duplication of services and service costs. This model also increases the continuity of care; consumer quality of life and stable/independent living.

Internal Cost Efficiencies

ADAMH has looked inward during the current levy cycle to ensure that our statutory duties are being carried out in the most efficient way possible. By taking advantage of technology and streamlined policies and procedures, ADAMH has reduced the number of full-time employees by over 20 percent since 2005. Overall, ADAMH administrative operating costs in 2013 are over eight percent less, when adjusted for inflation, than operating costs in 2005. ADAMH has paid off the bonds on its 447 East Broad Street location and is strategically planning the upkeep of the building without incurring additional long-term debt. ADAMH has operated within its budget every year of the current levy cycle while upgrading its entire information technology platform including system servers and software, disaster readiness and HIPAA compliance.

Moving forward, ADAMH has formed a Council of Government (COG) with the Hamilton County Mental Health and Recovery Services Board and the Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County known as the Three C Recovery and Healthcare Network.

The impetus for forming the COG is to fund and implement a community mental health and addiction management information system known as SHARES (Shared Health and Recovery Enterprise System). SHARES is necessary to support the payor role of ADAMH, as a component of the local authority's statutory responsibility for developing, funding, overseeing and evaluating mental health and substance abuse care for their respective jurisdictions.

It is anticipated that the COG may be expanded to include additional community mental health and/or ADAMH Boards in the future. It is also anticipated that the COG will offer services to any and all of the other Boards in the Ohio behavioral health system in addition to sharing services within the COG. For additional information on the SHARES project, refer to the *Internal Efficiencies* discussion on page 82 of this fact book.

Challenges

Fiscal Challenges

When ADAMH passed the current replacement levy, gross revenues increased by 48 percent, from $43.6 million in 2006 to $64.4 million in 2007. The planned approach to managing this increase was to fund new programs during the first couple of years and set aside sufficient reserves to consistently grow community investments throughout the remainder of the 10-year levy cycle. In other words, accumulate cash reserves in the first five years and spend down the reserves during the second half of the levy cycle.

This plan can be illustrated by graphing "Net Revenues" for each year of the levy cycle. Annual net revenues are quantified by subtracting annual expenses from annual revenues. As addressed above, the initial plan was to build up a reserve of revenues during the first half of the 10-year levy cycle and then spend down the reserves (deficit finance) the second half of levy cycle to maintain a steady growth in community investments. The light blue line in the chart entitled, *ADAMH Original vs. Current Levy Revenues for Levy Cycles* (page 54), represents ADAMH's initial planned approach to manage levy funds during 2007 through 2016.

The navy blue line graphically represents what has actually occurred (2015-16 are projected values). Below is a timeline of events that have occurred during the current levy cycle and how ADAMH has responded to these fiscal challenges.

2007-2008: "Business as Planned"

During the first couple of years of the current levy cycle, ADAMH's spending went as planned. Levy revenue collections were as anticipated, which afforded ADAMH the resources to increase community funding by over $8 million per year from 2006 to 2008.

2009-2011: "The Recession"

During this period of time, the fallout from the national recession impacted ADAMH in several arenas:

Expenses

- ADAMH immediately experienced double digit growth in Medicaid expenses, funding cuts from the state, and a surge in state mental health hospital expenses.
    - In 2010, ADAMH made significant cuts to non-Medicaid community program funding and board operations.
    - ADAMH's Board of Trustees passed a resolution limiting (capping) the amount of levy funds that could be used to finance the State: Federal Medicaid program.
        - In 2012, the state took responsibility for funding its Medicaid costs, relieving ADAMH of the burden placed on its levy resources.

Revenues

- Levy revenue collections peaked in 2010 ($65 million) and have steadily declined since ($57.4 million in 2014). Two factors have driven this decline:
    - Housing Values – during the 2011 Sextennial assessment, Franklin County's assessed values declined by 6.2 percent.
    - Tangible Personal Property (TPP) Tax – House Bill 66 resulted in major Ohio business tax reforms. One key change was the phase-out of taxing business personal property (equipment, fixtures, inventory, etc.). This phase-out was initially planned to occur through 2018, but with the recession, the phase-out was accelerated. Financially, ADAMH's TPP revenues peaked in 2005 ($4.8 million) and are now less than $1.1 million.

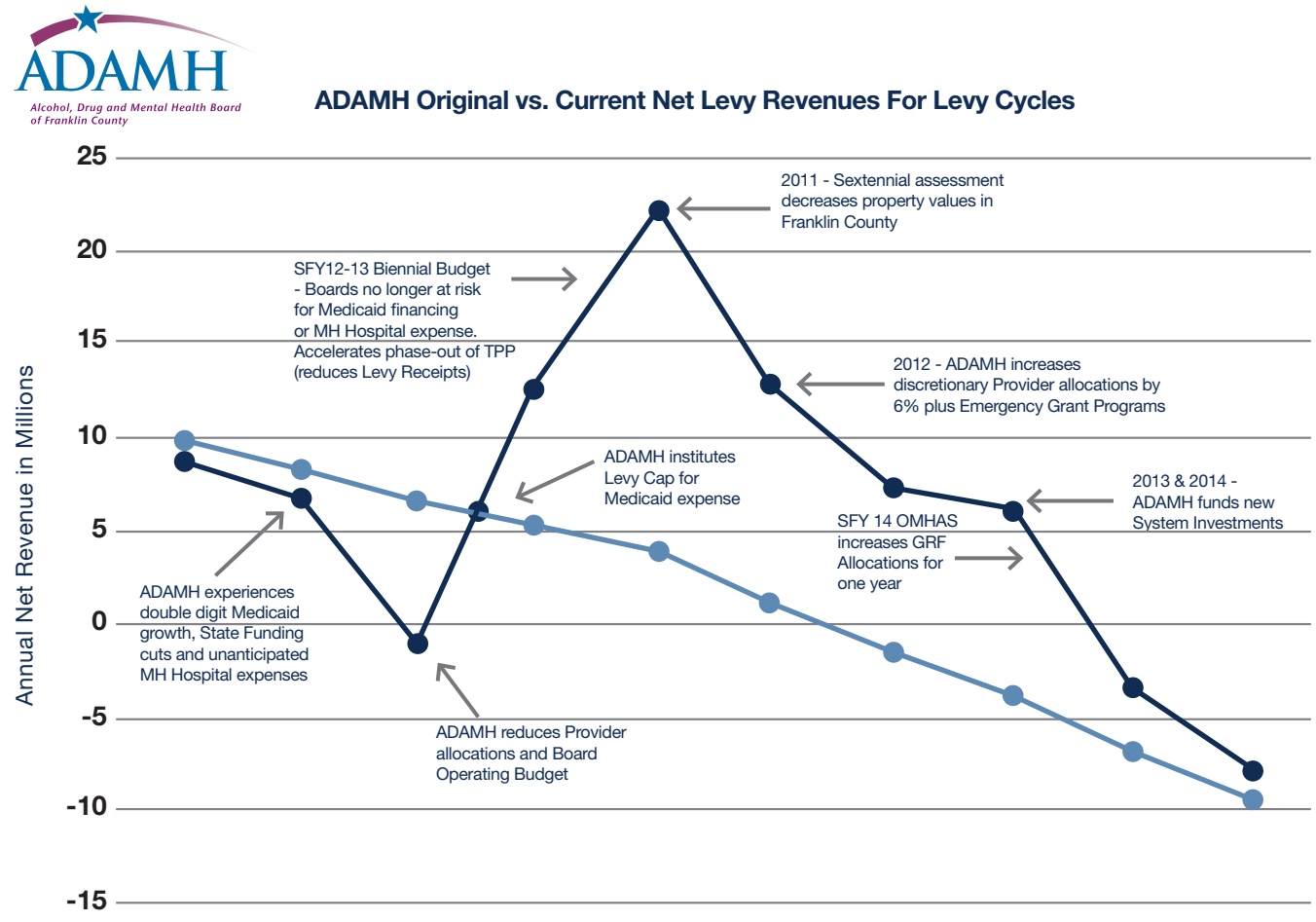
2012-2016: "The Recovery & Insurance Reform"

Beginning in 2012, ADAMH was able to begin increasing community investments again. From 2011 through 2014, annual allocations to providers increased from $56.2 million to $76.5 million.

ADAMH had conversations with community leaders and interested stakeholders to gain a better understanding of the community's unmet behavioral healthcare needs. As a result of the conversations, we started releasing Request for Proposals (RFP) to expand funding to address some of the areas of unmet need.

Significant insurance reform, including parity legislation, national healthcare and Medicaid eligibility expansion in Ohio, are beginning to have a material impact on what types of services ADAMH purchases from the community. As more Franklin County residents obtain insurance coverage for mental health and addiction treatment services, the demand for ADAMH-paid treatment services is beginning to decline. This transition, if continued by policymakers, will allow ADAMH to purchase much-needed prevention, evidence-based programs, crisis care and recovery supports (residential, vocational, intervention, etc.), not covered by Medicaid.

ADAMH Original vs. Current Net Levy Revenues for Levy Cycles



	CY07	CY08	CY09	CY10	CY11	CY12	CY13	CY14	CY15	CY16
Original	$9.464494	$8.276243	$6.4511	$5.178736	$3.810085	$0.840796	$-1.520502	$-3.85863	$-6,887279	$-9,413346
Current	$8.74455976	$6.81841292	$1.20585148	$12.66570426	$22.18581313	$12.44691142	$7.21497751	$6.11880872	$-3.763218071	$-8.173389815

Inpatient Care Challenges

One of the major challenges that faced Franklin County in the past levy cycle is the significant shortage of inpatient psychiatric beds for the most fragile consumers of mental health treatment. An article published in the *Columbus Dispatch* on April 13, 2014 (*State's Psychiatric Beds Fail to Meet Demand*, B. Sutherly) highlighted this issue. At the time of the article, there were only 23.5 adult psychiatric beds per 100,000 people. This number is significantly lower than the other large metropolitan areas of Ohio, with 37.2 beds per 100,000 in northeastern Ohio and 31.3 in the Cincinnati area. While some inpatient beds have opened since that article, they have all been at private, for-profit hospitals which do not accept individuals who are indigent or those with Medicaid who are between the ages of 21 and 64. Like all disease processes, individuals with mental illness whose condition worsens need adequate resources to be treated in a safe, intensive setting.

The lack of access to inpatient beds has been even more striking for children and adolescents in our community. During this levy cycle, Ohio Hospital for Psychiatry closed its inpatient adolescent unit. In fact, until the recent phased opening of youth beds at NCH, the only available beds for children and adolescents needing inpatient care have been those at OSU and Pomegranate.

The lack of psychiatric beds in the community puts an additional strain on the outpatient providers and the mental health system, which must work to meet the needs of these individuals in the community, even at times when they might be better served in the hospital. Additionally, due to the pressures on the hospitals to move people through these beds, average lengths of stay in the hospitals have been decreasing. Twin Valley Behavioral Healthcare has seen their average length of stay drop from 17.8 days in 2010 to 12.3 days in 2014. This leaves little time for community-based providers to prepare for their consumers' discharge needs to ensure stability in the community.

Adult Crisis Care Challenges

Another challenge in this levy cycle that is closely tied to the shortage of psychiatric beds is that of the over-burdened crisis psychiatric system. The available services for those in a mental health crisis represent a fragmented group of hospital-based EDs, standalone emergency rooms and ADAMH-funded Netcare crisis centers on South Central Avenue and East Broad Street. The fact that there are so many components to this system is a challenge for ADAMH, our contract agencies, law enforcement and individuals in need of crisis care as it can be difficult to know how to access crisis services.

Early in the current levy cycle, the Central Ohio Hospital Council, the local hospitals and emergency care providers and ADAMH came together to address the issue of moving individuals from crisis settings to inpatient hospital beds. Out of these meetings, the Franklin County bed board was created and in 2009 they agreed on a community protocol, whereby patients waiting the longest for placement in a psychiatric bed were to be placed in the next available bed, regardless of the facility in which the patient was waiting. This process was accomplished through daily conference calls between the emergency settings and hospitals and eventually an electronic, web-based "bed board" was funded by the Columbus Foundation to allow real time monitoring of those individuals waiting for a higher level of care. While this project proved successful in reducing wait times and improving community collaboration, the system is again at a critical point with volumes of those presenting in psychiatric crisis increasing by about 5.9 percent a year.

Not only has the number of individuals awaiting a bed increased dramatically during the past levy cycle, but so has the total number of people presenting in crisis at Netcare and emergency departments. While the system-wide data is not available for total crisis visits, it is known that it is much higher than the 800-plus people who are placed on the bed board, waiting for an inpatient bed each month. For example, Netcare alone performed 10,744 crisis evaluations in FY2014 and only 28.2 percent of those evaluations needed a higher level of care in a hospital setting.

Youth Mental Health System Challenges

The impact of mental illness on the children and adolescents in Franklin County must not be overlooked. National Institute of Mental Health (NIMH) data from 2005 indicates that 11 percent of children between ages 8 and 11 currently have or had a mental illness with severe impairments and 22 percent of those, between 13 and 18, have had a mental illness with severe impairment in their lifetime. Only 50 percent of youth with a mental health disorder receive any behavioral health treatment. Based on this data, one would expect over 60,000 children and adolescents in Franklin County have had a mental illness with severe impairment in their lifetime.

The penetration rate for children implies there is a significant number of youth receiving treatment in Franklin County, it is important to recognize the penetration rate does not include youth who were in need of mental health services but could not obtain care because of long wait times or lack of capacity to provide care. Currently, Nationwide Children's Hospital (NCH) outpatient services triage callers needing mental health assessments and psychiatric visits in order to assure that those with the highest need have quick access to these resources. Those patients in need of general, routine care have a much longer wait time. (For additional information on the children penetration rate, refer to page 33 of this fact book.)

The number and profile of youth presenting in crisis has also changed during the current levy cycle presenting a challenge in the delivery of crisis mental health services. While the number of youth crisis episodes at Netcare has remained relatively stable from 2007 to 2013, the number of days needed to diffuse these crises has steadily increased. In 2007, the number of days utilized for crisis services were approximately 1,500, however by 2013, 2,000 days of crisis treatment were needed, reflecting increasing acuity of the crisis and longer wait times to get youth who needed a higher level of care into inpatient beds. Given the dramatic increase of youth in crisis, one can deduce the overall need for mental health treatment services is not currently being met.

Local emergency departments (EDs) are also seeing a rise in the number of youth presenting in crisis. OSU reports that, on average, 1,200 youth present to their EDs annually in psychiatric crisis with many needing an inpatient level of care. Between 2012 and 2013, Netcare, OSU, OhioHealth, and Mount Carmel Hospitals EDs combined cared for 2,171 children and adolescents while they were waiting for placement in a psychiatric hospital.

Additionally, NCH has seen an increase in the amount of youth presenting in its emergency department in need of psychiatric care. Even as early as 2010, NCH reported an 84 percent increase in the number of patients accessing its ED in need of primary psychiatric care from previous years (see *NCH Psychiatric Emergency Department Visits by Year* chart, page 36). This number does not include youth with a primary medical concern who received a psychiatric consultation in addition to the reason for their visit. During the same time period, NCH's Crisis Team also reported a 91 percent increase in the number of youth in the community needing crisis intervention. As a result of the number of children and adolescents presenting in crisis, the Youth Crisis Stabilization Unit (YCSU) at NCH has had to admit children into general medical beds so they are not in the chaotic environment of the emergency department. According to NCH, in 2014, 1,104 such youth were admitted into a general medical bed with an average length of stay of 2.6 days.

Network and System Challenges

State Medicaid Elevation – In 2010, ADAMH established a 'cap' on the amount of local levy funds that would be spent to cover the state of Ohio's share of Medicaid match on the State: Federal state entitlement program. This local advocacy triggered mediation with the state of Ohio that ultimately resulted in the elevation of the Medicaid program to be administered at the state and match covered with state funds. Elevation went into full effect on July 2013, which allowed local levy funds the discretion to meet local unmet needs.

Decoupling of Hospital Care from Community Care – From 2008 to 2011, the rate of hospitalization at Twin Valley Behavioral Healthcare (TVBH) increased an average of seven percent per year, which required additional local resources to meet that unplanned and urgent need. In 2012, the shared risk between hospitalization and community-based care was severed. While the immediate financial impact was beneficial to ADAMH's financial position, from a clinical continuity of care perspective, this has created barriers and a fracturing of the system of care. We continue to work on re-establishing priority linkage contract standards with network providers to ensure optimum community-based care for individuals being discharged from an acute care setting.

Healthcare Reform – Some policymakers and members of the general public may erroneously assume that Medicaid expansion and ACA have fully addressed all the requirements for publicly funded mental health and addiction treatment. In fact, as outlined in the *Covered and Uncovered Behavioral Health Services After Implementation of the Affordable Care Act and the Mental Health Parity and Addiction Act* chart (page 73) , Medicaid taxonomy services or other insurance coverage often does not cover vital services such as: psychiatry; intensive services such as ACT or MST; acute intensive services such as 23-hour crisis stabilization and 24/7 crisis hotline; residential services such as children's mental health residential, therapeutic foster care and clinically managed 24-hour care. No private or public insurance will cover recovery support services like safe, affordable housing, supported employment or peer supports.

System Workforce – Results from a recent survey from network providers indicate that recruiting and retaining qualified staff to deliver quality care continues to be one of the greatest challenges facing the system. Providers indicate that in competing for licensed and certified staff, it is very difficult for the public system to offer competitive salary and benefit packages when compared to private healthcare systems.

Cultural Competency Challenges

It is evident that ADAMH invests a significant amount of resources to address cultural competence in our system of care. The information included in this section provides some brief insight into the breadth of activities related to this area. ADAMH will further its work in these areas based on information obtained from the 2014 Needs Assessment regarding issues raised by leaders from various immigrant/refugee, and other ethnic populations.

ADAMH takes cultural competency initiatives very seriously and has engaged in multiple efforts to ensure that diverse communities have access to culturally and linguistically appropriate services. ADAMH has initiated both proactive and reactive strategies based on existing and emerging diverse community needs and issues. These strategies are designed to help ensure that the unique needs of culturally diverse populations are considered in our design and implementation of prevention, early intervention and treatment services. Additionally, one of ADAMH's strategic initiatives, Community Collaboration and Engagement, was created to ensure that our services and supports are offered in key community outposts and in partnership with diverse community organizations in order to ensure better access to and design of our services. ADAMH spent considerable time learning about Franklin County's diverse communities and identified national best practice models and constructed evidenced-based programs and services that target these populations.

The following initiatives were implemented in the current levy cycle and new efforts are readily being developed to anticipate the growing needs of our diverse service population.

- Developed a Culturally Competent Assessment Tool for providers to evaluate their organizations based on 11 key cultural competence standards, to be completed every four years. This tool is the foundation for how system contract agencies assess their own level of competence, but also provides ADAMH with a roadmap of how they anticipate and respond to the needs of culturally diverse communities (See Cultural Competence Assessment Tool, APPENDIX 6).

  Ongoing monitoring of contract agency efforts are conducted annually through the Agency Service Plan (ASP) process that requires providers to identify their top two or three priorities to address areas of improvement in their cultural competence plan. ADAMH offers technical assistance to its providers to improve areas of concern and staff development.

- Designed system cultural competence trainings to improve administrator, clinician and line staff services to diverse communities. There has been significant emphasis on immigrant and refugee staff training to ensure that the system understands their unique needs and can provide the best possible services.

  - Hosted immigrant culture and language classes for system clinical staff.
  - Partnered with Multiethnic Advocates for Cultural Competence (MACC) to provide a training to system staff that focused on the needs of immigrant/refugees, veterans, LGBTQ, faith-based and other target communities.

- Launched outreach and engagement activities to ensure that ADAMH was an active partner with key immigrant/refugee, diverse community leaders, faith leaders and their respective organizations.

  - Established specific marketing and educational campaigns to educate immigrant leaders and their communities to better recognize mental health signs, symptoms and services.
  - Developed language specific videos, brochures, billboards, radio and television spots to educate the community on culture differences.
  - Participated with various cultural affinity groups, cultural/faith leader engagement and participated in dozens immigrant/refugee community activities and organizations.
  - Offered mini-grants to multiple immigrant/refugee/minority community educational and awareness activities to reduce the stigma associated with behavioral health issues.
  - Collaborated with Columbus Department of Health Office of Minority Affairs to address multiple/ holistic needs of Franklin County residents.

- Engaged faith-based organizations to help them better support their congregations and communities. Since 2006, ADAMH learned that many faith leaders are confronted with mental health and substance abuse problems with little knowledge of how to address them (i.e., youth suicide, domestic violence, youth and gang violence, opioids and other drugs, divorce, death, etc.). To address these issues, ADAMH:

  - Met with dozens of faith leaders to learn more about their problems, needs and interests as part of our annual community ascertainment strategies.
  - Offered a series of trainings for faith leaders to recognize mental health/alcohol and other drug signs and symptoms, crisis supports and referral information.
  - Hosted a faith leader symposium in 2011 to offer over 30 sessions taught by clinical professionals and faith leader representatives from all disciplines to address key behavioral health and health topics, 200 were in attendance.
  - Participated in a statewide training/education initiative supported by SAMHSA.
  - Trained more than 45 faith leaders in the White House endorsed Mental Health First Aid, an international best-practice training model.
  - Funded a wide-range of prevention programs in collaboration with faith institutions.
  - Established a faith leader advisory committee for input on program development.

- Developed programs that were identified from meetings with immigrant/refugees and cultural communities. ADAMH actively sought the creation and implementation of a wide range of culturally and ethnically-specific services and unique programs to address the growing challenges faced by these communities. During the current levy cycle, ADAMH has:
    - Developed several immigrant/refugee specific services, ranging from trauma-based care (i.e., services for those suffering with PTSD related to wars and unrest, etc.), urban youth programming and family immigrant services (i.e., support immigrant families address intergenerational conflict).
    - Implemented an international middle school program to address immigrant student truancy, disciplinary problems and family dynamics.
    - Provided a translators training for working in system to better serve those with Limited English Proficiency (LEP).
    - Monitored disparities and other key performance indicators based on race/ethnicity, age, gender, and related primary and secondary dimensions of diversity.
    - Required all new system/school-based investment applicants to explain how they will address cultural competence in their program/service proposals.

- Offered recruitment and training for Institutions of Higher Learning to target and better inform college students as it relates to working in diverse communities. ADAMH supported several efforts to recruit and hire diverse staff to reflect the service population including:
    - Targeted advertising to contract agencies to identify and hire diverse staff.
    - Collaborated with Columbus State Community College and OSU on various projects to train undergraduate and graduate students on the importance of ADAMH's work associated with cultural competence.
    - Offered institutions opportunity to place students (domestic and international exchange) in our system for field placements/practicums.
    - Encouraged immigrant community leaders to explore social work and other human service degree programs with students.
    - Worked with researchers from the Wright State University Center for Global Health and Boonshoft School of Medicine to conduct a World Health Organization survey to refugees about their quality of life in Central Ohio.
    - Worked with OSU to offer graduate students services in federally qualified health centers (FQHC) that services large immigrant communities.

During the next levy cycle, ADAMH will identify resources to continue to address awareness and stigma in order to improve immigrant community knowledge of mental health and addiction problems. The stigma associated with these issues often prevents individuals from these communities to seek or engage prevention and treatment services. In addition, ADAMH will partner with other health and social service organizations to broaden its coordinated/integrated service array to address the holistic needs of diverse communities.

As the system builds workforce and other resource capacity, it will be a goal during the next cycle to establish cultural centers of excellence that are operated by the immigrant communities we seek to serve.

Human Services Levy Review Committee (HSLRC) Recommendations

In the August 2005 Levy Review Committee Report, the Human Services Levy Review Committee issued ADAMH nine recommendations.

Below is each recommendation as well as the steps ADAMH has taken to meet the recommendation during this levy cycle.

Recommendation #1: *The Levy Review committee recommends that ADAMH re-evaluate the strategies used to increase its consumer base of individuals new to the system.*

From 2009 to 2013, more than 80 percent of consumers served by the ADAMH network were new to the system, demonstrating the relatively short-term dependency on ADAMH services while also demonstrating the ongoing demand for new consumer services.

During this timeframe, the following strategies and tactics were utilized to better reach individuals that are in need of mental health and/or addiction treatment and not yet served in our system:

1. Collaborative partnerships with specialty courts to allow courts to refer to treatment and reduce jail time for low-level offenders.
2. Development of new integrated care initiatives to allow consumers to recognize mental health and physical health challenges and get mental health treatment, if needed.
3. Development of new school-based initiatives to allow school administrators, teachers and parents to recognize the signs and symptoms of mental health issues and refer for further intervention, if needed.
4. Expanded community education and outreach: Paid advertising; increased participation in community health fairs; expanded outreach into new neighborhoods through community mini-grant program.
5. Launched Mental Health First Aid program for Franklin County.
6. Collaborative partnership with the CSB to engage and link homeless adults in mental health treatment.
7. Prioritized linkage between Netcare Access and Maryhaven's Detox Program through a MOU.
8. Launched Recovery Works, a web-based, peer-support network to empower consumers on their recovery journey and offer real time support anytime, anywhere.

Recommendation #2: *The Levy Review Committee recommends that ADAMH takes steps to ensure that excessive amounts of administrative costs are not built into its provider contracts.*

Provider-STAT was implemented by ADAMH in 2003 as an interdisciplinary contract agency provider performance and quality improvement monitoring tool. Each contract agency is required to participate in a minimum of one Provider-STAT session per calendar year. The Provider-STAT data template includes the following core business areas: Financial Performance Indicators, System Quality Indicators (outcomes, clinical quality, access to services, average cost of services), Access to Services (#'s of Consumers Served versus Commitments), Customer Satisfaction and Contract Compliance.

Provider administrative expenses are specially monitored though the financial performance indicators. Each provider is scored from 1 to 5 with the optimum range being between 7 percent to 10 percent administrative cost to overall costs. Providers overall score affects the providers eligibility for incentive based funding, new ADAMH awards and year-end performance payments.

For further information regarding ADAMH's efforts to address provider efficiencies, please see the *Future Efficiencies* discussion starting on page 81 of this fact book.

Recommendation #3: *The Levy Review Committee recommends that ADAMH identifies thresholds for its consumer satisfaction surveys.*

ADAMH investigated whether or not thresholds had been developed and/or recommended by the publisher of its consumer satisfaction tool (CSQ Scales: CSQ-8). To date, there are not publisher-established thresholds or recommendations.

After reviewing the available CSQ-8 and its consumer satisfaction data, ADAMH established a minimum threshold (24: satisfied to mostly satisfied) and desired performance target (27: mostly to very satisfied) in 2006 for the average (agency or system) CSQ-8 composite score. Additionally, following the performance indexing methodology used with other system/agency indicators, consumer satisfaction performance is indexed 1-5 (unsatisfactory – outstanding) and these data impacts composite performance indexes equally with other indicators, resulting in consumer satisfaction being reviewed in Provider-STAT, RFR, and value-based contracting processes.

Recommendation #4: *The Levy Review Committee recommends that ADAMH continues to develop and then implement evaluation processes of its prevention programs.*

ADAMH supports over 80 prevention programs that target youth and young adults, adults and seniors. We offer prevention, early intervention services for youth through ADAMH providers including after-school programs, summer day camps, faith-based summer day camps, AOD prevention/MH promotion activities, peer-led activities and an HIV early intervention program.

Also, ADAMH offers prevention, early intervention services and recovery supports for adults through ADAMH providers. These programs include education support groups, drug risk reduction programs, anger management courses, parenting skills, workforce readiness and population based approaches: campaign to reduce problem gambling and campaigns to reduce drinking or drug use and HIV early intervention programs.

ADAMH contract agencies complete the Resselaerville Outcome Framework, now called the Prevention Outcomes Management section, as part of the ASP and budget process. Since 2006, the narrative for each prevention program funded in their budget includes: the name of the evidenced-based model or prevention model, program projections and customer milestone steps and the evaluation tool the program will use to measure outcomes for the year. For evaluation purposes, providers use evidenced-based programs or science driven approaches to ensure that prevention programs implemented address the identified priority problems and reach identified target populations with the culturally appropriate intervention.

ADAMH also monitors prevention through quarterly submissions of the TARGETrak template, an outcome projection and tracking tool for prevention programs. Combined, these two reports help ADAMH monitor the implementation of the prevention programs and compare projections with their progress quarterly. ADAMH collects this data and inputs information into a collective scorecard. The scorecard allows staff to compare like programs and services in order to evaluate the impact in communities that are in greatest need.

Historically, prevention programs have lagged behind other clinical services that have tested evaluation tools. As part of the SHARES project, further discussed in the *Internal Efficiencies* section starting on page 82 of this fact book, ADAMH will be able to receive uniform information and easily generate reports to effectively monitor and make more informed decisions about prevention programs. Currently, prevention staff from the three board areas are finalizing the parameters and metrics for the prevention evaluation platform.

Once the platform is constructed in SHARES, providers will have real-time monitoring capacity, generate data, correspond, and submit timely reports to their respective boards. ADAMH will use the reporting platform to comprehensively determine impact and use these data to determine how best to use future resources with a high level of confidence.

Recommendation #5: *The Levy Review Committee recommends that ADAMH adjusts its levy revenue projections to incorporate the state's fiscal year 2005 personal tax reforms, which will result in a $10 million levy revenue reduction over property the 10-year levy cycle.*

ADAMH is projecting to receive $32 million in TPP tax revenues and legislative hold harmless funds during the current 10-year levy cycle. The modeling for the next 10-year levy cycle projects $10.5 million in TPP hold harmless revenues based on current legislation.

Recommendation #6: *The Levy Review Committee recommends that ADAMH reduce its provider rate expense increase to 3 percent in the first year of the levy.*

Providers have received an average increase of three percent annually to their allocations during the current levy cycle. The next levy cycle models a two percent across ADAMH annual provider allocation increase. Moving forward, ADAMH does plan to increase performance standards in order for providers to qualify for a base allocation annual increase. These standards may include service quality indicators and historical allocation earnings.

Recommendation #7: *The Levy Review Committee recommends that a two percent annual salary expense increase be budgeted for ADAMH Board employees over the next 10 years.*

ADAMH currently offers staff an annual two percent cost of living adjustment (COLA) plus up to a one percent merit increase. While no specific COLA is budgeted in the new levy cycle, ADAMH is limiting its overall annual administrative expense increase at two percent per year.

Recommendation #8: *The Levy Review Committee recommends that ADAMH budgets a 12.5 percent annual increase in healthcare expense over the next 10 years.*

ADAMH's fringe benefit actual expense during the current levy cycle has averaged a one percent increase per year (from 2006 to 2014). While many factors impact this trend including healthcare, ADAMH has modeled a two percent fringe benefit increase over the life cycle of the next levy.

Recommendation #9: *The Levy Review Committee recommends that ADAMH evenly spreads its projected $4.5 million innovation total, $450,000 per year, over the 10-year levy cycle.*

Based on a 10-year 2.2 mill renewal with a 0.5 mill increase property tax levy, ADAMH will be able to invest approximately $5.1 million per year in new initiatives. The amount that will be invested in year one of the new cycle depends on the level at which new programs and new program capacity can be developed.

PERFORMANCE MEASURES

ADAMH's performance measures are updated annually as part of the ongoing Managing for Results (MFR) process, which was initiated at the county level in 2000. The intent of the MFR initiative was to help county government operate more like private industry by focusing on results for customers. ADAMH embraced the MFR framework and has changed almost every planning, funding, and evaluation function within the organization to align with the tenants of a result-based performance structure. ADAMH's MFR system is designed to ensure that public resources are being used in the most efficient and effective manner to serve as many consumers as possible with quality behavioral health treatment and prevention services.

ADAMH's annual strategic performance plan is the cornerstone of the MFR system, which incorporates both the **strategic results** portion that are the longer range and overarching goals and the **operational results** portion that details the annual goals of ADAMH. Operational results must align to a strategic result or ADAMH's mission, vision or core values.

Every three to five years the ADAMH Board of Trustees set new strategic results for the ADAMH system of care based on business environment issues that face Franklin County. The strategic results are stretching, not business as usual. Strategic results may take the entire five years to work on incrementally and provides a guidepost to allocate staff and funding resources.

Once the strategic portion is established, then the operational portion of the business plan is developed to measure quarterly and annual progress toward achieving the strategic results and fulfilling the mission, vision, and core values of the organization.

Taken together, all of the components are important for clarity and alignment for all employees to effectively focus on performance and to understand how their individual work contributes to the overall performance plan.

> "...the Franklin County Alcohol, Drug and Mental Health Board, an agency that is run with an efficiency not always found in government organizations...has cut costs, tightened its belt and is managing its money well in the face of an economic downturn that has flattened its income"
>
> - *The Columbus Dispatch Editorial*, Oct. 9, 2005

Goals and Accomplishments

During this levy cycle, the board of trustees identified three sets of strategic results that cover the following time periods: 2006-2009 (APPENDIX 7); 2010-2011 (APPENDIX 8); and 2012-2017 listed below.

Current Strategic Results (2012-2017)

1. By January 2017, ADAMH will expand access to care for uninsured people through integrated models of primary care, addiction treatment, and mental healthcare to help achieve identified outcomes and recovery.
2. By January 2017, ADAMH will improve access to clinically appropriate and necessary treatment services and supports for children, youth, families and individuals to help achieve identified outcomes and recovery.
3. By January 2017, ADAMH will advocate to local, state and national elected officials and decision makers to provide increased support for community-based services and treatment for children, youth, families and individuals.
4. By January 2017, ADAMH will increase support from Franklin County communities for ADAMH's mission by sustaining and expanding its collaboration and outreach with community partners.
5. By January 2017, ADAMH will streamline service delivery to increase system efficiencies, expand access to care, and sustain clinical quality and cultural competency through value-based contracting.

Based on our current strategic results, below is a summary report to show our progress toward each result.

Progress Report (2012-2014)
Every MFR program is expected to meet milestones associated with annual operational results. Under the current set of strategic results, which end in January 2017, the following milestones in support of the the strategic results were achieved in the first two years of the planning cycle. Many other operational results remain active and will continue through 2017.

ADAMH Progress Report 2012-2014

Strategic Result	Progress to Date
1. By January 2017, ADAMH will expand access to care for uninsured people through integrated models of primary care, addiction treatment and mental healthcare to help achieve identified outcomes and recovery.	• Funded seven locations throughout Franklin County to provide integrated healthcare services, new programs were funded through a competitive proposal process • Opened the Southeast, Inc. Integrated Healthcare Center at Franklin Station, the first-ever integrated care clinic at a permanent supportive housing facility in collaboration with Southeast and CMHA.
2. By January 2017, ADAMH will improve access to clinically appropriate and necessary treatment services and supports for children, youth, families and individuals to help achieve identified outcomes and recovery.	• Collaborated with 14 suburban school districts to provide more than $2.3 million for prevention, early intervention, treatment and referral services for elementary, middle, and high school students. Services range from mental health school-based services (e.g., suicide prevention, etc.); AOD prevention/intervention services; and early detection/ screenings. • Provide engagement and counseling supports for at-risk students during evening hours at targeted recreation centers and summer festivals as part of the city of Columbus Mayor's Application for Pride, Purpose, and Success and Columbus Public Health. • Improved crisis / detox linkage to ensure timely access to sub-acute detoxification services for Netcare consumers in crisis, including strong collaboration between Maryhaven intake and Netcare crisis services. • Strengthened access for pregnant women, a priority population, by convening a new community workgroup to collaborate on public health planning with ADAMH providers and local physicians. • Developed a new evaluation tool to ensure consumers at residential care facilities receive the appropriate level of care treatment. There has been a reduction of more than $400,000 per year and these funds have been shifted to meet other urgent, unmet needs in the ADAMH system. • Secured 17 units of transitional housing for adults being discharged from an acute care setting (TVBH) who are homeless and without income and linked to ADAMH treatment provider. • Secured 121 units of safe, affordable housing for ADAMH adult consumers at the following permanent supportive housing locations: Franklin Station (CMHA); Inglewood (CHN); NCR and four Recovery Residences. • Secured 79 units of housing, expected for lease up in late summer / fall 2015: 39 units of service enriched housing at Hawthorne Grove (CHN); 40 units of permanent supportive housing at Van Buren Village (VOA). • Expanded peer supported services by investing in The P.E.E.R. Center's new Franklinton location. • Launched new investment with Legal Aid Society of Columbus to ensure ADAMH consumers have quality legal assistance for issues like appealing benefits, domestic/family, evictions etc. Since 2013, legal aid assisted more than 230 consumers with legal issues, 92 percent of the cases closed obtained positive outcomes.
3. By January 2017, ADAMH will advocate to local, state, and national elected officials and decision makers to provide increased support for community-based services and treatment for children, youth, families and individuals.	• Met with 71 community leaders, including local and state elected officials, business and faith leaders from 2012-2014. • Secured private and public grant funding of $ $5,123,441 for targeted, unmet needs from 2012-2014. • Funded RecoveryWorks in partnership with COVA to promote self-directed recovery through a personalized approach. Consumers can seek support and empowerment through Recovery Guides and find support on their wellness journey, all through the use of technology.
4. By January 2017, ADAMH will increase support from Franklin County communities for ADAMH's mission by sustaining and expanding its collaboration and outreach with community partners.	• Launched new Somali and Latino Immigrant Women's Support Groups through Columbus Public Health to offer transitional services, socialization, as well as mental health / AOD / health educational resource information to support the women and their entire family. • Partnered with the Children's Defense Fund Freedom School program, through the Shalom Zone on the west and near east sides, allowing at-risk students an opportunity to sustain academic learning and socialization in safe and drug-free locations. • Collaborated with two summer-based faith programs that target at-risk youth on the south and north sides, offering leadership resiliency, social and emotional development. Includes year-round parenting support program on Southside. • Provided community mini-grants to 123 organizations serving 115,860 people from 2012 – 14. • Launched new ADAMH Mental Health First Aid trainings, conducting 10 training sessions reaching 250 people from 2012 – 14. • Developed ADAMH System Orientation for new employees of any Franklin County organization that interfaces with customers that may need mental health or AOD services through the ADAMH system of care, in response to community partners' request. Train an average of 75 people per year. • Launched new social media platform to educate additional residents and community partners about ADAMH-funded services and share anti-stigma messages. • Increased new collaborations for anti-stigma and prevention messages and outreach about ADAMH-funded services with groups like: Schottenstein Chabad House, Rise Sister Rise and Faith Leaders. • Collaborated with the CSB and CMHA to develop USHS, a centralized front door for eligibility determination and placement at a permanent supportive housing location for adults and families who have experienced homelessness and / or are disabled. Since 2012, USHS has placed more than 700 people in safe, affordable housing.
5. By January 2017, ADAMH will streamline service delivery to increase system efficiencies, expand access to care, and sustain clinical quality and cultural competency through value based contracting.	• Implemented a quality improvement plan for ADAMH's outcomes and evaluation system. • Evaluated ADAMH provider network and assigned a value rating based on the cost and value of the services. These rates determine the eligibility for rates above the Medicaid fixed fee rate and new ADAMH investments awarded through a competitive process. • Identified payment strategies that reward performance and incentivize provide behavior for future contracting decisions. These include performance-based incentives; case rate; fixed fee; fixed fee hybrid; fee for service hybrid; consumer voucher; capitation; and sub-capitation. • Piloted five value-based contracts that evaluated the effectiveness of moving from a fee-for-service model to one that rewards quality and outcomes for providers with improved outcome-based results, such as social connectedness for mental health consumers, and improved cost efficiencies.

New Performance Measures*

Based on our 2015 Business Plan here are some of our new results:

Youth Crisis Care: Expand the number of crisis beds at NCH. There will also be an increase in the number of youth committed to the YCSU at NCH.

Adult Emergency/Crisis Psychiatric Services: Implement re-design recommendations for community crisis care services from the Community Psychiatric/Emergency Services Task Force.

Permanent Supportive Housing: Increase transitional housing units by 30 and permanent supportive housing units by 25.

Heroin/Opiate and AOD Treatment: Increase investment to purchase additional MAT and detox services. There will be an increase in the number of new people served with MAT and Detox Services by 2025.

Youth Suicide Prevention: Increase investments to implement additional evidence-based suicide prevention programs for youth. Work with community stakeholders to decrease the rate of suicide in Franklin County by 2025.

Re-entry Services: Establish a liaison program with the county jail system to facilitate linkages and expand community-based services and supports. Individuals identified by the jail will receive appropriate treatment services within 21 days.

**Based on available funding.*

ADAMH determines success of our community investments and our progress toward our strategic results by using two accountability platforms called ADAMH-STAT and Provider-STAT. The "STAT" systems are based on the CitiStat model out of Baltimore, Maryland, which was introduced by Mayor Martin O'Malley upon his election in 1999. ADAMH adopted its models in 2002.

- **ADAMH-STAT** is the internal performance platform that monitors all of the results in ADAMH's annual strategic performance plan.
- **Provider-STAT** is the external performance platform that monitors ADAMH's investment of federal, state and local funds into the system of care.

Both platforms rely on ADAMH's data warehouse, which consolidates data from multiple sources into a single repository that is used for reliable analysis and reporting. The warehouse is a compilation of more than 22 million behavioral healthcare claims for more than 215,000 consumers. ADAMH staff can mine for service patterns and trends and outcomes of services rendered.

ADAMH-STAT

ADAMH-STAT is the internal performance platform that establishes the metrics of the most pressing business environment challenges related to ADAMH's responsibilities to plan, fund and evaluate mental health and substance abuse treatment, prevention and recovery support services. These operational results, monitored in ADAMH-STAT, which are incorporated into the annual strategic performance plan, must align to ADAMH's strategic results or its mission, vision or core values. Fifty or more results are identified and worked on annually. The ADAMH Board of Trustees reviews and approves the plan in the first quarter of every year.

Externally-focused results are determined by reviewing national and state benchmarks and best practice standards of behavioral healthcare. Internally-focused results are based on compliance with federal, state and local laws and regulations and quality standards for high performance organizations. Upon plan approval, program staff members employ project management skills and business intelligence, the processes, tool and technologies required to turn data into information and information into knowledge and plans to drive effective business activity, to meet the milestones or create deliverables associated with their results.

Key Performance Indicators

Progress is reported and monitored as a key performance indicator. Progress must be backed up by data.

- Results that are met are identified with a green status indicator.
- Results in which progress is being made are identified by a yellow status indicator.
- Results that will not meet the goal are identified in red.

Key Performance Indicators

Indicator	Goal	Value	Status
G1 Community Leaders Engagement	12	33	
G2 System Investments (Advocacy)	120	103	
G3 Funding Proposals	2,000,000	1,265,487	

Program leads are asked to identify any structural or procedural hindrances for results that are a problem (red indicator), as well as provide a recommendation for removing or lessening the impact of those barriers.

Annual Accomplishments Reports

Every year, the board of trustees is provided with a snapshot of ADAMH's progress at meeting milestones aligned with the strategic results. In the following example from 2013, 27 of the 54 non-workgroup results met stated goals, another 15 made progress on the goals, but 5 did not meet targets. Reasons for not making a goal are then detailed in the report.

STATUS	#	%
MET GOAL	27	57%
MAKING PROGRESS	15	32%
DID NOT MEET GOAL	5	11%
WORKGROUP	7	

The corresponding indicators and associated milestones for every result are incorporated into the report. A typical entry looks like this:

RESULT	DESCRIPTION	YEAR-END RESULT	FINAL STATUS	MILESTONES
Community Leaders Engagement	12 community leaders will have face to face meetings with ADAMH leadership that will expand their awareness and increase their support of ADAMH.	35 community leaders		ADAMH leadership met with 35 community leaders including multiple local and state elected officials, community leaders, business leaders, and faith leaders in 2013.

Consumer-Specific Results

ADAMH's annual performance plans focus on three different lines of business: Consumer Care; System of Care Planning and Evaluation; and Administrative Support.

Below are some highlights of our key results from 2013 and 2014 as it relates to consumers and the care they receive from our contract agencies:

Treatment Services for Adult Mental Health Consumers

- Almost 62 percent showed improvement or continued stability in at least two of the following measures of recovery: reduction of symptoms/problems; quality of life; and social connectedness.

Treatment Services for AOD Consumers

- One hundred percent of addicted pregnant women will receive an appointment or a referral for services within 48-hours of their call seeking services.

Crisis Care Management

- Almost 95 percent of frequent users of ADAMH system crisis care services were provided a coordinated crisis care plan in an effort to stabilize individuals and reduce their use of crisis care services.

Provider-STAT

The external performance platform establishes accountability expectations within the ADAMH system of care by comparing the same data elements for every contract provider to better understand individual agency performance against system average performance.

To ensure the effective use of public funds, the accountability of the provider network and the continuous improvement of care and service delivery within our system, ADAMH routinely evaluates system outcomes and consumer satisfaction and shares this information with providers in the system of care.

System Outcomes

Every year, ADAMH evaluates system treatment outcomes by service population. The current outcomes evaluation instruments are:

- The Adult Consumer Form: A form for adults receiving mental health treatment services
- The Ohio Scales Parent Form: A form for children and adolescents receiving mental health treatment services
- The Addiction Severity Index (ASI): An index for adults receiving alcohol and drug treatment services

The measurement and reporting of consumer outcomes allows ADAMH to manage consumer care, improve the service delivery system and account for public records. Successful outcomes are important because they show that treatment works, consumers receive quality and effective care and there are great returns on public investment.

Consumer Satisfaction

Every year, ADAMH conducts independent consumer satisfaction surveys by service population to solicit consumer opinion on service quality and areas for improvement. Consumer-to-consumer telephone surveys are conducted by service population (mental health adult, AOD and parents of children and adolescents) using a random survey methodology with phone rosters submitted by our contract agencies.

Providers are given individual scores and a system composite. ADAMH defines the minimum threshold as 24 (satisfied to mostly satisfied) and the desired performance target as 27 (Mostly to very satisfied). In this example, the provider has met the desired performance target in every category for two years (see Consumer Satisfaction Chart, APPENDIX 9).

Provider-STAT Dashboard

ADAMH then uses a data-driven and multi-disciplinary tool that focuses on a provider's business, clinical and programmatic operations. Various measurements, including outcomes and consumer satisfaction, are grouped into the following categories on that tool:

Provider-STAT Dashboard Measurements

Category	Measurements
Financial Performance	Timeliness of claims and enrollments Percentage of allocation shadow claimed Financial performance indicators Claims lag triangle
Access to Care	Total consumers New consumers Readmitted consumers Consumer counts and expenditures for populations served People with at least one BHO admission
Appropriateness of Care	Active participation in decision concerning treatment (for ADAMH-paid consumers) Percentage of ADAMH-paid people who have less than 3 crisis episodes at Netcare Percentage of ADAMH-paid people discharged from state BHO who receive psychiatric services within 14 days Percentage of ADAMH-paid people discharged from state BHO who receive an outpatient service within 7 days Percentage of ADAMH-paid people with multi-day holdovers at Netcare who receive an outpatient service within 7 days
Outcomes of Care	Percentage of state BHO discharges that remain in the community over 30 days for ADAMH-paid consumers Adults: percentage of ADAMH-paid consumers who experience decreased psychological distress Youth: Decreased level of symptoms/problems for ADAMH-paid consumers Adults: Impairment from substance use for ADAMH-paid consumers Youth: Impairment from substance use for ADAMH-paid consumers Percentage of ADAMH-paid consumers who experience an increased level of functioning or quality of life
Contract Compliance	Behavioral healthcare data submission Outcomes data submission
Consumer Satisfaction	Consumer satisfaction

On every measurement, the providers are rated on a five-point scale: 5 = Outstanding; 4 = Good; 3 = Meets; 2 = Needs Improvement; 1 = Unsatisfactory. Where available, they are also provided a historical snapshot for comparison.

Based on these numbers, ADAMH staff members hold a data quality review prior to the meeting and flag items to discuss with the providers. Some years, ADAMH invites executive directors and key provider staff to ADAMH to discuss performance at a Provider-STAT session. Other years, ADAMH distributes the same reports for providers to use for quality improvement purposes or outside licensure requirements (e.g., Joint Commission). Beginning in 2012, ADAMH has rewarded providers who meet performance thresholds by offering incentive-based contracts.

This page was intentionally left blank.

BUSINESS ENVIRONMENT

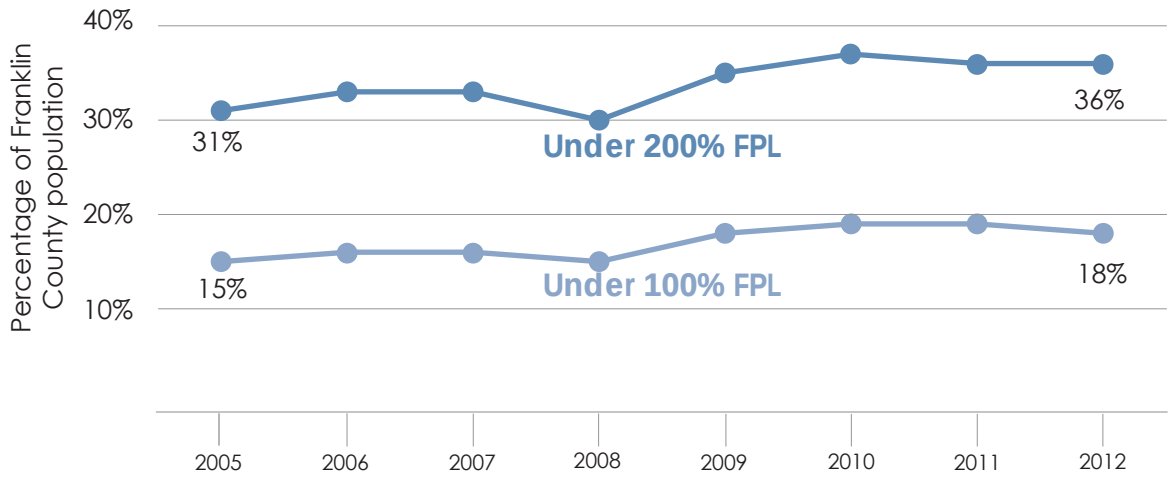
Recent policy changes at the state and federal level will continue to provide challenges to ADAMH in the provision of quality, timely and appropriate mental health and substance abuse treatment healthcare. Population growth, persistent poverty, changing community demographics, access to care and uncertainty about the role of state government in meeting the behavioral healthcare needs, beyond the scope of Medicaid, brings unprecedented challenges, as well as opportunities.

Population Growth
Franklin County's population size has grown steadily over the past decade and is projected to grow 14 percent from 2015 to 2040.

Persistent Poverty
The percentage of Franklin County residents who live below 200 percent of poverty rose from 31 percent in 2005 to 36 percent in 2012.

- The CSB's 2013 Annual Homeless Assessment Report identified 9,809 individuals and children were served in emergency shelters in Franklin County, a 7 percent increase compared to the previous year.

Poverty in Franklin County, 2005-2012



Source: 1-year ACS estimates, 2005-2012

Immigration
The percentage of Franklin County residents who were born outside the U.S. rose from six percent in 2000 to 9.5 percent in 2012. ADAMH must continue to strengthen and expand culturally competent contract services that are delivered by culturally-capable professionals.

Access to Care
As a result of Medicaid expansion at the state level, and ACA at the federal level, it is still unclear how many individuals will remain uninsured or under-insured with very high deductibles for mental health and/or addiction services. In addition, many necessary services, as indicated by the SAMHSA comprehensive behavioral health continuum, are not covered under the Medicaid program.

"I am happy now, thanks to Maryhaven and ADAMH who make these programs possible, I am very grateful, they saved my life."

– Jacqueline C.

Therefore, ADAMH has a role to play in serving as a "payer of last resort" for the following services from the SAMHSA continuum:

- Acute intensive services
  - Peer-based crisis
  - 23-hour crisis stabilization
  - 24/7 crisis hotline
- Out-of-home residential services
  - Crisis residential/stabilization
  - Clinically-managed 24-hour care
  - Clinically-managed medium intensity care
  - Adult mental health residential
  - Children's mental health residential
  - Therapeutic foster care
- Intensive support services
  - Assertive Community Treatment (ACT)
  - Intensive Home-Based Treatment (IHBT)
  - Multi-Systemic Therapy (MST)
- Medication services
  - Medication Assisted Therapy (MAT) for addiction
- Outpatient services
  - Family therapy
  - Multi-Family Therapy (MFT)
- Prevention (including promotion)
  - Brief motivational interviews
  - Wellness recovery support
  - Warm line
- Community support (rehabilitative)
  - Supported Employment
  - Permanent Supported housing
  - Recovery Housing
- Other supports (habilitative)
  - Respite
  - Supported education
- Recovery supports
  - Peer support
  - Recovery support coaching
  - Recovery support center services

Covered and Uncovered Behavioral Health Services After Implementation of the Affordable Care Act and the Mental Health Parity and Addiction Act

Key

- Services covered by Medicaid, Medicare and/or private insurance
- Services not covered
- Services paid for by the ADAMH Board of Franklin County in 2012
- ♦ **Services NOT covered by Medicaid** (or covered by Medicaid with restrictions) that were paid for by the ADAMH Board of Franklin County in 2012

Types of services From SAMHSA's "Good and Modern Addictions and Mental Health Service System" continuum*	**Payers**		
	ADAMH Board of Franklin County (payer of last resort)	**Medicaid**	**Medicare and private insurance**
Acute Intensive Services			
Mobile crisis		Covered as MH crisis intervention for clinical assessment and referral	
Medically monitored intensive inpatient		Covered for expansion population; non-expansion population limited to 30 days annually	Some coverage, but may be cost sharing & benefit limits
Peer-based crisis	♦		
Urgent care		Covered as MH crisis intervention or med/somatic (under EHB 1)	Likely some coverage, but may be cost sharing & benefit limits
23 hour crisis stabilization	♦		Likely some coverage, but may be cost sharing & benefit limits
24/7 crisis hotline	♦		Some level of service may be accessible through nurse hotlines
Out-of-Home Residential Services			
Crisis residential/stabilization	♦	Not covered for people aged 22-64 who reside in facilities that meet the Federal definition of an institution for the treatment of mental disease	Likely some coverage, but may be cost sharing & benefit limits
Clinically managed 24-hour care	♦	Not covered for people aged 22-64 who reside in facilities that meet the Federal definition of an institution for the treatment of mental disease	Likely some coverage, but may be cost sharing & benefit limits
Clinically managed medium intensity care	♦	Not covered for people aged 22-64 who reside in facilities that meet the Federal definition of an institution for the treatment of mental disease	Some coverage, but may be cost sharing & benefit limits
Adult mental health residential	♦	Specific "treatment services" may be covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
Children's mental health residential services	♦	Specific "treatment services" may be covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
Youth substance abuse residential	♦	Specific "treatment services" may be covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
Therapeutic foster care		Specific "treatment services" may be covered under FFS or MCO	
Intensive Support Services			
Substance abuse intensive outpatient		Covered	Some coverage, but may be cost sharing & benefit limits
Substance abuse ambulatory detoxification		Covered	Some coverage, but may be cost sharing & benefit limits
Partial hospital		Covered but defined more broadly to include Day Habilitation	Some coverage, but may be cost sharing & benefit limits
Assertive community treatment (ACT)	♦	Bundled services not covered. Specific services may be billed and reimbursed separately	Some specific services may be covered, but may be cost sharing & benefit limits
Intensive home based treatment (IHBT)	♦	Bundled services not covered. Specific services may be billed and reimbursed separately	Some specific services may be covered, but may be cost sharing & benefit limits
Multi-systemic therapy (MST)	♦	Bundled services not covered. Specific services may be billed and reimbursed separately	Some specific services may be covered, but may be cost sharing & benefit limits
Intensive case management		Covered as CPST or health home	May be covered, depending on insurance plan design/model

Covered and Uncovered Behavioral Health Services After Implementation of the Affordable Care Act and the Mental Health Parity and Addiction Act (cont.)

Types of services From SAMHSA's "Good and Modern Addictions and Mental Health Service System" continuum*	**Payers**		
	ADAMH Board of Franklin County (payer of last resort)	**Medicaid**	**Medicare and private insurance**
Outpatient services			
Individual or group evidence based therapies		Covered; MH services limited to 52 hours per year for adults; AOD services limited to up to 30 hrs./wk. when combined with case management & medical somatic for non-expansion; no limits for expansion	Some coverage, but may be cost sharing & benefit limits
Family therapy	♦	Covered for MH services when the primary patient is under age 21 and interventions are directed at addressing the MH issues.	
Multi-family therapy	♦		
Consultation to caregivers		Covered as CPST, AOD case management, or health home	
Healthcare Home/Physical Health			
General and specialized outpatient medical services		Covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
Acute primary care		Covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
General health screens, tests, and immunizations		Covered under FFS or MCO	Some coverage, but may be cost sharing & benefit limits
Comprehensive care management		Covered if in health home or MCO care management program	May be covered, depending on insurance plan design/model
Care coordination and health promotion		Covered if in health home or MCO care management program	May be covered, depending on insurance plan design/model
Comprehensive transitional care		Covered if in health home or MCO care management program	May be covered, depending on insurance plan design/model
Individual and family support		Covered if in health home or MCO care management program	
Referral to community services		Covered under CPST, AOD case management, health home or MCO care management program	May be covered, depending on insurance plan design/model
Medication Services			
Medication management		Covered; MH services limited to 24 hours per year for adults; no limits for expansion population	Some coverage, but may be cost sharing & benefit limits
Pharmacotherapy (including Medication Assisted Therapy) for addiction treatment	♦	Covered; MH services limited to 24 hours/ yr. for adults; no limits for expansion population	Some coverage, but may be cost sharing & benefit limits
Laboratory services			
Engagement Services			
Assessment		Covered; MH services limited to 4 hrs annually for adults; no limits for expansion population	Some coverage, but may be cost sharing & benefit limits
Specialized evaluations (psychological, neurological)		Covered; MH services limited to 4 hrs annually for adults; no limits for expansion population	Some coverage, but may be cost sharing & benefit limits
Service planning (including crisis planning)		Covered as Health Home, CPST, or AOD case management	
Consumer/family education		Covered as Health Home, CPST, or AOD case management	
Outreach		Covered as Health Home, CPST, or AOD case management	
Prevention (including Promotion)			
Screening, brief intervention, and referral to treatment		Covered for medical professionals only	Likely covered, but may be cost sharing
Brief motivational interviews	♦		

Covered and Uncovered Behavioral Health Services After Implementation of the Affordable Care Act and the Mental Health Parity and Addiction Act (cont.)

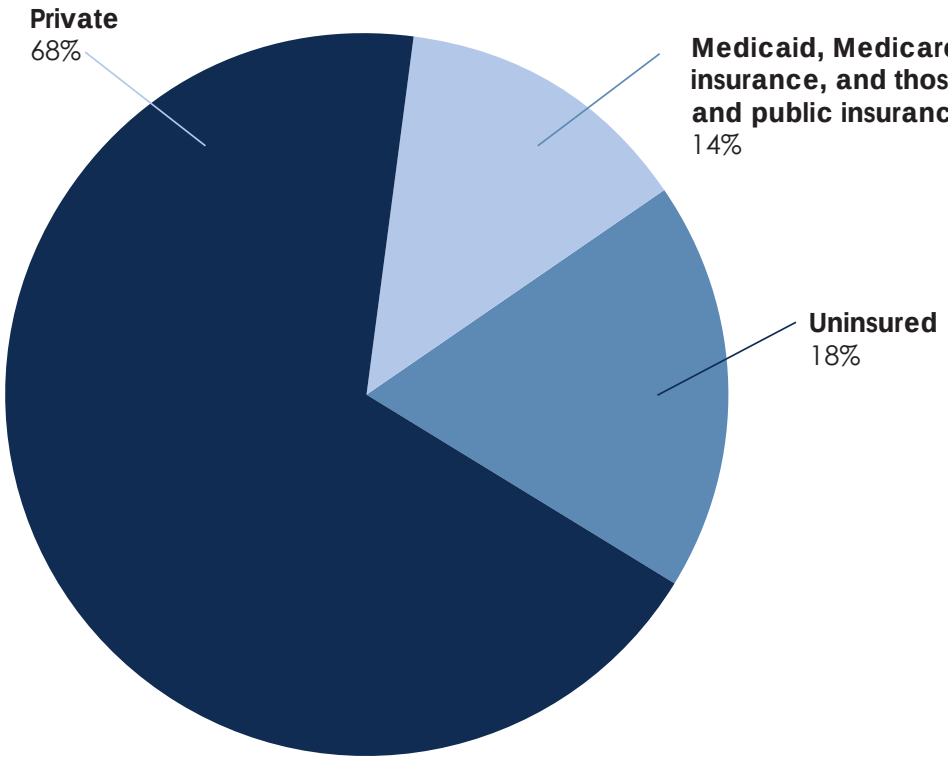
Types of services From SAMHSA's "Good and Modern Addictions and Mental Health Service System" continuum	Payers		
	ADAMH Board of Franklin County (payer of last resort)	Medicaid	Medicare and private insurance
Prevention (including Promotion) (cont..)			
Screening and brief intervention for tobacco cessation		Covered for medical professionals only	Covered by Medicare, may be covered by some private insurers
Parent training		Covered as BH counseling or CPST if addressing a MH/AOD issue specifically; may be offered by some MCOs	
Facilitated referrals		Covered under Health Home or MCO	
Relapse prevention		Covered under AOD case management	
Wellness recovery support	♦		
Warm line	♦		
Community Support (Rehabilitative)			
Parent/caregiver support		Covered as CPST or AOD case management	
Skill building (social, daily living, cognitive)		Covered as CPST or AOD case management	
Case management		Covered as CPST or AOD case management	May be covered, depending on insurance plan design/model
Behavioral management		Covered as BH Counseling, CPST, or AOD case management	
Comprehensive community support		Covered as CPST or AOD case management	
Supported employment	♦	Covered as CPST	
Permanent supported housing	♦	Covered as CPST	
Recovery housing	♦		
Therapeutic mentoring	♦		
Day habilitation		Covered as partial hospitalization	
Other Supports (Habilitative)			
Personal care			
Homemaker			
Respite	♦	Covered by some MCOs	
Supported education	♦		
Transportation		Covered by MCOs	
Assisted living		Covered by MCOs	
Recreational services			
Interactive communication technology devices			
Recovery Supports			
Peer support	♦		
Recovery support coaching	♦		
Recovery support center services	♦		
Supports for self-directed care	♦		
Continuing care for substance use disorders	♦		

- FFS=Fee for Service
- MCO=Managed Care Organization

* SAMHSA. Medicaid handbook: Interface with behavioral health services. Module 3. 2013. (downloaded August 2014 from http://store.samhsa.gov/shin/content/SMA13-4773/SMA13-4773_Mod3.pdf

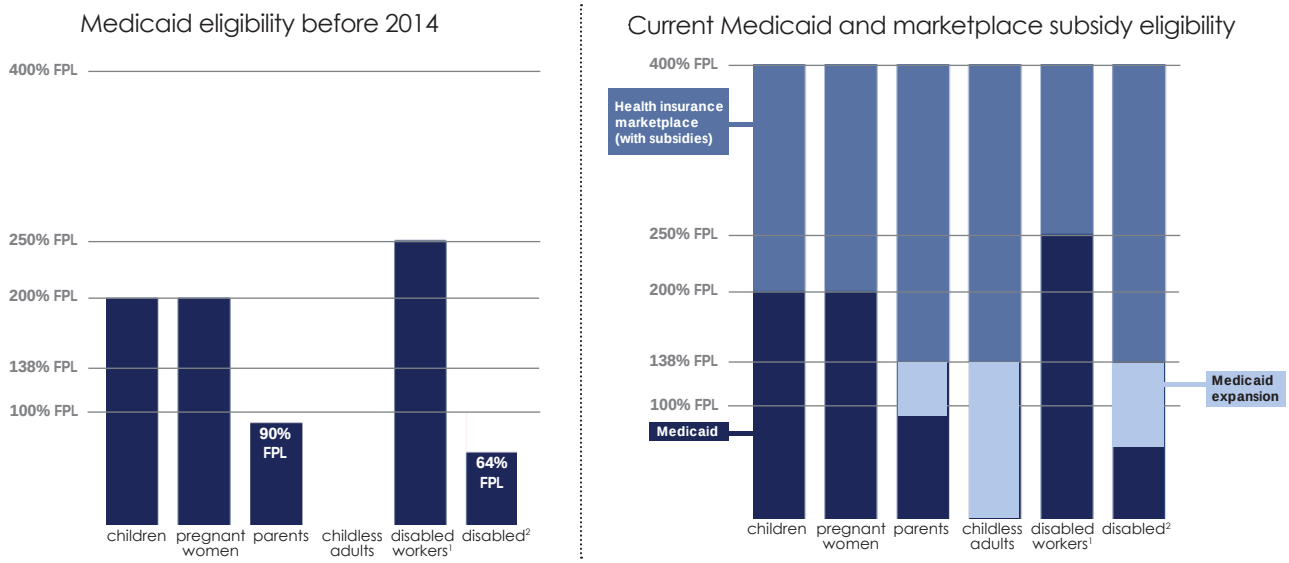
Additionally, Medicaid enrollment in Franklin County was significantly lower than other urban counties in Ohio during 2014. It is unclear whether enrollment will increase to the projected levels in 2015 and beyond. In Franklin County, an estimated 67,721 uninsured 18-64 year olds are eligible for Medicaid due to the expansion. As of July 31, 2014, 28,559 Franklin County residents had enrolled in Medicaid through the expansion, which represents 42.2 percent of the eligible population in the county.

Where did Franklin County residents get health insurance coverage before the ACA? Ages 18-64



Source: US Census Bureau, American Community Survey, 1-year estimates, 2012

Subsidized Health Coverage Eligibility for Ohioans after the ACA and Medicaid Expansion



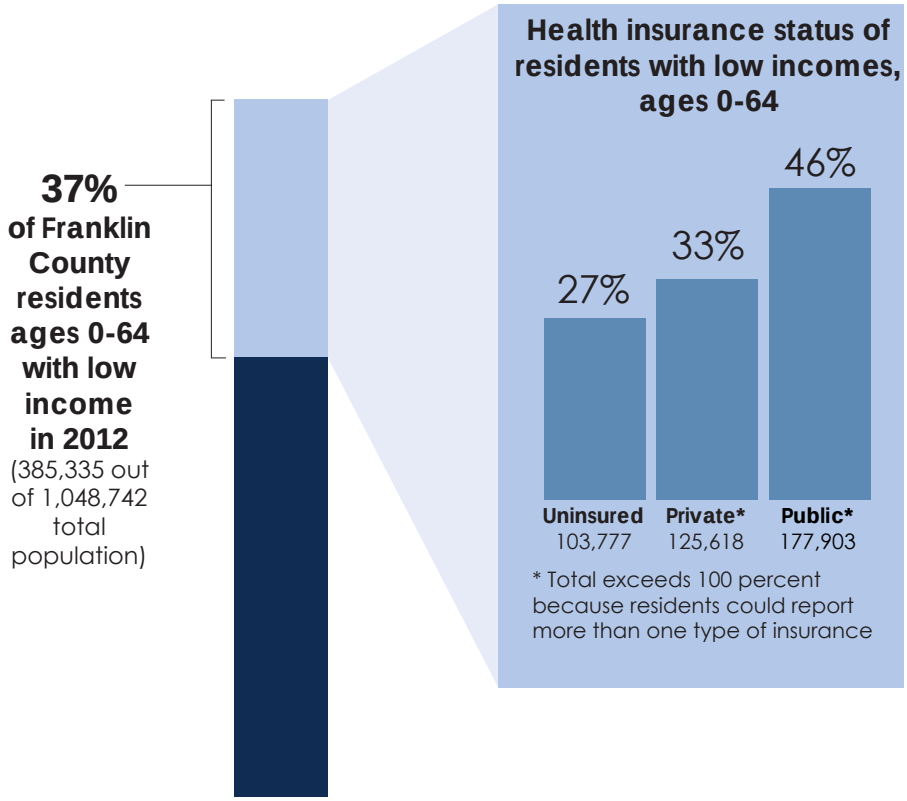
1. Disability in this category of Medicaid follows the Social Security Administration criteria for disability determination and includes both children and adults.
2. Through the Medicaid Buy-in for Workers with Disabilities program, people with disability who wish to work can still receive their Medicaid benefits.

For more details on Medicaid coverage for people with disabilities, see HPIO's "Health and Disabilities Basics" publication at **http://bit.ly/UWzCrY**

Uninsured Population Continues to Evolve

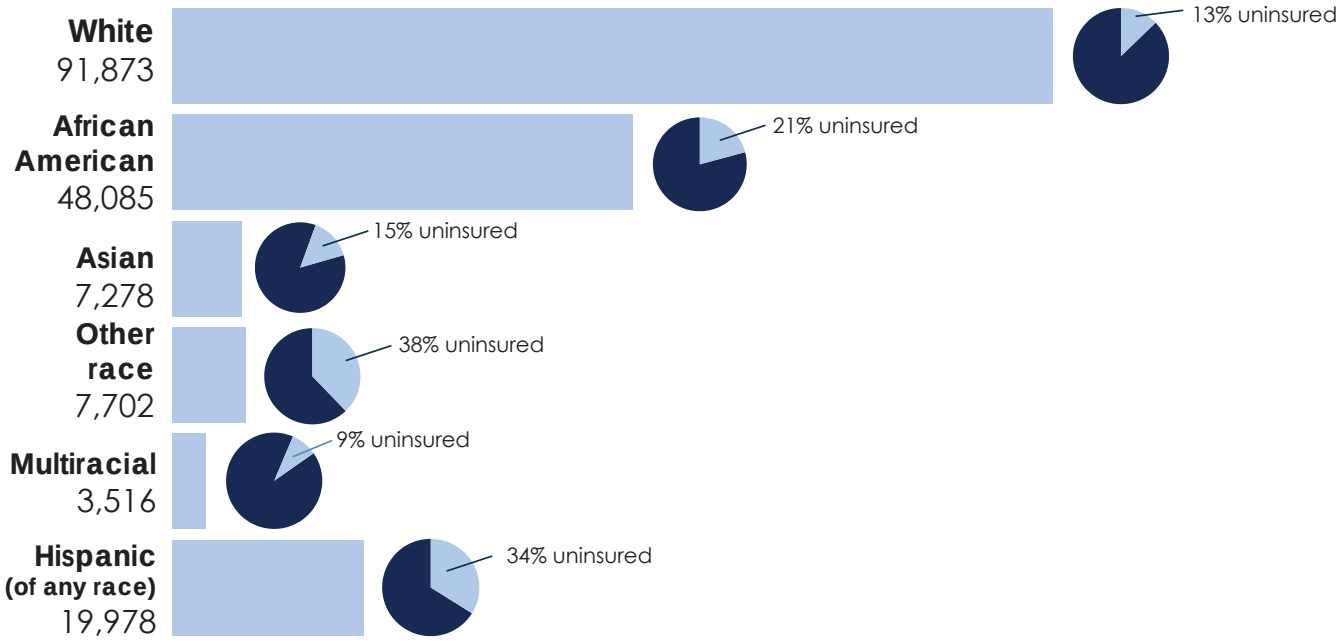
As federal and state healthcare reform rolls out, the number of individuals who are uninsured remains in flux. As illustrated in *Franklin County Residents with Low Incomes, Ages 0-64, 2012 (Less than 200 Percent FPL)* chart below and *Number and Percent of Franklin County Residents who were Uninsured in 2012, by Race and Ethnicity, Ages 0-64* (page 78), there are more than 103,000 individuals are uninsured in Franklin County and below 200 percent of poverty. Of those individuals, there are significant disparities among by race and ethnicity: 34 percent of Hispanics; 21 percent of African Americans and 38 percent of Other Race were uninsured.

Franklin County Residents with Low Incomes, Ages 0-64, 2012 (Less than 200 Percent FPL)



Source: US Census Bureau, American Community Survey, 1-year estimates, 2012
Note: Numbers presented in these graphs only include Franklin County residents for whom poverty status was determined and are therefore slightly lower than the total estimated population size of the county for 2012.

Number and Percent of Franklin County Residents who were Uninsured in 2012, by Race and Ethnicity, Ages 0-64



Source: U.S. Census Bureau, American Community Survey, one-year estimates, 2012

State Policy Uncertainty

As introduced, the Governor's Biennial Budget, supports the continuation of Medicaid expansion, it is possible that many members of the Legislature may introduce policy options to limit cost growth alternatives to the Medicaid program during the biennial budget process that will conclude by June 30, 2015.

As the uncertainty surrounding Ohio's Medicaid program continues, ADAMH monitors the progress of healthcare reform to better serve Franklin County residents who live with mental health or substance abuse issues.

Continued Changes to Local Government Funding

As further detailed in the *Fiscal Challenges* starting on page 53, levy revenue collections peaked in 2010 ($65 million) and have steadily declined since ($57.4 million in 2014). Two factors have driven this decline:

- Housing Values – During the 2011 Sextennial assessment, Franklin County's assessed values declined by 6.2 percent.
- Tangible Personal Property (TPP) Tax – House Bill 66 resulted in major Ohio business tax reforms. One key change was the phase-out of taxing business personal property (equipment, fixtures, inventory, etc.). This phase-out was initially planned to occur through 2018, but with the recession, the phase-out was accelerated. Financially, ADAMH's TPP revenues peaked in 2005 ($4.8 million) and are now less than $1.1 million.

This page was intentionally left blank.

OPERATIONAL NEEDS

Staffing Counts

As illustrated in the ADAMH table of organization (APPENDIX 4), the anticipated staffing level for the new level cycle is 51 employees. It is projected that ADAMH will create three new positions. It is likely these will be needed because of healthcare reform and the ever-evolving changes that it brings to the healthcare landscape. The new positions will help the organization keep abreast of these changes and identify emerging trends and patterns on the horizon.

Future Efficiencies

External Efficiencies

Number of Service Providers

During the last five years (2011-2015), the ADAMH network of contract agencies has remained relatively stable. With the exception of some mergers and consolidations (see the discussion on *System-Wide Cost Efficiencies* starting on page 52 of this fact book) the core network is unchanged.

In 2011, ADAMH contracted with 42 contract agencies. In 2015, ADAMH now contracts with 33 agencies that provide treatment, prevention, community support and advocacy services. This is a reduction of more than 20 percent in the last four years.

Perhaps a more telling story has less to do with the number of contract providers within the ADAMH network but has more to do with the make-up of the network. Several new providers have been added to the network in recent years that reflect the changing demand for ADAMH services.

In 2011, National Church Residences (NCR), a community housing provider, was added to the network. Of NCR's portfolio, they manage 55 ADAMH units. One of our first collaborative projects with NCR was the Commons at Buckingham. It is designed as supported or service–enriched housing. The complex, located at 328 Buckingham Street, has 100 small, efficiency-style units that are attractive, affordable and amenable to the design of the neighborhood. The units are designed for single adults, of which 23 units are dedicated to serve ADAMH consumers.

In 2013, the Alvis House was added to the network. A human trafficking initiative that provides specialized treatment services for this underserved population and was identified as a clear service gap in Franklin County for survivors and victims of human trafficking. The Franklin County Municipal Court has developed a specialty docket that serves women who have been arrested on criminal charges of solicitation of prostitution or related charges.

In 2013, the Village Network was added to the system of care. ADAMH and the Juvenile Court collaborated to change the "front door" of the juvenile justice system and reduce the number of youth who enter the juvenile detention center by providing immediate access to services and resources. The Reception Center Intervention is comprised of three components:

- **Reception Center**- Screening, assessment and linkage to care for youth who become involved in the juvenile justice system.
- **Shelter Care**- Short term alternative care setting for youth that cannot safely return home.
- **Evening Reporting Program**- Assessors at the Reception Center may refer appropriate youth to this program. This intervention provides structured activities and mental health and substance use groups to increase supervision during the key times of day when delinquency tends to occur.

In 2013, ADAMH launched a new initiative with the Legal Aid Society of Columbus to ensure that poor, mentally disabled adults receive appropriate legal assistance for vital issues like benefits, advocacy, housing issues and domestic-related issues. The Legal Aid Society provides advocacy and legal services to ADAMH system consumers that may have exhausted all other advocacy options and who are referred by the system Ombudsmen. Since 2013, the initiative has served 230 consumers.

In 2014, OSU Harding Hospital was added to the network. The CALM unit is an eight-bed psychiatric observation unit designed to move patients in crisis promptly from triage to treatment; avoiding lengthy and often counter-therapeutic ED stays while preserving actual inpatient psychiatric beds for those who are most in-need of that level of service.

Value-Based Contracting

During the current levy cycle, ADAMH has begun to develop a value-based contracting initiative incentivizing provider performance based on quality and price of their services and not just on the quantity of services. Performance output and outcome metrics have been identified which can be measured by ADAMH in order to evaluate the effectiveness of the programs and services and link payment structures to incentivize the best possible performance.

Over the last three contract years, including 2015, ADAMH has entered into 18 performance-based contracts valued at over $1 million with seven different providers.

The services in these contracts include integrated addiction and mental health best practice models, LGBTQ services, alcohol and drug addiction residential treatment, medically assisted addiction services, detoxification services and integrated primary (physical) healthcare and behavioral healthcare services.

Quality metrics that have been used to this point include improvement or continued stability in reduction of symptoms/problems, quality of life and social connectedness.

ADAMH will continue to evolve this initiative throughout the upcoming levy cycle to include additional programs, more sophisticated methods of measuring quality outcomes and effective payment mechanisms.

Ultimately, ADAMH will be in a position to refine its investments in those programs and services that most effectively and efficiently serve consumers in Franklin County. These programs will evaluate the effectiveness of moving from a fee-for-service model to one that rewards quality and outcomes. It rewards providers for improved outcome-based results and improved cost-efficiencies. As healthcare reform progresses, we will review the impact of different outcome-based payment approaches to evaluate how different approaches improves the healthcare delivery for ADAMH consumers.

Internal Efficiencies

Council of Government (COG)

ADAMH has formed a COG with both the Hamilton County Mental Health and Recovery Services Board and the Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County known as the Three C Recovery and Healthcare Network.

The impetus for forming the COG is to fund and implement a community mental health and addiction management information system known as SHARES. SHARES is necessary to support the payor role of ADAMH, as a component of the local authority's statutory responsibility for developing, funding, overseeing and evaluating mental health and substance abuse care for their respective jurisdictions.

To enhance the individual boards' ability to fulfill their statutory responsibilities with progressive technology and enterprise-wide functionality, SHARES will replace MACSIS for COG members and Boards that become customers of the COG. MACSIS is a state developed (1999) claims system that has become a "legacy system" whose useful life is coming to an end.

The following is a description of the system's primary functionality:

- Healthcare Management Information System (SHARES): Used to manage member eligibility and enrollment, manage provider networks, make referrals and authorize services to providers, track services delivered, coordinate services and reimburse providers. Supports intensive clinical care and outcomes management, as well as automation of business rules and workflows.
- HIPAA Transaction Engine: Used to process HIPAA transactions in compliance with Electronic Data Interchange (EDI) specifications and standard code sets.
- Provider Portal: A web-based, 24/7 provider connectivity and communication solution for conducting secured transactions and exchange data through the internet. Authorized provider staff can submit or update enrollment, assessment, authorization, outcomes and claims data, and/or check on the status of eligibility, benefits and claims.
- Business Intelligence and Reporting Warehouse: A stand-alone SQL Server database uses rebuilt data storage models (i.e. de-normalized databases) to offer an easy-to-use environment for ad hoc and custom reporting. Allows users to aggregate, stratify and analyze data from multiple sources.

This page was intentionally left blank.

Listed in the table below is ADAMH's actual revenue and expenditures for the past five years and projections for the remainder of the current levy cycle (through 2016).

ADAMH Historical Revenue and Expenses

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Alcohol, Drug and Mental Health Board of Franklin County
Historical Revenue and Expenditures
Calendar Years 2010-2016

	2010 Actuals	2011 Actuals	2012 Actuals	2013 Actuals	2014 Actuals	2015 Projection	2016 Projection
Beginning Cash:	27,648,278	42,380,099	64,374,557	74,266,717	82,573,022	88,835,948	85,072,730
Revenue:							
Levy Funds (Current 2.2 Mill through 2016)	65,040,211	62,915,255	58,547,943	57,744,126	57,388,039	57,571,731	58,136,925
Medicaid Funds	55,604,228	73,579,597	50,935,003	544,895	0	0	0
Federal Funds	16,436,981	13,053,227	8,904,258	8,019,871	6,903,598	5,836,436	7,261,469
State Funds	18,639,365	15,935,381	3,173,457	7,164,262	10,642,477	5,546,591	3,465,005
Local Funds	1,132,856	1,681,357	2,463,926	1,876,288	3,170,328	2,469,145	2,469,145
Miscellaneous Funds	421,042	313,855	512,565	907,277	2,376,433	400,000	400,000
Total Revenue	157,274,683	167,478,671	124,537,152	76,256,719	80,480,874	71,823,903	71,732,544
Expenditures:							
Personal Services	3,231,362	3,205,007	3,414,056	3,351,714	3,489,311	3,787,029	3,862,770
Fringe Benefits	1,288,611	1,249,901	1,306,258	1,291,191	1,365,786	1,582,776	1,614,432
Materials & Services	1,388,524	2,987,146	1,583,084	2,150,011	1,958,178	2,595,255	2,615,093
Capital Outlays	8,518	60,526	46,481	36,990	0	20,000	50,000
Grants	1,500	6,975	101,850	225,000	412,700	750,000	500,000
Interfund	458,496	0	0	0	242,963	0	0
Social Services	136,165,850	137,974,658	108,193,263	60,895,508	66,749,011	66,852,061	71,263,640
Total Expenditures	142,542,861	145,484,214	114,644,992	67,950,414	74,217,948	75,587,121	79,905,934
Ending Cash Balance:	**42,380,099**	**64,374,557**	**74,266,717**	**82,573,022**	**88,835,948**	**85,072,730**	**76,899,340**

Community Medicaid

In reviewing the *ADAMH Historical Revenues and Expenses* chart (page 85), one of the most significant changes that occurred in the last five years is the state's decision to assume financial responsibility and operations of the Community Medicaid program.

Since its inception in the mid-1990's, local ADAMH Boards operated the Community Medicaid program. The Boards' responsibilities included processing Medicaid claims and making payments to providers participating in the program. In theory, the state provided sufficient funds to boards' to finance Medicaid claim payments.

When the national recession occurred, Medicaid expenditures grew exponentially and the state cut funding to our local board. This put ADAMH in an untenable position of financing the State: Federal Medicaid program with local funds. The board of trustees adopted a hard cap that limited the amount of local resources that could be used to finance the Medicaid program.

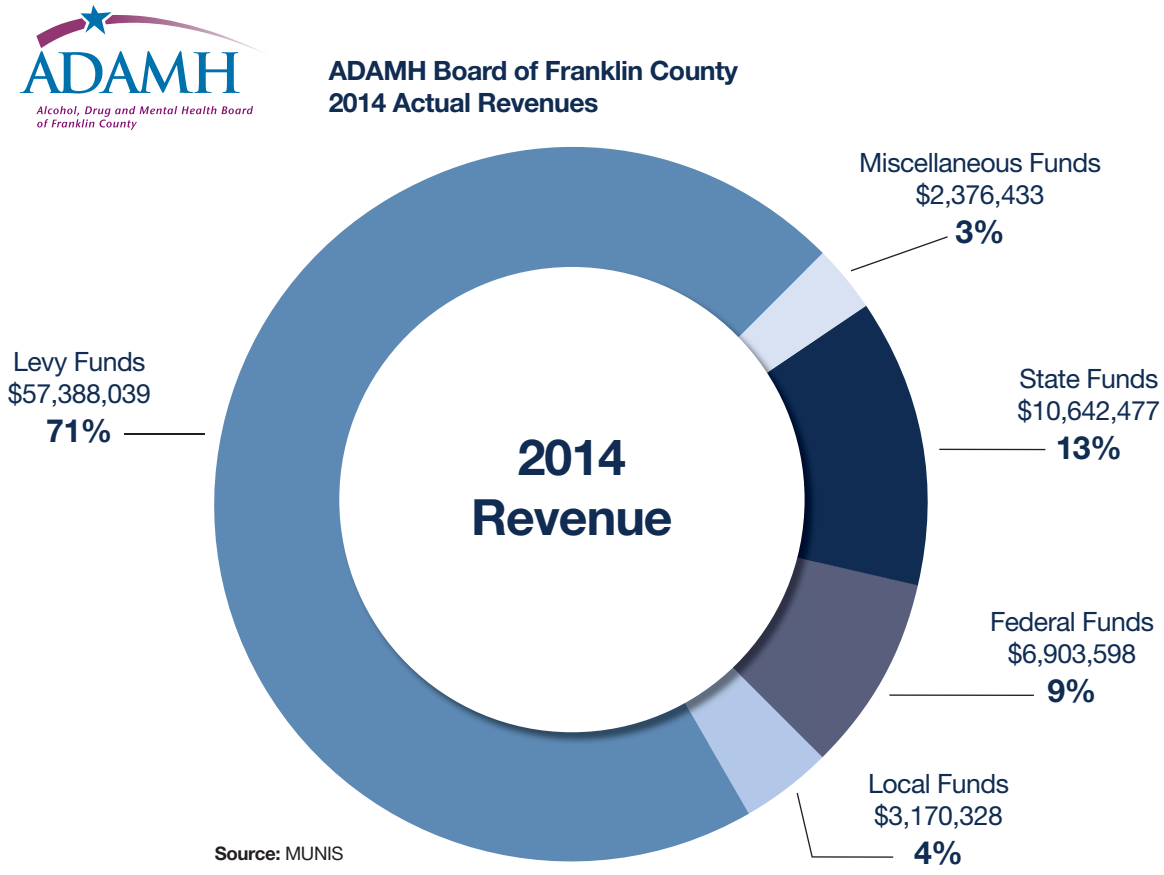
In June 2012 (SFY 2012-13 Biennial Budget), the state assumed financial and operating responsibility for the Medicaid program.

The overall reduction in revenues and expenditures between 2012 and 2013 in the *ADAMH Historical Revenues and Expenses* chart on page 85 of this fact book can be primarily attributed to the Medicaid program.

ADAMH revenues are currently derived from four primary funding sources:

- ADAMH Levy;
- Federal Revenue;
- State Revenue; and
- Local Revenue.

2014 ADAMH Actual Revenues

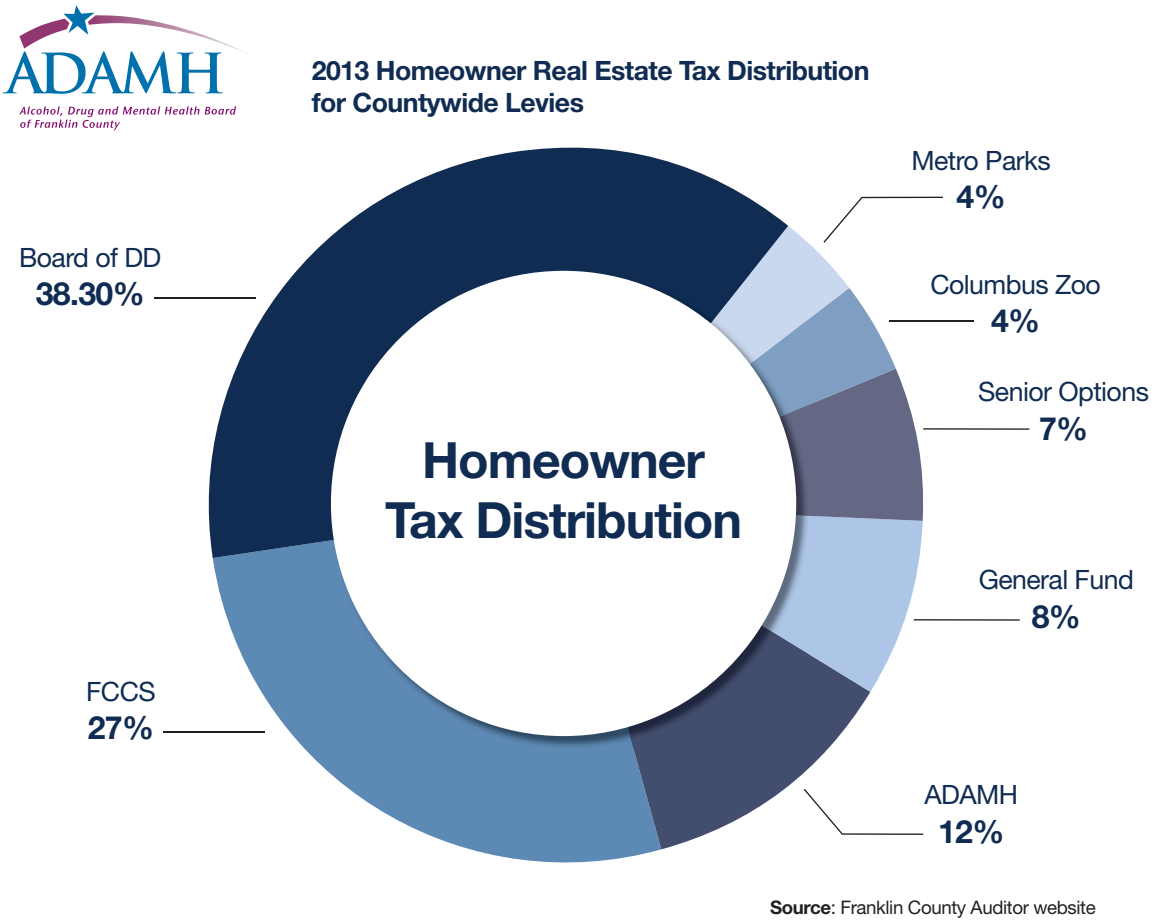


ADAMH Levy

Current levy revenue is generated through a 10-year, 2.2 mill replacement property tax levy approved by voters in November 2005. The 2014 levy revenue was approximately $57 million. Levy revenues are used to purchase social services (mental health and alcohol and other drug treatment and prevention services) and annual ADAMH administrative expenditures to plan, fund and evaluate the services purchased.

As the *2013 Homeowner Real Estate Tax Distribution* chart below indicates, of the seven countywide levies (including the Franklin County General Fund), the ADAMH levy constitutes 12 percent of the overall distribution of homeowner real estate tax.

2013 Homeowner Real Estate Tax Distribution

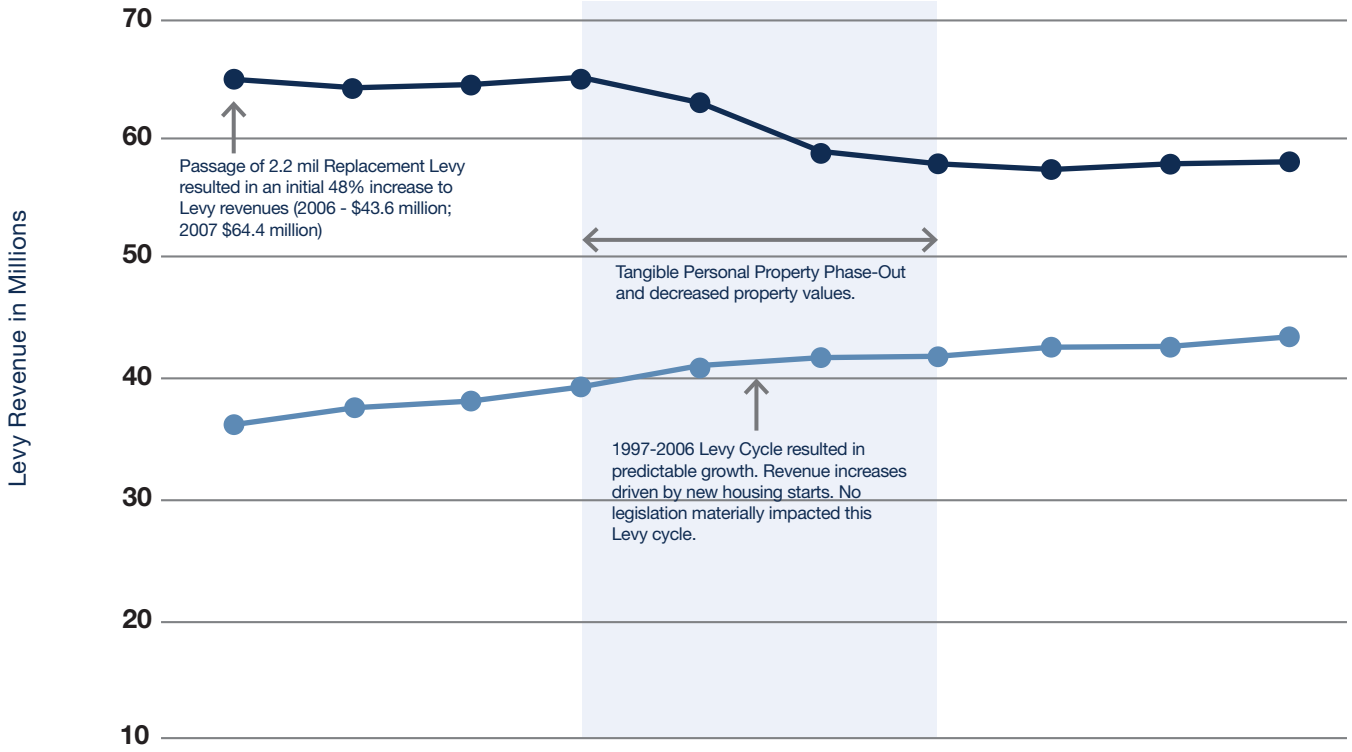


Source: Franklin County Auditor website

Over 71% of the ADAMH system's resources come from a single property tax levy approved by voters.

Levy revenues during the current cycle have declined by 12 percent, from over $65 million in 2010 to less than $57.4 million in 2014. The *ADAMH Levy Collections Prior & Current Levy Cycles* chart below compares levy revenues from the current levy cycle (navy blue line) to the previous cycle (light blue line).

ADAMH Levy Collections Prior & Current Levy Cycles



	1997/2007	1998/2008	1999/2009	2000/2010	2001/2011	2002/2012	2003/2013	2004/2014	2005/2015	2006/2016
1997 - 2006	$36.368816	$37.30607187	$38.45469233	$39.554041987	$40.820569	$41.807602	$42.01968672	$42.53842289	$42.74721514	$43.55859742
2007 - 2016	$64.40428839	$64.13756254	$64.28100258	$64.04021068	$62.91525451	$58.54794254	$57.72989095	$57.38803875	$57.57173122	$58.13692484

Two factors materially impacted levy revenue collections in the past five years. Housing values declined by over 6 percent in Franklin County as a result of the national recession and state business tax reform has resulted in ADAMH receiving significantly less Tangible Personal Property (TPP) tax receipts (refer to the *Fiscal Challenges* discussion starting on page 53 of this fact book).

Federal Revenue

ADAMH receives the majority of federal revenues from the OMHAS. All Federal revenues are used to purchase social services (mental health and alcohol and other drug treatment and prevention services). Federal revenues in 2014 were $6.9 million. Approximately two thirds of federal revenues are derived from the Substance Abuse Prevention & Treatment (SAPT) block grant. Other Federal revenues sources include Title XX and the Mental Health Block Grant.

State Revenue

ADAMH receives the majority of state revenues from OMHAS. All state revenues are used to purchase social services (mental health and alcohol and other drug treatment and prevention services). State revenues in 2014 were $10.6 million.

When the SFY 2014-15 Biennial Budget was adopted, ADAMH received a temporary increase in state funding (2012 funding was $3.2 million vs. $10.6 million in 2014). Subsequent to the passage of the SFY 2014-15 Biennial Budget, the state has expanded eligibility of the Medicaid program. Consequently, ADAMH is anticipating state revenues to revert back to 2012 levels with the next biennial budget.

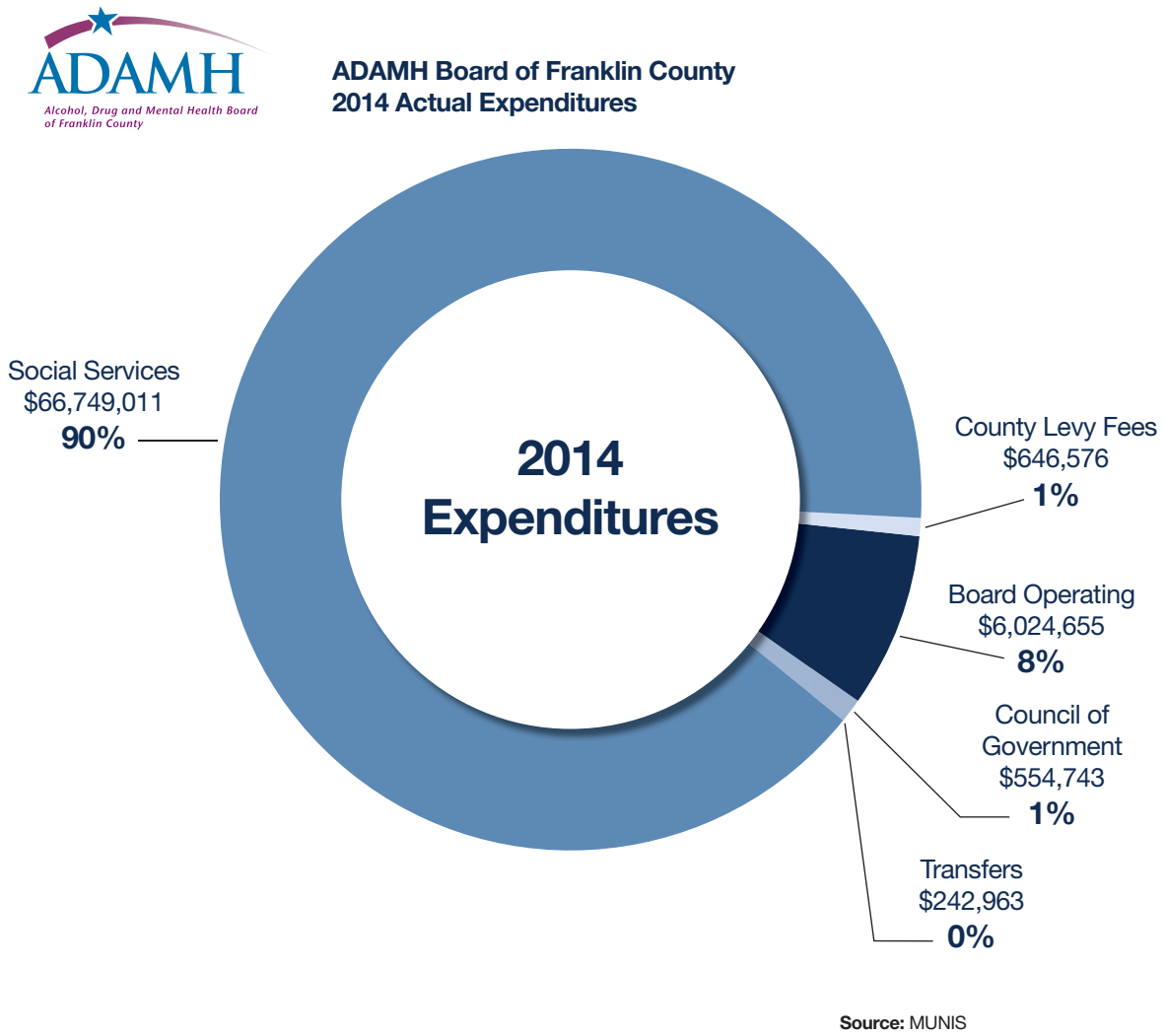
Local Revenue

In addition to local levy funds, local revenues are received from the City of Columbus, Franklin County Children Services, the Franklin County Board of Developmental Disabilities, the Franklin County Family & Children First Council and Franklin County's Courts. City revenues are used to purchase substance abuse prevention programs. County funds are generally used to purchase evidence-based treatment programs that address specific populations (i.e., criminal justice, adolescents, gender-specific) in need of services. Revenue levels are contingent upon grant awards, which vary from year to year.

ADAMH expenditures can be summarized in four categories:

- Social Service Expenditures;
- Board Operating Expenditures;
- County Levy Fees; and the
- Council of Government.

2014 ADAMH Actual Expenditures



Source: MUNIS

- **Social Services Expenditures** - In 2014, ADAMH invested more than $66 million in behavioral health services for residents of Franklin County. Of this amount, $45.6 million (68 percent) is supported by the ADAMH levy. Social service expenditures constitute 90 percent of the expense budget. In 2015, ADAMH has contracted with 33 organizations (see chart below) through our ASP and budget process to provide mental health and alcohol and other drug addiction treatment, prevention and recovery support services.

2015 ADAMH Providers

2015 ADAMH Providers	
AFRICENTRIC PERSONAL DEVELOPMENT SHOP	MENTAL HEALTH AMERICA OF FRANKLIN COUNTY
ALVIS HOUSE	NAMI FRANKLIN COUNTY
AMETHYST	NATIONAL CHURCH RESIDENCES (NCR)
BUCKEYE RANCH	NATIONWIDE CHILDREN'S HOSPITAL (NCH)
CHOICES FOR VICTIMS OF DOMESTIC VIOLENCE	NEIGHBORHOOD HOUSE, INC.
COLUMBUS AREA INTEGRATED HEALTH SERVICES INC.	NETCARE CORPORATION
COLUMBUS PUBLIC HEALTH	NORTH CENTRAL MENTAL HEALTH SERVICES
COLUMBUS URBAN LEAGUE	NORTH COMMUNITY COUNSELING SERVICES
COMMUNITY FOR NEW DIRECTION	OHIO STATE UNIVERSITY - TBI NETWORK
COMMUNITY HOUSING NETWORK (CHN)	THE P.E.E.R. CENTER
COMPDRUG	SCHOTTENSTEIN CHABAD HOUSE
CONCORD COUNSELING SERVICES	SOUTHEAST, INC.
DIRECTIONS FOR YOUTH & FAMILIES	ST. VINCENT FAMILY CENTERS
HOUSE OF HOPE	SYNTERO
HUCKLEBERRY HOUSE	THE VILLAGE NETWORK
MARYHAVEN	TWIN VALLEY BEHAVIORAL HEALTHCARE - COMMUNITY SUPPORT NETWORK
	UMADAOP OF FRANKLIN COUNTY

- **ADAMH Operating Expenditures** - ADAMH operating expenses include salaries, fringe benefits, materials and services for ADAMH. Operating expenses in 2014 supported up to 50 staff (although we currently employ 47) and constituted 8 percent of total expenditures.
- **County Levy Fees** - Levy fees are assessed by the Franklin County Auditor's Office for levy collection and advertising expenses. Levy fees average 1.6 percent of gross revenues and amounted to 1 percent of total expenses in 2014.
- **Council of Government Expenditures** - The COG was formed under Chapter 167 of the Ohio Revised Code. The COG is a collaboration between Hamilton, Cuyahoga and Franklin Counties for the purchase of the new healthcare information management system (SHARES). COG expenses constituted 1 percent of total expenses in 2014.

Estimated Revenue and Expenses: 2017-2026 Levy Cycle

The *Estimated Revenue and Expenditures 2017-2026 Cycle* chart on the next page is ADAMH's projected revenue and expenditures for the next proposed levy cycle (2017 - 2026) based on a 10-year 2.2 mill renewal with a 0.5 mill increase property tax levy.

Estimated Revenue and Expenditures 2017 - 2026 Levy Cycle

Alcohol, Drug and Mental Health Board of Franklin County
Estimated Revenue and Expenditures
2017-2026 Levy Cycle
10 Year 2.2 Mill Renewal with additional 0.5 Mill
Purchased $5.1 million in New Services in 2017

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Beginning Cash:	76,899,342	75,867,809	73,979,334	71,209,837	67,534,691	62,928,703	57,366,106	50,820,547	43,265,074	34,672,123
Revenue:										
Levy	71,581,835	72,287,130	72,999,477	73,718,949	74,445,614	75,179,547	75,920,819	76,669,503	77,425,674	78,189,407
Federal Funds	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469
State Funds	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005
Local Funds	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145
Miscellaneous Funds	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Total Revenue	85,177,454	85,882,749	86,595,096	87,314,567	88,041,233	88,775,166	89,516,437	90,265,122	91,021,293	91,785,026
Expenditures:										
Personal Services	3,940,025	4,018,825	4,099,202	4,181,186	4,264,810	4,350,106	4,437,108	4,525,850	4,616,367	4,708,695
Fringe Benefits	1,646,720	1,679,655	1,713,248	1,747,513	1,782,463	1,818,112	1,854,474	1,891,564	1,929,395	1,967,983
Materials & Services	2,865,138	2,910,746	2,957,154	3,004,374	3,052,424	3,101,317	3,151,070	3,201,699	3,253,219	3,305,649
Capital Outlays	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Grants	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Interfund	0	0	0	0	0	0	0	0	0	0
Social Services	77,207,104	78,611,998	80,044,989	81,506,641	82,997,525	84,518,228	86,069,344	87,651,482	89,265,264	90,911,321
Total Expenditures	86,208,987	87,771,224	89,364,593	90,989,714	92,647,222	94,337,762	96,061,996	97,820,595	99,614,245	101,443,647
Ending Cash Balance:	**75,867,809**	**73,979,334**	**71,209,837**	**67,534,691**	**62,928,703**	**57,366,106**	**50,820,547**	**43,265,074**	**34,672,123**	**25,013,502**

Key Projection Assumptions

- Levy Revenues - Projected levy revenues are based on a 10-year, 2.2 mill renewal with a 0.5 mill increase. This scenario will generate an estimated $71.6 million in 2017 ($14 million more than 2014 levy revenue).
  - Levy revenue in the subsequent 9 years (2018-2027) will grow 1 percent annually from new housing/ business starts.
  - ADAMH will continue to collect $1,052,389 annually from TPP Hold Harmless State reimbursement.
- Federal, State & Local Revenues – Projected revenues will remain flat (2016 levels) for the duration of the next levy cycle.
- The cost to purchase mental health and alcohol and other drug addiction treatment, prevention and recovery support services will increase 2 percent annually.
- The cost of ADAMH operations will increase by an average of two percent annually (2007-2014 average growth was 1.74 percent).

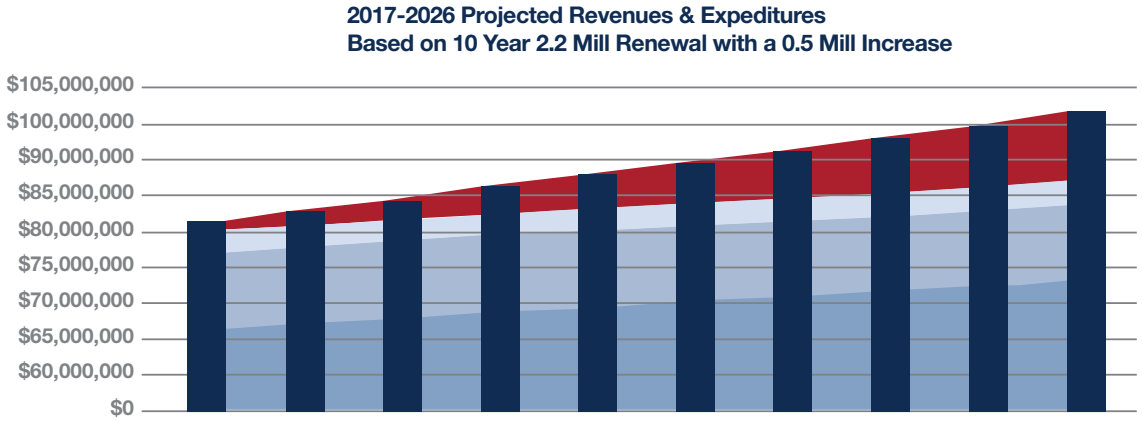
Projected Cash Reserve – Current Levy Cycle

Cash reserves for the current levy cycle include a 60-day Operating Reserve of $14.5 million and a $52 million budget stabilization reserve.

Levy revenues are predominately received in two lump sum payments (March and August). The 60-day operating reserve will provide a sufficient cash flow to maintain business operations until the first levy deposit is received in March 2017.

With the onset of the economic recession, ADAMH began to set aside levy revenues to accumulate a budget stabilization reserve. As the following chart illustrates, this reserve will be used to deficit finance (i.e. annual expenses exceed annual revenues) the ADAMH system of care throughout the next levy cycle. The vertical bars on this chart reflect projected annual expenses. For each year, expenses exceed projected revenues (represented by the horizontal area of the chart). The amount of deficit financing ranges from $1 million in 2017 to $9.7 million in 2026 (see red shading in chart below).

2017-2026 Project Revenues and Expenditures with Renewal Plus New

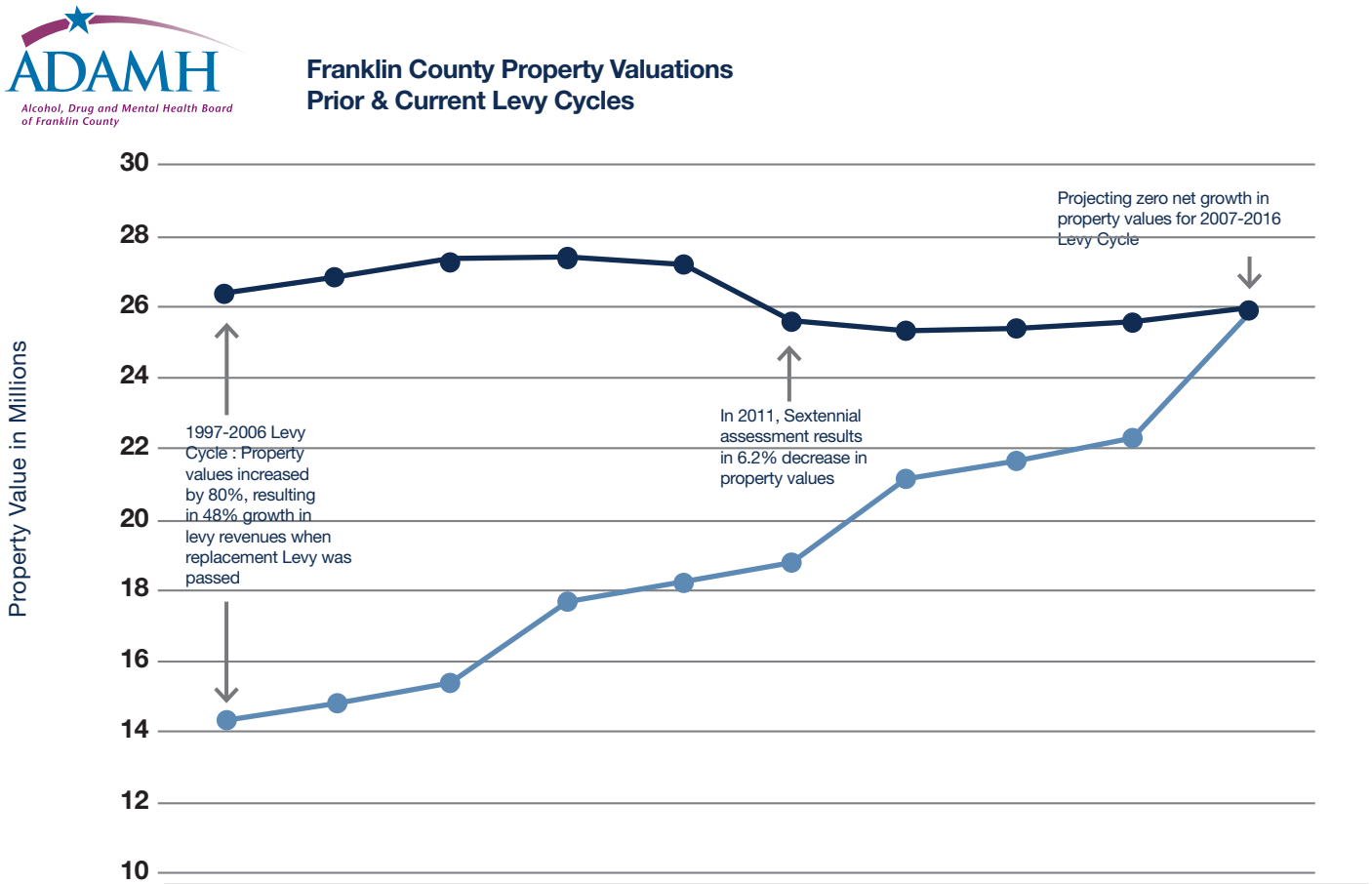


	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Levy Revenues	$71,581,835	$72,287,130	$72,999,477	$73,718,949	$74,445,614	$75,179,547	$75,920,819	$76,669,503	$77,425,674	$78,189,407
State & Federal Revenues	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474	$10,726,474
Local & Misc Revenues	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145	$2,869,145
Expenditures	$86,208,987	$87,771,224	$89,364,593	$90,989,714	$92,647,222	$94,337,762	$96,061,996	$97,820,595	$99,614,245	$101,443,647
Budget Stabilization Fund	$1,031,533	$1,888,475	$2,769,496	$3,675,146	$4,605,988	$5,562,597	$6,545,559	$7,555,473	$8,592,952	$9,658,621

The need for a budget stabilization reserve was further predicated by the lack of property value growth in Franklin County during the current (2007-2016) levy cycle. ADAMH is projecting property values in 2016 (assessed value of $25.83 billion) to be relatively the same as 2006 ($25.82 billion).

As the following graph indicates, property values during ADAMH's prior levy cycle (1997-2006, represented by the light blue line) increased by 80 percent. Consequently, when the current replacement levy was passed, levy revenues increased by 48 percent. Since property values during the current levy cycle (represented by the navy blue line) are stagnant, neither a renewal nor replacement levy (absent of new millage) would generate increased revenue in a future levy.

Franklin County Property Valuations - Prior & Current Levy Cycles



	1997/2007	1998/2008	1999/2009	2000/2010	2001/2011	2002/2012	2003/2013	2004/2014	2005/2015	2006/2016
1997 - 2006	$14.30424157	$14.73766642	$15.3605952	$17.68928711	$18.20457769	$18.74900436	$21.2469226	$21.7608095	$22.2664298	$25.81819283
2007 - 2016	$26.43990361	$26.84294458	$27.34839704	$27.46340507	$27.33807393	$25.64810055	$25.43673103	$24.42363319	$25.5707511	$25.82645861

Cash Reserve – 2017-2026 Levy Cycle

The ending cash balance for the 2017-2026 levy cycle reflects a 90-day Operating Reserve of $25 million. This reserve will provide a sufficient cash flow to maintain business operations until the first deposit of a future levy is received in March 2027.

LEVY REQUEST

ADAMH is requesting that the Franklin County Board of Commissioners place a 10-year 2.2 mill renewal with a 0.5 mill increase property tax levy on the November 3, 2015 general election ballot.

It is estimated the levy will generate $71.6 million annually ($14.2 million more than 2014 collections), and will cost the owner of a $100,000 house $84.88 annually (an additional $17.50 per year, which amounts to less than $1.50 a month).

Example: Franklin County Homeowner

	$100,000	Fair Market Value of Home (2016)
x	35%	Assessment Percentage
	$35,000	Assessed Value
x	0.0022	2.2 Mills (Renewal Levy Tax Rate)
x	0.875	State Rollback Factor
	$67.38	Annual Taxes Paid for Renewal Portion of Levy
	0.0005	0.5 Additional Mills
	n/a	State Rollback Factor - not applicable on new millage
	$17.50	
	$84.88	Total homeowner cost of 2.2 Renewal with a 0.5 Increase Levy

As a point of comparison, the last ADAMH levy that was passed (2.2 mill replacement in 2005) cost a property owner an additional $27.95 per $100,000 per year.

The earliest date that ADAMH can go on the ballot to replace the current levy is November 3, 2015. If the taxpayers pass the levy, collections will begin in 2017 and the levy will expire on December 31, 2026.

Levy History

ADAMH is currently operating with a 10-year, 2.2 mill replacement levy that began collections in 2007. The levy was passed on November 8, 2005 by a 62.8 percent margin (131,563 of 209,215 Franklin County voters) and generates $57.4 million in revenue annually (2014).

The current voted and effective millage rates are as follows:

Levy History Millage Rates

Voted Levy in 2006	Commercial/Industrial Effective Rate in 2015	Residential/Agricultural Effective Rate in 2015
2.2	2.2	2.19

Since ADAMH was created in 1968, levy results are as follows:

Levy History Millage Rates

Month-Year	Result	Levy Request
May 1970	Failed	.75 mill new, 5-year levy
November 1970	Passed	.75 mill new, 5-year levy
November 1974	Passed	.75 mill renewal, 10-year levy
November 1984	Passed	.8 mill renewal, 5-year levy (.05 mill increase from 1974 levy)
November 1988	Passed	1.2 mill, 5-year levy (.4 mill increase from 1984 levy)
November 1991	Passed	2.2 mill, 5-year levy (1 mill increase from 1988 levy)
November 1995	Failed	2.4 mill, 10-year replacement levy
November 1996	Passed	2.2 mill replacement levy
November 2005	Passed	2.2 mill replacement levy

Levy Options

The following discussion details the three different levy options that ADAMH evaluated. Each option requires the use of ADAMH's $52 million budget stabilization reserve from the current levy cycle to finance the system into the next levy cycle.

It is worth noting that a 10-year renewal levy with no additional millage is not sustainable beyond five years without material reductions to community investments

All options listed utilize the same assumptions as previously identified (refer to *Revenues and Expenses: 2017-2026 Levy Cycle* discussion starting on page 91 of this fact book).

A 10-year renewal levy with no additional millage is not sustainable beyond five years without material reductions to community investments.

Option 1: 10-Year 2.2 Mill Renewal with 0.5 Mill Increase Property Tax Levy

- $5.1 million increase to community investments for each of the 10 years
    - Youth Crisis Services
    - Adult Emergency and Crisis Psychiatric Services
    - Permanent Supportive Housing
    - Heroin/Opiate and AOD Addiction Treatment
    - Adult Suicide Prevention
    - Youth Suicide Prevention
    - Re-entry Services
- Allows ADAMH to adjust investments for the increasing cost of services over 10 years.
- Provides for sufficient levy reserves throughout the levy cycle.

Option 1: 10-Year 2.2 Mill Renewal with 0.5 Mill Increase Property Tax Levy

Alcohol, Drug and Mental Health Board of Franklin County
Estimated Revenue and Expenditures
2017-2026 Levy Cycle
10 Year 2.2 Mill Renewal with additional 0.5 Mill
Purchased $5.1 million in New Services in 2017

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Beginning Cash:	76,899,342	75,867,809	73,979,334	71,209,837	67,534,691	62,928,703	57,366,106	50,820,547	43,265,074	34,672,123
Revenue:										
Levy	71,581,835	72,287,130	72,999,477	73,718,949	74,445,614	75,179,547	75,920,819	76,669,503	77,425,674	78,189,407
Federal Funds	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469
State Funds	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005
Local Funds	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145
Miscellaneous Funds	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Total Revenue	85,177,454	85,882,749	86,595,096	87,314,567	88,041,233	88,775,166	89,516,437	90,265,122	91,021,293	91,785,026
Expenditures:										
Personal Services	3,940,025	4,018,825	4,099,202	4,181,186	4,264,810	4,350,106	4,437,108	4,525,850	4,616,367	4,708,695
Fringe Benefits	1,646,720	1,679,655	1,713,248	1,747,513	1,782,463	1,818,112	1,854,474	1,891,564	1,929,395	1,967,983
Materials & Services	2,865,138	2,910,746	2,957,154	3,004,374	3,052,424	3,101,317	3,151,070	3,201,699	3,253,219	3,305,649
Capital Outlays	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Grants	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Interfund	0	0	0	0	0	0	0	0	0	0
Social Services	77,207,104	78,611,998	80,044,989	81,506,641	82,997,525	84,518,228	86,069,344	87,651,482	89,265,264	90,911,321
Total Expenditures	86,208,987	87,771,224	89,364,593	90,989,714	92,647,222	94,337,762	96,061,996	97,820,595	99,614,245	101,443,647
Ending Cash Balance:	**75,867,809**	**73,979,334**	**71,209,837**	**67,534,691**	**62,928,703**	**57,366,106**	**50,820,547**	**43,265,074**	**34,672,123**	**25,013,502**

Option 2: 5 Year Renewal - 5-Year Renewal with 0.78 Mill Increase in 2022

First Five Years: 2017-2021

- Minimal increase to community investments (refer to *Social Services* row in chart on next page).
- This option creates enhanced fiscal risk at the end of the first 5-year levy cycle in the event that the second 5-year levy fails (ADAMH would be deficit financing the system by $13 million annually at the end of the first levy cycle).
    - Absent the increased millage, ADAMH will more than likely need to reduce community investments beginning in 2017.

Second Five Years: 2022-2026

- $5.1 million increase annually to community investments contingent upon passing renewal levy with increased millage.
- This option increases the required millage rate from 0.5 (in 2017) to 0.78 (in 2022).
    - Delaying new millage for five years increases the amount of deficit financing that will need to be addressed in the second five years.
    - The necessary revenues to underwrite the deficit financing from the first five years in addition to the necessary revenues to increase investments in the second five years will be collected within a condensed five-year period.

Option 2: 5-Year Renewal - 5-Year Renewal with 0.78 Mill Increase in 2022

Alcohol, Drug and Mental Health Board of Franklin County
Estimated Revenue and Expenditures
2017-2026 Levy Cycle
5 Year 2.2 Mill Renewal in 2017; 5 Year 2.2 Mill Renewal with additional .78 in 2022
Purchased $5.1 million in New Services in 2022

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Beginning Cash:	76,899,342	67,674,519	57,557,395	46,524,470	34,551,717	21,614,570	24,120,246	25,728,766	26,414,140	26,149,774
Revenue:										
Levy	58,520,823	59,095,508	59,675,939	60,262,175	60,854,273	82,859,049	83,677,116	84,503,363	85,337,873	86,180,728
Federal Funds	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469
State Funds	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005
Local Funds	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145
Miscellaneous Funds	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Total Revenue	72,116,442	72,691,126	73,271,558	73,857,794	74,449,892	96,454,668	97,272,735	98,098,982	98,933,492	99,776,347
Expenditures:										
Personal Services	3,940,025	4,018,825	4,099,202	4,181,186	4,264,810	4,350,106	4,437,108	4,525,850	4,616,367	4,708,695
Fringe Benefits	1,646,720	1,679,655	1,713,248	1,747,513	1,782,463	1,818,112	1,854,474	1,891,564	1,929,395	1,967,983
Materials & Services	2,654,855	2,698,361	2,742,645	2,787,720	2,833,603	3,224,957	3,275,946	3,327,824	3,380,606	3,434,309
Capital Outlays	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Grants	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Interfund	0	0	0	0	0	0	0	0	0	0
Social Services	72,549,664	73,861,409	75,199,389	76,564,128	77,956,163	84,005,817	85,546,685	87,118,371	88,721,490	90,356,671
Total Expenditures	81,341,265	82,808,250	84,304,483	85,830,547	87,387,038	93,948,992	95,664,214	97,413,609	99,197,858	101,017,658
Ending Cash Balance:	**67,674,519**	**57,557,395**	**46,524,470**	**34,551,717**	**21,614,570**	**24,120,246**	**25,728,766**	**26,414,140**	**26,149,774**	**24,908,464**

Option 3: 5-Year Renewal - 5-Year 2.2 Mill Replacement (10 Percent Total Property Value Growth) in 2022

- No new community investments for either levy cycle.
- Without community investment reductions, ADAMH would be funding the system below the operating reserve by 2022 and would exhaust all cash reserves by 2024.
- In order to maintain community investments through 2026, Franklin County property values would need to increase by 27 percent when the replacement levy is passed.

Option 3: 5-Year Renewal - 5-Year 2.2 Mill Replacement (10 Percent Total Property Value Growth) in 2022

Alcohol, Drug and Mental Health Board of Franklin County
Estimated Revenue and Expenditures
2017-2026 Levy Cycle
5 Year 2.2 Mill Renewal in 2017; 5 Year 2.2 Mill Replacement (10% Property Value Growth) in 2022
Purchased No New Services

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Beginning Cash:	76,899,342	67,674,519	57,557,395	46,524,470	34,551,717	21,614,570	13,630,665	4,691,008	(5,230,055)	(16,158,753)
Revenue:										
Levy	58,520,823	59,095,508	59,675,939	60,262,175	60,854,273	67,492,284	68,156,683	68,827,726	69,505,480	70,190,011
Federal Funds	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469	7,261,469
State Funds	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005	3,465,005
Local Funds	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145	2,469,145
Miscellaneous Funds	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000	400,000
Total Revenue	72,116,442	72,691,126	73,271,558	73,857,794	74,449,892	81,087,903	81,752,302	82,423,345	83,101,099	83,785,630
Expenditures:										
Personal Services	3,940,025	4,018,825	4,099,202	4,181,186	4,264,810	4,350,106	4,437,108	4,525,850	4,616,367	4,708,695
Fringe Benefits	1,646,720	1,679,655	1,713,248	1,747,513	1,782,463	1,818,112	1,854,474	1,891,564	1,929,395	1,967,983
Materials & Services	2,654,855	2,698,361	2,742,645	2,787,720	2,833,603	2,977,552	3,026,067	3,075,446	3,125,704	3,176,858
Capital Outlays	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Grants	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Interfund	0	0	0	0	0	0	0	0	0	0
Social Services	72,549,664	73,861,409	75,199,389	76,564,128	77,956,163	79,376,037	80,824,310	82,301,548	83,808,330	85,345,249
Total Expenditures	81,341,265	82,808,250	84,304,483	85,830,547	87,387,038	89,071,807	90,691,960	92,344,408	94,029,797	95,748,785
Ending Cash Balance:	**67,674,519**	**57,557,395**	**46,524,470**	**34,551,717**	**21,614,570**	**13,630,665**	**4,691,008**	**(5,230,055)**	**(16,158,753)**	**(28,121,908)**

Summary of Three Options

Impact	10-yr 2.2 Mill Renewal with 0.5 Mill Increase	5yr Renwal then 5yr Renewal with 0.78 Mill Increase	5yr Renewal then 5yr Replacement (assumes 10% Property Value Growth)
New Community Investments	2017 - 2026	2022 - 2026	none
Community Investment Reductions	None	Potential	Yes - 2017
Net Community Investment Impact	$50,000,000	$25,000,000	($50,000,000)
Change in Number of Consumers Served	21,739	10,870	(21,739)
Increased Millage	2017	2022	none
Additional Annual Cost to Property Owner	$17.50 in 2017	$27.30 in 2022	$6.74 in 2022

Property Owner Levy Cost Analysis

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

Alcohol, Drug and Mental Health Board of Franklin County
Property Owner Levy Cost Analysis

	OPTIONS		
	10 Year, 2.2 mill Renewal with 0.5 mill increase	**5yr Renewal then 5yr Renewal with 0.78 Increase**	**5yr Renewal then 5yr Replacement**
Fair Market Value of home	$100,000	$100,000	$110,000
x Assessment Percentage	x 35%	x 35%	x 35%
Assessed Value	$35,000	$35,000	$38,500
x 2.2 Mills	x 0.0022	x 0.0022	x 0.0022
x State Rollback Factor	x 0.875	x 0.875	x 0.875
Annual Taxes paid for Renewal portion of Levy	$67.38	$67.38	$74.11
Additional Mills	0.0005	0.00078	0
State Rollback Factor - not applicable on new millage	n/a	n/a	n/a
	$17.50	$27.30	$0.00
Total Cost	$84.88	$94.68	$74.11
Increase from Current Cost	$17.50	$27.30	$6.74

ADAMH
Alcohol, Drug and Mental Health Board of Franklin County

RESOLUTION
REQUESTING PLACEMENT OF A 2.2 MILL RENEWAL WITH A 0.5 MILL INCREASE PROPERTY TAX LEVY ON THE NOVEMBER 3, 2015 BALLOT

WHEREAS, the ADAMH Board of Franklin County has the responsibility to contract for publicly funded mental health and substance abuse treatment, prevention services and supportive services for adults and youth of Franklin County; and

WHEREAS, ADAMH has been responsive to the community by being good stewards of resources entrusted through its role as planner, funder and evaluator of the ADAMH system of care; and

WHEREAS, ADAMH has one 2.2 mill property tax levy, which is due to expire on December 31, 2016; and

WHEREAS, ADAMH has determined the amount of county revenues needed, when combined with available state and federal revenues to effectively perform its functions and duties as required by Chapter 340 of the Ohio Revised Code; and

WHEREAS, a renewal with increased millage levy is crucial to ADAMH's ability to maintain and expand vital services to an increasing number of youth and families whose needs for services is projected to continue to grow; and

NOW, THEREFORE, BE IT RESOLVED by the ADAMH Board of Franklin County that it recommends and requests that the Franklin County Board of Commissioners submit to the electorate in the general election to be held on November 3, 2015, a 2.2 Renewal with a 0.5 mill Increase tax for the benefit of providing mental health and substance abuse treatment and prevention services and supportive services pursuant to Chapter 340 of the Revised Code, for a ten-year period, first due in the calendar year 2017.

WITNESS THEREOF, I hereunto subscribe my name on this twenty fourth day of February, two thousand and fifteen.

David A. Royer, CEO
ADAMH Board of Franklin County

Derek Anderson, Chair
ADAMH Board of Franklin County

Date: February 24, 2015

Resolution: 20150224-01

APPENDIX 1 – List of Acronyms

ACA – The Affordable Care Act
ACT – Assertive Community Treatment
ADAMH – The Alcohol, Drug and Mental Health Board of Franklin County
ADHD – Attention Deficit Hyperactivity Disorder
ALOS – Average Length of Stay
AMI – Any Mental Illness
AOD – Alcohol and Other Drugs
ASI – Addiction Severity Index
ASP – Agency Service Plan
ATOD – Alcohol, Tobacco and Other Drugs
Bed Board - Franklin County Mental Health Bed Board
BH – Behavioral Health
BHO – Behavioral Health Hospitalization
Board of Trustees – The ADAMH Board of Trustees
CALM Unit - Crisis Assessment Linkage and Management Unit
CEBP – The Center for Evidence-Based Practices
CHAT House – Changing Habits Attitudes and Thoughts House
CHN – Community Housing Network
CMHA – Columbus Metropolitan Housing Authority
COG – Council of Government
CSB – Community Shelter Board
CY – Calendar Year
EBP – Evidence-Based Practice
ED – Emergency Department
FACT – Family Alcohol and other Drug Collaborative Team
FCBDD – Franklin County Board of Developmental Disabilities
FCCS – Franklin County Children Services
FCFCFC – Franklin County Family and Children First Council
FPL – Federal Poverty Line
FQHC – Federally Qualified Health Centers
GFOA – Government Finance Officers Association
HCV – Home Choice Voucher
HSLRC – The Human Services Levy Review Committee
IHBT – Intensive Home Based Treatment
IHC – Integrated Healthcare
IOM – Institute of Medicine
IOP – Intensive Outpatient Treatment
KY – Contract Year
LGBTQ – Lesbian, Gay, Bisexual, Transgendered, Questioning
MACC – Multiethnic Advocates for Cultural Competence
MACSIS – State-Developed Claims System
MAT – Medication Assisted Treatment
MDE – Major Depressive Episodes
MFR – Managing for Results

MFT- Multi-Functional Therapy
MH – Mental Health
MHPAEA – Mental Health Parity and Addiction Equity Act of 2008
MOU – Memorandum of Understanding
MST – Multi-Systemic Therapy
NCH – Nationwide Children's Hospital
NCR – National Church Residences
NIMH – National Institute of Mental Health
NSDUH – National Study on Drug Use and Health
ODADAS – The Ohio Department of Alcohol and Drug Addiction Services
ODMH – The Ohio Department of Mental Health
OMHAS – The Ohio Department of Mental Health and Addiction Services
OSU – The Ohio State University Wexner Medical Center
PIPAR – Prevention Investment and Planning Reporting System
POPS – Proving Ohio Prevention Success Reporting System
PSH – Permanent Supportive Housing
RCF – Residential Care Facility
RFP – Request for Proposals
RFR – Request for Results
SAMHSA – The Substance Abuse and Mental Health Services Administration
SAPT – Substance Abuse Prevention & Treatment
SED – Severe Emotional Disturbance
SFY – State Fiscal Year
SHARES – Shared Health and Recovery Enterprise System
SMD – Severe Mentally Disabled
SMI – Severe Mental Illness
SPMI – Severe and Persistent Mental Illness
The P.E.E.R. Center – Peers Enriching Each Others' Recovery Center
TPP – Tangible Personal Property Tax
TVBH – Twin Valley Behavioral Healthcare
US – United States
USHS – Unified Supportive Housing System
VOA – Volunteers of America
YCSU – Youth Crisis Services Unit

APPENDIX 2: Ohio Revised Code 340.01

[Effective 9/15/2016] Alcohol, drug addiction, and mental health service district.

(A) As used in this chapter:

1) "Addiction," "addiction services," "alcohol and drug addiction services," "community addiction services provider," "community mental health services provider," "drug addiction," "gambling addiction services," "mental health services," and "mental illness" have the same meanings as in section 5119.01 of the Revised Code.
2) "Medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the United States food and drug administration for the treatment of drug addiction, prevention of relapse of drug addiction, or both.
3) "Recovery housing" means housing for individuals recovering from drug addiction that provides an alcohol and drug-free living environment, peer support, assistance with obtaining drug addiction services, and other drug addiction recovery assistance.

(B) An alcohol, drug addiction, and mental health service district shall be established in any county or combination of counties having a population of at least fifty thousand to provide addiction services and mental health services. With the approval of the director of mental health and addiction services, any county or combination of counties having a population of less than fifty thousand may establish such a district. Districts comprising more than one county shall be known as joint-county districts.

The board of county commissioners of any county participating in a joint-county district may submit a resolution requesting withdrawal from the district together with a comprehensive plan or plans that are in compliance with rules adopted by the director of mental health and addiction services under section 5119.22 of the Revised Code, and that provide for the equitable adjustment and division of all services, assets, property, debts, and obligations, if any, of the joint-county district to the board of alcohol, drug addiction, and mental health services, to the boards of county commissioners of each county in the district, and to the director. No county participating in a joint-county service district may withdraw from the district without the consent of the director of mental health and addiction services nor earlier than one year after the submission of such resolution unless all of the participating counties agree to an earlier withdrawal. Any county withdrawing from a joint-county district shall continue to have levied against its tax list and duplicate any tax levied by the district during the period in which the county was a member of the district until such time as the levy expires or is renewed or replaced.

APPENDIX 3: Ohio Revised Code 340.03

[Effective 9/15/2016] Board of alcohol, drug addiction, and mental health services - powers and duties.

(A) Subject to rules issued by the director of mental health and addiction services after consultation with relevant constituencies as required by division (A)(10) of section 5119.21 of the Revised Code, the board of alcohol, drug addiction, and mental health services shall:

1) Serve as the community addiction and mental health services planning agency for the county or counties under its jurisdiction, and in so doing it shall:
   a) Evaluate the need for facilities and community addiction and mental health services;
   b) In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations, assess the community addiction and mental health needs, evaluate strengths and challenges, and set priorities for community addiction and mental health services, including treatment and prevention. When the board sets priorities for the operation of addiction services, the board shall consult with the county commissioners of the counties in the board's service district regarding the services described in section 340.15 of the Revised Code and shall give priority to those services, except that those services shall not have a priority over services provided to pregnant women under programs developed in relation to the mandate established in section 5119.17 of the Revised Code;
   c) In accordance with guidelines issued by the director of mental health and addiction services after consultation with board representatives, annually develop and submit to the department of mental health and addiction services a community addiction and mental health services plan listing community addiction and mental health services needs, including the needs of all residents of the district currently receiving inpatient services in state-operated hospitals, the needs of other populations as required by state or federal law or programs, the needs of all children subject to a determination made pursuant to section 121.38 of the Revised Code, and priorities for facilities and community addiction and mental health services during the period for which the plan will be in effect.
   d) In alcohol, drug addiction, and mental health service districts that have separate alcohol and drug addiction services and community mental health boards, the alcohol and drug addiction services board shall submit a community addiction services plan and the community mental health board shall submit a community mental health services plan. Each board shall consult with its counterpart in developing its plan and address the interaction

between the local addiction services and mental health services systems and populations with regard to needs and priorities in developing its plan.

e) The department shall approve or disapprove the plan, in whole or in part, according to the criteria developed pursuant to section 5119.22 of the Revised Code. Eligibility for state and federal funding shall be contingent upon an approved plan or relevant part of a plan.

f) If a board determines that it is necessary to amend a plan that has been approved under this division, the board shall submit a proposed amendment to the director. The director may approve or disapprove all or part of the amendment. The director shall inform the board of the reasons for disapproval of all or part of an amendment and of the criteria that must be met before the amendment may be approved. The director shall provide the board an opportunity to present its case on behalf of the amendment. The director shall give the board a reasonable time in which to meet the criteria, and shall offer the board technical assistance to help it meet the criteria.

g) The board shall operate in accordance with the plan approved by the department.

h) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies.

2) Investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving services from a community addiction or mental health services provider certified under section 5119.36 of the Revised Code or alleging abuse or neglect of a resident receiving addiction services or with mental illness or severe mental disability residing in a residential facility licensed under section 5119.34 of the Revised Code. If the investigation substantiates the charge of abuse or neglect, the board shall take whatever action it determines is necessary to correct the situation, including notification of the appropriate authorities. Upon request, the board shall provide information about such investigations to the department.

3) For the purpose of section 5119.36 of the Revised Code, cooperate with the director of mental health and addiction services in visiting and evaluating whether the services of a community addiction or mental health services provider satisfy the certification standards established by rules adopted under that section;

4) In accordance with criteria established under division (E) of section 5119.22 of the Revised Code, conduct program audits that review and evaluate the quality, effectiveness, and efficiency of services provided through its community addiction and mental health contracted services and submit its findings and recommendations to the department of mental health and addiction services;

5) In accordance with section 5119.34 of the Revised Code, review an application for a residential facility license and provide to the department of mental health

and addiction services any information about the applicant or facility that the board would like the department to consider in reviewing the application;

6) Audit, in accordance with rules adopted by the auditor of state pursuant to section 117.20 of the Revised Code, at least annually all programs and services provided under contract with the board. In so doing, the board may contract for or employ the services of private auditors. A copy of the fiscal audit report shall be provided to the director of mental health and addiction services, the auditor of state, and the county auditor of each county in the board's district.
7) Recruit and promote local financial support for addiction and mental health services from private and public sources;
8)
    a) Enter into contracts with public and private facilities for the operation of facility services and enter into contracts with public and private community addiction and mental health service providers for the provision of community addiction and mental health services. The board may not contract with a residential facility subject to section 5119.34 of the Revised Code unless the facility is licensed by the director of mental health and addiction services and may not contract with a community addiction or mental health services provider to provide community addiction or mental health services unless the services are certified by the director of mental health and addiction services under section 5119.36 of the Revised Code. Section 307.86 of the Revised Code does not apply to contracts entered into under this division. In contracting with a community addiction or mental health services provider, a board shall consider the cost effectiveness of services provided by that provider and the quality and continuity of care, and may review cost elements, including salary costs, of the services to be provided. A utilization review process may be established as part of the contract for services entered into between a board and a community addiction or mental health services provider. The board may establish this process in a way that is most effective and efficient in meeting local needs.
    b) If either the board or a facility or community addiction or mental health services provider with which the board contracts under this division proposes not to renew the contract or proposes substantial changes in contract terms, the other party shall be given written notice at least one hundred twenty days before the expiration date of the contract. During the first sixty days of this one hundred twenty-day period, both parties shall attempt to resolve any dispute through good faith collaboration and negotiation in order to continue to provide services to persons in need. If the dispute has not been resolved sixty days before the expiration date of the contract, either party may notify the department of mental health and addiction services of the unresolved

dispute. The director may require both parties to submit the dispute to a third party with the cost to be shared by the board and the facility or provider. The third party shall issue to the board, the facility or provider, and the department recommendations on how the dispute may be resolved twenty days prior to the expiration date of the contract, unless both parties agree to a time extension. The director shall adopt rules establishing the procedures of this dispute resolution process.

i. With the prior approval of the director of mental health and addiction services, a board may operate a facility or provide a community addiction or mental health service as follows, if there is no other qualified private or public facility or community addiction or mental health services provider that is immediately available and willing to operate such a facility or provide the service:

ii. In an emergency situation, any board may operate a facility or provide a community addiction or mental health service in order to provide essential services for the duration of the emergency;

iii. In a service district with a population of at least one hundred thousand but less than five hundred thousand, a board may operate a facility or provide a community addiction or mental health service for no longer than one year;

iv. In a service district with a population of less than one hundred thousand, a board may operate a facility or provide a community addiction or mental health service for no longer than one year, except that such a board may operate a facility or provide a community addiction or mental health service for more than one year with the prior approval of the director and the prior approval of the board of county commissioners, or of a majority of the boards of county commissioners if the district is a joint-county district.

The director shall not give a board approval to operate a facility or provide a community addiction or mental health service under division (A)(8)(b)(ii) or (iii) of this section unless the director determines that it is not feasible to have the department operate the facility or provide the service.

The director shall not give a board approval to operate a facility or provide a community addiction or mental health service under division (A)(8)(b)(iii) of this section unless the director determines that the board will provide greater administrative efficiency and more or better services than would be available if the board contracted with a private or public facility or community addiction or mental health services provider.

The director shall not give a board approval to operate a facility previously operated by a person or other government entity unless the board has established to the director's

satisfaction that the person or other government entity cannot effectively operate the facility or that the person or other government entity has requested the board to take over operation of the facility. The director shall not give a board approval to provide a community addiction or mental health service previously provided by a community addiction or mental health services provider unless the board has established to the director's satisfaction that the provider cannot effectively provide the service or that the provider has requested the board take over providing the service.

The director shall review and evaluate a board's operation of a facility and provision of community addiction or mental health service under division (A)(8)(b) of this section.

Nothing in division (A)(8)(b) of this section authorizes a board to administer or direct the daily operation of any facility or community addiction or mental health services provider, but a facility or provider may contract with a board to receive administrative services or staff direction from the board under the direction of the governing body of the facility or provider.

9) Approve fee schedules and related charges or adopt a unit cost schedule or other methods of payment for contract services provided by community addiction or mental health services providers in accordance with guidelines issued by the department as necessary to comply with state and federal laws pertaining to financial assistance;
10) Submit to the director and the county commissioners of the county or counties served by the board, and make available to the public, an annual report of the services under the jurisdiction of the board, including a fiscal accounting;
11) Establish, to the extent resources are available, a continuum of care that provides for prevention, treatment, support, and rehabilitation services and opportunities. The essential elements of the continuum of care shall include the following components :
    a) To locate persons in need of addiction or mental health services to inform them of available services and benefits;
    b) Assistance for persons receiving services to obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income;
    c) Addiction and mental health services, including all of the following:
        i. Outpatient;
        ii. Residential;
        iii. Partial hospitalization ;
        iv. Where appropriate, inpatient care;
        v. Sub-acute detoxification;
        vi. Intensive and other supports;
        vii. Recovery support;

viii. Prevention and wellness management;

ix. (ix) In accordance with section 340.033 of the Revised Code, an array of treatment and support services for all levels of opioid and co-occurring drug addiction.

d) Emergency services and crisis intervention;

e) Assistance for persons receiving services to obtain vocational services and opportunities for jobs;

f) The provision of services designed to develop social, community, and personal living skills;

g) Access to a wide range of housing and the provision of residential treatment and support;

h) Support, assistance, consultation, and education for families, friends, persons receiving addiction or mental health services, and others;

i) Recognition and encouragement of families, friends, neighborhood networks, especially networks that include racial and ethnic minorities, churches, community organizations, and community employment as natural supports for persons receiving addiction or mental health services;

j) Grievance procedures and protection of the rights of persons receiving addiction or mental health services;

k) Community psychiatric supportive treatment services, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured;

l) Any additional component the department, pursuant to section 5119.21 of the Revised Code, determines is necessary to establish the continuum of care.

12) Establish a method for evaluating referrals for involuntary commitment and affidavits filed pursuant to section 5122.11 of the Revised Code in order to assist the probate division of the court of common pleas in determining whether there is probable cause that a respondent is subject to involuntary hospitalization and what alternative treatment is available and appropriate, if any;

13) Designate the treatment services, provider, facility, or other placement for each person involuntarily committed to the board pursuant to Chapter 5122. of the Revised Code. The board shall provide the least restrictive and most appropriate alternative that is available for any person involuntarily committed to it and shall assure that the listed services submitted and approved in accordance with division (B) of section 340.08 of the Revised Code are available to severely mentally disabled persons residing within its service district. The board shall establish the procedure for authorizing payment for services, which may include prior authorization in appropriate circumstances. The board may provide for services directly to a severely mentally disabled person when life or safety is

endangered and when no community mental health services provider is available to provide the service.

14) Ensure that apartments or rooms built, subsidized, renovated, rented, owned, or leased by the board or a community addiction or mental health services provider have been approved as meeting minimum fire safety standards and that persons residing in the rooms or apartments are receiving appropriate and necessary services, including culturally relevant services, from a community addiction or mental health services provider. This division does not apply to residential facilities licensed pursuant to section 5119.34 of the Revised Code.

15) Establish a mechanism for obtaining advice and involvement of persons receiving publicly funded addiction or mental health services on matters pertaining to addiction and mental health services in the alcohol, drug addiction, and mental health service district;

16) Perform the duties required by rules adopted under section 5119.22 of the Revised Code regarding referrals by the board or mental health services providers under contract with the board of individuals with mental illness or severe mental disability to residential facilities as defined in division (A)(9)(b)(iii) of section 5119.34 of the Revised Code and effective arrangements for ongoing mental health services for the individuals. The board is accountable in the manner specified in the rules for ensuring that the ongoing mental health services are effectively arranged for the individuals.

b) The board shall establish such rules, operating procedures, standards, and bylaws, and perform such other duties as may be necessary or proper to carry out the purposes of this chapter.

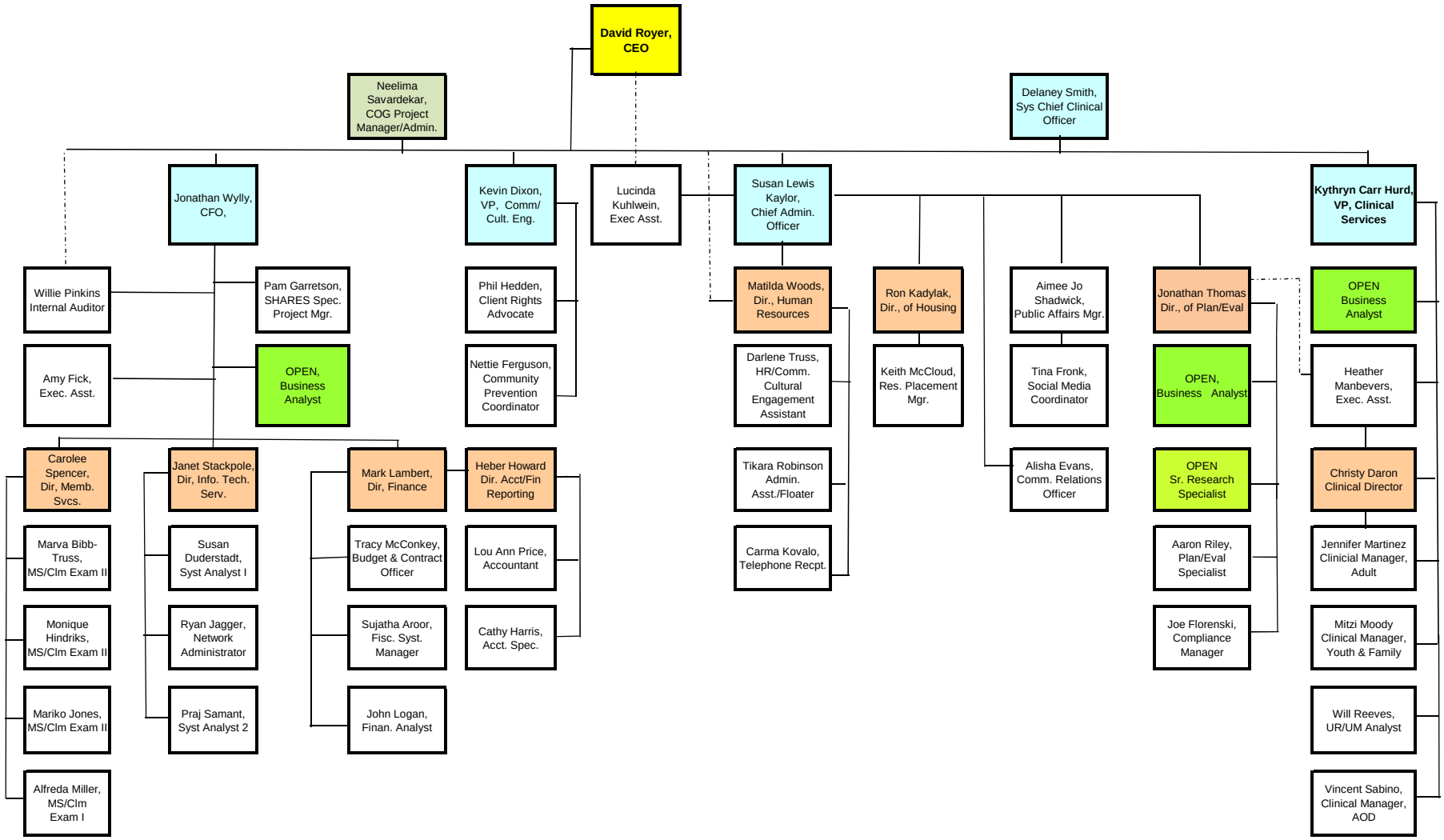
c) A board of alcohol, drug addiction, and mental health services may receive by gift, grant, devise, or bequest any moneys, lands, or property for the benefit of the purposes for which the board is established, and may hold and apply it according to the terms of the gift, grant, or bequest. All money received, including accrued interest, by gift, grant, or bequest shall be deposited in the treasury of the county, the treasurer of which is custodian of the alcohol, drug addiction, and mental health services funds to the credit of the board and shall be available for use by the board for purposes stated by the donor or grantor.

d) No board member or employee of a board of alcohol, drug addiction, and mental health services shall be liable for injury or damages caused by any action or inaction taken within the scope of the board member's official duties or the employee's employment, whether or not such action or inaction is expressly authorized by this section or any other section of the Revised Code, unless such action or inaction constitutes willful or wanton misconduct. Chapter 2744. of the Revised Code applies to any action or

inaction by a board member or employee of a board taken within the scope of the board member's official duties or employee's employment. For the purposes of this division, the conduct of a board member or employee shall not be considered willful or wanton misconduct if the board member or employee acted in good faith and in a manner that the board member or employee reasonably believed was in or was not opposed to the best interests of the board and, with respect to any criminal action or proceeding, had no reasonable cause to believe the conduct was unlawful.

e) The meetings held by any committee established by a board of alcohol, drug addiction, and mental health services shall be considered to be meetings of a public body subject to section 121.22 of the Revised Code.

APPENDIX 4: ADAMH Table of Organziation



APPENDIX 5: Timeline of Accomplishments

Year	Initiative	Description
2006	Distribution of New Levy Funds – Phase 1	Conducted post-levy focus groups with consumers, providers and community partners to determine community needs. First phase of new levy funds distributed by request for results (competitive) process to provide new programming for AOD detox; AOD medically-assisted services; consumer-operated services; older adult primary health; system training; and trauma care.
2006	Distribution of New Levy Funds – Phase 2	Based on the post-levy focus groups, a second phase of new levy funds was distributed for criminal justice/probation teams; older adults ID/early intervention; school-based prevention; programming at South-Western City Schools; transition-age youth (in collaboration with FCCS); and youth crisis capacity expansion.
2006	Franklin County Specialty Dockets	Invested in Prevention Specialist to serve the Franklin County Mental Health Court Specialty Docket. Invested in Treatment is Essential to Success (TIES) program to serve Franklin County Common Pleas Court, a comprehensive program designed to reduce recidivism in the criminal justice system and return individuals healthy and sober back to the community.
2006	Crisis Intervention Team (CIT) Training for Franklin County public safety officers	Conducted voluntary trainings for public safety officers to receive 40 hours of training in psychiatric disorders, substance abuse issues and de-escalation techniques, and in legal issues related to mental health and substance abuse. Collaboration with Columbus Police Department, NAMI Ohio, NAMI Franklin County, Mental Health America of Franklin County and Netcare Access.
2007	Multisystemic Therapy (MST) expansion for youth	Collaborated with FCFCFC and FCCS on home-based services for youth and their families to reduce serious behavior problems.
2007	SAMHSA Assertive Adolescent Family Treatment	Implemented a Substance Abuse Mental Health Services Administration funded Assertive Adolescent Family Treatment model in our community to provide an evidence–based treatment for recovery from AOD abuse and limits custody relinquishment solely for the purpose of accessing behavioral health services.
2007	Supportive Housing	Added 33 units of permanent supportive housing at E. Broad Street location (CHN).
2008	Targeted Youth Investments	Launched or expanded targeted evidence-based programs to serve youth: Earlier Intervention Services for Hispanic/Latino Children; Access to Better Care (ABC) Early Childhood Initiative and The Incredible Years Program.
2008	Supportive Housing and Transitional Housing	Added 42 units of permanent supportive housing at Southpoint Place (CHN) and Neil Avenue. Added 15 units of transitional housing added at YMCA for homeless men with no income, being discharged from TVBH.
2008	Integrated Dual Disorder Treatment (IDDT)/ Assertive Community Treatment (ACT) Team Initiative	Invested in two IDDT/ACT teams to serve high-risk adult consumers utilizing the evidenced-based IDDT/ACT community-based treatment teams to provide an array of intensive treatments emphasizing community psychiatric supportive treatment (CPST), pharmalogical management, peer support services, outreach and vocational services to serve adults with severe and persistent mental illnesses and/or an accompanying substance use disorder.
2008	Functional Family Therapy (FFT)	Collaborated with Behavioral Health Juvenile Justice (BHJJ), Franklin County Children Services (FCCS) and Franklin County Juvenile Court to provide treatment using a Functional Family Therapy treatment mode, an evidence-based intervention for families who have significant conflict and youth who have behavioral health issues and are involved with children services and/or the juvenile justice system.
2009	OSU Social Work Cohort	Collaborated with the Provider Leadership Association and OSU College of Social Work to provide a cohort for ADAMH provider employees. Classes are offered downtown at ADAMH, rather than on-campus.

APPENDIX 5: Timeline of Accomplishments (cont.)

Year	Initiative	Description
2010	Medicaid Cap	ADAMH Board of Trustees declared a cap on local Medicaid match to protect levy funds.
2010	Supportive Housing	Added 41 units of permanent supportive housing at Dogwood Glen location (CHN).
2010	Federal Stimulus Funds to serve Homeless Adults	Collaborated with CSB to manage time sensitive federal stimulus through Homeless Prevention and Rapid Re-Housing Program (HPRP), to provide transitional housing supports and supportive housing assistance.
2010	The P.E.E.R. Center	Funded with 2006 new levy funds, the consumer-operated center created by Columbus Area, Inc. becomes its own non-profit.
2010	Faith-Based Outreach Initiative	Initiated at the request of board members who recommended ADAMH engage the faith leader community on a consistent basis.
2011	Faith-Based Summer Pilot Project	Piloted a summer youth prevention initiative, as part of the faith-based outreach initiative, involving CND and three faith-based organizations.
2011	System Investments	Planned and funded new "system investments" to obtain more capacity including programming for addicted pregnant women; advocacy center; AOD detox; AOD recovery coaches; AOD residential treatment; dual diagnosis treatment; human trafficking; immigrant supports; integrated care; juvenile justice early intervention; LGBTQ care; and school-based services.
2011	Youth Crisis Services Unit at NCH	Invested in a crisis services unit to serve youth in mental health crisis in need of short-term crisis stabilization services with the goal of diverting them from inpatient psychiatric treatment.
2012	Anti-Bullying Initiative	Partnered with the Educational Council, City of Columbus, and the Ohio Department of Education to implement an anti-bullying pilot program in three county school districts.
2012	Community Mini-Grants	Offered strategic small dollar investments that demonstrate community partnership and collaboration efforts by investing in events and projects that reduce stigma and increase awareness of ADAMH-funded services for Franklin County residents.
2012	Mental Health First Aid	Certified ADAMH staff members as Mental Health First Aid trainers. Mental Health First Aid is a international training model that teaches people how to help people developing a mental illness or in a crisis while waiting for medical professionals to arrive.
2012	Three C Health Care and Recovery Council of Governments	Consists of ADAMH of Franklin County; Hamilton County Mental Health and Recovery Services Board and Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County. See full description on page 82 of this fact book.
2012	Immigrant Women's Support Groups	Launched new Somali and Latino Immigrant Women's Support Groups through Columbus Public Health to offer transitional services, socialization, as well as mental health / AOD / health educational resource information to support the women and their entire family.

APPENDIX 5: Timeline of Accomplishments (cont.)

Year	Initiative	Description
2013	Integrated Care System Investments	Identified, evaluated and used three models of integrated healthcare (co-location; facilitated referrals; joint staffing) to solicit competitive proposals for new integrated care investments.
2013	At-Risk Youth Engagement & Counseling	Provided engagement and counseling supports for at-risk students during evening hours at targeted recreation centers and summer festivals as part of the city of Columbus Mayor's Application for Pride, Purpose, and Success and Columbus Public Health.
2013	At-Risk Youth/Faith Based Investments	Partnered with the Children's Defense Fund Freedom School program, through the Shalom Zone on the west and near east sides, allowing at-risk students an opportunity to sustain academic learning and socialization in safe and drug-free locations. Collaborated with two summer-based faith programs that target at-risk youth on the south and north sides, offering leadership resiliency, social and emotional development. Includes year-round parenting support program on Southside.
2013	Collaboration with Legal Aid Society of Columbus	Launched new investment to ensure ADAMH consumers have quality legal assistance for issues like appealing benefits, domestic/family, evictions etc.
2013	Supportive Housing and Transitional Housing	Added 91 units of permanent supportive housing at Inglewood (CHN), Franklin Station (CMHA), CHAT House (Alvis House), Recovery Houses (House of Hope) and two units of transitional housing added at YWCA for homeless women with no income being discharged from TVBH.
2013	ADAMH System Orientation	Developed ADAMH System Orientation for new employees of any Franklin County organization that interfaces with customers that may need mental health or AOD services through the ADAMH system of care, in response to community partners' request.
2013	The Power of Art Program	Community-based murals featured in Columbus, Westerville and Dublin that convey messages of hope, unity and diversity and reduce the stigma associated with mental health and substance abuse issues.
2013 and 2014	School-Based Investments	Collaborated with 14 suburban school districts to provide more than $2.3 million for prevention, early intervention, treatment and referral services for elementary, middle, and high school students. Services range from mental health school-based services (e.g., suicide prevention, etc.); AOD prevention/intervention services; and early detection/ screenings.
2014	Franklin County Guardianship Services Board	Formed to address the growing needs of county residents who are most in-need of guardianships.
2014	Franklin Station Integrated Care Clinic	Opened the Southeast, Inc. Integrated Healthcare Center at Franklin Station, the first-ever integrated care clinic at a permanent supportive housing facility in collaboration with Southeast and CMHA.
2014	Consumer Advocacy	Funded RecoveryWorks in partnership with COVA to promote self-directed recovery through a personalized approach. Consumers can seek support and empowerment through Recovery Guides and find support on their wellness journey, all through the use of technology.
2014	The P.E.E.R. Center – Westside Location	Expanded peer supported services by investing in The P.E.E.R. Center's new Franklinton location.

APPENDIX 6: Culturally Competent Assessment Tool

ADAMH CULTURAL COMPETENCY PLAN

SECTION I. INTRODUCTION

AGENCY NAME:

CC CONTACT PERSON:

EMAIL ADDRESS:

PHONE NUMBER:

1. Indicate if you have noticed any changes in demographic situation and how it affects service delivery, how your agency manages these challenges. (Please type your responses in and use as much space as you need).

2. Have you done a cultural competence assessment in last 5 years?
   If so, indicate when and what assessment tool you used.
   If not, indicate when you plan to conduct the assessment.

3. Based on assessment or due to changing consumer demographics, has your agency instituted any new improvements and/or initiatives towards cultural competence in CY 20xx? What new improvements and/or initiatives you are planning for CY 20xx?

4. Do you collect any data about consumer demographics, beyond MACSIS requirements? (e.g. ethnicity, country of origin, primary language, etc.) If so, please indicate what data elements you track.

5. What is your estimated budget to maintain/improve cultural competence in CY 20xx?

SECTION II. STANDARDS & COMPLIANCE INDICTORS

STANDARD 1. ACCESS TO SERVICES. Cultural or ethnic background will not be used to screen out people otherwise eligible for services.

1.1. Organizational statements demonstrate that the organization is open to all persons of all backgrounds and strives to provide culturally competent services to all clients. The language or intent of this standard should be embodied in these statements. Among these important statements are mission and value statements, strategic plans, employee handbooks, consumer handbooks, policy and procedure manuals (especially concerning access, case finding, entry/intake, and referral), reports and other key documents.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

1.2. Organizational demographics and service data demonstrate that persons of all backgrounds are being served. If the organization cannot do this due to technical incapacity, then these improvements should be targeted as part of this initiative.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

1.3. Demonstrating or documenting that the organization has developed skills and knowledge in working with persons of diverse backgrounds, allocates resources to serving people with diverse backgrounds (i.e., skill acquisition), and has plans or linkages (e.g., interpretation/translation services) clearly targeting people from diverse backgrounds.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

1.4. Demonstrating and documenting that employees have been trained that this organizational value is an expectation.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

1.5. Organizations interior design, decorations, displayed art, and produced materials are welcoming, inclusive and culturally/linguistically sensitive to diverse consumers in the targeted service area.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

1.6. Persons served from diverse backgrounds report satisfaction with organizational services and effort.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 2. ASSESSMENT: Cultural and demographic factors will be considered as part of the assessment process.

2.1 Having statements in policy related to assessment guidelines that describe how cultural factors are to be addressed in conducting and documenting assessment information.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

2.2 Demonstrating through quality assurance and improvement activities that data findings support that the organization addresses cultural factors during the assessment process.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

2.3 Demonstrating that employees training to address cultural factors as part of the assessment process is an integral and ongoing part of the staff development program.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

2.4 All system professionals conducting assessments of persons seeking mental health or AOD services are addressing cultural factors and/or are engaged in training to become proficient.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

2.5 Individual Service planning for persons with specific culturally related needs can be linked to the assessment process.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 3. CASE MANAGEMENT: Caseworkers and clinicians whose caseloads are wholly or substantially composed of those reflective of diverse cultures shall have specific training and knowledge related to those consumers.

3.1. Having statements in organizational plans and policy that indicate that workers serving specific cultural groups are knowledgeable about serving that group.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

3.2. Having training programs that lead to proficiency in serving specifically targeted cultural groups.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

3.3. Demonstrating that employees are engaged in targeted training and development.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

3.4. Employee feedback data that demonstrates that employees believe that they have access to training/resources to acquire the required competencies.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

3.5. Feedback from persons served demonstrating that consumers believe that targeted employees are culturally respectful and responsive.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

3.6. Clinicians' demographic composition reflects clients' demographics.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 4. CROSS-CULTURAL LINGUISTICS AND COMMUNICATION SUPPORT: Cultural competence plans must state how interpretive and translation services are made available.

4.1. Demonstrating in written organization statements (policy, procedure, guidelines, etc.) that the organization provides interpretation and translation services, including ASL, TTY/TDD services.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.2. Demonstrating that agency's administrative and clinical staff is aware of LEP (Limited English Proficiency) clients rights (Title VI of the Civil Rights Act of 1964).

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.3. Demonstrating in written procedural statements the process for handling incoming LEP consumers phone calls and walk-ins, demonstrating that staff is trained and capable to utilize such services as needed.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.4. Demonstrating that main agency Forms/Information/Directions provided in client's primary language.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.5. Demonstrating in written procedural statements the process for linking persons served to translators and interpreters, demonstrating that staff is trained and capable to utilize interpreter services as needed.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.6. Demonstrating with financial data that the organization pays for interpretation and translation services.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

4.7. Demonstrating with QA/QI data that persons served are satisfied with interpretation and translation services.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 5. CULTURAL COMPETENCE PLANNING: A cultural competence plan must be written with manageable, but concrete timelines.

5.1. Written plan for cultural competence that shows how the organization embraces the system's working definition as well as the system standards.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

5.2. Cultural Competency Plan must have clearly stated desirable outcomes and concrete timelines to achieve them.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

5.3. Demonstrated participation and representation of top and middle management administrators, front-line staff, consumers and/or their family members and community stakeholders in developing and integrating the cultural competence plan.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

5.4. An individual at the executive level who shall take responsibility for and have authority to monitor implementation of the plan.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

5.5. Demonstrating that agency staff is aware of cultural competence plan and agencies goals to improve cultural competence levels.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

5.6. Demonstrating how agency is making continuing and constant progress in becoming more culturally competent.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 6. GOVERNANCE: Each governing entity should be reflective of the cultural/ethnic characteristics of the consumer populations.

6.1. Demonstrating how agency board demographics represent client demographics.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

6.2. Demonstrating in the records of governing board activity that the board has discussed and taken the position that is reflected in the written plan for cultural competence.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

6.3. Demonstrating involvement of culturally, ethnically and linguistically diverse consumers, family members, advisory committees, local community organizations input to organizational development and strategic planning process.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 7. HUMAN RESOURCES DEVELOPMENT: Staff training leading to additional competence must be provided to all levels of the organization.

7.1. Organizations demonstrating a commitment to cultural competence through its mission, policies, practices and training.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.2. Cultural competence and diversity is incorporated in all training activities, programs and materials.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.3. Training all levels of the organization, including Board members, management, program staff, support staff, and volunteers.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.4. Facilitating the involvement of diverse cultural groups and communities to track complaints and assist in the development of training programs.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.5. Allocating necessary resources (funds, time, etc.) for cultural competence training activities.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.6. Demonstrating how cultural competence performance is an integral part of the employee performance evaluation system.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.7. Cultural competence is included in job descriptions/responsibilities.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

7.8. Job vacancies are advertised through media accessible for targeted service areas.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 8. MANAGEMENT INFORMATION SYSTEMS: The organization must have (or have in development) the capacity for its MIS to compare important aspects of care across cultural, racial, and/or ethnic lines.

8.1. Demonstrated capacity to track, sort, compare, and analyze data related to important aspects of care across cultural, racial, and/or ethnic lines. Important aspects of care are the major functions/junctures associated with access, entry, service provision, discharge, transfer, utilization, outcome, etc.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

8.2. If the MIS capacity is limited, produce a plan to show how this capability is being developed in a meaningful way.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

8.3. Organization capacity to monitor emerging trends and patterns in all aspects of service delivery that might require attention in order to better address the needs of persons served.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 9. PREVENTION, EDUCATION, AND OUTREACH: Prevention activities must consider cultural differences, must be based on what the community needs/wants, and must educate professionals and consumers about ways diverse populations can become more responsible for their own health. Prevention agencies must inform consumers about available services.

9.1. Developing a policy that is clearly understood and publicly stated so that both staff and participants and the larger community are aware of the cultural aspects of the services.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

9.2. Demonstrating how agency is taking into account the specific cultural characteristics, issues, or barriers that may contribute to the risk factors that exist for their target population(s) and identifying them in the agency plan.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

9.3. Developed mechanisms to increase the provider's knowledge of what the community wants and needs.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

9.4. Specific programs offered to educate professionals and consumers about how diverse populations can be more responsible for their own mental wellness and prevent alcohol and other drug abuse.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

9.5. Providing consumers from diverse populations and their families with education and information about available services in the community, how to access them, while taking into consideration the family and the community systems in which they live.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

9.6. Establishing and maintaining an updated listing of community resources that may be beneficial in providing other valuable services to the specific population.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 10. QUALITY MONITORING AND IMPROVEMENT: The organization's Quality Improvement plan must outline ways in which higher levels of cultural competence will be attained.

10.1. Demonstrating how cultural competence is part of program evaluations and linked with overall quality assurance.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

10.2. Demonstrating in the QI plan which activities are involved with assuring and achieving higher levels of cultural competence.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

10.3. Producing and reporting results data in the QI reports reflective of the agency's particular structure for quality improvement and assurance.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

10.4. Organization has an effective process for tracking program's success, including outcomes, cultural competence and the impact on targeted population.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

STANDARD 11. TREATMENT PLAN/INDIVIDUAL SERVICE PLAN: When a consumer's cultural background relates directly to his mental health, the treatment plan must address this.

11.1. Having written statements in policy and other organizational documents indicating that the organization addresses specific needs related to culture, etc., in the ISP process.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

11.2. Demonstrating that employee development includes training with respect to developing ISP's for persons served from specific populations (this would be especially important when organizations feel that they are lacking skill with a certain group or when a particular population group is very important to the organization for some reason).

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

11.3. Demonstrating how the ISP format and process accommodates meeting culturally specific needs of persons served.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

11.4. Demonstrating consumer involvement and satisfaction in addressing specific cultural needs in ISP development process.

☐ **Compliant** ☐ **In progress (Explain)** ☐ **Will address (Explain how)**

SECTION III. SUMMARY

1. Indicate main barriers or obstacles in the process of becoming culturally competent and strategies to address them in the future.

2. What assistance is expected from ADAMH Board at this time? Please, be specific.

3. If you have any comments/feedback about cultural competence initiative and planning process please, share.

APPENDIX 7: ADAMH Strategic Results Close Out (2006-2009)

STRATEGIC RESULT #1	STATUS/MILESTONES
By January 2010, the ADAMH system of care will be viewed as the "Employer of Choice" among behavioral healthcare professionals who seek to deliver clinically and culturally appropriate services to consumers, as evidenced by:	PARTIALLY MET
1A. 10% reduction in turnover among clinicians, caseworkers and psychiatrists.	--% decrease/increase TBD after 2009 data secured via Agency Service Plans 2007: 10.17% turnover in direct service staff (baseline) 2008: 13.49% turnover in direct service staff 2009: In progress. Will secure data based on ASP
1B. Creative recruitment strategies	Developed a Jobs Page on ADAMH website to post job openings at provider locations - 4,772 average monthly hits. Purchased paid recruitment advertising in Toledo & northeastern Ohio to attract Latino staff. Chaired an ADAMH/Provider Leadership Association workgroup to address the recruitment & retention of medical professionals in the ADAMH system of care. Workgroup came up with strategies and funds to support next steps. Developed a shared print recruitment advertising campaign for direct service positions among six lead agencies. Designed print advertisement, brokered cost with Dispatch printing and developed proposed process for sharing resumes that were secured as a result of shared advertising.
1C. The provision of system continuing education and training opportunities related to culturally competent and capable care	Board provided leadership for Multiethnic Advocates for Cultural Competence, including statewide cultural conferences 2006-09 that addressed issues of disparities in behavioral healthcare, which were held in Franklin County & marketed to system providers. Created Maryhaven Training Institute to address administrative, clinical & cultural issues: - 300 training hours offered in 2007 - 500 training hours offered in 2008 - Cancelled at the end of 2008 due to major funding reductions.
1D. Partnerships among universities and learning institutions to create an increased supply of future healthcare professionals who choose to work for the ADAMH system of care	Secured an OSU College of Social Work intern interested in cultural competency who took lead on reviewing cultural sections of 2007 agency services plans. Partnered with PLA & OSU College of Social Work to create *ADAMH System Master's Degree in Social Work Program which began Sept. 09*. Evening classes held @ 447 East Broad Street to provide a central location off campus to accommodate those that work full time. Providers support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunties for shared internships.

APPENDIX 8: ADAMH Strategic Results Closeout (January 2010-October 2011)

STRATEGIC RESULT #1	STATUS/MILESTONES [Significant Progress]
By January 2015, ADAMH will seek to ensure access to service for non-Medicaid individuals to help achieve identified outcomes and recovery.	By protecting local resources (Result #3), ADAMH was able to invest an additional 6% of local levy funds to expand access to care (August 2011). First increase in allocations to contract providers in four years.
STRATEGIC RESULT #2	**STATUS/MILESTONES [Significant Progress]**
By January 2015, Franklin County residents will sustain their support of the ADAMH system of care as evidenced by continuing financial support for the Board's mission.	Maintained high performance in proactive Public Affairs efforts: • New outreach to faith leaders that included two trainings for faith leaders (May and September 2010) and the 2011 Faith Leaders Symposium. • Increased community collaboration • 45 media placements • 26 community events • 22 community presentations • 2 % increase in traffic to website (47,310 visits this year) Remained strong stewards of public funds by managing for results, which required reductions in workforce, internal restructuring, and managing the Network of Care within available resources.
STRATEGIC RESULT #3	**STATUS/MILESTONES [Achieved]**
By January 2015, ADAMH will protect local discretionary resources needed for increased demand for service.	We withdrew our potential lawsuit against ODMH as result of the agreement by State of Ohio to meet its responsibility to fund match requirement of Medicaid. This resulted in the protection of $4 million of local funds annually.
STRATEGIC RESULT #4	**STATUS/MILESTONES [Achieved Targets]**
By January 2015, ADAMH will expand sources of revenue for local behavioral healthcare services and supports.	2010 - $2,251,457 2011 - $2,002,725
STRATEGIC RESULT #5	**STATUS/MILESTONES [Some Progress]**
By January 2015, ADAMH will streamline service delivery to increase system efficiencies and sustain clinical quality and cultural competency through performance accountability.	We provided strong support to one merger (Partners in Active Living & Peers) based on the contract agencies initiation. Additionally, we recommended, to Board of Trustees, re-deploying a significant prevention allocation based on prior performance of a contract agency. ADAMH worked closely with Maryhaven and Netcare effecting policy and procedure change within both organizations to prioritize sub-acute and ambulatory detoxification services for individuals presenting to

-over-

	Netcare. To date in 2011, direct referrals from Netcare to Maryhaven represent 27% of all detoxification service admissions. As a result of implementation of both Integrated Dual Disorder Treatment and Assertive Community Treatment, consumers served on these evidenced-based practice intensive service teams are reducing the numbers of days spent in State Hospitals (69% reduction), crisis episodes at Netcare (58% reduction) and days spent in Residential Treatment (21% reduction). As a result of our ongoing work with Franklin County Juvenile Court, FCCS, FCFCFC and an additional successful grant application to ODYS, a significant reduction in the number of youth admitted to Ohio correctional facilities has decreased since the implementation of the Franklin County Behavioral Health Juvenile Justice initiative in Franklin County (34% reduction in admissions in SFY 2011). In the last two years, ADAMH has worked to standardize the Residential Care Treatment facility rates having developed a consistent methodology, resulting in both right-sizing and consistently applied financial efficiencies.

APPENDIX 9: Consumer Satisfaction Chart

		Overall ADAMH System		Provider	
		N	SCORE	N	SCORE
AOD Adult	2012	699	28.43	13	29.46
	2013	598	28.67	10	28.60
MH Adult	2012	1,229	27.72	127	27.43
	2013	1,129	28.15	81	29.05
Parent	2012	908	28.13	10	30.20
	2013	650	28.17	9	29.22