MUTUAL SYSTEMS PERFORMANCE AGREEMENT
FY 2004 THROUGH FY 2005

Between the

ADAMH/CMH BOARDS

and the

OHIO DEPARTMENT OF MENTAL HEALTH

ADAMH/CMH Board: Athens-Hocking-Vinton 317 Board

March 17, 2003

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SECTION ONE: Introduction

The foundation of the Mutual Systems Performance Agreement (MSPA) is quality improvement. That is, representatives of the Ohio Association of County Behavioral Health Authorities (OACBHA) and the Ohio Department of Mental Health (ODMH) agree that the ultimate goal of the mental health system is to provide accessible quality care, prevention and intervention services to persons with mental illness, measure performance, identify opportunities for improvement and actual improvements in local systems. The information and data provided through this MSPA process will be used by the Executive Policy Management Committee (EPMC) to identify statewide issues and best practices, and work collaboratively to develop a statewide approach regarding these issues.

This MSPA is also an effort to positively build upon the Community Plan requirements of the Ohio Revised Code (ORC 340.03 and 5119.61). Its intent is to create a clear and meaningful agreement regarding mutual expectations and performance, to establish a process of identifying and resolving mutual concerns and to identify local best practices, successes and exemplary programs.

The MSPA document represents one portion of those ORC requirements. Other elements of the Plan include, but are not limited to: 1) the local system's service plan to address the needs of the community at large, the needs of persons with a severe mental disability (SMD) and children and youth with a serious emotional disturbance (SED) as represented on the financial planning form, DMH-FIS 040a and; 2) the 408 Allocation forms that address inpatient needs.

Because of the fiscal crisis in the state, the MSPA/Community Plan for the 2004 – 2005 biennium will be completed in two phases this year. The first phase will include the Assurances, Requirements and Mutual Focus Areas. This document will be sent to the ADAMH/CMH Board December 18, 2002, completed and returned to ODMH March 28, 2003. The second phase will include the financial planning documents sent to the ADMH/CMH Board for completion after the General Assembly passes the state budget.

The complete and successful submission of all documents for both phases (including all appendices) will constitute the approved Community Plan for the ADAMH/CMH Board. Completion and approval of the phase one documents will enable the ADAMH/CMH Board to request its first quarter allocation for SFY 2004. Completion and approval of the phase two documents will enable the ADAMH/CMH Board to request allocations for subsequent quarters.

SECTION TWO: General Parameters

2.1. This Mutual Systems Performance Agreement ("MSPA") is entered into by and between the Alcohol, Drug and Mental Health/Community Mental Health (ADAMH/CMH) Board of Athens-Hocking and Vinton Counties, whose primary location is, 7990 Dairy Lane, Athens, OH 45701 and the Ohio Department of Mental Health (ODMH).

2.2. This MSPA is part of a process between ODMH and the ADAMH/CMH Boards that defines areas of work that are of mutual concern, success and responsibility, focuses on mutual performance, and requires submission of a document that presents the ADAMH/CMH Board's plan to advance those areas of mutual focus. The MSPA, along with other planning documents, constitutes a proposal to ODMH by the ADAMH/CMH Board to satisfy Community Plan requirements of the Ohio Revised Code (O.R.C. 340.03 and O.R.C. 5119.61)

2.3. This MSPA shall commence on the 1st day of July 2003, and shall terminate at the end of the 30th day of June 2005.

2.4. The ADAMH/CMH Board and the Director of ODMH shall approve the formation, validity and the enforceability of this MSPA.

2.5. The ADAMH/CMH Board must submit the completed and signed MSPA, and receive ODMH approval, in order to receive funding from ODMH. In addition, the ADAMH/CMH Board must submit required reports in a timely manner to avoid potential suspended payment of allocation.

2.6 Many provisions within this Agreement contain sections and/or portions of sections of the ORC, OAC, federal statutes and regulations. Both the ADAMH/CMH Board and the ODMH agree and acknowledge that other sections and/or portions of sections of these codes that may not be referenced here, may be relevant to the parties' performance of their obligations, and any omission of said sections and/or portions of sections are not intended to limit said performance of obligations.

2.7 Both ODMH and the ADAMH/CMH Board shall perform their respective duties under the MSPA in accordance with applicable requirements, including the federal statutes and regulations, O.R.C., O.A.C. and ODMH Certification Standards.

SECTION THREE: Funding

3.1 The MSPA document represents one portion of O.R.C. requirements for the Community Plan. Other elements of the Plan include, but are not limited to: 1) the local system's service plan to address the needs of the community at large, the needs of persons with a severe mental disability (SMD) and children and youth with a serious emotional disturbance (SED) as represented on the financial planning form, DMH-FIS 040a; and 2) the 408 Allocation forms that address inpatient needs.

3.2 The ODMH will provide an addendum to this section of the MSPA requesting the completion of the DMH-FIS 040a and the 408 Allocation forms, within 60 days of the legislatively passed budget, with final figures based upon the approved Budget Bill signed by the Governor.

3.3 Both ODMH and the ADAMH/CMH Boards understand that implementation of some of the

activities described herein may be contingent upon the state budget passed by the legislature and approved by the Governor.

SECTION FOUR: Legal Authority and Responsibilities

4.1 The legal responsibilities of the ADAMH/CMH Board and the ODMH shall be in accordance with the various requirements of the O.R.C. and the O.A.C., including but not limited to those sections that include:

4.1.1 Planning, Assessment & Auditing: O.R.C. §340.03(A)(1)(a) through (c)], [O.R.C. §340.03(A)(3), (4) and (6)]

4.1.2 Quality Assurance: [O.A.C. §5122-28-03(F)], [O.R.C. §340.03(A)(3)], [O.A.C. §5122-28-03(K)(1)&(4) and (L)(6)]

4.1.3 Housing and Residential Services: [O.A.C. § 5122-31-01&-02] [O.R.C. §340.03(A)(5), (14)&(16) and [O.R.C. §340.09(K)]

4.1.4 Affirmative Action: [O.R.C. §340.12]

4.1.5 Consumer/Public Participation: [O.R.C. §340.011(A)(8)], [O.R.C. § 340.03(A)(15)] and [O.R.C §340.03(E)]

4.1.6 Community Support System: [O.R.C. §5119.06(A)(1)] [O.R.C. §340.03 (A)(11)(a) through (k)]

4.1.7 Client Rights & Grievances: [O.A.C. §5122:2-1-02(H) and (I)] and [O.R.C. §5119.612]

4.1.8 Information Management: [O.R.C. §5119.61(H)]

4.1.9 Contracting and Contract Disputes: [O.R.C. § 340.03(A)(8)(a)]

4.1.10 Forensic Monitoring: [O.R.C. §5119. 57]

4.1.11 Residency Disputes: [O.R.C. §5122.01(S)]

4.1.12 Utilization Review: [O.R.C. § 340.03(A)(8)(a)]

4.1.13 Waiting Lists: [O.A.C. §5122-28-03(C)(5)(c)(vii)]

4.1.14 Neglect and Abuse: [O.R.C. §340.03(A)(2)]

4.1.15 Major Unusual Incidents: [O.A.C. §5122-26-13(D)]

4.1.16 Service Evaluation: [O.A.C. §5122-28-04(B)(3)]

4.1.17 Research: [O.A.C. §5122-28-05]

4.1.18 Medicaid Contract: [O.R.C. §5111.022(E)] [O.R.C. §340.03(8)(a)]

4.1.19 Annual Reports: [O.R.C. §340.03(A)(10)]

4.1.20 The director of mental health shall ensure that at least one member of the board is a person who has received or is receiving mental health services paid for by public funds and at least one member is a parent or other relative of such a person. [O.R.C. §340.02]

4.1.21 ODMH shall review each ADAMH/CMH Board's plan submitted pursuant to section 340.03 of the Revised Code, and approve or disapprove it in whole or in part. ODMH and the Board shall resolve any disputes related to the plan. [O.R.C. §5119.61 (I)] and [O.R.C. §340.03(A)(1)(c).

4.1.22 This agreement may be modified, in writing, by mutual consent of the parties consistent with O.R.C. Section 340.03 (A)(1)(c).

4.1.23 ADAMH/CMH Boards shall be responsible for individuals committed to them in accordance with Revised Code Section 5122.15(C)(4) and Section 340.03(A)(12).

4.1.24 ADAMH/CMH Boards and ODMH shall work collaboratively to plan care for "the needs of all residents of the district now residing in state mental institutions" for "delayed days" as well as civil. [O.R.C. §340.03] [O.R.C. §5119.61(B)]

4.2 The legal responsibilities of the ADAMH/CMH Board and of the ODMH shall be in accordance with the various requirements of federal statute, including but not limited to:

4.2.1 Nondiscrimination in employment or the provision of services on the basis of disability - 42 U.S.C. §12111 et seq. (The Americans with Disabilities Act); 29 U.S.C. §794 et seq.; 45 C.F.R. Part 94 (Section 504 of the Rehabilitation Act of 1973).

4.2.2 Nondiscrimination in the provision of services on the basis of age - 42 U.S.C. §6101 et seq. (Age Discrimination Act of 1975).

4.2.3 Nondiscrimination in the provision of services on the basis of race, color, or national origin

(Limited employment) - 42 U.S.C. §2000d-1 et seq, - 45 C.F.R. Part 80 (Title VI of the Civil Rights Act of 1964)

4.2.4 Nondiscrimination in employment on the basis of race, color, religion, sex or national origin - P.L. 88-352 (Title VII of the Civil Rights Act of 1964)

4.2.5 Nondiscrimination in housing on the basis of race, color, religion, sex, handicap, familial status or national origin. - P.L. 100-430 (Fair Housing Act Amendments of 1988).

4.2.6 The ADAMH/CMH Board shall ensure that the terms of the use of, and conditions for Block Grant funds are followed appropriately throughout the system.

SECTION FIVE: Applicable Requirements

5.1 The ADAMH/CMH Board and the ODMH shall carry out all duties under the MSPA in a manner that promotes:

5.1.1 Mutual agreement that leads to the development, maintenance and improvement in a quality system of care. Quality elements should reflect system values and outcomes in both clinical and administrative functions.

5.1.2 The recovery and resiliency processes of adult, children and youth consumers.

5.1.3 The rights of consumers and their families as defined in applicable federal and state laws and in ODMH Certification Standards.

5.1.4 The involvement of consumers and their families in all phases of treatment, and organizational planning and evaluation and quality assurance processes.

5.1.5 The sharing of information between the ODMH and the ADAMH/CMH Board that will help to improve the quality of the system, but maintain the confidentiality of consumer records as required by applicable state and federal statutes, including O.R.C. §5122.31.

5.1.6 The cooperation between the ADAMH/CMH Board and ODMH in all monitoring activities for all services rendered, that are paid in whole or in part using state or federal public funds, including but not limited to, certification audits, program reviews, outcomes reviews, capital reviews, Medicaid reviews/audits, housing outcomes reviews, Title XX compliance reviews and fiscal audits.

5.1.7 The development and implementation of local system-wide quality improvement (QI) processes that are yet to be defined. Such QI measures shall include, but are not limited to:

5.1.7.1 Core service access and capacity for both SED/SED and non-SMD/SED

5.1.7.2 Utilization Review

5.1.7.3 Client Outcomes

5.1.7.4 Client Rights & Grievances and Major Unusual Incident data

SECTION SIX: Information and Reporting

6.1 The ADAMH/CMH Board shall provide the following information and reports to ODMH for SFY 2004 and 2005.

6.1.1 DMH-FIS-040 (Actual) - FY 2003 ADAMH/CMH Board Actual **are due by January 1, 2004**; FY 2004, **January 1, 2005**; and FY 2005, **January 1, 2006**.

6.1.2 DMH-FIS-062 (Actual) - FY 2003 Agency Actual **are due by January 1, 2004**; FY 2004, **January 1, 2005**; and FY 2005, **January 1, 2006**.

6.1.3 Housing Outcomes Performance Evaluation (HOPE) Report: This report includes reporting for board-determined allocations for HAP and SHOP. One report per fiscal year will be required by ODMH. This report will combine year-end report for FY 2003 and projections for FY 2004. Mid year report will be required only if changes are made to board-determined allocations for HAP and SHOP activities (fiscal and/or program). First quarter funds for FY 2004 are available immediately, draw down for remaining quarters is contingent upon submission, review and approval by ODMH of the combined **FY 2004 outcomes projection report and FY 2003 HOPE Year End Report due August 15, 2003.**

6.1.4 Block Grant Annual Reports (for special funded projects only) **shall be submitted as instructed in NOFA** (Notice of Funding Award).

6.1.5 Agency Fiscal Audit Report **is due within six months of end of agency's fiscal year**.

6.1.6 ADAMH/CMH Board Annual Report is **due within 30 days of completion** for each respective fiscal year.

6.1.7 Community Capital Plans for the FY 2005 - 2006 biennium will be **due September 2003**.

6.1.8 Community Forensic Risk Management and System Development (Line Item 401 C) year-end report due in the Office of Forensic Services by **September 10, 2004, September 10, 2005 and September 10, 2006**.

6.1.9 Community Medication Subsidy **FY 2004** Central Pharmacy-Agency Allocation (Form PSC-042) **due September 2, 2003**, for FY 2005 **due September 2, 2004**, and for FY 2006 **due September 2, 2005** to Patrick Mascaro, Office of Support Services, Medical Complex, 2150 West Broad Street, Columbus, Ohio 43223-1200.

6.1.10 Block Grant Assurance Statements **are due before MSPA can be finalized** (see Section 12, Appendices 2 & 3).

6.1.11 Board Appointment Data Sheets **are due before the MSPA can be finalized** (see Section 12, Appendix 4).

6.2 The ODMH shall provide the following information and reports to the ADAMH/CMH Board for SFY 2004 and 2005.

6.2.1 Weekly MACSIS claims status reports.

6.2.2 Biweekly MACSIS member maintenance reports.

6.2.3 Weekly MACSIS member and claims extracts.

6.2.4 Monthly and yearly Patient Care System admission, discharge and resident day reports.

6.2.5 Daily access to the Patient Care System as consistent with applicable state and federal laws, and if desired by the ADAMH/CMH Board

6.2.6 Meetings with BHO staff, upon request of the ADAMH/CMH Board, to discuss the continuum of care of individuals being served by the BHOs.

6.2.7 MSPA summary information.

6.2.8 EPMC will develop a process to determine additional information/reports needed under this section.

SECTION SEVEN: Mutual Focus Areas

7.1 Background and Context: This section outlines agreements made between ADAMH/CMH Board and ODMH regarding information that shall be provided to assess whether planning and action is occurring

to ensure the integrity of the local and statewide public mental health system. The EPMC will use the data provided in this section to:

7.1.1 Identify areas of mutual statewide concern and success among ADAMH/CMH Boards and ODMH regarding adults with SMD and children and youth with SED;

7.1.2 Identify changes in local system plans since the Safety Net Survey that accompanied the SFY 2003 MSPA Addendum;

7.1.3 Identify critical gaps in planning and actions to deal with statewide and local fiscal pressures;

7.1.4 Identify local systems that are maintaining/improving quality despite fiscal pressures;

7.1.5 Identify technical assistance needs (not limited to that available at ODMH); and

7.1.6 Identify critical gaps in planning and action to deal with access and continuum of care issues between the ADAMH/CMH Boards and the BHOs.

7.2 Administration: Data sent to ODMH will include 1) MACSIS enrollment, 2) MACSIS claims, 3) Behavioral Health Module, and 4) Outcomes System data.

7.2.1 Enrollment: ADAMH/CMH Boards will enroll clients into MACSIS in a timely manner with a goal being to return Unique Client Identifier (UCI) numbers for previously enrolled clients within 3 business days and newly enrolled clients within 5 business days. ODMH will centrally support the Member function and supply operational and management reports to the ADAMH/CMH Boards in a timely manner.

7.2.2 Claims Processing: ADAMH/CMH Boards will ensure that claims and encounter records are collected for all Medicaid and Non-Medicaid services that meet the MACSIS guidelines for client services paid in whole or in part through the ADAMH/CMH Boards. Claims will be paid in a timely manner with a goal of payment within 2 weeks of receiving a valid remittance advice for claims. Please note the absolute standard is 30 days. ODMH will centrally support the claims function, run all edits, accounts payable and check post functions in a timely manner with a goal of adhering to the posted weekly schedule.

7.2.3 Behavioral Health Data: ADAMH/CMH Boards will encourage the submission of Behavioral Health Data in a timely manner for all clients admitted and discharged from funded providers and who have services paid for in whole or in part by the ADAMH/CMH Board. The goal will be to have all admission and discharge records into MACSIS within 30 days of the end of the fiscal year. ODMH will provide reporting and file access to this data in such a way as to protect confidentiality and comply with state and federal laws.

7.2.4 Outcomes: Forty-three ADAMH/CMH Boards have received Outcome Incentive Grants and are in the process of implementing the Ohio Mental Health Consumer Outcomes System in accordance with the Outcomes System Procedural Manual and the Implementation Planning Checklist. These ADAMH/CMH Boards will have an established flow of data from the Providers through the ADAMH/CMH Board to the Department and back to the Provider. For other ADAMH/CMH Boards, sending data to the Outcomes System is optional at this time.

The ODMH will provide error reports to the ADAMH/CMH Boards concerning data flow and will provide aggregate comparative data reports to ADAMH/CMH Boards and their Providers when data flow has been established from a sufficient number of ADAMH/CMH Boards.

7.3 Public Mental Health System Focus Areas: Priorities for the next two years evolved from the SFY 2003 - 2004 MSPA. The state fiscal realities called for some changes to the previous priorities. The focus areas for the SFY 2004 – 2005 MSPA are: Access, Quality, Recovery/Resiliency, Juvenile and Criminal Justice, Consumer Protections and Emerging Public Policy/Service Issues.

Please respond to the questions in each section below. Each response must include information about both adults with SMD and children and youth with SED for the response to be complete. Also, while there is much concern about the current fiscal realities, positive results can emerge from any crisis. Please include any such positive results in your responses.

Responses that are not complete will be returned to the Board. The information provided in this section will be used by the EPMC to fulfill the purposes noted in section 7.1 and to assist ADAMH/CMH Board planning for each focus area.

7.3.1 ACCESS: Goal – Maintain access to care while decreasing disparities in access for diverse populations.

[Note: This biennium, prevention, housing and medication have been subsumed within Access.]

7.3.1.1 What steps is the Board system engaged in to develop a culturally competent system of care? What plans are either in place or being developed to address the needs of adults with SMD and children and youth with SED that are culturally specific or relevant? This section should address any specific services that are available, language access, geographic availability of mental health services, and the coordination of care to vulnerable groups. This section should also address how the Board system is or plans to reduce barriers to mental health care that deter these individuals from accessing treatment services.

The 317 Board serves three rural, Appalachian counties in southeastern Ohio. The area is abundant in natural beauty and has a rich cultural heritage. People who live in these rural counties value their long-standing ties to land, communities and families. A culturally competent system in Southeast Ohio must address the needs of an Appalachian culture in which individuals and families are prideful and reluctant to go outside of their immediate family for assistance. There is a sense of individual choice and self-directedness that is pervasive among this population. In order to adequately address the needs of this population our Board, and more specifically our agencies, have a large majority of their staff who are a part of this culture. Caseworkers, counselors, psychologists and psychiatrists alike have all resided in this area for much of their careers and have a deep understanding of the culture and the unique needs of these individual consumers. The majority of our Board members and Board staff likewise are from this area and possess many of the same personal characteristics of our Appalachian culture. This deep awareness and understanding of the unique needs of our consumers is one of our most salient assets.

The Ohio Department of Mental Health initiative of Mental Health Recovery and emerging best practices has been a major initiative of this Board because it fits so effectively with this Appalachian prideful nature. In the past three years we have trained over 150 professionals, consumers, family members, university students and staff members on the Recovery Model. The self-directed and decision-making nature of this model enables our population of consumers to receive reinforcement of their culturally related belief system. Consumers are able to make their own decisions relative to their needs, which ultimately influence and determine their own life experience. For over three years this Board has supported a dual diagnosis or SAMI project which includes a Consumer Council. This council has acted as an advisory body for a four Board and ten county area, and consists of consumers from these areas as well as Board staff. By listening to the concerns of recovering consumers we have been able to more effectively understand and respond to specific needs of our area. We see this as a viable way to reduce any barriers to accessing mental health care and treatment services. Two of our contract agencies have collaborated with local school systems to develop an alternative school that also houses partial hospitalization for our SED population and intensive outpatient services for AOD children. This cooperative effort with the schools and among Mental Health and AOD agencies has provided a much better coordination of services and consistent support for this special needs population. Additionally, there are several consumer support groups and consumer run business opportunities being supported by this Board. By helping to empower consumers to not only make their own decisions but also to demonstrate their capabilities through consumer business initiatives they are able to simultaneously bust through some of the stigma issues currently plaguing mental health and AOD consumers.

Tri-County Mental Health and Counseling, Inc. (TCMHC), our primary community mental health agency, has an office and presence in each of the three counties making it easy for consumers to access services. Employees are from their respective counties and are a part of the local culture. TCMHC regularly offers training in cultural competency and requires all staff to attend. TCMHC has a specialized geriatric team to reach out to isolated older persons who may be reluctant to access mental health services at the clinics. The case management system offers the same outreach for persons who live in rural parts of the counties and may not have access to transportation. TCMHC also provides transportation services for persons who would not otherwise be able to make it to the clinic for psychiatric and counseling services.

The Board believes that its services are culturally competent and county citizens feel comfortable accessing the services when needed. There have been no complaints or grievances related to cultural competency concerns.

7.3.1.2 For adults with SMD and children and youth with SED, what are the greatest access problem areas in the Board's local system, and how is the Board successfully managing them or planning to manage them? Are there system consequences for focusing on SMD/SED populations? Are there other access issues in your local system? Include in the response any particular local system efforts regarding prevention, housing and medication.

In general, poverty, transportation and housing are issues that can challenge access to services. The geography of the area (distance and landscape) has limited the economic development in the area. Athens and Vinton Counties are classified as "economically distressed" by the Appalachian Regional Commission (ARC) and Hocking County is considered "transitional". On indicators of economic well being, all three counties are worse than state averages. Some of the key demographic indicators include:

- Vinton County ranks second highest in unemployment among Ohio's 88 counties (Ohio Department of Development, 2000) and highest amongst the 13 Appalachian counties (Appalachian Regional Commission, 2000).
- Athens County ranks 85th of the 88 counties in median income (1999 income amounts; OSU Extension Data Profiles).
- Vinton County is the most sparsely populated county of the Ohio Appalachian counties (ARC, 2003).

Although our primary mission is to serve the SMD/SED populations, the community also expects the Board and its contract agencies to address many other mental health issues in the community. With the growth of Medicaid services in the region, the Board has reached a point where growth in Medicaid comes at the expense of non-Medicaid funded programs—often those that serve the working poor who are above the income limits for Medicaid, but who do not have health insurance or have inadequate private health insurance coverage. The Board is fortunate to have recently passed a local levy in November 2002. However, to maintain community support for the levy, there is a risk of alienating core constituency groups if the Board reduces funding for services for largely non-SMD/SED programs (senior citizens, Careline, drop-in centers, etc.). The well being of the SMD/SED populations is inextricably linked with the general mental health needs of the community. A decision to focus exclusively on the SMD/SED may actually do more harm to services for this group.

The provider agencies closely monitor and mange their waiting lists. At TCMHC, the wait for routine care (not urgent), is less than ten business days. The agency monitors this closely and has protocols in place to address situations when demand increases the wait. Access to psychiatric services is more difficult.

Other access issues in our area include:

Prevention: With cutbacks in non-Medicaid funding, prevention services have all but gone away. When funding is limited, prevention programs are the first to be eliminated. Tri-County Mental Health and Counseling offers two prevention programs—Child Assault Prevention Program (CAPP) and Youth Diversion Day. Both programs are at risk of discontinuation due to limited funding.

Housing: Access to safe, affordable, permanent housing continues to be an important issue in the counties. The HAP/SHOP funds serve as a catalyst for addressing these needs. The Board has strong working partnerships with each of the county housing authorities and takes a leadership role in the Continuum of Care to address the needs of homeless persons. In 2003, using several different funding streams (including ODMH Capital funds), the Board will open a new five-unit housing unit in Athens County for homeless persons with dual diagnoses of SMD and substance abuse. Securing housing for persons with criminal histories or a poor tenancy history continues as a challenge for the future. The ability to locate stable, affordable housing for persons is vital to consumer recovery and will continue as priority for the next two-year plan.

Residential State Supplement (RSS) Program provides funding for supervised living options is suffering under the current state budget crisis. As of January 2003, there were 164 persons on the waiting lists for the programs serving Athens, Hocking and Vinton counties. Although the program is administered by the Ohio Department of Aging and operated by the Area Agencies on Aging, 51% of all persons under the age of 60 served through the program have a primary diagnosis as mental illness. The RSS program is a vital component of the community continuum of care, particularly for some of our most vulnerable populations. If funding is not restored for this important program hospital discharges may be delayed because of the lack of supervised placements for persons who need them.

Medication: Access to medication is an on-going concern. Unfortunately, TCMHC's central pharmacy budget was cut 21% (from $86558 to 68287) in FY '03 because for the first time in years, the agency came in slightly under-budget. Coming in under-budget was not a reflection of reduced need, but an attempt by the agency to ensure that it did not overspend in a year of extremely tight budgets. Unfortunately the agency was unfairly penalized for attempting fiscal prudence. TCMHC has aggressively worked to increase the amount of medication for consumers through the pharmaceutical companies indigent drug programs. TCMHC has increased the value of these medications from $250,000/year (2 years ago) to over $300,000 last year. However, future funding from the indigent drug programs is uncertain and the Board would like to see the central pharmacy line item restored to the FY '02 funding level.

Levels of Care: We do not provide all levels of care due to our rural setting. There are no hospital services or residential facilities for SED kids. As a result of this, children with special needs must be shipped off to treatment centers in other parts of the state. In response to community concerns about the number of youth being sent out of county for treatment, TCMHC developed a partial hospitalization service at the Athens County Alternative School (in November 2002). This program increases access to mental health treatment for some for some of the most SED youth in the county. Through the Family and Children First Council's Cluster Groups, the Board will continue to provide leadership to develop local options for these kids.

<u>Psychiatric Services:</u> There is more demand for psychiatric services than can be met with existing resources. TCMHC has added more psychiatric availability and it is still not enough. Psychiatric services for children is the most difficult to meet. The agency system must balance needs—psychiatric services could be increased, but would have to come at the expense of some other agency service. Having said this, TCMHC works hard to manage the existing resource. Agency staff triage the referrals to meet the most urgent needs first. An advanced practice nurse works with the child psychiatrist to greatly extend this service. Staff work with family doctors to transfer patients back to their care once symptoms are stable and for persons who cases are not complex. The agency has had success with this, however some doctors have been unwilling to resume this care, either because they do not think they have the expertise, or because of financial disincentives of serving patients with Medicaid or no health insurance.

The Board is working on several strategies to address this issue. In collaboration with other Boards in southeast Ohio, we are seeking funding to increase the availability of advance practice nurses in the clinics. In another effort, the Board is working to develop telemedicine. Telemedicine is a promising option for improving access to psychiatric services in rural communities, and would greatly enhance access to child psychiatric service in Vinton and Hocking counties. The Board has actively worked with the Southern Consortium for Children and the state Telemedicine Work Group to develop rules for making this a billable service.

7.3.2 QUALITY: Goal – Improve clinical quality and system performance.

7.3.2.1 <u>Consumer Outcomes</u>: How is the implementation of the Ohio Mental Health Consumer Outcomes System measurement proceeding in the Board's system of care? If other outcomes systems are being used, how is the implementation proceeding? How is the Board using consumer outcomes data? What are the Board's future plans for the use of outcomes data?

The primary contract agencies are beginning to implement the Ohio Mental Health Consumer Outcomes System. We have been using the Interactive Voice Response System IVR to input consumer satisfaction surveys for several years. We anticipated using that same system to input/record outcomes data but have found it to be somewhat inefficient, ineffective and have had problems integrating data with the Department's system. We have had several discussions with the primary mental health services providers and are looking at various options to help with the administrative barriers of implementing the outcomes system. We are currently partnering with our primary mental health provider to identify various data collection strategies and have offered to provide other technological input systems and supports in order to get the Ohio Mental Health Outcomes in line with ODMH and our own expectations. We anticipate using this same data input system for the Ohio Scales to determine outcomes for child/adolescent consumer populations. Currently this Board has not received sufficient outcome data to analyze or to identify trends or service needs. However, as we dialogue with our contract agencies we continue to move forward in

developing outcomes data, which can be used to improve the effectiveness of treatment programs and services.

The Board is asking agencies to report outcomes as part of its FY 2004 Non-Medicaid contracting process. We are taking a proactive role in training our local providers in the benefits of outcomes data usage. This Board's Clinical Systems Manager has been trained as one of the ODMH trainers of the "Using Adult Consumer Outcomes to Support Service and Recovery Planning" curriculum. We anticipate he will provide local training for clinicians and other professionals on how to use outcome data to develop recovery management plans. We anticipate providing this training for our local agencies as a way of furthering the effort to implement the effective use of outcomes as it pertains to recovery planning. The Board is also participating in the ODADAS outcomes framework and will encourage agencies to take advantage of future training offered through the Rensselaerville Institute. The Board is considering bringing staff from the Rensselaerville Institute to do a workshop for providers and Board members.

7.3.2.2 Evidence-Based Practices: What evidence-based practices has the Board implemented in its system of care? What process does the Board use to select evidence-based practices?

This Board has worked for the past three years training local professionals, consumers, and other interested persons on the ODMH Recovery and emerging best practices model. We have trained over 150 individuals which included consumers and professionals alike. We have also worked very closely with the Southern Consortium for Rural Care (SCRC) to implement Dual Recovery or the Dartmouth model within a 10 county area. Our clinical systems manager actively participates with the Southern Consortium for Children (SCC) to review evidence-based models of treatment for SED youth. This four board, ten county consortium has worked together to bring integrated treatment for dually diagnosed adolescents to our region. Tri-County Mental Health and Counseling has implemented an ACT team and a jail diversion program—both of which are based upon best practice models. The Board, in partnership with Tri-County Mental Health and Counseling has applied for a federal grant to implement a mental health court. We have had exceptional success in working with our contract agencies to incorporate these models within our system of care. We are aggressively pursuing collaborative efforts with school systems, parents and treatment providers. On April 15, 2003, there is a scheduled regional conference related to collaboration between these groups to better coordinate the behavioral health needs of school aged children and their families.

This Board has selected evidence-based practices, which fit the cultural needs of our consumer population. The Recovery Model is ideal for our clientele due to the sense of empowerment that the model supports. We use the Dartmouth dual recovery model because it works well with our dually diagnosed individuals and we have developed a cadre of trained professionals of this treatment modality. The Ohio Department of Mental Health has provided many opportunities to explore the various evidence-based best practices through statewide training and the development of the CCOE's. This network of support is essential for further implementation of these evidenced based practices. There are additional needs for training opportunities for new direct line staff to gain expertise in both models and adaptation of the models for use with children and adolescents. We have the local resources to continue Recovery training and hope to

garner further resources from the CCOE and ODMH in order to support expansion of our use of the Dartmouth Dual Recovery model.

7.3.2.3 <u>Quality Improvement:</u> In anticipation of new requirements around quality improvement, what steps is the Board taking to successfully transition its local system from a Quality Assurance to a Quality Improvement approach in improving clinical quality and system performance? Is the transition different for adults with SMD and children and youth with SED? (Quality Assurance concentrates on identifying poor providers rather than defective processes, with providers looking to themselves to determine what should be improved rather than to their customers.)

Quality is not only the type, frequency and duration of services that are being provided, but is also the character of those services. Quality is not only the efficiency in which services are provided or their effectiveness but also includes a "humanistic reality". This humanistic reality is when the provider considers the real life situations and needs of their consumer population and individualizes the services to meet those needs.

This Board has developed a comprehensive quality improvement review system in which we check for the traditional Medicaid service requirements and Departmental certification standards but also review for clinical appropriateness of services. We review our adult and child and adolescent records in outpatient settings as well as our adult female and adolescents residential treatment settings. We are proud of the fact that we have an exceptional working relationship with our contract agencies and they truly understand that these reviews are strictly designed to help improve what they do and are not used as a potentially punitive process. Use of MACSIS data has enabled us to track the efficient use of services and we are better able to ensure better use of resources. We are able to track the type, frequency and duration of treatment and also to identify all agencies that are working with an individual consumer. This has lead to better coordination of services between multiple agencies and has enhanced the administrative, fiscal and clinical efficiency of all concerned.

This Board has recently initiated quarterly meetings with service providers to engage them in further conversation about program data—what it means and how it can be used to increase the quality of the services we provide. In cooperation with provider agencies, the Board is developing an improved quarterly reporting system that will provide useful information that is presented in a consistent format. The quarterly reports will include: data on access to services; description of best practices; summary of consumer protection issues; summary of outcome measures; description of staff development; and progress in meeting short and long term goals/plans. The goal is to create a meaningful system for understanding program data so that it is used to improve services.

7.3.3 RECOVERY/RESILIENCY: Goal – Increase the provision of emerging best practices for children, youth and adults that maximize the quality of life of those living with SED/SMD.

[Note: This biennium, Employment and School Success (individual priorities of the last MSPA), have been subsumed within Recovery and Resiliency.]

7.3.3.1 How is the Board supporting Recovery for adults with SMD and Resiliency for children and youth with SED? Include in the response any particular local system efforts regarding consumer employment and school success.

We are creating an environment in which the consumers of mental health and AOD services are reinforced in their own recovery process and ultimately lead a more fulfilling life. This transition of acceptance and empowerment is the same for children as it is for adults with major mental and emotional disorders. There are, of course, specific programming differences related to meeting the needs of children but the sense of empowerment and hope is the underlying theme that we are supporting throughout our treatment system.

As mentioned previously, over 150 individuals in our three county area have been trained on the Recovery model. Those trained have included hospital personnel, outpatient providers, adult and children providers, consumers, family members and Board and agency administrative staff. The Board has made a concerted effort to promote the recovery model, but ultimately it is the agencies who must embrace the philosophy and build it into their daily practice. This Board is supporting the development of several consumer initiatives, including a consumer-run business and consumer community support program. Our two primary provider agencies have collaborated with the local school board to develop an alternative school that also houses mental health treatment and AOD treatment for those severely challenged children who need an alternative environment in which to learn and thrive. These activities are a continuing effort to establish our Board area as an empowering and hope generating system of care and support. Additional ODMH funding to launch new employment initiatives would enable us to develop these efforts further.

7.3.4 JUVENILE AND CRIMINAL JUSTICE: Goal – Reduce criminalization of persons with mental illness while promoting public safety via improved forensic services and monitoring.

The Office of Forensic Services provided funds for Boards in SFY 2002 - 2003 for local system forensic planning. Please describe the outcomes of those planning efforts for persons with SMD/SED by answering the questions below:

7.3.4.1 Every Board or Board area should have an oversight or task force committee that meets regularly to collaboratively plan for local mental health, juvenile and criminal justice issues. This committee should include representatives from all the relevant systems. Please list the membership of your committee and tell how often you meet.

The AHV Board has two on-going committees—one that meets around issues related to juveniles and one related to adults. The adult committee is centered around the Jail Diversion Project and includes the following members: 317 Board, NAMI-Athens, Athens City Police, Athens County Sheriff, Ohio University Police, Nelsonville Police, Athens Municipal Court Judge, Community Forensic Monitor, Ohio University Psychology Department, Tri-County Mental Health & Counseling, Inc. The Committee has met four times so far in FY 2003. There are plans to expand this committee to include additional stakeholders if the Mental Health Court Grant is approved (see below).

The juvenile committee meets around the Athens Re-Entry Initiative. Participants include: 317 Board, The Ohio Department of Alcohol and Drug Addiction Services (ODADAS), The Department of Youth Services (ODYS), Athens, Hocking and Vinton County Juvenile Court representatives, Treatment Alternatives to Street Crime (TASC), Tri-County Mental Health and Counseling, Inc. (TCMHC) and Health Recovery Services, Inc. (HRS). One-third of the youth served in this program are severely emotionally disturbed.

In addition to the above, the Board is involved in the Athens County Community Corrections Advisory Board. This group provides another venue for building community partnerships with the judicial system.

7.3.4.2 What successes/collaborative efforts have arisen out of this task force in your local area

The different committees described above serve as a forum for strengthening relationships between the criminal justice and mental health systems. In our rural communities, there is a history of collaboration—there is little turnover in personnel and we "bump" into one another outside the professional sphere—at Kroger's, the gym, restaurants, etc. With the state hospital located in Athens County, the judicial system is very familiar with the mental health system. The committee structures provide additional forums for coordination—often around a particular initiative.

In the Jail Diversion Program, over 100 persons have been diverted from arrest to the Crisis Respite program for assessment and treatment. Forty-seven officers have received training to help them understand mental health issues and resources, identify persons appropriate for diversion and de-escalate crisis situations. The committee is currently planning additional officer training.

In addition to the Jail Diversion Program, TCMHC provides weekly mental health consultations to the Southeast Ohio Regional Jail. Although this outreach is greatly appreciated by the regional jail, the time available only begins to meet the need. Southeastern Prevention Treatment Alternatives (SEPTA) in Nelsonville has contracted with TCMHC for the services of two full-time staff persons to provided AOD treatment services and follow-up after discharge. Health Recovery Services (HRS) also provides weekly groups in the regional jail to address the needs of substance abusers.

One morning each week, TCMHC staff attend the Athens County Juvenile Court hearings to provide mental health screening and facilitate access to community services for juveniles identified by the court. The juvenile court also purchases psychological evaluations and other consultation advice from a court-designated psychologist at TCMHC.

The Athens Re-Entry Initiative targets high-risk youth who are leaving an ODYS facilities and returning to community placement in the three counties. As of January 2003, 26 youth have been served with an 87% success rate (only four have been returned to a stay in the criminal justice system. Thirty-one percent of these youth have a mental health diagnosis in addition to their substance abuse issues.

The Board's Community Forensic Monitor, Becky Grashel, is an important resource on forensic issues and is actively involved in the Board's work related to the criminal justice system.

The Board is actively involved in each of the county's Family and Children First Councils and works closely with each juvenile judge on addressing the needs of at-risk youth through the Councils.

7.2.4.3 What are the greatest juvenile/criminal justice problem areas in the Board's local system?

The AHV Board has a successful pre-booking Jail Diversion program that provides community police officers with a reliable, safe, responsive alternative for persons with mental illness who would benefit more from treatment than from involvement with the criminal justice system. However, not all persons are diverted at this stage (appropriately so) and the municipal judges identify the need for a mental health liaison—boundary spanner—to work closely with the courts to assess, treat and monitor those persons with mental illness who come into the court system. In 2002, Tri-County Mental Health and Counseling, Inc. (TCMHC) received 182 referrals from the court. Of these, 21% (38) met SMD criteria. Judges report the court dockets are filled with repeat offenders who have clear mental health problems, but who are not yet effectively engaged in treatment.

The Board's contract agencies—HRS and TCMHC—collaborate with the local school systems to provide prevention and treatment to at-risk youth. The services provided at Athens Alternative School is a proactive attempt to reach at-risk kids to prevent further involvement with the criminal justice system.

Potential loss of funding is the biggest issue that threatens the successes described earlier. The jail diversion program and juvenile court services are provided with funding that is at risk because of state budget cuts. Although the mental health court may bring in new federal funds to the board area, the grant is only for two years, creating a need to find another funding source in the future.

7.2.4.4 What plans have been made to manage the identified problem areas?

One of our goals in the FY 2002-03 MSPA was to pursue funding for a Mental Health Court. In September 2002, the AHV Board, in partnership with TCMHC and the municipal judges in each of the three counties, applied for a Mental Health Court grant through the Bureau of Justice Assistance. Our application was approved in the initial review, and in January 2003, we were invited to submit additional information. If this grant is approved, it will provide the Board with the opportunity to take a more systematic and comprehensive approach to criminal justice issues. If the grant is not approved, the Board will likely approach a local community foundation for a planning grant—similar to the work being done in Hamilton/Paint Valley areas. The Board is appreciative of ODMH support for exploring rural options.

7.2.4.5 Who is your forensic monitor? Give name, address and telephone number.

Becky Grashel, M.A.
Community Forensic Monitor
P.O. Box 147
Portsmouth, OH 45662

1-800-706-4772

7.2.4.6 **Who is your contact for the prison Community Linkage Program? Give name, address and telephone number.**

Terry Hayes, Ph.D., Clinical Director
Tri-County Mental Health and Counseling, Inc.
90 Hospital Drive
Athens, OH 45701
(740) 594-5045

7.2.5 CONSUMER PROTECTION: Goal –Assure adequate protections to persons with mental illness within the Board area.

There are several initiatives within our Board area to insure that client rights and protection are maintained. During quality reviews, the Clinical Systems Manager critiques client grievances to ensure that action has been taken to meet the needs of those who have identified a concern or problem within the system of care. We monitor the client satisfaction data on a quarterly basis to ensure that those consumers who provide feedback, related to agency effectiveness, are satisfied with their treatment. The NEO/APPCARE CQRT team has interviewed consumers in our area and we are hopeful it will yield valuable data that can be used to improve our system of care. When issues are identified through satisfaction questionnaires the Board's Clinical Systems Manager contacts the agencies to follow up and to ensure those issues are resolved. We are currently revising our Major Unusual Incident (MUI) policy and procedure to conform to the new HIPAA requirements but also to ensure that agencies understand their role in reporting such incidences. We feel that the MUI system is a very important tool in identifying the major issues and concerns that arise during clinical services and is perhaps the most important indicator of opportunities to improve quality of care.

7.2.5.1 What are the local system barriers to receiving treatment for the person living with SMD/SED?

System barriers for treatment of SMD are directly related to transportation problems as well as availability of employment opportunities for consumers. With Recovery as our focus and employment being the number one need expressed by consumers, we are at a huge disadvantage to provide supports in this area. Our rural environment results in a challenge for many consumers to access our available clinical services, and the lack of industry and other job opportunities limits the access to employment. Due to our rural environment and smaller population, we do not have a complete range of level of care services for our children. Residential treatment and hospitalization services for children are not available in our area.

7.2.5.2 How is the Board monitoring and dealing with these barriers?

The Board is supporting and encouraging consumer businesses and all other consumer initiatives such as support groups, membership on committees as well as councils and other community activities. Transportation issues are a constant concern and many creative avenues have been and are being explored to address this problem. Two of our agencies have collaborated to create an alternative school and treatment center that is meeting a level of care need that is an alternative to residential treatment. This proactive collaboration includes extensive wrap around services that are thought to limit the number of children who will need more costly residential care.

7.2.5.3 Please provide the name, address and phone number of the Board's Client Rights Officer (CRO).

Roger P Buck, Ph.D. Clinical Systems Manager
The Alcohol, Drug Addiction and Mental Health Services Board serving Athens, Hocking and Vinton Counties
7990 Dairy Lane
Athens, OH 45701
(740) 593-3177
roger@ahv317.co.athens.oh.us

7.2.5.4 The ADAMH/CMH Board's Client Rights and Grievances Annual Summary for the biennium SFY 2004 - 2005 has a specified format. Please review Appendix 5 for the details of the format. The first due date for submitting the Annual Summary using this format will be September 2004 for period of SFY 2004.

7.2.6 EMERGING PUBLIC POLICY/SERVICE ISSUES: Goal – Identify the unintended consequences, especially as they relate to consumer and/or societal risk, of current public policy/services and actions needed to mitigate that risk.

7.3.6.1 Looking 2 to 3 years into the future, where will these unintended consequences take the public mental health system if not addressed? During the next 2 to 3 years, what actions should be taken in public mental health to ameliorate the unintended consequences listed above?

Issue: Growth in Medicaid combined with flat or reduced non-Medicaid funding: The substantial growth in Medicaid entitlement services in the past two years and the lack of increased state funding to keep pace, is having significant detrimental effects on the local service system. The chart below (p. 26), shows the growth in Medicaid from FY '00 to FY '04 for this Board area. Medicaid is a valuable and reliable funding source because of its ability to expand to meet demand. However, there are important needs that cannot be addressed with Medicaid (outreach, prevention, serving the working poor and those without health insurance, hotlines, housing, community integration, etc.). Similar to the tree symbol of the Outcomes system, we picture Medicaid funding like the soil and substance of the system, and the non-Medicaid funding like the fertilizer that enriches the system and fosters the growth.

There is a growing incompatibility in the system between the funding amounts/types and the goals of recovery. The mental health system has learned a great deal in the past five years about program models that encourage recovery. However, at the same time, there have been less financial resources to invest in these new models. Although the Board strongly supports recovery and encourages its contract agencies to build their practice upon this model, the Board does not have new funding to encourage and reward new initiatives. Development of new models requires time for clinicians to "re-tool". Funding pressures at the provider level—high billing expectations, lack of availability and usage of technology and bureaucratic standards—present real obstacles to the Board's and agencies intentions to fully implement best practices. Indeed, the quality of the current system will be undermined if new funding is not forthcoming.

Issue: Increased hospital per diem & potential for hospital closures: Proposed increases in hospital costs for FY 2003 to FY 2004 will have a substantial impact on local budgets and will force boards to reduce hospital days or make large cuts in community services. As the average hospital stay is already very short, it appears there is little room for safely reducing bed days. If ODMH has a goal of further reducing the usage of hospital days, there must be a commitment to adequate funding of community services. While community services are a fraction of the cost of hospital care, the goal of consumer recovery will be difficult to achieve unless there are further investments into community care.

Closure of Appalachian Behavioral HealthCare—Athens Campus would have a catastrophic effect on the

system and jeopardize care for consumers at every level. There are no private alternatives in the area. Closing of the hospital would result in a significant cost shift to the local system—mental health, law enforcement, families—in time and transportation costs to travel to distant facilities. Continuity of care would be compromised as well. The Appalachian communities of southeast Ohio are not able to absorb such a cost shift.

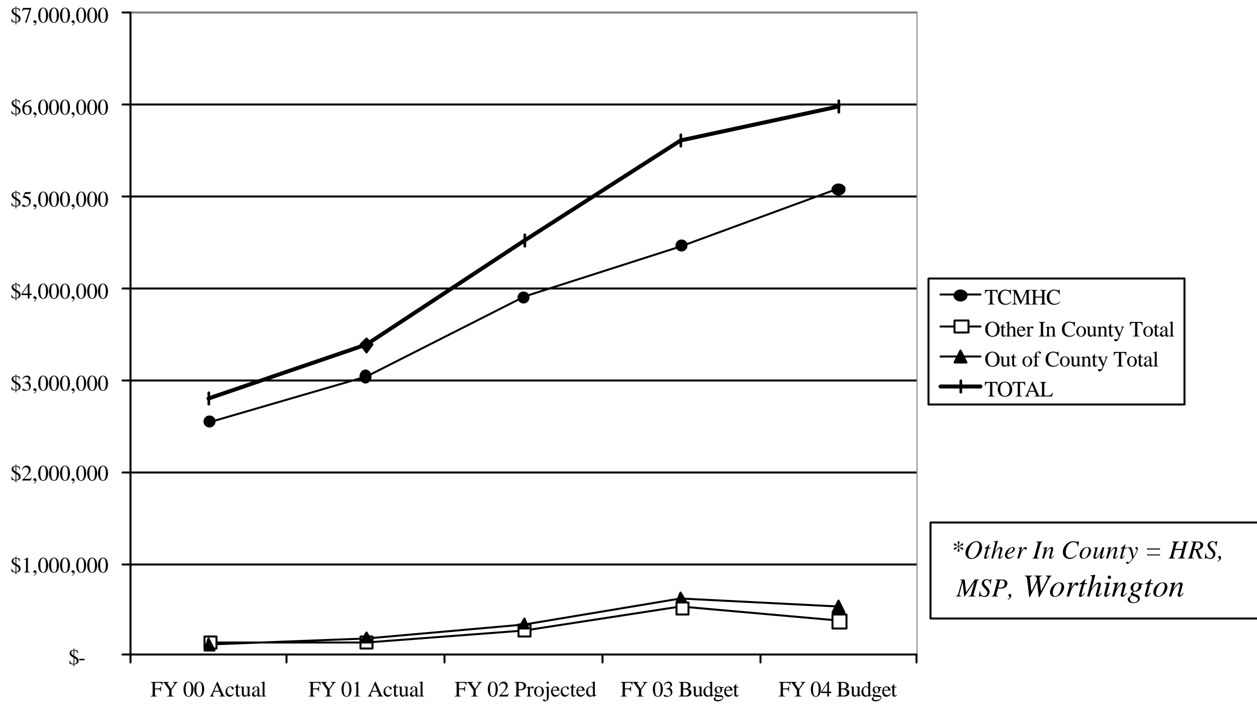
Recommended Actions:

- Creation of a Medicaid match line item in the Department's budget that is funded to offset the growth in Medicaid.

- Maintain state commitment to Appalachian Behavioral HealthCare and limit per diem increases to those of other health care industry averages.

- Dedicated funding to address the needs of persons involved with the criminal justice system to prevent inappropriate incarceration of persons with serious mental illnesses.

- Alignment of the funding stream with the values of recovery:
    - Implementation of administrative rule changes to control Medicaid costs and increase service options that promote recovery.
    - Adoption of Assertive Community Treatment (ACT) for SMD adults and Home and Community Based Services for SED children with bundled rates which would allow greater flexibility in the delivery of recovery-focused services to consumers.
    - Additional sources of non-Medicaid funding to develop the new models of "best practices" that promote recovery—clubhouses, housing, employment supports, community integration, educational programming, etc.
    - Investment into the direct line staff of the mental health system—competitive compensation, computer access, realistic productivity standards, time and budgets for training, etc. are needed to ensure quality services to persons with mental illness.



SECTION EIGHT: Miscellaneous

8.1 Attachments

8.1.1 All attachments to this first phase of the MSPA are incorporated as a part of this FY 2004 – 2005 MSPA.

8.2 Warranty

8.2.1 The signatures of the ADAMH/CMH Board Executive Director and Chairperson validate that appropriate ADAMH/CMH Board action has been taken to approve the format and content of this first phase of the MSPA.

8.2.2 The signature of the Director of the ODMH validates that appropriate approval has been given to the formation and acceptance of this first phase of the MSPA.

SECTION NINE: Signatures

9.1 These affixed signatures indicate the complete and successful submission of information that, together, constitutes an approved Community Plan.

ADAMH/CMH Board: Athens-Hocking-Vinton 317 Board

______________________________ ______________________________

Executive Director of ADAMH/CMH Board * Chairperson of ADAMH/CMH Board

______________ ______________

Date of Signature Date of Signature

____

** Michael F. Hogan, Ph.D., Director,
Ohio Department of Mental Health

____

Date of Signature

NOTES:

* Please provide a copy of the ADAMH/CMH Board motion approving submission of this MSPA to the ODMH.

** Upon submission, please provide the signatures of the ADAMH/CMH Board Executive Director and Chair. After ODMH review and any further clarification requested, the Director of ODMH shall affix his signature.

*** Please mail hard copy of signatures to your Area Director at ODMH

SECTION TEN: Appendices

10.1 Definitions

10.2 Block Grant Assurances- Certifications

10.3 Block Grant Assurances- Non-Construction Programs

10.4 Board Data Appointment Sheet

10.5 Client Rights and Grievance Annual Report

Appendix 1: Definitions

ADAMH: Alcohol, Drug and Mental Health

Behavioral Health Data: Demographic and other types of data formerly collected in ODMH's computer system previous to MACSIS, the Mental Health Information System (MHIS), e.g., living arrangement, employment, drug abuse history, etc.

BHO: Behavioral Health Organization (formerly known as state psychiatric hospitals)

CMH: Community Mental Health.

Consumer: Person who is receiving or has received public mental health services and/or supports.

Community Linkage Contact: A person, agency or entity designated by the ADAMH/CMH Board to be contacted for community linkage appointments for offenders leaving state prisons.

CRO: Client Rights Officer

CSN: Community Services Network

Cultural Competence: a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables this system, agency, or those professionals to work effectively in cross-cultural situations.

DMH-FIS-040a: the financial planning form, *Report of Planned Receipts, Expenditures and Service Units - ADAMH/CMH Boards*

Employment: is any activity conducted in a competitive, community work setting for which an individual is paid at least minimum wage**.** No minimum hours per week or month are included in the definition, and the target population is adults, ages 18 and older, with serious and persistent mental illness.

EPMC: Executive Policy Management Committee. Formerly known as the MSPA/QI Committee

Evidence-Based Practices: those treatments, supports and approaches that are shown with some degree of rigor to maximize positive outcomes for adults living with a mental illness and children and youth living with emotional disturbances.

Forensic Monitor: A person, agency or entity designated by the ADAMH/CMH Board to monitor Not Guilty by Reason of Insanity acquittees and Incompetent to Stand Trial-Unrestorable-Criminal court Jurisdiction (IST-U-CJ) defendants on Conditional Release Commitment in the community.

Family: persons identified by the consumer as either family members or significant others

HAP: Housing Assistance Program- short-term rental subsidy assistance and/or loans for start-up costs. Used with housing that includes a standard tenant landlord lease and no requirements for clinical treatment required as part of the assistance.

HOPE: Housing Outcomes Performance Evaluation funded through 508H/Block Grant and monitored through the Housing Outcomes process. This allows Boards to plan, in the most flexible manner with a focus on outcome accountability, to meet the array of housing needs that exist in that community. Funding for HOPE includes HAP and SHOP programs.

IBHS: Integrated Behavioral Health System, those consumer service elements of the public mental health system that are operated directly by the ODMH including, but not limited to CSNs and BHOs.

MACSIS: ODMH's current computer system: Multi Agency Community Services Information System.

MSPA: Mutual Systems Performance Agreement. Part of the community plan as defined by the Ohio Revised Code Sections 340.03 and 5119.61.

OAC: Ohio Administrative Code

OACBHA: Ohio Association of Community Behavioral Healthcare Authorities

ODJFS: Ohio Department of Job and Family Services.

ODMH: Ohio Department of Mental Health.

ORC: Ohio Revised Code.

Outcome: The result of the performance (or nonperformance) of a function or process.

Outcome Measure: A measure that indicates the result of the performance (or non-performance) of a function or process.

Providing Culturally Competent Services: the manner of providing services in which customers perceive services to the problems as helpful to achieving their desired outcomes.

Quality Assurance: The efforts to determine the quality of care, to develop and maintain programs at an acceptable level, and to institute improvements when the opportunity arises or the care does not meet the desired standard of care.

Quality Improvement: An approach to the continuous study and improvement of the processes of providing health care services to meet the needs of individuals and others. Synonyms include continuous

quality improvement, continuous improvement, organization-wide performance improvement, and total quality management.

Quality of Care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: patient perspective issues; safety of care environment; and accessibility, appropriateness, continuity, effectiveness, efficacy, efficiency, and timeliness of care.

Recovery: the personal process of restoring a meaningful life despite serious mental illness

Resiliency: is the goal of children and families achieving the capability to cope successfully in the face of significant adversity or risk

Safety Net Survey: A survey sent to all of Ohio's 50 ADAMH/CMH Boards that was designed to collect information on service demand, access, quality, financial and intersystem issues that currently threaten the viability of the mental health safety net in Ohio.

SED: Severely Emotionally Disturbed. A designation for those individuals under 18 years of age who have serious emotional disturbances and are at the greatest risk for needing services.

SFY: State Fiscal Year: Begins July 1st of one calendar year and ends June 30th of the succeeding calendar year, i.e., SFY 2004 ends June 30, 2004.

SHOP: Supportive Housing Option for Prosperity- Funds used to meet housing and residential needs other than rental assistance, e.g., supportive housing staff and lease technicians, etc.

SMD: Severely Mentally Disabled. A designation for those adults with severe and persistent mental illnesses who are at the greatest risk for needing services.

UCI: Unique Client Identifier used in MACSIS.

Utilization Review: "In contracting with a community mental health agency, a board shall consider the cost effectiveness of services provided by that agency 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 shall be established as part of the contract for services entered into between a board and a community mental health agency. The board may establish this process in a way that is most effective and efficient in meeting local needs." [O.R.C. § 340.03(A)(8)(a)]

CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to be best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about—
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will—
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such

conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted—
   (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designed the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, SW
Washington, DC 20201

3. Certification Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence," agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his/her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S.C. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than

$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties.
The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Services

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/grantee (for grants certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

By ____ Date ________________
(Signature of Official Authorized to Sign Application)

For ____
(Name of Grantee)

ASSURANCES — NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal, gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29.S.C. § 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L.92-255), as amended relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970-(P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. 290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§ 3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 U.S.C. § 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et. Seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§ 7401 et. Seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et. Seq.) Related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. § 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et. seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§ 2131 et. seq.) Pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4831 (b) et. seq.) Which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE EXECUTIVE DIRECTOR
APPLICANT ORGANIZATION ATHENS-HOCKING-VINTON 317 BOARD	DATE SUBMITTED MARCH 18, 2003

BOARD APPOINTMENT DATA SHEET

List all members – use additional pages as needed. This form can be printed and completed, or wordprocessed for electronic transfer via e-mail. If wordprocessed, replace the appropriate checkbox with an "X."

Board Name
Athens-Hocking-Vinton 317 Board

Date Prepared
3/03/03

Board Member
Roger Stivison

Mailing Address (street, city, state, zip)

P.O. Box 150
Union Furnace, OH 43158

Telephone (include area code)
(W) 740-385-3251
(H) 740-583-0322

County of Residence
Hocking

Occupation
Equipment Operator

"X" One
X Partial Term First Full Term Second Full Term

Year Term Expires
2004

Appointment: ODMH, ODADAS, x County, Chairperson

Sex: x Male, Female

Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other

Representation: "X" Only One

Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician

Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate

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Board Name
Athens-Hocking-Vinton 317 Board

Date Prepared
3/05/03

Board Member
Dr. Roy Bontrager

Mailing Address (street, city, state, zip)
P.O. Box 947
Logan, OH 43138

Telephone (include area code)
(H) 740-385-4528
(W) 740-385-9646

County of Residence
Hocking

Occupation
Physician

"X" One
X Partial Term First Full Term Second Full Term

Year Term Expires
2003

Appointment: ODMH, ODADAS, County, Chairperson

Sex: X Male, Female

Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other

Representation: "X" Only One

Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, X Physician

Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate

---

Board Name
Athens-Hocking-Vinton 317 Board

Date Prepared
4/23/02

Board Member
Esther Crownover

Mailing Address (street, city, state, zip)
P.O. Box 467
McArthur, OH 45651

Telephone (include area code)
(H) 740-596-4365
(W) 740-596-5119

County of Residence
Vinton

Occupation
President, Crownover Lumber Co.

"X" One
Partial Term First Full Term X Second Full Term

Year Term Expires
2003

Appointment: ODMH, ODADAS, x County, Chairperson

Sex: Male, X Female

Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other

Representation: "X" Only One

Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician

Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate

---

Board Name
Athens-Hocking-Vinton 317 Board

Date Prepared
4/23/02

Board Member
Steve Follrod

Mailing Address (street, city, state, zip)
16 Farhills Dr.
Athens, OH 45701

Telephone (include area code)
(H) 740-594-2874

County of Residence
Athens

Occupation
Pharmacist

Appointment: ODMH, ODADAS, X County, Chairperson

Sex: X Male, Female

Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other

Representation: "X" Only One

Mental Health: Consumer, Family Member

Alcohol/Drug Addiction: Consumer, Family Member

"X" One			Year Term Expires	MH Professional	Professional
Partial Term	First Full Term	X Second Full Term	2004	Psychiatrist	Advocate
				Physician	

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14.2 BOARD APPOINTMENT DATA SHEET

Board Name Athens-Hocking-Vinton 317 Board	Date Prepared 4/23/02
Board Member William M. Garrett	Appointment: ODMH, x ODADAS, County, Chairperson Sex: x Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip) 201 West High St. McArthur, OH 45651	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, X Advocate
Telephone (include area code) (W) 740 596-5222 (H) 740-596-4317	County of Residence Vinton
Occupation Funeral Director	
"X" One Partial Term, First Full Term, X Second Full Term	Year Term Expires 2003

Board Name Athens-Hocking-Vinton 317 Board	Date Prepared 4/23/02
Board Member Luther Haseley	Appointment: ODMH, X ODADAS, County, Chairperson Sex: X Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip) 9865 Oxley Rd. Athens, OH 45701	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, X Professional, Advocate
Telephone (include area code) 740-592-3680	County of Residence Athens
Occupation Professor – Counselor Education	
"X" One Partial Term, First Full Term, X Second Full Term	Year Term Expires 2004

Board Name Athens-Hocking-Vinton 317 Board	Date Prepared 4/23/02
Board Member Laura Hopstetter	Appointment: ODMH, ODADAS, X County, X Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip) 31610 Mays Rd. Logan, OH 43138	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate
Telephone (include area code) (W) 740-385-7352	County of Residence Hocking
Occupation Owner, Internet Provider Service	
"X" One Partial Term, X First Full Term, Second Full Term	Year Term Expires 2003

Board Name Athens-Hocking-Vinton 317 Board	Date Prepared 4/23/02
Board Member	Appointment: ODMH, ODADAS, County, Chairperson Sex: Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip)	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional Alcohol/Drug Addiction: Consumer, Family Member, Professional
Telephone (include area code) (H) 740-385-9666 (W) 740-385-8575	County of Residence Hocking
Occupation Receptionist	

“X” One Partial Term First Full Term Second Full Term	Year Term Expires 2003	Psychiatrist Advocate Physician

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BOARD APPOINTMENT DATA SHEET

Board Name Athens-Hocking-Vinton 317 Board			Date Prepared 4/23/02
Board Member Sandi Krivesti		Appointment: ODMH, ODADAS, X County, Chairperson Sex: Male, XFemale Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 11135 Salem Rd. Athens, OH 45701		Representation: "X" Only One Mental Health: Consumer, X Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (H) 740-592-5701 (W) 740-593-4162	County of Residence Athens		
Occupation Accountant			
"X" One Partial Term / First Full Term / X Second Full Term	Year Term Expires 2006		

Board Name Athens-Hocking-Vinton 317 Board			Date Prepared 4/23/02
Board Member Jim McMullen		Appointment: X ODMH, ODADAS, County, Chairperson Sex: X Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 19 E. Carpenter St., Apt. 19 Athens, OH 45701		Representation: "X" Only One Mental Health: X Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (H) 740-592-4955	County of Residence Athens		
Occupation Retired Teacher			
"X" One Partial Term / First Full Term / X Second Full Term	Year Term Expires 2003		

Board Name Athens-Hocking-Vinton 317 Board			Date Prepared 4/23/02
Board Member David Rickard		Appointment: ODMH, X ODADAS, County, Chairperson Sex: X Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 1A Spring St. Athens, OH 45701		Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: X Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (W) 740-753-1917 (H) 740-593-8243	County of Residence Athens		
Occupation Psychology Assistant			
"X" One Partial Term / X First Full Term / Second Full Term	Year Term Expires 2005		

Board Name Athens-Hocking-Vinton 317 Board			Date Prepared 4/23/02
Board Member Claudia Shealy		Appointment: X ODMH, ODADAS, County, Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 507 Richland Ave. Athens, OH 45701		Representation: "X" Only One Mental Health: Consumer, Family Member, X MH Professional Alcohol/Drug Addiction: Consumer, Family Member, Professional	
Telephone (include area code) (W) 740-593-8001 (H) 740-592-5869	County of Residence Athens		
Occupation Director of Special Education			

"X" One Partial Term First Full Term X Second Full Term	Year Term Expires 2005	Psychiatrist Advocate Physician

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BOARD APPOINTMENT DATA SHEET

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member Donna Voelkel	Appointment: ODMH, ODADAS, County, Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 23032 Buena Vista Rockbridge, OH 43149	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (W) (H) 740-385-0552	County of Residence Hocking	
Occupation Physician		
"X" One Partial Term / First X Full Term / Second Full Term	Year Term Expires 2003	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member Patricia Smith-Hunt	Appointment: ODMH, ODADAS, X County, Chairperson Sex: Male, X Female Minority: X African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 14 Elmwood Place Athens, OH 45701	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (W) 740-593-2618	County of Residence Athens	
Occupation Head Preservationist Librarian		
"X" One Partial Term / First Full Term / X Second Full Term	Year Term Expires 2006	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member Teena Stambaugh	Appointment: ODMH, ODADAS, X County, Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 13522 Strouds Run Rd. Athens, OH 45701	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate	
Telephone (include area code) (H) 740-593-8400	County of Residence Athens	
Occupation Nurse		
"X" One X Partial Term / First Full Term / Second Full Term	Year Term Expires 2003	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member Tom Steenrod	Appointment: ODMH, ODADAS, X County, Chairperson Sex: X Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other	
Mailing Address (street, city, state, zip) 659 Poplar St. Nelsonville, OH 45764	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional Alcohol/Drug Addiction: Consumer, Family Member, Professional	
Telephone (include area code) (H) 740-753-9309 (W) 614-233-6818	County of Residence Athens	
Occupation Exec. Director, State Association		

"X" One Partial Term / X First Full Term / Second Full Term	Year Term Expires 2005	Psychiatrist, Physician / X Advocate

14.2 BOARD APPOINTMENT DATA SHEET

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member Constance White		Appointment: X ODMH, ODADAS, County, Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip) 1 Yankee Dr. Wilkesville, OH 45695		
Telephone (include area code) (H) 740-669-7001	County of Residence Vinton	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate
Occupation Computer Program Specialist		
"X" One X Partial Term / First Full Term / Second X Full Term	Year Term Expires 2003	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared 4/23/02
Board Member		Appointment: ODMH, ODADAS, X County, Chairperson Sex: Male, X Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip)		
Telephone (include area code)	County of Residence	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate
Occupation Computer Program Specialist		
"X" One Partial Term / First Full Term / X Second Full Term	Year Term Expires 2003	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared
Board Member		Appointment: ODMH, ODADAS, County, Chairperson Sex: Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip)		
Telephone (include area code)	County of Residence	Representation: "X" Only One Mental Health: Consumer, Family Member, MH Professional, Psychiatrist, Physician Alcohol/Drug Addiction: Consumer, Family Member, Professional, Advocate
Occupation		
"X" One Partial Term / First Full Term / Second Full Term	Year Term Expires	

Board Name Athens-Hocking-Vinton 317 Board		Date Prepared
Board Member		Appointment: ODMH, ODADAS, County, Chairperson Sex: Male, Female Minority: African-American, Hispanic, Alaskan Native, Asian or Pacific Islander, Native American, Other
Mailing Address (street, city, state, zip)		
Telephone (include area code)	County of Residence	Representation: "X" Only One Mental Health: Consumer Alcohol/Drug Addiction: Consumer

<table>
<tr><td colspan="2">Occupation</td><td rowspan="2">Family Member
MH Professional
Psychiatrist
Physician</td><td rowspan="2">Family Member
Professional
Advocate</td></tr>
<tr><td>“X” One
Partial Term First Full Term Second Full Term</td><td>Year Term Expires</td></tr>
</table>

DMH-0164 DMH-ADM-036

The ADAMH/CMH Board's Client Rights and Grievances Annual Summary for the biennium SFY 2004 - 2005 has a specified format. The first due date for submitting the Annual Summary using this format will be September 2004 for the period of SFY 2004. [O.A.C Sections 5122:2-2-1-02 (G) (H) & (I)]

Using SFY 2004 data for consumers' grievances, complete the attached matrix:

Types of Grievances by **Client Rights Categories** (See below for which of the 22 Rights fall into which category)	Number of grievances received.		Resolution status of grievance, i.e., number of grievances resolved to the satisfaction of the consumer.		Number of grievances resolved within 20 working days from the date of filing.	
	Agencies	Board	Agencies	Board	Agencies	Board
Right to Dignity and Respect						
Right to Informed Choice and Treatment						
Right to Freedom						
Right to Personal Liberties						
Right to Freely Exercise All Rights						

Client Rights Categories

There are 22 rights outlined in Ohio Revised Code and Ohio Administrative Code that apply to consumers receiving public community mental health services. These mental health rights fall into the **following major categories:**

The Right to Dignity and Respect

- Dignity, Respect, Autonomy, and Privacy – Right #1
- Service in a Humane Setting with the Greatest Possible Freedom – Right #2

The Right to Informed Choice and Treatment

- Information of Current/Suggested Services – Right #3
- Accept or Reject Any Service – Right #4

The Right to Informed Choice and Treatment (continued)

- Current, Written, Individualized Service Plan – Right #5
- Active and Informed Participation – Right #6
- Participation in Any Service Even if Other Services are Refused – Right #9
- Advance Notice if Any Services Are to be Discontinued – Right #15
- Clear Explanation of Denial of Any Service – Right #16

The Right to Freedom

- Unnecessary Medication – Right #7
- Unnecessary Restraint and Seclusion – Right #8
- Unusual or Dangerous Treatment – Right #10
- Intrusion of One-Way Mirrors, Photographs, Tape Recorders (audio or visual) and Movies - Right #11

The Right to Personal Liberties

- Consultation – Right #12
- Confidentiality – Right #13
- Read and Get Copies of Psychiatric, Medical or Other Treatment Records – Right #14
- Non-Discrimination – Right #17
- Know the Cost of Services – Right #18

The Right To Freely Exercise All Rights

- Fully Informed of All Rights – Right #19
- Exercise Any and All Rights Without Being Threatened or Punished – Right #20
- File a Grievance – Right #21
- Have Oral and Written Instructions for Filing a Grievance – Right #22