2023-2025 Community Assessment and Plan
Athens-Hocking-Vinton ADAMHS Board

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Background and Statutory Requirements

The new Community Assessment and Plan (CAP) process is designed to better support policy development, strategic direction, strategic funding allocation decisions, data collection and data sharing, and strategic alignment at both the state and community level. This planning process balances standardization and flexibility as the Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards identify unmet needs, service gaps, and prioritize community strategies to address the behavioral health needs in their communities. Included in these changes is an increased focus on equity and the social determinants of health that are now imbedded in all community planning components.

Based on the requirements of Ohio Revised Code (ORC) 340.03, the community ADAMH Boards are to evaluate strengths and challenges and set priorities for addiction services, mental health services, and recovery supports in cooperation with other local and regional planning and funding bodies. The boards shall include treatment and prevention services when setting priorities for addiction services and mental health services.

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has redesigned the CAP to support stronger alignment to the 2021-2024 OhioMHAS Strategic Plan, and to support increased levels of collaboration between ADAMH Boards and community partners, such as local health departments, local tax- exempt hospitals, county Family and Children First Councils (FCFCs), and various other systems and partners. The new community planning model has at its foundation a data-driven structure that allows for local flexibility while also providing standardization in the assessment process, identification of disparities and potential outcomes.

Required Components of the CAP

Assessment – OhioMHAS encourages the ADAMH Boards to use both quantitative and qualitative data collection methods and to partner with other organizations, such as local health departments, tax-exempt hospitals, county FCFCs, community stakeholders, and individuals served to conduct the assessment. During the assessment process, ADAMH Boards are requested to use data and other information to identify mental health and addiction needs, service gaps, community strengths, environmental factors that contributes to unmet needs, and priority populations that are experiencing the worst outcomes in their communities (disparities)

Plan – ADAMH Boards develop a plan that identifies local priorities across the behavioral health continuum of care that addressed unmet needs and closed service gaps. The plan also identifies priority populations for service delivery and plans for future outpatient needs of those currently receiving inpatient treatment at state and private psychiatric hospitals.

Legislative Requirements – This new section of the CAP is reserved to complete and/or submit statutorily required information. The use of this section may vary from plan-to-plan.

Continuum of Care Service Inventory – ADAMH Boards are required to identify how ORC-required continuum of care services (340.033 and 340.032 Mid-Biennial Review) are provided in the community. This information is to be completed via an external Excel spreadsheet.

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CAP Plan Highlights – Continuum of Care Priorities and Age Groups of Focus

The CAP Plan priorities section is organized across the behavioral health continuum of care and two special populations. Each of the Plan continuum of care priority areas will be defined on the following pages. The information in this CAP Plan will also include the Board's chosen strategy identified to address each priority, the population of focus, identification of potential populations experiencing disparities, the chosen outcome indicator to measure progress ongoing, and the target the Board is expecting to reach in the coming years.

For each identified strategy, the Board was requested to identify the age groups that are the focus for each identified CAP Plan strategy. These age groups include Children (ages 0-12), Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64), and Older Adults (ages 65+). The table below is an overview of which ages are the focus of each priority across the continuum of care.

Continuum of Care Priorities	**Children** (ages 0-12)	**Adolescents** (ages 13-17)	**Transition-Aged Youth** (ages 14-25)	**Adults** (ages 18-64)	**Older Adults** (ages 65+)
Prevention	●	●			
Mental Health Treatment	●	●	●		
Substance Use Disorder Treatment		●	●	●	
Medication-Assisted Treatment				●	
Crisis Services				●	
Harm Reduction		●	●	●	●
Recovery Supports				●	
Pregnant Women with Substance Use Disorder		●	●	●	
Parents with Substance Use Disorder with Dependent Children	●	●	●	●	

CAP Plan Highlights – Continuum of Care Priorities

→ ***Prevention***: *Prevention services are a planned sequence of culturally relevant, evidenced-based strategies, which are designed to reduce the likelihood of or delay the onset of mental, emotional, and behavioral disorders. **

- **Strategy:** Support Handle with Care program expansion across all school districts in region.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17)
- **Priority Populations and Groups Experiencing Disparities:** General Populations
- **Outcome Indicator(s):** Number of school districts implementing Handle With Care
- **Baseline:** 6
- **Target:** 9 districts by 2025

→ ***Mental Health Treatment***: *Any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's condition or mental health.*

- **Strategy:** Promote family stability and child well-being by working with state partners and local treatment providers and other stakeholders to build out Ohio Rise services for multi-system youth.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25)
- **Priority Populations and Groups Experiencing Disparities:** General Populations
- **Outcome Indicator(s):** Number of Behavioral Health Respite services available in the Board area
- **Baseline:** 0
- **Target:** 3 services by 2025

**All definitions of the BH Continuum of Care are from Ohio Revised Code (ORC) and Ohio Administrative Code (OAC)*

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Substance Use Disorder Treatment***: *Any care, treatment, or service to treat an individual's misuse, dependence, and addiction to alcohol and/or legal or illegal drugs.*

- **Strategy:** Create a local workforce environment that attracts and retains high quality employees within the BH system. Provide workforce recruitment and retention funding to increase staffing levels.
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** General Populations
- **Outcome Indicator(s):** Number of clients accessing SUD treatment.
- **Baseline:** 1,188
- **Target:** 1,556 by 2024

→ ***Medication-Assisted Treatment***: *Alcohol or drug addiction services that are accompanied by medication that has been approved by the USDA for the treatment of substance use disorder, prevention of relapse of substance use disorder, or both.*

- **Strategy:** Provide funding to increase access to MAT services for uninsured and underinsured.
- **Age Group(s) Strategy Trying to Reach:** Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** General Populations
- **Outcome Indicator(s):** Number of individuals accessing MAT services through funding assistance for uninsured and under-insured
- **Baseline:** 237
- **Target:** 261 individuals by 2024

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Crisis Services***: *Any service that is available at short notice to assist an individual to resolve a behavioral health crisis or support an individual while it is happening.*

- **Strategy:** Provide workforce recruitment and retention funding to increase staffing levels at Adam-Amanda Crisis Stabilization Unit.
- **Age Group(s) Strategy Trying to Reach:** Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Resident of Rural Areas, Residents of Appalachian Areas, Persons with Serious Mental Illness
- **Outcome Indicator(s):** Adam-Amanda utilization rate
- **Baseline:** 2,622 (50%)
- **Target:** 5,480 (90%) by 2024
- **Next Steps and Strategies to Improve Crisis Continuum:** Rolled out Workforce Recruitment and Retention funding agreement with board-contracted agencies. Purpose is to create a local workforce environment that attracts and retains high quality employees within the BH system.

→ ***Harm Reduction***: *A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.*

- **Strategy:** Increase access to naloxone
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64), Older Adults (ages 65+)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Resident of Appalachian Areas, People Who Use Injection Drugs (IDUs), Persons with Opioid Use Disorder
- **Outcome Indicator(s):** Unintentional drug overdose deaths (rate per 100,000 pop.)
- **Baseline:** 23
- **Target:** 15 by 2025

CAP Plan Highlights – Continuum of Care Priorities Cont.

→ ***Recovery Supports***: *Services that promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs to "be well," manage symptoms, and achieve and maintain abstinence).*

- **Strategy:** Develop new contracts with local housing authorities to increase units available.
- **Age Group(s) Strategy Trying to Reach:** Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Residents of Appalachian Areas, Persons with Serious Mental Illness
- **Outcome Indicator(s):** Number of housing units prioritized for persons with SPMI in the Board area to promote long term stability and prevent re-hospitalizations.
- **Baseline:** 38
- **Target:** 50 by 2025

CAP Plan Highlights - Special Populations

Due to the requirements of the federal Mental Health and Substance Abuse and Prevention Block Grants, the Board is required to ensure that services are available to two specific populations: Pregnant Women with Substance Use Disorder, and Parents with Substance Use Disorder with Dependent Children.

→ ***Pregnant Women with Substance Use Disorder:***

- **Strategy:** Identify women in agency's electronic health record with pregnancy episode and SUD diagnosis to provide specialized services resulting in a healthy delivery.
- **Age Group(s) Strategy Trying to Reach:** Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** Women, Pregnant Moms
- **Outcome Indicator(s):** Number of pregnant women with SUD diagnosis who will receive specialized services to promote healthy deliveries and parent/child bonding
- **Baseline:** 4
- **Target:** 5 by 2025

CAP Plan Highlights - Special Populations Cont.

→ ***Parents with Substance Use Disorder with Dependent Children:***

- **Strategy:** Work with Public Children Services Partners to support the START program to address the SUD needs of families involved with Child Protective Services.
- **Age Group(s) Strategy Trying to Reach:** Children (ages 0-12), Adolescents (ages 13-17), Transition-Aged Youth (ages 14-25), Adults (ages 18-64)
- **Priority Populations and Groups Experiencing Disparities:** People with Low Incomes or Low Educational Attainment, Residents of Rural Areas, Residents of Appalachian Areas, SUD Parents with Children Involved with Child Welfare
- **Outcome Indicator(s):** Number of families agreeing to participate in the voluntary program and who stay engaged in the program during the year
- **Baseline:** 13
- **Target:** 20 by 2024

CAP Plan Highlights - Other CAP Components

→ ***Family and Children First Councils:***

- **Service Needs Resulting from Finalized Dispute Resolution Process:** There have been no disputes within Athens, Hocking and Vinton Counties. We attribute this to on-going collaborative Board leadership in FCFC planning and problem-solving.
- **Collaboration with FCFC(s) to Serve High Need Youth:** The AHV Board invests into pooled funding for high need/multi-system children in each county. The Board is an active partner with each Family and Children First Council—on the full council and with county cluster meetings. The Board is collaborating with Integrated Services for Behavioral Health and FCFC(s) to build relationships and infrastructure for OhioRise. Significant work is needed in this area.
- **Collaboration with FCFC(s) to Reduce Out-of-Home Placements:** The AHV Board invests into pooled funding for high need/multi-system children in each county. The Board is an active partner with each Family and Children First Council—on the full council and with county cluster meetings. The Board is collaborating with Integrated Services for Behavioral Health and FCFC(s) to build relationships and infrastructure for OhioRise. Significant work is needed in this area.

CAP Plan Highlights - Other CAP Components

→ ***Hospital Services:***

- **Identify How Outpatient Service Needs Are Identified for Current Inpatient Private or State Hospital Individuals Who Are Transitioning Back to the Community:** The AHV Board funds a Hospital Liaison position at Hopewell Health Centers (HHC) to coordinate in-reach and aftercare for both state and private hospitals. Coordination with Appalachian Behavioral Healthcare (ABH) is excellent. A continuity of care agreement outlines care coordination terms. ABH and HHC exchange psychiatric records and information to ensure continuity of care as patients move from the hospital to the community. The Adam-Amanda Rehabilitation Center is often used for step-downs after hospitalization. HHC staff participate in the treatment and discharge planning and routinely consult with ABH hospital staff. There is a monthly case review meeting as well. Coordination with private psychiatric hospitals in Columbus is more challenging due to changing personnel at the hospitals and short lengths of stay. It would be helpful for the state to require care coordination metrics to further this coordination with community providers. Access Success and Multi-System Adult funding are significant resources for meeting the needs of person transitioning back to the community.
- **Identify What Challenges, If Any, Are Being Experienced in This Area:** Lack of communication/cooperation from state regional psychiatric hospital, Lack of access to state regional psychiatric hospital, Workforce shortages, Lack all types of housing: permanent, permanent supportive housing, group homes
- **Explain How the Board is Attempting to Address Those Challenges:** Relationships with indigent funds have helped to build relationships with private hospitals, but state Medicaid investments are needed to fund longer length of stays for the small number of people who are not stabilized in 7 days. The Board and HHC is developing an AOT program with hopes that this will increase community stability. The Board is investing in workforce initiatives. The Board partners with Housing Authorities and other partners to expand housing.

→ ***Optional: Data Collection and Progress Report Plan:***

- The AHV ADAMHS Board gathers program outcomes from agency partners and is currently migrating the process to an online platform for project and process management. The online platform has automations, alerts, reports, and dashboards and will be helpful in monitoring and communicating data

→ ***Optional: Link to Other Community Plans:***

As of February 2023

- Athens County CHA https://www.athenspublichealth.org/about_us/reports.php#outer-105
- Hocking County CHIP https://www.hockingcountyhealthdepartment.com/
- Vinton County Health Strategic Plan https://vintonohhealth.org/

CAP Assessment Highlights

As part of the CAP Assessment process, the Board was required to consider certain elements when conducting the assessment. Those elements included identifying community strengths, identifying mental health and addiction challenges and gaps, identifying population potentially experiencing disparities, and how social determinants of health are impacting services throughout the board area. The Board was requested to take these this data and these elements into consideration when developing the CAP Plan.

→ ***Most Significant Strengths in Your Community:***

- Collaboration and Partnerships
- Availability of Specific Resources or Assets
- Creativity and Innovation

→ ***Mental Health and Addiction Challenges:***

Top 3 Challenges for Children Youth and Families

- Mental, Emotional, and Behavioral Health Conditions in Children and Youth (overall)
- Youth Suicide Deaths
- Children in Out-of-Home Placements Due to Parental SUD

Top 3 Challenges for Adults

- Adult Serious Mental Illness
- Adult Substance Use Disorder
- Drug Overdose Deaths

Populations Experiencing Disparities

- People with Low Income or Low Educational Attainment, Residents of Rural, Residents of Appalachian Areas, LGBTQ+, People Who Use Injection Drugs (IDUs), People Involved in the Criminal Justice System

CAP Assessment Highlights Cont.

→ ***Mental Health and Addiction Service Gaps:***

Top 3 Service Gaps in the Continuum of Care

- Mental Health Workforce
- Substance Use Disorder Treatment Workforce
- Housing

Top 3 Access Challenges for Children Youth and Families

- Lack of Follow-Up Care for Children Prescribed Psychotropic Medications
- Respite
- Intensive Home-Based Services

Top 3 Challenges for Adults

- Transportation
- Stigma
- Unreliable Internet and Cellular Services

Populations Experiencing Disparities

- People with Low Income or Low Educational Attainment, Residents of Rural, Residents of Appalachian Areas, People Who Use Injection Drugs (IDUs), People Involved in the Criminal Justice System

→ ***Social Determinants of Health:***

Top 3 Social and Economic Conditions Driving Behavioral Health Challenges

- Poverty
- Stigma, Racism, Ableism, and Other Forms of Discrimination
- Family Disruptions (divorce, incarceration, parent deceased, child removed from home, etc.)

Top 3 Physical Environment Conditions Driving Behavioral Health Challenges

- Lack of Affordable of Quality Housing
- Lack of Broadband Access
- Food Insecurity

Populations Experiencing Disparities

- People with Low Income or Low Educational Attainment, Residents of Rural, Residents of Appalachian Areas, People Who Use Injection Drugs (IDUs), People Involved in the Criminal Justice System

Optional: Link to Other Community Assessments:

As of February 2023

- Athens County CHA https://www.athenspublichealth.org/about_us/reports.php#outer-105
- Hocking County CHIP https://www.hockingcountyhealthdepartment.com/
- Vinton County Health Strategic Plan https://vintonohhealth.org/