

***HAMILTON COUNTY
ALCOHOL AND DRUG ADDICTIONS SERVICES BOARD***



**COMMUNITY PLAN
FOR THE PROVISION OF ALCOHOL
AND OTHER DRUG SERVICES
SFY 2004 - 2005**

**Submitted to:
OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES
March 28, 2003**

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**COMMUNITY PLAN FOR THE PROVISION OF
ALCOHOL AND OTHER DRUG ADDICTION SERVICES
SFY 2004 - 2005**

SIGNATURE PAGE

Each Alcohol and Drug Addiction Services (ADAS) and Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) a plan for the provision of alcohol and other drug addiction services in its area. The plan, which constitutes the Board's applications for funds, is prepared in accordance with procedures and guidelines established by ODADAS. This Community Plan is for State Fiscal Years (SFY) 2004 - 2005 (July 1, 2003 to June 30, 2005).

The undersigned is a duly authorized representative of the ADAMHS/ADAS Board and on behalf of the Board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2004-2005 is complete and accurate.

Hamilton County ADAS Board

Sherry Knapp, Ph.D., Chief Executive Officer

Date

H. Richard Duval, Chairperson

Date

HAMILTON COUNTY ALCOHOL AND DRUG ADDICTION SERVICES BOARD

MISSION STATEMENT

The Hamilton County Alcohol and Drug Addiction Services Board plans, funds and monitors public alcohol and drug treatment, prevention and education services for the citizens of Hamilton County.

VISION STATEMENT

No individual should suffer from the impact of substance abuse and addiction.

SECTION I

CURRENT CIRCUMSTANCES

A. Legislative and Environmental Context of the Community Plan

Legislative Context of the Community Plan

The Hamilton County Alcohol and Drug Addiction Services Board (Board) is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) a plan for the provision of alcohol and other drug addiction services in its service area. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS. This plan covers state fiscal years (SFY) 2004 - 2005 (July 1, 2003 through June 30, 2005).

H.B. 317

Section 340.033(A) of the Ohio Revised Code stipulates the Board's responsibilities as the planning agency for alcohol and drug addiction services. The responsibilities of the Board as described in the legislation are:

1. Assessing service needs and evaluating the need for programs;
2. Setting priorities;
3. Developing operational plans in cooperation with other local and regional planning and funding bodies;
4. Reviewing and evaluating substance abuse programs;
5. Promoting, arranging and implementing working agreements with public and private social agencies and with judicial agencies;
6. Assuring effective services that are of high quality.

H.B. 484

Section 340.15 of the Ohio Revised Code requires Boards to consult with county commissioners in setting priorities and developing plans for services for public children services agency (PCSA) service recipients referred for alcohol and other drug treatment. The plan must identify monies the Board and county commissioners have available to fund the services jointly. The legislation prioritizes services to parents, guardians and caregivers of children involved in the child welfare system.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

The SAPT Block Grant requires prioritization or set aside of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant also requires that 20% of federal funds be used for prevention services.

Environmental Context of the Plan

Hamilton County (County) is situated in the extreme southwestern corner of the State of Ohio and covers an area of 414 square miles. Within the County are 37 municipalities, including 21 cities, 16 villages, and 12 townships. Hamilton County is the third largest in the State in terms of population. (Source: www.hamilton-co.org/about.asp) A report of economic indicators reveals the urban core area has experienced a population decline over the past ten years due in part to the flow of population to suburban areas and surrounding counties.

Through its Regional Planning Commission, the County continues with its strategic planning initiatives that focus on four key strategies: 1) Develop alliances and innovative coalitions with stakeholders for creating community plans; 2) Provide data analysis and benchmark analysis to support local communities; 3) Create a long-range plan for development through a comprehensive process, and 4) Become solutions oriented with appropriate diversity and capacity to enable increased focus on long-range regional planning, community building and problem solving.

Welfare reform continues to have an impact on the service delivery environment in the following ways:

- ✍ Case worker staff of the Hamilton County Department of Job and Family Services' (DJFS) lack clinical expertise in identifying substance use, therefore DJFS contracts with the Board to provide assessment and referral services for clients identified by DJFS staff as potentially involved with alcohol and drug abuse
- ✍ The individuals referred for assessment by DJFS continue to demonstrate multiple problems, specifically co-occurring substance abuse and mental illness. As a result of the increased numbers of individuals with co-occurring disorders, treatment episodes have lengthened and medical somatic services have increased thus increasing the average cost of services for this population.
- ✍ Reductions in eligibility for Medicaid negatively impacts treatment providers' revenue.

Characteristics of Clients Receiving Services

The following excerpts of client profiles were taken from the Outcome Management Plan written and submitted by provider agencies.

- 1) "Jane is a 50 year old widowed African American female who has been crack cocaine dependent for 10 years. Jane is unemployed and estranged from her family. Jane was arrested for theft. She stole to support her drug habit".
- 2) "Mary is a 31 year old single Caucasian mother of 7 minor children. Mary was arrested 6 months ago for solicitation. Mary solicited to maintain a 15-year heroin addiction. Mary completed the eighth grade, but is average in intelligence. Mary is motivated to obtain her GED".
- 3) "The average patient is a single 32 year old African-American male. His drug of choice is crack/cocaine usually with alcohol as a secondary drug. He has had prior legal involvement. He is unemployed and in need of a stable living environment. The average female patient is of the same age group, race is fairly evenly split between White and African-American. Her drug of choice tends to be the same. She has usually suffered sexual abuse sometime in her life and is in treatment because her children are at risk – referred by the Department of Human Services".
- 4) "30 year old AA (African-American) female. She is a high school graduate but illiterate. She has a 10- year history of alcohol and crack dependence. She has a diagnosis of paranoid schizophrenia. She

has a 6 month old daughter who is the result of a rape”.

In SFY 2002, Alcohol, crack cocaine, and marijuana remain the most abused substances among adult clients in ADAS funded agencies. Admissions for opiates and opioids were up 9%, and intravenous/intramuscular heroin admissions were up 42% from SFY 2001. Admissions in all other substance categories were down slightly from SFY 2001. SFY 2002 figures for adolescents were similar to those in SFY 2001.

Overall, more men are admitted to treatment than women. However, admissions are more often female for opiates and opioids other than heroin (largely pharmaceuticals). In all categories, boys are more likely than girls to be admitted for treatment. This may be due to the fact that boys are more likely to be involved in the criminal justice system, which produces many juvenile referrals to treatment.

Although overall admissions are equally divided among Caucasian and African-American clients, there are large discrepancies in race among substances. Other opiate and opioid using clients are overwhelmingly Caucasian. Taken together with the gender data, this suggests that white adult women are the group of County residents among which opiate use is growing. Heroin using clients are also largely white, and crack using clients are largely African-American.

White adolescent clients are more likely than black adolescent clients to have been admitted for alcohol abuse. Black adolescent clients are somewhat more likely than white adolescent clients to have been admitted for marijuana abuse.

In SFY 2002, 38% of referrals for adults originated in the criminal justice system. Self-referrals and human services referrals constituted most of the rest. Referrals for adolescents originated primarily in the criminal justice system.

Alcohol use and marijuana use typically begin earlier than use of other substances. Alcohol abusers wait much longer to enter treatment than other drug abusers.

Heroin users are the least likely to be employed and the most likely to report that their parents had a history of substance abuse. Crack users are also rarely employed, are likely to report histories of substance abuse, physical abuse and sexual abuse in their families, and are most often homeless.

Adolescents admitted for alcohol abuse were more likely to report a history of domestic violence or physical or sexual abuse in their families than adolescents admitted for illicit drug abuse.

In SFY2002, roughly 50% of treatment clients originated from a relatively small area in and around downtown Cincinnati. In this area, as much 2% of the population was admitted for treatment, even excluding homeless clients and clients in residential treatment in this area. This admit rate is as much as 10 times greater than the admit rate in other areas of the County. While some of the areas with low admit rates are higher income and thus more likely to be able to afford private treatment, many of these areas are lower income, and are surely in need of more AOD treatment.

Taken together, these circumstances influence the capacity of the system to respond to constituent expectations. The following limitations reflect environmental barriers in meeting the current demand for care:

- ✍ Shortage of residential and other intensive services for adolescents
- ✍ Decline in financial resources to serve the uninsured and underinsured
- ✍ Lack of well-designed, integrated, transitional housing programs

- ✍ Lack of sufficient resources to serve the needs of persons with co-occurring substance abuse and mental health disorders
- ✍ Lack of age-specific treatment models for older adults
- ✍ Barriers in geographic access to alcohol and drug services as the majority of alcohol and drug provider settings are concentrated in the urban core, City of Cincinnati
- ✍ Lack of adequate alcohol and other drug treatment and aftercare services for criminal justice groups

Expectations of the community and other constituents

Feedback from external customers has yielded expectations for improving system performance. The community relies heavily on the Board to promote quality of services, coordinate among varying systems, and produce outcomes that support the efficacy of AOD services. Specific expectations of the Board as stated by the community include:

- ✍ Collaborate with community resources to ensure housing options
- ✍ Support evidence-based, best practice models of care
- ✍ Ensure continued commitment to culturally sensitive programs
- ✍ Continue to facilitate coordination among providers in managing existing service delivery
- ✍ Seek additional resources that support the development of services identified as lacking within the continuum
- ✍ Ensure continuity through all appropriate levels of care
- ✍ Assist clients who require continuing care beyond treatment

Ongoing planning to strengthen programmatic initiatives include:

- ✍ Collaboration that brings everyone to the table
- ✍ Continued technical assistance in the development, review and communication of client outcomes
- ✍ Intersystem collaboration focused on the needs of individuals with limited English proficiency
- ✍ Family drug court
- ✍ Day treatment models for chronic offenders
- ✍ Treatment model for older adults
- ✍ Community based case management services

B. System Capacity to Meet Client Needs and Community Expectations

Capacity of the service system to respond to client and constituent expectations.

Provider agencies continue to have difficulty attracting and retaining a sufficient number of qualified staff. Provider agencies continue to see a high turnover rate that results in the loss of agency productivity, low morale, and disruption in the continuity of care for clients. The Board maintains ongoing discussions with the agency directors regarding the Board's role in assisting agencies to attract and retain qualified staff. The Board provides funds for system-wide training of agency staff.

Table 1, based on SFY 2004 projected data, provides an inventory of alcohol and other drug treatment and prevention providers with which the Board contracts. The services are categorized by levels of care and together make up the continuum of services from primary prevention to residential treatment.

The comprehensive continuum consists of nine treatment agencies, and ten agencies providing prevention

services. Clients may receive an assessment from any of the treatment agencies, and through the coordinated system project managed by The Alcoholism Council of Greater Cincinnati. The Alcoholism Council, a NCADD certified substance abuse treatment facility is responsible for the Coordinated System Access project that provides 24-hour telephone access, comprehensive assessment, information and referral, and transitional case management services for persons waiting for placement into a treatment program.

Adolescent treatment services include individual and group outpatient, intensive outpatient, day treatment, gender-specific residential, case management, TASC, relapse prevention, transitional case management, family counseling, and home-based services. Adult services include detoxification, individual and group outpatient, intensive outpatient, short and long term residential, case management, relapse prevention, transitional case management, and TASC services. There are two women's residential services, both of which allow mothers to bring their dependent children into the residential program. The Crossroads Center allows children up to age six years, and First Step Homes allows children up to age 12 years to accompany their mother in the residential program. The Board provides funding to the Drop Inn Center, an emergency shelter for homeless persons. The Drop Inn Center also provides residential alcohol and other drug treatment services. Specialized services for adult and juvenile offenders reentering the community following incarceration include assessment and referral, case management, the full continuum of treatment services, relapse prevention and linkage to ancillary services through TASC. Adult and Juvenile TASC provides assessment, intensive case management, screening, referral to treatment, and linkage with a variety of ancillary and non-ADAS system services including housing, employment/vocational training, mental health, and primary health care. The Crossroads Center operates a day care program for women in the agency's residential treatment program. The Crossroads Center operates culturally specific programming for African Americans, and also provides system-wide training and assistance with ensuring cultural competency in programming.

Funding Trends

Funding for the Board's service area has decreased with reductions in state allocations. The Board receives approximately 1.5 million dollars from the Health and Hospital Levy (Drake) to implement the Drug Court treatment program, known as ADAPT. The Health and Hospital Levy (University of Cincinnati/Children's Hospital) was renewed for five years in calendar year 2003. The Board receives 2.5 million dollars from the Health and Hospital Levy (University Hospital/Children's Hospital) to provide indigent care services and additional drug court treatment services. This is an increase of 41% over the previous allocation of 1.77 million dollars.

Costs for adjunctive services are included in the unit cost of services and therefore, are not billed separately. Twenty percent of federal and state per capita funds will be used for prevention services. Services are available on a sliding fee scale. Provider fees are designed to not only maximize access to services, but to ensure affordability of care.

The Board is in the final year of private foundation funding to conduct ongoing needs assessment, and to provide adolescent treatment enhancement services (ATEP).

The Board has partnered with provider agencies, and other community systems including mental health, Juvenile Court, and the Cincinnati Health District to apply for federal and private foundation funding. The Board facilitates a Grant Coordination Committee, a workgroup in collaboration with provider agencies to identify potential grant funding sources, and to coordinate efforts when applying for grants.

The Board manages out-of-county Medicaid clients in accordance with the guidelines and operating principles for residency determinations as set forth by the State of Ohio. In regards to non-Medicaid out-

of-county clients, the Hamilton County Prosecutor has informed the Board that the Board has no legal authority or obligation to cover the costs of treatment.

Physical Infrastructure

The Board purchased a 135,000 square feet building in Cincinnati from the State of Ohio in 2002. The Board leases space in this building, called The ADAS Center, to two treatment agencies. The Board contracts with Substance Abuse Management and Development, Inc. (SAMAD) for property management services at The ADAS Center.

Several buildings that are owned by provider agencies and which had previously housed client services are currently unoccupied due to reductions in funding.

Trends in Client Application for Services

Provider agencies report that there is an increasing complexity of issues that clients present at the time of treatment. Clients are requiring a higher intensity of services, including services that address co-occurring substance abuse and mental health needs, and physical health. As in previous years, problems related to safe, stable housing are a critical issue for all client populations.

SECTION II

Community Needs Review

Methods used to assess need

In assessing the system's needs, the Board has continued to implement the goals for treatment, prevention, and infrastructure improvements that were identified through a community-based, strategic planning process. Through a variety of qualitative approaches, the Board obtained expert opinions from provider representatives, consumers, and community leadership in determining the future direction and priorities of addiction prevention and treatment services in Hamilton County. Primary information was generated through participation in intersystem partnerships of public sector providers, individual interviews and focus groups with certified alcohol and drug prevention and treatment providers. The Board utilizes various qualitative and quantitative reports to identify trends and needs within the system of care. These reports include, but are not limited to, continuous quality improvement reports from providers, peer review audits, and utilization data. By identifying what has worked, who benefits and how, and measuring what really needs to be done to both prevent and reduce the incidence of alcohol and other drug-related consequences, the system can more effectively direct planning strategies that strengthen the level of the community's access to care and increase the efficiency of the existing service continuum.

The Board receives funding from a private health foundation to support the ongoing needs assessment of the AOD system. The Board works with a range of stakeholders to collect, compare, and analyze information on the incidence and prevalence of substance abuse and the social, behavioral, environmental, economic, cultural and health effects of substance-related consequences in Hamilton County. The results are used to generate projections that describe unmet needs/service gaps. Following are some of the results of this needs assessment process.

- ? Nationally, only 16.6% of those with abuse and dependence on drugs received specialized treatment for substance abuse. Applying SAMHSA prevalence data to Hamilton County (weighted for Hamilton County demographics) we estimate 14,000 persons in the County abuse or are dependent on illicit drugs during a given year. In Hamilton County, approximately 3000 persons per year receive treatment for illicit drug use, which represents 21% of the total who need treatment.
- ? The prevalence of alcohol dependence (by DSM IV criteria) nationally is 2.3%. Thus, an estimated 16,000 county residents are dependent on alcohol in a given year. In Hamilton County, approximately 2500 persons per year receive treatment for alcohol use which suggests only 16% are receiving the treatment they need.
- ? Nationally, of those meeting the criteria for alcohol and or other drug abuse or dependence in the past year, only 7.5% acknowledged a need for treatment. Two percent said they sought treatment but could not get it. In Hamilton County, some 3000 persons who did not receive treatment might be expected to acknowledge a need for substance abuse treatment. Between 700 and 950 might be expected to say that they have sought treatment but could not get it, and some 2300 might be expected to say that they needed treatment but did not seek it.
- ? The ODADAS sponsored Research Triangle Institute's Social Indicator analysis models, when applied to Hamilton County, predict that in the last 18 months between 9,600 and 17,600 persons will have been dependent on a substance. The ADAS system registered fewer than 10,000 new clients over the last 18 months. Thus, it is likely that several thousand persons who were dependent on a substance in the last 18 months did not receive treatment.

- ? Bottle liquor sales have risen steadily over the last five years in Hamilton County. In 2002, the number of bottles sold was up 11% from 1997, despite a decline in the County's population during that time.
- ? Over the last five year, the number of hospital discharges in Hamilton County for conditions related to opiate and opioid abuse (including dependence) has risen sharply in all ages groups. 2002 figures were up over 50% from 1997.
- ? Over the last five year, the number of hospital discharges in Hamilton County for conditions related to cocaine abuse (including dependence) has risen sharply for adults 36 and over, but has declined for younger age groups. 2002 figures were up 61% for those 36 and older, but were down 32% for those younger than 36. There has been a similar increase for adults 36 and over in discharges related to marijuana abuse.
- ? 2001 saw a dramatic drop in arrests and convictions for Possession of Drugs and Drug Paraphernalia. 2002 saw a dramatic increase in arrests and convictions for Trafficking in Drugs offenses, as the City of Cincinnati's newly created violence task force switched its efforts to combating street drug commerce. Neither of these changes in enforcement practices has had any apparent affect on the number of County residents referred for public alcohol and drug treatment.
- ? Since 1993 there has been a large increase in the number of accidental deaths determined by the Coroner's Office to have involved drugs of abuse (excluding alcohol). Cocaine, heroin and opiates were the substances associated with this increase.

To date the information gained through the ongoing needs assessment process has contributed to the development of the Special Populations Planning Committee which addresses language and disability needs, and a targeted review of adolescent services. The needs assessment process has led to enhanced collaboration with public sector delivery systems, set criteria for program improvements in adolescent services, and facilitated various partners seeking funding for a Family Treatment Drug Court and for services for individuals with co-occurring substance abuse and mental illness.

Unmet prevention, treatment and infrastructure needs/service gaps

The results of the community needs assessment led to the following general observations regarding the alcohol and drug system in Hamilton County:

- ? The Board's admissions data suggests that less than ten percent of Hamilton County residents in need of alcohol and other drug prevention and treatment services are actually receiving services through the existing public system of care
- ? Gaps in the delivery of services diminish access to care for the county's most vulnerable populations
- ? An appropriate mix of services and levels of care are not available for children, adolescents, older adults, persons with limited English proficiency, and persons with co-occurring disorders

The key areas of access, public participation, workforce, funding, and management information systems were identified in SFY2000 planning processes and remain priorities. In addition, special needs populations, continuity of care, and a greater focus on client outcomes, have been identified as population needs and emerging trends during this last year. Special needs populations have been defined as hearing impaired, sight impaired, and individuals with limited English proficiency.

The Board's programmatic priorities target the provision of evidence-based prevention and treatment models, including youth mentoring, family drug court, TASC (Treatment Alternatives for Safer Communities), care management for pregnant women, and collaboration with faith-based organizations. System (information) priorities incorporate upgrades in the areas of information technology, needs assessment, and outcomes measurement.

SECTION III

TREATMENT, PREVENTION AND INFRASTRUCTURE PRIORITIES FOR SFY 2004-2005

A. Priorities and Criteria Used

Priorities For SFY 2004 – 2005

The Board's planning process takes into account mandated population priorities as well as new and emerging issues among the county's unserved and underserved groups. Mandated priorities are: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, individuals of all ages at risk for HIV disease, children/adolescents, individuals involved with the criminal justice system, TANF recipients, and individuals involved in the child welfare system. Pregnant women, intravenous drug users, current and former Supplemental Security Income and Supplemental Security Disabled Income Drug Addicts and Alcoholics and medically indigent clients are given preference for admission. The Board, through arrangements with local public health entities, ensures services and early interventions are available for clients and staff at risk of tuberculosis. The following summarizes locally defined categories in the Board's schemata of treatment, prevention and programmatic priorities for SFY 2004-2005:

- ? Adolescents
- ? Young children ages eight-eleven
- ? Females, age twelve through seventeen years old
- ? Disabled Persons
- ? Gay Men and Lesbian Women
- ? Homeless Persons
- ? Juvenile Offenders
- ? Offenders
- ? Older Adults
- ? Limited English Proficiency
- ? Persons with Co-occurring Substance Abuse & Mental Health Disorders
- ? Racial, Ethnic and Cultural Groups
- ? Veterans
- ? Women, Pregnant Women and Women of Childbearing Age
- ? Programming for Special Populations at-risk for HIV/AIDS
- ? Parents

Treatment and prevention needs remain consistent with the previous community planning assessment and are based on the Board's historical application and long-term strategic planning objectives. The Board's priority treatment, prevention and infrastructure needs reflect continuous efforts to meet needs identified through its long-range strategic planning process. A full continuum of services does not exist for the county's most vulnerable populations, mainly, children/adolescents, older adults, persons with co-occurring substance abuse and mental health disorders, and persons with limited English proficiency. Needs assessment results confirm limitations in expanding service coverage in suburban areas. There is a need to enhance the use of age-specific, best practice models for prevention and treatment services. A continuing need exists for services that support long-term, neighborhood level participation in recovery within the community setting through home-based settings. Collaboration with multiple systems that serve these groups has resulted in opportunities to further define and identify relevant service models and solutions. The absence of financial resources needed to implement and sustain comprehensive services remains a significant barrier in delivering the planned priority services to meet client/consumer needs.

The Board has prioritized the local needs in order to respond to the needs of the community. The following summarizes the extent of treatment, prevention, and program support resources that are currently needed to fully substantiate a full continuum of care:

Treatment Services:

Adolescents

Adolescent services, including detoxification services, residential treatment beds, and ongoing intensive family-focused case management, continue to be identified by community stakeholders, providers, and families as insufficient to meet the demand. Adolescents continue to be referred to out-of-county treatment services due to the lack of long-term intensive services for adolescents with substance abuse and mental health needs. The Board collaborates with the mental health system, private funding sources, the educational system, the juvenile justice system, and the public children services agencies (PCSA) to address the needs of adolescents. Coordination of services among the various child-serving systems is achieved through intersystem collaborations.

Young children ages eight-eleven

The absence of any substance abuse treatment services for young children, ages 8 through 11 years old represents a crosscutting theme for the entire population of children and adolescents. While adolescent services are available through a limited number of residential and outpatient settings, the county's public alcohol and drug system does not provide any levels of care for children.

Females, age twelve through seventeen years old

Female adolescents require gender-specific services that combine alcohol and drug services with developmentally appropriate psychological and psychiatric interventions. Provider observations indicate females, ten to fourteen years old, may experience a higher rate of local public emergency room encounters related to suicidal attempts by toxic ingestion.

Disabled Persons

Providers who contract with the Hamilton County Alcohol and Drug Addiction Services Board maintain compliance with federal mandates regarding services to disabled persons, however, providers have expressed difficulty managing the challenges of persons with chronic physical, developmental, intellectual, and health issues who require more intensive, individualized monitoring and supervision.

Gay Men and Lesbian Women

Services to gay men and lesbian women should be integrated into existing services provided by the alcohol and other drug addiction services system. Planning data indicates the extent of prevention, education and outreach activities to gay men and lesbian women and the education of professionals within the system have been difficult to measure.

Homeless Persons

ADAS provider representatives indicate the need to organize service delivery that addresses concurrent treatment and housing issues. Programming should be expanded to reach those who do not access shelters, including increased outreach services for runaway adolescents, dually diagnosed persons, and homeless persons who are HIV positive. Children of alcohol and other drug dependent parents who are housed in shelters throughout the community require specialized models for treatment, prevention, and intervention services that promote continuity of care.

Juvenile Offenders

High-risk adolescents who are being released from the criminal justice institutions need consistent treatment and continuing care groups that are available in various community settings throughout the city and suburbs.

Offenders

The Board maintains formal linkages with the Hamilton County Criminal Justice system through joint participation in county wide planning groups. While the need for substance abuse service expansion within the criminal justice setting has been addressed through programs such as the Drug Court, IDAT, and TASC, local planning indicates there is additional need for treatment services within all correctional settings.

Older Adults

There is only one specialized treatment program in Hamilton County that addresses the age specific challenges that face older adults. Community-based case management services are needed, as well as prevention and treatment activities in retirement centers, community centers, or other locations convenient to older adults.

Persons with Limited English Proficiency

The Board has implemented a Special Populations Planning Committee to review the cultural and linguistic needs of persons with limited English. Representatives from multiple community systems including AOD providers, mental health providers, the Community Mental Health Board, Legal Aid, Jobs and Family Services, Cincinnati Chamber of Commerce, the Latino professional community, and the International Family Resource Center have joined with the Board to develop a system of care that addresses the specific needs of this population. It is anticipated that aggressive recruitment of Spanish-speaking treatment professionals, additional outreach and home based services, and additional foreign language interpreters will be needed to meet the demand for services.

Racial, Ethnic and Cultural Groups

Agreed-upon, system-wide culturally appropriate models of treatment and prevention should be established. System wide standards for evaluating the cultural needs of individuals and for implementing organizational competence in managing cultural diversity should be implemented.

Persons with Co-occurring Substance Abuse and Mental Health Disorders

Treatment services for persons with co-occurring substance abuse and mental health disorders should be expanded to provide a continuum of care. Recommendations include the expansion of training and program development to enhance cross-system knowledge and best practice models of service delivery. Substance abuse providers lack adequate staff to provide comprehensive mental health assessment, diagnosis, and medication monitoring.

Veterans

Linkage between the Veterans Hospital in Hamilton County and the Hamilton County Alcohol and Drug Addiction Services Board system to improve access of veterans and their families to Veterans Administration treatment services should be enhanced.

Women, Pregnant Women and Women of Childbearing Age

The continuum of care for women, pregnant women and women of childbearing age should be enhanced. Prevention and health promotion initiatives aimed specifically at substance-using pregnant women and women of childbearing age should be expanded and coordinated. Information on the prevalence of maternal addiction and the number of affected infants and children should be tracked, providing necessary information for the planning of needed resources and evaluation of the effectiveness of prevention and treatment strategies.

Programming for Special Populations at-risk for HIV/AIDS

Currently, the system offers early intervention services, specifically, HIV intervention, testing, case management, risk reduction, and health screening to increase access to services and to decrease the spread of the disease. More specialized programming is necessary to manage the behaviors, health status and

geographical preferences that are exhibited within the system's service area.

Public at Large

Hamilton County developed the Cincinnati branch of the Ohio Citizens Advocates' Faces and Voices of Recovery in the Fall of 2001. Additional opportunities focusing on the needs of persons seeking treatment or in recovery would be helpful to ADAS planning and development efforts.

Prevention Services

There is a need to expand prevention services and increase the use of age-specific, best-practice models. The rise in prescription drug abuse has led to the need for the development of prevention programs in this area. Targeted prevention/education strategies for all populations in the areas of tobacco prevention, parent involvement, and faith-based programming have been recommended. Prevention providers have also identified the need for improved capacity for disseminating prevention information to the community.

Infrastructure

SAMAD, in close collaboration with the Board, has implemented a long term planning process involving ADAS funded providers. This study determined there is a need for well-designed transitional housing programs. Such programs will (1) increase capacity of residential treatment programs by allowing for earlier discharge from a residential treatment bed and, (2) reduce the failed recovery for chemically dependent persons. One agency has submitted a capital funding application to ODADAS to cover costs of updating their existing building.

Criteria Used to Determine Priorities

For a service to be considered a priority, the service must be recognized in the Board's approved Community Plan and meet at least one (1) of the following criteria:

CRITERION #1: The Board's priority as defined through its strategic planning process is to resist further erosion of services and protect the level and quality of services that now exist. *Decision-factor:* If this service is critical to the Board's capability to maintain the current level of services, the service is considered a priority.

CRITERION #2: The Board's priority as defined through its long-range planning process is to build an acceptable baseline of services for all target population groups. *Decision-factor:* If the needs assessment cannot substantiate that the level of service provision demonstrates an acceptable baseline, the service is considered a priority. *A baseline of services means a level of comprehensive service continuum that has the capacity to make a significant impact on the community need.*

CRITERION #3: The Board's vision embodies the availability of a coordinated, continuum of care specific to the needs of the target populations within the Board's catchment area. *Decision-factor:* If the population-specific prevention curriculum or treatment services are not available within the continuum of care, the service is considered a priority.

CRITERION #4: The Board, as a member of the Family and Children First Council, has adopted the *Children First Plan*, a countywide plan for developing and coordinating key strategies that improve social, health, emotional, and educational outcomes based on four (4) priorities: Increase the connection students feel with their school; Reduce the number of children pre-school through grade 6 who are suspended, excluded, or truant from school; Reduce the number of high school dropouts; Reduce the number of children who are abused or neglected. *Decision Factor:* If a recommended service targets individuals who are affected by these characteristics, the service will be considered a priority.

CRITERION #5: The Board participates in a variety of collaborative partnerships designed to meet locally defined needs. *Decision Factors:* If the Board participates in a written or working agreement to plan, fund and/ or evaluate services for a priority population, the service will be considered a priority. If the Board has received local funding to implement intersystem programming, the service will be considered a priority.

CRITERION #6: The Board's priorities should take into account the mandated priority populations: Women, Pregnant Women and Women of Childbearing Age; Children and Adolescents; Disabled Persons; Gay Men and Lesbian Women; Homeless Persons; Offenders; Older Adults; Persons with co-occurring substance abuse and mental illness disorders; Veterans; Racial Ethnic and Cultural Groups; persons at risk for HIV/AIDS; injecting drug users, uninsured clients (includes ODADAS population of former SSI clients and SSDI) and persons (including staff) at risk of tuberculosis. *Decision Factor:* If a proposed service addresses the needs of at least one of the mandated target populations, the service will be considered a priority.

B. Implications for Contracting

The Board will take these priorities into account as a component of its annual funding applications and contracting process for alcohol and other drug prevention and treatment services. Recommendations for program funding will be reviewed in conjunction with the SFY 2004 applications for Board funding. The priorities are taken into consideration as part of the overall contract allocation review process. The contract allocation review process includes the following steps:

1. Distribution of SFY 2004 applications.
2. Board schedules an informational session.
3. Board staff performs internal fiscal and programmatic analyses and recommendations.
4. Staff analyzes the funding requests and makes recommendations to the Program Committee.
5. Funding recommendations from the Program Committee will be submitted for final Board approval and actions.
6. Provider agencies receive notice of awards.

Service Growth

New and Expansion Treatment and Prevention Services and Programs

As a result of decreased funding, the Board cannot develop new or expand services without additional resources. The Board has implemented a Grants Coordination Committee with provider agencies to identify funding opportunities to address service needs/gaps, and to coordinate the submission of funding applications to federal, state, and local grant making authorities.

The ADAS Board has identified the need to expand treatment services for the elderly, persons with co-occurring disorders, persons with limited English proficiency, gay and lesbian persons, persons with hearing impairments, homeless persons, and adolescents. When financial resources are identified, these service and training needs will be addressed.

On behalf of a community-wide collaboration, the Board anticipates submitting a multi-system federal grant application in April 2003 to increase services to homeless persons. The Board has also submitted SAMHSA applications for SAMI services, and for the development of a community-wide adolescent collaborative. To date, funding decisions have not been determined on these two applications.

Reduction of Existing Treatment/Prevention Services or Programs

The decrease in HIV funds from ODADAS will result in a reduction in the services available through the HIV Early Prevention and Intervention Program (EPIP). The Board eliminated a contract with an adolescent provider agency due to non-compliance with contract requirements. Two other provider agencies collaborated to submit a joint proposal to provide the Day Treatment Services that were unavailable with the elimination of the contract. The Board funded this joint proposal. The Board also worked with the initial provider to ensure continuity of care of clients once the agency was defunded. An outpatient services program was closed during the previous community plan biennium as a result of funding reductions. In addition, the reduction of funds from the Hamilton County Criminal Justice system resulted in the closure of an assessment program for court involved adolescents.

Program Support Resources

Providers have indicated potential opportunities for expanding services and facilities, however, lack operational funds and capital to support new initiatives. Private fundraising efforts have not resulted in dollars to manage the full costs of new services and public dollars are generally not available to support these programs.

The Board recognizes the need for resources to maintain existing services or programs successfully in the following areas:

1. Increased funds to facilitate the ability of treatment and prevention agencies to attract and retain qualified professional staff through competitive salaries.
2. Training in treatment of specialized populations that have the most difficulties accessing services.
3. Training in best practices and risk/protective factors in substance abuse prevention.
4. Training in best practices in substance abuse outcomes measurement.
5. Increased funds to cover Medicaid match for out of county placements. The extent and cost of these placements is variable.

Fewer people will be able to receive services as a result on rising administrative costs and level or decreased revenue. The implementation of HIPAA regulations will result in increased costs related to the management of information, including changes that will be required within the CMHC information management system that is utilized by the Board as well as by the provider system.

C. Quality of Services – Key Findings of the Board’s Continuous Quality Improvement Plan

Utilization review

Each provider agency has adopted the ODADAS Clinical Protocol and revised its internal quality management and review procedures to incorporate utilization review processes. There is a different oversight process for services offered through collaborative projects, such as the Interagency Managed Care Partnership for the Provision of Alcohol and Chemical Dependency Treatment (IMPACT) as these projects utilize an interagency quality assurance team in performing concurrent and retrospective chart reviews and require service authorization and referral to a level of care and provider.

The Board's quality improvement plan incorporates on-going project teams to continuously assess and direct the planning results and to identify additional quality improvement opportunities. The utilization review process builds on performance indicators in the following areas: consultation/intervention; admission criteria; intake process; treatment planning; referral (appropriateness); treatment services; discharge planning; continuing care; treatment referral processes; and clinical outcomes.

The Board conducts utilization review and management in the following ways:

1. Retrospective review of service utilization within the scope of the annual allocation process
2. Annual peer review audits conducted by an independent auditor
3. Targeted service/program area review
4. Monitoring of quarterly provider CQI reports.

The Referral Process, Waiting List Management and Access to Services

The Board contracts with fourteen addiction treatment and prevention agencies. Each agency maintains an independent referral mechanism, including procedures for triage, intake, and referral to an appropriate level of care. This decentralized mechanism serves as the primary referral process for the general population. Reports from agency providers indicate all populations are subject to variations in waiting time due to increasing demands for service.

The Board has implemented a pilot project for the coordination of access to the system, and has worked with providers to implement centralized referral approaches such as the Mount Airy project for uninsured males, Drug Court, TASC, and IMPACT. Evaluation procedures have been designed to not only maximize access to services for special populations, but to measure timeliness of access, appropriateness of placement, and clinical outcomes.

Waiting lists for services are generated at the provider level and submitted to the Board on a quarterly basis. The coordinated system access project will maintain daily statistics of availability of treatment services by provider agency. Clients who have received an assessment and referral to a treatment services, but who are on a waiting list for the service will receive transitional case management through the coordinated system access project staff. Waiting list reports consist of individual client demographic information, date of referral, and level of care determination. In addition, the waiting list specifies the disposition of each client on the waiting list, indicating date of request for services, date client was assessed, date admitted to treatment, date of interim services, and date of last contact with the client. The client's waiting list status is reported at the close of the period. Each provider agency's report includes the number of clients assessed, the number of clients referred to a mental health center, and the number of clients referred to a medical facility for a medical assessment. Provider agency reports also specify the disposition of clients on the waiting list from the previous reporting period.

As reported in the previous Community Plan, agency reports continue to indicate that all populations are subject to variations in waiting time due to increasing demands for service. Women and criminal justice groups encounter less difficulty in accessing the system due to specialized protocols for referral per contractual arrangements between the Board and the Department of Jobs and Family Services, the Probation Department, and the Juvenile Court.

Populations that seem to experience more difficulty in accessing services due to the lack of a coordinated system, or specialized referral networks that target referral arrangements include the following:

Adolescents – Age and gender-specific programming is lacking resulting in the continued placement of adolescents in treatment agencies in other counties.

Homeless persons – The system lacks services that identify, engage, and refer non-shelter using homeless persons to treatment. Homeless persons within shelter settings may be difficult to engage in treatment if not concurrently addressing housing needs.

Older adults do not access treatment through the traditional alcohol and other drug delivery system. There are no specialized models or continuum of care available that uniquely address the age and gender-

specific challenges facing older adults. Effective models should incorporate community-based case management services and treatment activities in retirement centers, community centers, or other locations convenient to older adults.

Persons with limited English proficiency are unwilling or unable to access the system due to a variety of factors including concerns about immigration status, language and cultural barriers.

Persons with co-occurring substance abuse and mental illness disorders enter the system through all agencies, however, limitations in the availability of comprehensive services and staff to concurrently assess and provide mental health and substance abuse disorders restricts the individual provider's ability to fully engage these clients in a continuum of appropriate services.

School-aged children in the public school setting, who were alcohol and/or drug exposed during infancy through a genetic or environmental relationships with dependent parents, currently lack a comprehensive, coordinated referral network of intervention services that might facilitate identification, evaluation and follow-up of alcohol and other drug related sequelae that manifest at later stages of development.

SECTION IV

COLLABORATION FOR RESULTS

A. Achievements and Challenges of Collaborative Efforts as Required by Statute

The Board, in accordance with its long-term planning objectives, has demonstrated effective leadership in joining diverse partners and in facilitating enhanced community perceptions around the primary impact of alcohol and drug addiction issues and solutions. The Board has initiated and maintained continuous involvement in multiple system models and planning endeavors aimed at 1) improving and expanding services, 2) increasing collaboration to improve efficiencies and generate new revenue sources. **Table 2** highlights the Board's inter-system, state, local, and provider partnerships.

As a direct result of its long-term history of partnerships in Hamilton County, the Board has not experienced major challenges in involving others in the planning process, especially with respect to obtaining their cooperation to attend meetings and otherwise become actively involved in providing necessary input and achieving consensus about community alcohol and other drug needs, services and priorities.

A few examples of ways that coordination and collaboration have been successful for the Board are:

- ? Submitted successful application to SAMHSA and received funding to implement a Family Treatment Drug Court;
- ? Received funding through the Health Foundation of Greater Cincinnati to implement a Substance Abuse/Mental Illness pilot project for adult offenders reentering the community after incarceration;
- ? Partnered with the University of Cincinnati to present evidence-based best practice training to providers;
- ? Implemented the Outcome Management Plan across the provider network;
- ? Presented inter-system training through the Family and Children First Council;
- ? Provided AOD assessment training for JFS case worker staff;
- ? Implemented site visits at provider agencies by Board of Trustees, Program Committee members to increase Board member knowledge of funded agencies operations and programming
- ? Improved client access through coordination with Jobs and Family Services (IMPACT program), Juvenile Court (Youth Reentry Program), Adult Corrections (SAMI pilot project), Partnership Teams (managed care contracts for multi-system Children's Services clients).
- ? Implemented a coordinated system access project in collaboration with provider network to increase knowledge of the general public about the AOD system, improve access, coordinate and track referrals, and provide transitional case management services for individuals waiting for placement in a treatment program.
- ? Maintained a liaison with the Coalition for a Drug-Free Greater Cincinnati. Among the clear successes of the Coalition has been an increase in the public knowledge regarding the use and abuse of drugs among children and adolescents.

**SECTION V
EVALUATION OF THE COMMUNITY PLAN**

A. Outcomes Achieved Through Previous Community Plan

Major findings of the Board's evaluation of the SFY 2002 - 2003 Community Plan targeted critical mandates in assessing the system's priorities to maintain the current level of services and to recommend a baseline of services for the County's unserved and underserved citizens. The criteria used in formulating key outcomes coincide with the Board's Strategic Plan for SFY 2002-3003 for improved access, increased public awareness, quality management, and the development of partnerships for collaboration in service coordination, generating funding, and advocacy for the alcohol and other drug system. The implementation of the previous community plan resulted in the following achievements:

- 1) Continuation of a comprehensive service delivery.
- 2) Maintenance of the outpatient, residential, and sub acute levels of care.
- 3) Expanded outreach and early intervention services to adolescents at risk for contracting HIV.
- 4) Conducted a targeted service audit of adolescent services resulting in revisions to programming including best practice models, expansion of services to SAMI adolescents, and training in Life Space Crisis Intervention.
- 5) Added to new providers, Mallory Center and Wyoming Youth Services, to the prevention provider network.
- 6) Implemented a coordinated system access project to improve access, increase the public's knowledge about the AOD system, coordinate assessment and referrals, and provide transitional case management for persons waiting placement in a treatment program.
- 7) Compiled and summarized treatment data for SFY 2001 and 2002.
- 8) Collected data from outside sources such as Ohio Hospital Association, Hamilton County Court Management System and the Coroner's Office.
- 9) Participated in quarterly meeting of the Ohio Substance Abuse Monitoring Network.
- 10) Participated in ONDCP Pulse Check data collection for Fall 2002 report.
- 11) Hired a Certified Prevention Specialist and appointed him as the primary contact for prevention.
- 12) Provided training to the Board of Trustees on prevention.
- 13) Increased media attention significantly over past two years.
- 14) Sponsored a quarterly Prevention Forum to give prevention providers and the Board opportunities to plan, network, share information, and address issues specific to prevention services.
- 15) Continued funded, formal agreements with the local court system and Jobs and Family Services.
- 16) Participated in the implementation and evaluation efforts of the Children First Plan.
- 17) Maintained linkages with professionals in others systems, including mental health, social services, criminal justice, domestic violence, maternal and child health, early intervention, home visitation programs and educational centers.
- 18) Continuation of strategic leadership in advocating the needs of the local and statewide alcohol and drug addiction system.

- 19) Continued participation in local, regional, and national planning efforts to improve funding and evaluation of alcohol and other drug addiction prevention, treatment, and education services.
- 20) Maintained a formal partnership with Hamilton County Jobs and Family Services, Mental Health Board, MR/DD, and Juvenile Justice to coordinate and fund services for multi-system children.
- 21) Maintained a formal partnership with the Hamilton County Jobs and Family Services and the Hamilton County Mental Health Board to implement an administrative services contract for a centralized management information system.
- 22) Participated in the implementation of the Southwest Ohio Community Action Program through a grant awarded by the U.S. Department of Health and Human Services to implement a regional initiative for improving access to primary and behavioral care for uninsured and underinsured.

Major management performance results include:

- 1) Executed the Hamilton County ADAS Board 2002-2003 Two Year Strategic Plan.
- 2) Implemented the State mandated Multi-Agency Community Services Information System (MACSIS) Medicaid claims processing system.
- 3) Developed and monitored service contracts with fifteen provider agencies.
- 4) Managed the Board's Medicaid program.
- 5) Initiated a planning process for the implementation of HIPAA regulations.
- 6) Began creation of a database to ensure reconciliation of claims billed, remittance advice report and Board payments.
- 7) Formulated a sub-group to determine the reports needed from the database to decrease provider time in reconciliation of accounts.
- 8) Compared the process of cost finding between the Board, the local Mental Health Board and other OHIO ADAS providers to review various processes. As a result of this process, the Board revised its position on administrative and support costs allowing the providers more flexibility.
- 9) Participated in the Governor's Shareholders Working Group which could provide more reduction in reporting requirements and support the need for standardized reporting between ODADAS and ODMH.
- 10) Implemented a comprehensive needs assessment process.
- 11) Implemented an Outcome Management Plan.
- 12) Implemented several task forces/committees in response to strategies identified during Board/provider retreats, and/or identified during regular ongoing communications with providers:
- 13) Information and Technology Task Force
- 14) Legislative Committee
- 15) Grant Coordination Committee
- 16) Special Populations Committee
- 17) Maintained funding through the Hamilton County Indigent Care Health and Hospital Tax Levy to expand services for the indigent.
- 18) Maintained funding through the Hamilton County Health and Hospital Tax Levy (Drake), \$1.5 million from this levy to fund the ADAPT programs, which serve persons referred by the

Hamilton County Drug Court to treatment.

- 19) Combined the Clinical Outcomes Workgroup, which worked to identify outcomes measures for treatment services, with the Information Systems Users Workgroup to improve efficiencies in entering outcome data into the system.
- 20) Continued prominent position on the Ohio Association of County Behavioral Health Authorities working on issues of statewide importance.
- 21) Awarded a contract by the Hamilton County Probation Department to assist them in preparing grant proposals for alcohol/drug services in the criminal justice system, evaluating proposals, and monitoring and evaluating services.
- 22) Implemented the requirements of House Bill (HB) 484 regarding treatment services for individuals referred by the Hamilton County Department of Job and Family Services.
- 23) Published The ADAS Provider, a quarterly newsletter with information regarding the alcohol/drug field, service providers, ADAS Board, and ODADAS. This newsletter is mailed to over 1200 interested persons and organizations in Hamilton County.
- 24) Sponsored a planning retreat, which included senior staff of the ADAS Board and the thirteen ADAS, funded agencies. This retreat generated ideas and strategies to further enhance the system of services.
- 25) Facilitated the Prevention MIS/Evaluation Workgroup, which reviewed outcome measures specific to prevention services, selected measures useful to the ADAS system, and added these measures to the CMHC information management system.

Challenges

The Board received funding in 2001 to implement an ongoing countywide needs assessment process. Due to staff turnover in the position responsible for the implementation, the gathering of statistical information regarding local county incidence and prevalence rates, expected utilization across the system, and service outcomes estimates had been delayed. At this time the Board has focused increased effort on capturing relevant community statistics and outcome data.

B. Community Plan Evaluation Process

The evaluation process is ongoing. Performance-based contracting criteria and monitoring standards are set forth in the annual contract with provider agencies and communicated to the agencies during the annual contract hearing. When any evaluations reveal that resource utilization is less effective or efficient than anticipated, the Board will perform an internal review. Following an agency review, the Board staff request the provider agency to submit a plan to resolve any discrepancies. A follow-up review and conference is scheduled to determine satisfactory completion of the agreed upon actions.

Client, consumer and provider or others' input will be incorporated into the evaluation of the plan. Public perceptions regarding the value of substance abuse services drive the Board's long-term success. That the public (including community and legislators) possesses a clear understanding of substance abuse and the benefits of prevention and treatment remains a central factor in determining whether the planned strategies actually strengthen the existing service system by meeting customer expectations. To obtain input into the evaluation of the plan, the Board will conduct an analysis using quantitative approaches and focus groups; complete a stakeholder impact analysis; update consumer interests; define market characteristics and community preferences to capture information relevant in coordinating the

strategic planning priorities.

The Board conducts comprehensive site surveys, peer review audits, and in April, 2003 will implement a Quality Management Plan within its' operations. The Quality Management Plan includes internal and external reviews of Board administration and operations, and provider quality monitoring processes including review of outcome data, and research of best-practice models of service delivery.

The Board has modified the provider contract performance requirements to include reporting guidelines for waiting list monitoring, client grievance, client satisfaction, 90 percent capacity information and status of clinical protocol implementation. On a quarterly basis, information on grievances, waiting list management and 90% capacity information is obtained and reviewed by the Board staff. Results of provider reports on treatment satisfaction and prevention services participant satisfaction are collected every six months. During the upcoming biennium, the Board will complete its independent peer review process designed to evaluate the quality, appropriateness and efficacy of funded services.

The Board implemented the Outcome Framework Initiative for the local system of care to coincide with the SFY2002 contracting process with providers of services. The Board had facilitated a two-year planning process with treatment providers, and separately with prevention providers to identify outcomes system-wide treatment and prevention client outcomes. The treatment outcomes were identified through research of national programs. The Board is currently in the process of reviewing and comparing the existing outcomes the providers used for their various prevention programs. The Board will make a recommendation to prevention providers on common outcomes that may be incorporated into all Board funded prevention services. In addition, providers conduct a number of independent outcomes projects within their organizational plans.

The proposed outcomes for the *system* are:

1. Improve system performance by enhancing quality and increasing efficiency while maintaining the integrity of the existing service continuum.
2. Build capacity to measure service outcomes.
3. Improve knowledge of drug trends among groups that are unserved or underserved by the current alcohol and drug addiction system.
4. Continue to improve prevention programming to populations that are at risk of developing a pattern of alcohol and other drug abuse and who do not require treatment for substance abuse.
5. Continue to expand treatment service delivery by increasing access to a continuum of alcohol and other drug abuse treatment services and levels of care.

The proposed *client outcomes* that the Board seeks from the delivery of prevention and treatment services are included as Appendices A and B. In addition the Board proposes the following long-term client outcomes:

1. Enhancement of life skills to sustain positive life-style changes (education, treatment).
2. Ability to increase the periods of abstinence (education, treatment).
3. Ability to define and avoid high-risk behaviors (prevention, education, treatment).

The prevention framework supports increased knowledge of best practices for strengthening prevention programs and to identify prevention outcomes indicators such as participant knowledge of substance abuse, perceived risk of harm, attitude regarding drug use, changes in the level of positive behavior among participants in ADAS funded prevention services.

The treatment clinical outcomes consist of a common set of outcome measures that address client level

achievements across the continuum of care. Post discharge follow-up evaluation has been implemented by some, but not by all of the treatment providers due to limited resources. The Board continues to seek resources to fund a post discharge follow up process administered by the Board.

In addition to monitoring outcomes, the Board monitors provider's contract performance. The following outline details the provider performance indicators that the Board currently utilizes in its contract monitoring process:

Service Monitoring and Evaluation

1. The contract amount or quantity of service has been achieved.
2. 75+ percent of the individuals/families served have demonstrated improvement from the service provided - major/some progress has occurred related to the outcome goals.
3. 75+ percent of the individual/families served are satisfied with the quality of the service and the way they treatment by staff.
4. A comprehensive assessment and subsequent referral is based on ODADAS Protocols for Level of Care.
5. An individualized treatment or service plan exists for each individual/family receiving services.
6. The treatment plan has been reviewed/updated every 90 days for outpatient services and 30 days for residential services
7. The service facility is adequate to perform the required contracted activities:
 - Accessible to public transportation and accommodations for the physically handicapped
 - Adequate space for staff, client privacy, and group meetings
 - Properly equipped
 - Condition of facility and maintenance - clean, safe, temperature control, lighting, visual appearance
8. Communication and referrals occur with other relevant providers, helping professionals, and community support persons during service provision (with the client's consent). This includes assistance and follow-up communication in scheduling other needed referral services.

Personnel Monitoring and Evaluation

1. Direct service staff are qualified and trained to perform the contracted service activities.
2. Staff turnover has been less than 20 percent during the contract period being monitored and staffing changes have not disrupted the quality and quantity of service(s) to be provided.
3. Job descriptions and personnel policies exist for all staff. Copies of job description and personnel policies have been made available to each staff person.
4. Staff receives an adequate amount of supervision on a weekly basis - one hour individualized supervision and one hour of group staff supervision. The quality/content of the supervision is relevant to job functions.
5. All staff is provided at least 20 hours of training per year for improvement in skills related to their day-to-day activities and functions.
6. Staff is mostly satisfied and motivated (75 percent of the time) in performing their job duties and functions.

Agency Management Monitoring and Evaluation

1. Provider has statement of mission or goals and a written plan describing how the organization intends to achieve its mission/goals. A planning process exists for involvement of staff, Board, and the community. There is evidence of plan implementation.
2. Provider is able to clearly define and describe the contracted service(s) - service activities, target population served, outcome goals, number of people served, units of service provided, this includes preparation for the monitoring interview and completing the requested information.
3. Provider's Outcome Management Plan for the service includes targets and milestones consistent with the Board's published treatment outcomes in addition to program specific outcomes, targets and milestones.
4. Expenditures have been consistent with the contract budget and have not exceeded the contract amount unless previously amended.

5. Administrative and supportive costs do not exceed 35% of the total cost.
6. Record keeping procedures are adequate to provide an audit trail to verify eligible clients, number of clients served, and amount of service provided.
7. Written fiscal policies/procedures exist and a fiscal audit has been conducted within the past year.
8. There is evidence of a commitment by the Provider's Governing Board for improving the quality of services provision. An internal process exists to review the quality of service provision.
9. An updated inventory exists of all equipment and fixed assets purchased in whole or in part with ADAS Board funds - including the identification of ownership or lease/rental agreements for facilities, equipment and vehicles.
10. There is evidence that the Provider's Governing Board is in compliance with its own By-Laws and operating policies.

Evaluating outcomes and benefits associated with the SFY 2004-2005 Community Plan will result in an improved understanding of the Board's capacity and limitations in developing a system of care that extends beyond an acceptable baseline of services. Based on an extensive review of the goal achievement, the Board is perceived as successful in establishing a baseline of services. However, a baseline of services does not exist for all target populations.

During the previous community-planning period, the Board began implementing actions developed to strengthen the Board's capacity for managing a "seamless" system of alcohol and drug addiction treatment and prevention services. Although progress has been made in several areas, the Board anticipates continuing with additional system wide benefits including:

- ? Standardized assessment protocols
- ? Implementation of a case management model using a comprehensive clinical record, not only of an individual encounter within the system, but covering all interventions
- ? Proof of outcomes demonstrating cost effectiveness of care, not just on one encounter, but over a longer period, for example, a five-year period
- ? Clear identification of the Hamilton County market (drug trends, numbers of people in the target populations to be served)
- ? An organized, proactive and *system-wide* marketing effort to private and public entities
- ? Enhanced community acceptance and knowledge of prevention strategies and local initiatives

SECTION VI

WAIVERS

Waiver Request for Inpatient Hospital Rehabilitation Services

No funds disbursed by or through ODADAS may be used to fund inpatient hospital rehabilitation services. However, under circumstances where rehabilitation services cannot be adequately or cost effectively produced, either to the population at large, such as in rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds. Complete this form to request a waiver.

Medicaid eligible recipients receiving services from hospital-based programs are exempt from the waiver.

Hospital	ODADAS ID NO.	ALLOCATION	UNITS

Describe the circumstances for requesting a hospital inpatient services waiver.

NO WAIVER REQUESTED

Request for Generic Services

No generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program can be funded with ODADAS dollars without a waiver from the Department. Each ADAS/ADAMHS Board must complete this form to request a waiver to purchase these generic services from a provider other than a funded alcohol or other drug program.

Agency Name	ODADAS ID NO.	Service	Allocation	Units

Describe the circumstances for requesting a generic services waiver.

NO WAIVER REQUESTED

TABLES

Table 1: Type and Range of services Available (Based on SFY 2003 Board Contracts)

Column 1	Column 2	Column 3
LEVEL OF CARE	PROVIDER	PROGRAM (Provider Specific)
PREVENTION (Federal Definitions)		
Information Dissemination	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	Coordinated System Access
Education	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program, Mallory Center	
Problem Identification and Referral	Crossroads Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	
Community-Based Process	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	

Environmental	Alcoholism Council, Crossroads Center, Central Community Health Board, Drug and Poison Information Center, Talbert House, Urban Minority Alcohol and Drug Abuse Outreach Program	
Alternatives	Alcoholism Council, Urban Minority Alcohol and Drug Abuse Outreach Program	
OUTREACH	Alcoholism Council, Crossroads Center, Central Community Health Board, Talbert House	
CONSULTATION AND EARLY INTERVENTION (Level 0.5)		
OUTPATIENT (Level 1)		
Outpatient	Alcoholism Council, Crossroads Center, Center for Chemical Addictions Treatment, Central Community Health Board, First Step Home, Talbert House, and TASC (Treatment Alternatives for Safer Communities)	Youth Reentry Adolescent Treatment Enh

Intensive Outpatient/Day Treatment	Center for Chemical Addictions Treatment, Central Community Health Board, Talbert House	ADAPT – Women Youth Reentry
COMMUNITY RESIDENTIAL (Level 2)		
Non-Medical	Crossroads Center, Center for Chemical Addictions Treatment Crossroads Center, First Step Home, Prospect House, Talbert House	Chaney Allen Adolescent Treatment Enh ADAPT-Women ADAPT-Men
Medical		
SUBACUTE (Level 3)		
Ambulatory	Center for Chemical Addictions Treatment	
23-Hour Observation Bed	Center for Chemical Addictions Treatment	
Sub acute Detoxification	Center for Chemical Addictions Treatment, Crossroads Center	
ACUTE HOSPITAL DETOXIFICATION (Level 4)		
Acute Detoxification		

Table 2: Collaborative Partnerships

Intersystem Partnerships	Purpose of Involvement Improved Outcomes and/or Expanded Services
Hamilton County Board of County Commissioners	Hamilton County Family and Children First Council Establish comprehensive, county-wide plan for service coordination, including pool mechanisms through: <ol style="list-style-type: none"> 1 Executive Council 2 Mid-level Managers 3 Intersystem Training 4 Service Coordination 5 Children’s First Advisory 6 Early Start Advisory 7 Financial Workgroup
Joint Advisory Council (Department Of Job and Family Services)	Participate with local service providers (including HMOs and private sector) to ac Medicaid programs under welfare reform.
Law Enforcement/Judiciary	Corrections Planning Board Law Enforcement/Mental Health/Substance Abuse Committee TASC Advisory Committee
Juvenile Court, Public Defenders, ProKids, JFS, Providers	Implemented a Family Treatment Drug Court for parents/guardians at risk of losing dependent child/children due to their substance use. To date four individuals/familie services through this voluntary program.
Drug Court	Responsible for representation and leadership;Hamilton County Commissioners, Co Administrator, Counsel of the Prosecutor’s Office, Chief Probation Officer, Director Services
Common Pleas Court	Drug Court Implementing Agency and member of Hamilton County Criminal Justice Committee
Hamilton County Probation Department	Maintained contract to provide coordinated treatment for indigent persons convicted
Hamilton County Mental Health Board & Council on Aging	Participate as a member of the Mental Health and Aging Coalition; Advisor to the E that specializes in planning to address substance abuse among older adults
Community Task Force	Coalition for a Drug-Free Greater Cincinnati County-wide Strategic Planning and Prevention Collaboration
Substance Abuse Management and Development Corporation	Management entity for state-owned property and development of transitional housin
City of Cincinnati, Homeless Coalition, Health Foundation of Greater Cincinnati	Collaboration to submit Super Nofa: HUD/SAMHSA/HRSA/VA. Application to b

Intersystem Partnerships	Purpose of Involvement Improved Outcomes and/or Expanded Services
Hamilton County Department of Jobs and Family Services (JFS)	Continued the IMPACT program with Jobs and Family Services as a treatment model treatment services for persons in the child welfare system in accordance with H.B. 4
Domestic Violence Coordinating Council	Serve as a member of Hamilton County Domestic Violence Coordinating Council.
Drugs Don't Work	Maintain a joint agreement with the Chamber of Commerce to provide consultation businesses in Hamilton County.
Hamilton County Court of Common Pleas/Municipal Court	Leadership participation on the Hamilton County's Intermediate Sanctions for Women
Mental Health Board, Criminal Justice, 2 Provider Collaboratives, United Way, JFS, Schools	Substance Abuse/Mental Illness Initiative: Implementation of a pilot project for adult community after incarceration. Leadership team participation – responsible for coordination services.
Partnership Team	In collaboration with JFS and the Mental Health Board, continued a partnership to implement administrative services contract for centralized management information system. Reissued in 2002 that included a reduction in services from the previous contract. JFS, MHB, and the Board assume additional responsibilities for care coordination and information system management.
JFS, Mental Health Board, MR/DD, Juvenile Court	Partnership for coordination of services to children involved with multiple systems. Released an RFP and entered into a contract with a new management contractor. The partnership assumes additional oversight responsibilities with the new contract.
United Way of Greater Cincinnati	Joined the Health People Vision Council Leadership Team, the Behavioral Health Council, and chair the Program Review and Funding Committee.
Junior League, Children's Hospital, JFS, Cincinnati Public Schools, Juvenile Justice, Mental Health Board, Mr/DD, Health Foundation	Participate in the MindPeace Initiative to identify and quantify behavioral health care needs, assess gaps in services, provide advocacy, increase public awareness of the issues, provide training, and training.
Clients and Consumers	The Board solicits advice and incorporates client surveys in the strategic planning process.
Public Participation	A public hearing is typically held to obtain information and public reaction to the Board's strategic plan update.
Coalition for a Drug Free Greater Cincinnati	The ADAS system supports the endeavors of this community-based coalition, which is focused on promoting the message of abstinence among the area's high-risk children, adolescents, and young adults. The Board will continue to endorse funding proposals that support the efforts of the coalition.

Intersystem Partnerships	Purpose of Involvement Improved Outcomes and/or Expanded Services
Provider Partnerships	1) Revised adolescent residential treatment services to incorporate best-practice models 2) Implemented new day treatment program for clients referred from Juvenile Justice 3) Facilitated an Adolescent Treatment Enhancement Committee. 4) The Board funded a pilot project to improve access to the AOD system for any person with information and referral for education, prevention and treatment services. This coordinated access project provides information, triage, assessment, referral, and transitional case management for persons waiting for placement into a treatment program. 5) The Board operates a Prevention Provider Forum, which meets on a quarterly basis and serves as an open meeting for all providers interested in sharing information about prevention and advocating recommendations regarding the planning and evaluation of prevention services in the county. Participation includes agency representatives involved in the Drug Prevention Programs, Drug-Free Community Coalitions, and the Safe and Drug Free Schools Program.
State/Local Partnerships	Purpose of Involvement Collaboration to improve efficiencies and/or generate new revenue streams
Ohio Association of County Behavioral Health Directors	Advocacy and representation of addiction, treatment and prevention service planning Substance Abuse Division Meeting Clinical Leadership Committee Finance Committee Kids Committee
Provider Partnerships	
Treatment and Prevention Providers	Implemented the Grant Coordination Committee to identify funding opportunities and coordinate the submission of grant applications.
Inter-system Partnerships	
City of Cincinnati, Homeless Coalition, Health Foundation of Greater Cincinnati, Providers	Collaboration to submit a proposal for the Super Nofa: HUD/SAMHSA/HRSA/VA submitted 4/03. Proposal increases housing opportunities and services coordination for persons residing in four of the city's shelters.
Mental Health Board, Criminal Justice, 2 Provider Collaboratives, United Way, JFS, Schools	Collaborated with the Hamilton County SAMI Leadership Team in submitting an application to the Robert Wood Johnson Foundation to expand services to meet the needs of persons with psychiatric disorders (mental illness/AOD addictions).
Juvenile Court, Public Defenders, ProKids, JFS, Providers	Submitted and received funding through SAMHSA to implement a Family Treatment Program.
Cincinnati Health District, Providers	Submitted an application for tobacco prevention programming. This application did not receive funding, however the collaborative continues to seek additional grant opportunities, including an application in March 2003 for tobacco prevention programming.

APPENDICES

Appendix A

ADAS Prevention Service Outcome Measures

- ? Percent of youth demonstrating decreased number of incidents of aggressive behavior
- ? Percent of youth demonstrating increased number of incidents of positive behavior
- ? Percent reporting that they perceive great risk of harm in using marijuana once a month
- ? Percent reporting that they perceive great risk of harm having five or more drinks of alcohol once or twice a week
- ? Percent reporting that they perceive great risk of harm in using crack/cocaine once a month
- ? Percent reporting that they perceive great risk of harm using inhalants
- ? Percent reporting that they perceive great risk of harm using amphetamines
- ? Percent reporting that they perceive great risk of harm using heroin
- ? Percent reporting that they perceive great risk of harm using other opiates
- ? Percent reporting that they perceive great risk of harm smoking cigarettes or cigars
- ? Percent reporting that they perceive great risk of harm using smokeless tobacco
- ? Percent reporting that they perceive great risk of harm using hallucinogens
- ? Percent demonstrating significantly more knowledge regarding substance use
- ? Percent decrease in the number of "yes" answers on COA Screening Test
- ? Percent demonstrating significantly more knowledge regarding HIV risk reduction behaviors
- ? Percent change in attitude regarding experimentation with drugs
- ? Percent change in attitude regarding drug use
- ? Percent change in attitude regarding admiration of drug culture
- ? Percent change in attitude regarding belief that drugs are needed to feel good about self

APPENDIX B

ADAS CLINICAL OUTCOME MEASURES

FACTOR	MEASURE
Substance Abuse	% negatives Abstinence Clean urine Clean urine + methadone Clean urine + prescribed medication
Treatment Completion Rates	Complete detox-absence of withdrawal symptoms. Discharge-must meet a condition in 4 out of 6 dimensions and provide follow-up linkages.
Employment and level of functioning	Change in status: unemployed to employed; part-time to full time; percent employed at discharge.
Involvement with legal system	Percentage of adults who reduce the frequency of arrest during the 90 days following discharge. No arrests or encounters with legal authorities have occurred in the most recent three-month period.
Living arrangements	% change homeless or institution to own arrangement, living with relatives to living at home; change from drug-involved arrangement. See ICD-9-CM codes for lack of housing and inadequate housing.