INTRODUCTION TO THE FY2013 SERVICE PLAN

As Woodland Centers, Inc. presents this Service Plan to the Gallia-Jackson-Meigs Board of Alcohol, Drug Addiction, and Mental Health Services it must be noted that FY2013 is going to present some unique challenges and opportunities for the agency. After successfully responding to a $1.2 million budget cut in FY2010, and an additional reduction in revenue of approximately $500,000 in FY2012 due to the new Medicaid cost containment benefit limits and tiered rates, FY2013 is going to require a significant paradigm shift as we consider our future viability and what we will need to do differently – or in addition to – traditional strategies like reducing costs and increasing revenue. In FY2012, we focused on partnerships. In FY2013, we will need to move more aggressively into integration with primary care and the Medicaid Health Home, as well as embrace regionalization in both crisis services and housing.

As a small, stand-alone mental health agency with a minor AOD component, Woodland Centers has to recognize its vulnerability in the current climate of health care reform, medical homes, and integration of specialty services with primary care. FY2012 has seen a "perfect storm" of financial issues resulting in a weakened fiscal position, but we still have a solid reputation for high quality services. Sustaining our core services with no new funding is becoming increasingly difficult, and the Medicaid cost containment and tiered rates have required a new emphasis on case utilization review while providing a mix of services to address high-end users of services to prevent maxing out available units.

It is clear that community mental health centers are no longer the "safety net" for the indigent, and there is every indication that FQHCs will be assuming that position with the integration of behavioral health and primary care and the funding that comes with that model. Since there are no FQHCs in Gallia County, Woodland is looking to partner with Holzer Health Systems to pursue the Medicaid Health Home concept. Staff are attending planning meetings now, and we plan to submit a Letter of Intent to become a Medicaid Health Home by January 2013. It appears that the "handwriting on the wall" is that stand-alone community mental health centers will be "a thing of the past" in the next 2-3 years – if that long.

We will also be an active member of the 505 Regional Collaborative as a provider of crisis beds for the Appalachian Region. Woodland is developing the training for this program, and will provide 3 crisis beds to the region which will help pay for continued operation of the Crisis Stabilization Unit.

The new paradigm adopted by ODMH as a result of the state's budget crisis sends a clear message that it's no longer about best practice, evidence based treatment, or person-centered care. It is about managing scarce resources, doing more with less, and turning to a more acute care model of treatment. Most recently, the announcement of the merger between ODMH and ODADAS is another indication of a system "in flux" with more questions than answers regarding the eventual impact on client care. As we learn to

navigate this new set of challenges, Woodland will continue these successful programs and services:

- Moral Reconation Therapy (MRT) with Gallipolis Municipal Court.
- Autism Spectrum Disorder treatment services including parent and sibling support groups in all 3 clinics.
- IDDT for the dually diagnosed population (SA/MI) in Gallia and Jackson.
- Supportive Housing in all three counties which ends December 2012. With regionalization of the Continuums of Care by ODOD, it is unclear at this point in time whether or not additional housing funding will be available.
- Child Abuse Prevention services and Teen Pregnancy/Family Stability services in the Gallia County and Gallipolis City Schools.
- It is also unclear whether or not there will be ongoing funding for the ECMH consultant to Head Start in Gallia, Meigs, Jackson, and Vinton counties.
- Implementation of our new Electronic Medical Record "go live" date is July 2012 which is a requirement to become a Medicaid Health Home.

These three strategies – our partnership with Health Recovery Services, delivering an array of services that meet the needs of the community, and aggressively pursuing integration with primary care – hold the key to our future, while at the same time, we strive to keep the consumer at the focus of our efforts as we continue to serve the mental health needs of Gallia, Jackson, and Meigs counties.

I. AGENCY MISSION, VISION, and STRATEGIC GOALS

Mission Statement: Woodland Centers, Inc. is a community behavioral health agency that provides comprehensive mental health and chemical dependency services to support and promote improvement of the quality of life for the residents of Gallia, Jackson, and Meigs counties.

Vision: To make a positive difference in the overall health of the communities we serve by focusing on core competencies, technology, and partnerships; engaging in thoughtful outreach; and managing our resources effectively and efficiently

Values: In order to accomplish our mission and move toward our vision, we believe in the following values to support our corporate culture.

- Transparency
- Empowerment
- Accountability
- Person-Centered
- Corporate Citizenship
- Survey Ready Every Day
- Ethical Behavior, Ethical Treatment
- Continuous Performance Improvement

Strategic Goals and Objectives:

1. To focus on our core programs and services: individual and group counseling, case management, crisis intervention, crisis stabilization, and med-somatic services.
    a. Continue to develop and expand AOD/MRT/IDDT/Partnership with HRS for AOD services in Jackson and Gallia.
    b. Continue to apply for Housing Trust Fund grants as they become available to sustain supportive housing program on the CSU.
    c. Add Incredible Years (Children's Trust Fund – Gallia County) to Children's Programming. Continue to develop the Autism Program in all 3 counties. Continue to support Outreach, Teen Pregnancy, Alternative School, Summer Program, After-school Program, and school-based services.
    d. Develop appropriate response to benefit limits and prior authorization requirements with regard to the delivery of traditional Outpatient services.
    e. Implement the Electronic Health Record.
    f. Identify ways that we proactively deliver culturally competent services.
    g. Identify ways with med-som staff to lay the foundation for integration with primary care.

2. To do thoughtful outreach to meet the identified needs of our community partners where it makes sense given our financial and human resources.
    a. Develop a protocol for handling mental health emergencies for Meigs Juvenile/Probate Court and the Sheriff's Department. Establish liaison with the jail.
    b. Continue to develop relationship with Gallia Municipal Court including MRT programs.
    c. Determine what our role should be in Jackson with their Drug Court.
    d. Work with the ADAMH Board and Head Start programs to determine the future of the ECMH program.
    e. Determine what the agency's role will be with the Continuum of Care after 2012 (when we are no longer the fiscal agent for the COC).
    f. Transportation program – Prepare for the end of the RHISCO funding.
    g. Continue to explore future opportunities in our partnership with HRS.

3. To manage our resources (fiscal, human, facilities) efficiently and effectively to support the goals identified above.
    a. Demonstrate accountability to all stakeholders through a plan of continuous performance improvement that is carried out through the agency's standing committees: Quality Improvement Committee, Risk Management Committee, Safety Committee, and Housing Committee. The plan should include mechanisms for gathering input from stakeholders, analyzing the input, and using the input to make decisions regarding service delivery and business operations. Determine

appropriate tool/method for tracking outcomes. Conduct Employee Satisfaction Survey in 2012.

b. Maintain a strong fiscal position by (1) having a "0" balance in the line of credit; (2) maintaining a minimum balance of $275,000 in the sweep account; (3) having less than $50,000 in payables; (4) having less than $600,000 in outstanding accounts receivable.
c. Develop department/clinic budgets.
d. Develop a marketing strategy – placemat ads, radio spots, newspaper articles, guest speakers/trainers, participation in health fairs, etc.
e. Explore additional grant opportunities.
f. Ensure compliance with HIPAA/ ICD-10.
g. Maintain bed days under target by tracking utilization and liaison with ABH liaison.

II. AGENCY PHILOSOPHY

Woodland Centers' philosophy and array of services are grounded in the vision of meeting the needs of the community. To that end:

1. Clients are admitted for services without regard to age, sex, creed, national origin, handicap or ability to pay for services. Client Rights Policies and Grievance procedures will be maintained.

2. Services will be provided in a manner consistent with respect and empowerment of families and individuals. Services will be provided in the least restrictive environment consistent with the needs of the individual.

3. Services generally will be short-term, solution focused, and will view the client within the total context of his or her environment. Treatment will emphasize a team approach with behavioral health counseling and therapy, pharmacologic management, community psychiatric supportive treatment and crisis intervention mental health services. Therapy will generally be short-term or intermittent with appropriate levels of community psychiatric supportive treatment and pharmacologic management interventions. In selected instances, especially for the severely mentally disabled population, long-term therapy or maintenance is often indicated.

4. Emphasis will be placed on designing the mode of treatment to fit the client's presenting problem rather than attempting to force the client's problems into a preconceived, uniform method of treatment. This implies the need for a continuum of treatment services and modalities and individualized treatment based upon assessed client needs and strengths. Services will not only include a continuum of traditional mental health services, but will address basic needs such as food, clothing and shelter as well as social, vocational and recreational needs.

5. In those instances where the presenting problem lies outside the expertise of any staff member, WCI will locate, contact, refer and serve as liaison to another program or individual able to provide the needed service.

6. Services will be available, accessible, acceptable and appropriate. This implies the need for services to be provided in a culturally sensitive manner. Consequently, a diverse staff of behavioral health professionals will be recruited to maximize the range of culturally competent services we can offer.

7. The agency is the primary contractor for the Gallia-Jackson-Meigs Board of Alcohol, Drug Addiction, and Mental Health Services. In addition to general outpatient services, the agency provides 24-hours a day 7-days a week Behavioral Health Hotline (Crisisline), Crisis Intervention, and Crisis Stabilization services. WCI is also the designated gatekeeper for the State inpatient facility.

III. POPULATIONS SERVED

The area served by Woodland Centers, Inc. includes Gallia, Jackson and Meigs Counties in rural Southeastern Ohio. Unemployment and poverty rates are among the highest in the State. It is estimated that one in four persons live in poverty. There is no public transportation. Given the rural location of the area, this means that many residents are socially isolated. Working with collaborations and coalitions is an imperative. WCI works closely with community partners to efficiently and effectively utilize scarce resources to meet the ever-growing needs of the community.

There is a shortage of decent rental units and long waiting lists for government assisted housing. Many owner occupied dwellings are also substandard. The Gallia Jackson Meigs Vinton Continuum of Care has been formed to address housing issues and transportation barriers in our community.

The population of 86,900 is composed of approximately 97% Caucasian, 2% African-American and 1% Other. The culture is overwhelmingly Appalachian. However, recognizing that the Appalachian culture is not homogeneous, the agency's approach to cultural competence will also include a range of sub-cultures including children, single parents, victims of domestic violence, persons living in poverty, and others.

Approximately 3,000 unduplicated clients are seen annually by Woodland Centers, Inc. These clients can basically be divided into three broad categories:

1. Adults who are experiencing a variety of stressors, crisis, interpersonal problems or depression. Many of these problems are caused or intensified by socioeconomic factors such as poverty, domestic violence, sexual abuse, substance abuse,

unemployment, single heads of households, etc. Mental Health categories include depression, anxiety, substance abuse disorders and a variety of other "non-psychotic" diagnoses.

Most of these persons are in need of crisis intervention or short-term solution focused counseling with assistance in obtaining needed services, stabilizing interpersonal situations, or teaching new skills to deal with parenting, divorce, unemployment or life circumstances.

A small number of these persons are in acute crisis and may require short-term hospitalization or crisis residential services. Others may need more long-term services to deal with more intractable problems. Some will require pharmacologic management services, generally on a short-term basis.

Approximately 60% of clients served by the agency are in this category.

2. Severe and Persistent Mental Illness (SPMI) Adults: These persons suffer from major mental illness such as schizophrenia or major affective disorders. A significant number are dual diagnosed Mentally Ill/Mentally Retarded or Substance Abuse/Mentally Ill. Many have had one or more psychiatric hospitalization with a small percentage being "revolving door" hospital admissions. Functional limitations vary from minimal to severe but all meet ODMH criteria as Severely Mentally Disabled and all need some level of maintenance and support services to be able to live in the community. Service level and intensity of service may vary dramatically, depending on individual needs and the status of any particular individual over time. Services are needed for symptom management; skill development; assistance with daily living; access to basic needs; safe, affordable housing; and emotional support.

   Types of services needed generally include some combination of pharmacologic management, community psychiatric supportive treatment, behavioral health counseling and therapy, social/recreational and residential services. Short-term inpatient hospitalization or crisis residential services will be needed from time to time for a small percentage of this population.

   In addition to suffering from major Mental Illness, the SPMI population experiences the same or greater levels of poverty, social isolation, unemployment, physical and sexual abuse, physical illness, and use of emergency rooms for primary care needs, than the general population.

   Approximately 15% of clients served are in this category. However, because of the intensity and duration of services needed by this population, over 60% of the agency's resources are spent to provide services to the severely mentally disabled population.

3. Children and Adolescents: Approximately 20% of persons seen by Woodland Centers, Inc. are between the ages of 3-18. These children and adolescents present

with a variety of problems exhibited at home or school. Many are victims of physical or sexual abuse or neglect. Socioeconomic factors are identical to those described for the adult general population.

Diagnostic categories include depressive disorders, attention deficit, oppositional, anxiety disorders, autism spectrum disorders, or other emotional disorders of childhood. Approximately 15% of these children are Severely Emotionally Disabled. Many are involved with other systems such as Children's Services Boards or Juvenile Justice.

The needs of this population include individual and/or family therapy, parenting skills training for parents, crisis stabilization, linkage and collaboration with other systems. In more severely disturbed children pharmacologic management, residential treatment, or hospitalization services may be indicated and some will need long-term care.

Regardless of age or diagnostic categories, factors common to almost all persons served are socioeconomic factors such as unemployment, poverty, social isolation, etc. which are known to contribute to family breakdown and increased prevalence of mental illness. Depressive disorders are the most common diagnoses among all age groups.

Approximately 65 percent of persons served are Medicaid recipients. Another 25-30% require some degree of financial assistance, which is provided through the agency's sliding fee scale, Title XX program or other state or federal subsidies. It is estimated that between 80-90% of persons served have incomes below the federal poverty level. In FY2010, the majority of the agency's Title XX funds were eliminated, and the agency limited its acceptance of new clients to Medicaid-eligible individuals. Exceptions were made for hospital discharges, persons in crisis, and other cases determined to be at risk by the clinical directors. The agency maintains statistics on the number of clients turned away due to funding source or inability to pay.

Currently, there is a critical need for funding to support services to individuals with no funding. The community mental health center is no longer the "safety net" of the past where persons can be served regardless of the ability to pay. The inability to serve these individuals beyond emergency care is resulting in increased frustration for law enforcement, courts, and emergency rooms because of the lack of resources available in the mental health community. This is a serious issue for children and adolescents where there is a real lack of placement options (Ohio Hospital for Psychiatry, for example, stopped accepting adolescents on April 1, 2012). Other needs identified by the various consumer and community surveys, formal and informal, discussions with other community entities and consumers include the need for timely response to requests for services (intakes and crisis services), and the need for increased consultation with other human service systems. A major identified problem continues to be the need to educate other agencies/systems regarding the mental health system's role, mandates and limitations, and appropriate referral procedures as well as challenges presented by HIPAA privacy and security rules.

However, in keeping with State and Federal mandates and as identified in the ADAMHS Board's Community Plan, priority populations to be served are adults with Severe and Persistent Mental Illness (SPMI) and Seriously Emotionally Disturbed (SED) children who are in crisis and/or at risk of hospitalization. Other identified priority populations include:

- Victims of crime
- Victims of physical or sexual abuse
- Dually diagnosed (mentally ill/mental retardation; mentally ill/developmentally disabled; mentally ill/substance abuse)
- Children who are SBH (seriously behaviorally handicapped)
- Forensic clients
- Homeless/mentally ill
- Elderly/mentally ill
- Veterans
- Physically disabled; hearing impaired
- General population/other

Persons with no funding source will be seen for crisis services, when they are at risk for hospitalization, and when discharged from an inpatient facility for medication stabilization and referral to other providers with indigent funding.

IV. DESCRIPTION OF RESOURCES and SERVICES PROVIDED

Based upon the needs of the person served, outpatient treatment offers a variety of modalities that are designed to assist the person served achieve his or her goals related to areas such as psychological or social functioning, self esteem, and coping abilities or external opportunities such as vocational, educational, or social activities. Comprehensive, coordinated, and defined services may vary in level of intensity and address a variety of needs, including but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, addictions, eating or sexual disorders, and the needs of victims of abuse, domestic violence, or other trauma.

The organizational structure of the agency is designed to maximize the total number of direct service staff and minimize the number of administrative staff. The Executive Director is directly responsible to the governing Board for the operation of the agency. Professional clinical staff represent a variety of disciplines, including but not limited to the following: psychiatry, psychology, social work, counseling and nursing.

The clinical team includes three Directors of Clinical Services, one assigned to each clinic, who provide oversight to the agency's Outpatient Programs and Services and the Crisis Stabilization Unit. These Directors report to the Executive Director. The Medical Director oversees all services related to Pharmacologic Management services and also reports to the Executive Director. Clinical supervision is assigned as indicated by ODMH and ODADAS standards and codes and rules of the licensing boards governing the various disciplines.

Specific programs are assigned managers/supervisors who oversee day-to-day operations of designated programs and report to the designated administrative supervisor including Managers of Children's Programs and the Manager of Crisis Services.

Administrative and support services include Finance, Management Information Systems, Human Resources, Environmental Services, Transportation, and Clinical Records. Day to day supervisory functions are performed by the Fiscal Administrator and Director of Operations who both are responsible to the Executive Director as indicated on the Table of Organization.

Woodland Centers, Inc. is certified by the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) with selected programs and services accredited by CARF (Commission on Accreditation of Rehabilitation Facilities). WCI provides the following Outpatient Services:

- Assessment,
- Individual and Group Therapy,
- Pharmacologic Management,
- Crisis Intervention,
- Crisis Stabilization,
- Community Psychiatric Supportive Treatment; and
- Other Services including Consultation and Education.

In addition to traditional outpatient services, WCI has staff trained in several specialties including Moral Reconation Therapy which is used primary with court-referred adults and adults in the work release program in Gallia County, the Incredible Years for parents, and Autism and Autism Spectrum Disorders. This year we hope to add Integrated Dual Disorder Treatment (IDDT) to the list of evidence-based practice services offered by Woodland Centers.

ASSESSMENT: This is an intensive clinical evaluation of a person and may include the subsequent issuance of a formal report (i.e., Intake/Assessment, Mental Status Examination, and Psychological Evaluation). The focus may be on determination of functional level, psychological state, formulation of a diagnostic impression, assessment of need, or assessment of physical health status. In addition, the appropriate Level of Care is determined for AOD clients using a substance use/abuse screening tool.

Mental Health assessment services are provided by qualified mental health professionals on a face-to-face basis who have the ability to be sensitive and responsive to persons/clients of varied backgrounds, to those with disabling conditions and to factors of their social and physical environment. Mental Health assessments for children and adolescents includes information gathering from parents and/or guardians. Efforts are made to include the family and significant others as part of the treatment team.

Mental Health assessments are supported by written procedures for making appropriate referrals. A preset protocol is used to determine the initial diagnosis or diagnostic impression that indicates the condition of the person served. The protocol contains

procedures for consulting with, as necessary, a licensed individual when the agency staff member performing the diagnostic assessment is not qualified to make a diagnosis according to criteria of the DSM-IV or subsequent version. Along with formulating a diagnosis the assessment will identify the individual's strengths and how they can facilitate recovery, as well as helping the individual overcome personal/environmental barriers.

Mental Health assessment protocols include requirements to inform persons of their rights, the availability of a client rights officer and the client grievance procedure is presented, either in writing or verbally according to the client's need. Clients, who are deaf, have a communication disorder or who have a primary language other than English are assessed in the presence of a person who is proficient in American Sign Language or with a qualified interpreter.

INDIVIDUAL and GROUP THERAPY: This is a face-to-face interaction, usually verbal, with a person served where the focus is on treatment of the person's mental illness or emotional disturbance, or co-occurring substance use/abuse issues. When the person served is a child or adolescent, the face-to-face interaction may also be with family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individualized Service Plan/ISP.

Providers qualified per OAC 5122-29 provide Behavioral Health Counseling and Therapy services. Careful attention is given to client privacy and confidentiality.

Behavioral Health Counseling and Therapy services include individual, family, couples or group formats. The therapy is guided by the Individual Service Plan, which is completed with the person served. The ISP identifies the reason for seeking therapy; specific, measurable goals in the client’s own words which lead to resolving the presenting issues; and the frequency of sessions along with the expectations and duration of treatment. These are a series of time limited, structured face-to-face sessions that are geared towards the attainment of mutually defined goals as identified in the Individualized Service Plan (ISP). If the person served is a child or adolescent, the face-to-face intervention may include timely collateral visits with family members and/or parent, guardian, significant others, other agencies and providers of other services as these contacts are determined to be in the best interest of the client.

PHARMACOLOGIC MANAGEMENT (med-somatic services): Woodland Centers offers Pharmacologic Management services that are face-to-face medical interventions which may include, but not be limited to: physical examination, prescription or supervision of medication, medical education, consultation, referral and medical intervention that addresses the mental health needs of the person being served. These face-to-face services may also be provided via videoconference in accordance with applicable ODMH rules.

Medication Management is a focus for our staff as they serve the clients that require subsidy for their prescriptions. Through positive relationships with a number of pharmaceutical

companies we utilize samples to offset the expense for our clients around medications. WCI also aggressively pursues indigent funds for medications and relies heavily on funds from ODMH to cover the medication expenses. This is a priority for our clients since it aids a greater level of community treatment versus days in the state hospital.

Staffing for Pharmacologic Management consists only of qualified staff as specified in OAC 5122-29-05 who will provide these Pharmacologic Management services including, but not limited to, the process of responding to physician's orders, dispensing or administering medication, monitoring side effects and adverse reactions to medications, or conducting medication groups or classes. Clinicians who order medications and persons who receive medication orders shall be appropriately licensed and acting within the scope of their practice.

Staff prescribing medication or providing information or education about the use of medications shall be educated regarding medication issues for persons such as children, elderly, and minority populations, as well as persons with a severe mental disability or serious emotional disturbance.

CRISIS SERVICES (Crisis Intervention, Crisis Stabilization Unit – Adult Residential, and Hotline Services)

Since FY2010, there has been limited funding for crisis services. In August 2009, the agency's contract with the ADAMHS Board was cut by over $1 million because all non-medicaid funds had to be used for Medicaid match. $233,000 of those funds were restored in January 2011, and in FY2012 the ADAMHS Board provided $318,000 to fund the Crisis Unit based on the under-utilization of state hospital bed days. In FY2013, CSU costs will be covered by both the remaining Supportive Housing funds designated specifically for 4 housing beds which ends in December 2012, and by the 505 Collaborative which involves "selling" 3 beds to the Appalachian Collaborative Region. This innovative program will help cover the cost of the CSU in the amount of $275,940; however, utilization will be monitored, and if the 3 designated beds are not fully utilized, it may impact funding for the remainder of the year.

If that funding is reduced, crisis services including the 24-hour hotline and 24-hour emergency workers, as well as the unit itself remain at risk with the following impact:

- The inability to serve clients on the CSU will result in an increase of inpatient utilization.
- The inability to service clients who rely on the Hotline for stabilization will result in an increase in bed days and the need for additional ancillary services.
- The increase of emergency room utilization will have an impact on our relationships with primary care hospitals and other community partners.

CRISIS INTERVENTION: The agency's Crisis Intervention/Emergency Services are coordinated through Crisis line and can be accessed 24 hours a day, 7 days a week by calling 446-5500 or 1-800-252-5554. The Crisis Intervention program at WCI offers

assessment and immediate stabilization of acute symptoms of mental illness, alcohol and drug abuse, and emotional distress due to acts of domestic violence or abuse/neglect in response to an individual, family or system which is experiencing a crisis or emergency situation. The goal of the service is to assist the person or system to resolve or cope with situations in which there may be a threat to life or property or where the usual coping mechanisms have failed to resolve the precipitating event. Our program has the capability to access a continuum of services including least restrictive alternatives. Our state hospital diversion efforts are supported by the 13-bed Crisis Stabilization Unit.

Crisis Intervention Mental Health Services may be provided face-to-face, or by phone at the agency, in the person's natural environment or at other appropriate agency or community settings or other environments that afford safety to the client and emergency worker.

Behavioral Health Hotline **(Crisis line)** workers dispatch and coordinate the 24-hour, 7 day a week crisis intervention service to and from the community's emergency systems, including hospitals, emergency rooms, law enforcement, emergency medical services, etc. as well as for other providers and individuals. Consultation with a psychiatrist is available 24 hours a day, 7 days a week.

WCI relies upon written emergency procedures that address screening for medical conditions, making referrals to emergency medical services when indicated, and identifying personnel trained in emergency procedures.

Choices involving the intervention and treatment plan of the person served and use of natural support systems shall always be considered. Procedures are followed to involve significant others in the crisis intervention.

A list of available emergency housing or shelter (including the agency's crisis stabilization residential unit), which can be accessed in crisis situations, is available to Crisis Intervention Mental Health workers through the Behavioral Health Hotline. Staff providing the service are qualified per OAC 5122-29 and have received training in CPR/First Aid and techniques for intervention and de-escalation of disruptive or aggressive acts, situations or persons. Backup support for Crisis Intervention Services is available by deployment of other staff on duty or on a call-in basis. All crisis calls will be triaged to determine if an emergency, consultation or referral, with the goal of responding to emergencies within one hour. Response time for crisis situations will vary depending on the nature of the crisis.

ADULT RESIDENTIAL CRISIS STABILIZATION/RESPITE UNIT (Type I Residential Treatment Facility): The Crisis Stabilization Unit (CSU) is a 13-bed unit which provides short-term crisis intervention, crisis residential and respite service for the severely mentally disabled population and others at risk of psychiatric hospitalization. The CSU also serves as a step-down unit for clients who have been psychiatrically hospitalized. The CSU also provides supportive housing for homeless clients who meet eligibility criteria. Effective

July 1, 2012, the CSU will also provide crisis beds for the 505 Regional Collaborative as described above.

Clinical assistants providing direct client care are trained as QMHSs including CPR, First Aid and techniques of intervention and de-escalation for disruptive acts, persons or situations. Clinical staff including a therapist, case manager, and nurse are assigned to the CSU to provide additional treatment interventions as indicated in the residential agreement and individual treatment plan including aftercare planning.

Backup support for Crisis Stabilization staff is available through the Manager of Crisis Services or designee. Psychiatric consultation is available to Crisis Stabilization staff 24 hours a day, 7 days per week. Crisis Intervention, Behavioral Health Counseling and Therapy, and CPST, and other appropriate mental health services are available in the Outpatient Department.

Feedback from Persons Served: Feedback regarding satisfaction with service and input into service planning will be solicited via Consumer Satisfaction Surveys.

BEHAVIORAL HEALTH HOTLINE: Behavioral Health Hotline service is available 24-hours per day, 7 days a week to all individuals, agencies and systems in the catchment area. This service can be accessed toll-free from Gallia, Jackson and Meigs Counties through 1-800-252-5554. Hearing impaired persons can access the system through the agency's Telecommunications Device for the Deaf (TDD) located in the Gallia Clinic.

Behavioral Health Hotline services include, but are not limited to: short-term intervention and crisis counseling by telephone; suicide prevention services; appropriate linkages to all available community services and resources as needed and available; information and referral services; and a clearly identified linkage to immediate psychiatric and medical services when necessary.

In addition, the Behavioral Health Hotline functions as part of the ADAMHS Board's Emergency Crisis Plan for the service district. The service is included in each county's disaster plan as the means to contact emergency crisis mental health services which can be dispatched with the local EMA for local disaster needs.

The service receives/dispatches and coordinates all requests for crisis intervention and pre-hospital screening service for the catchment area, including calls from local health care providers, emergency rooms, emergency medical services, law enforcement agencies, other mental health services, and other social service agencies.

The agency's Crisis Intervention on-call workers are dispatched by this service through the agency's rotating on-call system and the behavioral health hotline provides support, backup and necessary linkage for these services. A current list of available emergency housing is maintained and available to individual callers and/or crisis workers.

The Behavioral Health Hotline has access to CPST service workers and can contact CPST 24-hours a day, 7 days a week. CPST Managers and other service providers can utilize the "clinical alert" system to notify Crisis line workers of anticipated crisis and recommendations.

While other mental health agencies in the community maintain their own system for availability of CPST services after hours, the behavioral health hotline service is available and when requested serves as backup to these CPST systems as well.

All staff providing Behavioral Health Hotline services are QMHSs and receive training in crisis intervention.

If callers are known to the agency, a copy of the crisis log is routed to the primary provider and to the client's ICR. All crisis calls are documented per agency policy.

COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT (CPST) SERVICES:
Community Psychiatric Supportive Treatment Services shall consist of rehabilitation, recovery, environmental support, and targeted case management activities which are considered essential to assist the person served in gaining access to necessary services; and in the provision of rehabilitative services intended for maximum reduction of symptoms of psychiatric illness to restore the client to the best possible functional level; and which are identified in the ISP of the person served. Program goals include:

- Reduce psychiatric hospitalization.
- Assist the person to function more effectively in the community.
- Assure that basic human needs are met.
- Reduce impairment of mental illness.

In addition, CPST provides the following services:

- Performance of necessary evaluations and assessments to identify barriers that impede the development of skills necessary for independent functioning in the community. Performance of such evaluations must be consistent with professional licensure rules.

- Participation in the development of the person's ISP. Assistance and support in crisis situations involving the person served.

- Support, including education and consultation for family/significant others which is directed exclusively to the well-being and benefit of the person served and assistive to maintaining independent living in the community.

- Individual intervention, which shall have as its objective the development by the person served of interpersonal and community coping skills, including adapting to home, school and work environments.

- Symptom monitoring and self-management of symptoms, which shall have as its objective the identification and minimization of the negative effects of psychiatric symptoms which interfere with the individual's daily living, financial management, personal development or school or work performance.

- Assistance to the person served in increasing social support skills and networks that ameliorate life stresses resulting from the person's disability and are necessary to enable and maintain the individual's independent living. If necessary, accompanying the person served to activity sites and assistance in daily living activities.

- Coordination to gain access to and from the coordination of necessary evaluations and assessments.

- Coordination of services identified in the ISP of the person served including community support program services.

- Assistance in gaining access to essential community resources, including housing and other basis resources necessary to enable and maintain the individual's independent living in the community.

- Necessary monitoring and follow-up to determine if the services accessed have adequately met the recipients' needs and to determine needed follow-up activity.

CPST services are not site-specific. A significant portion of CPST services will be provided face-to-face and outside agency settings. The CPST worker has the ability to follow the client into the community and will provide services in the home, school or other community settings as appropriate to client needs.

The Behavioral Health Hotline can work with CPST services on a priority basis and can coordinate contact with CPST worker or supervisor and on-call crisis intervention worker in emergency situations. In addition, CPST services can use the "clinical alert" procedure whereby they can notify the Behavioral Health Hotline of anticipated crisis/events and make recommendations and provide input to Behavioral Health Hotline or crisis worker.

Although each person is assigned a primary CPST worker who is responsible to the person, other team members depending on specific need of the client and availability of the primary CPST worker may provide services. Caseload ratios range from 30:1 to 15:1 depending on characteristics or needs of the caseload. Case management services are limited to 104 hours per year (combined individual and group services). In addition, only the first 90 minutes of services per day are paid at the full rate. Thereafter, CPST services are billed at 50%. This has severely impacted how we serve our SPMI population, and has required us to use a mix of services to make sure this vulnerable population does not run out of services before the end of the year.

The assigned CPST worker is responsible to develop the person's ISP which must reflect input from and expressed wishes of the person served and their families and to revise the ISP as necessary to reflect that input.

Consumer satisfaction and input from persons served and their families can be obtained through the Consumer Satisfaction Survey, focus groups, and other service evaluation activities. Revisions will be made based on this input.

Note: As mentioned above, the Tiered Rates and Benefit Limits that went into effect in November 2011 have had a significant impact on the agency's ability to provide CPST services to what has historically been identified as its priority populations: SPMI and SED clients, those at risk for hospitalization, and the indigent for whom the community mental health system has been the safety net. CPST has been a major factor in maintaining these clients in the community using a combination of strategies to manage symptoms, maintain medication compliance, increase opportunities for socialization, and decrease the need for inpatient hospitalization. It has required significant case utilization management, and an adjustment in agency philosophy to manage the State's Medicaid Cost Containment strategy to ensure that clients don't end up being victims of this budget initiative.

CONSULTATION SERVICE**:** This is a formal and systematic information exchange between Woodland Centers and a person other than a client, who is directed towards the development and improvement of individualized service plans and/or techniques involved in the delivery of mental health services. Consultation service can also be delivered to a system (e.g., school or workplace) in order to ameliorate conditions that adversely affect mental health.

Consultation on mental health and other related matters is available upon request to Woodland Centers. Woodland Centers solicits feedback from its affiliates in order to determine the need for consultation. Every effort is made to collaborate with other social services and health care agencies to identify and respond to requests in a timely and professional manner. Woodland Centers maintains a record of all consultation services provided. Although services are based at the locations listed below, the service will be provided at locations convenient to the public.

<u>Populations Served</u>:

Other Mental Health Providers
Schools
Head Start Facilities
Law Enforcement Agencies/Jails/Courts
Children's Services
Department of Jobs and Family Services
Hospitals/Physicians
Emergency Service Providers
Nursing Homes
Other Community Agencies

Public Health Departments

MENTAL HEALTH EDUCATION SERVICES**:** This service consists of formal educational presentations made to individuals or groups that are designed to increase community knowledge of and to change attitudes and behaviors associated with mental health problems, needs and services. One area of focus is through the work at each of the Head Start programs and early childhood mental health education. WCI has an opportunity to serve both staff and families through educational services.

Focus is on educating the community about the nature and composition of a community support program and is designed to reduce stigma toward persons with mental illness or emotional disturbances.

Woodland Centers provides a wide range of information and education on mental health issues to the community at large upon request, as well as based upon a needs assessment which the agency conducts on an annual basis. In the public interest, educational activities are carried out by distribution of pamphlets, newspaper articles, and other media services. Agency presentations are available to community organizations upon request. Although services are based at the locations listed below, the service will be provided at locations convenient to the public.

Populations Served:

Health care providers
General Public
Schools
Head Start Facilities
Courts/Jails
Human Services Organizations
Children's Services
Nursing Homes

SUPPORTIVE HOUSING PROGRAM and HOMELESS PREVENTION AND RAPID RE-HOUSING PROGRAM: These grant funded housing programs are designed to provide rent and utility assistance to specific populations to prevent homelessness. CPST and other mental health services are offered to assist the consumer to find and maintain safe, affordable housing.

Private sector housing, group homes, one transitional apartment at Carr Street Apartments, and four designated beds on the CSU may be utilized as appropriate. When housing assistance is an identified need, this will be included in the Individualized Service Plan.

As the State regionalizes its housing programs (Woodland is now part of Region 17's Continuum of care), it is unclear how this will impact local housing programs. We are still

waiting for new guidelines so we can determine whether it will be possible to apply for housing grant funds in FY2013.

RIVER HEIGHTS APARTMENTS (Other Mental Health Service: Residential Support): River Heights is a HUD, nine-unit, one-bedroom, independent living complex located in Meigs County which serves Severely Mentally Disabled individuals. All residents have access to a case manager/CPST who can provide linkage to support services and assistance with daily living. Facility inspections are scheduled and conducted by HUD appointed entities.

River Heights
47466 TR 100
Racine, Ohio 43771

CARR STREET APARTMENTS (Other Mental Health Service: Residential Support): Carr Street Apartments is a HUD, 16-unit, one-bedroom, independent living complex located in Jackson County, Ohio which serves mentally ill individuals. All residents have an assigned CPST or primary health provider to assure linkage to supportive services and assistance with daily living. Facility inspections are scheduled and conducted by HUD appointed entities.

Woodland Housing Opportunities (Carr Street Apartments) are governed by a Board of Directors. Management services are provided via a contract with Woodland Centers, Inc.

Woodland Housing Opportunities, Inc.
Carr Street Apartments
529 Carr Street
Jackson, Ohio 45640

INSERT Table of Organization CHART & Clinical Staff list
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STAFFING/LOCATIONS

Outpatient Services are provided at Woodland Centers' outpatient clinics at the following locations although this service may be provided at other locations, i.e., hospital, residential facility, etc. Service providers: MD/DO, Nurse Practitioner, Psychologist, Psychology Assistant, LISW, LSW, LPCC, LPC, LICDC, CDCA, Counselor Trainee, Qualifies Mental Health Specialist/Trained Other. When applicable, service providers will be supervised by an ODMH and/or ODADAS eligible supervisor.

Gallia Clinic: 3086 State Route 160, Gallipolis, Ohio (740) 446-5500
M-F - 8:00 a.m. - 5:00 p.m.; evening hours Mondays & Thursdays until 9:00 p.m.

Jackson Clinic: 500 Burlington Road, Suite 240, Jackson, Ohio (740) 286-5075
M-F - 8:00 a.m. - 5:00 p.m.; evening hours Tuesday until 8:00 p.m.

Meigs Clinic: 112 East Memorial Drive, Pomeroy, Ohio (740) 992-2192
M-F - 8:00 a.m. - 5:00 p.m.

ADMISSIONS

All admissions to the agency are routed through the Outpatient Department. With the exception of emergencies and crisis intervention services, all persons are provided an assessment prior to the provision of services. If the referral is from another ADAMHS Board contract agency, the assessment may not be repeated but Woodland Centers, Inc. reserves the right to conduct further evaluation to determine appropriateness for specialized programs.

All new admissions receive an orientation to services which includes information about client rights and grievance procedures, their right to privacy under HIPAA, their financial responsibilities, and other basic information regarding treatment and services.

CHILDREN AND ADOLESCENTS

Programs for children and adolescents consist of an array of behavioral services designed specifically to address treatment needs of children and adolescents. To determine a developmentally appropriate treatment approach, an assessment of each child served includes:

- Developmental history such as developmental age factors motor development and functioning
- Medical / physical health history

- Culture/ethnicity
- Treatment history
- School history
- Language functioning
- Visual functioning
- Immunization record
- Learning ability
- Intellectual functioning
- Family relationships
- Interactions with peers.
- Environmental surroundings
- Prenatal exposure to alcohol, tobacco, or drugs
- History of use of alcohol, tobacco, or other drugs
- Parental guardian custodial issues
- Parent/guardian willingness to participate in services.

In additional to traditional outpatient programs, Woodland has experienced significant expansion of services to children, primarily through several special contracts in FY2011. The table below shows which programs will continue in FY2013. However, the knowledge gained can be applied going forward either in traditional outpatient services and/or as new special contracts are sought. These programs have included:

	Community Partner	Program or Service	Date Funding Ended	Will Funding/Program Continue in FY13?
1.	GCDJFS	Autism start-up	9/30/10	No/Yes
2.	GCDJFS	Teen Pregnancy prevention	6/30/12	Yes/Yes
3.	City/County Schools	Child Abuse Prevention	5/31/12	Yes/Yes
4.	Children's Services	Child Abuse Prevention	6/30/12	Waiting for RFP
5.	OCTF	Incredible Years	6/30/12	Yes/Yes
6.	GC Juv. Court	Summer Resiliency	August 2010	Unknown/Yes
7.	GC Juv. Court	After School Program	FY2010	Unknown/Yes
8.	Univ. of Rio Grande	MH Counseling	August 2012	Unknown

For the majority of continuing programs, it will be necessary to identify and refer those children who can benefit from outpatient services, and open them as clients since the majority of children are Medicaid eligible. However, this will require increased case management and innovative ways to reach parents such as meeting them in the schools. The impact of the state budget proposals on these programs is yet to be determined.

To the extent that funding has been available, Woodland Centers staff in all three counties has participated in training for programs especially geared to children and adolescents such as Incredible Years, as well as training specific to children with autism and autism spectrum disorders. WCI staff has applied this training to interactions and interventions with juvenile court, schools, children's services, and local Head Start programs. These programs target family stability, children at risk for out of home placement, diversion, resilience, and problem solving.

V. COMMUNITY PARTNERS, REFERRALS, AND LINKAGES

INTRA-AGENCY REFERRAL AND LINKAGE

Once the intake is completed, the person will be referred to appropriate internal or external services or for more intensive evaluation by a psychologist or psychiatrist. Intra-departmental coordination of services is assured via clinical staff meetings, sharing of clinical supervision, the intra-agency referral process, internal consultation and other formal and informal mechanisms. Persons who are Severely and Persistently Mentally Ill or Severely Emotionally Disabled will be referred, as appropriate, to Community Psychiatric Supportive Treatment services for linkage and coordination of services. The Outpatient Department will provide needed pharmacologic management, behavioral health counseling and therapy, crisis intervention and/or other appropriate services to Severely Mentally Disabled and Severely Emotionally Disabled persons. The CPST worker or the person's primary care provider will assure consistency and continuity of care for clients. HIPAA challenges with regard to privacy rules influence interactions with courts, schools, and community education.

INTER-AGENCY REFERRAL AND LINKAGE

Referrals to external agencies will be made via the agency's Interagency Referral Policy. Referral agencies will include, but not be limited to: Human Services, physical health services, substance abuse providers, other mental health providers, Bureau of Vocational Rehabilitation, state and private psychiatric inpatient facilities, Family and Children First Council's intersystem collaborative, and other appropriate services. The person's primary provider will assure coordination of services.

In the event a client is a referral from another agency or system, the primary therapist or CPST worker at Woodland Centers, Inc. will be responsible to assure consistency and coordination of services internally as well as with the other agency or systems.

Most recently, WCI has developed a Memorandum of Understanding with Health Recovery Services to deliver substance abuse treatment services in Woodland's Jackson and Gallia offices with a focus on prescription drug abuse. HRS has rented office space from WCI as part of this partnership.

LINKAGES TO ADMINISTRATIVE/SUPPORT SERVICES

Linkages and coordination of activities with administrative and support services are provided via supervision, administrative and clinical program management meetings, Performance Improvement meetings and liaison provided by the Directors of Clinical Services.

INTEGRATION OF BEHAVIORAL HEALTHCARE WITH PRIMARY CARE

As healthcare reform unfolds, it is clear that community mental health as we currently know it will look different in the next 2-3 years. However, there is no one universally accepted model of what that really means or what it's going to look like.

Given that uncertainty, Woodland Centers Inc. has already taken steps to position itself to capitalize on its historical and current relationships with primary care, as well as to initiate additional partnerships. The following is a list of these efforts.

- On-call workers in emergency rooms
- Bariatric and lapband evaluations. Woodland psychologist credentialed to conduct these for Holzer.
- Co-located offices in Holzer Medical Center – Jackson.
- Relationships with pediatricians for autism program.
- Ongoing discussions with Holzer to develop a program that integrates primary care with behavioral health.
- Plan to submit Letter of Intent with ODMH to become a Medicaid Health Home in January 2013.

TRANSPORTATION

Woodland Centers, Inc. currently maintains a fleet of eight vans which provide transportation services to the residents of Gallia, Jackson, and Meigs counties. The transportation program makes nearly 4,000 trips per year as follows.

- Clients can request transportation to their appointments at any of Woodland Centers' clinics. Transportation is provided for individual, group, and med-som services.
- We provide non-emergency medical transportation for residents of Gallia and Meigs counties through contracts with Departments of Jobs and Family Services in both counties.

The agency continues to expand its fleet with grants from the Ohio Department of Transportation. An application for three new handicap accessible vehicles was submitted for FY2013.

VI. PERFORMANCE IMPROVEMENT

All departments and services participate in Performance Improvement activities. A Performance Improvement Plan and Outcomes Measurement System have been implemented which is designed to follow our mission, vision, and goals as stated in Section I. of this document.

As WCI works toward achieving those goals, the organization is committed to the principles of continuous improvement in all our programs, services, and operations. To that end, we

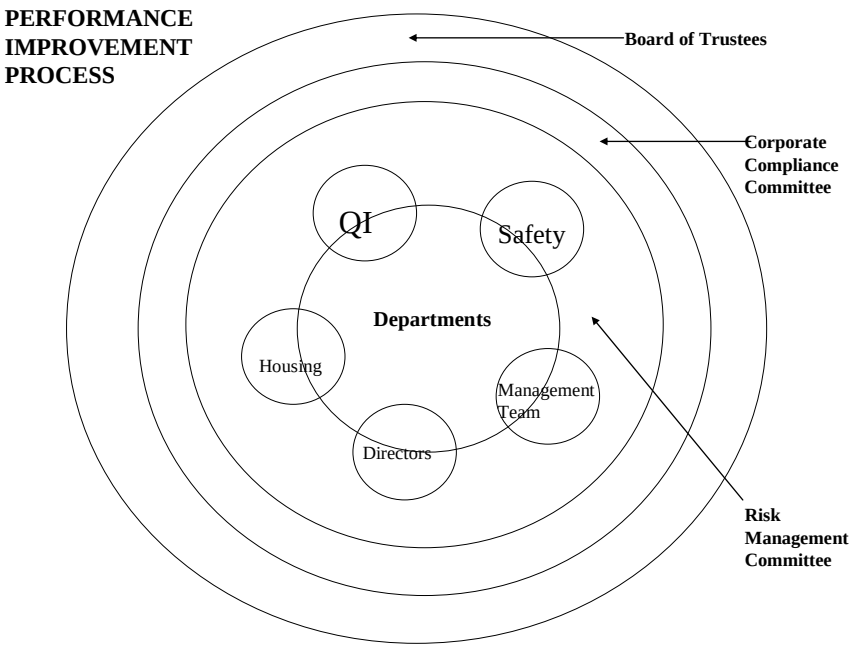
have developed this Performance Improvement Plan and Outcomes Management System that combines the essential elements of the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services with the CARF standards on Information Measurement, Management, and Performance Improvement.

The purpose of the Performance Improvement Plan and Outcomes Management System is to establish a methodology for collecting and analyzing information for the improvement of business operations and service delivery in the domains of effectiveness, efficiency, accessibility, and satisfaction. Data will be collected from a variety of sources including clients, community partners and other stakeholders, and staff, as well as financial reports, risk management reports, human resources reports, health and safety reports, the agency's accessibility plan, strategic plan, and other relevant reports.

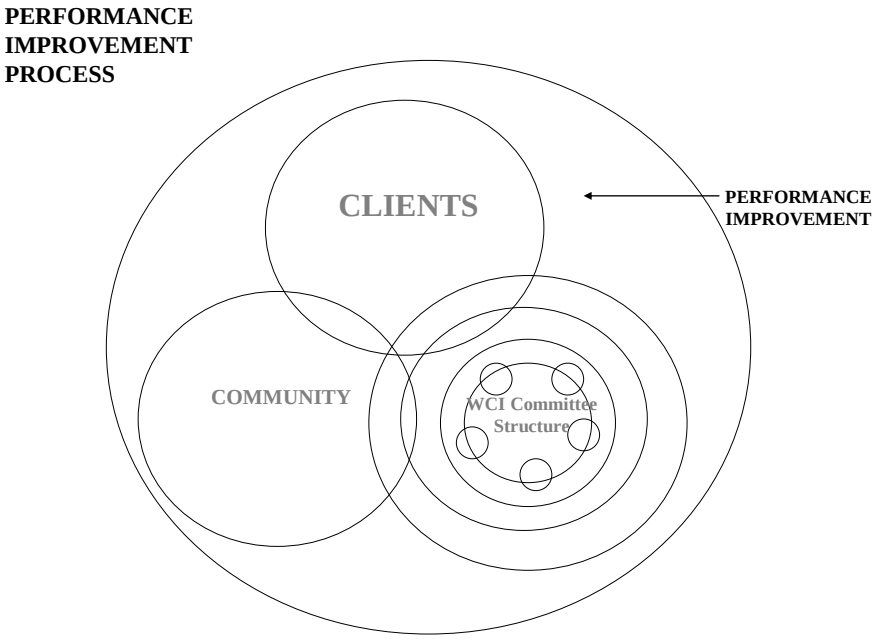
The agency's performance improvement is illustrated in the diagrams below, beginning with some basic Performance Improvement Principles:

- Commitment to continually improve the agency and service delivery.
- Data collection and analysis (Committee reports, budget, service statistics, incidents, grievances, outcomes, etc.).
- Multi-directional communication.
- Interdependence.
- Performance improvement is everyone's job!

Essentially, the agency's performance improvement process is accomplished through the agency's committee structure. Data is collected and analyzed by these committees which make recommendations for performance improvement activities and interventions including training and development.



The diagram below illustrates that performance improvement is not just an internal process, but rather includes accountability to our clients and the communities we serve.



A performance analysis will be conducted on an annual basis. This analysis is comprised of annual reports from Corporate Compliance Committee, Risk Management Committee, Quality Improvement Committee, and Health and Safety Committee which are presented to the Board of Trustees in September following the end of the fiscal year. The agency will also communicate results of its performance improvement efforts to persons served and

other stakeholders. In addition, there are also annual reports from agency departments including Human Resources and Finance. Each of these reports:

- Identifies areas needing performance improvement.
- Includes action plans to address the improvements needed to reach or revise established outcome measures and improve the quality of programs, services, and operations.
- Facilitates organizational decision-making with regard to our progress toward fulfilling our mission and achieving our goals.
- Creates a summary report that can be shared with our clients, staff, and other stakeholders in appropriate and meaningful ways.

Even though the Ohio Department of Mental Health discontinued the use of the Ohio Scales, WCI continues to use the Ohio Scales as one of its outcome measures. WCI also participates in the Ohio Department of Alcohol and Drug Addiction Services' behavioral health reporting system These outcomes management systems address the following:

- Outcomes will be measured from the client's perspective.
- Outcomes will be measured from the direct care staff's perspective.
- Outcomes will measure the domains of functioning, quality of life, and symptom distress.
- Outcomes will demonstrate cultural sensitivity and competency.
- Outcomes will have reasonable levels of cost and burden for the agency, consumers, and families.
- Outcomes will reflect empowerment of the consumer and support for consumer recovery.

As the Outcomes Management System has evolved, WCI has identified its own Performance Indicators for FY2013 as measures of the quality of our core programs and services for children, adolescents, and adults including: Outpatient; Community Psychiatric Supportive Treatment (case management); Crisis Intervention; Crisis Stabilization (adults only); and Pharmacologic Management. Complete Program Descriptions for each of these programs and services can be found in the following agency policies:

- Outpatient Services WCI-C-402
- AOD Services (Dual Diagnosis) WCI-C-425
- Emergency Services (Crisis Intervention) WCI-C-430
- Med-Somatic Services (Pharmacologic Management) WCI-C-450
- Crisis Stabilization WCI-C-475
- Community Psychiatric Supportive Treatment (Case Management) WCI-C-480

ACCESSIBILITY

Clinical Indicators

Accessibility is defined as a measure of individuals and the community's ability to obtain mental health services in a timely manner. For FY2013, we will focus on two specific measures of accessibility:

1. Percentage of persons scheduled for an intake (assessment) within two weeks
2. of initial contact.
3. No shows, client cancels, and staff cancels.

Data will be collected by staff scheduling appointments (Crisisline staff), compiled into a report by the MIS Specialist, and analyzed by the QI Committee which is also responsible for setting a threshold for performance and developing any corrective action plans.

Other data that may be collected includes length of stay on the Crisis Stabilization Unit as a factor of the number of clients on the CSU who are homeless; the number and disposition of emergencies. If performance thresholds are met for the two focus areas identified above, the QI Committee may choose to focus on one or more of the other clinical indicators for which data is collected on an ongoing basis. Additional measures may be identified as a result of the 505 Regional Collaboration.

Finally, the QI Committee will review and analyze the survey of referral sources originated by the ADAMHS Board to determine if any accessibility issues are identified.

Business Indicators

The agency Directors are responsible for reviewing the agency's Accessibility Plan on an annual basis and developing a status report with action items, persons responsible, and timeframes for completion. The Accessibility Plan addresses the following barriers to services: architectural, environmental, attitudinal, financial, employment, communication, transportation, and others as identified by staff, clients, and community partners. The current Plan identifies the ability to recruit qualified staff, staff access to data/computers, and housing as additional barriers. Refer to the 2011 Accessibility Barriers Status Report for more specific information. The agency is applying for ARC funds to improve access to care by installing handicap-accessible doors in the Gallia Clinic and replacing its videoconference equipment in FY2013.

In FY2008 Woodland Centers Inc. received a grant from the Osteopathic Heritage Foundation to develop a transportation program linked to our housing programs through the Gallia-Jackson-Meigs-Vinton Continuum of Care. Since then, that grant has been renewed twice, with FY2012 as its final year. The agency has used that initial project to leverage additional funding through contracts with Meigs and Gallia Departments of Job & Family Services to provide non-emergency transportation to medical appointments in both counties thereby increasing accessibility to services. The agency will re-apply for both contracts in FY2013.

EFFICIENCY

Clinical Indicators

Efficiency is a measure of how well resources are used to accomplish agency program goals. The major focus of performance improvement in FY2013 will be the efficient use of staff under the state's Medicaid Cost Containment strategy. This indicator is being driven by both funding and services, and involves staff, clients, and community partners.

Efficiency in this case will be measured in two ways:

1) By the number of clients who, based on historical use of services, will run out of units before the end of the fiscal year.
2) By the mix of services we can develop to maintain the client in the community. We will also need to measure community partner and referral source satisfaction with this change. It is not enough to achieve efficiency without also maintaining customer satisfaction with services. Therefore, see also clinical indicators for Satisfaction.

Business Indicators

The most significant indicator of efficient use of resources is productivity. Every clinician has a productivity expectation assigned to his/her job description. Productivity reports are generated monthly and monitored by the directors of clinical services at each site. Productivity is also a critical measure for developing the agency's budget.

In FY2010-11, the agency established an agency-wide goal for efficiency related to Medicaid billing. The purpose of creating an agency goal was to emphasize the fact that it takes the whole team – all departments and all staff – for the agency to be successful. When the agency achieved the goal, there were rewards for all staff at the end of the year. Those employees who consistently exceeded their productivity targets receive special recognition. However, this type of productivity incentive is not be realistic for FY2013 given the benefit limits and tiered rates for CPST. The only way targets like this would be feasible is if there is a corresponding marketing campaign to increase the number of new clients.

EFFECTIVENESS

Clinical Indicators

Effectiveness measures how well treatment promotes desired change. While the Ohio Scales and other state-level measures are under revision, WCI will measure effectiveness using two indicators:

1) State hospital bed-day utilization as a measure of the effectiveness of outpatient and crisis services. Hospital bed-day utilization is monitored daily. At a cost of $525 per diem, the agency has been assigned 1836 days for FY2013 including both civil and forensic beds. We will continue monthly meetings with state hospital personnel will continue, as well as managing admissions and discharges to the state hospital. The effectiveness of these actions will be measured throughout FY2013.
2) The frequency with which clients who are discharged from the CSU and/or the state hospital re-present for crisis services. Re-admission rates will be monitored as well

as crisis intervention emergencies. Adult wraparound strategies may be implemented for clients with frequent re-admits.

Business Indicators

Effectiveness in operations will be measured as follows:

1) Employee turnover and retention rates which is monitored by Human Resources.
2) Incident reports are monitored by QI (client related incidents), Safety (health and safety incidents), and Risk Management (HIPAA/PHI related incidents) Committees as a measure of effectiveness of our risk management activities, safety program, and to some extent, clinical services. Risk Management Committee has overall responsibility to analyze all incident reports after each committee has reviewed their assigned category of incidents, identified trends and patterns, and the need for training if applicable.

SATISFACTION

Clinical Indicators

The agency will use Consumer Satisfaction Surveys to evaluate client satisfaction with services. Front desk staff at each clinic will collect data using a paper and pencil survey on an ongoing, random basis. All services, including the CSU, will be included in the survey. Data will be analyzed quarterly and distributed to the QI Committee for action. Client focus groups have been used to address specific issues that fell below the 90% threshold. We will continue to utilize the surveys to see if the focus groups have an impact on client satisfaction.

In addition, the agency will use the ADAMHS Board referral source survey to assess the satisfaction of law enforcement, health care, and school referral sources. This survey is done annually.

Business Indicators

Client grievances will be monitored as part of the agency's QI activities. This process will continue to be used as a measure of client satisfaction.

The agency will also use an Employee Satisfaction Survey to measure employee satisfaction with their work and the agency. The survey is distributed every two years beginning in 2004, 2006, 2008, and 2010. The return rate continues to be very high, and has shown steady improvement over the past six years. The survey will be distributed again in 2012.