Prioritization of Services

Mental Health & Recovery Services Board Serving Coshocton, Guernsey, Morgan, Muskingum, Noble and Perry Counties

Foundation

The Mental Health & Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble and Perry Counties (MHRSB) is the local authority for planning, funding, monitoring, and evaluation behavioral health services. This responsibility is outlined by Ohio Revised Code, Chapter 340 and described in the statements below:

Mission Statement:

Our mission is to distribute federal, state, and local funding to community providers in response to community need and in a way that facilitates the existence of – and access to – high quality mental health and substance use recovery services in our six counties.

Core Values:

We believe that quality mental health and substance use recovery services are:

- recovery-oriented;
- person-centered and responsive to the diversity of identities and lived experiences of persons served;
- accessible;
- built on evidence-based practices; and
- dependent upon effective coordination amongst partners.

Vision Statement:

We envision a world in which all citizens of our six counties have timely access to quality mental health services that reflect their needs and provide support in breaking unhealthy cycles and moving towards recovery.

Introduction

MHRSB recognizes that funding streams are not constant. There are changing target populations, levels of funding and restrictions for use. MHRSB recognizes that historical patterns and level of funding for programs and populations may change at any time. It is incumbent on MHRSB to use resources efficiently, effectively, and ethically to maximize fairness. This is the philosophical basis for funding decisions.

Guiding Principles

The purpose of this document is to clarify ethical decisions related to choosing between marginal improvements for those who are relatively stable or those who are at risk of death, serious harm, or causing serious harm to others.

Each of the following is a guiding principle used in the consideration of funding decisions:

1. Efficiency- Return on investment without consideration of the outcomes.
2. Effectiveness- Maximizes client benefit while looking only at the best possible outcome.
3. Equality- Distribution of resources across clients in hopes of similar outcomes.
4. Equity- Distribution of services that does the least harm to all potential clients.

On their face, each of these appears to be equal in importance. However, in making budgetary decisions in times of complicated funding when it may not be possible to do everything that we have historically done or would like to do, it is imperative to place the funding in the areas that will impact those at greatest risk of serious negative outcomes.

MHRSB is the behavioral health safety net that places equity as the highest priority in making budgetary and programmatic decisions in treatment. Inclusion of efficiency, effectiveness, and equality as influencing factors in the decision-making process identifies this as the best model for MHRB. Focus on serving those who do not have access to a third-party payer or sufficient personal resources to secure services ensures that maximization of resources can occur. If there are people who by their choice do not access a third-party payer option, these persons shall not be a service priority for MHRSB.

Prioritization

After analysis, there are three categories of funding to be considered.

1. Hard mandates- Those funds that are given with specific uses defined.

2. Soft mandates- Those funds that are given with defined areas, but no specific use designated.

3. Discretionary funds- Those funds that are without funder restrictions other than those that are inherent in good, ethical stewardship and can be used to meet the priority populations and services designated by MHRB as necessary carve-outs.

The safety net of services includes not only those services mandated by Ohio Revised Code and other funding bodies, but services that without such, would negatively impact the lives of those in Coshocton, Guernsey, Morgan, Muskingum, Noble and Perry Counties. Service mix is determined by community need and is included in the community plan, which serves as MHRSB's application for funding from the Ohio Department of Mental Health and Addiction Services. Local needs are determined by assessment of current conditions, forecasting emerging trends, and evaluating existing community resources. This results in a process that is not only fluid, but responsive to the needs of the community. All services, programs and populations have been prioritized according to the level of urgency and immediacy associated with client need. All services, programs and populations have been broken into five priority areas.

Priority Area	Target Population	Category Name	Definition
Priority 1		Hard Mandates	Services we are legally required to provide.
Priority 2	Everyone in Coshocton, Guernsey, Morgan, Muskingum, Noble and Perry Counties	Crisis	1) Risk of urgent and imminent harm includes need for emergency or urgent services due to danger to self/others or inability to care for self, 2) Potential life-threatening symptoms resulting from withdrawal from substances, 3) Loss of basic self-care skills (secondary to Priority Population), 4) Likely degeneration of condition that would result in imminent risk,
Priority 3	Priority Populations only	High Risk	Significant or severe functional issues requiring high intensity community-based level of services to prevent hospitalization or out-of-home

Priority 4	Priority Populations only	Serious Risk	Significant functional issues related to SMI/SED/SEVERE SUD*; that, without intervention, would likely need a higher-level priority service at some point in the mom-imminent future.
Priority 5	Non-priority populations or general populations	Legitimate Needs	Services that increase the quality of non-urgent outcomes with regard to any of the issues addressed in other

Primary considerations that will impact MHRSB priorities that have multiple organizations in competition for funding are listed below:

1. Highest priority will be given to programs that serve priority populations and identified carve-out services.

2. Higher priority will be given to non-redundant programs which address underserved or emerging programs.

3. Higher priority will be given to programs that leverage outside resources in a way that reduces Board expenditures.

4. Higher priority will be given to programs that demonstrate the ability to coordinate services across organizations.

5. Higher priority will be given to programs that demonstrate that individuals served are likely to experience a reduction in system dependence.

6. Higher priority will be given to programs that are innovative and that are evidenced based.

7. Lower priority will be given to programs/services that MHRSB is not mandated to provide.

*Severely Mentally Ill, Severely Emotionally Disabled, Substance Use Disorders

Priority Populations

SMI/SPMI: Adults with Serious Mental Illness

- The SMI/SPMI population is defined as 18 years or older that has a DSM 5 diagnosis lasting over 6 months and may have a history of psychiatric hospitalization. The following diagnoses are excluded:
  - Developmental disorders
  - Substance related disorders
  - Dementia or other physical conditions that mimic mental health conditions.

SED: Children or Adolescents with Serious Emotional Disturbance

- Youth identified as Seriously Emotionally Disturbed in accordance OAC 5122-24-01 with the exception of the age criteria which has been extended by MHRB to those under the age of 21.

Substance Related and Addictive Disorders:

- Substance related and addictive disorders include 10 separate classes of drugs as referenced in the Diagnostic and Statistical Manual – 5 th edition (DSM-5). Gambling disorders are also included. Substance use disorders can be mild, moderate, or severe, as well as include substance intoxication and withdrawal and substance induced disorders. (Refer to the DSM-5 for specific criterion for these disorders.) In terms of prioritization, certain substance use disorders pose a greater risk than others and are given higher priority. Programs and services for those with a severe substance use disorder will have priority over programs and services for those with a mild substance use disorder. Likewise, substances that are most likely to have imminent risk or death without intervention will be given more attention and priority than those substances likely to be of milder severity.

Service demands will be determined by a variety of sources including community needs and local trends and may change from funding cycle to funding cycle. While MHRB recognizes that all substances of abuse can have damaging effects on a person's health and well-being, resources will be directed to those populations people with life threatening disorders.

MHRSB will fund services we are legally required to provide to the extent resources are available.

Carve-Out Services

Carve-out (Recovery and Prevention) services are those that MHRSB annually commits to a determined budget allocation to be able to service the greater interest of the priority populations, as well as the community in general. These amounts are separated from the funds for the clinical pool of services.

Priority Area	Target Population	Service Type	Category Name	Definition

Priority 1	Priority Populations only	Mental Health Housing, Recovery Housing	Serious Needs	Services that assist individuals to obtain and/or maintain stable housing.
Priority 2	Priority Populations only	Peer Support, Vocational Linkage,	Important needs	Services that assist individuals to obtain and/or maintain: 1. Prosocial relationships/ activities 2. Employment or education that best supports their level of recovery and reflect their choice.
Priority 3	Priority Populations only	SED Recovery Support, Transportation, Guardianship	Significant Needs	Services that aid with social, personal, and living skills
Priority 4	Everyone in the Behavioral Health Population	NAMI Homeless Shelters	Legitimate Needs	Services that provide support, assistance, consultation and education for families, and persons receiving addiction service, mental health services, and recovery support.

Prevention

Priority Area	Target Population	Category Name	Definition

Priority 1	Priority Populations Only	Urgent Risk	Indicated prevention strategies are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms of, as well as biological markers that indicate a predisposition to, mental, emotional, or behavioral disorder(s). These signs and symptoms foreshadow such a disorder but do not meet diagnostic criteria at the time of the intervention. Early Intervention occurs after serious risk factors have already been discovered or early in disease progression soon after diagnosis. The goal is to halt or slow the
Priority 2	Priority Populations Only	High Risk	Indicated prevention strategies are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow mental, emotional, or behavioral disorder, as well as biological markers that indicate a predisposition in a person for such a disorder but does not meet diagnostic criteria at the time of
Priority 3	Priority Populations Only	Serious Risk	Selective prevention strategies are targeted to individuals or to a subgroup of the population whose risk of developing mental, emotional, or behavioral disorders are significantly
Priority 4	Priority Populations Only	Important Needs	Universal prevention strategies are targeted at the general public or a whole population group that has not been identified based on individual risk. The intervention is desirable for everyone in

Guidelines

Required: All providers must meet all applicable federal, state and MHRSB contract requirements and any applicable standards for service provision.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization 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 (SUD programs only). Provider agencies receiving funding through this source MUST demonstrate that these recipients have priority for services.

Services are to be compliant with Civil Rights, Equal Employment Opportunity, CLAS* Standards, and consistent with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR part II (where applicable).

* Culturally and Linguistically Appropriate Services

Additional: Preference will be given to programs and services that:

Are comprehensive, client centered, family centered and receive input from consumers, clients, and community partners.

Use approaches based on current research and best practices.

That provides trauma-informed care and services.

That address age, race, ethnicity, gender, sexual orientation and deliver culturally- and linguistically-appropriate services.

That can demonstrate achievement of agreed upon outcomes. All providers will be responsible for providing evidence that they are achieving the agreed upon outcomes. All outcomes must align with local, state, and federal priorities.

That utilizes data as a foundation for changing practices and improving services.

That are accessible and provided in a variety of locations such as homes, schools, and neighborhoods.

That incorporates the principles of recovery, resiliency, and cultural competence.

Allocation Methods

MHRSB's intent is to incorporate these defined measures and criteria into evaluating requests for funding. Programs and providers that can demonstrate the ability to meet the needs for priority populations and priority services will be given preference above those that cannot. This transition will begin in FY25 contracting and may take several funding cycles to fully implement.