Advancing **equity** through **measurement**

MHRB
Mental Health Recovery Board
Clark | Greene | Madison

Prepared by the Health Policy Institute of Ohio (HPIO) for the Mental Health Recovery Board of Clark, Greene, & Madison Counties (MHRB)

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Acknowledgments

The Mental Health Recovery Board of Clark, Greene & Madison Counties (MHRB) contracted with the Health Policy Institute of Ohio (HPIO) to produce this plan and worked closely with HPIO throughout its development. HPIO and MHRB are grateful to the organizations that provided administrative data requested for this project:

- Clark County Health District
- Dayton Children's Hospital
- Greene County Public Health
- Mercy Health System
- Nationwide Children's Hospital
- Ohio Department of Education
- Ohio Department of Job and Family Services
- Ohio Department of Mental Health and Addiction Services

Author
Amy Bush Stevens, MSW, MPH

Layout and design
Nick Wiselogel, MA

Contributors
Amy Rohling McGee, MSW
Becky Carroll, MPA
Lexi Chirakos, PhD
Edith Nkenganyi, BA

MHRB team
Greta Mayer, EdD
Jennipher Brown, CMP, OCPSA
Rachel Huffman, LPCC-S, LICDC-CS

Purpose and process

Background

The Mental Health Recovery Board of Clark, Greene & Madison Counties (MHRB) is one of 50 Ohio behavioral health boards across the state and provides pathways to care for every individual and family in the three-county service area. Publicly funded by local, state and federal dollars, MHRB works with care providers and community partners to find strategic, cross-systems solutions to the most pressing mental health and substance use concerns in the counties it serves.

MHRB began behavioral health equity efforts in July of 2019 by hosting the first stop on RecoveryOhio's minority health listening tour. In partnership with providers, stakeholders and the Ohio Department of Mental Health and Addiction Services (OhioMHAS), MHRB recruited a diverse panel of local experts, including Black community members from Clark, Greene and Madison counties, to share their insights in mental health, addiction and health care.

In June 2020, MHRB adopted a resolution declaring racism a public health crisis and committed to taking meaningful action. An ad hoc committee of the Board was created to guide the next steps. By December 2021, the Board set aside $231,031 to advance behavioral health equity strategies. The Board also committed to working collaboratively with communities impacted by racism to uncover problem areas and develop data-driven strategies to mitigate the problem areas in the region.

What is behavioral health equity?

MHRB aligns to the Substance Abuse and Mental Health Services Administration (SAMHSA) **definition** of Behavioral Health Equity as the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders.

Community engagement process

MHRB continued to engage Black communities through a series of virtual and in-person discussions in 2020-2022:

- Focus groups in December 2020-September 2021 (one group for each county)
- Community forum in October 2021
- Virtual roundtables in February 2022 (one group for each county)
- Community forum in March 2022

In December 2021, MHRB contracted with HPIO to assist with planning for equity activities and to summarize the findings of these community conversations. The following are key insights from the summary:

- Black community members are **not treated with dignity and respect** in behavioral health settings, and that affects mental health.
- Respondents described a need for a diverse behavioral health **workforce** that is trustworthy and understands their experiences.
- Local **leaders and providers** should reflect the communities they serve.
- Providers should be **located in the neighborhood**, accessible and part of the community.
- **Stigma** about behavioral health in the Black community needs to be addressed.
- **Young people** struggle the most and need prevention and early intervention.

Drawing upon these qualitative findings, HPIO worked with MHRB to plan the Advancing Equity through Measurement project. The objective of the project was to provide intensive technical assistance to MHRB staff focused on measuring and improving access to care and mental health and substance use outcomes for Black residents across the life course.

As part of this process, MHRB and HPIO reviewed data and developed the SMART objectives in this report. MHRB prioritized the goals and objectives using the following criteria:

- Addresses an issue that was identified in the qualitative assessment (see key insights listed on page 3)
- Addresses an issue with large racial disparities and/or troubling trends for Black residents and is highly relevant to racial equity
- Relevant to resource allocation and policy decisions made by the Board
- Data can be meaningfully tracked on a regular basis to monitor performance (quarterly or annually)
- Data will be consistently available from a credible source over time
- Balanced across the continuum of care, and between adult and youth

How this document will be used

MHRB will use this document to guide the implementation, evaluation and improvement of equity activities over the next seven years. This is a "living document" that can be updated and revised over time as conditions in the community change and new data becomes available.

This document is aligned with the 2023-2025 Community Assessment and Plan (CAP), in that it addresses relevant topics along the continuum of care (see matrix on page 15) and uses the SMART objective framework required by OhioMHAS for the CAP. The CAP is a plan to improve behavioral health outcomes that must be updated every three years. The SMART objectives in this document provide a "deeper dive" with additional detail and focus on equity, while the CAP addresses the overall needs of the three counties. This document also includes five logic models that describe resources and short-term outcomes for selected objectives. MHRB will use these logic models to plan services, programs and policies, and to track progress toward the goals.

SMART objectives

SMART objectives are a specific format for describing a desired outcome. SMART objectives are specific, measurable achievable, realistic and time-bound. MHRB's SMART objectives are presented in figures 1, 5, 8, 16 and 18 in a table format that includes these elements.

Data limitations

All indicators in the SMART objectives have data for Black residents of Clark, Greene and Madison Counties. Due to the relatively small population size of the MHRB area, it is challenging to obtain county-level data that can be disaggregated by race. The indicators selected for this project represent the best data available at this time. In some cases, the available data may present a more narrow or broad view of the outcome of interest, and MHRB may implement strategies that result in changes that cannot yet be tracked through available data. MHRB will continue to advocate for better access to local disaggregated data so that future planning efforts can rely upon more precise and comprehensive information.

Goals and objectives

MHRB identified five goals to improve well-being in Black communities:

1. Prevent mental health and addiction-related crises and deaths among Black community members
2. Improve the quality of behavioral health care for Black youth and adults
3. Ensure Black children, youth and families thrive in their home, school and community
4. Strengthen behavioral health workforce diversity and equitable location of services
5. Build capacity to collect actionable equity data in the future

There are several SMART objectives within each goal, listed below. All baseline data is for residents of Clark, Greene and Madison Counties. MHRB staff set the target data values to reflect the goal of improving outcomes for Black residents, and eliminating racial disparities (when present). The target year varies by objective. Several objectives specify 2025 as the target year to align with the Community Assessment and Plan (CAP submitted to the Ohio Department of Mental Health and Addiction Services). Others have a longer or shorter time horizon, reflecting the amount of time needed to make changes in services, programs and policies that will affect the long-term outcomes.

Goal 1. Prevent mental health and addiction-related crises and deaths among Black community members

- **Objective 1.1.** Reduce youth suicide attempts, as measured by emergency department (ED) encounters
- **Objective 1.2.** Reduce youth overdoses, as measured by ED encounters
- **Objective 1.3.** Reduce adult suicide attempts, as measured by ED encounters
- **Objective 1.4.** Reduce adult overdoses, as measured by ED encounters
- **Objective 1.5.** Reduce suicide and drug overdose deaths (all ages)

Figure 1. **Goal 1 equity SMART objectives**

Objective	Indicator	Data source	Baseline year	Baseline data	Target year	Target data
1.1	Number of hospital **ED encounters for suspected suicide attempts** among Black **youth** ages 17 and younger	Dayton Children's Hospital (DCH) and Mercy Health System	2022	15 (DCH: 4 Mercy: 11)	2025	13
1.2	Number of hospital **ED encounters for suspected overdose** among Black **youth** ages 17 and younger	DCH and Mercy Health System	2022	23 (DCH: 12 Mercy: 11)	2025	20
1.3	Number of hospital **ED encounters for suspected suicide attempts** among Black **adults** ages 18 and older	Mercy Health System	2022	12	2025	10
1.4	Number of hospital **ED encounters for suspected overdose** among Black **adults** ages 18 and older	Mercy Health System	2022	27	2025	24
1.5	Number of drug overdose and suicide **deaths** among Black residents (all ages)	Ohio Department of Health (Public Health Data Warehouse)	2021*	19	2024	13

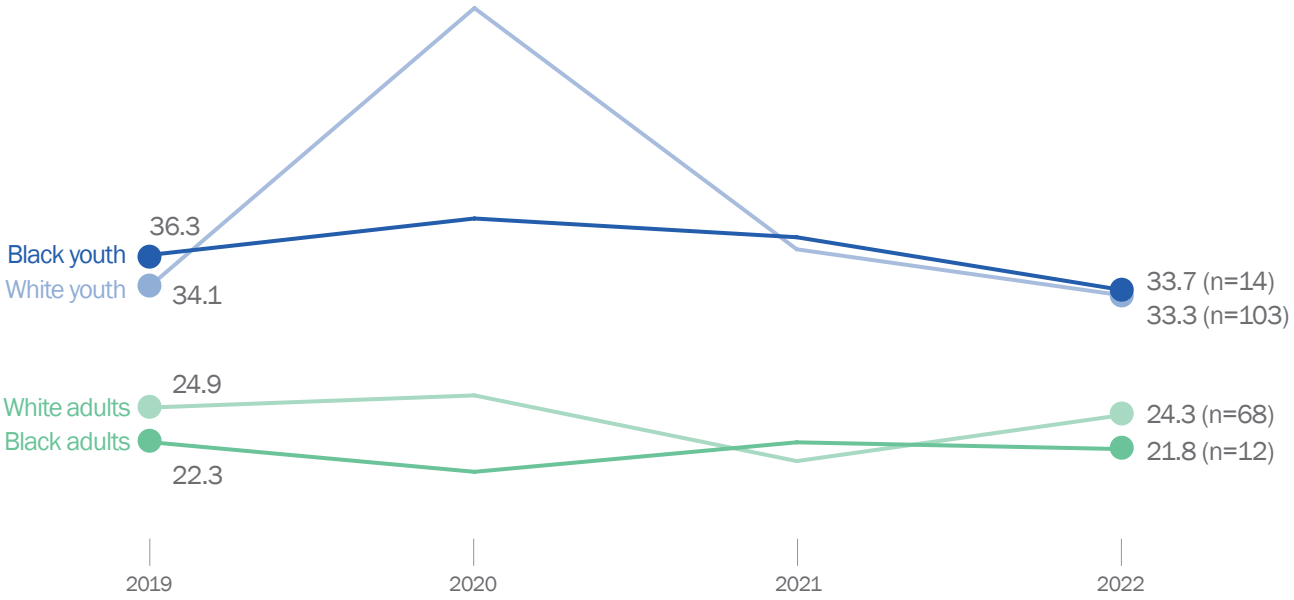
*Preliminary

Baseline data for goal 1

Figures 2-4 provide trend data for the goal 1 indicators. These graphics display rates, rather than numbers, to allow for meaningful comparisons between racial groups. Numbers (as used in the SMART objectives) are useful for planning purposes and are easy to compile and communicate. Rates are useful for understanding disparities because they allow for an "apples to apples" comparison of groups that is not skewed by differences in population size. (Seven percent of the Board area population is Black.)

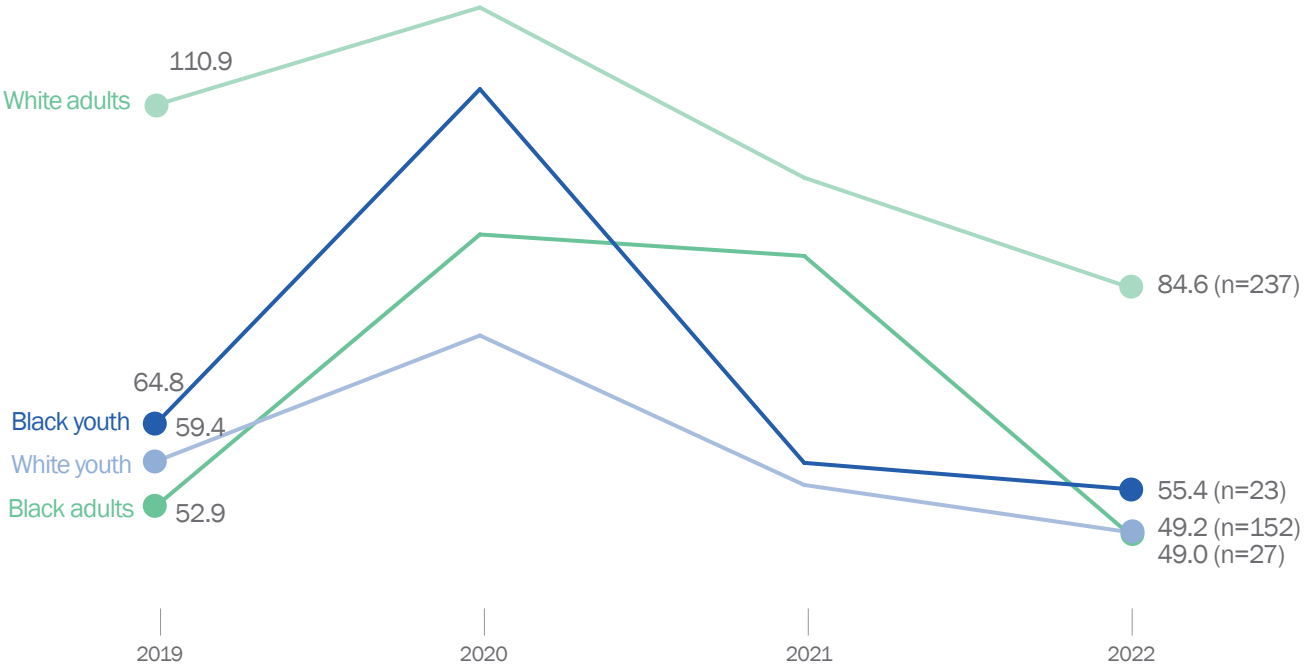
The rate of ED encounters for suspected suicide attempts was higher for youth than for adults (figure 2). The pattern was different for ED encounters for suspected overdose; white adults had the highest rates (figure 3). Figure 4 displays trends in overdose and suicide deaths. These two causes of death are combined to allow for disaggregation by race. After being lower than the white rate for many years, the Black combined overdose and suicide death rate increased sharply between 2019 and 2021, surpassing the white rate in 2021.

Figure 2. **Rate of hospital ED encounters for suspected suicide attempts.** Number of hospital ED encounters for suspected suicide attempts per 10,000 ED encounters, youth and adults, residents of Clark, Greene and Madison counties, by race, 2019-2022



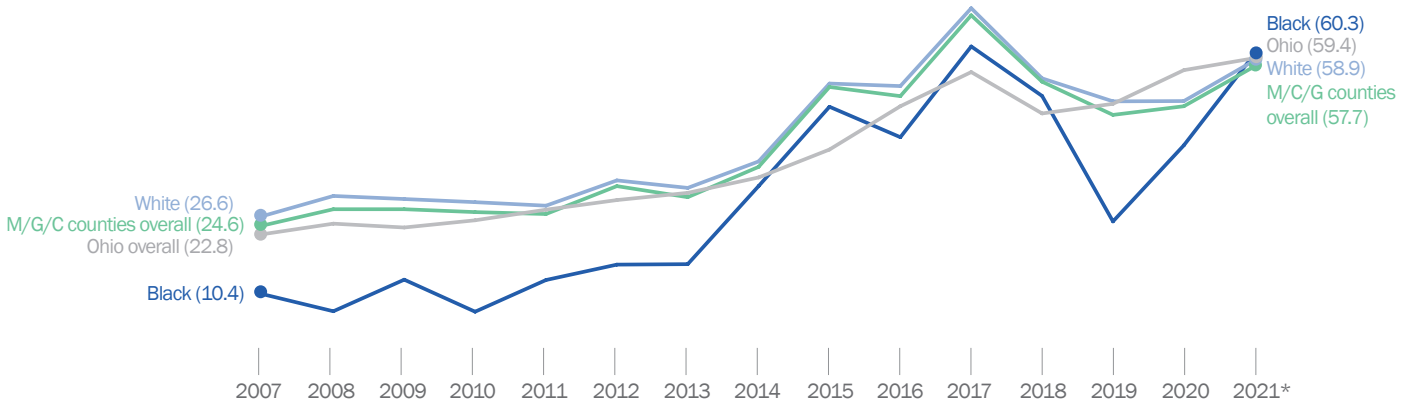
Note: All lines include data from Mercy Health, which is for residents of Clark, Greene and Madison Counties. Youth lines also include data from Dayton Children's Hospital, which does not include residents of Madison County.
Source: Mercy Health (Springfield Regional Medical Center) and Dayton Children's Hospital (youth data)

Figure 3. **Rate of hospital ED encounters for suspected overdose.** Number of hospital ED encounters for suspected overdose per 10,000 ED encounters, youth and adults, residents of Clark, Greene and Madison counties, by race, 2019-2022



Note: All lines include data from Mercy Health, which is for residents of Clark, Greene and Madison Counties. Youth lines also include data from Dayton Children's Hospital, which does not include residents of Madison County.
Source: Mercy Health (Springfield Regional Medical Center) and Dayton Children's Hospital (youth data)

Figure 4. **Overdose and suicide death rate.** Number of unintentional drug overdose deaths and suicide deaths (combined) per 100,000 population (crude rate), residents of Clark, Greene and Madison counties, by race, 2019-2022



* 2021 data is considered partial and may be incomplete
Source: Ohio Public Health Data Warehouse, accessed Feb. 21, 2023

Goal 2. Improve the quality of behavioral health care for Black youth and adults

- **Objective 2.1.** Improve timely follow-up after hospitalization for mental illness (among Medicaid enrollees)
- **Objective 2.2.** Improve timely follow-up after ED visit for mental illness (among Medicaid enrollees)
- Add crisis services quality objective in the future (see goal 5)
- Add client experience of services objective in the future (see goal 5); address extent to which clients feel they are treated with dignity and respect

Figure 5. **Goal 2 equity SMART objectives**

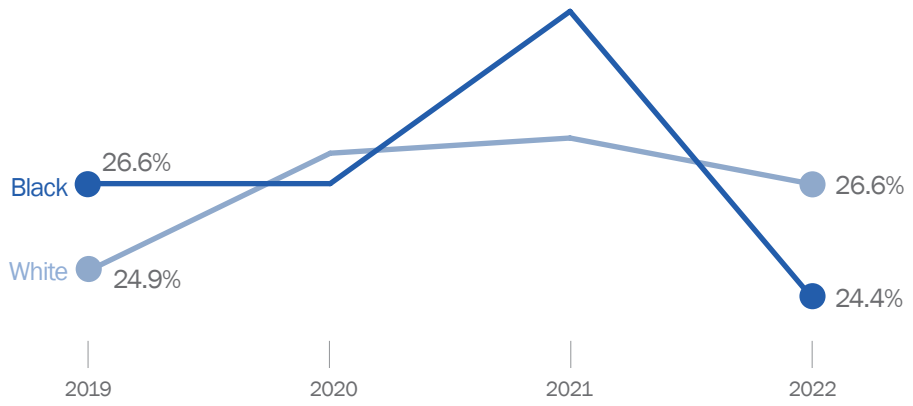
Objective	Indicator	Data source	Baseline year	Baseline data	Target year	Target data
2.1	Percentage of Black Medicaid enrollees, ages 6 and older, who received **follow-up within 30 days** after **discharge from the hospital for mental illness**	Ohio Department of Medicaid (ODM) via OhioMHAS (Healthcare Effectiveness Data and Information Set [HEDIS] metric)*	2022	24.4%	2025	27%
2.2	Percentage of Black Medicaid enrollees, ages 6 and older, who received **follow-up within 30 days** after an **emergency department visit for mental illness**	ODM via OhioMHAS (HEDIS metric)*	2022	27.2%	2025	30%

* Currently, this data is only available for Medicaid enrollees. MHRB will expand these objectives to include patients with other payers if that data becomes available in the future.

Baseline data for goal 2

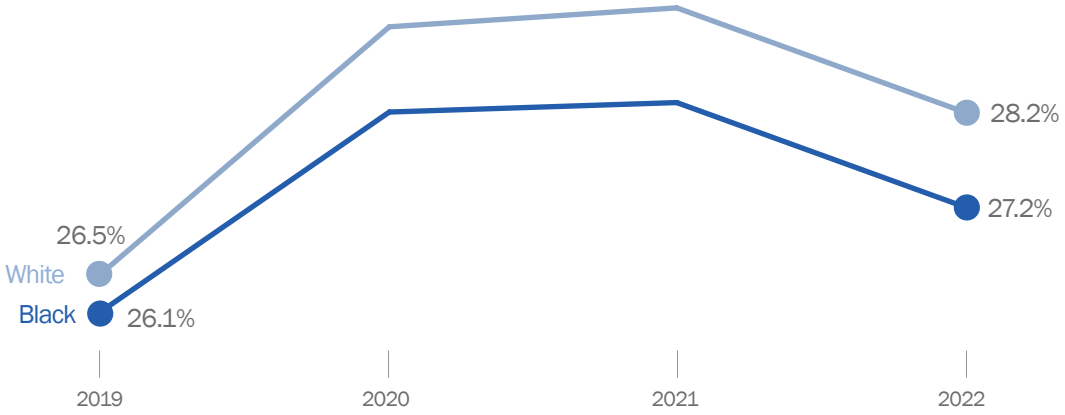
Figures 6 and 7 provide trend data for the goal 2 indicators. This Medicaid data shows that about three quarters of patients do not get timely follow-up care after an ED encounter or hospitalization for mental illness, regardless of race. Hospitalization follow-up rates are important indicators of quality of care. Low follow-up rates indicate the need for system improvements to ensure that patients have coordinated care following a behavioral health crisis.

Figure 6. **Follow-up after hospitalization for mental illness.** Percent of Medicaid enrollees, ages 6 and older, who received follow-up within 30 days of discharge from the hospital for mental illness, residents of Clark, Greene and Madison Counties, by race, 2019-2022 (n=1,317 in 2022)



Notes: (1) Follow-up was defined as any non-inpatient and non-ED claim(s) with a mental health diagnosis. Follow-ups are not limited to behavioral health service providers. (2) When two inpatient hospitalizations were less than seven days apart, they were collapsed as a single episode. (3) In cases where an individual had multiple inpatient hospitalizations during a year, only the last hospitalization was included. (4) Data for Other Race and Hispanic or Latino cannot be reported for hospitalizations due to small numbers.
Source: Ohio Department of Medicaid claims data. Analysis by the Ohio Department of Mental Health and Addiction Services; Bureau of Quality, Planning and Research.

Figure 7. **Follow-up after ED visit for mental illness.** Percent of Medicaid enrollees, ages 6 and older, who received follow-up within 30 days after an emergency department visit for mental illness, residents of Clark, Greene and Madison counties, by race, 2019-2022 (n=919 in 2022)



Notes: (1) Follow-up was defined as any non-inpatient and non-ED claim(s) with a mental health diagnosis. Follow-ups are not limited to behavioral health service providers. (2) When two inpatient hospitalizations were less than seven days apart, they were collapsed as a single episode. (3) In cases where an individual had multiple inpatient hospitalizations during a year, only the last hospitalization was included. (4) Data for Other Race and Hispanic or Latino cannot be reported for hospitalizations due to small numbers.
Source: Ohio Department of Medicaid claims data. Analysis by the Ohio Department of Mental Health and Addiction Services; Bureau of Quality, Planning and Research.

Goal 3. Ensure Black children, youth and families thrive in their home, school and community

- **Objective 3.1.** Reduce out-of-home placements*
- **Objective 3.2.** Reduce school suspensions and expulsions among K-12 students
- **Objective 3.3.** Increase connections to trusted adults among middle and high school students
- Add youth mental health objective in the future (see goal 5)

Figure 8. **Goal 3 equity SMART objectives**

Objective	Indicator	Data source	Baseline year	Baseline data	Target year	Target data
3.1	Number of Black and multi-racial children **in public children's services agency (PCSA) custody***	Ohio Department of Job and Family Services	2022	88	2025	75
3.2	Rate of **disciplinary occurrences** per 100 students among Black K-12 students (in school districts with at least 10% of enrolled students who are Black)	Ohio Department of Education	2021-2022		2028-2029	
	Springfield			44		21
	Fairborn			36		18
	Xenia			34		17
3.3	Percentage of middle and high school students who report there are "**a lot of adults** in the neighborhood (town, community) **to talk to about something important**: yes."	Ohio Healthy Youth Environments Survey (OHYES!)	2018-2019 SY	55%**	2025	60%

*MHRB's preference was to focus on out-of-home placements due to parental substance use disorder or mental health issues, but the numbers were too small to report in a consistent way. This broader indicator is therefore used for the SMART objective.
**This percentage is based on a small number of school districts (four districts in Madison County) and for all students (not specific to Black students) and should be revisited once a larger number of schools participate in the survey in the same school year.

Baseline data for goal 3

Figures 9-12 provide trend data on children services involvement, including data for objective 3.1. Figure 9 displays the number of children removed from the home each year due to parental substance use. Many of the numbers are not reported because they are too small (the Ohio Department of Job and Family Services does not report small numbers in order to protect family confidentiality). Figure 10 is broader and includes the number of children removed from the home for any reason. Figure 11 provides a cumulative look at the total number of children in the custody of the Public Children Service Agency (PCSA, e.g., the Clark County Family and Children Services); these numbers are larger because they include children who may have been removed from the home in an earlier year and remain in PCSA custody in the year reported.

Figure 9. **Children removed from the home due to parental substance use.** Number of children removed from the home due to parental substance use, Clark, Greene and Madison counties, by race, 2017-2022

	2017	2018	2019	2020	2021	2022
Total (all races)	61	42	56	29	29	34
White	48	25	40	20	23	20
Black/ African American	<10	<10	<10	<10	<10	<10
Multiracial	<10	10	10	<10	<10	12
Other	<10	<10	<10	<10	<10	<10

Source: Ohio Department of Job and Family Services (data request, April 2023)

Figure 10. **Children removed from the home for any reason.** Number of children removed from the home due to any reason, Clark, Greene and Madison counties, by race, 2017-2022

	2017	2018	2019	2020	2021	2022
Total (all races)	218	140	184	147	133	125
White	153	95	119	94	89	88
Black/ African American	<30	18	26	25	19	<15
Multiracial	29	<20	29	<25	<20	24
Other	<10	10	10	<10	<10	<10

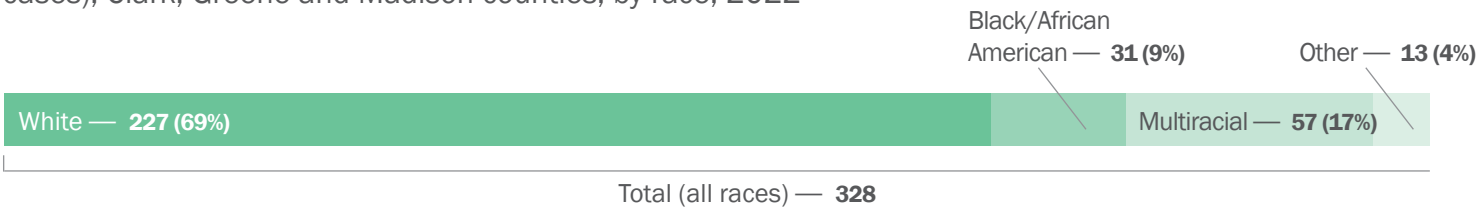
Source: Ohio Department of Job and Family Services (data request, April 2023)

Figure 11. **Children in PCSA custody.** Number of children in custody (any reason/all cases), Clark, Greene and Madison counties, by race, 2017-2022

	2017	2018	2019	2020	2021	2022
Total (all races)	466	407	411	366	344	328
White	323	276	268	231	229	227
Black/ African American	52	53	53	51	45	31
Multiracial	58	48	62	65	54	57
Other	33	30	28	19	16	13

Source: Ohio Department of Job and Family Services (data request, April 2023)

Figure 12. **PCSA custody, race percentages.** Percent of children in PCSA custody (any reason/all cases), Clark, Greene and Madison counties, by race, 2022



Source: Ohio Department of Job and Family Services (data request, April 2023)

Figures 13-15 provide data relevant to objective 3.2 (disciplinary occurrences). Figure 13 provides background information about the percentage of students who are Black in each public school district in the Board area. This information was used to prioritize three school districts for the disciplinary occurrence objective. Figure 14 displays discipline rate data for objective 3.2. Figure 15 provides a different way of looking at this information by comparing the percent of disciplinary incidents that were among Black students, compared to the percent of the overall student population that is Black.

It is important to note that child behavioral problems such as oppositional defiance, hyperactive behavior and aggression can stem from or be exacerbated by several factors including poverty, parental mental health status and their social environment.[1] The frequency of school disciplinary actions is one indicator of the prevalence of behavior challenges in schools. Disciplinary responses such as suspensions and expulsions, which can be harmful to students, may signal that schools are not properly equipped to effectively support positive behavior.[2]

Figure 13. **Percentage of K-12 students who are Black, 2021-2022 school year**

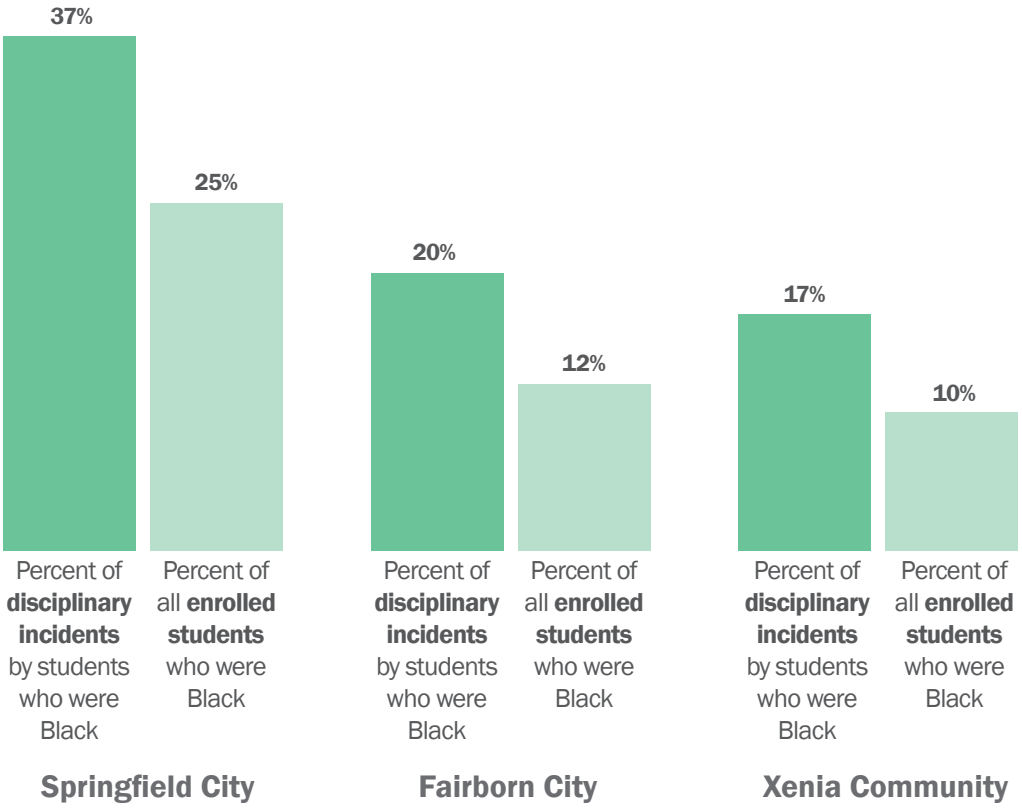
District Name	County	Percent of all enrolled students who were Black 2021-2022
Springfield City School District	Clark	25%
Fairborn City	Greene	12%
Xenia Community City	Greene	10%
Yellow Springs Exempted Village	Greene	7%
Beavercreek City	Greene	4%
Bellbrook-Sugarcreek Local	Greene	4%
Clark-Shawnee Local	Clark	4%
London City	Madison	4%
Northeastern Local	Clark	2%
Greenon Local	Clark	1%
Northwestern Local	Clark	1%
Madison-Plains Local	Madison	1%
Jonathan Alder Local	Madison	1%
Tecumseh Local	Clark	1%
Southeastern Local	Clark	*
Cedar Cliff Local	Greene	*
Greeneview Local	Greene	*
Jefferson Local	Madison	*

*Too small to report
Source: Ohio Department of Education

Figure 14. **Disciplinary incident rates.** Number of disciplinary incidents per 100 students, by race and school district, 2021-2022 school year

Source: Ohio Department of Education

Figure 15. **Disciplinary incident percentages.** Percent of disciplinary incidents by race and school district, 2021-2022 school year



Source: Ohio Department of Education

Goal 4. Strengthen behavioral health workforce diversity and equitable location of services

- **Objective 4.1.** Increase understanding of workforce diversity among MHRB-contracted provider staff
- **Objective 4.2.** Increase service opportunities in underserved areas

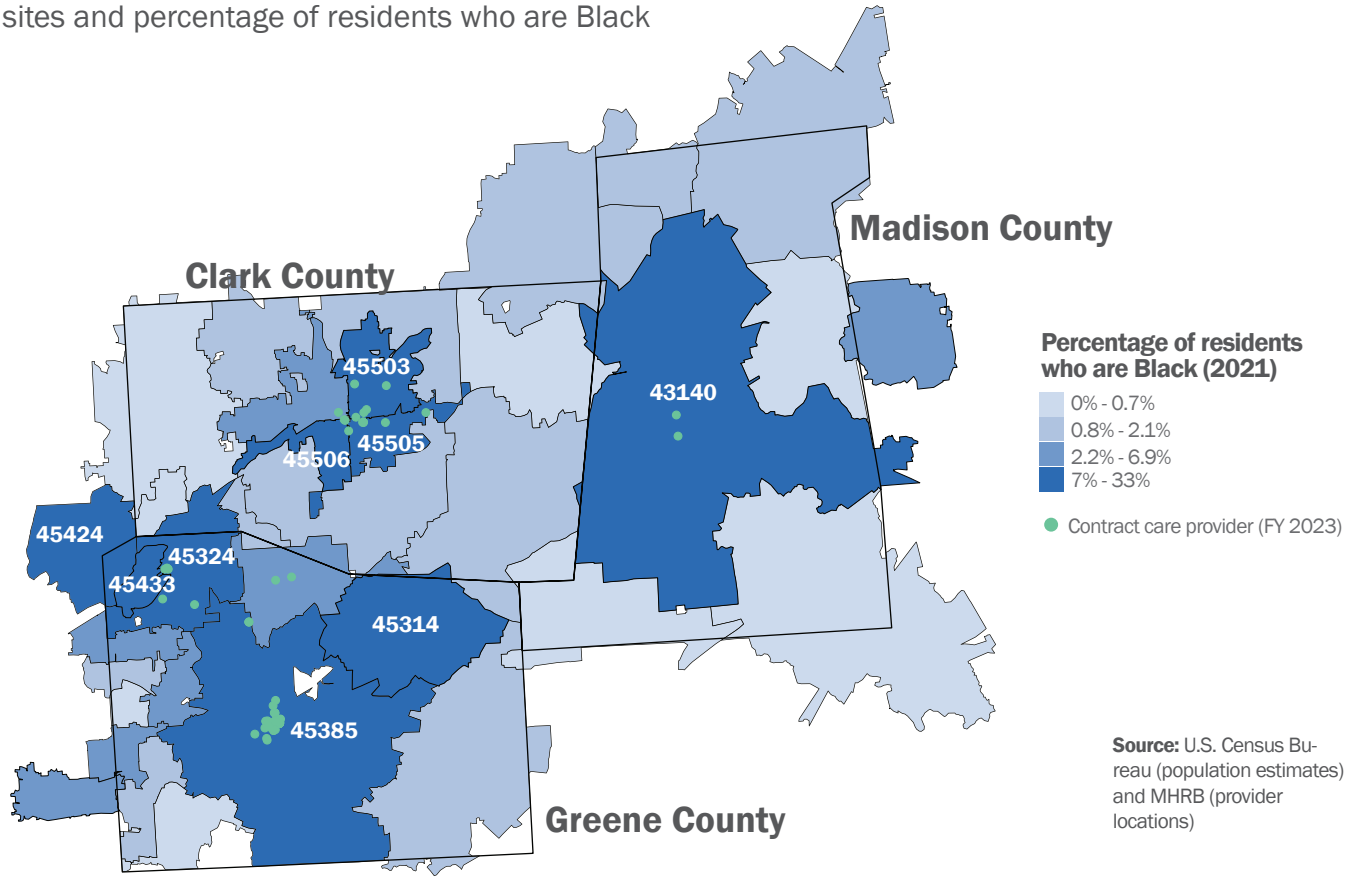
Figure 16. **Goal 4 equity SMART objectives**

Objective	Indicator	Data source	Baseline year	Baseline data	Target year	Target data
4.1	Percent of MHRB-contracted provider staff who complete the **Provider Staff Competency and Diversity Survey**	New survey to be developed by MHRB	2022	0%	State Fiscal Year (SFY) 2024 (Q1 for largest 3 providers; Q3 for remaining providers)	85%
4.2	Number of **service opportunities located in under-served areas** Service opportunities may include a new site or satellite location of a Board-contracted provider, a mobile service, or extension of another provider. Underserved areas include the 45314 and 45433 zip codes, or other outlying areas without a provider site, as shown in figure 17.	MHRB list of provider locations and U.S. Census Bureau population data	2023	0	SFY 2027	2

Baseline data for goal 4

Figure 17 displays data for objective 4.2 (provider locations). This map displays the percentage of the population that is Black within each zip code in the Board area, with dark blue indicating a higher proportion of Black residents compared to other zip codes. The map also indicates the location of MHRB-funded behavioral health providers with green dots. Taken together, this information indicates that the 45314 and 45433 zip codes would benefit from additional provider sites to improve access to care for Black residents.

Figure 17. **Behavioral health provider locations.** Location of MHRB-funded behavioral health provider sites and percentage of residents who are Black



Source: U.S. Census Bureau (population estimates) and MHRB (provider locations)

Goal 5. Build capacity to collect actionable equity data in the future

- **Objective 5.1.** Increase ability to monitor youth well-being (disaggregated by race) through coordinated collection of school-based surveys
- **Objective 5.2.** Increase ability to monitor client satisfaction (disaggregated by race) among community members served by MHRB-contracted mental health and substance use disorder treatment and recovery providers through coordinated collection of a standardized client survey
- **Objective 5.3.** Increase ability to monitor crisis service quality (disaggregated by race)
- **Objective 5.4.** Increase ability to assess provider capacity to effectively address Adverse Childhood Experiences (ACEs) through a provider survey

Figure 18. **Goal 5 equity SMART objectives**

Objective	Indicator	Data source	Baseline year	Baseline data	Target year	Target data
5.1	Percentage of middle and high schools that have administered the **OHYES!* survey** (on a coordinated schedule)	MHRB, Educational Service Centers (ESCs) and/or OhioMHAS	2022-2023	21% (8 of 39)	2024-2025	51% (20 of 39)
5.2	Percentage of MHRB-contracted mental health and substance use disorder treatment and recovery providers administering an MHRB-approved, standardized **client survey** (with ability to disaggregate data by race)	MHRB	2022	0%	2024	50%
5.3	Existence of a data collection and reporting system to track **crisis service quality** among Board-contracted providers*** (with ability to disaggregate data by race)	MHRB	2022	0	2025	1
5.4	Percent of MHRB-contracted provider staff who complete an MHRB **survey about ACEs** (awareness of ACEs, ability to address ACEs, training needs, and gaps in trauma-informed care, including a focus on addressing ACEs among Black clients)	New survey to be developed by MHRB (to be administered at same time as the Competency and Diversity survey described in objective 4.1)	2022	0%	SFY 2024 (Q1 for largest 3 providers; Q3 for remaining providers)	85%

*Or other standardized, commonly agreed-up survey used by all districts within the county (e.g. all districts within Clark County use the YRBS or all districts in Madison County use the OHYES!). OHYES! Is preferred because it includes the question about trusted adults and other protective factors. Note that several schools in Clark County participated in the YRBS in the 2021-2022 school year, which is planned to be repeated every other year.

** Crisis quality metrics[3], such as:

- Percent of crisis calls that are resolved without having to dispatch police
- Percent of individuals who receive crisis follow-up care within 48 hours
- Other metrics, as needed

Crosswalk: Equity SMART objectives and Community Assessment and Plan (CAP) SMART objectives

✓ Direct alignment

Related

Equity SMART objectives	CAP SMART objectives								
	Prevention	MH treatment	SUD treatment	MAT	Crisis services	Harm reduction	Recovery supports	Pregnant women with SUD	Parents with SUD
ED encounters (1.1-1.4)									
OD and suicide deaths (1.5)									
Hospitalization follow up (2.1-2.2)									
Out-of-home placements (3.1)									
Disciplinary actions (3.2)									
Trusted adults (3.3)	✓								
Workforce diversity (4.1)									
Geographic equity (4.2)									
School surveys (5.1)									
Client satisfaction (5.2)									
Crisis quality (5.3)									
ACEs (5.4)									

Logic models

The following logic models describe the plan of action to achieve the goals described above, focusing on five specific SMART objectives. MHRB will develop similar logic models for the other SMART objectives in the future.

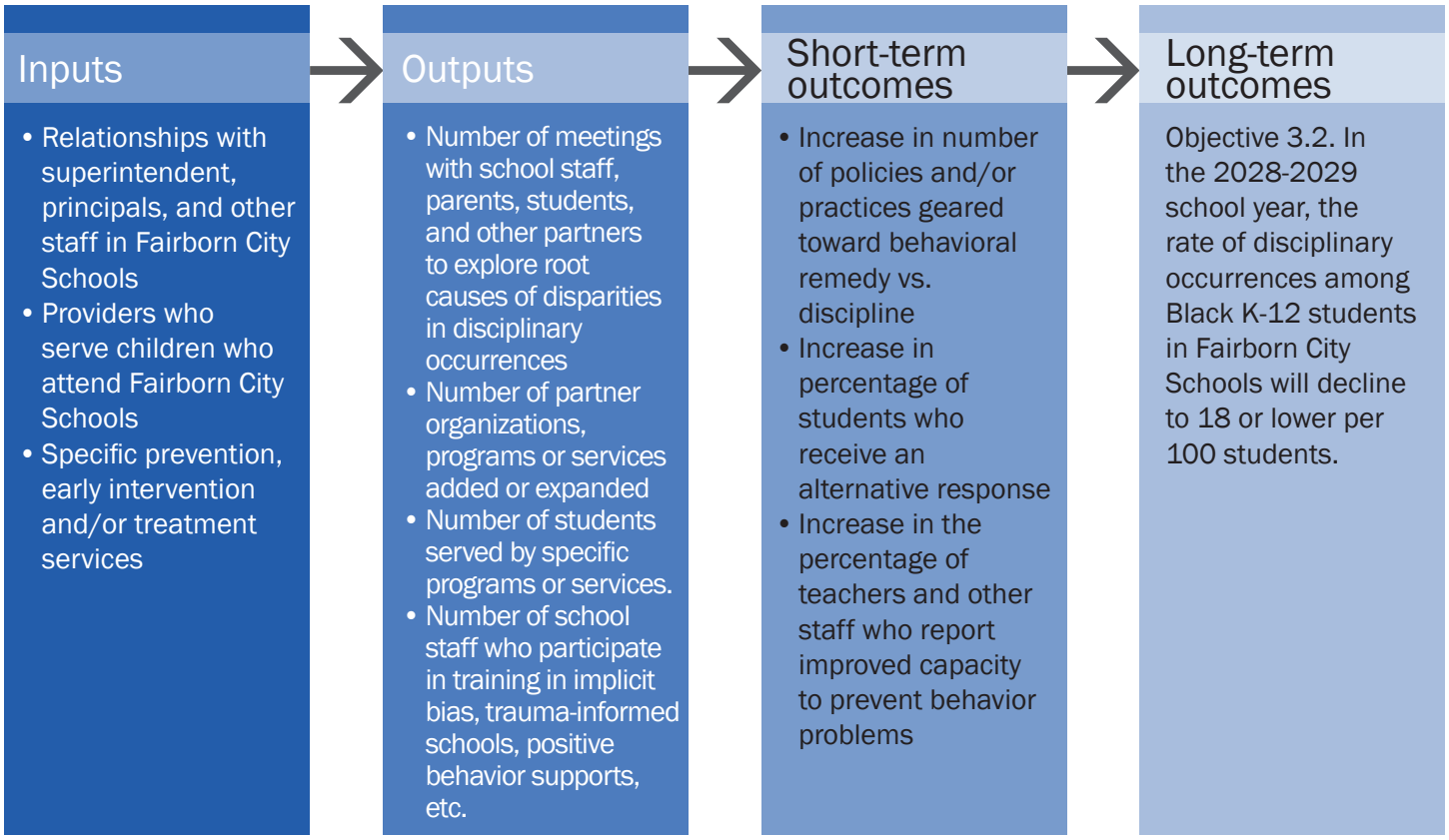
Logic model for objective 1.1. Reduce youth suicide attempts, as measured by emergency department (ED) encounters

Inputs	Outputs	Short-term outcomes	Long-term outcomes
• Youth-led prevention opportunities (Prevention professionals learning community training, etc.) • Providers of youth-led prevention	• Youth-led prevention capacity assessment completed in each county (to assess training, funding, etc.) • Number of organizations partnering to increase youth-led prevention	• Increase the number of youth-led prevention providers to at least 1 per county • Increase the number of young people involved in youth-led activities • Increase the number of youth who can identify positive adult allies and peer relationships	Objective 1.1. In 2025, the number of hospital ED encounters for suspected suicide attempts among Black youth ages 17 and younger will decline to no more than 13.

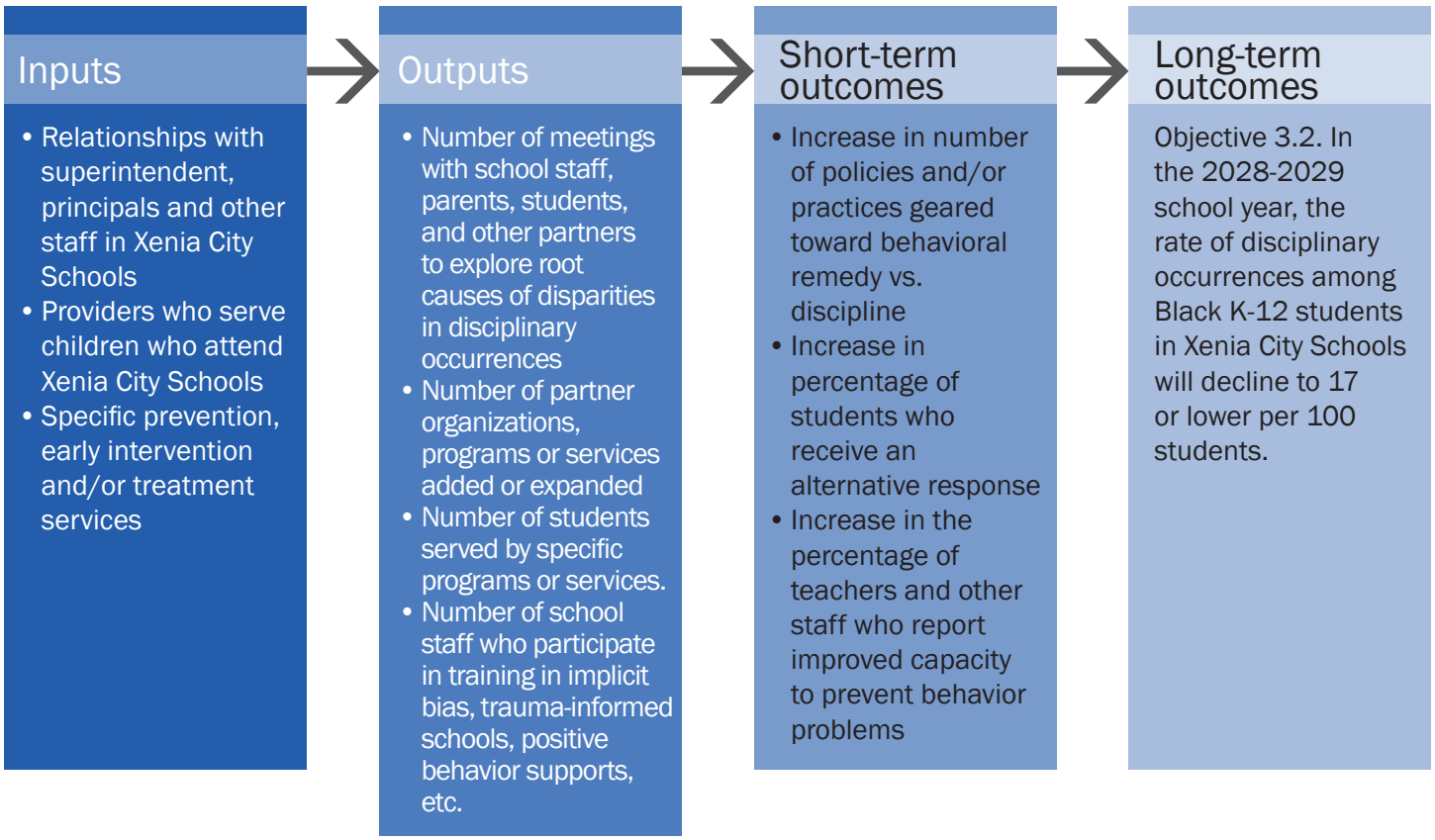
Logic model for objective 3.2. Reduce school suspensions and expulsions among K-12 students: Springfield

Inputs	Outputs	Short-term outcomes	Long-term outcomes
• Relationships with superintendent, principals, and other staff in Springfield City Schools • Providers who serve children who attend Springfield City Schools • Specific prevention, early intervention and/or treatment services	• Number of meetings with school staff, parents, students, and other partners to explore root causes of disparities in disciplinary occurrences • Number of partner organizations, programs or services added or expanded • Number of students served by specific programs or services • Number of school staff who participate in training in implicit bias, trauma-informed schools, positive behavior supports, etc.	• Increase in number of policies and/or practices geared toward behavioral remedy vs. discipline • Increase in percentage of students who receive an alternative response • Increase in the percentage of teachers and other staff who report improved capacity to prevent behavior problems	Objective 3.2. In the 2028-2029 school year, the rate of disciplinary occurrences among Black K-12 students in Springfield City Schools will decline to 21 or lower per 100 students.

Logic model for objective 3.2. Reduce school suspensions and expulsions among K-12 students: Fairborn



Logic model for objective 3.2. Reduce school suspensions and expulsions among K-12 students: Xenia



Logic model for objective 3.3. Increase connections to trusted adults among middle and high school students

Inputs

- Organizations that serve youth and families, including those that provide parent education, parent support groups, mentoring programs, family peer support, and other services
- Evidence-based programs (curricula, training, funding, etc.):
  - Parenting education
  - Youth mentoring
  - Family peer support programs
- Relationships with Black community members and parents and input on how to tailor the above programs to meet the needs of Black families
- Adaptations of existing parent education or other programs that incorporate greater creativity and flexibility

Outputs

- Number of programs serving Black families:
  - Parenting education
  - Youth mentoring
  - Family peer support programs
  - Family peer support
- Number of Black parents who participate in a parenting education program
- Number of Black youth who participate in a youth mentoring program
- Number of Black families who participate in a family peer mentoring program

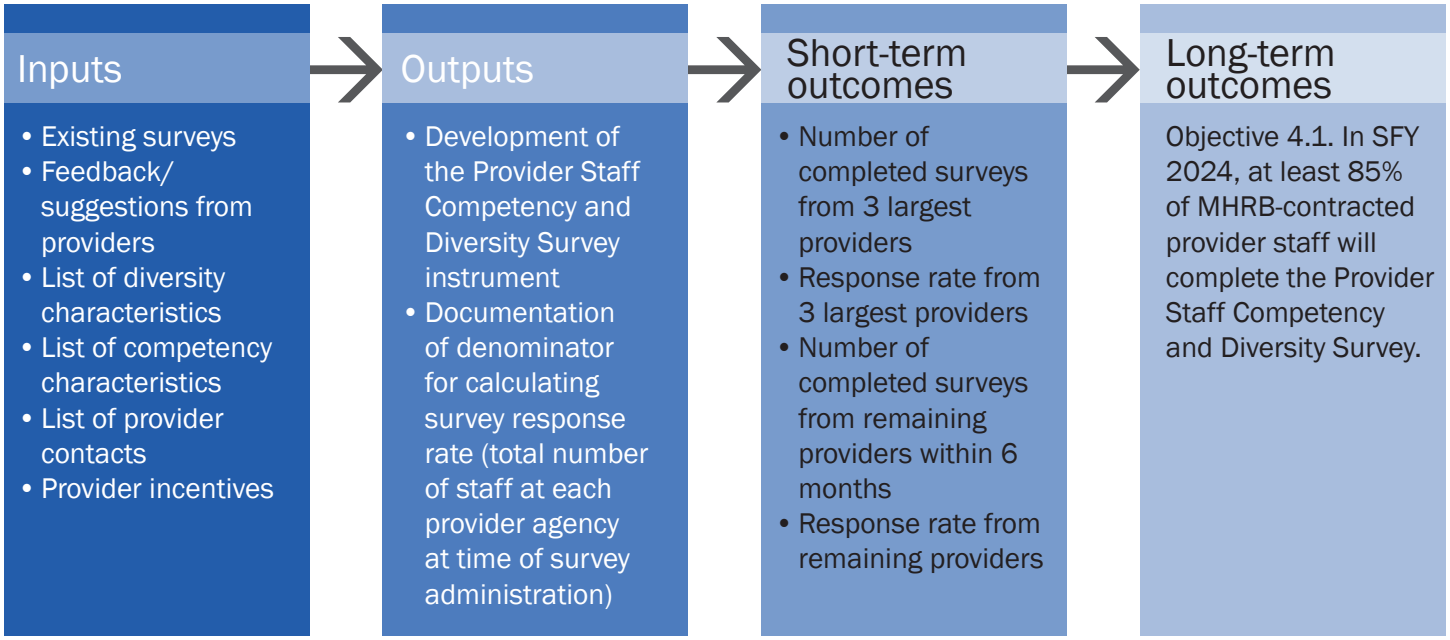
Short-term outcomes

- Improved parenting skills among parents of adolescents
- Improved relationships between parents (and other caregivers/family members) and their adolescent children (including increased communication and family time)
- Increased opportunities for adolescents to build relationships with adults beyond their family

Long-term outcomes

Objective 3.3. In 2025, at least 60% of Black middle and high school students will report there are "a lot of adults in the neighborhood (town, community) to talk to about something important."

Logic model for objective 4.1. Increase available information about workforce diversity among MHRB-contracted provider staff

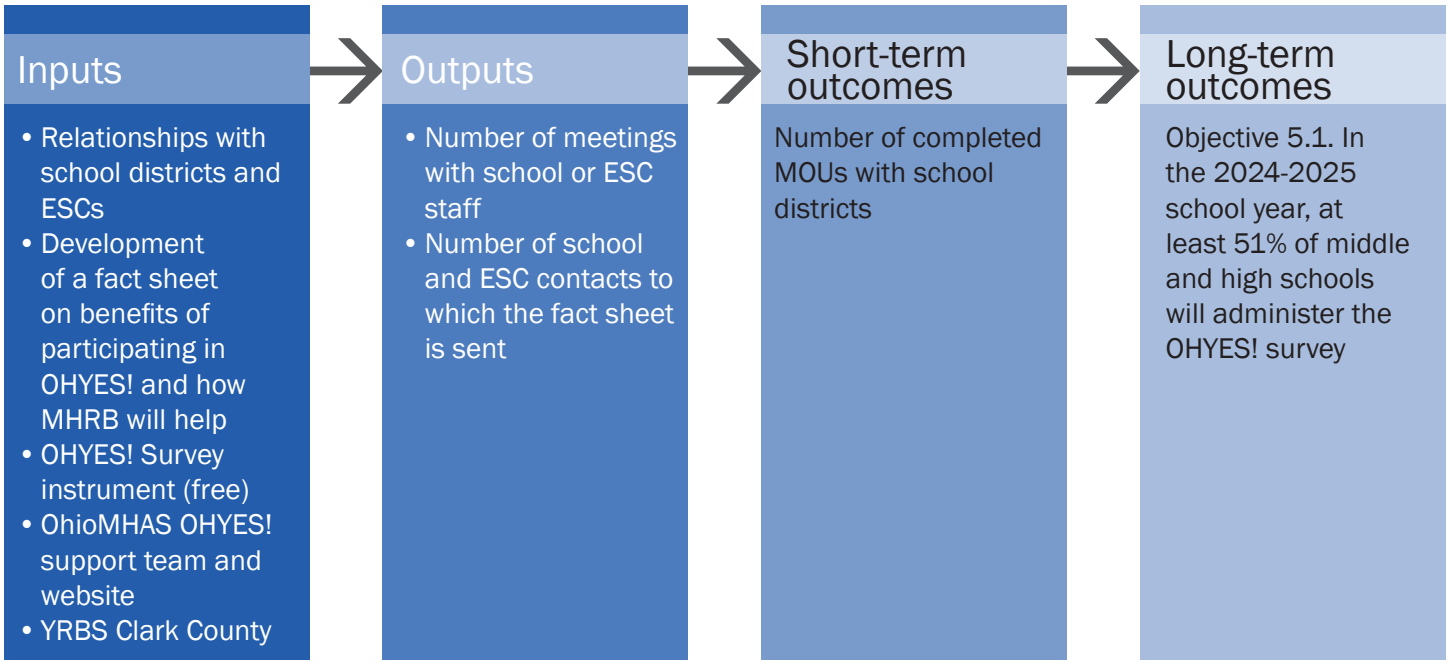


Notes on next steps for increasing workforce diversity

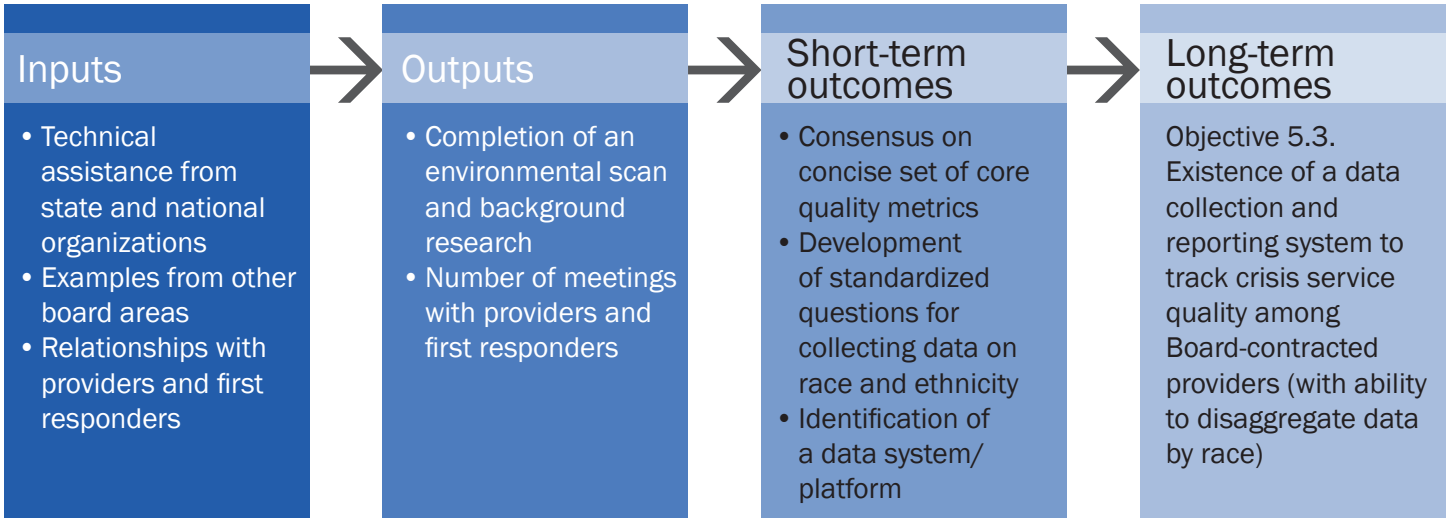
MHRB will use the results of the Provider Staff Competency and Diversity Survey to develop a Behavioral Health Equity (BHE) Workforce Development Plan, which may include:

- Establishment and recruitment for a BHE Regional Advisory Council
- Facilitation of quarterly meetings of the BHE Regional Advisory Council
- Earmarking of funds to support BHE initiatives
- Identification of BHE competency trainers
- Facilitation of monthly lunch and learns focused on BHE workforce development
- Creation of a behavioral health tech program at the high school level

Logic model for objective 5.1. Increase ability to monitor youth wellbeing (disaggregated by race) through coordinated collection of school-based surveys



Logic model for objective 5.3. Increase ability to monitor crisis service quality (disaggregated by race)



Appendix A
Data collection plan

Objective(s)	Indicator(s)	Data source	Frequency	Instructions
1.1, 1.2	• Number and rate of hospital ED encounters for suspected suicide attempts, per 10,000 ED encounters, among Black youth ages 17 and younger • Number and rate of hospital ED encounters for suspected overdose, per overall ED volume, among Black youth ages 17 and younger	Dayton Children's Hospital (DCH) and Mercy Health System	Annual updates, starting with 2023 data to be requested in 2024	• Send the HPIO data request* and the Excel* with the 2018-2022 data to hospital contact and ask them to update the data for 2023 • To update the rates in the data graphics, replicate the HPIO process to calculate the updated annual rates
1.3, 1.4	• Number and rate of hospital ED encounters for suspected suicide attempts, per 10,000 ED encounters, among Black adults ages 18 and older • Number and rate of hospital ED encounters for suspected overdose, per 10,000 ED encounters, among Black adults ages 18 and older	Mercy Health System	Annual updates, starting with 2023 data to be requested in 2024	• Send the HPIO data request* and the Excel* with the 2019-2022 data to hospital contact and ask them to update the data for 2023 • To update the rates in the data graphics, replicate the HPIO process to calculate the updated annual rates
1.5	Number and rate of drug overdose and suicide deaths per 100,000 population (crude rate) among Black residents (all ages)	Ohio Department of Health: **Public Health Data Warehouse, Mortality data** (Note that ODH plans to transition this data set to **DataOhio** in the future). This data could also be obtained directly from each county health department.	Annual updates, starting with 2022 (Note that death data is considered "preliminary" by ODH for over a year. Coroners have up to 6 months to finalize a cause of death, so waiting at least 6 months into the new year is recommended. Using preliminary data is acceptable, as long as you label it as such.)	• Use HPIO instructions* to obtain data about overdose and suicide deaths from ODH, disaggregated by race • To update the rates for the data graphic, calculate the combined rate (refer to HPIO Excel file* to replicate)
2.1, 2.2	• Percentage of Black Medicaid enrollees, ages 6 and older, who received follow-up within 30 days after discharge from the hospital for mental illness • Percentage of Black Medicaid enrollees, ages 6 and older, who received follow-up within 30 days after an emergency department visit for mental illness	Ohio Department of Medicaid via OhioMHAS (HEDIS metric)	Annual updates, starting with 2023	• Use the **OhioMHAS online data request form** to request updated annual data • Refer to the HPIO data ask for supplement* for specifications

*The HPIO data request instruction materials are saved in this DropBox folder: **https://www.dropbox.com/request/J6CHVSWk77LoT2CPg0VW**

Data collection plan (continued)

Objective(s)	Indicator(s)	Data source	Frequency	Instructions
3.1	Number of Black and multi-racial children in public children's services agency (PCSA) custody	Ohio Department of Job and Family Services (Note that this data could also be obtained directly from each county children services agency.)	Annual updates, starting with 2023	• Use the online **ODJFS data request form** to ask for updated annual data • Refer to the HPIO data request supplement* for specifications • See also: **https://www.pcsao.org/factbook**
3.2	Rate of disciplinary occurrences per 100 students among Black K-12 students (in Springfield, Fairborn and Xenia city schools)	Ohio Department of Education	Annual updates, starting with the 2022-2023 school year	• Submit data request to ODE • Refer to HPIO data request supplement* for specifications
3.3	Percentage of middle and high school students who report there are "a lot of adults in the neighborhood (town, community) to talk to about something important: yes."	OHYES! survey and Clark County YRBS supplement	Annual updates, starting with the 2023-2024 school year	• Ask for lead entities (schools, ESC, health department or OhioMHAS) to report responses to this survey question disaggregated by race in a way that provides percentage of Black students who reported "yes" to this question. • Ask them to provide the numerator (number of Black students who said "yes") and the denominator (number of Black students who responded to that question). • Using the numerator and denominator from each school or county, add them together to calculate an overall rate for the Board area.
4.1	Percent of MHRB-contracted provider staff who complete the Provider Staff Competency and Diversity Survey	MHRB	Annual updates, starting in 2023	Calculate the percentage using: • Numerator= number of MHRB-contracted staff who completed the survey • Denominator= total number of staff at MHRB-contracted providers
4.2	Number of service opportunities located in under-served areas (Service opportunities may include a new site or satellite location of a board-contracted provider, a mobile service, or extension of another provider. Underserved areas include the 45314 and 45433 zip codes, or other outlying areas without a provider site, as shown in figure 15.)	MHRB	Annual updates, starting in 2024	Count any additional service opportunities added in 45314 and 45433 zip codes, or other outlying areas without a provider site, as shown in figure 17

*The HPIO data request instruction materials are saved in this DropBox folder: **https://www.dropbox.com/request/J6CHVSWk77LoT2CPg0VW**

Data collection plan (continued)

Objective(s)	Indicator(s)	Data source	Frequency	Instructions
5.1	Percentage of middle and high schools that have administered the OHYES! (or YRBS) survey	MHRB, ESCs and/or OhioMHAS	Annual updates, starting with 2023-2024 school year	• Ask each ESC (or other partners) to report which school districts participated during the school year. Calculate the percentage using: • Numerator= number of middle and high schools that administered the survey • 39= denominator (total number of public middle and high schools in the Board area)
5.2	Percentage of MHRB-contracted mental health and substance use disorder treatment and recovery providers administering an MHRB-approved, standardized client survey (with ability to disaggregate data by race)	MHRB	Annual updates, starting in 2023	Calculate the percentage using: • Numerator= number of MHRB-contracted providers that administer the survey • Denominator= total number of MHRB-contracted providers
5.3	Existence of a data collection and reporting system to track crisis service quality among Board-contracted providers (with ability to disaggregate data by race)	MHRB	2025	Document that this data system exists and produces data that can be disaggregated by race
5.4	Percent of MHRB-contracted provider staff who complete an MHRB survey about ACEs (awareness of ACEs, ability to address ACEs, training needs, and gaps in trauma-informed care, including a focus on addressing ACEs among Black clients)	MHRB	Annual updates, starting in 2023	Calculate the percentage using: • Numerator= number of MHRB-contracted staff who completed the survey • Denominator= total number of staff at MHRB-contracted providers

*The HPIO data request instruction materials are saved in this DropBox folder: **https://www.dropbox.com/request/J6CHVSWk77LoT2CPg0VW**

Appendix B
Continuous quality improvement (CQI) plan

Timeline

MHRB will monitor the SMART objectives on an annual basis and logic models on a quarterly basis using the following timeline:

Time period	Deadline	CQI tasks
2023 Q4 (Oct, Nov, Dec)	1/31/24	• Report quarterly progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Celebrate wins and identify lessons learned • Identify action steps and staff responsible for any needed improvements
2024 Q1 (Jan, Feb, March)	4/30/24	• Report quarterly progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Review follow-up from previous quarter CQI action steps • Celebrate wins and identify lessons learned • Identify CQI action steps and staff responsible for any needed improvements
Annual	4/30/24	• Submit data requests for 2023 data from agencies specified in the data collection plan (see Appendix A)
2024 Q2 (April, May, June)	7/31/24	• Report quarterly progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Review follow-up from previous quarter CQI action steps • Celebrate wins and identify lessons learned • Identify CQI action steps and staff responsible for any needed improvements
Annual	7/31/24	• Continue to follow up, as needed, on requests for 2023 data from agencies specified in the data collection plan (see Appendix A)
2024 Q3 (July, Aug, Sept)	10/31/24	• Report quarterly progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Review follow-up from previous quarter CQI action steps • Celebrate wins and identify lessons learned • Identify CQI action steps and staff responsible for any needed improvements
2024 Q4 (Oct, Nov, Dec)	1/31/25	• Report quarterly progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Review follow-up from previous quarter CQI action steps • Celebrate wins and identify lessons learned • Identify CQI action steps and staff responsible for any needed improvements
2024 annual	1/31/25	• Summarize annual progress on outputs and short-term outcomes (completed, on track, off track/no activity) • Celebrate wins and identify lessons learned • Identify CQI action steps and staff responsible for any needed improvements • Report updated actual data values for all SMART objectives (annual performance on long-term objectives)

Continue annual and quarterly pattern

Staffing

MHRB will assign staff to take responsibility for documenting progress on the logic models and for requesting and compiling data:

Objective	Activities and partnerships (see logic models for details)	Staff responsible
1.2. Reduce youth suicide attempts, as measured by emergency department (ED) encounters	Youth-led prevention	*
3.2 Reduce school suspensions and expulsions among K-12 students	School district policies and procedures, and school-based early intervention, and treatment services in Springfield, Xenia and Fairborn	*
3.3 Increase connections to trusted adults among middle and high school students	Parent education, parent support groups, mentoring programs, and family peer support	*
4.1 Increase available information about workforce diversity among MHRB-contracted provider staff	Provider Staff Competency and Diversity Survey and development of a Behavioral Health Equity (BHE) Workforce Development Plan	*
5.4 Increase ability to monitor youth well-being (disaggregated by race) through coordinated collection of school-based surveys	School districts and ESCs	*
5.3 Increase ability to monitor crisis service quality (disaggregated by race)	Working with crisis service providers to develop core quality metrics and a data collection system	*

*MHRB will assign staff

Transparency and accountability

MHRB will engage representatives of Black communities to inform the inputs and outputs described in the logic models above. MHRB will primarily do this through quarterly meetings of the Regional Advisory Group. MHRB is continuing outreach to ensure representation from Black community members in this group.

MHRB will prepare an annual report to share progress on the SMART objectives with key audiences, including the Board, Regional Advisory Group, Black communities, contracted providers and the general public. The annual reports will be posted on the MHRB website, and MHRB will disseminate it through mass emails to key partners and other methods.

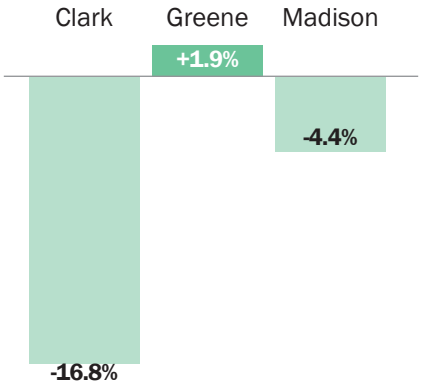
MHRB will also include information about progress toward the SMART objectives in their annual report.

Appendix C
Background data

Demographics

Figure 19 provides a projection of the size of the overall population in the three MHRB counties from 2020 to 2050. The population size of Clark and Madison counties are projected to decline, while Greene County is projected to grow somewhat. The overall projected population decline for the Board area should be taken into consideration when reviewing long-term trends and setting long-term goals. For example, if the number of suicide deaths declined over a ten year period and the number of residents also declined over that time period, it could falsely appear as if progress was being made to reduce suicide if only the number was considered. For long-term trends, it is therefore helpful to analyze changes in the suicide rate (per 100,000 population) to determine if outcomes are getting better or worse.

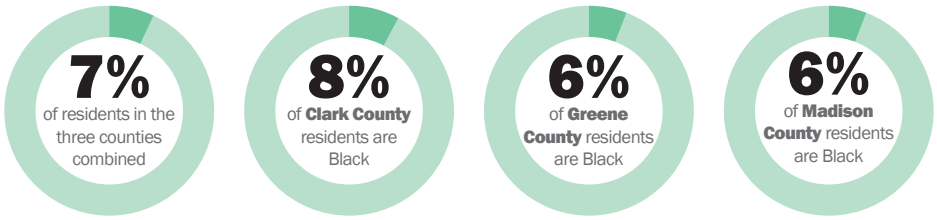
Figure 19. **Projected population change.** Projected change in the number of residents, by county, from 2020 to 2050



Source: Ohio Department of Development

Figure 20 displays the percentage of the population that is Black in the MHRB counties. Overall, an estimated 7% of Board area residents were Black in 2021. Clark County has the largest share of Black residents (8%).

Figure 20. **Percentage of population that is Black, 2021**



Source: 2021 American Community Survey (U.S. Census Bureau) 5-year estimates

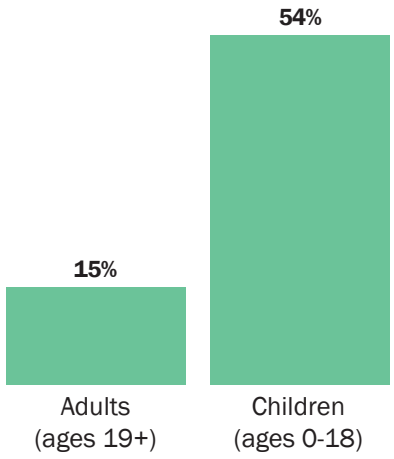
Medicaid enrollment

Figures 21 and 22 provide background information about Medicaid enrollment that is helpful for interpreting the data in figures 6 and 7, which display hospitalization follow-up rates for Medicaid enrollees only. As shown in figure 21, about half of all children in the MHRB counties are enrolled in Medicaid (54%). Medicaid enrollment for adults is much lower, at 15%.

Data on Medicaid enrollment by race within the MHRB counties is not available. However, data for Ohio overall provides information about Medicaid enrollment among Black residents that may be similar in the MHRB counties (figure 22).

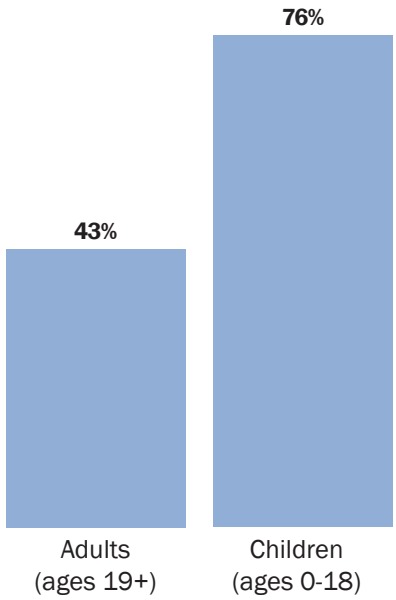
Overall, this data indicates that children (and likely Black children in particular) are better represented in Medicaid data than are adults. The hospitalization follow-up data (figures 6-7 for objectives 2.1 and 2.2) is therefore potentially more meaningful for understanding quality of care for children than for adults. The hospitalization follow-up data is only reported for ages 6 and up, rather than by age group. This is an important limitation, and more work is needed to encourage the Ohio Department of Medicaid, Ohio Department of Mental Health and Addiction Services and local behavioral health providers to report data on behavioral health quality disaggregated by race and age group.

Figure 21. **Medicaid enrollment in MHRB counties.** Estimated percentage of Clark, Greene and Madison County residents enrolled in Medicaid, by age, 2021



Source: 2021 Ohio Medicaid Assessment Survey

Figure 22. **Medicaid enrollment in Ohio.** Estimated percentage of Black Ohio residents enrolled in Medicaid, by age, 2021



Source: 2021 Ohio Medicaid Assessment Survey

Greene County

Greene County Public Health over-sampled Black residents for a household survey conducted for their 2022 Community Health Assessment. (Over-sampling is a data collection strategy to ensure a large enough number of respondents to allow for data disaggregation.) Selected results related to mental health are reported in figure 23. This data was not used in the SMART objectives because it is only available for Greene County. Efforts to over-sample Black respondents in future surveys in all three counties would provide valuable data that could be used in future assessment and planning efforts.

Figure 23. **Mental health findings from the Greene County Community Health Assessment Survey, by race, 2022**

	African American	White
During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?: Yes	12.5%	12.5%
Are you limited in any way in any activities because of physical, mental or emotional problems?: Yes	35.9%	29.3%
What major impairments or health problems limit your activities? Yes to mental health illness/ disorder (among those with major impairments)	8.3%	9.3%

Source: Greene County Public Health Community Health Assessment

Notes

1. Zhang, Han, Zu Xuan Lee, Tonya White, and Anqi Qiu. “Parental and Social Factors in Relation to Child Psychopathology, Behavior, and Cognitive Function.” Translational Psychiatry 10, no. 1 (February 26, 2020): 1–9. https://doi. org/10.1038/s41398-020-0761-6. 25.
2. LiCalsi, Christina, David Osher, and Paul Bailey. “An Empirical Examination of the Effects of Suspension and Suspension Severity on Behavioral and Academic Outcomes.” American Institutes for Research, August 2021. https:// www.air.org/sites/default/files/2021-08/ NYC-Suspension-Effects-Behavioral-AcademicOutcomes-August-2021.pdf.
3. Roadmap to the Ideal Crisis System, Group for the Advancement of Psychiatry, March 2021.