

**Ohio Department of Mental Health and Addiction Services (OhioMHAS)  
2026-2028 Community Assessment and Plan (CAP) Template:**

# PLAN

## Overview

This is the second of three sections in the Community Assessment and Plan (CAP) Template. The Plan section of the CAP Template will serve as the Board’s 2026-2028 Community Plan and is designed to be completed by ADAMH Boards and returned to OhioMHAS every three years.

## Template

<b>Board name</b>	Stark County Mental Health and Addiction Recovery
<b>Date</b>	January 20, 2026

## Key

<b>*</b>	Question that all Boards are required to answer
<b>Optional</b>	Question that Boards may choose to answer, but are not required to answer

1. **\*Board Type & Counties.** Please describe how your CAP applies to the area served by your Board:

- Our Board serves one county.**
- Our Board serves more than one county, and our Plan covers all counties together.

**\*Continuum of Care Priority Strategies**

Use the findings from the Assessment section of the CAP to guide selection of a set of priority strategies for your Plan. Briefly describe your community’s priority strategies, priority populations, priority outcomes, and capital funding needs using Table 2a below.

Each Board is required to identify ten priority strategies: seven that are specific to each aspect of the continuum of care (i.e., prevention, mental health treatment, substance use disorder [SUD] treatment, Medication-Assisted Treatment [MAT], crisis services, recovery supports, and criminal justice) and three that are specific to the required special populations (i.e., pregnant women with SUD, parents with SUD with dependent children, and youth). For each of these priority strategies, identify the targeted age group(s), priority population(s), outcome indicator(s), and if there will be capital funding needs. See Table 2a below for additional instructions and an example.

**\*Table 2a: Continuum of Care Priority Strategies [Required]**

Continuum of Care	Priority Strategy	Age Group	Priority Populations and Groups Experiencing Disparities	Outcome Indicator	Capital Funding Needs [Yes/No]
<p><b><i>Instructions: Identify a priority strategy for each of the seven aspects of the continuum of care and for each of the three special populations listed. For each strategy, check the age group(s) and priority population(s) that the strategy is designed to reach. For each strategy, select at least one outcome indicator that will be reported on annually, and identify if any capital funding will be needed to implement the strategy.</i></b></p>					
<p><b>Continuum of Care</b></p>	<p><i>Briefly indicate the service, program, or policy change you will implement.</i></p>	<p><i>Indicate which age group(s) the strategy will be designed to reach (choose all that apply):</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Children (ages 0-12)</li> <li><input type="checkbox"/> Adolescents (ages 13-17)</li> <li><input type="checkbox"/> Transition-aged adults (ages 18-24)</li> <li><input type="checkbox"/> Adults (ages 18-64)</li> <li><input type="checkbox"/> Older adults (ages 65+)</li> </ul>	<p><i>Indicate which group(s) the strategy will be designed to reach (choose all that apply):</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> People with low incomes or low educational attainment</li> <li><input type="checkbox"/> People with a disability</li> <li><input type="checkbox"/> Residents of rural areas</li> <li><input type="checkbox"/> Residents of Appalachian areas</li> <li><input type="checkbox"/> Black residents</li> <li><input type="checkbox"/> Hispanic residents</li> <li><input type="checkbox"/> White residents</li> <li><input type="checkbox"/> Other racial/ ethnic group (specify: ____)</li> <li><input type="checkbox"/> Youth (ages 17 and under)</li> <li><input type="checkbox"/> Transition-aged adults (ages 18-24)</li> <li><input type="checkbox"/> Older adults (ages 65+)</li> <li><input type="checkbox"/> Veterans</li> <li><input type="checkbox"/> Men</li> <li><input type="checkbox"/> Women</li> <li><input type="checkbox"/> Lesbian/Gay/Bisexual</li> </ul>	<p><i>Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.</i></p> <p><i>All indicators must be measurable, specific, and have a data source. All indicators must reflect outcomes that are relevant to the selected strategy and age group.</i></p> <p><i>If data are available, the indicator should be disaggregated for the selected priority population(s) and group(s) experiencing disparities.</i></p>	<p><i>Please identify if any capital funding will be needed to successfully implement the strategy.</i></p>

			<input type="checkbox"/> Immigrants, refugees, or English language learners <input type="checkbox"/> Pregnant women with SUD <input type="checkbox"/> Parents with SUD with dependent children <input type="checkbox"/> People who use injection drugs (IDUs) <input type="checkbox"/> People involved in the criminal justice system <input type="checkbox"/> Other, specify: _____	See the standardized indicator list for suggested outcome indicators.	
<b>Example: Prevention</b>	Universal school-based suicide awareness and education program in four school districts.	✓ Adolescents (ages 13-17)	✓ Residents of rural areas	Percent of participating students who report learning how to recognize suicide warning signs and how to take action.	No
<b>Prevention</b>	Selective and indicated behavioral health prevention programming across the county.	<input checked="" type="checkbox"/> Children (ages 0-12) <input checked="" type="checkbox"/> Adolescents (ages 13-17) <input checked="" type="checkbox"/> Transition-aged youth (14-25)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents <input checked="" type="checkbox"/> Youth (ages 17 and under) <input checked="" type="checkbox"/> Immigrants, refugees or English language learners <input checked="" type="checkbox"/> People involved in the criminal justice system	Percent of youth who demonstrate an improvement in ability to develop healthy interpersonal skills.  Percent of youth who maintain substance use abstinence, reduce substance use, or experience a reduction in suicide risk behaviors (program type dependent).	No
<b>Mental health treatment</b>	Access and Workforce initiatives	<input checked="" type="checkbox"/> Children (ages 0-12) <input checked="" type="checkbox"/> Adolescents (ages 13-17) <input checked="" type="checkbox"/> Transition-aged youth (14-25) <input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents	Percentage of individuals who were seen for a DA with same day access (0 days wait time).  Percentage of individuals who were	No

			<input checked="" type="checkbox"/> Youth (ages 17 and under) <input checked="" type="checkbox"/> People involved in the criminal justice system	<p>seen for their 1st session after DA within 10 working days.</p> <p>Ratio of population to mental health providers.</p>	
<b>Substance use disorder treatment</b>	Access and Workforce initiatives	<input checked="" type="checkbox"/> Adolescents (ages 13-17) <input checked="" type="checkbox"/> Transition-aged youth (14-25) <input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents <input checked="" type="checkbox"/> Youth (ages 17 and under) <input checked="" type="checkbox"/> People involved in the criminal justice system	<p>Percentage of individuals who were seen for a DA with same day access (0 days wait time).</p> <p>Percentage of individuals who were seen for their 1<sup>st</sup> session after DA within 10 working days.</p> <p>Ratio of population to mental health providers.</p>	No
<b>Medication-Assisted Treatment (MAT)</b>	Medication-Assisted Recovery programs	<input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents <input checked="" type="checkbox"/> People involved in the criminal justice system	<p>Unintentional drug overdose deaths.</p> <p>Number of deaths due to unintentional drug overdose (raw number).</p> <p>MAT retention.</p> <p>Percent of individuals, ages 12 and older, with an intake assessment who received one outpatient service within a week and</p>	No

				two additional outpatient clinical services within 30 days of intake.	
<b>Crisis services</b>	Mobile Crisis – Youth	<input checked="" type="checkbox"/> Children (ages 0-12) <input checked="" type="checkbox"/> Adolescents (ages 13-17) <input checked="" type="checkbox"/> Transition-aged youth (14-25)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents <input checked="" type="checkbox"/> Youth (ages 17 and under) <input checked="" type="checkbox"/> Immigrants, refugees or English language learners <input checked="" type="checkbox"/> People involved in the criminal justice system	Percent of crisis customers who have welcoming and hopeful customer experience.	Yes
	Mobile Crisis – Adult	<input checked="" type="checkbox"/> Transition-aged youth (14-25) <input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)		Percent of crisis calls that are resolved without having to dispatch police.	Yes
	Urgent Care and Drop-off Center	<input checked="" type="checkbox"/> Transition-aged youth (14-25) <input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)		Percent of mobile crisis team encounters resolved in the field without ER or police transport.	Yes
<b>Recovery supports</b>	Access and Workforce initiatives	<input checked="" type="checkbox"/> Adults (ages 18-64) <input checked="" type="checkbox"/> Older adults (ages 65+)	<input checked="" type="checkbox"/> People with low incomes or low educational attainment <input checked="" type="checkbox"/> People with a disability <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual <input checked="" type="checkbox"/> Black residents <input checked="" type="checkbox"/> Hispanic residents <input checked="" type="checkbox"/> White residents <input checked="" type="checkbox"/> People involved in the criminal justice system	<p>Percent of individuals served who were linked with services within 7 days of initial contact.</p> <p>Percent of individuals served who stayed linked with services past 7 sessions.</p> <p>Percent of individuals served whose families were also engaged collaboratively in the recovery process.</p>	No

<p><b>Criminal Justice</b></p>	<p>Access and Workforce initiatives</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Transition-aged youth (14-25)</li> <li><input checked="" type="checkbox"/> Adults (ages 18-64)</li> <li><input checked="" type="checkbox"/> Older adults (ages 65+)</li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> People with low incomes or low educational attainment</li> <li><input checked="" type="checkbox"/> People with a disability</li> <li><input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual</li> <li><input checked="" type="checkbox"/> Black residents</li> <li><input checked="" type="checkbox"/> Hispanic residents</li> <li><input checked="" type="checkbox"/> White residents</li> <li><input checked="" type="checkbox"/> Youth (ages 17 and under)</li> <li><input checked="" type="checkbox"/> People involved in the criminal justice system</li> </ul>	<p>Percentage of individuals who stayed engaged in treatment or recovery services post-jail via their Jail Liaison.</p>	<p>No</p>
<p><b>Specify: Mental Health &amp; Substance Use Treatment</b></p>	<p>Access and Workforce initiatives</p>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Transition-aged youth (14-25)</li> <li><input checked="" type="checkbox"/> Adults (ages 18-64)</li> </ul>	<p><b>Required: Pregnant women with SUD</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Pregnant women with SUD</li> <li><input checked="" type="checkbox"/> People with low incomes or low educational attainment</li> <li><input checked="" type="checkbox"/> People with a disability</li> <li><input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual</li> <li><input checked="" type="checkbox"/> Black residents</li> <li><input checked="" type="checkbox"/> Hispanic residents</li> <li><input checked="" type="checkbox"/> White residents</li> <li><input checked="" type="checkbox"/> Youth (ages 17 and under)</li> <li><input checked="" type="checkbox"/> People involved in the criminal justice system</li> </ul>	<p>Percentage of pregnant individuals who were admitted to the needed LOC within 24 hours of the initial assessment.</p> <p>Percentage of pregnant individuals who needed &amp; received interim services within 48 hours of the initial assessment.</p>	<p>No</p>

<p><b>Specify: Mental Health &amp; Substance Use Treatment</b></p>	<p>Access and Workforce initiatives</p>	<p><input checked="" type="checkbox"/> Transition-aged youth (14-25) <input checked="" type="checkbox"/> Adults (ages 18-64)</p>	<p><b>Required: Parents with SUD with dependent children</b>  <input checked="" type="checkbox"/> Parents with SUD with dependent children  <input checked="" type="checkbox"/> People with low incomes or low educational attainment  <input checked="" type="checkbox"/> People with a disability  <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual  <input checked="" type="checkbox"/> Black residents  <input checked="" type="checkbox"/> Hispanic residents  <input checked="" type="checkbox"/> White residents  <input checked="" type="checkbox"/> Youth (ages 17 and under)  <input checked="" type="checkbox"/> People involved in the criminal justice system</p>	<p>Percentage of parents (or guardians or custodians) with SUD who are referred from a public children services agency.  Percentage of parents (or guardians or custodians) with SUD who complete their initial DA within 2 weeks of referral.</p>	<p>No</p>
<p><b>Specify: Mental Health &amp; Substance Use Treatment</b></p>	<p>Access and Workforce initiatives</p>	<p><input checked="" type="checkbox"/> Children (ages 0-12) <input checked="" type="checkbox"/> Adolescents (ages 13-17) <input checked="" type="checkbox"/> Transition-aged youth (14-25)</p>	<p><b>Required: Youth</b>  <input checked="" type="checkbox"/> People with low incomes or low educational attainment  <input checked="" type="checkbox"/> People with a disability  <input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual  <input checked="" type="checkbox"/> Black residents  <input checked="" type="checkbox"/> Hispanic residents  <input checked="" type="checkbox"/> White residents  <input checked="" type="checkbox"/> Youth (ages 17 and under)  <input checked="" type="checkbox"/> Immigrants, refugees or English language learners</p>	<p>Percent of youth who indicate they attempted suicide during the past twelve months (Q31).</p>	<p>No</p>

**Optional:** Boards also have the opportunity to identify additional local priority strategies separate and apart from the required priority areas. Table 2b can be completed in the same manner as Table 2a with any additional strategies focusing on the continuum of care or other aspects of behavioral health.

Table 2b: Additional Local Priority Strategies [Optional]

<p><b>Optional: Local Priorities</b></p>	<p><b>Priority Strategy</b></p>	<p><b>Age Group</b></p>	<p><b>Priority Populations and Groups Experiencing Disparities</b></p>	<p><b>Outcome Indicator</b></p>	<p><b>Capital Funding Needs [Yes/No]</b></p>
<p><b>Instructions: Identify any additional local strategies focusing on the continuum of care or other aspects of behavioral health.</b></p>					

<b>Continuum of Care</b>	<i>Briefly indicate the service, program, or policy change you will implement.</i>	<i>Indicate which age group(s) the strategy will be designed to reach (choose all that apply). Refer to Table 2a for age groups.</i>	<i>Indicate which group(s) the strategy will be designed to reach (choose all that apply). Refer to Table 2a for priority populations.</i>	<i>Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator. Refer to Table 2a for additional information on outcome indicators.</i>	<i>Please identify if any capital funding will be needed to successfully implement the strategy.</i>
<b>Specify:</b> _____	[Open ended]	[age group check boxes]	[priority population check boxes]	[Open-ended]	
<b>Specify:</b> _____	[Open ended]	[age group check boxes]	[priority population check boxes]	[Open-ended]	
<b>Specify:</b> _____	[Open ended]	[age group check boxes]	[priority population check boxes]	[Open-ended]	
<b>Specify:</b> _____	[Open ended]	[age group check boxes]	[priority population check boxes]	[Open-ended]	
<b>Specify:</b> _____	[Open ended]	[age group check boxes]	[priority population check boxes]	[Open-ended]	

**2. \*SMART Objectives for Each Priority Strategy**

Using the outcome indicators you identified for each priority strategy, develop at least one SMART objective for each of the strategies outlined in Table 2a. SMART objectives are Specific, Measurable, Achievable, Realistic, and Time-bound. Please fill out Table 3a with each of the elements of the SMART objective.

**\*Table 3a: SMART Objectives for Priority Strategies [Required]**

<b>Continuum of Care</b>	<b>Outcome Indicator</b>	<b>Data Source</b>	<b>Baseline Year</b>	<b>Baseline Data Value</b>	<b>Target Year</b>	<b>Target Data Value</b>
<b><i>Instructions: Identify a SMART objective for each priority strategy that you selected.</i></b>						
<b><i>Continuum of Care or Priority Population</i></b>	<i>Fill in the relevant outcome indicator from the priorities table above.</i>	<i>Identify the data source for the outcome indicator.</i>	<i>Indicate the year (or other time period) the baseline data were collected.</i>	<i>Enter the baseline data value for the outcome indicator.</i>	<i>Indicate the year (or other time period) that you will set a target for to assess progress.</i>	<i>Enter the target data value for the outcome indicator that you aim to achieve, reflecting a decrease in a negative outcome or an increase in a positive outcome.</i>
<b><i>Example: Prevention</i></b>	<i>Percent of participating students who</i>	<i>Post-survey given after universal school-based suicide awareness and</i>	<i>2026</i>	<i>30.0%</i>	<i>2027</i>	<i>40.0%</i>

	<i>report learning how to recognize suicide warning signs and how to take action.</i>	<i>education program in four school districts.</i>				
<b>Prevention</b>	Percent of youth who demonstrate an improvement in ability to develop healthy interpersonal skills	Provider Agency Reports	2021	69%	2028	75%
	Percent of youth who maintain substance use abstinence, or reduce substance use, or experience a reduction in suicide risk behaviors (program type dependent).	Provider Agency Reports	2021	72%	2028	75%
<b>Mental health treatment</b>	Percentage of individuals who were seen for a DA with same day access (0 days wait time).	Provider Agency Reports	2023	50%	2028	75%
	Percentage of individuals who were seen for their 1 <sup>st</sup> session after DA within	Provider Agency Reports	2023	72%	2028	93%

	10 working days.					
	Ratio of population to mental health providers.	County Health Rankings and Roadmaps (CHRR)	2021	320:1	2028	300:1
<b>Substance use disorder treatment</b>	Percentage of individuals who were seen for a DA with same day access (0 days wait time).	Provider Agency Reports	2023	61%	2028	75%
	Percentage of individuals who were seen for their 1 <sup>st</sup> session after DA within 10 working days.	Provider Agency Reports	2023	83%	2028	93%
	Ratio of population to mental health providers.	County Health Rankings and Roadmaps (CHRR)	2021	320:1	2028	300:1
<b>Medication-Assisted Treatment (MAT)</b>	Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000.	202	2020	35.35	2028	22.55
	MAT retention. Percent of individuals, ages 12 and older, with an	Provider Agency Reports	2023	67%	2028	80%

	intake assessment, who received one outpatient service within a week and two additional outpatient clinical services within 30 days of intake.					
<b>Crisis services</b>	Percent of crisis customers who have a welcoming and hopeful customer experience.	Provider Agency Reports	2023	100%	2028	100%
	Percent of crisis calls that are resolved without having to dispatch police.	Provider Agency Reports	2023	55%	2028	60%
	Percent of mobile crisis team encounters resolved in the field without ER or police transport.	Provider Agency Reports	2023	49%	2028	55%
<b>Recovery supports</b>	Percent of individuals served who stayed linked	Provider Agency Reports	2023	52%	2028	66%

	with services past 7 sessions.					
	Percent of individuals served whose families were also engaged collaboratively in the recovery process.	Provider Agency Reports	2023	13.13%	2028	33%
<b>Criminal justice</b>	Percentage of individuals who stayed engaged in treatment or recovery services post-jail via their Jail Liaison.	Provider Agency Reports	2022	29%	2028	58%
<b>Strategy for pregnant women with SUD</b>	Percentage of pregnant women who were admitted to the needed LOC within 24 hours of the initial assessment.	Provider Agency Reports	2021	26%	2028	100%
	Percentage of pregnant women who received interim services within 48 hours of the initial assessment.	Provider Agency Reports	2021	No interim services needed	2028	100%

<b>Strategy for parents with SUD with dependent children</b>	Number of parents (or guardians or custodians) with SUD who are referred from a public children services agency.	Provider Agency Reports	2023	2	2028	10
	Percentage of parents (or guardians or custodians) with SUD who complete their initial DA within 2 weeks of referral.	Provider Agency Reports	2023	100%	2028	100%
<b>Strategy for youth</b>	Percent of youth who indicate they attempted suicide during the past twelve months (Q31).	OHYES	2023	18%	2028	13%
<b>Specify:</b>						
<b>Specify:</b>						
<b>Specify:</b>						

**Optional:** Boards also have the opportunity to develop SMART objectives using disaggregated data for priority populations and/or groups experiencing disparities (if available for their community). Table 3b can be completed in the same manner as Table 3a with any additional SMART objectives that monitor progress toward achieving equity.

Table 3b: SMART Objectives for Groups Experiencing Disparities [Optional]

Priority population or	Outcome Indicator	Data Source	Baseline Year	Baseline Data Value	Target Year	Target Data Value
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group experiencing disparities						
<b>Instructions: Identify a SMART objective for each population or group experiencing disparity.</b>						
<b>Indicate the priority population or group experiencing disparities.</b>	<i>Fill in the relevant outcome indicator from the priorities table above.</i>	<i>Identify the data source for the outcome indicator.</i>	<i>Indicate the year (or other time period) the baseline data were collected.</i>	<i>Enter the baseline data value for the outcome indicator.</i>	<i>Indicate the year (or other time period) that you will set a target for to assess progress.</i>	<i>Enter the target data value for the outcome indicator that you aim to achieve, reflecting a decrease in or elimination of a disparity.</i>
<b>Example: Males</b>	<i>Percent of participating <u>male</u> students who report learning how to recognize suicide warning signs and how to take action.</i>	<i>Post-survey given after universal school-based suicide awareness and education program in four school districts.</i>	2026	25.0%	2027	35.0%

**3. Optional: Collective Impact to Address Social Determinates of Health**

As identified during the CAP Assessment, Boards have the opportunity to identify how they will be leading, convening, or significantly contributing to a community effort to address up to three social determinants of health that are driving mental health and addiction challenges in the community. If Boards choose to complete this optional question, it is recommended that Boards seek to address the top ranked social determinants of health that they identified in the Assessment section of the CAP. Boards will then have the opportunity to identify up to three top community partners that will assist the Board in addressing each selected social determinant of health.

Table 4: Collective Impact to Address Social Determinates of Health [Optional]

Optional: Collective impact to address social determinants of health	Strategy	Key Partners	Priority Populations and Groups Experiencing Disparities	Outcome Indicator
<b>Instructions: Identify up to three top community partners that will assist in addressing any social determinants of health.</b>				

<p><b>Indicate the system (sector other than behavioral health or health care).</b></p>	<p><i>Briefly indicate the service, program, campaign, policy change, or initiative you will implement.</i></p>	<p><i>List the primary organizations involved in implementing this strategy.</i></p>	<p><i>Indicate which group(s) the strategy will be designed to reach (choose all that apply):</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> People with low incomes or low educational attainment</li> <li><input type="checkbox"/> People with a disability</li> <li><input type="checkbox"/> Residents of rural areas</li> <li><input type="checkbox"/> Residents of Appalachian areas</li> <li><input type="checkbox"/> Black residents</li> <li><input type="checkbox"/> Hispanic residents</li> <li><input type="checkbox"/> White residents</li> <li><input type="checkbox"/> Other racial/ ethnic group (specify: ____)</li> <li><input type="checkbox"/> Youth (ages 17 and under)</li> <li><input type="checkbox"/> Transition-aged adults (ages 18-24)</li> <li><input type="checkbox"/> Older adults (ages 65+)</li> <li><input type="checkbox"/> Veterans</li> <li><input type="checkbox"/> Men</li> <li><input type="checkbox"/> Women</li> <li><input type="checkbox"/> Lesbian/Gay/Bisexual</li> <li><input type="checkbox"/> Immigrants, refugees or English language learners</li> <li><input type="checkbox"/> Pregnant women with SUD</li> <li><input type="checkbox"/> Parents with SUD with dependent children</li> <li><input type="checkbox"/> People who use injection drugs (IDUs)</li> <li><input type="checkbox"/> People involved in the criminal justice system</li> <li><input type="checkbox"/> Other, specify: _____</li> </ul>	<p><i>Select at least one measurable outcome indicator from the Community Plan Standardized Indicator list or provide your own indicator.</i></p> <p><i>All indicators must be measurable, specific, and have a data source. All indicators must reflect outcomes that are relevant to the selected strategy.</i></p>
<p><b>Example: Housing</b></p>	<p><i>Buckeye County Affordable Housing Initiative (advocacy and planning)</i></p>	<p><i>Buckeye County Housing Alliance, Legal Aid, YWCA, Children’s Hospital Medical-Legal Partnership, United Way</i></p>	<ul style="list-style-type: none"> <li>✓ <i>People with low incomes or low educational attainment</i></li> <li>✓ <i>People with a disability</i></li> </ul>	<p><i>Affordable and available housing units (very low income). Number of affordable and available units per 100 renters with income below 50% of Area Median Income (very low income).</i></p>

<b>Example: K-12 schools</b>	<i>Buckeye County Healthy Learners Collaborative (attendance interventions for chronically absent students and school-based health centers)</i>	<i>Educational service center, one large urban school district, chamber of commerce, corporate foundations, health systems</i>	<ul style="list-style-type: none"> <li>✓ <i>Black students</i></li> <li>✓ <i>Hispanic students</i></li> <li>✓ <i>Students with a disability</i></li> <li>✓ <i>Economically disadvantaged students</i></li> </ul>	<i>Chronic absenteeism (K-12 students). Percent of students, grades K-12, who are chronically absent.</i>
<b>Stigma and increased access</b>	Media campaigns addressing stigma and access to services.	Media outlets with access to desired audience(s)	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> People with low incomes or low educational attainment</li> <li><input checked="" type="checkbox"/> People with a disability</li> <li><input checked="" type="checkbox"/> Lesbian, Gay, or Bisexual</li> </ul>	Click Through Rate (CTR) is at or better than national average for StarkMHAR's 4 chosen types of media outlets.
	Barbershop Program aimed at educating local barbers and stylists about the BH system, suicide prevention, & BH resources.	Local Barbershops, Beauty Shops, Salons, and Spas	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Black residents</li> <li><input checked="" type="checkbox"/> Hispanic residents</li> <li><input checked="" type="checkbox"/> White residents</li> <li><input checked="" type="checkbox"/> Immigrants, refugees or English language learners</li> <li><input checked="" type="checkbox"/> People involved in the criminal justice system</li> </ul>	Percentage of individuals who engage in conversations about mental illness, substance use, suicide prevention, and resources.

**4. \*Multi-System Youth**

Please answer a few questions about the Board's relationship with county partners that address the needs of multi-system youth.

5a. Describe any child services needs resulting from a finalized dispute resolution with a county FCFC(s) [340.03(A)(1)(c)]. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

*Stark County Family Council had no disputes filed.*

5b. Describe your collaboration with local partners (i.e., FCFCs, CMEs, other Child Serving Agencies) to serve high-need/multi-system youth. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

*a. The Service Coordination Committee (SCC) is made up of the executives of the public, child serving systems in Stark County: Stark County Family Council, Stark County Mental Health & Addiction Recovery, Stark County Family Court, Stark County Department of Job & Family Services - Children's Services, Stark County Board of Developmental Disabilities, Stark County Educational Service Center, and a representative of the Family Advisory Committee. The purpose of this committee is to develop, maintain and evaluate the collaborative processes and services described within Stark County's Service Coordination*

*Mechanism. It works to ensure an efficient, effective continuum of care that operates seamlessly across systems and to ensure that the needs of children (birth through 21) with complex, multiple needs are met as described in Ohio Revised Code 121.37. The committee meets monthly, based on need.*

*b. The Service Review Committee (SRC) consists of administrators and clinicians from the aforementioned organizations. The activities of the SRC supports the county's Service Coordination Mechanism in close connection with the Service Coordination Committee. Its activities focus on 1.) reviewing service requests for children with complex, multi-system needs; 2.) authorizing the purchase of needed services; and 3.) reviewing individual cases that need more restrictive placement settings. The primary goal of the SRC is to mobilize community resources to address individual needs, ensuring that identified children are receiving the most appropriate level of service intensity. The committee meets weekly, based on need. Additionally, Stark County Family Council also meets monthly with our CME to collaborate to ensure coordinated services for high/need/multi-system youth.*

5c. Describe your collaboration with county partners (i.e., FCFCs, CMEs, other Child Serving Agencies) to reduce out-of-home placements. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

*a. The Service Coordination Committee (SCC) is made up of the executives of the public, child serving systems in Stark County: Stark County Family Council, Stark County Mental Health & Addiction Recovery, Stark County Family Court, Stark County Department of Job & Family Services - Children's Services, Stark County Board of Developmental Disabilities, Stark County Educational Service Center, and a representative of the Family Advisory Committee. The purpose of this committee is to develop, maintain and evaluate the collaborative processes and services described within Stark County's Service Coordination Mechanism. It works to ensure an efficient, effective continuum of care that operates seamlessly across systems and to ensure that the needs of children (birth through 21) with complex, multiple needs are met as described in Ohio Revised Code 121.37. The committee meets monthly, based on need.*

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## 5. **✳Hospital Services**

Please provide information about the Board's relationship with local hospitals in terms of transition planning from inpatient care to any outpatient services that are needed.

6a. Identify how future outpatient treatment/recovery needs are identified for private or state hospital patients who are transitioning back to the community. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

*StarkMHAR will continue to partner with several local entities on a weekly hospital utilization committee that addresses discharge planning needs of individuals. StarkMHAR funds a Behavioral Health Navigator (BHN) at a local emergency room to divert hospitalizations. StarkMHAR also funds an AOT monitor, who helps determine appropriate referrals for the outpatient commitment program through local probate court. StarkMHAR's Forensic Coordinator oversees these programs, partnerships, and committees, with support from StarkMHAR's Recovery Program Manager. StarkMHAR also receives dollars from the state for the Access to Wellness program that has helped individuals transition from the hospital to the community and prevent re-admittance.*

6b. Identify what challenges, if any, are being experienced in this area. Select all that apply from the following list.

- Lack of Board capacity to staff a transition planning liaison
- Lack of communication/cooperation from state regional psychiatric hospital
- Lack of communication/cooperation from private psychiatric hospital(s)
- Lack of need for hospitalization
- Lack of access to state regional psychiatric hospital**
- Lack of access to private psychiatric hospital(s)
- N/A
- Other – consistency county to county within court system; discharge planning of individuals with medical needs who require PASSR**

6c. Explain how the Board is attempting to address those challenges. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

- *StarkMHAR has been a recipient of the state indigent dollars, which has allowed our local crisis provider to contract with private psychiatric hospitals and divert individuals to private inpatient care when there is a waitlist for the state hospital.*
- *StarkMHAR and the AOT monitor participate in the statewide AOT monitor's group run by the Treatment Advocacy Center. Stark's AOT monitor also continues to work collaboratively with other counties and problem solve issues and discrepancies in process as they occur.*
- *StarkMHAR has no oversight of PASSR process, but works with RPH continuously to support discharge planning process*

6. **Optional: Data collection and progress report plan.** Briefly describe plans to evaluate progress on the SMART objectives described above. OhioMHAS encourages Boards to develop a plan that includes data sources, data collection methods, partners involved in evaluation, a data collection timeline, and a plan for sharing and using evaluation results. (Note, this open-ended question has a character limit of 4,000 [approximately one typed page]. You will not be notified if your entry is greater than 4,000 characters and we will not be able to access it. Please ensure that your entry is less than 4,000 characters.)

*StarkMHAR will continue evaluating progress toward meeting SMART objectives through ongoing monthly and quarterly reporting and tracking mechanisms which are already established. Through use of “lean” constructs, StarkMHAR made numerous adjustments to reporting formats used by funded providers, so their reporting is better aligned with Stark’s CAP and output of work reduced. These efforts line up with internal strategic planning goals and ongoing continuous quality improvement work. Other data sources referenced in the CAP are already built into our reporting mechanisms or will be added in order to comprehensively monitor progress. Updates on progress on CAP objectives are a routine topic explored by the Continuous Quality Improvement committee, which is comprised of StarkMHAR staff and funded provider staff and meets quarterly. The Program and Evaluation committee of our Board, comprised of StarkMHAR staff and Board members, reviews and discusses the CAP and receives updates from the Continuous Improvement Manager and the Quality Improvement Coordinator, both of whom are directly involved in evaluation of funded programs and CAP objectives. Additionally, all 3 of the coalitions lead by the Coalition and Community Development Coordinator regularly collect, review, and discuss data relevant to their respective focus (please see the Local Prevention Coalition section of StarkMHAR’s CAP Assessment).*

7. **Optional: Link to the Board’s strategic plan.** Insert weblink(s) to your Board’s most recent strategic plan, impact report or other documents that are relevant to your plan.
- **StarkMHAR** – Most recent Strategic Plan updates are in development <https://starkmhar.org/>
  - **SDOH Platform**
    - StarkMHAR press release: <https://starkmhar.org/initiatives/connectwell-cie/>
    - ConnectWell site: <https://www.goodwillgoodskills.org/connectwell/>
8. **Optional: Link to other community plans.** Insert weblink(s) to any local or regional community improvement plans that are relevant to your Board, such as a local health department Community Health Improvement Plan (CHIP) or hospital Community Health Needs Assessment- Implementation Strategy (CHNA-IS).
- Stark County 2023-2024 CHIP Evaluation Report – <https://cms7files1.revize.com/starkcountyoh/2023-2024%20CHIP%20Evaluation.pdf?t=202505201357400&t=202505201357400>
  - Stark County 2023-2025 CHIP – <https://cms7files1.revize.com/starkcountyoh/2023-2025%20CHIP%20&%20Action%20Plans%20FINAL.pdf?t=202404091110060&t=202404091110060>
  - CHNA results currently being compiled; PPT from Summer 2025 – <https://cms7files1.revize.com/starkcountyoh/2025STARKCountyCHAPresFINAL.pdf?t=202506271426480&t=202506271426480>