Ohio | Department of Alcohol & Drug Addiction Services

Ohio | Department of Mental Health

Orman Hall, ODADAS Director • **John R. Kasich**, Governor • **Tracy J. Plouck**, ODMH Director

Director Tracy J. Plouck
Testimony before the House Health and Human Services Subcommittee
on the Ohio Department of Mental Health and Addiction Services

April 24, 2013

Good afternoon Chair Burke, Ranking Member Cafaro and members of the Medicaid Finance Subcommittee. Today, I appreciate the opportunity to present the very first budget for the Ohio Department of Mental Health and Addiction Services (MHA).

This new state agency, if approved by the legislature, will combine the resources of the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) to integrate care and reduce state bureaucracy. In partnership with local providers and recovery boards, the new agency will touch the lives of more than 3.5 million people based on recent statistics, including:

Service / Support	Number of Clients (FY 2012)
Substance use prevention activities	2.2 million
Community substance use treatment	98,900
Community mental health treatment	233,700 adults; 124,000 youth
Six state psychiatric hospitals	7,700 admissions
Workforce development	1,100 providers trained
Therapeutic Community-Pickaway Correctional Institution	250 residents
Pharmacy Services	65 health depts., free clinics or recovery centers; 36 correctional facilities, 9 developmental centers; many other inpatient and outpatient facilities and several state agencies

Additionally, MHA regulates over 400 provider agencies, 36 consumer-operated centers, 82 private hospital psychiatric units, 674 adult care facilities and 89 adult foster homes.

This afternoon, I will outline our most significant budget proposals; highlight budget-related aspects of our agency consolidation; and update you on key initiatives currently underway.

FY 14/15 Budget Initiatives

Extension of Medicaid Benefits

The Governor's proposal to extend Medicaid benefits to adults up to 138 percent of federal poverty level is the single most important investment for individuals with mental health and addiction needs in a generation of Ohio public policy.

Through this proposal, thousands of Ohioans – people who live in our communities and struggle with tremendous challenges that if untreated, can lead to terrible outcomes for themselves and their families – will get the help they need to become healthy and independent, and contribute to the workforce. This can help transform lives.

In Ohio, the safety net system for addiction and mental health services is funded by the state and 53 local board partners. This safety net exists for a wide variety of Ohioans, including but not limited to:

- Childless adults with substance use challenges that complicate their ability to work;
- People who have experienced significant trauma in childhood but, as adults, lack health care coverage necessary to access treatment; and
- Parents who are working low-wage jobs where health care is either cost prohibitive or simply not available.

Today, these individuals are not eligible for Medicaid. Instead, their mental health and addiction services are funded 100 percent by state and local resources to the extent that resources are available. In many Ohio communities, basic behavioral health needs are left unaddressed because there is a lack of funding and system capacity. Waiting lists of weeks or months are common, leading to crisis situations for individuals and families that could have been avoided. In rural areas, people may have to travel hours to access basic services.

This safety net is fragile at best, and the need for a sustainability plan has never been greater.

Chairman Burke and Ranking Member Cafaro, I've served in my current role for more than two years. I have talked with so many parents who are grieving because their adult child – possibly a high performer in high school who represented all of the hopes that they as parents ever held – died as a result of a drug overdose or suicide because they did not have access to the right kind of help. There was no health coverage, or insufficient coverage for mental health or substance use. I've met women who were victimized by prostitution because they were addicted and had no access to treatment, although they desperately wanted help. They lost their children, their health, their confidence – and certainly any ability to hold a job.

Keep in mind that mental illness and addiction affect people of all income levels and backgrounds. Recently, a woman came to my office, desperate because her young adult son with a mental illness was threatening to kill her. She had tried to reach out for help in so many different places without success so she decided to come to the state administrative offices. I could tell you countless stories like this.

As a community volunteer, I frequently talk with concerned sisters, grandmothers or fathers from all walks of life. Someone they love is addicted to heroin or prescription drugs and the family members are calling to find out how to get them connected with treatment before it is too late. The waiting lists are often prohibitively long. In some counties, we know that there are no services available. This is something that we have the opportunity to address.

Governor Kasich's brave decision to expand Medicaid will have a direct benefit on Ohio's behavioral health system. Most uninsured Ohioans who receive services from county boards of mental health and addiction services will become eligible for Medicaid under the extension.

Once these newly eligible Ohioans are enrolled, Medicaid coverage for clinical services will free up statewide an estimated $70 million annually in county levy and state subsidy dollars – funds previously spent on these same services but without Medicaid or any other payer source.

These funds can be spent on other recovery-oriented priorities such as housing and employment supports. Currently in most Ohio communities, there are insufficient resources to meet these basic needs, which are not part of the Medicaid benefit.

By expanding Medicaid, local communities will, over time, be able to redirect existing state subsidy and local resources (as available) to fill gaps in the local service continuum, reduce waiting lists, place a greater emphasis on wellness and prevention, and improve overall health outcomes within the community. In some cases, we will be able to treat people who have never been treated before. For example, in Washington County, which has no local levy.

Let me illustrate the difference that Medicaid coverage can make.

Tony, a 26-year old, has been suffering from delusions for a while and has been self-medicating with alcohol and marijuana. This behavior caused absenteeism from work, resulting in not only job loss, but also lack of access to health insurance. Tony recognizes that he needs help. However, when he contacts the local ADAMH board for services, he learns that because he's uninsured he can only access safety net services depending on availability. At this point, there is a long waiting list for treatment, as many resources are focused on meeting crisis-related needs. When Tony is able to access clinical services, they are paid fully from a local levy (if the county has one) or state subsidy.

On January 1, 2014, Tony will be eligible for Medicaid. His clinical services will be funded through that program, getting him the treatment he needs in a timely way. He may even be placed in a Medicaid health home, ensuring integration of services for both behavioral and physical health, enhancing the quality of his care. The funds that the board previously used for clinical treatment can now be redirected to a non-Medicaid support, such as employment assistance or housing assistance to get him out of the environment that encourages his addiction. His ability to succeed in recovery and get back to being employed is greatly enhanced. There are thousands of stories like this one.

It is noteworthy that this proposal actually builds on a major initiative from the previous budget bill that elevated the responsibility for Medicaid match within behavioral health to the state level. Boards no longer have to be concerned with meeting Medicaid obligations first. Prior to elevation of Medicaid, many board areas were seeing their entire state subsidy allocation swept into the Medicaid program. Some communities even had to dedicate local levy funds for this purpose. Today, these dollars are entirely separate, making the local responsibility for planning and providing non-Medicaid supports more clear.

I realize that the decision to extend Medicaid benefits to low-income Ohioans is difficult. However, please consider carefully the plight of Ohio individuals and families in every community in the state, who are struggling each day with these terrible circumstances.

The House changes with regard to Medicaid benefits have been well-publicized and sufficiently covered by Director Moody. However, I would be remiss if I didn't drawn to your attention the stark difference in the benefit to individuals with mental illness and addiction in the Governor's budget as it relates to the House passed version. The attached one-pager documents the value of

physical and behavioral healthcare and other supportive services which in sum total over $711 million more than the House version. In previous years, $100 million over the biennium would have been a huge achievement. However, it pales in comparison to the benefits to expansion to this particular population, and the House plan costs state taxpayers more.

Another component that we have only begun to analyze is the impact of the House's decision on the availability of acute psychiatric care in private hospitals. Without extended Medicaid coverage, Ohio hospitals will have a greater cost in providing uncompensated care. This may cause some of the 72 hospitals that provide inpatient psychiatric treatment to close their psychiatric units, since these services are generally provided at a net cost to the hospital. This will create access problems for individuals and families and strain the state hospital system, which is currently at 95% capacity. Missouri's Department of Mental Health estimates that state could lose more than 40 percent of its private hospital-based bed capacity. Depending on the extent of the impact in Ohio, additional needed investment in treatment at state hospitals could possibly require the state to build additional capacity, which could be an expensive proposition.

Now, I will move on to highlight other items within the budget that will address needs.

Community Innovations

The consolidation of ODADAS and ODMH is anticipated to save Ohio taxpayers $1.5 million annually in central administration costs, all of which is being redirected to a new Community Innovations program. Our new department will use these resources to invest in targeted demonstrations that result in savings for other parts of government. Over the next two years, we will focus on partnerships with the criminal justice system. Since April 2012, we've been meeting with members of the Buckeye State Sheriffs Association to develop a shared work plan to assist inmates with mental health and addiction challenges, and reduce costs in jails. To support safety within Ohio's jails and reduce recidivism, specific demonstrations in 2014 and 2015 will provide inmate assessments, connection with effective treatment, and meaningful planning in advance of release. It is anticipated that these efforts will improve client outcomes and help local jails to manage their health care costs.

Recovery Requires a Community

The Governor's budget includes several initiatives – called *Recovery Requires Community* – to assist nursing home residents under age 60 who have a primary diagnosis related to mental illness who want to move back into the community. On average, Ohio Medicaid spends $102,500 per year per person for Medicaid services in a nursing home for an individual under age 60 who is reasonably physically healthy but has a diagnosis related to severe and persistent mental illness. Many of these individuals could be served in less restrictive, clinically appropriate settings at lower taxpayer expense. Based on an analysis of more than 400 successful HOME Choice placements in 2011, Ohio Medicaid and the Ohio Department of Mental Health estimate the average cost avoided by assisting one of these individuals into a community-based setting was approximately $35,250 per year. By proactively shifting funds to community-based services, the state can achieve significant long-term savings and transition more people from nursing homes and into the settings they prefer.

Allow money to follow the person from a nursing home into the community.

The Executive Budget authorizes MHA, working with community partners and Ohio Medicaid, to assist 1,200 nursing home residents under age 60 with mental illness who want to live in the community. For each Medicaid beneficiary who makes the transition, the budget authorizes Medicaid to transfer the state share of the savings that otherwise would have been spent on nursing home costs to MHA so a portion of the money can "follow the person" into a community service setting. We will assist in the transition of at least 500 residents in the first year and 700 in the second, which will save $9.2 million ($3.3 million state share) in FY 2014 and $34.7 million ($12.7 million state share) in FY 2015. In addition, the budget provides $1 million over the biennium for MHA to pilot a similar program, called Access Success II, for individuals who are not Medicaid eligible and/or reside in institutional settings that are not reimbursed by Medicaid (for example, state psychiatric hospitals).

Increase access to safe and affordable housing.

Safe housing is critical for an individual who wants to reestablish community living, but it is often not affordable, particularly for persons with severe mental illness. The Executive Budget continues funding for the existing Ohio Residential State Supplement (RSS) program, which provides a monthly cash supplement to assist low income adults who have a disability and/or are over age 60 and want to exit a nursing home. The budget also creates a new housing voucher program from a portion of the savings that result from moving more residents out of nursing homes. More flexible than RSS, the new program, called Recovery Requires Housing, will prioritize individuals with mental illness and other disabilities who are living in an institutional housing, substandard housing, or are homeless but not eligible for the RSS program. The new voucher program is set at an amount that ensures the participating tenant does not pay more than 30 percent of his or her income on rent. The voucher may be used for independent housing or in a group home that meets the Housing and Urban Development (HUD) definition of a licensed facility.

Improve care coordination in adult care facilities.

The current rate for adult care facilities (ACFs) has remained unchanged for many years ($16 to $28 per day, depending on the kind of subsidy a resident receives). MHA will use a portion of the savings that result from moving more residents out of nursing homes to provide an incentive program for ACFs that connect residents to a Medicaid health home and appropriate case management. This will help stabilize housing options for residents of nursing homes who want to move into the community, particularly in cases that RSS is not available.

Reduce inappropriate admissions into nursing homes.

Current law allows an individual to move from a hospital into a nursing facility without a Pre-Admission Screening and Resident Review (PASRR) assessment to determine if the person meets criteria for a nursing home stay. The Executive Budget requires that residents of facilities licensed or operated by MHA (psychiatric hospitals or units) be assessed before being admitted to a nursing facility. This does not mean a person cannot be admitted to a nursing home from a psychiatric hospital; but rather, that an assessment must be conducted before an individual leaves a psychiatric hospital and moves to a nursing facility. Currently, ODMH completes a PASRR screen as a matter of practice for every person leaving a state hospital for a nursing facility. This has been working successfully since 2009. Combined with the support for community housing described above, this proposal creates a powerful opportunity to properly direct individuals to community settings when exiting inpatient psychiatric treatment instead of improperly placing that person in a nursing facility.

Consolidation

In May 2012, Governor Kasich announced plans to consolidate ODMH and ODADAS into a single cabinet agency effective July 1, 2013. The new Department of Mental Health and Addiction Services (MHA) will align state-level service delivery with the local system, where 47 of 53 county board systems already administer both types of services. Many providers are certified for both types of services and a significant percentage of consumers interact with providers in both systems. Nationally, 46 other states have agencies with a mission that crosses more than one system, and there is a combined federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Mental illnesses and addictions are both biological brain disorders with genetic and/or neurobiological factors, and both can be treated successfully. Unfortunately, they often remain undetected for years before treatment is accessed, and denial and stigma are common barriers to getting help. The social supports and community resources that people with both types of diseases need are very similar. Our goal is to provide a system for prevention and treatment of mental illness and addiction with no wrong doors, shared resources and combined expertise.

Significant work has occurred already to integrate the two departments. Most back office functions are now combined (fiscal, legislation, communications, information technology, legal and Medicaid policy). Most recently, a strategic planning process which will set the goals, mission and values of the new department has begun. A detailed transition plan is in place and a website devoted to the consolidation allows stakeholders to follow our progress (www.adamh.ohio.gov). This budget formalizes the consolidation by making the necessary changes to the Ohio Revised Code and restructuring the agency budget line items.

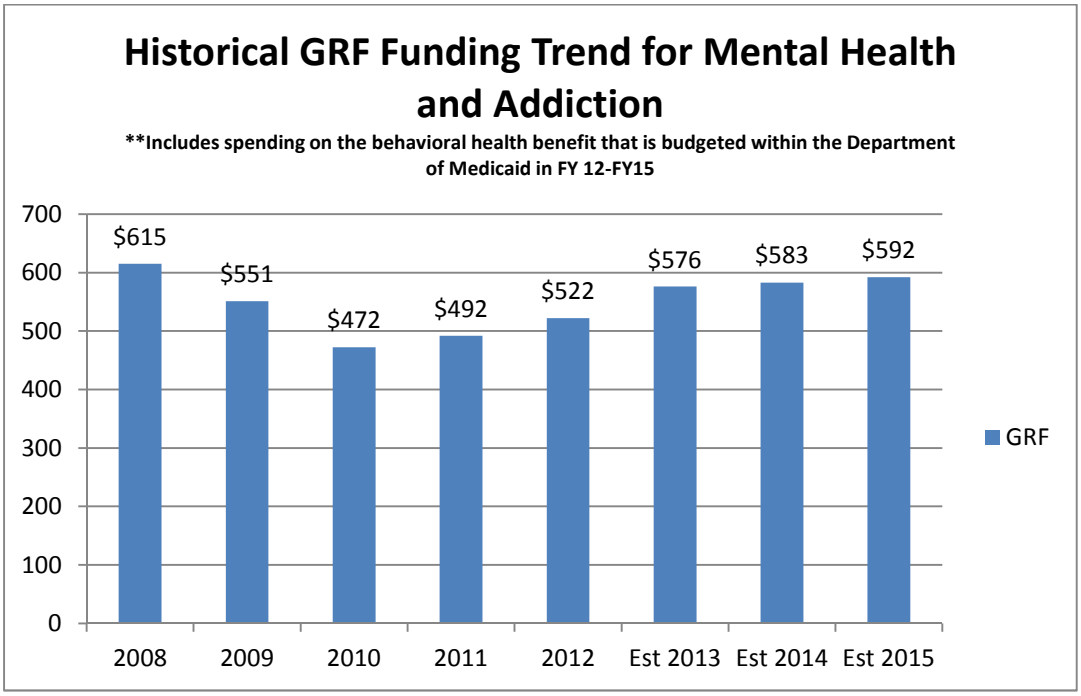
Language Consolidation

Our legal team approached the project with the rationale that we would not take on controversial topics unrelated to the consolidation, but would use the opportunity to align the agencies' permanent law and to eliminate outdated portions. In so doing, the ODADAS chapter 3793 was moved into 5119, which is the home of ODMH's code section. Updates to chapter 5122 governing the state's hospital system were made and the cosmetic name change of the agency was adjusted throughout the code.

Examples of substantive language changes made in consultation with stakeholders include:

- Changes to local Alcohol, Drug Addiction and Mental Health (ADAMH) board membership requirements to provide the option of reducing the board size due to recruiting difficulties in some communities; and
- Broadening the required qualifications for the agency's medical director (a psychiatrist) to include specialization in addiction science. Our current medical director, Dr. Mark Hurst, meets this requirement and has been serving as an additional clinical resource to ODADAS since his appointment in February 2012.

Historical Budget Trend



Given the many fundamental structural changes that have occurred within the budget for mental health and addiction in recent years, it is difficult to keep an eye on the bigger picture. The graph above illustrates the continued commitment the Governor and the legislature has made in helping to support the safety net services that saw drastic cuts several years ago. For this continued re-investment, I am very grateful.

New Budget Line Item Structure

Changes to the agency line item structure are necessary to reflect our new agency's scope; these changes were developed in full transparency and in consultation with stakeholders. For instance, a decision was made to consolidate all major state-subsidy-related GRF lines for both ODADAS and ODMH into one line item, which is now called "Continuum of Care." When compared to FY 13 funding in the former ODADAS and DMH subsidy line items, there is a zero percent change in the amount of subsidy going to the field for the Continuum of Care. However, communities now have more flexibility on how to spend the appropriated resources to meet the most critical local needs. Now, instead of being constrained by the bureaucratic requirements of separate line items, a community with an opiate crisis will be able to move additional funds to treat addiction, while another community might seek to spend more resources to support suicide prevention activities within the schools. We were very careful to take into account our federal Maintenance of Effort requirements for Block Grant resources, and will work closely with boards to ensure appropriate tracking of amounts spent for addiction and mental health services, respectively.

The Executive Budget maintains FY 13 GRF subsidy levels and, accordingly, I intend to maintain the current allocations level for each local community. I feel very strongly that need exists everywhere, and to cut state support from one area of the state and redirect the dollars to another is, effectively*, robbing Peter to pay Paul*. The price of destabilizing mental health or addiction programs in one community so that another can be augmented, particularly at a time when ALL communities could use more services, is creating a sort of chaos that can and should be avoided.

With that said, it is very important to note that while the Continuum of Care subsidy line item was flat funded by the Governor's budget, boards will see a tremendous opportunity to redirect state and local resources that are now being used to fund clinical care if the legislature moves forward with the Governor's proposal to extend Medicaid benefits for adults up to 138 percent of poverty, as discussed previously in my testimony.

I should note that the ODADAS and ODMH allocation approaches have been a longstanding point of contention for some of the boards around the state. The level of mental health "505" line item funding available to various communities has been a topic of great debate, especially in the Cleveland area. But it is important to note that a variety of state line items are distributed to local communities. For example, ADAMH boards' Medicaid obligations – many of which were on pace to outstrip the board's state and local resources – were lifted when the state took on responsibility for Medicaid match. As a result, the state investment in mental health has increased in most urban areas.

Taking Cuyahoga County as an example, the county's percentage of the state population is 11 percent, however, Cuyahoga residents received 15.4 percent of the state GRF spending on mental health in FY 12. Because the state has responsibility for matching Medicaid, Cuyahoga will see additional relief through the extension of Medicaid to 138 percent of poverty. Our estimates show that more than $9 million will be freed up for redirection to other non-Medicaid services, and we believe this to be a conservative estimate.

Undoubtedly, improvements can be made in the allocation methodology used by the state department. However, a sudden change would disrupt local systems in other areas of the state because cuts would need to be made in order to move funds around in order to put a new methodology in place. I prefer a path of stability, in which a portion of any future new funds in subsequent budgets would be used to address the acknowledged disparity in distribution. I recently discussed this concept over the course of several meetings with stakeholders, including many of the local board executives, prior to the budget being introduced.

It is important to note that language in the House passed budget would restrict the ability to make adjustments to the allocation methodology as it relates to the $100 million of new appropriation in line 335-507 Community Behavioral Health. Temporary law language dictates that the new department "shall allocate these funds to the boards using the same methodology use to allocate other mental health services subsidies." This language is very difficult to implement and would restrict the ability to correct for the the inequities of the current distribution model.

Secondly, temporary language also mandates that of the $20 million allocated each year for addiction services, "at least fifty percent shall be used for drug treatment using non-opiate drugs." Our interpretation of this language is that it is very narrowly intended to promote a non-opoid based medication called Vivitrol which has demonstrated success in eliminating the ability to get high on opioids and to reduce cravings. Vivitrol is one of several medications that, when used with counseling and other therapies, demonstrate success in treatment known as Medication-Assisted Treatment. We are all well aware of the opiate crisis in Ohio and willing to do all we can to combat it. However, this language takes a very narrow view of addiction in the state of Ohio and would tie the hands of local communities in addressing the particular needs in an area by dedicating such a significant amount of funds to a particular opiate treatment. The result would be funds that are unusable for priorities such as prevention campaigns, combating recreational drug use which makes individuals unable to pass employer drug tests, and other addiction needs such as problem gambling or alcoholism.

I look forward to working with the Senate to reconsider this restrictive language.

Other line item adjustments worth noting:

- Central Administration – Total reduction of $2.5 million in each year from FY 13 levels. A portion of this funding was transferred to Medicaid support. The actual reduction is $1.5 million in each year, which is savings that will result from efficiencies achieved through consolidation. This reduction will be managed without any layoffs; however, our total number of central office staff will decrease through attrition.
- Research Program Evaluation – Includes a $100,000 reduction in each year, which we do not believe will affect the number of research projects, as we plan to more aggressively pursue matching dollars in this area.
- Court Costs – These funds are used to pay for evaluations conducted for individuals whose competency status is being evaluated in the state hospital. We have heard from the judges that funding is not adequate to pay for costs. The additional $200,000 per year in this line will not fully fund the program, but is a demonstration that we hear the concern and are interested in working toward a solution.
- Residential State Supplement – A large increase in GRF line 335-506 is actually level funding for the program as a whole, as non-GRF funds from 335-622 are being eliminated.
- All funds reduction – This bottom line reduction is due to the run-out of Medicaid claims, which the agency is finished paying and the responsibility has now moved over to the Department of Medicaid.

One final note involves an operational change at the Office of Support Services (OSS), which provides pharmaceuticals, supplies and food to state facilities and other community agencies. The department will be downsizing offerings through OSS due to a decision by the Department of Rehabilitation and Correction to operate food services through an outside contract. I fully support Director Gary Mohr's decision to move in this direction. ODMH chose to use a vendor for food service at state hospitals in the late 1990s. On the whole, the experience has been a good one with cost savings implications ($2 million per year) and overall higher quality food. However, this decision will mean a reduction in force and possible layoffs at OSS. The full impact is not yet known. It should be noted that while our partnership with DRC is reduced in this aspect, it has grown on the other side of OSS operations – pharmaceuticals. OSS now provides inpatient prescription services to all of DRC's prisons. This operation has ramped up over the biennium and has resulted in cost savings for the state of over $3 million.

It is my privilege to serve as director of this new agency during such an exciting time. As you can see, we are tackling a huge number of initiatives, all of which have the ultimate aim of helping the people who we serve. The remainder of my testimony I will not read, but will leave with you as information and updates on our current initiatives. I am happy to answer any questions you may have at this time. Thank you.

Other MHA items of interest

Responding to youth and families in crisis

We all know that there have been far too many tragedies lately involving seemingly random acts of violence, including in Ohio. While it is nearly impossible to predict what causes these terrible crimes, it is important to be able to respond appropriately. ODMH and ODADAS have been focused on responding to communities who may be experiencing trauma due to an act of violence to ensure that the action is being taken at a local level. Additionally, ODMH Medical Director Dr. Mark Hurst recently released guidance to clinicians on the appropriate role of treatment providers in ensuring firearm safety. MHA has also committed to conducting a wellness campaign in May that spurs people to action if their friends and neighbors are exhibiting abnormal behaviors.

Finally, the Governor committed $5 million in CHIPRA bonus funding through the Office of Health Transformation to be used by MHA and the Department of Developmental Disabilities to target high-risk youth and young adults who may be prone to violence against themselves or their families. The funds will be used to help stabilize families, respond to crisis situations, and hopefully, prevent serious problems before they develop. We are currently reviewing the thirty-five applications for funding that have been submitted by local communities, and anticipate selecting grantees within the next month. I appreciate the interest of the General Assembly in this issue and we are committed to working with you and providing information and resources as needed.

Combating Opiate Abuse

My colleague, Orman Hall, will be focusing on this area in the upcoming biennium. As chair of the Governor's Cabinet Opiate Action Team (GCOAT), he has led the effort to combat this terrible epidemic. Some important successes have been achieved.

- Thanks in part to GCOAT and the passage of HB 93, Ohio has closed pill mills and reduced the amount of pills prescribed to residents of targeted southern Ohio counties by as much as 15 percent.
- Ohio has created new Opiate Task Forces in 23 counties to provide community education and work toward prevention of opiate addiction and overdose deaths.
- ODADAS and the Ohio Association of County Behavioral Health Authorities developed and launched the *Don't Get Me Started* campaign to educate Ohioans about the dangers of opiate painkiller addiction and overdose. The campaign delivered more than 30,000 visits to its online ads and website, and 45 million social media impressions.
- The Professional Education Workgroup of GCOAT, which is co-chaired by Dr. Ted Wymslo of the Department of Health and Bonnie Cantor-Burman of the Department of Aging, adopted statewide prescribing guidelines for emergency departments and created a website to provide promotional materials, including a pocket-size card, background documents and a guideline FAQ. These materials will save lives and help reduce the scourge of opiate abuse.
- ODADAS developed and distributed guidelines for the use of medication-assisted treatment to all publicly-funded addiction treatment agencies to improve long-term recovery for opiate addiction.

Additionally, in July 2012, Medicaid began paying for Medication Assisted Treatment at ODADAS certified facilities. In October 2012, Medicaid opened up access to a critical injectable medication that is used for treatment by adding it to the pharmacy benefit.

Work continues on the opiate fight. Future areas of work include:

- Evaluate prescribing practices for opiates;
- Launch of Southern Ohio Treatment Center;
- Medication-Assisted Treatment protocols; and
- Addressing Neonatal Abstinence Syndrome in babies born to addicted mothers.

Problem Gambling

During 2012, ODADAS, in contract with Kent State University, conducted a household telephone survey of 3,600 Ohioans to determine prevalence of problem/pathological gambling in Ohio. This was done in conjunction with the Ohio Casino Control Commission, Ohio Lottery Commission, and Ohio Racing Commission -- all of whom are partners in Ohio for Responsible Gambling (ORG) -- in anticipation of the expansion of gambling options through casinos and racinos. Survey findings estimated that the prevalence of at-risk and problem gambling in Ohio is 2.8 percent in total, or about 250,000 individuals aged 18 and older. The at-risk group of Ohioans, prime for prevention and responsible gambling education, is about 220,000 individuals. According to the survey, of the at-risk group, a majority are male and more likely to be between the ages of 18-24 years old; in some areas of the state more African-American males tend to be at-risk. These initial findings will guide the agency's work in this area, but are not yet statistically significant enough to be used as a basis for distributing funds. Research in this area will continue with the eventual intent of being able to target funds to at-risk populations and areas of the state.

The passage of a constitutional amendment in 2009 that allowed casinos to be built and operated in Cincinnati, Columbus, Cleveland and Toledo also included language that "two percent of the tax on gross casino revenue shall be distributed to a state problem gambling and addictions fund which shall be used for the treatment of problem gambling and substance abuse, and related research." Since the summer of 2012, ODADAS has received approximately $3.4 million from this new fund. Those resources will be allocated to the community through Ohio's ADAMH boards and will also support prevention, research and professional development at the state level. This month, the Ohio Casino Control Commission approved ODADAS' plan to combat problem gambling, which focuses on prevention in this initial stage while prevalence remains low. We look forward to continued work with our ORG partners on this issue.

Health Homes

Statistics show that an individual with mental illness has a significantly lower life expectancy due in part to unmanaged (or untreated) physical health conditions. The FY 12-13 biennial budget supported the design of a new, person-centered approach to integrate physical and behavioral health care needs. Case management provided through Ohio Medicaid health homes will coordinate mental health services and assist individuals in finding a family doctor, pediatrician, dentist, nutritionist or other specialist. In addition, reminders will be sent to beneficiaries regarding regular check-ups and preventative health care needs. Connections to supports such as transportation and child care will also be made available through this service. The objective of Medicaid health homes for persons with severe and persistent mental illness is to reduce cost growth over time by improving health outcomes. Ohio is a leader in this area, as one of the first states to launch this initiative. The first phase of the implementation, which included Adams, Butler, Lawrence, Lucas and Scioto counties, went live in October 2012. Approximately 14,000 individuals are already enrolled. By October 1, 2013, the benefit, delivered by community behavioral health providers, will be available statewide.

Housing

Clearly, a person's ability to manage daily challenges related to mental illness and/or recovery from addiction are exponentially complicated if stable housing is not available. Without a safe place to live, homelessness cannot be prevented and institutional recidivism from places such as jails, prisons, nursing homes and psychiatric hospitals will be more difficult to reduce. Personally, this is a key area of focus for me, and the agency is working on many initiatives, in addition to the Recovery Requires a Community proposal, to make a difference on this issue.

Investments in housing over the last biennium by mental health and addiction services include:

- $10 million to support housing in Ohio's most recent capital budget – These funds are used for projects identified by local boards of mental health and addiction services to assist the housing stock in the community.
- $1 million Adult Care Facility Critical Repair Grant – In January 2012, the Ohio Housing Finance Agency (OHFA) enabled us to administer an award of $1 million from the Ohio Housing Trust Fund. With these resources, we are funding critical repairs at 156 licensed adult care facilities throughout the state: structural defects, heating and plumbing defects, electrical hazards, and safety features. Many of the projects have already been approved to start repair work.
- Preservation of housing stock – In both FYs 12 and 13, OHFA reserved $1 million from the Housing Trust Fund specifically to assist ODMH-funded Permanent Supportive Housing projects with minor repairs and renovations. This will help maintain the housing stock in which we've invested over the past twenty years, thereby maintaining access to folks who need it.
- $500,000 sober housing project: Oftentimes, a person in the early stages of recovery may need a place to stay that is a safe, alcohol- and drug-free environment. Sober housing is a setting where a person in sobriety can find peer support and establish healthy and safe routines that promote a lifetime of sobriety. Many units are gender-based and may include an array of other supports, such as parenting education, that are helpful to the family unit.
- $500,000 of federal block grant funding has been used to offer mini-grants to communities to assist with housing planning, help local communities with their local match responsibilities for Housing Trust Fund projects, and train individuals on housing advocacy and competency.

Prevention and Education Services for Behavioral Health

Prevention promotes the health and safety of individuals and communities while focusing on preventing or delaying the onset of behavioral health problems (i.e. substance abuse, addiction, problem gambling and mental illness). Prevention services are a planned sequence of culturally appropriate, science-driven strategies intended to facilitate attitude and behavior change for individuals and/or communities.

<u>Six Evidence-Based Prevention Strategies</u>

1. Information dissemination is one-way communication that focuses on building awareness and knowledge of the nature and extent of mental illness, substance use, abuse and addiction and the effects on individuals, families and communities.
2. Education is two-way facilitated communication that focuses on the delivery of services to target audiences to influence attitudes and/or behavior.

3. Community-Based Process focuses on enhancing the ability of the community to provide prevention services.
4. Environmental strategy focuses on a broad range of services geared toward reducing the incidence and prevalence of substance use/abuse and addiction and mental illness/depression in the general population.
5. Alternatives strategy focuses on providing opportunities for positive behavior support as a means of reducing risk taking behavior and reinforcing protective factors.
6. Problem Identification & Referral is for individuals currently involved in prevention services and exhibiting behavior that may indicate the need for behavioral health or other assessment.

Hot Spots

In FY13, ODMH adopted a new paradigm for the investment of additional non-Medicaid community resources in its General Revenue Fund subsidy line item. Rather than employing a traditional formula-based approach wherein each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board area receives a small portion of additional state mental health resources, ODMH invested $10.6 million in additional subsidy resources in collaborative projects that transcend board areas and address "hot spot" concerns. These may vary from region to region in the state.

"Hot spots" may be defined as meeting one or more of the following criteria:

1. Specialized services for difficult to-serve-populations – high utilizers of service who do not achieve desired clinical outcomes;
2. Services for those with the greatest unmet needs – may be defined as highest cost clients; most clinically impaired clients; or a sub-set of clients who need services and a gap in the continuum of care exists;
3. Services that divert people from more restrictive and typically higher-cost settings (e.g., hospitals, jails/prisons, out-of-home placement for children, nursing facilities, etc.); and
4. Incentives to engage clients who are difficult to engage in behavioral health services and likely are costly to other systems.

The Department will continue this approach in FY 14-15 and extend it to addiction services.

Hospitals System of Care

During 2012, ODMH continued to provide high quality inpatient mental health care for citizens served by the county boards or placed by the local court systems. Despite reducing the number of buildings and overhead costs, ODMH has been able to maintain a constant capacity of about 1,100 beds during the last decade, ensuring that both civil and forensic patients can access treatment. The civil (or voluntary) patients make up about 40 percent of those in treatment with an average length of stay of 11.5 days. About 60 percent of those treated are "forensic," meaning under the jurisdiction of the civil or criminal courts. They may stay months or even years based on their charges and the direction of the court.

On a daily basis, approximately 1,000 individuals are receiving comprehensive inpatient treatment at ODMH's regional psychiatric hospitals. In the course of a year, more than 6,500 individuals are admitted and discharged. The hospital system also provides prevention, education and outreach programs in a community-supported environment. A strategic plan for Hospital Services is focusing on a shared set of goals, objectives and strategies moving forward.

The primary need for the state hospital system has been identified as an affordable electronic medical record (EMR) service that is in line with industry standards, and supports patient safety and healthcare reform. For clinical documentation, the hospitals have been using Netsmart's Avatar product, and its antecedents, for assessments, treatment plans and progress notes since 1995. The current system does not allow for a seamless transfer of records between institutions. However, the cost of advancing a new state-of-the art system has been a big consideration and hurdle to a much needed update.

The solution has been found through a shared services partnership with The Ohio State University Wexner Medical Center to host the state psychiatric hospitals' EMR services. OSU has received national recognition for its recent implementation of a fully mature, established EMR software system. Further, OSU is uniquely situated, as an authorized enterprise level organization, to extend its EMR to other providers, such as MHA. It is estimated that a 30- to 36-month implementation will be needed, and we plan to roll-out in one hospital every two months starting in January 2015. Funding for this proposal will be found through cost savings within the hospital system. The partnership with OSU makes this much needed upgrade an affordable option for the state. It will also allow for better patient care, allowing records to be accessed between institutions and facilities in a timely manner.

Impact of the House Choosing Not to Extend Medicaid Coverage to Ohioans Battling Mental Illness or Addiction

- The House Finance Committee's decision to reject health care coverage for low-income, working Ohioans will reduce overall spending by $577 million per year on services that people with a mental illness or substance abuse disorder need to recover.

- The House's budget provides NO SUPPORT for the physical health care needs for individuals with mental illness or an addiction disorder who would have been covered by the Governor's budget. These individuals commonly experience physical health issues related to their illness that can impede recovery and lead to high-cost chronic conditions.

House Sub Bill (in millions)	FY 2014	FY 2015
HB 59 mental health and addiction services eliminated by the House		
• Medicaid Behavioral Health[1]	($20)	($75)
• Other Healthcare Services [2]	($129)	($482)
• Local Funds[3]	($35)	($70)
TOTAL	**($184)**	**($627)**
Mental health and addiction services added by the House		
• Mental Health	$30	$30
• Addiction Services	$20	$20
TOTAL	**$50**	**$50**
Difference	**($134)**	**($577)**

1- Includes direct treatment (i.e., counseling, crisis intervention, detoxification)

2- Direct health care related to recovery (i.e., pharmaceuticals, doctor visits, hospitalization)

3- Freed up local match for other key services (i.e., supported employment, housing, prevention)