Alcohol, Drug and Mental Health Board of Franklin County
2015 2.2 Mill Renewal Levy with .5 Mill Increase Proposal

HSLRC Meeting Minutes
April 2, 2015

The Human Services Levy Review Committee (HSLRC) meeting was called to order by Chairman Jessie Hemphill on Thursday, April 2, 2015 at 3:10 p.m.

ROLL CALL

HSLRC members present: Jessie Hemphill, Denise Bronson, Jerry Friedman, Jean Carter Ryan, Zak Talarek, Nathan Wymer

HSLRC members absent: James Bowman

A committee quorum was present.

Office of Management and Budget (OMB): Heidi Hallas, Justin Nahvi, and Deputy County Administrator Erik Janas

Alcohol, Drug and Mental Health Board (ADAMH): Derek Anderson (Chair), Rory McGuiness (Vice Chair), Damon Muldoon (Treasurer), David Royer, Jonathan Wylly, Mark Lambert, Susan Lewis Kaylor, Kythryn Carr Hurd, Dr. Kevin Dixon, Dr. Delaney Smith, and Alisha Nelson

REVIEW AND APPROVAL OF MEETING MINUTES

Mr. Hemphill stated the next agenda item is the review and approval of their March 19th minutes. Mr. Freidman stated just a typo, it is not major. Dr. Bronson made a motion to approve the minutes with the correction. Mr. Wymer seconded the motion. All members voted "Aye" and Mr. Hemphill said motion carried.

DISCUSSION OF THE LEVY REQUEST

Mr. Hemphill said the next agenda item is the discussion with ADAMH staff regarding the levy request. The members were to submit to OMB any questions by last Thursday and they were then submitted to the ADAMH Board. The ADAMH Board is here to provide us with their written and/or verbal responses. So with that, Mr. Hemphill turned it over to David.

Mr. Royer replied thank you. Thank you for allowing us to be here and he would like to point out that Damon Muldoon, Board Treasurer, is here as well as Rory McGuiness, Board Vice Chair, and Derek Anderson, Board Chair. He thanked the committee for the quick turnaround on those questions. There were 28 questions and they tried to answer those and provide some narrative. Sometimes it is always difficult to make sure they are trying to get to the right answer the Committee is really seeking. Mr. Royer stated that he would like to approach this as more of a conversation than a question and answer session. On the other hand, he doesn't want to waste their time by reiterating things that they have already heard. That is not a constructive use of the Committee's time and so they really want to hone in on the things that they think are still outstanding.

Mr. Royer stated that the first question the Committee asked was actually an excellent question from a more global perspective. Would it be prudent to wait five years to request additional levy funds in order to better understand the Medicaid environment, the ACA, and the result of increased allocations as a result of Medicaid elevation? One of the things that struck him the other day in the newspaper was that Columbus

Legal Aid filed in Federal Court on behalf of four individuals who were terminated from Medicaid. The interesting part of that is they announced in March the state had terminated an additional 80,000 individuals. ADAMH had always had a view that the entire Affordable Care Act and Medicaid expansion is essentially an extremely elastic situation. For instance, the Supreme Court has already heard the arguments about the state exchanges versus federal exchanges and what that means for tax credits.

Mr. Royer indicated that when ADAMH looks at the issue of expansion, there is no doubt that there has been some improvement relative to the financing of the Board through that expansion. However, for the people that ADAMH serves, healthcare may not be a priority to them. They may not value it within the same constraints that probably almost all of them in this room value healthcare coverage. The other thing is by the pure nature of their illnesses and diseases, it may not lend itself to being able to do what is necessary to ensure continuing coverage. A very concrete example is 80,000 people terminated in March, 8,000 hypothetical Franklin County residents. ADAMH knows from prevalence rates there are X amount that are going to have a mental illness or an addiction. Their needs for care, especially within the context of mental illness, don't cease because the Medicaid expansion coverage was terminated. That means if prior to expansion they would have been funded through ADAMH dollars, if they go over to Medicaid and they can't fulfill the requirements of Medicaid with eligibility requirements and are terminated, they will come back on the ADAMH rolls because the care is required. Hopefully, it is within a positive construct that they are going to seek their care through the mental health center. Unfortunately, they also know that all too often it will occur maybe in an emergency room or some kind of psychiatric crisis. Mr. Royer indicated that the State of Ohio had estimated $9 million and at the end of the third quarter of 2014 it was really $3.7 million relative to "net savings" to the Board from Medicaid. It was significantly less in part because Franklin County has lagged in the enrollment process. Mr. Royer stated that he doesn't want to misrepresent the fact that they could see increasing enrollment, therefore, increasing perceived savings.

Mr. Royer stated that ADAMH is effectively collecting less today than when they passed the levy ten years ago and yet the population grows. The census data in the Dispatch this week indicated that within the next two to four years we will be the largest county in Ohio. The system is based on a population that was significantly less that today. The Dispatch reported yesterday that Dublin has proposed two additional new TIFs for the Dublin redevelopment. Those TIFS will bring a total just within the city of Dublin to 22 TIFS that are actively involved in the City of Dublin. If you understand how TIFS work, they divert property taxes. In fact, most of this downtown development has been TIFed by the city of Columbus. Mr. Royer would argue that if the TIF laws were not as hard on Boards such as the DD Board, the ADAMH Board, Children Services Board, that they would see the benefit of all this commercial economic growth. The reality is that with the devaluation from the recession in 2008 and the explosion of new commercial buildings that are not being brought to the duplicate for levy agencies, such as ADAMH, they just don't see a way out of the environment. Mr. Royer stated that ADAMH is realizing some benefits but does not believe they will see the full benefits. He is pretty much of the opinion that there is enough out there that if they were realizing every commercial development and it wasn't being diverted that ADAMH probably wouldn't be asking for the additional mileage.

Finally, Mr. Royer reiterated that they can go five years with a renewal. The question becomes for ADAMH, then what? What we do know from modeling is if there is not substantial growth in the residential markets, re-valuation of property taxes, and infusion of state dollars that is unforeseeable at this point in time, they will be playing essentially a game of chicken in five years. According to Mr. Royer, the fiscal cliff will be so severe that without new mileage, they will reduce significantly mental health care and addiction services almost to the tune estimated at $16.5 million each and every year for the next five years.

Mr. Royer stated that ADAMH believes the environment is as positive as it can be in relationship to the opportunity to ask the community to support mental health care. They base that on a couple facts: 1) unfortunately by the lack of support for mental health care in America, mental health care has become a page one item; 2) through the Friends of ADAMH and Public Opinion Strategies, Franklin County residents have never felt better about the future direction (see ADAMH Exhibit 5). In surveying 400 likely registered voters, 65% said yes we would be inclined to support new additional millage. As recently as yesterday, ADAMH talked to Public Opinion Strategies and they indicated they saw nothing that has changed since

that December polling that was done that would indicate any less positive support for Franklin County. In fact, the comment by the CEO was it appears that the issue of the economy is starting to fall back as number one. People are feeling better and better about the economy.

ADAMH would like to answer all the questions but Mr. Royer thinks it is really important to recognize when you are trying to envision a community providing mental health supports and addiction supports in a major American city, it is hard to imagine ADAMH would be able to get the job done without additional resources given the losses he mentioned and the unrealized revenue from economic development policies that frankly none of us control. It is a legislative decision.

Mr. Hemphill thanked Mr. Royer for the opening editorial. As the chair of this committee, he thinks the thing that they struggle with the most is the additional increase. If he looks back over the past twelve years for a track record, and there has been very few levy requests that included an increase. He indicated that the climate of the previous elections is serious voter apathy out there. This is one of the first agencies in the last three or four years that they have entertained that had an increase associated with it. Mr. Hemphill asked how do they bless that and tell that to the voting public given the fact that from the past election we saw a defeat of an agency that had an increase associated with it.

Mr. Royer stated they can only assess at a point in time relative to the environment of support and they have tried to do that constructively and share that information. He does believe that it is also a question of when they look at the relative position of some of the other levy agencies. ADAMH is talking about people with mental illness and addictions. They have one levy and not asked for an increase in millage in twenty years. Mr. Royer stated that they serve as many, if not more people, than any other levy agency in this county and we have the least amount of resources to do it. The reality is if you are addicted and you enter into recovery, recovery is sometimes a fragile proposition. Unfortunately, when you incur a severe and persistent mental illness, recovery is a relative term, it is essentially a lifelong disability and those individuals require support. Medicaid expansion goes to the treatment aspects of people who previously had not been eligible and that is an important issue that they should never minimize its value. As the population grows and what they know about prevalence, the rates of mental illness, and the reoccurrence of episodes of mental illness, ADAMH has to support them in the community. They cannot by the nature of their illness, without significant supports or families have significant resources, survive in the community. The result is an increase in shelters and increase in jail population. There will be more and more people walking downtown in these new beautiful developments that have severe and persistent mental illnesses with shopping carts full of junk. Go to any American city that doesn't support mental health care and that is what you see. Mr. Royer is a firm believer that the costs of mental illness are inescapable to a society. Every day the Commissioners incur a cost in the jail. The question is how constructively and how progressively are we going to view those individuals and embrace those individuals. What is great about Franklin County and the City of Columbus and what differentiates us from the rest of the world is that we embrace people that are different. We saw a press conference yesterday about sexual orientation that said bring your business to Columbus, Ohio. We believe that everybody matters. Mr. Royer doesn't think that stops at the water's edge of mental illness and one has to recognize that they have to have the resources to do the job.

Mr. Hemphill stated he thinks the only thing they can do as a committee is absorb responses to the questions, continue our efforts to do the due diligence to the task at hand, and come up with a recommendation that may or may not include the addition.

Mr. Royer indicated that he recognizes and respects the power of the committee and the weight that they undertake with all these deliberations. He thinks that in the responses that what they will see is really their best attempt to provide additional information as requested. It doesn't mean they can't make progress. One of the questions was, couldn't you just reprioritize? What ADAMH said in response to that is absolutely. They can reprioritize but will have to disinvest to build more ACT teams in the shelters. They could take mental health care out of suburban school districts. They could build more housing but then they are not going to work with the courts to treat prostitutes that have drug additions. They can reshuffle the deck but

at the end of the process they have the same deck. They will embrace the reality that the Committee offers them but it won't be without consequence. Mr. Royer thinks it would be foolish not to recognize that.

Mr. McGuiness stated in the presentation that ADAMH did at the last meeting, there is a graph that talks about the historic and projected levy collection revenues. Essentially, if they just did a renewal of the levy, it would be zero percent revenue growth for 20 years. They actually collected less revenue now than when the last levy was passed in 2005. So there is a major shortage of funds. The other thing that presentation addressed was the cost of treatment versus the cost of incarceration. The annual cost of incarceration is about $25,000 and the cost of comprehensive addiction treatment is $1600 annually and $7500 for mental health treatment. In Mr. McGuiness' opinion, it is a matter of arithmetic. They can chose to treat people that have the best outcomes at a much lower cost than a negative outcome of not treating it. Unfortunately, more and more often people are ending up in emergency care, which is far more expensive, or in prison. He looks at this as it is the right thing to do to take care of the mentally ill in our community but it is also the best financial decision they can make as well.

Mr. Hemphill asked if any of the committee members have any comments or questions so far.

Dr. Bronson asked if ADAMH could talk more about the polling of the community to get a sense of what is going on out there.

Mr. Royer said Exhibit 5 in your packet contains some of the data. The ADAMH Board and the Friends of ADAMH committee supported the initiative. They have a twenty year relationship with Public Opinion Strategies out of Alexandria, Virginia and they are probably a top four or five public opinion research firm in the United States. They conducted two focus groups of likely voters in July that reflected the characteristics of our community. Then in December the Friends of ADAMH committee worked with Public Opinion Strategies to do polling. These charts are actually from the presentation that Public Opinion Strategies offered us. They polled 400 likely voters (city, suburban, rural, Democrats, Independences, and Republicans). The first chart on Exhibit 5 is essentially what they call the right track/wrong track and what you can see is there has been a significant increase right track, almost exploding in 2012. People were starting to recover from 2008 shock. It is now at 74%. ADAMH asked the CEO yesterday via email, if he saw anything different three months later and he said no. Actually, the preoccupation about the economy is lessening which is a good thing. People are feeling more secure.

Mr. Royer indicated that the next page on this exhibit goes to the idea of so tell us about optimism about the economy. If there is no optimism in the economy and they don't believe we are heading in the right direction, it would be an impossible climb to ask for any support. So when asked do you believe the economy is getting better or getting worse, what you see is by party affiliation, and in fact, almost across the board people feel it is getting better. The same and better is dramatically better than worse.

According to Mr. Royer, one of the things ADAMH recognized prior to submitting their request was that they have to be grounded in some kind of reality. According to the survey results, ADAMH clearly has a high favorability. The problem they have always faced was because of the uniqueness of how they deliver services through a privatized system is people don't really know them. It is not like Children Services. ADAMH is prohibited by law from providing direct service. It is really hard for them to try to get their name identification up, but nevertheless, they have high favorables and low unfavorables.

Mr. Royer stated that when voters were asked what you would do about a renewal plus a new levy on the ballot, 66% said yes and 28% said no. When ADAMH polled the replacement in 2005, it was the exact same numbers. Interestingly, in 2005, ADAMH came in at 62.8% positive. They did lose some positive support in the replacement five years ago. When the poll asked about a strict renewal, which is essentially a no new tax campaign, 74% said yes. If ADAMH renews for five years, they don't believe they can remain solvent for more than five years, maybe six, depending on the developments that occur over the next several years. Clearly a renewal is a very doable deal. ADAMH would obviously know, that at 66%, our community has always supported replacements at a very high rate. Mr. Royer believes that a renewal plus new campaign, even without opposition, you will see a significant decrease in support. Mr. Royer thinks

they would probably come in at the 50's. His experience tells him that you see a more significant erosion of a new issue on the ballot than what your poling tends to lend.

Mr. Royer stated that ADAMH also tests key messages. The ones that actually resonated with these voters were that we are going to pay a lot more down the road if we don't try to deal with this now. It's the classic pay me know versus pay me later. It's effective. In addition, a message regarding more funding for suicide, depression, and other mental illnesses also resonates and is very effective. ADAMH wants their message to be simple, straight forward, and easy for the voters to understand because any confusion is an opportunity for any opposition to maximize its strength. From a historical prospective, the last time ADAMH did a replacement levy in 2005, they actually came in at an all-time high at 63.8%. Mr. Royer said it has never been an easy ask for mental health care and the reality is very few new issues from mental health care get passed in Ohio. But we are not the rest of Ohio and Mr. Royer believes they can make an effective argument about that. He think Lucas County is one of the very few counties that recently has passed new millage. That is essentially to Denise's point. ADMAH thinks it is a unique environment right now. ADAMH sees more and more evidence that parents are increasingly concerned as these violent situations are disturbing to a community. We've been blessed not to have those but bad things happen every day and bad things can happen at any moment. We see more and more murder/suicides, suicides rates are up, kids going into crisis emergency psychiatric services is on the rise, and drug addiction is on the rise. Mr. Royer is not going to tell you they can fix it and he does not believe they are quite at good enough yet.

Mr. Hemphill said they have asked this question of all the levy agencies that come for review. Is the ADAMH Board prepared to deal with a no vote? What are the consequences? What is your plan of action?

Mr. Royer said that is a great question. One of the things about having a relationships with people like Public Opinion Strategies is that you take your licks and you get up and you dust yourself off. You try to figure out why you lost and how bad of a loss was it, and then you look to May for a renewal and say the voters have spoken. That's what made this country so great. The voters get to decide. It is something they can make the decision on and that is what makes Ohio so great about its levy issues. He doesn't know how else to approach it. You try to figure out why and then you move on. They would be back here in May and say you know what, they were wrong. Defeat is an orphan except around somebody and he thinks you are looking at him and he's willing to take that on. Mr. Royer believes it's about trying to fulfill a vision that people with mental illness should have the same opportunities as every other citizen in our community. He supposes you could say it's rolling the dice, but he'd rather believe in our community and the strength of our community then just say that this is good enough. He may be dead wrong and naive but he thinks organizationally when they look at the future, and Jonathan can talk about this, it is a tough scenario to think how they are going to deal with increasing poverty in Franklin County, increasing population, increasing crime and violence sometimes in certain areas. Mr. Royer stated that mental illness and addiction is essentially a sentence to poverty and where do we incur most of our civil problems? It is in some of our poorest neighborhoods. It is really hard on people with mental illness and addictions. They can't escape it all too often and ADAMH tries to balance that.

Mr. Wylly stated even though it is a new levy ask in terms of millage, two thirds of that is just to sustain what they have already. It's not as though they're trying to raise new millage to start new programming. About a third of that would go towards new programming but most of it is just to sustain what we have over that ten year period. Of course we all know it is hard to project for ten years, but that is what they think they need. The only thing Mr. Wylly would add about Medicaid expansion is their modeling already assumes that there is a cost offset because of Medicaid expansion. In other words, Medicaid is picking up some of the services that ADAMH had picked up before. Even with that built into the model they still need these revenues to make it for a ten year period. That is a long time as Rory has pointed out to go with flat funds and so they are just trying to reestablish that slow growth revenue curve that they saw over the last ten to twenty years into the next ten years. Mr. Wylly doesn't want people to walk away thinking that new millage means it is just for new programming, because it's not. It is mainly to sustain what they have.

Mr. Royer stated to Jonathan's point that it is important again to note that our reserve fund is projected to be spent from day one of the next levy period regardless of the environment. It is not as if they are going

to sit on any reserves they hold. They are going to spend those monies and therein lies the problem with the five year window. Not only are they trying to recoup lost revenue they didn't realize because of other reasons, but they are also spending those reserves from day one to try to sustain a system and to meet the emerging needs.

There are going to be two reports that are worthy of mention according to Mr. Royer. One has actually been a Franklin County government initiative with The Council of State Governments and he thinks there are going to see some recommendations. The focus was how do we better divert mentally ill people from our jails? ADAMH showed the Committee slides where mentally ill people tend to spend fifteen days longer in jail then people without mental illness for the same crime. We know we are incarcerating them longer just by the fact that they have mental illness. There also is a task force that ADAMH has been working on with the Columbus Foundation on psychiatric emergency. They hope to make some changes that are going to lend itself to relieving essentially extreme pressure on the crisis and emergency system. That said, some of the recommendations are going to probably be such as 24/7, 365 mobile crisis response units. The will try to keep people out of the emergency rooms and Netcare by dispatching teams out to these people when CIT officers come across a mental health crisis. ADAMH has trained close to 600 officers in Franklin County with crisis intervention training. If they could have mobile crisis teams to dispatch out into the community to work with those officers they may avoid having these people accelerate their way into a very expensive level of care. Making mobile teams available to a community of this size, 365, 24/7 is a very expensive proposition because you are talking about highly trained mental health professionals. That includes master's level psychiatric social workers, a minimum of a psychiatric nurse, and a case manager as well as some form of security. In some situations, they will have to transport. So some of these recommendations to address a system that is already brittle are going to cost resources. ADAMH can do that with defunding other programs. Mr. Royer's guess is they are talking about a million dollar investment to make these teams available. Then you start thinking about how many teams do you need, what is your operational cost, what is your staffing cost, and then what do you do if you have multiple calls in the same evening. Mr. Royer thinks this is a very real recommendation that is going to come out.

Mr. Royer stated that the challenges moving forward that ADAMH has already talked about as new investments are adult crisis, youth crisis, heroin addiction on the rise, and suicide prevention. This is also an attempt to respond to mental health care in the schools with these young people that are experiencing mental health issues. ADAMH wants to sustain those investments of $3 million in 15 out of the 16 suburban school districts where they now have a mental health presence and a relationship between our mental health delivery system and these suburban school districts. They want to continue their investments with the Columbus City Schools in these areas as well.

Mr. Royer said the report on the jail will be issued in the next two to three weeks. The emergency psychiatric crisis report will probably come out in June. It is well underway and they are trying to jumpstart some solutions to that. ADAMH has been working hard with Nationwide Children's, Wexner Medical Center, and Netcare to look at is there a better way to serve children and adolescents regardless of whether they have insurance or no insurance so that every child can be served in an environment that is not a complicated environment where there are adult mentally ill in psychiatric crisis. Right now, children are transported to Netcare where they can actually be in a situation where you have adult people in psychiatric crisis. Then what happens is the police department has to go on diversion and transport them to the hospitals because you can't appropriately comingle these individuals. In addition, ADAMH has a rising number of adults and adolescents with the high levels of acuity that are acting out because of co-occurring substance abuse. This is becoming very volatile so they are trying to work on some positive solutions. The hospitals will tell you that they are very stressed about the presence of mental health patients and the length of time it takes. Mr. Royer stated that just to clarify, ADAMH doesn't fund inpatient care, which is an obligation of the state.

According to Mr. Royer, they don't know and can't speculate what Mt. Carmel is going to do about their license for 18 psychiatric beds. They can't comment on what they are going to do because they have not announced it. Mr. Royer stated that if they don't move those beds or keep those beds open that will have a severe impact on the crisis system in this county. That means that there are 18 less spots that they can churn

people out of emergency psychiatric services into an inpatient bed. Dr. Smith can talk to them about that in detail. That is a very difficult scenario for any of us to imagine. The system is already under bedded. Mr. Royer stated that long term from a more strategic perspective, what is even more dangerous is it is being reported to us that there is significant deterioration in the payer mix at the general hospitals for psychiatric services. That means they are getting less private insurance and more Medicaid. Medicaid reimbursements will not on its own support the costs. Even with insurance, it doesn't pay. It is a loss leader essentially for a full service hospital. One of the worst case scenarios for our community is that these general hospitals such as the Wexner Center or Ohio Health say we are just hemorrhaging money here and all the good money is going out to the for profit networks, so we just can't sustain 25 beds and have to pare it back to 20 beds. The system doesn't have enough bed space now and all that is going to do is stack people up in psychiatric crisis. It's like adding gasoline to a smoldering situation.

Dr. Smith stated Exhibit 2 does list the actual numbers of beds in the system as well as the level of care and prices for beds that ADAMH funds. Right now the system is very brittle. There is often a domino effect where one hospital has to go on a surge protocol. They have to get everyone out of their emergency room and they won't take people from the other emergency rooms. That impacts every emergency system's ability to move people out and into a bed. When the system is working at its best, people are waiting around 20 hours in emergency rooms to get a higher level of care. Even for those of us who don't have a mental illness, it is a very stressful environment to be in. It is not a good place, especially for kids whether they are around other adults with severe mental illness or watching people being coded with a crash cart and shocked in the halls. It is a very stressful environment. They actually tend to see people decompensate even more when they have to stay in the emergency room longer. So someone that might have been able to have a very short hospital stay has a very stressful time in the emergency room and might require emergency medications that can really impact the course of their mental illness. Obviously, the potential loss of any beds would have a pretty dramatic impact on the crisis system. The other thing that Dr. Smith wanted to mention is what David was speaking about with the recommendations from the Council for State Government group as well as the emergency psychiatric group. A lot of the recommendations that it looks like they are going to be making are things that are not typically reimbursable by Medicaid's normal treatment taxonomy of services. A lot of these are things like the mobile outreach, coordinating care, the ability to discuss high utilizers across the system, are things that ADAMH is really going to have to be supporting because it is not that typical outpatient or inpatient treatment that Medicaid most often covers.

Mr. Royer stated the other factor in this unknown environment that could lead you either way is they know that the state has indicated it is going to place all people with Medicaid with behavioral health requirements into managed care. ADAMH doesn't know if it is going to be a special carve out like Magellan or Optum Healthcare Solutions from United Healthcare or if it is going to Molina or Aetna. ADAMH serves people with Medicaid for their community support requirements. Right now, it is a community based system. Once you go to managed care, ADAMH will have a more difficult time understanding what the treatment protocols are going to be, what the medication formularies are going to be, are they going to see a dramatic shift of policy relative to any psychotics from first generation to atypical on a fail first premise. Are they going to see requirements for care managers to approve medical director's recommendation to any changes in psychiatric dosages? Why is that important to ADAMH and why is that important to the community? These folks are essentially fragile and it requires a lot of time. ADAMH can see through these policy initiatives the dramatic changes in what you currently view in the community relative to mentally ill people. It doesn't take much to knock them off their balance and they know the track records on treatment and medication compliance is not always great anyway.

Dr. Smith said the state has recognized and allowed psychiatrists to put people on the psychiatric medications that they need to be put on without having an automatic switch to a less expensive medication. They really do recognize that it is not like one beta-blocker for your blood pressure is equivalent to another beta-blocker. Different medicines really have different profiles. Dr. Smith thinks they realize there might be a financial loss up front if they are paying a little bit more for medication but it is really worth it to keep someone stable and keep them out of the higher level of care. The concern is when things move to a managed care type environment, will they lose those types of protections for these individuals and will they

not be able to get the same level of care resulting in more folks in the crisis system that is already overburdened and more people requiring inpatient beds when they are already under bedded.

Mr. Royer stated on the projections of provider expense the model does not reflect what he believes will be the natural consequence of managed care. Right now Medicaid pays for what is known as CPST which is essentially case management. The system has caseworkers out working with mentally ill people every day to try to make sure they are doing what they need to get done. If managed care moves away from that model, the question then becomes do you start having to increase administrative requirements to get protocols approved? He has already been approached from several providers that have asked will the Board help with CPST because they are concerned that if certain kinds of CPST functions that Medicaid currently pays for are taken away by the managed care companies, that the stability of the individual will be in question. What is the consequence at a community level, the risk of people becoming more destabilized and more systematic? What does that translate into? More jails, more homeless shelters, and more people on the streets. It is always dangerous to speculate but what is really clear is we've had for better or worse a fifty year model about how we have approached mental healthcare in America. We have not always had the funding necessary to get the job done and Mr. Royer indicated that we are not moving toward a cohesive system of care in this state. They are actually becoming more fragmented. It is one of the great ironies of having increasing coverage and yet increasing fragmentation. It is almost counter intuitive. You would think with greater coverage you would have greater continuity and coherence in the delivery model. That is not from where they sit a likely scenario. Mr. Royer believes they are actually going to see less available information about individuals and they already experience that today. That is the challenge they foresee over the next five to ten years. The question becomes are they going to have the resources to enable them to overcome some of this increasing fragmentation? There is a risk of declining service availability because of managed care.

Mr. Royer thinks it is a fair criticism of him and perhaps the Board, not the Board members, that they recognize now more than ever that they have been too slow to raise reimbursement rates for their providers. Their cost of business will continue to accelerate over the next five to ten years and if they are going to retain and attract people into this profession, ADAMH has to start a process of increasing their rates above the Medicaid rate. They have not been increased in at least twenty years. Can you imagine going as a healthcare or an insurance company or university where you don't have any revenue increases for twenty years off of one of your major paying sources? How do you stay in business? That is the risk they have. ADAMH has some marginalized nonprofits right now that are major mental health providers. Mr. Royer stated that he has been slow to recognize it and will take responsibility for it. They have to increase their reimbursements because the state is not increasing reimbursements from Medicaid. In fact, they look at every opportunity, he thinks, to cut Medicaid reimbursements. Part of ADAMH's challenge is to recognize without great caregivers they could have all the money in the world but they have major mental health operations that are marginally capitalized and will not improve without some creative financing solutions.

Mr. McGuiness wanted to add something about managed care and fail first. His brother is schizophrenic and he was on their insurance and was forced to go through the fail first process. This was a number of years ago now, but as a result of that, it took about three years for him to get to a medication that actually helped him. During that time, he was in and out of the hospital. Mr. McGuiness said growing up in a household of someone that has a severe mental health issue was a very difficult time for their family. Thankfully they have a strong family but so many families aren't. He said it would be much better to start with the best medications than medications that have the worst side effects and the most likelihood that people are not going to take the medication. One of the biggest problems is people being compliant with their medication. If you have to follow that course of action, it has very real consequences.

Mr. Friedman asked if they can bring the conversation more to this side of the table. He has some sense that the fragmentation is occurring. It kind of sounds like they are saying we are going to continue to stick our finger in the dike of this fragmentation as opposed to trying to move up stream and work with some of these other agencies. When he looks at their role as coordinating, they are really a purchaser in this environment. Mr. Friedman doesn't know how they avoid dealing with managed care. When he thinks about what the pressures on managed care are within the healthcare system, they have the same challenges

of trying to figure out the business case. What is the evidence for what we can do earlier in the process to prevent someone falling off at the other end? It seems to him that a lot of the commonality earlier on is the broader population that they serve.

Mr. Friedman said when you do a survey and you categorize people as any mental illness that is a pretty broad grouping. Then you have your crisis and your impatient cost at the other end. The committee doesn't have hearts of stone over here. Every issue ADAMH brings up absolutely is a problem for our community but what we have is a limited number of resources. What he sees continually is the silos that are created by each of these levy organizations as opposed to really taking the attitude to try and really focus on the whole person. He remembers working for Medicaid and looking at long term care where people with serious long term care, chronic illnesses, and severe mental illness had six case managers. Making sense out of that seems to him is the responsibility of someone who is a little closer at the local level. There are certainly medical neighborhood initiatives that are being employed to look at coordination of people between social service supports. A lot of the things ADAMH is talking about are independent actions where you go in and create a program and this is a need that we have identified. Without really grappling with who else might have some responsible in this circumstance and who else might have this individual as a client and in that context it doesn't seem like they are leveraging the resources that are out there. Medicaid is moving more and more in terms of medical activity is towards social determinates of health, behavior and life style, environment and to some degree genetics, but it is not about medical intervention. It is about avoiding medical intervention so Mr. Friedman can't see where there isn't some common pathway here that ADAMH can begin to get into. Talk about Children's Hospital and talk about Partners for Kids. Partners for Kids have a subcontract with every Medicaid managed care organization and they assume risk for a number of those kids. A lot of the interventions that ADAMH is talking about are just good health interventions. They are not about necessarily mental health and so how does ADAMH allocate that responsibility across people who have some common interests in the patients that ADAMH is serving?

Mr. Royer said Jerry's observation is correct, but he thinks they do try to build those collaborative efforts. They have invested significant resources with FQHCs around the city. They know that people, people that are unlike us, may not feel comfortable going to the big mental health centers for care. There can be shaming so ADAMH reached out and developed partnerships with neighborhood health centers. They have mental health care available that ADAMH reimburses for anybody that comes into a neighborhood health center that is evaluated. They partner with the Ohio State School of Social Work where they have Med-Tech students in there so there is a three-way partnership. They have done it at the Maloney Center, the new Dublin FQHC, the Westside FQHC, and they continue to work with Marty Miller's FQHC to better integrate mental health care as part of this new immerging environment. Another example in the last several years is ADAMH has entered into a contract in the amount of $1.5 million with Nationwide Children's Hospital to support their psychiatric crisis stabilization unit. They recently contracted with Wexner OSU Department of Psychiatry to underwrite in partnership at their financial risk of $400,000 for their new calm unit which is a better strategy about trying to deal with people in mental health crisis in that acute care and ED environment. ADAMH is in active negotiations with Nationwide Children's and Wexner at a pretty significant cost and believes this is the clear and more responsive system for children in crisis. ADAMH will be taking some recommendations to the Board in two weeks. These are almost seven figure kinds of commitments to Nationwide Children's and to Wexner OSU. Look at the investments at the FQHC centers, our major healthcare institutions, and a contract for medically complicated patients with OSU Department of Psychiatry when an individual doesn't have healthcare insurance. ADAMH doesn't have to contract with OSU to help pay for their psychiatric care because of their medical complications but they do that. They have a contract with Netcare that they perceive moving to Nationwide Children's so if a child needs inpatient acute care and they don't have any resources the Board will pay for that episode of care.

Mr. Royer referenced the school projects. They met with every superintendent and said to every superintendent in the school districts, tell us what you need. ADAMH didn't tell them what they needed, we ask them. ADAMH listened to them and asked who they want to partner with in the mental health community to deliver the services. They then came to the county board and told them what their project plan is and then ADAMH funded it. This was done successfully with fifteen suburban school districts by asking people what they need. That to Mr. Royer is not working in a silo, but that is tearing down silos to

say if they can get one kid into mental health care earlier, the chances of them being a long term consumer of mental health care is dramatically lessened. Are they guilty of silo thinking and thinking mental health community first? Yes. If you go back in the history of mental health care in America, the primary care community was very comfortable for a long time pushing these people over here so they had this very dichotomous delivery system up until the ACL. Then people's eyes started to open and say there is a better strategy here through integration. It wasn't because people wanted to embrace people with mental illness, it was because it was easier to shuffle them off to the institution. Even now we see stigma about how some physicians in the ED's perceive people with mental illness. They are problematic. Well they are sick and of course they are problematic.

Mr. Friedman stated they are still running an institution. They got rid of mental health institutions or at least significantly downsized institutionalized mental health and mental retardation in the 1970s. They are just beginning to deinstitutionalize medical care. The thrust is it is going to be to the hospitals advantage to keep people away. They are going to get paid on a per capita basis based on a risk pool and if you can keep someone away from the hospital all the better. So Mr. Royer's points are all again on target but they are still purchasing services. What he's saying is where is the revenue stream? 71% of your funds are now coming from the county. There are a lot of other people, manage care organizations, who have those dollars that are going to end with a hospital bill when that kid who is in crisis goes to play in traffic. They are on the hook. It has to be in their interest, there is a business case to be made to them that they are providing a preventive service that is of value in terms of their long term business plan and the protection of their beneficiaries. That is the side of the equation that he is trying to understand. Where are the other resources? No question on the service delivery front lines ADAMH has to provide it, but there are not going to be a lot of new monies coming into health care. If you look at the OECD countries in terms of their total expenditures for health, they are all about the same. They are roughly within the same area on a per capita basis. You look at how much we have allocated for medical care and not for supportive services that is where we are out of whack. We are spending that money on interventions at the end of that pipeline when people are so ill and they need so much investment as opposed to the front end. Mr. Friedman sees the broad plan to try to span that entire continuum, to do the preventive stuff, to handle the crisis. But ADAMH is a local agency and they are going only to the property owners in this county and trying to do a job that is much bigger then what they are actually funded to do so it is going to be never ending. It is going to be open-ended. ADAMH could spend as much money as we could give them.

Mr. Royer said yes, probably.

Mr. Friedman asked, would you solve the problem? Mr. Royer said no.

Mr. Friedman asked, so how much is enough? Mr. Royer said he didn't know.

Mr. Friedman said Mr. Royer is the expert. Mr. Royer said yes he guessed he is. At this point what they have asked for is a half mill.

Mr. Friedman said it was a 22% increase. Mr. Wylly said 26%. Mr. Friedman said it is not a modest increase. He's curious about their poling. Did they say it was going to be a 26% increase? Do people know what that means? Mr. Royer said no.

Mr. Friedman said the concern is about the optics. They stripped everything else away. You have the optics of ADAMH hasn't spent your money for the last couple of years. They have a huge reserve.

Mr. Royer said you know what the optics are? ADAMH is underwriting millions of dollars for behavioral health care to major institutions that sit on billions of dollars. That is an optic to me. So he is not going to allow Mr. Friedman to sit here and accuse of 50 million dollars that they plan on spending from day one as an optic. OK, it's an optic. Let's keep it in prospective. ADAMH wouldn't have to ask the homeowners if they didn't have a legislature that says you can just give away all this money to developers and they don't get the revenue. What about that optic? So ADAMH has to go and ask some poor guy in Linden to raise his taxes for mental health care and there are institutions that sit on billions of dollars.

Mr. Friedman said they don't have to go to the voters. That is the issue that the Committee is trying to grapple with. They have some serious concerns about the ability to justify an increase. At the end of the day it is ADAMH's responsibility, they will make a recommendation, but that is a consideration.

Mr. Royer said it should be and he has said that from day one. The other point he would make is eighteen months ago he met with Netcare and said 80% of your business is Medicaid and only 40% of your revenue because Medicaid will not pay for what it takes to operate a 24 hour crisis center. Mr. Royer said you have got to start working with these folks. The CEO of Netcare was in my office yesterday and Mr. Royer said it is going to be really hard. They can't keep spending $10.5 million to underwrite when 85% of these people are on Medicaid. The CEO said I took your advice and contacted every Medicaid company. He said I can't get them to return any of my phone calls. I tried to negotiate per diems. They just want a fee for service. Right now if you are in psychiatric crisis, Medicaid will only pay for the time that you have a direct medical intervention. They won't pay for the other 23 hours of the day. If it wasn't for the levy, they would be in the EDs of the hospitals. So realize that as an opportunity cost and what you see is pretty significant.

Mr. Friedman said what is the future? Is ADAMH going to assume risk or are they going to move to capitation. How do they begin to move away from fee for service?

Mr. Royer said first and foremost the concern is about the person's psychiatric crisis. What they have said to them repeatedly is as they go to managed care, you have to have a contract that begins to underwrite. ADAMH can't continue to just underwrite this, there are other needs. Whether or not Netcare takes it as a capitation, Mr. Royer would probably tell them don't take it as a capitation. The history of all this is pretty complete. A lot of this stuff is a cycle that states do and then the managed care companies find they really can't manage people with severe and persistent mental illnesses. Mr. Royer reiterated that schizophrenia is not a social determinate. A lot of ADAMH's most sick people have a very significant biologically based disease and so he can't imagine an environmental approach. There are so many people that are going to have schizophrenia that Mr. Royer can't imagine anything they could invest in that is going to stop that schizophrenia from occurring. Their first episode is the key episode.

Mr. Friedman said if they can isolate the lower risk part of the population and when you are talking about your children's services and your preventive services, managed care does have an interest. Then you can have somebody else contributing to that aspect would free those dollars up so ADAMH can deal with the people for whom prevention is not available but mitigation in some way or other is. That is what the world is coming to. That is where this all comes together and the question in his mind is how can ADAMH be more proactive? If you see this fragmentation, what are ADAMH's avenues in coming up with good ideas to test some of the interventions that actually are producing the evidence to make the business case to the folks that have money who are on the hook and who would benefit from this? It seems like ADAMH is at a unique flux point in that regard.

Mr. Royer said he would offer Mr. Friedman the things he discussed today in the current environment. That really is about trying to make a change in the middle of trying to swim upstream with a revenue stream that has deteriorated significantly over the last ten years, especially since 2008. ADAMH is actively trying to transform how they think about their mission while in essentially a bad situation. It's not as if they are sitting around thinking that they don't want to change. ADAMH is the one that went out to the FQHCs and to the environmental judge to say hoarders are sick people and let's try to treat somebody because it is a horrible thing if you are a family member that has a hoarder. The same thing with the children's psychiatric crisis, ADAMH has initiated these conversations and continues to initiate what they believe are progressive measures towards a different approach than simply having the mental health center on the hill. That is not what they want. ADAMH just worked with Southeast down here on West Broad Street to open up an integrated FQHC and behavioral health center that is placed literally at a Columbus Metropolitan Housing. They got priced out of the Short North where they had a peer center. They can't afford the rent. They are pushing the mentally ill into Franklinton so ADAMH moved the peer center to the low income

neighborhoods where they can afford to live. Mr. Royer stated he can embrace what Mr. Friedman says but rejects some of the notions that somehow they have been silo and unresponsive.

Dr. Smith said one of the points Mr. Friedman made, which is a good one, is the ways that they can demonstrate supportive services and services that aren't typically provided and how that can reduce costs overall. She does think that based on some of what they and other ADAMH Boards have provided, Medicaid is starting to see the value of things like assertive community treatment teams. As a result, they are now seeing Medicaid consider providing that, whereas historically they haven't because it required such intensive supportive services beyond just the treatment component. Dr. Smith does think the Boards do play an important role in showing the supportive services that you are not providing are really important to the person's overall wellbeing and how stable they are going to be in the community. That does move the way Medicaid reacts. Unfortunately it may not be as quick as they would like to see. That is something to keep in mind as they invest in things and show that they will be helpful.

Ms. Lewis Kaylor stated another example, just to come back to collaborations because they concur the world is not such that they want to work in silos, is the work they have done around housing as one of the main supportive services. We all know that Medicaid is never going to pay for housing. The example about the integrated health care clinic is something that ADAMH took to Columbus Metropolitan Housing Authority and brokered that clinic space in a 100 unit apartment building for formally homeless and mentally ill and/or addicted folks. They were able to leverage 20 units for consumers ready to move in from residential care facilities that were stable and would benefit from that. They work with Southeast to operate that integrated care center. For all of their housing projects, they are a minority funder by design and don't think they should be a majority funder. ADAMH works with developers to leverage housing tax credits, OFA money, and the state on the biannual budget and come in as the minority capital funder. They know onsite supportive services for folks to remain stable in those levels of housing are vital so that is where they are investing. ADAMH thinks they need to continue investing in these initiatives.

Mr. Friedman asked what kind of outcomes data do they collect and do they match that up against cost relative to the investment they are making. Who is the audience for that?

Ms. Lewis Kaylor said she thought the audience should be all of us. The Board set four years ago strategic results for value based contracting and quality and how they measure outcomes as a core part of that. The outcome system is at the provider level. With all the changes in the last three years with Medicaid elevation and expansion, they are designing their outcome system to be more real time in the real world based on the programs that they are funding. When ADAMH talked about the SHARES enterprise system, their outcome system is actually being designed more in line with some of the questions around the continuum of care and the services that Medicaid will never pay for. What ADAMH has been working on in their design for the last two years with the SHARES system is an outcomes module that is first and foremost going to give them the ability to drill down to the exact program and different populations that the previous outcome system didn't give them that ability to do.

Mr. Royer said historically ADAMH has tracked outcomes for fifteen years. It's a random sample. They have consumers with mental illness that help them with the process. The reality is that it was more agency based. As part of this transformation, they do want to get it down to the programmatic level so that they can even make better quality decisions about what they are getting for these individuals with these certain kinds of situations relative to the cost of investment. For the last fifteen years, they had a fulltime outcomes research team looking at this issue of the outcomes of mental health care. They also do consumer satisfaction and measure on certain core domains such as do they report decreased symptoms, is their employment status changed. They have had over the last several strategic initiatives from the Board the idea of paying for outcomes and quality. They will continue to do that as the new technology allows them to make really discernible, high quality, high confidence decisions. With the advent of electronic medical records, they will be transferring that information with the outcomes modules that they are building on a web based portal for all contract agencies. They hope to be testing the environment this fall. This is a joint venture between Cuyahoga, Franklin, and Hamilton counties. The three largest urban Boards created a Council of Governments. The first project is to build this enterprise system and they are sharing the cost

of the development of this enterprise system. It gets to enrollment, billing, adjudication, outcomes, prevention modules, and residential placement models so that there is a singular view of essentially the environment. Mr. Royer thinks they are heading in the right direction in that area have always historically cared about it.

Dr. Dixon said he wanted to mention Questions 5 in the packet. It addresses the collaboration that ADAMH does with city and county agencies and also there is Exhibit 1 that summarizes some of those collaborations.

Ms. Lewis Kaylor said that Exhibit 1 is about $1.7 million worth of collaborations. They are not one way investments, those are leveraging other sources. Now they will go back to the questions of treating the same folks in different systems.

Ms. Carr Hurd said with the juvenile justice system, they collaborate on a reception center so that diverts children from the detention center. They also collaborate on intensive treatment modalities with juvenile court as well as Franklin County Children Services. They are working to keep kids out of the detention center and out of residential levels of care or a higher level of care. In those collaborations, the court, Children Services, and the Family and Children First Council contribute at different levels to those initiatives. David talked about the work with the Council on State Governments that the Commissioners have sanctioned. Looking at the jail and the number mentally ill that is cycling in and out of the jail, some of the recommendations that are coming out will be leveraging resources from lots of systems not just the ADAMH system. The jail does not have a current screening or assessment system of people who come into the detention center. ADAMH has no way of knowing how many people in real time are in the jail that have a mental illness or substance issue. Some of the recommendations coming forward will be requiring some collaborative funding in the development of a system that will keep the mentally ill from cycling in and out of jail. They work with the probation department who allocates funds to ADAMH to purchase treatment for folks who are involved in probation. Exhibit 1 outlines a number of collaborations. In terms of PFK, she talked with them and they are not responsible for community based behavioral health care for children, they just pay for inpatient care. As you know, the Governor has announced that behavior health care is likely moving to managed care. They expressed an interest in having some discussions with the Board, but right now they are not financially liable for community based care. They see the need to start having those discussions but ADAMH is at a point in time where they are still in flux with regard to managed care and where the state is going with moving behavioral health to managed care.

Mr. Royer stated they were asked three months ago in January to support the infant mortality initiative and will be taking that to the Board. They have historically always partnered with some of the kids organizations. It is a small contribution they are asked to contribute to the organization with other support by the corporate community. They participate in a lot of partnerships that they ought to do a better job touting, but when they are asked, ADAMH is a responsive partner because that is how things get done in this community. ADAMH has tried to embrace it to the best their resources.

Dr. Dixon stated they do a lot with faith institutions, particularly ones on the west side, south side, and the northeast side where there is a lot of crime and violence. ADAMH came to the table and said they will support some of these initiatives but the agencies have to bring 50% of those resources along with you. They found ways to bring some of the resources and have been very successful programs. The need is great out there for the faith leaders that are trying to deal with crime and violence of their communities.

Ms. Lewis Kaylor said the other pretty significant collaboration, which they are still considering as a pilot and didn't put it in here prominently, involves Dr. Smith and Kythryn working very closely with the Community Shelter Board on the new system redesign. What they realized through their data sharing and analysis is a significant growing number people that are homeless are cycling in and out through the high acute care settings and they are coming in homeless and they are leaving homeless. They are going from that very high level of acute care and back into the shelters or sometimes the street because they have the right to be discharged if they are ready to be discharged. ADAMH has carved off $300,000 with Southeast who is the premier agency dealing with the homeless individuals in this community. They created specific teams just to work with folks that are right now in that large shelter environment that need to have some

kind of different intervention or motivational interviewing. They may not think they are mentally ill, they may not think they are addicted. ADAMH knows that with special interventions that are appropriate for the mental health system to provide they can link them and engage them and begin to be a part of that solution for ending their cycling between homelessness and shelters and streets and acute care settings. That is something that they launched in November and it is too early to say how that is working but they continue to work collaboratively with the Community Shelter Board.

Mr. Friedman said let me respond specifically to that. People say why does the ACA pick on hospitals? In hospitals, your acute care interventions, your emergency departments, if someone is admitted and discharged and they bounce back, the hospitals are on the hook for that. Why isn't the hospital contributing to the services that ADAMH is providing in terms of keeping that person in a stable setting in the community? The hospital is on the hook, they are going to be dinged for that readmission. Lutheran Socials Services has had a proposal kicking around this town for years around homeless respite because someone coming out of an acute care facility isn't going to be admitted into the shelter because they are too medically complicated so they are going to end up under a bridge. No one has been willing to pick up on that. It just seems to me that there are a lot of answers out there but everyone wants to go their way.

Mr. Royer stated yes, he supposes that is human nature. There is one mental health provider that they don't contract with, but other than Ohio State, the Department of Psychiatry has a very small outpatient program. They are it. The Medicaid program and the Board support all outpatient mental health care. Phil Kass said why doesn't Ohio State open up a community mental health center? It seems it would fit very nicely given the reimbursement structures, given the amount of people that appear. Mr. Royer could envision if that happened, OSU coming to them to say what about some of these folks that need supports. He agrees there is a window of opportunity for the transformation of health care institutions to more outpatient and it shouldn't just be limited to the traditional views of primary care. It goes back to this historical notion of separating these people from the main stream. He agrees with Mr. Friedman there is a strong opportunity.

Mr. Friedman stated the other issue is kind of the catch and release situation where Minneapolis had a program for more than ten years where the police are authorized to take someone who is drunk and disorderly or has a mental illness problem to a facility. ADAMH is talking about a decentralized approach where you are going to send crisis teams out to where people are. Do the police currently have the ability to bring folks? Aren't they the remote teams? They are the ones who are going to deal with the folks who ADAMH doesn't get to anyhow.

Mr. Royer said first they do fund Netcare which is a $10.5 million commitment by the Board for emergency psychiatric services, 24/7, 365 days and they are on divert a lot.

Ms. Kaylor said she wonders when they use that word if they don't do a good enough job explaining. Divert means from the police being able to take folks from the community. They are never on divert for individuals walking in. That is a big distinction. They can't go on divert no matter what, they are a crisis emergency room of their own.

Mr. Royer said every health care institution has limits of capacity and once you reach that limit for whatever reason you would be obviously creating a liability that is unacceptable. It is undersized and under supported. ADAMH supports it. 80% of these people had Medicaid and 40% of the revenues. They are hoping with managed care that they will start picking their fair share up. They've approached the state and they are not interested in changing the rules because they are waiting to offload it onto managed care. The mobile crisis is in addition to what exists that tried to stem the flow. Netcare is the engagement center that is actually to pick up public inebriates and transport them out there. They shower them and try to engage them in treatment, but most of them are not in the pre-contemplation mode of saying I have reached bottom. If there is somebody down here by Miranova who is intoxicated, their vans will be down there to pick them up or wherever throughout the community. The program is basically at capacity and it's seasonal. Those operational costs, Mr. Royer believes is $900,000 from the Board and $200,000 from the Community Shelter Board to operate. That doesn't include running the vans and making the vans available out into the downtown districts so they can get these folks. It is well over a million dollar investment for a special

population. There are so many systemic reasons why it is so problematic: lack of inpatient capacity, more and more people that are harder to figure out because of their drug usage and their underlying psychiatric illnesses, the acuity of it. ADAMH now has to have linkage programs for mentally ill people that get put in the state hospital because they are opium dependent and at the time they are psychotic from opium dependency and co-occurring drug usage. ADAMH is seeing new and emerging illness states and the different diagnosis requirements are pretty significant.

Mr. Hemphill said he wanted to bring closure to this session. He would like to take the remaining time to get the Committees' marching orders and timelines. It is obvious that the ADAMH Board and staff are very passionate about the services. He appreciates the time and effort that they put into answering these questions and the information they have given to document that. It is time for them to roll up their sleeves as a Committee and do the job of due diligence that it takes to come up with a recommendation and that is what they are going to begin as soon as they finish this session.

Mr. Royer said they are passionate and sometimes over passionate, but if you have a family member with a severe and persistent mental illness, not only does the person get a diagnosis that lasts for life but all too often it is the families that have the diagnosis that last for life. He firmly believes that we should put people with mental illness on equal footing that we put other people on. No one asked to be mentally ill and the idea that somehow something second rate for them is acceptable should never be acceptable to us as a community or community leaders. It is just his passion.

Mr. Friedman hopes he didn't detract from the great work that they are doing. The committee is in kind of a middle place, where the Commissioners look to them for a sounding board and to kick the tires. He thinks ADAMH is looking forward ten years and nobody knows. The reality is you have to plan within a vector. The state is talking about moving to a 1634 eligibility status and that will change life for a lot of people who have that disability. They will be automatically eligible for Medicaid. ADAMH will make up the shortfall by doing more volume, right?

Mr. Royer said he didn't know. Remember that when you go to a doctor that is one activity that sustains you in your life every day. When you have a major mental illness treatment that is one activity, it's the other 23 hours of a mentally ill persons life that we are charged with trying to support. That's what differentiates ADAMH from many other activities so not only do we support and underwrite health care treatment but our task when you go into the statute of chapter 340 (it is in the levy fact book) is to meet the needs of the mentally ill across the board from housing to socialization to clothing to shelter. That is a big challenge in a major American city when easily we have 9,000 really sick people. ADAMH doesn't get to narrow how they think about their mission or how people perceive ADAMHs mission of treatment. The statute actually says it is only an aspect of what we are required to do for people with mental illness. Mr. Royer think that is what they are trying to get at. It is hard to envision supporting people in a community, even given the benefits of expansion regardless of how it turns out. Thank you.

Mr. Wymer said one thing he wanted to clarify is that they made a comment early on that just said ADAMH could shuffle the dollars and they could make recommendations. He doesn't think that is the role of the committee here. Mr. Royer is very passionate and that is why he is good at his job. Mr. Wymer thinks at the end of the day, that is not their job.

Mr. Royer said he didn't mean to imply that.

Mr. Wymer said he didn't want Mr. Royer to think that the committee was trying to essentially tell him how to do his job better.

Mr. Royer said the question was couldn't you do that and what he tried to say was yes absolutely they can do that. They probably wouldn't look for their advice anyway.

(ADAMH staff left the conference room. Only HSLRC members and OMB staff remained)

Ms. Hallas said just a quick note since Mr. Royer was referencing the ORC. He mentioned the list of services to be supported. It is correct but to the extent that resources are available. They could probably do a ten mill increase to provide the extensive list of services that the ORC lays out. The list is what they are allowed to pay for not necessarily what they are mandated to pay for. As far as how they operate and referring to the fact that they serve a lot more than the other systems, it is much cheaper to serve folks with the average treatment costs when they want to compare to BDD, which is a life time commitment of services, or Children's Services, which pays for the housing and care of children. It is a very different type of system. Finally, when it comes to the extent of resources that are available, the question is what does the community want to expend on services? BDD is a mandated service, if there was no levy, the Board of Commissioners would be responsible for providing the services. The same with Children's Services. If that levy failed, the Commissioners would be responsible for meeting all those state mandates to protect children. With the Office on Aging and ADAMH, the Commissioners don't have that legal obligation. Some counties do not have ADAMH and Aging levies. Those ADAMH Boards without levies operate in the state with the minimal state and federal dollars they have left. They are really two unique systems as far as what is the mandate. Ms. Hallas agreed that they do not have hearts of stone, but it is balancing appropriate revenues and what the communities want to support versus what is available.

Mr. Hemphill asked Heidi if this document, the attachments, and the feedback they got back from them give her enough to start the process. If not, what does she need from the committee members?

Ms. Hallas said that some of the questions were not answered as thoroughly as they would have liked. She didn't get the responses in advance but as they were having the conversation, she was flipping through. It is really up to the committee if they want to ask for additional information. One question was previously asked about outcomes and what does that mean for prevalence rates and historically what do those look like. Those are not in the responses. Ms. Hallas did meet with the fiscal staff yesterday and went over their models so she did get a copy of all their model spreadsheets. She can start building that for the Committee to look at. It is really going to come down to if the committee agrees with their assumptions and what are they are willing to recommend based on the information given. Ms. Hallas will start building that model, provide them with a list of all the assumptions that currently exist, and they can talk about what that means as far as to the taxpayer. She did have a separate list of questions that OMB had which were more technical but she told ADAMH that today's questions were definitely the priority. When looking at the budget there wasn't enough detail to say what was driving the increase or what those assumptions were. As a committee, they can digest the additional information and let her know if there are any other questions. Ms. Hallas was hoping they would say here is our prevalence rates over the life of the levy since it is their mission to reduce the prevalence of mental illness and drug addiction. She asked the question what does that look like, how are they impacting this? Several of the committee members have asked if it was working. We are spending a lot of money, is it working? She didn't think that has been answered.

Dr. Bronson said they should make sure they know what they want to know. The question if it is working, to her, is not answerable so what do they want to see? Are they looking to see that the number of people being treated is going down? Well, that is not happening because the population is growing.

Mr. Talarek said if they look at ADAMH's own stats on page 19 and you compare 2009 to 2013, the number of customers is less. There are less people in the system despite all the growth in the county. He understands there are in certain segments.

Dr. Bronson said she wants to make sure that they are asking the right questions.

Mr. Friedman said to him it would be how do they define success? When do they have a successful outcome? He thinks that is different depending on where people's risk factors are. If you are talking about a suburban school kid, what is a successful intervention? If you are talking about someone who is sitting in an acute care hospital, what is a successful intervention and how do they track that?

Dr. Bronson said that one of the things she does know, she remembers from the last levy that they had more outcome data than any of the other systems that they have been talking to and they have been doing this

historically. That is why she is saying what do they want from them? They could ask them for specifics on this but at what level of detail do they want ADAMH to provide them. Just in the examples that Jerry gave, each of those is a whole set of outcomes data. How many other populations and ADAMH services are they providing? She is just asking a question to make sure they are asking for something reasonable and that they will actually use it in their decision making. Do they need to know how many suicides? Do they need to know how many kids in crisis were served?

Mr. Friedman said he felt that is the issue. They always say they are the experts. What are they trying to accomplish for these different populations?

Mr. Wymer said he thought the example Mr. Royer mentioned a couple of times about the outreach in the schools, are where they should be and that is a proactive measure versus a reactive measure. They are trying to get in front of the issue. You are never going to solve the issue all together but if you can impact it earlier then we don't have some of these major catastrophes that we are having around the country. He thinks that it is those kinds of things that they are trying to get to. He thinks he's more inclined to be supportive than not of this request.

Mr. Friedman said that he was not being unsupportive. He is just trying to understand. It just seems to him like they have said everything is mental health in the same way you can say everything is physical health. It is not going on in the doctor's office, it is happening in the community. He thinks a lot of these references are there is crime in the street. How is it that the mental health interventions that they are doing impacting that? What is the logic model that says that activities that they are spending money on are yielding the outcomes that they are saying they are trying to achieve? Tell him that. They can say they couldn't afford the rent on the peer support center so they moved it to the west side. What's the outcome? What's the population on the west side? What are the interventions you are doing? What has been the result of that? Is there a return on the investment? Is there a cost effectiveness model? Why spend it on that and not on additional crisis beds? Where are their real problems? To say that you have 70% of the population that has had an incident of mental illness within the last year is everything from someone who is depressed about breaking up with their boyfriend to someone who is jumping off the top of a building and they are not the same. He is sitting here telling us people are dying in the streets and we are having violence all over the place. That's at one end. What are they doing in terms of preventing people from getting there?

Dr. Bronson said they were dealing with the people that were depressed over a breakup. They are not the ones on the bridge yet, but if you don't intervene they may be the ones on the bridge.

Mr. Friedman asked so what is a unit of service?

Dr. Bronson said that he is asking them for something at a level of detail that they have not subjected any other levy review to and that they are providing services on so many levels, to so many different populations, both prevention and down the line on the continuum. As she hears that he is asking for this data, she thinks they might be holding their levy hostage to a request that could take them years to produce the information. She wants to make sure that they are being realistic.

Mr. Friedman said he wouldn't know how to interpret that data but he wants them to be a wise purchaser. They are spending taxpayer money and buying services and he doesn't have the sense that they are in control of that.

Mr. Wymer said the other side of that comment is how does the Committee know they're not?

Mr. Friedman said it is a leap of faith, right? They have to convince the Committee, don't they? Have they? Has he been convinced that they know what they are buying? He's not. Mr. Friedman doesn't think they have explored other revenue sources.

Ms. Carter Ryan said how can they hold them hostage to a systemic problem? She thinks what Mr. Friedman is talking about is a bigger systemic problem and that their levy should not be held hostage to correcting these much bigger issues that involve all the things he was talking about.

Mr. Friedman said they are saying the main problem is poverty, so they are trying to solve poverty?

Ms. Carter Ryan said they are saying if you are mentally ill then you are more likely to be in poverty. That makes sense.

Mr. Friedman asked what is their responsibility? Do they either address mental illness or address poverty?

Mr. Wymer said he thought one of the examples that they did give was infant mortality and that is related to poverty so they have been trying to work them. Again, he thinks that's another example of being proactive than reactive.

Ms. Carter Ryan stated from her perspective she would like to have a chance to go through these questions and answers to review them and see if they do think there is other additional information. She thinks about the question that Mr. Friedman raised about how much money are they spending and she is not really clear. They have got a certain amount of money that is maybe more than they would hope going into a levy asking for an increase that they are sitting on. What's the right amount? They seem to have some answers and she doesn't know if they are all the way answered. Why are they sitting on a larger pot of funds then would be held in your reserves. Those are the kind of things she would like to look at. Heidi doing her work in terms of looking at their assumptions would be helpful. Ms. Carter Ryan was impressed with them honestly. She thought Mr. Friedman raised some good issues but she didn't know if those are things that they could be answering right now or that they need to be thinking about going forward. Could they make a recommendation from this levy review committee that they should be talking to the providers and thinking through again where their collaboration should be? If they want to prevent getting tagged through the Affordable Care Act, then they need to be thinking about how to keep these people healthy and how they can work together to achieve that goal. She thinks these are all good discussion points but she doesn't know that they should have been doing that up until this point. Ms. Carter said there are a lot of acronyms being thrown around that she didn't know what they were talking about. She didn't know the answers to a lot of those questions.

Ms. Hallas said there is an acronym guide in the levy fact book.

Mr. Friedman said he agreed with Ms. Carter Ryan. He would like to know why they were sitting on a large percent of their budget and why they are going to then spend it on day one when the new levy goes in.

Mr. Talarek said it goes back to a question at the first meeting. After Medicaid was elevated, it did free up dollars. They were running at about $20 million and then Medicaid got elevated. As David mentioned, they were slow in reacting in freeing that up, but the balance basically in three years went from $20 million to $80 million. You look at their budget that Heidi presented at the last meeting and they have only been spending 70% to 75% of their budget and it leads to a capacity issue. Yes, he thinks they have a lot of ideas and there are a lot of needs to address, but how can the system absorb that? Is there ability in the system to absorb it? They need more social workers. If you have more money through the levy that is not necessarily creating the social workers coming to the county. You have to create that interest. Mr. Talarek thinks you have the flux of ten years ago, again a lot of the levy size was needed to make sure they could do the financial participation with Medicaid. That's now gone and there is less demand. There is so much flux in just the last three years. Do they want to go out ten years? The committee addressed this with Children Services at the last levy. It is hard enough to predict five, let alone ten. Should a decision be made on what the levy should be over a ten year period? Or is it because so much has been in flux and they know there is more coming with the other decision on managed care and what the state is going to do, does it make sense to think about this ten years out? As David said, they could live with five years. In their financial forecast under five years with a straight renewal, they would provide the same level of services and their

cash balance would just be down to the $20 million at the end of five years. Does it address the problem of maybe going ahead and start implementing these ideas to address the larger system of the collaboration and getting additional providers and money into the system? Mr. Talarek thinks everyone has an interest in doing it and breaking that silo approach of we are doing what we want to do. He is glad they are working with the Council of State Government and the Sheriff's Office. That is not on their list of current collaborations. That is something definitely that will impact the community as a whole, but right now they would probably look at it one way versus the Sheriff's Office. If you are building that capacity into the jails by bringing social workers, how is that going to address the needs for Netcare when the county is now going to become a player in that? Is there capacity in the system to do that and build the nonprofit sector? Those are questions going forward that he would be looking at in making a decision.

Mr. Friedman asked what's the downside of the five year?

Mr. Talarek said the Developmental Disabilities replacement was a little different because they have a continuous one too. Children Services was different because they had the two that are ten years and they could overlap, so there is an advantage.

Mr. Wymer said Jerry made a point earlier that has stuck with him. That there is the political field but then there is the General Assembly and unforeseen consequences of what they do on any given day. Ten years, who knows what that environment will look like in ten years? He struggles a little bit because that is a long time. Society will change and there is so many unforeseen things that they can't predict.

Ms. Hallas said when they passed the last ten and the ten before it, the system was pretty much what it was. It was the same system. No one imagined the Boards wouldn't be doing Medicaid processing. When they did this last levy, no one would have predicted what the system became today. She asked the question when she was meeting with their fiscal staff yesterday: Why ten? Let's take a shorter stance on this because so much has changed. They said they were used to ten years.

Dr. Bronson asked so would they would go back before the voters in five years if they did five years? How would this work then? Would they have to have a second levy? Would it be two five year levies?

Ms. Hallas said yes, they would just have to come again in five and then at that point they could go up to ten again.

Mr. Talarek said the statute lets you go a maximum of ten years.

Dr. Bronson asked would it be like FCCS that has two levies in place that happen to overlap or would this be one levy and each time the length of time changes?

Mr. Wymer said it could be a five year with an increase.

Ms. Carter Ryan asked Heidi how much time they have to talk about this. They have to make a decision with a recommendation and everything by when? What are their dates?

Ms. Hallas said they have to have their report to the Commissioners by the end of June so they can vote in July. They have three months to finalize. Normally, they know where they are headed by the end of May so she has time to write the report. They have four more meetings scheduled but they can always add more.

Ms. Hallas said they are concerned about what is the message when you are sitting on a lot of cash?

Mr. Wymer said can Ms. Hallas go back and ask that? In the political environment, he thinks it is huge. The two for questions for him would be the ten years and then how do they justify those dollars? They have had those dollars for a while, so what would be helpful is to try to understand that.

Mr. Friedman asked didn't David say they would be under water even at five years? Mr. Hemphill agreed that is what David said.

Mr. Talarek said even with the 0.5 mill increase they would because their goal would be to add $5 million in additional services in 2017. They would still be spending more than they would be bringing in year one. By having the increase, they wouldn't be drawing as much cash.

Dr. Bronson asked if the committee had that somewhere.

Mr. Talarek said the first one is on page 99 of the fact book. They are showing the first year of collections wouldn't be until 2017. They would be bringing in $85 million and spending $86 million, so they would be spending about $1 million more than they were taking in.

Ms. Hallas said that is what they are saying by maintaining services and providing an additional $5 million. If they go to the next levy model, it is a five year 2.2 mill renewal in 2017 and then they would be back on the ballot in 2022. There wouldn't be any additional investments. They would just be continuing with a 2% growth but no additional projects so they could make it five years.

Mr. Friedman asked how much is ADAMH sitting on?

Ms. Hallas said $88 million. They have a year and a half left in the current levy so the projections on page 85 shows where they believe they will be at the end of the levy, which would is about $77 million in cash.

Mr. Talarek said in 2016 they are looking at about a $4.5 million increase from 2015 to 2016 and that was based on higher utilization.

Ms. Hallas said there was a $5 million jump in social services for the last year of their current levy and she asked them to explain. They believe that at that point providers will be able to expend more dollars and the capacity will be better next year.

Mr. Friedman stated or are they just going to increase the rate?

Ms. Hallas said the 2015 projection assumption is 85% will be expended. Because it is fee for service, they give them ceilings. You can bill us for this much. They just don't say here's $5 million. They say based on your expenses the last several years, your available amount is up to this much. That is how they budget. So for 2015, they are saying the providers will bill at 85% of budgeted expenditures and then starting in 2016 it will be 89%. That is why they end up with $77 million instead of the $88 million that they see currently. That's no guarantee. That's optimistic. The argument will be ADAMH plans to expend more than they are taking in. They can make it five years but that would require them to draw down that cash and then ask for more in five years in order to make that up going forward. She will start building a model to say if they maintain current services, what will that look like? ADAMH didn't provide the scenario of maintaining services on a straight renewal for ten years.

Ms. Hallas said the Committee is scheduled for their next meeting on April 16th from 3:00 to 5:00 p.m. If they think of other questions, send them to her. The sooner the better so they will have them in advance of their next meeting. If they wait, that will just push the timeline out further. Ms. Hallas said per the Committee's discussion, she will ask ADAMH why are they sitting on so much cash and why ten years.

Mr. Hemphill adjourned the meeting at 5:20 p.m.