

ODMH Planning Council Meeting

MINUTES

JANUARY 26, 2013

10:00 A.M.

ODMH ROOM 806

CALL TO ORDER:	10:38 A.M.
TYPE OF MEETING	Planning Council
FACILITATOR	Pat Risser
NOTE TAKER	Anna Labaya
ATTENDEES	Jane Byrnes, Rebecca Civittolo, Jeannie Copper, Steve Copper, Karen Fabiano, Sharon Fitzpatrick, Linda Gable, Liz Gitter, Robyn Hoffman, Ken Jones, Anna Labaya, Aneese Locke-Hines (for Susan Pugh), Jennilee Mohler, Mark Smith (for Vicki Grosh – DOE), Pat Risser, & Nina Wycoff <i>Conference Call Attendees:</i> Esther Branscome, Cheryl Crayden, Cassandra Rufat, Kathy Stanley, & Sue Williams

The 01/26/2012 Agenda is attached to these minutes.

TOPIC	INTRODUCTIONS & APPROVAL OF MEETING MINUTES
	<ul style="list-style-type: none"> - Introductions were made by each Planning Council member and guests. - The minutes were not in the packets, but were distributed to all who were present during the meeting. - The Chairman reminded everyone to adhere to the Planning Council's Vision, Mission, and Responsibilities as stated on each individual name plate, and that we should remain civil and courteous throughout the meeting.

PRESENTER: Sharon Fitzpatrick

TOPIC	PEER SUPPORT UPDATE (Handout 1: Powerpoint)
	<ul style="list-style-type: none"> - As part of the Consumer Recovery Initiative, the information provided is an update about what Ohio is doing with Peer Support as it relates to Certified Peer Specialists. - Brief History: Carroll Hernandez, former Chief of ODMH Community Planning/Clients Rights together with Jack Cameron, Executive Director of OEC was summoned to participate in a conference with other states. After reviewing different models of peer support trainings and curriculum, they agreed on what was important to Ohio and developed a curriculum with Applachian Consulting Group that will be used to train Peer Support Specialists in our state. - Funding History: ODMH funded \$50,000 (money that was leftover from the TSIG Grant) the Margaret Clark Morgan Foundation contributed \$35,000, and the Health Foundation of Greater Cincinnati also gave \$35,000 to help with this initiative. - Training Criteria: Must be a peer willing to share your story to help someone progress in their recovery. Must complete 56 hours of training, 32 of which is core training. - Certification: ODMH approved the curriculum and designated OEC as the certifying body. Peers must pass with a 70% or better. For those who completed the training in another state, the grandfathering consideration is applicable. All that would be required is to pass the Whole Health and the Ohio Centric piece. - A rule was put into effect by the implementation team that the test can be taken three times and if the test is failed all three times, the individual must be retrained. - Training Update: As of May, 2011, OEC has facilitated 5 trainings. 135 individuals have been trained and 37 of them were taking the test earlier this month. 90 of the 135 have already passed the test. - RSC Peer Employment Project – An initiative that brings ODMH, OEC, and RSC together for a peer employment project. The goal is to have people not only trained as Certified Peer Specialists, but to have benefits counseling, and motivational interviewing. The process will last 9 months to 1 year. - Aneesa Locke-Hines of RSC added that there are currently 5 local boards participating: Logan/Champaign, Stark, Portage, Cuyahoga, and Trumbull. Each of these boards put up approximately \$6700 worth of match. The match was set up to pull down additional federal funding. The ratio is about 1:3.78 for every dollar. All of the monies go to the county to train the specialist in their area. The specialists are provided with the OEC Curriculum, a motivational interview, benefits training, and an internship period of up to 30 weeks over the next year. - BRSS TACS – Consists of 12 members from ODMH, ODJFS, Medicaid, Ohio Citizens Advocates, OEC, ODADAS, and community members that were in recovery from substance abuse and/or mental health issues. The focus is on peer support and the work is to identify the rules, funding, mechanisms, and other things for peer support. The goal is to make peer support accessible to anyone across the state who needs it.

-	Four goals were set by the committee. <ul style="list-style-type: none"> • Establish a shared definition of “Recovery”. A decision was reached and this has been posted on websites, with other people, and feedback was received. This goal is in its last phase • Establish and expand partnerships and collaborations among state agencies, Ohio Governor’s Office of Health Transformations, and community stakeholders to bring services and supports provided by persons in recovery to scale. • Develop a mechanism that promotes a recovery orientation in all services and supports including Health Care Homes and which expands access to recovery and peer services and supports. • Create partnerships to establish a trained, credentialed workforce to develop high quality recovery and peer services and supports. This includes developing a curriculum, identifying leaders to teach or facilitate the curriculum and dispense them geographically across the State. We have a draft of the curriculum and are working with a contractor on recommendations to ensure both AOD and MH is equally represented.
-	It is the intent to get a State Medicaid Plan Amendment to make peer support a standalone billable service and to have consumer operated services be eligible to bill Medicaid for those services.
TOPIC	CONCERNS, COMMENTS, QUESTIONS
-	Concerning the \$6700 match contribution from the boards, is that amount per peer and does it go toward paying them once they are employed? <ul style="list-style-type: none"> • The training curriculum with OEC is smaller than \$6700. This amount plus the match supports the individual with the OEC curriculum, Case Western University Curriculum and paid internships. It does not extend beyond that. The individuals would go on to seek permanent employment once the internship is done. The hope in forging this partnership is that Medicaid becomes a billable service on July 1 so that these individuals would have employment opportunities where local providers can hire them and be reimbursed through Medicaid.
-	When they first started talking about this, Scioto and Brown Counties was thought to be on the list. What happened? <ul style="list-style-type: none"> • There were originally approximately 12 interested Boards, but when it came down to having the funds to put up to enter into the partnership, only the 5 mentioned came through. Apparently, the others decided to invest elsewhere at this moment.
-	Like a lot of other states, it takes Ohio awhile to get things up and moving. The positive in this is the way the agencies are partnering together to help this initiative.
-	Question concerning the rate of reimbursement for peer support. The concern is that peer support would be relegated to an “Aid” position with minimal pay. While they may not be paid as 4-year degreed professionals, it would be good to place them within the hierarchy appropriately so they can paid a living wage commensurate with their skill level. This is an advocacy topic that Jack Cameron will not be silent about.
-	What is the scheduled amount that will be allowed to bill for that service? <p>This is being worked out in the Office of Integrated Care and it is a time-consuming process that involves costing services, consulting and comparing with other states, evaluating the job description, and obtaining information about it. The compiled information will go into the rate which has not been determined yet.</p>
-	Request to see updates concerning where billable service stands on the OEC website. <ul style="list-style-type: none"> • Will there be an incentive piece for the hiring and reimbursement to peer support providers that show this as a priority? • OED is conducting educational forums to encourage providers to use peer support as an option to experience the value that it brings. Education is a big piece because people are afraid of it. • Fears about liability and confidentiality were expressed.
-	The hope is that Peer Specialists grow and continue to be recognized a peer support services and not as clinical support services where they are used to pass out medication to people at their homes. That is clinical support, not peer support. There must be clear discussion about maintaining the value they bring in their peer support duties and ensure they do not perform the functions of a clinical team.
-	A child welfare program called START in Cuyahoga County utilizes peer support and they have very clear guidelines concerning expectations and roles. If information is desired, Kathy Stanley can provide that.

PRESENTER: John Hurley

TOPIC	SECLUSION AND RESTRAINT – Handout 2
-	On January 15 of this year, the State Board of Education approved the policy on positive behavior interventions and supports in restraint and seclusion. That policy is partially in the packets (Handout 3). The full document can be found and downloaded online at: www.ode.state.oh.us . It will be in effect for the school year 2013-2014. The reason for this is because of a process to put policies in place.
-	The policy (Handout 4) takes into consideration the Governor’s Executive Order 2009-138 issued by Governor Strickland and also follows the Restraints and Seclusions Resource Document issued by the Department of Education.
-	The policy starts with developing positive behavioral interventions and support and developing school-wide

<p>systematic approaches to evidence based practices and data-driven decisions to improve the climate and culture in schools. The thought is that by doing so, it decreases the needs for seclusion and restraint. The youth, also, are empowered to grow individually by using their talents.</p>	
<ul style="list-style-type: none"> - Positive strategies are being used to reinforce positive appropriate behaviors. Physical restraints and seclusion are only to be used when there's an immediate risk of physical harm to the students or others and no other remedy is available. Seclusion is viewed as a last resort in terms of safety intervention. The purpose of seclusion is to provide students an opportunity to regain control so they can rejoin the class in a productive way. Somewhere in the policy it mentions that seclusion rooms should not be locked. 	
<ul style="list-style-type: none"> - Functional behavioral assessments will be conducted when a student requires repeated seclusion and/or restraint. It is usually done by an outsider who evaluates the cause of that student continually ending up in restraints and seclusion. They evaluate the goal a student is attempting to reach by exhibiting those behaviors and try to find alternative ways to meet that need. 	
<ul style="list-style-type: none"> - Prone restraint is included in the policy. It is not permitted. Restraint must be performed in ways that are not life-threatening. 	
<ul style="list-style-type: none"> - The purpose of this presentation is not to say that I am the expert or the point of reference on this topic. I am doing this because I was asked to present. The Positive Behavior and Intervention Supports on the Department of Education website talks about this policy. I encourage everyone to visit the website. They have worked hard to make it user-friendly. Everyone can learn a lot about the various programs occurring within that Department. There's a wealth of information on there. 	
TOPIC	CONCERNS, COMMENTS, QUESTIONS
<ul style="list-style-type: none"> - Can an emergency restraint can be done without a behavioral assessment. <ul style="list-style-type: none"> • Yes. 	
<ul style="list-style-type: none"> - A question was raised concerning the assessments done by "outsiders". Does this mean that the individual is not connected to the school? <ul style="list-style-type: none"> • There is nothing clearly defined in the policy, however the belief is that it isn't an internal school function. 	
<ul style="list-style-type: none"> - Are we covering this or is this a full-fledged continuing problem? <ul style="list-style-type: none"> • We are not the expert on this and therefore cannot answer this question. However, with a new policy being issued by the State and that it is a cumbersome process to put new policies in place, there must be some concern. 	
<ul style="list-style-type: none"> - Is it true that Special Ed programs are reviewed every four years? If so, is there a way to review a child's IEP before years in order to address behavioral issues? <ul style="list-style-type: none"> • Mark from the Department of Education clarified that it's actually every three years. 	
<ul style="list-style-type: none"> - Three years seems like a long time to let something possibly fester. <ul style="list-style-type: none"> • Mark advised that IEPs are reviewed annually, and the 3-year review is actually a broader process that happens. Also, an IEP can be amended at any time the teen feels it is appropriate. If there is a critical behavior intervention that needs to be addressed, it can happen in a very short period of time. It does not have to wait until the 3-year evaluation or even the annual IEP review. 	
<ul style="list-style-type: none"> - What about the review of the school policy? If this is a big enough problem, a 3-year interval to review a school policy seems like a long time. Is there some protocol that the school has to restraints? Do the schools have to report seclusion/restraint incidents? <ul style="list-style-type: none"> • John Hurley advised that there are a couple of different requirements: 1) A requirement to report through the local boards and to the State Department of Education. 2) Every time a child is placed in seclusion and restraints, the parents are notified as well. This information is reviewed regularly at the regional level for schools and at the state level. 	
<ul style="list-style-type: none"> - What mechanisms are in place for oversight of documentation of behavior restraint/seclusion to make sure that those reviews are to be in place for students who are repeatedly in restraint and seclusion and are their own witnesses? Often these schools are multi-faceted , they are with DYS, juvenile services, Mental Health, and they are in alternative schools. <ul style="list-style-type: none"> • This question is best directed to the Ohio Department of Education who owns the policy, will be implementing it, doing the training, and making sure that schools are doing the right thing. • Mark offered to take this concern back to the Department and later respond to it. 	
<ul style="list-style-type: none"> - What about police restraints? Television depicts horrific cruel treatment by police who restrain and seclude the mentally ill. Is this going on in Ohio? <ul style="list-style-type: none"> • ODMH offers Crisis Intervention Training (CIT) to police officers and sheriffs throughout Ohio. For incidents involving the mentally ill, our goal is that a CIT Officer would be sent to the scene of the incident or to the location of the mentally ill person(s) and be the individual to query that person. They would be trained in how to do this and how to follow up. 	

TOPIC	SCHOOL SHOOTINGS
<ul style="list-style-type: none"> - The school shooting and violence in our society continues to draw America's attention. Ohio is not immune to this 	

as evidenced with the Chardon High School shooting in Geauga County. The Governor and the Department of Mental Health has tried to respond to these tragedies as they have occurred.	
<ul style="list-style-type: none"> - The Governor made an appearance talking to people and later was able to provide some money to make up for some support services for that community. - The Governor, through some money that was refunded through another medical program was able to free up \$5 million and he gave that to a work team that was headed up by the Department of Mental Health and the Department of Developmental Disabilities (Handout 5). Meetings were held about how that money would be spent over a two year period. A major part of this money will be respite care for families who need support for dealing with very difficult situations in their families with children who are mentally ill and also children in the autism spectrum. Thus, the money will be divided evenly between these two Departments. One of the provisions is that the \$5 million cannot be used to replace other money. New services will need to be created for families using that money. 	
- Immediately after the Connecticut shooting, Director Plouck put out information about that. It is included in your packet (Handout 6).	
- Dr. Hurst put out a letter addressing violence, firearms, and the mentally ill. He spoke about the dangers of discussing, as well as not discussing, these issues (Handout 7).	
- NAMI put out a good statement about how families could get help (Handout 8).	
TOPIC	CONCERNS, COMMENTS, QUESTIONS
<ul style="list-style-type: none"> - Regarding the \$5 million, will the money go toward covering service coordination as well? <ul style="list-style-type: none"> • There isn't a firm answer. I believe the Boards will work with the Family and Children's First Council to figure out how to do it, but I can't answer for every Board. All of the Boards are representatives on the Family and Children's First Councils, so that would include representation on how the money will be spent. 	
<ul style="list-style-type: none"> - We have the Family Services and Support which is jointly funded by Mental Health, ODADAS, DYS, DODD, and JFS. They were able to leverage over \$3.2 million each year that is sent to ODMH to do family-centered services and support. This includes respite for the population described. I want to ensure that our work is done in a coordinated effort. - PATH funds are available for adopted children as well for the same purpose. <ul style="list-style-type: none"> • This information will be passed to those working on that committee. 	
<ul style="list-style-type: none"> - Last year, we were able to secure some additional federal money from other states that didn't use all their money. So, we earmarked those for ODMH as well. We always need to include match with that. We can stretch this money as much as we possibly can to federal funds as well. <ul style="list-style-type: none"> • This information also will be passed along. The federal funds that the Governor is distributing may have limitations on matching, but that's for other people to discuss and make decisions about. 	
<ul style="list-style-type: none"> - Having experience using respite many times for the purposes that it is intended, several things should be noted: 1) Finding the place in the timeframe needed. It is difficult to find a family qualified to take a severely emotionally disturbed child, (and usually those are what we're dealing with), that are trained and can do it quickly. There is a backlog in hospitals, especially children's hospitals for intervention-type help. Akron has a Safe Landings place. It is widely used in Summit County. Something like this would probably reach the client and families faster than trying to find a family that will take a child while they sit in a hospital. <ul style="list-style-type: none"> • Thank you. Good observation. 	
<ul style="list-style-type: none"> - With regard to access to respite care, the Department of Aging is leading the State's efforts on the lifespan respite projects. The goal is to improve access regardless of age, disease, or disability. We want to be sure this will be aligned with that too. 	
<ul style="list-style-type: none"> - Our role as Planning Council is to advocate for people who have been identified as having mental illness. We want to ensure that our people in this state are not placed into a class of dangerous individuals due to linking, scapegoating, and stigmatizing. That is very discriminatory. 	

PRESENTER: Kathy Coate-Ortiz

TOPIC	ODMH UPDATES
<ul style="list-style-type: none"> - Concerning the consolidation of ODMH and ODADAS, a document prepared by Director Plouck titled, "Draft & For Discussion Only" (Handout 9). Directors Plouck and Hall have held regular meetings with the staff to share this topic of discussion. It is not a Table of Organization but a functional document. The frame around this document is focused on the people we serve. It is person- and family-focused. Cultural Competence is not seen in any of the boxes because it is pervasive throughout the entire department. This document is on our website and has been posted in public venues. We continue to seek input and feedback. - The two agencies have taken this great opportunity to continue to learn about each other. Many of our projects, such as BRSS TACS have strong collaborations. Working together with ODADAS is not new, but merging the two Departments is still a learning curve. Our definitions about things may be different, so we are finding a way to agree upon joint definitions. 	

- ODADAS has a unique thing called round tables, one for Prevention and one for Clinical. It was put in place for the State to find out from the community the things they need and want to promote, best practices, and how they want to see things promoted. My sense is that these will continue and perhaps even expand.
- Planning Council is unique to ODMH and will continue but we will be including people in recovery from addiction into the Council, as well as AOD (alcohol and other drug) organizations.
- The Director hired Tom Hayes as a Consultant to review the plans in this consolidation and provide us with suggestions and advice on how we can best move forward as one united agency. Tom has a lot of experience with this as he was Director when ODJFS combined with the Bureau of Employment Services.
- There are also structural changes occurring. Currently ODMH occupies floors 7, 8, 11, and 33. We will be adding the 36th floor as the ODADAS employees slowly move over. The first physical move will take place in about 30 days. It will include moving the Director's office, Communication, Legal, and Hospital Services. The 36th floor has a lot of conference rooms. Meetings for the Planning Council may be held on 36 in the future. We are not certain if telephone numbers will remain intact or be changed. Please be patient with us during this period of change.
- Currently, there are two Directors, but when we merge, Director Plouck will be the Director of the Consolidated Agency. Dr. Hall is continuing as the head of a commission addressing opiates that reports to the governor.

TOPIC	CONCERNS, COMMENTS, QUESTIONS
	<ul style="list-style-type: none"> - To what extent are the recipients being included in this merger? There should be nothing about us without us. Our voice is vital.) Also, how will the philosophical differences be resolved? (e.g. MH recovery means lack of symptoms and doing well with or without medication; whereas recovery in drug and alcohol is a not a goal you actually reach.) <ul style="list-style-type: none"> • Kathy Coate-Ortiz responds: We will develop a combined vision and mission to help us get to that place. There are 50 boards in this State that have already been combined so we can learn from them.
	<ul style="list-style-type: none"> - There is a consolidation website that provides information from every meeting and provides handouts: www.adamh.ohio.gov. There are different teams at work and the website provides information about the work. It is key to sign up on the home page. Signing up provides you with monthly information. The website allows people to submit comments and questions also.
	<ul style="list-style-type: none"> - We are very pleased to be working with Mental Health and Drug and Alcohol Addiction. Areas, such as the south, where there are very few services have a lot of mental health issues that tend to use alcohol and drugs to medicate themselves and it creates a lot of problems.
	<ul style="list-style-type: none"> - There are issues with treatment and questions concerning how ODADAS operates at the state and local level. What are the new initiatives? The Government doesn't cover detox for opiates. A lot of people are in jail without Medicaid support. There's a huge need and many are dying while these matters are not addressed. This seems to be more criminal justice than Mental Health. Crimes are being committed because they have no coping skills. There are only few resources for opiate treatment available in certain counties. <ul style="list-style-type: none"> • Trudy indicated that one advantage we have in this consolidation is that our Medical Director is not only certified in mental health, but also in addiction services. So, he is aware of all of those concerns. • Kathy Coate-Ortiz: Opiates are pervasive, and I heard it is an increasing problem in some of the jobs out there where they can't find skilled workers that are clean because they are using. Director Hall will continue to work on opiate projects. We hope to have more projects and communities to address the problem with heroin and opiates.
	<ul style="list-style-type: none"> - For those with dual diagnosis, there are huge issues and conflicts between mental illness and addiction. How do we address those issues? Are there consumers on the team to talk about our issues or are those just professionals? <ul style="list-style-type: none"> • Kathy Coate-Ortiz: I don't know if we have an answer right now. That is part of what we'll learn from each other. • Trudy Sharp: I do believe they are being represented because there is a very high percentage that have dual diagnosis. It is a topic that is frequently discussed in our meetings. Our Medical Director and Hospital Services unit is very focused on this. • John Hurley: The entire merger will move treatment programming coming from two directions to consolidation. Many people who work for ODADAS have come through the recovery into their profession. So, I'm certain that whether they are identified as consumers or not, there are people sitting at the table every day that are consumers. The truth is it gets harder to find people who aren't dual diagnosed because people cross back and forth between two things. That is part of what drives this consolidation effort.
	<ul style="list-style-type: none"> - Are we keeping the children and youth in separate departments? Are they still with special populations? <ul style="list-style-type: none"> • All we have is this functional grid and that the Director expects that we work together as a team.
	<ul style="list-style-type: none"> - Regarding the previous question about Medicaid coverage for narcotic addiction, is that strictly in the criminal justice arena? It is true that Medicaid will not pay if it's in a locked setting or for criminal justice settings, but covered in others? <ul style="list-style-type: none"> • Nina Wycoff responded that is not correct. Chemical dependency intakes and counseling are done through the health line and Medicaid will not fund. The local county boards absorb the costs of the opiate withdrawal through detox, so it is funded locally. It is not reimbursable through Medicaid.

- Are we keeping children and transitional youth in their own separate departments or will they still be with special populations?
 - Kathy Coate-Ortiz: We have the functional grid that is being discussed. At this point, there has not been a decision made about where services or specific programs will be. The Directors expects we will work together as a team.
- The Director has indicated the functional grid is not to be thought of as a table of organization. We are trying to figure out how to merge services to make sure we are serving all of our people. Once the functional array is sorted out, decisions can be made concerning where they fit into a table of organization. Our Director is a straight-shooter. If this was going to be the final plan, she would say this is it, but this is not what she is saying. She is clear in saying that we need to figure it out, and then we will figure out the best offices to place people in and ensure that the final decision reflects serving our entire population.
- When will the funds be available?
 - A small part of it will be available this year and then about \$2.5 million each of the next two fiscal years.

MEETING ADJOURNED FOR LUNCH AT 12:16 P.M.

MEETING CALLED BACK TO ORDER AT 12:49 P.M.

PRESENTER: Trudy Sharp

TOPIC	PROPOSAL: STATEWIDE CAMPAIGN FOR MENTAL HEALTH AWARENESS (Handout 10)
-	After the recent Newtown tragedy, the Governor met with several state Directors to discuss school safety. The Director decided to issue a statewide campaign raising mental health and addiction awareness.
-	I have been charged to lead this effort and it may be through venues such as radio, television, and public service announcements. While there has been no discussion about the budget, the goal is to educate people that we can no longer be silent when someone is in crisis. Hiding mental illness and addiction and not talking about it is what gets us in trouble.
-	The point is to encourage Ohioans to support people who are struggling. We won't call this a stigma campaign, because we do not want to perpetuate stigma. We want to encourage people to reach out and talk to the person and not be afraid to put the issue out on the table. We want to engage the people we know that are addicted to opiates or have trauma in their lives. It is a public awareness to engage.
-	I am here because I want consumer input. If there are people who want to be kept aware, get input, or be a part of this endeavor, they are encouraged to let me know by placing their names on this card being circulated or you can contact me and I will place you on an email list. I will share information and ask for input and feedback. My email address is: trudy.sharp@mh.ohio.gov .
-	Also, there is a video that has Nina's quote in it. It is something that has been in the works for years. Interns filmed some consumers and put it in a video that is approximately 12 minutes long and very focused on peer support, but it is still not complete. Anyone interested in previewing it, can come to my computer to view it. Once it is complete, it will be put out on YouTube.
TOPIC	CONCERNS, COMMENTS, QUESTIONS
-	Jane Byrnes: This is great and necessary. However, what we have found with awareness campaigns is that after making someone aware, they must be given something to do. What happens once the individual acknowledges they need help? <ul style="list-style-type: none"> • That is what we're talking about. Should we direct them to the boards or just be a friend?
-	Pat Risser: There are no biochemical markers or tests to prove this thing called mental illness. It is not a disease or physical illness. TB, diabetes, and cancer have clear, reliable measurable markers, but mental illness is related to thoughts, moods, and emotions and discrimination and prejudice can be legally actionable by law. I have spoken to young people who shared their experiences talking to struggling individuals. What they found is that the best help is when someone reaches out and cares. We need to be aware of people that are isolated and brooding. Our entire community needs to reach out and connect to people. <ul style="list-style-type: none"> • That is how our Director is viewing it. It is not a campaign about mental illness. It is a campaign to reach out to people who are struggling. My job is to put together something concerning reaching out. We were thinking of names for this campaign and considered "Reach Out", but that was too common. Other ideas were: "Start a conversation, Stop a crisis," but 'crisis' seems to have a negative connotation.
-	Pat Risser suggested tapping into the SAMSHA Campaign: "Be a friend" in order to access some of those dollars. He asked how this campaign would be any different than the existing campaign to reduce suicide. <ul style="list-style-type: none"> • It seems that most videos about mental illness and addiction are always in black and white and address people who fell through the cracks. That almost plays into the stigma. Doing it in color is one change. There was an interesting suggestion to create a graphic interactive novel (like a comic) where you enter in as a person with a particular situation and you choose what you do and it will branch you off to different areas. We aim to make it different, but it will come down to resources and there has been no discussion about money, forging partnerships, using current resources or putting some resources toward it.

ELECTION OF OFFICERS

TOPIC	NOMINATIONS RECOMMENDATIONS
-	There will be two people recommended by the membership committee to continue in their terms: Pat Risser, Chairperson and Esther Branscome, Vice Chairperson. Our Secretary, Victoria Webb has not responded concerning whether or not she wants to run another term. She missed the last meeting and is not here today. There is a vacancy in the Parliamentarian position as Vicki Grosh will not be able to continue another term.
-	Our Bylaws typically call for 1 year terms and people can be re-elected for a 2 nd term in that Office. We will be needing nominations on the floor for each position. The membership committee can recommend, but anyone can place a nomination on the floor. People in the meeting via tele-conference can also vote via e-mail and their votes will be included in the tally. ODMH workers are not eligible to vote. Thus everyone present is eligible except for those in attendance who are representing ODMH or attending as an alternate or guest.
TOPIC	NOMINATIONS
-	<p>CHAIRPERSON:</p> <ul style="list-style-type: none"> Pat Risser – Nominated by Jeannie Copper, second by Linda Gable. Call for any more nominations for Chairperson. No further nominations. <p>VICE CHAIRPERSON</p> <ul style="list-style-type: none"> Esther Branscome – Nominated by Steve Copper, second by Karen Fabiano. Call for any more nominations for Vice-Chairperson. No further nominations. <p>SECRETARY – Duties include meeting for approximately an hour a couple of weeks before Planning Council meetings via teleconferences. S/he must also review the minutes.</p> <ul style="list-style-type: none"> Sue Williams – Nominated by Kathy Stanley. Sue Williams declined. Kathy Stanley – Nominated by Sue Williams. Kathy Stanley declined. Jane Byrnes – Nominated by Nina Wycoff, second by Pat Risser. Call for any more nominations for Secretary. No further nominations. <p>PARLIAMENTARIAN – Charged with being assertive in meetings when the Roberts Rules of Order is not being adhered to. This person is also a member of the Executive team.</p> <ul style="list-style-type: none"> Mark Smith – Nominated by Pat Risser, second by Ken Jones. Call for any more nominations for Parliamentarian. No further nominations.
-	We have an unopposed slate, and therefore can proceed with a voice vote. All eligible voters unanimously voted in favor of all who have been nominated by saying "I", with no opposition. The motion is carried. Congratulations to the new officers.

PRESENTER: Jennifer Moses

TOPIC	IMPLEMENTATION OF HEALTH HOMES – (Handout 11: Powerpoint)
-	Effective October 12, The Zeph Center currently has 5 certified health home providers. In this presentation, I will be sharing what we have been doing in this process.
-	The difference with Health Home services vs. Traditional Behavioral Health Services is its care coordination activities. The focus is on the whole person through an integrated approach and not just dealing with behavioral health in one silo, mental health in another, dental in another, etc. It helps facilitate those services and developing a plan aimed to help the whole person get better.
-	The program is very client-focused and empowers them to take charge of their whole health. They are provided with the education and resources they need to access services.
-	The team is a multi-disciplinary one: Primary care doctor, Dentist, Pharmacist, Behavioral Health Individual participating. Each situation would vary depending on the comprehensive care plan and the needs assessment. Kids, for example, could have the schools involved, their CSB, or Children's Services. It is unlimited who could be involved because it is not broken up into silos. It involves people who can meet the client's social needs, behavioral health, physical, dental, etc.
-	Our main focal points include physical health services and access. We have co-located services and a primary care doctor as well as practitioners on site. While we do not have a dentist on site, we have a monthly scheduled visit from Northwest Ohio Dental and they perform any needed dental service in their mobile office. They can see up to 50 individuals daily (children or adults).
-	We seek for overall improvement of life for the whole person, which involves placing people in a different environment (e.g. those in long-term care facilities), providing access to preventative services; health, wellness, and promotion; educating them on how often to see the dentist, how often to have mammograms, etc. – empowering them to do it and help with access.
-	We are building programs that will help address issues like cholesterol management, high blood pressure, weight assessments, smoking cessation groups, etc. We have 12-step programs and Weight Watchers that come in. There are many resources and opportunities for individuals to access things that they might not have been able to historically.

- If anyone needs to contact me, I am part of the Planning Council and you should have my email. If you want to call me, you can email and I'll give you my number. Perhaps Liz could send out a list of Planning Council contacts. (Liz would be happy to do that.)

TOPIC	CONCERNS, COMMENTS, QUESTIONS
	<p>- Would this include things like diabetes, education classes, and smoking cessation?</p> <ul style="list-style-type: none"> • This is part of the huge initiative we are looking at with health, wellness, and promotion. We purchased a facility specifically focused on this and it will include group activities and interventions. We're looking to have an exercise facility because many of them do not have the ability to get a gym membership. This will help to address some hypertension, diabetes, obesity issues. The facility has a kitchen; so, this will be utilized to educate about preparing healthy meals. We have also partnered with UTMC, a local university, who has a community garden through a grant they have. We're one of the receivers of the vegetables and fruits they harvest. So, we teach how to can and freeze foods.
	<p>- Sharing of information is a concern. Many times it is deliberate that information between, for example, a primary care doctor and a cardiologist are not shared. Past medical history is purposely not shared in order to eliminate prejudice that doctors have. Some of them conclude that because a person is a mental patient, he must be seeking drugs. Medical prejudice against our people exists. In this type of setting, what is done to protect against this particularly since the information will be shared?</p> <ul style="list-style-type: none"> • I think it's an opportunity to remove that stigma. Multi-disciplinary teams will work together and the care manager working with the individual is there to advocate and promote a care plan that is in the best interest of the client. Because they aren't siloed, they aren't going to make these independent judgments without the facts.
	<p>- Is it outpatient or are you reaching out to people that would be coming from some sort of hospitalization or perhaps coming from jail back into the community?</p> <ul style="list-style-type: none"> • It could potentially be any of those if they had Medicaid and they elected to participate in a health home service. People in long-term care facilities can do the same. We would work with them and part of the goal would be to get them to a more independent living situation and if that's not possible we do what we can to improve their overall quality of life. This may be to get them to the health, wellness, and promotion center 3x a week or do something outside of the facility. The opportunities are endless.
	<p>- Is there a referral program?</p> <ul style="list-style-type: none"> • Internally, Zeph Center has a process of communicating with certain entities in the community. The issue now is that Health Homes is new and not everyone is educated on this service to refer the program to our center or another agency. So, we need to do more educating for our partners, criminal justice, nursing homes, and hospitals so they can refer. The managed care plans who work with some of these entities can refer to us. They can also link the client with a health home. It will be an evolving process to inform everyone of this new service, but it is our goal.
	<p>- There is a continuing struggle to access educational-related information and its relevance outside of the education system; However, there is interest in the Department of Education to reach out to Health Homes and coordinate activities. The data systems are not set up to interact at all. We aim to do better at this and we need to know how we can do better with Health Homes.</p> <ul style="list-style-type: none"> • Individual providers and counties work a little different, but we have a very good relationship with certain educational institutes with their charter schools or school systems in our area. We also currently run some after-school programs. They understand what we do. Teachers send notes about kids who have issues or things they are struggling with seeking to help them do better in the classroom. We continue to build on this. The data exchange piece is a harder obstacle and that's across the whole State because of the varying levels of technology at different providers and smaller organizations. Our system isn't ready for sharing information electronically. So this will be a greater struggle than the clinical aspect.
	<p>- There are four groups I'm aware of: Medicare, Medicaid, Private Insurance, and No Insurance. It looks like this is only for Medicaid. Is that correct?</p> <ul style="list-style-type: none"> • In the Health Home, there is only Medicaid, but Medicaid and Medicare clients (dual-clients/eligible) can be there. Medicare does not have a specific program for Health Homes. It is in the process of being developed to a program specific for the duals, but we have no further information. As an agency, we decided that if we strongly believe in this type of care and seek to promote it, we do not want to limit it to one group because of a payer source. So, we're trying to mimic it as much as we can throughout the whole organization. It's going to be the same model: care coordination; health, wellness, and promotion, education, etc.
	<p>- Is the idea to have a clinic model with multiple providers within a clinic?</p> <ul style="list-style-type: none"> • That's ideal but not mandatory.
	<p>- What happens for the process? What is the intake and referral process if someone walks in as a referral or just walks in? What is available? I am trying to visualize how services are delivered.</p> <ul style="list-style-type: none"> • When they come in for an intake, it's more of the traditional intake service: capturing diagnostic information and completing all the required paperwork for all of the bodies we are accountable to. Assessments are then made for health home during the intake vs. the other programming. However, a full assessment is done. If someone is eligible to participate in the Medicaid Health Home part, it will be offered.

-	Is that in a group setting? <ul style="list-style-type: none"> No, the diagnostic assessment is a one-on-one session. The orientation to the Health Home, if interested, is part of the diagnostic when they come in.
-	For someone currently receiving services in a Behavioral Community Health Only model, would they have to change their provider if they wanted to join a Health Home? <ul style="list-style-type: none"> If they were not a certified Health Home, yes. They would need to elect to come to our Center and be a part of our Health Home or one of the other providers. Because they could no longer get CPST services. They can still get psychiatric services. They would not be prohibited from seeing the doctor or the therapist because that's outside of Health Homes, but they could not get traditional case management services that they probably got at the agency if they were a part of our Center's Health Home.
-	They can't keep the same doctors, dentist, and/or psychiatrist? Will those be appointed to talk to them? <ul style="list-style-type: none"> No, the only thing limited is Case Management. Once you're a part of a Health Home, it's all included in the Health Home package, so they will no longer pay for Case Management activities. But, if the individual had a great relationship with their psychiatrist and their therapist, and they were stable, they could still continue to receive services, and we would encourage that. Those professionals would become part of the multi-disciplinary team. The limitation is just Case Management.
-	Do you operate within a specific geographic area? <ul style="list-style-type: none"> We're in Lucas County – the Toledo area.
-	What other choices are available for people with Medicaid? How do you measure things like recovery for our people? There are people in group homes who have been there for 20 years and not going anywhere. They're just stuck in a rut and don't know about recovery. Could this program help them? <ul style="list-style-type: none"> Yes, it could help them potentially. It is one of the goals of Health Homes, but not every client is able to leave a group home setting. We run 2 group homes that have 16 people and we have some that we can get into a good place and get more independent, and we have a handful that are not ever going to get there, but we do different things with them to promote other external activities in an overall healthy active environment for them. It is very consumer-driven and it's truly about empowering and about the best interest of that individual to improve their overall health.
-	Is it true that those who are now called Case Managers will be called Care Managers? <ul style="list-style-type: none"> ODMH has established that the Care Manager in the Health Home does not replace the traditional CPST services. They are a sort of lead of the care coordination. They guide the other individuals and connect them, facilitating communication and the building of care coordination. The Health Home Specialist works under them, an equivalent of the CPST. This is how 'case management' is built into the Health Home model. The service is, therefore, not lost, but expanded. The only thing that is lost is the ability to bill for Case Management services.
-	Are people looking at the overall medical picture? Some people smoke or even continually eat to offset some very unpleasant side effects of psychiatric medications. These things may result in weight gain, diabetes, smoking, etc. It seems that the victim is often blamed for what they are doing to offset terrible medicinal side effects. <ul style="list-style-type: none"> This is not what I was trying to say and that's why a pharmacist will be involved in the care coordination planning because they can also educate and provide suggestions for some of those side effects. The approach is not to push blame for people and their present health condition, whatever that reason may be. We have Clinicians that are obese or chain smokers. Some of them have agreed that they need to step up to the plate and even get in the group with them demonstrating their need for help also and a willingness to work together to figure out a better way. Peer Support Specialists will also be involved in this programming.
-	Once Health Homes become available for private insurance, what will happen to those young smokers who will reportedly be assessed a higher premium as will smokers who have been smoking 20+ years? How would Health Home be able to help them if they can't afford to keep that kind of insurance premium? Would they be penalized for smoking 20+ years? <ul style="list-style-type: none"> I haven't thought that far ahead. We're trying to deal with just setting up the program now. As an agency, we're committed to everyone we serve, not just Medicaid clients. Our uninsureds have access to the doctor. They can also go to the dentist and see the PTP on site. So, they get the same level of access to additional services as our Medicaid population. Then, we're lucky enough last October to be selected by SAMSHA for one of the integrated care grants, which really helps us to be able to provide our services. So, we are in good position to help all of the individuals we are working with and not just the Medicaid population. That was a difficult process, but it's been working out as best as it can.
-	Are you involved in any advisory councils or a structural strategic development for counties that are still in the process of implementing, so that they don't have to go through the same trial and error? <ul style="list-style-type: none"> The State has taken the initiative to lead that through learning communities. They have contracted with HRSA National Council to help with the lessons learned, what to avoid, what we need to build in the future. ODMH has done a really good job working on that. Interviews were held with our Clinicians about the troubles they were having, what they would like to see for more training, and what was the hardest part of the setup, etc. I personally have done a lot of these presentations at different events. We communicate regularly with Afet and Jody at ODMH, but we are not leading this. There will be webinars, training, and all kinds of learning potentials headed by ODMH and the National Council. It is a true team approach to learning. The problems

we have had on the Provider side, the State has had on the setup side with technology or communication, but everyone has been patient and working together.
<ul style="list-style-type: none"> - If people need more medical access to their physical medicine doctor, how will that work in the Health Home? <ul style="list-style-type: none"> • Having it on-site, we are able to juggle schedules and have been able to switch things around immediately for someone who needs to get in vs. making them wait until the next available appointment; and there are still many obstacles because access to medication, access to lab work, access to specialty care is a struggle; but we're working through it.

2013 PLANNING COUNCIL COMMITTEES

TOPIC	COMMITTEE DESCRIPTIONS
	<ul style="list-style-type: none"> - EXECUTIVE COMMITTEE: Comprised of the Planning Council Officers. This committee meets two weeks before each meeting to come up with an agenda and plan. Part of the agenda is to educate and have an environment to provide input, feedback, and offer advice. - MEMBERSHIP/BY-LAWS COMMITTEE: Reviews membership, new member applications, reviews the Bylaws and any changes. This committee will be busy this year because of the merger of ODMH and ODADAS. - BLOCK GRANT COMMITTEE: Works with Liz Gitter on annual Block Grant Funding. The committee works toward approving Block Grants and get them back to the Feds. The work this year will also involve merging Block Grants in ODMH and ODADAS.
TOPIC	COMMITTEE MEMBERS (Handout 12)
	<ul style="list-style-type: none"> - A sign-up sheet will be circulated. Anyone interested to be on these committees should sign and/or send an email to Liz Gitter. A follow-up email will be sent to those who were absent today. People can join later in the year. - This year we will be having a site visit from the Feds. They will be meeting with the Planning Council to ensure that our state is doing all of the good things we say we are doing.

NEW BUSINESS

TOPIC	SUGGESTED TOPICS FOR 2013 PLANNING COUNCIL MEETINGS
	<ul style="list-style-type: none"> - Youth involved in transitioning to the adult system – especially foster care and juvenile youth for the engage project and utilizing the TIP model and transition to independence. Kathy and John are representatives and can line up speakers on this topic as needed. - Information concerning how civil rights for consumers are being advocated. Who are people they can go to anonymously or people who have the same problems? - New psychiatric hospitals are like prisons and this must be addressed. It was suggested that someone from ODRC or Robyn Hoffman could do this. - Revisit the list of Block Grants allowing the Planning Council to make some recommendations. - Consensus development – If a statement is to come from the Planning Council, it will come from all of us as a consensus statement. Otherwise we are representing ourselves and should not speak for the Council. - Impact of the Affordable Care Act – Mark will think about who could speak on this. - Learn about the ODADAS System, what their Block Grants look like, who they are and what their priorities are.
TOPIC	OTHER
	<ul style="list-style-type: none"> - New Members and New Officers should be placed in the BH News.

ADJOURNMENT	3:05 p.m.
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