340 Review Stakeholder Workgroup

Wednesday, May 18, 2022

Meeting Minutes

I. Welcome

Lisa Musielewicz, OhioMHAS Staff Counsel and Department Lead for the Workgroup, welcomed Workgroup members and provided a reminder of hybrid meeting etiquette. All Workgroup members were present virtually or in person, except for Tony Coder, Executive Director, Ohio Suicide Prevention Foundation; Lovell Custard, President and Chief Executive Officer, Murtis Taylor Human Services System; Joan Englund, Executive Director, Mental Health and Addiction Advocacy Coalition; Sarah LaTourette, Chief Advocacy Officer, Ohio Children's Alliance; Cheryl Subler, Executive Director, County Commissioners Association of Ohio; and Patrick Tribbe, Chief Executive Officer and President, Hamilton County Mental Health and Recovery Services Board. The full list of members and OhioMHAS staff in attendance can be found on the last page of this document.

II. Continuation of Roundtable Discussion: Recovery Housing

R.C. 340.034 – Recovery housing

Lisa Musielewicz provided a refresher of the comments on recovery housing indicated on the survey and at the April meeting. She pointed out that in both forums, Workgroup members indicated a concern regarding unregulated and substandard recovery housing. She then started the discussion by asking "should recovery housing have some form of oversight by OhioMHAS?"

Cheri Walter asked about the latest letter that was sent on certification and funding for recovery housing, saying she felt it would impact the overall discussion. In response, Alisia Clark said that in looking at feedback from the field, one suggestion was to make sure OhioMHAS funding is tied to certification through Ohio Recovery Housing (ORH). From this, OhioMHAS decided that, beginning July 1, 2022, a recovery home must hold a certification approved by OhioMHAS to receive OhioMHAS funds (federal funds that

pass through OhioMHAS). Director Criss then explained that OhioMHAS has a relationship with ORH and that ORH uses the National Alliance for Recovery Residences (NARR) standards. She said that two other organizations also have nationally recognized standards: Oxford House and Commission on Accreditation of Rehabilitation Facilities (CARF). OhioMHAS has approved certification from all three organizations. Director Criss also acknowledged that recently introduced legislation on recovery housing in Ohio (HB 632) is based on model legislation that includes components already in other states' laws or being pursued by other states.

Believing that certification should be the standard to ensure quality, Duane Piccirilli commented that a year ago his Board required all recovery houses seeking Board funds to attain certification. He reached out to those that had not attained certification to let them know that the Board could use local levy money to assist with the certification process. He viewed it as red flag if an operator was opposed to certification. Precia Stuby asked what the rationale would be of not requiring certification. She also asked whether state certification would be preferred over ORH certification. Danielle Gray responded that Ohio has taken great care to treat recovery housing as housing--not as a care facility or treatment center; she said that if Ohio transitions its system to state certification, then housing becomes licensed care facilities. ORH has seen many "not in my back yard" (NIMBY) situations and she wants to keep housing as truly housing so that residents retain their rights under the federal Fair Housing Act. Once a place becomes a certified care facility, she said, it is easier for communities to discriminate against individuals with substance use disorders (SUDs) or mental illness. She added that the U.S. Departments of Housing and Urban Development and Justice have issued a letter stating that a government entity cannot regulate homes where individuals with disabilities choose to live together any differently than homes with typical families—that the individuals with disabilities are a protected class. States can, however, implement a system of voluntary certification and then require that certification for funding or referrals. She said many states have already done this. HB 632 takes Ohio in that direction.

Jamahal Boyd asked about the business aspect of implementing state certification of recovery housing and what resources would be needed to do that. Danielle Gray said that she could only speak from her experience with ORH, but that her organization does charge fees and has a partnership with OhioMHAS to adjust the process as needs dictate. She said that if ORH does not do its job well, it could lose its NARR affiliation. Jamahal then acknowledged that if OhioMHAS were to take over the function of certification, it would have fiscal and workforce implications for OhioMHAS.

Director Criss mentioned HB 632 and said this bill allows for both state certification and the state accepting national accreditation. She asked members whether one made more sense than the other for Ohio. Teresa Lampl responded by saying that Ohio has a long history of recognizing national accreditation and this is the model that Ohio has with ORH (since ORH operates under the NARR standards). She pointed out that recovery housing is not a residential program—it *is* housing—and Ohio does not license other types of housing. Given this, she believed HB 632's requirement that national accreditation be attained to receive funding is positive. She also expressed support for the bill's provisions concerning an OhioMHAS-operated registry where consumers could access quality information on recovery houses (similar to the nursing home registry).

Molly O'Neill commented that if the state requires higher quality recovery housing, the state must also provide the funding to support that. Precia Stuby asked about the implications of Ohio choosing national accreditation over state certification. Danielle Gray indicated that if HB 632 requires national accreditation as an option, she believes ORH would continue to exist. She pointed out that if you call NARR right now, NARR will direct the caller to ORH since ORH is NARR's Ohio affiliate.

Danielle also said there have been problems with local governments getting involved in the regulation of recovery housing. For example, Ironton created a registry of recovery homes and sent letters to all in their jurisdiction asking them to register with it. Thereafter, Ironton passed an ordinance limiting recovery homes to three or less unrelated adult residents. Ironton then contacted each home on the registry not meeting that requirement and cited them for noncompliance. She believed this action to be illegal, will spur lawsuits, and, accordingly, recovery housing in the community will be disrupted. She expressed concern with the creation of a state registry of recovery homes because of the stigma associated with such homes. Instead, she voiced support for HB 632's provisions that require national accreditation before referrals to those recovery homes may be made. She said there needs to be clear language regarding how local governments may treat recovery homes. For example, they should have a role in enforcing local building codes but should not be treating unrelated adults living in recovery housing any differently than typical families.

Duane Piccirilli asked about trademarking the term, "recovery house." Danielle Gray said she was not sure on trademarks, but said the Revised Code has a very solid definition of "recovery housing." She said a person who is operating a house that does not meet this definition should not be representing itself as a recovery house. She mentioned the Governor's recent speech where he said the system isn't broken, it just

wasn't fully built. She said recovery housing is a prime example of this; this is a part of the system that needs to be invested in and built.

Cheri Walter said Ohio needs a mechanism for dealing with homes that do not meet the definition of recovery housing yet hold themselves out as such. For example, she is aware of a home in Portsmouth that has sixteen residents, including three veterans, that advertises itself to the community as recovery housing. While she agreed with Danielle Gray that housing should be housing, Ohio must have a way of addressing situations that are clearly not acceptable. Tracey Campbell said when she started her career in the 1990s a similar discussion surfaced surrounding peer-run organizations. She said there was collaboration then to help such organizations achieve certification with the idea that any entity receiving state or federal dollars needs to be of a certain quality and accountable for the money received. She loved hearing about efforts, such as the one in Duane Piccirilli's Board area (Mahoning County), where the Board uses its funding to help organizations attain national accreditation. And she said national accreditation, rather than state certification, is the preferred mechanism so that individuals retain their fair housing rights. She felt that CARF is a provider-friendly model and said her organization would be willing to partner with a recovery housing operator to help them achieve this accreditation.

Michael Krause echoed the comments made about favoring national accreditation over state certification. Regarding the state registry, he felt that many individuals would look to their treatment providers to provide recommendations on recovery housing; for that reason, he said a state registry would be a valuable tool for these providers who want to ensure they are referring individuals to quality settings close to home—which may be different than the locales the treatment providers are familiar with.

Terry Russell commented that we need to think of the clients first and where they would go if we had more regulation of recovery homes and the substandard ones close. He acknowledged there are terrible living situations, but some of those operators provide loving care; he reiterated Molly O'Neill's comments that we must provide the resources to help recovery home operators provide quality living situations. Director Criss then summarized the comments made so far: she heard Workgroup members saying Ohio needs to ensure better quality and accountability with respect to recovery housing, but also avoid taking actions that would put individuals in worse living situations. She said there are programmatic and resources changes that could be made but asked whether Chapter 340 needs any changes to attain these objectives.

Danielle Gray thanked Terry Russell for his comments regarding focusing on clients but said she doesn't think that having quality standards will reduce the capacity of recovery housing. She said there is a substandard recovery house in Central Ohio, housing hundreds of people, that was closed and then taken over by a new operator. ORH worked with the new operator to develop new policies and ultimately attain ORH certification. ORH is available to do the same with other operators. Ultimately, she said, operators focusing on quality can benefit as they will attract new clients and grow. Any changes that would be made in the Revised Code and programmatically to facilitate that would be positive.

Tom Stuber agreed with Danielle Gray, saying having standards is essential and some level of certification is desired. Going back to Terry Russell's comments, Teresa Lampl commented that Ohio doesn't have enough affordable housing—period. She doesn't think that changing anything in Chapter 340 is going to improve this, but it's an issue that must be considered when discussing recovery housing access and funding. Terry said he couldn't agree more: that we need better quality recovery housing, but first we have to look at the problem of lack of affordable housing. Precia Stuby commented that there is a distinction between affordable housing and supervised housing. She said this goes back to the Workgroup's discussion at the April meeting of our system needing different levels of care. She said we need to right-size the capacity for supervised housing—which includes not only recovery housing but also housing for individuals with mental illness. She believes it should be a statutory responsibility for the state to ensure different levels (outpatient and inpatient) of supervised housing. Tracey Campbell said we need to look at how the Revised Code should be changed to specify that *state* dollars (not just local levy dollars) can be used to help recovery home operators attain national accreditation.

Bobbi Douglas said a huge issue in her community has been the lack of recovery home operators attaining the voluntary ORH certification. She said these operators tend to have less rules than ORH-certified homes and have become attractive to individuals who are still in active addiction. She also doesn't believe the NARR standards that ORH uses are that difficult to meet. Danielle Gray said many recovery homes obtain business through referrals from treatment providers. Many families and individuals trust this advice and do not think to do more research. She reiterated her comment from the April meeting that when families call ORH, they are shocked to learn that ORH certification is not required and that ORH is unable to take any action against an uncertified home. And if the home does not receive funding from its ADAMHS Board, then the Board also cannot take any action. She emphasized that requiring the national

accreditation for referrals from treatment providers is key. Michael Krause and Molly O'Neill agreed.

Samantha Shafer said she'd like to hear about the results from the policy requiring national accreditation for youth residential facilities—whether that resulted in facility closures. Or alternatively, whether existing housing was able to remain existing housing from supports that were available. She said her organization also does housing development and from that experience, she thinks a registry with limited access would be alright; but that Ohio isn't quite ready for a public access registry due to the stigma associated with recovery housing in many communities. She also believes that access to recovery housing in some communities needs to be considered: some areas have few options, and don't even have a homeless shelter.

Molly O'Neill said there was a significant connection in her former state between homeless coalitions and the behavioral health community. Does Ohio lack that connection and could there be more collaboration between behavioral health providers with homeless coalitions? Samantha Shafer said she believed there was significant collaboration in her area of that type, but more financial resources are needed.

Lisa Musielewicz asked Workgroup members to comment on the provision in R.C. 340.034 prohibiting an ADAMHS Board from owning and operating recovery housing. Precia Stuby said this language exists because of discrimination that occurred in Hancock County, where the Board, at the time, owned all recovery housing (Hancock County does not have a nonprofit housing developer). She was unsure why Ohio would prohibit a Board from owning this kind of housing when a Board isn't prohibited from owning other types of housing. Teresa Lampl pointed out that the statute literally says a Board may not own *and* operate recovery housing. She interpreted this to mean that a Board may not do both but could do either or. Director Criss asked if there is a concern with Boards operating recovery housing. Precia said, "yes," Boards should not be involved in operating recovery housing. Tom Stuber asked if Board ownership of recovery housing causes a conflict of interest, since the Board would then be the landlord. Precia responded by saying in her county this hasn't been an issue. The recovery organization in her county operates the home and the Board has a property manager that takes care of the home and collects fees.

III. Roundtable Discussion: ADAMHS Board Powers and Duties

R.C. 340.03 – Board of alcohol, drug addiction, and mental health services; powers and duties

Lisa Musielewicz explained that R.C. 340.03 specifies 14 ADAMHS Board powers and duties. She asked: "what should the essential functions of a Board be?" Molly O'Neill responded by saying she believes a Board's primary mission is to fill gaps in service delivery in the community. She felt that these gaps are happening a lot. She said that sometimes it is difficult to get the community involved in planning, but that can't be a red herring. Terry Russell said the biggest problem in communities is lack of accountability. He said that the Boards need the authority in statute to fix the problems identified in the Governor's State of the State speech—to build the system that was promised in 1988 but never built; and if they are given that authority and don't deliver, they need to be held accountable. Samantha Shafer said that as a provider entering new service areas, she could use more direction from the Boards responsible for those areas on how her organization can prove itself.

Tracey Campbell said that as a provider she would like to fill service delivery gaps but having a sufficient workforce to do that has been challenging and will probably continue to be so. She commented that Boards should engage in "collaborative bidding," not competitive bidding. She acknowledged that there will probably always be service delivery gaps, but if providers and Boards are more collaborative, this problem can be reduced. Samantha Shafer echoed this comment, saying that individual competitive bids do not help meet community service needs; and that Boards should be having planning discussions with the whole community of providers. Duane Piccirilli acknowledged that the workforce shortage has been a significant issue in his Board service area. But his Board does work collaboratively with providers by including them in regular planning meetings.

Michael Krause commented that in addition to the Boards making sure that providers are included in the planning process, they also need to ensure that persons with lived experience are included. Teresa Lampl said this is a good opportunity to look at how community planning is done and ensure resources are used efficiently. She said that her organization has established the 4 "Cs": (1) community planning, (2) connecting (how to get people connected to the care they need), (3) convening (how do we bring the right people to the table to problem solve), and (4) collaborative payor (how do we fill gaps to meet needs in a way that is person-centered).

Amy Price mentioned that she is particularly concerned about two groups: those who need behavioral health services but aren't accessing them, and those with severe and persistent mental illness. Regarding the first group, she acknowledged that it is challenging to think of adding more people to a system with an existing workforce shortage. This can particularly be so since these individuals may be from marginalized groups and need additional outreach or outreach that is culturally competent. Regarding the second group, she acknowledged that these individuals often enter and exit services and it's more challenging to keep them engaged. From a provider/Board standpoint, however, she felt it important to think about how to respond to the needs to these two groups.

Dustin Mets said that he wanted to emphasize Teresa Lampl's comments by saying that connecting individuals to services and community planning are two vital roles Boards must continue to play. The majority of individuals do not receive services from Board-contracted providers; instead, they must receive services from providers approved by their insurance plans. Yet these individuals need the services and are not getting connected to them. Boards must play a role in making sure the services are available and that people are getting connected to them, regardless of payor. The Director then asked how the group felt about Dustin's comment in light of Chapter 340. Jamahal Boyd responded by saying Chapter 340 will then need to define the lane and capacity of the Boards—what is their role in terms of engagement, gaps in services, oversight of services. Cheri Walter said that until we look beyond current Chapter 340, the Boards will be constrained in their planning function. She mentioned that the Board-contracted providers are not providing a lot of the behavioral health care now – it's the private physicians, federally-qualified health centers, and hospitals that are, and that Medicaid managed care plans, not the Boards, are the major payors of this care. This means policymakers need to think bigger at the local and state levels. Molly O'Neill said perhaps we need to think more creatively by reaching out to other planning processes, like the art of hosting (see https://artofhosting.org). She said this has been running through her head throughout the entire crisis task force project. Precia Stuby said she'd go back to Terry Russell's comment on accountability. The bottom line is how do we strengthen the language to identify who is accountable and what the consequences are when the accountable party fails. She said there are all these payors out there, not just the Boards. We must identify the locus of responsibility and get it to stand up and do what it's supposed to do. She also reminded everyone that planning is a fluid process; that we can't limit the planning to the creation of one document created at a discrete point in time.

Teresa Lampl said she also wanted to tie this discussion back to the discussion on continuum of care from the April meeting. She said that Cheri Walter used the word, "public behavioral health system"; but she said she doesn't think Chapter 340 is limited to this system. Rather, she offered that the Chapter crosses systems—public and non-public. She agreed that community planning is not a "one and done." Regarding the 4 "Cs" model she described earlier, she asked: "how do we tie convening with community planning?". She said it's critical when engaging in community planning to convene the right people – not only Boards and providers, but payors, hospitals, sheriffs, zoning boards. She said some communities do this well, but others don't. She believes the convening process could be better spelled out in Chapter 340.

Jamahal Boyd said a recommended change to the language could be to replace the concept of "continuum of care" – which is lateral – to "ecosystem of care" – which is circular. For example, if a patient comes into the behavioral health system under the side funded by a Board, but then leaves and receives care from the non-public side, the idea is that the patient is still in the ecosystem of care and the public and non-public sides have to communicate with each other, share data, and both ultimately be accountable for the patient. In other words, the accountability is elevated beyond the Boards. Cheri Walter agreed, saying Boards should continue to be the conveners, but that perhaps the scope of those who are convened needs to be broadened.

Following lunch, Lisa Musielewicz asked the Workgroup: "what should the Boards' functions be with respect to evaluating, reviewing, investigating, and auditing?" Samantha Shafer said she'd like to know the historical reasons or value added in having the Boards involved in these functions since the accreditation bodies are already engaged in these activities. Tracey Campbell added to Samantha's comments, saying that these functions impose duplicative requirements on providers that are burdensome. She explained that providers are already subject to extensive accreditation processes and have to report extensive data sets to the Ohio Department of Medicaid (ODM) and OhioMHAS (through the Ohio Behavioral Health Information System (OBHIS)).

Cheri Walter indicated that it is important for Boards to retain the ability to investigate abuse or neglect complaints. Boards are the feet on the ground – in the local communities – and can see and hear what is occurring. She pointed out that newer code language authorizes the Boards to advocate for Medicaid recipients. Molly O'Neill echoed these comments, although she has heard that investigations can be fraught with politics. Dustin Mets pointed out that OhioMHAS has an investigations unit; accrediting

bodies do as well. Would authorizing multiple Boards to investigate as another layer make sense? Providers serve multiple counties, so this could mean several investigatory levels.

Returning to the topic of planning, Precia Stuby said Boards can't do good planning without good information. Tracey Campbell agreed that Boards need data, but she believes R.C. 340.03 was enacted when providers were largely Board-funded entities. Since this is no longer the case (since Board funding accounts on average for only 20% of a provider's revenue), the Boards should be accessing the data directly from the sources of that data. For example, ODM should be providing Medicaid recipient data directly to the Boards. Terry Russell asked Tracey why her organization wouldn't want to supply Medicaid recipient information to the Boards. Tracey cited the costs inherent in doing that—she has to hire an IT professional to produce the reports and in her experience each Board has different formats in which they want the reports. This is burdensome for the providers. Cheri Walter said the Boards realize this and are having ongoing discussions with ODM to access Medicaid recipient data directly from that agency.

Cheri also said that Boards do not want to be certifying bodies. They would, however, like to know when new certified providers come into communities and when providers are being investigated—to stay in the loop. She said she wasn't sure on what exact changes are needed in statute, but that Boards do need to stay in the loop. Tracey Campbell responded to Cheri's comments by saying she agreed that Boards and providers do need to coordinate with each other. Molly O'Neill agreed regarding coordination.

Molly also addressed the data reporting requirements that Tracey Campbell had mentioned. She commented that data reporting in and of itself isn't a problem, the problem is technology. She said the behavioral health field must embrace technology and how it can be used to make data reporting easier. Kay Spergel agreed with Molly regarding technology; she said that, like the providers, Boards lack the resources to get the right technology infrastructure in place. She cited the crisis data survey as an example: she had multiple parties happy to give her data, but she had to hand-count everything. If optimal community planning is to occur, the technology infrastructure needs to be improved, but Boards need help in securing funding and obtaining training and technical assistance.

Tom Stuber said there is a fine line between collaborating and micromanaging. He said there needs to be more trust, more partnership between the Boards and providers.

Teresa Lampl said she wanted to build on Tom's comment. R.C. 340.03, she said, was enacted when the Boards were still responsible for Medicaid recipients. Now, these recipients aren't the responsibility of the Boards; the programmatic issues have shifted. Providers today, on average, contract with 35 different payors, meaning they have varying experiences with financial and program audits. The Ohio Council consistently hears that the time and effort in the amount of program review – which feels like executive management and should be done by the executive management of the provider organization – is, via statute, the role of the ADAMHS Board. And that, she commented, should not be their job. Providers should not be giving data to ADAMHS Boards regarding patients who do not receive Board-funded services. Instead, the Boards' duties should entail community planning, connecting, and convening. Audits are required by accrediting bodies and federal grant makers; there should not be the extra burden of audits by Boards.

From a person-served perspective, Molly O'Neill said there should be on-site audits by someone. There doesn't need to be audits by multiple parties. She again mentioned the need for better technology—multiple reports can be generated by the same database. Bobbi Douglas said she has been fortunate to have a collaborative relationship with her local ADAMHS Board. Her organization provides data *ad infinitum* to the state as well as this particular Board; and yet, she's not sure anyone is looking at all of this data. She said she has no problem providing some agreed-upon data pertinent to services provided by the Board, but she doesn't feel like all the currently required reports of data are looked at and ends up informing the community planning process.

Robin Harris said she wondered if her Board is an anomaly; her Board *does* accept the audits done by accrediting bodies and the State Auditor and doesn't engage in duplicative auditing. She feels like her Board is accountable to the local community; if she is going in to do an audit, it's because a community party – a family, judge, county commissioner, school superintendent, health commissioner, or county department of job and family services – has called the Board with a concern. There are predator providers; when someone does something poorly, the entire community is affected. That is why, she said, you see the actions by county commissioners as was done in Portsmouth. The Board's role in provider oversight and evaluating provider effectiveness can and should be done in a way that is responsible, that is not overly burdensome to providers.

Dustin Mets commented that the providers doing things well are likely the ones facing the greatest administrative burdens, while the ones not doing the right things are probably the ones not receiving scrutiny. Accordingly, the good providers feel forced to hire administrative staff over clinical staff. He went on to say that data is a pillar of his agency's strategic plan—he is 100% behind data. But, he emphasized, it's important to identify the data that is really needed and come to some common data definitions so that providers do not have 50 different asks for data from different sources. This is what is burdensome to providers. Tom Stuber agreed: uniformity in requests for provider data needs to happen. Cheri Walter said that planning isn't the only reason why Boards want data. The Boards are called when there are emergencies (e.g., a suicide or overdose trend) and the Boards need access to data to evaluate those trends. The Boards do agree, however, that the providers should not have to provide data in 50 different ways. The Boards being able to access the data – client level data – directly from ODM would be useful and less burdensome on providers. She pointed out that the Boards are government entities and, just like OhioMHAS, have to be accountable for the public dollars they distribute. Boards are not trying to be overly intrusive; instead, they are trying to be responsive to OhioMHAS in reporting how public dollars are being spent and the client outcomes associated with that spending. If there's a better way to do this, then she said the Boards would be supportive.

Bobbi Douglas asked if the Boards had ever done a survey to determine how much variation exists in data requests from the various Boards. She said that some – not all – Boards are asking for very detailed data and the requests are overreaching.

Terry Russell said a real problem is territorialism – clients getting turned away for services because they do not live in the county in which those services are provided. Chapter 340 needs to be changed to ensure clients can access services no matter where they are in the state. Tracey Campbell agreed, saying this has been a problem in her area which receives many tourists. A tourist may be staying a week or so in the area and have a behavioral health crisis. While any Board will pay for the crisis services, they will not pay for follow-up care because the providers of that area are not under contract with the Board of the client's county of residence. She said the Chapter does need to be fixed in this respect.

Director Criss asked Workgroup members to express their thoughts on access to crisis care, specifically inpatient care, and the need for system collaboration in this area so adults with serious mental illness can access the correct level of care for their needs and not feel like a commodity. Terry said that when the Mental Health Act of 1988 was

enacted, the Boards were responsible for paying the hospitals for any client they sent. This was changed, and he's not sure why it was. He commented that the Boards should be responsible for inpatient care for persons with chronic mental illness in the local communities. Responding to Terry, Teresa Lampl pointed out that we have a different payment structure than in 1988. She said every insurer should be paying for the service--period. But she said the pertinent question is: "how do we create the coordination and connection to discharge planning?" She said we do a pretty good job of getting people into a hospital, but how do we then create the discharge connection—what is the responsibility of the community *and* the hospital? If a person just gets discharged to a park bench outside the facility, that is a problem. The coordination/connection piece, she said, is where things fall apart.

Molly O'Neill mentioned the population that needs a higher level of care but who cannot be treated in the community. She said we need to think about who is accountable for finding the right treatment at the right time for this population. Duane Piccirilli emphasized Boards' roles as a connector and convener. He said his Board has established two navigators – a hospital navigator and a navigator to liaison with his local area agency on aging. The hospital navigator's job is to make sure patients discharged from a hospital following a psychiatric admission are connected to the correct providers. He said having this connection is vital. He also said Boards are supposed to be the ones doing the convening, the leading; he gave an example of a young person who died by suicide in front of a school. The young person's provider called, and Duane convened a meeting with the local school system and providers and made sure boots were put on the ground and the community got through it. In other words, the Board made sure things got done. If things aren't getting done, he said, the Board director needs to be held accountable.

Precia Stuby commented that Boards need to be a voice on behavioral health parity—it's a critical role for Boards to play to make sure patients are getting immediately connected to the proper treatment and not discharged to a park bench. She also agreed with the concept of navigators. But what she has noticed is that some emergency departments (EDs) are discharging people to boutique hospitals which are not the proper placement. Hospital ED physicians and staff, she said, lack training on the proper steps to take with discharging patients with psychiatric diagnoses. Robin Harris agreed; she has an ED in her area where at least two ED physicians will persistently kick out patients with severe and persistent mental illness who come to the ED weekly. She has no authority over this hospital and has felt powerless – all she can do is beg the sheriff to please the transport the patient to another hospital in a neighboring county, which

means that one hospital is useless in terms of getting patients with severe and persistent mental illness connected to the proper treatment.

Tracey Campbell commented that ED physicians lack the time to properly screen patients for behavioral health conditions and ensure they are connected to care in the least restrictive setting. Instead, she said, this should be the job of the behavioral health system to do this screening. She pointed out that the hospital Robin Harris described, which is kicking out patients, is violating federal regulations and may be reported to their accrediting organization (usually The Joint Commission). She did point out that there exists a lack of places to refer persons with persistent and severe behavioral conditions for housing; and so, as a last resort, they are referred to homeless shelters.

R.C. 340.037 – Operation of facility to provide addiction or mental health services
Lisa Musielewicz asked Workgroup members to consider the questions: "should there be any guardrails on a Board if it becomes involved in the daily operations of a residential facility? If so, what should those be?"

Dustin Mets asked: "in what other areas is a government entity allowed to go in and take over the practice of a health group?" "Is there an analogous situation we could look to regarding how this power is executed and is it necessary?" He said he was unsure the ADAMHS Boards should be operating an entity. Cheri Walter explained this power is exercised only in grave emergencies, for example, when there are no providers willing to take over the practice. Precia echoed Cheri's explanation and said this has only happened once (in 33 years) in her Board area. Molly O'Neill asked Precia if there are timelines on a Board exercising this authority. Precia said yes—no more than one year. Director Criss said she is aware of another situation where this happened in the last three years. It was a short term, "all hands-on deck" situation where OhioMHAS, the Board, and county commissioners collaborated to achieve proper continuity of care.

Lisa Musielewicz mentioned that several Workgroup members had indicated in their survey responses that division (B) of this section doesn't seem to match the operating environment where behavioral health services are provided by private non-community-based services. Lisa asked members to express their thoughts on whether the statute should be modified to specify that division (B) applies only to public community-based services. Robin Harris pointed out that a patient served by a private provider still needs continuity of care. Lisa also asked about the experience of rural areas with this statute. Robin said she has not had experience. Kay Spergel explained that her Board was given this authority with a prevention provider providing afterschool services. The provider

lost their ability to appropriately supervise the services, so the Board was given this authority on a short-term basis. She said it worked well in this situation, otherwise the program would have had to close immediately.

Dustin Mets asked about non-contracted providers: "what happens to them if they fall into financial trouble or some other trouble?" "How would Chapter 340 apply to them?" He said the patients they serve have every right to continuity of care as well. He asked those Workgroup members who have used the statute whether they believe there should be any guardrails on this authority. Precia Stuby said it's not stated in Chapter 340, but one thing her Board did was give regular reports to OhioMHAS, which could be a guardrail. In terms of non-contracted providers, she explained that there was a non-contracted private provider in her area experiencing financial troubles. This provider was serving many child welfare families, so her Board reached out to the child welfare agency to let them know about the provider's troubles and offer assistance in transferring care to other providers. When Boards know that something negative is happening with a provider, she said the Boards should be doing the outreach to community organizations to ensure individuals have continuity of care.

R.C. 340.05 – Complaint alleging abuse or neglect of individuals in a residential care facility

Lisa Musielewicz asked Workgroup members to consider the question: "what should a Board's role be in investigating complaints of abuse and neglect and taking action to protect residents?" Terry Russell explained that this statute was added about 23 years ago as a result of six terrible cases in a residential care facility in Steubenville (two rapes had occurred). Precia said she was aware of another situation where this statute was used. Both Precia and Terry said this statute won't be used often, but it is necessary for those times when needed.

Teresa Lampl agreed that this statute is necessary for those instances where significant concerns and challenges exist. For the patient, however, she cautioned that it could become overwhelming when there are various investigating entities involved giving different messages. For the provider, she said, it can become overwhelming too, because the provider is facing so many different regulators that it is not able to spend the time needed to focus on mitigating the issue and providing the support to the people directly involved—which may not only be the residents but also the staff. She said there may only be one or two bad actors, but their actions impact the entire organization. She also pointed out that this section references R.C. 5119.34, which does not include SUD residential, so there is a protection that exists for one part of the

system, but not the other. She also said a continuum of care problem is that there aren't many adult residential programs.

Samantha Shafer asked the Workgroup to consider the perspective of the person being served and how the system can mitigate confusion for that person. Because, she said, it seems like multiple entities could be involved with an investigation—the Board, OhioMHAS, adult or child protective services, law enforcement, Disability Rights Ohio. She asked: "where is the locus of responsibility?" It may be that each system has its own responsibilities, but, she asked, "is that helpful or hurtful to the individual being served?" Teresa Lampl added to Samantha's comments and her earlier remarks, saying she questioned the value of having multiple parties asking the same questions of someone who has just been through a traumatic experience. And for the provider, there is the issue of having the resources to deal with all of the different entities.

Molly O'Neill said that from a person-served perspective, she agreed with Samantha that it is confusing on where the person should register their complaint. Teresa Lampl said that providers must post a notice in facilities regarding all of the various entities through which an individual may initiate a complaint. Molly said she has learned of challenges in the grievance processes, where the systems that are very familiar with each other (particularly in less populated areas) may not pursue action because they know the people personally involved or are friends with them. There needs to be a guardrail that keeps the politics or "good 'ole boy system" from being the system that arbitrates the grievances. Robin Harris asked Molly if that would be a situation where the Board would be required to report the complaint to OhioMHAS for investigation. Molly responded, "yes," but only if the complaint is filed and taken seriously.

Terry Russell said the "any door is ok" approach in statute was intentional because if a Board or protective services isn't doing its job, there would be the ability of someone else to come in and do it. He said the "any door is ok approach" should not be eliminated but does think the statute could be modified to specify how the parties are to coordinate.

Director Criss commented that this is a very specific code section, pertaining to individuals who live in residential care facilities and receive outpatient services from another community provider. If that provider has a complaint, then this is what can happen for more immediate action. She suggested that perhaps all of the sections regarding client complaints and grievances could be the subject of a future meeting

where there would be a more complete picture of what the pathway looks like for any person accessing behavioral health services.

IV. Roundtable Discussion – ADAMHS Boards' Organization and Size

R.C. 340.02 – Organization of ADAMHS board

Lisa Musielewicz explained that R.C. 340.02 is the primary section in this group of statutes and that current law requires Boards to have either 14 or 18 members. For an 18-member Board, the OhioMHAS Director appoints eight members, while the board of county commissioners appoints ten members. For a 14-member Board, the OhioMHAS Director appoints six members, while the board of county commissioners appoints eight members. In a joint-county district, county commissioners of each participating county must appoint members in as nearly as possible the same proportion as that county's population bears to the total population of the district, except that at least one member must be appointed from each participating county. She also explained the statute's requirements on characteristics of the Board members.

Lisa first asked Workgroup members to consider the question: "is there a Board size that is too large or too small?" Cheri Walter said that this topic is addressed in Representative Swearingen's recently introduced bill, HB 523. She then explained that HB 523 requires a Board to have either 9, 12, 14, 15, or 18 members and that OACBHA supports it. Terry Russell explained that people with lived experience sometimes don't even know what an ADAMHS Board is, let alone how many members are supposed to be on a Board; what they care about is that their interests, and those of their families, are represented. He mentioned that the Governor had vetoed provisions in the budget bill pertaining to characteristics of Board members because representation by persons with lived experience and their family members had been reduced. In HB 523, Terry said, that representation has been restored. Cheri Walter commented that HB 523 actually increases representation of these groups.

Molly O'Neill pointed out that the perspectives of persons with lived experience versus the perspectives of their family members are different; she was concerned that HB 523 was not prescriptive enough on the proportion of each that had to be on a Board. Michael Krause agreed. Within the confines of the proportion specified in the bill, Cheri Walter said the bill gives the OhioMHAS Director discretion on the breakdown between persons with lived experience/family members for each individual Board. Terry Russell said he didn't read the bill the same way Cheri did. Considering that copies of the bill were not in front of Workgroup members and this bill is in its initial stages of

deliberation, Director Criss asked Workgroup members to consider only current law at this meeting. She said that what she was hearing was that Workgroup members absolutely wanted to ensure representation by persons with lived experience as well as representation by their family members, not either or.

Molly O'Neill commented that R.C. 340.02 should be made more prescriptive regarding the characteristics of persons with lived experience and their family members. In other words, the law should say that Board membership must include persons in recovery from mental illness, persons in recovery from SUD, family members of persons in recovery from mental illness, and family members of persons in recovery from SUD. Director Criss asked Workgroup members how they felt about the current law requiring membership of at least one clinician. Robin Harris said that this requirement has been very difficult to meet in less populated areas where clinicians who don't work for Board-contracted providers are scarce or non-existent. Molly asked if clinicians may recuse themselves from Board matters pertaining to their employers. Several Workgroup members responded, "no." Duane Piccirilli said that in his larger county, he doesn't have an issue with this requirement, but he understands the predicament for less-populated areas. He is supportive of removing the clinician requirement.

Lisa Musielewicz asked Workgroup members to comment on the ratio of appointments made by the OhioMHAS Director versus a board of county commissioners. Duane commented that he likes that the law specifies ratios—it keeps it less political. Precia Stuby suggested that in lieu of requiring a clinician, perhaps each Board could be required to have a member who is a part of a peer organization that interacts with that Board. Kay Spergel pointed out that this would be challenging, because then any peer organization represented on a Board would be ineligible for Board funding, but perhaps a member of a peer organization from a neighboring jurisdiction could be included. Michael Krause suggested requiring Boards to have a certified peer recovery supporter member. But then Kay pointed out that the employers of those peer recovery supporters are most likely Board-funded.

Lisa Musielewicz then asked if it made sense to eliminate any of the current prohibitions on Board membership and employment. Tom Stuber indicated that he supported maintaining the prohibitions, as boundaries do need to be maintained. Molly O'Neill commented that it sounds like it is a challenge to find Board members who meet all of the specified categories because of the prohibitions. She suggested consideration of requiring larger Boards where conflicts of interest could be mitigated through recusals on certain matters. Duane Piccirilli said he strongly disagreed: he understands what

Molly is saying, but recusals and abstaining from discussions puts the other Board members and Board director at a disadvantage. Cheri Walter said that any consideration of removing these prohibitions would require an analysis of Ohio ethics law and whether that law would permit the intended action.

Tracey Campbell said she supports maintaining the prohibitions. As a provider, she would not want any ADAMHS Board director or member to be a member of her provider board: the conflict of interest would pose difficulties if the Board and provider had a dispute. Molly O'Neill suggested that perhaps providers could rotate positions on an ADAMHS Board. Helen Jones-Kelley reminded the Workgroup that there are other systems out there (e.g., hospitals) where ADAMHS Board input would be valuable, and these prohibitions pose a barrier to that input being shared. Precia Stuby clarified that Helen was speaking to ADAMHS Board directors and members serving on other boards *other than* boards mentioned in R.C. 340.02 – like hospital boards. Helen verified Precia's clarification, again reiterating that ADAMHS Board directors and members have valuable input to share for broader community initiatives. Precia Stuby said she never thought of the statute in the same way as Helen, that perhaps the statute could be clarified to allow the kind of activity Helen referred to.

Lisa Musielewicz asked Workgroup members whether Chapter 340 should specify certain training requirements for ADAMHS Board members. Cheri Walter said OACBHA has always maintained that Board members should be trained in certain areas – e.g., their responsibilities, the basics of mental illness and addiction, and ethics. OACBHA has produced an orientation training manual for Boards to use. Tracey Campbell said Board members should also be trained on involuntary commitment, that there are nuances to those rules. Molly O'Neill commented that Board members should be trained on stigma-reducing language and how to read and interpret financial statements. Tracy Maxwell Heard commented that training on implicit bias should also be required.

Lisa Musielewicz explained requirements in current law on Board terms and asked Workgroup members to comment on those. Precia Stuby said that Board members should not be able to flip back and forth between having terms under different appointing authorities, so that they could indefinitely serve on a Board. Lisa said that on the surveys there was a consensus that R.C. 340.021 should be repealed because it describes separate MH/ADAS Boards, which no longer exist. Workgroup members again agreed with this assessment. Lisa mentioned that R.C. 340.022 has very limited applicability—it was enacted in the most recent main appropriations act to address a specific situation. Lisa asked Workgroup members their thoughts on having such a

statute, or whether it would be best to treat all ADAMHS districts consistently.

Cheri Walter acknowledged that R.C. 340.022 was enacted in response to a situation in Erie and Ottawa Counties. Teresa Lampl commented that there should probably be a process for mergers and withdrawals that applies consistently to all ADAMHS districts, rather than special statutes that apply to limited situations. Cheri agreed, saying there needs to be two distinct processes – one for boards to merge and another for them to withdraw from a joint-county ADAMHS district. Michael Krause commented that from his former experience working in affordable housing that there were repeated conversations about housing authorities merging. Going forward, he believes it is important to have a Board merger process in place because he foresees an increasing interest in mergers and these situations can be difficult conversations without some statutory guidance.

Going back to Board composition, Aimee Shadwick commented that the statute should ensure diversity of Board membership: diversity in professions represented, diversity in persons with lived experience represented, diversity in ethnicity, diversity in age, etc. Precia Study said that regarding the number of members Board should have, she believed it is poor public policy to have variations in these numbers. In other words, she said, there should be a set number for each Board.

Lisa Musielewicz then announced that the remaining sections in this group would be discussed at the next Workgroup meeting on June 30.

V. Public Comment Opportunity

Eric Stewart pointed out that Representative Swearingen's bill, HB 523, provides a mechanism for a Board to decrease its membership, but not to increase it. He said his Board might consider increasing its membership but would strongly oppose reducing it. He said his ADAMHS district is fortunate to have a wealth of individuals (consumers, family members, and behavioral health professionals) willing to serve. He said he could understand the struggle more rural areas might have with recruiting Board members. He said that at the very least, he'd like to have his Board remain at its current size or step up in membership.

Michael Matoney pointed out that there are different requirements pertaining to recovery housing for adolescents (e.g., pertaining to parent/guardian consent to enter

the housing). Michael also said he believes the list of duties and powers in R.C. 340.03 is way too broad—they need to be more narrowly defined.

VI. Upcoming Meetings

The current Workgroup meeting schedule is as follows:

- Wednesday, June 22, 2022 (10:00 a.m. – noon) – Public Comment Opportunity via Microsoft Teams (Workgroup members are not required to attend, but are welcome to listen in.)
- Thursday, June 30, 2022 (10:00 a.m. – 2:30 p.m.) – Regular Workgroup meeting at the Ohio Department of Public Safety Shipley Building (Workgroup members are welcome to attend in person or virtually; members of the public may attend virtually due to space limitations)
- Tuesday, August 23, 2022 (10:00 a.m. – 2:30 p.m. - NOTE DATE CHANGE) - Regular Workgroup meeting at the Ohio Department of Public Safety Shipley Building (Workgroup members are welcome to attend in person or virtually; members of the public may attend virtually due to space limitations)

More meetings may be added if further opportunities for discussion are needed. In Fall 2022 there will be five public listening sessions; information on them will be forthcoming.

<u>Workgroup Attendees</u>

Jamahal C. Boyd, Sr., Chief Executive Officer, The Crossroad Center
Tracey Campbell, Director of Operations, Firelands Health
Bobbi Douglas, Executive Director, OneEighty
Danielle Gray, Executive Director, Ohio Recovery Housing
Robin Harris, Executive Director, Gallia-Jackson-Meigs Alcohol, Drug Addiction, and Mental Health Board
Tracy Maxwell Heard, Executive Director, Multi-Ethnic Advocates for Cultural Competence
Helen Jones-Kelley, Executive Director, Montgomery County Alcohol, Drug Addiction & Mental Health Services Board
Michael Krause, Executive Director, Ohio Peer Recovery Organizations
Teresa Lampl, Chief Executive Officer, Ohio Council of Behavioral Health and Family Services Providers
Lynne Lyon, Deputy Director of Behavioral Health Policy, Ohio Department of Medicaid
Mark Mecum, Chief Executive Officer, Ohio Children's Alliance
Dustin Mets, Chief Executive Officer, CompDrug

Jeff O'Neil, President and CEO, Greater Cincinnati Behavioral Health Services
Molly O'Neill, Chief Executive Officer, Ohio Citizen Advocates for Addiction Recovery
Amy Price, Associate Advocacy Director, Disability Rights Ohio
Duane Piccirilli, Executive Director, Mahoning County Mental Health & Recovery Board
Terry Russell, Executive Director, National Alliance on Mental Illness (NAMI) Ohio
Aimee Shadwick, Director, RecoveryOhio
Samantha Shafer, Chief Executive Officer, Integrated Services for Behavioral Health
Kay Spergel, Executive Director, Mental Health and Recovery Board of Licking and Knox Counties
Thomas Stuber, President, Ohio Alliance of Recovery Providers
Precia Stuby, Executive Director, Hancock County Alcohol, Drug Addiction, and Mental Health Services Board
Aimee Wade, Executive Director, County of Summit Alcohol, Drug Addiction, and Mental Health Services Board
Cheri L. Walter, Chief Executive Officer, Ohio Association of County Behavioral Health Authorities

<u>OhioMHAS Staff Attendees</u>

Director Lori Criss, Greg Allison, Jonathan Baker, Alisia Clark, Douglas Day, Lisa Frederick, Beth Gersper, Lois Hochstetler, Nick Martt, Angelika McClelland, Vanessa McMahon, Merissa McKinstry, Lisa Musielewicz, Janel Pequignot, and Dr. Justin Trevino