Attachment 5: **Public Meeting Agenda & Summaries**

CONSOLIDATION PLANNING
Stakeholders' Meeting

October 22, 2007
1:00 – 4:30
Second Floor, 1400 West 25th St.
(CCCMHB Building)

Purpose: To share with contract agencies our process of consolidation planning and to provide an opportunity for them to express their concerns and recommendations.

I. Welcome and Introductions (1:00 – 1:05)

II. Vision and Purpose of the Consolidation (1:05 – 1:15)
Kathryn Gambatese, Chair, CCCMHB Board of Governors
Russell Johnson, Chair, ADASBCC Board of Trustees

III. Process, Complexities, and Timelines (1:15 – 1:45)
William M. Denihan, CEO, CCCMHB
Russell S. Kaye, Executive Director ADASBCC

IV. Break (1:45-2:00 with refreshments)

V. Focus Group Discussions (2:00 – 3:30)

- Board Members (facilitated by our Board Chairs)
- Agency Directors
  - Prevention and Education (Lisa Griffith, Jim Joyner, and Scott Osiecki)
  - Treatment (Frances Mills and Valeria Harper)
  - Finance (funding, MACSIS, contracting, auditing, and IT) (Rose Fini, Yancey Quinn, Christine Paternoster, Cassandra Richardson, and Bill Tobin)
  - Quality Improvement and Research and Evaluation (John Garrity and Laura Lambert)

Focus Group Discussion points: What are the **Opportunities, Challenges, Expectations, and Recommendations**

VI. Break (3:30-3:45)

VII. Report Out and Discussion (3:45-4:30)

Report out on focus group highlights

Discussion points: **Common Themes, Surprises, and Uniqueness**

Cuyahoga County
Community Mental Health Board

CCCMHB ADASB Consolidation Stakeholder Meeting
Monday, October 22, 2007
1:00 – 4:30 p.m.
Summary

Alcohol & Drug Addict Services Board of Cuyahoga County

On Monday, October 22, over 60 people participated in a Consolidation Stakeholders Meeting facilitated by the Consolidation Executive Steering Committee, consisting of Kathryn E. Gambatese, CCCMHB Chair; Russell Johnson, ADASB Chair; William M. Denihan, CCCMHB CEO; and Dr. Russell Kaye, ADASB Executive Director.

The meeting gave providers and partners the chance to express concerns and recommendations through participation in five workgroups:

1. Finance, Funding, MACSIS, Contracting, Auditing and IT
2. Prevention and Education
3. Board Members
4. Quality Improvement, Research and Evaluation
5. Treatment

Participants expressed common themes, including the need to slow the consolidation process to develop the best behavioral health system possible. Providers were also hopeful that a consolidated board would lessen the duplication of paperwork and audits.

The following is an *unedited* transcription of the flipcharts that each workgroup used to report its opportunities, challenges, recommendations and expectations.

FINANCE, FUNDING, MACSIS, CONTRACTING, AUDITING AND IT

1. Single Contract vs. multi contract.
2. State standards (ODMH and ODADAS) could drive contracting process.
3. Single auditing for non-Medicaid and potentially Medicaid.
4. Doing things differently: RFP, ADM, Growth, Outcomes, Demographics, Duplication.
5. Targeted Reduction
6. Prioritization of Services: suicide prevention overlap, bed days.
7. Incentives for agency to serve integrated population.
8. Cost savings at provider levels: Quality Improvement, Auditing, IT systems, etc.
9. Assessment tool and services – how to bill and provide to benefit both AOD/MH – true integrated assessment.
10. Although co-occurring is growing, don't make MH only and AOD only agencies provide information that does not pertain.
11. Review external sources to view co-occurring prior to making funding decisions.
12. Integrate BH with physical health – opportunities and challenges.
13. Track dollars from more entities – Federal, Foundations
14. Consolidation not so much $ savings but stronger BH.
15. Manage $ more efficiently vs. saving $ to create a greater impact on service delivery.
16. Strengthen the support of the BH system.

Recommendations:

- Baseline data on human conditions on major life functions to improve conditions.
- Review overlapping initiatives to assist in building baseline data.

PREVENTION AND EDUCATION

Opportunities:

1. Cross system training.
2. Share expertise on public awareness of prevention value.
3. Share advocacy agendas.
4. Advocate for wellness; explore optimal wellness and how to get there.

Expectations:

1. Maintain AOD program fidelity.
2. Transparence from Commissioners
3. No loss in prevention $ for next 5 years.
4. Commitment to benefit of prevention
5. Educate community on value of prevention and mental health.
6. Move prevention from the back burner to a place of equity (including financial equity) with MH and AOD treatment.
7. Allocate MH $ for increased prevention services including violence and suicide prevention.
8. Value/maintain community connectedness.
9. Understanding that AOD is #1 health issue and therefore deserves consideration as we move forward.
10. Equal representation in trustees for prevention

Challenges:

1. Separate State (ODMH/ODADAS) systems.
2. Imbalance of advocacy between MH and AOD.
3. How do providers get more out of the consolidation for their consumers?
4. How is this going to bring more $ for prevention?

Recommendations:

1. Reconsider the whole consolidation in a more transparent manner.
2. Commissioners should dialogue with providers before making decisions.
3. Equity in AOD/MH Board of Trustees.
4. Increase and enhance the level of evidence-based services.
5. Money must follow expansion of prevention services.

BOARD MEMBERS

Opportunities:

1. Cost savings – duplicity of functions.
2. Recognition of different populations – MRDD and others
3. Reduce process and paperwork (feedback from agencies)
4. Board/Staff communicate timely and with focus.

Challenges:

1. MH vs. AOD power and focus
2. Who drives? Theory, political, social/community values, medical (general health)
3. Grant descriptions
4. Re-Entry – prisons
5. Dual certifications - Impact on agencies (cross-training)
6. Who is driving $

Recommendations:

1. Need hard data on re-entries on substance abuse and mental health.
2. Hospitals process applications – MH/AOD
3. MRDD Dialogue
4. Criminal Justice Dialogue
5. Access to $ proportionate to need (MH and AOD).
6. Internet – two way blog.
7. $ for dual certification ($14,000 – 3 years – ORCA House - $2500 per person)

Expectations:

1. Equal MH and AOD.
2. Hard data on demographics
3. Hospital applications
4. Include Asian Population
5. Board of trustees

QUALITY IMPROVEMENT, RESEARCH AND EVALUATION

Opportunities:

1. Team effort for compliance reviews – one time once a year.
2. Focus on increasing compliance through TA, training etc., rather than punitive approach.
3. Re-clarify language – terms.
4. Implementing idea of recovery throughout the BH system.
5. Being able to do applied research – use data for grants, own studies, system studies.
6. Training, cross/training
7. Performance measures
8. Advocacy re: system – things that do not make sense.
9. Collaboration vs. competition.
10. System wide data reporting with individual agency.

Challenges:

1. Compliance review from both boards has different standards, regulations, approaches, as well as method obtaining of samples.
2. Performance Measures
3. Outcomes – AOD vs. MH

Recommendations:

1. Identify themes in regulatory requirements and identify areas that diverge.
2. Acclimate providers to performance measures; clarify definitions; what is already being done and required.
3. Develop "common language" – example: QI and QA.
4. Identify demonstration projects that will improve service delivery – integration
5. Focus on applied research relevant to area – use data.
6. Begin integrating AOD/MH/QI workgroups – at least sometimes regularly.

TREATMENT

Opportunities:

1. User friendly and accessible
2. Streamline process (one phone contact instead of two)
3. Need to "navigate" multiple providers.
4. CSP services for both AOD and MH
5. Improved integration of services
6. System re-design to reflect 21st Century Realities
7. Lower duplication of services
8. Centralized intake/screening/assessments/emergency crisis – "one stop shop"
9. Standardized Assessments
10. Cross-clinical training
11. Increase combined staff expertise.
12. Shared language – lower administrative stress
13. Increase relationships across systems
14. Increase workforce curriculum
15. Lower paperwork requirements
16. Lower required tracks – documentation
17. Lower costs due to fragmentation
18. Lower number of "hats" workers must wear.
19. Increase co-occurring treatment for adolescents.
20. Increase training capacity.
21. Increase public communication
22. Lower stigma
23. Increase advocacy
24. Greater response for disaster planning
25. Lower evals with residential rounds within AOD providers visa versa "MH/AOD"

Challenges:

1. Who monitors equity between systems?
2. How will we define BH?
3. Cost savings will not allow providers to serve the client best
4. Integrating staff – appropriate planning is needed to achieve this
5. Impact of agencies and clients whoa re NOT dual diagnosed.

6. Lower perception that AOD issues are serious. AOD could get lost or subsumed under MH, loss of AOD focus.
7. Achieving parity – dual commitment to AOD/MH
8. Competition for County $ - shift in funding – different reimbursement rates for AOD/MH services
9. Other ways to address clinical/operational issues – collaboration
10. Time it takes to cross-train/integrate "holistic" care
11. Jeopardize existing services AOD/MH specialties
12. Loss of flexibility to serve special target populations
13. Challenge of communication – rumor/fear/mistrust.

Expectations:

1. Slow down process – can't do in six months. A deliberate effort is needed to achieve positive outcomes - $$$$ to Board and providers.
2. Everyone can be heard – include in process.
3. Efficiency = lowering waiting periods for accessing care.
4. Unspent $$/savings into direct services.
5. Expect good customer service and cooperation – respect from Board.
6. Expect bumps in the road.
7. Flexible funding mechanism.
8. That planning process will be monitored – Objectively measure success and define success: benchmarks; outside evaluation; publish findings; consumer satisfaction involvement in process.
9. Quality communication
10. Increase penetration rates for services.
11. Collaboration with provider
12. Fewer audits.
13. Want to do outcome evaluation
14. Increased care coordinating consumers getting what they want and need.

Recommendations:

1. Few audits – focus on outcome and impact.
2. Consolidate healthcare costs for provider agencies to achieve cost efficiency.
3. Practice/test collaboration before actual consolidation.
4. Provider representation on planning team
5. Impact on consumer
6. Structure should include Deputy Directors for AOD/MH.

7. Standardized assessment/documentation/treatment plans/progress notes.
8. View transitional housing as an issue in AOD system.
9. Take lessons learned from other system integration – take enough time to learn limitations of integration.
10. Analysis of service gaps/priorities.
11. SAMI/CCOE involvement
12. Commitment not to reduce services/funding to target populations: women, adolescents, hearing impaired, MRDD, physical impairments.
13. Need Deputy Director of Special Populations.

CUYAHOGA COUNTY COMMISSIONERS
BEHAVIORAL HEALTH BOARDS CONSOLIDATION
PUBLIC MEETING

Friday October 26, 2007
10:00 a.m.
The Cleveland Foodbank
15500 South Waterloo Road
Cleveland, OH 44110

I	**Introductions** • Dennis Madden • Rick Werner • Russ Kaye • Bill Denihan	
II	**BOCC request for consolidation** • County budget • Levy overview	**Madden/Werner**
III	**Consolidation planning process** • The charge to consolidate • The principles • The planning teams • The community	**Kaye/Denihan**
IV	**Comments and input**	**Open**
V	**Timeline**	**Madden/Werner**

Council of Agency Directors and AOD Directors Association Issues and Concerns Re: Proposed Consolidation of the Cuyahoga County Community Mental Health and Cuyahoga County Alcohol and Drug Abuse Services Boards: 11-1-07

Service provider representatives of CAD and the AOD DA met on 10-31-07 at Positive Education Program to discuss issues and concerns related to the proposed consolidation merger of the Mental Health and Drug Boards. We would like to share the following:

1. This consolidation is a rare opportunity to re-conceive the MH/ADAS system with a new mission and vision that better meets consumer needs. This is a chance to make the system more consumer-user friendly and accessible.

2. The proposed consolidation of both Boards does not negate the fact that both systems are grossly under-funded. We hope that the current leadership does not curtail any attention or advocacy to this very important circumstance during the consolidation.

3. Likewise, we hope that the energy, cost, or new space needed for the proposed consolidation does not divert attention from consumer needs and the services and supports needed for their recovery and resiliency. Bureaucratic, governmental needs should not trump the needs of consumers and the service delivery system.

4. We hope that the new consolidated Board keeps the best parts of both systems and expands them into the other. For example, ADAS providers should have timelier billing reimbursements and the right to negotiate their contracts for delivery of services to non-Medicaid clients, just as MH providers would appreciate the collaborative approach to Medicaid audits that currently exists in the ADAS system. Indeed, it is hoped that coordinated Medicaid audits will make life easier for providers.

5. We hope that the new consolidated Board will retain and employ flexible reimbursement mechanisms, which are based on client needs and programming. One size does not fit all. Fee for service, for example, is not appropriate for all programs/services and/or client populations.

6. Working toward regulatory reduction for providers and administrative efficiencies within the new consolidated Board must be a high priority.

7. We are befuddled by public comments from Board officials that no Board staff jobs will be cut. Shouldn't this decision be driven by the consolidation process itself and the identification of where efficiencies might occur?

8. We hope that any dollars that might be saved as a result of this consolidation go for increased services for all of the behavioral health population and not to increase staffing levels of the new consolidated Board.

9. We hope that the new consolidated Board remembers that all providers continue to shoulder significant uncompensated care.

10. We seek collaboration among all MH and ADAS providers as a goal to benefit our mutually served consumer populations, whether dually diagnosed or not.

11. We recognize there are opportunities for a more coordinated behavioral health response to Medicaid Plan Health Maintenance Organizations. In partnership with the new consolidated board, we can improve integrated care for many of our consumers.

12. We recognize that co-occurring treatment is an opportunity for collaboration among providers in order to ensure that consumers receive holistic, integrated care. We hope the new consolidated Board will help facilitate this process.

13. Services for singular need consumers need to be preserved. Not all providers should be encouraged to become dually certified. There is strength in the integrity of the existing provider network and this should be preserved to every extent possible.

14. We are concerned also about preserving the diversity of providers in the consolidated system, particularly those that serve the minority communities.

15. We wonder about the role of smaller providers in the consolidation and whether smaller organizations in the system will be forced to merge to stay viable.

16. We acknowledge that there are differences in the MH and ADAS treatment philosophies. We hope the new consolidated Board facilitates ongoing discussion of this issue within the larger context of systemic capacity.

17. We need to better triage consumers in need at point of crisis and emergency and give folks the right services at the right time. Now, everyone will be directly affected by Cuyahoga County's utilization of state psychiatric bed days.

18. We see the consolidation as an opportunity to improve the management of referrals from the criminal justice system. Often, MH providers see client documentation that a referent has a major mental health disorder, when in reality s/he needs Alcohol and/or Other Drug services.

19. We would appreciate an assurance that providers will be at the table when decisions are made that affect direct service delivery. This is especially important, given the trend toward continuing limited resources.

20. Last and not least, we recognize that even with this consolidation, both the new Board and the providers will still have to answer to two separate state departments: ODMH and ODADAS.

CONSOLIDATION PLANNING
Stakeholders' Meeting

November 15, 2007
5:30 p.m. – 8:00 p.m.
Second Floor, 1400 West 25th St.
(CCCMHB Building)

Purpose: To share with contract agencies our process of consolidation planning and to provide an opportunity for them to express their concerns and recommendations.

VI. Welcome and Introductions

VII. Vision and Purpose of the Consolidation
Kathryn Gambatese, Chair, CCCMHB Board of Governors
Russell Johnson, Chair, ADASBCC Board of Trustees

VIII. Process, Complexities, and Timelines
William M. Denihan, CEO, CCCMHB
Russell S. Kaye, Executive Director ADASBCC

IX. Break

X. Focus Group Discussions

- Board Members (facilitated by our Board Chairs)
- Agency Directors
  - Prevention and Education (Lisa Griffith, Jim Joyner, and Scott Osiecki)
  - Treatment (Frances Mills and Valeria Harper)
  - Finance (funding, MACSIS, contracting, auditing, and IT) (Rose Fini, Yancey Quinn, Christine Paternoster, Cassandra Richardson, and Bill Tobin)
  - Quality Improvement and Research and Evaluation (John Garrity and Laura Lambert)

Focus Group Discussion points: What are the **Opportunities, Challenges, Expectations, and Recommendations**

VII. Report Out and Discussion

- Report out on focus group highlights
- Discussion points: **Common Themes, Surprises, and Uniqueness**

Consolidation Stakeholder Meeting
Thursday, November 15, 2007
5:30pm-8:00pm
CCCMHB 2nd Floor

Recommendations;

- Retain both CEOs
- Create "Consultant Board" structure
- Design process to ensure "smooth" transition including business operations

Expectations:

- Consumer involvement from both Boards in the process
- Enhance family support & services. (fellowship/prevention/early intervention)

Opportunities:

- Put together the "best pieces" from both systems
- Define and/or measure success by the outcome-improve all aspects of services provided
- Opportunity to merge "best practice" models from both systems

Challenges:

- Fear of over powering each other (manage feelings of being overwhelmed) (negative image of the disability)
- Impact on persons in the criminal justice system-dual diagnosed
- Cross training/orientation re: culture of consumers (AOD & MH)
- Reduction in services
- How will the success of the consolidation be evaluated?
- Sustain means in which effectiveness of treatment is reported
- Improve access to services

Miscellaneous:

- Plan meeting with AOD & MH Boards' Consumer Advisory Councils
- "Lessons learned"-orientation from other consolidated Board areas

CONSOLIDATION PLANNING

System Partners Meeting

Monday, November 19, 2007
Cleveland Food Bank

Name:	Agency:
Rick Werner	County Health & Human Services
Joe Gauntner	EFS
Jim McCafferty	CCDCFS
Robin Martin	FCFC
Janet Kronenberg	NVSW
Maria Nemec	CPB
Jerry Blake	HHS/Tapestry
Russ Johnson	ADAS
Bob Tobik	Public Defenders Office
Matt Carroll	Cleveland Dept of Public Health
Terry Allen	Board of Health
Ralph V. Cosiano	Magistrate for Judge John Donnelly
Bernie Brooks	DSAS
Denise Pietrzak	HHS

New Duties
- MH prevention
- Special populations

What changes?
- Efficiencies
- Better integration of services
- Reduced paperwork for providers
- Advocacy

Will providers need to be dually certified?
- This is at state level
  - May support
- Better partnerships w/AOD & MH

Behavioral Health Courts Combined

Admin. Phase In?

How can "we" help?
- Recommendations
- Discussions

Providers talk:

- $ w/Mental Health
- Program w/AOD

Concerns of Providers?

- $
- Not get lost

4 Tips:

1. Address anxiety of Board staff
2. Full strategic plan
3. Examine BH core services
   - What dept. pays for what services
4. Share BH "Columbus Agenda" w/county/BOCC
   - Consolidation

JOINT BOARD OF DIRECTORS MEETING

Alcohol and Drug Addiction Services Board of Cuyahoga County
and the
Cuyahoga County Community Mental Health Board

Monday, December 3, 2007
6:30 p.m. - 8:00 p.m.

Second Floor, CCCMHB Building, 1400 W. 25th Street, Cleveland

AGENDA

1. Calls to Order

2. Welcoming Comments

3. Introduction of Audience

4. Principles of the Consolidation Planning Process

   Resolution # 07-12-01 (ADASBCC)
   Support for the Consolidation of Boards
   to Advance Behavioral Health in Cuyahoga County

   Resolution # 07-12-01 (CCCMHB)
   Support for the Consolidation of Boards
   to Advance Behavioral Health in Cuyahoga County

5. PowerPoint Presentation of the Draft Consolidation Plan
   to the Board of County Commissioners

6. Other Business