

Hamilton County, Ohio

MENTAL HEALTH & RECOVERY SERVICES BOARD

Operations and Tax Levy Review: Final Report

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I. INTRODUCTION

The analysis contained in this report pertains to the operations and finance functions of the Hamilton County Mental Health and Recovery Services Board (HCMHRSB). The Board is the county government agency responsible for planning, system goals and priorities, contracting services with certified providers, monitoring and coordinating service delivery available to Hamilton County residents, and evaluating service effectiveness and outcomes. The vision of the Board is to be recognized as a statewide leader in the delivery of publicly funded behavioral healthcare services for the Hamilton County community.

The Project Team comprised of staff from MAXIMUS and TATC Consulting has conducted the following analysis under contract with the Hamilton County Tax Levy Review Committee as part of the Committee's responsibility to review the operations, to review finances, and to make recommendations regarding the forecasted use of Mental Health Tax Levy dollars to Hamilton County Commissioners in 2007.

A. PROJECT SCOPE AND ACTIVITY

The scope of the Project Team's review of services provided through the HCMHRSB, as requested by the Tax Levy Review Committee, initially included in the following areas:

- Evaluation of current operating efficiency relative to MHRSB's strategic plan, MHRSB's peers, and reasonable expectations,
- Compliance with and maximization of current and planned funding contracts,
- Recommendations for Tax Levy contract provisions between Hamilton County and MHRSB assuming successful passage of the proposed Tax Levy, and
- Recommendations for cost savings and/or revenue enhancements

The Hamilton County MHRSB expects to experience a steady increase in demand in both services funded through Medicaid and non-Medicaid dollars during the next five-year period. With the support of the Tax Levy Review Committee and the Hamilton County

project manager, the Project Team has developed a series of recommendations designed to address this growing need from a financial point of view.

In conducting the analysis contained in the following pages, the Project Team has undertaken the following work steps:

- Conducted interviews with all principal Hamilton County MHRSB managers, including executive staff, department directors, and key managers,
- Collected significant volumes of data pertaining to operations and finance from the Hamilton County Mental Health and Recovery Services Board.
- Conducted a peer comparative data review, comparing the HCMHRSB performance to those in Butler, Clermont, Cuyahoga, Franklin, Lucas, Summit, and Montgomery counties. The data for these comparisons was drawn from source contacts through the HCMHRSB.
- In addition to interviews with Hamilton County MHRSB personnel, we have conducted interviews with the representatives from service provision agencies that contract with the Board. Such agencies include Greater Cincinnati Behavioral Health, Central Clinic, Talbert House and affiliates, Beech Acres, St. Joseph's Orphanage, Excel Development, and CCHB.
- Conducted a thorough review of all Board operating and financial processes,
- Thoroughly examined and modeled projected revenues and expenditures, including cost reduction and revenue enhancement strategies.
- Reviewed contract management audits conducted by the Board for sample audited agencies and the annual operational audit submitted to the state.

B. OVERVIEW OF COUNTY MENTAL HEALTH SERVICES AND PROGRAMS¹

The Hamilton County MHRSB contracts with more than 50 community providers that offer mental health and substance abuse services and programs to adults and children with mental health and/or substance abuse issues. Under Ohio Law, the Board must encourage the development of a comprehensive community mental health system, bolster the creation and maintenance of high quality, cost effective, culturally sensitive services that are prevention, treatment, and rehab focused, and protect the personal liberty of mentally ill persons so that they may be treated in the least restrictive environment.

¹ The Project Team has made extensive use in this report of background, policy, operations and financial material previously developed by Hamilton County MHRSB. All observations, conclusions and associated recommendations are based on our underlying assumption that this material is both reliable and accurate.

Priority service populations include the following individuals:

- Adult SMD: Adults with a severe mental disability
- Child SED: Children who are seriously emotionally disturbed

These two populations combined utilize approximately 90% of funding.

Secondary service populations include the following individuals

- Adult Non-SMD: Adults with mental health needs who are not severely mentally disabled
- Adult SAMI: Adults who are mentally ill and are substance abusers
- Child CJS: Children with mental health needs who are in the criminal justice system
- Adult CJS: Adults with mental health needs who are in the criminal justice system
- Child Non-SED: Children with mental health needs who are not seriously emotionally disturbed

Programs and services funded by the Board were provided to over 11,681 adult and 6,494 child consumers in FY 2006. This represents a two percent increase over the previous year among adult and child populations, an 18% increase among children over those served in 2002, and an almost 5% increase among adults over those served in 2002. In FY 2007, 53% of funding was allocated to Adult SMD clients, 5% was allocated to Adult Non-SMD clients, and 42% was allocated for children in need of mental health services. The following table presents high-level service categories and the percentage of funding allocated to each service through the board:

Hamilton County MHR SB Service	FY 2007 Mental Health Funding
<p>Community Psychiatric Supportive Treatment (CPST) - A community psychiatric support is a rehabilitation and environmental support system of targeted case management activities that are considered essential in helping persons gain access to necessary services. The goal of community psychiatric supportive treatment is maximum symptom reduction and a return of the person to the best possible functional level. Individual community support activities may include: development of interpersonal skills, community coping skills, adapting to home, school or work environments, symptom monitoring and management, financial management, and personal development. CPST is provided both as an individual service and in small groups.</p>	39%
<p>Psychiatric Interview/Assessments/Evaluations - Face to face clinical evaluation provided at specified times or in response to treatment, or when significant changes occur. Process of gathering information to assess client needs and functioning in order to determine appropriate service based on identification of the presenting problem, evaluation of mental status and formulation of a diagnostic impression.</p>	7%
<p>Counseling/Therapy - Individual counseling/psychotherapy is a series of time-limited, structured sessions with a therapist, where the consumer works toward the accomplishment of mutually agreed upon treatment goals.</p>	15%
<p>Pharmacological Management - Pharmacological Management is a service conducted for the purpose of prescribing and/or supervising the use of psychotropic medication and other medications. At times, this service may also include medical assessment and medical treatments. This service is provided in face-to-face contact between a licensed physician/psychiatrist or a registered nurse and an enrolled client. Medical/somatic service includes the responsibility for evaluating the client's progress, adjustment to medication, and need for medication change.</p>	8%
<p>Other Mental Health "Other Mental Health Services" is an Ohio Department of Mental Health designation which incorporates a variety of services which are defined by local Mental Health Boards. Other Mental Health Services are certified by the Ohio Department of Mental Health. Services operated by the Sheriffs Department, the Probation Department, Juvenile Court and Pre-trial are included in this category. Additional services included in this category include; Co-treatment when more than one staff member provides treatment to a consumer in the same block of time for safety or therapeutic reasons, Banking-Payee Services, Intensive In-Home services, Outreach Services, Mobile Crisis Runs and On-Site Emergency Services at University Hospital.</p>	2%
<p>In-Patient Hospital - Inpatient services are provided at psychiatric hospitals or on the psychiatric unit of a community-based hospital. Residence and treatment are provided to consumers with the goal of stabilization and return to the community.</p>	2%
<p>Crisis Intervention - Crisis services provide for immediate interventions in emergency situations and timely interventions for crisis situations. Interventions take into consideration the person's preference and should provide services necessary to</p>	3%

Hamilton County MHR SB Service	FY 2007 Mental Health Funding
stabilize the crisis situation. These services also include linkage and referral to other providers in order to resolve the crisis situation and 24 hour consultation with a psychiatrist.	
Prevention and Education - Prevention services are based on a needs assessment and are provided according to identified priorities. A wide range of ages and diverse populations are targeted for prevention services. These may include activities such as competency skill building, stress management, self-esteem building, and mental health promotion Education services focus on educating the community about the nature and composition of a community support program. This service helps the community focus on issues that affect the population served or an identified under-served population. .	2%
Consumer Operated and Peer Support - Individuals with similar mental health issues provide peer support services to consumers. Self-Help/Peer support is intended to provide consumers with information and support from those who have had similar life experiences. Providers must be certified by the Ohio Department of Mental Health as a consumer operated agency.	1%
Residential Treatment and Housing - Intensive residential treatment facilities are designed for short-term stays. Residential treatment facilities conduct transitional, congregate programs that provide a variety of mental health and other support services. Such services include assistance with basic personal care, management of personal space, training for increased, independent community living, and appropriate integration of the client's treatment plan with residential treatment. Housing Subsidy is for active clients who are living in an apartment covered by the Ohio tenant landlord law. Generally, an exit strategy for the subsidy exists.	11%
Employment and Vocational - Employment Services provide job skills training or support on and off the work site during the term of employment. Vocational services assist the consumer with identifying, obtaining, or maintaining employment. This service is focused on preferences of the consumer and oriented toward career exploration and training for integrated, competitive employment. Vocational services promote the coordination of providers and systems in order to maximize rehabilitation opportunities for consumers.	1%
Partial Hospitalization² - A day measured program for adults or children, which addresses the needs of clients with significant behavioral health problems who require a structured goal-oriented program which provides an integrated set of individualized treatment interventions.	9%

² Definitions from Mental Health Board – County Commissioner levy agreement

As the table above illustrates, almost 40% of Mental Health funds are allocated to CPST services. The least amount of funding is allocated to Employment and Vocational services and Consumer Operated and Peer Support services with total funding for these services equaling 1% each. The Board allocates these funds to certified provider agencies that contract with the board. The following table lists all contracted agencies that provide mental health services. The Board contracts with additional providers for alcohol and drug addiction services:

Hamilton County MHRSB Mental Health Contracted Agencies		
Beech Acres	Greater Cincinnati Behavioral Health Services	Psychiatric Professional Services Inc.
Camelot Care Centers	Hamilton Choices	Quality Review Services
Catholic Social Service of Southwestern Ohio	Hamilton County Adult Probation	St. Aloysius Orphanage
Center for Children and Families	Hamilton County Department of Job and Family Services	St. Joseph Orphanage
Central Clinic	Hamilton County Family and Children First Council	The Salvation Army
Central Community Health Board	Hamilton County Juvenile Court	Specialized Alternatives for Youth of America
The Children's Home of Cincinnati	Hamilton County Pretrial Services	Summit Behavioral Healthcare – CSN
Cincinnati Children's Hospital Medical Center	Hamilton County Sheriff's Department	Talbert House
COAC, Inc.	Health Resource Center	Tender Mercies
Core Behavioral Health Centers	IKRON Rehabilitation Center	Psychiatric Emergency Services
The Counseling Source	Lighthouse Youth Services	GLAD House
Court Clinic	Mental Health Access Point	Pressley Ridge Schools – PRYDE
The Crossroads Center	Mental Health Consumer Network	Free Store/Food Bank
Excel Development Co.	Mental Health Association	Norcen Behavioral Health
Family Service of the Cincinnati Area		

Hamilton County Mental Health agencies supported by payments from the Mental Health Levy and interviewed by the Project Team are using traditional mental health services along with best practices and evidence-based practices, an action supported by the President's New Freedom Commission on Mental Health. Such practices include Multi-systemic therapy, assertive community treatment, consumer-operated services, jail diversion and community re-entry programs, school mental health services, and wraparound services.

Greater Cincinnati Behavioral Health Services, along with Talbert House and its affiliates, receive the most funding from the Board. Together, Talbert House and Affiliates, Greater Cincinnati Behavioral Health Services, CCHB, Central Clinic, St. Joseph's Orphanage, Excel Development, and Beech Acres receive approximately 67% of the Mental Health Levy Funds that are managed by the Board. Of these agencies, Greater Cincinnati Behavioral Health Services is the largest provider of CPST services.

At the beginning of FY 2007, the Board's operating budget was \$84.6 million, on revenues of \$83.4 million (includes programmed use of \$1 million in fund balance). At the end of FY 2006, the Board's fund balance was \$14.3 million (\$3.4 million Capital; \$11 million levy funds). In 2007, 40% of the budget derived from the Mental Health Tax Levy. Medicaid FFP represented 30% and State funds represented 26%. The remaining budget dollars derive from Title XX, Capital, Rental, and Miscellaneous, and Inter-County agreements. The Board has authorized a FY 06 staffing level of 41 full-time equivalent positions. This budget and staffing makes the Board a key funder for mental health and recovery services in Hamilton County.

The following table provides Board expenditures for the last five years:

Line Item Description	Actual				Budget
	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
Expenditures					
Agency Provider Contracts	\$ 71,789,032	\$ 76,606,441	\$ 74,674,641	\$ 81,654,757	\$ 79,937,913
ODMH Direct Payments	608,064	602,547	586,889	574,569	585,330
Subtotal Purchased Services	72,397,096	77,208,988	75,261,530	82,229,326	80,523,243
Salaries, benefits and taxes	\$ 2,693,093	\$ 2,708,169	\$ 2,774,783	\$ 2,846,310	\$ 2,780,074
Operating Expenses	600,413	605,194	658,357	707,883	736,022
Capital Outlay	1,240,730	446,517	83,273	110,560	131,153
County auditor & treasurer fees	226,219	414,205	444,729	428,418	409,338
TOTAL EXPENDITURES	77,157,551	81,383,073	79,222,672	86,322,497	84,579,830
Average Annual Rate of Increase		5.5%	-2.7%	9.0%	-2.0%

C. PRINCIPAL OBSERVATIONS

Our review of Mental Health services in Hamilton County yields the following principal observations, which are discussed in greater detail in the body of this report. These include:

- We are impressed with the coordination and operation of Mental Health services in Hamilton County. MHR SB and associated agency personnel appear to be very professional in demeanor, conduct, and performance. There is an appropriate focus on client service, accompanied by concern for the proper use of public funds.
- All agencies are required to be certified, and Board operational auditors effectively monitor certification as a part of their agency performance assessment.
- The Finance Division of the Board is anticipating the initiation of an insurance-based accounting system to more accurately and readily track program and service spending from its various funding sources. The current system would require the manual extrapolation of this data. Due to the current accounting system, the Financial Division of the department is unable to easily track and calculate which programs use levy funds and what percentage of levy funds are devoted to specific programs and services. The insurance-based system will be able to monitor this.
- Claims reconciliation is very efficient. All claims submitted to the Board of Mental Health prior to the reorganization were resolved within three weeks time.

- Over 50% of the Mental Health and Recovery Services Board expenditures are controlled by Medicaid expenditures due to Ohio Medicaid Law. Such control leaves little autonomy to allocate existing funds to the most effective and efficient service delivery operations.
- Agencies contracting with the Board are utilizing best practices and evidence-based practices of service delivery; however, several barriers limit the ability of agencies to expand such services and programming. These include: complex reimbursement policies, workforce training, and the shortage of qualified professionals.

D. SUMMARY OF SUGGESTED ADJUSTMENTS

The Project Team has identified specific adjustments that could have significant financial impacts on the operation of services monitored by the Hamilton County Mental Health and Recovery Services Board. We discuss each in a following section of this report. In order to maximize the effectiveness of mental health service delivery in Hamilton County, the Project Team proposes an increase in the levy amount equal to the cost of living increase over the previous 5-year levy period as well as using some of the levy balance for several service delivery enhancements. Together, these adjustments will reduce the gap between revenues and expenditures that the mental health board faces over the next levy period. These adjustments will allow Hamilton County to address the growing demand for mental health services.

The financial adjustments include:

REC. No. ³	ADJUSTMENTS	VALUE OVER LEVY PERIOD		
		INCREASED (REDUCED) REVENUE	REDUCED (INCREASED) EXPENSE	NET BENEFIT TO BUDGET
1	Increased/Continued partnerships with other agencies to create more collaborative programs such as the Family Access Partnership.	\$0	\$375,000	\$375,000
2	Acquisition of insurance-based information system that will monitor how levy funds are spent by agency, program, and by service. Train internal staff and agencies on how to utilize system.	\$0	(\$50,000)	(\$50,000)
3	Create Mental Health Access Point Quality Assurance Investigator position in MHAP that will take calls or complaints regarding Community Psychiatric Supportive Treatment (CPST) service at any agency, conduct an investigation, and oversee disciplinary procedures if necessary.	\$0	(\$200,000)	(\$200,000)
4	Address Rising Medicaid Service Demand.	\$15,706,268	(\$26,517,420)	(\$10,811,152)
5	Allowance for increase of 0.7% in cost for non-Medicaid services.	\$0	(\$4,113,009)	(\$4,113,009)
6	Address Needs of Early Childhood / School Aged	\$0	(\$625,000)	(\$625,000)

³ Recommendation numbers correspond to recommendations listed in the ‘Action Summary’ worksheet of the attached Financial Model.

REC. No.	ADJUSTMENTS	VALUE OVER LEVY PERIOD		
		INCREASED (REDUCED) REVENUE	REDUCED (INCREASED) EXPENSE	NET BENEFIT TO BUDGET
	Child Population.			
7	Address Increasing Service Demand from Criminal Justice System for MH Services.	\$0	(\$850,000)	(\$850,000)
8	Increase Number of Housing Certificates for Homeless – Mentally Ill population.	\$0	(\$1,970,000)	(\$1,970,000)
9	Increase Early Intervention Services to Non-SMD Consumers.	\$0	(\$750,000)	(\$750,000)
10	Publish a Quarterly Mental Health Performance Report to strengthen transparency and accountability with the public.	\$0	\$0	\$0
11	Develop GIS data-layer through MHAP to geographically pinpoint service populations and agencies to visually identify service needs in Hamilton County communities.	\$0	\$0	\$0
12	Acknowledge and Plan for Possible Changes in Children's Medicaid Eligibility	\$0	\$0	\$0
	TOTAL	\$15,706,268	(\$34,700,429)	(\$18,994,161)

II. SUMMARY OF OBSERVATIONS AND RECOMMENDATIONS

In this chapter, the Project Team addresses recommendations designed to enable the County to continue providing mental health services at as close to current service levels as possible while meeting the financial constraints of the next five years. This analysis is based on the forecast of steady demand for mental health services during the projected levy period. Without adjustments to revenues and expenditure, we project an accumulated cash flow short fall of \$18,994,161 over the next five-year levy period. This gap is based on Hamilton County's projections of a fixed levy yield and 3.0% inflationary increase in expenses, compounded, over the next five-year levy period. Our recommendations are described as follows:

1. Increase Partnerships and Collaborative Efforts

Senior staff members of the Hamilton County Mental Health and Recovery Services Board have already indicated that collaborative efforts are necessary, not only for continued savings, but also to produce more quality and effective services to clients. The Board has already experienced savings resulting from shared funding with the HC Department of Job and Family Services related to the Family Access Partnership program. Net savings to the Board are estimated at approximately \$75,000 per year for a total projected savings of \$375,000 over the levy period. Given the current state of development and agreement of the major parties involved, we believe that this will yield a full savings impact in Year 2008, as well as each year thereafter.

2. Procurement of an Insurance-Based Financial Management IT System

Currently, the Finance Department of the Board is unable to directly correlate programs and some services to specific funds, which limits the Board's accountability to the public for financial management of taxpayer dollars. 'Going live' with such a system will enable the Board to have a better sense of the programs and services that are funded by the Mental Health Tax Levy as well as bring the Board closer to utilizing the techniques common to performance-based budgeting for appropriated funds. Over the projected levy period, the total investment of such a system is estimated to cost \$50,000.

3. Mental Health Access Point (MHAP) Quality Assurance Investigator

The MHAP program has been termed the 'front door' for Mental Health service delivery in Hamilton County. Clients are able to access agency services at organizations that have the capacity to provide them with necessary services. However, the Project Team's interviews with consumers of Mental Health Services in Hamilton County indicated that the current method for resolving complaints regarding the quality of service delivery, particularly CPST services in various agencies, is not working effectively.

In order to address this service delivery issue, the Project Team recommends that the Board provide MHAP with additional funding to hire one individual who would receive calls specifically regarding client service delivery complaints. This position would not only take complaints; it would also be responsible for investigating the complaint and ensuring that proper disciplinary action takes place if needed and is documented. Over the projected levy period, this addition would require an additional \$200,000 and would include salary and benefits totaling approximately \$40,000 per year.

4. Address Rising Medicaid Service Demand

Fifty-two percent of the Mental Health Board's budget is controlled by Medicaid costs, which have rates that have been capped at the same level for the past ten years. The

demand for services by those on Medicaid is anticipated to conservatively rise by 4% each year during the next levy period. The rate of increase in demand for service among Medicaid eligible individuals is anticipated to grow at a faster pace than matching levy funding during this period.

5. Increase in cost of Non-Medicaid Services

During the upcoming five-year levy period, there will be some increase in the cost of non-Medicaid services. The unit rates of these services are not controlled by the Medicaid ceiling rates. It is recommended that the Board allow for a conservative growth of approximately 0.7% per year in costs of non-Medicaid services.

6. Develop Plan to Address School-Aged Children's Needs

Senior Board staff members mentioned several service populations that need increased financial and service provision support over the next levy period. The Board of Mental Health has observed a growing demand for services among the early childhood/school aged child population. In order to meet this need, evidence based individual and/or family therapy has been proposed. The proposed service growth would cost \$2,500/child for 50 children for a total cost of \$125,000 per year.

7. Develop Plan to Provide Additional Services to Incarcerated Population

Senior Board staff members mentioned several service populations that need increased financial and service provision support over the next levy period. The Board has observed an increase in demand among the incarcerated population. To assist with this demand, the Board wishes to hire 2 full time court liaison positions in Courtroom A to assess and screen 200 persons per month and to hire additional administrative time for the Mental Health Court. Costs would total \$170,000 per year.

8. Develop Plan to Provide Additional Housing to Homeless – Mentally Ill Consumers

Senior Board members mentioned several service populations that need increased financial and service provision support over the next levy period. In order to address the needs of the homeless – mentally ill, the Board would like to increase the number of Housing Subsidy Certificates available. These certificates would serve 82 homeless persons currently on a wait list at \$400 per month for a total cost of \$394,000 per year.

9. Develop Plan to Provide Additional Services to non-SMD Consumers

Senior Board members mentioned several service populations as areas that need increased financial and service provision support over the next levy period. Hamilton County has traditionally served individuals who are Severely Mentally Disabled (SMD) as a priority; however, the need among non-SMD potential clients is rising. In order to serve this population, the board would like to provide additional early intervention therapy focused on supporting productive functioning in the family and at work. The board anticipates this growth need as 2 full time therapy positions to serve 400 individuals at an annual cost of \$150,000 per year for a total five year cost of \$750,000.

10. Publish Quarterly Mental Health Performance Report

Publishing the performance and service impacts of the Board’s contracted agencies to the Hamilton County community will communicate to citizens the effectiveness in reaching service goals and mission. Such a report should be targeted to public officials, be made available to the public through the internet, and be strategically located at various community sites. Additionally, a performance report will serve as an advertisement to the community that mental health services do exist and are available to Hamilton County residents.

11. Develop GIS Data-layer through MHAP

The Board has relied traditionally on the geographic development of mental health services in Hamilton County through its ‘Catchments Areas’ initiated in the 1960s. Due to this design, MHAP has been able to link clients with services that are closest to them through a simple phone interview at initial assessment. While such improvements have contributed to the efficiency of service delivery by reducing waiting lists, an additional Geographical Information System data-layer will enhance the Board and service providers’ abilities to evaluate growth trends in service needs over time through identifying the location of services, client populations, and the spatial movement of both over time. It will enable evaluators and quality control professionals to determine whether the location and types of services available are meeting the needs of consumers of mental health services in Hamilton County.

The GIS data-layer would require staff to develop the data-layer as well as to provide maintenance over time so that it will remain current and useful to the Board.

12. Possible Change in Children’s Medicaid Eligibility

The Governor has proposed an initiative to change eligibility requirements for children, increasing the income allowed to 300% of the existing poverty level. Additionally, information available to the Board indicates that approximately 2,400 additional children who will require MH Treatment will be eligible for Medicaid benefits under the Governor’s proposal. The additional cost to the levy for Medicaid Match payments could significantly increase demand for levy funded services, but due to the uncertainty of the success of the Governor’s initiative to change Medicaid eligibility requirements for children to 300% of the existing poverty line, no recommendation is included for this potential liability at this time.

III. MHR SB HISTORY AND OPERATIONS OVERVIEW

In this section, we review the operations of mental health services coordinated through the Hamilton County Mental Health and Recovery Services Board as well as the financial planning process used to secure, manage and account for programmatic resources. We also evaluate the quality of the Board's five-year strategic planning effort. In the following chapter, we review mental health service delivery finances by service type.

A. REVIEW OF OPERATIONS

In 1968, Ohio HB 648 authorized the formation of county-based Community Mental Health Boards throughout Ohio with responsibility for planning, funding, and evaluating outpatient mental health services. The Hamilton County Board was created out of that mandate. In 1988, SB 156 modified the structure of the Boards. One significant impact was that the Board was given full financial responsibility for state hospital inpatient care. In 1989, under authority granted by Ohio HB 317, the Hamilton County Commissioners established separate Boards of Alcohol and Drug Addiction Services (ADAS) and Mental Health in Hamilton County. The existing MH Board continued, and a separate ADAS Board was created.

On October 19, 2006, under authority granted by Ohio HB 530, the County Commissioners combined the Hamilton County Boards of MH and ADAS into a single Mental Health and Recovery Services Board. The combined board has eighteen volunteer members for two, three, or four year terms. Ten of these volunteers are appointed by County Commissioners. The Director of the Ohio Department of Mental Health appoints four, and the Director of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) appoints four. The membership appointments of the board attempt to reflect the composition of the county as to race and sex. Statutory appointments include a MH psychiatrist, an AOD advocate, a mental health and an AOD professional, a mental health and an AOD family member, and a mental health and AOD consumer.

Under state law, the Board cannot engage in direct service delivery. Thus, the Board functions as the county government agency responsible for planning, funding and evaluating the effectiveness of community mental health services available to Hamilton County residents. This includes developing a network of community support services for those with serious mental or emotional disorders and coordinating appropriate care for persons committed for psychiatric treatment through the county probate court.

The Board's primary target populations are adults who are severely mentally disabled (SMD), children who are severely emotionally disabled (SED) and adults who are dually diagnosed with substance abuse and mental illness (SAMI). Secondary target populations of the Board include adults with mental health needs who are not seriously mentally disabled (Non-SMD), children with mental health needs who are not seriously emotionally disabled (Non-SED) and for both children and adults with mental health needs who are in the criminal justice systems (CJS). As measured by MACSIS service claims, the mental health system serves approximately 18,500 Hamilton County residents annually including 12,000 adults and 6,500 children. Thousands of additional individuals receive services annually that are not billed individually through MACSIS such as crisis intervention, hotline services and prevention activities.

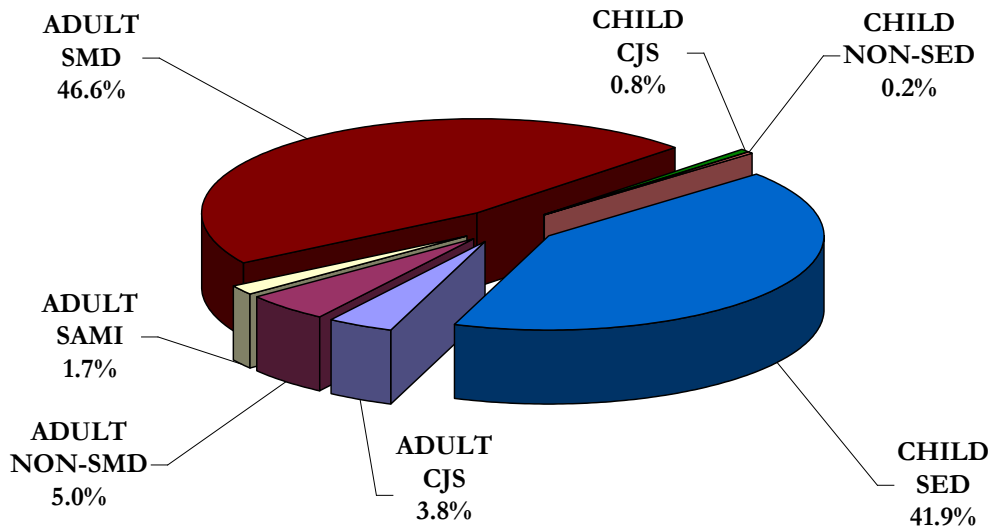
More than 50 local behavioral health organizations are under contract to the Board to provide a full range of community support services. These include hospitalization, partial hospitalization, case management, crisis and emergency services, outpatient counseling, residential treatment and care, vocational services and prevention and education.

In FY 2006, agencies contracted with the MHRSB served the following number of clients:

Population	% Funding Allocated	Total Number Served
Children	42%	6,494
Adults	58%	11,681

Populations that are a high priority for the current as well as projected levy period, which as Adult SMD and Child SED, receive the highest percentage of Federal and local funding through the Board. The following pie graph indicates the distribution of federal and local dollars in Proposed FY 2006:

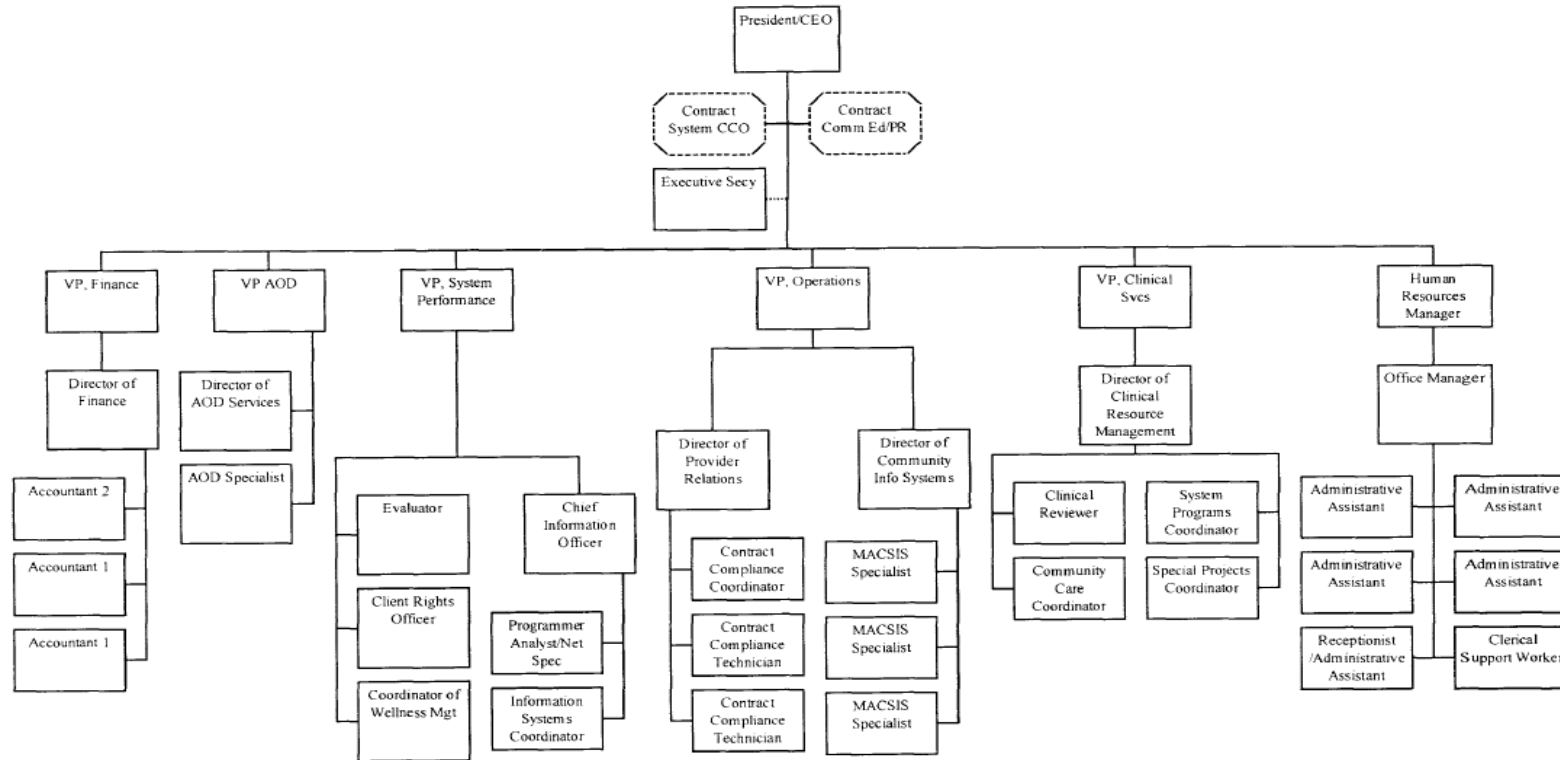
**HAMILTON COUNTY COMMUNITY MENTAL HEALTH BOARD
 PROPOSED FY 2006 FUNDING BY POPULATION**



On October 19, 2006, under authority granted by Ohio HB 530, the Hamilton County Commissioners abolished the Boards of Alcohol and Drug Addiction Services (ADAS) and Community Mental Health (CMH) to establish a single Mental Health and Recovery Services Board (MHRSB). Before the re-organization, the ADAS Board employed 14 FTEs while the

Community Mental Health Board employed 40 individuals. The organization of the new board can be found below:

Hamilton County MHR SB Organization Chart



OCTOBER 19, 2006

As the organization chart above illustrates, the main functions of the Board include: Finance, Alcohol and Drug Services, System Performance, Operations, and Clinical Services. The main responsibilities of these functions are described below:

- **Finance:** The finance department of the MHR SB does not have budget authority, but rather receives its annual appropriation from the county commissioners. Appropriation amounts are based on an annual county budget review process. The board utilizes the county's Performance financial system, which is centered on monitoring state and county funding streams. The finance department of the board reviews and ascertains that total billings submitted by individual agencies that contract with the board are within contracted amounts. Invoices are submitted by the Board to the County Auditor for direct payment to the agencies. Unit rate setting is determined on a Medicaid and non-Medicaid eligible basis; however, in Hamilton County, the non-Medicaid unit rate is the equivalent of the Medicaid unit rate. Over two-thirds of all claims are billed through MACSIS Information System; MACSIS payments are \$55 million of agency mental health service funding. Non-MACSIS invoices are \$26 million or 32% of agency mental health funding. Over one million claims per year are processed through MACSIS; this board has been identified as having the quickest turnaround in the state.
- **AOD:** This unit is the result of the re-organization of the Community Mental Health Board and the Alcohol and Drug Addiction Services Board. This unit is still in the development stages of the newly designed Mental Health and Recovery Services Board. One of the major responsibilities of this position will be to assure efforts are put into practice to serve AOD and dually diagnosed individuals as a key population group.
- **System Performance:** the State Administrative Code dictates duties of this function within the board. The systems performance function is responsible for ensuring that contracted agencies fulfill both the agency certification requirement as well as the agency accreditation requirements. The system performance function monitors and evaluates agency performance through the following mechanisms: quality assurance and improvement planning, customer satisfaction surveys, monitoring client protection, and through analyzing Consumer Outcomes data. Outcomes data are sorted by adult and youth populations and it is administered several times throughout the year, particularly at service inception, after 6 months, after 12 months, and annually thereafter until client discharge. Respondents to outcomes data surveys include consumers, providers and parents of child consumers. All agencies are required to maintain a production rate for the submission of its outcomes data of 80%. Hamilton County's production rate is the second highest of all Ohio mental health boards at 88.8% according to the ODMH Missing Data Report #13.

- **Operations:** The operations unit oversees the contractual responsibilities of the board. The Board contracts with 51 agencies that provide a range of Mental Health and Alcohol and Drug Addiction services. Of these agencies, 28 serve primarily the Mental Health population, 10 agencies serve primarily the AOD population, and 13 agencies serve both the Mental Health and AOD populations. The Ohio Department of Mental Health (ODMH) or the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) must certify agencies. Two staff members of the board conduct on-site audits of agency services to verify contract compliance and accuracy of billing. The Board follows an extensive ODMH designated audit protocol for both Medicaid and non-Medicaid services.
- **Clinical Services:** The clinical services unit is the planning entity for the Board in addition to providing over site of new initiatives sponsored by the Board through contracted agencies. The role of the clinical services unit is to foster understanding of the HCMHRSB mission and goals and translate them into actions. It also provides vision and leadership for driving system planning and execution of programs and services. Some of the initiatives of the Board include the following: Mental Health Access Point (MHAP), Family Access Partnership (FAP), Multi-County Systems Agencies (MCSA), and Criminal Justice Mental Health Courts serving adult and juvenile populations.

Overall, the Board has available resources to successfully monitor the effective and efficient use of levy funding through its robust performance evaluation and monitoring systems. The successful extension of this approach with the combined MH and ADAS operations is hampered by two constraints. First, none of the senior staff of the former ADAS board were recruited into the re-organized board, although a new Vice President of AOD Services position was created. This position has yet to be filled. Additionally, the only individual with historic knowledge of the finances of the ADAS board resigned in early 2007. These issues pose challenges to the Finance Department of the Board to learn and integrate the process structures of the ADAS Board into the re-organized MHRS Board.

B. REVIEW OF STRATEGIC PLAN

The Project Team conducted a review of the MHR SB strategic planning process and its current two-year strategic plan. Our observations are as follows:

- The planning process used by the Hamilton County Mental Health and Recovery Services Board is in a format mandated by the state, but is not consistent with traditional strategic plans. The purpose of this format is to assist ODMH in budget development and advocacy, identifying gaps, challenges, strengths, and emerging issues within the system, and to fulfill the mental health planning requirements of the Ohio Revised Code (ORC340.03 and 5119.61).
- It takes the form of a tactical plan more so than a strategic plan. In a strategic plan, each strategic goal is accompanied by relevant objectives and essential performance metrics. The Board's more tactical plan discusses what the Board currently does and how it intends to accomplish those responsibilities in the future.
- The plan has been adopted by the Board and is a tool that assists ODMH in meeting new Federal reporting requirements as well as structuring data and analysis in time for Board contracting processes with providers.

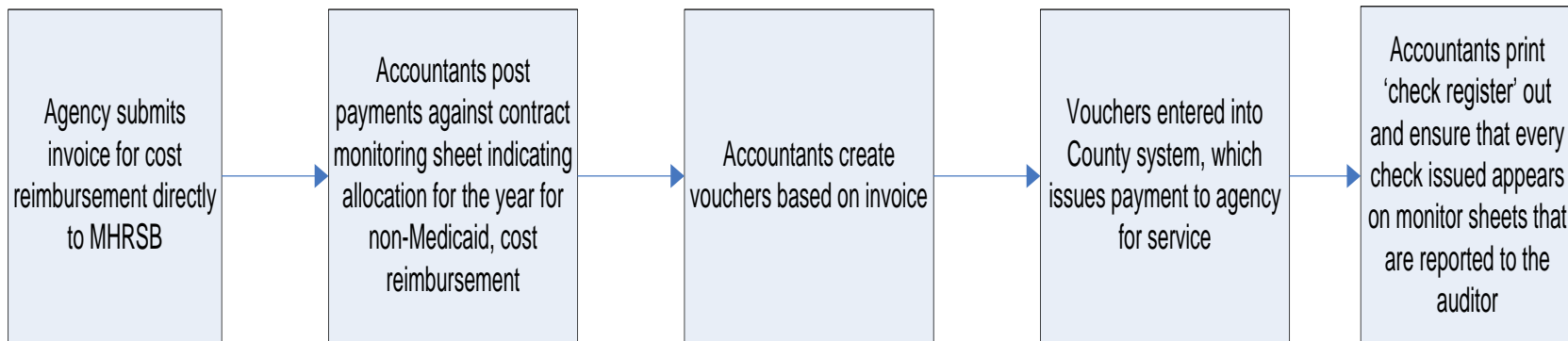
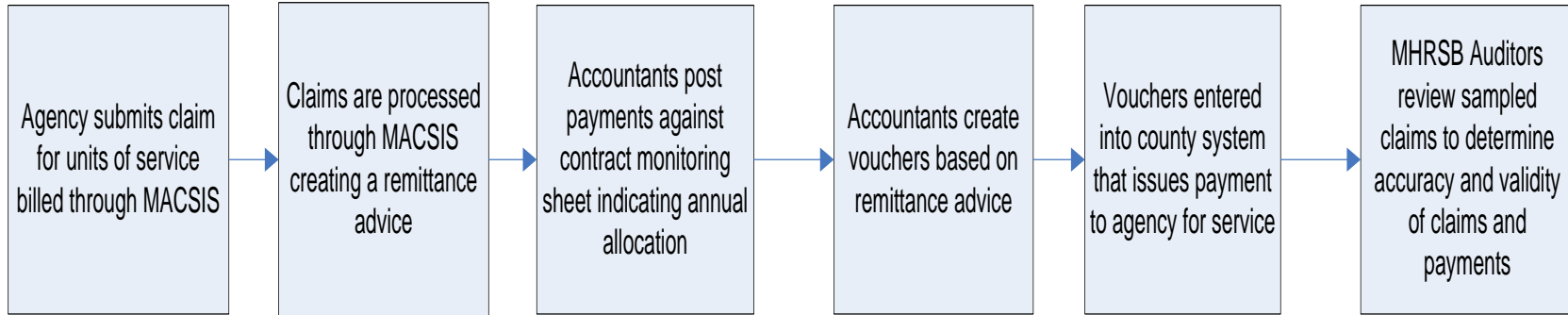
The Project Team has concluded that the format of the Board's Community Plan is satisfactory for its purposes as a contracting entity and meets statutory requirements. There is, however, a key deficiency in the agency's strategic plan, which the Project Team recommends be corrected in the next planning cycle. The financial elements required by the State of Ohio in the Board's plan are submitted separately from the plan and are based on reporting of projected services and revenues by providers, and are not future oriented. According to ORC 340.03, the plan should include, "a budget for moneys the board expects to receive." It is typical for a strategic plan to include the identification of financial needs and potential resources required for plan implementation. This serves two roles. First, by applying an evaluation of costs of implementation, the financial component serves as a constraint against unrealistic planning. Second, it establishes work responsibility for securing the necessary financial resources. We recommend that the agency initiate a revised strategic planning process during the coming year, connecting financial requirements and resources to desired activities during the planning process. This

will enable the agency to assess more precisely its capacity over the next five years and to identify financial resources necessary to undertake any growth in programs.

C. REVIEW OF FINANCIAL STRUCTURES AND PROCESSING

The agency operates with a public fund-centered billing and claims payment system known as MACSIS (Multi-Agency Community Services Information System). The system was implemented in FY 2000 in cooperation with ODMH and ODADAS. The majority of the Board's funding, over two-thirds, is billed and paid through MACSIS on a unit rate basis. Thirty percent is paid on a cost reimbursement basis, and the remaining funds include grant dollars and interagency collaboration. These funds are not prorated based on a unit rate. The Mental Health Levy is one of several funding sources supporting the Mental Health and Recovery Services Board. State and federal dollars as well as grant funding also supplement the MHRSB.

The following workflow illustrates the submission and payment of remittance advice:



The agency has established procedures for coding expenses appropriately. The general policy of the agency is to use all other funds before tax levy funds. The agency maintains control through the use of MACSIS coding procedures and every transaction processed in the agency consists of one accounting code. Each claim identified through a MACSIS code combination is charged against the County's budget and does not indicate the ultimate funding source. The County budget displays spending authority granted by the BOCC.

D. REVIEW OF MEDICAID STATE REIMBURSEMENT

In this section of the report, we review and discuss issues associated with past due State Medicaid reimbursements as well as the potential for additional recoveries over the next levy period and how or to what extent those recoveries could offset levy funding.

MHR SB Financial staff members indicate that there are currently no past due State Medicaid reimbursements beyond the normal two-month payment processing cycle. The processing of requests for reimbursement follows a "double-loop" cycle. ODADAS and ODMH jointly operate the statewide MACSIS system which links to ODJFS's CHRIS-E system. Although the final eligibility determination is not made until the ODJFS CRIS-E system is accessed during the second "loop", a preliminary determination on eligibility is made on the first "loop" and MHR SB bases its payment on this information. If ODADAS / ODMH change the entry from Medicaid to non-Medicaid on the second "loop", MHR SB determines if the providing agency has a non-Medicaid agreement / contract for services and corrects the payment source accordingly. If the agency does not have a non-Medicaid contract and services were originally processed and paid as Medicaid eligible services, and it is determined during second "loop" processing that the client was not eligible for Medicaid reimbursement, the MHR SB will recover the funds from the providing agency.

No other MHR SB funds are "held" by the State. The State provides annual allocation information to each County and the MHR SB draws down this amount quarterly.

IV. RESPONSIBILITY AND QUALITY

In this chapter, we review the scope of responsibility for mental health services as well as the quality of service provided in Hamilton County.

A. MANDATES

Mental Health services in Hamilton County are provided pursuant to mandates for service arising from the Federal government, State government, as well as federal, state and county courts. In general, the County has the authority to establish and provide mental health and alcohol / drug assistance programs subject to the availability of local resources. Specific responsibilities of the Board include the following mandates from Ohio Revised Code Chapter 340:

- Serve as the community mental health planning agency for the county or counties under its jurisdiction,
- Evaluate the need for facilities and community mental health services;
- In cooperation with other local and regional planning and funding bodies and with relevant ethnic organizations, assess the community mental health needs, set priorities, and develop plans for the operation of facilities and community mental health services;
- In accordance with guidelines issued by the director of mental health after consultation with board representatives, develop and submit to the department of mental health, no later than six months prior to the conclusion of the fiscal year in which the board's current plan is scheduled to expire, a community mental health plan listing community mental health needs, including the needs of all residents of the district now residing in state mental institutions and severely mentally disabled adults, children, and adolescents; all children subject to a determination made pursuant to section 121.38 of the Revised Code; and all the facilities and community mental health services that are or will be in operation or provided during the period for which the plan will be in operation in the service district to meet such needs.
- Receive, compile, and transmit to the department of mental health applications for state reimbursement;
- Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies.

- Investigate, or request another agency to investigate, any complaint alleging abuse or neglect of any person receiving services from a community mental health agency as defined in section 5122.01 of the Revised Code, or from a residential facility licensed under section 5119.22 of the Revised Code. If the investigation substantiates the charge of abuse or neglect, the board shall take whatever action it determines is necessary to correct the situation, including notification of the appropriate authorities. Upon request, the board shall provide information about such investigations to the department.
- For the purpose of section 5119.611 of the Revised Code, cooperate with the director of mental health in visiting and evaluating whether the services of a community mental health agency satisfy the certification standards established by rules adopted under that section;
- In accordance with criteria established under division (G) of section 5119.61 of the Revised Code, review and evaluate the quality, effectiveness, and efficiency of services provided through its community mental health plan and submit its findings and recommendations to the department of mental health;
- In accordance with section 5119.22 of the Revised Code, review applications for residential facility licenses and recommend to the department of mental health approval or disapproval of applications;
- Audit, in accordance with rules adopted by the auditor of state pursuant to section 117.20 of the Revised Code, at least annually all programs and services provided under contract with the board. In so doing, the board may contract for or employ the services of private auditors. A copy of the fiscal audit report shall be provided to the director of mental health, the auditor of state, and the county auditor of each county in the board's district.
- Recruit and promote local financial support for mental health programs from private and public sources;
- Enter into contracts with public and private facilities for the operation of facility services included in the board's community mental health plan and enter into contracts with public and private community mental health agencies for the provision of community mental health services listed in section 340.09 of the Revised Code and included in the board's community mental health plan. Contracts with community mental health agencies are subject to section 5119.611 [5119.61.1] of the Revised Code. Section 307.86
- A utilization review process shall be established as part of the contract for services entered into between a board and a community mental health agency. The board may establish this process in a way that is most effective and efficient in meeting local needs. In the case of a contract with a community mental health facility, as defined in section 5111.023 [5111.02.3] of the Revised Code, to provide services listed in division (B) of that section, the contract shall provide for the facility to be paid in accordance with the contract entered into between the departments of job and family services and mental health under

section 5111.91 of the Revised Code and any rules adopted under division (A) of section 5119.61 of the Revised Code.

- With the prior approval of the director of mental health, a board may operate a facility or provide a community mental health service as follows, if there is no other qualified private or public facility or community mental health agency that is immediately available and willing to operate such a facility or provide the service
- Establish, to the extent resources are available, a community support system which provides for treatment, support, and rehabilitation services and opportunities. The essential elements of the system include, but are not limited to, the following components:
- Locate persons in need of mental health services, assistance for clients to obtain services necessary to meet basic human needs for food, clothing, shelter, medical care, personal safety, and income, mental health care, including, but not limited to, outpatient, partial hospitalization, and where appropriate, inpatient care, emergency services and crisis intervention, assistance for clients to obtain vocational services and opportunities for jobs, the provision of services designed to develop social, community, and personal living skills, access to a wide range of housing and the provision of residential treatment and support, assistance, consultation, and education for families, friends, consumers of mental health services, recognition and encouragement of families, friends, neighborhood networks, grievance procedures and protection of the rights of consumers of mental health services, and case management, which includes continual individualized assistance and advocacy to ensure that needed services are offered and procured.
- The board shall provide the least restrictive and most appropriate alternative environment that is available for any person involuntarily committed to it and shall assure that the services listed in section 340.09 of the Revised Code are available to severely mentally disabled persons residing within its service district. The board shall establish the procedure for authorizing payment for services, which may include prior authorization in appropriate circumstances.
- Establish a method for evaluating referrals for involuntary commitment and affidavits filed pursuant to section 5122.11 of the Revised Code in order to assist the probate division of the court of common pleas in determining whether there is probable cause that a respondent is subject to involuntary hospitalization and what alternative treatment is available and appropriate, if any.
- Ensure that apartments or rooms built, subsidized, renovated, rented, owned, or leased by the board or a community mental health agency have been approved as meeting minimum fire safety standards and that persons residing in the rooms or apartments are receiving appropriate and necessary services, including culturally relevant services, from a community mental health agency. This

division does not apply to residential facilities licensed pursuant to section 5119.22 of the Revised Code.

- Establish a mechanism for involvement of consumer recommendation and advice on matters pertaining to mental health services in the alcohol, drug addiction, and mental health service district.

B. QUALITY OF SERVICES

Mental Health services are provided through a collaborative and cooperative arrangement between Jobs and Family Services, Mental Health Courts, associated County agencies and private mental health providers. The Mental Health and Recovery Services Board has made a considerable investment in development and maintenance of policies and procedures generally, and quality assurance processes specifically. Contract agencies must be accredited by one of three national accrediting organizations. The Board dedicates staff resources to continuous quality assessments of those agencies.

The Project Team investigated the incidence and use of waiting lists for mental health services through interviewing and collecting data from leaders of the eight main agencies that receive approximately 75% of levy dollars. Interviewees relate that the Mental Health Access Point (MHAP) founded in 1997 has mitigated the need for waiting lists. Interviewees related some very limited, ad hoc use of waiting lists associated with particular wrap around services and housing. However, clients in major service areas can expect assistance / intervention within established time periods.

The Mental Health Access Point (MHAP) Program has resolved many waiting list issues since its inception 10 years ago. The primary mission is to provide a standardized entry to a managed system of care that ensures services are available, accessible and of high quality. MHAP has resolved wait list issues by identifying the appropriate agency for incoming clients based on location and need, identifying if that agency has the capacity to serve that client, and linking that client with the appropriate services at an agency that has the capacity to meet the client need. MHAP strives to provide support, care and

connections for individuals, couples and families who need mental health services. The primary functions include:

- Assessment/ evaluations
- Authorization/Connection of services
- Utilization review and monitoring
- Quality assurance
- MACSIS member enrollment.

Mental Health Access Point (MHAP) is the ‘front door’ or access point to community mental health services in Hamilton County. It provides:

- Diagnostic assessment
- Counseling/psychotherapy
- Medical somatic
- Transitional Community support provider services to both children and adults

In order to receive services through MHAP, individuals must be a Hamilton County resident, and symptoms must suggest that the person has a mental health diagnosis.

As a policy, an individual that is SMD and in need of counseling services does not wait for services. According to the Director of MHAP, “[MHAP] does not have wait lists for clients to be seen. [MHAP] has a standard of offering first time appointments to clients with certain time parameters based upon the clinical need: Emergency – same day, urgent – 2 business days, and routine – 10 business days. [MHAP] has made recent adjustments to work flow and have recently been allocated a new diagnostic staff person given the significant increase in demand over the past year. Across all diagnostic priority categories, [MHAP] strives to offer appointments within benchmark 80% of the time.”

While MHAP has resolved many waitlist issues, some organizations still carry short wait lists. Below are comments from interviewed agencies regarding their wait lists:

- As of February 2007, Core Behavioral Health Center had 37 individuals on its wait list for its Outpatient department. Twenty-five of those individuals were on the wait list for 7 weeks.
- Excel Development Corporation also has a wait list. The housing corporation has a current waiting list of 742 individuals. Individuals are housed based on their priority status, with no wait list for first priority status. First priority status

individuals are eligible individuals in State or University Hospital. Individuals who are not first priority on the wait list could wait for housing for two years or more.

- The Central Community Health Board has a wait list of 100-150 for non-SMD outpatient counseling. The time for a non-SMD individual to get into counseling is approximately 3 months. As a result of the long wait list, some clients fail to pursue treatment due to the fact that potential clients are unreachable.
- Central Clinic has a much shorter wait list of three to four weeks for the adult program, three weeks for the child program, and two weeks for the Court Clinic Treatment Program, two days to two weeks for the Forensic Evaluation Program, and 10 days for the MHAP treatment program.

The Mental Health and Recovery Services Board's top priority clients do not have substantial waiting list concerns according to data that the Project Team has collected. Individuals in need of support services, such as housing or outpatient therapy may experience a waiting list. According to Board estimations, 1 out of every 5 individuals has a mental illness. As more of individuals seek services, particularly individuals with Medicaid insurance, waiting lists may grow if MHAP and contracted agencies do not have the capacity to keep waiting lists at their present levels.

The project team also reviewed field audit information provided by the Mental Health and Recovery Services Board. The purpose of these audits are to determine the degree of a service provider's compliance with all applicable federal, state, and local laws, rules and regulations, to verify whether the agency's policies, procedures and actual practices are compliant with the conditions set forth in the Board's contract for services. The randomly selected audit sample is comprised of both Medicaid and non-Medicaid cases. The Medicaid compliance sample size is determined by an ODMH formula based on the number of Medicaid cases served in the previous annual review period or 365 days. One-half of the total number of cases in the sample is chosen randomly, the other half consists of the highest cost Medicaid cases in the annual review period. A non-Medicaid compliance sample size is selected from the annual review period. A stratified sample is taken from the MACSIS caution reports from the annual review period in order to

illuminate potential problem areas such as ineligible diagnoses and excessive amounts of service provided.

The auditors of the Board are responsible for ensuring that necessary documentation has been included in case files, that documents are signed, and identify evidence that services were delivered. Audits of the board include the following actions:

- Assure that Medicaid cases in the sample reviewed for ten items of medical necessity documentation using an ODMH-approved review tool,
- Presence of a signed Diagnostic Assessment Form in the case record,
- Presence of a signed and dated Individualized Service Plan,
- Presence of a form signed by the client indicating receipt of clients rights information,
- Presence of a consent for treatment form signed by the client, and
- Presence of a signed fee agreement.

The Board provided the Project Team with a sample audit from a provider agency responsible for nearly 50% of all CPST or case management services. For purposes of confidentiality, the Project Team will not reveal the name of this audited agency. The number of case records for each item listed above varies based on the stratified random sampling method described above. The complete audit sample consists of a total of 80 case records: 35 randomly selected from the testing period, the 35 highest cost Medicaid clients, and 10 non-Medicaid clients selected from the annual review period.

For the Medical Necessity Documentation Review, 70 case records were sampled. One-hundred percent of those records contained a description of the client's symptoms, contained a description of the client's condition/functioning, and 100% of those required in the audit (three) contained consideration of the least restrictive setting for clients in residential settings where mental health services have been provided. Seventy case records contained a DSM IV or ICD-9 diagnosis code, and for 100% of cases required for the audit (70), the individual service plan addressed the client's symptoms. All sampled records contained interventions for each service goal, stated outcomes for each service goal, and contained documentation of the client's participation in the development of the individual

service plan. Almost all criteria were excellent for the Medical Necessity Documentation review. One case indicated that therapy was to be provided; however, there were no therapy progress notes in the record.

Eighty case records comprised both the Diagnostic Assessment Form (DAF) review as well as the Individual Service Plan (ISP) review. For the DAF audit, all forms were present in all case records as required. The ISP review, though, did not have 100% compliance. In one case record, the ISP review was not completed within the required time frame. The record dated 09-07-04 had not been updated until 11-03-05. Another ISP was not adequately documented. The physician signed the ISP dated 09-29-05 but did not sign the ISP dated 02-03-06, which covered the dates of service in the audit sample.

The above listed required client forms are required to be included in each case record. For the Fee Agreements, the audit found that one fee agreement was inadequate because it did not cover the date of service audited, and information was missing. All Client Rights Forms, however, were present in all case records. Additionally, Consent for Treatment forms were also present in all case records.

C. OUTCOMES MEASUREMENT

Ohio has historically required mental health agencies to conduct investigations of the impact of services upon their clients and to report those findings to their local mental health boards. With the recognition of significant disparity in methods and measures utilized in these individual efforts, and the associated, resultant inability to conduct comparisons between agencies and systems, the state began a planning process in 1996 that eventually resulted in the founding of the Ohio Consumer Outcomes effort. This effort produced a set of standardized measures and methods that could be utilized by mental health agencies in investigating treatment efficacy among their clients served.

In September of 2001, the Hamilton County Board began requiring the collection of this data from contract agencies, two years prior to a state mandate dictating use and collection of this data statewide. This early introduction to the effort proved highly

beneficial to Hamilton County in helping it to realize early and continued success in both production and use of this data.

The Board began providing regular feedback to agencies related to their Ohio Consumer Outcomes data production with the inception of the initiative. This process was formalized further in 2004 when a performance improvement effort focused on the outcomes topic was instituted. In support of this effort, the Board produces agency-level production reports for each contract agency providing tabular data on production by expected respondent (adult consumer; child consumer; parent; provider/agency worker) and time interval (initial; 6 month; 12 month; annual; discharge). Additionally, each agency receives detail reports providing client-level data for the twenty different analyses conducted so that the agency has the necessary resources available to research areas of deficiency. These efforts have been very successful, with Hamilton County maintaining a long-standing leadership role within the state, as illustrated in graph A through the State's most recent production report by board area.

The Board has also been active in providing reports to agencies related to their performance in assisting clients toward recovery. As data collection volume increases, so too has the ability to analyze findings at more discrete levels. Each contract agency receives a report detailing their agency findings alongside the findings for the entire system. Provision of the data in this manner, which permits agency comparisons, promotes the discovery of both strengths and weaknesses, when and where they exist, within the programs serving the assessed populations. Reports A and B serve as examples of reports disseminated during the current fiscal year. Report A is an example of an agency report that provides agency and system level findings for child/youth consumers diagnosed with Attention Deficit Hyperactivity Disorder. Report B reflects findings for an agency addressing adult consumers experiencing an affective disorder. Agencies are able to compare both their costs and treatment efficacy with those of the entire Hamilton County system through the use of these reports.

A relatively new addition to the tools being made available related to the Ohio Consumer Outcomes effort is the recently released Ohio Consumer Outcomes Data Mart. The Ohio Consumer Outcomes Data Mart is a unique web-accessed report generator unique in the United States that allows individuals to query information regarding the progress made by consumers through the course of treatment. Representatives of the Hamilton County Board system played an integral role in the development of this tool. A multitude of reports can be generated through this data mart with analyses focused upon the state, board, or agency level, and broken out by numerous demographic variables including age, gender, race, diagnostic category, and level of disability.

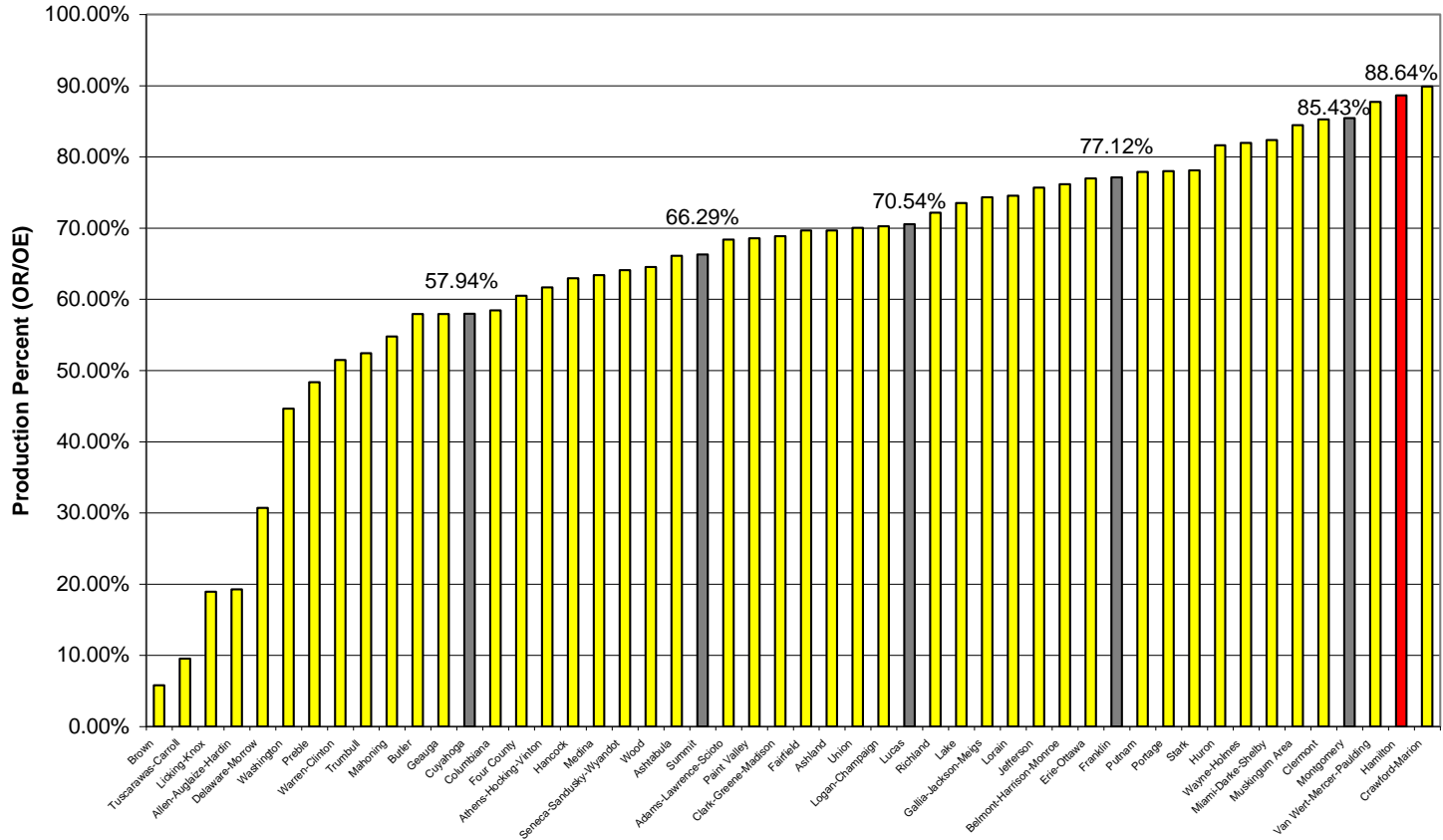
Hamilton County has found the Ohio Outcomes effort to be a considerable enhancement to the system of managing mental health service provision. In FY 2003 the Board began utilizing this resource when making decisions related to the disbursement of grant funding for new and/or special services. Additionally, 12 month agency contracts are no longer awarded prior to an agency evidencing compliance with Ohio Consumer Outcomes production. The Board continues to consider additional ways of incorporating this critical data gathered through the Ohio Consumer Outcomes effort in all funding and contracting decisions.

Additionally, the Board has had the opportunity to play a significant role in further-developing clinical tools that can be utilized in supporting the recovery of those reliant upon the public system for assistance. In fiscal years 2003, 2004, and 2005 the Board received special funding through the state in support of an initiative to develop a client-level clinical report to assist in treatment planning and monitoring. The product of this effort, known as the Achieving Recovery Resiliency the Outcomes Way (ARROW) report, has been shared and promoted statewide by the Ohio Department of Mental Health, and serves as a tool for helping clinical staff focus upon the most significant issues impacting a client and to plan interventions accordingly.

In the current fiscal year, the Hamilton County Board was able to develop, through use of items incorporated in the Ohio Consumer Outcomes Instrument, a Social Support

Scale that provides a measure of social resources (i.e., familial, peer, vocational) available to a client, and possibly predictive of progress toward recovery. The Ohio Department of Mental Health, having been apprised of this new scale, made slight modification to same and now utilizes the measure to satisfy certain Federal SAMHSA reporting requirements.

**Ohio Consumer Outcomes Overall Production Performance
 ODMH Missing Data Report #13 - Adult & Youth Scales Aggregated**



Report A: ADHD

Ohio Consumer Outcomes Clinical Change Summary

Population: Youth Period: FY 2005 Diagnosis: 314.xx (Attention Deficit Disorder)

Agency: XXXXXXXXXXXX

Average Service Costs by Quarter (Youth Consumer Group n=187)

Total Mean Costs (cases)								
	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Qtr. 5	Qtr. 6	Qtr. 7	Qtr. 8
System	\$878.37(187)	\$912.16(121)	\$939.26(83)	\$1,022.43(59)	\$822.52(42)	\$732.82(25)	\$557.88(11)	\$915.75(1)
Agency	\$680.26(89)	\$552.37 (54)	\$524.39 (35)	\$559.02 (24)	\$493.11 (17)	\$460.06 (11)	\$761.02 (2)	\$na (0)

Average Service Costs by Quarter (Youth Parent & Worker Groups n=573)

Total Mean Costs (cases)								
	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Qtr. 5	Qtr. 6	Qtr. 7	Qtr. 8
System	\$908.43(573)	\$894.64(391)	\$943.17(296)	\$927.27(231)	\$882.88(176)	\$748.49(107)	\$683.91(61)	\$563.41(15)
Agency	\$780.87 (273)	\$679.56 (177)	\$654.45 (132)	\$579.95 (103)	\$593.73 (77)	\$552.04 (48)	\$432.36 (22)	\$186.85 (3)

Problem Severity Change Over Time

Reporter	Level	Problem Severity @ service inception	SD	Problem Severity @ follow-up	SD	Number of Cases	Significant
Youth Consumer	System	25.46	12.70	17.95	10.68	41	.001
	Agency	26.11	13.32	19.05	10.47	19	.006
Parent/Guardian	System	31.59	15.89	24.36	16.43	145	.000
	Agency	32.54	16.68	25.35	17.74	69	.004
Agency Worker	System	27.91	13.24	19.87	12.02	211	.000
	Agency	29.86	14.37	20.22	12.20	97	.000

Functioning Change Over Time

Reporter	Level	Functioning @ service inception	SD	Functioning @ follow-up	SD	Number of Cases	Significant
Youth Consumer	System	51.53	15.76	59.53	10.93	40	.003
	Agency	54.53	12.60	59.11	11.01	19	.049
Parent/Guardian	System	39.39	14.54	47.45	14.10	146	.000
	Agency	39.07	14.53	47.52	15.74	69	.000
Agency Worker	System	40.31	11.30	47.40	11.73	211	.000
	Agency	39.46	10.32	46.68	12.33	96	.000

Hopefulness Change Over Time

Reporter	Level	Hopefulness @ service inception	SD	Hopefulness @ follow-up	SD	Number of Cases	Significant
Youth Consumer	System	9.29	3.65	8.11	3.26	35	.031
	Agency	9.42	3.50	8.21	2.96	19	.048
Parent/Guardian	System	12.01	4.35	11.23	8.67	135	ns
	Agency	12.10	4.49	10.43	4.26	68	.014

Methods

Claims data was queried for all individuals under the age of 18 with a diagnosis code of 314.xx (attention deficit disorder) during FY 2005. Cases exhibiting service inception for the current episode of care prior to FY 2005 were removed (first date of service is defined as the first date of MACSIS billed service following a service absence of greater than 120 days). Cases reflecting any claim during the episode of care with any diagnosis other than 314.xx were removed to ensure that all cases given consideration were under care for only the diagnosis under review. Cases exhibiting billed service by more than one agency during the episode of care were removed in the interest of allowing agencies to examine their performance exclusive of change that may have occurred as the result of treatment by another provider.

Ohio Consumer Outcomes (Ohio Youth Scales) data was integrated with the aforementioned claims data. Initial outcome administrations were determined by incorporating the earliest administration on record for a period of 60 days prior to the first date of service through 44 days following the first date of service. Follow-up administrations were determined by incorporating the last administration on record not exceeding 30 days following the last date of billed service.

The first two tables on the report reflect average (mean) claims by quarter at both system (Hamilton County) and specific agency level, along with the total number of cases (episodes of care for individuals served) for the quarter in parentheses (). These average costs by quarter are reported for those cases comprising the youth consumer group (those age 12 – 17) and those comprising the parent and worker groups (those representing children age 5 – 17). Some agencies may exhibit claims and cases in the first two tables without reflecting agency-level data in the clinical change tables. This occurs as the result of missed administrations and/or missing data within administrations.

For some agencies, agency-specific findings appear as blanks. This occurs when an agency did not have at least one client with an initial and follow-up outcome administration. The total number of clients for whom an agency should have had outcome administrations can be discerned through the average service costs data.

Note: Change, favorable or otherwise, may occur as the result of many circumstances. This report does not necessarily attribute change to the services provided. The report serves as a tool to provide an agency the ability to see how clients receiving services through their agency experience change and to examine those changes relative to changes that occur for all similar clients within the Hamilton County system.

Definitions

System scores represent the aggregate data for Hamilton County.

Quarter (Qtr.) reflects claims activity that occurred in 90 day increments beginning with the first date of service for each particular case.

Problem Severity scale scores are based upon the sum of the 20 OYS problem severity items. Higher problem severity scores indicate higher levels of difficulty experienced by the child/youth.

Functioning scale scores are derived from the sum of the 20 OYS functioning items. Higher functioning scores indicate fewer difficulties for the child/youth.

Hopefulness scale scores are based upon the sum of the four hope items in the OYS instrument. The scale scores are counterintuitive in that higher scores indicate lesser levels of hope.

The significant column in the report reflects the level of statistical significance obtained through analysis. Analyses involving fewer than 30 cases may result in inaccurate p (significance) values and caution should be exercised in interpretation of the data.

Change scores reflect the difference between the initial score and the follow-up administration score with a positive (+) sign always representing favorable (improved) change and a negative (-) sign always representing unfavorable (worse) change.

SD represents the standard deviation for the given score. The standard deviation is a measure of the variability in the scores and is statistically defined as the square root of the variance.

Report B: Affective Disorders

Ohio Consumer Outcomes Clinical Change Summary

Population: Adult Period: FY 2005 Diagnosis: 296.XX (Affective Disorders)

Agency: XXXXX

Average Service Costs by Quarter

	Total Mean Costs (cases)							
	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Qtr. 5	Qtr. 6	Qtr. 7	Qtr. 8
Average System Cost Per Case For Agency Cases	\$527.61 (45)	\$346.53 (19)	\$431.23 (8)	\$481.15 (4)	\$213.84 (3)	\$270.00 (1)	\$0 (0)	\$0 (0)
Average Agency Cost Per Case For Agency Cases	\$523.13 (45)	\$346.53 (19)	\$431.23 (8)	\$481.15 (4)	\$213.84 (3)	\$270.00 (1)	\$0 (0)	\$0 (0)
Average Agency Cost Per Case For System Cases	\$578.32 (2,169)	\$616.69 (858)	\$599.39 (614)	\$627.33 (463)	\$569.94 (368)	\$504.14 (247)	\$505.08 (154)	\$448.77 (84)

Symptom Distress Change Over Time

Level	Symptom Distress @ Inception	SD	Symptom Distress @ follow-up	SD	Number of Cases	Significant	Change	Average Days Between Administrations	Age
System	45.01	14.92	39.08	14.89	322	.000	+5.93	246.44	39.86
Agency	39.67	12.38	37.81	12.47	21	ns	+1.86	120.86	36.81

Overall Quality of Life Change Over Time

Level	Quality of Life @ Inception	SD	Quality of Life @ follow-up	SD	Number of Cases	Significant	Change	Average Days Between Administrations	Age
System	2.656	0.769	2.946	0.804	185	.000	+0.290	251.16	40.76
Agency	2.817	0.723	2.872	0.672	15	ns	+0.056	119.60	34.53

Activities of Daily Living (ADL - Functioning) Change Over Time

Level	ADL @ Inception	SD	ADL @ follow-up	SD	Number of Cases	Significant	Change	Average Days Between Administrations	Age
System	4.474	0.78	4.536	0.73	115	ns	+0.06	288.7	40.37
Agency	4.250	-	5.000	-	1	-	+0.75	141.00	26.00

Methods

Claims data was queried for all individuals over the age of 17 with a diagnosis code of 296.xx (affective disorder) during FY 2005. Cases exhibiting service inception for the current episode of care prior to FY 2005 were removed (first date of service is defined as the first date of MACSIS billed service following a service absence of greater than 120 days). Cases reflecting any claim during the episode of care with any diagnosis other than 296.xx were removed to ensure that all cases given consideration were under care for only the diagnosis under review. Cases exhibiting billed service by more than one agency during the episode of care were retained, resulting in the maintenance of some cases in which the individual was receiving services simultaneously from multiple agencies.

Ohio Consumer Outcomes data was integrated with the aforementioned claims data. Initial outcome administrations were determined by incorporating the earliest administration on record for a period of 60 days prior to the first date of service through 44 days following the first date of service. In cases in which multiple administrations existed during this period, the administration closest to the first date of service was selected. Follow-up administrations were determined by incorporating the last administration on record not exceeding 30 days following the last date of billed service.

The first table on the report reflects average (mean) claims by quarter for the agency including costs for the cases that were incurred through services by other providers (Average System Cost Per Case For Agency Cases), average (mean) claims by quarter for the agency excluding any costs for the cases that were incurred through services by other providers (Average Agency Cost Per Case For Agency Cases), and average (mean) claims by quarter per case for all cases within the Hamilton County system at the agency level (Average Agency Cost Per Case For System Cases). Some agencies may exhibit claims and cases in the first table without reflecting agency-level data in the clinical change tables. This typically occurs as the result of missed administrations and/or missing data within administrations.

Note: Change, favorable or otherwise, may occur as the result of many circumstances. This report does not necessarily attribute change to the services provided. The report serves as a tool to provide an agency the ability to see how clients receiving services through their agency experience change and to examine those changes relative to changes that occur for all similar clients within the Hamilton County system.

Definitions

System scores represent the aggregate data for Hamilton County.

Quarter (Qtr.) reflects claims activity that occurred in 90 day increments beginning with the first date of service for each particular case.

Symptom Distress Scale (SDS) scores are calculated by summing the available scores for the 15 individual SDS items that appear in the Adult Consumer survey when at least 11 of those items have been completed. Mean scores for the aggregated existing items are used in substitution for missing items in these situations. SDS scale scores are not calculated in situations in which fewer than 11 items have been completed.

Overall Quality of Life Scale scores are derived from the sum of the 12 quality of life items that appear in the Adult Consumer survey divided by the number of items for which a response was given when a minimum of 10 items have been completed.

Activities of Daily Living (ADL) scores are based upon the arithmetic average of the 8 ADL items that appear in the Adult Provider survey. The Adult Provider survey is completed only for Adult A Consumers (those adults experiencing serious and persistent mental illness – generally those who are receiving CPST or any day-measured service such as partial hospitalization), and as such do not include all clients for whom the report reflects information for the other scales. Additional information on the calculation of this scale (and all other scales that appear in this report) is available through “The Ohio Mental Health Consumer Outcomes System: Procedural Manual, Seventh Edition (Revised).

The significant column in the report reflects the level of statistical significance, or lack thereof, obtained through analysis (ns = not significant).

Change scores reflect the difference between the initial score and the follow-up administration score with a positive (+) sign always representing favorable (improved) change and a negative (-) sign always representing unfavorable (worse) change. SD represents the standard deviation for the given score. The standard deviation is a measure of the variability in the scores and is statistically defined as the square root of the variance.

Age represents the average age for all cases considered in the specific analysis.

V. OPERATIONS AND FINANCIAL ANALYSIS

MAXIMUS, Inc. has conducted a cost per unit of service analysis of service areas provided by the Hamilton County Mental Health and Recovery Services Board. The analysis contains cost information regarding Medicaid units of service and non-Medicaid units of service. Non-Medicaid dollars are either State grant fund 408, fund 502, or local Mental Health Tax Levy dollars. Due to the combined nature of local Mental Health tax levy and state dollars, the project team was unable to identify cost per unit of service based specifically on Mental Health Tax Levy dollars alone.

A rate ceiling for service delivery per unit has been determined by Medicaid requirements for Medicaid funded services. The MHRSB has a policy of contracting for services not funded through Medicaid dollars at a similar rate. For services funded through Medicaid, levy funds are used to leverage federal funds. Sixty percent of the cost of Medicaid services is provided through federal dollars and the balance through tax levy funds. While the Board has a policy that all State funds will be utilized for all payments first, over half of all Board levy funds are used to meet the Medicaid Match requirement.

The tables on the following pages present service units, respective costs incurred by the Hamilton County Mental Health and Recovery Services Board by program area, and derived service unit costs in the years 2003 and 2007. This presentation provides information regarding changes in absolute levels of effort (Service Unit Changes), changes in total service costs to MHRSB (Service Cost Changes), and possible programmatic changes to consumers (Service Unit Cost Changes). The service unit and cost data for all years 2003 – 2007 are provided in an attachment to this report.

Service Type	Service Unit Changes 2003 - 2007								
	2003 Units			2007 Units			Nominal Activity Change		
	Medicaid	Non-Medicaid	Total	Medicaid	Non-Medicaid	Total	Medicaid	Non-Medicaid	Total
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	16,482	9,996	26,478	18,057	11,473	29,529	1,574	1,477	3,051
COUNSELING	485,416	185,879	671,295	520,295	102,392	622,686	34,879	(83,487)	(48,608)
PHARMACOLOGICAL MANAGEMENT	20,252	14,571	34,823	22,562	7,570	30,132	2,310	(7,001)	(4,691)
OTHER MENTAL HEALTH	0	1,700	1,700	0	0	0	0	(1,700)	(1,700)
IN-PATIENT HOSPITAL	0	600	600	0	351	351	0	(249)	(249)
CRISIS INTERVENTION	3,874	15,978	19,852	2,208	7,426	9,634	(1,666)	(8,551)	(10,218)
PREVENTION & EDUCATION	0	9,658	9,658	0	11,527	11,527	0	1,870	1,870
CONSUMER OPERATED & PEER SUPPORT	0	3,024	3,024	0	0	0	0	(3,024)	(3,024)
RESIDENTIAL TREATMENT & HOUSING	0	51,088	51,088	0	40,701	40,701	0	(10,387)	(10,387)
EMPLOYMENT & VOCATIONAL	0	40,778	40,778	0	40,410	40,410	0	(368)	(368)
PARTIAL HOSPITALIZATION	44,294	25,104	69,398	51,668	30,675	82,343	7,374	5,571	12,945
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	796,067	619,723	1,415,790	903,085	350,724	1,253,809	107,018	(268,999)	(161,982)

Source: Computed by Project Team from annual Board agency allocation sheets

Service Type	Service Cost Changes 2003 - 2007								
	2003 Costs			2007 Costs			Nominal Cost Change		
	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	\$ 788,448	\$ 2,180,893	\$ 2,969,341	\$ 922,411	\$ 3,424,087	\$ 4,346,498	\$ 133,963	\$ 1,243,194	\$ 1,377,157
COUNSELING	\$ 3,767,112	\$ 3,720,430	\$ 7,487,542	\$ 4,209,079	\$ 2,124,914	\$ 6,333,993	\$ 441,967	\$ (1,595,516)	\$ (1,153,549)
PHARMACOLOGICAL MANAGEMENT	\$ 1,355,457	\$ 2,278,324	\$ 3,633,781	\$ 1,834,214	\$ 1,619,923	\$ 3,454,137	\$ 478,757	\$ (658,401)	\$ (179,644)
OTHER MENTAL HEALTH	\$ -	\$ 2,889,959	\$ 2,889,959	\$ -	\$ 1,919,882	\$ 1,919,882	\$ -	\$ (970,077)	\$ (970,077)
IN-PATIENT HOSPITAL	\$ -	\$ 1,799,710	\$ 1,799,710	\$ -	\$ 1,680,015	\$ 1,680,015	\$ -	\$ (119,695)	\$ (119,695)
CRISIS INTERVENTION	\$ 169,388	\$ 2,001,733	\$ 2,171,121	\$ 79,013	\$ 1,901,786	\$ 1,980,799	\$ (90,375)	\$ (99,947)	\$ (190,322)
PREVENTION & EDUCATION	\$ -	\$ 1,350,326	\$ 1,350,326	\$ -	\$ 1,385,431	\$ 1,385,431	\$ -	\$ 35,105	\$ 35,105
CONSUMER OPERATED & PEER SUPPORT	\$ -	\$ 1,002,046	\$ 1,002,046	\$ -	\$ 1,128,805	\$ 1,128,805	\$ -	\$ 126,759	\$ 126,759
RESIDENTIAL TREATMENT & HOUSING	\$ -	\$ 8,259,143	\$ 8,259,143	\$ -	\$ 9,149,532	\$ 9,149,532	\$ -	\$ 890,389	\$ 890,389
EMPLOYMENT & VOCATIONAL	\$ -	\$ 1,084,286	\$ 1,084,286	\$ -	\$ 1,117,626	\$ 1,117,626	\$ -	\$ 33,340	\$ 33,340
PARTIAL HOSPITALIZATION	\$ 2,110,937	\$ 1,164,242	\$ 3,275,179	\$ 2,421,361	\$ 1,565,265	\$ 3,986,626	\$ 310,424	\$ 401,023	\$ 711,447
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	\$ 6,798,671	\$ 17,228,410	\$ 24,027,081	\$ 7,362,163	\$ 14,257,138	\$ 21,619,301	\$ 563,492	\$ (2,971,272)	\$ (2,407,780)

Source: Computed by Project Team from annual Board agency allocation sheets

Service Type	Service Unit Cost Changes 2003 - 2007								
	2003 Cost / Unit			2007 Cost / Unit			Cost / Unit Change		
	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	\$ 47.84	\$ 218.18	\$ 112.14	\$ 51.08	\$ 298.46	\$ 147.19	\$ 3.25	\$ 80.27	\$ 35.05
COUNSELING	\$ 7.76	\$ 20.02	\$ 11.15	\$ 8.09	\$ 20.75	\$ 10.17	\$ 0.33	\$ 0.74	\$ (0.98)
PHARMACOLOGICAL MANAGEMENT	\$ 66.93	\$ 156.36	\$ 104.35	\$ 81.30	\$ 213.98	\$ 114.63	\$ 14.37	\$ 57.62	\$ 10.28
OTHER MENTAL HEALTH	NA	\$ 1,699.98	\$ 1,699.98	NA	NA	NA	NA	NA	NA
IN-PATIENT HOSPITAL	NA	\$ 3,000.19	\$ 3,000.19	NA	\$ 4,792.51	\$ 4,792.51	NA	\$ 1,792.33	\$ 1,792.33
CRISIS INTERVENTION	\$ 43.72	\$ 125.28	\$ 109.37	\$ 35.78	\$ 256.09	\$ 205.60	\$ (7.94)	\$ 130.80	\$ 96.23
PREVENTION & EDUCATION	NA	\$ 139.82	\$ 139.82	NA	\$ 120.19	\$ 120.19	NA	\$ (19.63)	\$ (19.63)
CONSUMER OPERATED & PEER SUPPORT	NA	\$ 331.40	\$ 331.40	NA	NA	NA	NA	NA	NA
RESIDENTIAL TREATMENT & HOUSING	NA	\$ 161.67	\$ 161.67	NA	\$ 224.80	\$ 224.80	NA	\$ 63.13	\$ 63.13
EMPLOYMENT & VOCATIONAL	NA	\$ 26.59	\$ 26.59	NA	\$ 27.66	\$ 27.66	NA	\$ 1.07	\$ 1.07
PARTIAL HOSPITALIZATION	\$ 47.66	\$ 46.38	\$ 47.19	\$ 46.86	\$ 51.03	\$ 48.41	\$ (0.79)	\$ 4.65	\$ 1.22
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	\$ 8.54	\$ 27.80	\$ 16.97	\$ 8.15	\$ 40.65	\$ 17.24	\$ (0.39)	\$ 12.85	\$ 0.27

Source: Computed by Project team from annual Board agency allocation sheets

As the tables above indicate, in general over the 5-year levy period, the total Board allocated cost per unit of service has increased in all areas except Prevention and Education, which decreased by \$19.63 per unit (14.0%), and Counseling which decreased \$0.98 per unit (8.8%) during the period 2003-2007.

Most agencies are nearing their service rate ceiling for Medicaid services. This is causing agencies to often take a loss when their cost per unit of service exceeds that which the board allocates as well as the Medicaid cap. Agencies such as Talbert House and CCHB have been able to benefit from economies of scale to lower its costs; however, smaller agencies are not as fortunate. Currently, advocacy efforts to increase the Medicaid ceiling are in place, especially since the Medicaid cap has not increased in the past ten years.

VI. BOARD CONSOLIDATION IMPACTS

On October 19, 2006, under authority granted by Ohio HB 530, the County Commissioners combined the Hamilton County Boards of Mental Health and Alcohol and Drug Addiction Services into a single Mental Health and Recovery Services Board. In creating the new board, developers needed to address legal barriers in working with civil service staff; most board staff worked under civil service protection. Based on County Prosecutor advice, both Boards including all staff positions were abolished. Staff of the previous Boards applied to fill available positions in the new entity.

In the consolidation process, fourteen staff reductions occurred. Four staff were hired from the former ADAS Board, a Vice President position for AOD was created, and a division of ADAS services was developed. The MHR SB currently has a total of 40 staff due to one resignation that occurred on January 2, 2007. Former ADAS staff employed by the new entity are currently provided salaries through various ADAS revenue sources. Former Community Mental Health Board staff employed by the new entity are paid through various state and local Mental Health revenue sources. The finance department of the MHR SB is currently working on developing a more appropriate cost allocation measure for Board staff as all staff will be responsible for tasks regarding both Mental Health and Alcohol and Drug recovery services.

As a part of the hiring process, several position and workflow adjustments have occurred and will continue to impact the new Board. Neither financial staff nor information systems staff was hired, which poses a high learning curve for new board staff to absorb historic ADAS financial information. The lack of historic knowledge poses significant barriers since the MHR SB will be liable for ADAS' use of levy funds for FY 2005 and FY 2006; no audit was completed during those years. Auditors may discover that un-reconciled accounts resulting in reimbursements for services will have to be supplied. An additional complication will result if the rate structure is different at the State versus the County level. Additionally, the MHR SB is currently in the process of

transitioning to internal billing for ADAS claims. In order to maintain service levels during the transition, the MHR SB has provided several agencies with pre-payments in order to maintain service levels. In cases where overpayments are found, the Board will engage in payback activities with those agencies that were found to be overpaid for services delivered. The MHR SB hopes to have all these issues reconciled by July of 2008, which begins the new fiscal year.

The following tables illustrate the costs as well as savings for the MHR SB due to the recent merger:

SALARIES BENEFITS & TAXES	HCCMHB		HCADASB		TOTAL	
	Salaries, Benefits & Taxes	FTEs	Salaries, Benefits & Taxes	FTEs	Salaries, Benefits & Taxes	FTEs
FY 2007 - FIRST YEAR						
PRE-MERGER BUDGETS	\$ 2,921,453	39	\$ 1,032,377	14	\$ 3,953,830	53
POST-MERGER BUDGET - HCMHR SB	\$ 2,510,044	35	\$ 416,001	5	\$ 2,926,045	40
GROSS RTS SALARIES, BENEFITS & TAXES - B/T&RC	\$ 411,409	4	\$ 616,376	9	\$ 1,027,785	13
TERMINATION / RETIREMENT COSTS	\$ (231,303)		\$ (169,108)		\$ (400,411)	
NET RTS SALARIES, BENEFITS & TAXES	\$ 180,106		\$ 447,268		\$ 627,374	

As the above table illustrates, the board has experienced a gross savings of \$1,027,785 on salaries, benefits, and taxes, with transition and retirement costs totaling \$400,411. The net annual savings from the consolidation totals \$627,274 with funded positions reduced from 53 to 40. All annual savings experienced by the merger have been committed to service provision for Hamilton County consumers.

Information provided to the Project Team by the MHR SB identified operating expenditure cuts of \$55,984 that occurred prior to Board consolidation. Operating expenditures for Mental Health services remained constant, while operating expenditures for ADAS decreased by 17.29% before adjustments. While operating expenditures were reduced for the ADAS board, additional expenditures were experienced due to the consolidation itself. These adjustments can be seen in the table below:

OPERATING EXPENSES FY 2007 - First Year	Operating Expenses			CONSOLIDATED OPERATIONS
	CMHB	ADASB	CMHR SB	
PRE-MERGER BUDGETS	\$ 725,145	\$ 323,865		\$ 1,049,010
OPERATING EXPENSE ADJUSTMENTS				
ADASB Ops	\$ -	\$ (55,984)	\$ -	\$ (55,984)
Improving Access Grant FY '07	\$ -	-	\$ 25,900	\$ 25,900
Directors & Officers Tail Insurance	\$ -	-	\$ 41,923	\$ 41,923
Agreed Upon Process Audit - HCCMHB	\$ -	-	\$ 15,000	\$ 15,000
SUBTOTAL OPS ADJUSTMENTS	\$ -	\$ (55,984)	\$ 82,823	\$ 26,839
TOTAL	\$ 725,145	\$ 267,881	\$ 82,823	\$ 1,075,849

Additional expenditures associated with the Board consolidation including the Improving Access Grant for FY 2007, Directors and Officers Insurance, and Audit expenditures totaled \$82,823. Factoring in the operating expenditure decreases for ADASB, the operating expenditures increased by \$26,840 after all adjustments. While net operating expenditures increased due to the consolidation, a net return to services was also experienced by the MHR SB totaling \$600,535. The table below provides detail on these net savings:

FY 2007 - 1ST YEAR	Net Return to Service (NRTS) Calculation			
	CMHB	ADASB	MHR SB	TOTAL
GROSS RETURN TO SERVICES	\$ 411,409	\$ 672,360		\$ 1,083,769
TERMINATIONS / RETIREMENTS / ADJUSTMENTS	\$ (231,303)	\$ (169,106)	\$ (82,823)	\$ (483,232)
NET RETURN TO SERVICES	\$ 180,106	\$ 503,254	\$ (82,823)	\$ 600,537

The consolidated Board has made a commitment that the net annual savings totaling \$600,537 will be returned to enhance future service delivery. The majority of this savings comes from AOD streams of funding and is dedicated to enhancing AOD services.

VII. FINANCIAL AND COMPLIANCE REVIEW

A. HISTORICAL REVIEW OF MENTAL HEALTH BUDGET AND PROJECTIONS

The table on the following page presents a comparison of the prior Mental Health Levy Plan and the actual and estimated experience during the levy period. Significant variances in relative revenues and expenditures should be disregarded due to the necessity of approaching the levy calculation from a different perspective. As mentioned earlier, the Department does not possess a true “claims-based” accounting system and the existing county system lacks the capability to accurately track and calculate the status of levy funds supporting Mental Health Service. Although the operating practice of the Board is to spend other funds prior to tax levy funds, we have not been able to categorically determine the use of levy funds and the resulting fund levy balance at the end of the period resulting from tax levy proceeds. Because of this shortcoming, we have elected to work from a relative perspective showing changes in state funds and local funds during the prior and projected levy periods.

We propose use of the fund balance as a financing source to supplement new Mental Health Tax Levy funding. The proposed financial model drives the fund balance attributed to the tax levy to \$0 by the end of the tax levy period.

The significant variance between levy plan and actual is primarily explained by a greater revenues and less expenditures than expected. This alone accounts for more than 2/3 of the eventual projected variance. The balance of the variance can be explained by higher than expected receipts from non-tax sources. Actual expenditures varied by less than 1/2 of one percent from the plan forecasts.

Mental Health Fund

Levy Plan	Year 1 2003	Year 2 2004	Year 3 2005	Year 4 2006	Year 5 2007	TOTAL
Beginning Balance	\$ 9,618,684	\$ 7,427,329	\$ 6,356,602	\$ 3,946,169	\$ 2,614,237	\$ 9,618,684
Revenues						
Tax Levy	\$ 32,831,211	\$ 32,993,208	\$ 33,155,203	\$ 33,317,199	\$ 33,305,704	\$ 165,602,525
Other	\$ 45,201,014	\$ 46,323,724	\$ 49,970,635	\$ 49,156,124	\$ 50,516,975	\$ 241,168,472
Total	\$ 78,032,225	\$ 79,316,932	\$ 83,125,838	\$ 82,473,323	\$ 83,822,679	\$ 406,770,997
Expenditures						
Expenditures	\$ 80,223,580	\$ 80,387,659	\$ 85,536,271	\$ 83,805,255	\$ 84,627,928	\$ 414,580,693
Other Financing Sources	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Ending Balance	\$ 7,427,329	\$ 6,356,602	\$ 3,946,169	\$ 2,614,237	\$ 1,808,988	\$ 1,808,988
Levy Actual / Estimated	Year 1 2003	Year 2 2004	Year 3 2005	Year 4 2006	Year 5 2007	TOTAL
Beginning Balance	\$ 8,532,306	\$ 11,467,054	\$ 15,487,977	\$ 18,547,509	\$ 15,532,919	\$ 8,532,306
Revenues						
Tax Levy	\$ 32,575,479	\$ 33,227,949	\$ 33,835,029	\$ 33,854,007	\$ 33,187,198	\$ 166,679,662
Other	\$ 47,481,820	\$ 51,861,047	\$ 48,352,458	\$ 49,139,955	\$ 50,191,339	\$ 247,026,619
Total	\$ 80,057,299	\$ 85,088,996	\$ 82,187,487	\$ 82,993,962	\$ 83,378,537	\$ 413,706,281
Expenditures						
Expenditures	\$ 77,157,551	\$ 81,383,073	\$ 79,222,672	\$ 86,322,497	\$ 84,579,830	\$ 408,665,623
Other Financing Sources	\$ 35,000	\$ 315,000	\$ 94,717	\$ 313,945	\$ -	\$ 758,662
Ending Balance	\$ 11,467,054	\$ 15,487,977	\$ 18,547,509	\$ 15,532,919	\$ 14,331,626	\$ 14,331,626
Levy Plan Variance	Year 1 2003	Year 2 2004	Year 3 2005	Year 4 2006	Year 5 2007	TOTAL
Beginning Balance	\$ (1,086,378)	\$ 4,039,725	\$ 9,131,375	\$ 14,601,340	\$ 12,918,682	\$ (1,086,378)
Revenues						
Tax Levy	\$ (255,732)	\$ 234,741	\$ 679,826	\$ 536,808	\$ (118,506)	\$ 1,077,137
Other	\$ 2,280,806	\$ 5,537,323	\$ (1,618,177)	\$ (16,169)	\$ (325,636)	\$ 5,858,147
Total	\$ 2,025,074	\$ 5,772,064	\$ (938,351)	\$ 520,639	\$ (444,142)	\$ 6,935,284
Expenditures						
Expenditures	\$ (3,066,029)	\$ 995,414	\$ (6,313,599)	\$ 2,517,242	\$ (48,098)	\$ (5,915,070)
Other Financing Sources	\$ 35,000	\$ 315,000	\$ 94,717	\$ 313,945	\$ -	\$ 758,662
Ending Balance	\$ 4,039,725	\$ 9,131,375	\$ 14,601,340	\$ 12,918,682	\$ 12,522,638	\$ 12,522,638

B. MENTAL HEALTH REVENUE, BUDGET AND LEVY FORECAST

The following tables present the Project Team financial forecasts and recommended Mental Health levy to support County operations related to mental health services. We have employed the “targeted balance” approach as discussed earlier. In our recommended scenario, the Mental Health fund balance is driven down to a targeted balance that represents half of the estimated balance at the beginning of the levy period attributable to non-tax resources. This approach is recommended in order to realistically acknowledge the requirement for some other fund balances, regardless of point in the tax levy cycle, for operational continuity while using tax proceed balances to partially fund recommended services to Hamilton County residents.

The following tables are based on the following assumptions:

- Levy fund balances for non-capital purposes decrease absolutely to County policy level of \$0.
- Constant levy revenue dollars.
- Standardized Hamilton County inflation projection of 3%.

The net effect of this projection plus identified issues discussed in a subsequent section would require an average increase in revenue from some source of approximately \$3.2 million in each year of the levy period.

**Hamilton County Mental Health and Recovery Services Board
Five Year Forecast for Calendar Years 2008-2012**

Line Item Description	Actual				Estimated	Forecast					
	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	TOTAL
Beginning Operating Fund Balance	\$ 8,532,306	\$ 11,467,054	\$ 15,487,977	\$ 18,547,509	\$ 15,532,919	\$ 14,331,626	\$ 14,386,430	\$ 13,213,039	\$ 10,962,171	\$ 7,548,969	\$ 14,331,626
Plus: Total Operating Revenue	80,092,299	85,403,996	82,282,204	83,307,907	83,378,537	84,219,079	85,176,214	86,249,171	87,365,112	88,525,139	431,534,715
Plus: ADDITIONAL LEVY REVENUE	-	-	-	-	-	3,182,223	3,182,223	3,182,223	3,182,223	3,182,223	15,911,115
SUBTOTAL REVENUE	80,092,299	85,403,996	82,282,204	83,307,907	83,378,537	87,401,302	88,358,437	89,431,394	90,547,335	91,707,362	\$ 447,445,830
TOTAL AVAILABLE FUNDS	88,624,605	96,871,050	97,770,181	101,855,416	98,911,456	101,732,928	102,744,867	102,644,433	101,509,506	99,256,331	461,777,456
Less: Total Operating Expenditures	77,157,551	81,383,073	79,222,672	86,322,497	84,579,830	87,346,498	89,531,828	91,682,262	93,960,537	96,259,123	458,780,248
Ending Operating Fund Balance	\$ 11,467,054	\$ 15,487,977	\$ 18,547,509	\$ 15,532,919	\$ 14,331,626	\$ 14,386,430	\$ 13,213,039	\$ 10,962,171	\$ 7,548,969	\$ 2,997,208	\$ 2,997,208
CAPITAL FUND BALANCE			3,681,138	3,614,801	3,519,070	3,420,467	3,318,905	3,214,296	3,106,548	2,997,208	
MISCELLANEOUS ADMINISTRATIVE FUND BALANCE			5,392,767	6,581,312	-	-	-	-	-	-	
LEVY FUND BALANCE			9,473,604	5,336,806	10,812,556	10,965,963	9,894,134	7,747,875	4,442,421	-	
ENDING OPERATING FUND BALANCE (FOOTS TO ABOVE)			18,547,509	15,532,919	14,331,626	14,386,430	13,213,039	10,962,171	7,548,969	2,997,208	
ESTIMATED BASE LEVY REVENUE						33,187,198	33,187,198	33,187,198	33,187,198	33,187,198	165,935,990
PLUS: ADDITIONAL LEVY REVENUE (ABOVE)						3,182,223	3,182,223	3,182,223	3,182,223	3,182,223	15,911,115
TOTAL LEVY COLA (DAS & HCMHSB 5 YEAR LEVY PLAN)						36,369,421	36,369,421	36,369,421	36,369,421	36,369,421	181,847,105

**Hamilton County Mental Health and Recovery Services Board
Five Year Revenue Forecast for Calendar Years 2008 - 2012**

Line Item Description	Actual				Estimated	Forecast				
	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Local Revenues										
Mental Health Levy										
Real Estate	\$ 23,283,444	\$ 24,301,673	\$ 24,754,177	\$ 24,666,964	\$ 24,389,409	\$ 24,389,409	\$ 24,389,409	\$ 24,389,409	\$ 24,389,409	\$ 24,389,409
Trailer	12,959	20,637	24,038	18,478	18,360	18,360	18,360	18,360	18,360	18,360
Personal Property	4,865,540	4,929,737	5,026,905	4,502,756	4,084,804	4,084,804	4,084,804	4,084,804	4,084,804	4,084,804
Payment in Lieu of Taxes	17,049	10,288	8,865	3,866	873	873	873	873	873	873
10K Personal	242,623	226,428	294,745	1,223,996	1,902,845	1,902,845	1,902,845	1,902,845	1,902,845	1,902,845
Rollback & Home	3,286,408	2,871,730	2,738,283	2,495,837	2,443,907	2,443,907	2,443,907	2,443,907	2,443,907	2,443,907
Public Utility	867,456	867,456	867,456	576,001	347,000	347,000	347,000	347,000	347,000	347,000
REA Surplus Correction	-	-	120,560	366,109	-	-	-	-	-	-
Subtotal Tax Levies	\$ 32,575,479	\$ 33,227,949	\$ 33,835,029	\$ 33,854,007	\$ 33,187,198	\$ 33,187,198	\$ 33,187,198	\$ 33,187,198	\$ 33,187,198	\$ 33,187,198
Average Annual Rate of Increase		2.0%	1.8%	0.1%	-2.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Capital and Rental Income (1)	\$ 576,583	\$ 527,473	\$ 47,029	\$ 44,223	\$ 35,422	\$ 36,484	\$ 37,578	\$ 38,706	\$ 39,867	\$ 40,456
Other match (1)	1,747,701	1,649,868	1,862,500	1,900,000	1,900,000	1,900,000	1,900,000	1,900,000	1,900,000	1,900,000
Miscellaneous (1)	436,216	272,231	248,517	333,939	225,089	75,500	1,000	1,000	1,000	1,000
TOTAL LOCAL	\$ 35,335,979	\$ 35,677,521	\$ 35,993,075	\$ 36,132,169	\$ 35,347,709	\$ 35,199,182	\$ 35,125,776	\$ 35,126,904	\$ 35,128,065	\$ 35,128,654
Average Annual Rate of Increase		1.0%	0.9%	0.4%	-2.2%	-0.4%	-0.2%	0.0%	0.0%	0.0%
Special Revenues										
State Grants	\$ 22,326,553	\$ 21,644,283	\$ 21,618,494	\$ 21,896,412	\$ 21,950,113	\$ 21,950,113	\$ 21,950,113	\$ 21,950,113	\$ 21,950,113	\$ 21,950,113
Medicaid	21,080,859	26,471,385	23,384,093	23,788,754	24,813,389	24,813,389	24,813,389	24,813,389	24,813,389	24,813,389
Title XX	704,932	693,259	604,936	602,058	681,995	678,528	676,832	675,135	673,447	671,759
Federal Grants	912	-	-	-	-	-	-	-	-	-
ODMH Direct Payments	608,064	602,548	586,889	574,569	585,331	585,331	585,331	585,331	585,331	585,331
TOTAL SPECIAL REVENUES	\$ 44,721,320	\$ 49,411,475	\$ 46,194,412	\$ 46,861,793	\$ 48,030,828	\$ 48,027,361	\$ 48,025,665	\$ 48,023,968	\$ 48,022,280	\$ 48,020,592
Average Annual Rate of Increase		10.5%	-6.5%	1.4%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Financing Sources										
Proceeds from long-term obligations	\$ 35,000	\$ 315,000	\$ 85,000	\$ 191,674	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Proceeds from sale of capital assets	-	-	9,717	122,271	-	-	-	-	-	-
TOTAL OTHER FINANCING SOURCE	\$ 35,000	\$ 315,000	\$ 94,717	\$ 313,945	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Average Annual Rate of Increase			231.5%	-100.0%	NA	NA	NA	NA	NA	NA
TOTAL CURRENT OPERATING REVENUE	\$ 80,092,299	\$ 85,403,996	\$ 82,282,204	\$ 83,307,907	\$ 83,378,537	\$ 83,226,543	\$ 83,151,441	\$ 83,150,872	\$ 83,150,345	\$ 83,149,246
Average Annual Rate of Increase			1.2%	0.1%	-0.2%	-0.1%	0.0%	0.0%	0.0%	0.0%
	\$80,057,299	\$85,088,996	\$82,187,487	\$82,993,962	\$83,378,537	\$83,226,543	\$83,151,441	\$83,150,872	\$83,150,345	\$83,149,246

**Hamilton County Mental Health and Recovery Services Board
Five Year Revenue Forecast for Calendar Years 2008 - 2012**

REVENUE NOTES:

Local Revenue

Capital and Rental Income (1)	Included in the Special Revenue category In FY 2003 and FY 2004. Presented here in the General Revenue section for consistency and readability.
Other match (1)	Included in the Special Revenue category In FY 2003 and FY 2004. Presented here in the General Revenue section for consistency and readability.
Miscellaneous (1)	Included in the Special Revenue category In FY 2003 and FY 2004. Presented here in the General Revenue section for consistency and readability.

**Hamilton County Mental Health and Recovery Services Board
 Five Year Levy Expenditure Forecast for Calendar Years 2008 - 2012**

Line Item Description	Actual				Budget	Forecast				
	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Expenditures										
Agency Provider Contracts	\$ 71,789,032	\$ 76,606,441	\$ 74,674,641	\$ 81,654,757	\$ 79,937,913	\$ 79,937,913	\$ 79,937,913	\$ 79,937,913	\$ 79,937,913	\$ 79,937,913
ODMH Direct Payments	608,064	602,547	586,889	574,569	585,330	585,332	585,331	585,331	585,331	585,331
Subtotal Purchased Services	72,397,096	77,208,988	75,261,530	82,229,326	80,523,243	80,523,245	80,523,244	80,523,244	80,523,244	80,523,244
Salaries, benefits and taxes	\$ 2,693,093	\$ 2,708,169	\$ 2,774,783	\$ 2,846,310	\$ 2,780,074	\$ 2,746,641	\$ 2,829,040	\$ 2,913,912	\$ 3,001,329	\$ 3,045,683
Operating Expenses	600,413	605,194	658,357	707,883	736,022	758,103	780,846	804,271	828,399	840,642
Capital Outlay	1,240,730	446,517	83,273	110,560	131,153	135,087	139,140	143,315	147,615	149,796
County auditor & treasurer fees	226,219	414,205	444,729	428,418	409,338	432,087	441,923	441,923	441,923	441,923
TOTAL EXPENDITURES	77,157,551	81,383,073	79,222,672	86,322,497	84,579,830	84,595,163	84,714,193	84,826,665	84,942,510	85,001,288
Average Annual Rate of Increase		5.5%	-2.7%	9.0%	-2.0%	0.0%	0.1%	0.1%	0.1%	0.1%

FACTORS:

General Inflation 3.00%

EXPENDITURE NOTES:

*A general inflation factor of 3% was assumed for forecasted years 2008-2012 for the 'Salaries, benefits, and taxes', Operating Expenses and Capital Outlay categories.

Hamilton County Mental Health and Recovery Services Board Five Year Levy Constant Forecast for Calendar Years 2008 - 2012
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Line Item Description	Forecast					
	2008	2009	2010	2011	2012	TOTAL
TOTAL OPERATING REVENUE	\$ 83,226,543	\$ 83,151,441	\$ 83,150,872	\$ 83,150,345	\$ 83,149,246	\$ 415,828,447
TOTAL EXPENDITURES	\$ 84,595,163	\$ 84,714,193	\$ 84,826,665	\$ 84,942,510	\$ 85,001,288	\$ 424,079,819
ANNUAL CASHFLOWS	\$ (1,368,620)	\$ (1,562,752)	\$ (1,675,793)	\$ (1,792,165)	\$ (1,852,042)	
CUMULATIVE CASHFLOWS	\$ (1,368,620)	\$ (2,931,372)	\$ (4,607,165)	\$ (6,399,330)	\$ (8,251,372)	
ACTION IMPACTS (NET ADJUSTMENTS)						
NEW PROGRAMS FROM LIST BELOW						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ 804,000	\$ 854,000	\$ 804,000	\$ 804,000	\$ 804,000	\$ 4,070,000
M'CAID/NON-M'CAID INCRS. FROM LIST BELOW						
Revenue	\$ 992,536	\$ 2,024,773	\$ 3,098,299	\$ 4,214,767	\$ 5,375,893	\$ 15,706,268
Expense	\$ 1,947,335	\$ 3,963,635	\$ 6,051,597	\$ 8,214,027	\$ 10,453,835	\$ 30,630,429
TOTAL ACTION IMPACTS FROM LIST BELOW						
Revenue	\$ 992,536	\$ 2,024,773	\$ 3,098,299	\$ 4,214,767	\$ 5,375,893	\$ 15,706,268
Expense	\$ 2,751,335	\$ 4,817,635	\$ 6,855,597	\$ 9,018,027	\$ 11,257,835	\$ 34,700,429
REVISED ANNUAL CASHFLOWS	\$ (3,127,419)	\$ (4,355,614)	\$ (5,433,091)	\$ (6,595,425)	\$ (7,733,984)	
REVISED CUMULATIVE CASHFLOWS	\$ (3,127,419)	\$ (7,483,033)	\$ (12,916,124)	\$ (19,511,549)	\$ (27,245,533)	
TOTAL OPERATING REVENUE (REVISED)	\$ 84,219,079	\$ 85,176,214	\$ 86,249,171	\$ 87,365,112	\$ 88,525,139	\$ 431,534,715
TOTAL EXPENDITURES (REVISED)	\$ 87,346,498	\$ 89,531,828	\$ 91,682,262	\$ 93,960,537	\$ 96,259,123	\$ 458,780,248
Action 1						
Increased/Continued Partnerships						
Increased/continued partnerships with other agencies to create more collaborative programs such as the Family Access Partnership would						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ (75,000)	\$ (75,000)	\$ (75,000)	\$ (75,000)	\$ (75,000)	\$ (375,000)
Action 2						
Insurance-Based Financial Information System						
Information system would monitor how levy funds are spent by agency, program, and by service. Training would occur for internal staff to utilize the						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ -	\$ 50,000	\$ -	\$ -	\$ -	\$ 50,000
Action 3						
MHAP Quality Assurance Investigator						
Creating a call option and hiring one position in MHAP that will take calls or complaints regarding CPST service provision at any agency, conduct proper investigation, and monitor disciplinary procedures if necessary to improve the quality of						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ 40,000	\$ 40,000	\$ 40,000	\$ 40,000	\$ 40,000	\$ 200,000
Action 4						
Rising Medicaid Demand						
Fifty Two percent of the Mental Health Board's budget is controlled by Medicaid costs, which are capped. The demand for services by those on Medicaid is anticipated to rise by 4% each year during the next levy period. Such a rate of increase is anticipated to grow at a faster pace than matching levy funding during this period.						
Revenue	\$ 992,536	\$ 2,024,773	\$ 3,098,299	\$ 4,214,767	\$ 5,375,893	\$ 15,706,268
Expense	\$ 1,675,732	\$ 3,418,492	\$ 5,230,962	\$ 7,115,933	\$ 9,076,301	\$ 26,517,420
Action 5						
Rising Non-Medicaid Demand						
The demand for services by those those clients not on Medicaid is expected to increase. The Mental Health Board's budget allows for 0.7% increase per year in Non-Medicaid services to partially meet this need.						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ 271,603	\$ 545,143	\$ 820,635	\$ 1,098,094	\$ 1,377,534	\$ 4,113,009
Action 6						
Services for Early Childhood/School Aged Children						
The Board of Mental Health has observed a growing demand for services among the early childhood/school aged child population. In order to meet this need, the following additional services, evidence based individual and/or family therapy has been proposed.						
Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expense	\$ 125,000	\$ 125,000	\$ 125,000	\$ 125,000	\$ 125,000	\$ 625,000

**Hamilton County Mental Health and Recovery Services Board
Five Year Levy Constant Forecast for Calendar Years 2008 - 2012**

Line Item Description	Forecast					TOTAL	
	2008	2009	2010	2011	2012		
<p>Action 7 Criminal Justice System MH Services An increased demand among this population has been observed by the board. To assist with this demand, the Board wishes to hire liaisons in Courtroom A to assess and screen 200 persons per month and to hire additional administrative time for the Mental Health Court.</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ 170,000	\$ 170,000	\$ 170,000	\$ 170,000	\$ 170,000	\$ 850,000
<p>Action 8 Housing for Homeless Mentally Ill In order to address this need, the Board would like to increase the number of Housing Subsidy Certificates available.</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ 394,000	\$ 394,000	\$ 394,000	\$ 394,000	\$ 394,000	\$ 1,970,000
<p>Action 9 Services for Individuals with Less Severe Mental Illness Hamilton County has traditionally served individuals who are Severely Mentally Disabled (SMD) as a priority; however, the need among non-SMD potential clients is rising. In order to serve this population, the board would like to provide additional early intervention therapy focused on supporting productive functioning in the family and at work. The board anticipates this growth need as 2 full time therapy positions to serve 400 individuals per year.</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 150,000	\$ 750,000
<p>Action 10 Quarterly Mental Health Performance Report Such a report will inform the public about the effectiveness of Mental Health Services in Hamilton County and provide information regarding available services.</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ -	\$ -	\$ -	\$ -	\$ -	-
<p>Action 11 Create GIS Data-Layer through MHAP The GIS data-layer would geographically identify service populations and agencies to visually locate service needs in Hamilton County communities</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ -	\$ -	\$ -	\$ -	\$ -	-
<p>Action 12 Possible Change in Children's Medicaid Eligibility The Governor has proposed an initiative to change eligibility requirements for children, increasing the income allowed to 300% of the existing poverty level. Additionally, information available to the Board indicates that approximately 2,400 additional children who will require MH Treatment will be eligible for Medicaid benefits under the Governor's proposal. The additional cost to the levy for Medicaid Match payments could significantly increase demand for levy funded services, but due to the uncertainty of the success of the Governor's initiative to change Medicaid eligibility requirements</p>	Revenue	\$ -	\$ -	\$ -	\$ -	\$ -	-
	Expense	\$ -	\$ -	\$ -	\$ -	\$ -	-

VII. PEER GROUP COMPARISONS

The Project Team reviewed performance metrics regarding operations of mental health services for a peer group of eight Ohio counties. The peer group included the following: Butler, Clermont, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, and Summit. These metrics included measures of costs per unit of service and of financial position (Board revenues and expenses). The Vice President of Finance of the HCMHRSB contacted Chief Financial Officers in the respective counties to obtain financial data that would mirror the financial and operational analysis supported by the Mental Health and Recovery Services Board in Hamilton County. Additionally, the Vice President of Systems Performance of the HCMHRSB retrieved data available to the Board regarding costs per unit of service in addition to demographic data of current clients. While certain counties provided more detailed information than others, all peer counties were cooperative in providing information for this study.

A. COST PER UNIT OF SERVICE COMPARISON

CLIENT POPULATIONS

Of the comparison counties, Butler and Clermont have approximately half the cost per capita of Lucas and Cuyahoga counties. Even though the Cuyahoga Mental Health Board has the highest per capita cost, it does not serve the largest percent of its population compared to its peer jurisdictions. Hamilton County's per capita cost is significantly lower than Cuyahoga County, yet it serves only .3% fewer individuals than Cuyahoga County.

With the exception of Franklin County, more than 50% of the clients in all of the comparison counties are considered Severely Mentally Disabled (SMD). Hamilton County serves the largest proportion of SMD clients (65.09%), while Franklin County has the least of the peer group (49.22%).

All jurisdictions have a majority of clients that are Medicaid eligible. In Butler County, close to 90% of its clients utilize Medicaid for services. Butler County has

received less Mental Health Tax Levy support from its citizens. Conversely, Franklin County has experienced much community support for Mental Health, which is evidenced in greater availability of resources outside of Medicaid funding. As the table below demonstrates, Hamilton County has 75.48% clients utilizing Medicaid resources⁴. Traditionally, Hamilton County residents have always supported the Mental Health Tax levy.

Board Area	Per Capita Cost	%Pop. Served	% Clients SMD	% Medicaid	% Non-Medicaid
Butler	\$ 36.13	1.51%	58.41%	87.61%	22.99%
Clermont	\$ 36.85	1.53%	59.53%	73.54%	39.72%
Summit	\$ 63.47	2.81%	54.78%	63.08%	50.22%
Montgomery	\$ 65.57	2.19%	59.06%	69.58%	50.29%
Hamilton MH	\$ 68.31	2.20%	65.09%	75.48%	48.28%
Franklin	\$ 70.72	2.81%	49.22%	62.22%	56.01%
Lucas MH	\$ 72.93	3.69%	51.92%	74.64%	40.88%
Cuyahoga MH	\$ 74.06	2.50%	63.88%	76.81%	36.71%

The table below provides demographic information regarding client populations served. Most jurisdictions follow normal population trends except for Hamilton County and Cuyahoga County, which both have a larger African American clientele than White.

Board Area	% White	% Black	% Unknown	% Age 0-17 Years	% Age 18-64 Years	% Age 65+ Years
Butler	84.55%	12.73%	2.72%	39.25%	59.10%	2.50%
Clermont	97.36%	1.78%	0.86%	42.02%	56.23%	2.74%
Summit	66.05%	28.99%	4.96%	32.12%	66.32%	2.49%
Montgomery	57.57%	40.06%	2.37%	29.37%	69.03%	2.40%
Hamilton MH	45.43%	51.85%	2.72%	35.70%	61.45%	4.03%
Franklin	56.09%	38.09%	5.82%	34.48%	63.66%	2.78%
Lucas MH	60.83%	33.55%	5.62%	32.60%	65.63%	2.63%
Cuyahoga MH	38.07%	51.43%	10.50%	36.99%	59.22%	4.88%

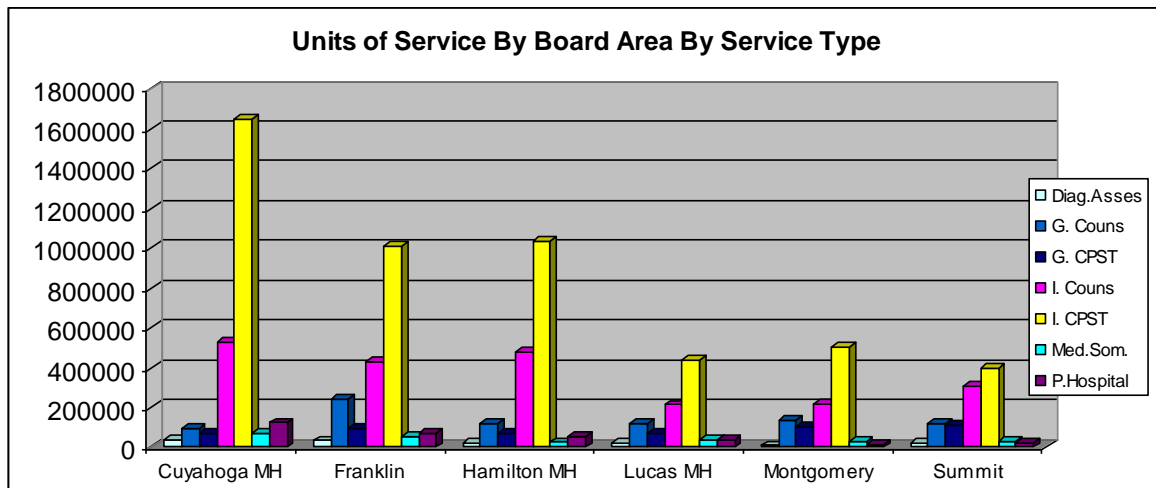
⁴ Percentages can sum to more than 100% due to payer status changes that occur during the period under review (FY 2006).

UNITS OF SERVICE

Mental Health services differ greatly between counties based on the needs and available resources of the potential client population; however, the services depicted below are Medicaid funded services and thus are consistent across comparison jurisdictions.

These services include the following:

- Diagnostic Assessment
- Group Counseling
- Individual Counseling
- Group Community Psychiatric Supportive Treatment (CPST)
- Individual CPST
- Medical Somatic Service, and
- Partial Hospitalization



As the graph above demonstrates, Individual CPST Services followed by Individual Counseling were the services in most demand. Butler County and Clermont County were excluded from this and following comparisons because these counties provided significantly fewer units of service than other peer jurisdictions. Butler and Clermont are not as urban as other included areas, and total population in these areas is significantly less.

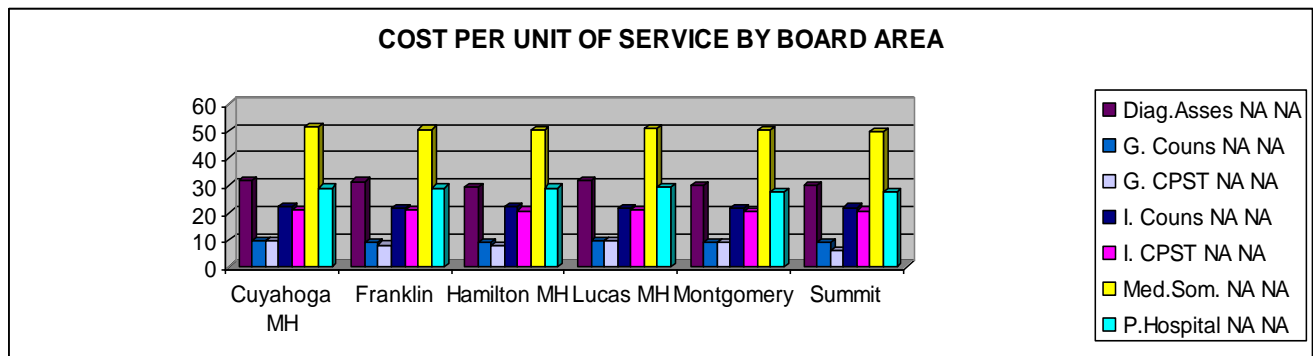
COST PER UNIT OF SERVICE

Cost per unit of service among jurisdictions for which data was made available ranged from \$8 to \$50. General Counseling and General CPST services have the lowest costs per unit of service while Medical Somatic services and Diagnostic Assessment have the greatest costs per unit of service. Partial Hospitalization follows closely behind, with all jurisdiction costs nearing \$30 per unit of service. Overall, costs for the same type of service among jurisdictions included in the presented analysis do not have a significant variance between counties.

Board Area	Diag.Asses	G. Couns	G. CPST	I. Couns	I. CPST	Med.Som.	P.Hospital
Cuyahoga MH	\$ 31.97	\$ 9.71	\$ 9.69	\$ 22.40	\$ 21.18	\$ 51.54	\$ 29.09
Franklin	\$ 31.48	\$ 9.30	\$ 8.19	\$ 21.70	\$ 21.20	\$ 50.56	\$ 29.11
Hamilton MH	\$ 29.50	\$ 9.27	\$ 7.94	\$ 22.07	\$ 20.69	\$ 50.12	\$ 29.10
Lucas MH	\$ 31.86	\$ 9.53	\$ 9.81	\$ 21.44	\$ 21.20	\$ 50.68	\$ 29.18
Montgomery	\$ 30.12	\$ 9.33	\$ 9.11	\$ 21.44	\$ 20.42	\$ 50.45	\$ 27.56
Summit	\$ 30.08	\$ 8.98	\$ 6.21	\$ 21.96	\$ 20.70	\$ 49.69	\$ 27.52

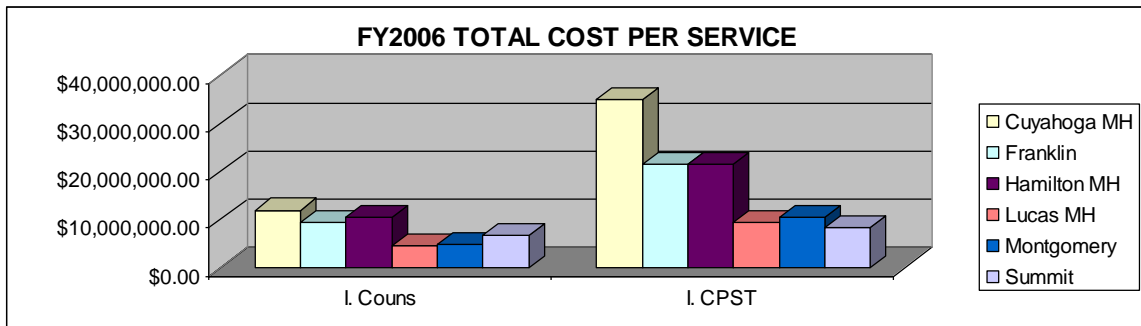
For ease of comparison, the above chart and the graph below shows ¼ of the unit rates for Diagnostic Assessment, Medical Somatic, and Partial Hospitalization. CPST and Counseling are normally billed in ¼ hour units.

The graph below highlights these trends:

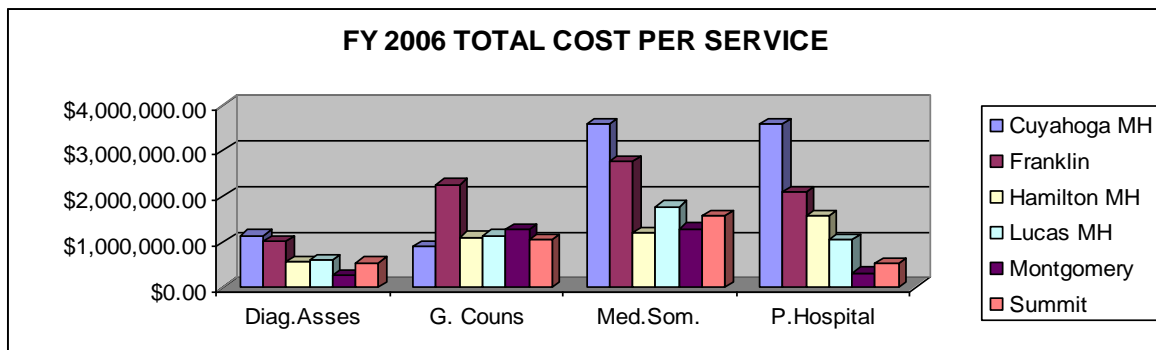


TOTAL COST BY SERVICE TYPE

In reviewing total costs by service type, there exists evidence of an obvious separation between services having a lower total expense and those having a higher cost total expense. This divide was observed among all responding jurisdictions. The graphs below demonstrate this divide:



Individual Counseling and Individual CPST experienced the highest total service costs based on total units served in FY2006. The graph below highlights the services for which total expenses were lower. Notice the difference in scale of these graphs:

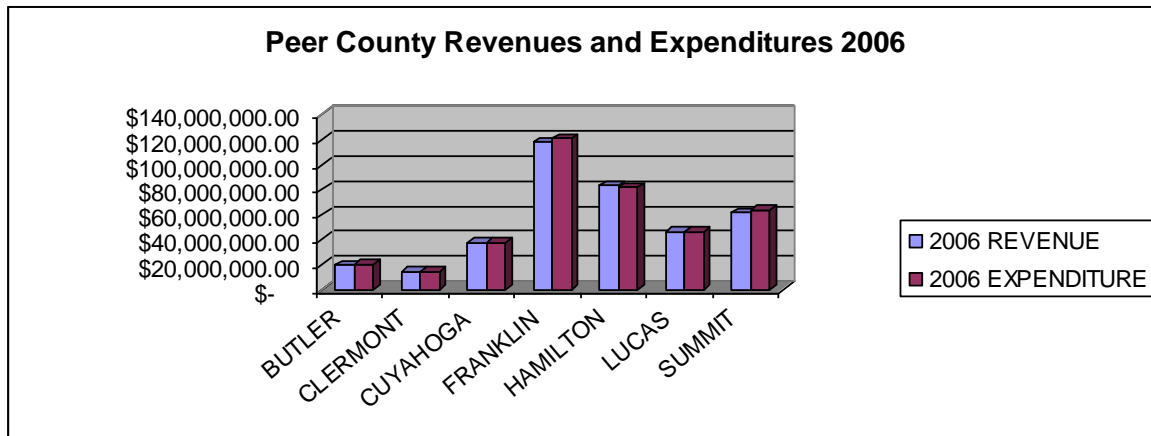


Hamilton County follows the general trends observed among all included jurisdictions. It maintains units of service, unit costs, and total costs close to the average of all jurisdictions.

B. FINANCIAL COMPARISON

It is difficult to make meaningful financial comparisons across such divergent organizations. We have limited our review to total revenue and expenditure data in order to benefit from consistency in data treatment and aggregation.

Hamilton County falls within expected ranges in terms of financing sources and relative rates of reliance.



COUNTY	2006	
	REVENUE	EXPENDITURE
BUTLER	\$ 19,752,845	\$ 20,351,115
CLERMONT	\$ 14,378,997	\$ 14,120,376
CUYAHOGA	\$ 37,794,105	\$ 37,793,883
FRANKLIN	\$ 117,424,362	\$ 120,305,563
HAMILTON	\$ 82,906,632	\$ 81,505,799
LUCAS	\$ 46,211,857	\$ 46,482,133
SUMMIT	\$ 61,346,347	\$ 63,784,881

VIII. ATTACHMENTS

ATTACHMENT 1

Service Area Units, Costs and Derived Unit Costs 2003 - 2007

Service Type	2003 Service Units and Costs								
	Units			Cost			Cost / Unit		
	Medicaid	Non-Medicaid	Total	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	16,482	9,996	26,478	\$ 788,448	\$ 2,180,893	\$ 2,969,341	\$ 47.84	\$ 218.18	\$ 112.14
COUNSELING	485,416	185,879	671,295	\$ 3,767,112	\$ 3,720,430	\$ 7,487,542	\$ 7.76	\$ 20.02	\$ 11.15
PHARMOCOLOGICAL MANAGEMENT	20,252	14,571	34,823	\$ 1,355,457	\$ 2,278,324	\$ 3,633,781	\$ 66.93	\$ 156.36	\$ 104.35
OTHER MENTAL HEALTH	0	1,700	1,700	\$ -	\$ 2,889,959	\$ 2,889,959	NA	\$1,699.98	\$ 1,699.98
IN-PATIENT HOSPITAL	0	600	600	\$ -	\$ 1,799,710	\$ 1,799,710	NA	\$3,000.19	\$ 3,000.19
CRISIS INTERVENTION	3,874	15,978	19,852	\$ 169,388	\$ 2,001,733	\$ 2,171,121	\$ 43.72	\$ 125.28	\$ 109.37
PREVENTION & EDUCATION	0	9,658	9,658	\$ -	\$ 1,350,326	\$ 1,350,326	NA	\$ 139.82	\$ 139.82
CONSUMER OPERATED & PEER SUPPORT	0	3,024	3,024	\$ -	\$ 1,002,046	\$ 1,002,046	NA	\$ 331.40	\$ 331.40
RESIDENTIAL TREATMENT & HOUSING	0	51,088	51,088	\$ -	\$ 8,259,143	\$ 8,259,143	NA	\$ 161.67	\$ 161.67
EMPLOYMENT & VOCATIONAL	0	40,778	40,778	\$ -	\$ 1,084,286	\$ 1,084,286	NA	\$ 26.59	\$ 26.59
PARTIAL HOSPITALIZATION	44,294	25,104	69,398	\$ 2,110,937	\$ 1,164,242	\$ 3,275,179	\$ 47.66	\$ 46.38	\$ 47.19
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	796,067	619,723	1,415,790	\$ 6,798,671	\$ 17,228,410	\$ 24,027,081	\$ 8.54	\$ 27.80	\$ 16.97

Service Type	2004 Service Units and Costs								
	Units			Cost			Cost / Unit		
	Medicaid	Non-Medicaid	Total	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	18,209	9,204	27,413	\$ 944,754	\$ 2,882,883	\$ 3,827,637	\$ 51.88	\$ 313.22	\$ 139.63
COUNSELING	459,373	139,441	598,814	\$ 3,776,531	\$ 2,863,350	\$ 6,639,881	\$ 8.22	\$ 20.53	\$ 11.09
PHARMACOLOGICAL MANAGEMENT	20,861	11,126	31,986	\$ 1,577,427	\$ 1,956,999	\$ 3,534,426	\$ 75.62	\$ 175.90	\$ 110.50
OTHER MENTAL HEALTH	0	1,592	1,592	\$ -	\$ 2,304,615	\$ 2,304,615	NA	\$1,447.62	\$ 1,447.62
IN-PATIENT HOSPITAL	0	579	579	\$ -	\$ 1,799,710	\$ 1,799,710	NA	\$3,110.77	\$ 3,110.77
CRISIS INTERVENTION	369	15,535	15,904	\$ 22,489	\$ 2,005,045	\$ 2,027,534	\$ 60.95	\$ 129.07	\$ 127.49
PREVENTION & EDUCATION	0	8,420	8,420	\$ -	\$ 1,350,726	\$ 1,350,726	NA	\$ 160.42	\$ 160.42
CONSUMER OPERATED & PEER SUPPORT	0	3,024	3,024	\$ -	\$ 873,478	\$ 873,478	NA	\$ 288.85	\$ 288.85
RESIDENTIAL TREATMENT & HOUSING	0	53,546	53,546	\$ -	\$ 8,848,141	\$ 8,848,141	NA	\$ 165.24	\$ 165.24
EMPLOYMENT & VOCATIONAL	0	113,291	113,291	\$ -	\$ 1,093,579	\$ 1,093,579	NA	\$ 9.65	\$ 9.65
PARTIAL HOSPITALIZATION	52,773	23,075	75,848	\$ 2,534,925	\$ 1,027,891	\$ 3,562,816	\$ 48.03	\$ 44.55	\$ 46.97
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	767,434	530,559	1,297,993	\$ 7,117,493	\$ 17,265,393	\$ 24,382,886	\$ 9.27	\$ 32.54	\$ 18.79

Service Type	2005 Service Units and Costs								
	Units			Cost			Cost / Unit		
	Medicaid	Non-Medicaid	Total	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	21,799	13,333	35,132	\$ 1,120,478	\$ 3,164,515	\$ 4,284,993	\$ 51.40	\$ 237.35	\$ 121.97
COUNSELING	485,807	111,260	597,067	\$ 4,034,333	\$ 2,173,071	\$ 6,207,404	\$ 8.30	\$ 19.53	\$ 10.40
PHARMOCOLOGICAL MANAGEMENT	20,490	8,233	28,722	\$ 1,658,833	\$ 1,618,663	\$ 3,277,496	\$ 80.96	\$ 196.62	\$ 114.11
OTHER MENTAL HEALTH	0	4,710	4,710	\$ -	\$ 2,528,468	\$ 2,528,468	NA	\$ 536.82	\$ 536.82
IN-PATIENT HOSPITAL	0	351	351	\$ -	\$ 1,680,015	\$ 1,680,015	NA	\$4,792.51	\$ 4,792.51
CRISIS INTERVENTION	1,388	22,118	23,506	\$ 48,572	\$ 3,273,107	\$ 3,321,679	\$ 34.99	\$ 147.98	\$ 141.31
PREVENTION & EDUCATION	0	10,908	10,908	\$ -	\$ 1,242,011	\$ 1,242,011	NA	\$ 113.86	\$ 113.86
CONSUMER OPERATED & PEER SUPPORT	0	0	0	\$ -	\$ 869,963	\$ 869,963	NA	NA	NA
RESIDENTIAL TREATMENT & HOUSING	0	48,060	48,060	\$ -	\$ 7,455,088	\$ 7,455,088	NA	\$ 155.12	\$ 155.12
EMPLOYMENT & VOCATIONAL	0	38,654	38,654	\$ -	\$ 924,710	\$ 924,710	NA	\$ 23.92	\$ 23.92
PARTIAL HOSPITALIZATION	47,017	14,682	61,699	\$ 2,238,917	\$ 758,810	\$ 2,997,727	\$ 47.62	\$ 51.68	\$ 48.59
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	919,321	369,483	1,288,803	\$ 7,286,045	\$ 13,229,621	\$ 20,515,666	\$ 7.93	\$ 35.81	\$ 15.92

Service Type	2006 Service Units and Costs								
	Units			Cost			Cost / Unit		
	Medicaid	Non-Medicaid	Total	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	18,819	10,630	29,448	\$ 967,031	\$ 3,282,886	\$ 4,249,917	\$ 51.39	\$ 308.84	\$ 144.32
COUNSELING	538,889	103,777	642,666	\$ 4,359,700	\$ 2,084,355	\$ 6,444,055	\$ 8.09	\$ 20.09	\$ 10.03
PHARMOCOLOGICAL MANAGEMENT	23,964	8,576	32,540	\$ 1,909,211	\$ 1,727,266	\$ 3,636,477	\$ 79.67	\$ 201.41	\$ 111.75
OTHER MENTAL HEALTH	0	0	0	\$ -	\$ 2,015,215	\$ 2,015,215	NA	NA	NA
IN-PATIENT HOSPITAL	0	351	351	\$ -	\$ 1,680,015	\$ 1,680,015	NA	\$ 4,792.51	\$ 4,792.51
CRISIS INTERVENTION	2,208	7,942	10,150	\$ 80,293	\$ 2,186,966	\$ 2,267,259	\$ 36.36	\$ 275.37	\$ 223.38
PREVENTION & EDUCATION	0	11,149	11,149	\$ -	\$ 1,328,570	\$ 1,328,570	NA	\$ 119.17	\$ 119.17
CONSUMER OPERATED & PEER SUPPORT	0	0	0	\$ -	\$ 861,945	\$ 861,945	NA	NA	NA
RESIDENTIAL TREATMENT & HOUSING	0	43,128	43,128	\$ -	\$ 8,880,903	\$ 8,880,903	NA	\$ 205.92	\$ 205.92
EMPLOYMENT & VOCATIONAL	0	40,922	40,922	\$ -	\$ 1,125,275	\$ 1,125,275	NA	\$ 27.50	\$ 27.50
PARTIAL HOSPITALIZATION	51,655	23,807	75,462	\$ 2,396,333	\$ 1,309,359	\$ 3,705,692	\$ 46.39	\$ 55.00	\$ 49.11
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	936,209	341,944	1,278,153	\$ 7,461,527	\$ 13,957,571	\$ 21,419,098	\$ 7.97	\$ 40.82	\$ 16.76

Service Type	2007 Service Units and Costs								
	Units			Cost			Cost / Unit		
	Medicaid	Non-Medicaid	Total	Medicaid Match \$ 0.4122	Non-Medicaid \$	Total HCCMHB \$	Medicaid Match	Non-Medicaid \$	Total HCCMHB \$
PSYCHIATRIC INTERVIEW / ASSESSMENTS / EVALUATIONS	18,057	11,473	29,529	\$ 922,411	\$ 3,424,087	\$ 4,346,498	\$ 51.08	\$ 298.46	\$ 147.19
COUNSELING	520,295	102,392	622,686	\$ 4,209,079	\$ 2,124,914	\$ 6,333,993	\$ 8.09	\$ 20.75	\$ 10.17
PHARMOCOLOGICAL MANAGEMENT	22,562	7,570	30,132	\$ 1,834,214	\$ 1,619,923	\$ 3,454,137	\$ 81.30	\$ 213.98	\$ 114.63
OTHER MENTAL HEALTH	0	0	0	\$ -	\$ 1,919,882	\$ 1,919,882	NA	NA	NA
IN-PATIENT HOSPITAL	0	351	351	\$ -	\$ 1,680,015	\$ 1,680,015	NA	\$ 4,792.51	\$ 4,792.51
CRISIS INTERVENTION	2,208	7,426	9,634	\$ 79,013	\$ 1,901,786	\$ 1,980,799	\$ 35.78	\$ 256.09	\$ 205.60
PREVENTION & EDUCATION	0	11,527	11,527	\$ -	\$ 1,385,431	\$ 1,385,431	NA	\$ 120.19	\$ 120.19
CONSUMER OPERATED & PEER SUPPORT	0	0	0	\$ -	\$ 1,128,805	\$ 1,128,805	NA	NA	NA
RESIDENTIAL TREATMENT & HOUSING	0	40,701	40,701	\$ -	\$ 9,149,532	\$ 9,149,532	NA	\$ 224.80	\$ 224.80
EMPLOYMENT & VOCATIONAL	0	40,410	40,410	\$ -	\$ 1,117,626	\$ 1,117,626	NA	\$ 27.66	\$ 27.66
PARTIAL HOSPITALIZATION	51,668	30,675	82,343	\$ 2,421,361	\$ 1,565,265	\$ 3,986,626	\$ 46.86	\$ 51.03	\$ 48.41
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT	903,085	350,724	1,253,809	\$ 7,362,163	\$ 14,257,138	\$ 21,619,301	\$ 8.15	\$ 40.65	\$ 17.24