JIM PETRO
AUDITOR OF STATE
STATE OF OHIO

CUYAHOGA COUNTY COMMUNITY MENTAL HEALTH BOARD PERFORMANCE AUDIT

OCTOBER 16, 2002

STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

To the Cuyahoga County Commissioners, Cuyahoga County Community Mental Health Board of Governors and the Citizens of Cuyahoga County:

In response to a request from the Cuyahoga County Commissioner's Office (County), and with support from the Cuyahoga County Community Mental Health Board of Governors (BOG), the Auditor of State's Office conducted a performance audit of the Cuyahoga County Community Mental Health Board's (CMHB) operations. Given the County's declining financial condition and recent leadership changes at CMHB, the County and BOG determined that a performance audit would help address concerns regarding the overall efficiency and effectiveness of CMHB.

This audit report assesses several key operational areas which include the following: Organization, Compliance and Board Governance; Human Resources; Finance and Funding; Technology Use and Claims Services; Risk Management and Consumer Affairs; Planning and System Development; Provider Relations and Quality Services; and External Affairs. The Auditor of State's Office conducted an independent assessment of these areas with the objective of providing recommendations to enhance the organizational structure of CMHB, assist the BOG in fulfilling its role and mission, ensure that staffing levels are efficient and adequate, improve the monitoring of outcomes for consumers, enhance the contract development and monitoring process, and examine strategies to control mental health spending in Cuyahoga County.

An executive summary has been prepared which includes the project history, an overview of CMHB, the purpose and objectives of the performance audit, and summaries of the key findings, recommendations, commendations and financial implications. This report has been provided to CMHB and the County and its contents discussed with the designated County liaison, CMHB management and representatives of the BOG. CMHB has been encouraged to use the results of the performance audit as a resource in improving its overall operations and financial stability.

Additional copies of this report can be requested by calling the Clerk of the Bureau's office at (614) 466-2310 or toll free at (800) 282-0370. In addition, this performance audit can be accessed on-line through the Auditor of State of Ohio website at http://www.auditor.state.oh.us/ by choosing the "On-Line Audit Search" option.

Sincerely,

JIM PETRO
Auditor of State

October 16, 2002

Executive Summary

Project History

In an attempt to improve service delivery to its citizens and optimize operational efficiencies, the Cuyahoga County Commissioners (County) and the Cuyahoga County Community Mental Health Board (CMHB) engaged the Auditor of State's Office (AOS) in November 2001 to conduct a performance audit. AOS has collaborated with the County to conduct other performance audits for the Juvenile Court and Veterans Service Commission. Since the County has recently begun to experience financial difficulties, the County and CMHB's Board of Governors (BOG) were concerned with the overall effectiveness and efficiency of CMHB's operations; and therefore, a performance audit was requested.

The overall objectives of this project are to assess selected areas of CMHB and develop findings, recommendations and commendations based on comparisons with peer county mental health boards (MHBs) and other benchmarks to improve CMHB's operations. The primary focus of the performance audit is to improve the overall effectiveness and efficiency of CMHB and to enhance the overall management of the organization, as well as Cuyahoga County's mental health service delivery system. Additionally, the performance audit provides an independent assessment of CMHB's operations and includes recommendations to enhance the overall organizational structure of CMHB, assist the BOG in fulfilling its role and mission, ensure that staffing levels are efficient and adequate, improve the monitoring of outcomes for consumers, enhance the contract development and monitoring process, and examine strategies to control mental health spending in Cuyahoga County.

Based on discussions with the County, CMHB's Board of Governors' chairperson, acting chief executive officer (CEO), CMHB's management staff, and various contracted providers, the following areas were selected for assessment:

- Organization, Compliance and Board Governance;
- Human Resources;
- Finance and Funding;
- Technology Use and Claims Services;
- Risk Management and Consumer Affairs;
- Planning and System Development;
- Provider Relations and Quality Services; and
- External Affairs.

Cuyahoga County and CMHB have acknowledged the need to address operational issues to improve overall performance and have been proactive in approaching AOS for assistance through the performance audit process. The recommendations resulting from the performance audit will provide a framework for change which can result in cost savings, revenue enhancements, operational improvements and increased quality of service. The high level of support for the audit process exhibited by the County and CMHB is an indication of the positive environment for change which currently exists with respect to CMHB's operations. Furthermore, CMHB has taken measures to improve its operations that are consistent with some of the recommendations in this report, such as reducing staffing levels in certain units and addressing the high use of hospital care in Cuyahoga County.

Objectives and Scope

A performance audit is defined as a systematic and objective assessment of the performance of an organization, program, function or activity to develop findings, recommendations and conclusions. Performance audits are usually classified as either economy and efficiency audits or program audits.

Economy and efficiency audits consider whether an entity is using its resources efficiently and effectively. They attempt to determine if management is maximizing output for a given amount of input. If the entity is efficient, it is assumed that it will accomplish its goals with minimal resources and with the fewest negative consequences. Program audits, on the other hand, are normally designed to determine if the entity's activities or programs are effective, if they are reaching their goals, and if the goals are proper, suitable or relevant. These audits attempt to determine if the actual outputs match, exceed or fall short of the intended outputs. The performance audit conducted on CMHB contains elements of both an economy and efficiency audit and a program performance audit.

Methodology

To complete this report, the auditors gathered and assessed a significant amount of data pertaining to the selected audit areas, conducted interviews with various individuals associated with CMHB, and assessed available information from selected peer county MHBs. In addition to reviewing this information, the auditors spent a significant amount of time gathering and reviewing other pertinent documents and information, such as state and national best practices in mental health and various DataMart reports from the Ohio Department of Mental Health (ODMH) which provide aggregated consumer billing information. Numerous interviews and discussions were held at many levels at CMHB and with individuals involved internally and externally with the organization. Furthermore, the following three peer MHBs were selected to provide benchmark comparisons: Franklin County Alcohol, Drug and Mental Health Board

(ADAMH); Lucas County Community Mental Health Board (Lucas MHB); and Stark County Community Mental Health Board (Stark MHB). Although Franklin County has a combined alcohol, drug and mental health board, this performance audit only focuses on the mental health activities performed by Franklin County. Therefore, Franklin County's ADAMH board will be referred to as Franklin MHB throughout this report. In addition, financial information was obtained from Hamilton County Community Mental Health Board (Hamilton MHB) for additional comparisons.

The performance audit process involved significant information sharing with the County and management from CMHB, including preliminary drafts of findings and recommendations as they were developed. Furthermore, periodic status meetings were held throughout the engagement to inform the County's designated liaison, BOG, and CMHB management staff of key issues impacting the selected areas, and proposed recommendations to improve and enhance operations. Sharing information and conducting periodic status meetings gave the County and CMHB numerous opportunities to provide input regarding key issues. Feedback provided by the County and CMHB facilitated the completion of each of the audit sections.

Overview of CMHB

CMHB is one of 50 community mental health and ADAMH boards coordinating the public mental health system in the State of Ohio. Governed by Ohio Revised Code (ORC) §340.02.1(A), CMHB is an agency legislated to develop a system that enables persons with mental illness and children with emotional disturbances to have access to quality services and programs. CMHB does not provide these programs directly to persons with mental illness, but enters into contracts with providers who deliver these services. In accordance with ORC § 340.03, CMHB is overseen by a Board of Governors (BOG) comprised of 18 members, 6 appointed by ODMH and 12 appointed by the County. CMHB is led by a chief executive officer (CEO), who reports directly to the BOG. The CEO, chief clinical officer (CCO) and chief operating officer (COO) provide overall leadership and oversight of CMHB's daily operations. As of July 2002, a new full-time CEO was hired to provide executive leadership for CMHB's 59 FTE employees. In addition, CMHB is the only mental health board in the State to have a collective bargaining agreement.

CMHB has legal responsibility and authority over the provision of mental health services to approximately 25,000 consumers in Cuyahoga County via 37 contracted providers. CMHB's mission is to develop a mental health system that enables consumers to access quality services and programs that assist them in a culturally competent manner to better control their illness, to achieve personal goals, and to develop skills and supports leading to living the most constructive and satisfying lives possible in the least restrictive setting available.

CMHB operates with the following main divisions to fulfill its role and responsibilities: External Affairs, Planning and System Development (PSD), Administrative Services, Risk Management and Consumer Affairs (RMCA), and Provider Relations and Quality Services (PRQS). External Affairs assists BOG in public relations to promote mental health issues in the community. PSD creates various program plans for adults, children and families receiving mental health services. Administrative Services consists of Human Resources (HR), Management Information Systems (MIS), Finance and the Claims and Membership Services (CMS) units. RMCA contracts with providers, serves as liaison to the legal counsel, and monitors and investigates consumer complaints and grievances along with providing consultation to providers concerning appeals. PRQS performs Medicaid compliance audits of all contracted providers, oversees inpatient care for mental health consumers, and functions as gatekeeper for all quality assurance activities at CMHB and contracted providers as directed by ODMH. Furthermore, PRQS coordinates external training for contracted providers, manages business relationships with agencies and serves as the primary contact for providers.

Key Findings and Recommendations

Organization, Compliance and Board Governance

- Based on peer comparisons and analysis, certain aspects of CMHB's organizational structure could be enhanced to operate more efficiently. Planning and system development is a separate division at CMHB. However, Franklin and Hamilton MHBs have combined planning and system development, quality improvement and utilization review functions in the same division and under one chief. Finance and risk management (contracting) are also combined under one chief at Franklin and Hamilton MHBs. In contrast, CMHB has contracting combined with consumer affairs.

  CMHB should consider combining Planning and System Development (PSD) with the Quality Improvement and Utilization Review units of Provider Relations and Quality Services (PRQS) under one division/chief. Benefits of combining PSD with these units include improving the ability of CMHB to evaluate outcomes and the success of plans, and potentially streamlining operations and using staff resources more efficiently. CMHB should also consider combining the Risk Management Unit (contracting) with the Finance Unit. The Finance Unit performs many activities related to contracts, such as working with providers to develop unit costs and reviewing financial aspects of the contracts. In addition, the CA Unit should report to the CEO, COO or CCO to bring it more in line with ODMH's recommendations and peer organizational structures. CMHB should also consider formally placing the HR Unit under the control of the CEO. Allowing the CEO to have direct oversight over this unit could lead to more efficient recruitment and hiring strategies, which can have a positive impact upon the staffing levels at CMHB. Based on these suggested

changes, CMHB should consider filling three chief positions, which would cost approximately $325,000 annually in additional salaries and benefits.

- CMHB's Board of Governors (BOG) is unclear over the role it serves in the governance and operations of CMHB. Engaging in the day-to-day operation of the organization, hiring staff other than the CEO, and making detailed programmatic decisions without consulting the staff are not primary responsibilities of a board. As a result of BOG's involvement in daily activities, effective oversight, employee morale and practical, long-range planning activities have declined.

  BOG should re-examine its role and influence over CMHB's operations to determine if its level of involvement is appropriate and effective, particularly in the areas of leadership, bylaws, committees, composition, recruitment, commitment, orientation, and strategic planning. Defining the appropriate role is particularly important since the chief executive officer, chief clinical officer, and chief operating officer positions have been filled.

- Aspects of BOG's bylaws are vague and in some cases, do not provide the necessary level of detail to effectively remove the ambiguity from its processes. More specific operating rules help eliminate confusion over how boards operate. In addition, clearly defined bylaws help to ensure that governing entities operate more effectively and in a consistent, fair and organized fashion, and provide stakeholders with clear expectations and standards for holding the board accountable.

  BOG should revise its bylaws to include statements about how the board operates, referring to the ORC only for support. Removing ambiguity from the rules of operation will help members and stakeholders remain aware of internal processes.

- Although CMHB has drafted a strategic plan, it has not been fully adopted and does not include specific responsibility for each of the broad action steps or a timeframe for their completion. Additionally, the plan lacks specific measurable goals and a mechanism for measuring the results and revising the plan. Without measurable goals and defined responsibility for achieving them, the accountability and ability to compare, evaluate, explain, and revise those goals is significantly diminished. Performance measures include results, outputs, demands, and efficiencies; and clearly describe how progress is to be measured, who in the organization is responsible for attaining the goals and how much money may be allocated in attaining particular goals.

  CMHB should capitalize on the work it has put into the existing strategic plan draft. BOG and the CEO should collaboratively review and update the goals identified in the drafted strategic plan. In addition to goal prioritization, CMHB should incorporate the methodology used by Franklin MHB to narrow goals into smaller ones that support its overall mission.

Goals should be clearly measurable and attainable within a specified timeframe. Specific CMHB employees should be identified in the document as accountable for each goal. Finally, CMHB's chief executive officer should be held accountable for effectively implementing an adopted and collaboratively developed strategic plan. To assist the CEO, elements and suggestions made by the GAO and other best practice organizations should be incorporated to achieve success, remove barriers and avoid costly mistakes.

Human Resources

- Human Resource (HR) staffing levels at CMHB are not adequate to serve the number of employees at CMHB. CMHB's ratio of staff to HR personnel is approximately 123 percent higher than the peer average, which indicates that CMHB's HR personnel have a higher workload than its peer mental health boards. Other factors increasing the workload in the HR Unit at CMHB include preparing payroll, overseeing receptionist functions, coordinating and monitoring internal training, and participating in union negotiations. The additional functions performed by CMHB's HR Unit, and the vacancy in the HR specialist position increases the HR director's responsibilities in comparison to peer boards. As a result, the HR director cannot focus on any one area, which has affected the performance evaluation process and job description development.

  CMHB should fill the vacant HR specialist position. By filling the HR specialist position and transferring receptionist functions out of HR, the HR director will be able to focus on labor issues, introduce performance measurement/goals, address morale, improve career development, and meet departmental/organizational goals. By filling the HR specialist position, CMHB would incur additional costs of approximately $47,300 in annual salaries and benefits.

- CMHB's negotiating team does not possess the skills and experience needed to effectively negotiate on its behalf. Additionally, CMHB has not been provided training and guidance from Cuyahoga County Human Resources (CCHR) Department, the State Employee Relations Board or other organizations offering training and guidance for its negotiation team. A negotiating team well-versed in tactics, strategy, and timing will be in a better position to avoid impasses and strikes, and will end up with a better agreement than a team composed of inexperienced people. Also, the union's demands should be carefully studied early in the negotiation process. The HR director indicated that the management employees involved with the labor negotiation team in 2001 are no longer employed at CMHB.

  Labor negotiation team members should be fully trained and start the preparation for negotiations in advance. To accomplish this task, the HR director and CEO should seek guidance, training and participation from CCHR in labor negotiations and labor relations. Potential sources for additional training and guidance are Cleveland State University and

SERB. Since the negotiation ground rules allow CMHB to include an outside party in the negotiation process, CCHR should be invited to participate. This will ensure that CMHB has a strong team entering into the negotiation process. During the course of this performance audit, the HR director has sought training from SERB and has indicated that CMHB will continue to engage SERB in addressing labor relation issues.

- Job descriptions have been updated for 39 of the 71 positions at CMHB since 2001, while all other job descriptions have not been updated in several years. CMHB has eight different job descriptions for the administrative assistant classification. Many CMHB job descriptions also lack measurable standards. The lack of clear and updated job descriptions can result in uncertainty of job functions and cause difficulty in developing an effective evaluation form.

  The HR director should work with supervisors to immediately review and update all job descriptions. In the future, job descriptions should be reviewed annually and updated as job functions change and should include measurable standards. Up-to-date job descriptions would lead to a greater understanding of job functions and responsibilities. The HR director indicated that a procedure for updating job descriptions is being implemented at CMHB. CMHB should also consider reclassifying the eight administrative assistant positions and developing one job description for this position.

- CMHB does not evaluate employee performance on a consistent basis as required in its policy manual or the OAPSE labor agreement. In addition, CMHB's evaluation process does not achieve important objectives, such as acting as a forum for career development and establishing goals for the future. CMHB does not have a performance plan, which has resulted in difficulty helping staff understand how their job supports the goals of the organization.

  The HR director should work with supervisors to conduct employee evaluations in accordance with CMHB policy and the labor agreement. The HR director should develop a performance appraisal plan similar to Franklin MHB's that meets the standards outlined by Business and Legal Reports and explains the procedure for completing performance evaluations. To maximize feedback and communication opportunities provided in the appraisal process, management should have regular conversations with staff and provide feedback concerning the recommendations given in the evaluation process.

Finance and Funding

- CMHB's total mental health costs per consumer were the highest of the peers in FY 2000 and FY 2001. In contrast to CMHB, all of the peers decreased in average units billed per consumer and average cost per consumer while increasing the number of consumers serviced, except for Lucas MHB which experienced a slight decrease in consumers. By

excluding those non-Medicaid services (costs and units) not provided by the majority of the peers, CMHB's cost per consumer was still the highest of the peers in FY 2000 and FY 2001. CMHB's cost per consumer increased while all of the peers' costs per consumer decreased, except for Hamilton MHB's slight increase of 0.9 percent, from FY 2000 to FY 2001. The average cost per unit at CMHB was the second highest as compared to the peers and increased 5.9 percent compared to the peer average of 1.5 percent from FY 2000 to FY 2001. The cost per unit for certain Medicaid eligible services is significantly higher at CMHB, impacting the higher costs per consumer at CMHB.

CMHB should take measures to control spending for mental health services while ensuring quality services are administered to consumers, including the following:

- Working with contracted providers to review pricing for units of service and administrative costs;
- Working with the Cuyahoga County DCFS in providing services to foster care children;
- Pooling funds spent by other County agencies on mental health services and by County agencies providing additional services to CMHB's consumers;
- Implementing a centralized intake or managed care system;
- Reviewing the use of the 1915a waiver; and
- Developing a standard assessment tool for providers to determine levels of care.

Based on FY 2000 and adjusting for the differences in cost of doing business in Cuyahoga and peer counties, CMHB could save approximately $830,000 annually by reducing costs per unit to the peer average for CSP-Individual services.

- CMHB does not develop budgets and track expenditures by division. As a result, divisions are not held fully accountable for their share of expenditures, which could negatively impact CMHB's financial condition. Additionally, CMHB does not track and monitor actual expenditures by line item which could be partially attributed to its current accounting system. By budgeting by division and tracking expenditures by line item, CMHB would appropriately control its operational finances and potentially maximize the amount of funding provided to consumers.

  CMHB should develop budgets by division, and divisions should develop their budgets by adequately planning costs for each unit within the division. Budgets by division and unit should be monitored to ensure all areas at CMHB are held fully accountable for expenditures. Furthermore, CMHB should track and monitor actual division expenditures by line item. Doing so would allow CMHB to adequately control expenditures, and determine how to address expenditures that are not being effectively controlled. Implementing a new accounting system could help the Finance Unit develop and monitor budgets and actual expenditures by division and by line item.

- CMHB has tracked annual funding by major source; however, funding is not forecasted beyond one year. GFOA recommends that government units at all levels forecast major funding and expenditures. The forecast should extend at least three years beyond the budget period and should be regularly monitored and periodically updated. By developing a forecast, as well as detailed accompanying assumptions, explanatory comments and the methodology used in deriving the financial estimates, CMHB will provide a more comprehensive understanding of its anticipated financial condition.

  CMHB should begin forecasting its funding and expenses beyond one year. CMHB should develop at least a three-year financial forecast to ensure that the budgeting process incorporates CMHB's future financial needs and goals. Furthermore, CMHB should analyze variances in forecasted to actual amounts before beginning the budget process to build on its understanding of why variances occurred and determine how to adjust the current year forecast to account for material variances.

Technology Use and Claims Services

- MIS Unit staffing levels comprise approximately nine percent of total CMHB staff and are commensurate with the peers based on available workload measures. Since the MIS Unit does not track computer service requests and lacks reliable budgetary information, appropriate unit staffing levels are difficult to determine. Although Cuyahoga County's mental health consumer population is larger than the peers, the CMS Unit's claims/membership specialists sufficiently process its relatively high number of claims and member enrollments; and therefore, the CMS Unit appears appropriately staffed.

  The MIS Unit should track computer service requests to identify those areas which frequently require technical assistance. Additionally, the number and frequency of computer service requests can be used as a potential workload measure which could provide justification for staffing adjustments by the MIS director. Without additional performance indicators, future increases in staffing levels will be difficult to justify. Maintaining appropriate staffing levels helps ensure a balanced workload and increased morale among staff members.

- CMHB does not have a comprehensive strategic technology plan to guide its long-term technology development and implementation activities. Funding constraints and the absence of an agency-wide strategic plan have impacted CMHB's ability to strategically plan its technical operations. Nevertheless, such a planning process would ultimately help alleviate high workloads and help coordinate technology expenditures.

  CMHB should develop a long-term strategic technology plan which addresses both short and long-term technology needs. Effective technology planning can result in a computing

environment which allows more efficient use of staff time. The result of this process should be a step-by-step action plan detailing how the agency expects to meet its long-term goals and objectives given the existing technical architecture. The timetable should be realistic in estimating CMHB's commitment to the implementation of new technologies. A sound methodology will help CMHB implement high quality applications with less risk and at a lower cost. The plan, along with the budget, should also address the issue of upgrades and future replacements of computer equipment, as well as software and associated staff development.

- Although claims processing involves a regimented lifecycle, the CMS Unit does not extensively use internal performance indicators to gauge the efficiency and effectiveness of claims processing operations at CMHB. Without an internal performance measurement system to monitor the efforts of the CMS Unit, CMHB is unable to effectively evaluate the success of completed work and corresponding outcomes.

  Under the supervision of the MIS director and claims manager, the CMS Unit should develop additional internal performance indicators to measure efficiencies and outcomes achieved in claims operations. This will help improve the mental health system by monitoring the quality and timely submission of contracted providers' claims, while ensuring timely reimbursement for services rendered.

Risk Management and Consumer Affairs

- CMHB employs a full-time risk management specialist, which is currently vacant. The main responsibilities of the risk management specialist involve planning and writing policies for risk management at CMHB. However, the peers do not have a risk management specialist position or another position which performs similar functions. CMHB also employs a full-time administrative assistant for RMCA. The administrative assistant performs basic administrative functions such as copying and filing for the CA Unit and helps support other consumer advocacy functions as needed. The administrative assistant, however, performs only minimal tasks for the RM Unit. None of the peers employ a full-time administrative assistant dedicated to risk management and consumer affairs support functions.

  In conjunction with reorganizing RMCA, CMHB should eliminate the risk management specialist position, as its vacancy has not significantly impacted the RM Unit's workload. CMHB should consider other ways to address risk management needs similar to peers, such as assigning the duties to other staff currently performing similar duties or contracting for certain services. This reduction would allow CMHB to focus funding on higher priorities and more closely align risk management staffing levels with those of the peers. Furthermore, CMHB should transfer the current administrative assistant to the Human Resources Unit to fill the human resource specialist position. After the transfer, CMHB

should reduce the administrative assistant position in RMCA to half-time and reassign the position solely to the CA Unit. Reassigning the administrative assistant position to the CA Unit will help accommodate the relatively high number of complaints and grievances handled by staff. CMHB could realize a cost avoidance of approximately $50,000 in salary and benefits if the risk management specialist position was eliminated. Reducing RMCA's administrative assistant position to part-time would produce a cost savings of approximately $24,000 annually.

- CMHB does not effectively utilize the information collected and maintained by the CA Unit. Every inquiry, complaint and grievance received by CMHB is entered into the consumer affairs database. Currently, CMHB is not using this critical information to monitor service quality, influence contract decisions, and identify trends and patterns. Sharing consumer affairs data within CMHB can ultimately improve the services received by consumers and help guide planning and system development activities.

  CMHB's CEO should develop a system which integrates consumer affairs data into the decision-making processes of certain CMHB units. In sharing this data, the CA Unit should take all necessary precautions to safeguard consumer confidentiality. Additionally, the CA Unit should use the consumer affairs database to generate quarterly summaries of the numbers, types and resolution status for all inquiries, complaints and grievances received.

- Currently, CMHB uses one standard contract for all Medicaid and non-Medicaid services, which ultimately prevents CMHB from using its enforcement authority. Because CMHB uses one contract for all services, Medicaid or non-Medicaid, it is unable to enforce penalties on the non-Medicaid funds without raising concerns about Medicaid funds and Any Willing Provider (AWP) restrictions. As a result, CMHB does not enforce any aspects of either Medicaid or non-Medicaid funding and applies only basic requirements to all funding. Both Franklin and Lucas MHBs use separate contracts for Medicaid and non-Medicaid funds.

  BOG should implement separate contracts for Medicaid and non-Medicaid funded services by consulting with Franklin and Lucas MHBs. By using separate contracts for Medicaid and non-Medicaid, CMHB will be able to apply more control over non-Medicaid funds. The non-Medicaid contract should also contain additional requirements allowing CMHB staff to use stricter measures to enforce all contract requirements. By applying stricter enforcement measures to the funds CMHB currently has control over, namely non-Medicaid funds, CMHB staff will be better able to apply the same standards to Medicaid funds when and if legal questions surrounding them are answered.

Planning and System Development

- CMHB appears to be overstaffed in the PSD Division. The number of FTEs in PSD exceeds the peer average in all functional areas. Most notably, PSD's number of administrative assistants and number of FTEs dedicated to residential planning and inspections significantly exceeds the peer average. PSD employs a higher number of FTEs to generate a level of output that falls below the peer average, resulting in an allocation of resources that could otherwise be used to fund consumer programs. A major factor impacting the higher staffing levels in PSD as compared to peers is the different organizational structure at CMHB.

  CMHB should consider reducing one administrative assistant position. CMHB should be able to allocate functions performed by this position to other positions in PSD. PSD would still have higher administrative assistant staffing levels with this reduction. CMHB should also consider combining planning with quality improvement and utilization review to streamline operations. A reduction in PSD staffing levels will increase operational efficiency by bringing CMHB closer to the peer average in output generated per FTE. Reducing one administrative assistant will result in an annual cost savings of approximately $38,000 in salaries and benefits.

- PSD plans are developed internally or via contracts with consultants. Consultants developed more than half of PSD's plans and needs assessments, at a cost of approximately $302,000, despite PSD's relatively high level of staffing in this area and expertise in research, housing, and forensics. Excessive use of consultants in plan development can lead to community perception that PSD does not have the required expertise to effectively engage in collaborative planning.

  Although there is some need to use consultants, PSD administrators should develop more plans internally. Internal development ensures PSD is more closely involved in the process and is in a better position to guide implementation. Resources previously spent on consultants can be allocated to fund programs and services for consumers. CMHB could save approximately $30,000 annually by reducing outsourcing costs.

- CMHB's strategic planning process does not effectively include input from PSD. Because CMHB does not have an agency-wide strategic planning process which includes PSD, program efforts may not be coordinated and may take place on an ad-hoc, or emergency basis.

  CMHB should include PSD and external stakeholders, such as the Council of Agency Directors, in the creation of its strategic plan. This will help to develop a coordinated and systematic process that charts the direction of future mental health service efforts, while ensuring public awareness of these efforts. An inclusive strategic planning process will help

to link all of PSD's plans and ensure they do not lack critical input from external stakeholders. An inclusive process will also ensure CMHB develops a clear direction, and that Federal and State funding are properly used.

- The Adult CSP, Children's, SAMI, Vocational/Employment, and Housing plans do not link funding sources to implementation. All planning goals will not necessarily be tied to funding, but goals involving increased staffing, large scale projects (utilization reviews), and new services should identify funding sources as a guarantee that recommendations will be implemented. Time spent by PSD developing plans that are not implemented or workable, can be better spent searching for additional program funding, providing system-training, and ensuring cultural competency in the mental health system.

  PSD should link funding sources to planning implementation and should receive necessary input from the grant writer and the Finance Unit. Linking funding sources to planning increases the chance recommendations will be implemented.

Provider Relations and Quality Services

- CMHB could enhance its monitoring process by actively researching, maintaining and using performance measures and outcomes to monitor Cuyahoga County's mental health system on a system-wide basis, as opposed to relying on reports and plans submitted by individual contracted providers and relying on minimum requirements set forth in the ORC and OAC. Only 22 of 37 contracted providers are participating in the Consumer Outcomes System Project at CMHB, which is intended to assist mental health boards in collecting and monitoring outcomes. Monitoring outcomes on a system-wide basis would provide information to help CMHB when making policy, administrative, clinical, and financial decisions.

  CMHB should develop a process to establish and monitor outcome measures on a system-wide basis, and stipulate and enforce the measures in the agreements with contracted providers. Requiring all of its contracted providers to participate in the Consumer Outcomes System Project would help in collecting and monitoring outcomes. Monitoring outcomes for all contracted providers would provide pertinent data to CMHB and stakeholders for identifying system deficiencies and improving effectiveness of services provided to consumers.

- Although the PR Unit is more than adequately staffed to meet its purpose, the Unit is currently not performing all of its job responsibilities and duties, thereby not functioning as intended. Job duties and responsibilities not being totally performed by the PR Unit and/or could be performed more effectively include being a single point of contact, developing appropriate timelines to respond to contracted providers' issues and developing internal

procedures for CMHB staff to notify the Unit when system issues or contracted provider issues arise.

The PR Unit should begin to perform all related duties and responsibilities. The recommendations presented in this audit report focus on the PR Unit adhering to what is outlined within job descriptions as well as implementing process improvements. Based on staffing analyses and peer comparisons to improve operational efficiency, the PR Unit should still be able to perform its responsibilities and implement improvements with a reduction of 2.0 FTEs (1.0 FTE PR manager and 1.0 FTE PR specialist). CMHB would save approximately $125,900 annually in salary and benefit costs by reducing the PR manager position and PR specialist position.

- CMHB has significantly higher education and training staffing levels than the peers. Outside of providing the SAMI training twice a year, the Education and Training Unit at CMHB only coordinates education and training. There are no managers or support personnel devoted to education and training at the peers. In addition, there is no standalone Education and Training Unit for any of the peers. Furthermore, technological skills and capabilities are lacking within the Unit, due to the need for computer training. Further, the Education and Training Unit appears to lack the knowledge of research and overall administrative functions needed to run the Unit. As a result, training gaps and needs may have been overlooked.

  CMHB should consider reducing staffing in this unit by 1.0 FTE, either the education and training specialist or clerical staff, and should consider eliminating the Education and Training Unit as a standalone unit. The remaining 0.5 FTE previously in the Education and Training Unit should be responsible for coordinating external training and should be transferred to the PR Unit. The PR Unit was established for the purposes of addressing the needs of contracted providers. Therefore, coordination of external training should also fall within its jurisdiction. The PR Unit already employs a staff member with a chemical dependency certification who should be able to provide the SAMI training. Increased utilization of the Education and Training Committee should also allow CMHB to effectively function without a standalone Education and Training Unit. CMHB would experience an annual cost avoidance of approximately $68,000 (1.0 FTE) in salary and benefits by not filling its current vacant manager of Education and Training position. Annual cost savings of approximately $39,000 in salary and benefits can be realized by eliminating the support and specialist positions (1.5 FTEs). Finally, this report provides a series of actions that CMHB should consider implementing to improve the education and training function, regardless of whether or not CMHB eliminates or maintains the Education and Training Unit.

- In Cuyahoga County, contracted providers admitted 1 in 23 consumers to a State hospital in FY 2001, as compared to the peer average of 1 in 51. Several factors could contribute to the high use of bed days and inpatient care at CMHB, such as lack of a central intake or managed

care system, absence of a standardized process for determining level of care, inadequate access to alternative community-based services, lack of access to private hospital beds, need for the utilization of effective treatment planning and absence of upfront discharge planning for hospitalized consumers. Other explanations for the high use of inpatient care at CMHB could be the lack of coordination between CMHB, contracted providers, the State hospitals, and other County agencies screening consumers to provide the least restrictive care alternatives.

CMHB should implement strategies to hold contracted providers fully accountable for admitting consumers to state hospitals, such as having contracted providers use a standardized assessment tool for determining level of care, enforcing contractual requirements to ensure contract providers regularly visit consumers in the hospital, and charging the contracted providers for a portion of the per diem hospital rate. Furthermore, CMHB should closely monitor each factor contributing to the unusually high need for bed days and identify processes to reduce bed day use to a level comparable to peer MHBs. If CMHB reduced the total number of admissions similar to Stark MHB's percentage of 3.8 percent of total consumers, CMHB would experience annual savings in bed day costs of approximately $2.2 million and would incur about $494,000 in other service costs. Therefore, CMHB would save approximately $1.7 million annually by reducing its percentage of total consumers admitted to that of Stark MHB.

External Affairs

- A communication plan has been developed internally by the Division; however, the plan lacks quantifiable measurements to gauge the success of the Division's activities. Although, the communication plan is actually a strategic plan for communications, the communication plan does not tie into a broader document that addresses the entire organization because CMHB does not have a strategic plan.

  The communication plan should be re-evaluated using best practices identified by the Institute of Public Relations (IPR) to provide quantifiable measurements to gauge the success of the Division's activities. Properly developed and managed, a communication plan that incorporates accurately identified and targeted audiences and stakeholders, clear objectives, performance measurement and a monitoring system could offer important support for CMHB's mission. During the course of the audit, the Division director indicated that press coverage was beginning to be tracked and monitored.

- The communication plan adopted by CMHB does not effectively address the current relationship between CMHB and the local media. During a four month period, eight articles appeared in local newspapers that could be characterized as unfavorable. Conversely, no favorable articles were published in that same time frame.

The communication plan should more effectively address the current media climate surrounding CMHB. CMHB should invest the necessary resources to improve its long-term relationship with the press. CMHB should assume a proactive role with the media to promote a positive image in the community. An effective relationship with the local media will enable CMHB to more easily garner support and build confidence among stakeholders in its ability to manage Cuyahoga County's mental health system.

Additional Findings and Recommendations

This section of the executive summary is organized by report section and highlights other findings and recommendations from those areas of the audit report. Each section of the audit report contains additional findings and recommendations.

Organization, Compliance and Board Governance

- While CMHB is in compliance with the majority of the Ohio Revised Code (ORC) and Ohio Administrative Code (OAC), it is not in full compliance with certain provisions, impacting CMHB's ability to operate efficiently and to improve performance.

  The report provides recommendations for each non-compliance issue, including the following major issues:

  - ODMH and Cuyahoga County should follow the directives in ORC §340.021 regarding the appointment of individuals to the BOG and ensure that any future appointments are clearly reflective of key demographic characteristics for Cuyahoga County.
  - BOG should take the necessary steps to ensure that all members are attending at least one inservice training session per year.
  - The executive specialist should be responsible for providing timely and proper notification to the appointing authorities when a vacancy occurs.
  - The appointing authorities should maintain a current list of prospective members to identify candidates in a more efficient manner, eliminating the amount of time that it takes to appoint new BOG members.
  - CMHB's executive specialist should be instructed to maintain formal BOG attendance sheets for all members.

- Franklin MHB has a more diverse group of board members than CMHB and effectively works with the appointing authorities to fill vacancies. According to Thomas Wolf and ORC § 340, board members should represent a variety of backgrounds as well as various segments of the community, including different minority and ethnic groups. Such diversity will give the board a broad vision and understanding of the meaning of community and public service.

An interest in the organization alone is not a sufficient reason to become a board member. The development of a skills inventory chart can be a mechanism for encouraging the board to analyze its needs.

BOG should develop a skills inventory chart to help analyze the needs of the governing body and to ensure effective representation from the community it serves. Effective representation will assist the BOG in developing policy, monitoring staff development, and choosing effective alternate courses of action. This skills inventory chart should be shared with the appropriate appointing authorities to ensure objectivity and that the needs of the BOG are being met.

- Several board members have expressed concern and frustration over having to routinely operate with less than a fully staffed board due to poor attendance and poor retention. Although State mandates allow CMHB to refer to the appointing authority any board member who is absent from four board meetings or two board meetings without prior notice for possible removal, it does not enforce this course of action, fearing that their removal would further add to the problem. By effectively addressing attendance issues immediately and professionally, BOG could be staffed by members who want to be involved, thereby increasing board member retention.

  The BOG chair should actively and immediately enforce attendance issues among board members to reduce the barriers of not meeting quorum. Enforcement should require a statement of recommitment or resignation from poor attending members. Furthermore, CMHB should work closely with the appointing authorities to stress the importance of timely appointments to fill vacancies.

- At CMHB, State reappointments require a different and more detailed set of requirements than the County's reappointments. Board member vacancies left unfilled for long periods of time have several negative effects on CMHB, including low morale among board members and a sense that poor communication between the BOG and the appointing authorities exists.

  The County should consider redefining board member reappointment criteria to more closely mirror the State's criteria and Franklin MHB's system. Additionally, the County should strive to make timely appointments to help in reducing board vacancies and increase a positive working relationship between the County and CMHB.

- CMHB's BOG has indicated collaboration with other boards, (i.e. Mental Retardation and Developmental Disabilities (MRDD), Alcohol and Drug Addition Services (ADAS), and other external stakeholders) does not consistently occur. Stark MHB is particularly active in involving external stakeholders by inviting them to participate in taskforce committees and scheduling annual meetings with each provider agency. Franklin MHB conducts biannual

board-to-board sessions with contracted providers and the board president to discuss various problems and issues.

CMHB's BOG should actively involve other peer boards, providers, consumers, and representative members of the community by inviting them to participate on a regular basis on committees and through scheduled, information sessions. Through more frequent interaction with external stakeholders, systems have a better chance of becoming more standardized; it is easier for the consumer to access services; and it allows providers to deliver services more efficiently.

Human Resources

- CMHB staff uses a high number of sick days. CMHB employees used an average of 9 sick days during FY 2001, which is 58 percent higher than sick leave used by the peers. The high usage of sick time suggests that employees may be dissatisfied with conditions at CMHB and are using sick time as a way to express their displeasure. The AOS employee survey noted that the overall morale and employee satisfaction of CMHB is negative. Furthermore, the employee survey indicated that staff is not satisfied with the current sick leave occurrence policy because it appears to be punitive.

  The HR director and CEO, with guidance from the County Prosecutor's Office, should rewrite the attendance/sick leave policy. The new policy should emphasize sick leave incentives over punitive measures. CMHB may also want to consider developing additional sick leave incentives. Prior to implementing a sick leave incentive program, CMHB should fully ensure that the policy is cost-effective by working with the CCHR and collective bargaining unit to establish adequate thresholds. CMHB can save approximately $48,000 annually by reducing the number of sick days taken by staff to the peer average.

- CMHB is the only mental health board in the State to have a collective bargaining agreement. In addition, CMHB's department average compensation is 17.5 percent higher than the peer average.

  Since some of the policies outlined in the collective bargaining agreement appear to be favorable to CMHB and employees, management should consider the following when negotiating future contracts: increase the probationary period to provide management with more detailed information to assess employee performance; adjust vacation accrual amounts to be more comparable to the peer average and Cuyahoga County; and negotiate merit based pay increases to replace guaranteed salary increases. CMHB could realize annual cost savings of approximately $30,000 by reducing its vacation accrual policy to be comparable to the peer average.

- The current CMHB personnel policy manual either does not cover certain topics or issues that should be in an effective personnel manual or those items are inadequately developed in certain sections. This is a result of the policy manual not being reviewed annually and updated as needed. The lack of clearly defined policies provides opportunities for unethical behavior to occur and can potentially increase an organization's liability. Additionally, communication with staff about management's expectations is reduced without descriptive policies that govern employee conduct.

  The HR director should work with the CEO, BOG, and Cuyahoga County Prosecutor's Office to develop or expand personnel policies. Once policies have been developed or expanded, the HR director should take steps to inform staff about the new policy changes. Developing adequate policies and expanding current policies can increase communication between management and staff, reduce CMHB's liability, and contribute to a uniform application of policies.

- CMHB's personnel files lack essential employee information and documents, such as copies of job descriptions, employee performance evaluations and documentation of training and education. Personnel files not containing required information may violate State laws and create opportunities for complaints and grievances. The HR director has begun to reorganize the employee files since September 2001.

  CMHB should complete the reorganization of its employee files, and ensure that all of the elements required by OAC are included. Keeping human resource records that contain the required elements will help the department better administer human resource policies and provide documentation to drive human resource activities.

Finance and Funding

- Although CMHB does not have a full-time position dedicated to provider audits, Franklin MHB has 1.0 FTE dedicated to working closely with the contracted providers and private auditing firms that conduct the annual financial audits of the contracted providers. By having a provider audits position, Franklin MHB is proactive in providing financial assistance to its contracted providers to ensure appropriate financial reporting and records, and that the contracted providers are effectively managing funding provided by Franklin MHB.

  CMHB should consider adding a position in the Finance Unit to work closely with the contracted providers and private auditing firms during the financial audits. This position should work closely in helping the contracted providers correct problem areas and ensure that contracted providers are using sound financial and business practices. Based on Franklin MHB, CMHB would incur approximately $65,000 annually in salary and benefits costs by employing a provider audits position.

- CMHB does not have an effective and technologically up-to-date internal accounting system. As a result, CMHB can not easily track and monitor expenditures by line item. In addition, the lack of an effective accounting system precludes the Finance Unit from doing many functions easily, such as preparing financial reports and budgets, and analyzing costs. These processes need to be manually entered on various spreadsheet reports and analyzed for information. Manual data entry could lead to errors and to information being reported incorrectly, as well as requiring additional staff time to manually enter all of the required data.

  CMHB should consider purchasing a new internal accounting system. However, prior to purchasing a new accounting system, the Finance Unit should fully evaluate benefits and costs of various systems and ensure that the new system will allow the Finance Unit to easily perform basic functions including tracking and monitoring expenditures by line item and by division. Implementing a new accounting system would allow the Finance Unit to function more efficiently and eliminate potential errors from the present system because data would not be manually transferred to spreadsheets. Based on information received from a computer vendor, it could cost CMHB approximately $30,000 to implement a new internal accounting system.

- The budget CMHB has presented to the Cuyahoga County's Office of Budget and Management (OBM) since 2000 does not contain adequate financial or written details to justify the funds requested. GFOA states that the budget document should be detailed to communicate key fiscal and policy decisions, issues, and tradeoffs. By generating a more detailed and comprehensive budget, CMHB would provide sufficient support that it is striving to maintain costs and to provide quality services to mental health consumers.

  The budget submitted to OBM and the County should contain adequate details of plans and proposals to justify requests, including suggestions made by GFOA. Before new requests are incorporated into the budget, CMHB should fully explain and justify the request with appropriate documentation and analysis. The existing budget should be subjected to a similar review and all spending plans should be thoroughly documented, providing the justification for requests as suggested by GFOA.

- As a result of presenting a budget to the County based on the State's Fiscal Year, CMHB and the County are unable to adequately perform budget comparisons. Franklin MHB budgets on the county calendar year while still providing the necessary budget information to ODMH by developing effective budgeting processes. Franklin MHB developed a five year forecast to appropriately plan for costs in future years, updates the forecast annually, and uses the updated forecast to provide the county with a calendar year budget. However, CMHB has not developed a five year forecast and does not consider a fiscal year over until almost all providers for the fiscal year have been reimbursed. In contrast, Franklin MHB formulated a

policy that any billing submitted after August 4th would be for the new fiscal year, which is only for its internal record keeping.

CMHB should work with OBM and the County to present a fair and accurate estimate of future budgets and costs for upcoming calendar years. CMHB would achieve a correct matching of accounting periods by presenting a calendar year budget to the County, which would allow a comparison of actual to budget data to be presented and reported by CMHB. To accomplish this, CMHB should perform the necessary planning to adequately prepare budgets as discussed throughout this section of the report. In addition, CMHB should establish an internal record keeping policy, which establishes a cut-off date for billings.

Technology Use and Claims Services

- CMS Unit job descriptions do not identify a position to provide appropriate backup in the absence of the claims manager. Although managerial coverage for the MIS director is not outlined within the MIS Unit, direction or authority regarding major information systems issues is available through CMHB's current outsourcing agreement with Active Networking, Inc. The agreement ensures availability of ongoing technical support to CMHB in the director's absence.

  The MIS director and claims manager should work with the Human Resources Unit to establish a team leader position among the claims/membership specialists to assume supervisory leadership in the absence of the CMS manager, and among MIS support staff to provide back up in the absence of the MIS director. This ensures a leadership presence in the absence of either supervisor. A backup position, in coordination with the disaster recovery plan, reduces CMHB's risk of failure in submitting accurate and timely data or providing security for MACSIS, should the MIS director become unavailable.

- Outsourcing for information technology services is expanding at CMHB and, within the past year, outsourcing expenditures have nearly doubled. These expenditures have increased primarily due to one-time costs associated with upgrading the network operating system and firewall, as well as redesigning the network architecture. Entities may consider outsourcing discrete projects that involve complex integration processes and highly technical applications, for which the entity does not have the expertise.

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  Although industry norms suggest an increased need for outsourcing in the technology field, CMHB can more effectively control outsourcing costs by obtaining competitive quotes from vendors and maintaining detailed monthly documentation of all outsourced functions. CMHB can effectively control costs and manage its need to outsource by assessing internal capabilities and including training as part of future outsourcing contracts. Improving the skill

sets of current MIS staff through training will allow certain previously outsourced tasks to be performed internally, and therefore, will help to reduce future outsourcing costs.

- Despite efforts to replace desktop PCs with Citrix, a multi-user system, CMHB does not have a formal technology equipment replacement plan to guide technology purchases. Best practices in technology recommend a two-year written and budgeted plan for the replacement of equipment, which helps disperse large capital equipment costs over a period of time rather than absorbing costs all at once. A formal technology replacement plan would enable the MIS Unit to anticipate future technology needs and budget for them accordingly.

  The Executive Committee should appoint a taskforce to write a technology equipment replacement plan. The technology replacement plan could become one of the MIS Unit's short-term goals and should be tied to the recommended strategic technology plan. Maintaining properly functioning equipment enhances user satisfaction and increases efficiency.

- CMHB is not connected to the County's Wide Area Network (WAN), and therefore, the Finance Unit is unable to access FAMIS, the County's mainframe for accounting applications. Without this access, the Finance Unit is unable to answer payment status questions from vendors and providers. Long processing cycles contribute to the number of provider inquiries. FAMIS inquiry-only access would allow for real time review of vendor and provider payment status information.

  The MIS director should facilitate measures for appropriate CMHB employees to gain access to FAMIS via the Internet. In addition to determining the status of provider claims, other pertinent accounting information could be shared electronically through the Internet. Gaining FAMIS inquiry-only access would allow staff members to more readily track, process and determine payment status of provider claims.

- CMHB does not use one standard office application, as employees use both Corel Office Suite and Microsoft Office for word processing, spreadsheet, and basic database applications. Maintaining both office suites can impact file sharing efficiencies internally among CMHB units and externally with contracted providers. There are also costs associated with future upgrades that may not be as significant if CMHB chooses one office suite over the other.

  CMHB should require standardized use of one office suite software application to more efficiently enable file sharing among units and contracted providers. Standardization of file sharing enhances internal communications and extends a higher level of service to providers through user-friendly technology.

Risk Management and Consumer Affairs

- CMHB's provider contracts lack detailed descriptions and expectations for both Medicaid and non-Medicaid services. For instance, if a Medicaid contract states the agency will provide services for crisis intervention, CMHB does not include specifics as to how these services must be provided and what is expected of the agency providing them. The same situation exists for non-Medicaid services.

  CMHB should develop a standard "scope-of-service" definition for Medicaid services eligible for State funding. These definitions should be included in Attachment 4 according to the specific services being provided and should include performance measurements and benchmarks where applicable. Since most of the contracts at CMHB are for Medicaid services, only one definition for each is necessary. This should help ensure continuity of service among providers since all providers would work from the same scope of services and definitions. In addition, CMHB should develop standard scope definitions for common non-Medicaid services as well. By including specific expectations and deliverables for all Medicaid and non-Medicaid services in the contract, not only will CMHB be able to track individual provider service, it will also help to standardize mental health services in Cuyahoga County by requiring all providers to work from the same set of expectations.

- CMHB does not have a plan or policy in place which defines risk management. Although an entire unit is named for risk management, there is not a comprehensive policy directing risk management efforts at CMHB. As a result, risk management is largely an ad-hoc process which consists mainly of legal consultation for BOG. While it appears CMHB has procedures in place addressing some areas of risk management, such as liability insurance and building inspection, the direction of these efforts is not concentrated in the RM Unit, nor are the efforts formally defined.

  BOG, in conjunction with risk management staff, should develop an overall risk management policy. This policy should address both internal and external risk management procedures including those related to personnel, insurance and liability, and physical structures. Furthermore, risk management position descriptions should reflect the tenets of this policy. CMHB should also assess the costs and benefits associated with contracting for risk management services from an outside consultant.

- Documents that constitute CMHB's grievance procedure, as required by OAC 5122:2-1-02 (H), are not consolidated or up-to-date. Having an up-to-date procedure would communicate clear performance expectations to consumers and other individuals filing a grievance.

  The CA Unit should consolidate relevant and compliant information from the 1988 *Client Rights and Grievance Policy*, the 1992 *Grievance Procedure* and the 1998 *Rights as a*

Consumer into one document, which would serve as CMHB's grievance procedure. The new procedure should also reflect current CA Unit practices and provide updated contact information for outside entities. The language used in the procedure should permit flexibility in responding to and resolving unique situations. Consumer affairs staff should annually verify contact information and make any necessary changes.

- CMHB does not disseminate a pamphlet which clearly and concisely details client rights to consumers and the public at large. In order to exercise their rights, consumers and family members must fully understand the client rights and grievance procedures.

  The CA Unit should develop a client rights pamphlet which is clear and concise. The pamphlet should list the 22 client rights listed in OAC 5122:2-1-02 and describe them using language which is easy to follow and to comprehend. To ensure the language used does not limit a client's rights in any way, the CA Unit should consult with the County Prosecutor and ODMH. Contact information for CMHB, ODMH, DHHS and relevant licensing boards should be included. The pamphlet should also be shared with contracted providers in electronic format.

Planning and System Development

- PSD and other divisions do not coordinate effectively to enhance mental health system planning. This is partially due to vacancies at the management level for CMHB divisions (see **human resources**). Without a formal mechanism to incorporate information from other divisions, PSD plans may not address all service needs and trends, reducing plan quality.

  The chief of PSD, in collaboration with PSD administrators, and the COO should improve and develop methods to incorporate input and information from other divisions into planning. PSD should meet regularly with other divisions to discuss how information can be shared. Options to improve coordination between CMHB divisions and PSD include enhancing planning and quality improvement staff ability to analyze system-wide outcomes, including the MIS Unit during plan development, including the External Affairs Division when communicating planning initiatives and new programs to the community, and improving the ability of planning, and PRQS staff to identify and share best practices and service needs with other divisions.

- MSPA priorities and CMHB planning are not clearly linked. In addition, CMHB does not use its Mutual Systems Performance Agreement (MSPA) as a guide to monitor the mental health system of Cuyahoga County and address quality service issues. Through the MSPA, ODMH is aware of county mental health board planning activities to improve and measure system performance. The MSPA agreement between ODMH and CMHB is ineffective if plans do not state how goals will be measured in relation to MSPA priorities and clearly

defined performance outcomes. Detailed information on the progress of CMHB plans could be reported on MSPA, and ODMH would be better informed on CMHB planning activities.

PSD planning initiatives should reflect MSPA priorities. Designing plans based on the MSPA would result in a standardized process for development and data tracking. Additionally, PSD planning would more effectively reflect ODMH priorities. Moreover, CMHB should use the MSPA as a guide for monitoring the mental health system in Cuyahoga County and proactively address each identified area to provide quality services for consumers.

- CMHB does not always develop a Memorandum of Understanding (MOU) when collaborating with other agencies to develop and fund programs. A formal memorandum of understanding (MOU) would provide written policies, procedures, and practices for regular meetings between staff, and outline how information would be shared. Without a formal process for collaboration, addressing the needs of persons with multiple diagnoses may not be accomplished efficiently or effectively.

  The chief of PSD, in collaboration with risk management staff, should fully develop formal relationships with the Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CMRDD), the Alcohol and Drug Addition Services Board (ADAS), the Bureau of Vocational Rehabilitation (BVR) and other external organizations. MOUs can be used when organizations have mutual objectives, are able to work together to leverage funding, and receive shared benefits by better defining lines of communication and responsibilities. Formal agreements can help address issues of service duplication, program deficiencies, timeliness of referrals, and other systemic problems. Outlining the responsibilities and guidelines for organizations to work together on joint projects and initiatives could result in additional system funding as well.

Provider Relations and Quality Services

- CMHB's preference of auditing a larger number of Medicaid and non-Medicaid billings as compared to the peers is reflected in the significantly higher average number of billings sampled per case by CMHB (19.3) as compared to the peer average (6.6). Of CMHB's billings sampled, 25 percent were non-Medicaid claims. According to the manager of Auditing, CMHB audits non-Medicaid claims to ensure that these billings are held to the same standards as Medicaid claims. Franklin MHB has stated that over time, it has found that contracted providers hold non-Medicaid claims to the same standards as Medicaid claims. This may be in part due to contracted providers not knowing which claims will be sampled and being held accountable for a plan of correction (POC) and recovery of funds, as is the case with Medicaid claims.

The Auditing Unit should determine whether, over time, its contracted providers have traditionally held non-Medicaid claims to the same standards as Medicaid claims, in order to reduce the amount of non-Medicaid billings sampled. Upon completion of this analysis and the determination of whether to engage in selective contracting for non-Medicaid services, the Auditing Unit should be able to better determine whether it is justified in continuing to audit its current level of non-Medicaid claims.

- Individualized Service Plan (ISP) documentation (problematic billing) was found to be the most prevalent problem discovered during the auditing process for FY 2001 at CMHB. During FY 2000, the Auditing Unit conducted a documentation training (train-the-trainer) to assist in efforts to reduce problematic and ineligible billing, but this was the last time the training was offered to contracted providers. Training that is relevant and customized can assist the Auditing Unit in preparing contracted providers for audit reviews as well as to clarify misinterpretations.

  The Auditing Unit should become proactive in its efforts to reduce the amount of non-compliant and problematic billings submitted by re-establishing its documentation training (train-the-trainer). In addition to continuing to consult with ODMH to minimize subjectivity, CMHB should work with ODMH to combine efforts in providing training, such as formal training to reduce the subjectivity involved with interpreting the narrative content of billings. Furthermore, accomplishing this objective could enable contracted providers to develop staff experts in documentation who are able to train staff as needed, and as contracted providers experience staff turnover.

- CMHB relies on County agencies and advocacy groups to investigate MUI reports. Because CMHB is responsible for monitoring the care provided to mental health consumers, it would be beneficial for them to actively participate in the investigations and educate other County agencies on their care. Peer MHBs rely on collaboration from other county agencies, conduct frequent site visits and closely monitor activities at contracted providers which allows problem areas to be addressed in a timely manner.

  CMHB should develop a memorandum of understanding with all other County agencies to ensure its awareness of all reported incidents. This would help to foster a good working relationship with key protection agencies throughout the County, such as the Department of Children and Family Services, Adult and Senior Services, police departments, and large area hospitals. Close collaboration and monitoring of such incidents could potentially reduce the number of MUIs occurring and reported to CMHB.

- The PR Unit's single point of contact model for contracted providers has not functioned effectively. Although Franklin MHB previously had a single point of contact model, it has since eliminated this practice after finding that the process was time consuming and learning

that the PR staff was unable to answer MACSIS and billing questions. Franklin MHB has also established customer standards that outline accountability and communication standards for its units to the PR team. According to the PR Unit, it was communicated to all CMHB employees in a staff meeting that the Unit would no longer be a single point of contact. However, providers interviewed during this performance audit were not informed of this change and job descriptions in the PR Unit have not been updated to reflect this change.

The PR Unit should not be the single point of contact for all inquiries made by contracted providers. CMHB should inform the contracted providers of this change and update job descriptions in the PR Unit to reflect this change. CMHB should design customer service standards outlining information routing protocols that will clarify the responsibilities of units regarding sending information to the PR Unit. Written guidelines and expectations for contracted provider contact with the PR Unit and other CMHB units should be developed and sent to all contracted providers. The implementation of these procedures could assist in ensuring consistent service delivery.

- CMHB has no training, including CSP, that mandates contracted providers' attendance. Without CSP training, contracted providers may have workers delivering mental health services at various skill levels, and who may not have had any formal training in their current positions.

  CMHB should consider re-establishing its CSP training (14 modules) as a mandatory training and including the requirement in its contracts with contracted providers. Additionally, CMHB should inform providers in advance which training is mandatory. CMHB should also re-evaluate its training schedule to better accommodate the needs of contracted providers. Establishing mandatory training can assist CMHB in creating a continuity of learning and understanding across contracted providers, and can also have a positive impact in contracted providers' overall performance and consumer satisfaction.

External Affairs

- The assumed roles of Division staff do not reflect the responsibilities defined by formal job descriptions and do not serve as the most effective use of the experience and expertise typically expected of director and manager positions. Because the duties performed by Division staff do not necessarily reflect formal responsibilities in accordance with job descriptions, Division staff risk duplicating assumed duties and performing tasks atypical of particular skill sets.

  CMHB should review the job descriptions and assumed roles of the director and manager of the Division to ensure the most effective and efficient use of their experience and expertise. The Division director should be expected to complete the responsibilities assigned to that

position. Some of the responsibilities assumed by the director should be delegated to the manager, such as newsletter development, press releases and legislative updates.

- CMHB has placed a high priority on the creation of a website for this year. Although the website was not complete as of May 2002, it was available for some minor viewing. The website will be launched the first full week of October 2002, as part of Mental Illness Awareness Week. Without a fully operational website, CMHB may miss opportunities to educate and provide guidance to those in need of mental health services.

  CMHB should continue to place a high priority on the development of its website. CMHB should also plan for the periodic evaluation, measurement and revision of the website for content, effectiveness, efficiency, service quality and usefulness. CMHB should also review readily available resources that could be included in its website to provide additional information to its users.

- CMHB does not regularly publish or facilitate the publication of any newsletters to provide current, pertinent, and accurate information to consumers, contracted providers, employees and/or the community at large regarding CMHB and mental health. Without CMHB produced publications, the community, consumers, family members, contracted providers and employees are forced to rely on local media coverage to disseminate information about CMHB, its activities, accomplishments and goals. Historically, CMHB published a general newsletter, *Forecast*. It has not been published since 1999; although the next publication date is slated for September 2002.

  CMHB should publish or facilitate the publication of several types of newsletters to provide current, pertinent, and accurate information to its consumers, contracted providers, employees and the community at large regarding CMHB and mental health. By developing its own publications, CMHB would be able to influence and gain more control over the information available to the public, as opposed to relying solely on local commercial media. By providing current and past publications on the CMHB website, similar to other county mental health boards, CMHB would also enhance the quality of information available to all interested web users.

Commendations

This section of the executive summary highlights specific commendations contained in the audit report. Each section of the audit report contains additional commendations.

- Contractual language providing management with decision-making authority necessary to effectively manage the employee workforce empowers CMHB with the flexibility to make sound personnel decisions. As a result, personnel issues can be reduced at CMHB.

- The use of a team approach to interviewing potential clients is an effective means of choosing candidates. The HR director and management have found that using both a team interview process and structured questions has had positive effects.

- The Finance Unit appears to be adequately staffed and appears to be maximizing output with minimal staffing resources. Establishing staffing of the Finance Unit at an appropriate level ensures that the work is being completed effectively while efficiently using resources.

- Having designated CSP training for direct service staff indicates that CMHB is devoted to supporting an area of employment that historically has a high percentage of turnover. These trainings provide needed support to direct service workers in meeting the needs of a challenging population that has many needs.

- CMHB's efforts to reduce bed day use by forming a bed day work group have succeeded in discharging consumers from hospital care and reducing the cost to CMHB for hospital care. The group has also identified target areas to further reduce bed day use for County consumers.

- The establishment of eight ACT teams in the County is a good start to providing effective services for consumers and has potentially prevented the re-hospitalization of participating consumers. Additionally, CMHB's commitment to providing continuing education to ACT teams continually improves the quality of the ACT services and enhances the knowledge base of ACT service providers.

- The MIS Unit has provided for the effective development of its technical architecture using Citrix and Ethernet upgrades. CMHB will realize greater information system efficiency as a result of the upgrade.

- CMHB effectively plans vocational/employment services by working with the Employment Alliance to meet consumer needs. Obtaining stable employment and job skills aids consumers in recovery and overcoming stigma associated with mental illness.

- Consumer affairs and risk management are the only units in CMHB that develop formal annual goals. RMCA's annual goals provide clear direction for staff.

- Effective maintenance of the consumer affairs database helps CMHB keep accurate and confidential client rights information. Entering each contact into the consumer affairs database ensures the numbers generated for internal and external reports are accurate.

- The CRO's unscheduled visits ensure that contracted providers comply with OAC requirements, and therefore, support consumers' right to grieve and lodge complaints. This practice is necessary because 85 percent, or 29 out of 34, contracted providers visited in FY 2001 were noncompliant.

- CRO Focus Group meetings provide a forum for contracted provider CROs to discuss client rights practices, share experiences, and offer input to CMHB. As a result of the CRO Focus Group, the CA Unit more directly involves its stakeholders and offers them a sense of ownership in CMHB activities.

- Through its legislative awareness program, CMHB and the director of the Division have developed a process to educate a large number of stakeholders on pertinent legislation impacting mental health.

- CMHB has extended its community outreach efforts through the Helping Hands awards and the Kathleen Burton awards. Through the public recognition of commendable service, CMHB fosters relationships with individuals and organizations who share common goals.

Summary of Financial Implications

The following table summarizes the performance audit recommendations which contain financial implications. These recommendations provide a series of ideas or suggestions which CMHB should consider when making the important decisions necessary to improve the effectiveness and efficiency of its operations while continuing to meet the needs of mental health consumers in Cuyahoga County. Certain recommendations are dependent on labor negotiations or community approval. Detailed information concerning the financial implications, including assumptions, is contained within the individual sections of the performance audit.

Summary of Financial Implications

Ref. No.	Recommendation	Estimated Cost Savings (Annual)	Estimated Implementation Costs (One-time)	Estimated Implementation Cost (Annual)
Organization, Compliance and Board Governance				
R2.3	Fill three vacant chief positions.			$325,000
R2.6	Promote one administrative assistant to the position of office manager.			$3,000
Human Resources				
R3.1	Fill the vacant Human Resources specialist position.			$47,300
R3.4	Reduce the number of sick days.	$48,000		
R3.10	Reduce vacation accrual policy.	$30,000		
R3.19	Purchase performance appraisal pamphlets.		$250	
R3.24	Purchase Drug Free Work Place pamphlets and implement drug testing.		$90	$250
R3.26	Avoid potential fines for I-9 Form non-compliance.	$59,000 [1]		
Finance and Funding				
R4.1	Employ a position to work closely in the financial audits of contracted providers.			$65,000
R4.7	Implement a new accounting system.		$30,000	
R4.8	Cost of an annual financial audit.			$20,000
R4.15	Attend GFOA training.		$7,000	
R4.23	Effectively control mental health cost.	$830,000		
Technology Use and Claims Services				
R5.12	Phase out use of individual printers and increase use of the four shared network printers.	$2,800		

Ref. No.	Recommendation	Estimated Cost Savings (Annual)	Estimated Implementation Costs (One-time)	Estimated Implementation Cost (Annual)
R5.13	Replace Bud server and reduce associated outsourcing costs.	$1,500	$4,500	
Risk Management and Consumer Affairs				
R6.1	Eliminate the vacant risk management specialist position.	$50,000 [1]		
R6.2	Reduce the administrative assistant position to half-time by transferring the current administrative assistant to fill the human resource specialist position.	$24,000		
Planning and System Development				
R7.1	Reduce PSD staffing levels by one FTE.	$38,000		
R7.10	Develop more plans internally, without consultants.	$30,000		
Provider Relations and Quality Services				
R8.29	Reduce one PR manager and one PR specialist positions.	$125,900		
R8.37	Do not fill vacant Education and Training Manager position.	$68,000 [1]		
R8.37	Reduce 1.0 FTE in the Education and Training Unit.	$39,000		
R8.42	Use CMHB staff to conduct CSP training.	$4,000		
R8.47	Do not fill vacant UR specialist position.	$58,600 [1]		
R8.48	Reduce bed days and admissions to state hospitals.	$1,700,000		
Totals		**$3,108,800**	**$41,840**	**$460,550**

[1] Amount represents annual cost avoidance.

Organization, Compliance and Board Governance

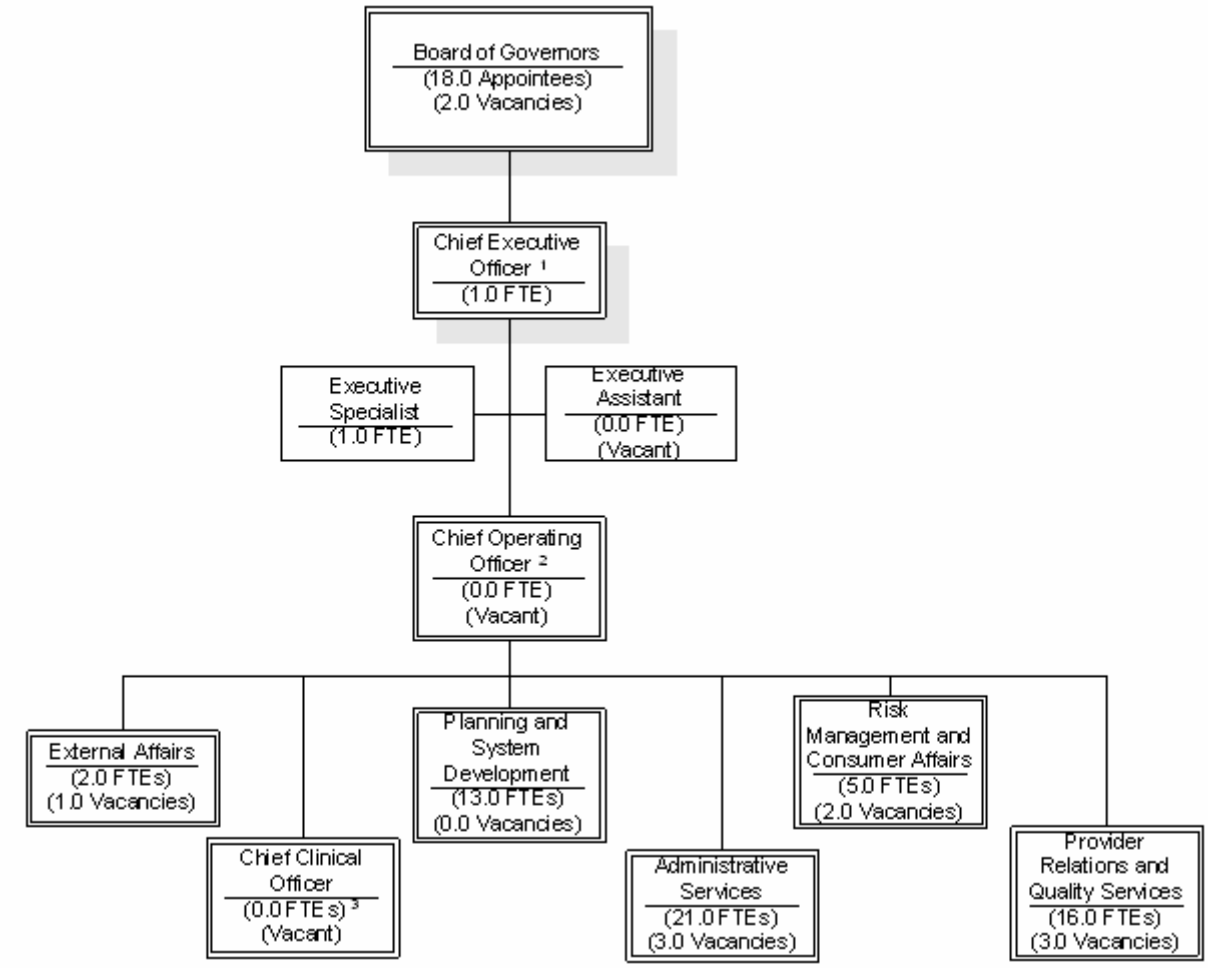
Background

This section focuses on the organizational structure, compliance and board governance of the Cuyahoga County Community Mental Health Board (CMHB). Comparisons are made throughout the report to the peer mental health boards in Franklin, Lucas and Stark Counties.

Organizational Chart

The functions of CMHB are carried out by various divisions. **Chart 2-1** illustrates the organizational structure and the number of full-time equivalent (FTE) employees at CMHB as of January 2002. For the purposes of this analysis, full-time equivalents are calculated based on a 37.5 hour work week because this is CMHB and Cuyahoga County's definition of a FTE.

Chart 2-1: Organizational Structure



[1] The chief of Planning and System Development served as the Acting CEO during the course of the audit. The CEO position has now been filled.
[2] The Chief Operating Officer position was vacant during the course of the audit. However, this position is currently filled.
[3] The Chief Clinical Officer position was vacant during the course of the audit. However, this position is currently filled.

Organizational Function

CMHB is an agency legislated by the Ohio Revised Code (ORC) §340.02.1(A) in order to develop a system that will allow persons with mental illness and children with emotional disturbances to have access to quality services and programs. These services and programs are tailored to the needs of all individuals in order to manage and improve their illness and allow

them to lead lives at an optimum level in the least restrictive setting available. CMHB does not provide these programs directly to persons with mental illness, but enters into contracts with providers who will supply these services. The main responsibilities of CMHB are to:

- Ensure mental health services are available to any persons residing in the County, (see the **finance and funding**, **planning and system development**, and **provider relations and quality services** sections);
- Plan for mental health services and recovery care that these individuals need, (see the **planning and system development** section);
- Contract with local providers to work as a system, (see the **risk management and consumer affairs** section);
- Fund services from local, state and federal sources, (see the **finance and funding** section) and;
- Monitor services to ensure that quality programs are provided and not duplicated, (see the **provider relations and quality services** section).

CMHB is one of 50 local mental health boards created in Ohio to build service systems. There are currently 43 combined Alcohol Drug and Mental Health Boards located in Ohio, while there are seven independent Mental Health Boards (MHBs) in the state. MHBs were established in 1967 with the passage of H.B. 648 in order to provide more appropriate care for individuals with mental illness. In 1971, MHBs were given the additional responsibility of developing community drug abuse programs and services. Until 1980, MHBs had mental health and mental retardation responsibilities, although their primary activity was in the area of community mental health services. However, S.B. 160, enacted in 1980, removed the responsibility for mental retardation services from MHBs and consolidated them within the creation of County Boards of Mental Retardation and Development Disabilities. In addition, this legislation clearly defined MHBs as the public agency responsible for planning, funding, monitoring and evaluating community mental health services at the county level.

The Mental Health Act of 1988 emphasized the importance and appropriateness of community-based services and the need to combine inpatient and community-based mental health services. The Act also recognized the importance of a community support system that could address human needs such as basic healthcare, housing and employment, along with mental health needs of citizens. During this time, MHBs were not only in charge of providing community-based mental health services, but also were given responsibility for providing drug abuse services. While the services being provided were meeting the needs of many people, the delivery of both community mental health services and alcohol and drug abuse services was often duplicative.

In 1989, the Alcohol and Drug Addiction Services Act created legislation which placed additional responsibility for expanding alcohol related services with community mental health boards. In all but seven of Ohio's most populous counties, MHBs were renamed Boards of Alcohol, Drug Addiction and Mental Health Services to reflect their additional duties. Public

officials in the seven counties chose to maintain the MHBs while establishing a separate Alcohol and Drug Addiction Services Board to help meet any chemical dependency needs in the county.

Summary of Operations

CMHB is organized into seven divisions: Executive Staff, Support for Executive Staff, External Affairs, Planning and System Development, Administrative Services, Risk Management and Consumer Affairs, and Provider Relations and Quality Services. CMHB is overseen by the appointed Board of Governors (BOG). The duties and responsibilities of CMHB divisions are as follows:

- The Executive Staff includes the positions of chief executive officer (CEO), chief clinical officer (CCO) and chief operating officer (COO) who provide overall leadership and oversight of CMHB's daily operations.

- Support for Executive Staff includes an executive specialist, who provides administrative functions for the BOG, and an executive assistant position, which is currently vacant.

- External Affairs is responsible for assisting BOG in relations with the external environment to promote mental health issues in the community. External Affairs staff also assists BOG to promote positive relations with public officials concerning mental health issues.

- Planning and System Development creates various program plans for adults, children and families receiving mental health services. This Division also looks for opportunities to enhance CMHB funding through the receipt of grants on the federal and state level.

- Administrative Services is comprised of Human Resources (HR), Management Information Systems (MIS), Finance and the Claims/Membership Units. The HR Unit monitors the implementation of personnel policies and procedures, recruits potential staff members, and oversees benefits administration and payroll. MIS implements and monitors access to the Multi-Agency Community Services Information System (MACSIS) to ensure that it interfaces with the Ohio Department of Mental Health (ODMH). MIS also must process data and provide information to the Board of Governors (BOG). The Finance Unit oversees the cash flow and operational expenditures for CMHB to ensure compliance with all required rules and regulations pertaining to the processing of federal, state and county funds. In addition, the Finance Unit requests and analyzes all audit reports from providers. The Claims/Membership Unit operates the MACSIS claims processing system to ensure that clients are properly enrolled, and that provider claims are processed in timely manner.

- Risk Management and Consumer Affairs is composed of two separate units. Risk Management is responsible for the creation of contracts with providers, and the chief of risk management serves as liaison to the legal counsel, which is the Cuyahoga County

Prosecutor's Office. Consumer Affairs monitors and investigates consumer complaints and grievances along with providing consultation to providers concerning appeals.

- Provider Relations and Quality Services includes the following units: Auditing, Utilization Review, Quality Improvement, Education and Training, and Provider Relations. Auditing conducts Medicaid compliance audits of all provider agencies contracting with CMHB as mandated by the Ohio Administrative Code (OAC). Utilization Review provides oversight of inpatient care for mental health consumers. Quality Improvement functions as gatekeeper for all quality assurance activities with CMHB and with contracted providers as directed by ODMH. Education and Training provides external training to contracted providers, while Provider Relations manages business relationships with agencies and also serves as the primary contact for providers.

The structure and role of the BOG is mandated by the ORC § 340.03. BOG is required to have 18 members; six of these members are appointed by the Ohio Department of Mental Health (ODMH) and 12 by the county commissioners. Additionally, ORC §340.03 requires the following membership structure:

- One member must be a former or current recipient of mental health services;
- One member must be a parent or relative of a recipient;
- One member must be psychiatrist or medical doctor;
- One member must be a mental health professional;
- The compilation of the board must reflect the population of the service district in regard to race and gender;
- All members must live in the county and be interested in mental health; and
- No member may have a family member or be professionally affiliated with other board members, mental health boards or provider boards.

Board members serve for a term of four years and may serve a total of two terms. In the event that a board member is appointed to serve out the remainder of a removed member's term, an additional two terms is permitted. Members are eligible for reappointment after one year of non-service.

BOG elects officers every year. The officers consist of a chairperson, a vice-chairperson, and a second vice-chairperson. At the April general meeting, a nominating committee of three members, appointed by the board chairperson, nominates candidates for the offices to be filled at the June general meeting. The nominating committee reports their nominations at the May general meeting. Before the election at the general meeting in June, additional nominations from the floor are permitted.

In addition to the membership requirements, the BOG is required to select a chief executive officer (CEO). The CEO reports directly to the BOG and should be a mental health professional with experience in administration or be a professional administrator with mental health experience. As of June 2002, a full-time CEO was hired to provide executive leadership for CMHB.

Committees

CMHB has documented seven standing committees, including the multi-cultural concerns committee and strategic planning committee which are both currently inactive. All other committees meet monthly and are comprised of only BOG members. Each committee chair is appointed by the BOG chairperson. The following listing is a description of each:

The Executive Committee. This committee consists of six members including BOG officers and committee chairpersons. BOG officers are Chairperson, Vice-Chairperson, and Second Vice-Chairperson. This committee is designed to provide oversight, consultation, and collaboration with all standing committees; review and approve board and system policies, and evaluate the annual performance of the executive director.

The Program Planning Committee. This committee consists of eight members (two of whom have recently resigned). This committee is responsible for reviewing current plans and developing new plans as they relate to the mental health consumer and provider. For more information, see the **planning and system development** section of this report.

The Operations and Finance Committee. Comprised of seven members, this committee reviews fiscal operations and funding sources, and approves all expenditures and contracts before they are referred to the full Board. For more information, see the **finance and funding** section of this report.

Quality Improvement Committee. The function of this committee is to provide feedback on the monitoring of contracts to the full Board and develop broader standards for quality assurance. Additionally, this committee recommends policies to improve quality to the full Board. For more information, see the **provider relations and quality services** section of this report.

Communications and Government Affairs Committee. The function of this committee is to help the Board manage its external environment; to develop an overall communication plan for the Board; and to plan and prepare for Board sponsored events with area legislators, elected officials, consumers, and families. Four members comprise this committee. For more information, see the **external affairs** section.

Multi-Cultural Concerns Committee. Although currently inactive, this committee was designed to develop and recommend multicultural policies, identify multicultural needs with input from diverse ethnic groups, provide oversight by introducing these issues to the full board, and to develop cultural competence throughout the system. For more information, see the **planning and system development** section.

Additionally, CMHB periodically appoints ad hoc committees to assist in more specialized and less frequent activities (e.g., the Search Committee, the Recruitment Committee, and the Nominating Committee). Two Search Committees were recently appointed by the BOG chairperson to assist in the selection of a chief executive officer and a chief clinical officer. The Recruitment Committee was appointed due to the current five vacancies and the term expiration of four additional board members. A Nominating Committee is appointed every April by the BOG chairperson to recommend officer candidates for election. Ad hoc committees may meet more frequently than monthly and disband once their charter has been fulfilled.

Staffing Levels

Table 2-1 presents budgeted positions and current staffing levels for CMHB as of January 2002. The staffing levels are presented by the following divisions and units: Executive Staff, Support for Executive Staff, External Affairs, Planning and System Development, Administrative Services, Risk Management and Consumer Affairs, and Provider Relations and Quality Services.

Table 2-1: CMHB Staffing as of January 2002

Function/Position	Actual Budgeted Positions	Actual Filled Positions	Percent of Actual Filled Positions
Executive Staff [1]	3.0	1.0	33.3%
Support Staff for Executive Staff	2.0	1.0	50.0%
External Affairs	3.0	2.0	66.7%
Planning and System Development	13.0	13.0	100.0%
Administrative Services	24.0	21.0	88.0%
Risk Management and Consumer Affairs	7.0	5.0	71.0%
Provider Relations and Quality Services	19.0	16.0	84.0%
Total Staff	**71.0**	**59.0**	**83.0%**

Source: CMHB Organizational Charts

[1] Executive Staff includes the positions of chief executive officer, chief clinical officer, chief operating officer. The CEO position is currently filled by an Acting CEO.

CMHB had 59 actual employees with 12 vacancies as of January 2002. As a result, 17 percent of CMHB's positions were vacant.

Provider Survey

A provider survey was distributed to 38 providers that have contracts with CMHB. The purpose was to obtain providers' feedback and perceptions of their interactions with CMHB. Responses were received from 21 providers, for a response rate of 55 percent.

The survey solicited responses to 40 statements concerning providers' working relationships with CMHB staff and understanding of CMHB procedures. Questions included scale ranking, yes/no and written responses. The scale was defined in the following manner: Yes/No, or 6 - Excellent, 5 - Good, 4 - Average, 3 - Fair, 2 - Poor. The following statements highlight key findings of the employee survey.

- Nearly 95 percent of providers do not feel that there is an appropriate amount of mental health programs for residents of Cuyahoga County.
- According to 57 percent of providers, they do not receive timely answers regarding the annual Medicaid budget and planning process.
- 71 percent of providers believe that there are new funding streams which could be introduced into the mental health system in Cuyahoga County.
- Providers are not satisfied with CMHB's planning process as indicated by an average response of 2.6.
- Nearly 57 percent of providers do not feel that requests for new services and programs are well received by CMHB.
- Nearly 48 percent of providers do not believe that reimbursement questions are answered promptly by CMHB.

The complete survey results are shown in **Table 2-2.**

Table 2-2: CMHB Provider Survey

CMHB Attributes	Provider Average	Corresponding Section
1) Is there an appropriate amount of mental health programs for residents of Cuyahoga County?	5% Yes	**Planning and System Development Organization and Compliance**
2) Does your agency have a good working relationship with CMHB?	81% Yes	**Provider Relations & Quality Services**
3) Do you consider CMHB to be a leader in the area of mental health in Ohio?	71% Yes	**Finance and Funding**
4) Please rank the following items according to importance in improving the mental health system. 1 is the highest priority, and 9 is the lowest.	Program Funding = 1.5 System Planning = 2.6 Provider Program Collaboration = 4.0 Program Development = 4.2 Board Leadership = 4.7 Organizational Structure of CMHB = 5.6 CSP Staffing = 6.1 Enhancing Involvement of Consumers = 7.3 Better monitoring of Programs and Services by CMHB = 8.3	**Board Governance** and other sections
5) Please rate your agency's relationship with CMHB's Board of Governors.	4.1 (Average)	**Board Governance**
6) Does a representative from your agency attend CMHB BOG meetings?	86% Yes	**Not applicable**
7) Please rate your agency's relationship with CMHB's Fiscal Unit.	3.8 (Fair)	**Finance and Funding**
8) Do you have a good understanding of how Medicaid billing affects your agency?	81% Yes	**Provider Relations and Quality Services**

Scale: 6 – Excellent, 5 – Good, 4 – Average, 3 – Fair, 2 – Poor

CMHB Attributes	Provider Average	Corresponding Section
9) Has your agency ever received training regarding Medicaid billing?	48% Yes	**Finance and Funding**
10) Are your questions regarding the annual Medicaid budget and planning process answered in a timely manner?	43% Yes	**Finance and Funding**
11) Are there new funding streams which could be introduced into the mental health system in Cuyahoga County?	71% Yes	**Finance and Funding; Planning and System Development**
12) Please rate your agency's relationship with CMHB's Planning and System Development division.	4.1 (Average)	**Planning & System Development**
13) Please rate your opinion of CMHB's planning process.	2.6 (Poor)	**Planning & System Development**
14) Are your requests for new services and programs well received by CMHB?	43% Yes	**Planning & System Development**
15) Please rate your agency's relationship with CMHB's Provider Relations Division.	4.5 (Average)	**Provider Relations & Quality Services**
16) Please rate CMHB's Provider Relations ability to resolve your questions / concerns in a timely manner.	4.3 (Average)	**Provider Relations & Quality Services**
17) Has training provided by CMHB been beneficial?	57% Yes	**Provider Relations & Quality Services**
18) Do you have a primary contact at CMHB to answer questions regarding claims, pricing, etc.?	62% Yes	**Technology**

Scale: 6 – Excellent, 5 – Good, 4 – Average, 3 – Fair, 2 – Poor

CMHB Attributes	Provider Average	Corresponding Section
19) Please rate your agency's relationship with CMHB's Quality Assurance Unit.	3.7 (Fair)	**Provider Relations & Quality Services**
20) Does CMHB assess program outcomes for provider agencies?	50% Yes	**Provider Relations & Quality Services**
21) How many times in the current / last contract has CMHB staff contacted your agency regarding compliance issues (either specific issues or routine monitoring)?	Less Than One = 4 One To Five = 12 Five or more =2	**Provider Relations & Quality Services**
22) How would you rate CMHB's overall audit process (frequency and quantity)?	4.2 (Average)	**Provider Relations & Quality Services**
23) Do you feel that auditing requirements place an excessive burden on your agency?	53% Yes	**Provider Relations & Quality Services**
24) Is your agency subject to Federal Regulation #A133?	57% Yes	**Not Applicable**
25) Please rate your agency's relationship with CMHB's Risk Management Unit.	3.9 (Fair)	**Risk Management and Consumer Affairs**
26) Did you initiate contact with CMHB to establish your current contract relationship?	44% Yes	**Risk Management and Consumer Affairs**
27) How long has your agency maintained a contract with CMHB?	Less Than One Year = 0 One Year to Five Years = 5 More Than Five Years = 15	**Risk Management and Consumer Affairs**
28) Rate your agency's experience with CMHB for contract negotiations.	4.2 (Average)	**Risk Management and Consumer Affairs**
29) Will you renew / reapply for another service period at the end of your current contract term?	95% Yes	**Risk Management and Consumer Affairs**

Scale: 6 – Excellent, 5 – Good, 4 – Average, 3 – Fair, 2 – Poor

CMHB Attributes	Provider Average	Corresponding Section
30) Please rate your agency's relationship with CMHB's Consumer Affairs Unit.	4.1 (Average)	**Risk Management and Consumer Affairs**
31) Does your agency receive prompt feedback from the Client Rights Officer Visits?	86% Yes	**Risk Management and Consumer Affairs**
32) Is training provided by the Consumer Affairs Unit adequate?	87% Yes	**Risk Management and Consumer Affairs**
33) Please rate your agency's relationship with CMHB's External Affairs Unit.	4.2 (Average)	**External Affairs**
34) Does your agency circulate literature about your services?	67% Yes	**External Affairs**
35) Does your agency literature make note of, or explain, your relation to CMHB?	81% Yes	**External Affairs**
36) Please rate your agency's relationship with CMHB's IT unit.	3.8 (Fair)	**External Affairs**
37) Are your questions regarding reimbursement of your services answered promptly?	48% Yes	**External Affairs**
38) Please rate your satisfaction with the ODMH billing reimbursement system (MACSIS).	3.2 (Fair)	**Technology**
39) Do you send / receive files electronically?	86% Yes	**Technology**
40) How would you rate the information sharing capabilities and practices between your agency and CMHB?	3.4 (Fair)	**Technology**

Scale: 6 – Excellent, 5 – Good, 4 – Average, 3 – Fair, 2 – Poor

Performance Measures

The following is a list of performance measures and analyses that was used to review CMHB's organization, compliance with the ORC and Ohio Administrative Code (OAC), and Board governance:

- Assess overall agency and division staffing levels
- Assess operational and organizational structure of CMHB
- Assess compliance with the ORC and the OAC
- Assess Board governance, structure and role
- Assess the Board's development and enactment of its mission, strategic plan, and other plans and initiatives to improve the mental health system in Cuyahoga County

A. Organization and Compliance

Findings / Commendations / Recommendations

Staffing Levels

F2.1 **Table 2-3** examines the staffing levels for CMHB and the peers. CMHB employees work 37.5 hours per week, making a full-time position at CMHB equate to 1.0 FTE. In contrast, the peer counties of Franklin, Lucas, and Stark MHB all work 40 hours a week, making a full-time position equate to 1.0 FTE (see the **human resources** section for further discussion). Although the peers do not have the same job titles or positions as CMHB, staffing comparisons were based on identifying similar job characteristics between CMHB and the peers. The staffing numbers that are reported for peers include all actual filled positions, and also positions that will be filled in the near future.

Table 2-3: Staffing Comparison

Position	CMHB Filled	CMHB Budgeted	Franklin MHB	Lucas MHB	Stark MHB	Peer Average
Executive Staff	1.0	3.0	2.6 [1]	1.4 [2]	1.8 [3]	1.9
Support Staff for Executive Staff	1.0	2.0	1.0	4.0	2.0	2.3
External Affairs	2.0	3.0	3.0	0.5	1.0	1.5
Planning and System Development	13.0	13.0	5.6	3.0	2.0	3.5
Administrative Services	21.0	24.0	26.0	10.7	11.0	15.9
Risk Management and Consumer Affairs	5.0	7.0	3.0	0.8	1.0	1.6
Provider Relations and Quality Services	16.0	19.0	9.7	2.8	2.2	4.9
Total	**59.0**	**71.0**	**50.9**	**23.2**	**21.0**	**31.6**
Two Year Average Consumers Served	30,555	30,555	28,869	13,696	7,674	16,746
Consumers per FTE	**517.9**	**430.4**	**567.2**	**590.3**	**365.4**	**530.0**

Source: CMHB and peer organizational charts and interviews.

[1] Executive Staff includes the positions of CEO, the Senior Chief Clinical Officer and a Vice President of Strategic Management. Franklin MHB does not have a COO.

[2] Executive Staff Includes the CEO and CCO. Lucas MHB does not have a COO.

[3] Executive Staff includes the positions of Executive Director and Chief Clinical Officer. Stark MHB does not have a COO.

As shown in **Table 2-3,** CMHB has the largest overall staff FTEs and has the highest number of FTEs in nearly every staffing category. In addition, CMHB is serving the second lowest number of consumers per budgeted and filled FTE as compared to the peers, indicating potential staffing inefficiencies. For a detailed staffing analysis of the divisions and units in **Table 2-3** based on additional workload, output and productivity measures, see each of the individual sections in this report.

F2.2 Empirical research that has been conducted on socio-economic factors has indicated that a positive correlation exists between poverty levels and mental illness rates. The United

States Surgeon General issued a report in 2000 that stated the lower socio-economic status an individual has, the greater chance that this individual will be affected with mental illness. The report further explained that individuals in the lowest socioeconomic status are 2.5 times more likely then those in the highest status to have a mental disorder. Therefore, when the results of this research are applied to Cuyahoga County, which has more individuals in a lower socioeconomic status than the peers, it is likely that greater numbers of individuals in Cuyahoga County will seek help for mental illness than in the peer counties. As a result, there is also a higher probability that these individuals will remain reliant upon the public mental health system in future years. **Table 2-4** provides poverty estimates, household income statistics and mental health consumers per 100,000 residents for Cuyahoga and the peer counties.

Table 2-4: County Statistical Figures

	Cuyahoga	Franklin	Lucas	Stark	Peer Average
Population, 2000	1,393,978	1,068,978	455,054	378,098	634,043
Consumers, FY 2001	30,238	29,317	13,650	8,209	17,059
Mental Health Consumers Per Capita, Per 100,000 Residents [1]	2,192	2,701	3,010	2,030	2,691
Estimated Number of People in Poverty, 1998	185,790	111,965	59,870	37,860	69,898
Percent of Individuals Living in Poverty, 1998	13.5%	11.0%	13.4%	10.2%	11.0%
Estimated Median Household Income, 1998	$38,522	$41,267	$38,833	$39,701	$39,934

Source: United States Census Bureau

[1] Mental Health Consumers Per Capita was calculated by taking the average number of consumers for FY2000 and FY 2001.

Table 2-4 shows that despite Cuyahoga County having a lower median income and higher poverty rates as compared to the peers, it has nearly 19 percent fewer mental health consumers per capita compared to the peers. As a result, Cuyahoga County may not be adequately identifying individuals who could benefit from available mental health services. For a further discussion of this issue, see the **planning and system development**, **provider relations and quality services** sections and **Table 2-2**.

Organization and Upper-Level Management Staffing

F2.3 CMHB has been without a CEO since June 27, 2001. Since that time, the chief of planning and system development has been appointed as the "acting CEO." As a result, this individual has had many important responsibilities to fulfill on a daily basis, which can be difficult because of the complexity of these duties. Therefore, long and short-term planning has not occurred, as evidenced by the lack of a strategic plan. For further information about strategic planning see the **board governance** section.

The CEO position has remained an area of concern at CMHB for the past decade. When the new CEO is hired, CMHB will have employed four CEO's over the past ten years. All of the peers have had greater stability in CEO leadership. Stark County MHB, for example, has had the same CEO for 22 years and Franklin County MHB has had two CEO's over the past 12 years. The average tenure by CMHB CEO's during the past ten years has been 2.5 years.

Frequent changes in the CEO position could have negatively impacted CMHB. For instance, the most commonly cited reason for the low morale was a lack of leadership at CMHB. See the **human resources** section for further discussion about the employee survey. In addition, the termination of the previous CEO has led to increased media attention and has affected relations between CMHB and public officials, providers and staff. The increased media attention has portrayed CMHB in a negative manner, helping to lower its image within the County. For further information about CMHB's image, see the **external affairs** section

The leadership void can be attributed to the fact that CMHB was not permitted to name a permanent CEO until all legal issues were finally settled with the previous CEO. It took CMHB nearly six months to resolve the legal issues associated with the previous CEO. This process took several months because the previous CEO exercised her right to an appeal process. As a result, CMHB negotiated a settlement with the prior CEO which revoked the termination and allowed this individual to retire from the position. During this process the CEO was on paid administrative leave. After CMHB had finalized a settlement, a new CEO was not hired for another six months which resulted in CMHB not employing a permanent CEO for over one year. To avoid any potential for future legal issues, CMHB is developing a contract to outline the employment of a new CEO.

R2.1 In order to provide leadership, a qualified CEO should be empowered and have the ability to create strong and stable leadership at CMHB. The CEO should be qualified and use previous high level administrative experience to improve the morale of employees and to strengthen the image of CMHB which will lead to increased stability. Stability within the CEO position could lead to more comprehensive long and short-term planning. Consistent expectations should be established for divisions and units; and programs and

initiatives should be planned, monitored and evaluated to determine whether they were successful or not. See the **board governance** section for further information about strategic planning. Improving the image of CMHB can be accomplished by holding regular meetings with providers and public officials in order to discuss areas of concern and to determine how to resolve problematic issues in an effective manner. Establishing a regular dialogue should lead to the development of a better working relationship between all parties and ensure greater stability in the CEO position.

The CEO will also need to establish a good working relationship with BOG. BOG is comprised of many individuals with a variety of backgrounds which will require the CEO to regularily communicate with BOG. However, in order to ensure that this dialogue is effective, the BOG will need to interact in a productive manner with the CEO. BOG should have high expectations for the CEO, but also should be realistic, and supportive, in their overall assessment of the CEO. Therefore, cooperation by both the CEO and BOG is crucial in order to resolve issues and create attainable goals.

F2.4 CMHB does not have a policy that requires the organizational structure to be regularly reviewed and revised. Although CMHB has contracted with numerous consultants over the past few years to analyze its operational and organizational structure, not all organizational structure recommendations have been implemented. The most significant of these analyses was completed by the Technical Assistance Collaborative (TAC) in February 2000. The report reviewed current staff and their functions, along with the general responsibilities of CMHB. Also contained within the report were recommendations for organizational improvements which included specific staffing functions that should be modified, strengthened or eliminated. CMHB made some organizational changes, such as increasing staffing levels in the MIS Unit. Other recommendations, such as removing human resources from the administrative services division, were not implemented by CMHB.

Since the TAC report was released, CMHB has not completed an internal review of its organization structure. CMHB does have an Executive Council which meets monthly to discuss organizational issues, including the structure of CMHB. However, during a review of the meeting minutes, AOS found little evidence of discussions held about organizational structure during the Executive Council meetings. Most discussions were tabled until the next month, or were not documented. Therefore, CMHB has not revisited its organizational structure on a regular basis in order to improve problematic areas or to eliminate any unnecessary positions. In contrast, Franklin County MHB conducts a yearly review of the organizational structure and makes any necessary revisions. Franklin County MHB's yearly organizational review coincides with the preparation of the annual budget. For further discussion about the organizational structure of CMHB as compared to the peers, see **F2.6**.

R2.2 The Executive Council should develop and adopt a policy which requires the organizational structure to be reviewed and updated on a regular basis. The policy should outline how to properly document any changes to the organizational structure or to employee positions. Any changes that are made to the organizational structure should be documented and employees should be provided with a copy of the change. Employees should also be provided with a copy of the updated organizational chart and with reasons why organizational structure changes were made. By regularly reviewing its organizational structure, CMHB can ensure it has an appropriate mix of staff, and that it will adequately be able to plan for any future staffing needs.

F2.5 CMHB has numerous position vacancies throughout its organization. Of the possible 71 authorized staff positions, CMHB has 12 vacancies. Of the three executive staff positions that are budgeted, only one is currently filled. However, all of the executive staff positions have been filled during the course of this performance audit. In addition, CMHB currently has four chief positions which are intended to oversee the areas of Planning and System Development, Administrative Services, Risk Management and Consumer Affairs, and Provider Relations and Quality Services. CMHB currently has vacancies in three of the four chief positions. One of these positions, chief of administrative services, has been vacant since September 2000. The chief of planning and system development is the only chief position that is filled. However, the individual who completes these duties was serving as the acting CEO since June 2001. During the course of this performance audit, a CEO was hired and the chief of planning and system development was promoted to COO. As a result of these vacancies, there has been a lack of leadership at CMHB which has lowered morale among staff. As indicated in the employee survey, CMHB staff had an average response rating of 1.9 when responding to the question of whether employee morale was positive, signifying a poor rating. For further discussion about CMHB employee morale, see the **human resources** section.

The most notable organizational change occurred in 1998 when CMHB promoted two staff members into chief positions, expanded the Consumer Affairs and Risk Management positions to include a director and an additional 1.5 FTEs, and added a Claims and Membership Unit. In 2000, CMHB added a chief operating officer (COO) position which supervises the various chief positions at CMHB and reports to the CEO. **Table 2-5** compares management staffing levels at CMHB and the peers.

Table 2-5: Management Staffing Comparisons [1]

	CMHB	Franklin County [2]	Hamilton County MHB	Lucas County MHB	Stark County MHB	Peer Average
Total Number of FTEs	71.0	64.1 [2]	44.0	23.2	21.0	38.1
Number of Budgeted Executive Staff	3.0	2.6	2.0	1.4	1.8	2.0
Ratio of Budgeted Executive Staff to all other Budgeted Staff	1:23.7	1:24.7	1:22.0	1:16.6	1:11.7	1:19.1
Number of Budgeted Chief Staff	4.0	4.0	3.0	2.0	N/A	3.0
Number of Budgeted Chief Staff to All Other Budgeted Staff	1:17.8	1:16.0	1:14.7	1:11.6	N/A	1:12.7
Number of Budgeted Managers Staff	12.0	7.0	8.0	6.5	4.0	6.4
Ratio of Budgeted Managers Staff to All Other Budgeted Staff	1:5.9	1:9.2	1:5.5	1:3.6	1:5.3	1:6.0
Total Number of Budgeted Management Staff [3]	19.0	13.6	13.0	9.9	5.8	11.4
Ratio of Total Budgeted Management Staff to all other Budgeted Staff	1:3.7	1:4.7	1:3.4	1:2.3	1:3.6	1:3.4
Total Consumers Served (Two-Year Average)	30,555	39,379 [4]	20,549	13,696	7,674	20,325
Total Consumers Per Executive Staff FTE	10,185	15,146	10,275	9,783	4,263	10,163
Total Consumers Per Chief Staff FTE	7,639	9,845	6,850	6,848	N/A	6,775
Total Consumers Per Manager Staff FTE	2,546	5,626	2,569	2,107	1,919	3,176

Source: CMHB and peer organizational charts

[1] Includes budgeted positions at CMHB. For peers, includes actual filled positions and current vacant positions that will be filled in the future.

[2] Includes total FTEs for mental health and alcohol and drug board at Franklin County because executive staff, chiefs and managers oversee and allocate time to both mental health and drug and alcohol functions.

[3] This total includes Executive Staff, Chief's and Managers.

[4] Includes alcohol and drug consumers because executive staff, chiefs and managers at Franklin oversee and allocate time to both mental health and drug and alcohol functions.

Table 2-5 shows that CMHB appears to be adequately staffed in executive and chief staff, based on and the ratios of executive staff and chief staff to all other staff. The ratio of consumers per executive staff and chief staff indicates that CMHB is adequately staffed with managers as compared to Hamilton, Lucas and Stark County MHBs. However, Franklin County's ratio of consumers per executive staff and chief staff is 48.7 percent and 28.9 percent, respectively, higher than CMHB. This could be attributed to differences in

organizational and reporting structure (see **F2.6** and **R2.3**) and executive and chief staff at Franklin County overseeing and allocating time to both mental health and drug and alcohol functions. The main distinction between CMHB, and Hamilton MHB and Franklin County is that neither Franklin County nor Hamilton County MHB employs a COO. The current CEO of Franklin County handles day-to-day decisions which the COO at CMHB is responsible for. In addition, Franklin County employs a part-time vice president of strategic management who also handles some job functions performed by CMHB's COO. Certain job functions of a COO at Hamilton County MHB are handled by the vice president of operations.

Further, the ratio of managers per FTE and consumers per management indicates that CMHB is adequately staffed with managers as compared to Hamilton, Lucas and Stark County MHBs. However, Franklin County appears to be more efficiently staffed with managers as compared to CMHB. Franklin County's ratio of management staff to all other staff and consumers per manager FTE is 55.9 percent and 121.0 percent, respectively, higher than CMHB. The area which appears to significantly contribute to CMHB's higher management staffing levels is provider relations and quality services, which employs 4.0 FTE managers. For a detailed analyses of manager and line staffing levels, please see the other sections of this performance audit.

F2.6 **Table 2-6** compares CMHB's organizational structure and functions to Franklin and Hamilton MHBs. CMHB, Franklin MHB and Hamilton MHB are the three largest mental health boards in Ohio.

Table 2-6: Comparing Organization of Functions [1]

Function	CMHB	Franklin [2]	Hamilton
External Affairs/Public Relations	No Chief One Director reporting to CEO	One Chief (Chief of Community & Organization Affairs) and One Director (Chief of Communications)	No Chief One Director reporting to CEO
Human Resources	Chief of Administrative Services	Chief of Community & Organization Affairs	HR Manager reporting to CEO
Technology (MIS)	Chief of Administrative Service	Director of MIS reporting to CEO	Chief of Operations
Finance	Chief of Administrative Services	Chief of Business Operations	Chief of Finance
Claims/Membership	Chief of Administrative Services	Director of MIS reporting to CEO	Chief of Operations
Risk Management (Contracting)	Chief of Risk Management & Consumer Affairs	Chief of Business Operations	Chief of Finance
Consumer Affairs (Client Rights)	Chief of Risk Management & Consumer Affairs	Chief of Strategic Management	Chief Clinical Officer
Planning and System Development	Chief of Planning and System Development	Chief of Planning, Evaluation & Quality Improvement	Chief of Clinical Services
Provider Relations	Chief of Provider Relations and Quality Services	Chief of Consumer Network Services	Chief of Operations
Compliance Auditing (Medicaid)	Chief of Provider Relations and Quality Services	Chief of Planning, Evaluation & Quality Improvement	Chief of Finance
Utilization Review	Chief of Provider Relations and Quality Services	Chief of Planning, Evaluation & Quality Improvement	Chief of Clinical Services
Quality Improvement	Chief of Provider Relations and Quality Services	Chief of Planning, Evaluation & Quality Improvement	Chief of Clinical Services
Education & Training	Chief of Provider Relations and Quality Services	Chief of Consumer Network Services	No such division. Training provided by each division based on topic.

Source: CMHB and peers

[1] CMHB's terminology (chiefs, directors, managers) is used to describe job functions performed by similar positions at peers.

[2] Franklin County is a combined mental health and drug and alcohol board.

Table 2-6 indicates the following major similarities in comparing CMHB's organizational structure to Franklin and Hamilton MHBs:

- Technology and claims are combined under the same division at all three MHBs.

- Utilization review and quality improvement are grouped together at all three MHBs. In addition, compliance auditing is in the same division as utilization review and quality improvement at CMHB and Franklin MHB.

- Education and training, and provider relations are combined under the same chief at CMHB and Franklin MHB.

- CMHB, Franklin MHB and Hamilton MHB have a director for external affairs reporting to the CEO.

In addition, **Table 2-6** illustrates the following major differences when comparing CMHB's organizational structure to Franklin and Hamilton MHBs:

- Planning and system development is a separate division at CMHB. However, Franklin and Hamilton MHBs have combined planning and system development, quality improvement and utilization review in the same division and under one chief. In addition, Franklin MHB has Medicaid compliance auditing under this division/chief.

- Finance and risk management (contracting) are combined under one chief at Franklin and Hamilton MHBs. In contrast, CMHB has contracting combined with consumer affairs. Additionally, CMHB has human resources, technology, claims membership and finance combined as one division and under one chief.

- Human resources (HR) is grouped differently by each mental health board. Hamilton MHB has the HR unit report directly to the CEO and Franklin has HR under the community and organizational affairs division. CMHB has its HR unit under administrative services with three other units.

- Consumer affairs is grouped differently by each mental health board. At CMHB, consumer affairs is combined with risk management. Franklin MHB has consumer affairs primarily under strategic management, which reports to the CEO, and an employee in consumer network services also performs some consumer affairs activities. Hamilton MHB has consumer affairs reporting directly to the CEO.

- CMHB has provider relations combined with quality improvement, utilization review, education and training, and auditing. Franklin MHB has provider relations, education and training, and a portion of consumer affairs under the same division. At Hamilton MHB, provider relations is grouped with technology and claims.

- Franklin MHB has a director of MIS, not a chief position, handle technology and claims membership. However, CMHB and Hamilton MHB have a chief position responsible for technology and claims, in addition to other job functions.

Furthermore, another major difference in organizational structures is that CMHB has all of its chiefs report to the COO while Franklin MHB and Hamilton MHB have their chiefs report to the CEO. As discussed earlier, Franklin MHB and Hamilton MHB do not employ a COO. However, employing a COO could allow CMHB to have a professional focus on the more technical and operational aspects of CMHB, while the CEO can focus on more administrative and high-level strategic issues to improve overall operations at CMHB.

R2.3 With the hiring of a CCO, COO and CEO, CMHB appears to have a strong leadership structure in place to improve operations and the overall mental health system in Cuyahoga County. CMHB should focus the roles of these executive staff positions in the following manner:

- The CEO should establish the overall strategic direction CMHB needs to take to improve the mental health system. The CEO should be responsible for administrative operations and ensure that the COO and other division heads have the tools they need to enhance operations.

- The COO should be responsible for the major operations and focus on the technical issues facing CMHB. The COO should ultimately be responsible for the daily operations at CMHB.

- The CCO should provide clinical guidance for the County's mental health system. Ensuring appropriate levels of care for consumers and monitoring service activity throughout the County should be primary objectives of the CCO position (see **provider relations and quality services**).

Based upon the peer comparisons and analysis in **F2.6** and **Table 2-6**, CMHB should consider reorganizing some of its functions. Specifically, CMHB should consider combining planning and system development with quality improvement and utilization review under one division/chief. Planning and quality improvement are linked in strong ways. For example, a plan can not be effective if it is not appropriately implemented and monitored for outcomes and quality improvement. Benefits of combining planning and system development with these areas include the following:

- Improve the ability of CMHB to evaluate outcomes and the success of plans;
- Enhance monitoring and data gathering by ensuring that all data is considered in a plan; and

- Potentially streamline operations and use staff resources more efficiently.

In addition, compliance auditing should either be combined with the above division or with finance. CMHB should also consider combining risk management (contracting) with the finance unit. The finance unit performs many activities related to contracts, such as working with providers to develop unit costs and reviewing financial aspects of the contracts. CMHB should also consider separating consumer affairs from risk management because these two areas do not share any similar job functions. Consumer affairs could report as a separate entity to either the CEO, COO or CCO; or it could be combined with provider relations, which is similar to Franklin MHB. See the **planning and system development**, and **risk management and consumer affairs** sections for further discussion on these organizational issues and potential reorganization of job functions.

Table 2-7A summarizes, based upon peer comparisons, what the revised responsibilities of each chief at CMHB would be after implementing these changes, assuming that CMHB fills all four chief positions. Based on the analysis in **F2.6**, functions in bold indicate a strong correlation to being combined in the same area and functions in italics indicate a lesser correlation.

Table 2-7A: Options to Revise Organizational Structure

Chief 1	Chief 2	Chief 3	Chief 4
Finance **Contracting** *Compliance Auditing*	**Planning & System Development** **Quality Improvement** **Utilization Review** *Compliance Auditing*	**Provider Relations** **Education and Training** *Consumer Affairs*	**Information Technology** **Claims Membership** *Human Resources* *External Affairs*

While all of the different units at CMHB could report directly to chiefs, who would then report to the COO, CMHB could adequately operate without having units reporting first to chiefs. For instance, human resources should report directly to the CEO (see **F2.8** and **R2.5**), which is similar to Hamilton MHB. Information technology and claims membership could report directly to the director of MIS, who could then report directly to the CEO or COO, which is the current process at CMHB due to the chief vacancy in Administrative Services. Additionally, this is the practice at Franklin MHB. As stated previously, consumer affairs could report as a separate entity to either the CEO, COO or CCO. Furthermore, the director of external affairs could continue to report to the CEO, which is also the reporting structure at Hamilton and Franklin MHBs. **Table 2-7B** displays another option CMHB should consider to alter its organizational structure, by having the above discussed positions report directly to the CEO.

Table 2-7B: Options to Revise Organizational Structure

Chief 1	Chief 2	Chief 3	CEO
Finance Contracting *Compliance Auditing*	Planning & System Development Quality Improvement Utilization Review *Compliance Auditing*	Provider Relations Education and Training	Information Technology Claims Membership Human Resources External Affairs Consumer Affairs

If CMHB decided to have the director of MIS (technology and claims), the manager of HR, the director of external affairs and consumer affairs report directly to the CEO or COO, CMHB may not need to fill one chief position. Therefore, CMHB should consider filling three chief positions.

Financial Implication: If CMHB filled three chief positions, it would incur costs of approximately $325,000 annually in salaries and benefits.

F2.7 CMHB does not have a formal process to review which staffing positions have priority within the organization and should be filled in a timely manner. As discussed in **F2.4**, the lack of a CEO has led to an increase in vacant leadership positions at CMHB which have remained unfilled for a substantial period of time. The chief of administrative services has been vacant since September 2000, the chief clinical officer has been vacant since September 2001 and the chief operating officer has been vacant for over two years. In addition, the chief of risk management and consumer affairs and the chief of provider relations and quality services are currently vacant. Therefore, the acting CEO must not only complete CEO-related duties, but is also required to handle the responsibilities of the vacant chief positions. As a result, the acting CEO must provide oversight for all CMHB divisions due to the high number of administrative vacancies.

Franklin County MHB reviews vacant positions every year during the preparation of the annual budget process. The CEO discusses, with each of the executive staff, potential staffing needs for their units. The executive staff is then required to submit, in writing, any new positions which will need to be filled in the coming year. The CEO makes decisions on new staffing requests, and determines whether any vacant positions should be eliminated. Although CMHB did analyze vacant positions during the past fiscal year, this process was only completed after Cuyahoga County officials requested all county agencies to reduce their expenditures during the next fiscal year. CMHB has not completed a review of its vacant positions in previous years.

R2.4 CMHB's Executive Council should create a formal process to review key staffing positions which should be filled in a timely manner when a vacancy occurs. The executive council should then meet regularly to discuss how to handle any vacant positions which exist at CMHB. Before the meetings, each member of the Executive Council should complete an assessment of all vacant positions that exist within their

respective area. The assessment should include details concerning the various functions that are assigned to the vacant positions. An assessment will allow CMHB to determine whether the vacant positions have any similar job characteristics when compared to other positions that exist at CMHB. If the vacant positions have duties that are found in other positions, or if the Executive Council determines that the vacant job functions are no longer relevant, the CEO should then take the necessary steps to eliminate positions from the organization chart. By reviewing vacant job positions regularly, CMHB can ensure that an optimal level of staffing exists. For a further discussion about job descriptions and job analysis, see the **human resource** section.

F2.8 CMHB has the HR Unit reporting to the Chief of Administrative Services, which is currently vacant. The Chief of Administrative Services monitors and coordinates the activities of the HR, MIS, Finance, and Claims/Membership Units. The majority of the responsibilities of this position concern the completion of financial and technical related tasks and only minimal human resource functions. Only two out of the 20 specified duties in the job description for the chief of administration services pertain to providing oversight for human resources. Due to the vacancy in the position of chief of administrative services, the human resources division is currently reporting to the acting CEO, which was previously done in the late 1980's and early 1990's at CMHB. The current reporting structure has allowed the CEO be more involved with HR initiatives such as policy and program development, and training. In addition, the CEO can work closely with HR to determine how to attract the best candidates to fill the vacant positions. However, no formal change in the reporting structure has been documented in the organizational chart despite the current change in the reporting structure, and the recommendation of a consultant, TAC, which advised CMHB to separate the human resources unit from the administrative services division in 2000. For further discussion on the human resources unit, see the **human resource** section. Additional information about filling vacant positions is presented in **F2.7**.

Franklin County MHB has similar reporting structure for its HR unit as CMHB. Franklin County MHB has the HR unit under the guidance of the chief of community and organization affairs. The chief of this area reports directly to the CEO. In contrast to Franklin MHB and CMHB, the HR unit reports directly to the CEO at Hamilton and Stark MHBs. Hamilton County MHB devised this reporting structure for the HR Unit because the CEO could be more actively involved in personnel and legal matters. Stark County MHB does not have a human resources unit, but requires the following positions to complete human resources related tasks: chief financial officer, fiscal specialist, associate director, director of community relations and an administrative coordinator. Supervision of these employees is provided directly by the executive director which allows for effective coordination of responsibilities and ensures that all relevant human resources information is maintained in an appropriate manner. Since HR impacts all of

the divisions throughout the organization, it may be more appropriate and effective for the HR Unit at CMHB to report directly to the CEO.

R2.5 CMHB should consider formally placing the HR Unit under the control of the CEO. Allowing the CEO to have direct oversight over this unit could lead to more efficient recruitment and hiring strategies, which can have a positive impact upon the staffing levels at CMHB. The CEO can also ensure that HR is creating and reviewing all policies, programs and initiatives, and that regular training sessions are being offered to employees.

F2.9 CMHB has assigned the responsibility of supervising the receptionist and the telephone system to HR. Although the management of the telephone system is the responsibility of the human resources specialist, the director of HR must handle these duties because the human resources specialist position is vacant. For further discussion about the human resource specialist, see the **human resources** section. As a result, the human resources director must allocate a substantial amount of time every week to coordinating receptionist duties and, at times, serving as a backup to the receptionist. These additional duties have not only increased the workload for the human resources director, but have resulted in the human resources director spending time on non-related tasks. For further discussion about this issue, see the **human resources** section.

Franklin County MHB, Stark County MHB, and Hamilton County MHB have allowed a designated staff member to provide supervision and oversight of other support and clerical staff. Stark County MHB has an administrative coordinator who oversees the receptionist and a support staff person, while Franklin County MHB has a maintenance coordinator who supervises the receptionist and a clerical staff person. Hamilton County MHB employs a receptionist who is supervised by an office manager. When the receptionist is out for a length of time, usually three days or more, a temporary worker is hired to answer the phone. However, when the receptionist is on break, or will only be absent for a temporary period of time, the officer manager constructs a telephone schedule. This schedule requires the four administrative assistants to spend equal amounts of time answering incoming phone calls. Each of these peers has created a system that ensures appropriate coverage for the receptionist position at all times.

R2.6 CMHB should consider promoting one of its seven administrative assistants to the position of office manager. The promotion of an administrative assistant will still allow CMHB to disperse the remaining six administrative assistants throughout the organization. The office manager can be responsible for supervising the administrative assistants, handling any issues with the telephone system, and coordinating a receptionist pool which can be utilized whenever the main receptionist is out. The receptionist should then be located in the division in which the office manager is located. This receptionist pool should involve all six CMHB administrative assistants, on a rotating basis, who can

be scheduled to provide phone coverage when the receptionist is absent. The creation of a receptionist pool will not only allow the phone system to be covered at all times, but also help to ensure that most coverage issues can be resolved prior to the receptionist being absent. In addition, implementing this reporting structure change should allow the human resources director to devote more time to HR-related functions.

Financial Implication: Assuming a 10 percent increase in current salary, CMHB would incur costs of approximately $3,000 annually by promoting a current administrative assistant to office manager.

Performance Measurement

F2.10 The Cuyahoga County Commissioners require CMHB to track and report on relevant performance measures. These performance measures include Inpatient Bed Day Management, Community Support Network and Board Operations. CMHB submitted a report to Cuyahoga County on February 19, 2002 which outlined performance measures that CMHB had been currently reviewing. Although the report outlined targeted goals, components for review, and a CMHB response, programs that were discussed were not fully defined. For example, a Wrap Around Program and a Bridgeway program were reviewed, but no information was presented about the types of services that these programs provide. In addition, much of the data, such as Inpatient Bed Day and Community Support Network, could not be accurately assessed because MIS could not extract the data or had not done so in the past. The report also had many attachments, such as Inpatient Bed Days, that were not fully explained. For further information about performance measurement, see the **provider relations and quality services** section. According to industry standards, performance measurement is defined as a system of customer-focused, quantified indicators that let an organization know if it is meeting its goals. Performance measures are also management tools that measure work performed and results achieved.

The types of performance measures most commonly used in government include:

- Inputs: Resources used (what is needed);
- Outputs: Activities completed (what is produced);
- Outcomes: Results achieved;
- Efficiency: How well resources were used;
- Quality: Effectiveness (How much CMHB has improved)

Each measure is designed to answer a different question. It is not necessary to use all of the types of measures to determine if an objective is being achieved. However, clear explanations are necessary to indicate what is being measured, the source of the information and how the value is calculated.

A strong performance measurement system was created in the City of Sunnyvale, California in the early 1980's. Managers in the city measure quantity, quality, and cost of service delivery. The city council then defines what expectations and improvements are to be made in the course of a year. Re-evaluation at the end of the year determines how well the agency did in achieving its goals. Between 1984 and 1994, the City of Sunnyvale recorded a 44 percent improvement in worker productivity and a 38 percent improvement in the cost of providing services which was attributed to the use of performance measures.

R2.7 CMHB should expand on the report that is currently provided to Cuyahoga County. Terms and attachments should be defined and the report should include explanations of inputs, outputs, outcomes, efficiency, and quality. The CEO should take the lead in developing goals for the overall organization which will help to determine effectiveness. Each division at CMHB should work closely with the CEO to develop these goals. Based on the goals, the CEO should also develop a methodology to obtain and analyze the results of internal performance. It is important that the performance measures be aligned with CMHB objectives to effectively evaluate performance. The implementation of a performance measurement system is an evolutionary experience in which measures will likely improve with experience. Initially, CMHB should focus on common indicators. The use and reporting of performance measures should increase CMHB's efficiency and will allow CMHB to better inform key stakeholders of its performance. Examples of issues that CMHB should consider measuring include the following:

- Number of employees monitoring contracted provider performance (Input);
- Number of cases reviewed per day (Output);
- Percentage reduction in bed day usage (Outcome);
- Staff time used to review applications (Efficiency);
- Percentage increase in customer satisfaction levels (Quality).

The Director of External Affairs should ensure that measurement results are publicized in CMHB's annual report, on its website and in its employee newsletter. In measuring and reporting progress towards identifiable outcomes, CMHB will become more accountable to taxpayers in providing high levels of service in an efficient and effective manner. Additionally, the performance measures can be used to help CMHB determine whether goals described in the strategic plan have been achieved. For further discussion of the strategic plan, see the **board governance** section. Also, for a full discussion about system-wide outcome measures, see the **provider relations and quality services** section.

Compliance

F2.11 Ohio Revised Code (ORC) is comprised of all statutes of a permanent and general nature of the State of Ohio, which are classified into general provisions, titles, chapters and

sections. ORC Chapter 340 Alcohol, Drug Addiction and Mental Health Services contains 23 sections; however, this review will focus primarily on those sections that are exclusive or significant to mental health boards and their operations.

Ohio Administrative Code (OAC) is a complete text of rules created by state agencies to implement provisions of the ORC. These rules require specific action from CMHB, Cuyahoga County or ODMH. CMHB's compliance with the ORC is illustrated in **Table 2-8**.

Table 2-8: CMHB's Compliance With ORC

Number	Brief Description	Section of Report	Comment
ORC 340.01	Alcohol, drug addiction and mental health service district. Stipulates the creation of a mental health district.	Organization, Compliance and Board Governance	In compliance
ORC 340.011	Interpretation and construction of provisions. States the services that must be provided by a mental health services district.	Organization, Compliance and Board Governance	In compliance
ORC 340.021	Alcohol and drug addiction services in certain counties. Addresses qualifications that are necessary to serve on a community mental health board, attendance requirements, how vacant positions should be filled and states training requirements which board members must satisfy.	Organization, Compliance and Board Governance	**F2.12/R2.8, F2.13/R2.9, F2.14/R2.10, F2.15/R2.11, F2.16/R2.12, F2.17/R2.13**
ORC 340.03	Duties of board Describes the information required in the community mental health plan, regulations governing committee meetings and the need to obtain consumer recommendation and advice and requirements for public meetings.	Organization, Compliance and Board Governance	**F2.18/R2.14, F2.19/R2.15, F2.20/R2.16**
ORC 340.032	Executive director, compensation, expenses and removal. Describes the requirements for hiring an executive director and the procedures which must be followed when terminating an executive director.	Organization, Compliance and Board Governance	In compliance
ORC 340.04	Duties of an executive director. Specifies the duties of an executive director.	Organization, Compliance and Board Governance	In compliance

ORC 340.05	Report or complaint of abuse or neglect of adult care facility resident. Describes the responsibilities when a mental health board receives a complaint.	Risk Management and Consumer Affairs	In compliance
ORC 340.06	Administration of existing facilities. Requires mental health services boards to administer state funds to mental health clinics and child guidance homes.	Finance and Funding	In compliance
ORC 340.07	Appropriation of money for facilities and programs. Allows the board of county commissioners to appropriate monies to a mental health board to operate, lease, acquire, construct, renovate, and maintain mental health services, programs and facilities for mentally ill and emotionally disturbed individuals.	Finance and Funding	In compliance
ORC 340.091	Contract with agency concerning residential state supplement payments and recipients. States that each mental health services board shall contract with a community mental health agency to monitor services and to determine whether individuals are in stable residences.	Risk Management and Consumer Affairs	In compliance
ORC 340.10	Auditor and fiscal officer; method of payment of state funds. Allows the county treasurer to be the custodian of funds and can be authorized to make payments from these funds by order of the county auditor, recommendation of the board, or the executive director when authorized by the board.	Finance and Funding	In compliance
ORC 340.11	Insurance against liability for board members and employees. Allows a mental health board to create policies and procure liability insurance for board members, employees of the board or agencies that the board has established a contract with.	Finance and Funding	In compliance

ORC 340.12	Discrimination prohibited; affirmative action program. A mental health board should not discriminate in providing services, in employment, or contract on the basis of race, color, creed, sex disability, national origin, or the inability to pay. Also, each board is required to have a written affirmative action plan.	Organization, Compliance and Board Governance	**F2.20/R2.16**
ORC 340.13	Minority business enterprise contract set aside. Defines how minority business contracts should be awarded, and the criteria that must be satisfied in order to be approved for a minority business contract.	Finance and Funding	In compliance

Source: Anderson ORC and AOS Analysis

F2.12 ORC §340.021(B) requires that a community mental health board should have 18 members and OAC § 5122:2-1-04 (see **Table 2-10**) stipulates criteria which must be satisfied by four members. The criteria from the OAC includes selecting the following individuals to serve on the board: psychiatrist/physician, or a mental health professional. The ORC requires a mental health board to select these individuals, in addition to appointing to the board an individual who has received mental health services and a parent or relative of such a person. CMHB has current board members who satisfy this requirement. However, the BOG has two vacancies on its board which have occurred within the past three months. Both of these vacancies are state seats, and must be filled by the director of ODMH within 60 days.

The final section of ORC §340.021 (B) concerns board membership reflecting the composition of the county in terms of race and sex. **Table 2-9** shows a list of key demographic characteristics for Cuyahoga County for the year 2000 and the corresponding demographic characteristics of the CMHB BOG.

Table 2-9: Demographic Characteristics for Cuyahoga County

Race	**Percentage of Cuyahoga County Residents**	**Numbers**
White	67.2%	938,863
African-American	27.4%	382,634
Hispanic	3.4%	47,078
American Indian	0.2%	2,529
Asian	1.8%	25,245
Sex	**Percentage of Cuyahoga County Residents**	
Male	47.2%	659,124
Female	52.8%	737,325
Race	**Percentage of CMHB BOG**	
White	75.0%	11.0
African-American	12.5%	2.0
Hispanic	6.3%	1.0
American Indian	0.0%	0.0
Asian	6.3%	1.0
Sex	**Percentage of CMHB BOG**	
Male	62.5%	10.0
Female	37.5%	6.0

Source: CMHB Documents

Table 2-9 indicates that the representation on CMHB's BOG is not truly reflective of key demographic characteristics for Cuyahoga County. CMHB has 14.9 percentage points fewer African Americans on the BOG when compared to the demographics of Cuyahoga County. In addition, CMHB has 15.3 percentage points more males on the BOG when compared to the demographics of Cuyahoga County.

R2.8 ODMH and Cuyahoga County, who both appoint CMHB BOG members, should follow the directives in ORC §340.021 regarding the appointment of individuals to the BOG. In addition, both ODMH and Cuyahoga County should ensure that any future appointments are clearly reflective of key demographic characteristics for Cuyahoga County. Before appointments are made, both appointing authorities need to be aware of the current demographic make up of the BOG, along with the most recent demographic statistics for Cuyahoga County. Any appointments made to the BOG should be reflective of the demographic information for Cuyahoga County.

F2.13 ORC § 340.02 requires that no person shall serve as a member of the board of alcohol, drug addiction, and mental health services whose spouse, child, parent, brother, sister, grandchild, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law or brother-in-law serves as a member of the board of any

agency with which the board of alcohol, drug addiction, and mental health services has entered into a contract for the provision of services or facilities.
An individual was appointed by Cuyahoga County whose application noted that his spouse is the president of a board with which CMHB has a contract. The individual was appointed to the BOG, and when the violation was discovered, he resigned a week later at the advice of the Cuyahoga County Prosecutor. Currently, this seat remains vacant.

R2.9 The CEO, executive specialist and the appointing authorities should review all conflict of interest forms prior to appointing individuals to serve on the board. Creating a review process at each level will eliminate the appointment of any unqualified candidates to the CMHB BOG.

F2.14 ORC § 340.02 states that each year every board member shall attend at least one inservice training session provided by or approved by the Ohio Department of Mental Health. Trainings that are approved by the ODMH must address one of the following guidelines:

- Ohio's public mental health system services and/or delivery mechanism;
- Skills, knowledge, or attitudes of board trusteeship;
- The Board's priorities, as written in the most current community plan;
- The Board's role in developing, monitoring, delivering and evaluating a mental health system.

All trainings must have clearly defined objectives and a listing of presenter qualifications. The training cannot be less than three hours in length, cannot be a regular meeting of the board, and cannot be a regular orientation session for new board members. The board is required to keep documentation of all sessions attended by board members. Documentation should include the date, title and content of each session.

In a review of BOG files, it was found that BOG members were not attending yearly training sessions. Of the 15 BOG files that were reviewed, nine BOG did not attend any training sessions for at least one of the years that they were on the BOG. In addition, all of the BOG have attended an orientation training for new BOG members. However, according to ODMH guidelines, orientation sessions cannot be used to fulfill the yearly training requirements. Although not required by ORC, CMHB does not having a training committee. A training committee could be useful in researching possible training topics and monitoring attendance by BOG members at training sessions.

R2.10 BOG should take the necessary steps to ensure that all members are attending at least one inservice training session per year. BOG should create a training committee which evaluates the training needs of its members, researches potential training sessions, and is responsible for scheduling all training sessions. The training committee should also keep

documentation of training sessions attended by BOG and should work with ODMH to ensure that any scheduled trainings are reflective of ODMH guidelines.

F2.15 ORC § 340.02 states that when a vacancy occurs on the BOG, the appointing authority shall be notified by certified mail and should fill the vacancy within 60 days of receiving notification

CMHB does not have a formal process which informs the appointing authorities when vacancies occur on the BOG. When a member resigns, CMHB will often forward the resignation letter to the appointing authority, or will sometimes call the appointing authority to provide information about the vacancy. CMHB does not notify the appointing authority via certified mail about any vacancies.

A review of the appointment dates for the CMHB BOG revealed that two seats were not filled within sixty days after the vacancy had occurred. One BOG member was appointed nine months after the vacancy occurred, and another BOG member was appointed seven months after the previous member had resigned. As a result, CMHB's BOG has been operating without the required number of members as stipulated in ORC. The lack of members could impact BOG's ability to provide the necessary guidance to the consumers and staff of CMHB. For further discussion of this issue, please see the *board governance* subsection.

R2.11 The executive specialist should be responsible for providing timely and proper notification to the appointing authorities when a vacancy occurs. This individual should notify the appointing authorities via certified mail when a resignation letter is sent to CMHB.

The appointing authorities should also follow the directives in ORC § 340.02 in order to maintain compliance for CMHB. The appointing authorities should also maintain a current list of prospective members. Maintaining a list will allow the appointing authorities to identify candidates in more efficient manner, eliminating the amount of time that it takes to appoint new BOG member.

F2.16 ORC § 340.02 states that if a board member misses either four board meetings within one year, or two board meetings without prior notice, the board shall notify the appointing authority which can remove the individual and select another person to complete the remainder of the term.

CMHB does not keep formal attendance sheets for any board meetings. Although the executive specialist lists all attending BOG members at the top of the meeting minutes, this individual has never been instructed to compile this information into a master attendance list. In addition, the appointing authorities have not been notified after board

members have missed more than four meetings, or two meetings without prior notice for a given year.

R2.12 CMHB's executive specialist should be instructed to maintain formal BOG attendance sheets for all members. Any attendance information should be regularly distributed to board members for their review. Compiling attendance information in this manner will allow CMHB to provide appropriate documentation to the appointing authorities when a board member has been absent from four meetings, or two meetings without prior notice. CMHB should provide this information to the appointing authorities on a periodic basis. The appointing authorities should review this information and take the necessary actions to ensure that CMHB is in compliance with this ORC section.

F2.17 ORC §340.03(c) states that a mental health board should submit to the ODMH a community mental health plan, known as the Mutual Systems Performance Agreement (MSPA), which lists community mental health needs. This plan must be submitted no later than six months prior to the end of the fiscal year in which the mental health board's plan is scheduled to expire. The plan should include the following information:

- A statement of services that the board intends to provide or purchase;
- An explanation of how the board intends to make any required payments;
- A statement of the inpatient and community-based services the board proposes ODMH should operate;
- An assessment of the number and types of residential facilities needed; and
- A budget for funds the board expects to receive.

CMHB submitted a plan to ODMH on March 14, 2001, which was about three months late. In order to be in compliance with the ORC, CMHB should have submitted the MSPA to ODMH in January 2001. In addition, CMHB's MSPA does not provide an explanation of how the board intends to make required payments, an assessment of the number and types of residential facilities needed, or a budget for funds that the board expects to receive. For further information about CMHB's MSPA, see the **provider relations and quality services section**.

R2.13 CMHB needs to work with ODMH to ensure that the MSPA is reflective of the requirements outlined in ORC §340.03(c). The CEO should review the finalized version of the MSPA before it shared with ODMH.

F2.18 ORC §340.03(A)(15) requires the establishment of a mechanism for the inclusion of consumer recommendations and advice on matters pertaining to mental health services in an alcohol, drug addiction, and mental health service district.

CMHB does hold activities for the benefit of consumers. These activities include monthly brown bag lunches on general topics that pertain to mental health issues. Fliers are posted in provider agencies and consumer attendance is taken at these brown bag lunches. Although CMHB does have consumers on the BOG, it does not have a single, permanent, long-standing consumer advisory council which could provide further information about mental health issues, as Franklin MHB does. The Consumer and Family Advisory Council (CFAC) was created by a Franklin MHB staff member in order to identify consumers and family members who could provide feedback about the services offered, and operations of, Franklin MHB. See the **risk management and consumer affairs** section for further information about consumer involvement.

R2.14 Although CMHB does provide opportunities for consumers to attend information sessions about mental health issues, it should create a centralized consumer advisory council or consumer forum to solicit increased involvement and help ensure that CMHB is compliant with this section. A centralized consumer advisory council would represent all consumer and family organizations, and allow CMHB to be provided with first hand feedback on services and activities which are being funded by CMHB.

F2.19 ORC §340.03(E) states that any meetings held by any committee established by a board of alcohol, drug addiction, and mental health services shall be considered to be meetings of a public body subject to section 121.22 of the ORC. ORC §121.22(a) states the following:

- All meetings of a public body are declared to be public meetings open to the public at all times. A public body is defined as a committee or subcommittee of any board, commission, committee, council, or similar decision-making body of a state agency, institution or authority, and any legislative authority or board, commission, committee, council, agency, authority, or similar decision-making body of any county, township, municipal corporation, school district, or other political subdivision or local public institution.

ORC §121.22(C) requires:

- All meetings of any public body are declared to be public meetings open to the public at all times. A member of a public body shall be present in person at a meeting open to the public to be considered present or to vote at the meeting and for purposes of determining whether a quorum is present at the meeting. The minutes of a regular or special meeting of any public body should be promptly prepared, filed, and maintained and should be open to public inspection. The minutes should only reflect general subject matter of any executive session discussions.

ORC §121.22(F) requires:

- Every public body, by rule, shall establish a reasonable method whereby any person may determine the time and place of all regularly scheduled meetings and the time, place, and purpose of all special meetings. A special meeting should only be held unless the public body gives at least 24 hours advance notice to news media who have requested notification.

ORC §121.22 (G)(1) states:

- The members of a public body may hold an executive session only after a majority of a quorum of the public body determines, by a roll call vote, to hold an executive session and only at a regular or special meeting to consider the appointment, employment, dismissal, discipline, promotion, demotion, or compensation of a public employee or official, or the investigation of charges or complaints against a public employee, official, licensee, or regulated individual, unless the public employee, official, licensee, or regulated individual requests a public hearing.

CMHB has one subcommittee, the recruitment committee, which is not in compliance with the provisions of this ORC section. The recruitment committee does not keep minutes of its meetings, and does not have a formalized process to distribute the time and place of any meetings. The recruitment committee felt that due to holding discussions about individuals and employment opportunities, meeting minutes did not have to be kept or meeting schedules did not have to be distributed.

R2.15 All CMHB committees should review and follow the provisions of ORC §121.22. All times and dates of any committee or subcommittee meetings should be published in local print media, minutes should be kept, and quorums should occur in order for executive sessions to be convened.

F2.20 ORC §340.12 requires each mental health board to have a written affirmative action program which includes goals for employment and utilization, including contracts with members of economically disadvantaged groups which reflects percentages of these disadvantage groups that are located in the district served by the mental health board. Each mental health board is required to file a description of its affirmative action program and a progress report concerning the implementation of this plan with ODMH.

CMHB has an affirmative action plan which was completed by the previous CEO. However, no completion date was specified in the plan. In addition, the plan creates the position of EEO coordinator who is responsible for implementing all CMHB affirmative action programs and activities. The EEO coordinator position has been eliminated from

CMHB's organizational chart, and no staff member at CMHB currently is responsible for these duties. The percentages of minority residents referenced in the plan is based on the demographics of Cleveland area only, and not Cuyahoga County demographics. In addition, the demographic analysis was compiled from 1990 census data. CMHB has not filed a progress report with ODMH concerning the implementation status of the plan.

R2.16 CMHB should review its current affirmative action plan to assess which areas of the plan need to be revised. The affirmative action plan should then be reviewed yearly by CMHB's upper level management staff, who should use current census data to review the goals and objectives of the previous year and to determine whether CMHB has met its outlined affirmative action objectives. The management team should also ensure that the report is distributed to ODMH, and that yearly progress reports are also provided to ODMH.

Ohio Administrative Code (OAC)

The OAC is a complete text of rules created by state agencies to implement provisions of the ORC and provides a summary of codes that requires specific action from CMHB, Cuyahoga County or ODMH. CMHB's compliance with OAC is illustrated in **Table 2-10**. For information concerning Medicaid compliance audits and monitoring activities, see the **provider relations and quality services** section.

Table: 2-10 CMHB's Compliance With OAC

Number	Brief Description	Section	Comment
OAC 5122:1-3	Financial Requirements for Community Mental Health Boards. Establishes financial reporting requirements for mental health boards	Finance and Funding	**F2.21/R2.17**
OAC 5122:2-1	Client rights and grievance procedures. Defines responsibilities that mental health boards have in providing oversight regarding the grievance procedure of providers.	Risk Management and Consumer Affairs	**F2.22/R2.18**
OAC 5122:2-1-04	Department of mental health appointments to community mental health boards. Stipulates the requirements that mental health boards must satisfy in filling any vacant board position	Organization, Compliance and Board Governance	**F2.12/R2.8**
OAC 5122:2-1-09	Community plan. Describes the requirements which mental health boards must satisfy in preparing the community mental health plan	Organization, Compliance and Board Governance.	**F2.17/R2.13**

Source: OAC and AOS Analysis

F2.21 OAC §5122:1-3-01 (7) (a) requires that mental health boards receiving funds from ODMH be audited by the state auditor's office. However, GASB 14, observed by the state auditor's office and issued by the American Institute of Certified Public Accountants (AICPA) Government Auditing Standards Board, states that if an entity is part of the whole structure, and the structure is audited, then the parts do not have to be audited individually. As a result, CMHB is considered to be audited when Cuyahoga County is audited each year. However, CMHB would ensure accountability and integrity to its presented financial information if it was audited in more detail by an outside entity. For further discussion about this topic, see the **finance and funding** section.

R2.17 CMHB should consider having an audit of its financial information and operations conducted annually. This audit should be completed by an independent CPA firm which would verify financial information recorded by CMHB and would provide legitimacy regarding CMHB's financial reporting.

F2.22 According to OAC §5122:2-1-02 (H) (1), each community mental health board, in its community plan (MSPA), should assure that each contract agency has a grievance procedure in place.

CMHB's MSPA does not contain information verifying that each of CMHB's contracted providers have a grievance procedure that complies with OAC requirements. CMHB's Client Rights Officer (CRO) reviews grievance procedures during unscheduled visits to contracted providers and forwards this information to the quality improvement specialist, who reviews the information. However, this information is not summarized in the MSPA

R2.18 CMHB should include grievance information in the MSPA. Documenting and verifying that providers have grievances in place in the MSPA would help ensure that consumers' rights are protected.

B. Board Governance

F2.23 CMHB's BOG is unclear over the role they serve in the governance and operations at CMHB. As a result of interviews conducted with BOG, questions and practices pertaining to the roles and responsibilities of CMHB board and staff arose as some members' opinions of their role differed from others. Many stated that their role as governors changed due to the absence of a chief executive officer and others have stated that poor communication and politics are the reason that their roles and responsibilities have shifted. For example, BOG is directly involved in the search and selection of management personnel other than the CEO. Additionally, some board members have stated that their involvement in the daily operation of CMHB is a result of the perception that they have lost credibility with the County through bad publicity over various issues. This over-involvement is a reaction to that perception.

According to Mr. Thomas Wolf in *Managing A Non-Profit Organization in the 21st Century*, the following list represents the five areas of responsibility for board members:

- Determining the organization's mission and setting policies for its operations, ensuring that the organization's charter and law are being followed. Although CMHB's mission and BOG policies are in place, assurances of their effectiveness do not occur (see **R2.21 and R2.36**).
- Setting the organization's overall program from year to year and engaging in long range planning to establish its general course for the future. One board member stated that it is their responsibility to give direction to the staff; however, without a plan in place, no direction can be provided. Others stated that insufficient direction was caused by ineffective leadership and an absence of necessary resources (see **R2.34 and R2.35**).
- Establishing fiscal policy and boundaries with budgets and financial controls (see the **funding and finance** section).
- Selecting, evaluating, and if necessary, terminating the appointment of the CEO. CMHB's board members are all very clear in their responsibility to select, evaluate, and terminate the CEO (see **R2.21**).
- Developing and maintaining a communication link to the community, along with promoting the work of the organization (see **R2.32** and the **external affairs** section).

Board member duties should not include the following:

- Engaging in the day-to-day operation of the organization.
- Hiring staff other than the CEO.

- Making detailed programmatic decisions without consulting the staff.

As a result of BOG's inappropriate involvement in daily activities and expending board member energy on hiring personnel other than the CEO, effective oversight, employee morale and practical, long-range planning activities have declined.

R2.19 CMHB's BOG should re-examine their role and influence over CMHB's operations to determine if their level of involvement is appropriate and effective, particularly in the areas of leadership, bylaws, committees, composition, recruitment, commitment, orientation, and strategic planning. Defining the appropriate role is particularly important since the chief executive officer, chief clinical officer, and chief operating officer positions have been filled. In the report that follows, BOG should consider and discuss their role in each of the findings and recommendations.

Leadership

F2.24 BOG has stated, and the AOS survey of CMHB employees indicated, that a critical need of CMHB is effective and long-term leadership. CMHB has a history of short-term, tumultuous leadership as noted in the last 33 years. Since CMHB's inception in 1969, there have been a total of seven chief executive officers and all but two have been fired. Even in the last five years, there has been particular unrest at CMHB as the previous chief executive officer was criticized by BOG for poor leadership, ignoring board directives, and taking an unauthorized bonus. According to an article in the Plain Dealer on March 18, 2002, the most critical work for the next leader to accomplish at CMHB is to internally streamline administrative staff, build relations with the commissioners and other external stakeholders, lead the charge for regulatory reform in with the State, and obtain additional money from non-traditional sources, such as government grant and charitable foundations (see the **planning and systems development** and **finance and funding** sections).

To address these issues, the BOG developed a comprehensive job description to assist them in their search for viable CEO candidates. Several required competencies as defined by the ORC § 340 include the following:

- Serve as executive officer of the board, and subject to the prior approval of the board for each contract, execute contracts on its behalf;
- Supervise services and facilities provided, operated, contracted, or supported, by the board to the extent of determining that programs are being administered;
- Provide consultation to agencies, associations, or individuals providing services supported by the board; and

- Recommend to the board the changes necessary to increase the effectiveness of the mental health services and other matters necessary or desirable to carry out;

Other responsibilities assigned by the CMHB's BOG include:

- Leading and conducting a two to four year overall reassessment and turnaround effort for CMHB;
- Directing the development, implementation, and ongoing revision of a strategic plan to make CMHB more efficient, effective and better organized in its delivery of services to consumers who are seriously emotionally disturbed or severely mentally disabled;
- Increase the overall revenue of the mental health system in order to meet the unmet, growing need for mental health services in Cuyahoga County;
- More fully integrate the mental health system in the overall system of mental and physical health care in the broader community;
- Strengthening and maintaining the partnership with all of the CMHB funders, including the county commissioners, ODMH, and all of CMHB's provider agencies;
- Facilitating the transition of CMHB to a recovery model of service delivery and care;
- Conducting a strategic communication effort with the public to deepen their understanding of the board, its mission, programs, services, and mental health in general;
- Catalyzing the development of greater measures to prevent the occurrence of mental illnesses in Cuyahoga County;
- Lessening the Cuyahoga County mental health system's reliance on in-patient hospital stays through the development of clinically appropriate, cost-effective community-based solutions; and
- Developing a strategy for CMHB to address the increasing demand for, and cost of, community mental health Medicaid services.

Some board members have indicated that maybe no one can embody all the skills identified as necessary to be successful. Realizing the broad range of skill required, one board member indicated that the BOG intends to design a team of leaders consisting of the chief executive officer, the chief clinical officer, and the chief operating officer. These three CMHB leaders and the BOG will share the leadership role and embody all the needed strengths and skills necessary to successfully, and jointly, lead CMHB forward.

Franklin and Stark MHB disagree with the idea of shared leadership between the board and the executive staff. Stark MHB's chief executive officer has filled that role since 1979. The success of his administration is due, in part, to the level of involvement in the

day-to-day operation among their board of governors as well as their willingness to include other mental health staff and community members in pre-board activities. For example, the board of Stark MHB does not involve itself in hiring for any position other than CEO nor do they consider committee work to be strictly composed of board members. Additionally, there has been low turnover among staff during this administration which suggests that levels of morale are satisfactory. The CEO of Franklin MHB indicated that it was important for the board and the CEO to operate from different roles and those roles should be clearly separated and adhered to, not only for accountability's sake, but for the sake of morale as well.

In January 2001, the United States General Accounting Office (GAO) identified lack of effective leadership as one of the critical challenges faced by many agencies in the United States. An effective organization includes a senior leadership team committed to developing more effective ways of doing business, accomplishing results, and investing in human capital. Perhaps the most important element of successful management reform is the demonstrated commitment of leaders to change. Political leaders, as well as senior career executives, demonstrate this commitment by personally developing and directing reform, driving continuous improvement, and characterizing the agency's mission in reform initiatives. Agency leaders should be held accountable and should hold others accountable for the ongoing monitoring and refinement of human capital approaches to ensure continuous effectiveness, constant improvement, and increased mission accomplishment within the agency.

Successful organizations know the importance of fostering a committed leadership team and providing reasonable continuity through succession planning and executive development. Two mechanisms for fostering a committed leadership team are an executive development program and comprehensive succession planning which are linked to agency goals and objectives. The executive development program can include planned developmental opportunities, learning experiences, and feedback for candidates. Support for, and use of, government and nongovernment executive development programs can help agency leaders in establishing an active executive development program.

Agency leaders have other opportunities for displaying their commitment including:

- Continuous-learning efforts;
- Employee-friendly workplace policies;
- Competency-based performance appraisal systems; and
- Retention and reward programs.

The sustained provision of resources for such programs can show employee and potential employees the commitment agency leaders have to strategic human capital management.

R2.20 BOG should foster an environment at CMHB that provides for effective and long-term leadership by developing a comprehensive succession planning and an executive development program. By developing these programs, BOG will help ensure long standing, committed executives whose goals are linked to the goals of CMHB. Evaluation of the achievement of those goals should be built into the job description and performance appraisal system to include management competencies, technical skills, and the accomplishment of program results. Furthermore, BOG should adopt incentive systems that emphasize the consideration of long-term consequences of management in addition to the immediate results.

Additionally, the BOG should select, evaluate, and if necessary, terminate the CEO, but should not involve itself in the hiring of other personnel. This activity undermines the authority given to the CEO, potentially causing low morale and shifting the accountability of personnel from the CEO to the BOG. BOG should clearly define the authority and responsibility of the CEO as the accountable position for CMHB's effectiveness and further entrust the selected leadership to appropriately act on those authorities and responsibilities. BOG should refrain from practicing the concepts of shared leadership.

BOG should determine the organization's mission and set policies for its operations, ensuring that the organization's charter and law are being followed and should support the CEO to carry out that mission and policies. Board members should not involve themselves in the day-to day operations of CMHB, including personnel matters, that fall under the responsibility of the chief executive officer.

Bylaws

F2.25 Aspects of BOG's bylaws are vague and in some cases, do not provide the necessary level of detail to effectively remove the ambiguity from its processes. BOG's bylaws, dated May 24, 2000, contain twelve articles and rely mostly on references to the ORC to provide the rules and guidance for conducting its business. For example, some articles refer directly to the ORC and do not attempt to customize processes for agency use as shown in the following list:

- Article III, Membership of the BOG, and Article IV, Powers and Duties of the BOG, refer directly to the ORC and do not provide any additional language explaining the structure, eligibility, responsibilities, attendance expectations, term descriptions, volunteer status, conditions for removal, or a statement indicating that the duties of the board are an integral part of the bylaws.

- In Article V of the bylaws, the document describes how to fill a vacancy in any elected office of the BOG, but does not explain how to fill the vacancy of a non-

officer. The bylaws do not include how to fill member vacancies; only officers. Even though it is described in the ORC, excluding this information from the bylaws makes them appear incomplete and unnecessarily biased by only focusing on officer activity and not member activity as well.

- In Article VIII, the bylaws do not specifically describe the purpose and composition of the standing committees. Instead, the bylaws state that they may create committees from time to time as prescribed by the BOG. While creating committees from time to time is the right of the board, there are currently several longstanding committees whose purposes/charters are not clearly defined in the bylaws to show how the board is structured and composed. A brief statement describing the allowance of ad hoc or task force committees is not included to allow for short term goal achievement (see *Committees* for more information).

- Article IX, Chief Executive Officer, states that the title, duties, and compensation are in accordance with the ORC, but does not explain specific accountability and ex-officio status at all committee and board meetings. No explanation leading directly to a job description or requiring the CEO recommend changes necessary to increase the effectiveness of services is included. Additionally, there is no statement requiring the BOG to hire and annually review the performance of the Chief Executive Officer.

- No statement or description exists regarding the practice of audience participation during committee or BOG general meetings. For example, according to the executive specialist, the audience may actively participate during committee meetings, but at BOG general meetings, there is a designated 15 minutes set aside at the beginning and at the end for audience participation. The beginning 15 minutes is designated for audience input regarding any agenda item and the last 15 minutes is designated for audience input regarding any item.

Additionally, of the board members that were interviewed about the bylaws, most stated that the bylaws have a very limited influence on the way the board operates. Overall, BOG awareness of the bylaws is relatively low as indicated in several BOG interviews and in the June 2001 general board meeting when the Chair was not sure about the process for holding the election of BOG officers.

Lake and Lorain MHB's bylaws are more specific in each of the above categories and go beyond ORC mandates. Their bylaws more clearly define how their boards operate and more clearly state what level of control they exercise within the parameters of the ORC. For example, Lorain MHB's bylaws state that the secretary of the board is responsible for the minutes of the meetings and that the secretary shall keep a record of the attendance at all such meetings. There is no provision in the CMHB's bylaws that assign responsibility

for that function. Additionally, Lake MHB's bylaws clearly indicate quorum requirements for board meetings and committee meetings, but CMHB's only define quorum for board meetings. It is not clear in CMHB's bylaws whether a quorum for committee or task force work is necessary.

More specific operating rules help eliminate confusion over how boards operate. In addition, clearly defined bylaws help to ensure that governing entities operate more effectively and in a consistent, fair and organized fashion, and provide stakeholders with clear expectations and standards for holding the board accountable. Rules that govern operations define the way governing entities do business internally and place the focus on the situation at hand, not on the process for handling the situation.

R2.21 BOG should revise its bylaws to include the following statements about how the board operates referring to the ORC only for support:

- The methodology used to fill board member vacancies;
- Standing committee purposes and charters, including structure and composition;
- Specific board member duties including attendance expectations, term descriptions, volunteer status, eligibility, and conditions for removal;
- Specific accountability of the CEO; and
- The manner in which audience participation will occur.

Removing ambiguity from the rules of operation will help members and stakeholders remain aware of internal processes. This awareness will increase efficiency in their operation as members and stakeholder time will not be spent looking for a particular ruling or waiting until the next meeting to move forward on a particular issue. Finally, specific bylaws intended to prevent delays in decision making will add to BOG's credibility by helping members stay organized and consistent.

Committees

F2.26 BOG has seven documented standing committees, including the multi-cultural concerns committee and the strategic planning committee which are both currently inactive. The following lists the standing committees at CMHB:

- Executive Committee,
- Program Planning Committee,
- Operations and Finance Committee,
- Quality Improvement Committee, and
- Communications and Government Affairs Committee.

In addition to these standing committees, CMHB periodically appoints ad hoc committees to assist in more specialized and less frequent activities (e.g., the Search Committee, the Recruitment Committee, and the Nominating Committee.) Two Search Committees were recently appointed by the BOG chairperson to assist in the selection of a chief executive officer and a chief clinical officer. The Recruitment Committee was appointed to review applications and recommend potential members to the county commissioners due to the current five vacancies and the term expiration of four additional board members. A Nominating Committee is appointed every April by the BOG chairperson to recommend officer candidates for election. Ad hoc committees may meet more frequently than monthly and disband once their short term goals have been met. In all, there is the potential for nine standing and ad hoc committee meetings per month, in addition to the monthly general meeting.

CMHB board members who were interviewed estimated that they spend an average of 26.7 hours per month on board activities as compared to Stark and Franklin MHB chairpersons spending 23.5 and 12.5 respectively. Due to the frequent and high number of committees, CMHB board members spend more time on board activities than peer board chairpersons do on a monthly basis. Consequently, more CMHB staff time is spent on board and committee meeting preparation as well.

Stark MHB has one standing committee: The Executive, Coordination and Review Committee. Stark's board explained that managing several standing committees was not only time consuming and largely ineffective, but also that the structure of those committees was not conducive to a goal-oriented environment. Stark MHB's board chairperson explained that their committees were not talking to each other and tended to work in isolation.

Stark MHB's focus has since changed from long-term standing committees, to shorter-term task force teams. These teams are formed as a result of an identified need or goal either by the board, providers, or staff, and are appointed by the board. A team may meet for six months to one year, and when the task is complete, the team may either regroup to further the efforts as defined by the board or disband and move on to something completely different. At least one board member serves on all task force teams and the team's work is reviewed annually at the organizational meeting by the board officers, who advise the board whether the team should continue or not. Task force teams are more effective than standing committees because as issues are resolved, or as plans are completed, there is a heightened sense of accomplishment, and progress is more apparent.

Franklin MHB manages two standing committees; the Executive Committee and the Fiscal Committee and has not utilized any ad hoc committees in the last two years. The Executive Committee is comprised of board officers and the Fiscal Committee is a committee of the whole; meaning that each board member is a standing member. The

Fiscal Committee invites providers to discuss issues and create the consent agenda for the general meetings. The advantage to this structure is that it streamlines the way Franklin MHB does business by engaging many stakeholders at once. Another advantage to this structure is it is conducive to the current fiscal environment where no new money is available and the board is forced to maintain the current stream of resources. By not adding anything extra to the system, the board must come together to find ways of meeting current demands.

In addition to the streamlined structure, Franklin MHB board meetings are held to nine regular sessions per year as a result of a survey sent to board members. Their preference indicated that, due to summer and holiday season demands, no board meetings would be held in the months of June and August, with a combined November/December session held in early December. This schedule has proven to be an efficient approach to board governance by reducing the need for staff preparation time and increasing the likelihood of greater board member attendance.

Franklin MHB's CEO maintains that two additional committees should be considered that would add value to its board's limited resources: Planning and Quality Improvement Committee and a Strategic Planning Committee. The Planning and Quality Improvement Committee would be responsible for effective review and oversight of provider services, provide a direct line for accountability, and be able to think two to three years ahead about how changes may affect the consumer's quality of services. The Strategic Planning Committee would be responsible for clearly defining the board's goals and accomplishments, ensuring effective implementation, and being able to think in the longer term (five to seven years ahead).

Because of CMHB's frequent and high number of committees, there is less time available to board members and staff to effectively prepare and plan for CMHB's future, which may cause members to become overburdened, disillusioned, and question whether their influence is productive.

R2.22 CMHB's BOG should redesign and reorganize its standing committee structure by reducing the number of standing committees from five to four. Structuring standing committee work in the following way will cover a range of areas where few, if any, issues would fall outside committee oversight: executive, financial, planning and quality services, and strategic planning. Time spent by board members and staff would ultimately be reduced through more focused meetings around pertinent and value added topics. And finally, BOG should follow Franklin MHB's example and consider reducing the number of general meetings per year from twelve to nine. Reducing the number of meetings to nine per year will assist the BOG in addressing its attendance concerns and may reduce untimely resignations due to time constraints (see *Attendance* for more information). While more background BOG preparation time may be required due to less

meetings, it will be at each board member's discretion to schedule that preparation time as best fits within their schedule. The four standing committees are recommended as follows:

- Executive Committee. Responsible for performing routine board administration tasks, forging new relationships with other county boards, and conducting the performance evaluation of the chief executive officer. Board officers and committee chairpersons should convene as leaders of the BOG to ensure continuity of progress on initiatives.

- Finance Committee. Responsible for reviewing fiscal operations and funding sources, and approving all expenditures and contracts before being referred to the full board. BOG should consider making this committee a committee of the whole and should actively invite providers and other external stakeholders to participate. This committee is key for board members to make effective and consistent decisions especially in a diminished resource environment.

- Planning and Quality Improvement Committee. This committee links provider contracts with provider performance by identifying the needs of the community and planning for the future. This committee is a combination of CMHB's Program Planning Committee and Quality Improvement Committee. It links the provider's implementation of programs with the quality of that service and approaches planning in the shorter term allowing for more immediate reaction to problems and change.

- Strategic Planning Committee. Responsible for the development and implementation of a strategic plan, monitoring its progress, and developing new goals. This committee would have the ability to conduct long-term planning initiatives and is different from the Planning and Quality Improvement Committee because it addresses internal process improvement exclusively.

The Multi-Cultural Concerns Committee and the Communications and Government Affairs Committee should be discontinued as standing committees. BOG should approach these committees on a shorter term basis by developing specific charters to be completed within six months or one year (see **external affairs and planning and system development** section).

Additionally, BOG should eliminate all ad hoc committees and implement the use of task force teams to achieve its shorter term goals. Inherently, ad hoc committees differ from task force teams in their design since ad hoc committee charters tend not change over time while task force team charters are more focused, attainable within a year, and are disbanded once the goals are met. Consequently, CMHB's ad hoc recruitment committee

should disband and recruitment efforts should become the responsibility of each board member to effectively recruit members in cooperation with the CEO, through their daily interactions and volunteer work (see *Board Recruitment and Selection* for more information). Additional problem solving teams should be formed on a short-term, task force basis and should involve external stakeholders with the expertise and experience to achieve the limited goals within the year.

F2.27 Other than ad hoc search committees, CMHB does not permit non-board members to serve on committees. One board member cautioned that even though it could be a potential solution to the sometimes poor attendance, it would be too risky to allow non-board members to serve on committees. The agenda or motive of these non-board members would be unknown and they may not be committed to serving the consumer, particularly the severely mentally disabled. However, another board member stated there would be no difficulty in allowing non-board members to serve on committees.

Stark MHB allows non-board members to serve on either of their two standing committees as need dictates. Such appointments are made by the board, upon the recommendation of the committee chairperson. Members of the standing committees serve from the time of their appointment until the time of the annual organizational meeting. The number of non-board members on a standing committee does not exceed the number of board members serving on the committee. Service of non-board members is advisory only and they have no voting authority for board business. The CEO of Stark MHB indicated that this has been effective for them.

The board president of Franklin MHB indicated that they do not currently allow non-board members to serve on committees; however, he stated that the concept is a positive one. Further, the board president stated that external stakeholder participation at that level could enhance relations and effective decision making. The potential gain could outweigh the risk.

Overall, MHB's could benefit by allowing non-board members to serve on committees since the demands on board member's time would be reduced and the involvement of the community would be increased.

R2.23 CMHB should consider permitting non-board members to serve on standing committees and task force teams as needed by adopting the policy and documenting it in their bylaws, similar to Stark MHB. Adopting a policy of this nature will assist CMHB in more effective decision making through needed and selective expertise, provide an opportunity for more community involvement, and assist committees in meeting their quorum requirements. Permitting non-board members to serve may also relieve some pressure on board members whose skills are valuable, yet whose time is less available.

Board Composition

F2.28 According to Thomas Wolf and ORC § 340, board members should represent a variety of backgrounds as well as various segments of the community, including different minority and ethnic groups. Such diversity will give the board a broad vision and understanding of the meaning of community and public service. The following are the skills and knowledge that an effective board should collectively possess:

- Organizational training;
- Financial/accounting;
- Fundraising;
- Personnel management;
- Legal matters, especially relating to contracts and personnel; and
- Public relations.

An interest in the organization alone is not a sufficient reason to become a board member. The purpose of having board members with specific expertise is not to encourage encroachment on day-to-day activities that are staff's responsibility, but to provide a monitoring capability for the board. Such expertise helps the board in formulating policy, reacting to staff recommendations, and choosing among alternative courses of action. For this reason, the development of a skills inventory chart can be a mechanism for encouraging the board to analyze its needs. A skills inventory chart lists the specific skills down the left margin and lists existing and potential board members along the top axis.

Of CMHB's thirteen members, five are in the mental health and sociology field, two are in the business field, one is a medical doctor, one is a lawyer, one has experience in fundraising, and the rest are either family members or consumers as required by state law. Some board members have indicated that appointments made by appointing authorities, outside of the state requirements, are made without consultation and may not consider the skill needs of CMHB. Some members have complained that many times, appointing authorities do not review applications or interview the applicants for interest or knowledge in any particular area before determining the appointees. As a result, CMHB lacks specific expertise in several areas including finance and accounting, public relations, and organizational training.

Franklin MHB's board composition consists of three members in the banking and finance field, three lawyers, two members in the nonprofit and government field, a human resource professional, two educators, one physician, one consultant, a businessperson, an architect, a family member, and one consumer. The board president indicated that as soon as a vacancy exists, the appointing authority is notified along with their recommendation of how it should be filled. Furthermore, the board president indicated that county and

state appointing authorities are generally mindful of their needs and objective when appointments are made using the recommendations from the board. (see the **compliance** section for an assessment of CMHB's demographic data)

Due to the limited areas of expertise on CMHB's BOG, the overall monitoring capability is challenged and can be a barrier to formulating effective policies and determining constructive courses of action.

R2.24 BOG should develop a skills inventory chart to help analyze the needs of the governing body and to ensure effective representation from the community it serves. Effective representation will assist the BOG in developing policy, monitoring staff development, and choosing effective alternate courses of action. This skills inventory chart should be shared with the appropriate appointing authorities to ensure objectivity and that the needs of the BOG are being met.

Board Recruitment and Selection

F2.29 CMHB's policy on the recruitment of board members authorizes an ad hoc recruitment committee to make recommendations to the BOG. More specifically, the following describes the committee's responsibility in recruiting new board members:

- Conduct a board composition breakdown to determine the qualities/qualifications desired in this position; this information to be disseminated to the appointing authorities;
- Coordinate the placement of notices to apprize interested parties of the board vacancy. All board members, contract and community based agencies, as well as interested others may submit referrals. Such notices shall include qualities/qualifications sought by the board;
- Receive prospective board member applications;
- Review applications and agree upon the best candidate; and
- Forward recommendations to the board chair.

It is the responsibility of the BOG to forward the names of the recommended candidates to the appropriate appointing authority. The latest review of this policy by the BOG on April 24, 2002, removed the requirement of the Recruitment Committee to interview the potential candidate. The Recruitment Committee chair agreed with the decision and explained that interviewing the candidate is not necessary since the process could unknowingly dismiss a needed characteristic. However, in reviewing the community board application, there is no indication of gender or race of the individual located on the application, and without an interview process, complying with the ORC in selecting individuals that represent the community is largely left to chance. In addition, according to the Recruitment Committee chair, the Recruitment Committee does not follow the

requirements of the Sunshine Law, ORC §121.22, therefore evidence of adherence to the action steps described above is not available (see the **compliance** section for more information).

According to one board member, the Recruitment Committee efforts appear haphazard since CMHB does not usually have 18 board members serving all at once. Membership has sometimes been as low as 12 members. For example, at the January 2002 board meeting, the Recruitment Committee chair announced that the committee was looking to make a recommendation for the one county vacancy and it was interested in recruiting a psychiatrist or a consumer to fill that slot. However, no evidence of a needs assessment was provided and no supporting evidence was available to support the recommendation.

Additionally, as many board members have acknowledged, it is an unpredictable situation when making recommendations to the appointing authorities since they tend to fill the vacancies for reasons other than satisfying the specific demographic or community representation needs of CMHB. However, by providing the appointing authorities with a skills inventory list and representation needs of the community, it becomes the responsibility of both BOG and the appointing authorities to appropriately fill vacancies in a timely manner. It is further acknowledged that communication in this area could be improved.

Stark MHB board members are very active in recruiting board members and many are forthcoming through word of mouth. According to the chief executive officer, a one or two hour meeting is scheduled with each potential candidate to discuss what it means to be a board member, followed up with an outline of what the appointment entails, including their role and responsibility. When the meeting is over, the CEO makes a recommendation to the board on whether this candidate would be suitable and committed to serve as an active participant. If so, a meeting may be scheduled with the board chair or a member of the executive committee to discuss in more detail the expectations and needed commitment. Stark MHB does not have a formal recruitment committee and according to the board chair, "We all just work together."

Franklin MHB board members are also very mindful of the importance of active and ongoing recruitment methods. For example, according to the Franklin MHB board chair, when a board member's term expires or the member resigns, that person usually provides a list of potential candidates that may be in a position to fill the vacancy. Potential candidates are forwarded to the CEO and are given the opportunity to ask questions and understand the expectations of a board member. If the candidate indicates interest, the CEO forwards the candidate's application to the appointing authority where another interview may take place. Appointments are typically made within two or three months from the point of vacancy.

According to Thomas Wolf, author of *Managing A Nonprofit Organization in the 21st Century*, boards need to have a clear recruitment process which spells out the roles and responsibilities for board members, along with having an orientation session for individuals who have agreed to join the board. The following is an example of a recruitment process:

- A nominating committee is set up. The committee is made up of members either elected by the board or appointed by the president.
- The committee analyzes board needs, and evaluates the performance of members up for re-election, solicits the names of other prospective members, and reviews the potential members with the full board.
- After the names of the potential members are approved by the board, appointments are made with these potential members. Each prospective member is visited by at least one member of the board, often the president, who is sometimes accompanied by a member of the executive committee. At this meeting the roles, responsibilities, and requirements for board members are discussed and a copy of the board manual is left with the prospective member so it can be studied in detail before a decision is made.
- One week after the visit, the prospective members should be asked for a final decision. If the answer is yes, the individual will be officially recommended for appointment according to the process set out in the bylaws.

The effects of CMHB's Recruitment Committee efforts are unproductive compared with the peers' approach to individual board member recruitment efforts. Both Stark and Franklin MHBs stated that their recruitment efforts are effective by giving the responsibility to each board member and further, interviewing candidates to provide a realistic representation of the mental health board issues and expectations.

R2.25 BOG should re-examine and redesign its recruitment efforts from the committee perspective to the individual board member perspective. Every board member should be an active recruiter through their daily interactions and activities. As board members, part of their responsibility is to engage and educate the community concerning their role. One of the ways they can do that is through individual and active recruiting. In addition, the following aspects should be included in CMHB's recruitment process:

- Require at least one interview with the potential candidate to discuss expectations of time, attendance, and committee work;
- Designate a board member or officer to maintain a board needs assessment with regard to the community's demographics and representation needs;

- Require and maintain formal attendance records of members;
- Formally require active individual recruitment in the duties of the BOG;
- Require and expect that when members resign or when their terms expire that they present to the remaining BOG a list of potential candidates; and
- Enlist the commitment of the appointing authorities to appoint members in a timely and appropriate manner, considered to be an asset to CMHB with no discernible conflicts of interest.

Disbanding the Recruitment Committee and making each board member responsible for new member recruitment will reduce the time spent on committee bureaucracy, including the amount of travel and time spent onsite, and instill a teamwork attitude within the BOG by involving all members around a common goal.

Board Attendance and Retention

F2.30 Several board members have expressed concern and frustration over having to routinely operate with less than a fully staffed board due to poor attendance and poor retention. Several board members stated that meeting quorums, both in the general meeting and committee meetings, is a major problem and further indicated that they meet quorums only about 75 percent of the time. Another member indicated that having to wait for months to get board members appointed is not unusual and many times, there have been as many as six vacancies at once. Board members have stated that the reason for vacancies on the board is due primarily to untimely appointments made by the appointing authorities, as evidenced by the nine current vacancies. In addition, some persons wish to build a good resume and are later disillusioned with the time commitment, busy and changing work/travel schedules, and not knowing if they are making a difference. Expectations of BOG attendance and criteria for reprimand are not included in CMHB's bylaws (see *Bylaws* for more information).

State law provides an avenue for mental health boards to follow should BOG attendance become an issue. ORC § 340.02 states that within one year, any board member who is absent from four board meetings or two board meetings without prior notice should be referred to the appointing authority for possible removal. CMHB does not enforce this course of action, fearing that their removal would further add to the problem. The BOG does not require or maintain formal board member attendance records; however they do record attendance at each meeting as indicated on the minutes.

Stark MHB actively approaches attendance issues as soon as possible. When lack of attendance is detected, the president of the board either calls or writes a letter to the offender, reminding them of their commitment and asking them to either recommit or resign. Typically, being up front about the expectations is very effective and there are no hard feelings. Stark MHB's board president indicated that taking that measure up front is

what is best for the board and that there is no room for members that wish to use the board as a resume builder. Stark MHB's board president indicated their board does not have issues with meeting quorum requirements. Similar to CMHB, Franklin MHB avoids using the ORC to force member attendance or resignation and only pursues it in extreme circumstances. However, when attendance does become an issue, the board president approaches the offender as soon as possible to gain a recommitment or encourage the individual to step down.

For members whose travel schedules prevent them from attending meetings, the ORC §1702.31 states that unless otherwise provided in the articles, regulations, or bylaws, board members may attend meetings via teleconference, provided both parties can hear and effectively communicate with each other. Implementing this communication tool could provide CMHB with increased attendance and longer term stability as a way to keep board members informed and engaged at general board meetings, as well as standing committee and task force meetings.

By effectively addressing attendance issues immediately and professionally similar to the methods employed by Stark and Franklin MHBs, BOG could be staffed by members who want to be involved, thereby increasing board member retention.

R2.26 BOG chair should actively and immediately enforce attendance issues among board members to reduce the barriers of not meeting quorum. Enforcement should require a statement of recommitment or resignation from poor attending members. Also, reducing the number of board sessions per year from twelve to nine would assist board members and staff to better focus their agendas and become more effective in presenting information as indicated in Franklin MHB. Attendance policies and enforcement of them should be included in the bylaws. In addition, BOG should consider permitting teleconferencing meetings on a limited basis for board members whose schedules or situations would otherwise not allow their participation. And finally, CMHB should work closely with the appointing authorities to stress the importance of timely appointments to fill vacancies.

Board Member Reappointment

F2.31 The County, as indicated by the minutes of the February 2002 BOG general meeting, requires the following information regarding reappointment of board members:

- A letter from the board member expressing interest in being reappointed;
- An updated resume;
- A letter from either the board chair or agency director recommending reappointment; and

- The attendance record of the board member.

State reappointments require a different and more detailed set of requirements including:

- Verification of notification to relevant constituencies and the general public regarding the vacancy;
- Completed applications of three persons with the board's prioritized recommendation for all new applicants, which includes unexpired terms;
- A listing, by name, of all other applicants;
- A completed application which includes verification that the incumbent is in compliance with ODMH board member training policy;
- An updated list of all members, including indication of required representation; and
- Current board composition (race and gender) and its reflection of the board area's composition (race and gender).

Staff indicated that even though the State's requirements demand more work, they are better than the County's criteria because they are more objective and thorough. In the past, County reappointments have taken an exceptionally long time, in one case as long as four years, and even though a board member's attendance is questionable, they may still be reappointed.

Franklin MHB's re-appointment procedure is different than CMHB's in that board members wishing to be re-appointed must complete an application as though they were new members. In lieu of an additional application, the County will accept a letter from the CEO to take the place of an application. Letters and applications are reviewed and placed on file in the same manner as the initial appointment.

Franklin MHB's CEO is generally notified by the board four to six months in advance when a board member is coming up for reappointment or going off the board. Although this communication varies somewhat, it is handled between the CEO and the individual board member.

Board member vacancies left unfilled for long periods of time have several negative effects on CMHB, including low morale among board members and a sense that poor communication between the BOG and the appointing authorities exists.

R2.27 The County should consider redefining board member reappointment criteria to more closely mirror the state's criteria and Franklin MHB's system. Additionally, the County should strive to make timely appointments to help in reducing board vacancies and increase a positive working relationship between the County and CMHB.

Board Orientation

F2.32 CMHB's BOG orientation is currently not meeting the needs of board members to effectively understand operations and mental health system issues. According to CMHB's board president, the orientation process they currently employ is overwhelming and it does not allow members the opportunity to effectively understand the material. Members of CMHB's management team assemble a book and present the information to new board members, usually after regular office hours or on a Saturday, and preferably in groups of three or four at a time. Several board members have indicated the orientation is a good idea, but ineffective because of the vast amount of information contained. The complex issues and terminologies take a long time to absorb. Some board members stated a smaller, ongoing orientation would be more effective, allowing board members to be less pressured and more open to the new information being presented.

The most current orientation program is dated November 1998, and the most recent orientation session occurred in May 2002. The following topics and attachments are included in CMHB's orientation program to new board members:

- An Introductory Guide giving new board members a brief history, answers to frequently asked questions, additional resources, abbreviations and jargon, and fiscal terms and budget line items;
- Conflict of Interest Statement;
- Board Bylaws;
- Current BOG roster; and
- BOG committee structure.

The presentation includes the following topics and is presented by CMHB staff:

- Introduction to CMHB's mission/vision;
- Rights and Responsibilities of board members;
- Role, Responsibilities, General Liability Statement, and Board policies;
- Board organization, including current committee structure, CMHB bylaws, board staff table of organization, and board staff committee structure;
- Authority and relationship between board members and executive director;
- Overview of system including consumer operated programs, family member organizations, agencies that serve children and the services provided, agencies that serve adults and the services provided, housing programs and resources, and employment/vocational programs and resources;
- Overview of budget;
- Structure and function of Metro Behavioral Health Care Network (MetNet), now known as the Ohio Association for Behavioral Health Authority;

- Overview of ODMH and its relationship with the board; and
- The relationship of the board and the County Commissioners.

CMHB's board president or executive officer also provides a brief overview of board member expectations. While the information presented is relevant and necessary for board members to understand, the process of introducing the information is ineffective. Franklin MHB takes a less formal approach to board member orientation by having the new member spend a half day with the chief executive officer. During the course of this half day session, the chief executive officer escorts the new board member around to get acquainted with principle staff members and to discuss the board member's interests. According to the chief executive officer, it does not matter how formal or how involved the orientation may be, the board member will need at least six months to one year of actual board activity to absorb and understand the processes and issues.

Stark MHB's Board Orientation Program is similar to CMHB's program in its formality and length of presentation. According to the Director of Community Relations of Stark MHB, it is too much information to present at one time. With all the different backgrounds and experiences of board members, it is important to move more carefully allowing them to absorb and become comfortable with the information before moving on to other, more complicated topics such as finance and program development. An overview of the public mental health system and the critical role the board member plays within that system is probably enough for them to have to absorb in one session. Another session, held at a different time, could discuss just the financial portion and lastly, schedule a program and educational portion. A smaller and more focused orientation would be more effective.

By not offering new board members the opportunity to become better acquainted with the mental health industry's background, operations and issues at a more manageable pace, members feel overwhelmed and awkward, preventing them from more actively participating sooner and more confidently.

R2.28 CMHB should continue to provide formal orientation sessions to new board members but redesign the structure to break out the information into smaller, more manageable topics. To accommodate smaller, more focused sessions, orientations should be scheduled immediately before or after board or committee meetings and centered around one or two topics at a time.

For example, CMHB should break out the original set of orientation materials into three distinctly different areas lasting one or two hours each, perhaps even offering them several times per year, as outlined below:

- **BOG Structure and Role.** This session should include topics such as a brief history and current status of the public mental health system, ORC requirements, committee structure, bylaws, and relationship between the BOG and the various stakeholders including the chief executive officer, county commissioners, ODMH, providers, and consumers. Offering this session in January and July would most benefit the BOG since board terms expire in June. For board members appointed after July, this section of the orientation would occur in January.

- **Funding and Finance.** This session should include an overview of BOG's fiduciary responsibility, an overview of MACSIS and Medicaid, and a review of the budgetary structure and funding streams. Offering this session twice a year, in March and September, would help board members retain this complex set of information and may also serve as an ongoing refresher for members that have already attended but feel they need more understanding.

- **Providers.** This session should include an overview of the system, including consumer operated programs, family member organizations, agencies that serve children and the services provided, agencies that serve adults and the services provided, housing programs and resources, and employment/vocational programs and resources. CMHB should offer this session twice a year, in May and November, to help ensure that the most current information is being provided and to offer more specific, known issues regarding each provider that may otherwise have been overlooked due to time constraints.

Board staff should prepare and present the material. By providing these sessions on a staggered basis throughout the year, and scheduling them around already required meetings, board members will have a greater opportunity to attend. As economic and legislative climates change, these sessions should also be offered to veteran board members in need of an update.

Board Involvement with Personnel

F2.33 The role of a board member is often not clear among members and in some cases, among the appointing authorities. For example, during CMHB's search for a chief executive officer, the appointing authorities stated in a letter to BOG that among those candidates under consideration, some candidates' qualifications were questionable for the position. Some board members stated that the County's and State's involvement in that process undermined the authority of the BOG and caused a strain between the board and the community, and between the board and the appointing authorities.

Additionally, according to several members of BOG, the activities of BOG have fallen outside of the traditional board responsibilities due to recent and frequent leadership changes. The absence of a chief executive officer has caused over-involvement of board members in the day-to-day operations of CMHB and low morale among staff. For example, in addition to searching for and hiring the next chief executive officer, the BOG passed a resolution to form a committee to search for the next chief clinical officer. Further, some board members have stated that as a requirement of the next chief executive officer, the appointment of a chief operating officer will be made at the BOG's discretion, thus forming a team of leaders designed to co-lead CMHB.

Franklin and Stark MHBs have indicated their board members do not involve themselves in the searching for or hiring of any personnel other than the chief executive officer. Personnel selection is the duty of the CEO as defined in the ORC §340.02, which states that it is the responsibility of the CEO "to employ and remove from office such employees…subject to the approval of the board…as may be necessary for the work of the board."

Additionally, one CMHB board member indicated in the past, there has been disagreement over the roles played by the BOG and the chief executive officer. For example, the development of the strategic plan and its implementation did not occur because of a lack of understanding over the roles each party was to play in the process. Further, roles played in hiring staff other than the CEO were unclear as board members have indicated their dissatisfaction at not taking part in that process.

The following tables (**Tables 2-11, 2-12,** and **2-13**) were developed by consolidating responses from each of the board's chief executive officers as well as from the Management Assistance Program for Nonprofits (MAPN). For purposes of comparison, MAPN is considered as the standard to which all other boards are compared. The following table is an example of how board and staff responsibilities are divided in regard to personnel responsibilities. While neither CMHB nor two of the peers exactly match the standard, it is important that board and staff understand and agree on roles and responsibilities.

Table 2-11: Personnel Responsibilities

ACTIVITY	STANDARD	CMHB	Franklin	Lucas	Stark
Personnel:					
Employ chief executive	Board	Board	Board	Board	Board
Direct the work of staff	Staff	Joint	Staff	Staff	Staff
Hire and discharge staff member	Staff	Staff	Staff	Staff	Board
Decision to add staff	Board	Staff	Board	Joint	Board
Settle discord among staff	Staff	Staff	Staff	Staff	Joint

Source: Management Assistance Program for Non-Profits and MHB CEOs.

BOG involvement with directing the activities of staff are unproductive and outside the traditional role of governing entities as noted by the standard and the peers. BOG involvement in this area constitutes a micro-managed environment causing low morale and poor communication among staff. In addition, BOG's absence of input in the decision to add staff is also misplaced since this decision affects CMHB's long range planning and funding (see *Role* for more information).

R2.29 CMHB's BOG should not involve itself in hiring staff other than the position of the chief executive officer. While the board should be involved in the decision to add additional staff, the selection of that staff should remain the responsibility of the CEO and staff. Additionally, BOG should remove itself from the day to day operation of the agency and permit the leadership of CMHB to direct the work of staff. Reducing their involvement in this area is clearly appropriate and necessary in order to facilitate a good trusting relationship with the chief executive officer and improve morale among the staff. A clear understanding of these roles should be discussed and agreed upon.

Board Involvement with Programmatic Responsibilities

F2.34 **Table 2-12** illustrates suggested lines of responsibilities based on MAPN standards, and the practices of CMHB and the peers regarding programs. For CMHB, reversed roles in several areas exist including training volunteer leaders; overseeing the evaluation of products, services and programs; and ensuring the annual audit of organization accounts. For Franklin MHB, having the staff train volunteer leaders is effective because the staff are closest to the process and are considered to be the most knowledgeable in terms of current issues and pending legislation.

Table 2-12: Programmatic Responsibilities

Programming:	Standard	CMHB	Franklin	Lucas	Stark
Assess stakeholder (customer, community) needs	Staff	Staff	Staff	Staff	Joint
Train volunteer leaders	Staff	Joint	Staff	Staff	Staff
Oversee evaluation of services and programs	Board	Staff	Staff	Staff	Staff
Maintain program records; prepare program reports	Staff	Staff	Staff	Staff	Staff
Prepare preliminary budget	Staff	Staff	Staff	Staff	Staff
Finalize and approve budget	Board	Board	Board	Joint	Board
See that expenditures are within budget during the year	Staff	Joint	Joint	Joint	Joint
Approve expenditures outside authorized budget	Board	Board	Board	Board	Board
Ensure annual audit of organization accounts	Board	Staff	Joint	Staff	Joint

Source: Management Assistance Program for Non-Profits and MHB CEOs.

The BOG role in effectively overseeing the evaluation of services and programs is important because it provides valuable information from the community while allowing BOG to maintain its objectivity. For staff to perform that oversight may not provide enough involvement to encourage a better evaluation of providers.

Ensuring expenditures are within budget during the year is more appropriately performed by staff since they are closest to the process. Responsibility for that function should fall on the staff, heightening their accountability for all money spent and taking ownership of budgetary guidelines. However, as indicated in **Table 2-12**, CMHB and all the peers ensure this activity jointly in the interest of preventing that expenditures exceed the budget. Similarly, the appropriate role for the BOG is to ensure that an annual audit of organization accounts is performed. In practice, CMHB and the peers have ensured this activity either jointly or as a staff function.

R2.30 The differences in the roles for programmatic responsibility between CMHB's BOG, the peers, and the standard are relatively few and do not appear to affect overall effectiveness in this area. In the differences identified between CMHB and the standard however, BOG should discuss and ensure that their roles match those as defined by the standard as closely as possible, where differences exist, BOG should ensure that the process used is effective. Clearly defined roles help prevent communication problems and free up the energies of people to perform their work instead of duplicating effort or assuming another has performed the work. Additionally, clear roles improve morale by giving employees a framework in which to work without fear of reprisal.

Board Involvement with External Stakeholders

F2.35 CMHB's BOG has indicated collaboration with other boards, (i.e. Mental Retardation and Developmental Disabilities (MRDD), Alcohol and Drug Addition Services (ADAS), and other external stakeholders) does not occur. With the exception of the Kids Initiative Team, other involvement is not sought among the peer boards, the community, or provider agencies. One board member indicated there was a huge need to collaborate; even in the area of consistent paperwork. If, for example, clients and providers were required to complete one form instead of many different forms that essentially contain the same information, significant savings could be realized. As one board member pointed out, the success of the Kid's Initiative Team was primarily due to effective input from several different stakeholders, including board members from the MRDD and ADAS, providers, and staff. The results from that interaction proved successful and were further praised by the board member as an example of how problems should be solved and how teams should function.

In addition to the praises associated with the Kid's Initiative Team, two external consultants with extensive national experience in the field of co-occurring disorders spent

considerable time meeting with key local stakeholders and examining the service array related to clients with multiple problems. Their draft report, dated December 2001 and entitled *Both Sides of the Bridge*, was submitted to CMHB's BOG and supported ongoing interface with the Alcohol and Drug Addiction Services Board and other stakeholders. The report describes both the current status of service and system responses to clients struggling with mental illness and chemical addiction, as well as how the local system might enhance activities at both the service and system levels. The following recommendations were provided to more effectively collaborate with other boards:

- Conduct regular joint meetings of trustees and board members from both systems to discuss the needs of persons with multiple diagnoses;
- Conjointly plan efforts to address issues that bring together program and planning staff from multiple systems, including mental health, alcohol/drug, housing, jail, courts, etc.;
- Develop ongoing cross-training activities that bring together training and staff development efforts from the multiple systems with which clients interact. These trainings must seek to bridge the gap created by the different philosophical perspectives and historical treatment protocols that drive each system;
- Construct Requests for Proposals that represent efforts to blend funding and require responses that mobilize cross-system collaborative activities that reach across traditional system boundaries; and
- Identify boundary spanner positions at multiple levels of the Cuyahoga County system in order to ensure that dedicated staff is addressing cross-system integration activities that reach all components of existing structures and services on an on-going basis. The boundary spanner roles are critical in implementing the types of low-cost, high-impact system and service level changes identified above in the discussion of current versus desired systems interface (see **finance and funding** for an assessment on costs). Further, these boundary spanner positions must operate at no fewer than four different levels of the existing systems in order to maximize opportunities for success in collaborative efforts to promote integration. These levels include: Board executive, senior agency executive, supervisory, and service.

Stark MHB is particularly active in involving external stakeholders in their design by inviting them to participate in task force committees and scheduling annual meetings with each provider agency. To keep the task force committee diverse, provider management, provider staff, consumers, and provider boards are encouraged to join. Even though they are not permitted to vote, Stark MHB's board president explains there is not a lot voting that goes on at that level since task force committees are called upon to make recommendations and not make policy decisions or implement them. Recommendations that come out of these task force committees are submitted to the executive committee. From there, if there are no issues at the executive committee level, the recommendations

go onto the full board for adoption or amendment. This system works very well for two reasons: It gives the stakeholders an opportunity to participate at the foundation giving them an understanding of how decisions are made and why. Secondly, it assists the board members to acquire valuable experience and relevant expertise in helping to solve problems and improve situations that ensure consumers obtain consistent care for the money that is spent (see **R2.23**).

In addition to the task force committee meetings, Stark MHB also involves stakeholders by scheduling annual, one-on-one meetings with each provider agency to discuss issues and problems the provider is facing. In addition to any problems, it also serves to better understand all the services of the provider agency, how the provider allocates money, and how the board can help them serve their consumers better. Stark MHB considers this a valuable communication link with their external stakeholders.

Franklin MHB also has what it calls board-to-board sessions with providers where twice a year they invite the provider's chief executive officer and the board president to come and discuss any problems they are having or issues they are facing. It is an open forum where the providers set the agenda collectively and they select a spokesperson to address the board. Franklin MHB board president indicated it is an excellent way to keep the lines of communication open and stated the more information they receive from the community, the better equipped they are to make sound decisions.

Limiting stakeholder involvement in CMHB board operations prevents good working relationships within the community and among peer boards. By actively soliciting the participation of stakeholders, entities are well-equipped to make informed decisions that focus on supporting the needs of the consumer.

R2.31 CMHB's BOG should actively involve other peer boards, providers, consumers, and representative members of the community by inviting them to participate on a regular basis on committees and through scheduled, information sessions. Through more frequent interaction with external stakeholders, systems have a better chance of becoming more standardized; it is easier for the consumer to access services, and it allows providers to deliver services more efficiently.

Additionally, CMHB should implement the system changes as recommended in the *Both Sides of the Bridge* report regarding system interface and board collaboration, beginning with the identification of boundary spanning positions. The boundary spanner roles are critical in implementing the types of low-cost, high-impact system and service level changes identified above in the discussion of current versus desired systems interface. Further, these boundary spanner positions should operate at no fewer than the following four different levels of the existing systems in order to maximize opportunities for

success in collaborative efforts to promote integration: Board executive, senior agency executive, supervisory, and service.

Board Involvement with Planning

F2.36 **Table 2-13** illustrates the roles among CMHB and the peers in relation to MAPN standards for planning responsibilities.

Table 2-13: Planning Responsibilities

ACTIVITY	Standard	CMHB	Franklin	Lucas	Stark
Planning:					
Direct the process of planning	Staff	Staff	Joint	Joint	Joint
Provide input to long range goals	Joint	Joint	Joint	Joint	Joint
Approve long range goals	Board	Board	Board	Board	Board
Formulate annual objectives	Staff	Joint	Staff	Joint	Staff
Approve annual objectives	Board	Board	Board	Board	Board
Prepare performance reports on achievement of goals and objectives	Staff	Staff	Staff	Staff	Staff
Monitor achievement of goals and objectives	Joint	Staff	Joint	Staff	Joint

Source: Management Assistance Program for Non-Profits and MHB CEOs.

Although neither CMHB nor any of the peers match the standards exactly, Stark and Franklin MHB agree with all but one of the categories, and CMHB with all but two of the categories. For CMHB, the categories not matched are the formulation of annual objectives and monitoring the achievement of those objectives. The CEO of Stark MHB likes the process of having the staff formulate objectives and jointly monitor the achievement of those objectives and explained that by having the staff formulate annual objectives, the board is essentially empowering the staff to utilize their expertise and stimulate the thinking of the board. Recognizing the board's time is very limited, it is more effectively utilized in the monitoring role while the staff is able to take a higher sense of ownership for the objectives identified. Further, the staff is able to better synthesize what is going on in the community through their positions. Since board member terms could be more temporary due to term limits and elections as compared to CMHB staff, staff has the ability to garner more in-depth knowledge and information about community needs.

CMHB's BOG has admitted to being more involved than usual in daily staff operations, which they largely attribute to the vacancies in several high level management positions, placing the BOG in a position of crisis management. However, the amount of involvement is less an issue than the manner of involvement as indicated by the respective roles in the formulation and monitoring of objectives.

R2.32 CMHBs BOG should empower the staff to formulate annual objectives and jointly monitor their progress toward them. By removing the BOG from that function, staff can take ownership of the goals and be more effective in working toward their attainment (see the **planning and systems development** section).

Strategic Plan

F2.37 CMHB does not operate from a strategic plan. Although never adopted or implemented, several board members stated that a draft of a strategic plan was developed two years ago, primarily by a hired consultant with some input from top management and staff. Other board members indicated that failure to implement the plan was due largely to top management and staff resistance. Additionally, because of the long development phase, the plan was never formalized out of the draft stage and subsequently never adopted by the BOG. One board member stated because the consultant was so heavily involved in the plan's development, it caused board members to remove themselves from the process. This lack of ownership during the development process made it difficult for board members to know what part of the plan their decisions impacted. Further, even if the plan had been adopted, implementing it would have been difficult since the plan did not include specific responsibility for each of the broad action steps or a time frame for their completion. However, several board members stated that the strategic plan was a solid and useable document and blamed CMHB's leadership for its lack of implementation. Stable leadership, they contend, will allow CMHB to move forward with strategic plan development.

CMHB's strategic plan draft includes a mission and vision statement, in addition to the following goals:

- Increase customer access to needed mental health services;
- Engineer a system that provides a consistent, high quality level of care and services;
- Take the lead in creating a mental health system that maximizes efficiency and effectiveness;
- Increase recognition of CMHB's leadership role in the community; and
- Increase resources available for mental health services in Cuyahoga County.

Broad, preliminary action steps further develop each goal; however, there is no indication of specific CMHB responsibility and little reference made to specific, measurable actions.

In September 2001, the BOG authorized a Strategic Plan Steering Committee. As stated in the board meeting minutes, this Steering Committee would provide recommendations as to where the mental health system should be going, assist in developing an action plan

and provide input regarding CMHB's priorities. With respect to continued communication with external stakeholders, one board member stated that this effort may provide a way to communicate on an ongoing basis and develop increased trust in their working relationships. However, this steering team was never formed. In lieu of a strategic plan, BOG passed a resolution in January 2002 to consider the existing strategic plan draft as operating principles from which an integrated system-wide strategic plan could later be developed. BOG's chairperson indicated there is an intention to develop the strategic plan in the Fall of 2002.

According to the CEO of Franklin MHB, the effectiveness of their strategic plan is as yet undetermined due to the plan having just been adopted in February 2002. However, the completeness and structure of the plan provides an excellent framework from which to build and accomplish continuous improvement in their operations. The actual completion of the document was largely motivated by the Franklin County Commissioners' desire to emphasize planning and outcomes in all agencies countywide. The development began with a facilitated retreat where outcomes, goals and periodic benchmarks were identified.

The organization of Franklin's MHB's strategic plan begins with its mission and vision statement and follows a scheme directly supporting them. The plan is logical and each of the concepts presented progresses toward more specific goals and responsibilities that are measurable and attainable. For example, the document identifies each specific line of business, including consumer services, system of care planning and evaluation, clinical management services, specialized services, and administrative and leadership services. Within those lines of business, specific goals are defined which include not only the desired outcome, but also the timeframe in which it is to be completed. Lastly, performance measures include results, outputs, demands, and efficiencies and clearly describe how progress is to be measured, who in the organization is responsible for attaining the goals and how much money may be allocated in attaining that goal.

In addition to the plan, and to assist in maintaining focus, Franklin MHB created the position of a vice president of strategic planning. This part-time position is responsible for the following:

- Coordinating strategic planning retreats and presentations among staff and board relating to the strategic plan;
- Working in cooperation with senior staff on establishing strategic goals, measurable benchmarks and reporting results to community stakeholders;
- Serving as liaison to the county commissioners office relating to the strategic plan;
- Ensuring that measurable progress is being made in meeting agreed upon strategic plan benchmarks;
- Overseeing the management of team activities; and

- Identifying opportunities to build skills and enhance knowledge of health and human service trends which impact the Franklin MHB service delivery system.

CMHB does not have a specific position dedicated to coordinating the strategic plan activities; however, adding these responsibilities to the chief operating officer's list of responsibilities would be appropriate considering this position's role and function within CMHB. Franklin MHB does not have a chief operating officer position.

According to the California State Auditor's office, the following elements are essential in developing a sound strategic planning process:

- Defining a mission;
- Formulating goals consistent with the mission, including outcome goals, and establishing priorities among them;
- Establishing actions necessary to achieve goals;
- Defining quantified targets for goals, including targets for desired results, or outcomes;
- Measuring the results of operations;
- Comparing results to targets to evaluate and report performance;
- Explaining under-performance and the actions planned to meet goals; and
- Revising the plan in light of performance and changing circumstances.

CMHB's drafted strategic plan incorporates several essential elements for an effective plan including the establishment of the mission and vision statement, some broad goal establishment, and some preliminary prioritization. However, the plan lacks specific measurable goals, specific responsibility for achieving them, and a mechanism for measuring the results and revising the plan. Without measurable goals and defined responsibility for achieving them, the accountability and ability to compare, evaluate, explain, and revise those goals is significantly diminished.

R2.33 CMHB should capitalize on the work they have put into the existing strategic plan draft. The work performed thus far is of value to CMHB and should be updated and expanded to reflect current situational and economic conditions. BOG and the CEO should collaboratively review and update the goals identified in the drafted strategic plan. In addition to goal prioritization, CMHB should incorporate the methodology used by Franklin MHB to narrow goals into smaller ones that support their overall mission. Goals should be clearly measurable and attainable within a specified timeframe. Specific CMHB employees should be identified in the document as accountable for each goal, giving them the authority to implement procedures, create reporting mechanisms through the hierarchy of the organization, and if possible, allowing them to make decisions within a predetermined budget. Employees responsible for implementing the strategic plan should have the authority to explain under-performance and identify the actions needed to

meet the goals. Employees and BOG should work together to revise the plan in light of performance and changing circumstances on a regular basis. Furthermore, since CMHB's operations directly impact external stakeholders, it should solicit external stakeholder involvement in the strategic planning process, including consumers and contracted providers.

CMHB should delegate the part-time responsibility for maintaining and communicating the results of the strategic plan to the employees and external stakeholders and facilitating strategic planning efforts to the chief operating officer (see the **planning and systems development** section).

Implementing the Strategic Plan

F2.38 According to the January 2001 United States General Accounting Office (GAO) report, the involvement of employees both directly and through employee organizations is crucial to successful implementation of a strategic plan. Involving employees in the planning process helps to develop agency goals and objectives that incorporate insight about operations from the front-line perspective. Including employees can also serve to increase employees' understanding and acceptance of organizational goals and objectives, and improve motivation and morale.

In addition to considering employee input, leading organizations studied by the GAO create a set of mission-related guidelines within which managers operate, and give their managers extensive authority to pursue organizational goals. They seek to ensure that internal processes provide managers with the authority and flexibility they need to contribute to the organization's mission. Allowing managers to bring their judgment to bear in meeting responsibilities rather than having them merely comply with rigid rules and standards, can lead to more effective operations.

Overall, the GAO suggests that in order to be a leading organization in strategic plan implementation, the following steps should be taken to foster an environment that empowers and involves employees:

- Demonstrate top leadership commitment to management reform. For CMHB, at the time when the strategic plan was being developed, a tumultuous relationship between the CEO and BOG had already begun. True commitment to long term planning could not be achieved due to a high level of distrust among the employees.

- Engage employee unions. At CMHB, union employees were split as the level of distrust escalated to the point of choosing sides between supporting BOG or the CEO.

- Train employees to enhance their knowledge, skills, and abilities. Focus was strained due to poor relationships fostered at the top management level. The importance placed on training employees was a secondary consideration.

- Use employee teams to accomplish agency missions. Resistance to implementing the CMHB's drafted strategic plan prevented effective team management.

- Involve employees in planning and sharing performance information. BOG expressed concern and frustration over broken communication links and holes in the information provided.

- Delegate authority to front-line employees. At CMHB, no formal plan to delegate authority to front-line employees was in place.

One way to embed a results-orientation is to align individual employee performance expectations with agency goals so that individuals understand the connection between their daily activities and their organization's success. High performing organizations have recognized that a key element of a fully successful performance management system is to create a "line of sight" that shows how individual responsibilities can contribute to organizational goals. As a first step, these organizations align their top leadership's performance expectations with the organizational goals and then cascade performance expectations to lower organizational levels.

Additionally, according to C. Davis Fogg's book entitled *Implementing Your Strategic Plan*, the following five broad categories of strategic planning tasks should occur in order to successfully implement any strategic plan:

- Set accountability. An effective accountability system aligns action steps throughout the organization with the overall plan.

- Fix the organization. People are the most important keys to successful implementation. Ensure that employees with the appropriate skills needed are in the appropriate positions within the organization. Foster creative leadership and mental toughness because without it, implementation will not occur.

- Remove resistance from the organization by identifying ways to address resistance to the plan. Seek out and streamline or remove internal policies, procedures, systems, and processes that inhibit plan action.

- Manage teams from the top-down. Use cross-functional teams to execute complex cross-functional projects but avoid the propensity to see teams as the solution to every problem.

- Enable and align action. Define the cultural values and the norms the organization now has and those the organization will want in the future to guide actions.

- Empower the execution of team's work to meet their objectives. Give them the personal skills, wide but well delineated latitude in decision making, the resources needed to do their jobs, and management systems that quickly surface and address critical issues and provide decisions beyond their empowered limits.

- Provide an environment in which people can excel. Training and personal development of people is an inexpensive way to give the organization the new skills needed to execute the plan now and in the future.

- Communicate to everyone all the time. The organization must ensure that everyone understands the plan, believes in it, accepts his or her part in making it happen and is continuously advised of the plan's essence and progress. Otherwise, people will under-perform their strategic tasks or, more damaging, undermine the desired direction.

- Judging and rewarding. Develop an integrated review system that includes the review and revision of the overall plan and departmental, team, and individual objectives.

- Design a balanced compensation and reward package that rewards long-term strategic accomplishment as well as on-going results from each of the contributing organization units – functional departments, cross-functional teams, and of course, individuals. Make sure that the reward system reflects the conditions of the organization.

Implementing a strategic plan does not happen in a vacuum nor are they one-time events. They play out over time, often four to six years, in the context of a strategic change process. During this process, the psychology of the organization, its ability to change, the change barriers, leadership styles required, and strategic results are relatively predictable. Knowing what to expect may help expedite the change process in the face of an organization's natural resistance to change.

R2.34 CMHB's chief executive officer should be held accountable for effectively implementing an adopted and collaboratively developed strategic plan. To assist the CEO, elements and suggestions made by the GAO and C. Davis Fogg's strategic planning tasks should be incorporated to achieve success, remove barriers and avoid costly mistakes.

Self Assessment

F2.39 According to BOG's chair, no self-assessment of CMHB BOG performance has occurred, primarily due to the board's lack of stable leadership. In September 2000, the United States General Accounting Office (GAO) published a report endorsing agency self-assessments as a starting point for creating focus on valuing employees and aligning policies to support organizational performance goals. The Government Performance and Results Act (GPRA) requires agencies to pursue performance–based management, including strategic planning, result-oriented goal setting, and performance measurement.

According to the Baldrige National Quality Program, thousands of U.S. organizations stay abreast of ever-increasing competition and improve performance by using the Malcolm Baldrige Criteria to assess performance on a wide range of key business indicators including customer, product and service, financial, human resource, and operations by helping to align resources, improve communication, productivity and effectiveness, and achieve strategic goals. By performing a self-assessment against all of the seven categories of the criteria, organizations can identify strengths and target opportunities for improving processes and results. The following is a summary of those categories:

- **Leadership**. This category examines how the organization's senior leaders address values, directions, and performance expectations, as well as focus on customers and other stakeholders, empowerment, innovation, and learning. Also examined is how the organization addresses its responsibilities to the public and supports its key stakeholders (see the *Leadership* section).

- **Strategic Planning**. The strategic planning category examines how the organization develops strategic objectives and action plans. Also examined are how the chosen strategic objectives and action plans are deployed and how progress is measured (see the *Strategic Planning* section).

- **Customer and Market Focus**. This category examines how the organization determines requirements, expectations, and preferences of customers and markets. Also examined is how the organization builds relationships with customers and determines the key factors that lead to customer satisfaction (see the **external affairs** section).

- **Information and Analysis**. This category examines the organization's information management and performance measurement systems and how the organization analyzes performance data and information (see the **provider relations and quality services** section).

- **Human Resource Focus**. The human resource focus category examines how the organization motivates and enables employees to develop and utilize their full potential in alignment with the organization's overall objectives and action plans. Also examined are the organization's efforts to build and maintain a work environment and an employee support climate conducive to performance excellence and to personal and organizational development (see the **human resources** section).

- **Process Management**. This category examines the key aspects of the organization's process management, including customer-focused design, product and service delivery, key business, and support processes. This category encompasses all key processes and all work units.

- **Business Results**. The business results category examines the organization's performance and improvement in key business areas – customer satisfaction, product and service performance, financial and marketplace performance, human resource results, and operational performance. Also examined are performance levels relative to those of competitors. A copy of the E-Baldrige Self-Assessment and Action Planning document may be obtained by contacting www.quality.nist.gov.

In the absence of periodic self-assessments, creating a performance-based organization will be increasingly difficult for BOG to achieve since no clear indication of CMHB's strengths and targets for improvements will be identified.

R2.35 CMHB's BOG should conduct periodic self-assessments using the Malcolm Baldrige Quality Program criteria to help align its policies with organizational performance goals. By performing a self-assessment against the seven categories of the Baldrige criteria, CMHB can more accurately identify strengths and target opportunities for improving processes and results:

- Leadership;
- Strategic Planning;
- Customer and Market Focus;
- Information and Analysis;
- Human Resource Focus;
- Process Management; and
- Business Results.

Additionally, BOG should incorporate the results of the self-assessment into its strategic planning efforts by aligning resources and improving communication, productivity and effectiveness to support the achievement of those goals.

Financial Implication Summary

The following table represents a summary of estimated cost savings and estimated implementation costs for recommendations in this section of the report. For the purpose of this table, only recommendations with quantifiable financial impacts are listed.

Summary of Financial Implications

Recommendation	Implementation Cost (Annual)
R2.3 Fill the three vacant chief positions.	$325,000
R2.6 Promote one administrative assistant to the position of office manager.	$3,000
Total	$328,000

Conclusion Statement

Many of the issues that CMHB is facing can be attributed to a lack of leadership among upper level management positions, which is further supported by survey results obtained from CMHB employees. CMHB was without a permanent CEO for nearly a year because of the need to negotiate a settlement with the previous CEO. The lack of leadership is not only evident in the number of CEO's which CMHB has had over the previous ten years, but also in the number of executive staff and chief position vacancies which exist currently at CMHB. However, by CMHB's hiring of a strong CEO with high level administrative experience should work to improve morale and ensure greater stability among staff at CMHB. In addition to increasing morale and stability, the CEO and the BOG will need to cooperate and work closely with each other in order to respond to difficult system-wide issues that CMHB is currently facing.

By filling the CEO position, CMHB has taken the first step in addressing its staffing needs. Based on peer comparisons, CMHB should consider altering its organizational structure to better meet the needs of consumers and to function more efficiently. CMHB should consider combining the planning and system development division with quality improvement and utilization review into one division. Also, CMHB should consider combining risk management and the finance unit. The consumer affairs unit should be separated from risk management and report directly to either the CEO, COO or CCO. Furthermore, the HR unit should report directly to the CEO. As a result of potential organizational changes, and to enhance the reporting structure and ensure stability in its organizational structure, CMHB should consider filling three chief positions.

In general, CMHB has been in compliance with the portion of the ORC and OAC that pertain specifically to mental health boards. However, a critical non-compliance issue is CMHB not using a formal process to inform the appointing authorities of vacancies on the BOG. As a result, the appointing authorities were not selecting candidates within the required time frame stipulated in the ORC. In order to resolve this issue, CMHB should establish a formal process to notify the appointing authorities of any vacancies. In addition, the appointing authorities should maintain a list of prospective board members.

Another crucial non-compliance issue is CMHB not maintaining a formal attendance record for BOG members. As a result, CMHB has not notified the appointing authorities when board members have missed more than four meetings, or two meetings without prior notice in a given year. CMHB should enforce this attendance policy to ensure that board members are actively participating to improve the mental health system within Cuyahoga County. CMHB can bring itself into compliance with the ORC and OAC with minimum changes and by implementing recommendations made in the compliance section.

CMHB's BOG is inconsistent and unclear about the role they play in the governance and operations of CMHB as evidenced by the absence of effective leadership, low awareness of

bylaws, poor attendance and member retention, poor relations with external stakeholders, the lack of a strategic plan, and lack of self-assessment. As a result, CMHB suffers bad publicity and low morale.

Long-term and effective leadership was identified by the board members as the most critical need of CMHB. In the last five years, there has been particular unrest at CMHB as the previous chief executive officers were removed from office and criticized for poor leadership, leaving staff and the community without a stable executive management philosophy or direction. By fostering a committed leadership team and providing reasonable continuity through succession planning and executive development, BOG will help ensure long-standing committed executives whose goals are linked to the goals of CMHB. Since the positions of CEO, COO, and CCO have recently been filled, BOG should actively support their efforts to improve CMHB's operations and relationships, while maintaining an appropriate distance and level of involvement in daily activities. Collective agreement and understanding on the roles of BOG and staff should be made clear and remain consistent throughout CMHB as identified by the Management Assistance Program for Nonprofits.

Ambiguous bylaws, and BOG's low awareness of them, contributes to the perception that CMHB's governing body is unaccountable and that they make decisions in a vacuum. By clearly defining internal board processes such as how to fill vacancies of non-officers and establishing the purpose and structure of standing committees, greater consistency, organization, and credibility will result.

The high number of vacancies at the governance level and poor attendance occur for several reasons, including untimely appointments, term limit expirations and disillusioned volunteers with time constraints and who feel as though they are not making a difference. More pro-active recruitment methods, enforcement of attendance requirements, and re-design of the board member orientation program, will allow CMHB's board to be staffed by informed members who want to be involved, thereby increasing board member retention.

Identifying boundary spanner positions, as recommended in the *Both Sides of The Bridge* report, is an excellent way for CMHB to improve external stakeholder involvement. These positions should be identified at multiple levels of the Cuyahoga County system in order to ensure that dedicated staff are addressing cross-system integration activities that reach all components of existing structures on an on-going basis.

An undeveloped strategic plan has contributed to the perception that BOG lacks accountability and consistent decision making. By documenting and effectively communicating the goals of CMHB, BOG will be brought into a better position of governance where high level policy making, greater standardization, and better relations with stakeholders can make a positive impact on the public mental health system in Ohio.

Finally, the lack of conducting periodic self-assessments, using tools such as the Malcolm Baldrige Quality Program criteria, has resulted in an environment that does not focus on valuing employees and aligning policies with organizational goals, causing unproductive practices to perpetuate. By performing comprehensive self-assessments, BOG can identify strengths and target opportunities for improving processes and results.

Human Resources

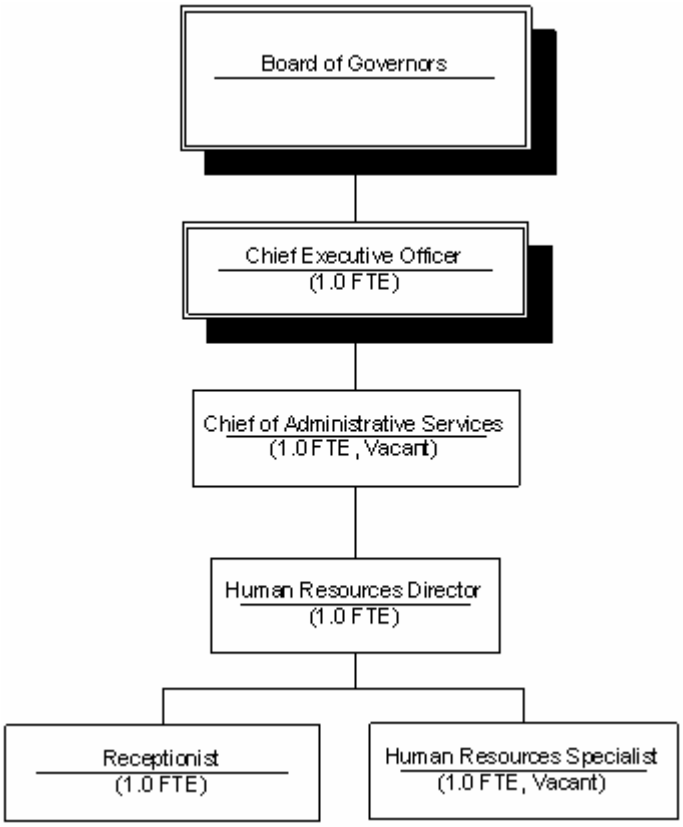
Background

This section of the performance audit reviews the organizational structure and departmental functions of CMHB's Human Resources Unit (HR). For the purpose of illustrating various operational issues, the majority of the comparisons are made to the following peer mental health boards: Franklin, Lucas and Stark Counties. In addition, information from other mental health boards is used for benchmark and comparison purposes.

Organizational Chart

The HR Unit is a part of the Administrative Services Division and has three budgeted positions, including one director, one HR specialist and a receptionist. The HR specialist has been employed since 1997 and was recently promoted to the position of HR director on January 14, 2002. The HR specialist position is currently vacant due to the HR specialist's promotion and a hiring freeze at CMHB. The following chart provides an overview of the unit's organizational structure and FTE staffing level.

Chart 3-1: Organizational Chart



Organization Function

Prior to 2000, HR reported directly to the chief of administrative services. The chief of administrative services position has been vacant since September 2000. As a result, HR is currently reporting directly to the acting CEO. CMHB has a centralized HR department, which acts as a liaison to the County Human Resources Office.

The HR department is responsible for all aspects of HR activities at CMHB including:

- Training;
- Recruitment;
- Policy development;
- Labor relations;
- Performance assessment and job description development;

- Employee relations;
- Timekeeping; and
- Payroll.

Summary of Operations

HR director currently acts as the lead in planning, organizing and directing internal training activities at CMHB. To help organize and coordinate these training activities, the Organizational Development Committee comprised of the CEO, HR director and members of all the units at CMHB focus on coordinating internal staff training and staff development planning. The Organizational and Development Committee reimplemented training sessions on the first Friday of every month for the CMHB staff in 2001. These training sessions have been used to provide training for staff in the areas of e-mail use, public employee retirement system (PERS) and ethics. CMHB also offers tuition reimbursement to its employees, which is coordinated by HR.

HR director also coordinates the employment functions at CMHB by planning and implementing staffing projections, developing recruitment strategies and pursuing HR goals. HR is responsible for posting vacant positions, coordinating interviews, completing selection paperwork and conducting orientation. Currently, CMHB's external recruitment efforts have focused on posting available positions in the area newspaper and on Monster.com. Interviews are typically conducted by an interview committee that consists of the hiring manager and other divisional managers. Upon selection and subsequent acceptance of the position, orientation is conducted by HR. The orientation lasts about two and a half hours and covers such topics as:

- Human resources policies;
- Healthcare coverage;
- PERS (public employee retirement system);
- Badge requirements; and
- Phone system usage.

A seven and a half hour general orientation is later provided to new employees on the third Monday of the month. During the orientation, representatives from each division meet with the new employee to explain how their unit functions within CMHB.

The HR director develops policies and procedures for CMHB in accordance with the current labor agreement. These policies are developed by HR with input from management and Board of Governors (BOG). After being approved by the BOG, the policies are placed in an employee handbook and distributed to staff. The handbook is updated to coincide with changes in the labor agreement with AFSCME Local 328.
CMHB is the only mental health board in Ohio to have a collective bargaining agreement, which

was the result of the organization concerns found at CMHB in 1997. CMHB has one collective bargaining agreement with the Ohio Association of Public School Employees and its affiliate local AFSCME, AFL-CIO #328 (OAPSE), which covers all staff except:

- Managers;
- Supervisors;
- Administrators;
- Contract Specialist;
- Executive Assistant;
- HR specialist; and
- Executive specialist.

The agreement typically covers a three-year period at the end of which, new negotiations will occur. The current labor agreement expires July 2004. CMHB's labor agreement covers such issues as job posting, grievance procedure, probationary periods, leave policy and separation.

The HR director also ensures that the performance appraisal process occurs on the 60th and 120th day for probationary employees and annually for regular staff. HR assists in developing job descriptions and performance evaluation forms. Furthermore, the HR director is responsible for enrolling staff in benefit plans and ensuring that the appropriate deductions are taken.

Benefits provided to employees include: health care, medical reimbursement, and life insurance benefits, with the employee's share of the cost dependent upon the plans and benefits selected. Currently, the staff is offered three health care packages, which are provided through Cuyahoga County. These healthcare packages include Qual Choice, Kaiser Permanente and Summa Care. The HR specialist oversees the healthcare enrollment process. The HR director also monitors payroll, and transmits leave balances and hours to the Cuyahoga County central HR department (CCHR) to record payroll data and print the checks.

The HR director supervises and acts as the backup to the receptionist. However, once the HR specialist position is filled, the HR specialist will act as the backup to the receptionist. The receptionist is responsible for greeting and directing visitors. The receptionist has both telephone duties and clerical duties. The remaining duties of the HR specialist are to address employee concerns, monitor time keeping, and oversee the telephone system.

Table 3-1 presents the key operating statistics for CMHB and peer mental health boards.

Table 3-1: 2001 Key Human Resources Operating Statistics

Category	CMHB	Franklin	Lucas	Stark	Peer Average[2]
Number of Employees [1]	71.0	60.0	21.5[2]	27.0	43.5
Number of Separations	9.0	12.0	N/A[2]	4.0	8.0
Turnover Rate	12.7%	20.0%	N/A[2]	14.8%	18.4%
Average Length of Service	7.4	6.9	3.8	3.7	4.8
Average Compensation Rate	$27.44	$24.38	$21.30	$24.37	$23.35

Source: CMHB and peer Boards
[1] Number of employees at the beginning of FY 2001
[2] Lucas MHB could not provide number separations for FY 2001. Therefore, peer average does not include Lucas MHB.

Table 3-1 illustrates that CMHB has the highest average compensation rate and length of service of the peers (see **F3.15** for further discussion). In addition, CMHB's turnover rate is lower than the peer average (see **F3.33** for further discussion).

Employee Survey

An employee survey developed by the Auditor of State's Office was distributed to all CMHB staff in March 2002. Its purpose was to obtain employees' feedback and perceptions of overall operations, employee relations, customer service and human resources/personnel issues. Responses were received from 45 of the 58 staff.

The survey solicited responses to 53 statements concerning CMHB operations, human resources functions, procedures and policies. Survey questions either gave a response choice of yes/no or used the following scale: 5 - Strongly Agree, 4 - Agree, 3 - Neutral, 2 - Disagree, 1 - Strongly Disagree. In addition, portions of the survey gave CMHB employees the opportunity to provide written responses on important subject matters. The following statements highlight key findings of the employee survey:

- Nearly 68 percent of respondents do not feel that clear goals have been communicated to them by management, as indicated by an average score of 2.3 (see **R3.5**).

- Nearly 88 percent of respondents characterized the morale at CMHB as negative, which is supported by an average response rate of 1.9 (see **R3.6**).

- Nearly 78 percent of respondents do not feel that an effective cross-training program has been implemented at CMHB, which is evidenced by an average response rating of 2.4 (see **R3.36**).

- Nearly 72 percent of staff found that BOG did not have strong leadership at CMHB, which is further evident in the average response of 1.9 (see **Organization, Compliance and Board Governance**).

- Nearly 73 percent of respondents were either dissatisfied or neutral about management's response to recommendations given in the employee performance evaluation (see **R3.19**).

- Nearly 75 percent of respondents either found that the evaluation form is not effective or efficient (see **R3.20**).

- Nearly 35 percent of respondents commented that CMHB can improve the evaluation process by developing a new evaluation form. The remainder of respondents stated that CMHB can improve the evaluation process by implementing more training, and improving consistency (see **R3.20**).

- Nearly 75 percent of respondents do not feel the organizational structure of CMHB is adequate and sufficient (see **Organization, Compliance and Board Governance**).

The complete survey results are shown in **Table 3-2**.

Table 3-2: CMHB Employee Survey

CMHB Attributes	CMHB Staff Average	Corresponding Recommendation
1. **I understand all of the duties covered by my job description.**	4.0	**R3.17**
2. **My job description accurately reflects my actual daily routine.**	3.6	**R3.17**
3. **If a co-worker within my department became ill, our department could effectively maintain productivity on a short-term basis.**	4.0	**R3.36**
4. **An effective cross-training program has been implemented at CMHB.**	2.4	**R3.36**
5. **The opportunity to attend training, programs, conferences, or seminars that are work-related have been offered by CMHB.**	4.1	**R3.32, R3.33**
6. **Staff training is effective at CMHB.**	3.0	**R3.32, R3.33**
7. **The hours of service at CMHB are sufficient to serve contracted providers and consumers.**	3.5	**N/A**
8. **I receive constructive feedback about how to improve my performance on a weekly basis from my supervisor.**	3.1	**R3.19**
9. **I receive constructive and timely feedback on how to improve my performance through the evaluation process.**	3.2	**R3.19**
10. **The form used in the evaluation process is effective and efficient.**	2.8	**R3.20**
11. **Management responds and acts on recommendations made in evaluation sessions.**	2.8	**R3.19**
12. **My immediate supervisor is approachable.**	4.2	**R3.6**
13. **Employees are treated with dignity and respect by their supervisors.**	3.3	**R3.6**
14. **There is a formal and effective process in place to inform employees about changes made in policies and procedures.**	2.9	**R3.11**
15. **I believe that CMHB's procedures for vacant job positions are adequate in attracting qualified and eligible candidates.**	2.9	**R3.22**
16. **I believe that CMHB's procedures regarding job posting and hiring are effective.**	4.2	**R3.22**
17. **I am satisfied with the procedures regarding enrollment, updates and changes in insurance benefits are effective.**	3.1	**N/A**
18. **Current grievance procedures are fair and effective.**	2.9	**R3.9**
19. **Current discipline procedures are fair and adequate.**	3.0	**R3.9, C3.2, C3.3**
20. **Current follow-up procedures for dismissal and discipline are adequate.**	3.0	**R3.9, C3.2, C3.3**
21. **CMHB's sick leave and vacation policy is fair.**	3.1	**R3.4**
22. **I believe the salary I receive is at a fair market rate.**	2.9	**R3.10**
23. **For non bargaining staff, I believe the salary increase are linked to my performance**	3.1	**R3.10**
24. **Union and management appear to have a positive relationship.**	2.9	**R3.9**
25. **Clear goals regarding the direction of CMHB have been communicated to employees.**	2.3	**R3.5**
26. **I understand how my job fits into the goals and mission of CMHB.**	3.3	**R3.5**
27. **I believe that the overall morale and employee satisfaction of CMHB is positive.**	1.9	**R3.6**
28. **I am satisfied with overall effectiveness of CMHB's current HR management policies and procedures.**	2.9	**R3.11**
29. **The last time I received a performance evaluation was?**	-	**R3.19**
30. **How could the performance evaluation process be improved upon?**	-	**R3.20**
31. **Overall, I am satisfied with my job.**	3.8	**R3.6**

32. **I expect to be employed by CMHB one year from now.**	-	**R3.28**
33. **Number of years employed at CMHB.**	-	**R3.28**
34. **How did you come to be employed at CMHB?**	-	**R3.22**
35. **How has turnover affected your division's operations and workload?**	-	**R3.28**
36. **How can morale be improved at CMHB?**	-	**R3.6**
37. **What divisions within CMHB do you collaborate with? Explain the results and benefits of the collaborations with other CMHB divisions?**	-	**Provider Relations & Quality Services**
38. **Board of Governors' leadership is very strong and effective in meeting CMHB's needs and consumer needs.**	1.9	**Organization, Compliance & Board Governance**
39. **Do you feel the organizational structure of CMHB is adequate and sufficient? If not, how could it be reorganized?**	75% said no	**Organization, Compliance & Board Governance**
40. **CMHB and the County are providing adequate resources to effectively serve mental health consumers.**	2.8	**Finance & Funding**
41. **CMHB has an effective working relationship with provider agencies.**	3.0	**Provider Relations & Quality Services**
42. **CMHB's level of auditing, monitoring and oversight of provider agencies and the mental health system in general ensures that services provided to mental health consumers are effective.**	3.3	**Provider Relations & Quality Services**
43. **CMHB contracting process for services (excluding Medicaid contracts) is effective and helps to promote positive / successful outcomes of services provided to consumers.**	3.3	**Finance & Funding, Risk Management**
44. **CMHB develops effective plans to provide adequate services for the mental health population, enhances services provided to consumers and helps to improve the overall quality of the life for consumers**	3.4	**Finance & Funding, Planning & System Development**
45. **CMHB actively promotes community awareness about mental health issues.**	3.3	**External Affairs**
46. **Please list the internal committees that you serve on at CMHB?**	-	**N/A**
47. **About how many hours do you devote each year to serving on these internal committees?**	-	**N/A**
48. **Please list other external committees that you serve at CMHB representing your agency and the mental health system (e.g. ODMH committees, committees with the County, etc).**	-	**External Affairs**
49. **About how many hours do you devote each year to serving on these external committees?**	-	**External Affairs**
50. **Do you spend any of your personal time outside of your employment at CMHB promoting community awareness about mental health issues by serving on other external boards or committees? If so, please list:**	-	**External Affairs**
51. **About how many personal hours annually do you devote to these activities?**	-	**External Affairs**
52. **Overall, does CMHB adequately serve Cuyahoga County's mental health population?**	65% said yes	**All Sections**
53. **What do you feel are the most important issues currently facing CMHB? What areas at CMHB do you feel could be improved to better ensure that consumers are adequately being served in Cuyahoga County?**	-	**N/A**

Scale: 5- Strongly Agree, 4 - Agree, 3 - Neutral, 2 - Disagree, 1 - Strongly Disagree
Note: (-) indicates that comments were given instead of a number selections

Performance Measures

The following performance measures were used to analyze the HR unit:

- Review historical and background information
- Assess staffing levels and composition of staff in the HR Unit
- Assess key labor agreement issues in comparison to the peers
- Compare the CMHB compensation package to peers
- Assess the development and administration of human resources policies and procedures
- Assess the adequacy of job descriptions and the performance evaluation process
- Assess the effectiveness of recruitment and retention efforts
- Determine adequacy of training for CMHB employees

Findings / Commendations / Recommendations

Staffing and Organizational issues

F3.1 HR's staffing levels are not adequate to serve the number of employees at CMHB. **Table 3-3** shows CMHB's staffing levels in comparison to peer mental health boards.

Table 3-3: Staffing Comparison Based on Current Staffing Levels

	CMHB	Franklin	Lucas[1]	Stark	Peer Average
HR Director	1.00	1.00	N/A[2]	N/A[2]	1.00
Human Resource Specialist	0.00	1.00	0.21[3]	1.00[4]	.74
Training Specialist	0.00[5]	1.00	0. 00[5]	0.00[5]	.33
Total number of HR Staff	1.00	3.00	0.21	1.00	1.4
Receptionists	1.00	1.00	1.00	1.00	1.00
Total FTE Staffing	2.00	4.00	1.21	2.00	2.40
Total number of board staff	59.0	50.9	23.2	21.0	31.6
Ratio of FTE staff to board staff	1:29.5	1:12.7	1:19.2	1:10.5	1:13.2

Source: CMHB and Peers

[1] Lucas County does not have a human resource position. Instead, HR functions are shared by several staff and the CEO

[2] N/A indicates that this position does not exist for this mental health board

[3] A percentage of the CEO and two employees' time is devoted to HR, which makes up the .21 FTE staffing level.

[4] According to the CEO's, six individuals are responsible for HR functions, which comprise 1.0.

[5] Training functions are handled by several staff at Stark and Lucas, and by the HR director at CMHB.

Table 3-3 indicates that CMHB's current HR staffing levels is about 17 percent lower than the peer average. In addition, CMHB's ratio of staff to HR personnel is approximately 123 percent higher than the peer average, which indicates that CMHB's HR personnel have a higher workload than its peer mental health boards. Other factors increasing the workload in the HR Unit at CMHB include the following:

- Preparing payroll. HR uses the Kronos time keeping system to keep track of all employees time (see **F3.5**). This system allows the HR director to print attendance reports, which are used to submit payroll to Cuyahoga County Central HR office, who is responsible for printing and mailing the checks to staff. However, this function is done in the finance departments of peer mental health boards.

- Overseeing receptionist functions (for further discussion see **F3.2**). Receptionist functions are not organized under HR at the peers. Receptionist staffing levels for peers have been included in **Table 3-3** to develop appropriate comparisons to CMHB.

- Coordinating and monitoring internal training. Currently, all internal training is handled by the HR unit at CMHB. However, the director is unable to monitor the effectiveness of training programs (see **F3.39** and **R3.34**), partly as a result of the vacancy in the HR specialist position. Internal training functions are also completed by the HR units at Lucas and Stark MHB's. However, Franklin MHB has 1.0 FTE to handle internal training, mainly as a result of the consolidation of the alcohol and drug board with the mental health board. The HR director at CMHB indicated that monitoring and controlling internal training could be effectively performed if the HR specialist position was filled.

- Participating in union negotiations (see **F3.8**). CMHB is the only mental health board in the state with a collective bargaining agreement. As a result, the HR director's workload increases during the union negotiation period. Furthermore, significant time is spent addressing labor management issues, communicating with union officials (see **F3.10**), and participating on a labor management committee (see **F3.9** for further discussion).

The additional functions performed by CMHB's HR Unit, and the vacancy in the HR specialist position increases the HR director's responsibilities in comparison to peer boards. As a result, the HR director cannot focus on any one area, which has affected career development efforts (see **F3.37**), performance evaluation process (see **F3.24**), policy and job description development (see **F3.16** and **F3.22**), and goal attainment (see **F3.6**) in the HR Unit.

R3.1 CMHB should fill the vacant HR specialist position. The ratios contained in **Table 3-3** coupled with the additional functions completed by CMHB's HR Unit suggest that it has a significantly larger workload, and requires additional staffing to operate its HR unit in an effective and efficient manner. By filling the HR specialist position and transferring receptionist functions out of HR (see **R3.2**), the HR director will be able to focus on labor issues, introduce performance measurement/goals, address morale, improve career development, and meet departmental/organizational goals.

Financial Implication: By filling the HR specialist position, CMHB would incur additional costs of $47,300 in annual salaries and benefits.

F3.2 The housing of the receptionist and telephone functions in the HR unit can potentially reduce the HR director's productivity. The HR specialist is responsible for overseeing the telephone system, acting as the backup to the receptionist and completing HR functions. The HR director indicated that almost three hours a day is spent coordinating receptionist duties at CMHB. Furthermore, additional hours are spent in training new staff on telephone usage,

and addressing telephone issues. Recently, this time has been reduced as a result of the HR specialist being promoted to HR director position. However, time is still spent overseeing and acting as a backup to the receptionist.

Franklin MHB's Organization Development and Community Affairs Unit houses a HR department. While the switchboard operator is housed in this unit, this position does not report to HR and HR staff does not devote significant staff time to this area. Specifically, the HR generalist (the equivalent to the HR specialist at CMHB) only acts as the backup to the switchboard operator when an administrative assistant is not available. This organization allows the HR generalist at Franklin MHB to devote less time to non-HR functions. Non-HR functions require a significant portion of the HR director's time that could be spent focusing on core HR functions.

R3.2 The receptionist and telephone system functions should be coordinated by an office manager to allow HR personnel additional time to focus on HR related issues. For further discussion refer to the **organization, compliance and board governance** section of this report.

F3.3 The HR specialist and HR director functions at CMHB are not clearly defined. **Table 3-4** compares the duties and responsibilities contained in CMHB's job descriptions to those defined in job descriptions developed by the Society for Human Resource Management (SHRM).

Table 3-4: Job Description Comparison

CMHB		SHRM Standards	
HR Director	**HR specialist**	**HR Director**	**HR Generalist**
• Coordinate employment functions. • Monitor job descriptions. • Develop and update personnel policies. • Develop guidelines and procedures. • Coordinate new employee orientation • Perform compensation duties. • Assist staff with resolution of personnel related issues. • Assure performance appraisals are completed. • Performs collective bargaining related duties. • Plan, employee Training activities. • Perform EEO/AA duties • Recommend org. changes. • Supervise HR specialist and receptionist. • Supervise the maintenance of personnel records. • Act as a liaison to dept. of Admin. Services. • Coordinate HR special projects	• Maintain all personnel records. • Administer timekeeping system • Prepare and maintain all payroll activities • Administers benefits program. • Maintain employee ledgers on sick, vacation, compensation, personal, and holiday time. • Administer PERS, workers comp, FMLA, Tuition reimbursement etc. • Prepares requests for HR data. • Serves as the telephone administrator • Track EEO data. • Verify and review materials for polices and procedures. • Research and compile data. • Update and maintain employee lists and performance evaluations. • Maintain a supply of HR forms	• Annually reviews and makes recommendations to Executive management. • Maintains knowledge of industry trends and employment legislation. • Responsible for agency compliance with Federal state legislation pertaining to all personnel matters. • Communicates changes in Agency personnel policies and procedures. • Assists management in the annual review of salary program. • Coordinates and/or conducts exit interviews • Consults with legal counsel as appropriate concerning personnel matters. • Works with department managers to assist them in carrying out personnel responsibilities. • Recommends, evaluates, and participates in staff Development. • Develops and maintains HR systems. • Supervises staff in the Human Resources Department • Participates on committees.	• Assist departments in carrying out HR programs. • Participates in developing department goals and objectives, and systems. • Assist in the administration of compensation program • Participates in Benefits administration. • Participates in recruitment effort for exempt and nonexempt personnel. • Conducts new employee orientations, administers pre-employment tests, writes and places advertisements and conducts reference checks. • Files EEO-1 report annually; and maintains records. • Assist in Exit interview process. • Assist in organizational training and development efforts. • Maintains HR information system records and compile reports from database as needed. • Participate in administrative staff meetings and attends other meetings and seminars • Help maintain organization org charts. • Performs other duties.

Source: CMHB and SHRM

SHRM provides sample job descriptions for HR positions. These job descriptions act as benchmarks for job description development for HR departments. **Table 3-4** illustrates that CMHB's job descriptions do not include detailed explanations of duties for HR staff. The following lists the HR functions suggested by SHRM that are not described under either the HR director's or HR specialist's job description for CMHB:

<u>HR director</u>

- Completing annual organizational reviews;
- Ensuring compliance with federal and state legislation pertaining to all personnel matters;
- Participating in compensation program review; and

- Participating on labor committees.

HR Specialist

- Completing recruitment activities;
- Participating in goal development;
- Conducting new employee orientations, and reference checks;
- Participating in staff meetings; and
- Helping to maintain the organizational chart development.

The HR director indicated that the job descriptions currently do not contain all HR functions and require clearer separation of duties for the HR director and HR specialist. The HR director further indicated that the HR director and HR specialist job descriptions will be updated so that there is a separation in the HR duties completed by the HR specialist and HR director. The proposed revisions to the job descriptions include a separation in HR functions in the following way:

HR Director

- Oversees payroll/timekeeping functions;
- Addresses all labor relations issues (this has never occurred at CMHB);
- Develops and reviews personnel policies;
- Develops and reviews job description and performance evaluation; and
- Participates on committees.

HR specialist

- Completes payroll and timekeeping functions;
- Schedules interviews, conducting background checks;
- Oversees and entering training data;
- Completes benefits activities;
- Works with recruitment activities;
- Conducts new employee orientation.

Without job descriptions that clearly explain the HR functions to be performed, HR activities may not be performed in an efficient manner. Furthermore, there may not be an efficient separation of HR functions between the HR director and HR specialist.

R3.3 The HR director, with input from the CEO, should develop new job descriptions for the HR director and HR specialist positions. These job descriptions should include information provided by SHRM and should reflect a clear separation of duties for the HR director and HR specialist. By having clear separation of duties, the HR director will be able to spend more time on labor relation issues (see **F3.8** and **F3.9**). According to the HR director,

information from SHRM has been obtained and will be used to update the HR job descriptions.

F3.4 CMHB has a high amount of sick day usage. **Table 3-5** illustrates the amount sick leave taken by CMHB in comparison to peer mental health boards for FY 2001.

Table 3-5: Sick Day Usage FY 2001

Category	CMBH	Lucas	Stark	Peer Average
Sick days used	642.0	162.0	114.0	138.0
No. Employees	71.0	21.5	27	24.3
Average sick days per employee	9.0	7.5	4.2	5.7

Source: CMHB and peer HR leave reports
Note: Franklin MHB is not included in the comparison since leave data could not be obtained. Also, number of employees is for the beginning of FY 2001.

Table 3-4 illustrates that CMHB employees used an average of nine sick days during FY 2001. This is 58 percent higher than sick leave used by the peers. Lucas MHB and Stark MHB averaged 7.5 and 4.2 days per employee. The high usage of sick time taken by CMHB employees suggests that employees may be dissatisfied with conditions at the CMHB and are using sick time as a way to express their displeasure. This dissatisfaction has resulted in low employee morale (see **F3.7**) and indicates that a possible correlation may exist between the high amounts of sick leave taken and a low level of employee morale. The employee survey (**Table 3-2**) noted that the overall morale and employee satisfaction of CMHB is negative with an average response of 1.9. Employee morale is further discussed in **F3.7**. Furthermore, the employee survey indicated that staff is not satisfied with the current sick leave occurrence policy. The occurrence policy found at CMHB was not found at any of the peer mental health boards.

An occurrence is given to staff for violating the sick leave policy and remains in the employees personnel file for up to one year. While respondents were neutral to whether the policy is effective, 42 percent indicated that the sick leave policy should be addressed. According to CMHB's sick leave occurrence policy, an employee will receive an occurrence for the following situations:

- Non-physician certified family illness;
- Unscheduled doctor's appointments;
- Patterns of tardiness; and
- Sick leave without pay.

Staff identified problems with this policy in a 2000 survey conducted by CMHB. However,

no attempt has been made by management to make the policy more incentive based and less punitive. This is a result of management's view that the policy has incentives. Specifically, CMHB has a rolling year occurrence system, where sick leave occurrences are removed from the employee's personnel records one year after is given. However, this language is not included in the attendance policy. As a result, the punitive nature of the policy is emphasized.

The American Society for Public Administration recommends that organizations encourage employees to use leave programs properly by using cash incentives or other benefits to address the negative impacts of absenteeism. Without applying such methods, an organization can be negatively impacted by sick leave abuse. According to Business and Legal Reports in their report "How to Improve Employee Attendance" the negative effects of absenteeism include:

- Missed deadlines as a result of time lost;
- Resentment and low morale among co-workers who have to step in to make up work for missing employees;
- Use of overtime on the part of co-workers of the absent employee, which costs the company money;
- A drop in the quality of customer relations;
- General deterioration toward good attendance; and
- Production standards for quality/ and or quality not being met.

R3.4 The HR director and CEO, with guidance from the County Prosecutor's Office, should rewrite the attendance/sick leave policy. The new policy should emphasize sick leave incentives over punitive measures. This will be accomplished by emphasizing the rolling year system. CMHB may also want to consider developing additional sick leave incentives. Examples of common incentive programs are:

- Converting sick leave to insurance at retirement;
- Converting sick leave to disability insurance; and
- Converting sick leave to wellness expenses.

Prior to implementing a sick leave incentive program, CMHB should fully ensure that the policy is cost-effective by working with the CCHR and collective bargaining unit to establish adequate thresholds. Also, after implementing **R3.19** to make attendance a category covered on the performance evaluation, the HR director should monitor sick leave usage annually. Using the data as a basis, the HR director and the Organizational Development Committee should determine reasons for increased absenteeism, and develop additional recommendations as needed.

Management should also hold a meeting with staff to explain the new policy in depth and to highlight the incentives. This will allow staff to voice any concerns, and help increase morale. The creation of sick leave policies that have these components will make employees more accountable for sick leave time taken, and should reduce the amount of sick leave taken by employees. By emphasizing the incentives in its sick leave policy, and increasing moral, CMHB can potentially reduce the amount of sick days taken by staff, which can reduce its personnel costs.

Financial Implication: Based on the average salary earned per day ($206.55) at CMHB and the annual reduction in sick leave days by reaching the peer average (234 days), CMHB can save approximately $48,000 annually by reducing the number of sick days taken by staff to the peer average.

F3.5 CMHB has implemented an effective means of tracking employee's time. In 1993, CMHB purchased a timekeeping software package, Kronos Timekeeper Central. The system allows for monitoring and tracking of employee activities and whereabouts for a two-week period. Approximately 200 codes are programmed into the timekeeping system. These codes are for all of the agencies and most frequently visited locations in the community, as well as for vacation, sick, personal, and compensatory time.

Peer mental health boards use time sheets to track employee time. This manual system requires manager approval, and HR review to ensure that punches are accurate. This potentially could result in inaccurate time tracking due to errors, and increased time processing paperwork. According to the HR director, these problems led to CMHB implementing a software driven time tracking system in 1993. The system produces detailed documentation, which allows for accurate recording and tracking of employee time. Further, HR has the ability to generate time reports, which are given to both the manager and employee to review. The major advantages of using the Kronos time tracking system include:

- Allows the software to apply new information immediately so it can provide reports that are current and accurate, because of real-time reporting;
- Allows management and HR to track employee time, which can be used to assess attendance;
- Allows HR and management to generate employee specific reports;
- Allows HR to import time and accrual data into database programs, so trends can be assessed; and
- Allows HR to setup schedules in the system, which can:
  - Enforce restrictions;
  - Produce absent and tardy reports; and
  - Generate punches from schedule.

Furthermore, the use of the Kronos system has reduced the HR director's workload in processing payroll (see F3.1 for further discussion)

C3.1 CMHB has taken a proactive approach to effectively tracking employee time. The implementation of the Kronos timekeeping system has increased HR's ability to effectively assess attendance, enter payroll, and monitor employee's location during the day.

F3.6 Nearly 80 percent of respondents in the employee survey were not satisfied or neutral that clear goals regarding the direction of CMHB have been communicated. The responses are indicative of a lack of planning and goal development throughout CMHB. Departmental goals have been established by Risk Management and Consumer Affairs Division and provide the division with a means of focusing planning and assessing departmental performance. However, these goals have not been established in HR and other units as a result of a lack strategic planning (see the **organization, compliance, and board governance** section for further discussion). Goals are needed to develop performance measures that can inform management of whether or not they have achieved the departmental goals.

Performance measures are defined as a system of customer-focused quantified indicators that let an organization know if it is meeting its goals and objectives and are management tools that measure work performed and the results achieved. The types of performance measures most commonly used in government include:

- **Inputs**: Resources used (what is needed). Sample input measures are the amount of staff time used and number of staff working with the activity;
- **Outputs**: Activities completed (what is produced). Sample output measures are the number of activities completed, and number of requests handled;
- **Outcomes**: Results achieved. Sample outcome measures include improved status of an activity, or successful completion of activities;
- **Efficiency**: How well resources were used. Sample efficiency measures are meeting a projected target or a prompt response to an activity; and
- **Quality**: Effectiveness (How much has HR improved). This type of measure is often used to assess whether a department has met its established departmental goals. Sample quality measures increase in employee satisfaction level and goal attainment.

The absence of performance measures hinders management from improving customer service, determining effective resource use and assessing departmental performance.

R3.5 CMHB should develop a strategic plan with input from HR, other organizational units and

external stakeholders. The strategic planning goals should be used as a basis by the HR director and CEO to develop departmental goals. Once departmental goals have been established, the HR director and CEO should develop performance measures to assess the results of internal performance and goal attainment. The use of performance measures will increase the efficiency and should better inform key stakeholders about HR's performance. The following are areas where HR's performance can be measured:

Inputs:
- Staff time used to address concerns

Outputs:
- Number of employee grievances
- Number of position audits completed for reclassifications and compensation requests

Outcomes:
- Percentage of formal grievances resolved prior to mediation/arbitration
- Percentage of new employee's successfully passing probation.

Efficiency:
- Prompt referral of job candidates from recruitment to referral
- Prompt filling of job vacancies

Quality:
- Percentage increase in employee satisfaction levels

F3.7 According to the employee survey shown in **Table 3-2**, low employee morale exists at CMHB. The survey results show that 88 percent of employees either strongly disagreed or disagreed with employee morale being positive. The survey also asked respondents to list three reasons why morale is low. The following is a list of repeated issues identified by respondents, ranked from the strongest issue to the least:

1. Lack of strong leadership (23 comments);
2. Management relationship to staff (11 comments);
3. Communication between management and staff, and staff to staff (10 comments);
4. BOG relations (10 comments);
5. Staff togetherness (9 comments);
6. Negative news (9 comments);
7. Potential job loss (5 comments);
8. Vision and clearly defined goals (4 comments);
9. Budget constraints (3 comments);

10. Salary levels (3 comments); and
11. Lack of regular training, mentoring and retention programming (2 comments).

Additional areas that impact morale obtained from the employee survey include:

- Employees responded neutrally concerning whether they are treated with dignity and respect by their supervisors; and
- 73 percent of employees responded negatively when asked about the leadership and guidance provided by BOG.

A R.M. Steers study, "Major Influences on Employee Attendance: A Process Model" provides two ways management can help motivate employees to attend work and increase morale. These include the following:

- Make employees feel needed and appreciated.
- Communicate openly with employees. The benefits of having open communication between staff and management include:

    - Helping management gain suggestions on improving procedures;
    - Providing managers with information on employee needs, attitudes, and perceptions;
    - Helping employees feel that their expertise is valued by management; and
    - Involving employees in the decision making process, which encourages commitment, dedication and loyalty.

Low morale may have hampered the productivity and overall efficiency of CMHB and strained the lines of communication between management and staff. This low morale may also account for high absenteeism at CMHB (see **F3.4),** and turnover (see **F3.33**). Without open lines of communication, employees have completed their work with little feedback from upper level management. A lack of communication has contributed to employees feeling that little respect is given them by upper level management and has led to employees characterizing the relationship between staff, management and BOG as poor. All of these factors have resulted in staff being less than enthusiastic about their work.

R3.6 CMHB should address low employee morale in several ways:

1. Management should promote stability in upper management positions by hiring competent and qualified staff, and by providing training. For further discussion, refer to the **organization, compliance and board governance** section of this report.

2. CMHB staff members can be further involved in the organization by more effectively using work teams to address personnel and other concerns. These teams should be allowed to make recommendations to the executive director about how to improve the efficiency, productivity and morale of the organization. The teams should also develop a systematic approach to setting goals and reviewing the results. An action plan should be developed that indicates how the goals will be accomplished. Quarterly reviews to discuss how well the goals were accomplished should also be held. The review process will provide feedback and evaluate the progress towards the attainment of the goals. By changing some of the decision-making processes within the organization, employees will have a greater sense of involvement. This will promote a sense that CMHB management is listening to the concerns of staff, which will improve management's relationship with staff.

3. Management should continue having all staff meetings. Establishing regular dialogue through monthly meetings not only promotes employee well-being but will lead to increased employee involvement in operational issues. Furthermore, the HR director should work with management to provide regular feedback to staff on performance and communicate goals of department. This can be achieved by implementing a regular performance evaluation process, in which management works with staff to set goals. Management should send out the meetings agenda several days in advance to allow staff an opportunity to make additions. This will provide an opportunity to address employee concerns with management on a regular basis.

4. The HR director and CEO should attempt to establish a mechanism whereby, the BOG understands staff's concerns with operations. For further discussion refer to the **organization, compliance and board governance** section of this report.

5. CMHB should develop recognition, mentoring, training and other retention programs for employees. These programs will provide staff with the support and motivation to complete job functions.

Labor Agreement Issues

F3.8 CMHB is the only mental health board in the state to have a collective bargaining agreement. As a result, CMHB has a labor negotiation process that requires a significant portion of HR staff time every three years, while peer mental health boards do not (see **F3.1** for discussion of the effect of additional HR duties on workload).

CMHB's negotiating team does not possess the skills needed to effectively negotiate on behalf of CMHB. The labor negotiation team in 2001 consisted of three staff members the

chief of risk management (spokesperson), HR director and a contract specialist. The team design had the following challenges:

- No team members possessed a background in labor relations.
- Team members did not receive training in the collective bargaining process, which resulted in an inability to effectively gather data and negotiate.
- Ground rules established by the Ohio Association of Public School Employees and its affiliate local AFSCME, AFL-CIO #328 (OAPSE) and CMHB, indicate that both committees may invite up to one resource person on an as needed basis. However, CMHB did not invite representatives from CCHR to participate in the process.

Each of the challenges are a function CMHB's inexperience in labor relations and labor negotiation. Despite this inexperience, CMHB has not provided training and guidance from CCHR or the State Employee Relations Board for the negotiation team. Upon request, CCHR will provide the following assistance to County agencies:

- Provide training in labor negotiation and other labor relations issues;
- Participate in the negotiation process;
- Participate in the grievance process; and
- Provide guidance in developing appropriate data gathering methods.

SERB will provide organizations with training in various labor relation issues upon request. SERB's Bureau of Mediation offers more than 100 training modules to organizations in the area of Labor Management Committee effectiveness training, interest-based bargaining, interest-based problem solving, and interest-based grievance mediation.

An additional source for training is Cleveland State University. Labor relations training can be found at Cleveland State University's College of Business Administration, which has established a Labor Management Relations Center (LMRC). LMRC has designed programs and services for individuals and organizations involved in the labor relations process. LMRC can customize programs to reflect the specific circumstances that CMHB encounters. LMRC also can provide training in areas that would be relevant to CMHB including the following:

- Contract negotiations;
- Dispute Resolution;
- Basic grievance handling workshop;
- Contract administration, grievance processing and arbitration;
- Team building;
- Arbitration training for the non-lawyer;
- Sexual harassment; and
- Performance appraisal and evaluation.

According to E. Edward Herman, author of *Collective Bargaining and Labor Relations*, the effectiveness of a bargaining team is determined by its ability, knowledge and experience. A team well-versed in tactics, strategy, and timing will be in a better position to avoid impasses and strikes, and will end up with a better agreement than a team composed of inexperienced people. Furthermore, the Bureau for Employer's Activities suggests that managers develop objectives for the negotiation process and a tentative plan to achieve these objectives. Also, the union's demands should be carefully studied early in the negotiation process. The following is a list of the areas the organization should study prior to negotiations:

- Assess the economic impact of the demands on the company.
- Make a comparative study of wage rates in the industry and in allied or similar businesses, the minimum wage, if any, and the rates applicable in other collective agreements.
- Separate the demands which the company has no intention of fulfilling or giving, either on a question of principle or due to economic incapacity.
- Prepare the company's position in regard to the other demands, *e.g.* the conditions on which the company may be prepared to grant them or compromise on them.
- Identify the demands which may be of crucial importance to the union or to the employees. This is crucial to success in negotiations because, without a proper assessment of such demands, a negotiated settlement may not result or, if one results, it may lack durability because it has not addressed the main problems.

Since CMHB's team members did not possess a background in negotiation, they may not have effectively prepared for the process as outlined by Bureau for Employer's Activities. As a result, the team may not have effectively negotiated on behalf of CMHB. This is illustrated in the union articles covering pay increases, vacation accrual, probationary period and grievances, which appear to be more generous as compared to policies found in other human service agencies, peer mental health boards, and CCHR (for further discussion, see **F3.13**). The HR director indicated that the management employees involved with the labor negotiation team in 2001 are no longer employed at CMHB.

R3.7 Labor negotiation team members should be fully trained and start the preparation for negotiations in advance. To accomplish this task, CMHB should take the following steps:

1. The HR director and CEO should seek guidance, training and participation from CCHR in labor negotiations and labor relations. Potential sources for training and guidance are CCHR, Cleveland State University and SERB.

2. Since the negotiation ground rules allow CMHB to include an outside party in the negotiation process, CCHR should be invited to participate. This will ensure that CMHB has a strong team entering into negotiation process. Furthermore, the knowledge gained from working with officials from CCHR who have past experience in labor negotiation will help increase skills for future negotiations.

During the course of this performance audit, the HR director has sought training from SERB and has indicated that CMHB will continue to engage SERB in addressing labor relation issues.

F3.9 CMHB has not effectively used its Labor Management Committee. Article 18 of the labor agreement requires CMHB to establish a Labor Management Committee, whose purpose is to discuss concerns of either the union or employer. Other requirements mentioned in this article include:

- The union is entitled to at least three representatives;
- The Committee will meet as needed but no more frequently than quarterly; and
- Official minutes will be taken at every meeting.

CMHB has developed a Labor Management Committee as required by the labor agreement, which consists of three union representatives, the HR director and the CEO. However, the Committee meets less than quarterly and no training has been provided to the team members. Furthermore, minutes are not taken for these meetings and a purpose statement defining the role of the committee could not be found.

According to a Cornell University report on collective bargaining released in 1998, labor management committees are cooperative structures that focus on problem solving and building trust. They typically handle issues including workplace safety, work hours, training, personnel issues, and daily workplace problems. The goal of these committees is often to build a level of trust between labor and management that allows them to deal with more complex organizational problems. Additional functions of these committees include:

- Addressing a broad spectrum of workplace concerns;
- Emphasizing relationships; and
- Creating an environment where employees feel their input is valued and decisions are made by consensus.

The importance of training management and staff is also emphasized in the Cornell report. According to the report, training a committee in conflict resolution and consensus decision making may help the Committee operate more smoothly. Training sessions establish commitment to the concept of labor relations and forge cooperative relationships. A source

of training sited in the report is the State Employment Relations Board (SERB). Without training, and a clearly defined purpose it is difficult for a Labor Management Committee to build the necessary level of trust to make the Committee useful to CMHB.

R3.8 CMHB should consider amending the collective bargaining agreement in future negotiations to allow labor committee meetings to be convened more frequently than quarterly. Minutes for these meetings should be taken as required in the labor agreement. In these meetings, the Committee should establish a purpose statement and objectives for addressing workplace safety, work hours, training, personnel issues, and daily workplace problems. Furthermore, the Committee should request training from SERB in labor relations (see **F3.8** for labor relations training information).

F3.10 CMHB's management currently does not have a good working relationship with the union. The AOS employee survey indicated that 63 percent of the staff were not satisfied or had no response to whether management and the union had a good working relationship. An indicator of a poor relationship between management and the union is the number of grievances filed. CMHB has only had two grievances since the beginning of the fiscal year, which would suggest that there is no problem between the union and management. However, an additional indicator of a poor relationship between management and the union is that the union has informally opposed several new policies instituted by CMHB. This indicates that management and the union do not have discussions about the new policies prior to their implementation. The lack of these discussions creates animosity between management and union, and can affect the policies acceptance by staff.

According to Workforce Magazine, it is increasingly important for management to establish a good relationship with the union to achieve a "harmonious" workplace. In their view, effective HR directors build a good relationship with unions. Employees are usually in closer contact with consumers than management. As a result, organizations need to capture their employees' perceptions about consumer's and their ideas for improvement, and incorporate these ideas into improving their products and services. This requires effective employee participation and empowerment programs, which are difficult to establish without the active involvement of the union. Workforce Magazine also suggests that Labor Management Committee officials and management receive training to improve management's interactions with the union. Potential sources of training include CCHR, SERB and Cleveland State University (see **F3.8** and **R3.7**).

The problems between management and union may stem from lack of consistent Labor Management Committee meetings and adequate training as explained in **F3.9.** The lack of a good relationship between management and staff can result in the following:

- Effective training programs are not established for unionized workers;
- Effective mechanisms for increasing productivity may not be developed; and
- Effective strategies for finding real solutions to complicated problems are not developed.

R3.9 CMHB should improve its relationship with the union by providing training to its non bargaining-unit employees dealing with labor relations. Training ensures that management and supervisors understand their role in the grievance and labor relations process. Training reduces the number of employees who are filing improper grievances and improves relations with union members. Labor relations training should be sought from CCHR, Cleveland State University and SERB.

F3.11 The OPSE/AFSCME contract provisions provide management with the flexibility to effectively manage the workforce, including the authority to determine employee placement and administer disciplinary procedures. Specifically, Article 14 defines management rights and states that CMHB reserves all of the rights to determine matters inherent to management policy, which include the right to do the following:

- Direct and supervise;
- Determine the number of employees;
- Maintain and improve efficiency and effectiveness of operations;
- Develop and enforce rules to ensure orderly and effective operations;
- Discipline, demote or discharge for just cause;
- Determine adequacy of the workforce;
- Determine the mission of the employer; and
- Enforce any other rights specified under 4117.08.

The ability to determine management policy provides management with an opportunity to alter operations to benefit CMHB.

C3.2 Contractual language providing management with decision-making authority necessary to effectively manage the employee workforce empowers CMHB with the flexibility to make sound personnel decisions. As a result, personnel issues can be reduced at CMHB.

F3.12 In the OAPSE agreement, the following mechanisms are provided to control the amount of compensatory time gained:

- Compensatory time must be approved in advance by the employee's immediate supervisor and such approval must be documented on appropriate forms;

- Compensatory time off will be granted at a time mutually convenient to the employee and the supervisor; and
- Employees must request to use compensatory time within 120 days.

C3.3 By having mechanisms in place to ensure the effective use of compensatory time, management can control use in the organization. Therefore, CMHB can ensure that the use of compensatory time will not adversely impact operations.

F3.13 **Table 3-6** shows CMHB's contractual policies in comparison to the policies at CCHR and peer mental health boards.

Table 3-6: Union Contract/Policy Comparison

Policy	CMHB	Cuyahoga County	Franklin	Lucas	Stark
Probationary Period	120 days	180 days	180 days	120 days	Non exempt- 90 days Exempt- 180 days
Length of Work Day	8.5 hrs including 1 hour for lunch	8 hours with a lunch break of uniform duration established by the department head to meet the operating needs of the agency	9 hours including a 1 hour for lunch	9 hrs including 1 hour for lunch	9 hours including 1 hour for lunch
Actual Time Worked per Day	7.5 hours	7 hours	8 hours	8 hours	8 hours
Evaluations	Annually for regular employees and at the 60 day and 120 day mark for probationary staff	Annually for regular employees and twice throughout the probationary period	Annually for regular employees and none specified for probationary	Annual for regular employees and before the end of the probationary period for probationary employees	Non-exempt employees are evaluated at the 6 week mark and for exempt and the 12 week mark. Regular employees are evaluated annually
Sick Leave Accrual	4.32 hrs for every 75 hrs of services in active pay status (15 days)	4.6 for each 80 hours of service (15 days)	4.6 hours for each 80 hrs of service (15 days)	4.6 hours for each 80 hours of service (15 days)	4.6 for each 80 hours of services (15 days)
Maximum Number of Sick Days Accrued	Accumulated without limit	Accumulated without limit	Can only accrue up to the amount in a pay period (80hrs)	Accumulated without limit	Accumulated without limit
Payment of sick leave upon separation	Once a employee has at least 5 years upon termination, the employee will be paid 50 percent of any unused sick balance	Employees will not be paid for any unused sick leave upon termination of employment. However, upon retirement employees with ten or more years may receive one-fourth (25 percent) the value of the accrued amount	Upon termination, the employee will be paid 50 percent of any unused sick balance	Employees will be paid 33 1/3 percent	Employees with at least 10 years of services or otherwise terminated shall be paid one-fourth (25 percent) of the value of their accrued sick leave credit

Policy	CMHB	Cuyahoga County	Franklin	Lucas	Stark
Vacation Time Accumulation	Accrual occurs after six months of employment: -1-3 years: 12 days -3-5years: 15 days -5-15 years: 20 days -15-years: 25 days	Accrual occurs after six months of employment: -1 -4 years: 10 days -5- 14 years: 15 days -15 - 25 years: 20 days -25 years and over: 25 days	Accrual occurs after six months: -0-2 years: 10 days -3-4 years: 15 days -5 and over: 20 days	Accrual occurs after six months of employment -1-4 years: 10 days -5-10 years: 15 days -10 year and over: 20 days Employees may accumulate 480 hrs of vacation	Accrual occurs after six months of employment: -1-8 years: 10 days -8-15 years: 15 days -15-25 years: 20 days - 25 year and over: 25 days
Number of Personal Days Received	3 days	None	2 days	4 days	5 days
Number of Holidays	11	11	8	8	8
Number of Leave Days to Conduct Union Business	5 days (not paid by CMHB)	N/A	N/A	N/A	N/A
Number of Days to File a Grievance	Ten days after the occurrence	Ten days after the occurrence	Five days after the occurrence	Seven working days after which the appeal is directed.	Within ten days
Overtime Pay	Employees are not paid overtime. They are paid comp time at a rate of time and one half. Exempt employees are not eligible.	Non-exempt Employees may accrue comp time at a rate of time and one half. Exempt employees are exempt from wage and hour provisions	Exempt employees are not eligible. Non-exempt receives time and one-half for all hours above 40 hours.	Exempt employees cannot receive overtime. Non-exempt employees who work more than 40 hrs a week receive one and one-half time employees' base rate	Non-exempt employees are entitled to one and one-half times the base pay after working more than 40 hrs in a week. Exempt employees are not eligible.
Healthcare Contribution	Employer: 80% Employee: 20%	The share of the premium the county contributes depends on the plan selected and the employee's status	Employer: 100% Employee: 0%	Employer: 80% Employee: 20%	Employer: 100% Employee: 0%
Pay Increases	Annually 5 percent the first year, and 4 percent for the next two years of the labor agreement (see **F3.15**)	None	Increase is based upon performance evaluation	None	Based on results of the performance evaluation
Drug Testing Requirement	Upon suspicion of drug or alcohol usage	Testing is required for applicants and pre-hires	Required prior to employment and upon suspicion of drug or alcohol usage	Required prior to employment and upon suspicion of drug or alcohol usage	Upon suspicion of drug or alcohol usage

Source: OAPSE contract for CMHB and personnel manuals for the peers.

Table 3-6 illustrates that CMHB's union contract terms and HR policies are more generous than peer contracts in many areas including:

- CMHB has a shorter workday than the peers. CMHB staff work seven and-a-half hours a day, while peer mental health boards work 8 hour days.

- CMHB has a shorter probationary period than the peers. Peer organizations average 180 day probationary for staff, while CMHB only has a 120 period. The probationary

period allows management to assess employee performance. According to the OAPSE labor agreement, CMHB can assess the probationary employees on the 60th and 120th day. Based on the results of the evaluation, management may decide to continue or discontinue employment. Longer probationary periods allow management a greater opportunity to assess performance and make better decisions.

- CMHB pays more sick leave at separation than its peers. CMHB staff receives 50 percent of their sick leave upon separation, which is 50 percent higher than the peer average of 33.3 percent. This could result in CMHB having higher personnel costs, which reduces the amount of the budget that can be used to fund providers and mental health services (see **F3.4** for more information on sick leave use at CMHB).

- CMHB is more generous than peers in terms of vacation accrual. CMHB staff receives two extra days after one year of service, which differs from other human service agencies as reported by SERB and all the peers. Also, CMHB receives 25 days of vacation at 15 years of service whereas Stark and Cuyahoga County give staff 25 days after 25 years of service. Furthermore, a review of contracts from various human service agencies across Ohio provided by SERB indicates that 88 percent of human service agencies throughout the state receive 25 days only after 21-25 years of service. The higher amount of vacation accrual results in CMHB staff receiving 104 more vacation days over a 30 year period as compared to the peer average. In addition, CMHB staff receives 101 more vacation days over a 30 year period as compared to Cuyahoga County.

- CMHB staff is given 11 days of holiday pay, while peer mental health boards are given eight. Furthermore, the SERB report indicates that 38 percent of human services agencies receive fewer than 11 holidays per year.

- CMHB staff is given an opportunity to file a grievance within 10 days, while peer mental health boards and the county average is 8 days. A shorter the time frame allows the grievance process to be handled more quickly.

- CMHB's negotiated salary increases in future years are not in line with industry standards. Article 25 of the labor agreement states that employees shall receive 5.0 percent in their base rate of pay immediately and receive a 4.0 percent increase in July of FYs 2002 and 2003. In a recent compensation analysis of mental health boards across the U.S. conducted by Business and Legal Reports Inc, the average percent increase in salaries for FY 01 was 3.30 percent. Furthermore, the report indicates that the anticipated salary increase in future years will be an average of 3.24 percent in FY 02. CMHB's pay increase is 51 percent higher than the standard

given for 2001, and will be 23 percent higher than the standard projected for 2002.

- CMHB hires employees without conducting a pre-employment drug testing. Two of the peers and CCHR require potential candidates to undergo a drug test (see **F3.29**).

Recommendations relating to contract provisions and compensation are addressed in **R3.10**.

Compensation

F3.14 This section of the report focuses on the compensation packages for CMHB employees and the peers based on average base salaries, PERS contribution, employee healthcare contribution, actual time worked during the year and the cost of doing business factor. These factors are used in a formula to determine each department's adjusted average hourly compensation package by job function. Once the adjusted average hourly employee compensation package is determined, it is compared to similar job functions from the peer mental health boards. Based on interviews, policy reviews and the compensation information obtained from peer mental health boards, differences exist in the respective HR policies. The following lists the factors used to calculate the compensation package for CMHB and the peers, and explains differences in certain policies:

- **Value of the PERS contribution paid on behalf of the employee**. Franklin MHB's employees' PERS contribution is 5.0 percent whereas CMHB's and the other peers is 13.5 percent.
- **Employee healthcare contribution**. Franklin MHB and Stark MHB pay 100 percent of employees' healthcare cost whereas CMHB and Lucas MHB pay 80 percent.
- **Actual time worked during the work day**. There was a difference in the time worked for peer boards and CMHB, which required adjustments. For example, Franklin MHB, Lucas MHB, and Stark MHB require employees to work 40 hours per week (2,080 hours per year) while CMHB employees work 37.5 hours per week (1,950 hours per year).
- **Overtime payments**. CMHB does not pay staff for overtime, whereas the peers do.
- **Average 2001 base salary for all employees**.
- **Longevity payment**. Franklin MHB pays its employees longevity payments, whereas CMHB and the peers do not.
- **The cost of doing business factor (CODBF)**. CODBF reflects the difference in the cost of living in Cuyahoga County compared to peer counties.

F3.15 **Table 3-7a** presents the FY 2001 compensation levels (average hourly employee compensation) for functions at CMHB and peers.

Table 3-7a: Average Hourly Compensation Comparison[1]

	CMHB	Franklin	Lucas	Stark	Peer Average	% Above/ Below Peer Average
Executive Management[2]	$78.73	$64.63	$46.88	$74.40	$61.97	27.0%
Other Management[3]	$32.88	$29.23	$27.15	$33.15	$29.84	10.2%
Fiscal Staff	$17.02	$19.80	$14.31	$14.62	$16.24	4.8%
MIS/Claims Staff	$21.42	$19.86	$14.92	$14.15	$16.31	31.3%
Clerical[4]	$16.01	$12.95	$12.32	$10.66	$11.98	33.7%
Line (Other Staff)	$23.36	$19.12	$23.19	$18.62	$20.31	15.0%
Organization Average	$27.44	$24.38	$21.30	$24.37	$23.35	17.5%

Source: CMHB and peers

[1]Includes all positions as of 2001. Adjustments for annual salaries were made for employees that began during 2001.

[2]Executive management consists of the chief executive officer, and chief clinical officer. CMHB did not employ a chief operations officer in 2001.

[3]Other management consists of positions that have staff reporting to them, except for Franklin MHB's director of training, director of cultural competency and director of housing, which are very similar to CMHB positions.

[4]Clerical staff consists of office managers, executive assistants, administrative assistants, clerical aids, executive specialists, receptionists, office assistants.

Table 3-7b presents the FY 2001 length of service average for staff at CMHB and the peers.

Table: 3-7b: Length of Service Comparison[1]

	CMHB	Franklin[2]	Lucas	Stark	Peer Average	% Above Below Peer Average
Executive Management	6.6	3.5	8.0	13.4	8.3	(20.5%)
Other Management	7.5	6.5	2.7	5.1	4.8	57.3%
Fiscal	2.5	8.9	9.5	0.2	6.2	(59.7%)
MIS/Claims	8.4	11.9	1.3	1.5	4.9	71.4%
Clerical	10.3	7.4	7.5	0.1	5.0	106.0%
Line (Other Staff)	6.9	2.9	0.6	3.7	2.4	187.5%
Organization Average	7.4	6.9	3.8	3.7	4.8	54.2%

Source: CMHB and peers

[1]Consists of all positions as of FY 2001

[2]Length of Service for staff employed less than a year at Franklin MHB was counted as zero

Table 3-7a indicates that the department average compensation for CMHB is 17.5 percent higher than the peer average. Furthermore, in all six of the job categories, CMHB's compensation package is higher than the peer average. The greatest difference occurred in the clerical, MIS and executive management staff categories.

Often, compensation levels are correlated with length of service. **Table 3-7b** was calculated to analyze length of service (LOS) at CMHB. CMHB's average LOS is 54.2 percent higher than the peer average, which could contribute to the higher compensation levels. However, while the average compensation for executive management and fiscal is 27.0 percent and 4.8 percent higher than the peer average, the average LOS is 20.5 percent and 59.7 percent lower

than the peer average, respectively. Other factors that could contribute to the higher compensation packages at CMHB include the 1998 compensation study that resulted in higher salaries (see **F3.23**) and the negotiated salary increases in the collective bargaining agreement (see **F3.13**).

R3.10 Since CMHB's organization average compensation is 17.5 percent higher than the peer average, and since some of the policies outlined in the collective bargaining agreements appear to be favorable to CMHB and employees, management should consider the following when negotiating future contracts:

- Increase the probationary period, which will provide management with more detailed information to assess employee performance.
- Adjust vacation accrual amounts to be more comparable to the peer average and Cuyahoga County.
- Negotiate merit based pay increases to replace guaranteed salary increases. CMHB should consider linking pay increases to actual performance, which is done at Stark and Lucas MHBs.

Financial Implication: Based on CMHB's current average years of service (seven years), average compensation rate ($27.44), the additional number of vacation days as compared to the peers over seven years (17 days) and current staffing levels, CMHB could realize annual cost savings of approximately $30,000 by reducing its vacation accrual policy to be comparable to the peer average.

Human Resource Policies and Procedures

F3.16 CMHB has not updated its personnel manual since the signing of its last labor agreement in August 2001. Furthermore, 65 percent of respondents to the employee survey were not satisfied or neutral with the overall effectiveness of CMHB's current HR management policies and procedures. Franklin MHB and Stark MHB have established work groups or committees to identify best practices in policy development and to review the current practices. In addition, Franklin MHB implemented the following steps for updating policies:

- Establish recommendations for changes;
- Review of recommendations by the Service Manager;
- Review and approval by the BOG;
- Develop a new handbook;

- Develop a signed acknowledgement that new policies were received and understood; and
- Offer in-service training on policy changes.

CMHB is currently using this method to update its manual, but it does not require a signed acknowledgement form (see **F3.19**), and does not hold training sessions on policy changes. According to Business and Legal Reports, it is a common best practice to update policy manuals as new labor agreement or departmental issues occur. Business and Legal Reports also suggests that personnel manuals be reviewed and evaluated carefully by a team of people, including a labor and employment attorney at least annually, to reflect changes in departmental policy and in applicable laws. Without an up-to-date personnel manual, the following can occur:

- A lack of communication with staff about management expectations, and departmental and legal requirements;
- A lack of compliance with requirements; and
- Inconsistent decision making.

R3.11 The HR director should take a proactive approach to policy development at CMHB. To accomplish this, the HR director, with input from CEO, Cuyahoga County Prosecutor's Office and BOG, should continue the process of updating the personnel manual. In updating the manual, CMHB should address all missing policies and those needing expansion in the next revision, such as policies for business ethics and training(for additional policies, see **F3.17**). Potential resources for assistance in developing effective policies and procedures are HRnext.com and Business and Legal Reports. HRNext.com provides online assistance in various HR topics and has sample copies of personnel policies. Additionally, HRNext.com provides a checklist that is helpful in updating policies for the future. Business and Legal Reports provides various publications on developing personnel policies, sample policies, checklists, and how to address questions concerning personnel policies.

Once the manual has been updated, HR should to take adequate steps to ensure that staff is made aware of changes to the manual by doing the following:

- Posting notices in the workplace of the impending revision;
- Issuing the changed manual pages before its effective date;
- Stating an effective date which supercedes all previous versions;
- Requiring employees to sign an acknowledgment form to be placed in each employee's personnel file(see **F3.19**); and
- Providing a training session to discuss policy changes.

By providing an up to date employee manual, CMHB will be able to accomplish the following:

- Communicate policies and procedures;
- Play a key role in the orientation process for new employees;
- Serve as a valuable employee relations vehicle for educating current and prospective employees;
- Contribute to uniform and consistent application, interpretation, and enforcement of policies;
- Protect against claims of improper employer conduct; and
- Protect against legal claims.

F3.17 The current CMHB personnel policy manual either does not cover certain topics or issues that should be in an effective personnel manual or is inadequately developed in certain sections. This is a result of the policy manual not being reviewed annually and updated as needed (see **F3.16**). **Table 3-8** illustrates the topics not covered or needing expansion in CMHB's manual based on industry criteria and the corresponding recommendations in this report.

Table 3-8: Policy Assessment

Topics not covered in the Personnel Manual		**Topics Needing Expansion**	
Policy	Corresponding Rec.	Policy	Corresponding Rec.
• Leaves of absence	• R3.4	• Confidentiality	• R3.15
• Reference Request Policy	• R3.12	• Business Ethics	• R3.16
• Affirmative Action Plan	• R3.12	• Drug and Alcohol Policy	• R3.24
• Separation/resignation	• R3.12	• Immigration Policy	• R3.26
• Telephone Usage	• R3.13	• Employee Recognition Policy	• R3.30
• Office Equipment Usage	• R3.13	• Training Policy	• R3.32 and R3.33
• Voice and E-mail Usage	• R3.13		
• Internet Usage	• R3.13		

Source: Business and Legal Reports, HR director

According to a recent Workforce Magazine article, court decisions reflect favorably on the employer when corporate efforts are made to inform, train and take swift action in employee relations. This confirms the importance of establishing written policies and procedures to minimize risks. However, the lack of clearly defined policies provides opportunities for unethical behavior to occur and can potentially increase an organization's liability.

Additionally, communication with staff about management's expectations is reduced without descriptive policies that govern employee conduct.

R3.12 The HR director should work with the CEO, BOG, and Cuyahoga County Prosecutor's Office to develop or expand the policies listed between management and staff. Once policies have been developed, the HR director should take steps outlined in **R3.11** to inform staff about the new policy changes. Developing adequate policies and expanding current policies can increase communication between management and staff, reduce CMHB's liability, and contribute to a uniform application of policies.

F3.18 Office policies have not been maintained in a central policy manual. For example, CMHB currently has personnel policies located in the HR department, equipment usage policies in the fiscal department, and internet and computer usage policies in MIS. It is a best practice for organizations to have all major policies in a centralized location so that employees can easily access them. Lucas MHB currently has a policy manual that can be characterized as a centralized policy, in that it includes all policies and procedures that effect the organization. Without a centralized policy manual, staff may not be aware of certain policies.

Furthermore, Workforce Magazine suggests that organizations add additional provisions in its policy manuals. Some of these additions include privacy policies, and use of email, voice mail, computers, software, internet, and miscellaneous electronic systems.

R3.13 The HR Director and CEO should place all organizational policies within a central manual. Once the manual has been developed, the steps for distributing the new manual outline in **R3.11** should be followed. Having all policies contained in a centralized manual is an effective means of communicating expectations and requirements to staff. Furthermore the HR director and CEO should ensure that the manual includes privacy policies, and the use of email, voice mail, computers, software, internet, and miscellaneous electronic systems.

F3.19 CMHB employees are not required to sign a receipt acknowledging that they have received, read and understand the contents of the policy manual. According to Workforce and HRnext.com, organizations should require signed acknowledgment forms for policy manuals, and confidentiality statements to document that an employee is aware of both policies and the proposed discipline for noncompliance. These signed acknowledgements can protect organizations from lawsuits in the event of disputes. Each of the peer mental health boards require staff to sign acknowledgement forms. Without signed acknowledgment forms, there is a potential for misunderstandings, increased grievances and lawsuits.

R3.14 The HR director should develop an acknowledgement form that is to be signed by all staff upon reviewing the updated policy manual or policies. The acknowledgment form should

state the following:

- The employee received, read, and understood the contents of the handbook or manual.
- The employee may meet with her supervisor or the human resources manager regarding any of the organization's policies, practices, or procedures.
- The handbook or manual replaces and/or supersedes all such previous documents.
- The handbook or manual merely serves as a guideline, and the agency retains complete discretion to interpret, amend, or replace the document at any time and in any manner it deems appropriate.

A carefully crafted acknowledgment form can provide potentially useful written evidence showing that the employee received, read, and understood the handbook or manual.

F3.20 CMHB currently does not require all staff to sign confidentiality statements. CMHB has a business ethics policy which informs staff that they may be required to sign confidentiality statements upon request. However, CMHB only requires members of the major unusual incidents committee, temporary employees and staff in the MIS/Claims division to sign confidentiality statements since they handle client and agency information. CMHB also provides booklets entitled *Ethics is Everybody's Business* from the Ohio Ethics Commission. This booklet is meant to inform staff of their ethical responsibilities as an employee of CMHB. To ensure that staff understand the information provided in this booklet, employees are also asked to sign an Ohio Ethics Certification form that is placed in the employee's personnel file. However, not all employee files have a signed certification form, since all staff were not given the booklet. Staff who previously participated in the ethics training, prior to the summer of 2001, were not required to sign the form. As a result, potential liability issues may occur at CMHB.

According to the National Mental Health Association, confidentiality agreements and training are the two primary processes used to ensure that employees maintain the confidentiality of sensitive consumer information. There are five best practices given for developing and implementing effective confidentiality policies found throughout many managed care operations and includes:

- Signed statements that policies have been read and were understood;
- Agreement to participate in orientation and ongoing training sessions on confidentiality;
- Reiteration of applicable state and federal laws;
- Information for the executive responsible for addressing any questions or areas

of uncertainty; and
- Notices that breaches are grounds for termination and liability under state and federal law.

During the course of this audit, CMHB attempted to implement AOS's preliminary recommendation to have all staff sign confidentiality statements. However, the HR director and CEO did not include an in-service training in the "rollout" of this new policy. This in-service would have allowed management to discuss the new policy with staff, and address any concerns. Without this mechanism, several staff and the union representatives resisted signing the confidentiality forms since they did not understand its purpose. This resistance has not been addressed by management, despite that fact that the labor agreement allows management to request signed confidentiality statements. Article 42 of the labor agreement states:

- An employee may be requested to sign confidentiality statements;
- No employee without proper authorization shall disclose any confidential information concerning the employer or its contract agencies;
- Nothing contained in this article shall be construed as prohibiting employees from exercising rights under ORC § 4113.52; and
- Violations of this article constitute a cause for disciplinary action.

Without signed confidentiality statements, CMHB's liability is increased and confidential client information could potentially be mishandled.

R3.15 The HR director, with assistance from the CEO, should ensure 100 percent compliance with the confidentiality requirement. CMHB has taken effective steps to protect confidential client information by requiring signed confidentiality forms, distributing ethics booklets and scheduling training, which should be continued.

Based on conversations with the HR director, the new confidentiality agreement does not make it difficult for staff to share information within the organization. However, to ensure that staff interpret the policy's meaning and purpose properly, the HR director and CEO should develop an in-service training. This training should also explain the following:

- The importance of signed confidentiality statements;
- What is considered to be confidential information;
- What is stated in the labor agreement regarding confidentiality; and
- What disciplinary action will be taken for not signing the form.

Disciplinary action should then be taken against employees who do not sign the form after the in-service is given. Each of these signed forms should be kept in the employee's personnel file. The labor agreement should be amended to specifically state that staff is required to complete confidentiality forms.

Training sessions provide an excellent overview of the state requirements, and should be used throughout CMHB. Furthermore, the use of the Ohio Ethics booklet, signed certification form, and continued training, is essential to ensuring that ethical and confidentiality issues are understood by each employee.

F3.21 CMHB's ethics policy does not contain essential elements. The current policy covers acceptance of gifts, confidentiality, conflict of interest and outside activities. However, none of the issues are explained in detail and the policy does not provide actions to be taken in the event of violation. According to Business and Legal Reports' publication, *Business Ethics Section 1105,* formal policy statements outlining exactly what is considered unethical behavior and what steps will be taken reduces an organization's liability and protects its best interests. Without clearly defined ethics policies, and an understanding of the implications of the policy, the organization's liability increases.

R3.16 CMHB should rewrite its ethics policy to include headings, specific descriptions explaining what constitutes unethical behavior in each category, and the steps to be taken if the policy is violated. The following categories should be discussed in more detail:

- Outside employment;
- Acceptance of gifts and gratuities;
- Conflict of interest;
- Nepotism; and
- Confidentiality.

The expansion of the ethics policy can reduce liability and increase employee understanding.

Job Descriptions and Performance Evaluations

F3.22 Job descriptions have been updated for 39 of the 71 positions at CMHB since 2001, while all other job descriptions have not been updated in several years. CMHB has eight different job descriptions for the administrative assistant classification. While employees generally feel their job descriptions reflect daily routine, they often commented in the employee survey that new duties have not been included. The new HR director has implemented a procedure for updating job descriptions. The HR director attaches the job description to the annual

performance evaluation form, and the supervisor reviews it with staff to ensure that it matches current job functions. If changes are needed they must be submitted to the HR director who makes the revisions. Although this process is a first step in updating job descriptions, it does not include a mechanism for completing a thorough job analysis (see **F3.23**).

Many CMHB job descriptions also lack measurable standards. According to James Neal's book, *The Number One Guide to Performance Appraisals*, job descriptions should be specific in describing standards of performance, including phrases like how much and how frequent. The job descriptions should follow a consistent format and coincide with the criteria in performance evaluations (see **R3.19**).

Additionally, the information contained in certain job descriptions is not up-to-date. According to HRNext.com, companies should have a formal schedule for reviewing all job descriptions. Preferably, because of the legal climate, a review should occur at least once a year. If a yearly review is not possible for every job, then at the very least, certain jobs should be classified as benchmark positions for the purposes of review. These jobs should be reviewed yearly, and updated as appropriate. In addition, a job description should be reviewed and revised when:

- The job content changes;
- There is an organizational structure change;
- Staff or management requests a review;
- There is only one incumbent in the job, and that person leaves the job; and
- There are continuous problems in a department or division.

The lack of clear and updated job descriptions can result in uncertainty of job functions and cause difficulty in developing an effective evaluation form (see **F3.25**). Additionally, preparing an evaluation form that is based on an out-of-date job descriptions can demoralize an employee and undermine the entire appraisal process.

R3.17 The HR director should work with supervisors to immediately review and update all job descriptions. In the future, job descriptions should be reviewed annually and updated as job functions change and should include measurable standards. CMHB should also consider reclassifying the eight administrative assistant positions and developing one job description. Up-to-date job descriptions would lead to a greater understanding of job functions and responsibilities. Job descriptions can also be used to assess employee performance and productivity.

F3.23 A job analysis has not been completed by CMHB since 1998. In 1998, Cuyahoga County

offered all agencies that requested salary increases and reclassifications an opportunity to undergo a compensation analysis conducted by DMG, at the County's expense. Based on the results of the study, Cuyahoga County would pay for all proposed salary increases or reclassifications. However, CMHB decided not to accept the County's offer and instead contracted with an outside agency to complete a compensation analysis which compared salary levels at CMHB to similar positions in the market. The study did not compare CMHB salary levels to peer mental health boards. The compensation analysis found in **F3.15** and **R3.10** of this report also compares CMHB to peer mental health boards.

The results of the analyses used in CMHB's 1998 compensation study were expected to be maintained in the future, by ensuring that jobs were re-evaluated throughout the year. The study resulted in the creation of salary grades, job classifications and increases in salaries. However, CMHB has not completed a follow-up job analysis since this study was released.

A job analysis is defined as the process of determining what is performed and accomplished in the job. According to HR.com, a job analysis needs to be completed every two years. Furthermore, the most important use of job analyses is to develop the responsibilities and expectations in a job description, which can facilitate basic human resource problem solving. Other important uses of job analyses are the following:

- Indicating training needs;
- Putting together work groups or teams;
- Providing information to conduct salary surveys;
- Providing a basis for determining a selection plan;
- Providing a basis for putting together recruitment; and
- Describing the physical needs of various positions to determine the validity of discrimination complaints.

Without a job analysis, it is difficult for job descriptions (see **F3.22**) and evaluation forms (see **F3.24** and **F3.25**) to be developed.

R3.18 The HR director should conduct a job analysis at least every two years. CMHB should also maximize the use of county and other resources in conducting future job analyses and compensation studies. CMHB employees should actively participate in the job analysis to highlight key functions and duties of jobs performed. The completion of the job analysis will ensure that job duties are reflective of work responsibilities. The results of the analysis should then be used to develop new job descriptions.

F3.24 CMHB does not evaluate employee performance on a consistent basis as required in its policy manual or the OAPSE labor agreement. This could be a result of a lack of stability in

managerial and supervisory positions at CMHB. A review of personnel files and the employee survey results revealed the following performance issues:

- 10 out 20 files reviewed either had no documentation of performance, no probationary performance evaluations, or evaluations were not done annually; and
- 73 percent of respondents were either dissatisfied or neutral about management's response to recommendations given in the evaluation.

CMHB's personnel manual and labor agreement require all probationary employees to be evaluated at the 60th and 120th day of the probation period and all regular employees to be evaluated annually (see **F3.13** and **R3.10** for discussion of probationary periods). The overall objectives of an employee performance evaluation program are to measure, maintain, and improve job performance. According to Business and Legal Reports, most evaluation programs:

- Provide a framework of goals and standards from which to measure performance;
- Serve as a tool to determine salary increases based on a worker's contribution to the organization;
- Develop action and training plans to correct performance problems, and establish goals for the next time period;
- Identify employees who should be promoted or given greater responsibility;
- Serve as a valuable communication tool;
- Act as a forum for individual career development issues; and
- Assure a formal time and a place for all these events to occur.

Currently, CMHB's evaluation process does not achieve any of these objectives. Franklin MHB implemented a performance plan in 2001. The following is the performance evaluation procedure at Franklin MHB:

- The supervisor develop measurable goals for the employee;
- An action plan is developed to support individual and departmental goal attainment. (See **F3.38**);
- Management and HR keep track of the employee's progress;
- The performance review is completed; and
- The action plan is then updated.

This performance plan has allowed Franklin MHB to streamline its performance evaluation process. Similar performance plans are in place at Lucas and Stark MHBs. Furthermore, these plans have linked goal attainment to both career development and performance. CMHB

does not have a performance plan, which has resulted in difficulty helping staff understand how their job supports the goals of the organization.

Scheduled meetings between staff and management and training sessions are often suggested as methods to explain a new performance plan. One method for providing managers training on the performance evaluation process is to offer an in-service training that explains the form, procedure and methodology. After this in-service has been offered, HR can also provide management with pamphlets that explain the purpose of the performance evaluation process. Without performance evaluations, employees are not given adequate feedback on performance, which may result in their performing duties in an inefficient manner.

R3.19 The HR director should work with supervisors to conduct employee evaluations in accordance with CMHB policy and the labor agreement. The HR director should develop a performance appraisal plan similar to Franklin MHB's that meets the standards outlined by Business and Legal Reports and explains the procedure for completing performance evaluations. Once the plan is in place, regular and probationary evaluations should be completed by supervisors in a timely manner. Management should use the performance appraisal process as a means to communicate the following:

- Recognizing employee accomplishments;
- Correcting recurring errors;
- Communicating expectations; and
- Gaining recommendations from staff about how to improve performance.

To maximize the feedback and communication opportunities provided in the appraisal process, management should have regular conversations with staff and provide feedback concerning the recommendations given in the evaluation process. HR should also develop a training session to explain the new plan in detail. Afterwards, HR should provide management and staff with a pamphlet that explains the importance of the performance evaluation process and provides tips on completing the evaluation effectively. One potential source of these pamphlets is Business and Legal Reports. The pamphlet titled "BLRS Pocket Guide: Performance Appraisals explains:

- Types of performance appraisals;
- Setting performance goals; and
- Measuring performance.

Providing frequent feedback on performance will have the following positive effects on CMHB:

- Ensuring employees receive clear feedback on areas for improvement;
- Facilitating the professional improvement of the employee;
- Providing evidence about the quality of employees' professional performance;
- Improving efficiency and effectiveness of the employees in carrying out the duties of the job description;
- Improving employee morale;
- Monitoring an employee's success and progress;
- Helping supervisors determine whether staff are meeting the expectations outlined in the unit, which can then be used for bonuses, termination, and continued training emphasis; and
- Protecting the organization from employment lawsuits.

Financial Implications: The cost of providing pamphlets to management and staff will be $250 for a staff size of 71 based on the pricing established by Business and Legal Reports.

F3.25 CMHB's current performance evaluation form is not consistent with current industry standards. CMHB uses a form to assess employee performance that has not been updated since 1998. The current form used by CMHB was taken from CCHR. However, in 1999, DMG-Maximus conducted a compensation and job classification study for Cuyahoga County (see **F3.23**), which resulted in the creation of a new performance evaluation form. CMHB did not participate in this process, and as a result, it has not updated the current evaluation form. The current form used by CMHB has the following deficiencies in comparison to its peer boards and industry standards:

- No description of the rating methodology;
- No review of attendance and sick leave usage (see **F3.4** and **R3.4**);
- No area on the form for improvement through training and career development; and
- No process for developing an individual development plan (see **F3.38** and **R3.33**).

In addition, the average response to whether CMHB's evaluation form is effective and efficient was 2.5, which indicates staff dissatisfaction. Further, nearly 75 percent of respondents found that the evaluation form is not effective or efficient, and nearly 35 percent of respondents commented that CMHB can improve the evaluation process by developing a new evaluation form. The remainder of respondents found that CMHB can improve the evaluation process by implementing more training and improving consistency.

According to James Neal in his book *The Number One Guide to Performance Appraisals*, the first step in developing a performance evaluation program is that performance evaluation forms need to be developed to meet specific responsibilities and measurement standards as outlined in the job description. Furthermore, an evaluation form requires several essential

elements. According to the Society for Human Resource Management and Business Legal Reports, effective evaluation forms have the following elements:

- *Identification*: This section of the evaluation forms should begin with the name of the organization, employee's name, job title, and other pertinent information. This element is currently included in CMHB forms.

- *Instructions*: The instruction section should explain the process for completing the evaluation form, how often they are to be completed and the approval procedures. This section should also include a description the rating methodology to reduce subjectivity in the process. CMHB's performance evaluation form does not include a detailed explanation of the rating methodology.

- *Focus of Measurement:* This section of the form includes the areas that will be assessed. The categories commonly measured are job duties/responsibilities, performance standards, goals and objectives, skill and knowledge, or individual results. CMHB's form currently has this element, but it does not explain performance standards in detail.

- *Attendance:* This section of the form should be used as a means of reviewing attendance and punctuality of the employee. This section is commonly used as a means of clarifying expectations and documenting attendance issues. This section has not been included on CMHB's performance evaluation form.

- *Employee Development*: This section should be included in the evaluation form as a means of improving performance through training and career development. This section should commonly be used to make training recommendations. CMHB's evaluation form does not have an area for discussing employee development.

- *Employee Input:* This section of the evaluation form should allow the employee the opportunity to provide feedback on their evaluation and future performance planning. CMHB's evaluation form does have an area for employee feedback.

Once the form has been developed, Neal suggests that management monitor the form continuously. Revised forms are warranted whenever there are significant changes in the organization, market place or company systems. Additionally, new forms cannot be effective unless management is provided training to inform them of the rating methodology, procedures, and purpose of the process. Without each of these elements and a procedure for monitoring the form, CMHB may not have an effective tool to make performance assessments, training recommendations, promotion decisions, and pay raises.

R3.20 The HR director should develop a form that promotes consistency, and objectivity, and forces supervisors to evaluate employees in specific areas. The actual form should have at least the following sections: instructions, identification of rating methods, focus of measurement, attendance and sick leave usage, employee development (action plan), and employee input. The HR director should also provide training as outlined in **R3.32** and **R3.33**. This training will ensure that management understands the measurement scale, purpose of the process, and how evaluations should be conducted. Once the form is in place, it should be monitored continuously for effectiveness and updated whenever significant changes in the organization, market or agency systems occur.

F3.26 CMHB's personnel files lack essential employee information and documents. The OAC Chapter § 5122 governs mental health agencies. Section 26-04 through 26-06 explains information that needs to be contained in personnel files. In addition, Business and Legal Reports provide additional information that should be contained in personnel files. **Table 3-9** shows the results of a review of a sample of 20 employee files using the criteria contained in OAC, and Business and Legal Reports.

Table 3-9: Personnel File Checklist Results

Item	Included	Missing	Corresponding Recommendation
Employment Application Form and references	13	7	**R3.21**
Job Title	19	1	**R3.21**
Job Description	11	9 (not done consistently or not at all)	**R3.17; R3.21**
Employee Classification (exempt from overtime or non exempt)	0	20	**R3.17; R3.21**
Hire Date	19	1	**R3.21**
Salary History	19	1	**R3.21**
W-2 Form	0	Kept at Central HR	**N/A**
W-4 Form	19	1	**R3.21**
Drug Test Results	1	19	**R3.24; R3.21**
Employment Contracts (Letter of Offer)	19	1	**R3.21**
Employee authorization to Release Information	20	0	**R3.25**
Documentation of employee orientation, mission, policies and procedures (Signed Acknowledgment form)	0	20	**R3.14; R3.21**
Employee Resume	19	1	**R3.21**
Employee Performance Evaluation	10 were consistently done annually	10 were either not done at all or not consistently	**R3.19; R3.20; R3.21**
Discipline (will not be included in every file)	8 (tardiness, sick usage)	N/A	**R3.9; R3.21**
Grievances (will not be included in every file)	1	N/A	**N/A**
Performance Goals	Not Done	Not done	**R3.19; R3.21**
Document of training and education, work experience and continuing education		13	**R3.35; R3.21**
Signed Confidentiality Forms	5	15	**R3.15; R3.21**
Verification of citizenship and employment eligibility	0	20	**R3.26; R3.21**

Source: OAC, Personnel File Review

Table 3-9 illustrates that CMHB's personnel files do not have all the information outlined in OAC chapter § 5122, sections 26- 04 through section 26-06 and include the following main areas:

- Document of training and education, work experience and continuing education, which 65 percent of CMHB files did not contain (see **F3.40** and **R3.35**);
- Employment application and references, which 35 percent of CMHB files did not contain;
- Copy of job description, which 46 percent of CMHB files reviewed did not contain

(see **F3.22** and **R3.17**);

- Employee performance evaluations, which 50 percent of CMHB files reviewed did not contain (see **F3.24** and **R3.19**);
- Documentation of employee orientation, mission, policies and procedures, which 100 percent of CMHB files did not contain (see **F3.19** and **R3.14**); and
- Verification of citizenship and employment eligibility, which none of CMHB's files contain (see **F3.31** and **R3.26**).

Additionally, CMHB files did not contain drug test results (see **F3.29**). The HR director indicated that file maintenance was not emphasized in the past, which results in personnel files lacking essentials documents. The HR director has begun to reorganize the employee files since September 2001. Personnel files not containing the above information may potentially violate state laws and create opportunities for complaints and grievances.

R3.21 CMHB should complete the reorganization of its employee files, and ensure that all of the elements required by OAC and listed above are included. Keeping human resource records that contain the required elements will help the department better administer human resource policies and provide documentation to drive human resource activities.

Recruitment and Retention

F3.27 All potential recruitment sources have not been used by CMHB. Hiring practices for bargaining unit positions are governed by the collective bargaining agreement while hiring for non-bargaining positions are governed by the personnel manual. Most job openings for bargaining positions are posted internally for 10 days and non-bargaining positions are posted for five days. Then, CMHB sends the posting to the local newspaper. In other County agencies, once staff has been given an opportunity to respond to an internal posting, an external posting is sent to CCHR. The CCHR office then sends posting to all County agencies, its website and external entities. Other mental health boards use several sources for external recruitment. **Table 3-10** compares the external resources used by CMHB, peer mental health boards, and CCHR.

Table 3-10: Current Recruitment Sources

CMHB	CCHR	Franklin	Lucas	Stark
• Plain Dealer • Monster.com	• CCHR website • All county offices • Over 300 community service agencies throughout the city. • Career fairs and several college career programs.	• Columbus dispatch • Franklin County Commissioners office • Department of Veteran's Affairs • Columbus Urban League • NAACP, Columbus chapter • GTC-3 • Minority Communicator News • ADAMH Website • OSU Office of Minority Affairs • Employee Referral • Partners in Active Living through Socialization	• The Toledo Blade • The Toledo Journal • La Prensa	• Newspaper • County agencies

Source: CMHB and Peer boards

Table 3-10 illustrates that CMHB has not used many of the external resources for recruitment used by the peers and CCHR. As result, CMHB cannot maximize its employment pool. Additionally, many organizations send external postings to various agencies as a means of ensuring that EEO and affirmative action practices are met. Without this mechanism, CMHB may not be adhering to acceptable EEO and affirmative action practices.

R3.22 The HR director should identify and fully use all available recruitment resources. By expanding its recruitment resources, CMHB can attract a diverse employment pool and increase the likelihood of attracting qualified applicants. Additionally, drawing applicants from a more diverse employment pool will ensure that EEO and affirmative action requirements are met. CMHB should also establish a working relationship with CCHR so that its postings can be sent to a more diverse population.

F3.28 CMHB currently uses a team or a one-on-one approach to interviewing applicants,

depending on the supervisor and job. However, the process for interviewing staff is not uniform or expressed in a written policy. Once a candidate has been chosen for an interview, CMHB may assemble a team of three to five managers or the immediate supervisor to conduct an interview. Group interviews have been held for administrative/clerical positions, as well as for managerial positions. These interviews have been done in one of two ways. The hiring manger may conduct the initial interview, select the top candidates, and then have the group participate in the second round of interviews or the group may conduct all the interviews.

If the available position is for a line position, the team could be composed of the hiring manager and the other unit members, or only the senior manager of the department. Once the interview method is chosen, interviewers are provided copies of the candidate's application and resume, with an interview summary sheet. This summary sheet is completed by the interviewer and used to develop structured questions.

According to HR.com, team interviews are an effective means of choosing the best candidate. The following is a list of additional benefits of using this approach, which have helped CMHB in choosing candidates:

- Ensures that everyone hears the same information;
- Helps experienced interviewers coach inexperienced interviewers;
- Leads to better probing, as a result of the opportunity for various types of questions; and
- Allows for candidate ratings to be made after the interview.

C3.4 The use of a team approach to interviewing potential clients is an effective means of choosing candidates. The HR director and management have found that using both a team interview process and structured questions has had the following positive effects:

- Helps to compare and rank the applicants;
- Allows the process to be more unbiased since each applicant is asked the same questions; and
- Provides additional feedback, which facilitates the selection of the best candidate.

R3.23 The HR director and the CEO should develop a uniform and standard interview process, and include it in the personnel policy manual to ensure interviews are conducted in a consistent fashion at CMHB. CMHB should also consider using a team interview all of the time so that the agency can assess an applicant from multiple viewpoints.

F3.29 CMHB currently does not have a drug and alcohol- free work place comprehensive plan.

CMHB has a substance abuse policy that requires staff to undergo a drug test if there is an allegation of drug usage made by an immediate supervisor. However, CMHB does not require pre-employment drug testing, unlike most other county agencies. Two of CMHB's peer mental health boards also require pre-employment drug testing (see **Table 3-6**). According to the U.S. Department of Labor, organizations that have comprehensive drug and alcohol programs can effectively protect themselves from the impacts of drug and alcohol usage. A comprehensive plan typically contains five elements:

- **Component 1: Writing a Drug-Free Workplace Policy.** An effective policy contains reasons for implementation, clear descriptions of prohibited behaviors, and consequences for violating the policy. Each of these components is found at CMHB and contains each of the elements.
- **Component 2: Supervisor Training.** Supervisor training is needed to ensure that drug abuse policies are applied properly. CMHB has not provided supervisors training to explain the policy or to help recognize employees who have performance problems. As a result, staff may not have received necessary assistance and low performance may be allowed to continue.
- **Component 3: Employee Education.** Effective employee education programs provide specific information about the details of the drug-free workplace policy and program. CMHB has not incorporated this element into its comprehensive plan. However, the HR director indicated that more will be done in this area.
- **Component 4: Providing Employee Assistance Programs (EAP).** These programs provide short-term counseling and referrals, and supervisor training and employee education. CCHR indicated that its EAP provider (who is also Metro Health) is frequently used to provide free drug and alcohol training to agencies. However, CMHB has not used its EAP as a training resource.
- **Component 5: Alcohol and Drug Testing.** The Society for Human Resources Management (SHRM), suggests that agencies use pre-employment drug testing to screen all applicants. CMHB currently has reasonable suspicion drug testing. However, CMHB does not have a pre-employment drug testing policy. CCHR, Lucas and Franklin MHBs have a pre-employment drug testing policy. The medical center charges Cuyahoga County $28.00 per applicant for pre-employment drug testing.

According to SHRM, substance abuse can result in decreased workplace safety, increased accidents, and decreased productivity.

R3.24 As an agency receiving federal funding, CMHB should implement a comprehensive drug and alcohol free plan in accordance with federal standards. To implement an effective and

comprehensive drug and alcohol free plan, CMHB should do the following:

- Provide training to management and staff, component two and three of the U.S. Department of Labor's standards. The HR director should contact the employee assistance program provider to arrange training sessions for management and staff. These training sessions should discuss the impact of drug and alcohol abuse on organizations, ways to detect drug and alcohol abuse, and techniques for addressing employees who are abusing drug and alcohol. Management will be better equipped to handle drug and alcohol issues within the department. By quickly identifying and addressing these issues, management may be able to address performance issues before service delivery is reduced.

- Provide updates about the problems associated with drug and alcohol usage, component four of U.S. Department of Labor's standards. The HR director should also provide continued training to employees. This training could be done by distributing pamphlets, or other materials to staff with their time sheets. Also the HR director could work with the director of external affairs to develop articles on drug and alcohol issues that can be placed in the employee newsletter. A potential resource for pamphlets, posters and other forms of employee communication on drug-free workplaces is Business and Legal Reports. The pamphlet titled "BLRS Pocket Guide: The Drug Free Workplace," contains information about the Drug-Free Workplace Act, effects of specific drugs, sources of assistance for drug problems, and what companies and employees must do to comply with the law. Providing training updates ensures that staff can identify if they need help, and who to contact for assistance. Furthermore, increased employee and supervisor awareness helps the CMHB avoid costly lawsuits.

- Institute a pre-employment drug test, component five U.S. Department of Labor's standards. The HR director and the CEO should work with the Prosecutors office to develop a pre-employment drug testing policy. This policy will deter or identify a significant number of applicants with drug and alcohol issues.

Financial Implication: The purchase of 71 Drug Free workplace pamphlets would cost CMHB $90 based on Business and Legal Reports pricing. Based on the cost per applicant of $28 for drug testing in Cuyahoga County and CMHB's turnover rate of nine employees in 2001, it would cost approximately $250 annually to implement pre-employment drug testing.

F3.30 Prior to 1999, CMHB did not conduct background checks on at least 31 of its staff. Background checks began in 1999 as a result of an incident in which HR could not verify the educational references of a new employee. Currently, CMHB contracts with Selection Management Systems (SMS) to complete all of its background checks. The company

provides the following services:

- Social Security number verification,
- County criminal search,
- Motor vehicle report, and
- Degree verification.

The company also can provide credit reports, workers compensation claims, and reference checks for additional fees. However, CMHB has not used these services. Currently, reference checks are completed by the HR director. However, once the HR specialist position is filled (see **F3.1** and **R3.1**), the HR specialist will complete many of the references checks on potential new hires.

According to Employment and Screening Resources (ESR), the law requires that employers take reasonable steps to hire employees that are fit for the particular job. When an employer hires someone who causes injury and the injury could have been avoided if the employer had taken reasonable steps to make sure that a safe person was being hired, the employer can be held legally responsible. The employer can be sued for "negligent hiring." To reduce the organizations liability, a safe hiring commitment is needed. The following is a list of ESR's suggested steps to help organizations institute effective hiring systems:

1. Have each job applicant sign a consent form for a background check, including a check for criminal records. This is done by CMHB.

2. Ask an applicant, both in the interview and in writing (on the consent form or application), if they have any criminal convictions or pending cases. This is done by CMHB.

3. Verify the applicant's employment for the past seven years and ask them in an interview what they think the previous employer would tell you. This is not done at CMHB.

4. Ask for residence addresses for the past seven years. This is not done at CMHB.

5. Do a criminal check in at least the county of residence. The best protection is a seven year criminal check of every county where a person has lived, worked or studied, based upon the person's job and residence history, as well as a social security trace report. For higher positions, an employer can check Federal court records as well. This is done at CMHB.

By not conducting a background and reference check, the employer may be subject to lawsuits, penalties and court awards if an unchecked employee commits a crime against a client or fellow employee. The average jury award for negligent hiring against a company was $870,000 in 2000, according to InfoLink Screening Services.

R3.25 The HR director should continue to outsource background checks and should conduct reference checks on all new hires. CMHB should also verify the applicant's employment for the past seven years, and complete a criminal check for the entire state and county of residence. Furthermore, the HR director should seek a legal opinion concerning whether to conduct background checks on all staff hired prior to 1999. Conducting background and reference checks can benefit CMHB in the following ways:

- Helps organizations reduce hiring and training costs;
- Creates an environment in which violence, crime and sexual harassment are kept to an absolute minimum;
- Provides information that can be used to check the accuracy of employment dates;
- Helps organizations reduces turnover;
- Reduces the organizations liability;
- Prompts some applicants to opt out so they won't be scrutinized;
- Encourages applicants to be open about their past indiscretions; and
- Provides organizations with the information needed to make better hiring decisions.

F3.31 CMHB does not have an immigration policy requiring staff to complete immigration forms (I-9 forms). As a result, CMHB has not been able to comply with federal immigration laws. Under the Immigration Reform Act of 1986 (IRCA), employers must hire only persons who can legally work in the United States. Anyone hired to perform labor or services after November 6, 1986 must complete an Employment Eligibility Verification Form (I-9 form) issued by the Immigration and Naturalization Services (INS). The employer must also request two forms of evidence to verify the identity and employment eligibility of anyone to be hired. Employers may be audited by the INS to determine whether I-9 forms are maintained. Employers who fail to complete and/or retain the I-9 forms may be subject to the following penalties:

- Failure to properly complete an I-9 form may result in a penalty ranging from $100 to $1,000 per I-9 offense.

- Knowingly hiring, continuing to employ or contracting with an unauthorized alien may result in a penalty ranging from $275 to $2,200 per I-9 violation for the first offense.

Pattern and practice of I-9 compliance failure may result in a penalty ranging from $275 to $2,200 per I-9 violation for the first offense. If the INS were to conduct an investigation, CMHB could, at a minimum, be charged with failure to complete an I-9 form, which would cost the agency from $5,900 to $59,000 since no employees have completed this form.

R3.26 HR should develop an immigration policy, which requires all newly hired staff and staff hired after 1986 to complete I-9 forms. HR should request two forms of ID, which should be photocopied and attached to the completed I-9 form. The documentation should be placed in each employee personnel file.

Financial Implication: By requiring staff to complete I-9 forms, CMHB could avoid approximately $59,000 in potential fines for noncompliance with Federal Immigration laws.

F3.32 Although CMHB provides 10.5 hours of orientation, it does not provide formal mentoring for new employees. HR provides staff with a two tier orientation process. In the first orientation session, HR covers the telephone system, time keeping, benefits, safety, policies, and has the employee complete required forms. The second session is held on the first Monday of the month, and lasts for seven hours and provides a basic overview of the responsibilities of other departments.

The HR director indicated that staff in various departments are encouraged to work with new employees until they become familiar with their job duties. However, while some new employees may receive a form of mentoring from staff, no formal policy or program has been established. Thus, participation is dependent on staffing levels and workload. Mentoring opportunities provide new staff with an opportunity to work closely with more experienced staff and observe how they perform their duties. In 2001, the Organization and Development Committee made a recommendation that committee members act as mentors for new staff. However, this recommendation was not implemented. The lack of a mentoring program may result in new employees not receiving training and support, which can lead to turnover and performance issues.

R3.27 The HR director and CEO should consider expanding the orientation program and providing newly hired staff with a more comprehensive understanding of agency operations. One approach would be to develop a formal mentoring program. The new employee should be paired with another employee who can act as a mentor for the first 30 days of employment. This would provide new employees with a better understanding of agency procedures and enable them to benefit from the knowledge of more experienced employees. To ensure that the different mentors pass along the same type of information to new employees, current procedures must be documented by the supervisor and passed to employees so that inefficient practices do not get communicated. A successful mentoring program can establish

the framework that a new employee will need to be productive in their new position. In the absence of a formal mentoring program, the HR director should ensure that management provides employees with as much training and support as possible through one-on-one meetings, training courses, etc.

F3.33 **Table 3-11a** illustrates the turnover rates for CMHB and the peers for FYs 2000 and 2001.

Table 3-11a: Turnover Rates for FY 2000-2001[1]

Categories	CMHB	Franklin	Stark	Peer Average
2000				
Total Number of Employees [2]	62.0	68.0	21.0	44.5
Total Number of Separations	8.0	9.0	3.0	6.0
Turnover Rate	12.9%	13.2%	14.3%	13.5%
2001				
Total Number of Employees [2]	71.0	60.0	27.0	43.5
Total Number of Separations	9.0	12.0	4.0	8.0
Turnover Rate	12.7%	20.0%	14.8%	18.4%
Average Turnover Rate for 2000-2001	12.8%	16.6%	14.6%	16.0%

Source: CMHB and peer board's reports submitted to the State

[1] Lucas MHB is not included in this analysis since turnover information could not be provided

[2] Number of employees at the beginning of FY 2000 and FY 2001

For the analysis in **Table 3-11a and b**, turnover was calculated by dividing the total number of full-time employees at year end by the total number of employees exiting CMHB during the year. Overall, CMHB's turnover rate was 4.4 percent lower than the peers in FY 2000 and 20 percent lower than the peers in 2001.

The *2000 Retention Practices Survey* released by the Society for Human Resource Management found that the average voluntary turnover rate in respondents' organizations was 17 percent. Based on this average, the CMHB's turnover rate was about 24 percent lower than the market average in FY 2000 and FY 2001.

Table 3-11b illustrates the reasons for separation at CMHB and the peers for FYs 2000 and 2001.

Table 3-11b: Reasons for Turnover for FY 2000-2001

Reason	CMHB	Franklin	Stark	Peer Average
Pay	0.0	0.0	0.0	0.0
Termination	1.0	1.0	1.0	1.0
Deceased	1.0	0.0	0.0	0.0
Retired	2.0	2.0	1.0	1.5
Resigned	13.0	18.0	5.0	11.5
Other[1]	0.0	0.0	0.0	0.0
Totals	17.0	21.0	7.0	14.0

Source: CMHB and peer board's staffing reports
Note: Lucas MHB is not included in this analysis since turnover information could not be provided
[1]Other consists of pregnancy leaves, or moving out-of-state.

Table 3-11b illustrates that resignation was the common reason for separation for both CMHB and peer boards. Specific reasons for these separations at CMHB were difficult to determine, because CMHB does not have a formal exit interview policy. As a result, the reasons for turnover are difficult to assess. Franklin and Stark MHBs have exit interview policies requiring staff to complete exit interviews. In addition, through conversations with staff and employment survey comments, it was determined that the departure of the CEO in 2001 may have had a significant impact. The vacancy created by the departure of the CEO, the circumstances surrounding that departure, and the lack of a new CEO appear to have a significant effect on the staff at CMHB.

Although CMHB has a lower turnover rate than the peers, CMHB has experienced turnover in several of the upper management staff (refer to the **organization, compliance and board governance** section for further discussion). According to Training and Development Magazine, losing employees is also expensive. Studies have found that the cost of replacing lost talent is 70 to 200 percent of the employee's annual salary. These costs include:

- Advertisement expenses;
- Recruitment expenses;
- Managers' and team members' time spent interviewing;
- Work put on hold until replacement is found;
- Overload of work on the remaining staff;
- Loss of other employees;
- Orientation costs;
- Training of new employees; and
- Decreased productivity until the new employee understands the position.

To reduce turnover, Workforce magazines suggests that organizations fully analyze the causes.

R3.28 The HR director should work with the CEO, BOG and Cuyahoga Prosecutors Office, to develop an exit interview policy that requires all staff to complete an exit interview prior to separation. Once the exit interview policy has been developed and implemented, the HR director, with assistance from the Organization Development Committee, should do the following to assess turnover:

1. Use the information collected from exit interview to analyze reasons for turnover;
2. Conduct a survey to learn organizational beliefs about retention;
3. Develop retention projections for the future, and have management discuss them to uncover reasons for separations;
4. Gather insight from assessments and interviews to find out more detailed information from staff; and
5. Compile all the information and develop recommendations.

Monitoring reasons for separation may identify specific issues that would allow CMHB to improve management policies, procedures and future recruiting strategies. Receiving feedback from terminated employees could also assist CMHB in identifying steps to improve employee relations. Conducting exit interviews can provide the following benefits:

- Defining the reason for the turnover;
- Establishing potential trends for future assessments;
- Gauging the morale of employees;
- Providing criteria for changes in future contractual issues.
- Obtaining information about improper or questionable management practices connected with the employee's termination;
- Obtaining information about a supervisor's management skills; and
- Obtaining information about how effectively a department operates.

F3.34 CMHB provides reimbursement towards the tuition costs of college courses approved in advance by the personnel director. Reimbursement decisions are made based on the following guidelines:

- Full-time employees are eligible for 100 percent tuition reimbursement;
- Reimbursement is based upon the program;
- The maximum dollar amount of reimbursement is equal to a maximum of 18 semester hours annually. The CSU rate ranges from a low of $3,206 to a high of

$6,083 annually (average of $3,100) depending on the number of hours taken and the degree type;
- Tuition reimbursement only applies to tuition costs and not parking, registration fees or books;
- A satisfactory grade ("C" or better and/or pass) must be obtained in the course for reimbursement; and
- The course must be completed prior to reimbursement.

By offering a tuition reimbursement program CMHB has provided staff an opportunity to enhance their career development. According to Work force Magazine, organizations that offer tuition reimbursement programs experience the following benefits:

- Results in increased productivity. Studies show that companies realize a $10 return in productivity for every $1 invested in employee education;
- Shows that management values staff; and
- Motivates employees.

The Auditor of State's Office (AOS) and CCHR also have tuition reimbursement programs that have guidelines similar to CMHB's. However, both have the following additional guidelines:

- Repayment of reimbursement must be made if the employee does not remain in AOS employment for a period of one year after reimbursement.
- Reimbursement is made up to one specific amount. CCHR pays up to $1,000 annually and AOS pays up to $2,500 annually for tuition reimbursement per employee.

Since CMHB's reimbursement is not based on a specific amount, it could experience high education costs. In fiscal year 2001, CMHB spent an average of $2,534 in tuition reimbursement peer employee. Additionally, without out an employment requirement after reimbursement, CMHB could not only lose the cost of the reimbursement, but the increased skill and knowledge gained by the employee.

C3.5 The initiation of a tuition reimbursement program at CMHB encourages continued growth and development of employee's skills, and benefits CMHB by proactively advancing its goals.

R3.29 CMHB should include a minimum employment period in its tuition reimbursement policy and procedure. Also, CMHB should consider making the maximum tuition reimbursement amount more specific. Each of these mechanisms will increase accountability and allow

CMHB to benefit from the increased employee's skill, while ensuring the program is cost effective.

F3.35 CMHB does not have an employee recognition program and policy to recognize employees for excellence. In the employee survey, the average response to whether employees understand how their job fits into the goals and mission of CMHB was 3.3 (neutral). This response suggests that management has not effectively communicated to employees the role they have in achieving CMHB's overall mission. Furthermore, it suggests that management does not effectively praise or reward staff for helping to achieve CMHB's overall mission. According to Workforce Magazine, two things employees want from the jobs are recognition and praise. Non-cash awards and incentives can raise morale, increase productivity, improve quality and safety standards, and increase customer services. Furthermore, in a Workforce survey conducted from September 1999 to 2000 on the U.S. Postal Service, managers reported that recognition programs had the following effects:

- Helps better motivate employees;
- Helps to increase employee performance;
- Provides employee with practical feedback;
- Makes it easier to get the work done;
- Helps employees become more productive;
- Helps management to achieve their personal goals; and
- Helps employees reach job goals.

Franklin MHB has an "Employee of Excellence" recognition program. An Employee of Excellence is someone who has gone above and beyond the expected in one or more of the following categories:

- Contributes above and beyond expectations on a specific board project;
- Shows dedication, reliability, and/or an unusually positive attitude;
- Exhibits a high level of innovation and creativity;
- Works unusually well across teams to provide support and collaboration;
- Works to improve wellness and quality of life of CMHB staff; and
- Exhibits outstanding leadership or initiative.

Management and staff are encouraged to submit nominations to the employee recognition committee, which makes the final decision. The purpose of this policy is to promote increased performance, reward success, and highlight staff's importance in achieving the overall mission. Without such programs, employee's morale may decrease (see **F3.7**).

R3.30 The HR director and the Organizational Development Committee should develop an

employee recognition program and policy to help motivate staff. To develop this program, the Committee should do the following:

- Determine specific criteria for excellence;
- Establish a format to nominate employees;
- Develop a format to review all nominations; and
- Develop a policy to explain the program's importance, criteria and nomination procedure.

Training

F3.36 CMHB has an Organization Development Committee. The purpose of this Committee is to:

> Look objectively at the organization as a whole in an ongoing effort to identify strengths and what is working well along with opportunities for improvement...To offer creative, practical suggestions, and implement ways to support and maintain a positive and productive organizational climate.

Every division is represented on the Committee. Each member is asked to provide feedback from the meetings to their division and bring back any concerns. The Committee discusses potential training courses, mechanisms for improving morale and other organizational issues at CMHB. A review of the minutes from the Committee's 2001 meetings illustrates that the Committee has developed effective recommendations for improving morale, and increasing training at CMHB. The following is a list of recommendations made by the Committee:

- Implementing training requirements (**F3.37** and **R3.33**);
- Developing a mentoring program (**F3.32** and **R3.27**);
- Addressing sick leave occurrence by staff (**F3.4** and **R3.4**);
- Sending out an employee survey;
- Instituting monthly training sessions; and
- Coordinating a retreat.

However, the Committee has not implemented all of its recommendations, many of which mirror the recommendations in this performance audit. This could be a result of the lack of stability in leadership at CMHB, which has produced an inability to implement recommendations. According to Business and Legal Reports, organizations should develop work groups to help address organizational issues in a quick and effective manner. However, the work completed by these work groups cannot have a positive impact on the organization if recommendations are not implemented.

C3.6 Creating an Organizational Development Committee is an effective means of addressing

training, and other organizational issues at CMHB. By having the Committee in place, CMHB is able to generate diverse ideas for addressing development concerns.

R3.31 The Committee should not only make recommendations for change, but also help to implement them as well. As a member of the Committee, the HR director should introduce recommendations to the CEO and BOG so that recommendations can be approved and implemented. Early in 2001, the team identified and proposed recommendations to address performance issues that are now being discussed in this performance audit. If recommendations had been implemented, these issues could have been addressed.

F3.37 CMHB allocates funds for training annually. **Table 3-12** provides the training budget for CMHB and actual expenditures for its peers.

Table 3-12: FY 2001Total Training Expenditures

Year	CMHB	Franklin	Lucas	Stark	Peer Average
Training Expenditures	$60,000[1]	$51,200	$2,500	$12,941	$22,214
Personnel Costs Budget	$4,045,874	$4,237,573	$889,700	$982,493	$2,036,589
Percentage of Budget Devoted to Training	1.5%	1.2%	0.3%	1.3%	1.1%
No. Employees [2]	71.0	60.0	21.5	27.0	36.2
Training cost per employee	$845	$853	$116	$479	$614

Source: CMHB and peer mental Health board's budget summaries
[1] The budgeted amount was used since CMHB could not provide training actuals.
[2] Number of employees at the beginning of FY 2001.

Table 3-12 illustrates two training issues:

- CMHB devotes an average of $60,000 of its budget for internal staff training, which is 1.5 percent of CMHB's personnel costs. However, an assessment of actual expenditures could not be made because actual training costs could not be provided. This is a result of the way training expenditures are reported at CMHB (see the **Finance Section** for further discussion). Since HR cannot track training expenditures, training costs cannot be monitored annually (see **F3.39**). CMHB's training budget is 36 percent higher than the peer average's actual training expenditures of 1.1 percent.

- CMHB allocates an average of $845 per employee for training, which 38 percent higher than the peer average. In the American Society for Training and Development's International Comparisons Report notes that overall, employers spent an average of $630 per employee on training in 1998. CMHB's training budget per employee is 35 percent higher than this standard.

In 2001, the Organization and Development Committee made a recommendation to implement a training requirement for all staff, but CMHB has not acted on this recommendation. The lack of a clear commitment to training, training planning (see **F3.38**) and training monitoring (see **F3.39**) occurs at CMHB because a training policy has not been developed by management. Without adequate financial support for training programs, capacity building and performance improvement is reduced.

R3.32 Training is an important tool for increasing the capacity of staff to complete their tasks, and should be a primary goal of any high performance organization. The HR director should work with the finance director to develop a line item in the expenditure report that will allow for tracking of training expenditures in the future. Furthermore, CMHB should develop a training policy to define training requirements, how to request training and how training information will be disseminated (see **R3.34**). To emphasize the importance of training programs at CMHB, the CEO and HR director should attempt to establish a training budget of at least $630 per employee, which is based on the American Society for Training and Development's International Comparisons benchmark.

F3.38 CMHB does not have a training policy and HR has not conducted a training needs assessment or developed training plans for its employees. An assessment of current skills and training requirements is needed to develop effective training plans. The needs and goals assessment process is often completed through the use of an Individual Development Plan (IDP) that is developed by both the supervisor and employee. Though IDP's differ, they are typically comprised of five sections:

1. Training needs;
2. Career goals both short-term (within two years) and long term (two to five years);
3. Education and development needs;
4. Development objectives (specific performance to show how needs have been met); and
5. Development activities (ways to achieve the development objectives).

When each of these sections has been completed, the employee and supervisor develop a training plan. According to Accel Team, a major HR consultant, the planning process follows these steps:

1. Establish a priority ranking of each need and goals for when they can be reached;
2. Describe, in writing, the performance standards that will demonstrate when each need and objective has been met;
3. Discuss alternatives or future training courses needed to accomplish objectives; and
4. Set a review date to discuss progress.

This process is currently being used at Franklin MHB as a means of enhancing employee skills and improving the performance assessment process. Employees are given a resource guide that explains the purpose of Franklin MHB's policy, the individual development plan (IDP) and its benefits, and the process staff should follow to enroll in training courses. According to Franklin MHB, an IDP is a tool cooperatively developed between the employee and team leader, in which development and training needs of the employee are forecasted and scheduled in order to enhance the employee's competencies. Without IDPs at CMHB, the following has occurred:

- Supervisors, and employees are unable to identify the competencies needed for their current position;
- Employees are unable to plan for future job duties and career development;
- Employee retention and morale has suffered;
- Employees' level of commitment to the organization is decreased;
- Management is unable to forecast training costs and needs; and
- CMHB does not have a tool that establishes a commitment from the employee to target professional growth.

R3.33 Once the HR director has developed a training policy as outlined in **R3.32,** an IDP plan for each employee should be completed annually. The HR director should refer to Franklin MHB's training process to develop the procedure for administering the plan. Once the IDP is in place, the immediate supervisor should meet with the employee quarterly to assess whether they are achieving the goals outlined in the plan, and if additional assistance is needed from HR. Implementing this plan could ensure that staff obtain the necessary training to achieve organizational and departmental goals.

F3.39 HR does not monitor the effectiveness of training activities. Staff has an opportunity to attend in-house and outside training sessions, but only 57 percent of respondents were satisfied or neutral as to whether staff training is effective at CMHB. Several respondents also commented that staff training has been inconsistent prior to 2002. In the summer of 2001, the new HR director and Organizational Development Committee developed and coordinated several in-house training sessions. However, HR does not assess the effectiveness of the training sessions offered, since participants are not required to complete a survey to assess the course.

Outside training opportunities are driven by the employees desire to attend training and not an IDP or needs assessment (see **F3.38**). Respondents in the employee survey were satisfied with the opportunities to attend training, programs, conferences, or seminars that are work-related, with an average response of 4.1. While respondents where satisfied with the opportunities to attend outside training sessions, it is difficult to assess the effectiveness of

outside training opportunities for the following reasons:

1. HR has no involvement or control over requested offsite training courses;
2. HR is not sent the training request information so it can be entered in a database and tracked;
3. HR is not provided documentation of annual training expenditures from Finance;
4. HR does not require staff to disseminate information from the training session;
5. HR does not require staff to submit proof of attendance; and
6. HR does not require staff to assess the effectiveness of the training session.

In contrast, Franklin MHB follows the same format as CMHB, but information is submitted to both the training and HR departments. HR enters the training request information into a database so it can be assessed. The database provides the following information:

- A description of the training taken;
- The cost of the training course;
- The location and course length;
- An explanation of how the training will improve job performance;
- An explanation of what has been gained from the training session; and
- The number of training sessions attended in the fiscal year.

Franklin MHB has also included a tickler file in its database that alerts the HR specialist to have the employee assess the training course attended. This information is used by Franklin MHB to assess current training programming and to identify common training needs among staff. Without a means for tracking the type, frequency and costs of training, CMHB cannot assess the effectiveness of its training programs. Furthermore, they cannot ensure that staff receives the information needed to increase performance and achieve departmental goals.

R3.34 HR should begin to monitor all training programs at CMHB. Training requests should be forwarded to the HR Unit by the Finance Unit to ensure that follow up with the employee occurs. Once the information is received by HR, it should be entered into a database or spreadsheet format and assessed at least annually.

CMHB should include a tickler file the database so that staff are reminded to assess the effectiveness of the training course, and determine whether other staff should attend. The HR director should also develop a survey to assess the effectiveness of training sessions offered onsite. This survey should be distributed to staff at the end of every training session and the results should be assessed.

Staff should also be required to establish a means for disseminating information learned in

offsite training sessions. Ways of disseminating information can include the following:

- Staff can summarize what they learned in the session and include the information in the employee newsletter;
- Staff can use the shared drive to post available training resources and write-ups of training attended; and
- Staff can provide training to other staff.

F3.40 HR does not monitor employee licensing. In general, CMHB's job descriptions indicate that licensing is suggested but not a requirement for employment. As a result, CMHB has not monitored training requirements for licensed staff. However, CMHB uses licensed staff to offer training, and other services to both providers and staff. The use of licensed staff to perform these functions suggests that licensing is important to the service that CMHB offers externally and internally, and needs to be maintained.

In January 2002, ORC § 5101:3-27-06 was implemented. According to this requirement, mental health boards must conduct medical necessity documentation reviews. These reviews can only be conducted by state licensed staff. Despite the knowledge of this new law in January 2002, no efforts made by HR to develop a policy requiring that licenses and continuing education credits are maintained.

Typically, licensed staff are required to complete a minimum of 30 to 35 hours of continuing education training hours (CEUs) by the state board governing the position. Employees can obtain this training from a variety of sources, including in-house training classes, local colleges and universities. Employees can also elect to participate in the TOPS Human Services Program, whereby the state reimburses employees for tuition-related expenses associated with classes taken at local colleges and universities that are directly related to their jobs. HR's responsibility is to maintain accurate personnel files that include copies of CEU documentation.

Franklin MHB ensures that staff receive necessary CEUs and other training hours by developing annual individual development plans (IDP). This ensures that staff gain training to increase knowledge and maintain licensure. For further discussion of IDP's, see **F3.38** of this report.

The lack of license monitoring could result in staff not receiving the required CEUs hours. Without these hours, staff cannot maintain their licenses, and cannot render services covered by this license. In effect, a lack of monitoring can result in service erosion and an inability to adhere to state requirements.

R3.35 The HR director should monitor the training requirements and expiration dates for all licensed staff. This can be achieved through completing a training needs assessment and IDP (see **R3.33)**. By monitoring training requirements, HR will be able to help staff maintain their licenses. The HR director, CEO and executive management should also determine whether licensing should be required for employment since staff are used to offer training and other services to mental health professionals.

F3.41 CMHB has not implemented an effective formal cross-training program for staff. In the employee survey, 91 percent of respondents indicated dissatisfaction with the implementation of a cross-training program at CMHB.

According to Claire Belilos, a training consultant, cross-training is an effective training technique that results in motivation. Cross-training programs should be carefully planned and presented as learning opportunities. For these programs to be successful, employees must "buy" into the idea, be encouraged to give feedback and make suggestions for improvement. Once in place, cross-training programs can achieve the following objectives:

- Prevent stagnation;
- Offer a learning and professional development opportunities;
- Rejuvenate all departments;
- Improve understanding of the different departments;
- Lead to better coordination and teamwork;
- Erase differences, enmity and unhealthy competition;
- Increase knowledge, skills and work performance;
- Improve overall motivation; and
- Lead to the sharing of organizational goals and objectives.

R3.36 The HR director should work with the management of each unit to develop cross-training programs for staff. These programs should be included in each employees' IDP (see **F3.38**) and the employee training budget (see **F3.37**). By implementing a cross-training program, CMHB will be better able to maximize employee's productivity.

Financial Implications Summary

The following table summarizes the total estimated savings and implementation costs from the recommendations made in this section of the report. Certain recommendations are dependent on labor negotiations and only those recommendations with quantifiable financial implications are included.

Summary of Financial Implications

Recommendation	Estimated Cost Savings (Annual)	Estimated Implementation Cost (One Time)	Estimated Implementation Cost (Annual)
R3.1 Hire a HR specialist			$47,300
R3.4 Reduce the number of sick days to the peer average	$48,000		
R3.10 Reduce vacation accrual policy to peer average	$30,000		
R3.19 Purchase of performance appraisal pamphlets		$250	
R3.24 Purchase Drug Free Work Place pamphlets and implement drug testing.		$90	$250
R3.26 Avoid potential fines for I-9 Form non-compliance.	$59,000 (Cost Avoidance)		
Total	**$137,000**	**$340**	**$47,550**

Conclusion Statement

CMHB has taken a proactive approach to strengthening its HR Unit through promoting its HR specialist to HR director, implementing time tracking systems, instituting group interviewing and negotiating several effective labor agreement articles. However, CMHB should do more to strengthen its HR Unit. The HR director's effectiveness is hindered by a lack of staff. The HR specialist position should be filled, which will allow the HR director to better implement effective HR practices. HR can further be strengthened by developing an effective relationship with CCHR, which will result in increased training opportunities and assistance in addressing labor relations issues.

HR should ensure that fundamental policies and procedures are expanded or included in the personnel manual. These policies include: formal employee evaluations, sick leave, confidentiality, a training plan and budget, exit interview policy and various leave management policies. Without these policies, CMHB faces excessive leave and compensation costs, and its ability to operate efficiently is significantly limited.

CMHB should maximize its use of available recruitment resources to attract employees, including those resources used by peers. CMHB has experienced turnover in its leadership positions which has resulted in decreases in employee morale and productivity. To reduce these negative effects and maximize its recruitment resources, CMHB needs comprehensive policies and procedures in place to ensure that qualified staff are hired, retained, and developed. Furthermore, HR should institute effective hiring practices including: conducting background checks on all staff, maintaining I-9s, and implementing drug testing. CMHB must also begin to offer new staff ongoing training opportunities such as cross-training and mentoring. This training will provide staff with the support needed to succeed in their jobs, which will result in increased productivity, efficiency and morale.

CMHB should emphasize developing job descriptions and completing performance evaluations in accordance with guidelines contained in the personnel manual and labor agreement. By developing up-to-date job descriptions and completing performance evaluations, CMHB will be able to more effectively assess staff performance, and have a means of reinforcing performance expectations.

The 2002 AOS survey of CMHB staff indicated that morale was very low. To increase employee morale and decrease turnover and sick day usage, CMHB should use more incentive based language in its sick leave policy, better assess turnover, implement more retention programs and improve communication between management and staff. HR must also ensure that career development is emphasized through developing IDPs. IDPs can help staff achieve career development goals and improve efficiency.

Finally, the CMHB labor contract and negotiation process are also critical issues that should be

addressed. CMHB needs to be more systematic in preparing for negotiations and provide training to assist key staff in preparing for negotiations. This preparation should begin by collecting data and performing analyses that will provide factual support and a detailed rationale for the contract terms it seeks.

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Finance and Funding

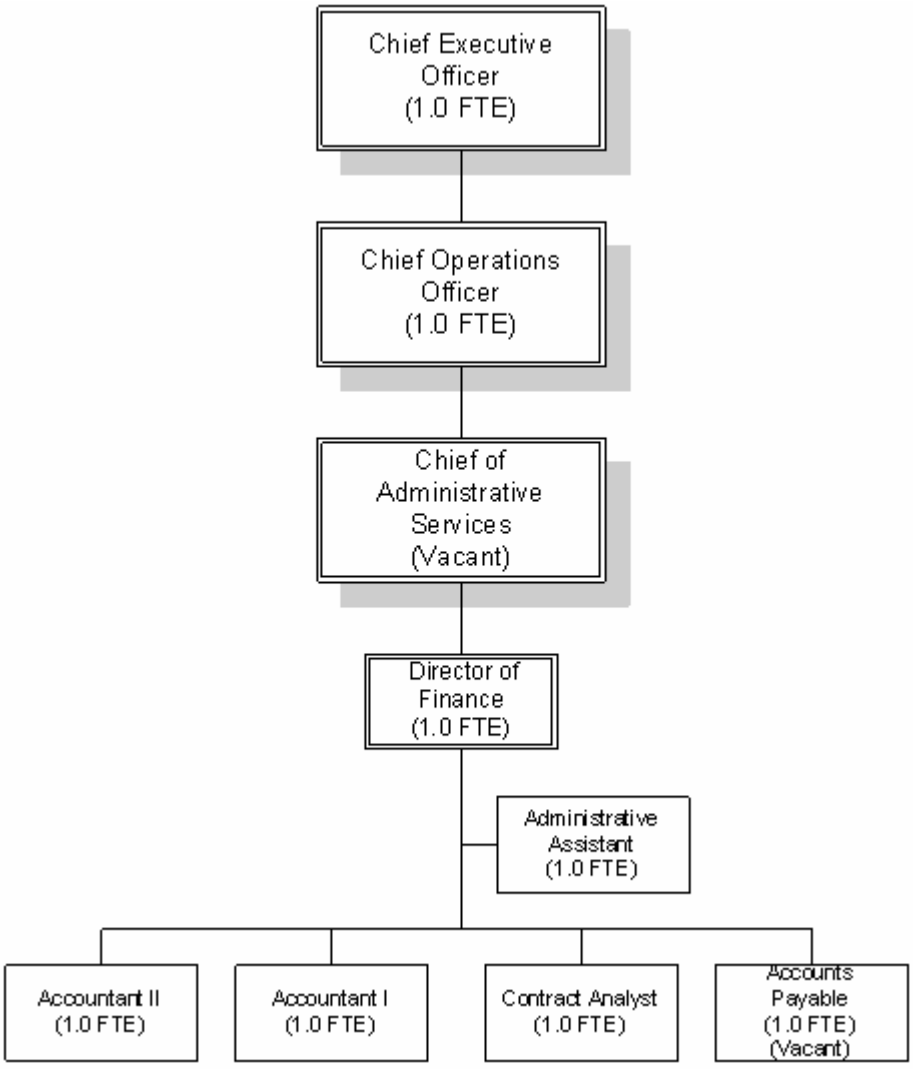
Background

This section of the performance audit focuses on the Finance Unit, funding and spending issues of the Cuyahoga County Community Mental Health Board (CMHB). The Finance Unit is responsible for planning and monitoring the fiscal affairs of CMHB and for assuring the Board of Governors (BOG) is in compliance with the Ohio Revised Code (ORC), the Ohio Administrative Code (OAC) and the Ohio Department of Mental Health (ODMH) in fiscal reporting. For the purpose of illustrating various operational issues, comparisons are made to the following peer mental health boards: Lucas County Mental Health Board (Lucas MHB), Stark County Mental Health Board, (Stark MHB) and Franklin County Mental Health Board (Franklin MHB). In addition, financial information has been obtained for Hamilton County Mental Health Board (Hamilton MHB) for additional comparisons.

Organizational Chart and Staffing

Chart 4-1 provides an overview of the organizational structure and staffing levels for the Finance Unit of CMHB as of January 2002. The finance director reports to the chief of administrative services (CAS). However, since the CAS position is vacant at this time, the director of finance is reporting directly to the acting Chief Executive Officer (CEO). CMHB employees work 37.5 hours per week and are considered full time (1.0 FTE) for payroll and benefit purposes. At the time of this audit, the accounts payable position is vacant. The function of accounts payable is being performed by a person from a temporary agency.

Chart 4-1: Finance Unit



As shown in **Chart 4-1,** the Finance Unit consists of six budgeted FTEs with a vacant accounts payable position. The job duties of each Finance Unit position, as outlined in **Chart 4-1**, are briefly described as follows. The director of finance is responsible for all accounting and financial functions, overall supervision of the staff and board compliance with all policies, state laws and accepted accounting practices. The accountant II position maintains accounting and budgeting systems, performs compliance reviews of contract agencies, reconciles third party billing, and assists in the coordination and performance of agency reviews and reconciliation of contract funding. The accountant I is responsible for reconciling general ledger accounts, preparing cash receipts, performing internal audits, performing contract funding reconciliations

and for maintaining the fixed asset inventory. The accounts payable specialist controls accounts payable and the purchasing system. The contract analyst monitors, reviews and analyzes financial data of contracted providers submitted to CMHB. The administrative assistant performs secretarial duties, and some accounting and bookkeeping functions.

Organizational Function

The primary functions of the Finance Unit at CMHB include the following:

- Provider services,
- Budgeting,
- Accounts payable,
- Purchasing controls,
- Inventory and control of equipment,
- Accounts receivable,
- Financial reporting, and
- Operations and Finance Committee relations.

Summary of Operations

The primary responsibilities of CMHB's Finance Unit are to review the budgets developed by the contracted providers of mental health services for annual Ohio Department of Mental Health (ODMH) budgeting, process accounts payable vouchers, prepare CMHB's budget, and prepare and submit operational and fiscal reports. Each year, the Finance Unit undertakes a project lasting from mid-March through May to revise the providers' unit costs for the coming ODMH mental health service budget fiscal year which runs from July 1 through June 30. A billable unit of service is defined as an hour-measured, face-to-face contact between a consumer and a professional authorized to provide services as outlined in OAC 5101:3-27-03. As covered under the Medicaid program, a unit cost is the cost of providing an hour or day-measured unit of service. ODMH, in conjunction with the federal Medicaid program, bi-annually establishes a rate ceiling amount on each Medicaid service unit cost. The Medicaid rate ceiling limits the dollar amount of funds reimbursed for the Medicaid service. The unit cost and the agreed to rate ceiling provide the basis for CMHB's providers to be reimbursed promptly for their services for all Medicaid eligible consumers of mental health throughout Ohio. In addition, CMHB works with providers in the same fashion as described for budgeting unit costs for non-Medicaid services. The Finance Unit works with the contracted providers of mental health services to obtain the providers' annual audited financial statements as required by OAC 5101:3-27-05 (C). These reports are presented to ODMH by CMHB. For each contract provider to continue in the Medicaid system, an audited financial statement must be submitted to ODMH no later than 180 days from the end of ODMH's fiscal year.

The Finance Unit is responsible for the preparation of CMHB's annual budgets. CMHB prepares two budgets, one for Cuyahoga County, based on a calendar year, and one for ODMH based on the State Fiscal Year of July 1 through June 30. ODMH processes entail high interaction between the contracted providers and the Finance Unit of CMHB. The Finance Unit is responsible for sending the instructions and forms to the contracted providers, answering all questions about the budget process and making sure all deadlines are achieved. The unit costs, the units budgeted and the total projected cost makes up the budget sent to ODMH for a fiscal year. ODMH then appropriates the total funds for CMHB's mental health spending.

The County budget process entails reviewing the mental health programs, operations and administrative costs as they pertain to CMHB's budget and performance indicators. The administrative expenses are supposed to form the basis for CMHB's internal budget. CMHB does not prepare internal division budgets. Because division budgets are not prepared, the other divisions at CMHB do not adequately participate in CMHB's administrative budgeting process.

The Finance Unit prepares vouchers which are submitted to the Cuyahoga County Auditor's Office to reimburse the providers. Voucher information for reimbursement originates from ODMH's system called the Multi-Agency Community Services Information System (MACSIS), which helps to control costs in Ohio by not allowing unit costs above the established rate ceilings. The Finance Unit also handles most of the contracted providers' reimbursement questions. The Finance Unit is responsible for assuring funds are available when needed by ordering the state quarterly subsidy of mental health funds, by reviewing the monthly Medicaid receipt of funds and by reviewing the county's journal entries to allocate levy funds. Funds are also received from grants, foundations and other publicly funded boards. The actual maintenance of the bank deposit account, containing all funding and disbursement activity, is controlled by the Cuyahoga County Auditor's Office (ORC 340.10).

The Finance Unit is responsible for CMHB's purchase order system used to acquire non-provider related goods and services. As purchase orders are fulfilled, and the invoices for the purchases are received, the invoices are matched to the approved purchase orders, vouchered and sent to the County Fiscal Department for check processing. As an adjunct of the purchase system at CMHB, the Finance Unit is responsible for the inventory and control of all equipment at CMHB. The control of CMHB's fixed assets is kept in paper ledger form.

The Finance Unit is responsible for preparing all internal and external fiscal reports. The monthly financial report is prepared for BOG's operations and finance committee (OFC). The Finance Unit is responsible for providing answers to questions raised on the data presented and for the reports' overall presentation. The Finance Unit receives data from various sources, compiles them into a database maintained on CMHB's internal Management Information System (MIS) and reviews the reports for accuracy. These reports are available for review to anyone having access to CMHB's MIS system. External reporting is primarily ODMH and Medicaid

driven. Examples of external reports are various block grant reports required to verify the use of the funds allocated for the block grant programs (Title XX funds of the Medicare Act). The Finance Unit works with each contract provider receiving block grant funds to compile the reports. Block grants are the largest non-Medicaid reports provided by the Finance Unit to an external group.

The Finance Unit performs duties required by the BOG mainly through the OFC. OFC is made up of eight persons, seven BOG members and the CEO (see **board of governance** section), and meets the third Wednesday of each month. OFC members are volunteers; and they elect a chairperson whose primary duties are to conduct the meetings, maintain order and establish the meetings' agendas with CMHB staff. A quorum of five members is required to be present to vote on issues presented before the body. OFC's main duties are to monitor the financial status of the board, approve changes in funding or programs, approve the budgets and discuss issues that need board approval. From the discussion and voting on issues, resolutions are submitted to BOG for their consideration and approval.

Medicaid and Other Funding Sources

Medicaid, a Federal entitlement program authorized by Title XIX of the Social Security Act, started in 1967 as an amendment to the original Medicare health program. It is designed to provide medical benefits for eligible aged, blind, disabled and low-income persons. The program is to be used primarily by those who are below certain levels of income, children of these families, foster care children and the aged. It is funded in part by the federal government and the remainder by state funds. Medicaid is always to be considered the payer of last resort. Any other source of payment for which a Medicaid recipient is eligible must discharge liability before a claim for payment will be accepted by Medicaid. The federal portion of this funding changes annually but is never less than 50 percent nor more than 83 percent for any one state. A state's portion of this program is calculated by taking its median income in relation to the nation's median income. The federal share reimbursed to states is referred to as the Federal Financial Participation Rate (FFP). Ohio received 58.78 percent for Fiscal Year 2002 and will receive 58.83 percent for Fiscal Year 2003 in reimbursements from the federal government.

Federally mandated Medicaid funds are distributed to each state. In Ohio, the funds go to the Ohio Department of Job and Family Services (ODJFS) for distribution for all state Medicaid expenditures. ODMH, through a contractual agreement with ODJFS, is allocated the mental health portion of the federal funding. The Ohio State Legislature then allocates funds to be used for state expenditures for mental health services through ODMH.

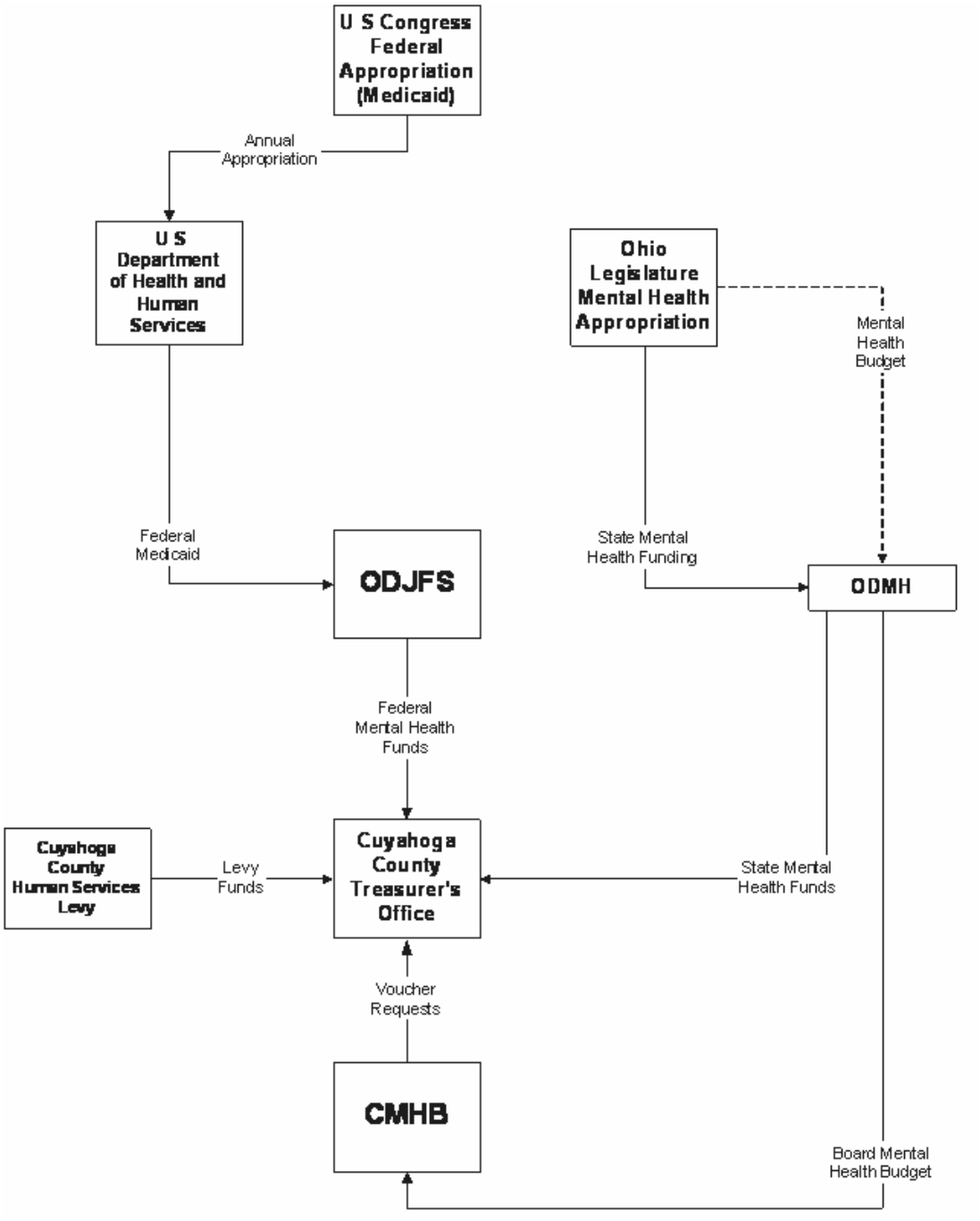
CMHB also receives funding for non-Medicaid county programs through a County Health and Human Services tax levy on personal property and real estate. Included in these levy funds are funds to be expended for those in need of mental health services not covered by Medicaid, such

as housing and employment programs. According to CMHB, its administrative expenses, such as payroll and rent, are paid with the county and state funds.

CMHB, through its contract with ODMH (OAC 5101:3-27-05 [A]), agrees to fund the majority of its share of Medicaid cost with state funds. These state funds, along with the FFP received from ODJFS, are used to reimburse the providers of mental health services for Medicaid consumers of Cuyahoga County. The providers agree to receive reimbursement for their services at rates as mandated by ODMH. Medicaid funds are paid to the provider at 100 percent of billed value up to the established ODMH rate ceilings.

Chart 4-2 illustrates the steps needed for CMHB to receive its annual funding for mental health services.

Chart 4-2: CMHB Funding



The mental health funding program starts with the federal appropriation of Medicaid funding to ODJFS. After ODMH informs ODJFS of CMHB's Medicaid funding allocation, the Medicaid funding passes to Cuyahoga County Treasurer through ODJFS. The Ohio legislature budgets and appropriates the state portion for mental health funding to ODMH. ODMH distributes the state mental health funds to the local mental health boards through county treasurers. Local funding is obtained from the Cuyahoga County Human Services Levy through the county treasurer's office.

Chart 4-3 illustrates the steps required of CMHB providers (both contract and non-contract) to receive their reimbursement for providing mental health services to CMHB consumers.

Chart 4-3: Provider Reimbursement

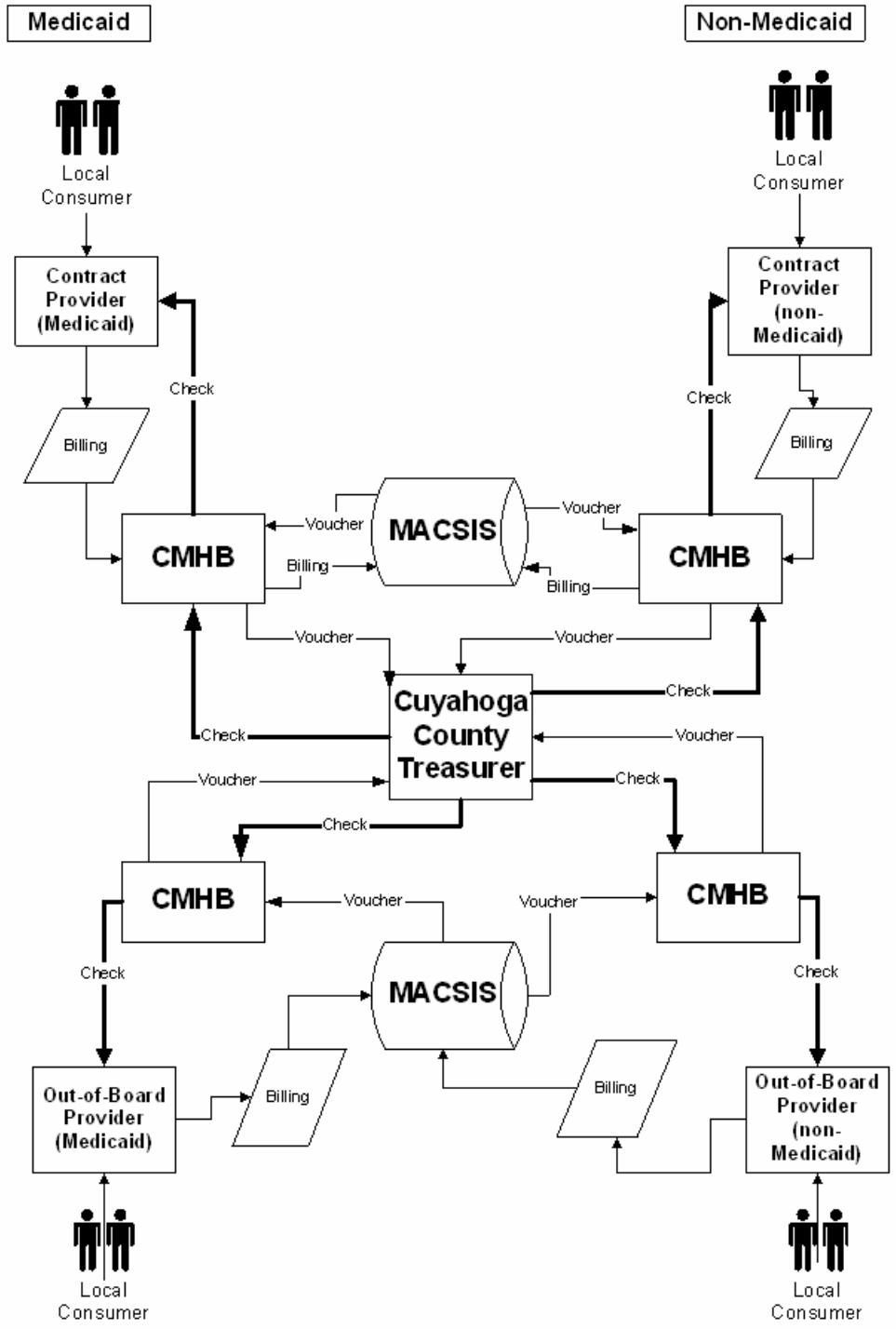


Chart 4-3 diagrams the steps needed to reimburse the providers of mental health services. Providers service two types of consumers, Medicaid and non-Medicaid. Because of the Any Willing Provider (AWP) clause in Medicaid, and ODMH altering how providers are reimbursed in 1999 (**F4.38** and **F4.39)**, the Medicaid mental health consumers in Ohio may choose any Medicaid contract provider in the state. This creates out-of-county board consumers and in-county-board consumers receiving services at a contract provider. The major difference in the provider reimbursement process is that MACSIS directs the billing to the local mental health board where the out-of-county consumer resides, whereas the billing for in-county consumers originates from the local mental health board. According to the finance director, CMHB does not pay for out-of-county board consumers receiving Non-Medicaid services, except for certain crisis services.

After preparing vouchers from the billing information generated from MACSIS, the vouchers are submitted to the county treasurer's department for check preparation. After check preparation, the check is sent back to CMHB, verified for accuracy by accounts payable, and is mailed to each provider.

Financial Data

The information in **Table 4-1** provides a general overview of CMHB's actual financial data for FY 2000 and FY 2001, and budget for FY 2002. Actual expenditures and budget information is based on the State's fiscal year of July through June.

Table 4-1: CMHB Financial Summary

Description	FY 2000 Actual	FY 2001 Actual	FY 2002 Budget
State Funds	$37,372,033	$41,041,847	$40,180,449
Federal Funds	$1,050,245	$2,073,959	$944,613
Title XX Funds[1]	$1,327,722	$1,268,854	$1,268,854
Title XIX Funds[2]	$24,958,367	$28,120,579	$32,136,419
County/Other Local Funds	$18,384,673	$19,446,519	$17,472,286
Total Board Revenue	**$83,093,040**	**$91,951,757**	**$92,002,621**
Board Operating Budget	$4,745,746	$5,210,812	$5,285,068
Disbursements to Contracted Providers	$78,224,570	$85,508,891	$87,133,553
Total Board Expenditures	**$82,970,316**	**$90,719,703**	**$92,418,621**

Source: CMHB Annual Reports
[1]**Definition**: Block Grant to states for social services
[2]**Definition**: Grants to States for medical assistance programs (Medicaid)
Note 1: FY 2000 actual Board Operating Budget was published in the annual report as $4,868,470. See **F4.15** for explanation.

Total disbursements to contracted providers, as shown in **Table 4-1**, were 94.3 percent of the total board expenditures in both FY 2000 and 2001, and total budget in FY 2002. CMHB's

operating expenses increased by 9.8 percent from FY 2000 to FY 2001 and are budgeted to increase 1.4 percent in FY 2002. Since CMHB does not track actual expenditures by line item, it can not provide a detailed breakdown of the budget (see **F4.17** and **R4.16**). As a result, CMHB can not provide specific explanations for variance in its operating budget from year-to-year. However, based on the FY 2001 budget, the increase in FY 2001's expenditures could have been attributed to a 16.7 percent increase in salaries and 116.0 percent increase in professional and technical services (see **Table 4-3** and **Table 4-4)**. The salaries increased due to additional employees in the claims unit, and the professional and technical services increased due to anticipated consultants' costs. Further, CMHB could not explain the decrease in federal funds from FY 2001 to FY 2002.

Additional spending on mental health services by other public agencies in Cuyahoga County was approximately $1.5 million and $1.6 million, respectively, for FY 2000 and FY 2001 (see **F4.24**). Consequently, CMHB spent about 98.1 percent and 98.2 percent, respectively, of the total public mental health spending in Cuyahoga County for FY 2000 and FY 2001.

Further, the budget as presented for fiscal year 2002 was later decreased by the county because of anticipated lower tax revenues. This decrease amounted to ten percent of the county appropriations total. As of the date of this report, agreement as to how much the decrease is to by line item has not been determined.

Performance Measures

The following performance measures were used to review CMHB's Finance Unit:

- Review of CMHB revenues and expenditures (two years' history and one year budget)
- Evaluate staffing levels and review organizational structure
- Assess the adequacy of internal controls
- Assess the adequacy of the financial process to ensure financial accountability is clearly defined and communicated within the agency
- Assess the adequacy of CMHB's budget process
- Assess the adequacy of CMHB's current funding to meet the needs of the County's mental health consumers
- Evaluate the fee-for-service payment system
- Assess the impact of the "Any Willing Provider" implementation and its impact on CMHB and Cuyahoga County's funding
- Review the CMHB operations and financial committee to determine the level of financial knowledge and training

Findings / Commendations / Recommendations

Staffing & Organizational Issues

F4.1 **Table 4-2** shows Finance Unit staffing levels by job function at CMHB and the peers.

Table 4-2: Finance Unit Statistics for FY 2000 and 2001

Position	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average
Supervision	1.50	1.50	0.75	0.50	0.90
Budgeting	0.50	0.50	0.75	0.50	0.60
Provider Budget and Contracts	2.00	1.75	0.50	1.00	1.08
Contract Funding	0.50	0.25	0.50	0.25	0.30
Accounts Payable	1.00	1.00	0.50	0.75	0.75
Provider Audits	0.00	1.00	0.00	0.00	0.30
Administrative	1.00	1.00	0.00	0.00	0.30
Total Staff FTE	6.00	7.00	3.00	3.00	4.23
Consumers (2001)	30,238	29,317	13,650	8,209	17,059
Consumers per FTE	5,040	4,188	4,550	2,736	4,033

Source: CMHB and peers

As indicated by **Tale 4-2**, the Finance Unit's ratio of consumers per FTE is the highest of the peers and approximately 25 percent higher than the peer average. This indicates that the Finance Unit is maximizing output with minimal resources. However, the Finance Unit does not track workload measures more relevant to financial staffing levels, such as the number of transactions, which could be attributed to its technology (see **R4.7**). As a result, fully determining the adequacy of staffing levels in the Finance Unit could be difficult.

In addition, **Table 4-2** illustrates that CMHB has a higher number of FTEs in provider budgets and contracts as compared to the peers because CMHB has a significantly higher number of contracted providers. CMHB and Franklin MHB have 38 and 23 contracted providers, respectively. Although CMHB does not have a full-time position dedicated to provider audits, Franklin MHB has 1.0 FTE dedicated to working closely with the contracted providers and private auditing firms that conduct the annual financial audits of the contracted providers. This position provides assistance during the audits, participates in the exit conferences after the audit has been completed and assists the contracted providers in correcting problem areas found during the audit. By having a provider audits position, Franklin MHB is proactive in providing financial assistance to its contracted providers to ensure appropriate financial reporting and records, and that the contracted providers are effectively managing funding provided by Franklin MHB.

According to the finance director, one accountant spends approximately 30 percent of his time working with providers during their financial audits. However, considering the larger number of contracted providers at CMHB as compared to Franklin MHB, employing a full-time position to provider audits would fully ensure that CMHB is providing adequate financial assistance for its contracted providers. This would also allow the finance unit to have more time to implement necessary improvements to its operations as discussed throughout this report. Further, CMHB's payroll processing is performed by the Human Resources unit. In contrast, the peers perform this function in their Finance Units. For more information, see the **human resources** section of this report.

C4.1 The Finance Unit appears to be adequately staffed and appears to be maximizing output with minimal staffing resources. Establishing staffing of the Finance Unit at an appropriate level ensures that the work is being completed effectively while efficiently using resources.

R4.1 CMHB should consider adding a full-time position in the finance unit to work closely with the contracted providers and private auditing firms during the financial audits. This position should work closely in helping the contracted providers correct problem areas and ensure that contracted providers are using sound financial and business practices. In addition, providing more financial assistance would allow contracted providers to focus more time and resources to providing effective and quality services to consumers.

Financial Implication: Based on Franklin MHB, CMHB would incur approximately $65,000 annually in salary and benefits costs by employing a provider audits position.

F4.2 The accounts payable staff position is vacant and has been staffed by a temporary employee since 2001. In contrast, the peers use regular staff to perform activities related to accounts payable. Using a temporary employee could cause disruptions in work flow because the Finance Unit is always in a training mode due to the turnover of temporary staff. In addition, by not filling the accounts payable position with a regular employee, the Finance Unit has not been able to take on additional tasks, such as using ODMH's Web site to obtain and analyze important mental health spending and funding information.

R4.2 CMHB should consider filling the accounts payable position with a permanent employee. CMHB should invest in the new employee by providing the necessary initial training and subsequent training to ensure that the employee fully understands their responsibilities and contributes to enhancing overall financial operations. As the new employee becomes acclimated and fully understands their role, the Finance Unit can devote more time to other necessary activities, including analyzing ODMH data and improving its budgeting

process (see **R4.11** through **R4.21**). Furthermore, since the rate charged by the temporary agency is comparable to the salary and benefit costs of employing 1.0 FTE in accounts payable, there would be no financial impact related to this recommendation.

F4.3 Job descriptions in the Finance Unit have not been changed since the introduction of MACSIS in July 1999. In addition, job descriptions in the Finance Unit are not descriptive of various new duties performed by the Finance Unit employees since 1999. Some of the missing information includes non-Medicaid unit costing, working with the MACSIS system for information and tracking, and processing MACSIS billing information. Also, the present job descriptions are vague as to how responsibilities are to be performed and where to obtain procedures needed to fulfill the staff's responsibilities. Not updating job descriptions to reflect all duties and responsibilities and not including specific and detailed information in the job descriptions could result in staff not fully understanding their responsibilities. Updated job descriptions are an essential and effective management tool when tied to performance reviews, training and other staff needs. See the **human resources** section for further discussion on updating job descriptions.

R4.3 The Finance Unit should update all job descriptions. New responsibilities and functions, such as the additional responsibilities related to the implementation of MACSIS, should be added to fully describe current responsibilities. Updating the job descriptions should ensure that staff understand their responsibilities and can effectively perform job functions. In addition, the updated job descriptions should be used to evaluate employee performance (see **R4.5**).

F4.4 The Finance Unit does not have a policy and procedures manual. The purpose of a policy and procedures manual is to establish a uniform decision making process and formalize daily operations. Also, access to a policy and procedures manual is important to ensure continuity and consistent application of CMHB's and the Finance Unit's policies and procedures. Clarity in departmental policies reduces the chance of misunderstanding and helps to preserve institutional memory when turnover occurs. In addition, documented and enforced policies and procedures increase the level of accountability throughout CMHB and the Finance Unit. See the **human resources** section for further discussion on a policy and procedures manual.

R4.4 The Finance Unit should develop a written policy and procedures manual and establish a process for regularly review and revision. The policies and procedures manual should document all procedures and processes within the department, by functions performed, so it can be used by all employees. A policy and procedures manual will enable employees unfamiliar with all the Finance Unit's activities to understand the steps required to complete job functions when other employees are on vacation or leave.

The Finance Unit should ensure the policy and procedures manual is distributed to all employees. Employees should acknowledge receipt and understanding of the policy and procedures manual through a signed statement maintained in the employee's personnel file. The manual should be reviewed on an annual basis to determine if changes, deletions or additions are needed.

F4.5 The Finance Unit of CMHB does not follow a set policy for employee reviews. Employee reviews for the last four years have been done in a random fashion, with no set pattern of timing. Employee reviews are used to provide employees and management an opportunity to measure accomplishment of goals and objectives and to assess the progress a person is making in their employment growth. Reviews are a valuable tool to monitor staff progress by management and to highlight employees' weaknesses and set timelines, programs and training to improve areas of lower performance. Conversely, the reviews are an opportunity to commend an employee on a task or job well done. See the **human resources** section for further discussion on employee reviews.

R4.5 CMHB should establish a set schedule for employee reviews. The review process for each employee should be at least annually and could coincide with their CMHB anniversary date or completed as a department at one time, such as the end of the fiscal year. Intermittent reviews should be completed as determined by CMHB management in addition to this schedule. Employee reviews are a valuable tool for both management and the employee and should be viewed as a critique of what management assesses the abilities of the staff to be in relation to their responsibilities, and as a tool for further development. Goal setting and developing attainable levels of performance for the coming year should be a primary focus of this process. Therefore, management should also view this as a time to set goals for the coming evaluation period and for the employee to agree or ask that the goals to be amended. Intermittent reviews may be needed to assess progress in attaining these goals and determine levels of performance.

F4.6 Although the Finance Unit job descriptions state that certain positions should assist others in carrying out some functions, the Finance Unit does not cross-train staff members on a consistent basis. Cross-training is needed to ensure important tasks are completed when the primary person performing the task is absent. In addition, effective cross-training would ensure that operations are not adversely impacted when a position becomes vacant. See the **human resources** section for further discussion on cross-training.

R4.6 The Finance Unit should implement a cross-training program for staff members. The training should become part of a planned training schedule and, when training is completed, the persons trained for other positions should perform the functions on a scheduled basis to reinforce and maintain what they have learned. CMHB will benefit by covering absences more effectively and with fewer disruptions in work flow. Effective

cross-training should become an integral part of the planned work flow of the Finance Unit

Financial Accountability and Internal Controls

F4.7 CMHB does not have an effective and technologically up-to-date internal accounting system. According to CMHB's Management Information System (MIS) director, the internally designed system to control vouchers is over eight years old and is operated on an outdated hardware platform that is very costly to maintain. The MIS director also stated that the manufacturer of the hardware no longer supports the system and the hardware will only support the current operating system. The software was internally designed, and the current MIS staff cannot support it. In addition, the software cannot be operated on any other platform.

The Finance Unit uses the County's Financial Accounting Management Information System (FAMIS) for tracking cash receipts and expenditures. However, the summaries of FAMIS data entries are not posted to any general ledger control at CMHB. As a result, CMHB can not easily track and monitor expenditures by line item. In addition, the lack of an effective accounting system precludes the Finance Unit from doing many functions easily, such as preparing financial reports and budgets, and analyzing costs. These processes need to be manually entered on various spreadsheet reports and analyzed for information. Manual entering of data could lead to errors and to information being reported incorrectly, as well as requiring additional staff time to manually enter all of the required data. For example, administrative and operating expenditures reported in the FY 2000 annual report were actually the administrative and operating budgeted amounts (see **F4.15** and **R4.14**). Furthermore, tracking and monitoring workload measures (e.g., number of transactions processed) to ensure staffing levels are adequate is difficult with the current system. See the **technology section** for further discussion on the Finance Unit's software and hardware issues.

R4.7 CMHB should consider purchasing a new internal accounting software and hardware system to support FAMIS and a general ledger. However, prior to purchasing a new accounting system, the Finance Unit should fully evaluate benefits and costs of various systems and ensure that the new system will allow the Finance Unit to easily perform the following functions:

- Tracking and monitoring expenditures by line item (see **R4.16**);
- Tracking and monitoring budgets and expenditures by division (see **R4.16**);
- Analyzing trends in costs and expenditures from year-to-year;
- Tracking work load measures to assess productivity and staffing levels;
- Preparing vouchers in the County format; and

- Producing custom and ad-hoc reports.

If a new accounting system is implemented, the Finance Unit should train all of its employees on its use to ensure that all of the new system's functions and capabilities are fully used. Implementing a new accounting system would allow the Finance Unit to function more efficiently and eliminate potential errors from the present system because data would not be manually transferred to spreadsheets. See the **technology section** for further discussion on software and hardware issues.

Financial Implication: Based on information received from a computer vendor, it could cost CMHB approximately $30,000 to implement a new internal accounting system.

F4.8 GASB 14, from the American Institute of Certified Public Accountants' (AICPA) Government Auditing Standards Board (GASB), determined that if an entity is part of the whole structure and the whole structure is audited, then the parts do not need to be audited individually. Based on GASB 14, CMHB is considered a "part" of the County's annual financial audit because the County's Human Services Tax Levy Fund is audited. Therefore, CMHB is not individually audited by an outside entity.

The Government Finance Officers Association (GFOA) states that strong government financial reporting is based upon generally accepted accounting principles (GAAP) and annual independent audits of financial statements. In addition, GFOA recommends that government entities obtain an annual independent audit of their financial statements performed in accordance with generally accepted auditing standards (GAAS) or generally accepted government auditing standards (GAGAS). Franklin County MHB was individually audited annually through calendar year 2000 by an independent accounting firm and produced an annual report including the audit firm's opinion on the presented financial and management information. Due to cost constraints within Franklin County, Franklin MHB will not be audited separately in 2001. However, Franklin MHB is requesting a separate operational audit be performed by an independent firm during the year to ascertain that policies and procedures are being followed.

R4.8 CMHB should seek an annual outside financial audit of its specific financial information. By obtaining an annual financial audit, CMHB will bring a level of confidence, accountability and integrity to its presented financial information. Furthermore, an annual financial audit would also provide opinions as to CMHB's compliance with laws pertaining to its operations, procedures governing various financial processes and effectiveness in maintaining adequate financial records. As a result, an annual financial audit would serve as an effective tool to ensure that CMHB is appropriately maintaining its financial information as well as enhancing overall financial operations.

Financial Implication: Based on Franklin MHB's data, the cost of an annual financial audit would be approximately $20,000.

F4.9 CMHB and the County are maintaining adequate internal controls by appropriately separating duties for processing cash receipts and disbursements between the County Treasurer's Office and CMHB. CMHB is not involved in the deposit processing of any appropriated funds. CMHB prepares vouchers for reimbursement of contracted suppliers and vendors of goods and services, and submits them to the County for check processing. The County Treasurer's Office and Auditor's Office are responsible for receiving and disbursing CMHB's funds. In addition, the Cuyahoga County Prosecutors' Office has ruled against any county board or agency having a bank account not under the Cuyahoga County Treasurer's direct authority.

C4.2 As a result of the County Prosecutor's ruling and the process used for processing payments, CMHB handles very little cash and writes no checks internally, which has led to strong internal controls at CMHB for processing of cash entries. Additionally, CMHB does not have to spend time processing actual payments. Consequently, CMHB can devote more time to other important financial activities, such as cross-training employees (see **R4.6**) and improving the budgeting process (see **R4.11** through **R4.21**).

F4.10 CMHB's current purchasing policy is written to provide for two types of purchases, the ordering of supplies and the ordering of equipment. The effective date of the policy is unknown. The policy states the Finance Unit will be responsible for the ordering, distributing and monitoring of all supplies and equipment for CMHB. In addition, the policy states the director of finance shall approve all supplies and equipment ordered. No other position, except the director of MIS operations in the case of equipment, is stated in the policy to approve requests should the director of finance not be available. Therefore, all requisitions are to be approved by the Finance Unit before ordering goods or services. However, CMHB is not following the written policy. Currently, CMHB divisions are able to order supplies directly without dollar limitations or Finance Unit approval (see **external affairs** for further discussion).

To have an effective purchase order system, established policies and procedures need to be followed or re-written to meet current needs. GFOA states a government entity should develop policies to guide service provision and capital asset acquisition, maintenance, replacement, and retirement. These policies and plans give direction to the government entity regarding the level of services and types of capital assets to be acquired, and the manner in which the services and capital assets will be provided. The policies and plans should be consistent with each other.

R4.9 All requisitions should either follow CMHB's current policy of centralizing purchasing activities or the policy should be amended to describe the decentralized procedure currently in effect. Benefits and costs exist with both purchasing processes. Using a centralized purchasing process could better control inventories, but would require a centralized receiving and distribution plan to ensure all divisions and units understand and adequately follow the process. A decentralized process would allow division managers to control their own costs. However, CMHB would need to effectively budget by division and line item, and hold divisions accountable for all expenditures (see **F4.17**). Whichever process is implemented by CMHB, all divisions should adhere to the policy, which should be dated and distributed to all employees.

F4.11 CMHB's purchasing policy does not adequately address Cuyahoga County's current purchasing procedures to order office supplies. Cuyahoga County has established an arrangement with an office supplier to maintain a central warehouse of office supplies which are available to all county offices on a just-in-time basis. For example, supplies ordered by facsimile today will be delivered by noon tomorrow to the office ordering them. Although CMHB's purchasing policy does not address the County's just-in-time system, CMHB follows the County policy by allowing each division to order their own supplies. However, since CMHB does not develop budgets by division and does not track expenditures by line-item (see **R4.16**), CMHB may be ordering unnecessary supplies, divisions are not held accountable for purchases, and a possible duplication of effort in purchasing could exist.

R4.10 CMHB should update its purchasing policy to reflect the County purchasing policy for office supplies. If CMHB allows divisions to order supplies through the County's just-in-time system, the divisions should be held fully accountable for those purchases. Further, the purchases should be budgeted by division, and monitored and tracked on a consistent basis (see **R4.16**). If CMHB decides to centralize the purchasing process, CMHB should implement appropriate internal controls and ensure that all divisions understand and adhere to the policy (see **R4.9**).

Budgeting

F4.12 The budget CMHB has presented to the Cuyahoga County's Office of Budget and Management (OBM) since 2000 does not contain adequate financial or written details to justify the funds requested. Increases or adjustments to expenditures do not explain why changes are needed from year-to-year. GFOA states that the budget document should communicate key fiscal and policy decisions, issues, and tradeoffs. In order to facilitate stakeholder understanding of the choices to be made, it is essential that materials be prepared in a format that is clear and comprehensible. Budget documents should describe key financial and programmatic plans and goals, with goals and objectives for individual

programs included in the budget documents. Information in the budget documents should include:

- Program descriptions,
- Goals and objectives,
- Organization charts,
- Means of providing major funding,
- Information related to organizational units,
- Management approaches,
- Staffing information by unit,
- Uses of funds, and
- Performance measures.

GFOA states identification of key programmatic and financial policies, plans, and goals assists stakeholders in determining the appropriateness of a government entity's direction and allows stakeholders to develop their own opinions as to whether the entity's programs and decisions conform to, or are likely to achieve those goals.

Since CMHB does not submit detailed information with its budget requests, OBM and the Board of County Commissioners (BOCC) could have a difficulty in ensuring that CMHB is adequately and effectively managing its finances. By generating a more detailed and comprehensive budget, CMHB would provide sufficient support that it is striving to maintain costs and provide quality services to the mental health consumers of Cuyahoga County.

R4.11 The budget submitted to OBM and BOCC should contain adequate details of plans and proposals to justify requests, including suggestions made by GFOA. CMHB's BOG and staff should recognize the responsibility of BOCC to the taxpayers of the County to ensure that the budget is an effective use of taxpayers' dollars. Before new requests are incorporated into the budget, CMHB should fully explain and justify the request with appropriate documentation and analysis. The existing budget should be subjected to a similar review and all spending plans should be thoroughly documented, providing the justification for requests as suggested by GFOA. The proposed internal accounting system (**R4.7**) could assist in the management of the budget by allowing CMHB to more effectively manage costs and explain variances by having more detail available for analysis. Providing adequate details and justifying budget requests would indicate to the County that CMHB has effectively planned for the amount and purpose of funds committed to contracted providers.

F4.13 **Table 4-3** presents the administrative and operating budgets submitted by CMHB, and approved by BOCC, for the County calendar years of 2000, 2001 and 2002. Since

CMHB does not track actual expenditures by line item, it can not provide a detailed breakdown of actual expenditures (see **F4.17** and **R4.16**). As a result, CMHB can not provide specific explanations for variance in its actual expenditures from year-to-year.

Table 4-3: OBM and BOCC Budget for the Years of 2000, 2001 and 2002

	Budget 2000	Budget 2001	Percent of Change	Budget 2002	Percent of Change
Salaries	$2,794,898	$3,261,195	16.7%	$3,261,195	0.0%
Workers' Compensation	12,000	30,000	150.0%	30,000	0.0%
Unemployment	5,000	10,000	100.0%	10,000	0.0%
Hospitalization	225,310	200,000	(11.2%)	200,000	0.0%
Retirement	390,456	441,892	13,2%	441,892	0.0%
Medicare	36,028	42,787	18.8%	42,787	0.0%
Copy Supplies	12,000	13,500	12.5%	13,500	0.0%
Housekeeping Supplies	2,500	3,500	40.0%	3,500	0.0%
Miscellaneous Supplies	17,000	20,000	17.5%	20,000	0.0%
Prof & Tech Service	250,000	540,000	116.0%	250,000	(53.7 %)
Prof & Tech Service-MIS	25,000	25,000	0.0 %	25,000	0.0%
Liability Insurance & Bond	17,500	17,500	0.0 %	17,500	0.0%
Malpractice Insurance & Bond	6,000	6,500	8.3%	6,500	0.0%
Bldg. Grounds Maintenance	25,000	25,000	0.0%	25,000	0.0%
Equipment Maintenance	16,000	18,000	12.5%	18,000	0.0%
Equipment Contract	30,000	31,000	3.3%	31,000	0.0%
Office Rent	413,328	417,444	1.0%	417,444	0.0%
Equipment Rental	500	0	(100.0%)	0	0.0%
Postage	20,000	20,000	0.0%	20,000	0.0%
Telephone	60,000	60,000	0.0%	60,000	0.0%
Travel In	5,250	5,250	0.0%	5,250	0.0%
Travel Out	35,000	35,000	0.0%	35,000	0.0%
Miscellaneous	40,000	40,000	0.0%	40,000	0.0%
Education/Training-System	150,000	135,000	(10.0%)	135,000	0.0%
Education/Training Staff Elective	60,000	60,000	0.0%	60,000	0.0%
Publications	5,000	5,000	0.0%	5,000	0.0%
Printing	40,000	40,000	0.0%	40,000	0.0%
Association Dues	16,000	18,500	15.6%	18,500	0.0%
Advertising	18,000	18,000	0.0%	18,000	0.0%
Equipment	35,000	35,000	0.0%	35,000	0.0%
Total Operating Expenses	$4,762,770	$5,575,068	17.1%	$5,285,068	(5.2%)

Source: CMHB budget submittals

Table 4-3 shows that the budget for 2002 is identical to 2001, with the exception of professional and technical services. This indicates that CMHB may not be adequately planning and budgeting for upcoming years. According to CMHB and BOG, it was agreed to that CMHB would operate on a two year budget cycle. Therefore, the same budget used in 2001 was used and presented to the County in 2002. While BOG and

CMHB agreed to operate on a two year budget cycle, not spending time to develop a budget in 2002 could result in poor planning and managing of its operating expenditures. In addition, CMHB is presenting a budget to the County based on the State's Fiscal Year of July to June. However, the County operates on a calendar fiscal year (January to December). Consequently, there is an 18 month period of time in which the following occurs (e.g., July 2001 to December 2002):

- The County operates without an actual budget from CMHB for the last six months of any calendar year.
- CMHB presents to the County a budget that has actually been in use for the last six months of the previous calendar year.

As a result, CMHB and the County are unable to adequately perform budget comparisons. Franklin MHB budgets on the county calendar year while still providing the necessary budget information to ODMH by developing effective budgeting processes. Franklin MHB developed a five year forecast to appropriately plan for costs in future years, updates the forecast annually, and uses the updated forecast to provide the county with a calendar year budget. However, CMHB has not developed a five year forecast (see **F4.18** and **R4.17**).

Furthermore, CMHB does not consider a fiscal year over until almost all providers for the fiscal year have been reimbursed. Medicaid and ODMH allow up to twelve months to elapse before a provider has to submit a billing. Therefore, CMHB has difficulty reporting actual expenditures for a fiscal year in a timely manner. In contrast, Franklin MHB addressed this problem by formulating a policy that any billing submitted after August 4th would be for the new fiscal year, which is only for its internal record keeping. With this policy, Franklin MHB is able to adequately budget on a calendar year for the county. All provider contracts are still budgeted on ODMH's fiscal year.

R4.12 CMHB should work with OBM and the County to present a fair and accurate estimate of future budgets and costs for up-coming calendar years. CMHB would achieve a correct matching of accounting periods by presenting a calendar year budget to the County, which would allow a comparison of actual to budget data to be presented and reported by CMHB. To accomplish this, CMHB should perform the necessary planning to adequately prepare budgets as discussed throughout this section of the report. Consideration must always be given to anticipated events, and data must be presented as accurately as possible.

In addition, CMHB should establish an internal record keeping policy, similar to Franklin MHB, of establishing a cut-off date for billings. This policy would allow CMHB to produce financial statements in a more timely fashion for fiscal and calendar years. The

budget should also be easier to generate by period as CMHB would know the period costs in a timely manner and be able to estimate costs for both calendar and fiscal years.

F4.14 **Table 4-4** reviews the administrative and operating budget amendments for the County calendar years of 2000, 2001 and 2002 as passed by CMHB's BOG.

Table 4-4: Budget Amendments for the Calendar Years of 2000, 2001 and 2002: Revised Budget Totals

Board Resolution Number	Description	Budget 2000	Budget 2001	Budget 2002
00-01-03	Cultural Competence Grant	$17,500		
00-01-04	Recovery System Development Grant	60,000		
00-01-04	Local Match for Recovery Grant	18,000		
00-04-07	Claimchk Software-MACSIS	10,200		
00-01-03	Cultural Competence Grant		$28,100	
00-01-04	Recovery System Development Grant		60,000	
00-06-09	Consultants		290,000	
00-12-04	Ohio Outcomes Initiative		6,000	
00-12-05	Consumer Outcome Grant		33,310	
01-05-08	Consumer Information Booklet		8,000	
01-05-09	Diagnostic Classification Training		7,000	
01-05-10	Scholarship Award-ODMH		400	
01-07-07	Recovery System Development Grant			$60,000
01-09-10	Consultants (Carry-Over from FY 2001)			142,100
Total Amendments		$105,700	$432,810	$202,100
Total Budget Table 4-3		4,762,770	5,575,068	5,285,068
Calendar Year Revised Budget		$4,868,470	$6,007,878	$5,487,168

Source: CMHB budget and BOG resolutions

Table 4-4 describes the annual amendments to the CMHB budgets approved by BOG. The amendments, after BOG approval, were not submitted to OBM for approval by the BOCC. The amendments increased the total budget by 2.2 percent, 7.8 percent, and 3.8 percent, respectively, for FY 2000, FY 2001 and FY 2002. GFOA states that from time to time, a government entity may need to adjust the budget based on the review and assessment of financial and budget conditions. Processes are needed to ensure these adjustments are formally presented to decision makers and other stakeholders and receive adequate consideration.

R4.13 Amendments to CMHB's budget which are approved by BOG should be submitted to OBM for consideration and passage by BOCC. By following this practice, CMHB will ensure OBM is aware of the needed change and the reason for the change. Also, after passage by BOCC, the budget being used by CMHB and the County will remain in agreement and results can be reported against an actual budget.

F4.15 CMHB did not report actual administrative and operating expenditures in its published annual report for FY2000 and instead, reported only its administrative and operating budget. As a result, the published annual report for 2000 can be misleading as to the actual financial activity. In addition, the GFOA states actual results should be reported to monitor, measure, and evaluate budgetary performance and financial condition.

R4.14 CMHB should always present and report actual expenditures in its published annual reports to appropriately inform the public of its financial situation. If budget data is presented, it should be shown as a comparison to actual results.

F4.16 CMHB does not have a budget process in place that involves all CMHB personnel, which could impact its ability to budget and track expenditures by division (see **F4.17**). GFOA recommends that a government entity establish an administrative structure that facilitates the preparation and approval of a budget in a timely manner. GFOA also recommends procedures be established for ensuring coordination of the budget process. A process is also needed to develop and communicate the policies and guidelines for budget preparation. GFOA states that in order for the budget to be adopted in a timely manner, processes should be developed to assist stakeholders in understanding tradeoffs and to help decision-makers make choices among available options.

R4.15 To prepare a budget to meet CMHB's goals for next year, CMHB should provide to all divisions a budget package that includes the following:

- A general discussion of the budget philosophy and methodology;
- Long-term goals of CMHB and major changes that will affect the budget year;
- Mental health demographic and economic trends;

- CMHB funding projections;
- Budget organization/classification;
- Timetable for the entire budget process, up to and including approval by BOG;
- A summary by division of prior years' staffing, expenses and revenues (two or three years); and
- Forms to be used with instructions, including division's program descriptions, goals and objectives, staffing, operating expenses and capital items.

A new budgeting process for CMHB will require educating division and unit heads, CMHB staff, management and BOG. There are a number of budgeting seminars available through GFOA which could benefit CMHB at a cost of $350 - $750 per person. The seminars are *Best Practices in Budgeting*, *Budgeting for Budget Analysts*, *Advanced Governmental Budgeting*, *Capital Budgeting and Infrastructure Finance*, and *Effective Budget Presentation*.

Financial Implication: Based on the average cost of $500 per person, CMHB would have to spend approximately $7,000 in one-time costs for its 14 division and unit managers to attend GFOA training.

F4.17 CMHB does not develop budgets and track expenditures by division. As a result, divisions are not held fully accountable for their share of expenditures, which could negatively impact CMHB's financial condition. Franklin MHB develops budgets and tracks expenditures by division and indicated that the process has been relatively easy to perform because of its effective internal accounting system. CMHB's internal accounting system should be enhanced (see **F4.7** and **R4.7**). In addition, some managers at CMHB have expressed concerns about not being fully informed of the final budget and not receiving reports during the year comparing actual expenditures to the budget. Although CMHB develops a budget by line item (e.g., salaries, benefits, supplies, etc.), it does not track and monitor actual expenditures by line item which could be partially attributed to its current accounting system (see **F4.7** and **R4.7**). Consequently, the Finance Unit can not perform the following activities:

- Determine how effectively CMHB budgeted and planned for specific expenditures;
- Determine which line items are negatively impacting CMHB's financial condition;
- Adequately monitor and control expenditures; and
- Report actual expenditures by line item.

By budgeting by division and tracking expenditures by line item, CMHB would appropriately control its operational finances and potentially maximize the amount of funding provided to consumers.

R4.16 CMHB should develop budgets by division and divisions should develop their budgets by adequately planning costs for each division and unit. Budgets by division and unit should be monitored to ensure all areas at CMHB are held fully accountable for expenditures. To adequately prepare divisions, CMHB should provide the necessary training in budget development (see **R4.15**). CMHB should distribute final budgets to all division heads with the expectation that they will adhere to and monitor their division/units actual activity to the budget. CMHB should establish a process of reporting results of actual expenditures to the planned budget to the divisions, which would help management carry out and control operations. If variations between actual results and budget arise, management should resolve the situation by either correcting the weakness in performance or modifying the budget. Organizations that adopt appropriate budgetary controls have better management control of operations and are better able to modify them to meet expectations.

Furthermore, CMHB should track and monitor actual division expenditures by line item. Doing so would allow CMHB to adequately control expenditures, and determine how to address expenditures that are not being effectively controlled. Implementing a new accounting system could help the Finance Unit develop and monitor budgets and actual expenditures by division and by line item (see **R4.7**).

F4.18 CMHB has tracked annual funding by major source; however, funding is not forecasted beyond one year. Similarly, CMHB does not develop a cash forecast or calculate any of the financial ratios often used to begin a basic analysis of an agency's financial strength. The trends in funding, cash flow, expenses and key financial ratios can provide the basis for long term forecasting of CMHB's resources and needs.

According to GFOA, a governmental unit should have a financial planning process that assesses the long-term financial implications of current and proposed policies and programs. The process should include assumptions that develop appropriate strategies to achieve its goals. A key component in determining future options, potential problems and opportunities is the forecast of funding and expenditures. Funding and expenditure forecasting does the following:

- Provides an understanding of available funding;
- Assesses the likelihood that specific levels of service can be sustained;
- Identifies future commitments and resource demands; and
- Identifies key variables that cause changes in the level of funding.

GFOA recommends that government units at all levels forecast major funding and expenditures. The forecast should extend at least three years beyond the budget period and should be regularly monitored and periodically updated. Franklin MHB prepares a

five year forecast which is updated and revised annually. By forecasting five years into the future, Franklin MHB is aware of trends in funding and expenditures. In addition, GFOA recommends the forecast, along with its underlying assumptions and methodology, should be clearly stated and made available to participants in the budget process. The forecast should be referenced in the final budget document. To improve future forecasting, the variances between previous forecast and actual amounts should be analyzed. The variance analysis should identify the factors that influence funding, expenditure levels and forecast assumptions. Franklin MHB uses its forecast as a tool to analyze variances between funding and spending and in preparing the annual budget. By presenting more projected financial information, as well as detailed accompanying assumptions, explanatory comments and the methodology used in deriving the financial estimates, CMHB will provide a more comprehensive understanding of its anticipated financial condition.

R4.17 CMHB should begin forecasting its funding and expenses beyond one year. CMHB should develop at least a three-year financial forecast to ensure that the budgeting process incorporates CMHB's future financial needs and goals. The forecast should become part of the budgeting documentation provided to the County and ODMH. Furthermore, CMHB should analyze variance in forecasted to actual amounts before beginning the budget process to build on its understanding of why variances occurred and determine how to adjust the current year forecast to account for material variances.

F4.19 CMHB does not prepare a written summary of the budget line items to assist the readers with an understanding of the key issues. The finance director delivers the detailed funding data to each BOG member before the monthly meeting. At OFC meetings, the finance director presents the overall budget, emphasizing funding and the contracted providers. However, BOG members and the public have various backgrounds and training, and do not always understand the financial information presented.

GFOA states that a summary should be publicly available for both the proposed budget and the adopted budget. At a minimum, a budget summary should do the following:

- Summarize the major changes in priorities or service levels from the current year and the factors leading to those changes;
- Articulate the priorities and key issues for the new budget period;
- Identify and summarize major financial factors and trends affecting the budget, such as economic factors, long term outlook, and significant uses of, or increases in, fund balances; and

- Provide financial summary data on funding and expenditures for at least a three-year period, including prior year actual, current year budget and/or estimated current year and actual budget.

The summary can take many forms, including a transmittal letter, budget message, executive summary or budget-in-brief. Because of the time required to read and understand the entire budget document, a concise summary and guide to key issues and aspects of the budget is valuable to ensure the education and involvement of BOG.

R4.18 CMHB should present a concise summary and guide to the key issues and aspects of the operating components of the budget to ensure the understanding and involvement of BOG. A summary would ensure that BOCC, BOG, management and division heads understand the issues and can make informed decisions. The summary should be available and disseminated in an easily accessible manner that is likely to be communicated to BOG and generate meaningful discussions. In addition, the summary should be as nontechnical and easy to read as possible.

F4.20 CMHB's budgeting process does not include coordination with an overall strategic plan or performance measures. CMHB does not prepare a five-year plan for operating and capital planning. Instead of using a strategic plan, or performance measures, CMHB bases its proposed expenditures exclusively on available funding. The effect of planning for one year at a time severely limits CMHB's ability to react to events by being proactive and planning for contingencies (see **R4.17**).

GFOA recommends performance measures be established for all government entities. Potential performance measures for the financial function of CMHB include the following:

- Standards for key financial ratios that help to determine CMHB's financial strength. Examples include: number of consumers, units of service billed, average unit cost billed for Medicaid and non-Medicaid, and the average cost of services per consumer billed;

- Standards for variances between initial budget and actual funding and expenses;

- Standards for timely reporting of month-end and year-end financial information; and

- Standards for timely payment of invoices;

A key responsibility of state and local governments is to develop and manage services, programs and resources as efficiently and effectively as possible, and to communicate the results of these efforts to the taxpaying public.

R4.19 CMHB, with the involvement of the BOG and CEO, should develop appropriate performance measures for its overall financial operations. Unit management should develop performance measures for their areas of responsibility and have them approved by the division, CEO and BOG. Meaningful performance measurements should assist OBM and BOCC in identifying financial and program results, evaluating past resource decisions, facilitating qualitative improvements in future decisions regarding resource allocation and service delivery options, and communicating service and program results to the community. Performance measures should be monitored and the results included in the budgetary reports.

F4.21 CMHB and the peers used in this performance audit do not develop non-Medicaid budgets by program, consumer population or service for the funding disbursed to provide mental health services to consumers. Instead, CMHB and the peers develop budgets by contracted provider. In the past, developing budgets by program, population or service could be difficult because of the lack of available data. However, data is now readily available and easily accessible through ODMH for all mental health boards in the State (see the *Funding and Spending* subsection).

R4.20 CMHB should determine standard levels of funding for different populations, programs and services; and should consider allocating funding for the mental health system in Cuyahoga County by using data from ODMH and other sources to develop funding plans by program, population and/or service type. After CMHB has developed a funding plan, it could then determine non-Medicaid funding to be distributed to the contracted providers. By first planning how much to spend for each program, service and/or population, CMHB would be prioritizing the needs of its mental health consumers. In addition, allocating funding by program, service and/or population should coincide with CMHB's overall strategic plan and priorities for improving the mental health system in Cuyahoga County (see **board governance** section for strategic planning).

F4.22 **Table 4-5** demonstrates the cash reserve balances for CMHB and peers for the years ended December 31, 2000 and December 31, 2001.

Table 4-5: CMHB and Peers Cash Reserve Balances

	CMHB	Franklin MHB [1]	Lucas MHB	Stark MHB	Peer Average
FY 2000					
Cash Balance	$15,055,784	$27,214,467	$3,699,631	$1,983,523	$10,965,874
# of Consumers	30,871	39,780	13,742	7,138	20,220
Balance per Consumer	$488	$684	$269	$278	$542
FY 2001					
Cash Balance	$12,067,027	N/A	$3,954,907	$4,351,099	N/A
# of Consumers	30,238	38,938	13,650	8,209	20,266
Balance per Consumer	$399	N/A	$290	$530	N/A

Source: Cuyahoga County Office of Budget and Management and Peers
N/A: Not Available
[1] Data includes mental health and alcohol and drug since Franklin is a combined board.

Table 4-5 shows that CMHB had the second highest cash reserve balance in FY 2000 and the second highest ratio of cash reserve balance to consumers in FY 2000 and FY 2001 as compared to the peers. Although it appears that CMHB is maintaining an adequate cash reserve balance, it does not have a formal policy defining the level of funds that should be maintained in the reserve.

GFOA recommends that government entities establish a formal policy on the level of unreserved funds that should be maintained in the fund or reserve account. The adequacy of unreserved funds should be assessed based upon a government's own specific circumstances. Nevertheless, GFOA recommends, at a minimum, that government entities, regardless of size, maintain unreserved funds of no less than 5 to 15 percent of regular operating revenues, or of no less than one to two months of regular fund expenditures. A government's particular situation may require levels of unreserved funds in excess of minimum levels. Furthermore, such measures should be applied within the context of long-term forecasting (see **F4.18** and **R4.17**), thereby avoiding the risk of placing too much emphasis upon the level of unreserved funds at any one time. In establishing a policy governing the level of unreserved funds, a government entity should consider a variety of factors including the predictability of its revenues, the volatility of its expenditures, and needed liquidity levels based on forecasts.

CMHB's disbursements were almost $83 million and $91 million respectively, for FY 2000 and FY 2001 (see **Table 4-1**). Based on GFOA's recommended range of 5 to 15 percent, the year end reserve balance would have been between $4.2 million and $12.5 million for FY 2000 and between $4.6 million and $13.7 million for FY 2001. Using GFOA's other benchmark of one to two months of regular fund expenditures, the year end reserve balance would have been between $6.9 million and $13.8 million for FY 2000 and $7.6 million and $15.2 million for FY 2001. Based on GFOA's benchmarks,

CMHB was slightly over-reserved in FY 2000 and maintained an adequate reserve for FY 2001.

R4.21 CMHB, in conjunction with OBM, should develop a formal policy defining the amount of funding that should be maintained as a reserve balance, consistent with policies and benchmarks developed by GFOA. By establishing a formalized policy and developing forecasting procedures (**R4.17**), CMHB would be able to effectively plan for the use of its funding and ensure that an appropriate reserve balance is maintained for emergency situations. In addition, CMHB should implement procedures to reconcile the cash reserve balance to ensure it is adequate and meets potential future needs.

Funding & Expenditures for Mental Health Services

This section of the report analyzes the funding and spending for Medicaid and non-Medicaid services at CMHB and peers. The Medicaid and non-Medicaid information was obtained from the ODMH information Web site (DataMart). DataMart compiles the information from ODMH's billing and information system (MACSIS). Additional information and tables are included in the appendix following this report.

F4.23 **Tables 4-6** and **4-7** exhibit the sources of funding and percent of each source to the total funding for FY 2000 and FY 2001 at CMHB and peers.

Table 4-6: Funding Sources Fiscal Year 2000

	Funding			
	State	**Federal**	**County**	**Total**
Franklin MHB [1]	$27,452,942	$31,652,383	40,323,861	$99,429,186
Percent of funding	27.6%	31.8%	40.6%	100.00%
Lucas MHB	$13,413,778	$8,660,881	$9,699,231	$31,773,890
Percent of funding	42.2%	27.3%	30.5%	100.0%
Stark MHB	$12,533,717	$8,822,976	$4,944,435	$26,301,128
Percent of funding	47.7%	33.5%	18.8%	100.0%
CMHB	$37,372,033	$27,336,334	$18,384,673	$83,093,040
Percent of funding	45.0%	32.9%	22.1%	100.0%
Peer Average %	33.9%	31.2%	34.9%	100.0%

Source: CMHB and peer data

[1] Franklin County was unable to distinguish between mental health and alcohol and drug addiction funds. Therefore, data includes funding for mental health and drug and alcohol services.

Table 4-7: Funding Sources Fiscal Year 2001

	Funding			
	State	**Federal**	**County**	**Total**
Franklin MHB	$27,745,073	$34,990,365	$40,871,890	$103,607,328
Percent of funding	26.8%	33.8%	39.4%	100.0%
Lucas MHB	$13,976,130	$10,485,029	$9,620,355	$34,081,514
Percent of funding	41.0%	30.8%	28.2%	100.0%
Stark MHB	$12,584,004	$8,892,123	$5,875,807	$27,351,935
Percent of funding	46.0%	32.5%	21.5%	100.0%
CMHB	$41,041,847	$31,463,392	$19,446,519	$91,951,758
Percent of funding	44.6%	34.2%	21.2%	100.0%
Peer Average %	32.9%	32.9%	34.2%	100.0%

Source: CMHB and peer data

[1] Franklin County was unable to distinguish between mental health and alcohol and drug addiction funds. Therefore, data includes funding for mental health and drug and alcohol services.

Tables 4-6 and **4-7** show that CMHB's percentage of total funding is similar to Lucas and Stark MHB's. CMHB, Lucas MHB and Stark MHB's receive most of their funding from the State (41 to 46 percent) and the lowest amount from the County (21 to 28 percent). In contrast, Franklin MHB received a higher portion of its funding from the county. Regardless of funding sources, this report shows that CMHB is spending the highest amount of mental health funding per consumer in comparison to Franklin, Hamilton, Stark and Lucas MHBs (see **F4.25**)

F4.24 **Table 4-8** illustrates spending by CMHB and the peers not presently recorded in the MACSIS billing system for FY 2000 and FY 2001. According to ODMH, CMHB and the peers, all other mental health costs are recorded in the MACSIS system, which will be assessed throughout this report.

Table 4-8: Spending Not Recorded in MACSIS for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Fiscal Year 2000						
Bed Days	$15,849,636	$8,770,873	$12,989,260	$2,835,326	$4,159,302	$7,188,690
Central Pharmacy	$1,242,169	$2,016,374	$532,411	$606,389	$171,104	$831,570
Totals	$17,091,805	$10,787,247	$13,521,671	$3,441,715	$4,330,406	$8,020,260
Cost per Consumer	$554	$380	$673	$250	$607	$462
Fiscal Year 2001						
Bed Days	$15,801,948	$7,977,361	$11,848,256	$2,867,692	$3,632,218	$6,581,382
Central Pharmacy	$1,726,607	$1,990,962	$495,276	$491,139	$136,955	$778,583
Totals	$17,528,555	$9,968,323	$12,343,532	$3,358,831	$3,769,173	$7,359,965
Cost per Consumer	$580	$340	$587	$246	$459	$407
Percent of Change						
Bed Days	(0.3%)	(9.0%)	(8.8%)	1.1%	(12.7%)	(8.5%)
Central Pharmacy	39.0%	(1.3%)	(7.0%)	(19.0%)	(20.0%)	(6.4%)
Totals	**2.6%**	**(7.6%)**	**(8.7%)**	**(2.4%)**	**(13.0%)**	**(8.2%)**

Source: ODMH

As indicated in **Table 4-8**, CMHB's average bed day and central pharmacy costs per consumer are higher than the peer average. In addition, Franklin, Hamilton and Stark MHBs reduced their total bed day costs while CMHB's total costs decreased slightly from FY 2000 to FY 2001; and all of the peers' total central pharmacy costs decreased while CMHB's significantly increased from FY 2000 to FY 2001. For a full assessment of bed day and inpatient care costs, see the utilization review in the **provider relations and quality services** section of this performance audit.

In addition to the funding spent by CMHB, other agencies in Cuyahoga County are spending funding for mental health services. In contrast, the peers have indicated that all funding for mental health services in their respective counties is allocated and controlled by their mental health boards. Implementing a pooled funding arrangement could better ensure that funding spent on mental health services by other agencies in Cuyahoga County is appropriately controlled and coordinated (see **F4.31** and **R4.26**). Based on information provided by the County and other agencies, additional spending on mental health services by other public agencies in Cuyahoga County was approximately $1.5 million and $1.6 million, respectively, in FY 2000 and FY 2001. CMHB spent approximately $74.6 million and 78.7 million, respectively, in FY 2000 and FY 2001 for mental health services. Consequently, CMHB spent about 98.1 percent and 98.2 percent,

respectively, of the total public mental health spending in Cuyahoga County in FY 2000 and FY 2001.

F4.25 **Table 4-9** presents actual spending for Medicaid and non-Medicaid services and the percent of change between years by CMHB and the peers for FY 2000 and FY 2001. In addition, **Table 4-9** compares the average cost per consumer, average cost per unit, average units per consumer and average number of services per consumer at CMHB and the peers in FY 2000 and FY 2001.

Table 4-9: Mental Health Spending for Fiscal Years 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Population (2000)	1,393,978	1,068,978	845,303	455,054	378,098	686,858
Per Capita Income (2000)	$32,362	$31,685	$34,162	$27,707	$26,089	$29,911
Poverty Rate (1998)	13.5%	11.0%	11.2%	13.4%	10.2%	11.5%
Median Household Income (1998)	$38,522	$41,267	$38,726	$38,833	$39,701	$39,632
FY 2000						
Consumers	30,871	28,420	20,085	13,742	7,138	17,346
Services	65,981	64,828	46,733	35,219	15,594	40,594
Services per Consumer	2.1	2.3	2.3	2.6	2.2	2.3
Units Billed	886,066	743,999	725,170	285,085	169,470	480,931
Average Units per Consumer	**28.7**	**26.2**	**36.1**	**20.8**	**23.7**	**27.7**
Total Costs	$74,556,448	$62,186,263	$44,970,731	$28,402,794	$14,400,324	$37,490,028
Average Cost per Consumer	**$2,415**	**$2,188**	**$2,239**	**$2,067**	**$2,017**	**$2,161**
Cost per Unit	**$84.14**	**$83.58**	**$62.01**	**$99.63**	**$84.97**	**$77.95**
FY 2001						
Consumers	30,238	29,317	21,012	13,650	8,209	18,047
Services	66,156	66,560	47,503	34,923	18,363	41,837
Services per Consumer	2.2	2.3	2.3	2.6	2.2	2.3
Units Billed	927,926	732,960	640,491	267,134	175,810	454,099
Average Units per Consumer	**30.7**	**25.0**	**30.5**	**19.6**	**21.4**	**25.2**
Total Costs	$78,654,631	$62,456,765	$46,118,879	$26,958,586	$15,109,759	$37,660,997
Average Cost per Consumer	**$2,601**	**$2,130**	**$2,195**	**$1,975**	**$1,841**	**$2,087**
Cost per Unit	**$84.76**	**$85.21**	**$72.01**	**$100.92**	**$85.94**	**$82.94**
Percent of Change						
Consumers	(2.1%)	3.2%	4.6%	(0.7%)	15.0%	4.0%
Services	0.3%	2.7%	1.6%	(0.8%)	17.8%	3.1%
Services per Consumer	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Units Billed	4.7%	(1.5%)	(13.2%)	(6.3%)	3.7%	(6.0%)
Average Units per Consumer	7.0%	(4.6%)	(15.5%)	(6.1%)	(9.7%)	(1.0%)
Cost	5.5%	0.4%	2.6%	(5.4%)	4.9%	0.5%
Average Cost per Consumer	7.7%	(2.7%)	(2.0%)	(4.5%)	(8.7%)	(3.4%)
Cost per Unit	0.7%	2.0%	16.1%	1.3%	1.1%	6.4%

Source*:* ODMH MACSIS statistics from DataMart Web site, U.S. Census

Note: Some consumers were counted as both Medicaid and non-Medicaid consumers due to change in Medicaid status during FY 2000 and FY 2001. The unduplicated number of consumers in FY 2000 and FY 2001 was 26,050 and 25,645 for CMHB, 25,413 and 26,397 for Franklin MHB, 14,817 and 15,617 for Hamilton MHB, 11,698 and 11,785 for Lucas MHB, and 6,491 and 7,423 for Stark MHB.

As indicated by **Table 4-9**, CMHB's mental health costs per consumer are the highest of the peers in both years, and were 11.7 percent and 24.6 percent higher than the peer

average in FY 2000 and FY 2001, respectively. In addition, the number of consumers at CMHB decreased by 2.1 percent while average units billed per consumer and average cost per consumer increased by 7.0 percent and 7.7 percent, respectively, from FY 2000 to FY 2001. In contrast, all of the peers decreased in average units billed per consumer and average cost per consumer while increasing the number of consumers serviced, except for Lucas MHB which experienced a slight decrease in consumers. While Cuyahoga County has the highest poverty rate and lowest median income of the peers, it has the second highest per capita income of the peers. To take into account differences in demographics of each county, potential cost savings by reducing unit costs was adjusted based on differences in each counties' cost of doing business factor (see **R4.23**).

Although maximizing the number of units provided to a consumer could be desirable, it does not guarantee that consumers will be provided with effective services or be successfully treated. For example, a report by the Colorado State Auditor on community mental health programs in the state analyzed outcomes for consumers with similar levels of severity and found little relationship between the amount of services provided and average cost per consumer, and any resulting improvements in outcomes. Since CMHB has not monitored outcomes of services within Cuyahoga County, it can not determine if they are effective and successful (see **quality improvement** section for more information on outcomes).

Further, the analysis conducted in this report indicates that the major factor impacting the higher costs at CMHB is the cost per unit of service (see **F4.26**). Although the cost per unit at CMHB is comparable to Franklin and Stark MHB's, the cost per unit for certain Medicaid eligible services is significantly higher at CMHB (see **F4.26**). Overall, the analysis in **Table 4-9** indicates that CMHB is spending more per consumer when compared to the peers. However, a factor that could impact overall costs, cost per consumer and cost per unit of service is the different types of services provided by CMHB and peers. CMHB provides the second highest number of services and Hamilton MHB provides the highest number of services among the peers. **Table 4-10** presents another comparison of mental health costs by excluding those non-Medicaid services (costs and units) not provided by the majority of the peers. Services excluded from this analysis include Cuyahoga 1915 (a) waiver program, Foster Care, Housing, Respite Bed, Crisis Bed, Hotline, Consultation, Prevention, Information and Referral, Social Recreation, Residential Support, Community Residence, Community Education and Adjunctive Therapy. In addition, consumers per 100,000 population at CMHB is also compared to the peers in **Table 4-10**.

Table 4-10: Adjusted Mental Health Spending: Fiscal Years 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Population (2000)	1,393,978	1,068,978	845,303	455,054	378,098	686,858
FY 2000						
Consumers	30,871	28,420	20,085	13,742	7,138	17,346
Services	65,981	64,828	46,733	35,219	15,594	40,594
Services per Consumer	2.1	2.3	2.3	2.6	2.2	2.3
Units Billed	792,976	693,862	594,902	271,530	167,631	431,981
Average Units per Consumer	**25.7**	**24.4**	**29.6**	**19.8**	**23.5**	**24.9**
Total Costs	$67,667,375	$58,679,674	$40,402,954	$26,939,516	$14,240,421	$35,065,641
Average Cost per Consumer	**$2,192**	**$2,065**	**$2,012**	**$1,960**	**$1,995**	**$2,022**
Cost per Unit	**$85.33**	**$84.57**	**$67.92**	**$99.21**	**$84.95**	**$81.17**
Consumers per 100,000 Population	**2,215**	**2,658**	**2,377**	**3,020**	**1,888**	**2,524**
FY 2001						
Consumers	30,238	29,317	21,012	13,650	8,209	18,047
Services	66,156	66,560	47,503	34,923	18,363	41,837
Services per Consumer	2.2	2.3	2.3	2.6	2.2	2.3
Units Billed	776,169	696,238	597,782	257,086	173,549	431,164
Average Units per Consumer	**25.7**	**23.8**	**28.5**	**18.8**	**21.1**	**23.9**
Total Costs	$70,149,359	$58,765,742	$42,663,901	$25,841,362	$14,875,415	$35,536,605
Average Cost per Consumer	**$2,320**	**$2,004**	**$2,030**	**$1,893**	**$1,812**	**$1,969**
Cost per Unit	**$90.37**	**$84.40**	**$71.37**	**$100.52**	**$85.71**	**$82.42**
Consumers per 100,000 Population	**2,169**	**2,742**	**2,487**	**3,000**	**2,172**	**2,627**
Percent of Change						
Consumers	(2.1%)	3.2%	4.6%	(0.7%)	15.0%	4.0%
Services	0.3%	2.7%	1.6%	(0.8%)	17.8%	3.1%
Services per Consumer	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Units Billed	(2.1%)	0.3%	0.5%	(5.3%)	3.5%	(0.19%)
Average Units per Consumer	(0.4%)	(2.7%)	(4.1%)	(5.1%)	(10.2%)	(4.0%)
Cost	5.5%	0.4%	2.6%	(5.4%)	4.9%	0.5%
Average Cost per Consumer	5.8%	(3.0%)	0.9%	(3.4%)	(9.2%)	(2.6%)
Cost per Unit	5.9%	(0.2%)	5.1%	1.3%	0.9%	1.5%
Consumers per 100,000 Population	(2.1%)	3.2%	4.6%	(0.7%)	15.0%	4.1%

Source*:* ODMH MACSIS statistics from DataMart Web site, U.S. Census

Note: Some consumers were counted as both Medicaid and non-Medicaid consumers due to change in Medicaid status during FY 2000 and FY 2001. The unduplicated number of consumers in FY 2000 and FY 2001 was 26,050 and 25,645 for CMHB, 25,413 and 26,397 for Franklin MHB, 14,817 and 15,617 for Hamilton MHB, 11,698 and 11,785 for Lucas MHB, and 6,491 and 7,423 for Stark MHB.

Table 4-10 illustrates that CMHB's cost per consumer is still the highest of the peers in FY 2000 and FY 2001 when comparing only similar services. CMHB's cost per consumer increased while all of the peers' costs per consumer decreased, except for Hamilton MHB's slight increase of 0.9 percent, from FY 2000 to FY 2001. The average cost per unit at CMHB was the second highest as compared to the peers and increased 5.9 percent compared to the peer average of 1.5 percent from FY 2000 to FY 2001. In addition, CMHB provided the second highest number of units per consumer in FY 2000 and FY 2001 as compared to the peers.

Furthermore, CMHB could potentially not be reaching as many individuals with mental illness, considering that the ratio of consumers per 100,000 population is the lowest at CMHB as compared to the peers in FY 2000 and FY 2001. While this section and other sections of the performance audit provide recommendations which could potentially increase the number of mental health consumers (see **planning and system development**, and **provider relations and quality services**) in Cuyahoga County, fully analyzing access issues was beyond the scope of this performance audit. Additionally, the Federation for Community Planning (FCP) is in the process of studying access issues to fully determine if CMHB has the potential to reach additional individuals afflicted with mental illness. FCP will also be assessing the affect of different diagnoses on mental health spending. Implementing a centralized intake or managed care system (see **R4.27**) and developing a standard assessment tool for providers to determine levels of care (see **provider relations and quality services**) could ensure that diagnoses are performed in a standard and uniform manner.

Finally, while CMHB and the peers provide different services, Community Support Programs (CSP)–Individual account for the majority of services. In FY 2001, CSP–Individual services accounted for 47.1 percent and 19.1 percent of Medicaid and non-Medicaid services, respectively, at CMHB. For the same time period, CSP–Individual services accounted for 44.9 percent and 24.6 percent at Franklin MHB; and 44.2 percent and 27.7 percent at Hamilton MHB for Medicaid and non-Medicaid services, respectively. Since CMHB's unit cost for CSP-Individual services is higher than the peers (see **F4.26**, **F4.27** and **R4.23**), this is another factor causing the overall costs per consumer and cost per unit to be higher in Cuyahoga County. See the appendix for more information on services, and see the **provider relations and quality services** section for more information on CSP.

R4.22 CMHB should take measures to control spending for mental health services. The analysis in **Table 4-9** and **Table 4-10** indicates a significant need for CMHB to control spending. Recommendations in this report provide strategies which CMHB should consider to control spending for mental health services while ensuring quality services are administered to consumers, including the following:

- Working with contracted provider agencies to review pricing for units of service (see **F4.26** through **F4.28**, and **R4.23**);
- Working with contracted provider agencies to review administrative costs (see **F4.29** and **R4.24**);
- Working with the Cuyahoga County Department of Children and Family Services in providing services to foster care children (see **F4.30** and **R4.25**);
- Pooling funds spent by other county agencies on mental health services and by county agencies providing additional services to CMHB's consumers (see **F4.31** and **R4.26**);
- Implementing a centralized intake or managed care system (see **F4.32** through **F436**, and **R4.27**);
- Reviewing the use of the 1915a waiver (see **F4.37** and **R4.28**); and
- Developing a standard assessment tool for providers to determine levels of care (see *utilization review* section of the **provider relations and quality services** report).

In addition, CMHB should consistently monitor spending and other important data to determine trends and develop strategies to ensure that quality services are being provided in a cost-effective manner. Spending and service data is easily accessible for all mental health boards in the State through ODMH. By aggressively taking measures to control spending, CMHB could be able to provide services at lower costs and potentially reallocate cost savings to increase the number of consumers served. Assuming that CMHB is able to increase the number of consumers served by the peer average of 4.0 percent, it could serve an additional 1,210 consumers annually, resulting in a total consumer population of 31,448 for FY 2002.

If CMHB maintained total spending of approximately $70.1 million for services similar to those provided by the peers (see **Table 4-10**), the average cost per consumer would be approximately $2,230 for 31,448 total consumers, which is still significantly higher than all of the peers. Applying the peer average cost per consumer of $1,969 to the projected total number of consumers (31,448) at CMHB, total costs would be approximately $61.9 million for services similar to those provided by the peers, which is $8.2 million less than CMHB's current costs for services similar to the peers. Taking a very conservative approach in estimating potential cost savings, CMHB could save approximately $830,000 annually in mental health spending by effectively controlling costs for CSP-Individual services (see **F4.26**, **F4.27** and **R4.23** for additional information and support).

F4.26 A major factor impacting CMHB's higher costs per consumer (see **F4.25**) is unit costs for Medicaid (see **Table 4-11**) and non-Medicaid services (see **Table 4-12**). **Table 4-11** illustrates the average Medicaid rate per unit of service at CMHB and peers.

Table 4-11: Average Cost per Medicaid Service for FY 2000 and 2001

Diagnostic Service	Average Medicaid Rate per Unit of Service Billed						CMHB Difference
	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average[1]	
Fiscal Year 2000							
Crisis Intervention	$129.15	$78.34	$89.45	$114.41	$136.85	$88.80	45.4%
Pre-hospital Screening	$141.61	$128.76	$158.18	$164.08	$167.54	$156.06	(9.3%)
Diagnostic Assessment	$105.88	$97.36	$94.50	$127.36	$103.50	$106.13	(0.2%)
Med Somatic	$176.76	$166.89	$148.04	$187.64	$186.03	$171.62	3.0%
Counseling- Individual	$84.83	$79.46	$81.04	$82.88	$75.29	$79.94	6.1%
Counseling-Group	$26.44	$26.99	$30.82	$35.22	$36.19	$31.84	(17.0%)
CSP-Individual	$79.86	$73.90	$67.60	$82.97	$77.28	$73.82	8.2%
CSP-Group	$30.77	$25.35	$28.73	$33.35	$29.31	$28.02	9.8%
Partial Hospital	$110.05	$104.98	$110.72	$114.42	$101.92	$108.54	1.4%
Fiscal Year 2001							
Crisis Intervention	$139.42	$80.88	$92.37	$125.09	$131.05	$93.92	48.5%
Pre-hospital Screening	$141.43	$119.08	$151.88	$144.94	$151.75	$142.31	(0.6%)
Diagnostic Assessment	$114.08	$89.69	$101.06	$123.97	$122.04	$105.52	8.1%
Med Somatic	$193.55	$166.46	$162.43	$185.30	$181.30	$172.83	12.0%
Counseling- Individual	$85.74	$82.58	$83.94	$85.65	$83.31	$83.66	2.4%
Counseling-Group	$27.36	$29.08	$32.59	$36.66	$37.69	$33.65	(18.7%)
CSP-Individual	$83.27	$77.21	$71.22	$84.49	$78.05	$76.37	9.0%
CSP-Group	$32.91	$33.22	$26.43	$29.20	$22.54	$28.85	14.1%
Partial Hospital	$111.44	$108.73	$113.33	$114.76	$112.18	$111.70	(0.2%)
Percent of Change							
Crisis Intervention	8.0%	3.2%	3.2%	9.3%	(4.2%)	5.8%	
Pre-hospital Screening	(0.1%)	(7.5%)	(4.0%)	(11.7%)	(9.4%)	(8.8%)	
Diagnostic Assessment	7.7%	(7.9%)	6.9%	(2.7%)	17.9%	(0.6%)	
Med Somatic	9.5%	(0.3%)	9.7%	(1.2%)	(2.5%)	0.7%	
Counseling- Individual	2.7%	3.9%	3.6%	3.3%	10.7%	4.7%	
Counseling-Group	3.5%	7.7%	5.7%	4.1%	4.1%	5.7%	
CSP-Individual	4.3%	4.5%	5.4%	1.8%	1.0%	3.5%	
CSP-Group	7.0%	31.0%	(8.0%)	(12.4%)	(23.1%)	3.0%	
Partial Hospital	1.3%	3.6%	2.4%	0.3%	10.1%	2.9%	

Source: ODMH MACSIS statistics from DataMart Web site.

[1] Calculated by adding the peers' costs and peers' units, and then dividing the peers' total costs by the peers' total number of units.

Table 4-11 shows that CMHB had higher average Medicaid unit rates compared to the peer average in six of the nine services for both FY 2000 and FY 2001. CMHB's average Medicaid rate for crisis intervention is significantly higher than the peer average, but does not comprise a significant number of consumers and units (see the **appendix** for more information). CSP-Individual comprises the greatest number of consumers and services, and CMHB's average Medicaid rate per unit of service was 9.8 and 9.0 percent higher than the peer average in FY 2000 and FY 2001, respectively.

Table 4-12 presents the average non-Medicaid rate per unit of service for Medicaid eligible services at CMHB and the peers.

Table 4-12: Non-Medicaid Average Cost

Diagnostic Service	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average [1]	Percent Difference
Fiscal Year 2000							
Crisis Intervention	$126.74	$77.72	$95.04	$113.13	$122.01	$82.76	53.2%
Pre-hospital Screening	$110.68	$125.61	$158.45	$162.97	$153.07	$149.21	(25.8%)
Diagnostic Assessment	$106.40	$99.09	$85.95	$126.40	$86.26	$103.76	2.6%
Med Somatic	$188.96	$165.74	$145.76	$182.05	$153.80	$165.42	14.2%
Counseling-Individual	$84.39	$74.48	$80.03	$74.48	$64.67	$76.74	10.0%
Counseling-Group	$26.01	$22.08	$28.36	$34.45	$29.92	$26.94	(3.5%)
CSP-Individual	$78.32	$73.29	$66.95	$83.02	$69.65	$72.03	8.7%
CSP-Group	$26.05	$24.78	$28.91	$35.45	N/A	$28.53	(8.7%)
Partial Hospitalization	$109.90	$100.54	$103.51	$113.40	$87.57	$104.67	5.0%
Fiscal Year 2001							
Crisis Intervention	$114.33	$79.94	$93.04	$123.34	$116.92	$84.84	34.8%
Pre-hospital Screening	$97.79	$113.33	$167.60	$142.42	$139.79	$134.13	(27.1%)
Diagnostic Assessment	$115.57	$81.94	$90.05	$120.01	$109.98	$93.38	23.8%
Med Somatic	$196.93	$156.80	$159.19	$179.60	$154.93	$162.95	20.9%
Counseling-Individual	$84.33	$77.40	$81.35	$75.62	$74.20	$78.45	7.5%
Counseling-Group	$24.15	$23.37	$31.56	$35.38	$30.80	$28.67	(15.8%)
CSP-Individual	$80.22	$76.03	$70.11	$84.65	$75.43	$74.84	7.2%
CSP-Group	$21.18	$33.49	$25.63	$34.38	N/A	$29.23	(27.5%)
Partial Hospitalization	$105.24	$106.47	$115.38	$113.42	$109.64	$110.00	(4.3%)

Source: ODMH MACSIS statistics from DataMart Web site.

[1] Calculated by adding the peers' costs and peers' units, and then dividing the peers' total costs by the peers' total number of units.

Table 4-12 illustrates that CMHB pays a higher average unit cost per service in six of nine services and five of nine services in FY 2000 and FY 2001, respectively, as compared to the peer average for its Medicaid eligible services used by non-Medicaid consumers. However, CMHB had the second lowest overall average non-Medicaid unit cost of the peers in FY 2000 and FY 2001 (see **Tables 4A-20** and **4A-21** in the appendix).

The finance director stated CMHB has attempted to maintain rates by not allowing administrative costs to make up more than 40 percent of a unit's cost. This practice has

not been reviewed for several years (see **F4.29** and **R4.24**). In contrast, Hamilton MHB has worked with providers to develop ways to control spending and unit costs. For example, Hamilton MHB meets with its larger contracted providers on an annual basis to review previous years' cost and services provided. In an effort to ensure that physicians' costs are based more on direct time spent treating consumers and less on administrative time, Hamilton MHB recommends physician's time (i.e., direct, face-to-face time spent with consumers) to be billed at no more than 70 percent of their clinical time (i.e., total amount of time) instead of ODMH's performance standard recommendation of 80 percent. Since Hamilton MHB defines with its providers a doctors' clinical time at 50 percent, the maximum cost defined by the provider is 35 percent for physicians' time. According to Hamilton MHB, quality of services provided to consumers has not been negatively impacted with this billing policy. CMHB allows its providers to independently determine billing rates for physicians.

As a result of the billing practice for physicians at Hamilton MHB, many of its larger providers are contracting with doctors instead of hiring them. The providers contract with the physicians and only reimburse them for actual time spent with consumers. Also, the contracted provider saves costs by not paying for vacation and benefits (e.g., health insurance). Using the Hamilton example and omitting overhead costs, a contracted provider may reimburse a physician at much higher rates and still save money. For example, a provider previously paid a physician $75 dollars per hour for an 80 hour work period totaling $6,000. By increasing the physician's rate to $125 per hour but only paying for actual hours of clinical time (28 hours of an 80 hour work period), the provider will pay $3,500, which results in a cost savings of $2,500 per work period for the provider. This practice allows the physician to contract with other providers and increase their earnings potential.

F4.27 **Table 4-13** illustrates the potential costs savings available to CMHB by applying the peer average cost per Medicaid unit of service to CMHB's actual units of Medicaid services for the fiscal years 2000 and 2001.

Table 4-13: Estimated Cost Savings for FY 2000 and FY 2001 (Medicaid)

Diagnostic Service	Units	Peer Cost Per Unit	Calculated Cost	Actual Cost	Savings
Fiscal Year 2000					
Crisis Intervention	1,782	$88.80	$158,242	$230,144	$71,902
Pre-hospital Screening	316	$156.06	$49,315	$44,748	($4,567)
Diagnostic Assessment	15,680	$106.13	$1,664,118	$1,660,217	($3,901)
Med Somatic	29,592	$171.62	$5,078,579	$5,230,568	$151,989
Counseling- Individual	50,321	$79.94	$4,022,661	$4,268,665	$246,004
Counseling-Group	8,420	$31.84	$268,093	$222,646	($45,447)
CSP-Individual	231,674	$73.82	$17,102,175	$18,501,816	$1,399,641
CSP-Group	18,567	$28.02	$520,247	$571,296	$51,049
Partial Hospital	102,695	$108.54	$11,146,515	$11,301,701	$155,186
Totals	**459,047**		**$40,009,945**	**$42,031,801**	**$2,021,856**
Fiscal Year 2001					
Crisis Intervention	1,772	$93.92	$166,426	$247,044	$80,618
Pre-hospital Screening	353	$142.31	$50,235	$49,925	($310)
Diagnostic Assessment	18,648	$105.52	$1,967,737	$2,127,384	$159,647
Med Somatic	33,497	$172.83	$5,789,287	$6,483,363	$694,076
Counseling- Individual	63,365	$83.66	$5,301,116	$5,432,815	($131,699)
Counseling-Group	12,728	$33.65	$428,297	$348,214	($80,083)
CSP-Individual	220,962	$76.37	$16,874,868	$18,398,831	$1,523,963
CSP-Group	16,130	$28.85	$465,351	$530,775	$65,424
Partial Hospital	99,971	$111.70	$11,166,761	$11,140,566	($26,195)
Totals	**466,426**		**$42,210,078**	**$44,758,917**	**$2,548,839**

Source: ODMH MACSIS statistics from DataMart Web site.

If CMHB had the peer average cost per unit, it would have saved approximately $2.0 million and $2.6 million in FY 2000 and FY 2001, respectively, which could have been used to service more customers. **Table 4-14** demonstrates the cost savings available to CMHB by using the peer average cost per unit for non-Medicaid consumers using Medicaid eligible services in FY 2000 and FY 2001.

Table 4-14: Estimated Cost Savings for FY 2000 and FY 2001 (Non-Medicaid)

Diagnostic Service	Units	Peer Cost Per Unit	Calculated Cost	Actual Cost	Savings
Fiscal Year 2000					
Crisis Intervention	7,356	$82.76	$608,783	$932,318	$323,535
Pre-hospital Screening	4,823	$149.21	$719,640	$533,831	($185,809)
Diagnostic Assessment	6,676	$103.76	$692,702	$710,307	$17,605
Med Somatic	10,757	$165.42	$1,779,423	$2,032,640	$253,217
Counseling-Individual	12,884	$76.74	$988,718	$1,087,244	$98,526
Counseling-Group	3,052	$26.94	$82,221	$79,374	($2,847)
CSP-Individual	105,431	$72.03	$7,594,195	$8,257,574	$663,379
CSP-Group	6,428	$28.53	$183,391	$167,432	($15,959)
Partial Hospitalization	17,447	$104.67	$1,826,177	$1,917,391	$91,214
Totals	**174,854**		**$14,475,250**	**$15,718,111**	**$1,242,861**
Fiscal Year 2001					
Crisis Intervention	6,131	$84.84	$520,154	$700,966	$180,812
Pre-hospital Screening	6,292	$134.13	$843,946	$615,291	($228,655)
Diagnostic Assessment	6,908	$93.38	$645,069	$798,371	$153,302
Med Somatic	13,072	$162.95	$2,130,082	$2,574,215	$444,133
Counseling-Individual	11,937	$78.45	$936,458	$1,006,683	$70,225
Counseling-Group	3,239	$28.67	$92,862	$78,221	($14,641)
CSP-Individual	87,617	$74.84	$6,557,256	$7,028,950	$471,694
CSP-Group	6,313	$29.23	$184,529	$133,685	($50,844)
Partial Hospitalization	14,934	$110.00	$1,642,740	$1,571,624	($71,116)
Totals	**156,443**		**$13,553,096**	**$14,508,006**	**$954,910**

Source: ODMH MACSIS statistics from DataMart Web site.

If CMHB had the peer average cost per unit, it would have saved approximately $1.2 million and $950,000 in FY 2000 and FY 2001, respectively, which could have been used to service more customers. In total, CMHB could have saved approximately $3.2 million and $3.5 million in FY 2000 and FY 2001, respectively, if it had the peer average cost per unit of service for Medicaid services used by Medicaid and non-Medicaid consumers; while still maintaining the average units of service per consumer. As indicated in **Table 4-9**, CMHB had the second highest and highest average units per consumer as compared to the peers in FY 2000 and FY 2001, respectively. These potential cost savings could be used to increase the number of consumers in need of mental health services and/or increase the average number of units of service provided to a consumer (see **R4.23**).

F4.28 According to the Technical Assistance Collaborative (TAC) report on Lucas MHB, the pricing system for Medicaid in Ohio has a tendency to drive costs and rates to the maximum. The report states there are few incentives in Ohio for cost efficiencies since reducing costs through creative and efficient methods has the effect of reducing rates charged by contracted providers. Also, because rates are set individually based on each agency's costs, and because Medicaid providers are free to provide services and Medicaid enrollees are free to select service providers, there is virtually no price

competition in the system. For most providers, the business strategy is to increase costs as close as possible to the capped rate ceiling. However, as discussed previously and throughout the remainder of this report, Franklin and Hamilton MHBs have been able to work with providers to control unit costs and have implemented additional processes to control mental health spending while reaching more mental health consumers per capita as compared to CMHB.

To better control costs, the TAC report recommended that Lucas MHB implement a flat fee for non-Medicaid services. The flat fee system is intended to do the following:

- Assure that the largest number of priority consumers possible are served with state and local funding;
- Provide a strong incentive for contracted providers to maximize on the number of qualified consumers enrolled in Medicaid; and
- Reduce the overall costs of providing services, which would have the effect of reducing or containing Medicaid rates.

According to the report, a flat fee system would ensure that rates are established based upon the actual costs of providing a service, as opposed to how much the service has been made to cost by individual contracted providers. Lucas MHB indicated that the flat fee system for non-Medicaid services was implemented in FY 2002.

R4.23 CMHB should review its pricing with contracted providers to maintain or lower mental health Medicaid unit costs and non-Medicaid unit costs for Medicaid eligible services. CMHB and its contracted providers should strive to maintain their average unit costs at a level comparable to the peers. This can be accomplished by working with the contracted providers to review unit costs and recommending where savings could be found. Establishing ceilings for clinical billable time with the providers, having the providers contract with the physicians and clinicians for mental health services, and minimizing administrative costs (see **F4.29** and **R4.24**) are examples of how CMHB and the contracted providers can work together to lower costs.

In addition, CMHB should work very closely with the contracted providers to maintain non-Medicaid average unit costs for other services provided by CMHB as illustrated in **Tables 4A-20** and **4A-21** in the appendix. By maintaining these unit costs, CMHB will allow the total mental health funding system a chance to stabilize, ensure more funds will be available for new consumers and ensure appropriate levels of services for current consumers. Furthermore, CMHB should examine a flat fee service system for non-Medicaid services as another way to ensure that contracted providers are operating efficiently, and providing cost-effective and quality services.

Financial Implication: To conservatively estimate potential cost savings, CMHB should prioritize working with providers to reduce unit costs for its largest service, CSP-Individual. Based on FY 2000, CMHB could save approximately $1.4 million annually by reducing costs per unit to the peer average for CSP-Individual services. Based on differences in the cost of doing business factors (CODBF) in Cuyahoga and peer counties, AOS adjusted this estimate by applying these differences to the unit costs. As a result, CMHB could save approximately $830,000 annually by reducing unit costs for CSP-Individual.

F4.29 Administrative costs used in the calculation of contracted providers' average unit cost per service billed are higher for CMHB as compared to Franklin MHB. Franklin MHB's percent of administrative expenses is 8.9 percent while CMHB's administrative expense used in the average unit cost is 13.7 percent for FY 2003. As a result, CMHB is paying 4.8 percent more for administrative costs in contracted providers' unit cost as compared to Franklin MHB. Based on FY 2001 spending of approximately $78.6 million, this represents an additional $3.8 million for administrative costs when compared to Franklin MHB.

The administrative expenses budgeted by CMHB contracted providers with over $1 million in budgeted services, range from 5.01 percent to 26.89 percent for FY 2003. In addition, the highest budgeted administrative costs are 26.89 and 24.09 percent, respectively, for one contract provider with over $2 million budgeted and another contract provider with almost $11 million budgeted for FY 2003. In contrast, Franklin MHB's contracted providers' administrative costs range from 3.97 percent to 13.92 percent for all providers with a total budget request over $1 million for administrative expenses. The annual instructions for ODMH are specific as to what administrative expense are to be budgeted but are not specific as to how much is to go into the cost nor the overall percent. CMHB has left these decisions to the contracted providers without monitoring them closely.

For FY 2003 budget, there are 38 and 23 contracted providers of mental health services for CMHB and Franklin MHB, respectively. CMHB's providers have developed 159 unit costs for Medicaid services while Franklin MHB's providers have developed 104. CMHB's contracted providers have budgeted 102 of the 159 costs over the Medicaid rate ceilings (64 percent). Conversely, Franklin MHB's contracted providers have budgeted only 11 of the 104 unit costs over the Medicaid rate ceilings (10.5 percent). As a result, CMHB may have a difficult time managing and controlling spending. Furthermore, spending more in administrative costs takes resources away from providing direct services to mental health consumers.

R4.24 CMHB should monitor and work with the contracted providers of mental health services to reduce the administrative expense percent of the average unit cost per service billed. This should force the contracted providers to fully assess and evaluate their own operations to ensure that they are operating efficiently. CMHB should review all administrative expenses budgeted by contracted providers and establish guidelines for each provider beyond the ODMH annual budget instructions. This would represent a positive step toward stabilizing or reducing costs to provide more direct services to consumers.

CMHB should establish a goal of reducing the administrative costs budgeted to the level of Franklin MHB. The funds saved could be redistributed to the contracted providers who show a willingness to cooperate by giving them more units. By having more units available, these providers can spread their fixed costs (both service unit costs and administrative costs) over more consumers, which would allow CMHB and the contracted providers to serve more consumers, provide additional units to current consumers and to maintain costs. The overall financial impact of this recommendation is included in **R4.23**.

F4.30 **Table 4-15** compares total costs and average cost per child in foster care at CMHB and peers in FY 2000 and FY 2001.

Table 4-15: Average Medicaid Cost for Foster Care Children

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average	CMHB Difference
Fiscal Year 2000							
Consumers	1,895	1,049	697	385	458	647	192.8%
Cost	$9,945,246	$3,856,771	$3,320,949	$1,127,449	$1,330,644	$2,408,953	312.8%
Average Cost	$5,248	$3,677	$4,765	$2,928	$2,905	$3,722	41.0%
Fiscal Year 2001							
Consumers	2,066	1,190	747	364	461	691	199.0 %
Cost	$8,976,857	$4,016,755	$3,265,145	$1,281,971	$1,317,507	$2,470,345	263.4%
Average Cost	$4,345	$3,375	$4,371	$3,522	$2,858	$3,578	21.4%
Percent of Change							
Consumers	9.0%	13.4%	7.2%	(5.5%)	0.7%	6.8%	
Cost	(9.7%)	4.1%	(1.7%)	13.7%	(1.0%)	2.5%	
Average Cost	(17.2%)	(8.2%)	(8.3%)	20.3%	(1.6%)	(3.9%)	

Source: ODMH MACSIS statistics from DataMart Web site.

As indicated by **Table 4-15**, CMHB's cost per foster care child is approximately 20 percent higher than the peer average in 2001 despite a reduction in average cost from FY 2000 to FY 2001 of over 17 percent. The Department of Children and Family Services

(DCFS), and CMHB could not determine the cause for the 17 percent reduction in average cost per foster care child. Units billed for these consumers could contribute to the higher cost per consumer at CMHB and the reduction in average cost per consumer. However, this data could not be obtained from ODMH.

Foster care children are placed in residential facilities by DCFS. According to the Administrator of Contractual Placements at DCFS, these consumers are at their final placement destination when they reach the mental health system. The children in this category, usually early teenagers, have had to be removed from the first two possible placement areas; either from relatives or interested individuals, or DCFS provider foster care homes. The youths in this program are considered to have severe mental health issues and must receive institutionalized care at CMHB providers. DCFS approves all care for these consumers including mental health services which would be deemed necessary. CMHB does not have consistent interaction with DCFS, except in approving unit costs and total units detailed in its contracts with providers.

Hamilton MHB works very closely with other county agencies (**F4.31** and **R4.26**) in pooling funds and with providers for Severely Emotionally Disturbed (SED) children. This concept was formulated in Hamilton County as a way to control costs and to maintain the welfare of the child. In addition, Hamilton MHB has implemented managed care and Franklin MHB uses a centralized intake system to coordinate service delivery for children (see **F4.33** and **F4.34**).

R4.25 At a minimum, CMHB should work with DCFS to fully evaluate mental health costs for foster care children, which are contributing to the overall higher spending per consumer in Cuyahoga County. CMHB should routinely meet with DCFS to assess these issues. A pooled funding arrangement (see **R4.26**) and a centralized intake system or managed care relationship (see **R4.27**) could help control mental health spending for foster care children while maintaining quality services.

F4.31 CMHB has not implemented pooled funding for mental health services provided by all county agencies and/or for certain services provided by these agencies to CMHB's consumers, which could make it difficult to control mental health costs. As discussed in **F4.24**, funding for mental health services spent by other county agencies was approximately 1.6 million in FY 2001. Additionally, mental health services intertwine with those from many other public funded agencies, such as alcohol and drug boards, boards of mental retardation developmental disabilities, children's services and the criminal justice system. Pooled funding arrangements operate by having different agencies contribute funds to a centralized account to fund services provided by these different agencies to similar populations. In addition, pooled funding could help in gathering different ideas from these agencies to benefit consumers and all stakeholders in

the system. The pooled funding concept is promoted by ODMH in its instruction guide for the annual budget process. ODMH recommends local stakeholders use the pooled funding concept to maximize service and minimize cost.

Several attempts have been made in the past to implement pooling in Cuyahoga County. One attempt, organized by the Take a Stand for Kids (TASK) group of the Justice Affairs Board, has met with success in some common areas, such as alcohol and drug services. However, TASK has not been as successful in mental health. According to OBM, another attempt to implement pooled funding through a relationship between CMHB and the Alcohol and Drug Board has also not met with the desired results.

In addition, CMHB and other County officials indicated that double payments for certain mental health services have occurred because CMHB and the other agencies are not aware of all the services that are provided to consumers serviced simultaneously by multiple county agencies. For example, a child placed by DCFS in a residential facility could be provided with a range of services including mental health. Although the contracted provider would receive payment from CMHB for mental health services, DCFS may also incur these expenses as a portion of the overall services provided to the child by the same contracted provider.

Hamilton MHB has implemented a pooled funding arrangement with other boards, primarily Children's Services, to collaborate on funding services for severally emotionally disturbed (SED) children. In 2002, the amount of the pooled fund was $15.0 million, with each agency funding a specific share as established by agreement. In 2002, Hamilton MHB's share of funding was about 22 percent, or approximately $3.0 million. The funding contribution from Hamilton MHB is for mental health services that are provided as a component of the total services provided to a consumer. The pooled funds are administered by the Children's Services Board and it reports on how the funds are spent for mental health services. Hamilton MHB, by pooling its funding and mental health services with other county agencies, has helped to better control costs as compared to CMHB (see **F4.25**). In addition, Hamilton MHB has implemented managed care for mental health services (see **F4.34**). The consumers are diagnosed by one of two third-party managed care organizations to determine the type of treatment and services necessary, and then referred to a contract provider to administer services. Furthermore, Franklin MHB has implemented pooled funding arrangement through its centralized intake system (see **F4.33**).

In contrast to Hamilton MHB, Franklin MHB has different county agencies reimburse it for mental health services. All mental health spending is tracked by Franklin MHB, as a result of its mental health levy. Each county agency budgets for the total costs needed to serve their consumers, including mental health services. For example, the Children

Services Board's budget includes potential costs for mental health services. As the Children Services Board expends funds to its providers for children services, it may be determined that a child needs counseling which is a mental health service. Franklin MHB refers the child to one of its contracted providers through the centralized intake system for counseling services. The cost is entered into MACSIS by the contracted provider and paid by Franklin MHB. Through their agreements, the Children Services Board reimburses Franklin MHB for counseling costs.

R4.26 CMHB should consider implementing a pooled funding arrangement with other county agencies. Based on the peers, a pooled funding arrangement could be implemented in the following ways:

- All of the agencies could contribute funds in one centralized account, with one agency responsible for administering the funds. The amount of funding provided by each agency should be based on objective criteria, such as the percentage of total costs related to overall services provided to similar consumers. In addition, CMHB should have more control in the funding spent by other county agencies for mental health services.

- Each county agency providing mental health services could reimburse CMHB for the costs it incurs for providing those services.

Regardless of how CMHB and the other agencies implement pooled funding, a written agreement between CMHB and other involved agencies should be established to clearly define the arrangement, and the roles and responsibilities of each agency. By implementing a pooled funding arrangement, CMHB could better control spending for mental health services in Cuyahoga County and minimize the potential of double payments occurring.

F4.32 Concepts for controlling mental health costs have been studied in various governments and attempted in other states. One such concept is managed care. A consultant for health care organizations defines managed care as any form of health plan that initiates selective contracting between providers, employers and/or insurers to channel members to a specified set of cost effective providers. These providers have procedures in place to assure that only medically necessary and appropriate use of health care services occurs.

The Center for Mental Health Services, U.S. Department of Health and Human Services, indicates that almost 66 percent of individuals with mental health insurance are covered under managed care plans, and almost 80 percent of states are implementing changes in their Medicaid programs that will impact mental health systems. Managed care attempts to shift more financial risk to contracted providers. Since managed care systems impose

a financial risk on the provider, they provide financial incentives to actively manage patient care and costs.

F4.33 Franklin MHB has established a centralized intake system, which is operated in a manner similar to a managed care system, to control costs while providing appropriate services to consumers. To coincide with the implementation of a fee-for-service payment system in July 1999, Franklin MHB, including the Alcohol and Drug segment of its operations, established Net Care Works to collaborate with several other stakeholders on mental health issues and operate the centralized intake system. Centralized intake functions by referring new Medicaid and non-Medicaid consumers entering the mental health system for appropriate services based on a clinical assessment (see **quality improvement** for further discussion). The clinicians diagnosing the consumers' mental health problems are employees of the Franklin County Alcohol, Drug Addiction and Mental Health Board (ADAMH). Medicaid consumers are not required to go to the recommended service provider due to any willing provider (AWP) (see **F4.38** through **F4.40**), but are still encouraged to do so since many of them have no prior knowledge of any provider. According to Franklin MHB, about 50 percent of all new consumers entering the system are referred by centralized intake. Net Care Works is designed to avoid duplication of effort in initially diagnosing consumers and provide an initial clinical assessment in a uniform and standard manner.

Franklin ADAMH is presently using Net Care Works for three diagnostic areas: Children's Services, Job and Family Services (TANF program) and Forensics.

- Children's Services funds two diagnostic positions (cost $64,000) at their agency's location;

- Job and Family Services children's program (TANF) reimburses $500,000 per year to Franklin ADAMH; and

- Forensics uses Net Care Works and reimburses about $1.0 million per year to Franklin ADAMH.

According to Franklin MHB, the reimbursements from Job and Family Services and Forensics offsets the costs of operating the centralized intake system, which are the salary and benefit costs of the seven employees at Net Care Works that refer and diagnose mental health consumers. These seven employees also refer and diagnose alcohol and drug consumers.

In addition to implementing centralized intake to control mental health costs, Franklin County is creating a family court system. This court will be used for drug related issues,

with mental health being part of the potential diagnoses. The court's diagnostic staff will come from Net Care Works and will work in conjunction with Children's Services, Job and Family Services and Forensics. According to Franklin County officials, it is estimated Franklin MHB will be able to reach an additional 10 to 20 percent of the new mental health consumers with this new cooperative system.

F4.34 Hamilton MHB has implemented a managed care system for mental health services through two third party organizations, Magellan and Mutual Health Access Point (MHAP). Magellan is operated to provide services for children in residential/out-of-home placement facilities and refers adults to MHAP for referral to adult mental health contracted providers for treatment. Hamilton MHB had to allocate additional funding in 1998 to Magellan as a new contracted provider. The annual cost to Hamilton MHB for funding Magellan is approximately $2.2 million. However, Hamilton MHB did not increase overall spending by using MHAP. Rather, it reallocated funding for the diagnostic assessments from its largest contracted providers to MHAP because other contracted providers were no longer providing initial diagnostic assessments. The eight largest contracted providers agreed to fund MHAP in this manner. MHAP has been operating for over two years and is the standard bearer for diagnostic assessment of new mental health consumers in Hamilton County. According to Hamilton MHB, MHAP refers approximately 50 percent of new consumers to contracted providers for treatment. In addition, the funding allocated to Magellan and MHAP are captured and tracked in MACSIS (see **Tables 4-9** and **4-10**).

Through its managed care system, Hamilton MHB increased the number of consumers by 4.6 percent and reduced the average cost per consumer by 2.0 percent from FY 2000 to FY 2001. Through its centralized intake system, Franklin MHB increased the number of consumers by 3.2 percent and reduced average cost per consumer by 2.7 percent from FY 2000 to FY 2001. However, for the same time period, CMHB's number of consumers decreased by 2.1 percent and the average cost per consumer increased by 7.7 percent. Providing clinical assessments in a uniform and standard way could ensure that the units of service provided to consumers are adequate (see **quality improvement** for further discussion) and that clinical diagnoses are appropriate.

F4.35 The Colorado State Auditor released a report on the Colorado Department of Human Services Mental Health Community Programs in August 1997. Colorado was one of the first states to implement managed care for mental health services, specifically capitated managed care. Under capitated managed care, the state makes a flat payment for each Medicaid consumer (per capita) and the contracted providers agree to provide all medically necessary mental health services to any consumer requiring services within the capitated rate. Colorado has implemented capitated managed care for Medicaid consumers in 51 of 63 counties. Under the previous fee-for-services system which is

used in Ohio, providers had an incentive to deliver more services because they were paid for more services provided. By implementing capitated managed care, Colorado intended to eliminate this incentive, control costs through the coordination of care and improve the quality of mental health services to Medicaid consumers.

According to the report, capitated managed care has increased the availability of certain community services and reduced the use of inpatient services provided by the state. It has also caused contracted provider agencies to operate more efficiently, resulting in downsizing at some agencies. To address concerns that managed care would limit or reduce services, the state conducts site reviews, reviews clinical charts, provides technical assistance to providers, monitors consumer complaints, evaluates consumer satisfaction, reviews financial audits, and monitors service outcomes and other performance indicators (see **provider relations and quality services**). As discussed throughout this performance audit, CMHB has many of these same responsibilities in monitoring the service delivery in Cuyahoga County.

F4.36 The Alaska Legislative Auditor issued a report in September 1997 evaluating the State's community mental health center program and examining managed care systems. According to the report, some providers may prioritize providing services to Medicaid consumers over non-Medicaid consumers because financial incentives exist under a fee-for-service system to serve Medicaid consumers first. The report recommends the development of a managed care system to achieve long-term cost containment while maintaining accessible and effective mental health services. According to the report, access and quality of services can be successfully balanced with cost containment measures.

R4.27 CMHB should strongly consider implementing a centralized intake or managed care system, similar to Franklin and Hamilton MHBs. Having a central point in the mental health system to initially diagnose consumers in a uniform fashion and refer them to providers for appropriate treatment has allowed Franklin and Hamilton MHBs to incur lower costs per consumer, while reaching more consumers per capita and providing comparable units of service per consumer as compared to CMHB. Implementing a managed care or centralized intake system would require CMHB to actively monitor service quality on a comprehensive basis. Therefore, CMHB should monitor outcomes on a county-wide basis to fully ensure that services are successful in treating consumers and funding is being used effectively (see quality improvement in **provider relations and quality services** section).

In addition, CMHB should provide appropriate assistance to contracted providers because they will be forced to ensure their operations are efficient and cost-effective. Furthermore, education and participation of all stakeholders in the mental health system,

including consumers, is critical to successful implementation. As a result, CMHB should be proactive in educating all stakeholders when pursuing the implementation of a centralized intake or managed care system.

While ensuring that current and potential consumers have access to effective services should be the ultimate goal, controlling costs should also be a top priority of CMHB to ensure appropriate use of tax payer dollars. The potential financial impact of this recommendation is included in **R4.23**.

F4.37 The Cuyahoga 1915(a) waiver has been approved since 1992 and is a capitation cost for certain children who are SMD consumers residing in the cities of Cleveland and East Cleveland. Funding to administer services under this waiver has been provided by the federal government. It is a voluntary program entered into by the consumer, who moves in and out of the program at will. The waiver is a Prepaid Health Plan (PHP) and covers services normally outside the scope of Medicaid. PHP allows a flexible spending plan to be established which is unique to each consumer. The waiver service may only be used at CMHB's contracted providers. ODMH establishes a capitation contract with CMHB and funds it monthly. Capitation is a fixed cost per consumer which does not change regardless of what services are rendered or how often the services are given.

The providers code the billing differently in MACSIS for the waiver program. However, the providers are reimbursed at the normal unit cost for the service provided. As a result, Medicaid funding could potentially be used to reimburse providers for services that are reimbursable under the waiver program, causing Medicaid funding to be spent more quickly. The finance director has indicated that CMHB is in the process of fully analyzing the financial impact of this issue.

R4.28 CMHB should ensure that services provided under the waiver program are appropriately reimbursed through funding received from the federal government. To accomplish this, CMHB should implement effective internal controls to reimburse providers for the appropriate costs of administering services under the waiver program. Using the 1915 (a) waiver for its intended purpose allows flexibility in service to the consumer and permits normal non-Medicaid services to be paid with federal funds, freeing state and local funding for other services.

Any Willing Provider/Freedom of Choice

F4.38 A Cuyahoga County consumer of mental health services has the option to seek services from any provider in the mental health system contracted with a local mental health board to provide such services. If the consumer is a Medicaid consumer, this right is maintained by the Medicare Act. A Medicaid contract provider of mental health services

must serve the consumer and, after submitting their billing, is guaranteed reimbursement. Medicaid contracted providers receive the right to give Medicaid services from ODMH through a local board. Non-Medicaid providers contract with the local boards to serve the mental health consumers.

F4.39 The term "Any Willing Provider" (AWP) is used in the medical profession to describe a provider of Medicaid health services who is willing to give medical service to a consumer and be reimbursed for their service at a price not higher than the predetermined Medicaid rate ceiling. This concept has been a mandatory practice since the inception of Medicare and Medicaid.

Since inception of community Medicaid (Medicaid funding for behavioral health care services), the mental health system in Ohio has always worked under this concept for Medicaid consumers who have always had the right to elect which contract provider of Medicaid service they desired. The major change in the mental health service industry in Ohio has been the implementation of MACSIS and the reimbursement process for all providers.

On July 1, 1999, ODMH instituted two major changes to the reimbursement of providers. First, ODMH mandated that contracted providers of mental health services be paid only on a fee for service basis, with the exception of limited grant funded programs. Prior to July 1999, local boards, such as CMHB, reimbursed their contracted providers in several ways. CMHB elected to pay contracted providers on a grant basis. The grant method meant CMHB would reimburse contracted providers one twelfth of their annual contracted amount each month. CMHB and the providers would reconcile annually for any differences in the services performed and reimbursed. The change to fee for service altered this concept. Fee for service required that billing be submitted for each service performed. The capture of data through fee for service was promoted by ODMH with the introduction of MACSIS and its related billing system. Providers would now be paid as claims are processed through MACSIS, as long as the billing met the requirements for payment. With this new concept, some contracted providers are now reimbursed weekly.

Second, MACSIS provided the ability to effectively track services throughout the State and report the information to the county where the consumer resides. CMHB now pays contracted providers from anywhere in the state for services provided to Cuyahoga County residents. This raised the number of providers reimbursed annually from forty to over one hundred at CMHB. ODMH designed these changes to aid local boards in controlling mental health cost in their communities.

F4.40 **Table 4-16** presents the funding CMHB and peers provided to their local contracted providers and out-of-county providers for the local boards' resident consumers in FY 2000 and FY 2001, respectively.

Table 4-16: Out-of-Board Cost for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB
Fiscal Year 2000					
CMHB Payments to Out-of-County Providers	$1,148,948	$2,677,969	$1,414,591	$204,935	$402,048
Other Boards Payments to Cuyahoga County providers	$2,740,009	$1,240,984	$634,227	$656,653	$398,498
Fiscal Year 2001					
CMHB Payments to Out-of-County Providers	$1,602,302	$3,043,288	$1,446,446	$287,597	$517,887
Other Boards Payments to Cuyahoga County providers	$3,374,005	$1,223,373	$610,368	$809,505	$362,971

Source: ODMH MACSIS statistics at DataMart Web site.

Table 4-16 illustrates that contracted providers in Cuyahoga County received approximately $2.7 million in FY 2000 and $3.3 million in FY 2001 from other county boards for services. In addition, CMHB paid about $1.1 million in FY 2000 and $1.6 million in FY 2001 to other boards' contracted providers for Cuyahoga County consumers. Prior to MACSIS, CMHB reimbursed select Medicaid-only contracted providers the Federal funding portion for Medicaid services (59 percent). However, CMHB is now responsible for providing 100 percent reimbursement for Medicaid services. As a result, these selected contracted providers are receiving additional funding for services. Nevertheless, unit costs are higher at CMHB than peers (see **F4.26**).

R4.29 Considering that contracted providers are receiving additional funding for services, CMHB should work with the providers to reduce unit costs for services (see **R4.23**). Reducing unit costs will allow additional funding to treat more consumers and provide additional units of service to current consumers.

Operations and Finance Committee

F4.41 BOG attendance at OFC meetings can be improved. From November of 2001 through April 2002, there have been four meetings, all with low attendance. One member has missed all four meetings and two new members were named to replace members who resigned. OFC attendance determines the effectiveness of the group and its associated fiduciary responsibilities. Problems occur when items are carried over from previous meetings due to lack of a quorum, requiring them to be discussed from the beginning so

that missing members can be made knowledgeable. Meetings are, therefore, longer than they need to be.

R4.30 The OFC should develop continuity and stability in its membership. OFC should encourage BOG members to join who are committed to this position and associated duties and responsibilities. OFC is very important to the overall fiduciary responsibility of the BOG. The benefits to CMHB for regular meeting attendance should be faster decision making, more informed decisions, higher levels of service, lower costs, and better management of costs.

F4.42 The overall financial training of the OFC is not at the level needed to carry on the following duties:

- Advising BOG members on important financial items that must have their attention; and

- Interacting with CMHB management to gain an understanding of financial issues or to raise questions for clarification.

According to ORC, and to CMHB policy, special training or a financial background is not a prerequisite for membership on the committee. The depth at which issues are discussed does not lend itself to a complete understanding. An awareness of mental health funding and costing would enable an OFC member to more competently assess financial issues. Attending ODMH training or one of the several courses offered by various instructional groups could meet a member's needs. Also, the foresight to ask questions and discuss mental health issues is needed. Reading the agenda, knowing what is going to be discussed, and having questions prepared beforehand will speed up discussions and shorten meeting times. The lack of understanding of mental health funding is illustrated by the OFC not reviewing administrative expenses on a monthly basis and not asking why the monthly results are not presented.

R4.31 Training, such as financial and ODMH training, should be made available to all members sitting on the OFC and to other BOG members. In addition, BOG should attempt to attract qualified members to the OFC when vacancies occur and ensure that all members on the OFC are fully qualified and provided with necessary training to fulfill job duties. Individuals with backgrounds as accountants, lawyers, and bankers should be considered as potential members of the OFC. By providing the necessary training and ensuring that board members are fully qualified to sit on the OFC, CMHB should benefit through more informed decision making on important issues such as controlling the rising mental health costs in Cuyahoga Count and contributing to an improved level of customer service at CMHB.

Financial Implications Summary

The following chart presents a summary of the financial implications discussed in the finance and funding section. For the purpose of this chart, only recommendations with quantifiable financial impacts are included.

Summary of Financial Implications

Recommendation	Estimated Annual Cost Savings	Estimated Annual Implementation Costs	Estimated One-Time Implementation Costs
R4.1 Employ a position to work closely in the financial audits of contracted providers		$65,000	
R4.7 Implement a new accounting system			$30,000
R4.8 Cost of an annual financial audit of CMHB		$20,000	
R4.15 Attend GFOA training			$7,000
R4.23 Effectively control mental health costs in the County	$830,000		
Total	**$830,000**	**$85,000**	**$37,000**

Conclusion Statement

Certain aspects the Finance Unit's operations could be enhanced. Specifically, the budgeting process at CMHB lacks involvement of all division and unit managers because CMHB does not budget and allocate funding by division or unit. As a result, divisions and units are not held fully accountable for expenditures. The budget developed by the Finance Unit does not contain adequate details and plans to justify appropriation requests, and CMHB does not develop forecasts of future expenditures. In addition, the Finance Unit has had difficulty in adequately budgeting for the County. To improve the budgeting process, CMHB should develop budgets and track actual expenditures by division, educate all of the division and unit heads in the budgeting process, develop a multi-year forecast and update it annually to adequately budget for the County, support budget requests with detailed information, establish a cut-off date for billings (similar to Franklin MHB) and use GFOA as a resource to implement additional enhancements to the budgeting process. Moreover, amendments to CMHB's budget which are approved by BOG should be submitted to OBM for consideration and passage by BOCC.

Although CMHB has employed numerous temporary employees, the Finance Unit has been able to function with a minimal number of staff. CMHB should fill the accounts payable position with a permanent employee to minimize disruptions caused by frequent temporary staff assigned to the position. CMHB should also consider adding a position in the finance unit to work closely with the contracted providers and private auditing firms during the financial audits. Implementing a new internal accounting system could allow the Finance Unit to function more efficiently and improve aspects of its budgeting process. Additionally, CMHB should enhance personnel aspects of its operations by updating job descriptions, developing a policy and procedures manual, establishing a schedule for employee performance reviews and implementing a formal cross-training program. Further, CMHB should ensure that board members of the OFC committee are adequately trained in finance and funding, and are provided appropriate guidance to effectively understand key financial issues facing CMHB.

CMHB is spending more per consumer than the peers and its spending per consumer has increased at a higher rate from FY 2000 to FY 2001. A major factor contributing to the higher spending per consumer at CMHB is the higher unit costs for Medicaid eligible services. CMHB should explore many strategies that are available to effectively control mental health spending while ensuring that consumers are provided with quality services. Options include working with providers to review pricing for units of services and administrative costs, working with DCFS in monitoring costs for children in foster care, and implementing pooled funding arrangements with other county agencies also providing certain services to CMHB's consumers.

Finally, managed care systems could help control costs while providing needed services to consumers. Franklin MHB has implemented a centralized intake system using county employees, which functions like a managed care system. In addition, Hamilton MHB has implemented a

managed care system with two third-party organizations. Franklin and Hamilton MHBs have increased the number of consumers while reducing average cost per consumer from FY 2000 to FY 2001. During the same time period, CMHB's number of consumers has decreased and average cost per consumer has increased. Implementing a managed care or centralized intake system should be considered by CMHB and the County to control costs, reach additional consumers and provide appropriate levels of care to current and future consumers.

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Appendix

The appendix provides detailed spending information for CMHB and its peers. This information was used to analyze and develop conclusions about mental health spending in Cuyahoga County. In addition, the following information, along with all of the data and analyses contained in the body of the report, should be used by CMHB to more effectively control mental health costs in Cuyahoga County (see **R4.22**).

Table 4A-1: Overall Medicaid Spending for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Fiscal Year 2000						
Consumers	15,313	11,583	9,341	7,218	4,347	8,122
Consumers Serviced[1]	32,836	27,408	20,591	19,186	10,365	19,388
Average Number of Services Used By Consumers	2.1	2.4	2.2	2.7	2.4	2.4
Units Billed	460,895	378,733	317,389	180,040	139,922	254,021
Units Per Consumer	30.1	32.7	34.0	24.9	32.2	31.3
Cost	$44,992,297	$31,324,034	$24,105,062	$17,558,943	$11,553,258	$21,135,324
Cost Per Consumer	$2,938	$2,704	$2,581	$2,433	$2,658	$2,602
Fiscal Year 2001						
Consumers	17,159	12,834	10,319	7,588	4,837	8,895
Consumers Serviced	37,550	30,261	22,613	20,109	11,363	21,087
Average Number of Services Used By Consumers	2.2	2.4	2.2	2.7	2.4	2.4
Units Billed	469,415	376,342	335,004	174,451	132,200	254,499
Units Per Consumer	27.3	29.3	32.5	23.0	27.3	28.6
Cost	$47,945,295	$32,193,841	$26,281,362	$17,323,802	$11,118,815	$21,729,455
Cost Per Consumer	$2,794	$2,508	$2,547	$2,283	$2,299	$2,443
Percent of Change						
Consumers	12.1%	10.8%	10.5%	5.1%	11.3%	9.5%
Consumers Serviced[1]	14.4%	10.4%	9.8%	4.8%	9.6%	8.8%
Average Number of Services Used By Consumers	4.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Units Billed	1.6%	(0.1%)	5.5%	(3.1%)	(5.5%)	0.2%
Units Per Consumer	(9.3%)	(10.4%)	(4.4%)	7.6%	(15.2%)	(8.6%)
Cost	6.6%	2.8%	9.0%	(1.3%)	(3.8%)	2.8%
Cost Per Consumer	(4.9%)	(7.2%)	(1.3%)	(6.2%)	(13.5%)	(6.1%)

Source*:* ODMH MACSIS statistics from DataMart Web site.

[1] Consumers serviced will not equal the number of consumers because a consumer may receive several services.

Table 4A-2: Medicaid Spending by Age Group for FY 2000

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	6,653	5,055	3,635	2,872	1,916	3,370
Cost	$24,375,841	$14,433,056	$12,600,143	$6,800,683	$4,882,008	$9,678,973
Average Cost per Consumer	$3,664	$2,855	$3,466	$2,368	$2,548	$2,872
Age 18 Plus						
Consumers	8,619	6,586	5,774	4,385	2,465	4,803
Cost	$20,616,456	$16,890,978	$11,504,917	$10,578,261	$6,671,251	$11,411,352
Average Cost per Consumer	$2,392	$2,565	$1,993	$2,412	$2,706	$2,376
Total FY 2000						
Consumers	15,313	11,583	9,341	7,218	4,347	8,122
Cost	$44,992,297	$31,324,034	$24,105,062	$17,558,943	$11,553,258	$21,135,324
Average Cost per Consumer	$2,938	$2,704	$2,581	$2,433	$2,658	$2,602

Source*:* ODMH MACSIS statistics from DataMart Web site.
Note: Age groups will not equal total consumers because consumers turning 18 years old during the year will be captured twice.

Table 4A-3: Medicaid Spending by Age Group for FY 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	7,908	5,612	4,053	2,996	2,073	3,684
Cost	$26,084,280	$14,355,507	$13,676,929	$7,287,810	$5,051,416	$10,092,916
Average Cost per Consumer	$3,298	$2,558	$3,375	$2,433	$2,437	$2,740
Age 18 Plus						
Consumers	9,397	7,329	6,375	4,644	2,806	5,289
Cost	$21,861,014	$17,838,334	$12,604,433	$10,035,993	$6,067,399	$11,636,540
Average Cost per Consumer	$2,326	$2,434	$1,977	$2,161	$2,162	$2,200
Total FY 2001						
Consumers	17,159	12,834	10,319	7,588	4,837	8,895
Cost	$47,945,295	$32,193,841	$26,281,362	$17,323,802	$11,118,815	$21,729,455
Average Cost per Consumer	$2,794	$2,508	$2,547	$2,283	$2,299	$2,443

Source*:* ODMH MACSIS statistics from DataMart Web site.
Note: Age groups will not equal total consumers because consumers turning 18 years old during the year will be captured twice.

Table 4A-4: Age Group Percent of Change from FY 2000 to FY 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	18.9%	11.0%	11.5%	4.3%	8.2%	9.3%
Cost	7.0%	(0.5%)	8.5%	7.2%	3.5%	4.3%
Average Cost per Consumer	(10.0%)	(10.2%)	(2.6%)	(2.8%)	(4.4%)	(4.6%)
Age 18 Plus						
Consumers	9.0%	11.3%	10.4%	5.9%	13.8%	10.1%
Cost	6.0%	5.6%	9.6%	(5.1%)	(9.1%)	1.9%
Average Cost per Consumer	(2.8%)	(5.1%)	(0.8%)	(10.4%)	(20.1%)	(7.4%)
Total						
Consumers	12.1%	10.8%	10.5%	5.1%	11.3%	9.5%
Cost	6.6%	2.8%	9.0%	(1.3%)	(3.8%)	2.8%
Average Cost per Consumer	(4.9%)	(7.2%)	(1.3%)	(6.2%)	(13.5%)	(6.1%)

Source*:* ODMH MACSIS statistics from DataMart Web site.

Table 4A-5: Average Medicaid Cost by ADC for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average	CMHB Difference
Fiscal Year 2000							
Consumers	6,268	5,589	3,679	3,413	2,007	3,672	70.7%
Cost	$11,992,227	$9,535,051	$7,277,921	$5,092,170	$3,675,492	$6,395,159	87.5%
Average Cost per Consumer	$1,913	$1,706	$1,978	$1,492	$1,831	$1,742	9.8%
Fiscal Year 2001							
Consumers	7,474	6,482	4,236	3,704	2,435	4,214	77.4 %
Cost	$14,435,322	$10,315,351	$8,465,356	$5,505,203	$4,110,049	$7,098,990	103.3 %
Average Cost per Consumer	$1,932	$1,591	$1,998	$1,486	$1,688	$1,685	14.7 %
Percent of Change							
Consumers	19.2%	16.0%	15.1%	8.5%	21.3%	14.8%	
Cost	20.4%	8.2%	16.3%	8.1%	11.8%	11.0%	
Average Cost per Consumer	1.0%	(6.7%)	1.0%	(0.4%)	(7.8%)	(3.3%)	

Source: ODMH MACSIS statistics from DataMart Web site.

Note: ADC: Aid to Families with Dependent Children which, also known as Temporary Assistance for Needy Families (TANF).

Table 4A-6: Average Medicaid Cost by ABD for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average	CMHB Difference
Fiscal Year 2000							
Consumers	7,870	5,340	5,467	3,829	2,023	4,165	89.0%
Cost	$23,685,723	$17,984,118	$13,570,759	$11,345,516	$6,550,333	$12,362,682	91.6%
Average Cost per Consumer	$3,010	$3,368	$2,482	$2,963	$3,238	$2,968	1.4%
Fiscal Year 2001							
Consumers	8,501	5,624	5,730	3,817	2,138	4,327	96.5 %
Cost	$24,533,062	$17,861,736	$14,550,862	$10,536,628	$5,691,260	$12,160,122	101.8 %
Average Cost per Consumer	$2,886	$3,176	$2,539	$2,760	$2,662	$2,810	2.7 %
Percent of Change							
Consumers	8.0%	5.3%	4.8%	(0.3%)	5.7%	3.9%	
Cost	3.6%	(0.7%)	7.2%	(7.1%)	(13.1%)	(1.6%)	
Average Cost per Consumer	(4.1%)	(5.7%)	2.3%	(6.8%)	17.7%	(5.3%)	

Source: ODMH MACSIS statistics from DataMart Web site.
Note: ABD means Aged, Blind and Disabled.

Table 4A-7: CMHB Medicaid Spending for FY 2000 and FY 2001

	Units		Cost		Cost per Unit		
Diagnostic Service	**2000**	**2001**	**2000**	**2001**	**2000**	**2001**	**Percent Change**
Crisis Intervention	1,782	1,772	$230,144	$247,044	$129.15	$139.42	8.0%
Pre-hospital Screening	316	353	$44,748	$49,925	$141.61	$141.43	(0.1%)
Diagnostic Assessment	15,680	18,648	$1,660,217	$2,127,384	$105.88	$114.08	7.7%
Med Somatic	29,592	33,497	$5,230,568	$6,483,363	$176.76	$193.55	9.5%
Counseling- Individual	50,321	63,365	$4,268,665	$5,432,815	$84.83	$85.74	1.1%
Counseling- Group	8,420	12,728	$222,646	$348,214	$26.44	$27.36	3.5%
CSP-Individual	231,674	220,962	$18,501,816	$18,398,831	$79.86	$83.27	4.3%
CSP-Group	18,567	16,130	$571,296	$530,775	$30.77	$32.91	7.0%
Partial Hospital	102,695	99,971	$11,301,701	$11,140,566	$110.05	$111.44	1.3%
Cuyahoga Waiver[1]	1,848	1,989	$2,960,496	$3,186,378	$1605.00	$1602.00	(0.2%)
Totals	460,895	469,415	$44,992,297	$47,945,295	$97.62	$102.36	4.9%

Source: ODMH MACSIS statistics from DataMart Web site.
[1] Cuyahoga Waiver is a section 1915-A waiver of the Medicaid service provision.

Table 4A-8: Peer Medicaid Spending by Service: FY 2000 and FY 2001

Diagnostic Service	Franklin MHB		Hamilton MHB		Lucas MHB		Stark MHB	
	Units	Cost	Units	Cost	Units	Cost	Units	Cost
Fiscal Year 2000								
Crisis Intervention	23,981	$1,878,559	1,863	$166,650	7,724	$883,673	1,081	$147,930
Pre-hospital Screening	474	61,034	11	1,740	709	116,330	630	105,551
Dx Assessment	12,109	1,178,956	8,635	816,028	10,300	1,311,789	4,531	468,950
Med Somatic	28,050	4,681,369	14,765	2,185,831	20,955	3,932,005	10,057	1,870,864
Counseling-Individual	44,419	3,529,617	61,399	4,975,944	23,551	1,951,917	24,980	1,880,795
Counseling-Group	25,003	674,809	20,003	616,475	20,365	717,292	16,695	604,272
CSP-Individual	172,543	12,750,502	143,454	9,697,800	67,259	5,580,487	76,095	5,880,250
CSP-Group	12,630	320,228	21,979	631,377	3,367	112,288	26	762
Partial Hospital	59,524	6,248,960	45,280	5,013,217	25,810	2,953,162	5,827	593,884
Totals	**378,733**	**$31,324,034**	**317,389**	**$24,105.062**	**180,040**	**$17,558,943**	**139,922**	**$11,553,258**
Fiscal Year 2001								
Crisis Intervention	22,603	$1,828,216	301	$27,802	8,152	$1,019,765	1,100	$144,150
Pre-hospital Screening	370	44,058	17	2,582	488	70,730	757	114,876
Dx Assessment	13,898	1,246,490	9,903	1,000,803	10,044	1,245,137	4,773	582,512
Med Somatic	29,934	4,982,795	14,346	2,330,188	20,717	3,838,864	9,627	1,745,327
Counseling-Individual	48,060	3,968,881	68,882	5,782,061	21,503	1,841,658	27,098	2,257,414
Counseling-Group	24,590	714,976	22,754	741,635	19,354	709,428	19,490	734,583
CSP-Individual	168,790	13,032,200	148,084	10,546,045	62,876	5,312,259	65,472	5,110,360
CSP-Group	13,612	452,190	24,906	658,273	3,598	105,047	67	1,510
Partial Hospital	54,485	5,924,035	45,811	5,191,973	27,719	3,180,914	3,816	428,083
Totals	**376,342**	**$32,193,841**	**335,004**	**$26,281,362**	**174,451**	**$17,323,802**	**132,200**	**$11,118,815**

Source: ODMH MACSIS statistics from DataMart Web site.

Table 4A-9: Medicaid Service Units: Percent of Total Units

Diagnostic Services	CMHB		Franklin MHB		Hamilton MHB		Lucas MHB		Stark MHB	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
Crisis Intervention	0.39%	0.38%	6.33%	6.01%	0.59%	0.09%	4.29%	4.67%	0.77%	0.83%
Pre-hospital Screening	0.07%	0.08%	0.13%	0.10%	0.00%	0.01%	0.39%	0.28%	0.45%	0.57%
Diagnostic Assessment	3.40%	3.97%	3.20%	3.69%	2.72%	2.96%	5.72%	5.76%	3.24%	3.61%
Med Somatic	6.42%	7.14%	7.41%	7.95%	4.65%	4.28%	11.64%	11.88%	7.19%	7.28%
Counseling-Individual	10.92%	13.50%	11.73%	12.77%	19.35%	20.56%	13.08%	12.33%	17.85%	20.50%
Counseling-Group	1.83%	2.71%	6.60%	6.53%	6.30%	6.79%	11.31%	11.09%	11.93%	14.74%
CSP-Individual	50.27%	47.07%	45.56%	44.85%	45.20%	44.20%	37.36%	36.04%	54.38%	49.52%
CSP- Group	4.03%	3.44%	3.33%	3.62%	6.92%	7.43%	1.87%	2.06%	0.02%	0.05%
Partial Hospital	22.28%	21.30%	15.72%	14.48%	14.27%	13.67%	14.34%	15.89%	4.16%	2.89%
Cuyahoga Waiver	0.40%	0.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Totals	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: ODMH MACSIS statistics from DataMart Website

Table 4A-10: Medicaid Rate Ceilings

Diagnostic Service	Fiscal Year 2000 and 2001	Fiscal Year 2002 and 2003
Medication/Somatic Services	$210.87	$210.87
Diagnostic Assessment Services	$129.99	$129.99
Counseling, Individual	$90.01	$90.01
Counseling, Group (using Client Hour)	$39.48	$39.48
Crisis Intervention	$141.26	$154.35
Partial Hospitalization Services	$116.81	$116.81
Community Support Program, Individual	$85.33	$85.33
Community Support Program, Group	$39.25	$39.25
Pre-hospitalization/Screening Services	$170.50	N/A

Source: ODMH

Table 4A-11: Medicaid Cost to Rate Ceilings for FY of 2000 and 2001

Diagnostic Service	Rate Ceiling	CMHB	CMHB Difference	Franklin MHB	Franklin Difference	Hamilton MHB	Hamilton Difference
Fiscal Year 2000							
Crisis Intervention	$141.26	$129.15	91.4%	$78.34	55.5%	$89.45	63.3%
Pre-hospital Screening	$170.50	$141.61	83.1%	$128.76	75.5%	$158.18	92.8%
Diagnostic Assessment	$129.99	$105.88	81.5%	$97.36	74.9%	$94.50	72.7%
Med Somatic	$210.87	$176.76	83.8%	$166.89	79.1%	$148.04	70.2%
Counseling- Individual	$90.01	$84.83	94.3%	$79.46	88.3%	$81.04	90.0%
Counseling-Group	$39.48	$26.44	67.0%	$26.99	68.4%	$30.82	78.1%
CSP-Individual	$85.33	$79.86	93.6%	$73.90	86.6%	$67.60	79.2%
CSP-Group	$39.25	$30.77	78.4%	$25.35	64.6%	$28.73	73.2%
Partial Hospital	$116.81	$110.05	94.2%	$104.98	89.9%	$110.72	94.8%
Fiscal Year 2001							
Crisis Intervention	$141.26	$139.42	98.7%	$80.88	57.3%	$92.37	65.4%
Pre-hospital Screening	$170.50	$141.43	83.0%	$119.08	69.8%	$151.88	89.1%
Diagnostic Assessment	$129.99	$114.08	87.8%	$89.69	69.0%	$101.06	77.7%
Med Somatic	$210.87	$193.55	91.8%	$166.46	78.9%	$162.43	77.0%
Counseling- Individual	$90.01	$85.74	95.3%	$82.58	91.7%	$83.94	93.3%
Counseling-Group	$39.48	$27.36	69.3%	$29.08	73.7%	$32.59	82.5%
CSP-Individual	$85.33	$83.27	97.6%	$77.21	90.5%	$71.22	83.5%
CSP-Group	$39.25	$32.91	83.9%	$33.22	84.6%	$26.43	67.3%
Partial Hospital	$116.81	$111.44	95.4%	$108.73	93.1%	$113.33	97.0%

Source: ODMH MACSIS statistics from DataMart Web site.

Table 4A-12: Overall Non-Medicaid Spending for FY 2000 and 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
FY 2000						
Consumers	15,558	16,837	10,744	6,524	2,791	9,224
Consumers Serviced[1]	33,145	37,420	26,142	16,033	5,235	21,208
Average Number of Services per Consumer	2.1	2.2	2.4	2.5	1.9	2.3
Units Billed	425,171	365,266	407,781	105,040	29,566	226,913
Average Units	27.3	21.7	38.0	16.1	10.6	24.6
Cost	$29,564,151	$30,862,229	$20,865,669	$10,843,851	$2,847,788	$16,354,884
Cost per Consumer	$1,900	$1,833	$1,942	$1,662	$1,020	$1,773
FY 2001						
Consumers	13,079	16,483	10,693	6,062	3,372	9,153
Consumers Serviced[1]	28,606	36,314	24,890	14,814	7,001	20,755
Average Number of Services per Consumer	2.2	2.2	2.3	2.4	2.1	2.3
Units Billed	458,511	356,717	305,487	92,683	43,611	199,625
Average Units	35.1	21.6	28.6	15.3	12.9	21.8
Cost	$30,709,336	$30,269,916	$19,837,517	$9,634,784	$3,990,948	$15,933,291
Cost per Consumer	$2,348	$1,836	$1,855	$1,589	$1,184	$1,741
Percent of Change						
Consumers	(15.9%)	(2.1%)	(0.5%)	(7.1%)	20.8%	(0.8%)
Consumers Serviced[1]	(13.7%)	(3.0%)	(4.8%)	(7.6%)	33.7%	(2.1%)
Average Number of Services per Consumer	4.8%	(0.0%)	(4.2%)	(4.0%)	10.5%	0.0%
Units Billed	7.8%	(2.3%)	(25.1%)	(11.8%)	47.5%	(12.0%)
Average Units	28.6%	(0.5%)	(24.7%)	(5.0%)	21.7%	(11.4%)
Cost	3.9%	1.9%	(4.9%)	(11.1%)	40.1%	(2.6%)
Cost per Consumer	23.6%	0.2%	(4.5%)	(4.4%)	16.1%	(1.8%)

Source*:* ODMH MACSIS statistics from DataMart Web site.

[1] Consumers serviced will not equal the number of consumers because a consumer may receive several services.

Table 4A-13: Non-Medicaid Spending by Age Group for FY 2000

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	4,060	3,742	2,018	1,007	379	1,787
Cost	$8,887,140	$4,974,806	$4,969,979	$1,898,815	$228,582	$3,018,046
Average Cost per Consumer	$2,189	$1,329	$2,463	$1,886	$603	$1,689
Age 18 plus						
Consumers	12,148	13,222	8,807	5,545	2,423	7,499
Cost	$20,677,011	$25,887,425	$15,895,688	$8,945,035	$2,619,206	$13,336,839
Average Cost per Consumer	$1,702	$1,958	$1,805	$1,613	$1,081	$1,778
Total FY 2000						
Consumers	15,558	16,837	10,744	6,524	2,791	9,224
Cost	$29,654,151	$30,862,229	$20,865,669	$10,843,851	$2,847,788	$16,354,884
Average Cost per Consumer	$1,906	$1,833	$1,942	$1,662	$1,020	$1,773

Source*:* ODMH MACSIS statistics from DataMart Web site.
Note: Age groups will not equal total consumers because consumers turning 18 years old during the year will be captured twice.

Table 4A-14: Non-Medicaid Spending by Age Group for FY 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	2,888	3,356	1,856	885	378	1,619
Cost	$7,912,361	$4,835,804	$4,471,752	$1,556,456	$311,725	$2,793,934
Average Cost per Consumer	$2,740	$1,441	$2,409	$1,759	$825	$1,726
Age 18 Plus						
Consumers	10,278	13,205	8,903	5,195	3,006	7,577
Cost	$22,796,978	$25,434,113	$15,365,764	$8,078,327	$3,679,222	$13,139,357
Average Cost per Consumer	$2,218	$1,926	$1,726	$1,555	$1,224	$1,734
Total FY 2001						
Consumers	13,079	16,483	10,693	6,062	3,372	9,153
Cost	$30,709,336	$30,269,916	$19,837,517	$9,634,784	$3,990,948	$15,933,291
Average Cost per Consumer	$2,348	$1,836	$1,855	$1,589	$1,184	$1,741

Source*:* ODMH MACSIS statistics from DataMart Web site.
Note: Age groups will not equal total consumers because consumers turning 18 years old during the year will be captured twice.

Table 4A-15: Non-Medicaid Percent Change from FY 2000 to FY2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Age 0 thru 17						
Consumers	(28.9%)	(10.3%)	(8.0%)	(12.1%)	(0.3%)	(9.4%)
Cost	(11.0%)	(2.8%)	(10.0%)	(18.0%)	36.4%	(7.4%)
Average Cost per Consumer	25.1%	8.4%	(2.2%)	(6.7%)	36.8%	2.2%
Age 18 Plus						
Consumers	15.4%	(0.1%)	1.1%	(6.3%)	24.0%	1.0%
Cost	10.3%	(1.8%)	(3.3%)	(9.7%)	40.5%	(1.5%)
Average Cost per Consumer	30.3%	(1.6%)	(4.4%)	(3.6%)	13.2%	(2.5%)
Total						
Consumers	(15.9%)	(2.1%)	(0.5%)	(7.1%)	20.8%	(0.8%)
Cost	3.9%	(1.9%)	(4.9%)	(11.1%)	40.1%	(2.6%)
Average Cost per Consumer	23.2%	0.2%	(4.5%)	(4.4%)	16.1%	(1.8%)

Source*:* ODMH MACSIS statistics from DataMart Web site.
Note: Age groups will not equal total consumers because consumers turning 18 years old during the year will be captured twice.

Table 4A-16: CMHB Non-Medicaid Spending by Service

	Units			Cost		
Diagnostic Service	**2000**	**2001**	**Percent Difference**	**2000**	**2001**	**Percent Difference**
Crisis Intervention	7,356	6,131	(16.6%)	$932,318	$700,966	(24.8%)
Pre-hospital Screening	4,823	6,292	30.5%	$533,831	$615,291	15.3%
Diagnostic Assessment	6,676	6,908	3.5%	$710,307	$798,371	12.4%
Med Somatic	10,757	13,072	21.5%	$2,032,640	$2,574,215	26.6%
Counseling-Individual	12,884	11,937	(7.4%)	$1,087,244	$1,006,683	(7.4%)
Counseling-Group	3,052	3,239	6.1%	$79,374	$78,221	(1.5%)
CSP-Individual	105,431	87,617	(16.9%)	$8,257,574	$7,028,950	(14.8%)
CSP-Group	6,428	6,313	(1.8%)	$167,432	$133,685	(20.2%)
Partial Hospitalization	17,447	14,934	(14. %)	$1,917,391	$1,571,624	(18.0%)
Cuyahoga Waiver	3	0	(100.0%)	$4,806	$0	(100.0%)
Vocational Services	43,201	39,647	(8.2%)	$1,121,616	$1,061,295	(5.4%)
Employment Services	4,053	5,125	26.5%	$239,316	$438,657	83.3%
Residential Treatment-Cmp	23,909	35,715	49.4%	$3,029,472	$4,835,848	59.6%
Residential Treatment-Fac	10,379	4,675	(55.0%)	$1,212,987	$816,343	(32.7%)
Foster Care	3,645	2,817	(22.7%)	$426,838	$351,962	(17.5%)
Housing	49,146	24,277	(50.6%)	$1,123,285	$803,864	(28.4%)
Respite Bed	25,811	110,586	328.5%	$824,413	$2,700,829	227.6%
Crisis Bed	1,524	1,272	(16.5%)	$394,312	$328,938	(16.6%)
Hotline	5,692	5,707	0.3%	$475,056	$535,824	12.8%
Consultation	3,244	2,464	(24.0%)	$542,254	$390,197	(28.0%)
Prevention	0	708	100.0%	0	$59,191	100.0%
Info & Referral	2,197	1,937	(11.8%)	$132,807	$148,089	11.5%
Other MH	77,513	67,138	(13.4%)	$4,318,877	$3,730,293	(13.6%)
Totals	**425,171**	**458,511**	**7.8%**	**$29,564,151**	**$30,709,336**	**3.8%**

Source: ODMH MACSIS statistics at DataMart Web site

Table 4A-17: Peer Non-Medicaid Spending by Service: FY 2000

Diagnostic Services	Franklin MHB		Hamilton MHB		Lucas MHB		Stark MHB	
	Units	Cost	Units	Cost	Units	Cost	Units	Cost
Crisis Intervention	52,941	$4,114,567	420	$39,916	5,468	$618,622	2,428	$296,243
Prehospital Screening	706	$88,679	11	$1,743	648	$105,603	1,982	$303,383
Diagnostic Assessment	17,046	$1,689,097	4,729	$406,469	7,655	$967,624	551	$47,528
Med Somatic	27,386	$4,539,036	11,267	$1,642,316	17,065	$3,106,766	6,149	$945,698
Counseling-Individual	24,697	$1,839,448	31,566	$2,526,078	9,191	$684,511	2,229	$144,160
Counseling-Group	19,202	$423,953	6,798	$192,821	10,269	$353,802	2,160	$64,627
CSP-Individ	98,162	$7,193,988	84,350	$5,646,811	30,104	$2,499,230	10,319	$718,753
CSP-Group	6,025	$149,271	9,900	$286,254	2,728	$96,711	N/P	N/P
Partial Hospital	14,210	$1,428,603	5,288	$547,336	8,357	$947,704	471	$41,247
Social Recreation	2,260	$172,664	24,381	$665,518	N/P	N/P	N/P	N/P
Vocational Services	4,972	$457,516	57,478	$802,946	N/P	N/P	N/P	N/P
Employment Services	6,331	$215,477	3,587	$147,751	N/P	N/P	N/P	N/P
Residential Trmt-Cmp	7,639	$1,150,362	N/P	N/P	N/P	N/P	445	$55,866
Residential Trmt-Fac	19,398	$1,915,656	21,759	$1,136,624	N/P	N/P	980	$69,740
Residual Support	2,459	$237,352	2,309	$32,211	9,066	$1,225,364	1,834	$159,821
Community Residence	28,582	$3,079,737	78,582	$1,485,986	N/P	N/P	N/P	N/P
Consultation	73	$6,989	N/P	N/P	N/P	N/P	N/P	N/P
Community Education	148	$9,847	N/P	N/P	N/P	N/P	N/P	N/P
Adjunctive Therapy	N/P	N/P	1,601	$53,174	N/P	N/P	N/P	N/P
Foster Care	N/P	N/P	1,206	$112,098	629	$51,691	N/P	N/P
Housing	N/P	N/P	9,027	$1,279,448	N/P	N/P	N/P	N/P
Respite Bed	N/P	N/P	1,228	$106,593	N/P	N/P	N/P	N/P
Crisis Bed	N/P	N/P	1,812	$230,921	3,860	$186,223	N/P	N/P
Prevention	N/P	N/P	10,122	$601,828	N/P	N/P	N/P	N/P
Hotline	N/P	N/P	N/P	N/P	N/P	N/P	4	$70
Info/Referral	N/P	N/P	N/P	N/P	N/P	N/P	1	$12
Other MH	33,029	$2,149,987	40,360	$2,920,827	N/P	N/P	13	$640
Totals	**365,266**	**$30,862,229**	**407,781**	**$20,865,669**	**105,040**	**$10,843,851**	**29,566**	**$2,847,788**

Source: ODMH MACSIS statistics from DataMart Web site.
Note: N/P equals service not provided

Table 4A-18: Peer Non-Medicaid Spending by Service: FY 2001

Diagnostic Services	Franklin MHB		Hamilton MHB		Lucas MHB		Stark MHB	
	Units	Cost	Units	Cost	Units	Cost	Units	Cost
Crisis Intervention	51,195	$4,092,717	56	$5,210	5,169	$637,530	1,598	$186,831
Prehospital Screening	494	$55,985	5	$838	394	$56,114	1,208	$168,866
Diagnostic Assessment	16,469	$1,349,527	4,350	$391,701	6,636	$796,407	1,579	$173,658
Med Somatic	28,588	$4,477,896	9,538	$1,518,369	15,615	$2,804,476	6,044	$936,414
Counseling-Individual	25,401	$1,965,976	26,630	$2,166,338	7,694	$581,831	6,683	$495,862
Counseling-Group	16,562	$387,063	7,402	$233,578	8,753	$309,660	3,657	$112,652
CSP-Individ	87,777	$6,673,395	84,542	$5,927,448	29,200	$2,471,855	13,674	$1,031,404
CSP-Group	7,055	$236,241	11,618	$297,747	2,288	$78,661	N/P	N/P
Partial Hospital	12,724	$1,354,737	4,043	$466,486	6,886	$781,026	1,362	$149,334
Social Recreation	1,508	$123,095	3,743	$152,451	N/P	N/P	N/P	N/P
Vocational Services	5,118	$385,253	37,372	$622,073	N/P	N/P	N/P	N/P
Employment Services	3,270	$108,837	4,501	$205,505	N/P	N/P	N/P	N/P
Residential Trmt-Cmp	2,316	$314,061	N/P	N/P	N/P	N/P	2,724	$284,046
Residential Trmt-Fac	22,971	$2,832,488	18,874	$1,122,190	N/P	N/P	2,821	$217,537
Residual Support	1,364	$143,686	659	$23,447	5,502	$905,742	2,260	$234,340
Community Residence	33,464	$3,390,989	10,937	$207,475	N/P	N/P	N/P	N/P
Consultation	10	$619	N/P	N/P	N/P	N/P	N/P	N/P
Community Education	277	$25,642	N/P	N/P	N/P	N/P	N/P	N/P
Adjunctive Therapy	N/P	N/P	670	$32,639	N/P	N/P	N/P	N/P
Foster Care	N/P	N/P	1,341	$119,470	323	$26,547	N/P	N/P
Housing	N/P	N/P	2,625	$193,595	N/P	N/P	N/P	N/P
Respite Bed	N/P	N/P	10,763	$1,830,879	N/P	N/P	N/P	N/P
Crisis Bed	N/P	N/P	2,841	$321,317	4,223	$184,935	N/P	N/P
Prevention	98	$6,961	9,130	$573,705	N/P	N/P	N/P	N/P
Hotline	1	$31	N/P	N/P	N/P	N/P	1	$4
Info/Referral	N/P	N/P	N/P	N/P	N/P	N/P	N/P	N/P
Other MH	40,085	$2,344,717	53,847	$3,425,056	N/P	N/P	N/P	N/P
Totals	**356,747**	**$30,269,916**	**305,487**	**$19,837,517**	**92,683**	**$9,634,784**	**43,611**	**$3,990,948**

Source: ODMH MACSIS statistics from DataMart Web site.
Note: N/P equals service not provided

Table 4A-19: Non-Medicaid Service Units: Percent of Total Units

Diagnostic Services	CMHB		Franklin MHB		Hamilton MHB		Lucas MHB		Stark MHB	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
Crisis Intervention	1.73%	1.34%	14.49%	14.35%	0.10%	0.02%	5.21%	5.58%	8.21%	3.66%
Pre-hospital Screening	1.13%	1.37%	0.19%	0.14%	0.00%	0.00%	0.62%	0.43%	6.70%	2.77%
Diagnostic Assessment	1.57%	1.51%	4.67%	4.62%	1.16%	1.42%	7.29%	7.16%	1.86%	3.62%
Med Somatic	2.53%	2.85%	7.50%	8.01%	2.76%	3.12%	16.25%	16.85%	20.80%	13.86%
Counseling-Individual	3.03%	2.60%	6.76%	7.12%	7.74%	8.72%	8.75%	8.30%	7.54%	15.32%
Counseling- Group	0.72%	0.71%	5.26%	4.64%	1.67%	2.42%	9.78%	9.44%	7.31%	8.39%
CSP- Individual	24.80%	19.11%	26.87%	24.60%	20.69%	27.67%	28.66%	31.51%	34.90%	31.35%
CSP- Group	1.51%	1.38%	1.65%	1.98%	2.43%	3.80%	2.60%	2.47%	0.00%	0.00%
Partial Hospitalization	4.10%	3.26%	3.89%	3.57%	1.30%	1.32%	7.96%	7.43%	1.59%	3.12%
Cuyahoga Waiver	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Social Recreation	0.00%	0.00%	0.62%	0.42%	5.98%	1.23%	0.00%	0.00%	0.00%	0.00%
Vocational Services	10.16%	8.65%	1.36%	1.43%	14.10%	12.23%	0.00%	0.00%	0.00%	0.00%
Employment Services	0.95%	1.12%	1.73%	0.92%	0.88%	1.47%	0.00%	0.00%	0.00%	0.00%
Residential Treatment- Cmp	5.62%	7.79%	2.09%	0.65%	0.00%	0.00%	0.00%	0.00%	1.51%	6.25%
Residential Treatment- Fac	2.44%	1.02%	5.31%	6.44%	5.34%	6.18%	0.00%	0.00%	3.31%	6.47%
Residual Support	0.00%	0.00%	0.67%	0.38%	0.57%	0.22%	8.63%	5.94%	6.20%	5.18%
Community Residence	0.00%	0.00%	7.82%	9.38%	19.27%	3.58%	0.00%	0.00%	0.00%	0.00%
Community Education	0.00%	0.00%	0.04%	0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Adjunctive Therapy	0.00%	0.00%	0.00%	0.00%	0.39%	0.22%	0.00%	0.00%	0.00%	0.00%
Foster Care	0.86%	0.61%	0.00%	0.00%	0.30%	0.44%	0.60%	0.35%	0.00%	0.00%
Housing	11.56%	5.29%	0.00%	0.00%	2.21%	0.86%	0.00%	0.00%	0.00%	0.00%
Respite Bed	6.07%	24.12%	0.00%	0.00%	0.30%	3.52%	0.00%	0.00%	0.00%	0.00%
Crisis Bed	0.36%	0.28%	0.00%	0.00%	0.44%	0.93%	3.67%	4.56%	0.00%	0.00%
Hotline	1.34%	1.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%
Consultation	0.76%	0.54%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Prevention	0.00%	0.15%	0.00%	0.03%	2.48%	2.99%	0.00%	0.00%	0.00%	0.00%
Info & Referral	0.52%	0.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other MH	18.23%	14.64%	9.04%	11.24%	9.90%	17.63%	0.00%	0.00%	0.04%	0.00%
Totals	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: ODMH MACSIS statistics from DataMart Website

Table 4A-20: Non-Medicaid Average Cost for FY 2000

Diagnostic Service	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average	Percent Difference
Crisis Intervention	$126.74	$77.72	$95.04	$113.13	$122.01	$82.76	53.2%
Pre-hospital Screening	$110.68	$125.61	$158.45	$162.97	$153.07	$149.21	(25.8%)
Diagnostic Assessment	$106.40	$99.09	$85.95	$126.40	$86.26	$103.76	2.6%
Med Somatic	$188.96	$165.74	$145.76	$182.05	$153.80	$165.42	14.2%
Counseling-Individual	$84.39	$74.48	$80.03	$74.48	$64.67	$76.74	10.0%
Counseling-Group	$26.01	$22.08	$28.36	$34.45	$29.92	$26.94	(3.5%)
CSP-Individual	$78.32	$73.29	$66.95	$83.02	$69.65	$72.03	8.7%
CSP-Group	$26.05	$24.78	$28.91	$35.45	N/P	$28.53	(8.7%)
Partial Hospitalization	$109.90	$100.54	$103.51	$113.40	$87.57	$104.67	5.0%
Cuyahoga Waiver	$1602.00	N/A	N/A	N/A	N/A	N/A	N/A
Vocational Services	$25.96	$92.02	$13.97	N/P	N/P	$20.18	28.6%
Employment Services	$59.05	$34.04	$41.19	N/P	N/P	$36.62	61.2%
Residential Treatment-Cmp	$126.71	$150.59	N/P	N/P	$125.54	$149.21	(15.1%)
Residential Treatment-Fac	$116.87	$98.76	$52.24	N/P	$71.16	$74.09	57.7%
Foster Care	$117.10	N/P	$92.95	$82.18	N/P	$89.26	31.2%
Housing	$22.86	N/P	$141.74	N/P	N/P	$141.74	(83.9%)
Respite Bed	$31.94	N/P	$86.80	N/P	N/P	$86.80	(63.2%)
Crisis Bed	$258.74	N/P	$127.44	$48.24	N/P	$73.54	251.8%
Hotline	$83.46	N/P	N/P	N/P	$17.50	$17.50	376.9%
Consultation	$167.16	$95.74	N/P	N/P	N/P	$95.74	74.6%
Prevention	N/P $	N/P	$59.46	N/P	N/P	$59.46	N/P
Info & Referral	$60.45	N/P	N/P	N/P	$12.00	$12.00	403.8%
Other MH	$55.72	$65.09	$72.37	N/P	$49.23	$69.09	(19.4%)
Average Unit Cost	**$69.54**	**$84.49**	**$51.17**	**$103.24**	**$96.32**	**$72.08**	**(3.5%)**

Source: ODMH MACSIS statistics from DataMart Web site.
Note 1: N/P equals service not provided
Note 2: N/A equals not applicable
Note 3: CMHB unit costs are calculated from **Table 4A-16** and peer unit costs are calculated from **Table 4A-17**.

Table 4A-21: Non-Medicaid Average Cost for FY 2001

Diagnostic Service	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average	Percent Difference
Crisis Intervention	$114.33	$79.94	$93.04	$123.34	$116.92	$84.84	34.8%
Pre-hospital Screening	$97.79	$113.33	$167.60	$142.42	$139.79	$134.13	(27.1%)
Diagnostic Assessment	$115.57	$81.94	$90.05	$120.01	$109.98	$93.38	23.8%
Med Somatic	$196.93	$156.80	$159.19	$179.60	$154.93	$162.95	20.9%
Counseling-Individual	$84.33	$77.40	$81.35	$75.62	$74.20	$78.45	7.5%
Counseling-Group	$24.15	$23.37	$31.56	$35.38	$30.80	$28.67	(15.8%)
CSP-Individual	$80.22	$76.03	$70.11	$84.65	$75.43	$74.84	7.2%
CSP-Group	$21.18	$33.49	$25.63	$34.38	N/P	$29.23	(27.5%)
Partial Hospitalization	$105.24	$106.47	$115.38	$113.42	$109.64	$110.00	(4.3%)
Vocational Services	$26.77	$75.27	$16.65	N/P	N/P	$23.71	12.9%
Employment Services	$85.59	$33.28	$45.66	N/P	N/P	$40.45	111.6%
Residential Treatment-Cmp	$135.40	$135.60	N/P	N/P	$104.28	$118.67	14.1%
Residential Treatment-Fac	$174.62	$123.31	$59.46	N/P	$77.11	$93.41	86.9%
Foster Care	$124.94	N/P	$89.09	$82.19	N/P	$87.75	42.4%
Housing	$33.11	N/P	$73.75	N/P	N/P	$73.75	(55.1%)
Respite Bed	$24.42	N/P	$170.11	N/P	N/P	$170.11	(85.6%)
Crisis Bed	$258.60	N/P	$113.10	$43.79	N/P	$71.67	260.8%
Hotline	$93.89	$31.00	N/P	N/P	$4.00	$17.50	436.5%
Consultation	$158.36	$61.90	N/P	N/P	N/P	$61.90	155.8%
Prevention	$83.60	$71.03	$62.84	N/P	N/P	$62.92	32.9%
Info & Referral	$76.45	N/P	N/P	N/P	N/P	N/P	N/P
Other MH	$55.56	$58.49	$63.61	N/P	N/P	$61.42	(9.6%)
Average Unit Cost	**$66.98**	**$84.85**	**$64.94**	**$103.95**	**$91.51**	**$79.82**	**(16.1%)**

Source: ODMH MACSIS statistics from DataMart Web site.
Note 1: N/P equals service not provided
Note 2: Peer unit costs calculated from **Table 4A-18**
Note 3: CMHB unit costs were developed from **Table 4A-16**.

Table 4A-22: SMD Consumers and Spending

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
Fiscal Year 2000						
Consumers	14,001	10,843	9,954	6,424	3,290	7,628
Units	751,358	599,585	647,148	244,719	145,433	409,221
Cost	$64,463,019	$50,713,464	$39,659,707	$24,811,066	$12,059,203	$31,810,860
Units per Consumer	53.7	55.3	65.0	38.1	44.2	53.7
Cost per Unit	$85.80	$84.58	$61.28	$101.39	$82.92	$77.74
Cost per Consumer	$4,604	$4,677	$3,984	$3,862	$3,665	$4,170
Fiscal Year 2001						
Consumers	14,807	11,281	9,921	6,437	3,693	7,833
Units	782,292	593,919	560,619	227,613	151,033	383,296
Cost	$67,653,744	$51,632,036	$40,020,884	$23,340,472	$12,684,141	$31,919,383
Units per Consumer	52.8	52.6	56.5	35.4	40.9	48.9
Cost per Unit	$86.48	$86.93	$71.39	$102.54	$83.98	$83.28
Cost per Consumer	$4,569	$4,577	$4,034	$3,626	$3,435	$4,075
Percent of Change						
Consumers	5.8%	4.0%	(0.3%)	0.2%	12.2%	2.7%
Units	4.1%	(0.9%)	(13.3%)	(6.9%)	3.9%	(6.3%)
Cost	4.9%	1.8%	0.9%	(5.9%)	5.2%	0.3%
Units per Consumer	(1.7%)	(4.9%)	(13.1%)	(7.1%)	(7.5%)	(8.9%)
Cost per Unit	0.8%	2.8%	16.5%	1.1%	1.3%	7.1%
Cost per Consumer	(0.8%)	(2.1%)	1.3%	(6.1%)	(6.3%)	(5.3%)

Source: ODMH MACSIS statistics at DataMart Web site.

Table 4A-23: SMD and non-SMD Spending for FY 2000

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
FY 2000						
Total Mental Health						
Consumers	30,871	28,420	20,085	13,742	7,138	17,346
Units Billed	886,086	743,999	725,170	285,085	169,470	480,931
Cost	$74,556,448	$62,186,263	$44,970,731	$28,402,794	$14,400,324	$37,490,028
Units per Consumer	28.7	26.2	36.1	20.8	23.7	27.7
Cost per Unit	$84.14	$83.58	$62.01	$99.63	$84.97	$77.95
Cost per Consumer	$2,415	$2,188	$2,239	$2,067	$2,017	$2,161
SMD						
Consumers	14,001	10,843	9,954	6,424	3,290	7,628
Units Billed	751,358	599,585	647,148	244,719	145,433	409,221
Cost	$64,463,019	$50,713,464	$39,659,707	$24,811,066	$12,059,203	$31,810,860
Units per Consumer	53.7	55.3	65.0	38.1	44.2	53.7
Cost per Unit	$85.80	$84.58	$61.28	$101.39	$82.92	$77.74
Cost per Consumer	$4,604	$4,677	$3,984	$3,862	$3,665	$4,170
non-SMD						
Consumers	16,870	17,577	10,131	7,318	3,848	9,719
Percent of Consumers[1]	54.6%	61.9%	50.4%	53.2%	53.9%	56.0%
Units Billed	134,728	144,414	78,022	40,366	24,037	71,710
Percent of Units Billed[1]	15.2%	19.4%	10.8%	14.2%	14.2%	14.9%
Cost	$10,093,420	$11,472,799	$5,311,024	$3,591,728	$2,341,121	$5,679,168
Percent of Cost[1]	13.5%	18.4%	11.8%	12.6%	16.3%	15.1%
Units per Consumer	8.0	8.2	7.7	5.5	6.2	7.4
Cost per Unit	$74.92	$79.44	$68.07	$88.98	$97.40	$79.20
Cost per Consumer	$598	$653	$524	$491	$608	$584

Source: ODMH MACSIS statistics at DataMart Web site.
[1] Shown as percent of total mental health

Table 4A-24: SMD and non-SMD Spending for FY 2001

	CMHB	Franklin MHB	Hamilton MHB	Lucas MHB	Stark MHB	Peer Average
FY 2001						
Total Mental Health						
Consumers	30,238	29,317	21,012	13,650	8,209	18,047
Units Billed	926,926	732,960	640,491	267,134	175,810	454,099
Cost	$78,654,631	$62,456,765	$46,118,879	$26,958,586	$15,109,759	$37,660,997
Units per Consumer	30.6	25.0	30.5	19.6	21.4	25.2
Cost per Unit	$84.86	$85.21	$72.01	$100.92	$85.94	$82.94
Cost per Consumer	$2,601	$2,130	$2,195	$1,975	$1,841	$2,087
SMD						
Consumers	14,807	11,281	9,921	6,437	3,693	7,833
Units Billed	782,292	593,919	560,619	227,613	151,033	383,296
Cost	$67,653,744	$51,632,036	$40,020,884	$23,340,472	$12,684,141	$31,919,383
Units per Consumer	52.8	52.6	56.5	35.4	40.9	48.9
Cost per Unit	$86.48	$86.93	$71.39	$102.54	$83.98	$83.28
Cost per Consumer	$4,569	$4,577	$4,034	$3,626	$3,435	$4,075
Non-SMD						
Consumers	15,431	18,036	11,091	7,213	4,516	10,214
Percent of Consumers[1]	51.0%	61.5%	52.8%	52.8%	55.0%	56.6%
Units Billed	144,634	139,041	79,872	39,521	24,777	70,803
Percent of Units Billed[1]	15.6%	19.0%	12.5%	14.8%	14.1%	15.6%
Cost	$11,000,887	$10,824,729	$6,097,995	$3,618,114	$2,425,618	$5,741,614
Percent of Cost[1]	14.0%	17.3%	13.2%	13.4%	16.1%	15.2%
Units per Consumer	9.4	7.7	7.2	5.5	5.5	6.9
Cost per Unit	$76.06	$77.85	$76.35	$91.55	$97.90	$81.09
Cost per Consumer	$713	$600	$550	$502	$537	$562

Source: ODMH MACSIS statistics from DataMart Web site.
[1] Shown as percent of total mental health

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Technology Use and Claims Services

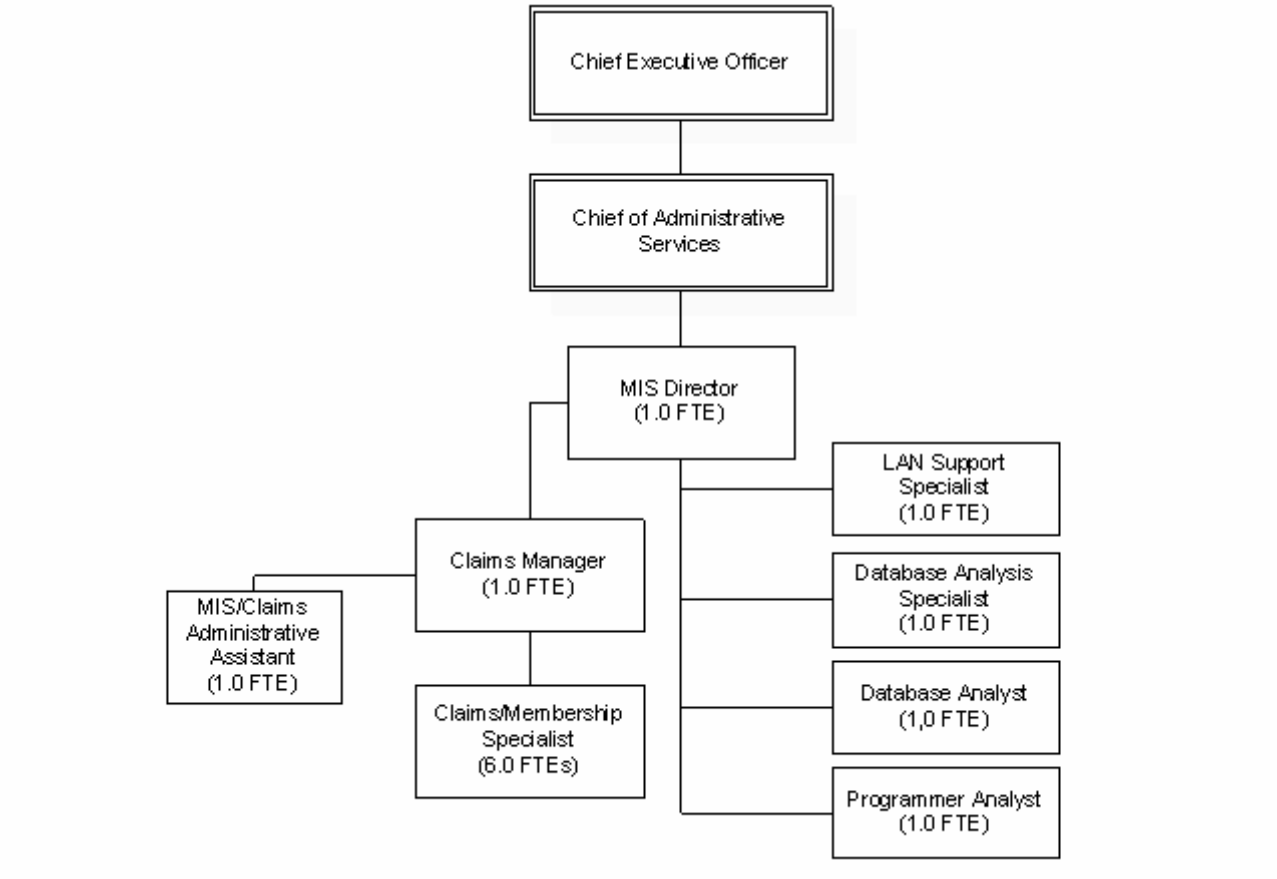
Background

This section of the performance audit focuses on the Management Information Systems Unit (MIS Unit), as well as the Claims and Membership Services Unit (CMS Unit), of the Cuyahoga County Community Mental Health Board (CMHB). The MIS Unit is responsible for agency-wide technology use while the CMS Unit focuses on claims billing and processing functions.

Organizational Chart

Chart 5-1 illustrates the structure of both the MIS and CMS Units as of January 2002.

Chart 5-1: Management Information Systems and Claims Units



Organization Function

CMHB relies on its MIS and CMS Units to ensure goals for provider information sharing and member billing are met. While CMHB serves approximately 30,000 County residents, the MIS and CMS Units are accountable to the State for maintaining standards in claims processing. In FY 2002, CMHB will receive approximately $16 million in funding from the County; however, most reporting requirements are to the State, and in turn, Federal requirements must be met as well. To support the reporting requirements of ODMH, the State provides free Multi-Agency Community Services Information System (MACSIS) hardware and software to CMHB. Overall, the MIS and CMS Units facilitate information sharing among stakeholders at the State, County, and consumer/provider levels.

The technology-related functions of CMHB are primarily performed by the MIS director and four MIS Unit staff. The claims manager also reports to the MIS director. The MIS director ordinarily reports directly to the chief of administrative services (CAS). However, this position has been vacant for nearly two years, so the MIS director currently reports to the chief executive officer (CEO). Major responsibilities of the MIS director include the following:

- Managing operations of the MIS and CMS Units; and
- Fulfilling the State-mandated role of security officer for the Multi-Agency Community Services Information System (MACSIS).

Responsibilities of the claims manager consist primarily of the following:

- Managing day-to-day operations of the CMS Unit: claims billing, processing and membership services in MACSIS;
- Overseeing development and implementation of and compliance with all policies and procedures;
- Overseeing the training, orientation, supervision and evaluation of all CMS staff; and
- Serving as a point-of-contact for CMHB staff, contracted providers, and ODMH regarding claims issues.

Summary of Operations

The MIS Unit is responsible for providing the necessary technical support, information and data communications services at CMHB. The MIS Unit assists other units and divisions at CMHB with technology issues. For example, MIS Unit staff members provide technical guidance and some software training to employees. Hardware and software purchases, implementation, as well as any network architecture and firewall security measures are maintained by the MIS Unit. Furthermore, the MIS Unit is closely involved with CMS Unit functions and data operations.

For example, the MIS Unit regularly develops data extract reports containing useful claims, member service and provider information for the CMS Unit. Management information systems activities at CMHB include the following:

- Maintenance of technical infrastructure;
- Maintenance of technology equipment (network hardware and computers);
- Provision of local area network (LAN) and other technical support to various CMHB Units;
- Aggregation of data from the State, contracted providers, and CMHB units and report preparation;
- Maintenance of in-house software applications;
- Review of technology purchases (programs, outsourced services and equipment);
- Implementation of new technologies;
- Processing and maintenance of data related to claims billing in MACSIS; and
- Maintenance of written applications based in the Massachusetts General Hospital Utility Multi-Programming System (MUMPS) used for accounting functions.

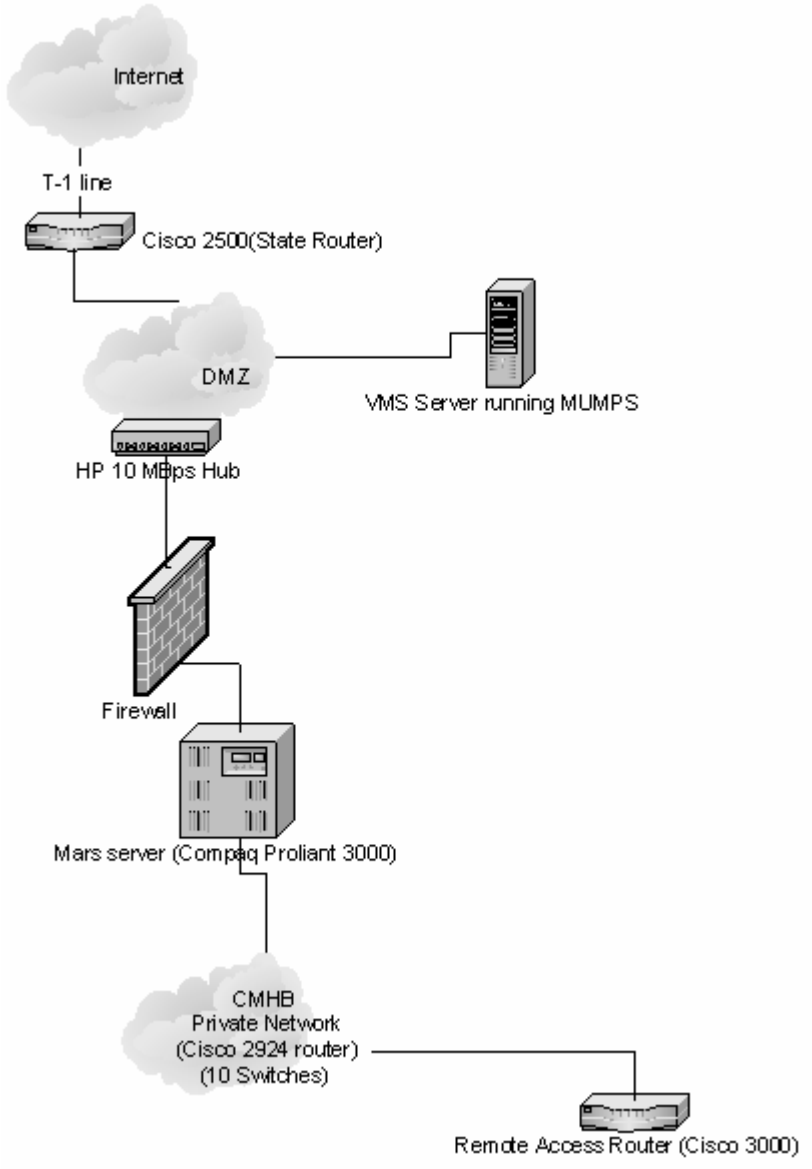
In 1999, CMHB began using the Diamond Claims Processing program in MACSIS for billing. The CMS Unit, with assistance from MIS staff, processes approximately 100 to 130 provider claim files per week, representing approximately 15,000 to 25,000 claims. Over the course of the year, CMHB will process approximately $75 million in Medicaid and non-Medicaid claims from over 100 provider agencies. Thirty-seven contracted providers are linked locally to CMHB; two of these are currently inactive. The remaining providers are located in various counties statewide and submit claims based on services provided to Cuyahoga County residents.

In addition to claims processing, enrollments and membership services are a significant part of the CMS Unit's production environment. Both claims and membership services operations are heavily dependent on the creation and submission of electronic reports by MIS Unit staff; thus, a high level of interaction is required between these two units at CMHB. While the CMS manager directly oversees the claims and enrollment activities within the Unit, the MIS director currently oversees both MIS and CMS Units due to the amount of work exchanged, the high level of coordination, and the vacancy in the chief of administrative services position. Completion of claims processing functions are also dependent on timely receipt of non-Medicaid pricing reports, a function currently performed in the Finance Unit. The MIS Unit also maintains the hardware and software used by the Finance Unit to perform accounting operations and print vouchers to be sent to the County for payment (checks are not printed at CMHB). The Executive Committee of CMHB has researched and reviewed new accounting software options to replace the current accounting system to allow for increased functionality and capability for general ledger reporting.

Technical Configuration

Computer hardware used to maintain the core information services systems are housed in a file server room located on the second floor at CMHB. **Diagram 5-1** shows the basic network architecture layout.

Diagram 5-1: CMHB Network Architecture Overview



Source: CMHB MIS Director

CMHB's network architecture includes an Internet connection via a State network T-1 line. A Cisco 2500 router is housed at CMHB but is owned and serviced by the State. A Mars server firewall provides network translation to CMHB's private network and a barrier between CMHB and the Internet. Firewalls are necessary to provide appropriate levels of system security and protect the confidentiality of mental health consumers. In addition, the Mars server provides certain network functions including: domain name server (DNS), dynamic addressing, and backup. A hub between the Internet Cisco 2500 router and the firewall provides a de-militarized zone (DMZ) for troubleshooting, monitoring, and access to the virtual memory system (VMS) Bud server which runs the MUMPS accounting system and file transfer protocol (FTP).

CMHB's private network primarily operates on a Cisco 2924 core router. From the router, information is dispersed through 10 Cisco switches and disseminated to end users. Also attached to the private network are five servers which perform various functions including: e-mail, database, Citrix solutions, and network management.

At CMHB, dial-in remote access service is provided to employees through a Cisco 3000 series router. The MIS director uses remote access to dial in to the CMHB network to perform system checks using a Citrix program solution. Contracted providers also dial in to the router to deliver and retrieve MACSIS-related electronic files (see **F5.14** for further discussion on technology architecture).

Six power supplies are used to filter power and provide run time in the event of a power failure. The power protection layout includes three units with extended battery packs.

Network Users and Equipment Summary

There are currently 85 computer workstations at CMHB. Of these, 66 are used on a regular basis, 13 are older and rarely used and 6 are available only for spare parts. Most CMHB computers are approximately four years old; however, formal equipment replacement plans have not been developed by the MIS Unit. One current MIS Unit initiative involves piloting two Citrix servers that may eventually allow the aging stock of PCs to be used as thin clients, computers without hard drives. This set-up would allow the bulk of data processing to occur on the servers, reducing the need to purchase new computers while increasing file sharing speed.

CMHB has four high-speed duplex printers and one color printer with shared network printing capabilities. In addition, employees can print to one of the large capacity copiers in the building. However, 56 workstations are also equipped with individual printers, many of which are laser printers.

Functional Overview of Software Applications

According to the MIS director, CMHB uses approximately 25 software applications, most of which include personal productivity software (such as word processing) with a functionality utilization rate of approximately 95 percent. Furthermore, the MIS Unit actively pilots and tests various applications for effectiveness and usefulness. For example, the MIS Unit is currently piloting TechExcel in the Provider Relations Unit to improve help desk support and provider relations management.

Additionally, CMHB is in the process of identifying new candidate software to perform accounting functions. The current MUMPS-based accounting system application was developed in-house approximately 10 years ago. The application runs on a virtual memory system (VMS) Bud server which is approximately 10 years old and is obsolete, offering limited functionality.

An AOS survey of CMHB technology use was distributed to all 59 CMHB employees. The purpose of the survey was to obtain user feedback on software knowledge and use, the quality of user support provided by the MIS Unit, and training needs. Responses were received from 40 employees (although not all 40 employees responded to every question), representing an overall participation rate of about 68 percent. Survey results are summarized below.

1. **Survey item:** Please estimate the percentage of time spent each day working at your computer.

Table 5-1a: Percentage of Time

1-25%		26-50%		51-75%		76-100%	
4	10%	8	21%	5	13%	21	55%

2. **Survey item**: What primary software applications are used to perform your job functions?

Table 5-1b: Primary Software Applications Used

Word Processing:	**Corel Word Perfect**		**MS Word**	
	28	72%	20	51%
Spreadsheet:	**Lotus 1-2-3**		**MS Excel**	
	5	13%	22	56%
E-mail:	**GroupWise**		**Other**	
	32	82%	0	0%
Other:	**Access**		**PowerPoint**	
	7	18%	6	15%

3. **Survey item:** How often do you feel you need assistance using a particular program?

Table 5-1c: Frequency of Technical Assistance

Often		Fairly Often		Seldom	
1	3%	2	5%	36	92%

4. **Survey item:** Would you consider additional training to be very helpful?

Table 5-1d: Benefit of Additional Computer Training

Very Helpful		Somewhat Helpful		Not Helpful	
27	69%	6	15%	4	10%

5. **Survey item:** Does your current software meet the needs of your job functions?

Table 5-1e: Needs Assessment and Functionality

Yes		Most of the Time		No	
34	87%	4	10%	0	0%

According to the survey comments, the computer is a critical tool necessary to the performance of day-to-day operations. Respondents indicate CMHB computer systems are reliable though somewhat slow. Regarding technical assistance, respondents generally express an infrequent need for help although eight percent require assistance several times per week (often or fairly often). Technical assistance is reported to be adequate and timely.

Most respondents indicate current software meets their needs. However, most feel they are not knowledgeable about all available software features. Nearly all respondents indicate an interest in attending additional computer skills training. While most respondents are confident that current software capabilities are adequate, 69 percent state they would benefit by attending either enhanced software skills training or by learning new applications.

Staffing

Table 5-2a and **5-2b** present staffing level information, by primary responsibility, for CMHB's technology and claims/membership operations. The number of staff is calculated using full-time equivalents (FTEs) as applied to individual responsibilities.

Table 5-2a: MIS Unit Staffing

Position	Budgeted Positions	Actual Number of Positions
MIS Director	1.0	1.0
LAN Support Specialist	1.0	1.0
Programmer Analyst	1.0	1.0
Database Analyst	1.0	1.0
Database Analysis Specialist	1.0	1.0
Administrative Assistant [1]	0.1	0.1
Totals	**5.1**	**5.1**

Source: CMHB

[1] Position has shared responsibilities between MIS and CMS Units.

Table 5-2b: CMS Unit Staffing

Position	Budgeted Positions	Actual Number of Positions
Claims Manager	1.0	1.0
Claims/Membership Specialist	6.0	6.0
Administrative Assistant [1]	0.9	0.9
Totals	**7.9**	**7.9**

Source: CMHB

[1] Position has shared responsibilities between MIS and CMS Units.

The MIS director is responsible for overall fiscal management of the MIS Unit and serves as liaison with other CMHB staff and the Board of Governors (BOG) regarding MIS Unit issues. The director develops departmental and organizational policies and procedures for the MIS Unit; directs the development of documents, reports, and records; and oversees management of file transfer protocol and electronic management mainly associated with MACSIS. These duties, coupled with the data security measures which must be followed in accordance with ODMH standards, result in the bulk of the director's time being spent dealing with CMS Unit issues. The director actively participates on the Executive Committee, an internal executive management team consisting of four unit managers (MIS, Provider Relations, Human Resources, and Finance), and the CEO. The MIS director serves as the primary internal and external resource on management information system hardware, software and data collection. The director is also responsible for staff hiring; training and development; and performance evaluations.

The claims manager is responsible for overall management within the CMS Unit and spends approximately 60 percent of time overseeing claims operations and 40 percent of time on member enrollment issues. The manager is the primary point of contact for providers regarding billing issues and facilitates internal communications by serving as liaison to other CMHB units such as fiscal and provider relations regarding pricing, billing and member enrollment issues. The manager is also responsible for claims/membership services staff hiring, training and development, and performance evaluations.

Other staff positions, including a brief description of associated duties, are outlined as follows:

- **LAN Support Specialist**: performs basic PC and LAN network administration functions; troubleshoots network and PC problems; installs PC hardware, software, and peripherals.

- **Programmer Analyst**: develops and programs computer system projects as assigned by the MIS director; performs operational duties associated with the maintenance, integrity and installation of CMHB computer systems.

- **Database Analyst**: develops, implements and maintains database applications; ensures data security and confidentiality.

- **Database Analysis Specialist**: provides analytical and reporting support to CMHB staff; helps ensure security and confidentiality of routinely-collected data.

- **MIS/Claims Administrative Assistant**: provides administrative support primarily to staff in the CMS Unit and maintains all information in accordance with applicable rules and procedures regarding confidentiality.

- **Claims/Membership Services Specialist**: (six staff positions) researches and validates provider claims; enrolls new members into MACSIS; enters assignment of member service plans and provider plans; researches, updates and corrects member information; performs help desk functions and serves as liaison to contracted providers for questions concerning member enrollment and claims payment status.

Financial Data

Similar to other CMHB units and divisions, budget details are not distributed to the MIS director and there are no accounting system reports available to show monthly budget appropriations and expenditures. Furthermore, the current internal accounting system does not contain general ledger capabilities, resulting in an approximated budget. The most recent MIS Unit budget information available from 1999 indicates that $150,000 was available that year. Additional financial information pertaining to all units within CMHB can be found in **finance and funding**.

Performance Measures

The following performance measures were used to analyze the MIS and CMS Units at CMHB:

- Assess adequacy and appropriateness of the MIS and CMS Unit staffing levels and organizational structure
- Assess the adequacy of technology planning activities
- Assess the adequacy and cost effectiveness of the existing technical architecture
- Determine the adequacy and cost effectiveness of CMHB hardware
- Determine the adequacy and cost effectiveness of CMHB software /major applications
- Determine the adequacy of technology training for CMHB employees
- Assess the MIS Unit's use of budget and expenditure information
- Assess the adequacy of claims department policies and procedures, performance measurement and the functionality of MACSIS billing system software

Findings / Commendations / Recommendations

MIS and CMS Unit Staffing Levels and Organization Structure

F5.1 MIS Unit staffing levels comprise approximately nine percent of total CMHB staff and are commensurate with the peers based on available workload measures. **Table 5-3a** shows the breakdown of MIS Unit staffing levels and select workload measures as compared to the peers.

Table 5-3a: MIS Unit Staffing Levels as Compared to Peers

	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average	CMHB to Peer Average
MIS Staff	5.1 [1]	4.0	2.0	2.0	2.7	2.4
Total Staff	59.0	51.3	21.0	20.9	31.1	27.9
MIS to Total Staff	8.6%	7.8%	9.5%	9.6%	8.7%	(0.1) %
Number of Active Workstations	66 [2]	63 [3]	26	44 [4]	44	22
Workstations to MIS Staff	12.9	15.8	13.0	22.0	16.3	(3.4)

Source: CMHB and peer MHBs

[1] Includes administrative assistant who spends approximately 10 percent of her time supporting the MIS Unit.

[2] CMHB maintains a total of 85 workstations, 13 of which are older and rarely used while 6 are used for spare parts.

[3] Franklin MHB maintains a total of 71 workstations, 8 of which are used in a lab setting and as spares.

[4] Thirteen of the 44 computers maintained by Stark MIS staff are used by the Stark County Family Council.

The MIS Unit comprises 8.6 percent of CMHB's total staff, which is in line with the peer average. Although CMHB actively maintains 22 more workstations than the peer average, the MIS Unit is responsible for approximately 3 fewer workstations per MIS staff member than the peer average. Nonetheless, CMHB's technology outsourcing costs are nearly half that of Franklin MHB, indicating that CMHB's MIS Unit staff provide more services in-house (see **F5.5**). This may explain CMHB's relatively high number of MIS Unit staff. Since the MIS Unit does not track computer service requests, and lacks reliable budgetary information (see **F5.22**), appropriate unit staffing levels are difficult to determine.

R5.1 The MIS Unit should track computer service requests to identify those areas which frequently require technical assistance. This information can be used to guide computer related training for CMHB staff (see **F5.21**). The MIS director could also aggregate data on frequently asked questions and provide solutions to common technical problems through such means as the intranet, internal memos or an employee newsletter as discussed in **external affairs**. Additionally, the number and frequency of computer

service requests can be used as a potential workload measure which could provide justification for staffing adjustments by the MIS director. Maintaining appropriate staffing levels helps ensure a balanced workload and increased morale among staff members.

F5.2 The CMS Unit appears to operate efficiently with its current level of staffing. **Table 5-3b** shows the breakdown of CMS Unit staffing levels and available workload measures as compared to the peers.

Table 5-3b: CMS Unit Staffing Levels as Compared to Peers

	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average	CMHB to Peer Average
Claims Staff	4.1 [1]	6.0	2.0	2.0 [2]	3.3	0.8
Total Annual Claims	1.3 M	1.4 M	0.4 M	0.7 M	0.8 M	0.5 M
Claims to Claims Staff	317,100	233,300	200,000	350,000	242,400	74,700
Enrollment Staff	2.9	5.0	2.5	2.0	3.2	(0.3)
Total Annual Member Enrollments	22,800	14,400	7,500	4,800	8,900	13,900
Total Annual Enrollments to Enrollment Staff	7,900	2,900	3,000	2,400	2,800	5,100

Source: CMHB and peer MHBs

Note: Figures have been rounded to the nearest 100.

[1] Includes claims manager who spends approximately 60 percent of her time overseeing claims operations, but excludes the administrative assistant who spends approximately 90 percent of her time supporting the CMS Unit.

[2] Claims processing for Stark MHB is outsourced to Heartland East Administrative Services Center with one director, one claims processor and two member maintenance specialists.

The number of claims staff at CMHB exceeds the peer average by 0.8 FTEs; however, the CMS Unit processes nearly 500,000 more claims annually than the peer average. Furthermore, each claims/membership specialist within the CMS Unit processes approximately 74,700 or 31 percent more claims annually than the peer average, indicating a higher level of output per FTE at CMHB.

With 2.9 FTEs, the CMS Unit uses fewer staff members to process approximately 13,900 more member enrollments annually than the peer average. Also indicative of a relatively high level of output, each claims/membership specialist at CMHB processes approximately 5,100 or 182 percent more member enrollments per FTE than the peer average.

Franklin MHB, closest in size to CMHB, uses five staff members to perform MACSIS member enrollments only, while six FTEs are solely responsible for claims processing duties. With the exception of the claims manager's responsibilities, claims and member enrollment functions are typically separated at CMHB with 2.5 FTEs routinely performing enrollment duties and 3.5 FTEs routinely performing claims tasks; though each staff member is cross trained to accommodate monthly fluctuations in both areas. Such cross-training improves CMHB's ability to effectively reallocate personnel resources.

Although Cuyahoga County's mental health consumer population is larger than the peers, the CMS Unit's claims/membership specialists sufficiently process its relatively high number of claims and member enrollments. Additionally, according to the MIS director, the CMS Unit is appropriately staffed to handle its current workload. Notwithstanding, CMHB uses a limited number of internal performance indicators to gauge the efficiency and effectiveness of its claims processing operations. Without additional performance indicators, not only would proposed future increases in staffing levels be difficult to justify, but CMHB will be unable to effectively evaluate the success of completed work and corresponding outcomes. See **F5.25** and **R5.20** for more information regarding internal performance measures for claims operations.

F5.3 Relative to Franklin MHB, and based on the interdependent and technical aspects of their functions, the current organizational structure of the MIS and CMS Units is reasonable. CMHB places supervision of these units under the MIS director. This structure is effective in serving the technological needs of CMHB and processing claims. An AOS survey of CMHB technology use indicates CMHB personnel are pleased with technical assistance provided by the MIS Unit (see **background**).

The reporting structure of Franklin MHB, which closely mirrors CMHB in population served and claims processed, is similar to CMHB. Franklin MHB consolidates MIS, claims, and enrollment staff into one unit.

In addition to workload efficiency, a high level of interaction is required between the MIS and CMS Units at CMHB. Claims operations, in particular, are heavily dependent on the creation and submission of electronic reports by MIS Unit staff. Specifically, raw MACSIS data is manipulated through the Microsoft SQL Server 7.0 database to create extract reports on useful claims information (e.g., Potential Duplicate Report). More importantly, however, consumer claims are processed through MACSIS which is a main component of CMHB's technical architecture, requiring the attention of MIS Unit staff. With these units reporting to one director, CMHB is better positioned to increase coordination and effectively manage these highly interdependent functions.

F5.4 CMS Unit job descriptions do not identify a position to provide appropriate backup in the absence of the claims manager. While the MIS director assumes these managerial duties, current workload demands do not allow him to remain readily accessible or available to resolve issues, answer questions, and provide direction within the CMS Unit. Although managerial coverage for the MIS director is not outlined within the MIS Unit, direction or authority regarding major information systems issues is available through CMHB's current outsourcing agreement with Active Networking, Inc. The agreement ensures availability of ongoing technical support to CMHB in the director's absence.

CMS Unit position descriptions have been reviewed within the past year. However, CMHB job descriptions, overall, are outdated and require annual review (see **human resources**). Updating job descriptions annually helps organizations establish performance evaluation standards.

R5.2 The MIS director and claims manager should work with the Human Resources Unit to establish a team leader position among the claims/membership specialists to assume supervisory leadership in the absence of the CMS manager, and among MIS support staff to provide back up in the absence of the MIS director. A job description should include the addition of cross training, so a team leader among the claims/membership specialists and among MIS staff may function as backup for management when necessary. This ensures a leadership presence in the absence of either supervisor. Circumstances, qualifications, and duties of the position should be clearly defined and included in the job description. Additionally, CMHB should include this type of risk in its disaster recovery plan (**R5.9**). A backup position, in conjunction with the disaster recovery plan, reduces CMHB's risk of failure in submitting accurate and timely data or providing security for MACSIS, should the MIS director become unavailable.

F5.5 Outsourcing for information technology services is expanding at CMHB and, within the past year, outsourcing expenditures have nearly doubled. These expenditures have increased primarily due to one-time costs associated with upgrading the network operating system and firewall, as well as redesigning the network architecture. According the MIS director, CMHB does not have the in-house expertise to perform highly technical, one-time technology functions such as network integration. In calendar year 2001, CMHB spent approximately $14,200 on MIS-related outsourcing activities, an increase of over $6,100, or 75 percent, from 2000. Franklin MHB spent nearly $29,000 in FY 2001 for MIS consulting, and budgeted over $50,000 for FY 2002, representing an increase of more than 72 percent. Furthermore, Franklin MHB's MIS plan will rely on outside consultants (Data Processing Sciences for network support, and Meritage Technologies for applications development and database setup) for the next three years.

CMHB purchases 40-hour blocks of time from Active Networking, Inc. for outsourced MIS Unit functions, such as server maintenance issues including networking, handling of

firewall issues, and router configuration. Additional outsourcing costs include the development and maintenance of the CMHB website, which has been contracted to Cuyahoga County Information Services Center (ISC). Details of the agreement include a cost estimate of approximately $2,700 with implementation upon approval by CMHB, and no annual hosting fee. ISC's rate of $77.20 per hour (including update fees) is well below the market average $125.00 per hour.

Previously, CMHB's website was hosted by Case Western University (CWRU). However, CMHB's partnership with CWRU is in doubt (see **planning and system development**), and in order for residents to have one-stop shopping for County services, the website has moved to the ISC Web Services site for County agencies. For further discussion regarding website navigability and features, see **external affairs.**

Results of the 12th Annual Healthcare Information and Management Systems Society (HIMSS) Leadership Survey, which focuses on trends in healthcare information technology (March 2001), indicate nearly two-thirds of provider organizations currently outsource some information technology functions for various reasons. Among the most frequently outsourced functions are partial-tasking jobs such as server maintenance and programming. According to industry standards, it is cost prohibitive to staff a full-time position to perform occasional, highly technical functions.

A recent study, conducted by the research firm Gartner, Inc., reports 87 percent of state governments and 80 percent of local governments do not have the MIS personnel required to perform all necessary functions. Difficulty in the recruitment and retention of qualified MIS professionals has made outsourcing an industry norm. Entities may consider outsourcing discrete projects that involve complex integration processes and highly technical applications, for which the entity does not have the expertise. Technology components of CMHB's agency-wide strategic plan, such as reliance on outside consultants for help with MIS Unit functions and support of technology infrastructure, may be considered opportunities to both train and enhance project management skills of current MIS Unit staff (see **organization, compliance and board governance** and **planning and system development** for more on strategic planning).

R5.3 Although industry norms suggest an increased need for outsourcing in the technology field, CMHB can more effectively control outsourcing costs by:

- Assessing internal staff ability before deciding to outsource;
- Obtaining competitive quotes from vendors, including ISC;

- Maintaining detailed monthly documentation of all outsourced functions including the task and associated costs, to enhance budgeting and planning in accordance with the overall technology strategic plan (see **organization, compliance and board governance**); and
- Seeking to include training as part of any outsourcing contract, as a means of acquiring new technologies and techniques.

CMHB can effectively control costs and manage its need to outsource by assessing internal capabilities and including training as part of future outsourcing contracts. Improving the skill sets of current MIS staff through training will allow certain previously outsourced tasks to be performed internally, and therefore, will help to reduce future outsourcing costs. See **R5.13** for reductions in outsourcing costs for the Bud server.

Technology Planning

F5.6 CMHB does not have a comprehensive strategic technology plan to guide its long-term technology development and implementation activities. Funding constraints and the absence of an agency-wide strategic plan have impacted CMHB's ability to strategically plan its technical operations. Nevertheless, such a planning process would ultimately help alleviate high workloads and help coordinate technology expenditures.

According to a study by the American Productivity and Quality Center (APQC) which examined best practices in aligning information technology with corporate strategy, best-in-class organizations involve MIS senior executives in the collaboration and development of strategic plans. Based upon APQC criteria, new technology acquisitions are clearly linked to program needs and to the agency's overall strategies.

A report by the U.S. General Accounting Office (GAO) identifies the following elements of an effective strategic plan:

- Individuals responsible for ensuring that specific action steps are achieved;
- Privacy, security and internal control requirements;
- Proposed funding sources;
- Organizational training needs; and
- Specific benchmarks to be used in determining the organization's progress toward achievement of goals.

Franklin MHB has developed a strategic technology plan which addresses both short and long-term objectives as determined in accordance with overall organizational goals. Examples of technology components of Franklin MHB's strategic technology plan include annual technical training requirements for MIS staff and established equipment replacement cycles. Without a long-term strategic technology plan, CMHB decreases its ability to organize MIS Unit activities to effectively support operations (see **organization, compliance and board governance** and **planning and system development** for more information on strategic planning).

R5.4 CMHB should develop a long-term strategic technology plan which addresses both short and long-term technology needs. In essence, the plan should describe CMHB's long-term objectives and how technical staff, funding and resources will help the agency achieve these long-term objectives. Once developed, the technology plan should be consistent with and support CMHB's agency-wide strategic plan. The plan should also be presented to agency management who must fully support the objectives and goals stated within the plan and ensure an annual review and revision process that will allow the strategic plan to evolve with changes in the agency and the community. The following steps should be taken to develop the plan:

- Identify and analyze the business and mental health environment that the strategic technology plan must support;
- Define key agency-wide goals and objectives and establish measurable success factors for those areas;
- Evaluate how existing hardware and software applications support the long-term goals and objectives of CMHB;
- Research significant industry trends relating to technology and mental health organizations;
- Determine what technology is needed to help CMHB achieve its long-term goals and objectives;
- Identify user requirements for mental health-related and financial software applications, as well as e-mail and Internet software;
- Clarify agency-wide training issues, such as basic computer skills development for all staff, and establish an internal process for scheduling more in-depth software training for particular staff members;
- Establish management reporting lines of communication with the CEO and BOG;
- Establish budget line items by section for computer hardware, software and training; and
- Develop an implementation plan.

Effective technology planning can result in a computing environment which allows more efficient use of staff time. The result of this process should be a step-by-step action plan detailing how the agency expects to meet its long-term goals and objectives given the existing technical architecture. The architecture is a blueprint that specifies the technical infrastructure (hardware, network configuration and system software), software application systems and database design. The proposed strategic plan should contain the following elements:

- A timetable;
- Funding requirements and funding sources;
- Individuals responsible for implementation;
- Estimated resource requirements to implement actions, including consultants, contractors or in-house staffing;
- Staff development;
- Expected benefits; and
- Benchmarks to determine progress in meeting stated goals.

The timetable should be realistic in estimating CMHB's commitment to the implementation of new technologies. A sound methodology will help CMHB implement high quality applications with less risk and at a lower cost. The plan, along with the budget, should also address the issue of upgrades and future replacements of computer equipment, as well as software and associated staff development.

The MIS Unit should establish a formal review and revision process that will allow the strategic plan to evolve with changes in the organization, the community, and new technologies. Plan implementation and monitoring should be performed by one of the standing committees as recommended in **organization, compliance and board governance**.

F5.7 CMHB does not have a standing committee dedicated to technology initiatives. Rather, the current Executive Committee consisting of three individuals (MIS director, finance director, and acting CEO), discusses major technology capital expenditures and related platform, application, or implementation needs as those concerns arise. As recommended in **organization, compliance and board governance**, CMHB's standing committees could initiate taskforces to achieve short-term organizational goals, including technology initiatives.

One potential initiative could involve automating the PEP Connections billing process within the CMS Unit. According to the CMS manager, support for this program requires 0.8 FTEs, significantly impacting the workload of the unit (see **F5.2**). While the program

itself serves only a few hundred child consumers, billing procedures are labor-intensive. The PEP Connections program uses an agency to issue vouchers for certain non-Medicaid services for children. A copy of the voucher is sent to the direct service provider and CMHB. Following service delivery, a claim is sent to CMHB for reimbursement. CMS Unit staff must manually verify the claim against the voucher.

Ultimately, a technology taskforce could help the MIS and CMS Units realize certain short-term goals, improving operational efficiency and effectiveness.

R5.5 CMHB should use the taskforce approach to implement short-term technology goals, in accordance with the recommended strategic technology plan. Taskforces could be formed with the expressed mission of completing particular short-term goals outlined in the strategic technology plan. For example, a taskforce could be established to review and recommend changes related to the automation of the PEP Connections billing process. By automating certain aspects of this process, the CMS Unit could realize greater efficiencies in claims and enrollments processed, as additional staff resources would be available to perform these functions. The taskforce approach is well suited for implementing short-term goals, as taskforces are designed to discontinue once their missions have been completed.

F5.8 Although pertinent unit information is available to all employees and managers internally via an intranet site, CMHB employees do not fully take advantage of the common information available through the intranet. For example, agency-wide memos, policies and news items are often posted on the intranet but may not be accessed by CMHB employees. According to the MIS director, the intranet is not widely used because employees prefer more familiar methods through which to share information, and CMHB management does not strongly encourage its use.

The intranet can be used to share common information such as budgets, policies and procedures, status reports and other organization specific data. Neither Franklin nor Stark MHBs currently employ an intranet, though both suggest it would eliminate certain paper driven processes while making information more readily available to staff. Franklin MHB is seeking to implement an intranet within six months.

According to Lucas MHB's information services director, an intranet is a vital tool in disaster recovery planning and paperwork elimination. An intranet allows for quick back-up of shared files, which can be recovered in the event of a fire or other disaster.

Effective use of the intranet allows for enhanced internal communications and allows CMHB employees to view secured information which is not accessible to individuals outside the organization.

R5.6 All CMHB managers should encourage employees to take advantage of the intranet to better coordinate information sharing among units and divisions and to reduce paper-driven processes. Encouraging agency-wide information sharing by emphasizing intranet use enables employees to frequently view written organizational goals and to track allocation of resources. Better use of the CMHB intranet should help eliminate certain paper driven processes and ultimately improve communications among several units and divisions. By reducing the use of paper, CMHB can better allocate administrative resources.

F5.9 The MIS Unit uses web content filtering software (Superscout) to monitor employee use of the Internet. Monitoring personal use assists management in pinpointing possible abuses. Excessive time spent on the Internet decreases productivity and increases opportunity for potential problematic issues such as abuse, breaches of security, or viruses. CMHB requires employees to sign a computer use policy form which is maintained on file in human resources (see **human resources**).

F5.10 Despite efforts to replace desktop PCs with Citrix, a multi-user system, CMHB does not have a formal technology equipment replacement plan to guide technology purchases. Citrix may be a cost efficient alternative until equipment can be updated, as it allows CMHB to provide access to server-based applications from a number of older CMHB computers (**F5.14**). Best practices in technology recommend a two-year written and budgeted plan for the replacement of equipment, which helps disperse large capital equipment costs over a period of time rather than absorbing costs all at once. Maintaining properly functioning equipment increases employee satisfaction (according to the AOS survey of CMHB technology use), and improves efficiency as measured by the following:

- Mean time between failures;
- Percentage of capacity of disk usage;
- Number of jobs handled; and,
- Percentage of computer processor capacity used.

CMHB is not directly overseen by the County Commissioners but is included in the County's annual budget process. According the director of MIS, the County fulfills requests for capital office equipment and furnishings. All items provided through the County remain tagged as a County asset. Therefore, obsolete or other equipment with no remaining useful life is sent back to the County for disposal or recycling. The LAN support specialist is responsible for processing purchase order requests once signed by the MIS director. A formal technology replacement plan would enable the MIS Unit to anticipate future technology needs and budget for them accordingly (see **finance and funding**).

R5.7 The Executive Committee should appoint a taskforce to write a technology equipment replacement plan. The technology replacement plan could become one of the MIS Unit's short-term goals and should be tied to the recommended strategic technology plan. Maintaining properly functioning equipment enhances user satisfaction and increases efficiency. As part of its replacement plan, the taskforce should also review the performance of two Citrix remote window application servers currently being piloted (see **C5.1**).

F5.11 CMHB does not consistently include the MIS or CMS Units in the development of program initiatives. Program initiatives of the Planning and System Development Division and other units of CMHB are often developed independent of MIS and CMS Unit input, although these units are often involved and greatly impacted by program implementation and required support. For example, the CMS Unit was not involved in the planning of the PEP Connections Program, although operations to support the program are labor-intensive for the CMS Unit (see **F5.7**). See **planning and system development** for more regarding MIS Unit involvement in planning.

According to a 1998 study by APQC, best-in-class organizations involve MIS management from the start of program initiatives to ensure that systems capabilities, limitations, and requirements are known and provided. Furthermore, the Stark MHB technician participates in budget preparation and capital planning processes. In this manner, the MIS Unit can effectively support the technology needs of new program initiatives and effectively impact desired program outcomes.

R5.8 CMHB should consistently include the MIS and CMS Units in the development of program initiatives and program reviews to ensure they can be adequately supported by the current system and staff within both units. During the planning phase of any program, it is necessary to determine the required level of technical support and whether current resources are adequate to support a program, once operational. The MIS director, in particular, should assist in advising and guiding budget preparation and capital planning processes because of his unique knowledge of both claims and MIS functions. MIS Unit representation throughout the planning phase will help avoid unnecessary delays or costs due to lack of network system capabilities or support. By including the CMS Unit, program planners will be cognizant of whether current claims staff can effectively process the amount of claims and new member enrollments resulting from a newly-created program.

F5.12 The MIS Unit has developed a draft disaster recovery plan to implement in the event of catastrophic loss or major system failure; however, the draft plan has not been approved, signed, or tested. According to the MIS director, CMHB does not currently have the capacity to adequately test the plan, and therefore, it is still in draft form. Furthermore,

CMHB does not include billing functions or provisions for alternative processing of data in its disaster recovery plan.

The draft outlines procedures for nightly system backup. The backup disk is kept by the MIS director until the weekend. Weekly backup of files is completed every Monday morning and the current tape is moved to off-site storage. A monthly backup is done on the last working day of the month and an annual backup on December 31. The task is normally performed by the LAN support specialist or a designee of the MIS director.

According to the Government Finance Officers Association (GFOA), minimum computer disaster recovery plans should accomplish the following:

- Formally assign disaster recovery coordinators for each department to form a disaster recovery team;
- Require the creation and preservation of back-up data;
- Make provisions for the alternative processing of data following a disaster;
- Provide detailed instructions for restoring disk files;
- Receive periodic testing; and
- Satisfy organizational concerns dealing with the adequacy of disaster recovery plans for outsourced services.

Compared to GFOA requirements, the MIS Unit's draft recovery plan includes only the creation of back-up tapes and the restoration of disk files. In the event of flood or fire, files can be recreated and programs loaded fairly easily if the required hardware is accessible. However, CMHB does not have a plan for equipment replacement; either for purchase or through agreement with a local social service entity for temporary use of hardware (see **F5.10**).

Stark MHB's disaster recovery plan includes reciprocal agreements with peer mental health boards to share resources in the event of catastrophic loss. Establishing a pre-selected peer board saves time and resources when business recovery processes need to be expedited and also expands the level of comprehensive risk assessment. A disaster recovery plan should also include a section regarding loss of key personnel as part of its detailed risk assessment.

R5.9 CMHB should finalize, approve and annually test its disaster recovery plan. Responsibilities of the disaster recovery team should be defined including procedures for assembling the team in the event of disaster with a list of names and telephone numbers maintained off-site with a copy of the formal disaster recovery plan. Additionally,

CMHB should incorporate those elements suggested by the GFOA in its disaster recovery plan.

As a part of the plan, CMHB should develop a formal agreement with the ADAS Board or other human service agencies to provide system back-up. Alternative data processing priorities should be established as part of the agreement. The ADAS Board is particularly well suited to provide back-up because it regularly uses MACSIS, serves similar populations and is similar in size to CMHB. An effective disaster recovery plan specifically addresses policies and procedures for minimizing the disruption of daily operations if computers or other advanced technologies should become disabled or rendered unusable.

F5.13 CMHB does not have a formalized contract for its telephone system to ensure ongoing availability of service. The contract for the existing Legacy telephone system has expired and the system is now being leased on a month-to-month basis at approximately $800. The average monthly cost for total telephone service, including equipment, maintenance and service, is approximately $4,000. Telecommunications duties were previously a function of the Human Resources Unit; however, these duties are not formally assigned to a specific position. In addition, the MIS director is not empowered to seek and formalize a new lease agreement and is currently waiting for direction from the CEO as to the next course of action. CMHB's Executive Council has recently entered into discussion toward resolution of telecommunications issues at CMHB and the implementation of an updated telephone system contract. According to the director of finance, a copy of the expired previous contract with Ameritech is no longer available; and therefore, a potential cost savings could not be estimated.

R5.10 CMHB should formally assign a position to oversee telecommunications operations and finalize a formal contract agreement for telephone services. Since there is no current telephone contract, CMHB has the opportunity to reduce costs by submitting a RFP to telephone service providers. Once an agreement is reached, CMHB should formalize its new telephone system lease to ensure ongoing service availability. CMHB should finalize and sign a minimum one-year lease agreement with a phone service provider to secure optimum pricing, avoid month-to-month lease payments, and minimize paper handling and voucher payment processing.

Technical Architecture

F5.14 The core backbone for all CMHB connections is built around 10 Cisco switches. Switch one is the core switch where all of the servers and other switches are connected. CMHB has made recent infrastructure upgrades to firewalls and Ethernet hubs to increase bandwidth and speed. A new Citrix server was also installed in the first quarter of 2002 to more evenly distribute processing and communications activity across the network.

The Cisco 2500 router is owned and maintained by the State for file transfer in MACSIS. The State also provides T-1 access at no cost to CMHB.

At CMHB, dial-in remote access service (RAS), for providers and CMHB staff, is provided through a Cisco 3000 series router. RAS provides contracted providers access to place or retrieve claims-related files. Additionally, RAS allows the MIS director to conduct remote system checks from home. CMHB network security for dial-in access is provided first with a standard user name and password. A second level of security is provided by the operating system accessed by the user. A RAS client program is required when accessing RAS from a remote computer.

The MIS director uses Citrix to perform daily remote network checks. Citrix applications have also been introduced as a pilot program in the Planning and System Development Division. By using Citrix, administration costs and complexity are reduced since these applications are installed, updated, and maintained on central servers instead of each CMHB computer. None of the peer mental health boards, however, use Citrix. Citrix software improves security and allows for high application performance by overcoming bandwidth constraints.

C5.1 The MIS Unit has provided for the effective development of its technical architecture using Citrix and Ethernet upgrades. Citrix is a powerful platform for application deployment and management. Its client-server technology allows CMHB to provide access to server-based applications from a wide variety of CMHB computers, reducing the need to purchase new computers and increasing file sharing speed.

Ethernet upgrades enhance bandwidth and increase speed to 100 mega-bytes per second which is considered standard. CMHB will realize greater information system efficiency as a result of the upgrade.

F5.15 CMHB is not connected to the County's Wide Area Network (WAN), and therefore, the Finance Unit is unable to access FAMIS, the County's mainframe for accounting applications. Without this access, the Finance Unit is unable to answer payment status questions from vendors and providers. Long processing cycles contribute to the number of provider inquiries. FAMIS inquiry-only access would allow for real time review of vendor and provider payment status information.

Furthermore, the current MUMPS system cannot show account credits. Therefore, staff must call the County administration office to obtain payment information since all CMHB vouchers are manually keyed into FAMIS for payment at the County Auditor's Office (see **finance and funding** and **F5.20** for information regarding a new accounting system). Previous reluctance to access FAMIS through the WAN was due to monthly costs of approximately $550 to maintain a frame relay connection. However, access to

FAMIS through the Internet may allow CMHB to avoid this expense. According to the MIS director, using a username and password to allow access to FAMIS has been unsuccessful and may require obtaining a digital certificate from the appropriate issuing authority. Nonetheless, access to FAMIS, whether through the County's WAN or the Internet, would expedite the review of vendor and provider payment status information.

R5.11 The MIS director should facilitate measures for appropriate CMHB employees to gain access to FAMIS via the Internet. In addition to determining the status of provider claims, other pertinent accounting information could be shared electronically through the Internet. Gaining FAMIS inquiry-only access would allow staff members to more readily track, process and determine payment status of provider claims.

Technology Hardware and Equipment

F5.16 CMHB has more than 50 percent of its computer workstations equipped with individual printers, despite the strategic placement of several network printers throughout CMHB. New individual printers cost approximately $200 and network printers cost approximately $3,500 (based on State term pricing). Replacement cartridges cost $60 for individual printers, $80 for medium capacity printers (used in claims) and approximately $180 for network printers. According to MIS staff, CMHB uses approximately 12 large network printer cartridges per year costing about $2,200. The current annual cost associated with replacing individual printers is $2,400, while individual cartridge replacement approximates $1,700. According to the MIS director, the current capacity for shared printing using four networked printers is adequate to meet agency-wide printing needs, with the exception of the CMS Unit's high volume printing requirements.

CMHB maintains an ongoing list of outdated technology related equipment, including non-functioning and obsolete items which are marked for return to the County. According to the MIS director, the County may either auction the old equipment or pay to have it appropriately disposed. Items returned to the County, are not necessarily replaced as the list of outdated equipment is not tied to a formal technology replacement plan (see **R5.7**). Although obsolete equipment may be sold by the County through auction, associated cost savings are unquantifiable.

R5.12 The MIS Unit should phase out the use of individual printers and increase the use of four shared network printers which are strategically located throughout the building. Individual printers typically have a relatively short useful life and do not provide the print quality available through most network printers. Staff members in the CMS Unit, the Human Resources Unit, and those staff who process Major Unusual Incident (MUI) reports may require private printers due to high volume printing and the content of confidential consumer information.

Individual printers not being used should be returned to the County and those that are used should not be replaced once the useful life has expired. New network printers should be acquired on an as-needed basis to replace non-functioning printers. Any purchases or changes in equipment use should be illustrated in the recommended replacement plan (see **R5.7**). MIS Unit staff estimates increased use of network printing (except for the CMS Unit) would raise the number of network printer replacement cartridges purchased annually to approximately 18, representing an increase of approximately $1,300 over current spending levels.

Financial Implication: CMHB would save $2,400 on individual printers and $1,700 on individual printer cartridges, by increasing the use of network printing. This would increase network printer cartridge costs by $1,300, creating a net annual cost savings of $2,800.

F5.17 The Bud server used for accounting purposes runs on a legacy system under a digital virtual memory system (VMS) which is obsolete and therefore, costly to maintain. According to current industry standards, most businesses have migrated to Windows New Technology (NT) as a major platform from the early virtual memory systems because of increased compatibility and efficiency. Furthermore, according to the MIS director, the Bud server is nearly 10 years old and is in fragile condition and at considerable risk of never regaining power even after a minor incident such as a brief power outage. The hardware manufacturer no longer supports the server which runs the MUMPS accounting system, requiring CMHB to outsource the required maintenance work since in-house staff is unable to perform the necessary maintenance or obtain replacement parts. Outsourcing costs for maintenance on this particular piece of hardware were approximately $1,500 in 2001. Without updated hardware, CMHB cannot adequately support its accounting system.

R5.13 The MIS Unit should replace the VMS Bud server that currently runs CMHB's accounting system. However, the MIS Unit should determine whether other existing NT servers could adequately maintain any new accounting software, before purchasing a new server. Replacement of the server should be done in conjunction with the purchase and implementation of new accounting software (see **finance and funding**). The server hardware upgrade would increase reliability and efficiency as well as decrease current outsourcing costs which approximate $1,500 per year for maintenance on the outdated VMS Bud server. Any purchases or changes in equipment use should be illustrated in the recommended replacement plan (see **R5.7**).

Financial Implication: Replacement of the current VMS Bud server hardware for the purpose of running accounting applications would represent a one-time cost to CMHB of approximately $4,500 for an equivalent, medium class server with an estimated useful life of approximately 10 years. Since the new server would require only minimal

maintenance even after several years, CMHB can save approximately $1,500 annually for maintenance costs on the outdated Bud server. The benefits of increased reliability and functionality may be unquantifiable in terms of overall savings and value to CMHB. Costs for implementing a new accounting system are included in **R4.7** in the **finance and funding** section.

Functional Overview of Software Applications

F5.18 According to the MIS director, CMHB uses approximately 95 percent of the 25 unit productivity software applications actively maintained at CMHB. Although some functional overlap exists between the Corel Suite and Microsoft Office packages, the majority of CMHB personal productivity software is used by staff to perform daily activities (see **F5.19**).

While few packaged applications are purchased, two were recently purchased and are currently being piloted. The two new software packages are at 80 percent of full functionality. TechExcel is a customer relationship management (CRM) application, currently being piloted in the Provider Relations Unit and with select managers (Claims, Finance, MIS, and the CEO). PeopleWare is training software used in the Education and Training Unit to generate continuing education certificates and track employee training.

To help identify in-house computer training needs, the MIS Unit is expanding the use of available help desk features. However, an internal help desk could also assist the MIS Unit in identifying those software functions which are currently underutilized. Monitoring the types and frequency of computer problems encountered by staff would ultimately help the MIS Unit determine the usefulness of various software packages.

R5.14 CMHB should review help desk activities to assess the impact of various software upgrades and identify technology training needs. Expanded use of additional help desk features will both increase overall software functionality and enhance technology support for users at CMHB. The data would also enhance distribution of computing resources among divisions and individuals.

F5.19 CMHB does not use one standard office application, as employees use both Corel Office Suite and Microsoft Office for word processing, spreadsheet, and basic database applications. According to the MIS director, CMHB is fully licensed for both office suites and currently does not incur annual licensing fees for these packages. Therefore, staff members are able to use either application. In addition, providers are not required to share files in any particular format.

Table 5-4 illustrates key software applications at CMHB by functional area.

Table 5-4: Software Application Use by Unit

Department	Software Application				
	Corel Office Suite	**MS Office**	**Lotus**	**GroupWise**	**Other**
Human Resources	√	√		√	
Finance	√	√	√	√	
Planning and System Development	√	√		√	
Claims	√	√		√	
External Affairs	√	√		√	
Risk Management/CA	√	√		√	FileMaker Pro
Research/ Development	√	√		√	SPSS
Provider Relations/QS	√	√		√	TechExcel
Education and Training	√	√		√	PeopleWare
MIS	√	√		√	SQL Server 7 Visual Basic MS Project

Source: CMHB MIS Unit

Based on results of the AOS survey of CMHB technology use, 72 percent of employees prefer Corel WordPerfect for word processing, but 56 percent prefer MS Excel for spreadsheet use. Although the Finance Unit uses Lotus applications on a regular basis, ODMH is migrating toward MS Excel for spreadsheet files. Furthermore, some providers have indicated a preference toward MS Excel for spreadsheet files. All CMHB employees use GroupWise for e-mail. In addition, various types of personal productivity software such as MS Project, PeopleWare, and Front Page Office are used by select individuals based on work processes performed in their respective units.

CMHB actively maintains most of the same software applications as Lucas MHB including licensing for both Corel Office Suite and MS Office. Franklin MHB, however, only uses MS Office as opposed to maintaining both suites. Franklin County has negotiated an enterprise licensing agreement (three-year) directly with Microsoft. Franklin MHB annually budgets and pays the County for the number of workstations covered under the license. In addition to receiving special or reduced pricing for other Microsoft products, Franklin MHB saves $300 for each new Dell workstation it purchases that does not include MS Office, as it is provided through the County license.

Maintaining both office suites can impact file sharing efficiencies internally among CMHB units and externally with provider agencies and ODMH. There are also costs

associated with future upgrades that may not be as significant if CMHB were to choose one office suite over the other.

R5.15 CMHB should require standardized use of one office suite software application to more efficiently enable file sharing among CMHB's units, provider agencies and ODMH. While software selection should be based on a consensus of staff and provider agency needs, associated costs should also be considered. To help identify savings in this area, CMHB should consult the County Information Services Center (ISC) to determine if it maintains licensing agreements, similar to that of Franklin County. CMHB should also seek to accommodate providers by sharing files in a standard office suite used or preferred by most providers. Standardization of file sharing enhances internal communications and extends a higher level of service to providers through user-friendly technology.

F5.20 CMHB is currently deciding how to replace the outdated MUMPS accounting system; however, it does not have a formal decision model to follow when selecting major software packages. A decision model is an analytical hierarchy used to evaluate the vendor software in relation to the client's pre-defined business requirements. The MUMPS-based accounting software program was customized in-house to meet the vouchering needs of the Finance Unit; however, the scope of functionality is extremely limited. The MIS Unit staff member who programmed the application 10 years ago is no longer employed at CMHB. According to the MIS director, the server running the system is outdated, unreliable and cost prohibitive to maintain (see **F5.17**). In addition, the program has very limited accounting features and does not perform general ledger functions which would allow for more detailed reporting (see **finance and funding** for information on a replacement for MUMPS).

Fairly extensive research on new accounting software has already taken place and the Executive Committee has met to review options. BOG has not yet been briefed on recommendations or costs associated with the new software purchase and implementation. However, in moving forward with the process, the Executive Committee, with input from the MIS and Finance Units, will present recommendations for purchase and implementation to BOG based on current accounting needs and the capacity of the new accounting program application to adequately meet CMHB's business requirements.

Use of a Software Selection Project Decision Model which assigns weighted values to specific business processes may serve as a useful tool in the selection and implementation process. Such a model simplifies complex decision-making by providing a structure to summarize the opinions and interpretations of the selection team. Business processes are generally ranked within each function in an organization, by assigning weighted values.

As a result, it becomes easier to evaluate software in relation to organizational priorities and timeframes.

R5.16 The Executive Committee should use a decision model to evaluate vendor software in relation to CMHB's pre-defined business requirements and accounting needs. Following a model will help simplify the process by providing a structure which summarizes the opinions and interpretations of committee members. BOG should be briefed on the level of risk associated with the performance of current equipment. The purchase and implementation process should proceed as quickly as possible to avoid maintenance costs associated with current equipment. If the purchase order request exceeds $15,000, submission of an RFP is required. Any purchases or changes in equipment use should be illustrated in the recommended replacement plan (see **R5.7**).

Technical Training

F5.21 Although new employee orientation incorporates some technology training components, a majority of CMHB staff surveyed believe additional computer training would be beneficial. Furthermore, CMHB does not have formal computer training procedures to facilitate agency-wide technology training activities, and CMHB does not survey end-users to determine skill levels to help identify training needs. Neither CMHB nor peer boards have formally stated technology training requirements; however, all CMHB and peer board staff members receive training from their respective IT personnel or can receive external training upon request.

There are several mechanisms in place at CMHB which allow for external technical training for all staff. Job-specific training is available through Cuyahoga County Community College and may involve a certain level of computer training. Managers may also request external training for a particular staff member to strengthen specific technical skills. CMHB employees can take advantage of training at a reduced rate through the County's training vendor. Internal technology training is also available from MIS Unit support staff upon management request. Despite the number of internal and external technical training opportunities available to CMHB staff, a majority of staff still believes additional computer training would be beneficial.

R5.17 CMHB should develop formalized technology training procedures to facilitate its various computer training activities. The procedures should include general requirements for a technology training survey and should also indicate the frequency of distribution. A technology survey would help determine the types of additional technology training required and would assess overall user satisfaction with information services. Training courses and employees who participate in training, whether internal or through an external vendor, should be tracked in a database to help create individual employee development plans (see **human resources**). Ultimately, formalized technology training

procedures should help establish a structure by which training needs can be identified to enhance the technical skill sets of end-users.

Funding for Technology

F5.22 CMHB does not provide monthly general ledger or expenditure reports to inform the MIS director of the annual budget or help monitor expenditures. In addition, the budget process does not serve as a management tool for the MIS director although the director is responsible for the fiscal management of the MIS Unit. An annual MIS Unit budget of $150,000 was established in 1999. The budget has not been revised; therefore, it is assumed to be approximately the same.

Without accurate expenditures, however, the MIS director is unable to determine historical costs or predict future outlays. Also, CMHB management and BOG are unable to determine if the resources committed to various technologies are a factor in the success of its programs as CMHB does not budget by unit or division (see the **finance and funding** section for further discussion of CMHB's budget process).

R5.18 Because budgets are dynamic documents, the MIS director should receive monthly, quarterly and annual, up-to-date budget expenditures from the Finance Unit. Accurate budget figures will also facilitate the prioritization of financial and personnel resources to be used in technology planning. In short, the budget process should be tailored to serve as a management tool for not only the MIS director but other CMHB managers as well. This will enhance the planning process and decision-making ability of the director with regards to MIS activities and program support.

F5.23 CMHB does not research grants for technology and does not have a designated grant writer to seek available grant funding. Inability or failure to solicit available grant funds specific to the MIS Unit increases the likelihood of drawing funds from line items that cannot support MIS Unit expenditures. Although peer mental health boards do not receive technology-specific grants, GFOA recommends that all government bodies adopt a policy that encourages a diversity of revenue sources to improve their ability to handle the fluctuations in funding flow and not become dependent on a single revenue source.

GrantSource is an Auditor of State quarterly newsletter which highlights grant opportunities for State and local governments and non-profit organizations. *GrantSource* is available online at the Auditor of State Internet homepage and subscriptions are provided free of charge. In addition, the city of Newark has published a directory, "Finding Funding in Your Backyard and Beyond," with a listing of 100 grant sources for nonprofit and governmental agencies (see **planning and system development**).

R5.19 CMHB should research technology specific grants to increase and diversify funding resources. Due to funding cutbacks, long-range planning should focus on the greatest return on investment through funding arrangements. An identified employee, with input from the MIS director, should research possible grant funding for technology initiatives at CMHB. With the current declining budget and rapidly changing technology environment, CMHB should seek additional means of increasing monies devoted to technology equipment and applications upgrades in order to increase efficiency within all divisions.

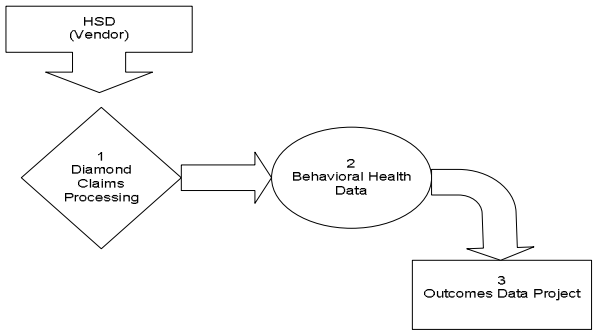
The availability of grant funds would help avoid the current practice of relying on various line items that may not be able to support MIS Unit expenditures. Furthermore, reports should be developed to track grants, their status, community match requirements and the success of programs that have been adopted. Grant funds for technology are available and should be sought diligently in support of enhanced mental health services to families.

MACSIS and Claims Operations

F5.24 CMHB has not developed a consumer outcome system that evaluates and monitors contracted providers according to access, quality, school success, employment, and consumer outcomes. See **planning and system development** and **provider relations and quality services** for more information regarding outcomes.

MACSIS is a consumer-centered system designed to capture information at the consumer level and link the information to the county of residence, for the purpose of electronically processing claims for mental health services. MACSIS integrates Medicaid with other public health funds, allowing for centralized monitoring of public funds and helping to prevent duplicate services and payments. Non-public funded services, however, are not reported through MACSIS. **Chart 5-2** shows the process for MACSIS implementation which is currently not fully operational.

Chart 5-2: Implementation of MACSIS



In 1999, CMHB began using the first module of MACSIS, called Diamond Claims Processing, for billing in conjunction with "fee-for-service" operations. Contracted providers charge a fee for each unit of service rendered. The number of service units and their associated prices comprise each claim entered by contracted providers in the Diamond Claims Processing application. Approximately 15,000 to 25,000 claims are processed each week at CMHB. The management, implementation and technical support of MACSIS is maintained at the State level through ODMH. Operating like a service bureau, the State provides the necessary hardware (router and T-1 line), software (Diamond) and support (MACSIS website, ODMH MIS) to mental health boards in order to process claims in MACSIS.

Peer mental health boards also use MACSIS for claims processing, citing its importance in obtaining real-time information from contracted providers and precise dollar amounts of mental health services consumed. ODMH is in the process of fully operationalizing the Outcomes System module of MACSIS. CMHB requested that volunteers from its contracted provider network participate in the Outcomes System. Participating contracted providers are currently in the process of completing the beginning phase of the project and anticipate aggregating data to standardize the assessment of outcomes. However, only 22 of 37 contracted providers are participating, significantly impacting the ability to measure and monitor consumer outcomes on a system-wide basis (see the **provider relations and quality services** section for more information on the Outcomes System). Furthermore, ODMH will not be providing additional grant funding for the Outcomes System and CMHB's non-participating contracted providers will have to find other sources of funding for the Outcomes System should they intend to participate.

In contrast to CMHB, all of Franklin MHB's providers are participating in the Outcomes System. Moreover, Franklin MHB had created its own outcome assessment initiative in 2000, prior to ODMH's introduction of the Outcomes System. Franklin MHB asked its contracted providers to sign a memorandum of understanding (MOU) for the initiative

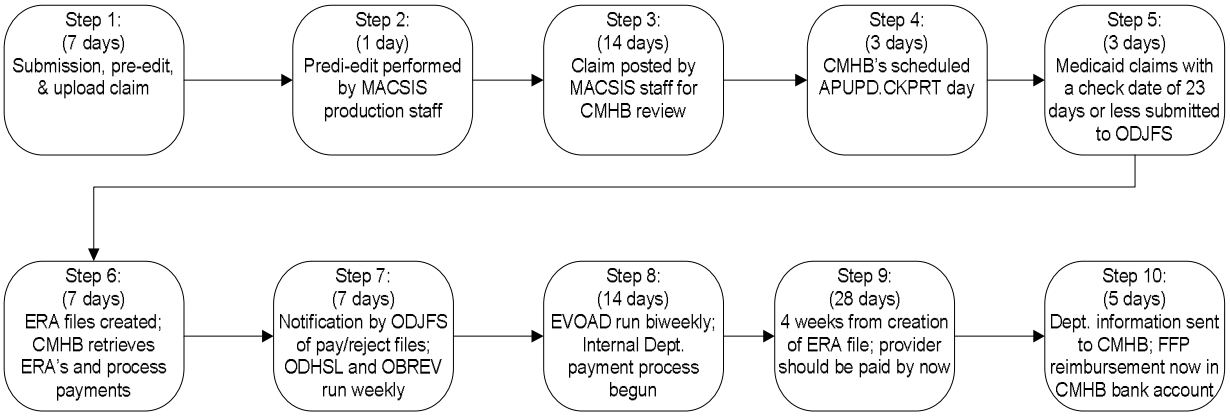
then supply Franklin MHB with outcomes on three consumer groups, including SMD adults, children and adolescents, and general and older adults. These outcomes are used to assess the following:

- Effectiveness of the treatment and prevention services in terms of the impact on consumers' lives and their recovery;
- Consumer satisfaction with services provided by the contracted provider network; and
- Cost effectiveness of treatment, access to services, and cultural responsiveness in the system.

Nearly 100 percent of Franklin MHB's contracted provider network supplies outcomes assessment data on approximately 25,000 consumers annually. See **provider relations and quality services** for additional information regarding CMHB's consumer outcome initiative.

F5.25 Although claims processing involves a regimented lifecycle, the CMS Unit does not extensively use internal performance indicators to gauge the efficiency and effectiveness of claims processing operations at CMHB. Boards are required to process claims according to ODMH guidelines using Diamond Claims Processing application within MACSIS. Processes are outlined in detail on the MACSIS homepage of the ODMH website. According to ODMH, the lifecycle for claims submitted by all boards should not exceed 90 days. However, this efficiency measure can be impacted by a high volume of claims and an increase in payment deductions in a given claims cycle. **Chart 5-3** illustrates the MACSIS 90-day claims cycle.

Chart 5-3: Claims Life Cycle



Note: Due to volume of claims and payment deductions, ODMH may take an extra week to complete the cycle.

The following steps detail the activities illustrated in **Chart 5-3**.

Step One (day 1): Provider submits claim file in HCFA 1500 format to mental health board. Board pre-edits file (checks for potential duplicates and errors) and uploads file to ODMH. If the pre-edit detects potential duplications or errors of 5 percent or 50 claim lines, the file may be returned to the provider for correction.

Step Two (day 8): If claim file passes initial scans and conversions, additional pre-edits are performed by State MACSIS production staff. The time it takes from initial submission to this step (also known as "predi-edit") will vary up to a maximum of seven days. Board reviews predi-edit reports and notifies State MACSIS production staff to post the claim.

Step Three (day 9): Board is notified by State MACSIS production staff that the claims file has been posted and is ready for review.

Step Four (day 23): Posted claims are finalized on the boards' regularly scheduled accounts payable day and can no longer be adjusted or "worked." However, some claims are automatically put on hold and are not processed until the board manually intervenes. For example, the PEP Connections program requires that staff manually verify service claims against their corresponding vouchers (see **F5.11**). Another reason claims may be placed on hold is duplication. When this problem arises CMHB contacts the contracted provider, who has thirty days to resolve the issue (see **F5.26**).

Step Five (day 26): Medicaid claims finalized with a check date of 23 days or less are extracted for submission to ODJFS for reimbursement.

Step Six (day 29): Electronic Remittance Advice (ERA) files which list provider payment information are created by State MACSIS production staff and electronically submitted to boards. Boards are expected to retrieve the ERAs and begin processing payments on the day they are created. Once processed, boards' claims departments notify ODJFS that claim files are on the mainframe and are ready for processing.

Step Seven (day 36): Claims departments are notified by ODJFS of paid and rejected claims through MACSIS.

Step Eight (day 43): Using the reimbursement summary derived from MACSIS, boards' internal finance units create and submit payment vouchers to the county auditor who issues actual payment to providers.

Step Nine (day 57): Providers should be reimbursed by this point which is four weeks from the creation of the ERA file.

Step Ten (day 85): Actual reimbursement information is sent to boards.

Using the Diamond Claims Processing application, CMHB currently measures the number of claims keyed per FTE on a weekly basis and is in the process of developing additional measurements such as sampling 10 percent of claims keyed per FTE and measuring the occurrence of errors.

Franklin MHB measures the speed at which contracted providers are paid, by tracking the date a MACSIS claim is received from a contracted provider to the time a reimbursement check is mailed by the County. According to Franklin MHB, this measurement helps to ensure contracted providers are receiving payment for services rendered, while encouraging contracted providers to submit claims in a timely manner.

Without an internal performance measurement system to monitor the efforts of the CMS Unit, CMHB is unable to effectively evaluate the success of completed work and corresponding outcomes.

R5.20 Under the supervision of the MIS director and claims manager, the CMS Unit should develop additional internal performance indicators to measure efficiencies and outcomes achieved in claims operations. This will help improve the mental health system by monitoring the quality and timely submission of contracted providers' claims, while ensuring timely reimbursement for services rendered. It is important that performance indicators be aligned with the proposed agency-wide strategic plan and BOG's vision of mental health in Cuyahoga County (see **organization, compliance and board governance** and **planning and system development**). Examples of indicators the CMS Unit can use to measure and report its performance levels include the following:

- Percentage of staff time devoted to member enrollments;
- Percentage of staff time devoted to claims by service type and other mental health programs;
- Claims filed per FTE;
- Number of claims-related trainings offered to providers;
- Decrease in overall duplicate payments;
- Number of duplicated or returned claims per claim file or claims cycle;
- Response times to provider inquiries; and
- Percentage decrease in duplicated or returned/rejected claims.

F5.26 Every mental health board is required by ODMH to perform checks for duplicate claims in MACSIS. CMHB helps reduce the number of duplicate errors by placing any

questionable claim on "hold" status. Once on hold, the provider is contacted to research the claim. It is the provider's responsibility to respond within 30 days to correct the issue. CMHB also strongly suggests each contracted provider use the Unique Transaction Identifier (UTI) code to minimize duplicate claims that require review. However, some providers do not have systems with the necessary technological capabilities to utilize the UTI reports.

CMHB uses various reports beyond those required by the State to reduce claims errors and payment delays. For example, in December 2001, CMHB developed and initiated use of the "All 5's SSN Report" which is sent weekly to providers so they can update UCI requests submitted with generic social security numbers and contact CMHB with data corrections, in an effort to help minimize duplication. The CMS Unit generates internal reports to maintain accuracy of data and to ensure accurate and timely claims payments. Implementing use of UTI numbers and the "All 5's SSN Reports" are additional measures taken by CMHB to maintain clean data and to minimize delays in the claims processing cycle.

CMHB also instituted the use of "Attachment A" reports to notify providers of potential duplicate claims and "Attachment B" reports as a mechanism for providers to correct data or reverse previously paid claims that were billed in error. These reports are available to peer mental health boards as well. CMS Unit staff review these reports as they are received and, when completed, send confirmation back to the provider to let them know what Electronic Remittance Advice (ERA) will be impacted by the changes. An ERA is a report from ODMH that states which claims have been paid. Efforts to communicate with contracted providers regarding billing issues at the beginning of the process helps to alleviate labor-intensive problem solving when errors are found in the 90-day claims processing cycle.

R5.21 The CMS Unit should continue communicating with contracted providers to solve billing process errors; however, the CMS Unit should also monitor the occurrence of these errors to reduce the number of future hold-status claims. Monitoring errors and reducing the number of hold-status claims will increase the speed at which contracted providers are reimbursed for services rendered, improving the efficiency of the mental health system.

F5.27 In an effort to maintain internal controls, non-Medicaid pricing functions are currently performed within the Finance Unit at CMHB. The CMS Unit, however, is dependent on the timely receipt of non-Medicaid pricing reports to complete weekly claims billing processes. The vast majority of pricing schedules for non-Medicaid services is performed annually between July and October and then entered into MACSIS. Changes or claims billing issues necessitating verification of pricing do occur on a smaller scale throughout the year. A delay in the verification process subsequently can create problems in completing that week's claims processing cycle. At Franklin MHB, final

approval and entry into MACSIS of non-Medicaid pricing is performed by the director of claims/pricing after initial testing and approval processes are completed by the finance unit.

To reduce communication gaps between the Finance and CMS Units regarding non-Medicaid pricing issues and contracted provider inquiry follow-up, the CMS manager has developed clearly defined procedures to facilitate internal communications regarding pricing issues. Specific understanding of procedures and roles assists in the timely completion of claims processes. An annual audit of all pricing in the system would further reduce pricing errors by identifying and correcting pricing errors that may still exist in the system.

R5.22 CMHB should monitor and review current procedures for enhanced internal communications between the Finance and CMS Units for efficiency. Furthermore, an annual audit of all non-Medicaid pricing should be considered in a proactive effort to further reduce opportunity for pricing errors. If appropriate, regular deadlines should be established to expedite the exchange of non-Medicaid pricing reports from the Finance Unit to the CMS Unit. The following efficiencies may be achieved if the CMS Unit is provided with timely pricing reports:

- Reduce paper handling between the Finance and CMS Units;
- Streamline communications to one centralized location for providers;
- Reduce risk to providers of losing dollars by claims being filed incorrectly; and
- Reduce overall workload of Finance and CMS Unit staff.

Ultimately, enhanced internal communications and the timely exchange of non-Medicaid pricing reports allow CMHB to reduce errors in claims processing and expedite claims payments to contracted providers.

F5.28 CMHB customizes and transmits the *MACSIS Bulletin* as a means of providing up-to-the-minute claims processing information to providers. ODMH creates statewide bulletins regarding system changes and posts them on the website. CMHB then makes any necessary modifications to customize the bulletin for CMHB providers and electronically disseminates the *MACSIS Bulletin* via fax and e-mail. Between March 2001 and February 2002, CMHB distributed 16 bulletins to contracted providers as a means of sharing information on various claims-related topics including upcoming submission changes, and how the provider should implement any necessary procedural changes. The bulletins are sent on an as-needed basis, rather than monthly, to ensure immediate provider awareness of any changes in procedure. Peer boards also communicate process changes to providers via fax, e-mail and letters.

As the primary users of MACSIS, providers must implement any ODMH required changes in claims processing. Keeping providers informed of changes as they occur helps avoid questions later and reduces the likelihood of miscommunication. The CMS Unit initiates one-on-one meetings with providers, when necessary, to answer questions, review processes, or discuss any problems or issues with claims billing. The timely sharing of information is important in terms of maintaining accurate and timely billing, informing providers of both State and board level changes, and for giving instruction on a particular process as needed.

Offering pertinent and timely claims processing information through the *MACSIS Bulletin* ensures contracted providers are trained on how to handle process changes and to promote accountability. Sending updated information on an as-needed basis helps to avoid miscommunications and proactively answers questions which may arise as a result of procedural changes. These efforts increase the understanding of provider requirements regarding the submission of claims.

F5.29 Although the Provider Relations Unit was established to address general questions from contracted providers, CMHB does not have a centralized communications path for provider inquiry regarding claims related issues. Two claims specialists, as well as the claims manager, currently provide help desk type services for provider inquiries and collectively receive nearly 20 inbound calls per day. Contracted provider inquiries usually involve payment delays and billing and filing errors. The Finance Unit and Provider Relations Unit also receive inbound calls; however, provider relations staff members can only answer general, non-technical questions due to their limited access to MACSIS and consumer confidentiality rules. Other divisions often instruct providers to simply resubmit claims which should be forwarded to the CMS Unit for research.

At peer mental health boards, provider inquiries are typically directed to their respective claims units. Similar to CMHB, Stark MHB member maintenance specialists spend approximately 20 percent of their time providing help desk functions on claims related questions; returning all phone calls from providers and responding to inquiries in a timely manner.

Without consistent, well-informed guidance regarding claims, contracted providers are likely to receive misinformation and may lose confidence in CMHB's ability to process claims in a timely and efficient manner.

R5.23 CMHB should develop a centralized help desk for contracted provider inquiry by designating staff in the CMS Unit to receive all claims-related questions. This should help CMHB avoid miscommunication resulting in billing errors, and strengthen provider relationships and overall confidence in CMHB's ability to process claims effectively.

Internal performance indicators should also be developed and tracked to measure the efficiency and effectiveness of CMS Unit help desk functions (see **R5.20**).

Financial Implications Summary

The following table is a summary of estimated costs and savings associated with the recommendations in this section. For the purpose of this table, only recommendations with quantifiable financial impacts are listed.

Summary of Financial Implications

Recommendation	Estimated Annual Cost Savings	Estimated One-Time Implementation Costs
R5.12 Phase out use of individual printers and increase use of the four shared network printers	$2,800	
R5.13 Replace Bud server and reduce associated outsourcing costs	$1,500	4,500
Total	**$3,300**	**$4,500**

Conclusion Statement

CMHB relies on its MIS and CMS Units to ensure goals for provider information sharing and member billing are met and are accountable to the State for maintaining standards in claims processing. The MIS and CMS Units are uniquely linked due to the technical nature of their respective operations. Therefore, the current organizational structure of these units is reasonable. Completion of claims processing functions are also dependent on timely receipt of non-Medicaid pricing reports, a function currently performed in the Finance Unit. CMHB should monitor and review current procedures for enhanced internal communications between the Finance and CMS Units. Ultimately, enhanced internal communications and the timely exchange of non-Medicaid pricing reports allow CMHB to reduce errors in claims processing and expedite claims payments to contracted providers.

MIS Unit staffing levels comprise approximately nine percent of total CMHB staff and are commensurate with the peers based on available workload measures. Since the MIS Unit does not track computer service requests and lacks reliable budgetary information, appropriate unit staffing levels are difficult to determine. Although Cuyahoga County's mental health consumer population is larger than the peers, CMS Unit staff sufficiently processes its relatively high number of claims and member enrollments. Without additional internal performance indicators, however, not only will proposed increases in staffing levels be difficult to justify, but CMHB will be unable to effectively evaluate the success of completed work and corresponding outcomes. It is important that the performance indicators be aligned with the proposed agency-wide strategic plan and the BOG vision of mental health in Cuyahoga County.

CMHB does not have a comprehensive strategic technology plan to address short and long-term technology needs. Either the Executive Committee or another standing committee should develop this plan and help coordinate other technology planning initiatives. For example, the Executive Committee should appoint a taskforce to write a technology equipment replacement plan. The technology replacement plan could become one of the MIS Unit's short-term goals and should be tied to the recommended strategic technology plan. Furthermore, CMHB should finalize, approve and annually test its disaster recovery plan with collaboration from ADAS to provide an adequate computer system back-up.

Although the director is responsible for the fiscal management of the MIS Unit, CMHB's budget process is incapable of providing monthly general ledgers or expenditure reports. As a result, the budget process does not serve as a management tool for the MIS director. The absence of budget detail reports at CMHB hinders planning and management and the ability for each unit to operate as efficiently as possible. For example, outsourcing for information technology services has expanded at CMHB and, within the past year, outsourcing expenditures have nearly doubled. According to the MIS Director, these costs have increased due to firewall upgrades, as well as upgrades in the network operating system, and the redesigning of CMHB's network architecture. Though outsourcing is necessary at times, CMHB can effectively control costs and manage its

need to outsource by assessing internal capabilities and including training as part of future outsourcing contracts.

The MIS Unit has provided for the effective development of its technical architecture using Citrix and Ethernet upgrades. To more efficiently enable file sharing among units and contracted providers, CMHB should require standardized use of one office suite software application. Furthermore, by replacing its outdated VMS Bud server, CMHB should be better able to support any new internal accounting software. Furthermore, the MIS director should facilitate measures for appropriate CMHB employees to gain access to FAMIS via the Internet. In addition to determining the status of provider claims, other pertinent accounting information could be shared electronically through the Internet. Gaining FAMIS inquiry-only access would allow staff members to more readily track, process and determine payment status of provider claims. To better serve providers, CMHB should develop a centralized help desk for contracted provider inquiry to receive all claims-related questions. The claims help desk should be centralized in the CMS Unit and should help CMHB avoid miscommunication resulting in billing errors, and strengthen provider relationships and overall confidence in CMHB's ability to process claims effectively.

Risk Management and Consumer Affairs

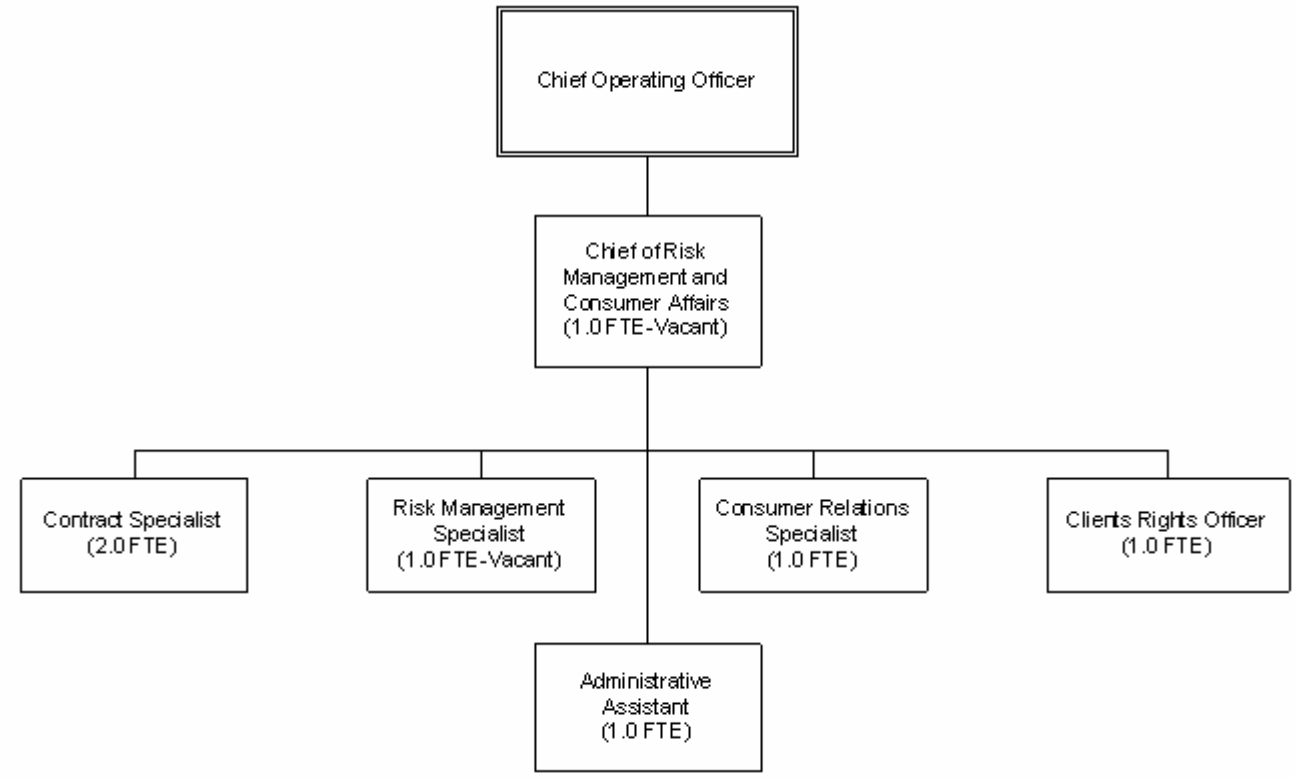
Background

This section of the performance audit assesses the operations and departmental functions of the Risk Management and Consumer Affairs Division (RMCA) within the Cuyahoga County Community Mental Health Board (CMHB). For the purpose of illustrating various operational issues, comparisons are made throughout the report with peer mental health boards in Franklin, Stark and Lucas counties. In addition, information regarding best practices was gathered and used from other Federal and nationally-recognized sources, including the U.S. Department of Health and Human Services (DHHS) and the National Alliance for the Mentally Ill (NAMI).

Organization Chart

Chart 6-1 provides an overview of RMCA's organizational structure and FTE staffing levels as of January 2002.

Chart 6-1: RMCA Organizational Chart



One of the two contract specialists left CMHB in June 2002. However, since the position was filled during the majority of the audit, calculations were made based on the number of FTEs as of January 2002. RMCA consists of two units, risk management and consumer affairs. The Risk Management Unit (RM Unit) is staffed with two contract specialists and a vacant risk management specialist. The Consumer Affairs Unit (CA Unit) is staffed with a consumer relations specialist and a client rights officer (CRO). The administrative assistant provides support for both units. As of January 2002, RMCA has approximately 71 percent, or 5 out of 7, of its positions filled.

Organization Function

According to CMHB job descriptions, RMCA staff is responsible for the following activities:

- Create and communicate policies and procedures to staff concerning risk management at CMHB;

- Draft contracts between CMHB and service providers as well as for any other contracted services, such as consulting or training;
- Participate in the compliance monitoring process;
- Develop and communicate the contract monitoring task assignment matrix to other CMHB staff;
- Review and analyze system wide performance to ensure consistency among contracted providers;
- Monitor contracted providers in their efforts to resolve alleged client rights violations and consumer relations problems;
- Investigate client rights claims of abuse and neglect; and
- Educate CMHB staff and providers regarding all applicable laws and regulations as interpreted by CMHB legal counsel.

Risk management staff is primarily responsible for those duties related to drafting contracts, developing risk management policies and procedures and providing legal counsel to CMHB. In addition, the RM Unit performs internal training for CMHB staff on various contract issues. Consumer affairs staff assumes responsibility for client rights issues including investigating claims of abuse and neglect, working with contracted provider CROs, and conducting community outreach to advise consumers of their rights.

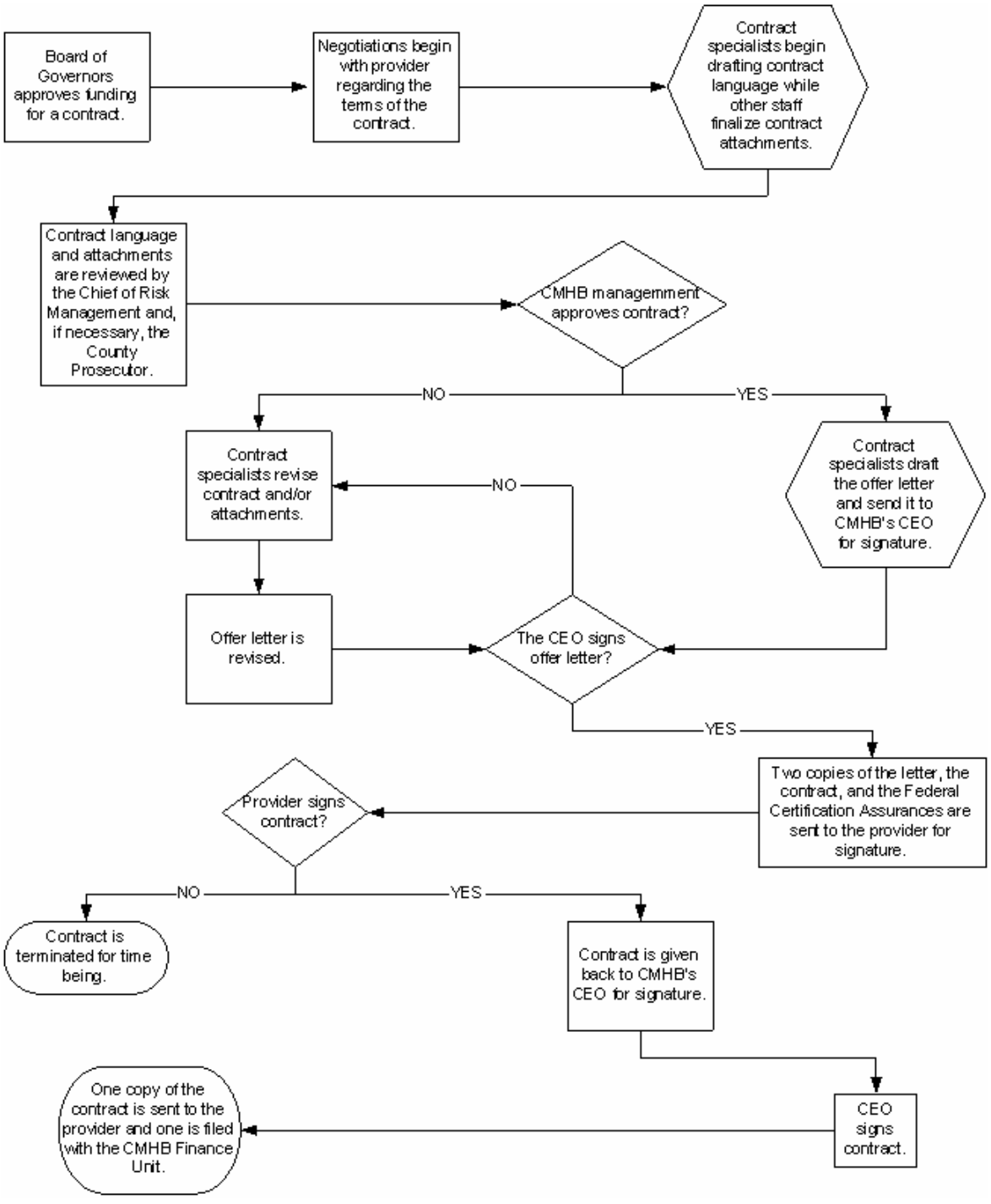
Summary of Operations

RMCA was created in 1997. Prior to its creation, risk management functions were completed primarily by the Cuyahoga County Prosecutor's Office. The decision to combine the risk management and consumer affairs functions was based on the common legal background shared by nearly all Division staff. CMHB, therefore, determined all legal staff should be managed by legally trained staff as well.

The RM Unit consists of two contract specialists who are typically overseen by the chief of RMCA. This Unit is primarily responsible for drafting and developing contracts with provider agencies. In addition, the RM Unit drafts contracts between the Board of Governors (BOG) and other entities for services such as training or consulting. This process begins once BOG passes a resolution authorizing the expenditure of funds for a particular program. Risk management staff also develops and distributes a matrix to all CMHB staff regarding contract monitoring and each division's respective obligations in the process. The matrix is updated on a regular basis to reflect changes with provider contracts.

The contract drafting and approval process is depicted in **Chart 6-2**.

Chart 6-2: The Contract Drafting Process



Risk management staff is responsible for producing the actual contract document once BOG has approved an authorizing resolution. This process involves negotiating with contracted provider staff to determine payment and the exact nature of services the agency will provide for CMHB consumers. The draft is reviewed internally at CMHB for language and content. Once the contract is approved by CMHB management, it is forwarded to the provider along with a copy of the Federal Certifications to sign. The Federal Certifications consist of laws by which CMHB and all its contracted providers must abide. If the provider signs all the associated documents, the contract is sent to CMHB's CEO for signature. Once this occurs, the contract is in full effect. Copies of the signed documents are sent to the provider and filed at CMHB.

The RM Unit is also responsible for keeping apprized of relevant risk management issues, developing policies and procedures regarding these issues, and sharing the issues with staff. For instance, if BOG passes a resolution regarding how to approach a certain client rights issue, it would be the responsibility of RMCA to communicate this policy to the rest of the organization. In addition, the chief of RMCA serves as CMHB's liaison to the County Prosecutor who is the organization's legal counsel according to the Ohio Revised Code (ORC). In cases where CMHB legal staff is unable to answer a question from BOG, the Assistant County Prosecutor would be contacted for an opinion on the issue.

The CA Unit consists of the chief of RMCA who supervises the CRO and the consumer relations specialist; however, the chief position is currently vacant. The consumer relations specialist acts as the first point of contact for consumers and family members. Consumer affairs staff receives all inquiries, complaints and grievances from people contacting CMHB. Initial contacts are either resolved by the consumer relations specialist or referred to the CRO for further investigation and resolution. The CRO conducts field investigations if required.

All contacts receive a response and consumer affairs staff speaks with each contact immediately or within 24 hours. If the CA Unit does not have jurisdiction over the issue, or the investigation requires the assistance of others, the individual is referred to the appropriate third party entity. For example, a consumer seeking a support group for schizophrenics may be referred to the local chapter of NAMI.

The CA Unit receives, records, and resolves three types of contacts: inquiries, complaints, and grievances. All calls received by the CA Unit are documented in the consumer affairs database. The database generates data for the CRO Annual Summary, enables the CA Unit to track trends and patterns, and permits the CRO and the consumer relations specialist to easily and quickly share information regarding contacts.

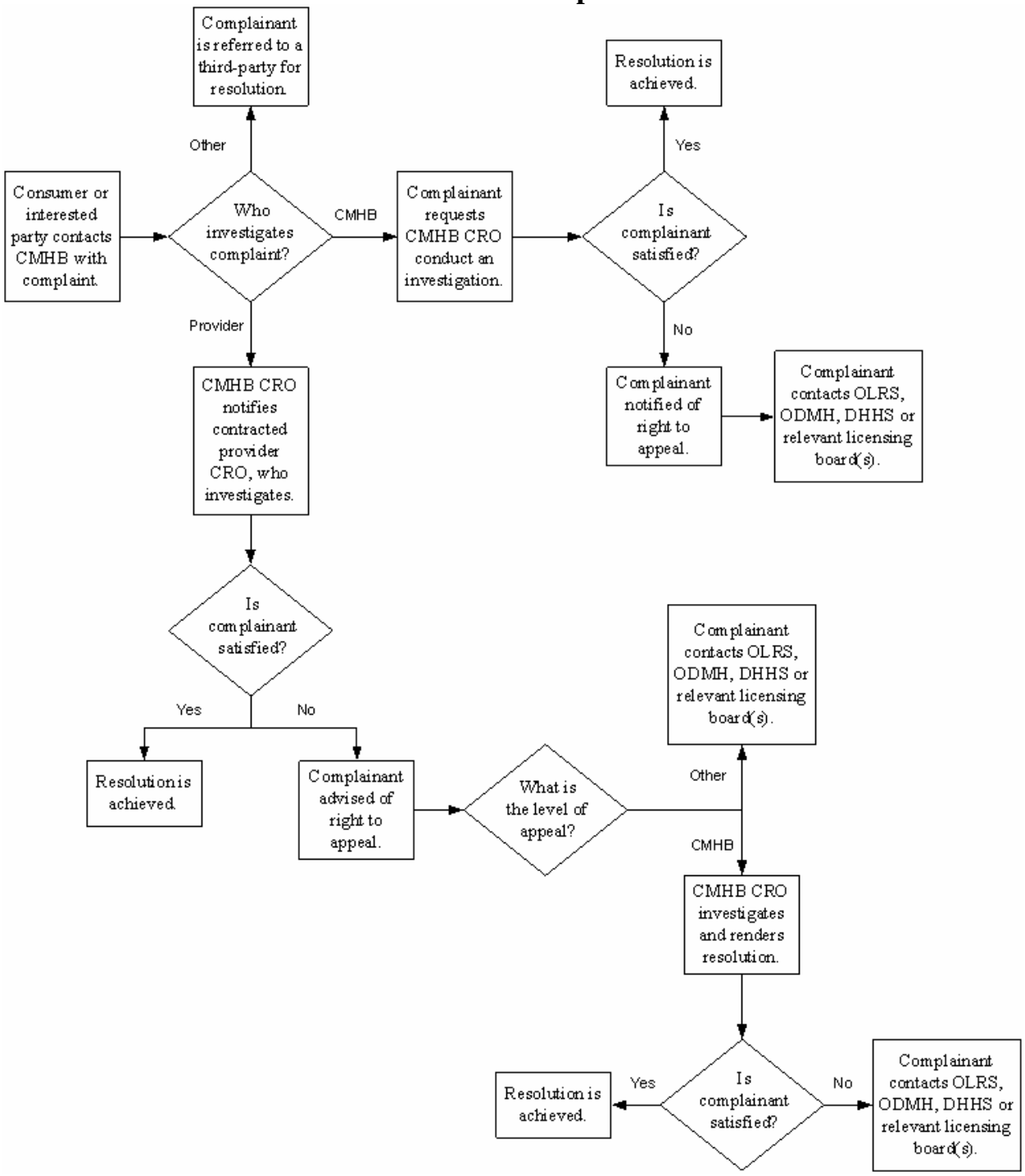
Per Ohio Administrative Code (OAC) 5122-2-1-02, grievants can initiate a complaint with any or all of the following entities:

- Contracted provider;
- Community mental health board;
- Ohio Department of Mental Health (ODMH);
- Ohio Legal Rights Service (OLRS);
- U.S. Department of Health and Human Services (DHHS); and
- Appropriate professional licensing and regulatory associations.

The CMHB inquiry resolution process is initiated when a consumer, family member, or third party contacts CMHB either by phone, letter or personal visit. These contacts are distinguished in ODMH's *Client Rights Manual* as, "A request for information that would clarify policy, procedures, services or any aspect of the complaint, grievance, mediation or appeal processes that might be in question." Inquiries are contacts for which CMHB provides information, refers the person to the appropriate service, or redirects the person to the proper entity. In FY 2001, there were 2,016 inquiries of CMHB. These contacts are immediately resolved by the CA Unit or referred to a third party if the issue is not related to mental health services funded by CMHB. For example, consumers who are having problems with their food stamps are referred to the Citizens of Cuyahoga County Ombudsman Office.

Chart 6-3 depicts the complaint resolution process after the point of initial contact. The CRO Annual Summary defines a complaint as a contact which expresses dissatisfaction with CMHB's service system and requires investigation and resolution on a level which is flexible and less formal.

Chart 6-3: CMHB Complaint Process



ODMH's *Client Rights Manual* defines a complaint as,

> Any concern communicated by a client or another person questioning the personal care or clinical treatment received by the person served, the environmental conditions, or any aspect of services received. Complaints consist of issues less severe and complex than a grievance. Any complaint alleging violation, denial, exercise or abuse of client rights is considered a grievance. A complaint is a less formal process than a grievance.

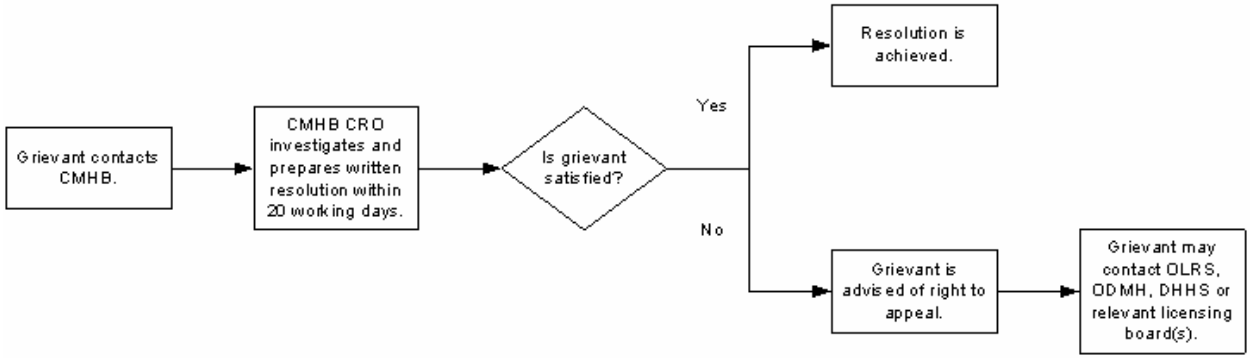
In a sample complaint, a consumer alleged she was treated rudely by a contracted provider staff member. In FY 2001, CMHB logged 295 complaints. Complaints, along with grievances and inquiries, are all logged into the consumer affairs database and entered onto an *Inquiry and Complaint/Grievance Report Form*, which will be discussed in greater detail later in this section.

Unless the complainant specifically requests the CMHB CRO to conduct the investigation, the complaint is forwarded to the appropriate contracted provider CRO. A consumer or family member may not feel the contracted provider's CRO will objectively investigate the complaint or may fear retribution, and can, therefore, request CMHB's CRO to conduct the investigation. Of the 295 complaints received in FY 2001, 215 were forwarded to the appropriate contracted provider CRO for investigation and an additional 35 were referred to third-party entities. Although contracted provider CROs spearhead these investigations and independently render resolutions, they may consult with CMHB's CRO. CMHB's CRO independently investigated 18 complaints and co-investigated an additional 27 with the residential specialist regarding adult care facilities.

CMHB policy requires complaints to be resolved within a reasonable time frame, defined as 30 calendar days. After investigation by either the contracted provider CRO or CMHB's CRO, a written resolution is forwarded to the complainant. Contracted provider CROs are required to send the CA Unit a written resolution detailing what the provider has done to resolve any complaint initially received by CMHB. Those CROs who fail to respond within 30 calendar days receive written notification from CMHB's CRO. This notification is also sent to the contracted provider's executive director and may be shared with CMHB's BOG. Complaints are investigated by either contracted provider CROs or CMHB's CRO. CMHB's CRO investigates a complaint if the consumer specifically requests that CMHB investigate. At any point during the process, the complainant may also contact ODMH, OLRS, DHHS and/or any relevant licensing board for resolution.

Chart 6-4 depicts the grievance resolution process after the point of initial contact. According to the CRO Annual Summary, a grievance is a contact which alleges a violation and must be investigated and resolved on a formal level employing a prescribed protocol.

Chart 6-4: CMHB Grievance Process



A grievance is defined in ODMH's *Client Rights Manual* as,

> Any unresolved written complaint initiated either verbally or in writing or a concern of a severe and complex nature expressed by a person served or any other person(s) or agency on behalf of a person served regarding the personal care or clinical treatment received by that person, environmental conditions, any other aspects of services received or the denial, abuse, exercise or violation of the rights of the person served. The filing of a grievance must follow the established and required procedure at the agency, board or Department.

Grievances are recorded in a manner similar to complaints, but generally deal with alleged abuse and/or neglect. In a sample grievance, a mother alleged contracted provider staff used excessive means to restrain her son. All grievances received by CMHB are investigated by CMHB's CRO, who works closely with the contracted provider CRO. This is unlike a complaint investigation where CMHB's CRO may turn the investigation over to the contracted provider CRO. Once the investigation is complete, a letter is sent to the grievant outlining the allegations and applicable rules, policies, procedures and laws, as well as the finding. Copies of the letter are also sent to CMHB's CEO and chief of RMCA and the contracted provider's CRO. Grievances must be resolved within 20 working days in accordance with OAC 5122:2-1-02.

Key Operating Statistics

Table 6-1 illustrates key risk management operating statistics for CMHB and the peer boards.

Table 6-1: FY 2001 Risk Management Board Comparisons

	CMHB	Franklin MHB [1]	Lucas MHB	Stark MHB	Peer Average
Number of Provider Contracts	37	47	13	13	24.3
Total Revenue for FY 2001	$91,951,758	$103,607,328	$34,081,514	$27,351,935	$55,013,592
Risk management FTEs	3.0 [2]	1.9	0.5	0.5	1.0
Contracts per FTE	12.3	24.7	26.0 [3]	26.0 [3]	24.3
Average amount per contract	$2,485,183	$2,204,411	$2,621,654	$2,103,995	$2,263,934
Total Consumers Served	30,238	38,938	13,650	8,209	20,266
Consumers per Risk Management FTE	10,079	20,494	27,300 [4]	16,418 [4]	20,266

Source: Financial and contract records from CMHB, Franklin, Lucas, and Stark MHBs

[1] Because Franklin MHB contract management staff is responsible for both mental health and alcohol and drug abuse service contracts, the total number of contracts and funding for both areas are included in this analysis.

[2] The Chief of RMCA is excluded from this FTE count.

[3] Stark and Lucas MHBs do not have 26 contracts; however, this number represents the relative number of contracts per FTE when compared to CMHB.

[4] Lucas and Stark MHBs do not have 27,300 and 16,418 consumers, respectively; however, these numbers represent the relative number of consumers served per FTE compared to CMHB.

In general, CMHB is responsible for more providers and more funding than most of the peers. Only Franklin MHB has more contracted providers and more funding because its contract management staff is responsible for both mental health and ADAS contracts. Furthermore, CMHB distributes approximately the same amount per provider as the peer average. The three FTEs for CMHB represent the two contract specialists and the vacant risk management specialist position. CMHB's risk management staff is responsible for approximately half as many contracts per FTE as the peer average. In addition, CMHB risk management staff serves far fewer consumers per FTE than the peer average (see the *Department Staffing Levels and Organizational Structure* sub-section for more discussion).

Table 6-2 compares key consumer affairs operating statistics for CMHB and the peer boards.

Table 6-2: FY 2001 Consumer Affairs Board Comparisons

	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average
Client Rights FTE	1.4	1.1 [1]	0.3	0.5	0.6
Consumer Relations FTE	0.6	N/A [2]	N/A [2]	N/A [2]	N/A [2]
Number of FTEs	2.0 [3]	1.1	0.3	0.5	0.6
Number of Contracted Providers	37.0	23.0 [4]	13.0	13.0	16.3
Contracted Providers per FTE	18.5	20.9	43.3	26.0	27.2
Total Consumers	30,238	38,938 [5]	13,650	8,209	20,266
Consumers per FTE	15,119	35,398	45,500	16,418	33,776
Number of Contacts	2,329	N/A [6]	N/A [6]	N/A [6]	N/A [6]
Total complaints and grievances received by the MHB	313.0	132.0 [7]	20.0	14.0	55.3
Number of complaints and grievances received by the MHB per FTE	156.5	120.0	66.7	28.0	92.2
Number of complaints and grievances investigated by the MHB	63.0	5.0	0.0	14.0	6.3

Source: CMHB and peer records

Note: If a peer did not have a position with the same title as the CA Unit, the job responsibilities of other positions were analyzed to determine the FTE.

[1] Franklin MHB's alternate CRO spends 15 percent (0.15 FTE) of his time performing client rights work; when rounded this becomes 0.2 FTE.

[2] None of the peers has a unique, internal position which performs work similar to CMHB's consumer relations specialist.

[3] The Chief of RMCA is excluded from this FTE count.

[4] These are mental health providers only.

[5] This represents the total consumers receiving mental health services or drug and alcohol services, or both. The number of total consumers receiving mental health services is 29,317.

[6] Only CMHB formally tracks the total number of contacts received. This includes inquiries, complaints and grievances.

[7] This includes the complaints and grievances received by Franklin MHB regarding alcohol and drug addiction services, as well as those received regarding mental health services. Franklin MHB does not formally track inquiries.

The CA Unit maintains a total of 2.0 FTEs, which is significantly higher than the peer average. None of the peer boards, however, have a position similar to the consumer relations specialist who spends approximately 40 percent of his time performing client rights related work and 60 percent performing consumer relations related work. CMHB has over twice as many contracted providers as the peer average. Additionally, CMHB serves nearly 10,000 more consumers and receives a significantly higher number of complaints and grievances than the peer average (see the *Department Staffing Levels and Organizational Structure* sub-section for more discussion).

Performance Measures

The following list of performance measures was used to conduct the review of CMHB's RMCA Division:

- Review historical and background information
- Assess department staffing levels and organizational structure
- Assess contract development process
- Examine contract-related tasks, especially monitoring activities, in overall agency and possible overlap
- Review risk management practices, policies and activities
- Assess adequacy of clients rights programs, policies, processes and procedures
- Evaluate programs and processes for addressing consumer concerns, maintaining or enhancing consumer relationships and obtaining/integrating their input

Findings / Commendations / Recommendations

Department Staffing Levels and Organizational Structure

F6.1 **Table 6-3** shows staffing levels for RMCA as compared to the peers. The comparison was made based on the responsibilities of each position at CMHB. If a peer did not have a position with the same title, the job responsibilities of other positions were analyzed to determine the FTE.

Table 6-3: Staffing Comparison as of January 2002

	CMHB		Franklin MHB	Lucas MHB	Stark MHB	Peer Average
Positions	**Budgeted FTE**	**Actual FTE**	**Actual FTE**	**Actual FTE**	**Actual FTE**	**Actual FTE**
Chief of RMCA	1.0	0	0	0	0	0
Contract Specialist	2.0	2.0	1.9[1]	0.5[1]	0.5[1]	1.0
Risk Management Specialist	1.0	0	0	0	0	0
Client Rights Officer	1.0	1.0	1.1 [2]	0.3 [3]	0.5 [4]	0.6
Consumer Relations Specialist	1.0	1.0	0	0	0	0
Administrative Assistant	1.0	1.0	0	0	0	0
Total Staff	**7.0**	**5.0**	**3.0**	**0.8**	**1.0**	**1.6**

Source: CMHB human resource information and peer interviews

[1] Peer totals for the contract specialist position only include time spent in contract development, not contract monitoring.

[2] Franklin MHB's consumer and family advocate is the appointed CRO and spends 90 percent of his time performing client rights work. The consumer services manager is the designated alternate CRO and spends 15 percent of his time performing client rights work.

[3] Lucas MHB's director of member services is the appointed CRO. The director of quality improvement serves as the alternate CRO and spends less then five percent of her time on client rights work. When rounded to the tenth this becomes 0.0 and Lucas MHBs staffing remains 0.3 FTE.

[4] Stark MHB's associate director is the appointed CRO and the director of care management is the designated alternate CRO. The clinical specialist and the support specialist also perform client rights work. These four positions account for the 0.5 FTE. Stark does fund an external consumer advocate who spends less than five percent of her time performing client rights related work. When rounded to the nearest tenth, this becomes 0.0.

Table 6-3 demonstrates CMHB is organized quite differently from the peers in terms of its risk management, contract development, and consumer affairs functions. The peers do not combine these functions in the same division. Furthermore, the peers do not have

staff dedicated directly to positions equivalent to the chief of RMCA, the administrative assistant or the consumer relations specialist.

F6.2 Based on its budgeted number of positions and select comparisons presented in **Table 6-1** and **6-3**, the RM Unit is currently overstaffed. According to **Table 6-3**, the RM Unit has twice as many contract specialist FTEs than the peer average. In addition, **Table 6-1** indicates that the RM Unit's ratio of contracts and consumers per budgeted FTE is the lowest of the peers. Although CMHB contracts with 37 providers, or 13 more than the peer average, **Table 6-1** indicates that the number of contracted providers per unit FTE at CMHB (12.3) is approximately half the peer average (24.3). Furthermore, as illustrated in **Table 6-1**, the RM Unit serves half as many consumers per unit FTE (10,079) than the peer average (20,266).

Of the peers, only CMHB employs a full-time risk management specialist, which is currently vacant. BOG does not plan to fill this position in the near future due to budget constraints. As a result, the risk management activities outlined in the position description have not been completed. The main responsibilities of the risk management specialist involve planning and writing policies for risk management at CMHB. However, staff indicates the absence of a risk management specialist has not caused any major problems. In fact, the position and its responsibilities were rarely mentioned by staff during the performance audit.

The peers do not have a risk management specialist position or another position which performs similar functions. In fact, the peers do not view these functions as necessary. As discussed in **F6.20**, peers interpret risk management as largely an insurance issue, while CMHB views it as an internal legal issue. For instance, Franklin MHB addresses its risk management needs by contracting with an outside consultant. Staff at Franklin MHB report this consultant also handles its insurance needs and is called in several times per year to review any changes to policies and procedures for risk implications. In addition, every few years, the consultant reviews the policies and procedures in their entirety to ensure validity. Franklin MHB staff members consider this a beneficial function which allows them to devote attention to other matters.

CMHB also employs a full-time administrative assistant for RMCA. The administrative assistant performs basic administrative functions such as copying and filing for the CA Unit and helps support other consumer advocacy functions as needed. The administrative assistant, however, performs only minimal tasks for the RM Unit. None of the peers employ a full-time administrative assistant dedicated to risk management and consumer affairs support functions.

R6.1 CMHB should eliminate the risk management specialist position, as its vacancy has not significantly impacted the RM Unit's workload. This reduction would allow CMHB to focus funding on higher priorities and more closely align risk management staffing levels with those of the peers. In conjunction with the risk management policy discussed in **F6.20**, CMHB should consider other ways to address risk management needs, such as assigning the duties to other staff currently performing similar duties or contracting for services similar to Franklin MHB.

Financial Implication: The average salary and benefit cost for other staff in the RM Unit was approximately $50,000 in FY 2002. Assuming the risk management specialist would receive a similar salary, CMHB could realize a cost avoidance of approximately $50,000 in salary and benefits if the position was eliminated.

R6.2 In conjunction with reorganizing RMCA (see **R6.3**), CMHB should transfer the current administrative assistant to the Human Resources Unit to fill the human resource specialist position. The transferred administrative assistant should be trained internally to perform the duties of the human resource specialist (see **human resources**).

Additionally, CMHB should reduce the RMCA administrative assistant position to part-time and reassign the position solely to the CA Unit. Reassigning the administrative assistant to the CA Unit will help accommodate the relatively high number of complaints and grievances handled by the consumer affairs staff.

Financial Implication: By transferring the current administrative assistant to fill the human resource specialist position, CMHB could reduce the administrative assistant position to half-time, resulting in a cost savings of approximately $24,000 annually. The annual costs of filling the human resource specialist position are included in the **human resources** section.

F6.3 Although the CA Unit appears overstaffed compared to the peer boards, CMHB's workload is much larger than the peers and justifies the relatively high staffing levels. According to **Table 6-3**, CMHB employs 2.0 FTEs for consumer affairs and client rights activities, which is significantly higher than the peer average of 0.6 FTEs. Furthermore, of the peer boards, only CMHB employs a full-time consumer relations specialist who performs the following key functions:

- Receives and resolves the majority of inquires, which in FY 2001 totaled more than 2,000 calls (see **Table 6-2**);
- Documents in the consumer affairs database contacts received (**F6.22**);

- Refers consumers, family members and other parties to the appropriate third-party entity (**F6.28**); and
- Co-facilitates CRO Focus Group meetings (**F6.31**) and consumer Brown Bag Lunches (**F6.33**).

As a trained social worker with experience in mental health services, the consumer relations specialist is well suited to provide an appropriate level of guidance for those who contact CMHB. Given the volume of inquiries received by CMHB and its efforts to document and track inquiry and consumer-related data, current staffing levels appear appropriate. Accurately documenting inquiries is critical because they indicate system trends and patterns, as well as gaps in service. Of the peer mental health boards, only CMHB actively documents and tracks this information. Although the CA Unit serves approximately half as many consumers per FTE and half as many contracted providers per FTE as the peer average, the CA Unit receives significantly more complaints and grievances per FTE than the peer average which justifies its higher staffing levels (see **Table 6-2**).

Possible factors, positive and negative, which could contribute to the higher percentage of complaints and grievances handled by CMHB and include the following:

- Better informed consumers and family members;
- Different methods for recording complaints and grievances;
- Harder to serve consumers; and
- Poor performance by contracted provider staff.

Since these factors are difficult to measure and are not documented or tracked by mental health boards, it is very difficult to determine which factors contribute more to the higher percentage of complaints and grievances at CMHB. Although it is difficult to determine the exact reasons CMHB receives more complaints and grievances than the peers, the CA Unit is still required to respond accordingly.

As indicated in **Table 6-2**, CMHB received 313 complaints and grievances in FY 2001. Of those, 215 were independently investigated by contracted provider CROs and 35 were referred to the appropriate third-party entity. CMHB's CRO independently investigated 36 and co-investigated an additional 27 complaints and grievances with CMHB's residential specialist regarding adult care facilities. This number is significantly higher than the peer average, indicating CMHB's higher staffing level allows the CA Unit to investigate and help resolve a significantly higher number of complaints and grievances than the peers.

F6.4 The RMCA Division does not appear to be a reasonable or effective combination of units, based on their respective organizational functions. According to CMHB, the RMCA Division was formed in 1997 due to the common legal backgrounds of the staff and former chief. In practice, however, the RM and CA Units have little in common and do not currently interact on a regular basis. In the absence of a chief, and given the varied nature of their duties, the RM and CA Units might function more effectively when separated.

CMHB is the only mental health board among the peers with this structure (see **F6.1**). In fact, peers either do not have an internal risk management function or do not specifically assign staff to this area. In addition, peers do not employ a comparable number of legally-trained staff. Instead, to handle routine risk management and other legal issues, Lucas and Franklin MHBs contract with outside consultants (see **F6.21**).

Franklin and Hamilton MHBs, comparable in size to CMHB, organize contract monitoring staff under the business manager, who is also responsible for the financial operations of the agency. Currently, CMHB's contract management staff is required to interact with the Finance Unit to develop provider contracts. Specifically, contract specialists require up-to-date unit costs for accurate provider payments. Therefore, these two units must frequently collaborate to produce accurate and timely provider contract amendments.

ODMH's client advocacy coordinator believes the client rights/consumer affairs functions should be as independent as possible. Consumers, family members and others with client rights and consumer affairs concerns may perceive that CMHB does not value these functions if they are not independent. An independent CA Unit which reports directly to the CEO would promote independence and consumer confidentiality by eliminating undue influence from other divisions. Due to the absence of a chief of RMCA, consumer affairs staff members currently interact with the interim CEO on a daily basis and feel they receive appropriate supervision, support and feedback. The CRO position at Franklin MHB reports to the chief of strategic management, which is similar to CMHB's chief operating officer (COO), and the CRO position at Hamilton MHB reports to the chief clinical officer (CCO).

R6.3 CMHB should divide the RMCA Division along functional lines. Risk management and contracting functions should move into the Finance Unit to foster collaboration between contract management and finance activities. In addition, CMHB should maintain the FTEs allocated to client rights and consumer relations because of the higher complaints and grievances handled by CMHB staff and the additional activities performed by the CA Unit to effectively serve mental health consumers, which will be further discussed and reviewed throughout this report.

Following the reorganization of RMCA and implementation of the recommendations found in the **organization, compliance and board governance** section of this report, the CA Unit should report independently to the CEO, the COO or the CCO. Ultimately, CMHB must decide which option holds the greatest benefit for mental health consumers and their families.

F6.5 Based on the recommended reorganization of RMCA, the position of RMCA chief may no longer be necessary. Although the former functions of the RMCA chief were cited both internally and externally as important to the success of the Division, staff reports that while the presence of the chief was helpful, no major problems have occurred in her absence. The previous chief provided the CA Unit with legal guidance on client rights issues. For the RM Unit, the chief provided advice on issues regarding public information requests and other provider-related legal questions. According to the ORC, however, the County Prosecutor is designated as the official legal counsel for CMHB and currently performs this function. In addition, much of the legal consultation provided by the chief could be performed by an outside consultant, with approval from the County Prosecutor. See the **organization, compliance and board governance** section of this report for recommendations regarding management structure at CMHB, which impacts the chief of risk management position.

F6.6 The consumer relations specialist is not formally designated as the alternate CRO, but in practice, serves this function. In the current CMHB job description, the quality improvement specialist, who is part of the Provider Relations and Quality Services Division, is designated as the alternate CRO. However, the only interaction the quality improvement specialist has with the CRO is to receive the client rights policies and grievance procedures obtained during the CRO's unscheduled visits (**F6.23**).

With the exception of investigations, the consumer relations specialist and the CRO presently share the duties and responsibilities for the CA Unit's operations. Investigations of complaints and grievances are conducted solely by the CRO. Furthermore, AOS found the consumer relations specialist's name and phone number listed as a contact person on the client rights posting at CMHB. The consumer relations specialist's position description does not detail all of his responsibilities and, therefore, cannot be used to fairly and accurately evaluate job performance. See the **human resources** section of this report for additional recommendations concerning position descriptions.

R6.4 The consumer relations specialist's job description should be updated to formally designate the consumer relations specialist as the alternate CRO. An updated job description would formalize current practice and provide management with accurate criteria to evaluate performance.

F6.7 The CA and RM Units develop client rights and risk management goals for each fiscal year, but do not link them to performance measures. Additionally, CMHB has not developed a strategic plan which ties division goals to an agency-wide mission. This is discussed further in the **organization, compliance and board governance** and **planning and system development** sections of this report. As a result, RMCA's goals are not linked to organizational goals. Strategic plans assist organizations in determining their future goals and how they will achieve these goals. Furthermore, the purpose of a strategic planning process is to ensure the direction of the organization is well thought out, appropriate, and resources are properly utilized. Goals are traditionally included in a strategic plan to develop a coordinated and systematic process which charts the direction of an organization's future efforts.

Consumer affairs goals are developed by the consumer relations specialist, CRO and chief of RMCA. Risk management goals are developed by contract specialists and the chief of RMCA. Activities to reach each goal are outlined in a matrix, with their respective due dates, staff assigned and completion dates. For example, the first goal listed for the CA Unit in FY 2001 was to "disseminate data which can be used to produce positive change in the delivery of service to consumers." A corresponding activity required the consumer relations specialist to distribute the CRO Annual Summary to CMHB's BOG, contracted provider executives and CROs, the Citizens of Cuyahoga County Ombudsman Office, OLRS and ODMH by September 30, 2000 and to CMHB staff by October 15, 2000. The consumer relations specialist completed this task on September 27, 2000. The RM Unit has a similar structure for its annual goals.

The development of yearly goals is not required by OAC, ORC, ODMH or CMHB. The goals are strictly an internal process to RMCA. Goals are used to prioritize work and identify trends and patterns. Clearly-defined goals allow for measurable objectives and performance measures to be created which should lead to improvements in decision-making. However, performance measures have not been linked to RMCA's goals. For additional discussion of performance measures, please refer to the **organization, compliance and board governance** section of this report.

The absence of unit goals which are linked to a strategic plan and performance measures hinders management from improving customer service, determining effective resource use and assessing unit performance.

C6.1 Consumer affairs and risk management are the only units in CMHB that develop formal annual goals. In addition, none of the peer MHBs develops annual goals for their client rights/consumer affairs programs. RMCA's annual goals provide clear direction for staff. Progress in achieving these goals can be used by stakeholders to evaluate the unit's

performance, and by CMHB management to conduct performance evaluations for RMCA staff.

R6.5 CMHB should develop a strategic plan with input from RMCA and other units, as well as from key stakeholders. Strategic planning goals should be used as a basis for altering current unit goals, as needed. Once unit goals have been linked to organizational goals, RMCA staff and the CEO should develop performance measures to assess the results of internal performance and goal attainment. The following is a list of consumer affairs performance indicators from which performance measures could be developed:

- Inputs: Staff time used to address inquiries, complaints and grievances;
- Outputs: Successful resolution of inquiries, complaints and grievances;
- Outcomes: CRO mails letter summarizing findings of unscheduled visits to contracted providers within 10 working days;
- Efficiency: Investigate complaints within 30 calendar days; and
- Quality: Percentage increase in consumer and family member satisfaction with resolutions.

Similar indicators should be developed for the RM Unit concerning contract development. When developing performance measures, RMCA should use indicators which address performance beyond complying with OAC/ORC and following CMHB policy. Performance measures would help CMHB evaluate staff performance, improve internal management processes and provide accountability to stakeholders.

Please see the **organization, compliance and board governance** and **planning and system development** sections for additional information on strategic planning.

Contract Development

F6.8 CMHB does not regularly issue formal RFPs to acquire Medicaid, non-Medicaid or other services. According to documentation provided by staff, RFPs are only used on some non-Medicaid projects. Plans produced by the Planning and System Development Division are often used as RFPs; however, the plans (Letters of Interest) are not necessarily designed according to the RFP guidelines. Most contracts at CMHB are for Medicaid services and are initiated by the provider. Since BOG is obligated by Any Willing Provider (AWP) laws to grant a Medicaid service contract to any certified provider agency, BOG must pass a resolution which allocates the funding necessary to accommodate the request. In addition, RFPs are not used for other contracted services, such as research studies (see **F6.17**).

CMHB has a draft policy which includes the following guidelines regarding minimum information for inclusion in the RFP:

- The purpose;
- How the requested service fits the Boards overall plan;
- The target population;
- Funding sources;
- A statement on the secrecy of proposals until the appointed opening time;
- The specific elements to be addressed in the proposal; and
- The criteria that will be used to rate the proposals.

In 2001, the Appalachian Partnership for Welfare Reform released a Contract Management Manual (CMM) which outlines information and standards that should be included in public sector contracts and requests for proposals (RFPs), particularly for the human services area. Moreover, the CMM provides a comprehensive guide to contract management in social service agencies. The CMHB draft policy contains nearly every required RFP element as recommended by the CMM. However, according to documentation provided by CMHB, all the elements listed in the policy are not necessarily included in the Letters of Interest produced by the Planning and System Development Division and used as RFPs. For instance, the Letter of Interest reviewed as part of the audit lacks some of the standard language recommended by the CMM. These standard caveats would do the following:

- Instruct the vendor to be truthful;
- Instruct the vendor to carefully examine the RFP before applying;
- Instruct the vendor that a proposal is a legally-binding contract;
- Outline the process that will be followed for any changes to the RFP;
- Remind the vendor that CMHB will not reimburse them for any costs as a result of the proposal;
- Reserve for CMHB and BOG the right to reject any proposals (non-Medicaid);
- Inform the vendor that any contracts that result from the RFP are contingent on the availability of funds;
- Instruct the vendor to keep confidential items confidential;
- Clearly define any outcomes that will be used to measure performance; and
- Inform the vendor on the type of contract that will be used.

All of these statements provide CMHB with some protection from allegations by vendors of inappropriate selection. They also allow CMHB grounds to deny a potential vendor if it is determined they are not in compliance with one of these requirements.

The peers also did not report using RFPs as a regular practice. Franklin MHB, for instance, has comprehensive RFP procedures but stated they are only used on an as-needed basis for some non-Medicaid contracts. The same was true of the other peers. RFPs are not used for Medicaid services due to the AWP laws which require boards to contract with any Medicaid certified provider. As a result, RFPs can only be used for non-Medicaid related contracts and services.

RFPs ensure the contracting agency receives the services it purchases. According to the CMM, a well-written RFP can also help ensure proposals are submitted in a common format to allow for more efficient selection of the vendor and provide the contracting agency with options for monitoring. Without regularly issuing RFPs, CMHB may not obtain the results intended and may spend scarce resources on inadequate or insufficient services.

R6.6 CMHB should formally adopt its draft policy for RFPs and regularly issue them for non-Medicaid and other services. By consistently issuing RFPs, CMHB would ensure that it receives cost effective mental health services. CMHB should also ensure policies and RFPs are well constructed and include all recommended language from the CMM regarding legal issues, confidentiality, cost restrictions, and other areas outlined above. Furthermore, the Planning and System Development Division should ensure all documents used as RFPs contain such language as well as any performance and outcome measures that will be used to evaluate the provider.

F6.9 CMHB policy does not state who is responsible for developing contract attachments, nor explain the required contents of the attachments, which creates confusion regarding contract development and administration responsibilities. Boilerplate contracts are used for all provider agencies. Boilerplate refers to a template which contains standardized language. To include requirements and funding explanations that are agency specific, CMHB creates attachments which are included along with the boilerplate. **Table 6-4** details each of the attachments.

Table 6-4: CMHB Contract Attachments

Attachment Number	Content	Prepared by:	Can the attachment be modified?
Attachment 1: Schedule of Required Reports	A month by month listing of all reports the provider agency is required to send to CMHB.	Contract Specialists with staff input. Not defined in CMHB policy.	Not usually.
Attachment 2: Allocations Summary, Payment Schedule, Special Financial Reconciliations	Includes maximum value of contract, payment schedule, compensation structure (Fee for Service FFS), and services the provider will supply.	Finance Unit, as defined in CMHB policy.	Yes, for reasons such as the addition of a Medicaid service or the elimination of one.
Attachment 3: Key Financial Performance Indicators	These are statements pertaining to restrictions on transfers among line items, return of unexpended funds, and budget revisions.	Finance Unit. Not defined in CMHB policy.	Not usually.
Attachment 4: Service Specific Requirements	Any specific requirements pertaining to the individual programs or services the agency is contracted to provide.	Various staff in the Planning and System Development, and Provider Relations and Quality Improvement Divisions, as defined in CMHB policy.	Yes.
Attachment 5: Reimbursement Adjustment Schedule	Table outlining the reimbursement schedule on monthly income after allowable adjustments.	Contract Specialists in the RMCA Division with help from other staff. Not defined in CMHB policy.	No.

Source: RMCA staff and contract documentation

Risk management staff is responsible for combining all the attachments with the actual contract while other divisions within CMHB write most of the specific attachments. Internal policy stipulates the unit responsible for creating Attachments 2 and 4, however it does not indicate which is responsible for Attachments 1, 3, and 5. Attachment 1 details the reports the agency is required to submit and Attachment 3 lists key financial performance indicators. Also, not all contracts contained all the attachments. For instance, some did not have an Attachment 5 because it was not applicable.

According to risk management staff, the contract specialists produce Attachment 1, with the input of other staff, and the Finance Unit produces Attachment 3 and 5. Unlike Attachments 2 and 4, 1 and 3 are not specific to the agency and cannot be modified throughout the year. Therefore, their creation is not specified in policy like Attachments 2 and 4.

Since a number of different staff members are involved in the process of developing provider contracts at CMHB, it is important to clearly define key duties and responsibilities to ensure none are overlooked or duplicated. Additionally, a policy that describes the necessary elements ensures continuity among similar contract attachments.

R6.7 CMHB policies should be revised to reflect which positions are responsible for producing all attachments pertinent to a contract. CMHB should be clear about all aspects of the contract development process, not just certain sections. In addition, the policy should outline, generally, what should be contained in each attachment so all attachments are similar in content for all provider contracts. By formally defining contract development responsibilities and requiring similar content in attachments, CMHB would ensure a consistent approach exists regarding contract development. See **R6.17** for specific instructions regarding how the RM Unit should be involved in monitoring the attachments.

F6.10 Provider contracts lack detailed descriptions and expectations for both Medicaid and non-Medicaid services. Attachment 2, the financial allocation summary, lists all services that will be provided as part of the contract, but there is little detail regarding the manner in which these services should be provided. For instance, if a Medicaid contract states the agency will provide services for crisis intervention, CMHB does not include specifics as to how these services must be provided and what is expected of the agency providing them. The same situation exists for non-Medicaid services.

As mentioned previously, the bulk of the CMHB contract is boilerplate and only the attachments are provider specific. Therefore, CMHB must include any information or expectations specific to the provider in the attachments. Service specific requirements are currently listed in Attachment 4. However, staff report the contents of this attachment vary greatly. While some may contain many specific requirements and measurements, others contain very few. In fact, in all Medicaid-only service contracts, Attachment 4 is blank, and does not contain expectations or requirements for services.

The CMM suggests that the purchasing agency know, very clearly, what it is purchasing through the contract. A detailed description of the services to be provided must be included in the contract in a "scope-of-service" section. This should clearly define the type of service being purchased. It should also list the deliverables, expressed in units of service or customers served, as well as the indicators that will be used to determine if the goals of the contract are met. Finally, the scope-of-service should include any benchmarks that will be applied to measure performance.

DHHS's report, "Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers," states performance measures in the mental health field generally fall into the following three categories:

- Measures of administrative processes (claims payment proficiency);
- Measures of clinical processes (compliance with patient placement criteria); and

- Measures of financial/utilization processes (population penetration rates and outcomes).

Essentially, performance-based service contracting should emphasize that all aspects of a contract be structured around the purpose of the work to be performed. These basic definitions should provide CMHB with guidelines on which to base specific measurements for each contracted Medicaid and non-Medicaid service. Due to Medicaid requirements, all providers deliver at least 1 of 16 standard services. Therefore, CMHB can develop one set of measurements and criteria for each type of Medicaid service for use in all provider contracts which refer to that particular service (see **provider relations and quality services** for further information on outcome measures in mental health).

The Office of Federal Procurement Policy (OFPP) states performance analysis should assign a performance requirement to each task, which determines how a service can be measured and what performance standards and quality levels apply. ODMH's Outcomes Initiative aims to apply outcomes to individual treatment, i.e., how a particular patient responds to different care options.

By including specific expectations and deliverables for all Medicaid and non-Medicaid services in the contract, not only will CMHB be able to track individual provider service, it will also help to standardize mental health services in Cuyahoga County by requiring all providers to work from the same set of expectations.

R6.8 CMHB should develop a standard "scope-of-service" definition for all 16 Medicaid services eligible for State funding. These definitions should be included in Attachment 4 according to the specific services being provided and should include performance measurements and benchmarks where applicable. Since most of the contracts at CMHB are for Medicaid services, only one definition for each is necessary. This should help ensure continuity of service among providers since all providers would work from the same scope of services and definitions. In addition, CMHB should develop standard scope definitions for common non-Medicaid services as well. CMHB should consult with ODMH on all definitions and benchmarks developed pursuant to this recommendation. More particularly, CMHB should ensure any measures implemented correlate with the Outcomes Initiative promoted by ODMH. Monitoring of the specific provisions could be added to the functions currently performed on the contracts by PRQS staff.

F6.11 CMHB does not use its enforcement authority, as enumerated in contract language, against providers that fail to abide by the terms of the contract. Currently, CMHB uses one standard contract for all Medicaid and non-Medicaid services, which ultimately prevents CMHB from using its enforcement authority. Federal Any Willing Provider

(AWP) laws require Medicaid funding agencies to distribute funds to any provider that meets basic standards and plans to provide a Medicaid service. CMHB, and other Medicaid distribution agencies, have interpreted this requirement to mean they cannot, in any way, withhold Medicaid funding from providers, even those not meeting the stipulations of the contract. Only when a provider is found substantially incompetent by the State, and their certification revoked, can the Medicaid agency stop the distribution of funds. This, however, is a lengthy process and does not often occur.

When compared to the CMM, the contract contains several areas of weakness, which are discussed in more detail in **F6.14** and **F6.15**. Staff members report providers often do not fulfill some of the administrative provisions of the contract. For instance, some providers are habitually late in submitting annual financial reports. When contracted providers are late in submitting these financial reports, CMHB is unable to accurately track how the providers spend funds (see the **finance and funding** section of this report for additional information).

CMHB currently does not enforce penalties on these providers, even though the contract, in Section 9.2.7, contains specific language which allows CMHB to do so if providers do not meet requirements for timely and complete reporting, compliance with CMHB requests, and documentation of billed services. Conversations with staff and BOG members reveal this is due to hesitation in placing any type of restriction on Medicaid funding.

The same restrictions, however, do not exist for non-Medicaid funds that CMHB distributes both separately and as part of Medicaid contracts. A common non-Medicaid service for which CMHB provides funding is residential housing. CMHB can place additional requirements on these funds that cannot be placed on Medicaid funds because they are not affected by AWP laws. Because CMHB uses one contract for all services, Medicaid or non-Medicaid, it is unable to enforce penalties on the non-Medicaid funds without raising concerns about Medicaid funds and AWP restrictions. As a result, CMHB does not enforce any aspects of either Medicaid or non-Medicaid funding and applies only basic requirements to all funding.

Both Franklin and Lucas MHBs use separate contracts for Medicaid and non-Medicaid funds. This approach allows them to place additional requirements and stipulations on the non-Medicaid funds that cannot be placed on the Medicaid funds due to AWP laws. Conversely, they are able to leave requirements for Medicaid services more general in nature to account for AWP laws. This arrangement allows the mental health boards to enforce non-Medicaid contract provisions and exclude Medicaid funds from enforcement, thereby alleviating any potential legal issues that might arise from such actions.

Table 6-5 outlines the sections of the Lucas MHB non-Medicaid provider contract which place additional restrictions on providers. Again, these restrictions are absent from Medicaid contracts.

Table 6-5: Lucas MHB Non-Medicaid Contract Inclusions

Area	Specific Language or Requirement
Reports	Outlines the consequences for chronically late and error-ridden reports, including withholding funds. This will be done only after the agency has had 10 days written notice and 14 days to submit a corrective action plan for excessive errors.
Records	Outlines the agency responsibilities for maintaining accurate, current, and complete records which must be provided to the Board in a timely manner upon request. Also states all consumer records should be maintained in confidentiality.
Withholding Payments	Allows Board to withhold payments, after notice, to the Agency for reasons, including an event of insolvency relating to the Agency; the suspension of any license or certification required by law or otherwise necessary to the operation of the Agency; reason to believe conditions exist relating to the Agency that represent a substantial risk of harm; reason to believe the Agency is in violation of any Board, State, or Federal billing procedure, rule or regulation; reason to believe a program, service or responsibility funded by the Board is not rendered by the Agency or is rendered in a manner substantially out of compliance with Board funding guidelines.
General	Outlines the responsibility of the Agency to cooperate with Federal, State, and Board representatives in all audits and reviews. The agency shall allow access to records and staff for these purposes.
Customer Satisfaction Surveys	States the Agency shall cooperate with these surveys which are conducted periodically by the Board.
Modification Based on Underutilization	Outlines the means by which the Board can withhold allocations if the Agency fails to deliver services and process claims according to contract stipulations. The section is included to ensure Board funds are not encumbered by an Agency which is not using them.

Source: Lucas MHB Non-Medicaid Provider Contract

This language allows Lucas MHB significantly more control over non-Medicaid funding than the current CMHB contract. As legal questions surrounding Medicaid funds are answered, Lucas MHB will have in place the groundwork to begin applying similar standards to contracts for Medicaid-reimbursable services.

R6.9 BOG should implement separate contracts for Medicaid and non-Medicaid funded services by consulting with Franklin and Lucas MHBs. By using separate contracts for Medicaid and non-Medicaid, CMHB will be able to apply more control over non-Medicaid funds. The non-Medicaid contract should also contain additional requirements allowing CMHB staff to use stricter measures to enforce all contract requirements. By applying stricter enforcement measures to the funds CMHB currently has control over, namely non-Medicaid funds, CMHB staff will be better able to apply the same standards to Medicaid funds when and if legal questions surrounding them are answered.

F6.12 The provider agency boilerplate contract has never been reviewed or approved by BOG legal counsel at the Cuyahoga County Prosecutors Office. Staff at the County Prosecutor was unsure as to the reason this had not occurred, and risk management staff was also unsure why the County Prosecutor was not previously involved in the process. While there have not been any problems at CMHB with the contract to date, there have been for other mental health boards. For example, there is currently a lawsuit in progress against the Eastern Miami Valley MHB. The majority of the suit focuses on the manner in which the contract with TCN Behavioral Health Services Inc. was terminated. In particular, it accuses the mental health board of failure to negotiate in good faith, actions taken in violation of sunshine laws, and arbitrary decision making.

Stark MHB staff report that the boilerplate contract used for provider agencies is reviewed regularly by its County Prosecutor. In addition, Stark MHB also has any changes made to the boilerplate reviewed by the County Prosecutor's Office. This ensures all changes are legally sound and keeps the County Prosecutor abreast of activities and issues facing Stark MHB. Generally, it is prudent to have any legally-binding documents reviewed by representative legal counsel. The Assistant Prosecutor in charge of coverage for CMHB indicated she would be willing to review the provider contract in its current form as well as any future changes.

R6.10 To protect itself from potential liability issues, CMHB should take all possible steps to ensure contracts and agreements are legally sound. RM Unit staff should approach the County Prosecutor about reviewing the current boilerplate provider contract in place at CMHB. In addition, staff should develop a system by which the County Prosecutor reviews changes to the contract as they occur as well as any substantial contracts for services other than mental health. Any changes made to the provider contracts as a result of **F6.14** should also be sent to the County Prosecutor for review and approval.

F6.13 Contracted providers are not required to alert CMHB to any changes in, or additions to, existing mental health services. Due to AWP laws which allow certified providers to offer any Medicaid service covered by the State, changes and additions in service occur frequently. These unexpected changes in service create problems in the Claims Processing Unit, as claims arrive for services which the provider is not formally contracted to deliver. When this occurs, Finance Unit staff members are alerted and must quickly produce a revised Attachment 3 which includes the new service. Simultaneously, contract specialists must draw-up a resolution for BOG to pass approving funding for the new service. All these steps must be accomplished quickly to allow the claim to be processed and paid within reasonable time limits. Staff members, particularly in the Finance Unit, report that producing these amendments is time consuming and diverts attention away from other responsibilities.

The Franklin MHB requires providers to alert the provider relations section with any service changes or additions they plan to make. This allows provider relations staff to funnel information to the appropriate sections and manage the amendment process from a central point, allowing staff adequate time to prepare the amendment and secure funding so claims can be processed with little delay.

Changes or additions to mental health services caused CMHB to process over 100 amendments to provider contracts in FY 2002. Of the 38 provider contracts signed in FY 2002, 36 or 95 percent were amended. The majority of these amendments were for the addition of Medicaid services. Significant staff time is spent preparing these amendments because there is no system in place to notify staff that amendments are needed. This could be reduced if a system was implemented whereby providers notified CMHB, through the Provider Relations Unit, of upcoming additions and changes at least 30 days prior to service implementation.

R6.11 Risk management staff should work with the Provider Relations Unit and BOG to implement a system whereby providers are required to alert CMHB at least 30 days prior to making any service additions or changes. This should include determination of what form the notification should take, written or verbal, and a plan for how the information is to be communicated to all staff involved in the amendment process, including risk management, financial, and the claims processing staff. Any new requirements should also be clearly defined in the provider contract.

F6.14 With the exception of the Medicaid auditing process, provider contracts do not contain a broad statement allowing CMHB to complete other monitoring and performance evaluation activities (see **provider relations and quality services** for more information on Medicaid audits). The current boilerplate contract is written largely to address Medicaid funding and is general in nature, due to AWP laws. However, a statement regarding CMHB authority to monitor providers need not infer funding will be impacted. As the disbursement body, CMHB has a general obligation to track and monitor the funds it dispenses.

The CMM suggests the contract contain language stipulating that the public entity reserves the right to complete periodic monitoring and evaluation activities as deemed necessary to ensure compliance with the terms of the contract. In addition, the contract should also indicate continuation of the contract may depend on satisfactory completion of such monitoring and evaluations. For instance, the Franklin MHB contract for Medicaid services includes a section instructing the provider to cooperate with the MHB on several different outcome initiatives that will serve to measure provider performance. CMHB does not include language of this nature in its provider contract.

The Lucas MHB non-Medicaid contract states that Board representatives may conduct inspections to obtain information concerning services, programs and financial matters. The contract does not state that available funding would be impacted by poor performance. By establishing this authority in the contract, Lucas MHB avoids confusion regarding contract monitoring and available funding and ensures proper delivery of services. Required reports, audits, Medicaid claims, and site visits are all tools available for monitoring providers.

R6.12 Risk management staff should work with BOG and the Assistant County Prosecutor to amend the boilerplate portion of the contract to include language regarding its freedom to evaluate and monitor the agency under contract. This language should include both general authority and any specific authority, such as is currently included for Medicaid audits. The contract should also state the tools and methods CMHB will use to perform monitoring activities. Any language added to the contract should be cleared with legal representatives at the County Prosecutor's Office. A general statement of monitoring authority is important in a contract so providers know exactly what they can expect and also to monitor for effectiveness, thereby ensuring that consumers receive quality services.

F6.15 The current contract does not contain stipulations pertaining to how long the agency must retain records for CMHB review. Sections 6.2 and 6.3 of the provider contract address documentation of services and third party records; however, they do not specify how long and why the provider must maintain complete and accurate records.

According to the CMM, the contract should specifically address the retention of records, including the types of records and how long they should be kept. This is especially important in the health care industry since much of the information on patient services and progress is kept on record in patient files. In addition, it is vitally important that providers keep the correct information on hand so Medicaid audits and other audits are completed in a timely and accurate fashion.

The Lucas MHB non-Medicaid contract contains the following language regarding record retention. It states that the provider must:

- Maintain accurate, current, and complete records;
- Provide records to the Board in a timely manner upon request;
- Maintain all consumer records in confidentiality;
- Have a record retention policy requiring clinical records be preserved for the period required by ODMH, and requiring all other records be preserved for the period required by Federal, State, or local law;

- Maintain all financial records other than payroll for at least 10 years; and
- Ensure all records of subcontractors are maintained in accordance with the requirements of this agreement.

These stipulations ensure Lucas MHB has the necessary resources available to guarantee providers are meeting legal and contractual stipulations. It also provides Lucas MHB with recourse should records not be kept appropriately.

R6.13 In conjunction with **R6.9**, risk management staff should add specific language to the contract pertaining to the length of time agencies should retain records for CMHB review. CMHB and BOG should consider adding this language to the non-Medicaid contract first, similar to the language used by Lucas MHB. This language may be appropriate in either the boilerplate or agency-specific sections of the contract. Any requirements for record retention should consider how the contract will be audited and should be determined based on State and Federal law. CMHB should apply similar requirements to Medicaid contracts as it becomes feasible.

F6.16 The current CMHB provider contract does not contain any incentives to encourage providers to achieve better and more efficient results. The contract does contain language allowing CMHB to withhold funds if a provider fails to fulfill contract requirements; however, this penalty is rarely enforced by CMHB because of concerns over Medicaid funding restrictions. Due to AWP laws and the current rate-based payment system, CMHB has been hesitant to apply any sanctions or incentives to Medicaid funding. Non-Medicaid funds do not have AWP restrictions; however, CMHB does not use sanctions or incentives for these funds either. The CMHB practice of using one contract for both Medicaid and non-Medicaid services prevents CMHB from applying different regulations to the different funds (see **F6.14**).

In its report on "Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers," DHHS defines an incentive as a predetermined reward, usually financial in nature, given to a provider for successfully meeting targeted, contract-specified performance goals. Incentives and sanctions usually take two forms:

- A flat dollar amount for failure to meet contractual standards or for exceeding contractual standards (for example, a $500 fine if a report is not submitted in time); and
- A percentage of the agreed payment to the provider.

Since providers are paid on a fee-for-service basis, a percentage sanction or incentive would be difficult for CMHB to implement. A flat fee system, however, would allow

CMHB to choose specific areas in which to apply the sanction or incentive. For instance, incentives could be applied to those providers with outside accreditations. Currently, providers are only required to be certified by the State to receive a contract for Medicaid services. However, it is possible for providers to become accredited by an independent organization such as COA or JCAHO. In the near future, this type of accreditation will be required for all providers. More information on this is found in the **provider relations and quality services** section of this report.

Currently, ODMH considers accreditation a best practice and encourages mental health boards to require it of non-Medicaid providers (See the **provider relations and quality services** section of this report for more information on accreditation). An incentive program which rewards both Medicaid and non-Medicaid providers would be a progressive step for CMHB in implementing best practices in the mental health system.

R6.14 Contract specialists should work with BOG and other CMHB staff to implement sanction and incentive language into the contracts for mental health services as appropriate. Staff should first concentrate on non-Medicaid funds and then work language into Medicaid contracts as legal questions regarding AWP laws are answered. Possible incentive areas might include national accreditation and service delivery efficiency. Any incentives should be outlined clearly in the contract and should specify:

- The manner in which, and at what intervals, sanctions and incentives will be applied; and
- When and by whom performance will be measured.

Performance measures should be determined for any sanction or incentive implemented and should correspond with any measures developed as part of the ODMH Outcomes Initiative, as described in the **provider relations and quality services** section of this report. By using sanctions and incentives on a regular basis, particularly for non-Medicaid funds, CMHB can help ensure consumers receive high quality mental health services in the most efficient and cost effective manner possible.

F6.17 Risk management staff routinely prepares contracts for training, consulting, and other services that do not involve the delivery of mental health services. The procedure for producing these contracts is the same as for provider contracts, and is depicted in **Chart 6-2**.

Similar to the provider contracts, other service contracts also contain little evidence of performance or outcome measures on which to evaluate vendor performance. They also do not employ incentives and do not routinely use the sanction and penalty language

which is included in the contracts. As detailed in the **external affairs** section, one contract in particular did not use a formal RFP process, did not provide for careful monitoring, and ultimately did not produce the results originally promised by the contractor.

Another long-standing contract relationship that did not produce the desired results was with Case Western Reserve University, and is described in more detail in the **planning and system development** section of this report. This contract did not stipulate clear deliverables or how CMHB would measure and monitor performance.

In its report on University Contract Administration, the Texas State Auditors office states, "Throughout the life of the contract, the institution must diligently and regularly monitor both the quality of other services contractors provide and whether contractors are using public funds effectively and efficiently." This is vitally important for all public contracts and is an area in which CMHB needs improvement.

Performance based contracting establishes a mechanism by which the purchaser may benchmark and gauge vendor services. Additionally, the purchaser is able to identify areas in which the vendor needs to improve to comply with agreed upon terms.

R6.15 CMHB and contract development staff should institute performance based contracting to ensure contract deliverables clearly reflect and meet expectations. All contract development should include the use of a RFP process (see **F6.8**) for solicitation and selection, whenever possible, for all non-Medicaid funding, clearly defined deliverables and expected output in the contract, and careful monitoring of all contract components.

Contract-related Tasks

F6.18 Currently, there are over 28 different positions at CMHB involved in the contracting process. Contract management refers to the overall administration of the following:

- Vendor solicitation;
- Contract drafting;
- Contract monitoring;
- Vendor evaluation; and
- Contract termination or renewal.

Contract monitoring is more specific, however, and refers to the process by which the entity purchasing contracted services assesses vendor performance to ensure the following:

- Services are delivered within the terms of the contract;
- Quality standards are met;
- Costs are appropriate; and
- Outcomes and outputs are met.

Currently, contract management responsibilities at CMHB are shared among several different divisions. Contract monitoring, however, is conducted primarily by the Finance Unit and the PRQS Division. **Table 6-6** displays the different divisions within CMHB and their responsibilities regarding contract management.

Table 6-6: CMHB Section Contract Administration Responsibilities

Risk Management and Consumer Affairs	Planning and System Development	Provider Relations and Quality Services	Finance and Budget Management
Contract drafting	Plan and implement programs and services	Develop and implement provider accountability standards	Maintain all accounting records directly related to contract performance
Negotiation with provider agencies	Develop new projects	Monitor provider contracts to ensure compliance	Request and analyze all audit reports
Developing and passing BOG resolutions for funding	Conduct needs assessment to determine what services CMHB should purchase	Ensure adequate monitoring and evaluations are incorporated into all systems	Assist in the negotiation of provider contracts

Source: CMHB Position Descriptions

The RM Unit and Planning and System Development Division are primarily responsible for the initial aspects of contract development, including service needs planning and actual contract drafting. The RM Unit does not produce the specific attachments for the contract, as detailed in **F6.9**. Staff in this section is only responsible for compiling attachments into the final contract. Risk management staff also does not review any of the reports or documentation submitted to other divisions to fulfill the requirements of these contract attachments.

Contract monitoring is primarily the responsibility of the PRQS Division and the Finance Unit. These two sections receive all reports, financial and otherwise, that providers are required to submit to CMHB, including the quality improvement and evaluation plans. Staff reviews the reports to ensure completeness and timeliness; however, the reports are not used to gauge provider performance. This is explained in more detail in the **provider**

relations and quality services section of this report. According to the current position description, the contract analyst in the Finance Unit initiates the contract monitoring process. This employee uses a spreadsheet to track how much providers have spent every month and compiles this information into a report comparing this amount to the total funds appropriated. The ratio of these two amounts allows CMHB staff and the BOG Finance and Operations Committee to assess whether contracted providers are spending funds in a timely manner. According to the contract analyst, this is the extent of the performance monitoring conducted and no other report is currently produced by any section to assess general provider performance regarding contractual obligations, with the exception of Medicaid compliance audits (see the **provider relations and quality services** section of this report for additional information on auditing functions).

The divisions within CMHB have little contact with each other regarding contracts. Each performs its contract-related duties in isolation, creating problems during contract re-negotiations. Risk management staff often receives complaints from providers that the contents of Attachment 4 (Service-specific requirements) are enforced in an irregular manner, in that some providers are required to perform responsibilities while others are not. However, Attachment 4 is produced by staff in the PRQS Division and contract specialists have little input into its contents or the manner in which it is enforced. Therefore, the RM Unit is unable to address provider complaints on the issue.

Franklin MHB requires providers to send all reports and other required documentation to its provider relations personnel, who are responsible for tracking provider performance and compiling annual provider profiles (see **provider relations and quality services** section). This creates a central point at which to receive and distribute all reports and documents. In its 1998 "Guide to Best Practices for Performance Based Service Contracting," the OFPP states monitoring for performance based service contracts should be comprehensive, systematic, and well documented. The system used at Franklin MHB helps achieve this goal.

R6.16 The sections involved in contract management, namely the RM Unit, Provider Relations Unit, Planning and System Development Division, and the Finance Unit, should work with BOG to implement a procedure whereby all provider reports and documentation are sent to a central point for cataloging and distribution. The Provider Relations Unit should be this central point and should measure the timeliness of reports and forward them to the appropriate unit for content review. Using the Provider Relations Unit to accumulate required reports from providers will help ensure regular and systematic monitoring activities occur, as one unit can collect and disseminate the required documentation to assess provider performance.

F6.19 Neither CMHB staff members nor BOG currently have a means to track and assess provider performance beyond fund expenditure rates. Currently, the risk management staff produces and distributes a matrix listing all portions of the contract as well as the CMHB unit responsible for monitoring the section. Since all reports and other correspondence from providers are sent to different divisions within CMHB, and these divisions do not efficiently communicate with one another, there is no cumulative effort to track and analyze vendor performance in all aspects of service delivery and contract compliance.

Franklin MHB's provider profiles detail vendor performance and provide staff the means to assess strengths and weaknesses. Provider profiles could be particularly helpful in tracking provider performance on Medicaid contracts. While CMHB does not have discretion over Medicaid funds, tracking Medicaid provider performance, particularly in the case of poor performers, would allow CMHB to adequately justify when, on the rare occasion, it must work with ODMH to revoke Medicaid certification from a provider. Currently, CMHB does not have a process in place to accomplish this.

Other county mental health boards do not employ full-time staff only to draft contracts. Even Franklin MHB, the peer closest in size to CMHB, only reports 1.9 FTEs working on contract management, including RFP and system development. Therefore, it is reasonable to assume staff at CMHB could take on additional enforcement responsibilities, particularly if the contract specialists are moved to the Finance Unit.

Provider profiles would enable CMHB to better defend any decision it makes regarding provider contracts, as it would represent a formal process to document vendor performance. A recent report from the Texas State Auditors Office on contract management at selected health and human service agencies noted that without complete and comprehensive information with which to evaluate a provider's history and past performance, there is a risk that low performers will continue to provide sub-standard services.

R6.17 Per **R8.34** in the **provider relations and quality services** section of this report, the Provider Relations Unit should use reports to compile and distribute profiles for all contracted providers. Any process developed should be reflected in the non-Medicaid contract recommended in **R6.9** and should be applied to Medicaid funds as legal questions are answered.

Risk management staff are well suited to assume the responsibility of tracking provider performance using the provider profiles, and implementing the enforcement process when necessary. Staff members in this unit already work with providers and, because of their responsibilities for drafting the contracts, are already familiar with their respective

contents and requirements. Contract specialists reported to AOS that they would be able to assume this responsibility, especially if the actual tracking work was performed in PRQS. Furthermore, the staff's legal training would allow them to better understand any legal ramifications of the enforcement process.

Once implemented, provider profiles can be used by risk management staff and BOG to help measure provider performance, gauge progress and determine whether expected outcomes were achieved in accordance with contract deliverables.

Risk Management Practices, Policies and Activities

F6.20 CMHB does not have a plan or policy in place which defines risk management. Although an entire unit is named for risk management, there is not a comprehensive policy directing risk management efforts at CMHB. As a result, risk management is largely an ad-hoc process which consists mainly of legal consultation for BOG.

Risk management at a mental health organization is somewhat difficult to define. The peers appear to view risk management from a slightly different perspective than CMHB. At the peers, risk management primarily involves the liability issues of officers and representatives. For instance, Franklin MHB staff concentrates risk management efforts on ensuring the staff psychiatrist and board members are adequately covered for any liability resulting from their official positions. In addition, it also focuses on liability issues arising from physical facilities by verifying all comply with code. The following definition is used for risk management at Franklin MHB:

> The ADAMH Boards risk management policies represent an attempt to balance various legal responsibilities including but not limited to legal, clinical and treatment authority; assurance that services meet minimum state standards of quality; assurance that housing, apartment or rooms subsidized by the ADAMH Board meet minimum fire safety standards; assurance of clients' rights.

CMHB risk management practices address this definition to some degree. For instance, the CA Unit addresses client rights issues, and the facility compliance examiner in the Planning and System Development Division works to ensure residential and other facilities are compliant with building and fire codes. These activities, however, are not formally tied into a risk management definition at CMHB and are not associated with the responsibilities of the RM Unit.

Franklin MHB contracts with an outside vendor to handle the insurance needs of the organization. This consultant periodically reviews agency policies to ensure their validity for $150 an hour. Franklin MHB estimates it will spend approximately $3,000 for risk management consulting in 2002. While it appears CMHB has procedures in place

addressing some areas of risk management listed above, such as liability insurance and building inspection, the direction of these efforts is not concentrated in the RM Unit, nor are the efforts formally defined. Such definition is essential for CMHB to receive the greatest benefit from any risk management functions performed on its behalf. Stark MHB views risk management similarly to Franklin MHB and industry standards.
In the September 2000 issue of *Public Management* magazine, aggressive risk management was defined as:

- Examining workplaces to be sure they are safe;
- Promoting safe practices in the operation of vehicles and equipment;
- Encouraging employee participation in practices that enhance wellness;
- Endorsing operating procedures that reduce vulnerability to liability claims; and
- Making prudent insurance decisions, keeping loss exposure and premiums in mind.

Risk management at CMHB, however, does not focus on these areas. For instance, liability insurance is maintained for BOG members and other high profile staff, but it is maintained in the Finance Unit of CMHB, not by risk management staff. The *Public Management* article also states risk managers need to ensure:

- Operations function efficiently;
- Accidents are promptly and thoroughly investigated;
- Claims are handled quickly; and
- Insurance coverage is kept up-to-date.

Job descriptions for the chief of RMCA and the risk management specialist do not list these functions, nor is there a policy in place for the RM Unit which satisfies these areas. In addition, contract specialists currently employed in the RM Unit do not perform typical risk management duties and are only responsible for drafting provider contracts, despite their required legal backgrounds. Therefore, in the absence of the chief of RMCA and the risk management specialist, the contract specialists have not assumed any risk management responsibilities.

CMHB also lacks internal risk management, which creates problems in areas such as human resources where there is no policy on how BOG will handle terminations. Given the high number of termination problems CMHB has faced in recent months, a comprehensive internal risk management policy would ensure CMHB is properly protected.

R6.18 BOG, in conjunction with risk management staff, should develop an overall risk management policy similar to Franklin MHB. This policy should address both internal and external risk management procedures including those related to personnel, insurance and liability, and physical structures. Furthermore, risk management position descriptions should reflect the tenets of this policy.

Should CMHB split Consumer Affairs into a separate unit and move RM Unit staff into the Finance Unit to assume additional enforcement duties (see **F6.4**), CMHB should assess the costs and benefits associated with contracting for risk management services from an outside consultant.

F6.21 Pursuant to ORC § 340.03, the Cuyahoga County Prosecutor is the official legal counsel for CMHB. Therefore, all legal matters require attention from this office. CMHB currently sends nearly all legal questions to the County Prosecutor's Office for review. This is due, in part, to the vacant chief of RMCA position. Staff formerly relied on this person to field some of the legal questions now sent to the Assistant County Prosecutor. Both staff at CMHB and the Assistant County Prosecutor report the relationship between the two organizations is positive.

Conversations with the Assistant County Prosecutor confirmed that many of the requests she receives are for routine questions which could be answered at CMHB. For instance, questions regularly arise regarding the Sunshine Laws and the release of public information. The Assistant Prosecutor reports she spends approximately 60 percent of her time on CMHB business and substantial questions from CMHB often have to wait while she answers questions about other, less important matters. If the workload for routine questions were decreased, more time would be available to spend on the more difficult questions raised by CMHB and BOG.

CMHB employs a disproportionate number of staff members with legal backgrounds compared to the peers (see **Table 6-3**). It appears that the skills of these staff members are underutilized. Some questions sent to the County Prosecutor, such as those regarding Sunshine Laws and public information, could potentially be answered internally. While such a role may not be appropriate for some RMCA staff, such as the CRO, others, such as the contract specialist, should be able to answer routine questions. However, these staff members are not currently authorized to perform such functions.

All of the peers work closely with their respective county prosecutors on legal issues. However, Lucas and Franklin MHBs also use outside legal consultants to answer some of the less important and technical legal questions. Lucas MHB has a formal agreement with the prosecutor's office which allows it to consult with an outside lawyer on routine matters which do not require the attention of the County Prosecutor. The FY 2003

budgeted amount for all legal services at Lucas MHB was $30,000. CMHB staff and BOG expressed some concern over current legal staff reviewing some of the issues due to inexperience. A legal consultant could prove especially useful in the absence of the chief of RMCA, and will continue to be should CMHB move contract monitoring responsibilities into the Finance Unit.

R6.19 BOG, in conjunction with the RM Unit and the CEO, should assess options for alternative legal review. Options might include assigning additional duties to legal staff already employed with CMHB or contracting with an outside law firm to provide these services. This will allow the County Prosecutor time to address more significant legal issues. If the option for contracting with an outside firm is chosen, CMHB and BOG should obtain a formal, signed agreement from the County Prosecutor to contract for such services.

Client Rights Programs, Policies, Processes and Procedures

F6.22 The CRO and consumer relations specialist effectively maintain the consumer affairs database. The database is installed on RMCA computers and only the CRO and consumer relations specialist have access. Each contact is entered and tracked in the database and in FY 2001, CMHB received 2,329 contacts. CMHB's *Client Rights and Grievance Response Operational Standards* require the CA Unit to document all calls received in the consumer affairs database, which ensure the data used to generate internal and external reports is accurate. Furthermore, ODMH's *Client Rights Manual* states,

> All records, applications, certificates and reports . . . that directly or indirectly identify a client, or former client, or person whose treatment has been sought shall be kept confidential . . . Information contained in client records is confidential and contains privileged information regarding potentially sensitive issues.

Of the peer boards, only Franklin MHB uses a database to maintain consumer affairs information. Additionally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Standards in Support of Patient Safety and Medical/Health Care Error Reduction* states the environment in which consumer information is stored should provide "timely, accurate, secure, and confidential recording and use." The consumer affairs database permits the CRO and consumer relations specialist to easily and quickly share with each other information regarding contacts, generates data for the CRO Annual Summary, and enables the CA Unit to track trends and patterns. Furthermore, this data is kept confidential and secure.

C6.2 Effective maintenance of the consumer affairs database helps CMHB keep accurate and confidential client rights information. Entering each contact into the consumer affairs database ensures the numbers generated for internal and external reports are accurate. It

also helps consumer affairs staff share information regarding complaints, grievances or allegations of abuse or neglect in a timely and secure manner. Additionally, limiting database access to the CRO and consumer relations specialist helps guarantee consumer information is kept confidential.

F6.23 CMHB's CRO performs annual unscheduled visits of contracted providers to verify compliance with OAC requirements. During these visits, the CRO does the following:

- Asks the contracted provider's secretary/receptionist to speak with the CRO to assess if the staff knows who the CRO is;
- Ensures the client rights policy and grievance procedure are conspicuously posted, per OAC 5122:2-1-02; and
- Requests a copy of the contracted provider's client rights policy and grievance procedure.

CMHB's CRO discusses any deficiencies with the contracted provider's CRO. CMHB's CRO also sends a letter summarizing the findings to the contracted provider's executive director, with copies to the contracted provider's CRO and to CMHB's CEO and chief of RMCA. An AOS survey of CMHB contracted providers indicates approximately 95 percent, or 18 out of 19, receive prompt feedback regarding these visits. The client rights policy and grievance procedure are given to CMHB's quality improvement specialist who verifies that it is the same document CMHB certified. This ensures consumers receive, and have access to, the most recent client rights policy and grievance procedure certified by CMHB.

None of the peer CROs conducts unscheduled visits. However, the consumer advocates at Advocates for Basic Legal Equity (ABLE) in Lucas County do verify Lucas MHB's contracted provider compliance with OAC posting requirements. By conducting unscheduled visits, CMHB ensures contracted providers consistently comply with OAC 5122:2-1-02. CRO visits are required by CMHB's BOG, but not by OAC, ORC or ODMH.

C6.3 The CRO's unscheduled visits ensure that contracted providers comply with OAC requirements, and therefore, support consumers' right to grieve and lodge complaints. This practice is necessary because 85 percent, or 29 out of 34, contracted providers visited in FY 2001 were noncompliant.

F6.24 The CA Unit does not require new contracted provider CROs to attend orientation. CRO orientation lasts approximately one hour and is offered each month prior to the CRO Focus Group meetings. Orientation covers the following information:

- Rules and laws governing client rights;
- Instructions on investigating complaints and grievances;
- Best practice guidelines for CROs;
- *Client Rights Manual* by ODMH; and
- *How To Do a Proper Investigation*, by the former CRO at Summit MHB.

New CROs are invited to attend the orientation and, if necessary, the CA Unit sends repeated requests for attendance. More experienced CROs are also invited to share their knowledge. Franklin MHB incorporates an orientation component into its quarterly training of contracted provider CROs. Neither Lucas MHB nor Stark MHB provides formal orientation for new contracted providers CROs.

JCAHO *Standards in Support of Patient Safety and Medical/Health Care Error Reduction* states an "orientation process provides job training and information and assesses the staff's ability to fulfill specified responsibilities" and "promotes . . . effective job performance." CRO orientation is not currently mandatory because it is not stipulated in the contract or required by OAC or ORC. Without mandatory orientation, contracted provider CROs may have different opinions and interpretations of relevant OAC regulations, ODMH's expectations, and CMHB's policies and procedures regarding client rights. As a result, consumers and family members may receive varying levels of advocacy and investigation.

R6.20 CMHB should make CRO orientation mandatory. Although orientation is not required by OAC, ORC or ODMH, CMHB should include mandatory attendance in its contract with providers as a performance standard to enforce attendance and to help determine incentives. For example, CMHB could provide an incentive to those contracted providers whose CRO completes orientation (see **F6.16** for information on contract incentives). Mandatory orientation would help ensure consumers receive consistent levels of service from CROs in the mental health system.

F6.25 CMHB does not effectively utilize the information collected and maintained by the CA Unit. Every inquiry, complaint and grievance received by CMHB is entered into the consumer affairs database (**F6.22**). Consumer affairs staff can query the database and run a report on any of the following fields listed on the *Inquiry & Complaint/Grievance Report Form*. Possible search fields include the date of contact, the type of contact (inquiry, complaint or grievance), the case number, the source, or the contracted provider's name, among others.

For example, the CA Unit could generate a report of all complaints received regarding a specific contracted provider for a given time period. Currently, CMHB is not using this critical information to monitor service quality, influence contract decisions, and identify trends and patterns. Sharing consumer affairs data within CMHB can ultimately improve the services received by consumers and help guide planning and system development activities.

JCAHO incorporates complaint data into its quality monitoring database to track accredited organizations and identify trends and patterns. Additionally, Franklin MHB's consumer and family advocate communicates any potential system issues directly to the network service managers. The consumer and family advocate's supervisor, the senior vice president of consumer and network services, also informs team leaders (unit supervisors) of any trends or consumer contacts which suggest a system issue.

R6.21 CMHB's CEO should develop a system which integrates consumer affairs data into the decision-making processes of certain CMHB units. In sharing this data, the CA Unit should take all necessary precautions to safeguard consumer confidentiality. To better understand the data available and the ways in which it can be queried, the CEO should meet with consumer affairs staff. The CEO should then hold a meeting with division chiefs and unit managers to explain available data, assess how it can be utilized, and establish a calendar for reports. The CA Unit should assume responsibility for running reports. However, if the volume of reports becomes too great, CMHB's CEO should determine how this responsibility can be shared or assumed by administrative support or other divisions.

Additionally, the CA Unit should use the consumer affairs database (see **F6.22**) to generate quarterly summaries of the numbers, types and resolution status for all inquiries, complaints and grievances received. This data should be summarized for the entire system, as well as broken down by contracted provider. The summaries should be distributed to the Provider Relations Unit for updating the provider profiles. The CA Unit should coordinate with other units to determine what information is needed to develop comprehensive provider profiles. Please see the **provider relations and quality services** section for additional information. Also, the CA Unit should distribute the quarterly summaries to the Quality Services Unit to assist in monitoring contracted provider services.

F6.26 CMHB complies with OAC 5122:2-1-02 (I) by annually submitting the *Cuyahoga County Community Mental Health Board Client Rights Officer Annual Summary* (CRO Annual Summary) to ODMH. ODMH's area directors use CRO Annual Summaries to determine the accuracy of mental health boards' Mutual System Performance

Agreements (MSPAs). Furthermore, the ODMH client advocacy coordinator compares the data to the complaints, grievances and appeals received directly by ODMH.

CMHB's CRO Annual Summary includes the numbers, types and resolution status of inquiries, complaints and grievances received by CMHB and each of its contracted providers. This information is displayed in numerous charts and graphs, such as a graph comparing the number of complaints and grievances received directly by contracted providers in FYs 1999-2001.

In addition, the CRO Annual Summary highlights the CRO's unscheduled visits to contracted providers and the CA Unit's interaction with consumers and contracted provider CROs. Addendums to the FY 2001 summary include contracted provider data on complaints, grievances and allegations of abuse or neglect, the number of consumers served and complaints received per contracted provider, and a list of training sessions and best practice guidelines for contracted provider CROs.

Franklin MHB's CRO Annual Summary includes a brief description of the board, client rights highlights, a system-wide analysis of complaints and grievances, and provider initiatives. Lucas MHB's CRO Annual Summary highlights the number, types and resolution status for complaints and grievances received by both the board and its contracted providers. It also includes a brief analysis of the number and type of complaints received, as well as three-year trend data. However, Lucas MHB does not distinguish between complaints and grievances, as both are referred to as complaints. Stark MHB's CRO Annual Summary briefly lists the number, types and resolution status for complaints and grievances received by both the board and its contracted providers.

OAC 5122:2-1-02 requires each MHB to annually summarize its records to include the number, type and resolution status of grievances received and submit this information to ODMH. Contracted providers are required to submit an annual summary containing this same information to their respective MHB, as well as ODMH. By submitting the CRO Annual Summary, CMHB is in compliance with OAC.

The CA Unit sends contracted provider CRO's a hard copy of the report summary template, as well as written guidance on completing the annual report. The guidance includes the following:

- Instructions regarding how specific statistics should be documented and calculated;
- Explanations of the "Personal Needs," "Family Needs and Concerns" and "Other" subcategories for allegations/grievances and complaints; and

- Definitions for abuse and neglect from OAC 5122-24-01, ORC §2151.031 and ORC §2919.22.

Contracted provider CRO's may also attend a voluntary training session on how to accurately complete the report.

C6.4 The information contained in the CRO Annual Summary exceeds the information required by OAC. OAC 5122:2-1-02 requires a mental health board to annually summarize its grievance data. CMHB's CRO Annual Summary contains additional detail, which includes the following:

- Summaries of the number and type of inquires and complaints received;
- A narrative of consumer affairs trainings attended; and
- Trend data on inquiries, complaints, grievances and allegations of abuse or neglect.

The detail contained in the CRO Annual Summary allows CMHB and its stakeholders to identify trends and patterns related to client rights. Furthermore, the written guidance sent to contracted provider CROs helps ensure the summaries received by CMHB contain the required data.

F6.27 Documents that constitute CMHB's grievance procedure, as required by OAC 5122:2-1-02 (H), are not consolidated or up-to-date. Community mental health boards are required to provide their grievance procedure to any individual requesting it. Individuals who request CMHB's grievance procedure are given the following documents:

- *Client Rights and Grievance Policy*, effective date February 24, 1988;
- *Grievance Procedure*, dated December 30, 1992; and
- *Rights as a Consumer of Community Mental Health Services: Where to File Complaints and Grievances*.

The *Client Rights and Grievance Policy* details the procedures CMHB must follow regarding client rights and grievances. It also defines how CMHB ensures CRO response to all grievances. In 1999, BOG approved a new *Client Rights and Grievance Policy*, which superceded and replaced the 1988 policy. Although it provides staff a process to follow when responding to consumer calls and resolving grievances, it does not reflect current consumer affairs practices. For example, consumer affairs staff enters all contacts received into the consumer affairs database (**F6.22**). Because this practice began after the CRO and consumer relations specialist joined CMHB in 1998, it is not included in the

Grievance Procedure. Furthermore, grievance resolutions are currently sent via first class mail, not by certified mail as indicated in the *Grievance Procedure*.

CMHB's *Rights as a Consumer of Community Mental Health Services: Where to File Complaints and Grievances* document is also outdated, as it has not been revised since its creation in 1998. This document provides contact information for individuals and entities with which consumers may file complaints and grievances, and from which they can obtain information relevant to their rights. Contact information for 8 out of the 17 listed outside entities is not up-to-date. For example, the Nurse Education and Nurse Registration Board and the Office of Americans with Disabilities Act have changed names. They are now the Ohio Board of Nursing and the Disability Rights Section, respectively. Additionally, the document does not provide the name of CMHB's CRO or ODMH's client advocacy coordinator. During the course of this audit, CMHB expressed plans to update the *Rights as a Consumer* document.

OAC 5122:2-1-02 (H) requires MHBs to include specific information in their grievance procedures. **Table 6-7** compares the documents which constitute CMHB's grievance procedure to the OAC requirements.

Table 6-7: Comparison of OAC Grievance Procedure Requirements

OAC 5122:2-1-02 (H) Complaint Procedure Requirements [1]	CMHB Client Rights and Grievance Policy [2]	CMHB Grievance Procedure	CMHB Rights as a Consumer	CMHB's overall compliance with OAC
Provision for accessing agency information relevant to the complaint	Yes	No	No	Yes
Provision of written copy of the MHBs grievance procedure available upon request	Yes	No	No	Yes
Specification of time line for grievance resolution not to exceed 20 working days	Yes	No	No	Yes
Provision for written notification and explanation sent to consumer, or other grievant, with consumer's permission	Yes	Yes	No	Yes
Statement regarding option to grieve to ODMH, OLRS, DHHS and appropriate professional licensing or regulatory organizations and their addresses and telephone numbers	No [3]	No	Yes	Yes
Provision for providing relevant information about a grievance to one or more of above mentioned organizations	Yes	No	No	Yes

Source: CMHB and peer grievance procedures and OAC 5122-2-1-02

[1] OAC 5122:2-1-02 uses the terms complaint and grievance synonymously.

[2] This refers to CMHB's Client Rights and Grievance Policy, effective date February 24, 1988.

[3] The Client Rights and Grievance Policy simply mentions that grievants can grieve elsewhere, it does not list the organizations to which a grievant may further appeal or provide their contact information.

Individually, none of the documents is in full compliance. However, because at least one document meets each OAC requirement, CMHB's grievance procedure complies with OAC. Each peer MHB has only one document which serves as its grievance procedure. Having one document reduces confusion and improves efficiency. Furthermore, consumers have only one document to reference.

CMHB's Policy Statement titled *Policy Development and Implementation* requires policies to be reviewed at least every two years. Although the *Grievance Procedure* and *Rights as a Consumer* document are not part of a formal CMHB Policy Statement, reviewing them would ensure the information provided to consumers is accurate and reflective of current practice. Having an up-to-date procedure would communicate clear performance expectations to consumers and other individuals filing a grievance.

R6.22 The CA Unit should consolidate relevant and compliant information from the 1988 *Client Rights and Grievance Policy*, the 1992 *Grievance Procedure* and the 1998 *Rights as a Consumer* into one document, which would serve as CMHB's grievance procedure. The consolidated grievance procedure should also include the following information:

- List the 22 client rights as stated in OAC 5122:2-1-02;
- Specify the name of CMHB's CRO and alternate CRO;
- Require the grievance procedure to be conspicuously posted at CMHB;
- Require prompt accessibility to CMHB's CRO;
- Provide an opportunity to file grievances within a reasonable time;
- Provide for assistance in filing grievances;
- Explain the grievance process;
- Define the alternative arrangements if CMHB's CRO is the subject of the grievance; and
- Require every CMHB staff member to be familiar with the grievance procedure and be able to identify the CRO.

The new procedure should also reflect current CA Unit practices and provide updated contact information for outside entities. The language used in the procedure should permit flexibility in responding to and resolving unique situations. Consumer affairs staff should annually verify contact information and make any necessary changes.

F6.28 Consumer affairs staff consistently refers all individuals with questions, concerns or problems beyond the realm of mental health to appropriate third-party entities. Additionally, of the peer boards, only CMHB tracks consumer contacts and third party referrals and can therefore better determine systemic needs. **Table 6-8** shows the entity and number of third party referrals for FY 2001.

Table 6-8: Referrals to Third Party Entities for FY 2001

Name of Entity	Number of Referrals
Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CCBMRDD)	46
Ohio Legal Rights Service (OLRS)	40
Legal Aid Society	32
Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC)	31
Hospital Client Rights Advocate	30
Social Security Administration (SSA)	24
Citizens of Cuyahoga County Ombudsman Office	21
ODMH Client Advocacy Unit	18
Private Lawyer, Family Lawyer, Lawyer Referral Project	16
Adult Protective Services (APS)	10
Department of Children and Family Services (DCFS)	10
Employment related entity (ADA, EEOC, Labor Board)	8
Rape Crisis	2
Total Referrals	**288** [1]
Average Referrals per Third Party Entity	**22**

Source: CMHB internal document
[1] Numbers may be duplicated.

As shown in **Table 6-8**, the CA Unit made 288 referrals in FY 2001, with an average of 22 referrals per third-party entity. CCBMRDD and OLRS received the greatest number of referrals with 46 and 40, respectively.

The CMHB *Client Rights and Grievance Response Operational Standards* requires CMHB staff to provide referrals to inquiries. These are defined as contacts from, or on behalf of, a consumer regarding matters other than the services provided by CMHB's contracted providers. Additionally, job descriptions for both the CRO and the consumer relations specialist require them to:

> Receive all inquiries from and provide effective response to consumers, contract service providers, and the general public concerning matters of customer information needs, customer relations, allegations of client rights violations, allegations of client abuse and/or neglect, or client complaints and grievances.

The consumer relations specialist is also responsible for resolving and monitoring all customer service requests not referred to the CRO. Although the peer MHBs make referrals, none track the number referred to specific entities. By providing referrals to third party entities, the Consumer Affairs Unit helps consumers and family members navigate a complex social service system.

C6.5 Tracking consumer contacts and third party referrals enables CMHB to identify potential areas of collaboration and service gaps in mental health services and plans. Furthermore,

it provides CMHB management an additional tool to evaluate the overall performance of the CA Unit. Referring contacts to the appropriate third-party may also increase overall consumer and family member satisfaction.

F6.29 Best practice guidelines for CMHB's contracted provider CROs address baseline performance and are not effectively communicated. These guidelines, which were developed by the CRO Focus Group, were distributed to contracted provider CROs as an addendum to the FY 2001 CRO Annual Summary. The CA Unit also provided AOS a copy of a memo addressed to contracted provider directors and CROs regarding the best practice guidelines. Although the memo is dated July 1, 2001, approximately 67 percent, or 6 of 9, contracted provider CRO's interviewed during the course of this audit were unaware of the best practice guidelines.

These standards, however, do not necessarily represent "best practices." **Table 6-9** compares CMHB's best practice guidelines with OAC (both current and proposed), CMHB's policies and practices, and generally-accepted practices. Generally-accepted practices are those considered, by either ODMH or the peer boards, to be essential client rights practices.

Table 6-9: Best Practice Guidelines

CMHB Best Practice Guidelines for Agency CROs	ODMH, OAC and CMHB Policies and Practices
• Interview the client or other person making the complaint	• ODMH's *Client Rights Manual* lists interviewing the persons involved as a step in an investigation. • A peer CRO stated that interviewing is a crucial step in the investigation process because it ensures a fair investigation. • ODMH's client advocacy coordinator cited interviewing the grievant as the most basic step in conducting an investigation.
• Address letter of resolution to client, parent, guardian or other complainant	• OAC 5122:2-1-02 (G)(1)(d) states, "A . . . written notification and explanation will be provided to the client, or to the grievant, if other than the client, with the client's permission."
• Submit course and findings of investigation to CMHB within designated time frames	• CMHB provided samples of letters which are sent to provider CRO's with overdue written resolutions. Tracking overdue resolutions indicates that CMHB expects contracted provider CRO's to submit resolutions in the designated time frame. • The *Overdue Written Resolutions to Grievances and Complaints (by Agency)* documents provided by CMHB state, "The CMHB CRO has informed the agencies that CMHB CRO expects, pursuant to OAC 5122:2-1-02 (G)(1)(g), written resolutions to complaints filed with the CMHB CRO which are conveyed to agencies for investigation and first level response."
• Provide (at least) annual training on client rights to agency staff	• While current OAC does not specifically require provider CRO's to conduct training, the proposed new OAC 5122-26-18 (F)(4) states, "All staff shall be trained at hire on client rights by the agency client rights advocate/alternate and receive additional training coordinated and/or provided by the agency client rights advocate/alternate as least annually thereafter." The inclusion of this requirement in the proposed OAC indicates ODMH considers it important.
• Ensure that all agency sites are in compliance with OAC regarding required postings	• OAC 5122:2-1-02 (F)(3) states, "A copy of the client rights policy shall be posted in a conspicuous location in each building operated by the agency." Section (G)(2) of the same rule states, "Each agency shall make provision for posting the grievance procedure in a conspicuous place." The contracted provider CRO is the individual responsible for assuring the provider's compliance with OAC 5122:2-1-02.

As illustrated in **Table 6-9**, CMHB's guidelines do not address exceptional performance. They are more indicative of required or suggested performance. The General Accounting Office (GAO) report, *Best Practices Methodology*, defines best practices as "the processes, practices, and systems identified in public and private organizations that

performed exceptionally well and are widely recognized as improving the organization's performance and efficiency in specific areas." None of the peer boards have established best practice guidelines for CROs.

R6.23 CMHB should revise its current best practice guidelines to include a higher level of performance and distribute these to contracted provider CROs. For example, a best practice recommending CROs thoroughly investigate and resolve grievances within 15 working days would represent a higher level of performance. This time frame is five days less than the 20 working days required by OAC 5122:2-1-02 and reflects exceptional performance, as long as the quality of the investigation and resolution is maintained. Since ODMH has not yet established best practice guidelines for client rights, CMHB and its contracted providers have an opportunity to develop standards of excellence which could be adopted by ODMH for use throughout the State. The CA Unit should include the revised best practice guidelines in CRO orientation to communicate clear performance expectations to new CROs. Furthermore, when new OAC requirements become effective, CMHB should work with ODMH to develop consistent categorization and record keeping regarding inquiries, complaints and grievances during the implementation phase (**F6.3**). Consistency would facilitate comparisons of MHB data on inquiries, complaints and grievances.

Consumer Relations

F6.30 CMHB does not have a permanent, long-standing consumer advisory group which is representative of all consumers and family members in Cuyahoga County. CMHB's Consumer Advisory Council (CAC) was created as an ad-hoc group under the 2000 Recovery System's Development Project (see **planning and system development**). The CRO and consumer relations specialist participated in CAC. The council's main responsibility was to develop a consumer manual for CMHB. The Self Help and Peer Empowerment (SHAPE) organizations are completing this task and CAC no longer meets.

The SHAPE organizations have a SHAPE Council, comprised of representatives from each organization, from which CMHB regularly solicits input and feedback. However, the SHAPE organizations represent only adult consumers. CMHB also solicits input and feedback from both NAMI organizations in Cuyahoga County, which are largely comprised of family members. Presently, CMHB does not have a single group representing all consumer and family member organizations, from which it can obtain input and feedback.

ORC §340.03 requires MHBs to "establish a mechanism for involvement of consumer recommendation and advice on matters pertaining to mental health services in the . . . mental health district." A consumer advisory group would satisfy this requirement.

Additionally, the National Association of State Mental Health Program Directors' (NASMHPD) *Position Statement on Consumer Contributions to Mental Health Service Delivery Systems* recognizes mental health consumers can make a "unique contribution to the improvement of quality mental health services." This is due to the "expertise they have gained as recipients of mental health services, in addition to whatever formal education and credentials they may have." When establishing a consumer advisory group, the association also recommends collaboration with other organizations.

Franklin MHB has an active and productive consumer advisory group. Reinstituted three years ago, the Consumer and Family Advisory Council (CFAC) is made up of consumers and family members who provide perspectives on the operations and services of Franklin MHB. CFAC has worked on the following system issues: cultural competency, workforce efficiency, training and HIPPAA implementation. CFAC also reviews contracted provider service plans and makes recommendations for service monitoring.

Without a permanent consumer advisory group, CMHB is lacking key input from the consumers and family members who receive direct services. Their unique experiences enable them to provide valuable feedback about the quality of services.

R6.24 CMHB should revive CAC and include its input in CMHB's operations and policy development. Responsibilities of CAC could include the following:

- Helping develop and evaluate programs;
- Assisting in policy development;
- Assisting in quality assurance;
- Helping to educate contracted providers;
- Reviewing CMHB publications;
- Organizing special activities to promote consumer input; and
- Advising BOG on how to best meet consumer needs.

CMHB should meet with each consumer and family group in Cuyahoga County to obtain their support and to help establish a core membership. The first several meetings should be highly advertised to reach a broad base of consumers and family members. CMHB should also use the CA Unit's Brown Bag Lunches as a forum to advertise the council directly to consumers and family members (**F6.33**). Additionally, CMHB should use the

CRO Focus Group to disseminate information to contracted providers who can then forward it directly to consumers (**F6.31**).

The CA Unit should contact Franklin MHB's consumer and family advocate and CFAC for advice and guidance throughout the process. By representing various consumer and family groups in Cuyahoga County, CAC can provide CMHB valuable feedback reflective of community needs.

F6.31 The CA Unit uses the CRO Focus Group to elicit input regarding CMHB's operations and policies related to client rights. CMHB's CRO and consumer relations specialist both participate in the Focus Group. All contracted provider CROs are invited to attend monthly meetings. Of the nine contracted provider CROs interviewed, eight indicated they regularly attend Focus Group meetings.

The Focus Group provides an opportunity for CROs to discuss issues and concerns affecting them and their client rights programs. Recently, the Focus Group reviewed ODMH's proposed changes to the OAC section covering client rights and developed comments and recommendations. The CA Unit then forwarded the comments and recommendations to ODMH.

Franklin MHB holds monthly case review meetings for its CROs which are similar to CMHB's Focus Group meetings. The meetings provide a safe, informal atmosphere to discuss issues such as the implementation of client rights procedures, difficult cases, and additional training needs. Case review meetings are also used to communicate and address Franklin MHB system issues CROs encounter. Lucas MHB holds semi-annual meetings with contracted provider CROs, and Stark MHB conducts similar meetings on an as-needed basis.

CMHB's CRO Focus Group meetings enable the CA Unit to obtain input from one of its primary stakeholders, the contracted provider CROs. As a result, their relationship has become one of mutual respect. Furthermore, the Focus Group provides contracted provider CROs an opportunity to discuss client rights issues and share their experiences which may increase the overall skill level and knowledge base of the CROs.

C6.6 CRO Focus Group meetings provide a forum for contracted provider CROs to discuss client rights practices, share experiences, and offer input to CMHB. As a result of the CRO Focus Group, the CA Unit more directly involves its stakeholders and offers them a sense of ownership in CMHB activities.

F6.32 The CA Unit does not formally survey users or contracted providers to determine their level of satisfaction and to improve consumer affairs processes. JCAHO *Standards in*

Support of Patient Safety and Medical/Health Care Error Reduction requires its accredited organizations to collect data about the needs, expectations, and satisfaction of individuals and organizations served, for the purpose of offering insight about process design.

According to the MSPA, CMHB staff monitors the consumer affairs database to illustrate how service quality is ensured. To determine the required consumer satisfaction level (95 percent), the CA Unit relies solely upon the number of consumer appeals to OLRS, ODMH, DHHS or appropriate licensing and regulatory associations. Essentially, consumer affairs staff assumes consumers are satisfied unless an appeal is made. A survey would provide a better means to calculate consumer satisfaction with the resolution of complaints and grievances. Without a formal survey, the CA Unit cannot accurately determine whether 95 percent of complaints and grievances are resolved to the satisfaction of consumers. Furthermore, the CA Unit does not have a formal mechanism in place to obtain anonymous feedback from contracted provider CROs.

R6.25 The CA Unit should implement a formal survey for persons filing complaints and grievances directly with CMHB, including those referred to contracted providers for resolution. Surveys should be mailed to the complainant's or grievant's home address with a self-addressed stamped envelope within 30 calendar days of the resolution. This would ensure responses are confidential and allow individuals to respond while the interaction is still fresh in their minds.

Additionally, the CA Unit should annually survey contracted provider CROs to obtain their satisfaction levels and recommendations for process improvement. This process should also be confidential to permit honest and constructive feedback. Both the consumer and contracted provider surveys should be summarized annually and be used to improve the CA Unit's processes and policies.

F6.33 The CA Unit holds monthly Brown Bag Seminars for consumers, family members and other interested parties to discuss client rights issues and trends. The seminars were started by the Biskind Public Law Fellow (BPLF) in FY 2000. Following the departure of BPLF, the CA Unit continued them at the request of consumers. **Table 6-10** shows the topic and number of participants for each seminar offered in FY 2001.

Table 6-10: Consumer Brown Bag Seminars for FY 2001

Date	Topic	Number of Participants
July 2000	Guardianship	25
September 2000	Group Homes	31
October 2000	Advanced Directives	15
November 2000	Mediation and Client Rights	N/A [1]
January 2001	What to Expect from Your CSP Worker: The Roles and Responsibilities of the CSP Worker	18
February 2001	Representative Payee: Do's and Don'ts	16
March 2001	What to Expect from Your Psychiatrist	17
April 2001	Returning to School or Preparing for Work	12
May 2001	What Should You Know About the Americans with Disabilities Act	15
June 2001	Becoming Independent – Housing Options	17

Source: CMHB's CRO Annual Summary for FY 2001
[1] The number of participants for this workshop was not provided.

As shown in **Table 6-10**, topics discussed at Brown Bag Seminars are diverse and address important issues in mental health services. Seminars averaged 18.4 participants, although attendance ranged from 12 to 31, depending on the topic. Also, consumers and family members can request that particular topics be presented.

Of the peers, Lucas MHB offers quarterly consumer training. ODMH's Office of Program Evaluation and Research (OPER) *Best Practices Booklet* states,

> Family members' satisfaction with mental health professionals, services, and systems in Ohio has decreased substantially over time . . . Their satisfaction is significantly associated with the amount of information they receive about their relative's mental health services. Increased communication among family members, service providers, and consumers is needed. This could strengthen consumers' support and family satisfaction.

Brown Bag Seminars enable CMHB to involve consumers and family members and inform them of pertinent information regarding client rights and mental health services. Consumers and family members who are knowledgeable about client rights and mental health services can better exercise their rights and make educated decisions about treatment.

C6.7 Brown Bag Seminars inform consumers and family members of their rights and provide them with educational opportunities regarding mental health services and legal issues. Ultimately, the seminars could improve consumer and family member satisfaction with mental health services in Cuyahoga County.

F6.34 The CA Unit does not have client rights information posted on the Internet because CMHB does not currently have an operational website. During the course of this audit, CMHB contracted with Cuyahoga County Information Services Center (ISC) to develop and maintain its website. Please refer to the **technology use and claims services** section for more information on the contract and the **external affairs** section for more information on website guidelines.

Several mental health boards and alcohol, drug addiction and mental health (ADAMH) boards throughout the State have placed client rights information on their websites. Hancock ADAMH Board's website and Hamilton MHB's website provide the most extensive information. Hancock ADAMH Board's website includes information such as the mission of the client advocates, links to ODMH's Community Client Rights Statements, contact information for the Board CRO, and Board grievance and complaint procedures.

Brown ADMAH and the Champaign/Logan ADAMH websites offer client rights information in Spanish. Furthermore, the Logan/Champaign ADAMH website also details minimum requirements for board and provider grievance procedures.

Consumers and family members must contact CMHB in person or provide their mailing address to receive hard copies of client rights information. Having client rights information on the Internet provides consumers and family members with instant access to pertinent information, while protecting their anonymity.

R6.26 CMHB's website should contain the following client rights information:

- Description of the CA Unit and its purpose;
- Explanation of client rights;
- Client rights as listed in OAC 5122-2-1-02;
- Description of the client rights using non-technical language;
- Name and contact information for CMHB's CRO;
- Name and contact information for contracted provider CROs;
- Contact information for ODMH, OLRS, DHHS and relevant professional licensing and regulatory associations;
- Minimum requirements for contracted providers' client rights policies and grievance procedures; and
- CMHB's grievance procedure.

To make the information easily accessible, client rights should be a menu item on CMHB's front page. Furthermore, the information should be updated as needed to reflect changes in CRO or contact information. CMHB should also consider providing this information in Spanish given the 49.7 percent increase from 1990 to 2000 in Cuyahoga County's Hispanic/Latino population.

F6.35 CMHB does not disseminate to consumers and the public at large a pamphlet which clearly and concisely details client rights. According to the CRO and consumer relations specialist, consumers, family members and interested parties are currently given a copy of the OAC. At times, the language in the OAC is ambiguous and technical. CMHB does have a one-page document, *Rights as a Consumer of Community Mental Health Services: Where to File Complaints and Grievances,* which provides contact information for CMHB's CRO, ODMH's client advocacy coordinator, OLRS and numerous outside entities. However, it does not provide the name of CMHB's CRO or ODMH's client advocacy coordinator, nor does it provide the name and contact information for contracted provider CROs.

Hamilton MHB's website divides the 22 client rights contained in OAC 5122:2-1-02 into six categories which include respect, the least restrictive environment possible, confidentiality, records, treatment plans, and medications/procedures. OAC-stipulated client rights which contain potentially technical or vague language are also explained. For example, the first client right listed in OAC 5122:2-1-02 is "The right to be treated with consideration and respect for personal dignity, autonomy, and privacy." Hamilton MHB explains this right using the following language:

- "A respectful attitude takes into account your self-esteem, your sense of well-being and your personhood."
- "Disrespect (or 'dissing') is stigmatizing behavior. It is disregard for your needs and culture. It can include ridicule, belittlement and coercion."
- "Physical, sexual and emotional abuse are violations of your right to be treated with respect."

In order to exercise their rights, consumers and family members must fully understand the client rights and grievance procedures. Confusion or misinterpretation potentially leads to consumers accepting treatments/medications they have a right to refuse and rights violations going unreported. Although client rights and grievance procedures are explained by contracted provider staff during intake, consumers would benefit from having an easily understandable reference.

R6.27 The CA Unit should develop a client rights pamphlet which is clear and concise. The pamphlet should list the 22 client rights listed in OAC 5122:2-1-02 and describe them using language which is easy to follow and to comprehend. To ensure the language used does not limit a client's rights in any way, the CA Unit should consult with the County Prosecutor and ODMH. Contact information for CMHB, ODMH, DHHS and relevant licensing boards should be included.

The pamphlet should also be shared with contracted providers in electronic format. This would enable providers to easily add their agency-specific information and supplement the following standard information:

- Explanation of client rights;
- Client rights as listed in OAC 5122:2-1-02 and explained using straightforward language;
- Statement regarding the availability of the client rights policy and grievance procedure;
- Name and contact information for contracted provider's CRO;
- Name and contact information for CMHB's CRO and ODMH's client advocacy coordinator; and
- Contact information for OLRS, DHHS and appropriate licensing and regulatory agencies.

Requiring contracted providers to include the same standard information would help reduce confusion among consumers who receive mental health services from several different providers. CMHB and its contracted providers should consider making this information available in Spanish as well as English. Additionally, the CA Unit should consult with the External Affairs Division to ensure the pamphlet's style is consistent with other CMHB documents.

Financial Implications Summary

The following table is a summary of estimated savings associated with the recommendations in this section. For the purpose of this table, only recommendations with quantifiable financial impacts are listed.

Summary of Financial Implications

Recommendation	Estimated Annual Cost Savings
R6.1 Eliminate the risk management specialist position.	$50,000
R6.2 Reduce the administrative assistant position to half-time by transferring the current administrative assistant to fill the human resource specialist position.	$24,000
Total	**$74,000**

Conclusion Statement

CMHB is organized differently from the peers in terms of its risk management, contract development, and consumer affairs functions. Unlike CMHB, the peers do not combine these functions in the same division, nor are staff dedicated directly to positions equivalent to the chief of RMCA, the consumer relations specialist or the administrative assistant. The RMCA Division does not appear to be an effective combination of units. In practice, the RM and CA Units have little in common and do not currently interact on a regular basis. In the absence of a chief, and given the varied nature of their duties, CMHB should divide the RMCA Division along functional lines. Current risk management staff should move into the Finance Unit to foster collaboration between contract management and finance activities, and to ensure all positions involved with the contracting process are in one division. The CA Unit should report to the CEO, COO or CCO to bring it more in line with ODMH's recommendations and peer organizational structures.

Based on the recommended reorganization of RMCA, the position of RMCA chief may no longer be necessary. According to its budgeted number of positions, the RM Unit is currently overstaffed as it employs twice as many contract specialist FTEs than the peer average. CMHB should eliminate the risk management specialist position, as its vacancy has not significantly impacted the RM Unit's workload. This reduction would allow CMHB to focus funding decisions on higher priorities and align risk management staffing levels with those of the peers. Furthermore, CMHB should transfer RMCA's administrative assistant to the Human Resources Unit to fill the human resource specialist position. Additionally, CMHB should reduce the RMCA administrative assistant position to part-time and reassign the position solely to the CA Unit. Reassigning the administrative assistant to the CA Unit will help accommodate the relatively high number of complaints and grievances handled by the consumer affairs staff.

CMHB does not regularly issue formal RFPs to acquire Medicaid, non-Medicaid, or other services. Furthermore, CMHB could better manage its funds if it focused on the areas where it has more authority, such as non-Medicaid funding. By using separate contracts for Medicaid and non-Medicaid services, CMHB would be able to apply more control over non-Medicaid funds. The non-Medicaid contract should also contain additional requirements allowing CMHB staff to use stricter measures to enforce all contract requirements. This approach will lay the groundwork for additional enforcement of Medicaid funds in the future. Furthermore, contract monitoring activities could be improved with better coordination among CMHB divisions.

Without a plan or policy in place to direct the RM Unit's activities, risk management at CMHB is largely an ad-hoc process which consists mainly of legal consultation for BOG members. Risk management activities of the peer boards are not organizationally segregated into one division. Rather, these activities primarily involve issues of liability and are inherent in the daily operations of certain board staff or outsourced to legal consultants. While it appears CMHB has

procedures in place to address some areas of risk management, such as liability insurance and building inspection, the direction of these efforts is not concentrated in the RM Unit, nor are the efforts formally defined or prioritized. Such definition is essential for CMHB to receive the greatest benefit from any risk management functions whether performed internally or externally.

CMHB currently has an effective client rights and consumer relations program. The CA Unit maintains extensive information on the inquiries, complaints and grievances received by CMHB which can be used by all divisions to evaluate and improve operations. Additionally, the CA Unit offers monthly educational opportunities to consumers and family members to inform them of client rights and mental health services and holds a monthly forum for contracted provider CROs to share information, express concerns and address system issues. CMHB's CRO also makes annual unscheduled visits to contracted providers to ensure they are in compliance with OAC requirements.

CMHB should consider several activities to strengthen its client rights and consumer relations program. CMHB should take immediate measures to fully comply with OAC 5122-2-1-02. CMHB needs to revive the Consumer Advisory Council and include its input in CMHB's operations and planning. It should also begin surveying consumers, family members and contracted provider CROs to assess satisfaction and improve performance regarding complaint and grievance resolution. Furthermore, CMHB should provide additional means for consumers, family members and other interested parties to obtain client rights information. The CA Unit should create and distribute a client rights pamphlet containing pertinent information, such as the CRO's name and contact information and the 22 client rights listed in OAC 5122-2-1-02. Client rights information should also be made available via the Internet.

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Planning & System Development

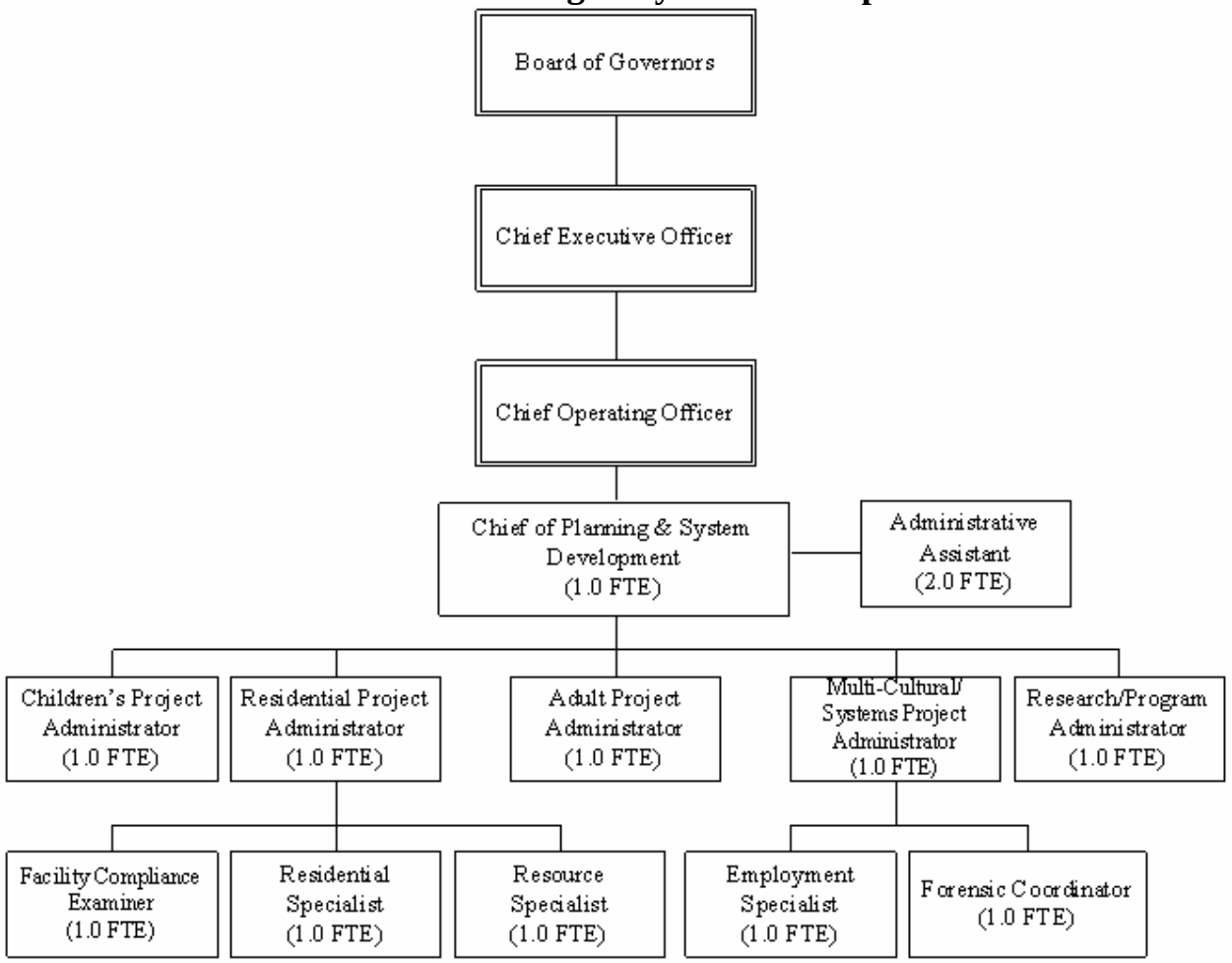
Background

This section of the performance audit summarizes the operations and departmental functions of the Planning and System Development (PSD) Division within the Cuyahoga County Community Mental Health Board (CMHB). Comparisons are made throughout this report to peer mental health boards in Franklin, Lucas, and Stark counties.

Organization Chart

PSD staffing consists of the chief of planning and system development, children's project administrator, residential project administrator, adult project administrator, multi-cultural/systems project administrator, research/program administrator, facility compliance examiner, residential specialist, resource specialist, employment specialist, forensic coordinator, and two administrative assistants. **Chart 7-1** illustrates the organizational structure of PSD with the total number of positions (FTE) as of January 2002.

Chart 7-1: Planning & System Development



Organization Function

Prior to the establishment of PSD, CMHB did not have a planning unit. Mental health system services were designed by the Adult and Children's Services and Community Resource Units. These Units were formally combined to form PSD in October 1999. According to the FY 2000 Administrative Capacity Review, PSD was created to define mental health system characteristics, services to be purchased, and provider requirements that assure continuity, access, quality, cultural competence, and clinical responsibility. PSD efforts are based upon service reviews, needs assessments, and best practice approaches to service delivery and systems design.

Currently, PSD performs various planning functions to address community mental health system needs. PSD collaborates with other systems, such as the criminal and juvenile justice system,

contracted providers, and schools in order to serve consumers in the mental health system. PSD performs the following functions:

- Plans and implements mental health services and programs;
- Ensures programs and services are culturally competent;
- Uses research findings in systems planning;
- Identifies and promotes a best practices approach for planning and services development;
- Develops a transition plan for programs and services which CMHB will no longer fund;
- Seeks to identify opportunities to expand services to special populations;
- Ensures housing and vocational needs are met;
- Researches grant funding for the mental health system;
- Develops adult and children's projects;
- Identifies and recommends policy changes;
- Interfaces with the broader community on mental health needs;
- Conducts needs assessments;
- Analyzes available service and demographic data;
- Attends community meetings relative to planning with County, State and other constituents or groups; and
- Monitors transition of new projects to provider status.

Summary of Operations

CMHB's mission is to develop a system that enables persons with mental illness and children with emotional disturbances to access quality services and programs that assist them in a culturally competent manner and are tailored to each individual. Programs and services attempt to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive setting available.

PSD is responsible for satisfying this mission by planning community mental health services for Cuyahoga County. Ohio Revised Code (ORC) § 340.03 requires mental health boards to assess community mental health needs, set priorities, and develop plans for the operation of facilities and community mental health services. PSD develops plans either to cover a broad topical area like vocational/employment or for a targeted purpose, such as reducing the number of hospital bed-days. PSD develops plans for a variety of reasons, including but not limited to the following:

- To implement a service system reflective of evidenced-based practices (e.g., Adult CSP);
- To respond to a RFP by ODMH (e.g., Recovery System's Development Project) which is competitive statewide; and
- To respond to a community need (e.g., Community Care for Hospitalized Consumers).

PSD plans covering broad topical areas include the following:

- **Mutual Systems Performance Agreement (MSPA) (2002-03)** - is a set of agreements and plans between the Ohio Department of Mental Health (ODMH) and either a combined county mental health/alcohol and drug addition board or county mental health board. Its purpose is to create a clear and meaningful agreement regarding mutual expectations and performance, and to establish a process for identifying and resolving mutual concerns.

- **Adult Community Support Program (CSP) Service Plan (1998)** - develops guidelines for levels of care; Level I CSP (intensive), Level II CSP (active) and Level III CSP (support). Levels of care are based on 1996 National Association of Case Management (NACM) guidelines. The purpose of the plan is to address concerns of adult consumers with the most severe needs, determine allocation of scarce resources, and incorporate outcome and performance measurement into individual client reviews. See **provider relations and quality services** for additional information on CSP.

- **Housing Plan (1993)** - provides recommendations for the housing of mental health consumers. Recommendations in the plan include developing a centralized admission and referral process, establishing an agreement with Cuyahoga Metropolitan Housing Authority (CMHA) for Section 8 vouchers, and hiring personnel to inspect residential properties.

- **Contracted Provider Capital Needs Assessment (2003-2008)** - is submitted to ODMH outlining necessary contracted provider capital projects. Examples of capital projects in the plan include permanent housing units, renovation of residential facilities, and a project to serve homeless persons with mental illness.

- **Vocational/Employment Services Plan (1999-2000)** - provides direction and a comprehensive framework for the planning, organization, and provision of vocational and employment services to mental health consumers.

- **Substance Abuse/Mental Illness (SAMI) Plan (1999)** - is submitted as a proposal to ODMH for the purpose of implementing a pilot project to enhance SAMI services. The most recent planning effort is the joint SAMI plan developed by CMHB and the Alcohol and Drug Addiction Services Board (ADAS) which includes recommendations for SAMI services.

- **Plan to Enhance Mental Health Services for Children, Adolescents and Families for Cuyahoga County (2001)** - addresses the under-funding of children's services, system-wide outcomes, prevention and early intervention, services for 0-3 and 16-22 year olds, staffing issues, administrative procedures, and the information and advocacy of mental health concerns.

Plans developed for a targeted purpose include the following:

- **Community Care for Hospitalized Consumers (2002)** - identifies community service options to reduce unnecessary State psychiatric hospitalizations. Plan development began in October 2001 and was completed in August 2002.

- **Recovery System's Development Project (2000)** - develops system-wide training and intervention on the recovery model. Clinicians and practitioners are trained to treat consumers as partners rather than passive patients. Intervention encourages consumers to identify people, resources, and everyday activities which may facilitate recovery.

- **Family Caregiver Plan (2000)** - helps ensure community resources are organized to be responsive to the needs of family caregivers. The plan highlights basic services needed by family caregivers, including outreach information, family and education support, and advocacy.

Contracted providers, consultants, consumers, family members, and local organizations provide input for developing plans. PSD uses stakeholder focus groups and committees to develop plans. The PSD administrator for each area takes the lead in developing and implementing plans. PSD typically monitors planned programs through their initial implementation phase, then transfers monitoring responsibility to the Provider Relations and Quality Services Division (see **provider relations and quality services**). PSD monitors programs during their implementation phase by performing site-visits to review documentation, consumers served and staffing. PSD monitors housing quality through scheduled on-site inspections.

Mental health consumers have access to various non-Medicaid and Medicaid reimbursable services. Non-Medicaid services include residential and vocational/employment services. Examples of Medicaid reimbursable services include crisis intervention, individual counseling and psychotherapy. SAMI and criminal justice are typically a combination of Medicaid and non-Medicaid services. CMHB contracts with providers who administer Medicaid and non-Medicaid services. PSD has more flexibility to plan non-Medicaid than Medicaid services because the any-willing provider rule requires CMHB to enter into a Medicaid contract with any provider who meets State requirements. However, PSD plans how Medicaid services such as CSP are implemented programmatically. For example, PSD identifies the desired frequency of service contacts, staff qualifications, and caseload size for CSP services. The list below summarizes major non-Medicaid services including, but not limited to, residential and employment/vocational. Also included are SAMI and criminal justice programs because they are both Medicaid and non-Medicaid services.

- **Residential** - programs include Shelter-Plus Care, Wrap-Around, and the Housing Assistance Program (HAP). Shelter-Plus Care is a federally funded program authorized under an amendment to the Stewart B. McKinney Homeless Assistance Act to provide rental housing assistance in connection with supportive services to homeless persons with certain disabilities and their families. Wrap-Around funds are geared toward enabling timely discharge of hospitalized patients to appropriate community settings. HAP offers support via CMHB in the form of rental assistance and start-up loans for people with mental illness and their families.

- **Employment/Vocational** - three contracted providers; Bridgeway Inc., Spectrum of Supportive Services, and the Epilepsy Foundation of Northeast Ohio, provide employment services to persons with mental illness. Spectrum of Supportive Services and Bridgeway Inc. merged resources in 1997 to form the Employment Alliance. The

Employment Alliance contacts employers, operates a job research center and rehabilitation readiness program, and offers specialized employment training.

- **SAMI -** programs include Bridgeway Inc.'s Assertive Community Treatment (ACT) team, the Roberta Florres Home residential treatment facility, and Northeast Ohio Health Services. CMHB funds the Roberta Florres Home and Northeast Ohio Health Services programs, and jointly funds the Bridgeway Inc. ACT team with Alcohol and Drug Addition Services Board (ADAS). PSD also collaborates with the SAMI Center for Excellence to train contracted providers on integrated treatment and has written a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to fund continued planning for SAMI.

- **Criminal Justice** - programs include the mentally disordered offenders program (MDOP), jail linkages, forensic liaison and others. MDOP is a collaborative effort between CMHB and the Cuyahoga County Adult Probation Department to serve adults convicted of a felony crime and found to have an illness involving psychosis. The jail linkages program is intended to link severely mentally disordered (SMD) inmates from the Cuyahoga County Corrections Center with mental health services upon their release from jail. The forensic liaison assists incarcerated mentally ill persons within the mental health system.

PSD also trains contracted providers to deliver culturally competent services. CMHB offers the following definition of cultural competency:

> When individuals and organizations recognize and respect differences, pay attention to the dynamics of differences, continually expand cultural knowledge and resources, take seriously the hiring of minority staff, consult with the community regarding service provisions and delivery, and are committed to cross-cultural training and policies that enhance programs for diverse populations.

The National Mental Health Association (NMHA) further defines a culturally competent mental health system as one that incorporates skills, attitudes, and policies to ensure it is effectively addressing the treatment and psycho-social needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds which vary by race, ethnicity, religion, and/or language.

PSD is also responsible for writing and researching grant proposals for the mental health system. CMHB receives grants for a variety of services and programs, including funding for early intervention/prevention programs assisting children, juveniles in the criminal justice system, and individuals who are dually-diagnosed with mental illness and substance abuse. Since FY 1999, CMHB has helped obtain $20.5 million in grants for Cuyahoga County's mental health system, 82 percent of which have come from the Federal government (see **Table 7-10**).

ODMH awards grants to CMHB once an application for funding is submitted, including a program description. Grants awarded to CMHB by ODMH in FY 2000 include the following:

- Training in the use of diagnostic classification for children under three;
- Hiring a benefits specialist for the Employment Alliance; and
- Developing a system-wide educational effort to increase the diversity of agency staff and CMHB members.

PSD collaborates with other community organizations on mental health issues. PSD works jointly with the Alcohol and Drug Addition Services Board (ADAS) on the Substance Abuse/Mental Illness (SAMI) project for persons suffering with co-occurring mental illness and substance abuse disorders. Collaboration occurs with the Social Security Administration and the Family & Children First Council (FCFC) to address the needs of various mental health consumers. CMHB collaborates with various agencies on housing planning initiatives, including CMHA's Section Eight Administrative Plan, the U.S. Department of Housing and Urban Development's Continuum of Care Process, County Office of Homeless Services, County Consolidated Plan and the City of Cleveland. CMHB's participation in housing planning initiatives centers on advocacy for fair treatment for consumers to receive adequate housing.

Furthermore, PSD collaborated with the Cuyahoga County Community Mental Health Research Institute (CMHRI), a partnership between CMHB and Case Western Reserve University (see **F7.29**), until its closing in June, 2002. CMHRI disseminated research findings to mental health clinicians, consumers, and family caregivers. CMHB has developed relationships with other organizations including the Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CMRDD), Office of Homeless Services, Cuyahoga County Metropolitan Housing Authority (CMHA), Cuyahoga County Court of Common Pleas, and Cleveland Municipal Court.

Staffing

In June 2001, the chief of PSD assumed the duties of acting CMHB chief executive officer (CEO) and was responsible for both roles. In July 2002, a new CEO was hired and the acting CEO/chief of PSD was promoted to COO. As of August 2002, a new chief of PSD had not been hired and the COO still oversees PSD.

Key PSD responsibilities include five major areas of planning: children's, residential, adult, multi-cultural/systems and research/program. Job duties described below are not all inclusive; they have been summarized from official CMHB job descriptions. The chief of PSD coordinates the planning and development of CMHB initiatives, while providing expertise and supervision to staff.

Two administrative assistants (AA), under supervision of the chief of PSD, provide clerical support to PSD administrators. Specifically, one AA is assigned to children's, adult, and research/program planning, and the other is assigned to residential planning.

The children's project administrator is responsible for program planning and project management of mental health services geared toward children. Primary duties include: attending meetings related to children's services, identifying best practices, working closely with contracted providers and consulting on problems, and developing the children's mental health plan. Additionally, the children's project administrator serves as mental health system liaison.

Permanent housing, residential program planning, and inspections are supervised by the residential project administrator. Residential planning support-staff include the facility compliance examiner, residential specialist, and resource specialist.

The residential project administrator plans, develops and monitors residential programs and capital development projects. The facility compliance examiner conducts inspections of those units not subject to licensure by the Ohio Department of Mental Health (ODMH) or the Ohio Department of Health (ODH) in accordance with ORC § 340.03. The residential specialist conducts reviews of Adult Care Facilities (ACFs) to ensure consumers of mental health services are residing in safe and supportive living environments. This position works with ACFs to process new license requests and license renewals. The residential specialist reviews and approves required ACF documentation on staffing, training, criminal records and resident files. In addition, this position provides assistance to the ACF Operator and CSP contracted provider to ensure issues and problems are addressed adequately by the system. The resource specialist assists with the development of procedures for various housing assistance programs, and reviews application requests from contracted providers for the Shelter-Plus Care, Replacement Reserve, and Wrap Around programs. All four FTEs participate in committees related to mental health consumer housing issues.

Adult mental health services are coordinated by the adult project administrator. Specific responsibilities outlined in the job description include: planning and developing programs, working closely with contracted providers and consulting on problems, and participating on committees related to adult consumers.

The multi-cultural/systems project administrator ensures PSD plans adhere to CMHB's cultural competency policy. In addition to supervising the employment specialist and forensic coordinator, the multi-cultural/systems project administrator develops diversity training programs for staff and contracted providers, works with the Education and Training Unit to support and arrange cultural competence training, serves as liaison to ODMH on cultural issues, and works with contracted providers to consult on problems.

The employment specialist monitors and trains contracted providers who deal with vocational and employment services, serves as liaison to the Self Help and Peer Empowerment (SHAPE) organizations, serves as liaison between CMHB and the Ohio Rehabilitation Commission, serves as Recovery Project Coordinator, develops and monitors a Vocational/Employment Service Plan in conjunction with the Vocational/Employment Work Group, and assists in developing a quality assurance review process and outcome indicators for vocational/employment services.

The forensic coordinator is responsible for services to consumers within the criminal justice system (forensic consumers). Other duties include monitoring legal status and consumer location, approving conditional release plans, serving as mental health liaison for the criminal justice system, distributing forensic monitoring data to pertinent hospitals and ODMH officers, developing policies and procedures pertaining to forensic consumers, attending relevant court hearings, assisting parole officers in finding mental health services for consumers from community providers, and maintaining a forensic consumer database in accordance with ODMH guidelines.

The research/program administrator conducts research studies and writes/edits PSD grant proposals. Other duties include conducting surveys, monitoring grant projects to assure adherence to standards, serving as liaison to the Office of Program Evaluation and Research (OPER) and analyzing national research projects for applicability in Cuyahoga County. The research/program administrator formerly served as CMHB's liaison to the Cuyahoga County Community Mental Health Research Institute (CMHRI), until its closing in June 2002.

All PSD staff members interact with and attend BOG meetings when necessary. Please see the **organization, compliance and board governance,** and **human resources** sections of this report for more information regarding BOG and CMHB job descriptions.

Performance Measures

The following list of performance measures was used to conduct the review of PSD:

- Review historical and background information
- Assess the appropriateness and adequacy of staffing levels, responsibilities and organizational structure of PSD
- Assess the effectiveness of the division's mental health plans and overall planning activities
- Assess new initiatives and specific programs implemented and monitored by Planning and System Development, and the effectiveness of these programs in meeting the needs of CMHB's consumers
- Assess the effectiveness of cultural competency within PSD
- Review and analyze the current grant types received and the resulting dollar amount, and assess the potential for CMHB to receive additional funding
- Review the relationship and partnerships with other County agencies (juvenile court, children services, etc.)
- Review the relationship and collaboration among CMHB divisions, and determine if any gaps or duplication of services exists

Findings / Commendations / Recommendations

Staffing and Organizational Structure

F7.1 CMHB's PSD Division has the highest staffing levels as compared to the peers. Analysis of PSD and peer staffing levels in **Table 7-1** is based on corresponding positions between boards and staff closely involved in planning. For example, since PSD includes a multi-cultural/systems project administrator, corresponding positions from the peers have been included for comparison.

Table 7-1: PSD & Peer Staff Analysis

Positions	CMHB		Franklin MHB [1]	Lucas MHB [2]	Stark MHB [3]	Peer Average
	Budgeted FTEs	Actual FTEs	Actual FTEs	Actual FTEs	Actual FTEs	
Chief of Planning & System Development	1.0	1.0	0.4	0.8	0.5	0.6
Administrative Assistants	2.0	2.0	0.1	0.2	0.0	0.1
Children's Planning						
• **Children's Project Administrator**	1.0	1.0	0.4	0.6	0.5	0.5
Residential Planning						
• **Residential Project Administrator**	1.0	1.0	0.7	0.1	0.0	0.3
• **Facility Compliance Examiner**	1.0	1.0	0.6	0.1	0.2	0.3
• **Residential Specialist**	1.0	1.0	0.0	0.1	0.0	0.0
• **Resource Specialist**	1.0	1.0	0.0	0.0	0.0	0.0
Adult Planning						
• **Adult Project Administrator**	1.0	1.0	0.4	0.6	0.5	0.5
Multi-Cultural/Systems Planning						
• **Multi-Cultural/Systems Project Administrator**	1.0	1.0	0.7	0.1	0.0	0.3
• **Employment Specialist**	1.0	1.0	0.4	0.2	0.1	0.2
• **Forensic Coordinator**	1.0	1.0	1.4	0.2	0.2	0.6
Research/Program Planning						
• **Research/Program Administrator**	1.0	1.0	0.5	0.0	0.0	0.2
Total	**13.0**	**13.0**	**5.6**	**3.0**	**2.0**	**3.6**

Source: PSD and peer organization charts and interviews, as of September 17, 2001
Note: Figures have been rounded to the nearest tenth.
[1] Since Franklin MHB is a combined board, the number of FTEs is based on 70 percent of time spent on mental health. As estimated by Franklin MHB, planning staff includes the senior vice president of evaluation, planning and quality improvement; the director of planning and evaluation; the housing director; the director of cultural competency; two research specialists; a facilities evaluator; and two forensic monitors. The senior vice president of evaluation, planning and quality improvement and facilities evaluator positions spend approximately 75 and 10 percent of their time on quality improvement, respectively. Network services staff allocate 30 percent of their time on planning functions. Additionally, 10 percent of an administrative assistant's time is spent on planning.
[2] Staff includes associate director of clinical and support services, director of child/adolescent and support services, director of adult services, director of member services, and the director of quality improvement.
[3] Staff involved in planning for Stark MHB is 2.0 FTEs, including the associate director of programs and services administration, director of care management and the director of evaluation. The program monitor clinical specialist and program monitor/support specialist monitor forensic and housing programs (0.4 FTEs).

According to **Table 7-1**, the number of FTEs in PSD exceeds the peer average in all functional areas. Most notably, PSD's number of administrative assistants and number of FTEs dedicated to residential planning and inspections significantly exceeds the peer average. Of the peer boards, only CMHB employs a resource specialist. Position duties include assisting with the development of procedures for various housing assistance programs, and reviewing application requests from contracted providers for the Shelter-Plus Care, Replacement Reserve, and Wrap Around programs; however, these duties do not specifically involve planning or inspection functions. The peers rely on their

contracted providers to perform these functions because they are service-related. As a result of CMHB employing a resource specialist, its contracted providers can focus more time on providing direct services to consumers as opposed to reviewing and processing paperwork. Additionally, peers have been able to function with fewer administrative assistants by having current positions perform these functions. Furthermore, CMHB contracts with consultants to perform certain functions (see **F7.10**); however, PSD has a relatively higher level of staffing which is qualified to perform these functions. CMHB appears to contract for additional work that could be performed internally (see **F7.10**). **Table 7-2** compares PSD and peer workload measures.

Table 7-2: PSD and Peer Workload Analysis

Measure	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average	Above or (Below) Peer Average
Total # of Planning & System Development FTEs	12 [1]	6	3	2	3.6	233%
# of Medicaid & non-Medicaid services provided in FY 2001	29	28	19	19	22	32%
Total Consumers served [2]	30,238	29,317	13,650	8,209	17,059	77%
Total Consumers served/FTE	2,520	4,886	4,550	4,105	4,739	(47%)
Child Consumers (ages 0-17) served	10,796	8,968	3,881	2,451	5,100	112%
Child Consumers (ages 0-17) served/Children Planning FTE	10,796	22,420	6,468	4,902	10,200	6%
Adult Consumers (ages 18+) served	19,675	20,534	9,839	5,812	12,062	63%
Adult Consumers (ages 18+) served/ Adult Planning FTE	19,675	51,335	16,398	11,624	24,124	(18%)
Contracted Providers	37	23	13	13	16	131%
Contracted Providers/FTE	3.1	3.8	4.3	6.5	4.4	(30%)
Plans developed	7	5	2	3	3	133%
Plans developed/FTE	0.6	0.8	0.7	1.5	0.8	(25%)
Residential Inspections (Non-Licensed Independent Housing Units and Adult Care Facilities) [3]	459 [4]	800	4	40	281	63%
Residential Inspections (Non-Licensed Independent Housing and Adult Care Facilities) / FTE	230	1,333	20	200	937	(75%)
Research Studies & Needs Assessments	12	4	1	2	2	500%

Source: CMHB and peer organizational charts; ODMH DataMart; PSD and peer staff

Note: Table 7-2 includes completed plans for FY 1999-01. PSD Phase I Adult CSP plan was developed in 1998, but is also included in **Table 7-2** because recommendations still apply. PSD and peers develop a MSPA and Capital Needs Assessment. Additional plans developed by Franklin MHB include the Strategic Housing Plan, Community Plan, Strategic Plan, and Review of System Assessment and Crisis Services. Other plans developed by Stark MHB include a Housing Plan and Adult CSP. Lucas MHB has developed a plan for the Forensic Treatment and Monitoring Project.

[1] Excludes resource specialist at PSD because these functions are performed by contracted providers at peers.

[2] Consumers served data for CMHB and peers is from FY 2001 DataMart.

[3] FTE includes residential specialist and compliance examiner. Residential inspections of non-licensed independent housing units and adult care facilities check for fire and safety problems. PSD and peers may also conduct site-visits for facilities that have had their license revoked, unlicensed facilities, new residential programs, and facilities that have had complaints.

[4] Beginning July 1, 2002, PSD facility compliance examiner will conduct inspections of 245 units subsidized by the Housing Assistance Program (HAP).

Based on various workload measures, **Table 7-2** illustrates that CMHB allocates a disproportionate amount of staff resources to its planning and system development functions. Although CMHB and Franklin MHB offer a similar amount of Medicaid and non-Medicaid services, CMHB uses six more FTEs in PSD. According to **Table 7-2**,

PSD has the lowest ratio of total consumers served per FTE, falling 47 percent below the peer average. CMHB has the second highest ratio of children consumers per children planning FTEs; however, Franklin MHB serves approximately twice as many children consumers per children planning FTEs than CMHB. Although CMHB has the second highest ratio of adult consumers served per adult planning FTEs, CMHB still falls 18 percent below the peer average. While the overall content of plans developed by CMHB appears to be similar to the peers and CMHB contracts more with consultants to develop plans (see **F7.10**), CMHB has the lowest ratio of plans per FTE. Enhancements to the content of CMHB's plans and overall planning process are discussed throughout this report. In addition, CMHB falls below the peer average in contracted providers per FTE (30 percent) and residential inspections per FTE (75 percent).

A major factor impacting the higher staffing levels in PSD as compared to peers is the different organizational structure at CMHB. CMHB has planning functions completed by separate positions while the peers have it combined with quality improvement and utilization review (see **F7.2**). This could contribute to the higher administrative assistant staffing levels at CMHB. For instance, CMHB could streamline and pool administrative resources by consolidating planning with quality improvement and utilization review, as well as potentially streamlining and/or pooling functions performed by all of the positions in PSD.

R7.1 CMHB should consider reducing one administrative assistant position. CMHB should be able to allocate functions performed by these positions to other positions in PSD. PSD would still have higher administrative assistant staffing levels with this reduction. Therefore, PSD should have enough administrative assistance to support operations. A reduction in PSD staffing levels will increase operational efficiency by bringing CMHB closer to the peer average in output generated per FTE.

CMHB should also consider combining planning with quality improvement and utilization review to streamline operations (see **R7.2**). Additional staffing adjustments could be achieved with this consolidation. CMHB should reassess its staffing levels in these areas after the consolidation because the peers have been able to operate more efficiently with this structure.

Even with reducing an administrative assistant, CMHB would still operate with higher staffing levels in PSD. Therefore, CMHB should prioritize implementing enhancements discussed throughout this report to fully justify these staffing levels. Tracking and monitoring outcomes on a system-wide basis is an important function that CMHB needs to fully perform (see **provider relations and quality services**). PSD could help in this endeavor to ensure that its plans are effective and meet consumer needs, and to ensure mental health consumers are receiving quality and effective services.

Financial Implication: Reducing one administrative assistant will result in an annual cost savings of approximately $38,000 in salaries and benefits.

F7.2 PSD's organizational function appears inefficient when compared to the peer mental health boards. Planning, quality improvement, and utilization review functions have not been consolidated at CMHB. CMHB used the FY 2000 Administrative Capacity Review to restructure organizational functions. As part of the restructuring effort, CMHB separated planning and quality improvement into two divisions. The Quality Improvement Unit of the Provider Relations and Quality Services (PRQS) Division is responsible for evaluating program outcomes, but has been unsuccessful in collecting and evaluating system-wide outcome data (see **provider relations and quality services**). Although certain plans developed collaboratively with other agencies (e.g., Adult CSP and Community Care for Hospitalized Consumers) may require the use of an external evaluation manager to assess program outcomes, the evaluation of PSD plans for system-wide outcomes has been problematic. If evaluation and planning functions are organizationally segregated, then mental health plans may lack crucial outcome data necessary to evaluate the effectiveness of planning activities.

Due to CMHB's current organizational structure, PSD job functions duplicate those of the Provider Relations and Quality Services Division in training, monitoring, and interaction with contracted providers. **Table 7-3** summarizes the duplication of job functions between the divisions.

Table 7-3: PSD and PRQS Duplication of Functions

Duplicated Job Functions	PSD	Provider Relations Unit	Quality Improvement Unit
Interaction With Contracted Providers	Consults on contracted provider problems; processes application requests from referring agencies for various housing programs	Acts as single point of contact and accountability for all contracted providers; facilitates application process for new agencies seeking certification and CMHB contract	Receive quality improvement data from contracted providers Point of contact for clinical related issues for contracted providers
Monitoring	Conducts on-site housing inspections; conducts program and utilization reviews	Monitor contracts with providers to ensure compliance	Conducts on-site Medicaid audits and conducts utilization reviews
Training	Conducts training modules for forensic, employment, and cultural competency	The Education and Training Unit coordinates training offered to contracted providers. [1]	Plan, develop, organize, and evaluate training for mental health professionals and special constituent groups

Source: PSD job descriptions, PSD interviews; CMHB division functions
[1] The Provider Relations Unit of PRQS does not conduct training.

For Franklin MHB, the senior vice president of evaluation, planning, and quality improvement, and the director of evaluation are involved in planning. Network services staff is also involved in the planning process (see **Table 7-1**). Franklin MHB has corresponding positions with PSD for cultural competency, housing inspection, forensic monitoring, and research. However, the Franklin MHB facility examiner does not inspect group homes because there are so few. Rather, Franklin MHB will offer assistance to group homes, as problems arise. Franklin MHB's forensic monitors, though involved in monitoring the Not-Guilty-By-Reason-Of-Insanity (NGI) population, are not directly involved in planning. The PSD research/program administrator has job duties comparable to the Franklin MHB director of evaluation, except the director of evaluation does not write grants.

Stark MHB and Lucas MHB do not have planning divisions because they serve fewer consumers than CMHB (see **Table 7-2**). For Stark MHB, the associate director for programs and services is the only full-time planning position. The chief financial officer, director of evaluation, and other staff contribute to planning at certain stages in the process. Stark MHB does not currently monitor group homes, like PSD, but will begin monitoring these facilities in FY 2003. Lucas MHB has staff in adult and children's planning positions, but not cultural competency. The director for member services monitors residential facilities, but this function comprises 10 percent of the director's time. Lucas MHB's adult administrator is responsible for monitoring and working with the forensic population.

Interviews with the executive directors of Franklin MHB, Hamilton MHB, Lake ADAMH, Lorain MHB, Mahoning MHB, Summit ADAMH, Montgomery ADAMH, and Muskingum ADAMH reveal that CMHB's organizational structure is unique. According to the directors, planning functions should be closely integrated with quality improvement and utilization review. Moreover, both Franklin MHB and Hamilton MHB consolidate planning and quality improvement functions. Although a standalone division specifically designated to planning is rare among Ohio MHBs, this organizational structure can create an internal system that does not effectively link planning with quality improvement and utilization review activities.

R7.2 CMHB should consider combining PSD with the Quality Improvement and Utilization Review Units of the Provider Relations and Quality Services Division (see **organization, compliance and board governance** and **provider relations and quality services**). Integrating planning and quality improvement functions will benefit CMHB in the following ways:

- Improve evaluation and monitoring of outcomes;

- Enhance monitoring and data gathering by ensuring all data is considered in a plan;
- Streamline operations and staff resources; and
- Reduce job duplication between PSD and PRQS.

Combining PSD with Quality Improvement and Utilization Review Units will improve CMHB's ability to evaluate the success of planned services. By centralizing monitoring and data gathering functions within one division, CMHB will be in a better position to link outcome data with planning and funding for future mental health services.

F7.3 Multi-cultural/systems project administrator supervision over the forensic coordinator and employment specialist positions is an organizational mismatch (see **Chart 7-1**). Job descriptions for these positions do not include multi-cultural planning or training responsibilities. As a result, the adult planning area of PSD appears to be understaffed by 1.0 FTE, while the multi-cultural/systems planning area appears overstaffed by 3.0 FTEs (see **Table 7-1**). Furthermore, the cultural competency director for Franklin MHB does not supervise any employees, while Lucas MHB and Stark MHB do not have cultural competency FTEs.

R7.3 CMHB, in collaboration with the multi-cultural/systems project administrator and the director of human resources, should remove the forensic coordinator and employment specialist positions from the direct supervision of the multi-cultural/systems project administrator and place each within the adult planning area of PSD. Responsibilities outlined in position descriptions of forensic coordinator and employment specialist match more closely with the adult planning area of PSD. Though the forensic coordinator works with juveniles, 60 percent of her time is spent on adult forensic issues. A reorganization of these positions will bring stated job description responsibilities more in line with organizational function.

F7.4 PSD job descriptions inaccurately reflect actual duties and are not up-to-date. CMHB does not update job descriptions annually and has not conducted a job analysis since 1998 (see **human resources**). The PSD forensic specialist, adult administrator, residential specialist and residential administrator indicated that their job descriptions do match actual job duties. Examples of duties not reflected in current job descriptions include grant writing and specific PSD planning initiatives. For example, the time spent on specific PSD initiatives such as vocational surveys or SAMI is not reflected in job descriptions.

The adult administrator suggests accuracy and completeness of job descriptions could be improved if job functions reflected PSD duties listed in the **background** section. Job descriptions could then provide specific information on how PSD accomplishes key

functions such as researching best practices, interfacing with the community and developing projects. Job descriptions which do not reflect actual job duties increase the risk of PSD staff allocating time to tasks unrelated to key job functions.

R7.4 Once appropriate organizational changes are made, the Human Resources Division, in collaboration with PSD, should annually ensure job descriptions match actual job duties (see **human resources**). Job descriptions should give specific information on how PSD staff members accomplish key functions such as researching best practices, interfacing with the community, and developing new projects. Updated job descriptions which reflect actual job duties can help CMHB ensure staff workload is distributed evenly on tasks that improve the current mental health system.

F7.5 PSD and other divisions do not coordinate effectively to enhance mental health system planning. This is partially due to vacancies at the management level for CMHB divisions (see **human resources**). For example, the MIS Unit is not always involved formally at the onset of planning efforts. Furthermore, since only 22 of 37 contracted providers at CMHB are participating in the Outcomes System module of MACSIS, using MACSIS to help plan programs could be more difficult at CMHB (see **technology use and claims services** and **provider relations and quality services**).

External affairs staff is generally involved in assisting PSD in formatting the physical appearance of plans, but is not directly involved with communicating CMHB planning initiatives to the community. The External Affairs Division is responsible for developing and implementing a mental health communication plan, but PSD planning initiatives are not reflected in this document (see **external affairs**). The lack of involvement of external affairs staff may result in planning initiatives not being effectively communicated and promoted to the community.

The Risk Management and Consumer Affairs (RMCA), and PRQS divisions generate reports which are submitted to PSD. RMCA produces an annual report that identifies consumer trends and complaints. PRQS analyzes trends for data that include bed-days and other outcomes. However, using outcome data to support planning has been problematic for CMHB (see **F7.7**). The Finance Unit also provides financial data that PSD uses for planning. However, PSD does not receive all relevant information from the Provider Relations Unit of the PRQS Division that could be used for planning. Information from the Provider Relations Unit, identifying best practices within the provider network and communicating service needs, is not distributed formally to PSD staff in a report or other mechanism. Without a formal mechanism to incorporate information from other divisions, PSD plans may not address all service needs and trends, reducing plan quality.

Franklin MHB coordinates division communication through weekly business operations meetings and the Managing for Results (MFR) strategic plan. Meetings comprise management staff from consumer/network services, information services, fiscal and planning/evaluation/quality improvement. Regular meetings improve Franklin MHB's ability to monitor the implementation of plans and to share information. Franklin MHB divisions also use the MFR strategic plan to outline division functions and monitor implementation of plans (see **F7.16**).

R7.5 The chief of PSD, in collaboration with PSD administrators, and the COO should improve and develop methods to incorporate input and information from other divisions into planning. PSD should meet regularly with other divisions to discuss how information can be shared. Options to improve coordination between CMHB divisions and PSD include the following:

- Enhance planning and quality improvement staff capability to analyze system-wide outcomes. Planning staff would have the capability to use outcome data to evaluate plans and gauge system-wide performance.

- Include MIS during plan development. MIS could provide input on the technology needed to implement plans.

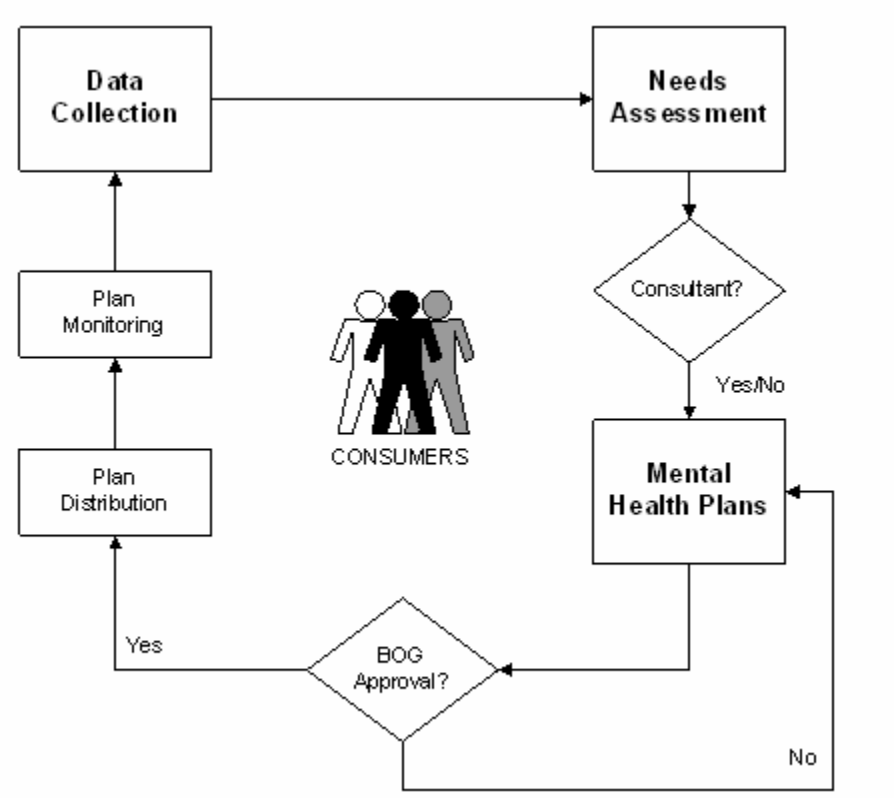
- Include the External Affairs Division when communicating planning initiatives and new programs to the community. The External Affairs Division's involvement with community planning initiatives could result in positive publicity for CMHB activities.

- Improve the ability of planning, and PRQS staff to identify and share best practices and service needs with other divisions.

Effectiveness of the Division's Mental Health Plans and Overall Planning Activities

Chart 7-2 describes the model process for developing PSD plans. PSD plans follow this process to varying degrees. Findings in this section correlate with categories in **Chart 7-2**.

Chart 7-2: PSD Planning Process



Specific CMHB divisions are responsible for functions listed in **Chart 7-2**. The RMCA Division collects data on consumer trends and complaints, while the Provider Relations Unit collects data from contracted providers. PSD may conduct needs assessments, but this function is generally contracted to consultants (see **F7.10**). PSD develops mental health plans either internally or with assistance from consultants, and BOG approves individual mental health plans and consultant contracts. PSD distributes mental health plans to contracted providers and stakeholders. In addition, PSD monitors plan implementation and reports on the status of plan implementation to BOG (see **F7.16**).

Similar to PSD, peer mental health boards develop plans and needs assessments internally or with assistance from consultants. Franklin MHB has developed additional formal planning processes, including an internal process to analyze system-wide outcomes and a Managing for Results (MFR) strategic plan (see **F7.7** and **F7.11**). Stark MHB has informal planning processes which focus on improved collaboration with providers. Lucas MHB also has informal planning processes and primarily uses workgroups to plan mental health services.

F7.6 PSD does not use a consistent methodology in developing plans. PSD's inconsistent plan development process occurs due to a lack of coordination between PSD, its chief, other CMHB divisions, and contracted providers. A consistent planning process includes components listed in **Chart 7-2** such as conducting needs assessment and regularly analyzing outcome data. Other components of a consistent plan development process include the development of a system-wide strategic plan, use of a Request for Proposal (RFP) process and coordination of grant writing functions. Franklin MHB has developed formal processes for analyzing outcome data (see **F7.7**), conducting needs assessment (see **F7.14**) and using a system-wide strategic plan to monitor plan implementation (see **F7.11**). Franklin MHB staff also indicated the best way to develop planned programs is through a RFP process, whereby RFPs are distributed to contracted providers to solicit specific services (see **risk management and consumer affairs**).

PSD planning processes for conducting needs assessments, analyzing outcome data, monitoring plans and using strategic planning are not fully developed, and are not consistently applied for planning programs. Additionally, contracted providers are not satisfied with CMHB's planning process (see **organization, compliance and board of governance**). Although PSD has distributed RFPs for some programs, the lack of a consistent plan development process results in programs being developed that may not be the highest priority for the system. Rather than developing programs based on a system-wide strategic plan, programs may be developed based on grant availability and whether a contracted provider wants to administer a new program. Also, without centralized grant-writing, programs may be developed inconsistently.

R7.6 The chief of PSD, in collaboration with CMHB division chiefs and contracted providers, should work to improve program planning and coordination. Program development should be coordinated by fully developing processes for outcome assessment, needs assessment, plan monitoring and strategic planning. The chief of PSD should perform this function and work closely with a grant writer to ensure the process for obtaining program grant dollars is coordinated. Centralized grant writing within PSD would also contribute to coordinating the search for grant funding for programs (see **R7.23**). RFPs should be used when feasible to select the most qualified contracted providers. With eight plans developed over the last three years (see **Table 7-2**), coordination is especially important so program planning is integrated and overlapping areas are identified. Furthermore, the chief of PSD should continue to coordinate program development with other systems, including but not limited to ADAS, CMRDD and CSS (see **F7.28**). Coordination with other systems helps create program best practices, maximize funding streams, and reduce the risk of program duplication.

F7.7 CMHB has not developed an internal process to analyze system-wide performance for use in planning (see **provider relations and quality services**). Contracted providers send various types of data to CMHB including, but not limited to, clinical outcomes via

quality improvement reports, quarterly or bi-annual reports containing program outcomes (e.g., recidivism rates), and responses to periodic satisfaction surveys. CMHB reviews individual program and provider outcome data, but comparisons across services and providers are not performed on a regular basis. According to CMHB, obtaining system-wide analysis of outcomes has been difficult in the past, because CMHB has had to wait for ODMH to define outcomes through the Ohio Outcomes System initiative. However, Franklin and Lucas MHB developed internal systems to monitor and analyze outcomes beyond the Ohio Outcomes System initiative (see **provider relations and quality services**).

Franklin MHB uses consumer satisfaction and opinion surveys, as well as an outcome evaluation process to perform a systemic review of outcomes for people with severe mental illness. Surveys measure statistical significance in declining costs, efforts to increase recovery, and the improvement of work skills over time. Consumer surveys demonstrate an improvement in satisfaction from 1999 to 2000.

Franklin MHB lists the following benefits to outcome evaluation:

- To use information as a basis of allocating funds to encourage and reward cost-effective practices;
- To contract with providers that can provide quality care at an affordable price;
- To improve accountability by demonstrating an effective use of dollars to funding sources (e.g., tax payers, Federal government, other); and
- To promote value-driven best practices (e.g., recovery).

According to a report produced for the Advisory Network on Mental Health, mental health system performance measures should be used to provide information on how the system as a whole is operating with respect to policy, evaluation, governance and funding, and human resource planning. The report provides the following examples of system performance measures:

- **Consumer Involvement** - a) amount of resources allocated to support consumer advisory structures and their activities as a percentage of the total mental health budget, b) proportion of consumers with serious mental illness who believe service and supports provided are appropriate to their needs (can be measured as consumer satisfaction);
- **Best Practices** - a) existence of best practice core programs (e.g., assertive community treatment), b) evidence of process for establishing, adopting, and maintaining best practice core programs and system strategies, c) percentage of consumers with serious mental illness (or selected diagnosis) receiving assertive

community treatment, d) percentage of consumers with serious mental illness (or selected diagnosis) receiving supported housing; and e) percentage of persons with serious mental illness (or selected diagnosis) in receipt of paid employment, supported employment, or other vocational/educational support;

- **Access** - a) dollars spent per 10,000 population on psychiatry services, b) psychiatric services per 10,000 population , c) number of primary care outreach services provided to persons with serious mental illness, and d) proportion of consumers within a mental health service provider population to persons with serious mental illness who are screened for physical health problems;

- **Resource Planning** - a) evidence of explicit process for systematically incorporating consumer population levels of need into resource intensity estimates, b) proportion of mental health sector-expenditures on best practice programs to total sector expenditures; and c) proportion of total expenditures service recipients with serious mental illness to all mental health consumers; and

- **Criminal Justice/Homeless** - a) rate of service provider population with serious mental illness apprehended or incarcerated compared to rate for general population, b) change in number of arrests within 30 days prior to admission to number of days at six and 12 months post-admission, c) number of mental health related police calls, d) number of homeless consumers receiving assertive community treatment as a proportion of the estimated number of homeless people with serious mental illness.

R7.7 PSD and Quality Services administrators should work together to develop an internal process to analyze system-wide performance for use in planning. By developing an internal outcome evaluation process, CMHB can more easily demonstrate to BOG, taxpayers, and external stakeholders that funds are used effectively. CMHB would also improve its capability to assess the quality of contracted provider services (see **provider relations and quality services**).

F7.8 PSD plans do not follow a standardized format. For example, the six-year Capital Needs Assessment lists contracted provider proposals for capital development, but does not include a linkage to strategic planning, assessment of existing resources, or other planning elements. Certain plans such as the Adult CSP have a timeline for implementation, while others, such as the SAMI plan, do not. One reason plans differ in format and content is because they are written either by consultants or PSD.

National Technical Assistance Center (NTAC) recommends planning elements that can apply to mental health. NTAC operates under an agreement between the National Association of State Mental Health Program Directors (NASMHPD), Center for Mental

Health Services (CMHS), and Substance Abuse and Mental Health Services Administration (SAMHSA). NTAC recommendations include the following:

- Data collection and analysis;
- Identification of existing gaps and barriers;
- Linkage of plans to the strategic planning process and overall mission for the organization;
- Development of a method to evaluate the progress and outcomes of system-change efforts;
- Development of specific roles and duties for participants and a timeline to monitor the plan,
- Assessment of existing systems and resources;
- Inclusion of input from internal and external stakeholders (stakeholders should include contracted providers, consumers, and other CMHB divisions); and
- Recommendations for systems changes that can be achieved incrementally (e.g., pilot projects) and/or proposals for structural adjustments to existing systems (e.g., integration of mental health and drug and alcohol system entry points to facilitate cross-training of staff).

Stark and Lucas MHBs have informal planning processes, and therefore, all plans may not contain NTAC planning elements. Franklin MHB mental health plans, however, generally contain NTAC planning elements (e.g., outcome evaluation and strategic plan) which helps to standardize the planning process.

R7.8 The chief of PSD, in collaboration with PSD administrators, should adopt and incorporate a template for all plans to contain the standardized planning elements discussed in **F7.8**. Specific time frames should be developed for recommendations so implementation progress can be tracked. In addition, all PSD plans should establish a clear link to the CMHB mission statement, as well as the CMHB strategic plan (see **organization, compliance and board governance**). This can be accomplished by publishing the mission statement at the beginning of every plan. A standard template for plans ensures uniform formatting and regular updating, while a published link to the mission statement establishes a clear prioritization of organizational responsibilities and objectives.

F7.9 Although CMHB uses various methods to obtain stakeholder input, an AOS survey of contracted providers indicates stakeholders may not be sufficiently involved in the planning process. PSD recently conducted a consumer satisfaction survey regarding vocational/employment services (see **F7.20**). Furthermore, CMHB used workgroups for the SAMI plan which included the Crisis/Hospital Group, Mental Health Providers

Group, Criminal Justice Group, and CMHB staff members. Also, in developing Bridgeway's Transitional Youth program, PSD incorporated feedback from stakeholders by holding focus group meetings with young adults transitioning between children and adult mental health services.

Although PSD has conducted surveys and held temporary workgroups in developing certain plans, an AOS survey of CMHB's contracted providers indicates there is a lack of regular stakeholder involvement in the planning process. Various contracted providers indicate a lack of early involvement for agencies, contracted providers, and consumers, as well as the lack of a forum to discuss new programs. Furthermore, CMHB does not receive outcome data from all contracted providers (see **provider relations and quality services**). Absent outcome data, stakeholder needs may not be effectively addressed in the planning process.

Strategies to improve collaborative planning include regularly surveying stakeholders and developing permanent workgroups. As part of its needs assessment, Franklin MHB surveys individuals external and internal to the system, using focus groups, face-to-face interviews, and telephone interviews to gather data. An administrator from the Corrections Planning Board (CPB) in Cuyahoga County indicates the County lacks a permanent workgroup comprised of representatives from housing departments, County and City government, the Alcohol and Drug Addiction Services Board (ADAS), CMHB, criminal justice, and other systems. The absence of a permanent workgroup results in various systems competing for the same funding, service duplication and increase program costs (see **F7.28** and **R7.26**).

R7.9 CMHB, in collaboration with PSD administrators, should develop a standardized planning process which regularly includes stakeholder input. The planning process should include stakeholder input through permanent workgroups comprised of representatives of various agencies and providers serving mental health consumers, and surveys conducted in conjunction with needs assessments, similar to Franklin MHB. PSD should also work with the PRQS Division to ensure outcome data is collected from all contracted providers. Effective utilization of stakeholder input alleviates competition between stakeholders, reduces costs, and reduces duplication of service and funding.

F7.10 PSD plans are developed internally or via contracts with consultants. Peer mental health boards also use in-house staff or consultant contracts. **Table 7-4** shows PSD plan status and cost, and whether the plan was developed internally or by a consultant.

Table 7-4: PSD Plan and Needs Assessment Status and Costs

Plan [1]	Internal or Consultant [2]	Date Developed	End Date [3]	Status	Cost
Adult CSP (TAC)	Consultant	1998	Ongoing	Active	$82,000
Needs Assessment (TAC)	Consultant	2000	Ongoing	Being updated	See Adult CSP
Housing	Internal/ Consultant	1993/2002	2002	Being updated	$20,000
Capital Needs Assessment	Internal	2001/02	2003-08	Submitted to ODMH for FY 2003-08	N/A
Vocational/ Employment	Internal	1999/2000	Ongoing	Being updated	N/A
SAMI	Consultant	2001/02	Ongoing	Draft of joint plan completed Jan. 2002	$30,000
Recovery System	Internal	2000	2002	Grant proposal scheduled to end June 2002	N/A
Children's	Consultant	2001	Ongoing	Active	$170,000
Family Caregiver	Internal	2000	Ongoing	Being updated	N/A
Total					**$302,000**

Source: PSD interviews and plans

[1] During the course of the performance audit, a community care plan to reduce bed-days was completed internally by PSD staff in August 2002.

[2] An internal plan is a plan developed by PSD staff without the assistance of consultants.

[3] End date refers to the process to develop and update plans.

Plans developed by consultants differ in purpose from those developed internally. Plans developed by consultants generally identify community needs, whereas plans developed internally are more likely to target a specific area and identify funds for programs. Consultants developed more than half of PSD's plans and needs assessments, at a cost of approximately $302,000, despite PSD expertise in research, housing, and forensics. The chief of PSD indicates speed as the primary factor in contracting consultants to develop mental health plans and needs assessments.

During the same timeframe, peers hired consultants for the following reasons: Franklin MHB spent approximately $65,000 for a needs assessment; Stark MHB spent approximately $46,000 for program/strategic planning; and Lucas MHB spent approximately $95,000 for two consumer surveys and a system-wide evaluation.

Excessive use of consultants in plan development can lead to community perception that PSD does not have the required expertise to effectively engage in collaborative planning (see **F7.9**). Funds are spent on the CMHB strategic plan and housing plans without clear benefits to the system or CMHB. CMHB's strategic plan is still in draft form and does not include action-oriented objectives (see **F7.11**). A consultant was hired and paid to

revise the housing plan, but was unable to complete the work for personal reasons (see **F7.17**).

R7.10 Although there is some need to use consultants, PSD administrators should develop more plans internally considering its relatively high staffing levels (see **F7.1**), and qualifications and ability of its staff to perform the work. PSD should contract with consultants only when the division does not have expertise in the planning area or the timeframe for completion is short-term (e.g., less than one year). PSD has expertise in housing, research/needs assessment, forensic care, and adult/child services. Internal development ensures PSD is more closely involved in the process and is in a better position to guide implementation. Resources previously spent on consultants can be allocated to fund programs and services for consumers.

Financial Implication: Lucas MHB consultant costs are approximately $7 per consumer, which is the highest among the peer boards. If Lucas MHB's cost per consumer is multiplied by the number of consumers in Cuyahoga County (see **Table 7-2**), total consultant costs would approximate $210,000, representing a potential accumulated cost savings of $90,000. Since the majority of the plans were contracted in the last three years (2000, 2001 and 2002), estimated annual cost savings would be approximately $30,000.

New Planning Initiatives and Programs

F7.11 CMHB's strategic planning process does not effectively include input from PSD. Although CMHB developed an agency-wide strategic planning draft, without consulting PSD, the draft contains broad objectives that are not action-oriented. For example, one of the objectives under the strategic goal for *Access*, is to mobilize consumers to take an active role in developing a mental health system that works for everyone. This objective provides neither action-oriented steps to accomplish the goal nor a link to existing plans. See **organization, compliance and board governance** for more on strategic planning.

PSD has developed nearly 10 plans during the last three fiscal years. Absent an instrument to tie these plans together, CMHB risks omitting critical input from its units, divisions, and external stakeholders (see **F7.9**). As another example, PSD's Housing and Vocational/Employment plans do not link to the Adult CSP, despite staff interviews which suggest the importance of improving relationships between housing and vocational services, and CSP.

Strategic planning is an important component of sound management practices and is necessary to coordinate agency funds with proposed programs. A five-year plan has a sufficiently long-range outlook to show the general direction of an agency or service system and the intended outcomes of its initiatives, while maintaining flexibility to alter the plan. A strategic plan should accomplish the following:

- Establish the overall mission, vision, goals, objectives and strategies of the organization;
- Provide an ongoing framework for action upon which decisions can be made about what is being preformed;
- Create an understanding regarding the intent of the program and how its actions are moving the program toward its desired outcomes;
- Provide a basis for the allocation of tasks, which includes the roles and responsibilities of each party;
- Assess the programs' current and past successes in order to inform the necessary parties;
- Identify resources required to achieve the desired outcome;
- Improve performance through monitoring and eliminating activities that are not contributing to desired outcomes;
- Involve consumers, contracted providers, and stakeholders in the process; and
- Increase accountability for stakeholders and management.

Because CMHB does not have an agency-wide strategic planning process, which includes PSD, program efforts may not be coordinated and may take place on an ad-hoc, or emergency basis.

R7.11 CMHB should include PSD and external stakeholders, such as the Council of Agency Directors, in the creation of its strategic plan. This will help to develop a coordinated and systematic process that charts the direction of future mental health service efforts, while ensuring public awareness of these efforts. An inclusive strategic planning process will help to link all of PSD's plans and ensure they do not lack critical input from external stakeholders. An inclusive process will also ensure CMHB develops a clear direction, and that Federal and State funding are properly used.

F7.12 Since CMHB has not implemented a strategic plan, the FY 2002-03 Mutual Systems Performance Agreement (MSPA) has not been used effectively to link and monitor planning activities. MSPA is a set of agreements and plans between ODMH and a county mental health board that must be completed bi-annually. Responses from CMHB's FY 2002-03 MSPA show CMHB has difficulty in addressing priorities (see **Table 7-5**). Interviews with BOG indicate the MSPA has not been fully used for planning (see **organization, compliance and board governance**). The FY 2002-03 MSPA requires county boards explain how they define and measure ODMH priorities, and to describe programs, services, or activities they plan to undertake over the next two years to impact each priority.

FY 2002-03 MSPA priorities include the following:

- Access,
- Quality,
- School success,
- Employment, and
- Consumer outcomes.

ODMH's report *Changing Lives: Ohio's Action Agenda for Mental Health* also focuses on access and quality, as well as system design, function, integration, and funding support. **Tables 7-5** and **7-6** summarize how CMHB and Franklin MHB measure ODMH priorities, and describe what programs, services, or activities are planned over the next two years which impact each priority.

Table 7-5: CMHB MSPA Responses

Priority	MSPA Responses
Access	CMHB does not formally measure access. The Board has developed a form intended to collect information on capacity and unmet need.
Quality	CMHB measures quality through databases which include, but are not limited to major unusual incident (MUI), consumer complaints and grievances, and Patient Care System (PCS) of Ohio. The Board also uses consumer satisfaction surveys. CMHB meets regularly with the Board of Governor's Quality Improvement Committee and is also in the process of implementing the Ohio Outcome System (see **provider relations and quality services**).
School Success	CMHB does not formally measure school success. Pilot programs referred to in the MSPA for children include Project Synergy, East Cleveland Alternative School Mental Health Project, and the Early Childhood Mental Health Pilot. The Ohio Scales instrument is being used for individual client outcome measurement for Project Synergy.
Employment	Quarterly reports are submitted by contracted providers with data that include number of referrals, number of job placements, and other. CMHB has implemented the Recovery Model. One outcome example is the number of adult SMD consumers engaged in work, education, or some other meaningful activity.
Consumer Outcomes	N/A[1]

Source: CMHB FY2002-03 MSPA
[1] CMHB MSPA does not contain a separate section for Consumer Outcomes.

Table 7-6: Franklin MHB MSPA Responses

Priority	MSPA Responses
Access	Access to services has been measured by contracted providers' compliance with contract obligations. An example of an access to service obligation is members in psychiatric or medical crisis shall be offered appropriate clinical treatment within three hours of requesting care from a contracted provider or shall be immediately referred to another contracted provider who can provide appropriate treatment. Franklin MHB is also progressing toward adding Capacity Tracking information from MACSIS to access to service measurements.
Quality	The Board implemented an evaluation process for SMD adults using a consumer outcome assessment tool and a satisfaction survey in order to begin measuring system cost-effectiveness for performance (see **F7.7**). The overall long-term goal of this evaluation effort is to measure relative cost-effectiveness by contract service provider for system improvement and contract decision-making.
School Success	The Board has implemented the use of the Ohio Scales for the client outcome evaluation purposes for all children and adolescents receiving mental health services. An example of Ohio Scales measure is tracking the extent to which child's problems "get in the way" of attending school and passing grades. The Board will also assess consumer and/or parent satisfaction with services over time to evaluate service providers.
Employment	The Board has been measuring and monitoring employment of persons with serious mental illness as part of the evaluation process for SMD adults.
Consumer Outcomes	The Board is implementing all population based Outcome Assessment tools as contained in the Ohio Mental Health Consumer Outcomes System Procedural Manual.

Source: Franklin MHB FY2002-03 MSPA

CMHB tracks few quality measures for consumers, such as complaints and grievances, and MUIs, but has not developed an integrated outcome system similar to Franklin MHB to evaluate and monitor contracted providers according to access, quality, school success, employment, and consumer outcomes. See **F7.7** for information regarding Franklin MHB's outcome evaluation and **technology use and claims services** for more information regarding the implementation status of MACSIS's Behavioral Health Data and Outcomes Data Project modules.

F7.13 MSPA priorities and CMHB planning are not clearly linked. Plans may informally address priorities in some way, but an explanation of how plans intend to address and measure MSPA priorities is not readily identifiable. For example, the Capital Needs Assessment prioritizes contracted provider capital projects, but there is not an explanation of how projects relate to MSPA priorities and how projects will be measured against priorities. The ODMH Northeast Ohio Area Director indicates CMHB plans should reflect service needs outlined in the MSPA. Other plans, such as Vocational/Employment and Housing, are outdated and may not necessarily reflect FY 2000-03 MSPA priorities.

Through the MSPA, ODMH is aware of county mental health board planning activities to improve and measure system performance. The MSPA agreement between ODMH and CMHB is ineffective if plans do not state how goals will be measured in relation to

MSPA priorities and clearly defined performance outcomes. Detailed information on the progress of CMHB plans could be reported on MSPA, and ODMH would be better informed on CMHB planning activities. The lack of tracking access standards and other outcomes has potentially impacted CMHB's ability to incorporate the measurement of MSPA priorities into planning.

R7.12 PSD planning initiatives should reflect MSPA priorities (see **Table 7-5**). PSD plans should show how recommendations and projects measure and address MSPA priorities. The development of an outcome assessment tool, similar to that of Franklin MHB (see **Table 7-6**), should support plan linkages and priority measurement (see **F7.7**). Revisiting and updating plans on a regular basis also ensures plan linkage to the current MSPA (see **F7.16**). Designing plans based on the MSPA would result in a standardized process for development and data tracking. Additionally, PSD planning would more likely reflect ODMH priorities.

F7.14 PSD needs assessments do not adequately include input from persons receiving services or their families, and other stakeholders. Although CMHB has surveyed consumers and providers for specific planning initiatives, CMHB has not integrated stakeholders' input into a needs assessment. The 2001 Cuyahoga Expenditure and Needs Assessment, developed by the Technical Assistance Collaborative (TAC), does not include input from stakeholders. The Federation for Community Planning (FCP) is conducting a new mental health needs assessment for the County. The proposal for FCP needs assessment includes focus groups with families and consumers and a survey of providers. Chapter 5122-38 (22-28-04) of the Ohio Administrative Code (OAC) requires needs assessments conducted by contracted providers to involve input from persons receiving services or their families. In contrast to CMHB, Franklin MHB used focus groups, face-to-face interviews, and telephone interviews to gather data from consumers, family members, and other stakeholders. Consumers surveyed for Stark MHB vocational needs assessment indicate employment as a top priority. If needs assessments do not reflect input from consumers, families, and other stakeholders, there is a risk PSD will develop a plan or program that does not meet consumer needs.

According to OAC Chapter 5122-38 (22-28-04), needs assessment methods to obtain consumer and family input include, but are not limited to, the following:

- **Consumer-oriented techniques** - refers to any standardized qualitative or quantitative assessment of expressed or observed needs existent among groups of persons receiving services within a specified time period;

- **Community forum** - refers to a method of securing public participation such as a town meeting in which community members are brought together to respond to

formulated questions regarding community needs for mental health services, and of the priorities to be placed on these needs;

- **Community survey** - refers to a survey by questionnaire or interview of a representative sample of the general population of a geographic area. Responses are sought to questions regarding past and present needs for mental health services, degree of mental health or impairment, predilection to use public mental health services, and related matters; and

- **Key informant techniques** - refers to any survey, by questionnaire, interview, or joint meeting, of significant members of the community, who represent human service organizations, persons served including ethnic, minority, and cultural groups to determine perceived needs for mental health services.

R7.13 PSD, in collaboration with the Quality Services Unit of PRQS, should ensure all needs assessments involve the input of consumers, families, and other stakeholders. PSD should provide input to the Federation for Community Planning (FCP) regarding which groups of consumers and stakeholders to survey. For future needs assessments, PSD should use techniques listed in **F7.14**. Consumer stakeholder input ensures planning activities reflect community preferences.

F7.15 The Adult CSP, Housing, Vocational/Employment, and Children's plans contain certain recommendations and goals that have not been implemented. Three factors contribute to plan implementation difficulty: funding sources not directly tied to implementation (see **F7.18**), irregular planning updates (see **F7.16**), and the lack of a strategic plan (see **F7.11**). In an AOS survey of CMHB contracted providers, 31 percent of providers responding to the question: "How can CMHB's planning process be improved," indicated CMHB has difficulty implementing planning initiatives. One provider commented, "Planning for funding has been more reactive than proactive. Other planning has attempted to be proactive, but has often not had enough emphasis or follow-through pieces to ensure process completion." An AOS survey of CMHB employees indicates plans may not be implemented due to inadequate resources. However, PSD has significantly higher staffing levels, as compared to peers, to develop and implement plans (see **F7.1**).

PSD Vocational/Employment and SAMI plans do not prioritize recommendations and goals, which negatively impacts implementation. Franklin MHB's Strategic Housing Plan provides an example of a plan that has prioritized recommendations. The order of priorities for the plan are service intensive housing, housing as housing, alcohol and drug addition/recovery based housing, and three to four bedroom units for families. CMHB prioritizes contracted provider capital projects in the Capital Needs Assessment, but not

housing service needs due, in part, to the lack of a current housing plan (see **F7.17**). Without adequate prioritization, plans do not explain what recommendations are most beneficial to the mental health system. In addition, plans do not describe which recommendations require increases in time and resources.

The list below gives examples of key PSD recommendations and goals that have not been implemented since the date of plan development (see **Table 7-4**):

- **Vocational/Employment Services** - the employment specialist indicates goals and objectives are ongoing. Progress on Goal V, supporting the collection of ongoing data by which to evaluate the long-term effects and impact of employment on mental illness, has been limited due to the inadequate technology capabilities of the Employment Alliance. The Employment Alliance does not have an integrated database that can be queried. As a result, CMHB does not have the capability to efficiently track consumers receiving vocational planning at the point of intake, consumers hired in the public and private sectors, and other goals contained in the State's employment action plan for people recovering from serious mental illness.

- **Housing** - a utilization review of supportive services attached to housing has not been implemented. CMHB is in the process of conducting a utilization review of services, with a tentative completion date of winter 2003. The lack of a utilization review affects system planning for housing because PSD does not know the existing quality and quantity of supportive services attached to housing.

- **Adult CSP** - CSP guidelines have been developed but have not been implemented for contracted providers. According to PSD staff, adherence to those guidelines has been difficult because of a funding shortage. For example, funding is unavailable for the hiring of new staff, which follows a plan recommendation to reduce caseload sizes per caseworker. A shortage of caseworkers limits service to consumers, and can cause "at-risk" persons to withdraw from needed service, become more ill, become dangerous to themselves or others, become homeless, or become at-risk for arrest.

- **Children's Plan** - According to the children's project administrator, two objectives have not been implemented: development of system-wide outcomes and preparation for Medicaid changes. CMHB staff indicates funding and staffing shortages at CMHB have stalled the development of outcomes, while the Medicaid change objective has become irrelevant, as anticipated changes in Medicaid law never occurred.

Although PSD indicates funding as an issue, CMHB spends more per consumer than peers for mental health services (see **finance and funding**).

When key recommendations and goals are not implemented, overall progress in the mental health system is adversely affected. Key areas, highlighted in *Ohio's Action Agenda for Mental Health,* such as providing access for appropriate mental health services, and quality assurance, are affected when PSD recommendations go unimplemented. A possible system-wide effect of not hiring additional CSP workers is increased waiting time for consumers and unsuccessful treatment outcomes.

Franklin MHB indicates no difficulty in the implementation of its plans, although some recommendations still need to be implemented. According to the senior vice president for planning, the implementation of specific planning recommendations depends on the circumstances of that plan. For example, funds may be available when a plan is developed, but over time, money becomes unavailable to implement the plan.

R7.14 The chief of PSD, in collaboration with PSD administrators, should identify recommendations and goals that have not been implemented, revise recommendations that are no longer feasible, and prioritize those that CMHB and stakeholders deem valuable and financially supportable. PSD should work with the Finance Unit to identify funding strategies. PSD should also prioritize recommendations for future plans such as SAMI and Community Care. Recommendation priorities should reflect strategic planning and MSPA priorities (see **F7.11** and **F7.12**); barriers should be identified, as well as any funding strategies. Implementation of key planning recommendations benefits the mental health system by improving consumer tracking, consumer referrals and overall consumer treatment.

F7.16 The Adult CSP, Housing, Vocational/Employment, and Family Caregiver plans have not been updated to reflect the current status of the mental health system. Although an effort was made to revise the 1993 Housing Plan, a revised plan has not been developed. The consultant hired to revise the plan was unable to complete the work for personal reasons. CMHB hired the consultant to provide technical expertise on best practices, Federal and State reporting requirements, and information on alternative methods to fund housing projects such as private foundations and banks. The Adult CSP, Vocational/Employment, and Family Caregiver plans have not been updated since the development of the plans in 1998 and 2000. According to PSD staff, plans have not been updated because of lack of new funding to implement recommendations and goals. However, CMHB spends more per consumer than peers for mental health services (see **finance and funding**).

The employment specialist indicates many of the vocational/employment service goals are ongoing, and the plan could be updated to include the recovery model initiative to increase the involvement of consumers in the recovery process. The

employment/vocational workgroup monitors adherence to these goals. Workgroup members include PSD's employment specialist and Employment Alliance staff. The adult administrator indicates continued progress toward meeting CSP guidelines has been on hold due to reductions in State and County funding. However, CMHB spends more per consumer than the peers (see **finance and funding**). Plans that are not regularly updated do not give an accurate picture of CMHB's current activities and progress towards planning goals. Furthermore, outdated plans do not reflect shifts in demographics, consumer preferences, and community needs over time.

Franklin MHB monitors and ensures results through its Managing for Results (MFR) strategic plan and the Mutual Systems Performance Agreement (MSPA). The MFR strategic plan includes a description of system planning services and responsible employees. System planning services include contract compliance reports, needs assessment and planning reports, network front-door assessments, community plans, and priority population identifications. Progress for division services is assessed through performance measures, which include, but are not limited to, increasing outreach for recruitment, providing specialized services, and improving access to services. Franklin MHB community plans, capital plans, housing plans, needs assessments, consumer outcomes, and satisfaction processes are updated each year via the MSPA (see **F7.12**).

R7.15 PSD should develop and regularly update detailed action steps to facilitate plan implementation. PSD should provide BOG with regular updates of the status of plan implementation. PSD should also develop a regular schedule to revisit progress towards meeting goals and objectives so plans reflect the current mental health environment for consumers. The finalization of a working strategic plan similar to Franklin MHB should improve PSD capability in monitoring plan implementation and results. Updating plans regularly would allow PSD to include current mental health best practices. Community needs and system priorities will remain current, and will not be based on outdated information. Updating plans regularly also makes it possible to identify new resource opportunities and changes in plan implementation. See **F7.17** and **R7.16** for information on the outdated housing plan.

F7.17 PSD 1993 housing plan is outdated. The consultant hired to revise the plan was unable to complete the work for personal reasons. PSD residential administrator indicated housing is needed for special populations, including SAMI and forensic. Housing shortages appear as a common response in the contracted provider survey, with 43 percent of indicating this as a concern. Housing needs specified in surveys included supported and subsidized housing and a disabled women's shelter. In additional interviews, criminal justice stakeholders indicated transitional housing was needed to facilitate the movement of prisoners from jail facilities to the community. Without an updated housing plan, there is a risk housing needs will not be addressed in a systemic way. Federal and State housing funds may not be allocated in areas that are a priority for the system. An updated

housing plan is necessary to facilitate a coordinated response to the housing needs for mental health consumers.

Franklin MHB's Strategic Housing Plan contains elements that can be used to develop a housing plan for CMHB. Franklin MHB's Strategic Housing Plan prioritizes system needs and links the Capital Needs Assessment submitted to ODMH to these system priorities. The plan also contains a section outlining provider and other system stakeholder preferences. Additionally, Franklin MHB works with neighborhoods to develop Good Neighborhood Agreements designed to educate the community on facts regarding mental illness and substance abuse, and foster an amenable living environment for consumers and the community. Franklin MHB participates in many ongoing planning processes including, but not limited to, Columbus/Franklin County Consolidated Plan, Columbus Metropolitan Housing Authority (CMHA) five year plan, and Columbus Coalition for the Homeless.

R7.16 The residential project administrator should update the housing plan to reflect current community housing needs. See **F7.16** and **R7.15** for additional information on plan updating. The housing plan should be a living document and a process should be developed to update the plan at least every two years to correspond with capital development requests to ODMH. PSD should consider developing the plan with elements similar to the Franklin MHB Strategic Housing Plan, such as a section for provider and community stakeholder preferences and linking capital development requests to system priorities. Additionally, PSD should review the concept of Good Neighborhood Agreements with neighborhoods to educate the community on mental health and substance abuse issues. Updating the housing plan would enable PSD to identify and prioritize current housing needs for mental health consumers.

F7.18 The Adult CSP, Children's, SAMI, Vocational/Employment, and Housing plans do not link funding sources to implementation. For example, the Adult CSP plan demonstrates a need for additional CSP supervisors but does not identify funds to pay for additional staff. Franklin MHB's Strategic Housing Plan links housing priorities to capital fund amounts requested from ODMH. The Strategic Housing Plan contains a chart of current and future capital resources for planning. All planning goals will not necessarily be tied to funding, but goals involving increased staffing, large scale projects (utilization reviews), and new services should identify funding sources as a guarantee that recommendations will be implemented. PSD plans that are tied to funding, such as the Recovery System and Capital Needs Assessment, are more appropriately structured because they are based on ODMH funding.

Plans developed by consultants that are not fully implemented or workable, absorb financial resources which can be put to better use in developing programs and assisting consumers (see **F7.10**). Time spent by PSD developing plans that are not implemented or

workable, can be better spent searching for additional program funding, providing system-training, and ensuring cultural competency in the mental health system.

R7.17 PSD should link funding sources to planning implementation. PSD should receive necessary input from the grant writer and the Finance Unit. Linking funding sources to planning increases the chance recommendations will be implemented. For example, if the planning process identifies a need for additional CSP caseworkers, CMHB should reserve funds, seek State and Federal grants, and identify alternative funding options to implement the project. If funding is unavailable, then projects should receive less priority until financial situations change. By taking a proactive approach, CMHB should be aware of available funds, as well as funds requiring additional research to meet a need. The centralization of grant writing responsibilities will allow PSD to better coordinate and plan grant funding for projects (see **R7.23**). CMHB should be better prepared to develop strategies to contend with changes in State, Federal, and County funding, as well as the expiration of grants.

F7.19 An AOS survey of CMHB contracted providers indicates PSD has not fully addressed service needs. Fifty-seven percent of responding contracted providers indicate requests for new services and programs are not well-received by CMHB (see **organization, compliance, and board of governance**). Contracted providers indicate program funding is the most important priority to address service needs, followed by system planning and contracted provider program collaboration. CMHB staff, however, indicates the lack of additional State and local funds limits PSD's ability to address service needs. **Table 7-7** is a summary of contracted provider responses on system needs.

Table 7-7: Contracted Provider Responses on System Needs

Category	Contracted Provider Responses
Housing/Residential [1]	Lack of housing/residential services was a common response from 9 (43%) contracted providers. Service needs specified included supported and subsidized housing and a disabled women's shelter.
Forensic	Two (9%) contracted providers indicated lack of forensic services. Specific responses included lack of forensic/mental health courts and lack of effective coordination with prison system. Many ill persons are being released in Cuyahoga County from prison each year with a lack of resources for them.
SAMI	Four (19%) contracted providers indicated lack of SAMI services.
Employment/Vocational	Two (10%) contracted providers indicated lack of employment or supported employment services.
Prevention	Four (19%) contracted providers indicated lack of prevention services.
Children/Transitional Youth	Eight (38%) contracted providers indicated the lack of children or transitional youth services. Specific responses included lack of outpatient child psychiatry, after school programming for youth, early childhood and SED children/youth caseloads too high.
Counseling	Ten (47%) contracted providers indicated lack of counseling/outpatient services.
Other	Other responses included lack of: inpatient units for the acutely ill, family services, more effective psychiatric emergency and crisis stabilization programs, MRDD/mental health, transportation, day programs, foster care, payeeship and social/recreation programming, med/som.

Source: AOS survey of CMHB contracted providers

Note: Responses do not equal 100 percent because contracted providers responded to more than one category.

[1] In Cuyahoga County, current residential options for adult consumers include respite (26 beds), residential treatment (99 beds), residential support (228 beds) residential services (22 beds), independent living (232 beds), adult care facilities (848 beds) and subsidized housing (250 units).

Counseling (10) and Housing/Residential (9) were the most prevalent contracted provider responses concerning system needs, followed by Children/Transitional Youth (8), SAMI (4) and Prevention (4). Contracted providers also gave examples of types of needs that are lacking, such as the absence of a mental health court for the system and lack of supported employment services.

PSD develops plans, locates funding, and is involved in various committees to address services needs. PSD has developed housing, SAMI, vocational, children's and Adult CSP plans addressing service needs indicated by providers, but plans are not fully implemented or up-to-date (see **F7.15** and **F7.16**). CMHB effectively seeks or obtains grant dollars from a variety of sources, including Federal agencies, National Institute of Mental Health (NIMH), private foundations, and ODMH. PSD requested approximately $13 million in capital funding from ODMH for permanent housing, supportive housing and other capital development projects. PSD staff members are currently involved in committees to develop jail diversion programs and a mental health court.

Although PSD has made efforts to address service gaps, an AOS survey of CMHB contracted providers illustrates service needs are not adequately addressed. Strategies to address service needs include the following:

- Distribute RFPs for new programs to contracted providers and the community. Stark MHB's Vocational Needs Assessment recommends a RFP be released to bidders including different employment service options.

- Continue to locate additional financial resources to fund services. Additional funding options include leveraging human service, housing and criminal justice grants to fund programs that also serve mental health populations, and utilizing private foundation funding (see **Table 7-11**).

- Improve the mental health planning process by using input from contracted providers and stakeholders, linking mental health plan implementation to funding, monitoring plans to ensure consistency with the strategic plan, and developing timelines to facilitate implementation of planning initiatives.

- Develop a process to identify key program best practices for a continuum of care. Program best practices should include supported employment/housing, consumer initiatives, consumer family involvement in system planning/evaluation, and assertive community treatment (ACT) models for special needs groups such as homeless and dual diagnosis.

R7.18 PSD should continue collaborating with ADAS, the Council of Agency Directors, and other stakeholders to address system needs. Strategies for addressing system needs should be developed in conjunction with CMHB strategic planning (see **organization, compliance and board governance** and **F7.11**). Additionally, PSD should develop strategies to consolidate contracted provider programs to streamline programming duplication and costs in the system. Improving the mental health planning process, locating additional funding sources, distributing RFPs for new programs and identifying key program best practices are strategies to address service gaps. Addressing service gaps will help to ensure that consumers receive appropriate mental health services.

F7.20 PSD employment/vocational planning initiatives include a vocational/employment plan, consumer survey and Recovery Model grant proposal. According to an article written by the executive director for the Ohio Advocates of Mental Health, out of 50 mental health boards, CMHB ranks in the top five boards in vocational/employment services. In FY 1999-00, a workgroup comprised of the PSD employment specialist and the Employment Alliance completed a vocational/employment plan, although the plan is not fully implemented because of lack of funding for support. Although funding is indicated as an issue, CMHB spends more per consumer than peers for mental health services (see **finance and funding**). Peer mental health boards have not completed employment/vocational plans. Other PSD employment/vocational planning initiatives include a survey of consumers for employment/vocational services and the Recovery

Model grant proposal. Stark MHB surveyed consumer employment/vocational preferences for its vocational needs assessment. Franklin MHB's outcome evaluation project tracked employment status for individuals with severe mental illness (see **F7.7**). Peer mental health boards have not received Recovery Model grant proposals. Although PSD has made progress in employment/vocational planning, outcome assessment for planning could be improved.

PSD has collected data for employment/vocational services through the Employment Alliance outcome measurement report and consumer survey. The outcome measurement report includes data on the number of persons served, average placement wage and 90 day retention rate. Peers were contacted to provide employment/vocational outcome data, but did not submit the data because they either did not track employment/vocational data or did not respond. Without outcome data, comparisons of employment/vocational programs cannot be made (see **technology use and claims services**). The consumer survey includes information on the percentage of respondents currently working and the percentage of respondents with a desire to work. PSD could improve employment/vocational outcome data by tracking additional measures similar to the Center for Vocational Alternatives (COVA), a contracted provider funded by Franklin MHB. COVA bases outcomes on employment/vocational measures developed by the Rehabilitation Commission. According to the director of COVA, employment/vocational measures include the following:

- Employment choice;
- Consumer ease in re-entering the mental health system;
- Access to employment services;
- Satisfaction of consumers, employers, referral services, case managers, NAMI and other stakeholders;
- Retention rates at intervals of 90 days, 6 months, 1 year and long-term intervals; and
- Consideration of cultural competency for vocational and employment services.

C7.1 CMHB effectively plans vocational/employment services by working with the Employment Alliance to meet consumer needs. Obtaining stable employment and job skills aids consumers in recovery and overcoming stigma associated with mental illness.

R7.19 The PSD employment specialist, in collaboration with the Employment Alliance, should enhance employment/vocational outcomes by tracking outcomes similar to COVA. The results of the outcomes should be used to make improvements in the system. Additionally, PSD should update the vocational plan and continue to monitor implementation of goals. Monitoring the implementation of vocational/employment

planning goals and enhancing system outcomes should generate more valuable employment/vocational information for decision-making.

Cultural Competency

F7.21 CMHB does not have a formalized, written cultural competency plan. As a result, formal standards and guidelines do not exist for providing in-house training. Additionally, there is less accountability for the measurement of contracted provider performance in the area of cultural competency. Without a formal written plan, CMHB may be under-representing its efforts in this area.

According to NMHA, access to mental health services and the effectiveness of the care consumers receive are greatly affected by the degree to which the delivery system is culturally competent. To improve the cultural sensitivity and responsiveness of mental health delivery systems, the NMHA recommends organizations have a formalized, written cultural competency plan.

The Center for Mental Health Services (CMHS) has identified several items which should be considered when developing a cultural competency plan:

- Development and integration with the participation of top and middle management administrators, front-line staff, consumers and their families, and community stakeholders;

- An individual at the executive level with responsibility for and authority to monitor plan implementation;

- Individual managers accountable for the success of the plan, based on their level within the organization;

- A process for integrating the plan into all aspects of strategic planning and in any future planning endeavors, (see **organization, compliance and board governance**);

- A process for determining unique, regionally-based needs and ecological variables within the community, using existing databases, surveys, community forums, or key informants;

- Identification of service modalities and models which are appropriate and acceptable to the communities being served (e.g., urban and rural), population

densities, and targeted population subgroups (e.g., children, adolescents, adults, the elderly, and sexual minorities);

- Identification and involvement of community resources (e.g., tribal and community councils or governing bodies, family members, churches, civic clubs, and community organizations) and cross-system alliances (e.g., corrections, juvenile justice, education, social services, substance abuse, developmental disability, primary care plans, and public and/or tribal health agencies) for purposes of integrated consumer support and service delivery;

- Assurance of cultural competence at each level of care within the system (e.g., crisis, inpatient, outpatient, residential, home-based, health maintenance, and community health liaison services);

- Stipulation of adequate and culturally diverse staffing and minimal skill levels (including gender, ethnicity and language, as well as licensing, certification, and credentialing) for all staff;

- The use of culturally competent indicators, adapted for specific minority cultural values and beliefs;

- Development of rewards and incentives (e.g., salary, promotion, bonuses) for cultural competence performance, as well as sanctions for culturally destructive practices (e.g., discrimination). Cultural competence performance shall be an integral part of the employee-provider performance evaluation system, and contracted provider performance evaluation system;

- Development of a plan to integrate ongoing training and staff development; and

- Development of, and monitoring of, indicators to ensure equal access, comparability of benefits, and outcomes across each level of the mental health system, and for all services.

Franklin MHB is currently in the process of developing a formal cultural competency plan. Interviews with Franklin MHB staff indicates such a plan is critical, as it would clearly define guidelines, standards, and expectations, while creating and institutionalizing parameters needed to evaluate cultural competency.

In addition, ODMH is currently developing the Consolidated Culturalogical Assessment Tool (C-CAT), an instrument designed to assist mental health organizations in

determining their cultural competency status while identifying quality improvement strategies. The C-CAT is comprised of five major elements:

- **System Profile** - collects demographic information to examine access, staffing and consumer issues within the entire mental health system;

- **Organization Profile** - collects demographic information to examine access, staffing and consumer issues within the mental health organization;

- **System & Organization Assessment** - measures the prevalence of conditions and practices pertaining to cultural competence in a given organization or system by asking persons with a vested interest about them. Both internal and external measurers are required;

- **Adult Service Recipient Assessment** - measures the prevalence of conditions and practices pertaining to cultural competence in a given organization or system by questioning consumers over the age of 17 and their families; and

- **Youth Service Recipient Assessment** - measures the prevalence of conditions and practices pertaining to cultural competence in a given organization or system by questioning consumers between the ages of 10 and 17.

R7.20 The multi-cultural/systems project administrator, with input from the Human Resources and Risk Management Divisions, should develop and implement a written, formalized cultural competency plan. This is necessary to ensure CMHB develops a coordinated and systematic process that charts the direction of future cultural competency efforts, by linking such efforts to the performance of CMHB personnel, as well as contracted providers. Implementation of a cultural competency plan also ensures public awareness of CMHB efforts. In addition to those listed above, see **F7.8** and **R7.8** for planning elements that should be included in the plan.

The multi-cultural/systems project administrator should also consult with ODMH on implementing C-CAT when it has been fully developed. This tool has the potential to provide a systematic process for determining the return on investment of activities dedicated to the improvement of cultural competency.

F7.22 CMHB recently suspended the activities of the Multi-Cultural Concerns Committee, until a full BOG could be established. This committee, whose membership was limited to BOG members, was in charge of collecting demographic data from contracted

providers and seeking to influence and implement culturally competent policies within the contracted provider network.

The Multi-Cultural Concerns Committee is still inactive. Instability in the CEO position, and the establishment of other priorities, such as the Recovery Plan, MACSIS implementation, and the Outcomes Initiative, have placed committee activities on hold indefinitely. This has resulted in a shift of priority away from providing culturally competent services.

Franklin MHB has created a temporary workgroup to develop cultural competency standards. This workgroup is part of a provider leadership association, which includes senior Franklin MHB staff and all contracted provider executive directors. The workgroup plans to recommend the creation of a standing committee to deal with cultural competency issues. CMHB lacks what Franklin MHB describes as an effective cultural competence committee, which has the authority to make decisions and affect change.

R7.21 The multi-cultural/systems project administrator should take the lead in re-instituting the Multi-Cultural Concerns Committee as a short term taskforce, rather than a standing committee (see **organization, compliance and board governance**). This taskforce should operate on an as-needed basis, as issues of cultural competence arise (see **external affairs**). Membership should represent all CMHB divisions, contracted providers, as well as BOG. This taskforce should work to implement national cultural competence standards as outlined by NMHA, CMHS, and ODMH, while providing guidance and accountability to the development of a formal cultural competency plan.

F7.23 Cultural competence standards and requirements are not included in contracts with providers. As a result, CMHB lacks a formal, written agreement with contracted providers to supply culturally competent services. CMHB policy requires consideration of cultural competency in all areas of responsibility. Without formal contract language, however, CMHB may have difficulty enforcing the cultural competency requirements for contracted providers.

Franklin MHB includes the following cultural competence standards in its 2003 Service Provider Contract:

- Services shall be culturally competent and shall respond effectively to:

    1. Consumer needs and values present in all cultures, including, but not limited to, the African-American, Appalachian, Asian, Latin, Hispanic, and Native American cultures;
    2. Needs based on consumer gender and sexual orientation; and
    3. Needs based on consumer age.

- The Provider shall work together with Franklin MHB in FY 2003 to develop and implement guidelines for culturally competent services.

R7.22 PSD administrators should work with the Multi-Cultural Concerns Taskforce, Risk Management, and Provider Relations Unit to ensure provider contracts require adherence to cultural competence standards. While incorporating language similar to that used by Franklin MHB, a formalized contractual statement could reduce program deficiencies or misunderstandings arising in the area of cultural competency. See **risk management and consumer affairs** for more information on CMHB contracts.

Grant Funding Potential

F7.24 Grant writing duties are not centralized or designated to one position at CMHB. The research/program administrator, however, researches, edits, and writes approximately six grant proposals per year, including proposals submitted by PSD staff. **Table 7-8** compares the amount of grant revenue for internal operations at CMHB and the peers.

Table 7-8: CMHB & Peer Grant Analysis

	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average
Grant Revenue FY99	$1,760,500	$1,877,300	$406,200	$128,400	$804,000
Grant Revenue FY00	$2,378,000	$1,928,700	$567,900	$246,000	$914,200
Grant Revenue FY01	$3,342,200	$2,271,500	$934,500	$1,047,200	$1,417,700
Total	**$7,480,700**	**$6,077,500**	**$1,908,600**	**$1,421,600**	**$3,135,900**
Grant Writer	No	Yes	No	No	N/A
Total # of Consumers (2001) [1]	30,200	29,300	13,700	8,200	17,000
Grant $ per Consumer (2001)	$111	$78	$68	$128	$83

Source: CMHB annual reports, Stark MHB, Franklin MHB, Lucas MHB, and MACSIS
Note: Figures have been rounded to the nearest 100 and do not include pass-through dollars which are distributed directly to contracted providers.
[1] See **Table 7-2**

From FY 1999 through 2001, CMHB obtained approximately $7.5 million in grant revenue for internal operations. The peer average over the same time period was $3.1 million. In addition, CMHB earned $111 in grants per consumer (FY 2001), while the peer average was $83 per consumer. According to **Table 7-8**, it appears CMHB's level of internal grant revenue is slightly above the peer average.

The grant writing process is decentralized within PSD. Individual administrators are responsible for researching, drafting, and editing proposals. Interviews with PSD staff

suggest application deadlines are often incompatible with the CMHB decision-making process. Grant opportunities are missed due to slow or late decision making on the part of PSD, while proposals are usually overnighted to grant providers one or two days before the deadline. CMHB recently instituted the Non-Traditional Revenue Generating Workgroup to address grant writing issues.

Table 7-9 illustrates the average amount of time PSD staff spends on the grant writing process per year.

Table 7-9: Average Time PSD Spends on Grant Process per Year

PSD Staff	Hours Spent (per year) Researching, Writing & Editing Grants
Chief of PSD	N/A
Children's Project Administrator	120
Adult Project Administrator	25
Multi-Cultural/Systems Project Administrator	N/A
Research/Program Administrator	360
Facility Compliance Examiner	N/A
Residential Specialist	25
Resource Specialist	N/A
Employment Specialist	50
Forensic Specialist	72
TOTAL	**652**

Source: Interviews with PSD staff
Note: The facility compliance examiner and the resource specialist indicate they are not involved in the grant process.

Of 13 FTEs within PSD, 8 individual administrators contribute to the research, writing and editing of grants. The chief of PSD and the multi-cultural/systems project administrator contribute to the process, but could not submit an average number of hours per year.

F7.25 Since FY 1999, CMHB has assisted contracted providers in obtaining $20.5 million in mental health system grant dollars from the following sources: ODMH, the Corrections Planning Board, U.S. Departments of Education, Justice, Health & Human Services, and Housing & Urban Development, the Woodruff Foundation, the National Institute of Mental Health (NIMH), Lorain MHB, the Nord Family Foundation, and the Bruening Foundation.

Table 7-10 illustrates the source and percentage of grant dollars (including pass-through) CMHB has assisted in obtaining for the mental health system from FY 1999 through FY 2001.

Table 7-10: Sources of Grant $ Received FY 1999 – 2001

Source	Amount	Percent of Total
U.S. Federal Agencies	$16,923,100	82%
ODMH	2,931,800	14%
Private Foundations	229,400	1%
NIMH	41,700	< 1%[1]
Other	396,000	2%
TOTAL	**$20,522,000**	**100%**

Note: Includes grant dollars given directly to contracted providers
Source: Research/Program Administrator
[1] Actual percentage of total is 0.2 %

In February 2002, Franklin MHB created a centralized grant writer position, which remains vacant. In interviews, the CEO of Franklin MHB suggested a grant writer is necessary to infuse more revenue into the mental health system, representing a strategic goal. With flat or declining revenues and increased costs, a grant writer assists in tapping new sources of funds.

In a 2002 management audit, it was reported the grant management functions of the Ohio Department of Education (ODE) were decentralized. The audit, citing best practices from KPMG Consulting and the Florida Office of Program Policy Analysis and Government Accountability, recommended ODE centralize its grant monitoring functions to provide a central point of coordination, create an oversight authority, increase accountability and reduce data inaccuracies.

R7.23 In lieu of hiring a new employee, CMHB should work with the Non-traditional Revenue Generating Workgroup to centralize its grant writing functions of eight individual administrators into one position, the research/program administrator. With additional input from the Human Resources Unit and BOG, PSD administrators, including the chief, should alter PSD job descriptions to reflect this shift in responsibility. The current research/program administrator has valuable experience in the field of grant writing, and currently spends 360 hours annually on the process. In addition, on June 30, 2002, the Cuyahoga County Community Mental Health Research Institute (CMHRI) closed (see **F7.29**), providing the research/program administrator more time to dedicate toward grant writing. PSD administrators with grant research/writing experience should assist the grant writer when multiple grants are being pursued simultaneously, but the majority of these responsibilities should be centralized with one FTE.

A centralized grant management process would streamline PSD by reducing staff involvement from eight to one, ensuring consistency and eliminating duplicative efforts. In addition, by shifting grant writing responsibility to the research/program administrator, a certain measure of speed and accountability will be added to the process, as opposed to being spread throughout PSD, resulting in more timely submission of grant applications.

PSD administrators spend nearly 700 hours per year on the grant proposal process (see **Table 7-9**), which could be assumed by the research/project administrator. The administrator's remaining 1,380 hours could be spent performing other planning and research functions for PSD.

F7.26 PSD has not maximized potential grant revenue earnings via private foundations. Since FY 1999, CMHB grant dollars from private, local, and national foundations account for $229,000. This is approximately one percent of total grant revenue (see **Table 7-10**). Although CMHB's grant dollars per consumer exceeded the peer average by approximately 22 percent in FY 2001 (see **Table 7-8**), a substantial amount is available for mental health system planning from the private foundations.

Table 7-11 lists local and national foundations which provide grant dollars for social, health, and human services programs.

Table 7-11: Potential Sources of Grant Funding from Private Foundations

Source	Contact Information	Types of Programs Funded
J.G. Bell Foundation	18519 Detroit Avenue Lakewood, OH 45107	• youth services
Cleveland Foundation	1422 Euclid Ave. Suite 1300 Cleveland, OH 44115-2001 (216) 861-3810	• cultural programs • health & human services
The Columbus Foundation	1234 E. Broad St. Columbus, OH 43205 www.columbusfoundation.com	• health • social services • urban affairs
Foundation For Healthy Communities	155 E. Broad St. 15th Floor Columbus, OH 43215-3620 www.ohanet.org	• collaborations between hospitals and local organizations
George Gund Foundation	1845 Guildhall Bldg. 45 Prospect Ave. W Cleveland, OH 44115 (216) 241-3114	• human services
William J. & Dorothy K. O'Neill Foundation	30195 Chagrin Blvd. Suite 250 Cleveland, OH 44124 (216) 831-9667	• health & human services
Reinberger Foundation	27600 Chagrin Blvd. Cleveland, OH 44122	• culture • health organizations

Source: *Finding Funding in Your Backyard and Beyond*, a directory published by the City of Newark, Ohio and The Foundation Center

CMHB, and the entire mental health system, benefit from the grant writing efforts of PSD administrators. However, the current, decentralized system results in the under-utilization of specific funding sources (see **F7.25**, **F7.26**, and **R7.23**). Eight PSD administrators contribute to the grant writing process of CMHB; however, not all have the time and resources available to develop relationships with private foundations.

R7.24 CMHB and PSD, through the efforts of a centralized grant writer position and the Non-traditional Revenue Generating Workgroup, should seek to establish more relationships with private, local, and national foundations (see **Table 7-11**), the United Way, and other funding sources, while maintaining its grant writing partnerships with contracted providers (see **R7.25**). Centralizing the grant writing function with the research/project administrator (see **R7.23**) would enhance CMHB's ability to establish long-term relationships with private funding sources and retrieve additional grant dollars for the mental health system of Cuyahoga County.

F7.27 An AOS survey of CMHB contracted providers indicates CMHB "needs to do more to generate increased and diversified funding" for mental health consumers. Of 21 contracted providers responding to the survey, 71 percent indicate new funding streams, such as additional grant dollars, exist but have not been found. The remaining 29 percent had no comment.

Under the current system, eight PSD administrators share grant research/writing responsibilities. As mentioned above, eight administrators with other job duties cannot succeed in establishing and maintaining long-term grant writing relationships with private foundations.

R7.25 CMHB, through the CEO and a centralized grant writer position, should improve its grant writing relationship with contracted providers by continuing to support contracted provider grant applications. These efforts should include the following: sharing needs assessment data, reviewing and editing proposals, and writing letters of support for grants.

As PSD administrators plan mental health programs that affect contracted providers, they should also consult with the grant writer on the type of plan being implemented (adult, children's, housing, etc.) in order to ascertain potential funding sources. The grant writer should then partner with affected contracted providers to contact foundations.

Relationships & Partnerships with Other County Agencies

F7.28 CMHB does not always develop a Memorandum of Understanding (MOU) when collaborating with other agencies to develop and fund programs. CMHB collaborates with the Corrections Planning Board to jointly fund the Mentally Disordered Offender Program and Adult Sex Offender Program. A MOU exists between CMHB and the Western Reserve Area Agency on Aging (WRAAA) regarding the Residential State Supplement (RSS) program. CMHB has an agreement with Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CMRDD) outlining responsibilities to operate and fund a residential program. CMHB also has a formal agreement with the Family and Children First Council (FCFC), which provides input for the planning of children's mental health programs.

Based on interviews with mental health system stakeholders, CMHB can expand and improve formal collaboration with other agencies. According to CMRDD staff members, additional benefits would result from more formal collaboration that targets populations and develops joint programs between agencies. CMHB does not have formal agreements with Alcohol and Drug Addition Services Board (ADAS) and Bureau of Vocational Rehabilitation (BVR), limiting the capability of the organizations to coordinate program development, consumer referrals and program funding. The joint SAMI plan recommended CMHB and ADAS increase collaboration by engaging in more joint planning efforts that bring together staff from mental health, ADAS, housing, and criminal justice systems. The ADAS executive director indicated a formal agreement would help identify service gaps and improve the system's ability to maximize funding streams. A formal memorandum of understanding (MOU) would provide written policies, procedures, and practices for regular meetings between staff, and outline how information would be shared. Without a formal process for collaboration, addressing the needs of persons with multiple diagnoses may not be accomplished efficiently or effectively.

In December 1998, Franklin MHB and Franklin County Children Services Board (FCCS) entered into an agreement that established a partnership, including a pooled funding arrangement made up of local, State, and Federal funds available to both systems for the care of children with protective service needs and their families served jointly by the two boards (see **finance and funding**). The ultimate goal of the agreement is the reunification and stabilization of families involved with FCCS. The agreement also describes who is eligible for services and states that all persons served through the initiative will be enrolled in Franklin MHB system's database in a separate category for the purpose of monitoring service costs and utilization.

R7.26 The chief of PSD, in collaboration with risk management staff, should fully develop formal relationships with CMRDD, ADAS, BVR, and other external organizations.

MOUs can be used when organizations have mutual objectives, are able to work together to leverage funding, and receive shared benefits by better defining lines of communication and responsibilities. Formal agreements can help address issues of service duplication, program deficiencies, timeliness of referrals, and other systemic problems. Outlining the responsibilities and guidelines for organizations to work together on joint projects and initiatives could result in additional system funding as well.

F7.29 The Cuyahoga County Community Mental Health Research Institute (CMHRI), a partnership between CMHB and the Mandel School at Case Western Reserve University (CWRU), closed on June 30, 2002. Funding from CMHB was discontinued in the face of County-wide budget reductions. ODMH kept CMHRI operational for one year but has not renewed funding. According to the research/program administrator, CMHB paid approximately $114,500 per year to operate CMHRI.

In addition to funding constraints, BOG indicates CMHRI projects do not reflect practical responses to mental health needs, nor do they utilize applicable data, gathered in consultation with locally contracted providers. A formal agreement between CMHB and Case Western Reserve University does not address BOG concerns that CMHB dollars be used to fund research projects reflective of the needs of Cuyahoga County, and that CMHRI research have a practical connection to mental health system planning via data gathered in consultation with locally contracted providers. See **risk management and consumer affairs** for more information regarding CMHB contracts.

Despite these inefficiencies, this partnership was mutually beneficial to both organizations, as it provided research topics to CWRU, while keeping CMHB abreast of potential issues arising in the mental health system. Most importantly, CMHRI offered CMHB the benefit of CWRU's reputation when applying for grant dollars. Since 1994, CMHRI generated 18 research studies and $3.2 million in grants for the mental health system, an annual average of $400,000. PSD plans which were guided by CMHRI include the Community Care for Hospitalized Consumers and Family Caregiver plans.

According to the Children & Family Research Center of the University of Illinois, Chicago (CFRC), research partnerships help determine where mental health problems are likely to arise and where resources are available to deal with them. In addition, partnerships help identify the strengths and weaknesses of human services practices and allow for the compilation of data necessary to affect change.

R7.27 BOG should consider reinstituting CMHRI in the future. Its loss, according to PSD staff interviews and CFRC best practices, may negatively affect research productivity and mental health system grant revenue, hindering the planning efforts of PSD. If another partnership is formed, a well-defined, formal agreement between CMHB, and CMHRI should be implemented, addressing the concerns of all parties. Specifically, the

agreement should state that CMHB dollars, with BOG approval, will be used to fund research projects reflective of the needs of Cuyahoga County, and that CMHRI research will have a practical connection to mental health system planning via data gathered in consultation with locally contracted providers. This will help alleviate BOG concerns and provide for continuing mental health research in Cuyahoga County.

Financial Implications Summary

The following table summarizes estimated costs and savings associated with the recommendations in this section. For the purpose of this table, only recommendations with quantifiable financial impacts are listed.

Summary of Financial Implications

Recommendation	Cost Savings (Annual)
R7.1 CMHB should consider reducing PSD staffing levels by one FTE.	$38,000
R7.10 CMHB should develop more plans internally, without consultants.	$30,000
Total	**$68,000**

Conclusion Statement

PSD is responsible for planning mental health services, conducting research, obtaining grant funding and ensuring cultural competency for the mental health system. PSD operations have been impacted by vacancies in management positions at CMHB.

Based on an analysis of PSD workload and staffing, output per FTE is below the peer average for plans developed, residential inspections and consumers served. A decreased level of output per FTE indicates PSD is not operating as efficiently as peers with staff resources. PSD should consider reducing one administrative assistant position. To streamline operations and staff resources, CMHB should also consolidate PSD with the Quality Improvement and Utilization Review Units of the Provider Relations and Quality Services Division. Benefits of consolidation include reduced job duplication, and improved CMHB ability to evaluate outcomes and gather data. Furthermore, the forensic coordinator and employment specialist positions should be removed from the direct supervision of the multi-cultural/systems project administrator and placed within the adult planning area of PSD to better reflect job functions.

PSD is responsible for developing plans that address mental health system needs. Plans identify services, capital development projects, and any required training. Plans which cover a wide array of topics allow PSD to use knowledge of specialized staff to address many different system needs. However, CMHB's large number of contracted providers and consumers complicates the planning process. Due to this complex service environment, PSD should standardize planning processes as much as possible to improve planning and oversight for such a large system. PSD should tie plans to funding sources and update plans on a regular basis to facilitate implementation of goals and recommendations. PSD should link plans to strategic planning and MSPA, resulting in a clearer set of priorities for the mental health system. By continuing to develop permanent partnerships and agreements with other agencies, CMHB can improve its collaborative and jointly funded planning efforts.

Without a system-wide outcomes measurement system, PSD and the Quality Services Unit continue to have difficulty incorporating data into mental health system plans. PSD may track outcome data for specific initiatives, but is unable to use quality services outcomes to compare data for the entire mental health system. Analyzing data for planning appears to be an informal process. Various data sources are available to PSD staff, but the information is not used in decision making. PSD should use data from many sources for planning to determine service quality and needs. Sources for data include, but are not limited to, needs assessments, contractor provider surveys, consumer data, and contracted provider outcome data. Increasing the role of other CMHB divisions in planning should improve PSD's capability to perform needs assessments and analyze relevant data. Data should be tracked over time to identify system trends and services that are working effectively.

Compared to peers, PSD is effective in obtaining grant dollars from sources such as Federal agencies and ODMH. From FY 1999-00, CMHB received approximately $7.5 million dollars in internal grant revenue, compared to the peer average of $3.1 million. PSD, however, could obtain additional grant revenue by establishing more relationships with local and national foundations, contracted providers, and other funding sources. PSD grant-writing is decentralized, with eight different staff members writing grants. PSD should streamline the grant-writing process by centralizing grant writing functions in one position, the research/program administrator.

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Provider Relations and Quality Services

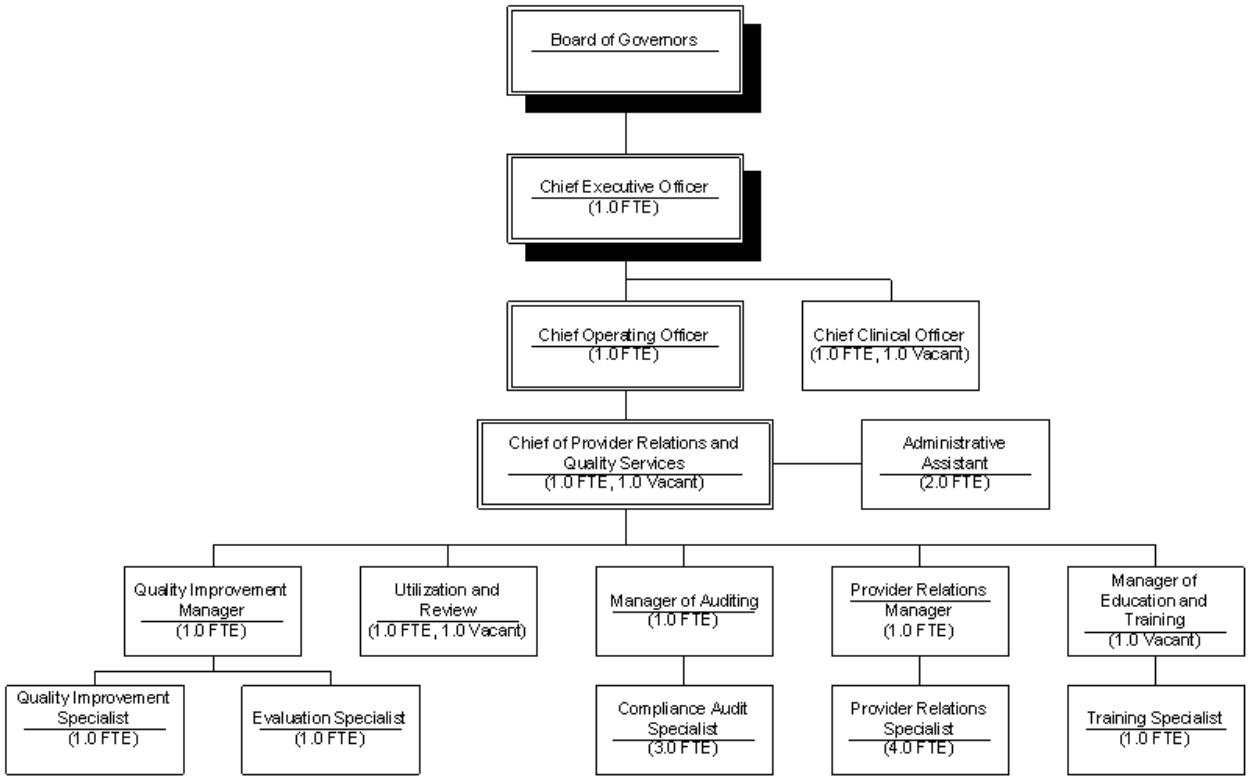
Background

This section focuses on the operations and departmental functions of the Provider Relations and Quality Services Division (PRQS). Comparisons are made throughout the report to peer mental health boards in Franklin, Lucas, and Stark Counties. Further, information from other mental health boards in Ohio and best practices are included for additional comparisons.

Organization Chart

PRQS consists of the Audit, Quality Improvement, Provider Relations, Education and Training, and Utilization Review Units. **Chart 8-1** illustrates the organizational structure of PRQS with the total number of full time equivalent (FTE) positions as of January 2002. During the course of this performance audit, the evaluation specialist position became vacant.

Chart 8-1: Provider Relations and Quality Services



Organization Function

PRQS was developed as a result of CMHB's reorganization in FY 2000. The Division was developed to provide contracted providers a resource to address program and operational issues and develop a quality improvement plan for CMHB. The Division includes the following five units:

- **Auditing** conducts Medicaid compliance audits of all provider agencies contracting with CMHB as mandated by the Ohio Administrative Code (OAC);
- **Quality Improvement** functions as gatekeeper for all quality assurance activities with CMHB and with contracted providers as directed by the Ohio Department of Mental Health (ODMH);
- **Provider Relations** manages the business relationship with contracted providers;
- **Education and Training** coordinates external training to contracted providers; and
- **Utilization Review** reviews inpatient care for mental health consumers.

Summary of Operations

The Auditing Unit is comprised of a manager (1.0 FTE) who coordinates and oversees the Unit's operations and assists the compliance audit specialists in performing audits. All specialists (3.0 FTE) are licensed mental health professionals, trained to conduct Medicaid compliance reviews and medical necessity documentation reviews of contracted providers.

The Auditing Unit performs annual Medicaid compliance reviews and medical necessity documentation reviews (MNDR) on all contracted providers that have both Medicaid and non-Medicaid agreements with CMHB. These reviews cover a defined time period (365 day period ending one month prior to the audit) to ensure the remittances qualify for Medicaid reimbursement. The audit team also ensures that the contracted providers are following ODMH standards and CMHB's contract and that there are no client rights violations. Quality improvement suggestions for documentation are provided verbally during the audit and in the audit report when warranted. In addition, the auditing team reviews non-Medicaid remittances per Medicaid rules and ODMH standards. Personnel records are areas also reviewed as a part of the audit process. The auditing team performs the following steps to conduct audits of contracted providers:

- Prepare and send audit notification letter;
- Prepare for audit by:
  - Notifying all CMHB staff with a request for outstanding issues or areas of concern;
  - Reviewing past audit reports, plans of correction, CMHB contracts and budget for the specific provider as well as letters and certifications;
  - Obtaining Electronic Remittance Advice (ERA) data from the Management Information System (MIS) Unit as well as a list of contracted providers' Medicaid caseload, and high cost Medicaid users;
  - Processing ERA data into the statewide review tools;
  - Selecting Medicaid sample based on OAC 5101:3-27-06 (06 Rule);
  - Selecting Non-Medicaid sample based on CMHB's criteria;
  - Reviewing contracted providers' list of supervisors and verifying current licensure via state websites.
- Conduct initial interview with contracted providers to discuss audit process;
- Perform audit based on Medicaid Rules, ODMH and ORC standards, and CMHB contract,
- Conduct exit interview to discuss audit findings and provide technical assistance;
- Prepare audit report;
- Review and approve agency plans of correction (POC) required to be developed to correct problems found during the audits; and
- Focus reviews as needed.

The Quality Improvement Unit (QI) includes a manager (1.0 FTE) who oversees the unit operations and manages the quality improvement specialist (1.0 FTE) and the evaluation specialist (1.0 FTE). The goal of the unit is to improve the quality of service delivery to mental health consumers within Cuyahoga County. This is accomplished through the compilation and review of a variety of reports submitted to QI staff from the contracted providers. QI requires agencies to submit the following reports:

- Quality improvement plan;
- Annual and quarterly summary reports of quality improvement activities;
- Biennial evaluation plan;
- Annual summary of evaluation activities;
- Major unusual incidents (MUIs); and
- Outcomes Project initiated by ODMH.

The QI Unit compiles the data from various reports to internal databases to monitor and track contracted provider quality improvement activities. The QI Unit evaluates and works with contracted providers to ensure that they are using and adhering to identified standards stipulated by ODMH. This is accomplished through an annual summary of evaluation activities, QI plans and reports, surveys, and QI network feedback and forums. CMHB has been selected to work with ODMH in developing the State Outcomes Project in an effort to standardize assessment and outcome tools measuring performance and effectiveness. In addition, the QI Unit has tried to develop internal quality improvement initiatives which focus on enhancing operations at CMHB.

Within the PR Unit, a manager (1.0 FTE) and PR specialists (4.0 FTE) coordinate with other CMHB units to handle contracted provider issues. This Unit was intended to centralize the process of responding to contracted providers' issues and concerns, and allow CMHB to perform the following tasks:

- Review contracted provider service plans;
- Facilitate the contracting process;
- Help keep CMHB staff informed on contracted providers' issues;
- Inform contracted providers on how their issues are being addressed;
- Alert CMHB to contracted providers that are not meeting requirements in areas of service and management; and
- Evaluate information for compliance with providers' contracts.

Issues and concerns brought about by the contracted providers are tracked, and CMHB has purchased software to make the tracking process more efficient.

The Education and Training Unit of CMHB was established in 1997 with a manager of education and training (1.0 FTE), two education specialists (2.0 FTE) and one administrative assistant. The Unit was created to meet the educational needs of the following constituent groups:

- Contracted provider staff;
- CMHB staff;
- CMHB Board of Governors;
- Consumers and family members;
- Targeted populations (e.g., law enforcement officers); and
- General public.

The Unit has attempted to meet the needs of these constituents by offering contracted providers a Community Support Program (CSP) curriculum that consists of 14 modules. The modules are designed to be taken in a sequential fashion and are targeted to CSP workers with less than two years of experience. The curriculum was developed to support the unique role of CSP workers who need knowledge in a wide array of topics. Each module has learning objectives that identify concepts which are considered to be key elements to the effective practice of community support work. As of November 2000, training for CMHB staff was transferred to the Human Resources (HR) Unit.

The Utilization Review Unit (UR) consists of a UR specialist (1.0 FTE) who is a registered nurse with certification in mental health nursing. The Unit performs utilization review and utilization management functions. The tasks include pre- and post-admission to hospital services, review and monitoring the treatment of CMHB committed consumers and intervening as needed. Additionally, the UR unit supervises the administrative aspects of the judicial commitment process, serves as the initial contact for clinical related issues, and oversees consumer assignment to community-based treatment programs to ensure appropriate use of high cost services.

Staffing

As of January 2002, the PRQS at CMHB employed 16.0 FTEs. **Table 8-1** illustrates staffing levels within each unit.

Table 8-1: CMHB Staff

Divisions	# of Budgeted FTEs	# of FTEs	Vacancies
Chief of PRQS	1.0	0.0	1.0
Auditing	4.0	4.0	0.0
Quality Improvement	3.0	3.0	0.0
Provider Relations	5.0	5.0	0.0
Education and Training	2.0	1.0	1.0
Utilization and Review	2.0	1.0	1.0
Support Personnel	2.0	2.0	0.0
Total	**19.0**	**16.0**	**3.0**

Source: CMHB interviews and Organization Charts

The chief of PRQS position is currently vacant and PRQS staff, with the exception of QI and auditing staff (staff report to the QI and auditing managers respectively, the managers report to the acting CEO), currently report to the acting CEO of CMHB. Support personnel consist of administrative assistants whose time is divided between the five units.

Performance Measures

The following list of performance measures was used to conduct the review of PRQS:

- Review PRQS historical and background information
- Evaluate the Medicaid compliance auditing process and methods for improvement
- Assess the process CMHB uses to evaluate provider performance
- Review the use of outcome measures to determine overall effectiveness of the mental health system in treating consumers
- Review how CMHB tracks and resolves provider questions to ensure high levels of customer service
- Assess the education and training activities offered to contracted providers
- Review bed day use and inpatient care
- Assess staffing levels in each area of PRQS

Findings/Commendations/Recommendations

Upper Level Management

F8.1 The units within PRQS Division function autonomously. There is very little communication and sharing of information for purposes of decision making. CMHB's need for improvement in the area of information sharing could be due in part to the absence of leadership for the Division. The chief of PRQS has been vacant since January 2002. Additionally, the responses to the AOS survey of CMHB employees regarding the question of whether clear goals have been communicated to employees are most frequently (33 percent) "disagree." Thirty-one percent of CMHB's employees that responded to the question of "what are the most important issues facing CMHB and what areas at CMHB could be improved to better ensure that consumers were adequately served," stated leadership. The job description for this position states that the chief of PRQS is to collaborate and coordinate with other divisions and functional areas daily. Another contributing factor to the absence of information sharing may be CMHB's need for analysis, monitoring and follow-up on the abundance of data that is received within the separate units. The units functioning autonomously, combined with the absence of leadership and data analysis, can make it difficult for CMHB to determine:

- Outcomes of contracted providers' and CMHB's performance;
- Impacts and effects of policies and procedures;
- Adequacy of information sharing;
- Adequacy or monitoring;
- Effectiveness of decision making; and
- Implementation of corrective action measures.

As discussed in the **organization, compliance and board governance** section, planning and system development is a separate department at CMHB. However, Franklin and Hamilton MHBs have combined planning and system development, quality improvement and utilization review in the same department and under one chief. In addition, Franklin MHB has Medicaid compliance auditing under this department. In order to ensure that information sharing occurs between units, Franklin MHB conducts weekly operational meetings, attended by representatives from all units. A restructuring of this division could ensure that information is shared with those units that have similar job functions.

R8.1 CMHB should consider combining quality improvement, utilization review, and auditing with planning and system development because these units share common job functions and compliment other functions. This reorganization should better ensure that these combined units function interdependently. To achieve this objective, CMHB should seek to fill a chief

position for these areas to oversee operations and provide strong leadership. In addition, based on peer comparisons, CMHB should consider combining provider relations and education and training together with other potential units as a separate division from auditing, quality improvement and utilization review. See the **organization, compliance and board governance**, and **planning and system development** sections of this performance audit for more information on proposed reorganizations.

F8.2 As of January 2002, CMHB did not have a chief clinical officer (CCO). The previous CCO provided support on the MUI Committee and served as CMHB's expert on clinical matters. According to the Ohio Department of Mental Health (ODMH) Northeast Area Coordinator, the CCO should set the direction for clinical care throughout the mental health community. The current job description for the CCO does not include any duties and responsibilities regarding collaborations with law enforcement. The CCOs for Franklin, Stark, and Summit MHBs perform the following activities to establish such guidance:

- Meet with contract provider psychiatrists regularly;
- Establish County mental health standards;
- Play an active role in public and private mental health service delivery;
- Collaborate with law enforcement to address forensic issues and deal jointly with psychiatric issues; and
- Oversee care of consumers in state hospitals.

The AOS survey of CMHB employees reveals that 21 of 28 respondents to the question "Do you feel that the organization structure for CMHB is effectively serving mental health consumers," stated "no". As stated previously, leadership was overwhelmingly cited in this survey as the most important issue currently facing CMHB and the area that could be improved in order to ensure that consumers are adequately being served (see **F8.1**). In the absence of a CCO, CMHB staff has had to make clinical decisions without the medical expertise of a certified psychiatrist. Additionally, CMHB has a psychiatrist on call to handle challenging issues. Although CMHB has stated that use of the on call psychiatrist has not been needed because the UR specialist has been able to handle issues that have arisen, CMHB struggles with clinical issues such as levels of care, high unit costs, high bed day usage at state hospitals, no coordination with the private mental system, and monitoring service activity throughout the County. The delays in the hiring of a CCO may be attributed to the need for a CEO at CMHB. While quality assurance is important to all mental health systems, focus on proactive activities as done by other CCOs would enhance the County's mental health services, ensure quality services, and reduce the need to react to potential crisis situations in the future.

R8.2 CMHB should identify and hire a CCO to provide clinical guidance to Cuyahoga's mental health system. By doing so, CMHB would be in a better position to address consumer needs

in a more proactive and less reactive fashion, potentially reducing the need for crisis intervention services. A CCO could address issues CMHB currently struggles with and enhance the quality of services provided to consumers. Additionally, the CCO should be required to collaborate with law enforcement to address forensic issues and deal jointly with psychiatric issues. A CCO should assist CMHB in the following areas:

- Ensuring appropriateness of levels of care; (see **R8.49**)
- Providing expertise and direction regarding expenditure of funds on the clinical needs of consumers; (see **finance and funding** section)
- Advising on the hospital utilization in the system; (see **R8.48**)
- Providing coordination between private and public systems; and (see **R8.52**)
- Monitoring service activity throughout the county. (see **R8.19**)

During the course of this performance audit, CMHB hired a CCO. CMHB should ensure that the CCO performs the above mentioned functions to ensure that clinical issues are appropriately addressed and to improve the quality of services provided to consumers.

Auditing

F8.3 The statistics and ratios in **Table 8-2** indicate that CMHB has overall higher staffing levels in the support and administrative areas. **Table 8-2** compares the Auditing Unit staffing levels and work load for CMHB and the peers.

Table 8 -2: Auditing Unit Staffing Levels

	CMHB		Franklin	Lucas	Stark	Peer Average
	Budgeted	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Directors (FTEs)[1]	0.2	0.0	0.1	0.2	n/a[2]	0.2
Managers (FTEs)[1]	1.0	1.0	n/a[3]	n/a[3]	n/a[3]	n/a
Compliance auditors	3.0	3.0	1.7	0.6	0.2	0.8
Clerical Staff[4]	0.1	0.1	0.2	n/a[5]	n/a[5]	n/a
Total (FTEs)	**4.3**	**4.1**	**2.0**	**0.8**	**0.2**	**1.0**
Administrators to auditing staff	1:2.6	1:3.1	1:20	1:3	n/a	1:4
Total billings sampled	13,419	13,419	2,732	780	893	1,450
Billings per auditor	4,473	4,473	1,607	1,300	4,465	1,812
Audits for FY 2001[6]		35	23	10	7	16.3
Audits per auditor		11.7	13.5	16.7	35.0	20.4

Source: CMHB and peer interviews.
[1]For the purpose of this calculation, administrative staff is defined as directors and managers.
[2]Stark MHB has no staff functioning as director with respect to auditing duties.
[3]Franklin MHB, Lucas MHB, and Stark MHB do not have managers of auditing.
[4]CMHB's clerical staff for the Auditing Unit also has responsibilities within QI, UR.
[5]Lucas MHB and Stark MHB do not have clerical staff for this unit staff.
[6]The audits for FY2001 represent the number of contracted providers who have submitted billings which may be different from the total number of contracted providers.

As shown in **Table 8-2**, CMHB's ratio of audits per auditor is the lowest of the peers. However, CMHB samples a significantly higher number of billings as compared to the peers during the audits, which contributes to a larger workload. CMHB's billings per auditor is significantly higher than Franklin and Lucas MHBs, indicating that CMHB is processing more output while minimizing input. As a result, CMHB appears to be efficiently staffed with compliance auditors.

CMHB's greater use and need of auditor staffing levels may be attributed to its practice of auditing a significant number of Medicaid and non-Medicaid claims (see **Table 8-3** and **F8.4**). The Auditing Unit uncovered a total of $129,656 in reimbursements for ineligible billings for FY 2001. Non-Medicaid reimbursements represented 33.9 percent ($32,868) of total reimbursements.

CMHB has the lowest administrator to staff ratio (1:3) in comparison Franklin MHB. While CMHB employs a manager of auditing, the peers have functioned without managers. Franklin MHB employs a director who oversees various units and contributes 10 percent of

work time to overseeing auditing functions. Furthermore, outside of supervising compliance audit staff, Franklin MHB's duties and responsibilities required of their compliance auditor are comparable to that of CMHB's manager of auditing.

While CMHB is the only peer with a manager of auditing, CMHB and peers' auditing process will be impacted by the changes in auditing standards taking effect in FY 2002. As a result, CMHB will sample an additional 195 cases to complete its Medicaid review of contracted providers for FY 2002 (see **F8.4** and **F8.6**). However, the number of additional billings reviewed on these cases will vary depending upon the volume of services rendered. Further, Franklin MHB indicated that it may need to hire a manager based upon the changes in the auditing rules and standards.

As previously mentioned, changes in auditing standards will impact the amount of billings sampled in FY 2002 (see **F8.6**), which would impact staffing levels in the Auditing Unit. For example, the auditing standard for Medicaid claims will change from reviewing a minimum of one month of billings to two weeks of billings in FY 2002. In addition, the new standards define the number of cases that need to be sampled based on the number of consumers served by contracted providers. While the changes in standards impact Auditing Unit staffing levels, it is not possible to project the amount of billings that will be sampled for FY 2002 due to numerous factors, including the following:

- Although the new standards define the number of cases that need to be sampled, the actual number of billings sampled from these cases could fluctuate.
- A contracted provider's growth in Medicaid and non-Medicaid cases may rise or fall during the year, thereby affecting the number of cases that must be sampled by the Auditing Unit.

Franklin MHB attempted to project the impact of the new standards on its auditing staffing levels, but could not adequately develop a projection based on these factors.

R8.3 In light of the recent changes in standards, CMHB should maintain its current level of staffing within the Auditing Unit. After CMHB has operated under the new rules for a period of time (e.g., one to two years) and has decided whether to maintain its current level of sampling of non-Medicaid claims (see **R8.4**), CMHB should re-evaluate the Auditing Units' staffing levels by performing a trend analysis on data collected to facilitate decision-making regarding the need for additional staff resources, staff reductions, and/or staff reallocations. This analysis should include the following:

- Average amount of billings received during a two week period; and
- Average Medicaid and non-Medicaid caseload for contracted providers.

F8.4 The Auditing Unit sampled a significantly larger number of Medicaid and non-Medicaid billings. **Table 8-3** displays the number of billings sampled for by CMHB and the peers.

Table 8-3: Medicaid Compliance Review Summary for FY 2001

	CMHB	Franklin	Lucas	Stark	Peer Average
Number of contracted providers	35	23[1]	10	7	13.3
Medicaid billings sampled	10, 024	2, 639	780	893	1,437
Non-Medicaid billings sampled	3,395	93	0 [3]	n/a[4]	45
Total Billings sampled	13,419	2,732	780	893	1,482
Contracted providers' Case Loads	10,863	5,395	3,814	1,755	3,654.7
Cases Reviewed	694	312	226	139	225.7
% of cases reviewed	6.4%	5.8%	5.9%	7.9%	6.2%
Average number of billings sampled per contracted provider	383.4	118.8	78.0	127.6	111.4
Average number of billings per Case	19.3	8.8	3.5	6.4	6.6
Average number of billings sampled per auditor	4,473.0	1,607.0	1,300	4,465	1,812

Source: Board Medicaid compliance review summary for FY2001, Data Mart.
[1]Audited contracted providers of Franklin MHB only include mental health contracted providers.
[2] Information from Stark MHB could not be provided.
[3] Lucas MHB does not audit non-Medicaid claims.
[4]Although Stark audits Non-Medicaid claims, these statistics are not included. Stark was unable to provide statistics on Non-Medicaid billings sampled.

As shown in **Table 8-3,** CMHB sampled 10,687 more billings than Franklin MHB. Of CMHB's billings sampled, 25 percent were non-Medicaid claims. According to the manager of Auditing, CMHB audits non-Medicaid claims to ensure that these billings are held to the same standards as Medicaid claims. In addition, the manager of Auditing stated that CMHB's contract with its providers states that the requirements for non-Medicaid consumers must be the same as that of Medicaid consumers. CMHB currently has only one contract with its contracted providers for Medicaid and non-Medicaid services and does not engage in selective contracting for non-Medicaid services (see **risk management** section). Furthermore, CMHB's preference of auditing a larger number of Medicaid and non-Medicaid billings as compared to the peers is reflected in the significantly higher average number of billings sampled per case by CMHB (19.3) as compared to the peer average (6.6). However, changes in auditing standards will impact the amount of billings sampled in the future (see **F8.6**).

Franklin MHB focuses on Medicaid claims, but will also audit Medicaid eligible (non-

Medicaid) claims if contracted providers have obtained them. These include non-Medicaid claims of clients who have had reviews of their Medicaid claims (e.g., residential services) Furthermore, Franklin MHB has stated that over time, it has found that contracted providers hold non-Medicaid claims to the same standards as Medicaid claims. This may be in part due to contracted providers not knowing which claims will be sampled and being held accountable for a plan of correction (POC) and recovery of funds, as is the case with Medicaid claims. According to the manager of federal programs at ODMH, although the Medicaid protocols required MHBs to audit non-Medicaid claims, whether MHBs engaged in this practice was left to their discretion. OAC 5101:3-27-06 (the 06 Rule), effective January 01, 2002, does not require the sampling of non-Medicaid billing (see **F8.6**). While auditing non-Medicaid claims can increase the amount of funds reimbursed to CMHB for unallowable billings and non-compliance, thereby holding contracted providers accountable for documentation standards and funding, it also increases compliance auditors' workload.

If CMHB sampled a similar amount of non-Medicaid claims as Franklin MHB, it would reduce its total billings sampled by 3,302 based on FY 2001 data. The amount of billings sampled per compliance auditor would decrease from 4,473 to 3,372 at CMHB, which is still significantly higher than Franklin MHB (1,607). The amount of Medicaid billings sampled has more of an impact on auditor staffing levels than non-Medicaid billings, which will be affected by changes in auditing standards in the future (see **F8.6**).

R8.4 The Auditing Unit should determine whether, over time, its contracted providers have traditionally held non-Medicaid claims to the same standards as Medicaid claims, in order to reduce the amount of non-Medicaid billings sampled. This could be accomplished by performing a trend analysis using existing statistics from previous audits conducted to determine the amount of non-compliance associated with non-Medicaid claims in comparison to non-compliance associated with Medicaid claims. Upon completion of this analysis and the determination of whether to engage in selective contracting for non-Medicaid services, the Auditing Unit should be able to better determine whether it is justified in continuing to audit its current level of non-Medicaid claims. The reduction in sampling could reduce the workload of the current auditing team.

F8.5 CMHB went beyond the minimum education requirements for staff conducting Medicaid compliance audits for FY 2001. The Auditing Unit's compliance audit specialists are licensed mental health professionals (licensed and independently licensed social workers). CMHB trained them to function as auditors as opposed to having unlicensed staff perform Medicaid audits. FY 2001 Medicaid protocols did not call for any specific educational background for those individuals conducting Medicaid audits. Up until January 2002, the Medical Necessity Documentation Review (MNDR), which has specific educational requirements, did not exist (see **Table 8-4**). As a result, all peers had staff members without clinical backgrounds conducting audits. Having clinical staff conduct compliance audits

could greatly increase the reliability of review findings. For example, clinical staff as opposed to staff with financial backgrounds, as was the case with two peers (Stark and Lucas MHB), are more aware of what constitutes an appropriate service. This educational requirement could greatly increase the likelihood that ineligible claims are recognized and that funds are reimbursed to CMHB or the State, thereby increasing the accountability for public funds used for non-Medicaid and Medicaid claims.

C8.1 CMHB's choice to go beyond the minimum education requirements for compliance auditors may have made the Auditing Unit's review findings more reliable, and placed the Unit in a position of being able to conduct all parts of the audit review, including MNDR. Although any staff member may still complete other segments of the review, having this composition of staff allows CMHB to rely on staff who routinely conduct compliance audits and are familiar with current standards to assist in completing reviews.

F8.6 **Table 8-4** presents changes in the auditing protocols from FY 2001 to FY 2002 as they apply to OAC 5101:3-27-06, Medicaid and Medical Documentation Review Protocols and ODMH Medicaid review protocols (Exhibit G).

Table 8-4: Comparison of Annual Medicaid Compliance Review Requirements

	FY 2001	FY 2002
Purpose	This Medicaid Compliance Review Protocol was developed as a tool to assist mental health boards (MHBs) and contracted providers during annual compliance reviews to identify areas that may potentially trigger repayments resulting from ineligible billings, or other problems. The protocols identify the areas for the Medicaid compliance review for ineligible and problematic claims.	Beginning January 1, 2002 MHBs shall review annually a number of clinical records for those individuals who have received services reimbursed provided through the community mental health Medicaid program to assure that minimum service compliance and medical necessity documentation review criteria are met.
Scope of the review	CMHB must perform at least annually, a Medicaid Compliance Review on all contracted providers which have direct Medicaid agreements with CMHB.	The annual review period is defined as the 365 day period concluding on the month prior to the date of the review. The annual review period should not overlap any days covered in the annual review period of a previous review. The Board shall review the number of cases of residents or its service district in each agency holding a Medicaid agreement with the Board except for agencies identified by ODMH as serving a large number of residents outside the Board service districts in which the agencies are located. For each of those specifically designated contracted providers, the MHB that has the Medicaid agreements with more than one mental health board, the MHB that has the largest number of mental health board residents receiving services from the agency shall conduct the review.
	The sample size of the review should be large enough to give the reviewer (s) confidence that the contracted provider findings are representative of the entire caseload. At a minimum, the review should be done on at least one month of service billings from at least one service category for	The compliance review should be done on at least two weeks of service billings from at least one service category for each case selected (testing period). Sample size:

	10 of the providers Medicaid cases. The MHB may want to review up to 30 cases in larger contracted providers in order to obtain a reasonable sample. If there are significant problems (i.e., a total ineligible billing rate in excess of 5 percent in all categories, or an ineligible billing rate exceeding 10 percent in one or more categories), the Board may increase cases reviewed. Additionally, the review should test for compliance with all service categories in the providers Medicaid agreement. Other non-Medicaid cases should also be reviewed to assure consistency of service documentation. The cases should be randomly selected by the MHB prior to the review.	A. Fewer than 10 clients = no annual review period B. 10 but < 100 = 10 cases (5 highest Medicaid users & 5 random samples) C. 100 but < 500 = 20 cases (10 highest Medicaid users & 10 random samples) D. 500 but < 1,000 = 30 cases (15 highest Medicaid users & 15 random samples) E. 1,000 but < 2, 000 = 50 cases (25 highest Medicaid users & 25 random samples) F. 2,000 or more = 70 cases (35 highest Medicaid users & 35 random samples)
	The contracted provider should not be notified of the selected cases more than one day prior to the review.	The contracted provider should be notified no more than one day prior to the review.
Review Instruments	Voluntary	Contracted providers are expected to be 100% compliant with MNDR and ISP checklists. Checklists are voluntary although information is not.
Compliance Testing	Ineligible: • No ISP (95%) • Ineligible Provider (95%) • Ineligible Supervisor (95%) • Time Discrepancies (95%) • Service out of compliance (95%) • No documentation (95%) Problems: • Insufficient documentation (95%) • ISP non-compliant (95%) • Other (95%)	Ineligible: • No ISP (90% compliance) • Ineligible Provider (95% compliance) • Ineligible Supervisor (90% compliance) • Time Discrepancies (85% compliance) • Service out of compliance (90% compliance) • No documentation (95% compliance) Problems: • Insufficient documentation (95%) • ISP non-compliant (95%) • Other (95%) ODMH shall conduct a follow-up focus review of a contracted provider if any of the thresholds identified are not met. ODMH will complete review no later than 6 months. The contracted provider must submit a plan of correction (POC) to ODMH for review and approval with 30 days of notification of the focus review. ODMH must schedule a follow-up compliance review no later than six months following approval of POC. If the follow-up review demonstrates that the contracted provider fails to meet any of the compliance thresholds ODMH shall terminate the Medicaid agreement for a minimum of one year. If the follow-up compliance review finds additional ineligible billing, an additional recovery of funds must be implemented by the MHB.
Review Follow-up	Citations in the problems section will require a plan of correction from the provider that is approved by the MHB. Continued citations in this area may result in sanctions or a recovery of funds. Following the compliance review, the reviewers should complete the form "Board Medicaid Compliance Review Summary." This form is due by October 01 of each year. Extensions are available upon request.	Within 15 working days of the compliance and medical necessity documentation reviews, the mental health board shall prepare a draft report of review findings and shall immediately provide the contracted provider with a copy of the report. The contracted provider must provide its response to the mental health board within 14 days of receiving the draft report. Final copy of the report to be submitted to ODMH. An agency may appeal to ODMH any findings contained in the

		final report issued by the MHB and any proposed or actual adverse determinations (i.e., recovery of funds). Citations for ineligible billing require that contracted providers reverse claims with the MHB. If ineligible thresholds are not met, the contracted provider will be placed on focus review status with ODMH. If problematic claims don not meet thresholds, the contracted provider is required to submit a plan of correction (POC) to be approved by the MHB.
Other		Medical necessity documentation reviews shall be performed by staff who are licensed as: • Medical doctors • Doctors of osteopathy • Psychologist • Licensed Independent social workers (LISW) • Licensed social workers (LSW) • Licensed professional counselors (LPC and Licensed Professional Clinical Counselors (LPCC) • Registered nurses • Staff certified as utilization review/management specialist Such staff must have received a minimum of one training and a certificate from ODMH before conduction reviews.

Source: OAC 5101:3-27-06 and Medicaid, Medical Necessity Documentation Review Protocols, Exhibit G (ODMH Medicaid protocols), and interviews with manager of Auditing.

Medicaid audits changed for FY 2002. These changes focus more on issues of clinical care and service utilization than in FY 2001. The revisions assist in facilitating more audit consistency across the state and include the following:

- The basic audit has remained the same in content, but the sample has been increased and specifically includes files of consumers who use large amounts of Medicaid service based on cost;
- A review of documentation regarding medical necessity has been added;
- Only individuals with special training are able to complete the medical necessity documentation review for the audits;
- Tighter time frames are established in which the audit process must be completed;
- A formal mechanism is identified for contracted providers to request review of the MHB's findings and decisions;
- No requirements for non-Medicaid are mentioned; and
- Lower thresholds are established for ineligible billings.

F8.7 The Auditing Unit for FY 2001 did not follow ODMH Medicaid protocols for sampling cases. According to the manager of Auditing, although some samples were chosen randomly, the Unit chose to audit additional samples that looked unusual and also chose claims by program or site as requested by providers. According to the manager of federal programs at ODMH, MHBs were to follow Medicaid review protocols which called for 10 to

30 cases to be randomly sampled and additional samples to be chosen only if the random sampling process did not produce claims that had all six service areas (i.e., partial hospitalization) paid for by Medicaid (see **Table 8-4**).

Case sampling for FY 2002 is now uniform across MHBs, due to the 06 Rule, and does not allow for the expansion of this sample size at the discretion of MHBs (see **Table 8-4**). Auditors must randomly sample a set number of cases based on the number of Medicaid consumers per contracted provider. Additionally, the new 06 Rule (effective January 2002) calls for focus reviews to be conducted by ODMH if compliance thresholds are not met (see **Table 8-4**). These reviews may reveal additional areas of non-compliance. Although the Auditing Unit sampled additional cases to determine compliance, this practice not only increased workloads, but also presented the potential appearance that the auditing team is "out to get" providers. This was reported on the survey of contracted providers conducted by the Auditing Unit (see **F8.18**).

R8.5 The Auditing Unit should strictly adhere to audit review protocols for sampling cases. In addition, the Auditing Unit should work with ODMH and other MHBs to further explore any impact of limitations on sample size. Since the 06 Rule now includes focus reviews by ODMH, these reviews can be analyzed to determine the extent of additional increase in non-compliance found during the follow-up reviews. This analysis can be constructed to support the continuing existence of the current standards or subsequent modifications. Adhering to review protocols for sampling may assist contracted providers in their understanding and expectations of the auditing process conducted by the Auditing Unit.

F8.8 CMHB had a high prevalence of individualized service plan (ISP) non-compliance for billings reviewed, as found in its FY 2001 audit reviews. Billings that are noncompliant are separated in to two categories (ineligible and problematic). Ineligible billings require contracted providers to reimburse Medicaid and non-Medicaid funds. Ineligible billings include:

- No ISP (file is lacking documentation of an ISP or the ISP is not dated until after the fourth session or 30-day deadline);
- Ineligible provider (provider not in accordance with OAC 5122-23);
- Ineligible supervisor (services not supervised by individuals meeting supervision criteria as identified in OAC 5122-29, or by staff members whose credentials have lapsed);
- Time discrepancies (services are reimbursed simultaneously by two funding sources; services provided during overlapping times; number of units billed is greater than those documented; length of session missing from progress note);
- Service out of compliance (provider has billed for an non billable service (e.g., recreation); services are not face-to-face; service provided is of a different type than

that billed; service is an alcohol and other drug service; medical interventions for non-mental health issues are billed as medication or somatic service); or

- No documentation (services without any documentation).

Problematic billings include the following:

- Insufficient documentation (type of service, narrative, signature, discipline, time of day, or site of service);
- ISP non-compliant (missing signatures of qualified staff member or no documentation explaining why signature is missing, 90 day review of ISP and update is not completed or is not timely; ISP is significantly out of compliance for the required elements); and
- Other (no evidence of diagnostic assessment; diagnostic assessment is not signed by a staff who can diagnose; 12:1 consumer to client ratio for partial hospitalization is not met; incorrect date; medical intervention for non-mental health issues are billed as medication or somatic service; modifier that does not match narrative in progress note).

Table 8-5 displays results of Medicaid compliance reviews for CMHB and the peers for FY 2001.

Table 8-5: Ineligible and Problematic Billing for FY 2001

	CMHB		Franklin		Lucas		Stark		Peer Average	
	Ineligible Billing									
	No. of billings	Error %	No. of billings	Error %	No. of billings	Error %	No. of billings	Error %	No. of billings	Error %
No Individualized Service Plan	86.0	0.6	13.0	0.0	0.0	0.0	1.0	0.1	4.7	0.3
Ineligible provider	2.0	0.0	12.0	0.0	0.0	0.0	0.0	0.0	4.0	0.3
Ineligible supervisor	19.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Time discrepancies	198.0	1.5	48.0	2.0	10.0	1.2	4.0	0.5	20.7	1.4
Service out of compliance	764.0	5.7	392.0	14.0	0.0	0.0	28.0	3.1	140.0	9.4
No documentation	569.0	4.2	121.0	4.0	7.0	0.8	26.0	2.9	51.3	3.5
Total	**1,638.0**	**12.0%**	**586.0**	**20%**	**17.0**	**2.0%**	**59.0**	**6.6%**	**220.7**	**14.9%**
	Problematic Billing[1]									
Insufficient documentation	1,102.0	8.2	357.0	14.0	0.0	0.0	45.0	5.0	134.0	9.0
ISP non compliant	2,072.0	15.4	110.0	4.0	0.0	0.0	62.0	6.9	57.3	3.9
Other	643.0	4.8	181.0	7.0	0.0	0.0	1.0	0.1	60.7	4.1
Total [1]	**3,344.0**	**24.9%**	**608.0**	**22.0%**	**0.0**	**0.0%**	**108.0**	**12.0%**	**238.7**	**17.0%**

Source: Board Medicaid compliance review summary for FY2001.
Note: Error percentage is determined by dividing number of ineligible or problematic billings by the total billing sampled. Total billings sampled in FY 2001: CMHB = 13,419; Franklin = 2,732; Lucas = 780; Stark = 893, and peer average = 1,482 (see **Table 8-3**).
[1]Non-compliance can be found in several categories, but will only be counted as one problematic billing in the total.

Individualized Service Plan (ISP) documentation (problematic billing) was found to be the most prevalent problem discovered during the auditing process for FY 2001 at CMHB. An ISP is a step by step plan that outlines interventions to remedy symptoms or achieve treatment goals. Although ISP non-compliance at CMHB has decreased since 1998, **Table 8-5** shows that CMHB's contracted providers' statistics in the area of ISP non-compliant are well above the peer average of 3.9 percent. During FY 2000, the Auditing Unit conducted a train-the-trainer documentation training to assist in efforts to reduce problematic and ineligible billing, but this was the last time the training was offered to contracted providers.

Despite CMHB's efforts to reduce the incidence of problematic billing, contracted providers have attributed problematic billing to the following:

- High staff turnover, which has resulted in new staff continuously needing training;
- Supervisors not having time to check all progress notes;
- Contracted provider staff not having time to adequately complete progress notes due to performing job requirements;
- Narrative content is subjective; and
- Too much information that needs to be recorded, thereby increasing potential errors.

Additionally, the compliance auditor at Franklin MHB stated that the narrative content of

progress notes could be subjective because it is at the auditors' discretion to determine whether enough is written about the intervention, activity and consumer response, to justify the time documented. According to the manager of auditing, CMHB tries to minimize subjectivity by participating in the Board Association of Compliance Staff to discuss findings for consistency, discussing the content of progress notes as a team, and consulting with ODMH. Nevertheless, an element of subjectivity still exists since each auditor at CMHB and each mental health board in Ohio has discretion in determining the adequacy of the narrative content in progress notes. Variances in documented contracted provider performance may be attributed to the following factors:

- Educational background and experience of auditors (see **F8.5**);
- Differences in sample size chosen (see **Table 8-3**, **F8.6,** and **Table 8-4**); and
- Sampling of non-Medicaid claims (see **F8.4**).

Consequently, contracted providers with more than one MHB auditing their billings may be subject to different levels of scrutiny by compliance auditors. Not meeting compliance thresholds results in POCs needing to be completed and implemented by contracted providers. Training that is relevant and customized can assist the Auditing Unit in preparing contracted providers for audit reviews as well as to clarify misinterpretations.

R8.6 The Auditing Unit should become proactive in its efforts to reduce the amount of non-compliant billings submitted by contracted providers. The Auditing Unit should re-establish its train-the-trainer documentation training to further assist in reducing the number of problematic billings. This training should also offer examples of provider "best practices" from those contracted providers who have consistently performed well on audits (see **F8.10**). In addition to continuing to consult with ODMH to minimize subjectivity, CMHB should work with ODMH to combine efforts in providing training, such as formal training to reduce the subjectivity involved with interpreting the narrative content of billings (see **F8.9**). Furthermore, accomplishing this objective could enable contracted providers to develop staff experts in documentation who are able to train staff as needed, and as contracted providers experience staff turnover. This could prevent contracted providers from having to wait for CMHB to conduct its semiannual training (fall and spring) in order to train staff, and enable providers' staff to be trained on an as-needed basis.

F8.9 Although CMHB has conducted documentation training, CMHB's contracted providers' performance on compliance audits falls below the peer average (see **Table 8-5**). Documentation training is conducted by the Auditing Unit as part of the Community Support Program (CSP) Modules each fall and spring in order to reduce problematic and ineligible see claims. The documentation training is attended primarily by CSP workers and some supervisory staff, but is also open to any contracted provider staff who wishes to attend to discuss ISP and progress note requirements. The training is conducted by the Auditing Unit

staff only. According to the manager of auditing, the Auditing Unit did not conduct the training in FY 2001 due to not knowing what the upcoming changes in the OAC standards would entail. This type of training is not being implemented by the peers, although it has been recognized as a needed training. Franklin MHB has stated that the training should be conducted by ODMH. Both the manager of federal programs (ODMH) and Franklin MHB have noted that those contracted providers that typically perform well on audits have strong internal quality assurance (QA) measures in place. Examples of strong QA measures include the following:

- Conducting internal records audits;
- Conducting peer reviews; and
- Conducting supervisor reviews of subordinate records.

The Auditing Units' establishment of documentation training can have a more positive impact on contracted providers' performance on audit reviews if the training is restructured to address specific problem areas as well as identify implementation of possible QA measures. The absence of these details may have contributed to the contracted providers' high level of non-compliance.

C8.2 Conducting documentation training benefits both CMHB and its contracted providers. The training keeps both parties up to date on the auditing process, compliance requirements and changes in the ODMH standards, and creates contracted provider experts that can provide accurate reviews of documentation in preparation for audit reviews.

R8.7 The Auditing Unit should restructure its documentation training to target specific areas that have been identified as having a high percentage of non-compliance (e.g., ISP noncompliant) in efforts to make the training more effective (see **Table 8-5**). The Auditing Unit should also seek to customize training for specific contracted providers who have a large percentage of non-compliance in specific areas. The Auditing Unit should collaborate with those contracted providers who have consistently performed well on audits in order to assist other contracted providers in implementing strong QA measures. The Auditing Unit should also collaborate in its documentation training with ODMH to assist in reducing misinterpretations of standards. These changes in training could facilitate the formulation of strong QA controls among contracted providers to assure documentation compliance.

F8.10 The Auditing Unit has not effectively communicated contracted provider "best practice" activities and has not ensured that these activities are consistently made known to other providers. CMHB has several contracted providers that have continually indicated strong compliance in different areas of the audit. The manager of Auditing has also identified contracted providers' best practices. An example of a best practice is a computerized ISP system that still allows for individualization, and the development of a useful system to

obtain required signatures for progress notes and ISPs. The Auditing Unit has, throughout its audit process, suggested certain contracted providers contact other providers who have a good understanding of Medicaid compliance. Furthermore, the manager of Auditing sends out bulletins periodically when a change in a standard arises. However, these bulletins are not used to communicate any of the following:

- System-wide audit performance results;
- System-wide compliance issues; and
- Recognition for exemplary performance on audits conducted.

The FY 2001 audit survey of contracted providers, conducted by the Auditing Unit, revealed the auditing process would be more beneficial if the auditing team discussed both positive and negative practices and procedures. Recognition for exemplary performance has also been requested by contracted providers. This same response was provided from one of the eight randomly chosen providers selected to be interviewed for this performance audit. Although the manager of Auditing and other responses on the Auditing Unit's survey reveals that positive feedback is given, the conflicting responses suggest that this needs to be broadly communicated to all providers. To accomplish this goal, Lorain MHB incorporates commendations for various practices (e.g, high standard of record keeping and taking steps toward change in program redesign) into its audit findings. Because information sharing is done on an individual level at CMHB, it does not assure that information is relayed consistently across contracted providers. Consequently, the benefits of relaying provider "best practices" are diminished. Uniform communication of contracted provider "best practices" can result in the following:

- Increase in audit compliance;
- Decrease in reimbursement (ineligible billing);
- Decrease in staff time allotted to providing technical assistance; and
- Increase in recognition for exemplary performance.

R8.8 The Auditing Unit should effectively communicate contracted provider "best practices" by expanding upon its use of bulletins and developing a mechanism to provide uniform dissemination of contracted provider best practices. This could be accomplished by inserting commendations into audit reports or identifying provider best practices that can be compiled in a newsletter strictly for auditing items and distributed among contracted providers. This newsletter should not only include provider "best practices," but also such items as:

- System-wide audit performance results;
- System-wide compliance issues;
- Changes in regulations;
- Audit requirements;

- Recognition for exemplary performance on audits conducted; and
- Upcoming training.

Assuring that all contracted providers uniformly receive this information could ensure the following:

- Reduction in problems found during audits;
- Increased assurance that only qualified billings are reimbursed;
- Reduction in the amount of staff time spent on providing technical assistance; and
- Recognition for exemplary performance on audits conducted.

F8.11 CMHB does not monitor contracted providers' plans of corrections (POC). A POC is required to be submitted by contracted providers to address a problematic billing revealed during audits (see **Table 8-4**). According to the manager of Auditing, after the plan of correction has been formulated, it is approved or disapproved by CMHB. Plans may be disapproved if it is determined that action steps cannot resolve problem areas. Upon approval, CMHB leaves it to the discretion of the contracted provider to monitor its POC. POCs must resolve issues within 60 days of approval.

Issues that are unresolved may or may not result in site visits by a team of staff determined by the Board of Governors (BOG) to resolve issues. As outlined in the job description for the manager of Auditing, plans of correction are to be reviewed and monitored in order to confirm compliance with established standards. Lucas MHB is attempting to finalize a plan for monitoring its POCs, although it has not done so in the past. Because CMHB does not monitor POCs, the Auditing Unit will not know if issues have been resolved until the next year's audit. At this point, the agency may already be in crisis and may require site reviews.

R8.9 The Auditing Unit should formulate protocols to monitor POCs in order to reduce the number of site visits that CMHB must conduct and to hold contracted providers accountable for POCs. These protocols should outline who will monitor the plan and how often it will be monitored. Monitoring could allow the Auditing Unit to provide adequate technical assistance to providers, as well as reduce the percent of non-compliance experienced for the following year's audit.

F8.12 CMHB currently has no criteria for determining the amount of non-compliance that will result in site visits. As stated previously, unresolved issues found during audits can result in site visits (see **F8.11**). The manager of Auditing has expressed interest in determining thresholds. Currently, CMHB's Executive Committee determines whether a site visit is necessary on a case-by-case basis. The BOG makes the determination regarding which units should be involved in the site reviews. Without clearly defined criteria for determining when site visits will occur, it is difficult for CMHB to make uniform decisions regarding what

issues found during the audit need further attention and assistance from CMHB. Additionally, the absence of criteria calls into question the rationale for CMHB's involvement in resolving issues, the uniformity of process implementation, and preparation by both entities to assist in the process.

R8.10 The Executive Committee, along with the Auditing Unit, should formalize criteria that would support the decisions made to perform site visits of contracted providers surrounding auditing issues. These criteria should then be made known to all contracted providers. The formulation and implementation of such criteria could result in several benefits for CMHB and contracted providers, such as the following:

- Provide support for CMHB's involvement in assisting contracted providers in resolving issues;
- Allow the process to be implemented uniformly, thereby reducing an appearance that CMHB "is out to get" contracted providers; and
- Provide advance notice for CMHB and contracted providers that this process will occur, thereby allowing both entities the ability to forecast time and resources needed to assist in the process.

F8.13 Although CMHB was aware of changes in upcoming standards that would affect compliance thresholds, completed FY 2001 Medicaid compliance audits showed no indication that Medicaid changes were forthcoming. However, CMHB's Auditing Unit conducted training in December 2001for contracted providers to inform them of the upcoming changes in the 06 Rule. The new standards for the 06 Rule became effective January 2002, thereby impacting the way audits would be performed and defining the compliance thresholds for Medicaid requirements in FY2002 (see **Table 8-4**). The manager of Auditing stated that contracted providers were asked to take their current audit results and look at the new thresholds to determine how they would have performed.

In contrast to CMHB, Franklin MHB took a more proactive approach in preparing its contracted providers for the changes in standards. Franklin MHB's FY2001 audits reflect not only areas for improvement, but display how the provider would have performed had the new standards already been in effect. Although there is no ODMH Medicaid standard that requires CMHB to establish this process as part of its audits, shifting the responsibility to contracted providers can leave room for error, thereby having an adverse impact on contracted providers' performance on future audits. Consequently, this may result in an increase in the amount of technical assistance provided by the Auditing Unit in order to explain the auditing requirements. Additionally, contracted providers' compliance, provider relations with the Board, and the development of training may be inhibited.

R8.11 The Auditing Unit should begin to incorporate into its audits a defined category that will

state anticipated changes in the standards and forecast how contracted providers would perform under those standards based on their current performance. Taking this proactive approach in preparing contracted providers for standard changes could improve the following:

- Provider-BOG relations;
- The auditing process;
- Knowledge of standards for both CMHB staff and contracted providers;
- Training development; and
- Contracted provider compliance.

F8.14 The Auditing Unit does not have contracted providers on a set schedule of upcoming audits. According to the manager of Auditing, contracted providers have been scheduled for approximately the same time each year. However, comparisons of audits scheduled for FY 2000 and FY 2001 reveal significant differences in the dates of audits from year to year. For example, a contracted provider was audited in March 2000 and then again in August 2001. In addition, six contracted providers were one month or more over due for their scheduled audits in FY 2001 and 14 contracted providers were audited twice in less than one year in FY 2001. New Medicaid protocols for FY 2002 recommend that contracted providers be audited the same time every year. The Auditing Unit notifies contracted providers 30 days prior to an audit.

Lucas MHB creates an audit calendar each year, disseminating it to contracted providers in the first quarter. The contracted provider is informed of the start date of the audit and approximately how many days to expect for the audit to be completed. The manager of Auditing at CMHB has stated giving contracted providers more advance notice would result in complaints from some contracted providers about others being given more notice of their audit, thereby having more time to prepare. However, the lack of a set schedule from year to year for contracted providers can have a negative impact on both the audit team and contracted providers' preparation for the upcoming audit. It can also affect provider relations with BOG in regards to implementing QA measures.

R8.12 The Auditing Unit should formulate a calendar that adheres to the same auditing dates from year to year. Furthermore, contracted providers should be given more advanced notice of their audit date along with an approximation of the time it will take to complete the audit. Allowing providers advance notice and a time approximation can present several benefits:

- Reduces the appearance that the auditing team is "out to get" contracted providers;
- Improves provider-Board relations;
- Allows contracted providers the ability to forecast staff needed to assist the auditing team in completing the audit in a timely fashion;

- Allows contracted providers to forecast time needed to conduct an internal audit of its records which can result in an increase in compliance; and
- Increases the audit team's ability to prepare for conducting audits of a particular contracted provider.

F8.15 During FY 2001, the Auditing Unit did not track audit findings that were challenged by contracted providers. Contracted providers can dispute audit findings with the auditing team during the audit or during the exit interview. The exit interview is conducted by the auditing team with the contracted provider at the end of an audit to report on findings and provide technical assistance. If contracted providers are still in disagreement with the auditing team's final decision, they can contact the chief of PRQS. If there was any further disagreement, CMHB would contact ODMH. However, there was no formal appeal process for contracted providers. According to the manager of Auditing, a minimal number of contracted providers went through this process last year, and questions revolved around service non-compliance (what is billable and what is not billable). However, the Audit Unit was unable to provide a precise number. With the new 06 Rule, contracted providers are now able to utilize a formal appeal process if they are in disagreement with the draft findings. This appeal is sent to ODMH, who in turn notifies CMHB of the appeal (see **Table 8-4**). By not tracking challenged audit findings, the Auditing Unit could have potentially missed opportunities to determine:

- Frequent misinterpretations of standards on the behalf of contracted providers and auditing team;
- Training opportunities for the auditing team and contracted providers;
- Areas of subjectivity; and
- Overall system-wide challenges.

R8.13 The Auditing Unit should begin to track findings that are appealed upon notification by ODMH. Doing so may reduce the potential for the auditing team to repeat errors in findings in the future. This could have a positive effect on future documented compliance of contracted providers. The Auditing Unit should utilize this information to formulate training for its staff and contracted providers surrounding appealed issues.

F8.16 According to the manager of Auditing, the Auditing Unit makes comments regarding clinical issues when obvious and known clinical errors are apparent. However, the Auditing Unit has not placed emphasis on clinical "best practices" during its auditing process. Instead, CMHB focuses primarily on the quality of documentation in conducting audits. Additionally, audit reviews are not used to identify areas of excellence, as well as areas for further program review, improvement, and technical assistance and training in which the QI unit could be involved. In contrast, Lorain MHB has for the past four years used independently licensed clinicians, under contract, to work alongside their staff to expand the

Medicaid audits from a review of documentation, to include reviews of clinical appropriateness and best practices. These clinicians have years of experience in mental health with expertise in specific areas such as children's mental health and geriatrics. ODMH Medicaid standards do not require that clinical best practices be incorporated into the audit findings. However, recommending best practices to contracted providers and encouraging their implementation can potentially have a positive impact on the following areas:

- Quality of services provided to consumers;
- Consumer satisfaction;
- CMHB's public image; and
- Contracted provider accountability.

R8.14 The Auditing Unit should make clinical best practice a primary focus, as it does quality of documentation, while continuing to follow the auditing process according to standards. To achieve this, the Auditing Unit should determine whether it already employs individuals with expertise in specific areas that are related to the population served by contracted providers. Using individuals with expertise could assist the Auditing Unit in making recommendations that go beyond what is minimally required in order to communicate clinical appropriateness and best practices to providers. Furthermore, these expanded reviews could help the Auditing Unit to identify areas of excellence as well as areas for further program review, improvement, technical assistance and training. Identification of these components should be shared with the Quality Improvement Unit (QI) for further assistance in follow-up (see *QI* subsection). The QI Unit should assess the information provided to determine potential areas of quality improvement regarding programs, consumer satisfaction, and contracted provider accountability.

F8.17 The Auditing Unit is currently not in the practice of checking for providers' accreditation. ODMH certification of providers that are willing to provide Medicaid services will be phased out in favor of accepting the accreditation by qualified bodies (e.g., the Council of Accreditation for Children and Family Services (COA), the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or the Commission on Accreditation of Rehabilitation Facilities (CARF)). ODMH is moving toward "deeming" providers eligible for certification if they have accreditation. CMHB's quality improvement specialist currently only tracks contracted providers' certification. The quality improvement specialist stated that it would be beneficial for the CMHB to begin formally tracking and monitoring which contracted providers currently have accreditation in anticipation of the "deeming process"(see *QI* subsection). Lucas MHB requires that all of its contracted providers provide documentation of accreditation in addition to ODMH certification. Currently, there is no ODMH standard that requires CMHB to verify providers' accreditation. By not being proactive in verifying accreditation, the Auditing Unit and its contracted providers may be

unprepared, resulting in many contracted providers having to seek accreditation when the change arrives.

R8.15 The Auditing Unit should begin checking for contracted providers' accreditation in anticipation of changes in ODMH certification. To accomplish this, the QI specialist should begin keeping a record of those contracted providers who have received accreditation and those who have not. Once compiled, this information should be routed to the auditing team before contracted provider audits are to commence. As part of the audit process, the auditing team should remind contracted providers of the progression towards being "deemed" as having met certification requirements if they have accreditation, and also offer technical assistance as appropriate. In taking this proactive approach to anticipated changes in standards, CMHB will be taking an active role in helping to ensure that it maintains contracts with qualified contracted providers. Furthermore, this practice will assist those contracted providers who do not currently have accreditation to become so.

F8.18 The Auditing Unit distributes audit surveys to its contracted providers. At the end of FY 2001, the Auditing Unit mailed requests for feedback on the audit process to all contracted provider executive directors, quality assurance (QA) staff and CMHB staff. Additionally, contracted providers were encouraged to make copies of the survey and distribute it to any staff involved in the process. The peers have not been in the practice of using auditing surveys. Overall, the survey contained adequate information in order to make changes and improvements. Distributing surveys to contracted providers cannot only improve communication with the Auditing Unit and can assist the Unit in improving its auditing processes, thereby increasing customer satisfaction.

C8.3 Distributing an audit survey for feedback on the auditing process displays the Auditing Unit's commitment to improving processes. The Auditing Unit's request for feedback on its processes, and subsequently implementing changes, is essential in establishing a successful partnership with contracted providers. In response to the audit survey responses, the following actions were continued:

- Technical assistance at audits upon request;
- Detailed information about audits in the cover letter;
- Ongoing documentation training, clients rights training, and supervisor training; and
- Changes or new information presented at the QI network meetings.

The manager of Auditing also stated that the following actions were added:

- Tracking of technical assistance on a shared drive (G: drive) to be analyzed at the end of the audit season to identify gaps in need;
- Using audit bulletins used to ensure quick dissemination of new information (see

R8.8); and

- Redesigning the audit survey to generate new information and to have the ability to track the data in a quantitative fashion.

F8.19 The actions taken by the Auditing Unit on its auditing survey do not effectively address survey responses and have not resulted in increased positive feedback to contracted providers. Although the auditing survey responses stated that positive feedback is given by the Auditing Unit's staff, a re-occurring response to a question, "What did you not find helpful about the auditing process," was that contracted providers wanted more positive feedback. Additionally, the actions do not convey how, when, and who will address responses. Although the audit survey has been redesigned to track the data quantitatively, previous results have not been used to benchmark against initial objectives. The Auditing Unit's unrelated actions to survey responses may pose an adverse impact on the relationship between contracted providers and the Unit, as well as on the Unit's ability to improve its processes over time.

R8.16 The Auditing Unit should seek to improve on its actions taken to address the results of audit surveys. More focus should be placed on whether responses are valid and how, when, and who will address them. Quantifying responses should allow the Auditing Unit to prioritize action steps based on response scores. Furthermore, this type of survey tool could be used to continually benchmark results against the objectives articulated at the outset. The survey can be used to determine whether desired results were achieved.

Quality Improvement

F8.20 The QI Unit was developed to ensure contract providers are complying with the Ohio Administrative Code (OAC) 5122.28.03 (**F8.22**). The QI Unit reviews the following documents provided by contracted providers:

- Quality improvement plan;
- Annual and quarterly summary reports of quality improvement activities;
- Biennial evaluation plan; and
- Annual summary of evaluation activities.

Upon receipt of these documents, the QI (1.0 FTE) and the evaluation (1.0 FTE) specialists review the documents, and approve or disapprove the content provided based on minimum OAC requirements. Additionally, QI staff performs duties related to the following:

- Review major unusual incidents (MUIs); (**F8.29**)
- Oversee the Consumer Outcomes Project initiated by ODMH; and (**F8.23**)

- Develop the Mutual Service Plan Agreement (MSPA). (**F8.25**)

QI activities at peer MHBs vary according to the structure of each MHB. Franklin MHB QI activities are performed by the Planning, Evaluation and Quality Services team. MUIs, QI and evaluation plans and reports are reviewed and approved by staff (2.62 FTEs) at Franklin MHB. In contrast, Lucas MHB combines QI activities with auditing, where staff are responsible for managing QI and evaluation plans and reports (1.6 FTEs). However, MUIs are monitored in the Member Services Department (0.5 FTE) which also monitors intensive services. Stark MHB also has a different structure compared to CMHB and the other peers. QI activities (which include review of MUIs) are combined with utilization review (UR) activities (0.3 FTE) and evaluations are managed in a separate department (1.0 FTE).

Table 8-6 illustrates the QI staffing levels at CMHB and peer MHBs, according to activities performed by CMHB QI staff.

Table 8-6: Quality Improvement Staffing Levels

	CMHB		Franklin	Lucas	Stark	Peer Average
	Budgeted	**Actual**				
Director	0.20	0.00	0.4	0.00	0.00	0.13
Number of Managers (FTEs)	1.00	1.00	0.00	0.60	0.00	0.20
Number of Quality Improvement Specialist	1.00	1.00	0.80	1.00	0.30[1]	0.70
Number of Evaluation Specialist	1.00	1.00	1.50	0.00[2]	1.00	0.83
Number of Administrative Assistants	0.21	0.21	0.20	0.00	0.00	0.07
Total Quality Improvement Staff	3.41	3.21	2.9	1.60	1.30	1.93
Number of QI Managers/Directors per staff	1:2	1:2	1:6	1:2	N/A	1:5
Quality Improvement Submissions[3]						
Number of QI Submissions[3]		222	138	78	72	96
Number of Evaluation Submissions[3]		74	n/a[4]	26	24	25
Number of MUIs		1,282	470	155	27	217
Total Number of QI Submissions		1,578	608	259	123	338
Quality Improvement Submissions Per Actual Staff						
Number of Total Submissions per QI Manager/Director		1,578	1,520	431	n/a	1,024
Number of QI Submissions per QI Specialist		222	173	78	240	137
Number of MUIs per QI Specialist		1,282	589	155	90	310
Number of Evaluation Submissions per Evaluation Specialist		74	n/a[4]	n/a[2]	24	30

Source: CMHB organization charts, interviews

[1] Percent value is estimated because Stark MHB QI and UR functions are intertwined

[2] Lucas MHB evaluation staff are included with QI staff.

[3] Based on number of contract providers, each contract provider is required to submit annual plans and quarterly reports and biannual plans and annual summaries.

[4] Franklin MHB has combined evaluation reports with the Consumer Outcomes System process and no longer require the submission of separate reports.

As shown in **Table 8-6**, the number of MUIs per QI specialist is the highest of the peers. However, CMHB could better control the number of MUIs submitted by developing criteria for opening and closing MUIs (see **R8.26**), sharing information with other staff (see **R8.27**) and developing a memorandum of understanding with other County agencies (see **R8.28**).

Table 8-6 also indicates that the number of QI submissions per QI specialist is the second highest as compared to the peers. However, peer MHBs are doing more with the documents submitted by contract providers as discussed in **F8.22**, which suggests CMHB QI staff are not operating as effectively as peer MHBs. For example, Franklin MHB, which has the most comparable staffing levels to CMHB, requires contracted providers to report evaluation information in the Consumer Outcome System and uses the submitted information by combining it into a report of how the system is serving its purpose. In contrast, CMHB relies on the standards evaluation reports, which could take more time to review and may not focus on reporting valuable information, such as outcomes. Furthermore, CMHB could enhance its monitoring of contracted providers, as discussed throughout this section of the report. Another factor impacting workload and staffing levels in the QI unit is the manner in which it is combined with different functions at CMHB and peers. Franklin and Hamilton MHBs, which are the most comparable in size to CMHB, have QI functions combined with planning and system development. However, CMHB has planning and system development separate from QI. In addition to potentially streamlining operations, combining planning and system development with QI could enhance monitoring and data gathering by ensuring that all data is considered in a plan and improve the ability of CMHB to evaluate outcomes and the success of plans. For further discussion on this issue and director/chief staffing levels, see **R8.1**, the **organization, compliance and board governance**, and **planning and system development** sections.

R8.17 CMHB should maintain its current staffing levels in the QI unit, which are comparable to Franklin MHB. However, CMHB should begin to implement identified recommendations in this report to operate more efficiently, and enhance overall monitoring activities to focus on outcomes and actively improve on the quality of services provided to consumers. For example, the number of MUIs reported may be reduced if CMHB monitors contract provider activities, ensuring consumers are receiving quality care in quality settings. In addition, CMHB should consider implementing a more streamlined process of gathering data to focus on measuring outcomes, similar to Franklin MHB. This can be accomplished by using ODMH's Consumer Outcomes System (see **R8.20**). CMHB should also consider combining QI with planning and system development (see **organization, compliance and board governance**, and **planning and system development** sections).

F8.21 QI specialist job descriptions are outdated. Listed responsibilities include serving as support for the clients' rights officer (CRO). Staff interviews reveal that this duty should be

removed from job descriptions since the chief of risk management and consumer affairs serves this function when necessary. As stated in the **human resource** section of this report, CMHB job descriptions have not been updated recently and do not accurately reflect staff activities and expectations. Not updating job descriptions to accurately reflect activities and expectations compromises CMHB's ability to effectively evaluate staff performance and identify areas for improvement.

R8.18 The chief of PRQS should work with Human Resources to ensure all job descriptions are reviewed and updated regularly (see **human resources**). This will ensure all PRQS staff are aware of official job responsibilities, which can be adequately assessed in future performance evaluations.

F8.22 CMHB could enhance its monitoring process by actively researching, maintaining and using performance measures or outcomes to monitor Cuyahoga County's mental health system on a system-wide basis, as opposed to relying on reports and plans submitted by individual contracted providers and relying on minimum requirements set forth in the ORC and OAC. Performance measures are defined as a system of client-focused quantified indicators that let an organization or system know if it is meeting its goals and objectives. Performance measures are a management tool that measures work performed and the results achieved. These same measures form a basis for management to plan, budget, structure programs, and control results. According to the provider survey conducted by AOS, 50 percent of the responding contracted providers reported not receiving outcome information for programs (see **organization, compliance and board governance** section). Measurement for performance helps to ensure the continuous provision of efficient and effective services. The lack of monitoring contracted provider performance places CMHB in a compromising position when making important decisions regarding funding, contract renewal, and utilization management.

According to ORC §340, MHBs are required to monitor the mental health system. However, MHBs do not have detailed directions on how to monitor the system as a whole. OAC §5122-28-03 and §5122-28-04 requires contracted providers to submit documents (QI plans, annual and quarterly QI reports, biannual evaluation plans, and annual evaluation summaries) to MHBs that contain a multitude of information regarding the services provided and needed throughout the service area. The QI and evaluation specialists critique and verbally discuss the contents of the plans with contracted provider staff, focusing on changes and possible inconsistencies. However, the full benefits of these documents are not maximized at CMHB because CMHB relies on the minimum requirements set forth in the OAC and ORC. Furthermore, the documents are filed away instead of being proactively disseminated to other units. As a result, CMHB does not have an accurate overview of the quality of services for Cuyahoga County mental health consumers and outcomes.

Peer MHBs request pertinent information from contracted providers to assess particular issues facing the mental health community. For example, Lucas and Stark MHB staff decide what needs to be evaluated for the year in order to develop a comparative analysis within the mental health system. Franklin and Lucas MHBs require contracted providers to submit information electronically to allow for the development of reports regarding outcomes of the system. Electronic submission of the reports allows Franklin and Lucas MHBs to access the data throughout the year to examine multiple factors in the mental health system in efforts to make improvements. Similarly, Stark MHBs require contracted providers to submit data used for analysis and statistical reporting such as the number of cases reviewed, the number of cases where the level of functioning improved, and assessment scores.

Additionally, Franklin MHB, as part of an incentive program, examined the following outcomes:

- Level of functioning (physical, personal care, interpersonal relationships, behavior, level of independence, and work skills);
- Symptom severity;
- Impacts of substance abuse; and
- Independent living.

This data was used to draw the following conclusions for consumers:

- Treatment effectiveness (if the agency produced better behavioral health it was more effective at treating consumers);
- Cost-efficiency (if the agency has lower per member, per utilization costs, it was more cost-efficient in treating consumers);
- Cost-effectiveness (if per dollar used at one agency produces better behavioral health than at others, the agency was more cost-effective in treating consumers than other agencies); and
- Service satisfaction (if the agency produces better service satisfaction than others agencies, the agency had higher performance than others).

This data was compiled to distribute incentive funding to higher achievers of system-wide performance outcomes based on a three-year study. Streamlining document submission could in better analyzing the mental health system and enforce accountability for the contract providers.

R8.19 CMHB should develop a process to establish and monitor outcome measures on a system-

wide basis, and stipulate and enforce the outcome measures to be monitored in the agreements with contracted providers (see the **risk management and consumer affairs** section). In identifying such a process, CMHB should consider the following:

- Identify pertinent outcomes which are consistent with CMHB's goals and objectives with the input of key stakeholders;
- Develop a set of measurable indicators for each target outcome by which progress may be assessed;
- Familiarize QI staff with MACSIS capabilities to be able to request and collect data on outcome indicators; and
- Incorporate the focus on outcomes into all levels of CMHB by maximizing the use of outcomes for planning and funding decisions.

CMHB should evaluate the contents of the documents submitted by contracted providers and compile the information in a formal report to provide the CMHB staff, BOG, contracted providers, and key stakeholders an overview of the quality of services and the mental health needs for the County. Contents of such a report should include contracted provider accomplishments, outcome achievement, and progress toward identified outcomes. By doing so, CMHB would be able to make decisions on funding, contracts, and other functions within CMHB based on the contract providers performance of service to consumers. Although OAC supplies the contract provider's with guidelines and minimum requirements for these submissions, CMHB should develop additional standards to support its efforts to improve quality of services for Cuyahoga County consumers in accordance with ORC and OAC requirements. Such standards should include defining specific outcome measures providers need to report on and should reflect progress in identified areas for improvement through previously submitted reports, audit findings, and site reviews. Upon the completion of the transition to the Consumer Outcomes System, CMHB should determine if Franklin MHB's method of electronic submission of report data is appropriate for its needs.

In measuring progress toward identifiable outcomes, CMHB should hold contract providers more accountable to consumers by ensuring quality services. The following is a list of possible performance measures CMHB could use to monitor the County's mental health system:

- Clinical Status;
- Quality of Life (Life Satisfaction and Fulfillment);
- Functional Status;
- Safety and Health/Welfare;
- Length of time required for services;
- Treatment success rates;
- Treatment recidivism rates;

- School success rates;
- Employment (gaining and retaining) rates;
- Criminal justice involvement;
- Waiting list data;
- Involuntary commitments; and
- Consumer satisfaction.

Periodic evaluation of these outcome measures would provide sufficient data for making systematic changes to enhance the quality of services. According to the QI Unit, outcome measures are beginning to be submitted in the Consumers Outcome Systems Project. However, CMHB would still have difficulty assessing outcomes for Cuyahoga County and making systematic decisions because only 22 of its 37 contracted providers are participating in the project (see **F8.23**).

Additionally, CMHB should actively research new methods of service delivery and monitoring to keep abreast of new methods of treatment. Upon identifying new treatment methods, CMHB should incorporate them in renewed contracts to ensure compliance with requirements for administering quality services. Basing renewal on outcomes could be an incentive for CMHB to effectively monitor and evaluate programs and for the administering contract provider to deliver quality services to all consumers. Furthermore, evaluations, report cards, incentive programs, QI plans, site visits, audits and clients rights could all be used to enhance the quality of services for consumers.

F8.23 Only 22 of 37 CMHB contracted providers are participating in the Consumer Outcomes System Project. Therefore, CMHB cannot fully assess Cuyahoga County's mental health system using this measurement tool. Participation requires contracted providers to use the same assessment and outcome tools when measuring performance and effectiveness of consumer services. At the start of the project, ODMH supplied participating MHBs grant funding for additional resources (equipment, software, hardware, or staff) to implement the project. CMHB requested volunteers from the contracted providers to participate and divided the grant funding between the volunteers. The participating contracted providers are completing the beginning phase of the project and anticipate using reported data in aggregate form to standardize the assessment of outcomes across the County, thereby establishing benchmarks for delivering mental health services. However, since the information does not include data from all of CMHB's contracted providers, this would not be a complete benchmarking tool. Consequently, ODMH will not provide the additional grant funding for the Outcomes System and CMHB's non-participating contracted providers would have to provide funding for the Outcomes System. The average cost incurred by the 22 contract providers currently participating is $14,500 at CMHB. All of Franklin and Stark MHBs' contracted providers are participating in the Consumer Outcome System project which will allow for more accurate benchmarking using the aggregate data reported.

The Consumer Outcomes System does not have the ability to track employment and housing outcomes, but identifies the following outcomes domains for measurement:

- Clinical Status;
- Quality of Life (Life Satisfaction and Fulfillment);
- Functional Status; and
- Safety and Health/Welfare.

Each domain is comprised of several specific outcomes. **Table 8-7** lists the Consumer Outcomes System domains and the specific outcomes that comprise each domain.

Table 8-7: ODMH Consumer Outcomes System Measures

Outcomes Domain	Outcomes Measures
Clinical Status	Level of symptom distress
	Number of psychiatric emergencies and emotional/ behavior crises
	Person/Family ability to understand, recognize and manage/seek help for symptoms, both physical and psychiatric
Quality of Life	Satisfaction with areas of life including family relationships, social involvement, financial resources, physical health, control over life and choices, individual and family safety, participation in community life, living situation, productive activity, and overall satisfaction with life.
	Feeling a sense of overall fulfillment, purpose in life, hope for the future and personal or parental empowerment
	Attainment of personal/family goals related to culture, spirituality, sexuality, individuality, developmental stage and liberty
	Family's sense of balance between providing care and participation in other life activities
Functional Status	Identifying, accessing, and using community resources to fulfill needs, such as spiritual, social, cultural, recreational, etc. by participation in organizations that are not primarily mental health organizations
	Developing and managing interpersonal relationships
	Managing money
	Managing personal hygiene and appearance, utilizing skills such as use of public transportation, phone books, grocery store, laundromats, etc. to maintain oneself independently as necessary, and maintaining a home environment in a safe, healthy and manageable fashion
	Advocating successfully for self with mental health professionals, landlords, families, public safety

	personnel
	Remaining in a home or family like environment as measured by stability and tenure
	Engaging in meaningful activity, e.g., work, school, volunteer activity, leisure activity
	Abiding by the law sufficiently to avoid incarceration and / or justice system involvement
Safety and Health	Does not want to or does not harm self
	Does not want to or does not die from suicide
	Does not want to or does not harm others
	Free from physical and psychological harm or neglect in the individual's social environment to include home, school, work, and service settings
	Person is physically healthy
	Treatment effects, including medication, are more positive than negative
	Safety and health is not threatened due to disabilities, being treated with lack of dignity, or discrimination in response to lifestyle or cultural differences
	Person/family terminates services safely and plan fully
	Person/family who receives little or no services, has secure sense that they can obtain more additional services in a timely manner

Source: ODMH Consumer Outcomes System Frequently asked Questions, Instrumentation and the Measurement of Outcomes

As illustrated in **Table 8-7**, the Consumer Outcomes System measures several outcomes to determine how well a consumer is progressing through treatment. Gathering such information periodically through the treatment process allows the therapist to ascertain needed adjustments to achieve desired results. When this data is collected in aggregate form, it could be used to assess the status of a mental health system.

Additionally, monitoring consumer outcomes ensures accountability of publicly funded behavioral health care by demonstrating effectiveness of services. County performance could be evaluated systematically from two perspectives, the contracted providers' performance over time and by comparing it to similar contract providers' performance as established with benchmarks. The following information identifies possible uses for outcome information:

- Monitor the analysis and improvement of outcomes of care by providers;

- Maintain performance data to continuously monitor organizational performance;
- Help organizations identify areas in need of attention;
- Identify exemplary performance;
- Document consumer improvement using a different and possibly less intensive level of care; and
- Demonstrate improved performance.

Furthermore, outcome and process data would provide information to help community MHBs when making policy, administrative, clinical, and financial decisions. For example, Franklin MHB has used this information to determine allocations for an incentive program and to assess performance for contract renewal. The following illustrates additional examples of how community MHBs could use outcome data, along with other information to better plan and make decisions:

- Make policy changes that would help implement identified best practices into the treatment process for contracted providers;
- Highlight gaps in services to close the gaps;
- Identify where less services are warranted;
- Project more accurately the total expense of care, using a cost-benefit analyses for various service combinations and types of consumers; and
- Conduct cost-efficiency analyses to determine if the timing of services is more effective.

Use of this information would also provide ODMH pertinent information to make critical decisions that would affect the public mental health system statewide. Although the Consumer Outcomes System provides many benefits for MHBs, these could not be maximized without full participation of the mental health system. Furthermore, CMHB is in the early stages of the initiative and has not been proactive in measuring outcomes or monitoring its mental health system. In contrast, Franklin MHB continuously monitors contracted provider performance, previously with its customized system and now using the ODMH Consumer Outcomes System.

R8.20 CMHB should require contract providers to use the ODMH outcomes tool to begin collecting outcome data for all publicly funded providers. This requirement should be detailed in each new contract and at the time of renewal for existing contracts. Requiring all contract providers to use the Consumer Outcomes System would provide CMHB the following benefits:

- Ensure compliance when ODMH mandates its use;
- Provide a complete picture of Cuyahoga's mental health system;
- Allow for educated decision making for funding services;

- Ensure accountability for CMHB and contract providers;
- Provide important benchmarking data for performance;
- Provide pertinent information for effective care management;
- Provide a standardized measurement tool for clinical status, quality of life, functional status, and safety and health/welfare; and
- Answer important questions to help monitor CMHB's mental health system.

Standardized measurement of outcomes and the processes that lead to those outcomes enables boards to identify what treatment works with which consumers and identify best practices in mental health services. To do so, outcome data must be used in conjunction with other sources of data such as service utilization and billing, quality assurance, grievances and appeals, vocational projects, research results, and others. The majority of this information is available in the state-level data warehouse (electronic location where MACSIS information is managed). Monitoring outcomes for all contract providers would provide pertinent data to CMHB and stakeholders for identifying system deficiencies and areas to maximize costs for services. Furthermore, since the ODMH Consumer Outcomes System does not have the ability to track employment and housing outcomes, CMHB should aggressively monitor these services. This could be done by developing a database and tracking use because access to these services could potentially reduce the number of consumers receiving indigent healthcare and prolonging a hospital stay because of the lack of housing.

F8.24 The role of quality improvement staff in monitoring contracted provider quality assurance activities has not been identified in preparation for proposed changes in certification standards. ODMH is in the process of revising several requirements for certified providers. One major revision requires providers to obtain accreditation from the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council of Accreditation for Children and Family Services (COA) (see *Auditing* subsection). Because of the level of quality maintained by these accrediting organizations, review of MUIs, QI plans and reports and site reviews could be completed with the accrediting organization staff, potentially reducing the workload for MHBs' QI staff. Additionally, these credentialing organizations require mental health providers to uphold nationally recognized standards for mental health services, including:

- Patient Rights and Organization Ethics,
- Assessment,
- Care of Patients,
- Education,
- Continuum of Care,
- Improving Organization Performance.
- Leadership,
- Management of the Environment of Care,

- Management of Human Resources,
- Management of Information,
- Infection Control,
- Governance,
- Management,
- Medical Staff, and
- Nursing.

The goal for this change is to raise the quality of services from contracted providers. Accreditation from a national organization offers the following benefits:

- Supports and enhances safety and quality improvement efforts;
- Strengthens community confidence;
- Emphasizes an integrated and individualized approach to services and outcomes;
- Increases accountability to funding sources, referral agencies, and the community;
- Encourages management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; and
- Supplies evidence to assure federal, state, provincial, and local governments of the quality of programs and services that receive government funding.

Stark MHB currently requires non-Medicaid providers be accredited in order to enhance the quality of mental health services. Accreditation is monitored by the evaluation director for contract compliance.

R8.21 CMHB should emphasize the importance of accreditation with its contracted providers. The Risk Management Unit should mandate accreditation through the contracting process, and the QI Unit should track the status of those contracted providers seeking accreditation. This will ensure nationally recognized standards for quality service are being met for mental health consumers of Cuyahoga County. Incorporation of these standards could potentially reduce the number of documents submitted to the QI Unit allowing the accreditation body to receive these documents, thus reducing the workload of QI staff (see **F8.20** and **R8.17**). Therefore, CMHB should play a more active role in monitoring the quality of services rendered to consumers. This should be done during site reviews for contracted providers as discussed in (**F8.28** and **R8.25)**. Monitoring the quality of services would include using information collected from evaluation and QI documents for decision making purposes (**F8.22**). Continuing to review these documents and beginning to compile the data would allow CMHB to monitor the mental health system and how each contract provider contributes to the system, thus increasing accountability for all aspects of Cuyahoga County's mental health system. Additionally, if the proposed accreditation standards are mandated, QI staff should obtain contract provider accreditation information to ensure compliance. By tracking contract provider accreditation status, CMHB could ensure that

nationally recognized standards are in place, thus delivering quality services to Cuyahoga consumers.

F8.25 CMHB does not use its Mutual Systems Performance Agreement (MSPA) as a guide to monitor the mental health system of Cuyahoga County and address quality service issues. The MSPA was developed to reflect changes in the public mental health system, with the expectation of moving toward a "shared accountability agreement" that is jointly developed between individual boards and ODMH, with both statewide applicability and local flexibility. The MSPA for CMHB identifies the legal authority for various tasks concerning consumers according to ORC and OAC. The MSPA also discuss the following items necessary for the agreement to be successful:

- Involvement of consumers and family members in all phases of treatment, planning, evaluation and QA;
- Submission of administrative reports by CMHB to ODMH throughout the course of the MSPA (these include fiscal, program [grants, housing, capital plans], and annual reports);
- Identification of processes for the collection of data to determine local best practices, performance indicators and measures and areas of concern;
- Provision of goals for enrolling clients, processing claims, processing admission and discharge records, completing the flow of outcome data; and
- Development of outcome measures to address access to and quality of services, school success and employment rates, and other consumer outcomes (**F8.22** and **F8.23**).

According to several CMHB staff, including the manager of QI and the acting CEO, most of the above listed items do not occur at CMHB (see **F8.22** regarding the lack of monitoring at CMHB). Instead, CMHB has consistently relied on providers to measure progress with no guidance or structure beyond OAC requirements. Moreover, the current MSPA indicates CMHB has not defined access standards for services and does not formally measure and monitor access to services on a routine basis. Furthermore, CMHB suggests that maintaining MUIs and consumer complaints, reviewing the Patient Care System for state hospitalization use, participation in the Consumer Outcomes System Project, and conducting QI committee meetings sufficiently measures the quality of care for consumers. Although these practices address some requirements, a more in depth analysis of systematic issues is needed (see **F8.22**). As result of this suggestion and CMHB's lack of measuring access to services, the MSPA recommends the following analyses to determine access:

- Degree to which services are available, convenient, timely, and provided (**F8.26** and **R8.23**);
- Number of consumers receiving appropriate services; and

- Number and characteristics of consumers receiving services.

To address the ODMH priorities of access, quality, school success, employment, and consumer outcomes in the MSPA, the following lists activities CMHB has not implemented, but which have been completed by Franklin MHB:

- Completed a needs assessment for the county to determine access;
- Implemented an evaluation process using an outcome assessment tool and satisfaction survey to measure the system and cost-effectiveness to improve quality;
- Implemented the Ohio Scales for outcome evaluation for youth in addition to measuring client and parent satisfaction to measure school success;
- Attempted to reduce disability costs by increasing employment and economic independence of consumers;
- Implemented outcome assessment tools listed in the Ohio Mental Health Consumer Outcomes System Procedural Manual to assess consumer outcomes; and
- Recognized the need to focus attention on consumers with criminal tendencies using improved forensic services and monitoring in efforts to reduce criminalization and promoting public safety.

Using the MSPA as a tool for measuring quality yields the following benefits:

- Identifies degree services meet generally accepted standards of care when possible and evidence based such as assertive community treatment (ACT) programs;
- Identifies the number of adult consumers reporting significant participation in treatment planning; and
- Identifies the number and clinical characteristics of consumers receiving services.

CMHB is required to work with ODMH for all monitoring activities involving contract providers who receive public funding. Although CMHB has not completed all of the following tasks, the MSPA suggests monitoring to be done by developing and implementing the following measures:

- Core service access and capacity;
- Utilization review; and
- Consumer outcomes.

The lack of following this suggestion results in CMHB's misunderstanding the services necessary to meet consumer needs and compromises the quality of services provided.

R8.22 CMHB should use the MSPA as a guide for monitoring the mental health system in Cuyahoga County and proactively address each identified area to provide quality services for

consumers. CMHB's consistent reliance on providers to independently measure progress without defining specific criteria for outcomes impairs its ability to gather an accurate knowledge of consumer needs. CMHB should view OAC requirements as the minimum and insufficient to produce quality services for its system. Implementing this practice would allow CMHB to accurately identify how effective mental health services are for consumers (**F8.22** and **R8.19**). In particular, monitoring access to services is essential in controlling the number of crisis situations that arise.

F8.26 According to the MSPA and to CMHB staff, access to services has not been monitored by CMHB to determine resources necessary for consumers to have therapeutic needs met. CMHB has speculated that contract providers have high staff turnover rates which result in its inability to serve consumers effectively. Additionally, reductions of staff and resources have caused contracted providers to close many satellite offices in an effort to further cut costs.

During FY 2001, CMHB reviewed contract provider waiting lists from April 30, through July 23, but has not reviewed them since then. At that time, there were 1,901 instances of consumers unable to be served due to their placement on waiting lists. This number could potentially include consumers seeking help at more than one contract provider, which amplifies the fact that the mental health system has deficiencies worthy of CMHB's attention. The analysis also reveals that an average of 177 children and adolescents and 69 adults per week sought services that the system could not provide. The review attributes causes for the inability to serve consumers to the following:

- Service capacity;
- Service needed did not match that offered by the contract provider;
- Consumers did not meet the admission criteria, specifically age and diagnosis of severe mental illness;
- Consumer's insurance provider did not cover services rendered by the contract provider; and
- Lack of subsidized services for uninsured consumers.

In an effort to assist consumers, contract providers referred consumers to other contract providers or provided services for part of what was identified as a need and referred the consumer elsewhere for the other needed services. Such activity could be accomplished consistently and more efficiently using a centralized intake or managed care system to refer consumers to appropriate services (see **F8.60** and the **finance and funding** section).

Peer MHBs continuously develop needs assessments to determine service capacity and measure how contracted providers are meeting the needs of consumers. Franklin MHB requires contracted providers to include such information in annual provider profiles (see

Provider Relations subsection), while Lucas MHB accomplishes this through the QI plans from the contracted providers. Because CMHB does not provide contracted providers with detailed guidance regarding submission of documents required by OAC and does not conduct frequent needs assessments to determine consumer access to services, it does not have a firm understanding of consumer needs and how to address those needs.

R8.23 CMHB should use the information identified in the review of consumers unable to be served along with suggestions identified by ODMH in the MSPA (**F8.25**) to measure the access to services for consumers. This should include continuous information from contract providers regarding consumers who were referred to other contract providers for services. The type of services referred should also be documented to determine trends in the system's ability to provide needed services. This information could be used by CMHB to determine what services are needed and how to best prevent the escalation of crisis intervention. Furthermore, data collected regarding consumers unable to be served and the types of services needed could form the basis for a system-wide needs assessment as identified in the **planning and systems development** section of this report.

Assessing the number of consumers unable to be served and the types of services needed should be simplified with the implementation of a centralized intake or managed care system (see **R8.55** and the **finance and funding** section). This organization would allow consumers to receive one assessment and referral to a contract provider who has the ability to provide needed services at that time. Requiring all consumers to search the mental health system without direction could potentially cause the consumer to avoid seeking help for problems which could eventually result in a crisis situation.

F8.27 Currently, no internal quality improvement initiatives are performed at CMHB. According to the QI manager, efforts to develop a survey to be completed by contracted providers identifying opinions to improve CMHB's performance have not progressed. This information would be incorporated in quarterly QI reports to be submitted to the BOG and compiled annually for the annual report. Additionally, CMHB has not been proactive in ensuring quality services and sufficient oversight.

While CMHB participated in the MetNet Consumer Satisfaction Survey, Franklin, Lucas and Stark MHBs are implementing internal quality improvements which include preparing for newly implemented legislation affecting MHBs, continually evaluating system-wide performance, and addressing identified deficiencies. Additionally, Franklin and Lucas MHBs have developed and issued surveys to assess how well the mental health system addresses consumer needs. These efforts could enhance the quality of service delivery throughout the County to better serve the needs of the consumers.

R8.24 CMHB should begin to implement internal quality improvement initiatives to fulfill its

mandate to monitor the mental health system in Cuyahoga County. CMHB should accomplish this using a survey to assess the performance of every division of CMHB. The survey should be distributed to all contracted providers, ODMH staff interacting with CMHB, consumers and other key stakeholders. The information collected from the survey should be used to guide CMHB in gaining an understanding of system needs and how best to address them. In addition, CMHB should actively prepare for newly implemented legislation that could impact the delivery of mental health services. This should include taking a proactive lead in educating and preparing CMHB staff and contracted providers for requirements of the new legislation. Implementing internal quality improvement initiatives would give CMHB a solid foundation for improving the quality of services provided to Cuyahoga County consumers.

F8.28 According to CMHB staff, site reviews occur when a contracted provider has been identified as a "trouble agency." This generally occurs as a result of audit findings, community calls, consumer representatives, and involvement of CMHB's QI Committee (see *Auditing* and *Provider Relations* subsections). Upon receiving this information, the BOG instructs staff to conduct site visits to determine the nature of problems and provide assistance with their resolution. There have been several instances where contracted providers lost Medicaid certification or were closed, resulting in unfavorable consequences for consumers. For example, one contracted provider closed and the contracted provider to which consumers were transferred could not meet all their needs. Although each contracted provider submits QI reports, MUIs, and annual evaluation summaries, CMHB does not ensure information reported is accurate. The reports are approved (unapproved reports are returned for corrections to be approved) and filed at CMHB (**F8.22**). Staff are not required to analyze submissions to report on the quality of service provided by contracted providers. Although the QI specialist job description requires site visits, this is only done when a problem arises. The failure to regularly visit the contracted providers, and reliance on submitted reports could potentially result in misrepresentation of information.

R8.25 CMHB QI staff should routinely conduct site reviews to review case notes and ensure information documented in the reports submitted to CMHB are factual. This should be done in coordination with provider relations staff when gathering information for provider profiles (**R8.35**) to avoid disrupting service delivery by the contract provider. Proactively monitoring activities would allow CMHB to reduce the number of gaps in quality services provided to consumers throughout the County and provide assistance to those experiencing difficulty before the contract provider is identified as a "troubled agency".

F8.29 Currently, CMHB has not established formal and documented criteria for the submission of major unusual incident (MUI) reports. CMHB requires contract providers to submit MUI reports to QI indicating the occurrence of the following incidents:

- Deaths at a provider agency;
- Patient abuse;
- Medication error;
- Serious bodily injury; and
- Life threatening situation.

Reporting of MUIs is accomplished when contracted providers submit documentation of the incident to the QI specialist. CMHB has developed a standard report form for MUIs which are reviewed by the MUI committee, comprised of the QI manager, QI specialist, chief clinical officer, chief of risk management, the housing specialist and a PRQS administrative assistant. The committee reviews the MUI reports to determine if a case should be opened, requiring more detailed information. If the contracted provider has submitted detailed information, the consumer has received appropriate care, and a resolution has been reached within the 24 hour reporting period, a case is not opened. If the contract provider has not submitted sufficient documentation, a case is opened and remains open until the contracted provider submits all documents regarding the investigation results from other County agencies to satisfy the MUI committee's requests.

Cases may be closed if the contracted provider has submitted three written requests for the investigation results to the County agency conducting the investigation and provides CMHB with copies of the requests. During the time the MUI case remains open, the contract provider receives notification of the open cases, identifying what is needed prior to closing, and a listing of cases which were closed during the month. Although peer MHBs have not formally developed documented criteria, and in some cases no committee has been developed, such criteria would aid contracted providers in determining what is appropriate for submission and potentially reduce the workload for the MUI committee members.

R8.26 In addition to the MUI reporting form, CMHB should develop formal and documented criteria for opening and closing MUI cases to ensure the safety of consumers receiving treatment at contract provider facilities. The criteria should identify what steps should be followed after an incident has occurred. Furthermore, CMHB should specify what information is required to avoid the opening of unnecessary cases. By establishing formal and documented criteria, contract providers would be able to submit all information and reduce the amount of follow-up CMHB has to do to receive a satisfactory MUI report.

F8.30 CMHB keeps all identifying MUI information confidential, limiting the amount of information shared with other divisions. According to ODMH's Quality Office, there currently are no OAC requirements for reporting MUIs by contracted providers. This is attributed to legal reasons and discovery issues for contract providers. Furthermore, some MHBs have better relationships with contract providers and receive more information or have worked out agreements under the quality assurance umbrella which are protected from

discovery. For this reason, CMHB has agreed to keep all MUI activity confidential among committee members. Franklin MHB has a MUI review team led by the director of QI that receives the reports and provides minimum follow-up when needed. When there is a concern with the report, particularly with deaths, additional follow-up is requested. Lucas MHB monitors MUIs and shares information in aggregate form with the entire organization, including the named contracted provider. This is also done in conjunction with the consumer rights and provider relations staff, and led by the director of member services. Receiving this information in total confidence from other areas of CMHB makes it difficult to ensure a contract provider is maintaining quality services because no other employees of CMHB are privy to the information. As a result, a potentially troubled contract provider may be overlooked and not receive necessary assistance from CMHB staff.

R8.27 CMHB should share MUI information with other CMHB staff such as the clients' rights officer and provider relations. This would ensure pertinent staff at CMHB are aware of potential problems for contract providers. Furthermore, this knowledge would allow CMHB to address concerns in a proactive, not reactive manner, before a contracted provider is labeled a "troubled agency." This could also reduce the amount of time necessary to assist a contract provider once it has been identified as a "troubled agency".

F8.31 CMHB relies on County agencies and advocacy groups to investigate MUI reports. Solely relying on other organizations to investigate the welfare of mental health consumers does not guarantee CMHB learns the cause of the MUI. For example, if a child is injured at a contracted provider's facility and Cuyahoga County Department of Children and Family Services (DCFS) finds no evidence of abuse, CMHB would not pursue a subsequent investigation because DCFS is the agency responsible for the child. When an advocacy group's findings are not in agreement with the County agency's disposition, the information is documented by the MUI committee, but the responsible agency's report remains the official documentation. Also, contracted providers servicing adults between the ages of 18 and 60 conduct their own investigations, as a result of the lack of collaboration between CMHB and Adult and Senior Services which generally focuses efforts on individuals over the age of 60. According to CMHB, its residential administrator is involved with MUI investigations related to residential and housing programs.

Because CMHB is responsible for monitoring the care provided to mental health consumers, it would be beneficial for them to actively participate in the investigations and educate other County agencies on their care. Furthermore, peer MHBs also rely on collaboration from other county agencies, conduct frequent site visits and closely monitor activities at contracted providers which allows problem areas to be addressed in a timely manner. **Table 8-6** shows CMHB receives a disproportionate number of MUIs compared to peer MHBs.

Additionally, ODMH is currently pursuing changes to the requirements for reporting MUIs.

It is proposed that the reports be forward to the Ohio Legal Rights Service Commission, alleviating the county MHBs of the exclusive oversight. Such a change could further reduce CMHB's role in the MUI investigation process. Therefore, intra-agency collaboration would be imperative to ensure consumer needs are met.

R8.28 CMHB should develop a memorandum of understanding with all other County agencies to ensure its awareness of all reported incidents and should remain a key party in the MUI process should changes in the law reduce MHBs' responsibility. This would help to foster a good working relationship with key protection agencies throughout the County, such as the Department of Children and Family Services, Adult and Senior Services, police departments, and large area hospitals. The memorandum of understanding should identify what steps are to be taken at the time an incident is reported to the respective agencies. The criteria identified should mirror those for contract providers reporting MUIs to CMHB as discussed in F8.30. Close collaboration and monitoring of such incidents could potentially reduce the number of MUIs occurring and reported to CMHB.

Provider Relations

F8.32 According the manager of Provider Relations and the acting CEO, the Provider Relations Unit (PR) was initially developed to serve as a liaison between CMHB and contracted providers, by being the single point of contact to respond to provider concerns of unresponsiveness. Furthermore, response times to contracted provider inquires were to be improved with the creation of the Unit. The Unit was also established in order to improve communication between CMHB's units.

Comparing job descriptions against current activities and productivity, the PR staff is currently not performing all of their job responsibilities and duties, thereby not functioning as intended. The following job duties and responsibilities have not been totally performed by the PR staff and/or could be performed more effectively:

- Be a single point of contact; (see **R8.33**)
- Develop and implement contracted provider accountability standards as a basis for a single provider profile report card; (see **R8.31**)
- Resolve contracted provider problems; (see **R8.36**)
- Develop procedures to track resolve and communicate exceptional performance (positive and negative); (see **R8.34**)
- Identify and assist in the implementation of best practices within provider networks;
- Monitor contract requirements; (see **R8.32**)
- Develop appropriate timelines to respond to contracted providers' issues; and (see **R8.33** and **R8.34**)

- Develop internal procedures for CMHB staff to notify PR Unit when system issues or contracted provider issues arise in order to increase communication and sharing of information on issues and to better coordinate efforts. (see **R8.41**)

The Unit's absence of follow through on job responsibilities and duties may be attributed to the following, which could also impact the staffing levels in the PR Unit (see **Table 8-8**):

- The need for administrative leadership (see **F8.1**);
- The need for clear operating procedures (see **F8.33**);
- The need for communication and information sharing between units (see **F8.36**); and
- The need for analysis and use of data (see **F8.34** and **F8.38**).

Table 8-8 presents staffing information as of January 2002 for CMHB and the peers and indicates that the PR Unit is more than adequately staffed to carry out stated job duties and responsibilities.

Table 8-8: Provider Relations Staffing Levels

	CMHB		Franklin	Lucas	Stark
	Budgeted	**Actual**	**Actual**	**Actual**	**Actual**
Directors	0.2	0.0	0.6	n/a[1]	n/a[1]
Managers	1.0	1.0	n/a[2]	n/a[2]	n/a[2]
PR Specialist	4.0	4.0	1.9	n/a[3]	n/a[3]
Clerical Staff	0.5	0.5[4]	0.8	n/a[5]	n/a[5]
Total PR Staff	**5.7**	**5.5**	**3.3**	**n/a**	**n/a**
Administrators to PR staff[6]	1:3.8	1:4.5	1:4.5	n/a	n/a
Contracted providers per PR staff	6.4	6.7	6.9	n/a	n/a
Contracted providers per PR specialist		9.2	12.1	n/a	n/a
Consumers Served FY2001		30, 238	29, 317	13, 650	8, 209
Consumers per PR specialist		7, 559.5	15, 430	n/a	n/a

Source: CMHB and peer interviews
[1]Lucas MHB and Stark MHB do not have directors for provider relations.
[2]Franklin MHB, Lucas MHB, and Stark MHB do not have managers for provider relations.
[3]Lucas MHB and Stark MHB have no provider relations specialist.
[4] The clerical staff for this unit also contributes 50% of their time to the Education and Training Unit.
[5]Lucas and Stark MHB have no support personnel for provider relations.
[6]For purposes of this calculation, administrators are defined as directors and managers

As shown in **Table 8-8**, CMHB's number of contracted providers per PR specialist is slightly lower than Franklin MHB. Franklin MHB is operating without a manager, and has 2.9 more contracted providers per PR specialist. Additionally, none of the peers are operating with PR managers. Furthermore, CMHB's number of consumers to specialist ratio is 48 percent lower than Franklin MHB. Franklin MHB has a director who oversees the PR Unit as well several other units. Overall, **Table 8-8** indicates that the Unit is more than adequately staffed to meet its purpose. However, the PR Unit has not met its purpose to be a liaison between contracted providers and CMHB and has not improved response times to provider inquires. If CMHB reduced its PR staffing levels by 2.0 FTEs (1.0 FTE manager and 1.0 FTE specialist position), the Unit would be comparable to Franklin in regards to total staffing levels and contracted providers per provider specialist, and the number of consumers to PR staff would still be lower than Franklin MHB.

R8.29 The PR Unit should begin to perform all related duties and responsibilities. The recommendations presented in this audit report focus on PR specialists adhering to what is outlined within their job descriptions as well as implementing process improvements. CMHB should maintain the unit if it begins to perform beyond its current level of functioning. However, even with the report recommendations implemented, based on the staffing analysis presented in **Table 8-8**, CMHB should consider reducing its staffing levels by 2.0 FTEs, a PR manager (1.0 FTE) and PR specialist (1.0 FTE). In taking this approach, CMHB should seek to reorganize its units and fill chief positions to be responsible for the units (see **organization, compliance and board governance** section).

Financial Implication: CMHB would save approximately $125,900 annually in salary and benefit costs by reducing the PR manager position and 1.0 FTE PR specialist position.

F8.33 The PR Unit's responsibilities have not been clearly defined and there are no operating procedures for the unit. As a result, PR specialists have expressed uncertainty regarding their responsibilities. As stated previously, many of the job responsibilities required of PR specialists are not being performed in whole or part, which may also be attributed to the manager of PR being on leave since December 2001. Since this time, the PR Unit has been reporting to the acting CEO. In contrast, Franklin MHB has clearly defined operating procedures for its provider relations staff. Some of these include the following:

- PR staff must be informed of contracted provider partner issues, needs and concerns;
- Specific details of when to work jointly and when something is technical or is a broader issue shall be discussed between the PR team and other teams;
- PR staff shall be informed and be participants in all meetings involving contracted providers and their issues, including specific projects such as those establishing outcomes, best practices, and clinical meetings; and
- Meeting results and/or agreements made with contracted providers on projects issues

or concerns should be documented by PR staff and a copy put in the central file.

Because operating procedures are not clearly defined and documented, staff members cannot easily understand how they are expected to provide services. This uncertainty can negatively effect customer satisfaction and the Unit's productivity.

R8.30 The PR Unit should develop clearly defined operational procedures that will guide its staff members through processes and assist them in meeting their day-to-day duties and responsibilities. Developing these guidelines can set parameters for the Unit, and serve as an accountability measure for the PR staff and Unit as a whole, thereby reducing the likelihood of misunderstanding regarding how and when services are to be provided.

F8.34 PR specialists have not created single provider profile report cards as indicated in their job descriptions. Profiles and report cards present comprehensive and detailed information about contracted providers' outcomes and are used to evaluate performance. The job description for PR specialists states that they are to monitor and track performance against provider accountability standards as a basis for a single provider profile report card. According to the manager of PR, this performance measure was intended to be profiles only and not report cards. The manager of PR further stated that the process of developing profiles has been on hold because the Unit has been waiting for the Board of Governors (BOG) and the Executive Council to determine what data will be used in the profiles. Additionally, the manager of PR stated that the profiles will be used to provide information to the BOG, to identify problem areas, and to eventually perform selective contracting. Also, there has traditionally been poor communication between units (see **F8.1**). The manager of PR stated that the Unit was meant to improve communication between CMHB's units. Although PR specialists stated that they have initiated communication with other units on a daily basis, this communication is not always forthcoming from other units. There is no formal process to hold other units accountable for this communication process (see **F8.36**).

In contrast, Franklin MHB is utilizing its provider profiles as an educational tool for staff, providers and the community. The profiles are used both as a management tool and during their weekly operational meetings attended by representatives from other units for the purposes of information sharing. These profiles will also be put into a book for each Board of Governors' member to facilitate decision making and will be updated yearly. The absence of analysis of data for decision making, coupled with the absence of communication between units, precludes CMHB from determining a contracted provider's overall performance, accountability, and growth over time. Furthermore, the absence of this practice prevents CMHB from bringing awareness to mental health issues and educating key stakeholders.

R8.31 The PR Unit should begin creating provider profiles by compiling and analyzing the pre-

existing data that is currently being routed to various units of CMHB from its contracted providers. This will allow the Unit to formulate single provider profiles that can assist CMHB in developing provider report cards. In order to accomplish this goal, CMHB should obtain data from various sources such as the following:

- Medicaid compliance reviews;
- Claims submissions;
- Outcome related measures;
- QI plans; and
- Income statements and balance sheets.

Additionally, CMHB should require that the needed reports be sent directly to the PR Unit (see **F8.35**). This information should measure providers' performance across several perspectives and be updated on a quarterly basis. Provider profiles could assist CMHB in measuring providers' performance in regards to finance, consumers, internal processes and to further gauge learning and growth. Provider profiles and report cards can also be used for the following:

- Increasing awareness of mental health issues in the community. A report card can focus on the diverse needs of mental health consumers and can indicate the extent to which the mental health system is successfully meeting the needs of its consumers.
- Establishing a measure of accountability for the entire mental health system. The report card can reveal how much progress has been made in achieving an adequate quality of life for mental health consumers. The report card sends a message that outcomes matter.
- Educating key stakeholders about specific areas of need.
- Improving service delivery. Contracted providers may redirect their efforts for consumers more effectively as a result of a report card or may refocus their attention to outcomes, rather than inputs.
- Putting mental health concerns in media spotlight. The report card can effectively give the media the facts needed to keep mental health issues and progress in the public eye.
- Tracking and communicating exceptional performance.

Furthermore, it is essential that ongoing communication between units occurs in order to further assure accuracy of information and facilitate information sharing in order to make educated management decisions. This can occur by having weekly meetings that include various representatives from CMHB's units.

F8.35 CMHB's PR specialists are not required to do site visits at contracted provider sites, nor do they collect any data or reports from contracted providers, although they do review agency

services plans. Agency services plans provide a general overview of the types of services that are provided to consumers. In contrast, Franklin MHB's PR staff receives reports directly from contracted providers and other units within Franklin MHB and make two required formal site visits and many informal visits to contracted providers to collect data needed for provider profiles. During Franklin MHB's site visits, information is also obtained from the following sources:

- Medicaid compliance reviews (e.g., overall ineligible claims and overall problem area);
- Planning, evaluation and QI team (PEQIT) (e.g., most current approved QI plan and outcome related measures);
- Claims submissions (e.g., people served, gender, race, age group, units);
- Fiscal status (e.g., income statement and balance sheet);
- Agency services plans (i.e. accreditation expiration dates) ; and
- Provider program survey (e.g., program population, specialty, services, and client slots).

The absence of required site visits by PR specialists to contracted providers could inhibit progress toward the following:

- Establishing a provider profile;
- Verifying and collecting data;
- Observing and inquiring about programs; and
- Observing and inquiring about processes.

R8.32 The PR Unit should be required to make a minimum of two on site visits to contracted providers for purposes of observing and inquiring about programs and processes. Doing so could allow the Unit to further obtain and verify the accuracy of reports received which can, in turn, be utilized for the establishment of provider profiles (see **F8.34**)

F8.36 The PR Unit's single point of contact model for contracted providers has not functioned effectively. According to the manager of Auditing and the PR specialists, not all contracted providers are communicating through the PR Unit to express issues and concerns or to field questions. The manager of PR stated that the Unit was set up approximately two years ago to respond to contracted providers' concerns of not having issues addressed. The acting CEO has stated that the Unit is to function as the single point of contact. However, having the PR Unit as the central point of contact has created an increase in the amount of time that it takes CMHB to respond to contracted provider inquires. The PR specialists have to call different units to resolve issues before getting back to the contracted providers with answers.

All of the eight contracted providers randomly selected to be interviewed for this audit stated

that they use other units in order to obtain answers to questions. Contracted providers cited the insufficient knowledge of PR staff to answer their questions and noted that going through this unit is time consuming. Additionally, the provider survey conducted for this audit reveals that of the 13 respondents who stated that they have a primary contact for claims, 11 of those contacts listed were not PR staff. Many of CMHB's contracted providers' questions pertain to MACSIS and billing and they are going directly to the MIS and Claims Units for answers to their questions.

In contrast, although Franklin MHB previously had a single point of contact model, it has since chosen to no longer operate in this capacity, after finding that the process was time consuming and learning that the PR staff was unable to answer MACSIS and billing questions. Franklin MHB does not have its PR specialists answer these types of questions; they are routed to the appropriate units. Furthermore, Franklin MHB has a hotline set up to route calls to Claims and Member Enrollment Units which serve as the primary contact for claims and billing issues in MACSIS (see **technology section**). Franklin MHB's contracted providers are able to call any unit to obtain answers. Franklin MHB has weekly operational meetings intended for information sharing between units.

Franklin MHB has also established customer standards that outline accountability and communication standards for its units to the PR team. The way in which units are to communicate specific information, and the sharing of reports with the provider relations team, is clearly defined. For example, client rights reports are to go to PR staff and information sharing expectations include periodic meetings, client rights site visit reports, and trends and patterns of concerns with providers. With CMHB's single point of contact model, there are significant opportunities for process breakdown if communication procedures between the PR Unit and other CMHB units are not clearly defined, documented and adhered to. Because the Unit has not been utilized as intended, contracted providers are, at their discretion, able to call any unit to resolve issues and questions. CMHB's lack of having continuity throughout units and its decentralization of provider contact can generate negative effects in the following areas if information sharing does not occur:

- Customer satisfaction;
- Uniformity of responses to inquiries;
- Communication and information sharing between units;
- Timely resolutions; and
- Data analysis of inquiries.

Consequently, a contracted provider may receive various levels of care and customer service throughout CMHB and may be getting conflicting information between units. According to the PR Unit, it was communicated to all CMHB employees in a staff meeting that the Unit would no longer be a single point of contact. However, providers interviewed during this

performance audit were not informed of this change and job descriptions in the PR Unit have not been updated to reflect this change.

R8.33 The PR Unit should not be the single point of contact for all inquiries made by contracted providers. CMHB should inform the contracted providers of this change and update job descriptions in the PR Unit to reflect this change. CMHB should design customer service standards outlining information routing protocols that will clarify the responsibilities of units regarding sending information to the PR Unit. Written guidelines and expectations for contracted provider contact with the PR Unit and other CMHB units should be developed and sent to all contracted providers. Adherence to these guidelines should be the responsibility of all CMHB staff members. Furthermore, the PR Unit should route all calls received in the Unit regarding billing and MACSIS to the claims department where individuals with expertise and access to the database can give accurate and timely answers to providers (see **technology** section). The implementation of these procedures could assist in ensuring consistent service delivery. In addition, information routing procedures can ensure that no information is omitted and that all procedures are clearly understood, agreed upon and communicated to the appropriate parties.

F8.37 The PR Unit does not consistently categorize provider inquires. When a PR specialist receives an inquiry from a contracted provider, it is categorized by each individual specialist and entered into a database. An inquiry can be categorized as urgent, high, medium, or low priority within the database. However, these priorities have not been clearly defined, which has resulted in individual interpretations as to how inquiries should be prioritized. Additionally, response times are not connected to these priorities and there is no procedure in place to inform PR specialists of what to do or who to notify when receiving one of these priorities. Priorities which are undefined and disconnected with mandated response times and protocols may result in decreased customer satisfaction and poor response times. Furthermore, uniformity in prioritizing inquires and notification and involvement of appropriate individuals, may not occur.

R8.34 The PR Unit should clearly define its contracted provider inquiry priorities to eliminate inconsistencies between PR specialists, thereby providing the appropriate attention, response and notification to issues and concerns presented. Connecting appropriate response times to these priorities should give the PR Unit a tool with which to measure goals and outcomes.

F8.38 Although this is a desired goal, the data entered into the database used for tracking provider inquiries is not being analyzed, mainly because the manager of PR has been on leave since December 2001, and no one was appointed to analyze this data in her absence. During the period of January 2001 to July 2001, the PR Unit tracked provider inquiries manually. In July of 2001, CMHB began using an Excel spreadsheet to track inquiries. This program was found not to meet the needs of the Unit. As a result, in October of 2001, Tech Excel was

purchased and customized to suit the needs of the PR Unit by MIS.

In the absence of the PR manager, PR specialists report to the acting CEO who does not have access to this database. The manager of PR is responsible for reviewing the information that PR specialists enter into the database. The lack of data analysis makes it difficult to ascertain whether the unit is functioning as intended, thereby posing the potential negative impact on customer satisfaction. Moreover, the PR Unit is unable to assess information relating to contracted providers' concerns or the need for additional training and staff resources.

R8.35 The PR Unit should establish set performance criteria and should generate reports and analyze the tracking database information on a monthly basis to facilitate monitoring of quality and satisfaction. The chief of this division should be appointed to carry out this responsibility. PR specialists should receive monthly feedback on these analyses to improve customer service satisfaction and accountability. The data can be analyzed in the following ways:

- To assess whether policy response times have been met by each provider relations specialist;
- To assess which contracted providers are having the most concerns, questions or issues;
- To assess frequently asked questions, issues, concerns;
- To assess the number of priorities received by category (urgent, high, medium, low);
- To assess the need for additional training on certain topics or issues; and
- To assess the need to devote additional staff resources to assist in resolving issues.

Developing and implementing a comprehensive set of quantitative reports can increase productivity and influence effective decision-making. The data outcomes can be used to drive change within CMHB regarding its processes (i.e., how and when priorities are responded to).

F8.39 Aside from responding to routine inquiries mentioned in **F8.37**, contracted providers do not always follow the process stated in their contracts regarding disputes. Contracted providers have been contacting the BOG directly, and the acting CEO is not always made aware of issues that have surfaced. The contract states that providers are able to contact the CEO in writing. According to the acting CEO, complaints typically are in relation to response times of the Fiscal Unit. Additionally, there are some issues that may go unresolved for long periods of times due to the involvement of an attorney. Among contracted providers interviewed, some expressed concerns about not receiving timely responses to their inquiries. While the PR Unit has some general response criteria for acknowledging receipt

of inquires within 24 hours and attempting to resolve them within five working days, the provider contracts do not state CMHB's response time to provider disputes, nor do they clarify how CMHB will respond to providers' complaints.

In contrast, Lucas MHB holds provider relations meetings with its contracted providers on a monthly basis. The purpose of the meeting is to disseminate information and respond to any concerns the contracted providers may have. The meetings are not mandatory for contracted providers, but usually there is a least one representative from each contracted provider agency. Lucas MHB's executive director and associate director of administration also attend these meetings. The other directors' attendance is not mandatory unless they have an agenda item for presentation. Furthermore, Lucas MHB allows its contracted providers to submit a "feedback loop" form. This form enables providers to ask questions and indicate the category to which they pertain (e.g., billing, information systems, clinical, finance, and client's rights). This form is routed to the appropriate units to handle and a response is given within 20 days. According to the supervisor of administrative support, Lucas MHB normally receives these forms from contracted providers around the time of contract negotiation.

The absence of clearly defined response procedures can have a negative impact on provider and BOG relations. A dispute resolution procedure outlining contact, tracking, monitoring and response information can better formalize the process thereby establishing clear expectations on behalf of all parties involved.

R8.36 CMHB should devise a formal mechanism for providers to submit disputes and hold contracted providers as well as CMHB staff accountable for adhering to it. This policy, along with a quality monitoring system (see *QI* subsection) to follow-up on open issues should outline the following:

- Who to contact;
- How inquiries will be documented;
- Who will be notified (at CMHB);
- Who will take action;
- How contracted providers will receive responses (fax, phone, email, written);
- When providers will receive responses regarding: delays, findings, and decisions; and
- How contracted providers can submit complaints for further review.

CMHB should also meet with contracted providers regularly to field questions and concerns, and to disseminate information regarding issues that can not be addressed immediately. A formalized process can be utilized to hold all involved parties accountable. This can help to ensure that all contracted providers receive adequate and timely information, responses, and resolutions in order to successfully function in partnership with CMHB and can have a

positive impact on provider-Board relations as well as customer satisfaction.

Education and Training

F8.40 CMHB has higher staffing levels dedicated to education and training than the peers and could improve its education and training operations in numerous ways (see **Table 8-9**). The Education and Training Unit at CMHB is responsible for coordinating training offered to providers. The only training directly provided by the Unit is the substance abuse and mental illness (SAMI) training. CMHB employs an Education and Training specialist and an administrative assistant within the Unit. Both report directly to the acting CEO due to the vacancy in the manager of education and training position. The duties carried out by both staff members have included coordination of training that includes the following:

- Registering participants;
- Handing out and collecting evaluations;
- Distributing continuing education unit (CEU) certificates;
- Entering training information into the computer (e.g., attendance); and
- Securing training locations.

Table 8-9 presents staffing levels as of January 2002 for CMHB and the peers.

Table 8-9: Education and Training Staffing Levels

	CMHB		Franklin	Lucas	Stark	Peer Average
	Budgeted	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Directors	0.2	0.0	.05	n/a[1]	n/a[1]	n/a
Managers	1.0	0.0	n/a[2]	n/a[2]	n/a[2]	n/a
Education and Training specialist	1.0	1.0	0.3[3]	0.3[4]	0.3[5]	0.3
Clerical Staff	0.5	0.5[6]	n/a[7]	n/a[7]	n/a[7]	n/a
Administrators to education and training staff	1:1.2	0.0	6.0	n/a	n/a	n/a
Total FTEs	2.7	1.5	0.35	0.3	0.3	0.3
Number of contracted providers	37	37	23	10	7	13.3
Contracted providers per Education and Training specialist	37:1	37:1	66:1	33:1	23:1	44:1
Consumers Served FY2001		30, 238	29, 317	13, 650	8, 209	20, 578
Consumers to Education and Training specialist	30, 238:1	30, 238:1	97, 723:1	45, 000:1	32,836:1	68, 593:1
Trainings offered FY 2001	83	83[8]	66	2	15	28
Trainings per FTE	30.7	55.3	188.6	6.6	50	93.3
Training Cost	$135,000	n/a[9]	$54,000	$2,500	$343,200	$133,233

Source: Training Budgets, Training Listings, staff interviews
[1]Lucas MHB and Stark MHB do not have directors for Education and Training.
[2]Lucas MHB and Stark MHB do not have managers of Education and Training
[3]Franklin MHB's director of training has responsibilities comparable to CMHB's Education and Training specialist (30 percent of time is devoted to education and training activities and 70 percent is devoted to provider relations).
[4]Lucas MHB director of QI has education and training responsibilities comparable to CMHB's Education and Training specialist (30 percent of time is devoted to education and training and 70 percent to QI).
[5]Stark MHB director of community relations has responsibilities comparable to CMHB's Education and Training specialist (30 percent of time is devoted to education and training activities and 70 percent is devoted to community relations).
[6]CMHB's clerical staff devotes 50 percent of time to PR Unit.
[7]Franklin MHB, Lucas MHB and Stark MHB do not have clerical staff for this unit.
[8]Trainings offered only represent trainings coordinated by Education and Training Unit and some training that occurs more than once per fiscal year.
[9]CMHB was unable to provide actually expenditures (see **finance and funding** section).

As shown in **Table 8-9,** CMHB has significantly higher education and training staffing levels than the peers. There are no managers or support personnel represented in the peers' staffing levels. Franklin MHB has been able to coordinate more training per FTE than CMHB. This could be due in part to Franklin MHB's effective use of resources to assist in the coordination of training activities (see **F8.42**). Furthermore, there is no stand-alone

Education and Training Unit for any of the peers. The Education and Training specialists have other responsibilities within the peer MHB (e.g., provider relations, community relations, QI). Franklin MHB's director of training, who has comparable responsibilities to those of CMHB's specialist, devotes 70 percent of their time to the PR Unit.

According to the education and training specialist, CMHB is moving toward only offering its CSP modules for the next fiscal year due to budget cuts. Therefore, this is the only training that has been coordinated out of the Education and Training Unit thus far for FY 2002. Thus, the Education and Training specialist's time spent on coordinating training has been significantly reduced. Although CMHB has cited insufficient staff time as a contributing factor as to why staff are not used to conduct training, this analysis shows adequate staffing levels within this Unit.

Consequently, CMHB has not effectively used its in-house resources to educate the mental health system. Additionally, technological skills and capabilities are lacking within the Unit, due to the need for computer training. As a result, other units at CMHB have had to generate reports and gather information from the computer system. In the past, the Education and Training Unit has had to rely on the QI Unit to develop, implement and analyze a training needs assessment which was conducted in 1998. Further, the Education and Training Unit appears to lack the knowledge of research and overall administrative functions needed to run the Unit. As a result, training gaps and needs may have been overlooked.

R8.37 CMHB should consider reducing staffing in this unit by 1.0 FTE, either the education and training specialist or clerical staff, and should consider eliminating the Education and Training Unit as a stand-alone unit. The remaining 0.5 FTE previously in the Education and Training Unit should be responsible for coordinating external training and should be transferred to the PR Unit. The PR Unit was established for the purposes of addressing the needs of contracted providers. Therefore, coordination of external training should also fall within its jurisdiction. With the reduction in the training needing to be coordinated out of the Education and Training Unit and the recommended increased utilization of its education and training committee (see **R8.39**), CMHB should not fill its vacant Education and Training manager position.

If CMHB reduces the education and training specialist, it should ensure that the clerical staff is adequately trained to coordinate training and perform related tasks. The PR Unit already employs a staff member with a chemical dependency certification who should be able to provide the SAMI training if the education and training specialist position is reduced. If the clerical staff position is reduced, the education and training specialist should perform the activities completed by the clerical staff position in the PR Unit, in addition to coordinating training. Furthermore, this report provides a series of actions that CMHB should consider implementing to improve the education and training function, regardless of whether or not

CMHB eliminates or maintains the Education and Training Unit.

Financial Implication: CMHB would experience an annual cost avoidance of approximately $68,000 (1.0 FTE) in salary and benefits by not filling its current vacant manager of Education and Training position. Annual cost savings of approximately $39,000 in salary and benefits can be realized by reducing the clerical position (1.0 FTEs).

F8.41 CMHB has not centralized its monitoring and tracking of training. Not all training is being tracked through the Education and Training Unit (e.g., training conducted by consumer affairs unit). Other units are tracking their own training and not relaying this information to the Education and Training Unit. Additionally, staff development training is approved by unit managers without any accountability for notifying the director of HR, where internal training has been transferred (see **human resources** section). Franklin MHB's internal and external training must all be tracked through the director of training, even though internal training and some external training does not originate in this unit. According to Franklin MHB's director of training, individuals seeking to administer internal or external training activities are required to submit information outlining the following:

- Core competencies;
- Objectives;
- Agenda; and
- Advertisement displaying the Board's logo.

There is no formal procedure in place to hold CMHB's units accountable for providing the Education and Training Unit with training information. Not centralizing the monitoring and tracking of all training impedes the ability to field questions from outside constituents regarding what, when, and where training is taking place. Additionally, decentralization impedes the ability to evaluate all trainings offered by CMHB.

R8.38 CMHB should centralize its monitoring and tracking of all training, and should develop formal procedures that hold staff accountable for this process. This centralization could improve CMHB's efforts in educating the mental health system as a whole, while increasing the accountability of other units for providing training that meets pre-existing needs. Incorporating a centralized monitoring and tracking system should enable CMHB to evaluate all of its training. Furthermore, evaluation of training can assist CMHB in the following areas:

- Validating training as a tool used to improve performance;
- Justifying costs incurred in training;
- Providing a basis for changes; and
- Helping in selecting training methods (e.g., classroom, on the job and self study

methods); and
- Ensuring training is effective and meeting needs of the system.

F8.42 Based on a review of committee meeting minutes from October 2000 to January 2002, CMHB does not maximize its use of the Education Liaison Committee. This committee is made up of contracted provider's education liaisons and CMHB's Education and Training Unit. The committee meets quarterly. In the past, the committee assisted in the development of training curriculum and trainer recommendations. According to CMHB's education and training specialist, this role changed approximately two years ago due to curricula already being established. Due to the change in their role, the education liaisons are currently only charged with relaying information back to their place of employment and making training suggestions. In contrast, Franklin MHB has established a Training Advisory Committee that is collaboration between the director of training, and contracted providers' staff that includes executive directors, training specialist and clinical staff. Franklin's committee assists the director of training in the following areas regarding training issues:

- Planning;
- Securing trainers;
- Writing learning objectives;
- Preparing agendas;
- Determining core competencies;
- Securing resumes of trainers; and
- Determining where events will be held.

The underutilization of this committee may impede the Education and Training Unit's ability to determine future training needs of the mental health system and to obtain expert opinions on learning objectives. In addition, CMHB's failure to use this committee in decision-making, may inhibit committee members' acceptance of decisions made by the Education and Training committee.

R8.39 CMHB should re-evaluate its use of its Education Liaison Committee in order to fully ascertain how it can be used or reorganized to better meet the training needs of the mental health system. The committee could function in a capacity similar to Franklin MHB's Training advisory committee. The committee should be inclusive of a variety of contracted provider staff in order to fulfill the needs of the system as a whole. The participation of these individuals can reinforce provider buy in and provide an additional benefit of having experts in the field assist in establishing training based on best practices.

F8.43 The Education and Training Unit does not track contracted providers' requests for training. However, the Unit does track currently offered training that it coordinates. According to the administrative assistant and education and training specialist, when a call comes with a

request for training, individuals are referred to existing training offered by the Education and Training Unit. If there is no established training to refer them to, individuals are referred to United Way's First Call for Help, which is a social service referral system. According to the education and training specialist, the United Way can direct individuals to organizations that offer services on the training topic requested. Without tracking requested training, it becomes difficult for the Education and Training Unit to determine commonality, need, and priority of training.

R8.40 CMHB should begin tracking requested training. This can be accomplished through the use of a spread sheet. Furthermore, CMHB should establish strong partnerships with contracted providers and consumers, working with them to identify existing or emerging issues that may require training-based attention and solutions. This may be accomplished through the increased use of the Education Liaison Committee (see **F8.42** and **R8.39**). Additionally, CMHB should ensure that training content and delivery methods address identified needs and reflect the latest thinking regarding effective training techniques. A key requisite for the achievement of both objectives is the continual infusion of new, improved and or updated training information and techniques. CMHB should establish a process for suggesting new topics or courses and ensuring that these suggestions are evaluated for merit. Establishing this process can assist CMHB in formulating a prioritized list of new training programs and initiatives to meet training needs.

F8.44 The Education and Training Unit has no existing criteria to select trainers. According to the Education and Training Unit, it researches the system and community to select trainers. In contrast, Franklin MHB is planning to take bids for its training spots. Three bids are to be taken into consideration by a small group consisting of the director of training and the unit that deals with the training topic, to fill trainer vacancies. A determination is made within seven days. Key elements taken into consideration are the type of training, the trainers' credentials, and the total cost of training. According to the Education and Training specialist, trainers were selected based on recommendations from CMHB staff and contracted providers. Because the Unit has not set criteria for trainers, it is difficult to ascertain whether CMHB has obtained the best individual and price for its training.

R8.41 CMHB should develop criteria for the selection of trainers. The criteria can include the type of training needed, trainers' credentials and the total cost for training. In addition, CMHB should engage in the following practices in order to obtain the best qualified and cost-effective trainers.

- Solicit bids for services;
- Observe the trainers in action;
- Speak with someone who has seen them teach; and
- Obtain references.

Developing criteria and soliciting bids for services should help prevent CMHB from contracting with inappropriate or incompetent trainers that could potentially compromise a well planned training program.

F8.45 CMHB has not sought to effectively utilize its own staff to educate the mental health system. Much of CMHB's CSP training is conducted by contracted presenters who are paid a flat rate per hour. CMHB is contracting with seven trainers who each conduct 3.5 hours of training and one trainer who conducts 2.5 hours of training each fall and spring. All contracted presenters receive the same compensation regardless of credentials. These trainings have curricula that have already been developed. In addition, CMHB has used seven of its employees to conduct modules in CSP training. The Alcohol and Drug Addiction Services Board (ADASB) also employs contracted presenters. In contrast to CMHB, the trainers are paid on a formal sliding scale basis, which relates to the trainer's experience, background and credentials. Additionally, Stark MHB has formulated a speakers' bureau of individuals who may be called upon to conduct its trainings. This bureau is comprised of both Stark MHB staff and contracted provider staff (see **external affairs** section). In preparation for training, seeking out qualified Stark MHB staff is the first priority.

The acting CEO and BOG have stated that using CMHB staff has been considered before and it was determined that having staff conduct training would result in too much time being taken away from their current regular duties. However, the staffing analyses in this report show that for the amount of productivity occurring within units, CMHB has higher staffing levels in comparison to the peers. The failure of CMHB to effectively utilize its own staff to educate contracted providers and the individuals they serve, could inflate CMHB's education and training budget and limit staff development.

R8.42 CMHB should ascertain whether it employs a qualified individual among its own staff to conduct specific training before seeking paid presenters. In the event that there is no CMHB staff qualified to conduct the training, CMHB should seek not only to recruit individuals with expertise in specific training subjects, but also pay presenters according to experience, background and credentials. Doing so can assist CMHB in minimizing training costs while still providing quality training. Additionally, using CMHB employees to conduct training should promote staff development.

Financial Implication: Based on a flat rate of $75.00 dollars per hour, paid for eight trainers conducting a combined total of 54 hours of CSP training for FY2001, CMHB could potentially experience a cost savings of approximately $4,000 per fiscal year, if it utilized its own staff to conduct CSP training.

F8.46 The Education and Training Unit has not effectively measured the impact and effectiveness

of training. The current evaluation technique used by the Education and Training Unit falls short of evaluating the transfer of knowledge gained through delivering the core curriculum in the field. In the report, "A review of the Education and Training Activities," prepared by the Education and Training Unit and presented to the BOG, a recommendation was made that new evaluation techniques be developed which focus on the transfer of knowledge. The report suggests that this can be achieved by obtaining data related to on the job behavior changes for those individuals that have been trained.

Currently, the Education and Training Unit has not acted on its own recommendation to measure transfer of knowledge. Evaluation forms are given to students at the end of each training session in order to obtain feedback. According to the education and training specialist, hard copies of evaluations results are kept on file. The scores are calculated and an average is produced. Evaluations are also mailed to the trainers. Franklin MHB compiles its statistical responses into charts that display evaluation responses of a particular training over time, which is not performed at CMHB. These responses are then distributed to units associated with the type of training offered. For example, if there is cultural competency training, the staff members that deal with cultural competency receive the training results.

Lucas MHB measures transfer of knowledge for a Crisis Intervention (CIT) training. Three months after the end of the first training, a second evaluation is sent to students (police officers). The intent is to determine the perception of the officers regarding the value of the training to their routine police duties. The results were used to influence changes in the CIT curriculum for the 2nd class. In addition, Stark MHB is beginning to measure transfer of knowledge for documentation training. A sample of the students' progress notes before the training is obtained to evaluate them. Six months after the training, Stark MHB is expecting to take another sample of those same students' progress notes to measure transfer of knowledge.

Although, CMHB's education and training specialist has attributed limited activities within the Unit to a need for additional staffing, the staffing analysis in this report shows that the Education and Training Unit has high staffing levels compared to the peers (see **F8.40**). Additionally, other factors impacting progress may be attributed to the absence of administrative leadership for the Unit and CMHB not requiring a research background for the Education and Training specialist position. Not connecting objectives with outcomes prevents CMHB from meeting the overall objective of an evaluation, which is to confirm or revise solution options, to revise training strategies, and to determine if organizational goals are met.

R8.43 CMHB should seek to expand upon its current evaluation technique by collecting both subjective and objective data from a number of sources, to more effectively evaluate the impact and effectiveness of the over all training program. This will require that the CMHB

follow up with participants, contracted providers, and other units within CMHB to obtain information related to transfer of knowledge. Furthermore, follow-up with training participants could serve to effectively measure training impact and effectiveness, thereby giving CMHB the ability to justify the continuation or modification of specific training. According to Dr. John Sullivan, College of Business at San Francisco State University, the following measures should be used to measure training effectiveness and impact:

Prior to training

- The number of people requesting training during the needs assessment process
- The number of people that sign up for training

At the end of training

- The number of people that attend the session
- Customer satisfaction (attendee) at the end of training
- A measurable change in knowledge or skill at the end of training (pre-test/post-test)
- Ability to solve a "mock" problem at the end of training
- Willingness to try or intent to use the skill/ knowledge at end of training

Delayed Impact (non-job)

- Customer satisfaction at X week after the end of training
- Retention of knowledge at X weeks after the end of training
- Ability to solve a "mock" problem at X weeks after the end of training
- Willingness to try (or intent to use) the skill/knowledge at X weeks after the end of the training

On the job behavior change

- Trained individuals that self-report that they changed their behavior/ used the skill or knowledge on the job after the training (within X months)

- Trained individuals who's managers report that they changed their behavior/ used the skill or knowledge on the job after training (within X months)
- Trained individuals that actually are observed to change their behavior/ use the skill or knowledge on the job after training (within X months)

On the job performance change

- Trained individuals that self-report that their actual job performance changed as a

result of their changed behavior/ skill (within X months)

- Trained individuals who's manager's report that their actual job performance changed as a result of their changed behavior/skill (within X months)
- Trained individuals who's managers report that their job performance changed (as a result of their changed behavior/skill) either through improved performance appraisal scores or specific notations about the training on the performance appraisal form (within X months)
- Trained individuals that have observable/ measurable (i.e., quality) improvement in their actual job performance as a result of their changed behavior/skill (within X months)
- The performance of employees that are managed by individuals that went through the training
- Departmental performance with X percent of employees that went through training

Other Measures

- Top management knowledge of/approval of/ or satisfaction with the training program
- Rank of training seminar by managers of what factors contributed most to productivity improvement
- Popularity (attendance or ranking) of the program compared to others

Additionally, CMHB should begin to maintain its evaluation response statistics in a spreadsheet format. This will allow CMHB to quickly obtain and produce reports that display evaluation ratings for a particular training over time.

F8.47 Since 1998, CMHB has offered community support program (CSP) training for its contracted providers. CMHB's CSP training consists of 14 modules. These modules are designed to be taken in sequential fashion and are targeted to CSP workers with less than two years of experience. The curriculum for the training was developed to support the unique role of CSP workers who need to be knowledgeable in a wide array of topics. The courses address topics identified in previous ODMH certification standards as content area for required continuing education. Each module has learning objectives that identify concepts which are considered to be key elements to the effective practice of community support work.

There are no OAC, ORC, or ODMH standards that require CMHB to provide this training. Although, only one of the peers (Stark MHB) has begun to conduct CSP training, the peers have provided the following reasons in support of the importance of offering CSP training:

- Agencies implement services very differently;
- Turnover for CSP staff is high (training must be continual);

- The mental health system delivers a high volume of service;
- Best practices will be kept in the forefront; and
- Staff licenses need to be maintained.

CMHB has actively sought to develop its own CSP curriculum in order to provide CSP workers with the tools needed to service the hard to serve. As a result of this training, CSP workers may be better equipped to effectively perform job responsibilities.

C8.4 Having designated CSP training for direct service staff indicates that CMHB is devoted to supporting an area of employment that historically has a high percentage of turnover. These trainings provide needed support to direct service workers in meeting the needs of a challenging population that has many needs. In addition, the Education and Training Unit indicated that Stark MHB contacted the Unit for information about its CSP training.

F8.48 CMHB has no training that mandates contracted providers' attendance. CMHB has eliminated language from its contracts with contracted providers that required CSP workers with less than two years of experience to attend this training. As a result training is now optional. According to the acting CEO, contracted providers expressed concerns about having to provide coverage at the agency for staff attending training. Furthermore, the frequency (weekly) with which training occurred may also have contributed to contracted providers reluctance in sending staff members to the training. For the Fall cycle, the training runs from September to December. The CSP modules for the spring cycle begin in February and end in May. A CSP module is conducted approximately every week and the majority of the trainings are half day sessions. Furthermore, contracted providers were unable to bill for staff time spent in training.

According to the three-year review report submitted to BOG by the Education and Training Unit, there has been poor attendance at CMHB's CSP training for contracted providers. The report stated that there is high turnover rate at contracted providers for CSP positions and workers may not be completing all 14 modules of the training. However, a training needs assessment conducted in March 2001 reveals that out of 27 responses from providers, the majority (17) were in favor of continuing CMHB's CSP core training.

As part of its provider contract requirements, Franklin MHB has included language that obligates providers to attend training determined to be mandatory. Mandatory training notices are sent to providers as they arise. Franklin MHB's mandatory trainings have included:

- Budget training;
- Agency Service Plans;
- Client's Rights;
- MACSIS; and

- Outcomes.

Without CSP training, contracted providers may have workers delivering mental health services at various skill levels, and who may not have had any formal training in their current positions.

R8.44 CMHB should consider re-establishing its CSP training (14 modules) as a mandatory training and including the requirement in its contracts with contracted providers. Additionally, CMHB should inform providers in advance which training is mandatory. CMHB should also re-evaluate its training schedule to better accommodate the needs of contracted providers. In determining whether other training should be considered mandatory, CMBH should take into account the following:

- Frequently asked questions/concerns by providers;
- System-wide problems found during audits;
- Training needs;
- Changes in standards;
- Outcomes;
- Best practices;
- Consumer grievances;
- Billing and reporting errors; and
- Consumer interests.

The increasing complexity of the work environment and mental health system requires continuing development of competencies and upgrading of knowledge and skills. In addition, changes in external regulations, policies, procedures and practices can create risk and liabilities which require the delivery of consistent, timely and essential information to contracted providers. Establishing mandatory training can assist CMHB in creating a continuity of learning and understanding across contracted providers, and can also have a positive impact in the following areas:

- Contracted providers' overall performance in their day to day operations;
- Consumer satisfaction;
- Provider accountability; and
- Quality of service.

F8.49 External trainings offered by CMHB lack a key component of training to address co-occurring disorders and chemical dependency. Although, CMHB does offer substance abuse and mental illness (SAMI) training as part of its CSP modules, this was the only chemical dependency training offered for FY 2001. In early, 2001 the Ohio Mental Health Commission published "Changing Lives: Ohio's Action Agenda for Mental Health," a

comprehensive plan to meet the needs of people with mental illness. Within the report, the Commission recommended that "The mental health and recovery services systems at the state and local level should work together to provide fully integrated services to people with co-occurring disorders." Furthermore, a December 2001 draft of a consultant's report "Both Sides of the Bridge" outlines measures to achieve this goal. The report states that within the service system funded by the public sector, more than 9,800 adults receive substance abuse treatment in any given year. More than 17,000 adults receive mental health services.

According to "Both Sides of the Bridge," applying national trends to the statistics for substance abuse treatment suggests that between 4,900 and 5,100 of the individuals receiving services in any given year in each of these systems is struggling with a diagnosable level of co-occurring mental illness and substance abuse. In addition,, the report recommends that because of the need to equip direct care staff with the skills required to assist complex consumers with multiple problems, CMHB and the Alcohol and Drug Addition Services Board should develop a cross-system "training bank" to address both mental illness and co-occurring substance abuse disorders (SAMI/COD) at the provider agency level. Agencies participating in the training bank would have the opportunity to send their staff to training at other agencies in return for welcoming other agency staff at their trainings being offered in-house.

Although CMHB solicited the assistance of consultants to meet this objective, CMHB currently does not collaborate with the Alcohol and Drug Addiction Services Board of Cuyahoga County (ADASBCC) in efforts to conduct cross training between systems. CMHB's lack of action on this recommendation may, in part, be attributed to the recent departures in key administrative positions throughout its various units. Consequently, the ability of both systems to effectively service consumers with co-occurring disorders may be diminished.

R8.45 In order to progress towards providing fully integrated services to individuals with co-occurring disorders, CMHB should seek to provide additional chemical dependency training to its providers, consumers, and systems with similar needs. Additionally, CMHB should continue to explore the recommendations outlined in "Both Sides of the Bridge," to determine feasibility and urgency of offering the training and participating in collaborative cross training efforts. To address this need, CMHB should utilize the following strategies:

- Have expert employees serve as instructors in classroom training provided onsite (see **R8.42**);
- Write or utilize pre-existing training manuals or create training videos that can be used repeatedly; and
- Provide training in conjunction with other agencies with similar training needs.

F8.50 CMHB does not distribute annual training calendars to its providers, consumers and general public detailing all training it will be conducting or sponsoring. Training schedules are disseminated by the Education and Training Unit according to the fall or spring schedule to educational liaisons of providers at their quarterly meetings with CMHB and are also mailed directly to contracted providers. The training advertised includes only training originated by the Education and Training Unit. As stated previously, not all CMHB training is tracked and monitored by the Unit (see **F8.41**). The failure to provide advance notice of all upcoming trainings can have a negative impact participant attendance. In comparison, Franklin MHB supplies contracted providers and other potential participants with semiannual calendars of all system-wide training events as well as announcements of upcoming trainings yet to be scheduled.

R8.46 CMHB should create a training calendar for upcoming years that lists all planned training offered by CMHB. Making potential participants aware of all of the year's training events in advance can potentially increase enrollment and encourage suggestions for future training and collaborations with other systems.

Utilization Review

F8.51 The Utilization Review (UR) Unit consists of a UR specialist (1.0 FTE) who is a registered nurse with mental health experience. The UR specialist is the contact person for clinical information at CMHB and works closely with the chief clinical officer (CCO). Other duties for utilization review include the following:

- Review individuals involuntarily hospitalized;
- Work with contracted nurses to complete probate court assessments; and
- Work with contracted attorneys to monitor inpatient care.

UR functions at peer MHBs are similar in that they oversee state hospital usage and crisis services. **Table 8-10** illustrates staffing in UR compared to peer MHBs.

Table 8-10: Utilization Review Staffing Levels FY 2001

	CMHB		Franklin	Lucas	Stark	Peer Average
	Budgeted	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
Number of Directors	0.20	0.00	0.05	0.00	0.10	0.05
Number of Chief Clinical Officers (CCO)	1.00	0.00	1.00	0.00	0.80	0.60
Number of Specialist (FTEs)	2.00	1.00	1.00	0.10[1]	0.30[2]	0.50
Number of Administrative Assistants	0.70	0.70	0.10	0.00	0.00	0.03
Total Clinical Staff	3.90	1.70	2.15	0.10	1.20	1.18
Number of Admissions	1,339	1,339	434	200	316	317
Number of Planned Bed Days	47,400	47,400	23,725	8,489	11,315	14,510
Number of Admissions per UR staff	343	787	202	2,000	263	269
Number of planned bed days used per UR staff	12,154	27,882	11,035	84,890	9,429	12,297

Source: Organization charts, interviews, and ODMH DataMart website

[1] UR duties are conducted by the adult program director using five percent of their time.

[2] UR duties are conducted by the QI specialist with equal amount of time for both.

As indicated in **Table 8-10**, CMHB has the highest number of bed days and admissions per budgeted UR staff as compared to Franklin and Stark MHBs. If CMHB better controlled bed days and inpatient care similar to peers, it could reduce workload in UR to be more comparable to Franklin and Stark MHBs (see **F8.52** and **R8.48**). **Table 8-10** illustrates that CMHB has a higher number of administrative FTEs as compared to Franklin MHB, which is similar in size to CMHB. Having more administrative help could allow the CCO and UR specialist at CMHB to focus more on clinical and quality of care issues.

In addition, the CCOs at Franklin and Stark MHBs play an integral role in determining the quality of care by providing clinical oversight for all divisions. This allows the UR staff at Franklin and Stark MHBs to conduct additional duties such as QI and administrative activities. As previously stated, from fall 2001 to spring 2002, the CCO position was vacant at CMHB and it had not benefited from such a resource, which could contribute the higher use of bed days compared to peer MHBs (see **Table 8-12**). Higher bed days and admissions to inpatient care not only increases the UR specialist's workload, but also the administrative assistant's workload, which includes maintaining an emergency commitment database. It also results in an increase in hearing and journal entries. In addition, the majority of assessments for consumers entering state hospitals involuntarily are done by contracted nurses at CMHB, and the administrative assistant in UR schedules the assessments. In contrast, Franklin MHB has a centralized intake system, which uses a single provider to conduct all assessments; and Lucas and Stark MHBs use a centralized crisis services agency to conduct assessments for consumers entering the state hospital system (**F8.60** and **R8.55**).

R8.47 Based on the strategies available to reduce bed days and admissions to state hospitals and the

larger amount of clerical assistance available to CMHB's UR Unit as compared to peers, CMHB should consider not filling the vacant UR specialist position. The newly hired CCO should take the lead in developing strategies to address the high use of bed days and high state hospital admissions (see **F8.52** and **R8.48**), with a goal of providing more effective services to consumers and reducing workload for the UR Unit.

Financial Implications: Not hiring the vacant UR specialist position would result in a cost avoidance of approximately $58,600 annually in salaries and benefits.

F8.52 According to ORC §340.03, MHBs are responsible for monitoring County consumers hospitalized in state hospitals while contracted providers are responsible for determining whether or not to admit consumers to state hospitals. During the second quarter of FY 2002, CMHB began focusing on reducing bed day use in state hospitals (**F8.54**). However, at that time CMHB had exceeded the budgeted number of bed days for the fiscal year. **Table 8-11** identifies the average length of stay for CMHB and peer MHB consumers.

Table 8-11: FY 2001 Average Length of Stay

Days	Cuyahoga	Franklin	Lucas	Stark	Summit	Peer Average
0-7 Days	476	44	23	102	11	45
8-14 Days	317	59	28	79	16	46
15-30 Days	256	120	50	79	26	69
31-90 Days	128	126	76	45	51	75
91-180 Days	37	39	25	5	6	19
181-365 Days	37	18	9	2	7	9
366-730 Days	19	12	6	4	14	9
731-1,095 Days	7	4	0	1	2	2
1,096-1,461 Days	1	4	0	0	2	2
1,462-1,825 Days	2	0	0	0	0	0
1,826+ Days	11	4	1	1	2	2
Total	1,291	430	218	318	137	278

Source: ODMH Patient Care System
Note: This data is based on consumers discharged in FY2001, so this will not reconcile with the actual number of admissions in FY 2001 (see **Table 8-12** and **8-13**).

According to **Table 8-11**, CMHB hospitalizations have a strong concentration of consumers in the zero to seven, and the eight to fourteen days categories while the peer average concentrations are in the 15-30 and 31-90 days categories. This suggests that a significant number of CMHB's consumers with a length of stay of zero to seven and eight to fourteen days categories may not need to be admitted to hospital care if provided with effective up-front services to divert them from inpatient care.

Table 8-12 details CMHB's bed day use compared to peer MHBs and the associated percent

of total consumers.

Table 8-12: Bed Day Usage for FY 2001

	CMHB	Franklin	Lucas	Stark	Summit	Peer Average
County Population	1,393,845	1,068,978	455,054	378,098	542,899	611,257
Total Consumers	30,238	29,317	13,650	8,209	11,600	15,694
Percent of Total Population	2.2%	2.7%	3.0%	2.2%	2.1%	2.6%
Inpatient Admissions	1,339	434	200	316	124	269
Percent of Total Consumers	4.4%	1.5%	1.5%	3.8%	1.1%	1.7%

Source: DataMart Web Site January 6, 2001

As illustrated by **Table 8-12**, CMHB currently serves a lower percentage of the total County population. However, approximately two percent more consumers in Cuyahoga County are admitted to state hospitals for care compared to peer counties. This suggests that CMHB may not monitor the mental health system sufficiently to control bed day usage.

Table 8-13 illustrates CMHB and the peers' admissions to state hospitals according to the legal status of voluntary, civil commitment, and other categories which includes sanity evaluations and incompetent to stand trial/unrestorable (ISTU).

Table 8-13: FY 2001 State Hospital Admissions

Type	CMHB		Franklin		Lucas		Stark		Peer Average	
Voluntary	32	2.4%	7	1.6%	0	0.0%	2	0.5%	3	0.9%
Emergency Commitments	1,029	77.1%	260	60.7%	106	57.3%	353	90.5%	240	71.7%
Other	273	20.5%	161	37.6%	79	42.7%	35	9.0%	92	27.4%
Total Number of Admissions	1,334		428		185		390		335	
Total Average Number of Consumers Served FY 2000 and FY 2001	30,238		29,317		13,650		8,209		17,059	
Total Number of Consumers per Admission	23		68		74		21		51	

Source: ODMH Patient Care System and Datamart Website
Note: Does not include "not guilty by reason of insanity" because mental health boards are not responsible for these individuals.

According to **Table 8-13**, CMHB admits approximately four times more emergency commitments than the peer average, and 10 times more voluntary admissions than the peer average. In Cuyahoga County, 1 in 23 consumers were admitted to a state hospital in FY 2001, as compared to the peer average of 1 in 51. In addition, based on $15,801,948 bed day costs in FY 2001, the average cost per admission at CMHB is $11,845, which is four times higher than the average cost per consumer for all other services of $2,601 (see **finance and funding**).

The high use of inpatient care at CMHB suggests that much attention should be given to the effectiveness of the processes for determining service delivery. Several factors could contribute to the high use of bed days and inpatient care at CMHB, including the following:

- Lack of effective utilization of central intake or managed care system for all publicly funded mental health services (**F8.60** and **R8.55**);
- Absence of a standardized process for determining level of care (**F8.53** and **R8.49**);
- Inadequate access to alternative community-based services (**F8.57**, **F8.58** and **R8.53**);
- Lack of access to private hospital beds (**F8.56** and **R8.52**);
- Need for the utilization of effective treatment planning (**F8.55** and **R8.51**);
- Absence of upfront discharge planning for hospitalized consumers (**F8.55** and **R8.51**); and
- Need for outcome measures to determine the overall quality of mental health services (**F8.23** and **R8.20**).

Other explanations for the high use of inpatient care at CMHB could be the lack of coordination between CMHB, contracted providers, the state hospitals, and other County agencies screening consumers to provide the least restrictive care alternatives. The large variance between CMHB and peer MHBs inpatient care targets systematic processes that could potentially allow consumers to "fall between the cracks" and experience a crisis situation which results in hospitalization.

R8.48 CMHB should implement strategies outlined throughout this section of the report (**R8.49**, **R8.51**, **R8.52**, **R8.53**, **R8.55**) to hold contracted providers fully accountable for admitting consumers to state hospitals and ultimately divert consumers from state hospitals to other appropriate services. Moreover, CMHB should closely monitor each factor contributing to the unusually high need for bed days and identify processes for improvement. Implementation of process improvements could potentially yield the following benefits:

- Reduced bed day utilization;
- Improved management and monitoring of units of service per consumer (see **finance and funding** section);
- Reduced costs for public funded mental health services (see **finance and funding** section);
- Increased quality of services provided for Cuyahoga County (**F8.22**); and
- Increased accountability for the public mental health system (**F8.22**).

Focusing on maximizing the benefits of these factors could potentially reduce bed day use to a level comparable to peer MHBs. If CMHB reduced admissions to the peer average of 1.7, 825 consumers would be diverted to other services within the community, resulting in a savings of approximately $9.7 million in bed day costs based on the bed day cost per admission of $11,845. Assuming that each consumer would require other services and based on the average cost per consumer of $2,601 for other services, CMHB would incur costs of approximately $2.1 million annually to address their service needs. As a result, CMHB

would experience annual cost savings of approximately $7.6 million by diverting 825 consumers from inpatient care to other services. If CMHB reduced the total number of admissions similar to Stark MHB's percentage of 3.8 percent of total consumers (diverting 190 consumers from inpatient care), CMHB would experience annual savings in bed day costs of approximately $2.2 million and would incur about $494,000 in other service costs. Therefore, CMHB would save approximately $1.7 million annually by reducing its percentage of total consumers admitted to that of Stark MHB.

In addition, CMHB could experience additional cost savings while ensuring that consumers are provided with effective services by diverting some of these consumers to private hospitals (see **F8.56** and **R8.52**) because the average cost per consumer for these services is less than $2,601. Furthermore, additional cost savings could be realized by diverting some consumers from inpatient care to ACT services because the cost per consumer, per day is lower for ACT services (see **F8.58** and **R8.53**).

Financial Implications: If CMHB could reduce the percentage of admissions similar to Stark MHB, it could experience annual cost savings of approximately $1.7 million. However, costs savings would be significantly greater if CMHB reduced its percentage of admissions to be more comparable to Franklin, Lucas and Summit MHBs.

F8.53 CMHB has not established criteria regarding the level of care for consumers receiving public funded mental health services. The absence of a chief clinical officer caused CMHB to lack clinical expertise necessary to ensure the appropriateness of services (**F8.2**). The Ohio Association of County Behavioral Health Authorities (OACBHA), formerly the Metropolitan Behavioral Health Network, has developed a level of care manual to strengthen the public behavioral healthcare system's capacity for managing publicly funded services and bring consistent managed care tools to the provider community.

While Franklin and Lucas MHBs were participants in the pilot group for implementing the manual, Montgomery MHB has fully implemented the manual, along with a standardized assessment tool for assessments completed by a centralized intake contract provider. Upon receipt of the assessment results, the assessor would use protocols identified in the manual to determine what level of care the consumer should receive and identify the most appropriate contracted provider to deliver the needed services. The use of the same tool at intake provides verification for the assessment to guarantee the level of care is appropriate. Results are based on the same criteria and capture the same recommendation from the time of the assessment to the start of services (if there is a delay in the start of services) and would provide consistency in determining level of care. Also, all consumers are assessed the same way with identical criteria and procedures. By doing so, Montgomery MHB's contract providers are able to better manage units of services and avoid providing inappropriate services and unnecessary inpatient care. Admitting only one percent of total consumers

suggests that only the consumers severely in need are admitted for state hospital care.

Additionally, the CCOs at Franklin, Stark, and Summit MHBs actively work with mental health professionals throughout their respective counties to assist and sometimes facilitate the treatment planning process. This could potentially be a cause for the lower number of admissions to state hospitals.

R8.49 CMHB should consider implementing the Metropolitan Behavioral Health Network level of care manual and a standardized assessment tool compatible with ODMH's standards. These tools should be used by staff at the contracted providers to ensure all consumers are assessed using the same criteria when determining the appropriate levels of care. Their use should ultimately improve the management of units of service per consumer (see **finance and funding** section) and reduce the number of consumers needing to enter state hospitals (**R8.48**). CMHB should require current contracted providers to use such a tool as a starting point when assessing consumers to enhance the diagnostic process. Furthermore, since a chief clinical officer has been hired, attention should be given to both the level of care manual and standardized assessment tool to ensure its applicability to services in Cuyahoga County and to ensure a thorough understanding of its purpose and administration. Routinely evaluating the applicability of the tools and reinforcing the purpose and process for using them would maintain a desired level of validity for CMHB, contract providers, and the consumers.

F8.54 CMHB has used an increased number of bed days for inpatient care since FY 2001. In attempts to reduce the number of bed days, CMHB has developed a work group to examine the causes for excessive bed day utilization in state hospitals and identify and implement alternatives to reduce the future need for hospitalization. The work group members include a variety of CMHB and contracted provider staff to examine the bed use problem from many perspectives. The workgroup has conducted an analysis of current bed day use, projections for future use, the needs of hospitalized consumers upon discharge, the use of wrap around funding for community services, the impact of forensic consumers, and the action steps needed to resolve identified problems. As a result of the work group efforts, CMHB has supported the discharge of 238 consumers from hospital care into community services.

Further examination of bed day use could include an assessment of resources such as contracted provider staff and the availability of services. Lack of such vital resources makes it difficult to keep consumers out of the state hospitals and functioning in the community. The time contract providers spend in the community servicing consumers in their natural environment makes a difference in consumer participation in recommended services. CMHB has made efforts to connect all consumers released from one local public hospital to intensive services, but if the consumer becomes homeless shortly after discharge, locating

them makes it difficult to follow through with recommended treatment. However, the requirements of being a community service provider necessitate the community support program (CSP) worker meeting with consumers in the community and CMHB holding contracted providers more accountable for providing services to consumers in their environment (see **R8.51**).

According to a bed day utilization report, the number of bed days has decreased since the work group began working with contract providers to comply with contract requirements and providing wrap-around funding to assist consumers. Other identified mechanisms for reducing bed day usage include the following:

- Increase the number of residential beds in the community providing 24 hour clinical supervision outside of the hospital;
- Provide supportive housing in the community;
- Assist consumers with obtaining and keeping entitlements which provide the opportunity to go to private hospitals;
- Collaborate with the drug board to treat consumers with dual diagnoses; and
- Mandate treatment for chemical dependency and mental health issues through a court order or a change in the law.

C8.5 CMHB's efforts to reduce bed day use by forming a bed day work group have succeeded in discharging consumers from hospital care and reducing the cost to CMHB for hospital care. The group has also identified target areas to further reduce bed day use for County consumers. Such accomplishments demonstrate CMHB's understanding of the financial constraints and the need to serve consumers in the least restrictive setting.

R8.50 Although CMHB has been effective in appropriately discharging consumers from hospital care into community services, continued attention should to be given to the bed day issue. In addition to reviewing recommendations contained in this report, CMHB should examine the possibility of using alternative services, ensure contracted provider staff are conducting activities to actively get consumers out of hospital care, and identify ways to increase residential care in the communities. Conducting these activities will allow CMHB to manage bed day use in a proactive manner, heading off problematic situations before they get out of control.

F8.55 The current contracts require contracted providers to coordinate with state hospital staff to ensure consumers are prepared for discharge when clinically approved. This process includes coordination between contract provider staff, the hospital social worker, and the psychiatrist. At the Franklin MHB, each contract provider must have staff representation for consumer treatment meetings at the state hospitals to play an active role in the care of the

consumer and prepare for the consumer's discharge. The UR specialist at Franklin MHB monitors the contract provider staff participation during the 30-day review of inpatient consumers. CMHB's Unified Service Agreement (USA) also requires that contracted providers work with state hospitals. The USA requires contracted providers and state hospital staff to agree to work together in helping restore hospitalized consumers to an optimal level of functioning and to return the consumer to the community in the shortest possible time. The USA includes requirements for the immediate involvement of the CSP worker in the following areas:

- Maintaining continuous communication with the consumer and hospital treatment team;
- Attending the initial and subsequent treatment team meetings to share and receive relevant information, advocate the consumer's needs, and take an active role in the discharge planning;
- Making contact with consumer soon after they learn about the admission;
- Meeting with hospitalized consumers at least once a week for those in acute care setting and at least once a month for those in extended acute care;
- Documenting meetings with the consumer and treatment team in the contract provider's consumer file;
- Working with the treatment team and family members to assist the consumer in developing a realistic discharge plan, locating a safe and decent home, and providing appropriate support services and a timely re-entry into the community; and
- Making appropriate psychiatric nurses and other therapist appointments prior to the consumer's discharge to ensure timely follow-up.

Although all parties to the agreement signed the document, this intervention does not occur on a consistent basis. According to interviews with CMHB staff, the agency has not enforced agreed upon requirements which has resulted in a lapse of services for the consumer, the increased potential of a psychiatric episode, and ultimately, re-hospitalization. According to the ODMH Northeast Ohio Director, some MHBs share the cost of bed day expenses with contract providers using contract negotiations to create incentives to keep consumers out of the hospital. For example, Franklin MHB charges a portion of the per diem to the contracted provider responsible for the hospitalized consumer for the first 180 days and the total per diem each day after. Therefore, contracted providers would be encouraged to actively work with hospital staff regarding the care of consumers to ensure a timely recovery. Likewise, contracted providers would be encouraged to comply with contract expectations if CMHB actively negotiated contract provisions to increase contracted provider accountability.

R8.51 CMHB should continue to work with contract providers to reduce bed day use. This could be done by enforcing contractual and USA requirements to ensure contract providers visit consumers in the hospital regularly to determine if the level of functioning has improved and

to prepare for their discharge. CMHB's UR specialist, with collaboration from the CCO (**F8.2**), should also conduct regular reviews of consumer case notes and treatment plans at the state hospital. Review of the consumers' treatment plans and case notes on a regular basis should determine if consumer care is monitored during hospitalization and ensure a smooth transition back into the community. Collaboration with hospital staff should also occur regularly to identify which contracted providers are complying with contract requirements to monitor consumers' in-patient care.

In addition, CMHB should consider charging the contracted providers for a portion of the per diem hospital rate, similar to Franklin MHB, to place more accountability on providers for placing consumers in hospitals. Enforcing contractual and USA requirements, closely monitoring the quality of care through reviews and contract provider staff participation in hospital treatment planning, and charging providers for a portion of hospital costs would potentially reduce the number of consumers hospitalized for inappropriate reasons and reduce the bed day use, reserving that option for consumers in extreme need of care.

F8.56 CMHB does not contract with private hospitals for the care of uninsured mental health consumers. Other counties have used contracts with private hospitals to divert clients from the state hospitals and reduce bed day costs. For example, Franklin MHB has a $350,000 contract with The Ohio State University for use of hospital beds and Montgomery MHB has a $500,000 contract with private hospitals. The provisions of the contracts allow the MHBs to send consumers to private hospitals in lieu of state hospitals to keep short-term treatment costs down while reserving state bed days for consumers who require extended intensive care. MHBs have also used private contracts to keep daily bed day usage within allocation. For example, Franklin MHB's UR specialist reviews the state hospital daily census report to determine if private beds are needed to maintain state allocated bed days. This helps Franklin MHB to avoid having to pay ODMH additional funds for excessive bed day use, which has occurred for the last few years at CMHB. **Table 8-14** presents the number of consumers admitted to private hospitals at Franklin and Montgomery MHBs in FY 2001.

Table 8-14: Private Hospital Admissions in FY 2001

	Franklin	Montgomery
Total Cost of Contract	$350,000	$500,000
Number of Private Hospital Admissions	178	396
Average Cost per Consumer	$1,966	$1,262
Average Length of Stay (Days)	8	7
Average Cost per Consumer, per Day	$245.75	$180.29

Source: Franklin and Montgomery MHBs

As indicated in **Table 8-14**, the average cost per consumer admitted in private hospitals at Franklin and Montgomery MHBs was $1,966 and $1,262 respectively, which is significantly

lower than the average cost per consumer in state hospitals (see **F8.52**). In addition, the cost per consumer, per day for state hospitals ($327) is higher than the private hospitals at Franklin and Montgomery MHBs. Further, the average cost per consumer in private hospitals at Franklin and Montgomery MHBs is less than CMHB's average cost per consumer of $2,601 for all other services (see **F8.52**). As a result, CMHB could save additional costs by diverting consumers from state hospitals to private hospitals.

R8.52 CMHB should seek contracts with local private hospitals and residential facilities in an effort to reduce the number of short-term consumers receiving help in State hospitals and ultimately reduce CMHB's bed day deficit. The use of contracts with private hospitals in other Ohio Counties has diverted most of the short-term consumers from the State hospitals, allowing for a cost savings when estimating the need for bed days at the beginning of the fiscal year and a cost avoidance at the end of the fiscal year because the private hospital contract provides alternatives for state hospitalization. Reducing CMHB's state hospital admissions by the number of consumers whose length of stay was less than two weeks would save CMHB funding for use on a private contract or diversion services (**R8.48**), and provide consumers with more community oriented services. The financial impact of diverting consumers from state hospitals to private hospitals is included in **R8.48**.

F8.57 Cuyahoga County has a total of eight intensive case management programs that follow the Program of Assertive Community Treatment (ACT) model and are monitored by the UR specialist. One of the ACT teams is funded through a contract with CMHB and the others bill CMHB for Medicaid services. All ACT teams in Cuyahoga County follow the evidence-based Wisconsin model and submit reports to the UR specialist on a monthly basis, identifying assignment and census data. CMHB has provided funding for ACT team members to attend training to enhance the performance of the teams and provide better services for consumers. The UR specialist and the ACT teams have manuals to provide guidance on ACT services for consumers. ACT is a highly structured, multi-disciplinary program of intensive treatment, rehabilitation and support services to clients in their homes, on the job and in social settings. Research has shown that use of ACT will result in decreased hospitalization, shorter lengths of stay, increased employment, less severe symptoms, and more positive social relationships. Additional benefits include the following:

- Enhances the quality of life by allowing the consumer to function in the community;
- Provides an alternative to service delivery, and a remedy for accessing services;
- Provides a manual to guide the clinicians through service delivery and the outcomes should be demonstrated in objective reliable measures;
- Emphasizes family psycho-education, supported employment, skills training in illness self-management, and integrated treatment for substance abuse and mental illness; and

- Keeps consumers involved in some form of treatment and ultimately reduces hospital use for consumers by about 60 percent.

However, program standards, including staff mix and qualifications, minimum staff-to-client ratios, treatment protocols and program operations must be well specified and monitored. Studies have proven ACT to be a best practice for community services and literature is available that could assist in improving the current program and identify funding opportunities to expand service availability. For example, ACT's multi-disciplinary team of nurses, social workers, psychiatrist, and the low consumer to staff ratio, allowing for the intensive case management for consumers, has yielded positive or neutral results. However, at least one ACT provider has not had a psychiatrist for a long period of time. The role of each professional on the ACT team is key to producing desired outcomes and because ACT programs are successful in reducing hospitalization, it plays a key role in Cuyahoga's mental health system.

Stark MHB has a team that is similar to the ACT philosophy and follows the Dartmouth, New Hampshire model for the Substance Abusing Mentally Ill (SAMI) intensive services while Lucas MHB ACT teams are modeled after the original ACT team from Wisconsin. Franklin MHB has also established ACT teams, focusing only on children's services.

C8.6 The establishment of eight ACT teams in the County is a good start to providing effective services for consumers and has potentially prevented the re-hospitalization of participating consumers. Additionally, CMHB's commitment to providing continuing education to ACT teams continually improves the quality of the ACT services and enhances the knowledge base of ACT service providers.

F8.58 CMHB does not have a provider contract for seven of the ACT teams. As a result, Medicaid reimbursements and provider funds pay for ACT services. Under Medicaid, ACT is usually funded under rehabilitation and targeted case management categories. Considering the multitude of benefits provided by ACT programs, CMHB could reallocate funding to initiate a contract for additional ACT teams by diverting consumers from inpatient care. The cost per consumer, per day of the one ACT contract at CMHB in FY 2001 was $78.13, which is significantly less than the cost per consumer, per day at state hospitals of $327. Consequently, CMHB could experience cost savings by increasing intensive services provided to consumers instead of admitting these consumers to state hospitals, which would assist CMHB in reducing the number of bed days used.

R8.53 CMHB should review the literature regarding ACT as a best practice for community services and assist ACT providers in implementing fully-staffed ACT teams. Furthermore, CMHB should continue to ensure ACT providers and pertinent CMHB staff receive quality continuing education for ACT services to enhance service delivery for consumers. Because

ACT is an evidence-based best practice for reducing hospitalization, CMHB should explore opportunities to increase the number of ACT teams in the County. When developing ACT contracts, CMHB should pay specific attention to the language regarding outcomes, quality assurance, consumer rights, and benefits. Increasing the number of ACT teams for CMHB could potentially reduce the number of consumers receiving inpatient care at state hospitals and ultimately reduce CMHB's bed day expenditures for reallocation to ACT services. The financial impact of diverting consumers from state hospitals to receive ACT services is included in **R8.48**.

F8.59 Currently, Cuyahoga County does not utilize involuntary outpatient commitments (IOC) as an alternative to hospitalization. IOCs are court orders from Probate Court, mandating consumers to attend outpatient treatment. In theory, consumers involuntarily committed to the hospital who are released prior to end of commitment could be considered IOC when attending services at a contracted agency upon discharge. Non-compliance with treatment plans could result in re-hospitalization after another court hearing. This is highly opposed in Cuyahoga County by civil rights attorneys and the National Alliance for the Mentally Ill (NAMI) as a violation to the consumer's civil rights. According to the UR specialist, a Probate Court judge would agree to IOC under stringent monitoring and intensive services, such as with ACT teams, to ensure the consumer would receive needed services for functioning in the community.

Summit MHB effectively operates an IOC program where consumers may be released from the state hospitals and mandated to attend treatment in the community. Consumers have the right to refuse this service. However, in order to be re-admitted to the hospital, they have to meet the involuntary admit criteria (a danger to self or others). If they no longer meet the criteria for involuntary commitment, the contract provider could only monitor the consumer closely. In order to request an IOC, a court hearing is scheduled and the consumer has to be eligible for release from hospital care but risky enough to merit an IOC status. Once an IOC is granted, the contact provider serving the consumer has to send Summit MHB progress reports every 30 days. If a problem arises, the parties have to go back to court and prove the consumer should be committed again.

R8.54 CMHB should consider using an ACT team to provide consumers an IOC option for involuntary commitments. As illustrated in **Table 8-13**, CMHB has 23 percent more emergency commitments than the peer average. When used appropriately with close monitoring and intensive service delivery, as with an ACT team, IOC assists in a step down approach for stabilizing a consumer in the community. The ACT team staff should be 100 percent dedicated to the consumers, ensuring they are not re-hospitalized. CMHB, Probate Court, and consumer advocacy groups should develop a method for ensuring staff follow through with treatment recommendations, making decisions with the input/expertise and experience of all team members, including physicians, to produce desired outcomes. By

doing so, CMHB could move consumers out of public hospitals while continuing to provide them with intensive services which would potentially reduce the likelihood of the consumer re-entering the public hospital system.

F8.60 Although all are funded through CMHB, each contracted provider operates assessment services according to criteria established by the administration of that agency. As stated in **F8.53**, CMHB does not identify criteria for assessing the need for and level of care for consumers. Additionally, access to the crisis services was designed to go through the Mobile Crisis team only in order for CMHB to approve funding. However, according to CMHB's documents of service referral by type, these services are accessed by consumers through various avenues such as police departments, private hospitals, County agencies, and family members. This uncontrolled access is the result of the lack of collaboration between contracted providers, County and local agencies, and CMHB as well as the failure to establish a centralized or managed care system for mental health services.

Without a centralized intake or managed care process, consumers could potentially get lost in the system until hospitalization is needed. Lucas and Stark MHBs organized a central intake system for crisis services while Franklin, Hamilton, and Summit MHBs have established systems where one agency serves as the first point of contact for all mental health services. These agencies do not provide mental health services to consumers but provide assessments, treatment recommendations, crisis stabilization and referrals to accomplish those recommendations for consumers in the County.

R8.55 CMHB should consider establishing a centralized intake or managed care system (see **finance and funding** section) to provide assessments and referrals to services for all consumers accessing publicly funded mental health services. Processes should be implemented to ensure collaboration with other public agencies, consumers and consumer family members for the determination of the appropriate level of care for each consumer as well as to maximize the use of the many services provided throughout Cuyahoga County. By providing a centralized intake or managed care system, CMHB would be able to closely monitor and quickly correct systematic problems of providing quality care for consumers participating in non-applicable treatment programs.

Financial Implications Summary

The following chart represents a summary of the annual cost savings, cost avoidances and implementation costs discussed in this section. For purposes of this table, only recommendations with quantifiable financial impacts are listed.

Summary of Financial Implications for PRQS Division

Recommendation		Cost Avoidance (Annual)	Cost Savings (Annual)
R8.29	Consider reducing 1.0 FTE PR manager and 1.0 FTE PR specialist positions.		$125,900
R8.37	Consider reducing 1.0 education and training staff and do not fill vacant manager of education and training.	$68,000	$39,000
R8.42	Use CMHB staff to conduct CSP training		$4,000
R8.47	Consider not filling the vacant UR specialist position	$58,600	
R8.48	Reduce bed days and admissions to state hospitals		$1,700,000
	Total	**$126,600**	**$1,868,900**

Conclusion Statement

The units within PRQS have traditionally functioned autonomously with very little communication between units, which could impact its level of operational effectiveness. Contributing factors could be the current vacancy in the chief position and the fact that some of these units do not share many common job functions and/or minimally impact other units' operations. Therefore, CHMB should consider reorganizing PRQS's current structure to foster linkages and communication. Based on peer comparisons and job functions, CMHB should consider combining planning and system development, quality improvement, utilization review and auditing, under one division; and combining provider relations with education and training. For a full assessment of chief staffing levels, see the **organization, compliance and board governance** section.

The Auditing Unit is processing a significantly higher number of billings per FTE when compared to the peer average, which indicates that it is minimizing resources and maximizing output. However, the Auditing Unit should reassess its staffing levels due to recent changes in auditing rules that will impact the number of billings sampled by all mental health boards. In addition, CMHB should assess whether its current level of non-Medicaid sampling is justified by conducting a trend analysis of audits to ascertain whether contracted providers have traditionally held non-Medicaid claims to the same standards as Medicaid claims. Reducing or increasing sampling of non-Medicaid claims can affect workloads, thereby contributing to decisions concerning staffing levels for the auditing unit. To further enhance the auditing process, the Auditing Unit at CMHB should be proactive in its efforts to reduce the number of non-compliant billings submitted by contracted providers, restructure its documentation training to target specific areas of non-compliance, formulate protocols to monitor plans of correction, and make clinical best practice a primary focus.

Due to an absence of leadership, clear operating procedures, communication and information sharing between units, and analysis and use of data, the PR Unit has not effectively functioned in its intended role to be the central contact point for contracted providers' questions and inquiries. CMHB needs to implement measures, such as developing contracted provider accountability standards, resolving contracted provider problems in a timely manner, monitoring contract requirements, developing and monitoring response times and developing internal procedures so that all CMHB staff understand the process required to resolve contracted providers' issues. Doing so would ensure that the PR Unit functions as intended and improve CMHB's level of customer service and satisfaction. Further, CMHB should consider reducing staffing levels in the PR Unit by 2.0 FTEs, which would not impact the Unit's ability to implement improvements and function effectively.

Considering that none of the peers have a stand alone Education and Training Unit, other resources available to coordinate trainings (e.g., committees) and the job functions and responsibilities of this Unit (i.e., only coordination of training), CMHB should consider eliminating the Education and

Training Unit (2.5 budgeted FTEs) and transferring its coordination of external training to the PR Unit. The PR Unit was established for the purpose of addressing the needs of contracted providers and should include coordination of external training. In addition, although CMHB offers CSP training for its contracted providers, CMHB and contracted providers could benefit from additional trainings offered with a focus on co-occurring disorders with chemical dependency.

Although certain peers have developed processes to measure outcomes on a system-wide basis, the QI Unit at CMHB does not actively research, maintain or use performance measures or outcomes to monitor Cuyahoga County's mental health system. In addition, only 22 of 38 contracted providers are participating in the Consumer Outcomes System Project at CMHB, which is intended to assist mental health boards in collecting and monitoring outcomes. CMHB should develop a process to establish and monitor outcome measures and stipulate the measures in the agreements with contracted providers. Requiring its contracted providers to participate in the Consumer Outcomes System Project would help in collecting and monitoring outcomes. The MSPA could also be used more effectively by CMHB as a guide to monitor critical system-wide outcomes including consumer access to services. Collecting and monitoring outcomes would ensure that consumers are providing with quality and effective services. Further, the QI Unit should enhance the MUI process by establishing criteria for opening and closing cases, sharing information with other staff and units at CMHB and developing a memorandum of understanding with other county agencies involved in the MUI process.

CMHB uses a significantly higher amount of bed days and inpatient care as compared to peers, which are very costly to the County and may not serve as the most appropriate means of effectively treating consumers. To address the high use of bed days and inpatient care, CMHB should implement a standard process for contracted providers to determine levels of care, increase access to alternative community-based services, and enforce contractual and USA requirements to ensure contract providers visit consumers and effectively prepare for their discharge. CMHB should also consider charging the contracted providers for a portion of the per diem hospital rate, similar to Franklin MHB, to place more accountability on providers for placing consumers in hospitals. Implementing a centralized intake or managed care system could also help to control bed days while ensuring that consumers are referred to more appropriate services.

External Affairs

Background

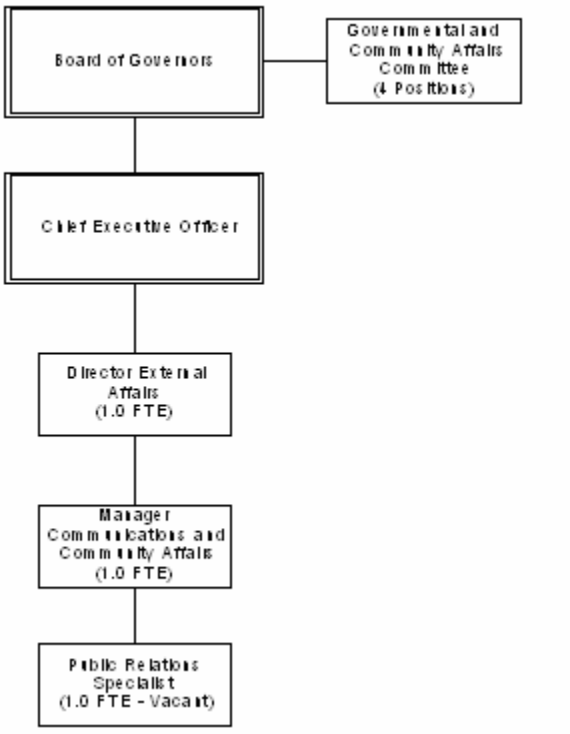
This section of the performance audit focuses on the External Affairs Division (Division) of the Cuyahoga County Community Mental Health Board (CMHB). For the purpose of illustrating various operational issues, comparisons are made throughout the report with peer mental health boards in Franklin, Stark and Lucas counties.

The External Affairs Division is responsible for planning and directing all external and internal communication activities which promote and establish support for mental health issues in the County.

Organizational Chart

Chart 9-1 provides an overview of the organizational structure and staffing levels for the Division as of January 2002.

Chart 9-1: External Affairs Division



As shown in **Chart 9-1**, the Division consists of an external affairs director, communications and community affairs manager and a public relations specialist position, which is currently vacant. The director reports to the chief executive officer (CEO) whose position was recently filled in July 2002. In addition, the Governmental and Community Affairs Committee of the Board of Governors (BOG) provides input into the Division's activities. This committee was established in 1998 to increase community awareness and to influence parity legislation for mental illness.

Organization Function

The Division is responsible for all CMHB communications. The primary responsibilities of the Division include the following:

- Media Relations;
- Special Events;
- Public Contact;
- Legislative Affairs;
- Mailing Lists;
- Advertising;
- Photography;
- Board of Governors (BOG) correspondence planning;
- Logo contract compliance; and
- Design and publication of CMHB's service directory, annual report and newsletter.

Summary of Operations

The Division is responsible for the planning and implementation of a communication plan that provides direction to external and internal communication strategies designed to address CMHB's stakeholders and their information needs. Also, the Division engages in a variety of activities and produces a number of items, such as leaflets and pamphlets, to ensure CMHB meets its objective to increase the public's understanding of mental illness and, particularly, CMHB's role in promoting mental health services throughout the County.

Staffing Comparison

Table 9-1 provides a comparison of staffing for the Division and the peer boards.

Table 9-1: Peer External Affairs Staffing Analysis

	CMHB		Franklin MHB	Lucas MHB	Stark MHB	Peer Average
	Budgeted	Actual				
Director	1.0	1.0	1.0	0.0	1.0	0.7
Manager	1.0	1.0	1.0	0.5	0.0	0.5
Public Relations Specialist or Administrative Assistant	1.0 [1]	0.0	1.0	0.0	0.0	0.3 [2]
Total	3.0	2.0	3.0	0.5	1.0	1.5

Source: CMHB, Stark, Lucas and Franklin Mental Health Boards

[1] The public relations specialist position which provides administrative support to the Division has been vacant since 1999 and is considered frozen.

[2] Of the three peers, only Franklin MHB currently employs an administrative assistant.

As shown in **Table 9-1,** the External Affairs Divisions at CMHB and the peers are relatively small. The public relations specialist position at CMHB has been vacant since June 1999 and is currently considered frozen. See **F9.1** for further discussion and analysis of staffing.

Performance Measures

The following performance measures were used to analyze the External Affairs Division of the Cuyahoga County Community Mental Health Board:

- Determine appropriateness of structure, staffing levels and responsibilities
- Assess the adequacy of the governmental affairs plan and activities to inform and educate local, State and Federal legislators
- Review CMHB's development and measurement of the community outreach plan and related activities
- Assess the effectiveness of the media relations plan and activities to promote the mission, operations and accomplishments of CMHB
- Assess the adequacy of interagency relationships to build an effective network for service delivery

Findings/ Commendations/ Recommendations

Staffing

F9.1 The assumed roles of Division staff do not reflect the responsibilities defined by formal job descriptions and do not serve as the most effective use of the experience and expertise typically expected of director and manager positions. Furthermore, the director of external affairs and the manager of communications and community affairs overlap in assumed duties and some activities reflect those normally performed by lower level positions. Some functions assigned to the manager are performed by the director such as writing press releases and providing agencies with flyers and alerts.

According to the job description for the manager of communications and community affairs, the position is responsible for the following:

- Plans and implements the communication strategy, including internal and external programs, media relations and publications;
- Directs the development, production and distribution of agency publications, including the annual report, newsletters, brochures, advertisements, flyers and audio and video productions;
- Serves as the chief writer of publications, advertisements, public service announcements, speeches and news releases;
- Develops an effective and active media relations program with local, State and national media with special focus on media covering mental health services and issues; and
- Plans and implements the community affairs strategy which includes serving as liaison with key stakeholders in the mental health community and opinion makers, and coordinating special events and community meetings.

In practice, the manager attends community awareness events such as health fairs as a representative of CMHB. In addition, the manager is the secondary spokesperson for CMHB, after the Division director, and is responsible for writing and providing follow-up for news releases. The manager's primary responsibility, however, involves the development of a "pitch calendar," which is a predetermined schedule of public service announcements or news releases.

According to the written job description for the Division director, the position is responsible for the following activities:

- Develops and implements strategic communication plan;
- Develops and evaluates annual goals;
- Represents CMHB at State and local meetings;
- Manages campaigns to support funding;
- Plans and directs mental health forums;
- Plans and directs neighborhood meetings;
- Ensures development of media relations;
- Promotes internal communication; and
- Builds community awareness.

Of the above mentioned responsibilities, the director has developed a communication plan and participates in State and local meetings. In addition, the director creates the newsletters and the annual report using "Page Maker" software. The director stated "in-house design is more economical and quicker than outsourcing." However, a newsletter has not been published since 1999 and the next publication date is slated for September 2002 (see **F9.15** for further discussion regarding publications). The creation of the newsletter and annual report are not reflective of a director position and are outlined in the job description for the manager of communication and community affairs. According to a memo from CMHB dated July 10, 2002, the director is assigned the tasks of creating newsletters and annual reports because the manager does not have the necessary experience working with PageMaker. According to the community affairs director of Stark MHB, a very small percentage of her time is spent creating printed materials. A much larger percentage of her time, however, is spent providing training, coordinating speaker's bureau engagements and maintaining legislative relationships. Because the duties performed by Division staff do not necessarily reflect formal responsibilities in accordance with job descriptions, Division staff risk duplicating assumed duties and performing tasks atypical of particular skill sets. This may also hinder the director's ability to effectively manage the Division and to steer internal and external communications.

R9.1 CMHB should review the job descriptions and assumed roles of the director and manager of the Division to ensure the most effective and efficient use of their experience and expertise. The Division director should be expected to complete the responsibilities assigned to that position. Some of the responsibilities assumed by the director should be delegated to the manager, such as newsletter development, press releases and legislative updates.

To fulfill the responsibilities established by the job description for the manager of communications and community affairs position, the manager should be encouraged to

attend a PageMaker publication software course. Cuyahoga County offers tuition reimbursement for career enhancement. Courses in PageMaker are often offered at local colleges, such as Cleveland State University, as a two day session at a cost of approximately $300. This would allow the Division director to fully plan and direct comprehensive external and internal communication strategies and programs. During the course of the audit, the manager of communications and community affairs attended a PageMaker course and is beginning to gain experience by assisting the Division director in developing the newsletter (see **F9.15**).

F9.2 **Table 9-2** illustrates the populations of Cuyahoga and the peer counties as well as the population served by external affairs staff. Since external affairs activities are directed to the community at large, County population rather than mental health consumer population statistics are used in the following peer comparison.

Table 9-2: External Affairs and Peer Staffing Analysis

	CMHB	Franklin MHB	Lucas MHB	Stark MHB	Peer Average
County Population	1,393,978	1,068,978	455,054	378,098	634,043
External Affairs Staff	2.0 [1]	3.0	0.5	1.0	1.5
Population per External Affairs FTE	696,989	356,326	910,108	378,098	422,695

Source: 1998 Governmental Unit Population Estimates by County by Ohio Department of Development

[1] Currently, CMHB has 2 employees in the Division. The public relations specialist position has been vacant since 1999 and is considered frozen.

Although current Division staffing levels are above the peer average, CMHB external affairs staff serves a significantly larger population per FTE than the peer average. Currently, each Division FTE serves approximately 700,000 County residents, which is nearly 65 percent more than the peer average. Furthermore, if the public relations specialist position was filled, increasing the Division's staffing level to three FTEs, CMHB's external affairs staff would still serve a slightly larger population per FTE than the peer average.

The Alcohol and Drug Addiction Services Board of Cuyahoga County (ADAS Board) serves the same community as CMHB and coordinates external affairs functions under the public information and training division with two FTEs. The ADAS Board has 30 employees, 54 contracted providers and provided treatment to approximately 11,000 consumers in 2001. In comparison, CMHB has 59 employees, 37 contracted providers and coordinates services to approximately 30,000 consumers.

Based on population served per Division FTE and the ADAS Board's number of staff involved in external affairs activities, CMHB's External Affairs Division appears appropriately staffed.

F9.3 With the exception of some interagency and consumer affairs activities, all internal and external communications for CMHB are managed and coordinated through the External Affairs Division. Additionally, the director of external affairs reports directly to the chief executive officer (CEO), as opposed to reporting to a division chief. This reporting structure mirrors that of Hamilton MHB, which is comparable in size to CMHB (see the **organization, compliance and board governance** section).

Conversely, at Franklin MHB, external affairs functions are performed in two separate divisions. The Communications Division is solely concerned with media and publications, while the Community and Organization Affairs Division is responsible for organization development, human resources, housing and community relations. The community relations function involves liaison work with locally-elected officials, community members, contracted providers, consumers and constituents. The two divisions collaborate on their public affairs action items.

Although much smaller in size but similar to CMHB, Stark and Lucas MHBs' external affairs activities are organizationally consolidated. This structure allows for increased accountability and control over agency communications. Furthermore, requiring the director of external affairs to report directly to the CEO ensures internal and external communications are in line with the organizational vision of the BOG and agency management.

C9.1 Because external and internal communications are managed and coordinated through one division which reports directly to the CEO, CMHB reduces the risk of miscommunication and increases its control and accountability in this area. Also, CMHB is better positioned to ensure consistent communications are disseminated to the community at large.

Governmental Affairs

F9.4 A communication plan has been developed internally by the Division; however, the plan lacks quantifiable measurements to gauge the success of the Division's activities. Although, the communication plan is actually a strategic plan for communications, the communication plan does not tie into a broader document that addresses the entire organization because CMHB does not have a strategic plan. See the **organization, compliance and board governance** and **planning and system development** sections for a discussion of organizational strategic planning. The final communication plan was adopted by the Governmental and Community Affairs Committee on April 8, 2002, after

nine months in the drafting process to reflect input of the committee (see **F9.5** for further discussion of the Governmental and Community Affairs Committee).

The plan identifies 6 priority stakeholders with 13 key messages regarding CMHB's performance. Twenty-six strategies have also been developed to deliver the key messages, and specific responsibilities have been assigned to Division staff to implement the plan. Although the plan states the responsibilities are measurable, a means of measurement is not identified.

Measurement has been defined as the act of collecting data that will be used to support decision-making. Measurement for a process is important for the following reasons:

- Measurement provides focus, direction and common understanding. Good measures establish the operational definitions, determine the focus of attention and underscore areas for improvement.
- Measurement ensures feedback on improvement efforts. Improvement requires data to evaluate the difference between current conditions and the desired future position.
- Data and measurement create a common language to communicate problems, progress, results, and accomplishments. The specificity of numbers creates a scoreboard that everyone can understand.

According to the Institute of Public Relations (IPR), *Guidelines for Setting Measurable Public Relations Objectives*, short-term objectives are the immediate effects of communication on the public, while long-term objectives affect the relationship with the public. According to IPR, a measurable objective must meet the following guidelines:

1. Specify a desired outcome (increase awareness, improve relationships, build preference, adopt an attitude, etc...)

2. Directly specify one or several target audiences (legislators, consumers, providers, etc…).

3. Be measurable, both conceptually and practically (increased awareness based on surveys and/or focus groups).

4. Refer to ends, not means. If your objective outlines a means to do something, (often prefaced by the words 'leverage' or 'use'), you have a strategy, not an objective.

5. Include a time frame in which the objective is to be achieved.

The IPR guidelines also define outputs and outcomes. According to IPR, outputs represent what is readily apparent to the eye (e.g., agency publications). Outputs measure how well an organization presents itself to others, the amount of attention or exposure the

organization receives. Outcomes measure whether target audience groups actually receive the messages directed at them, paid attention to the messages, understood the messages, and retained those messages in any shape or form. Outcomes also measure whether the communications materials and messages that were circulated have resulted in any opinion, attitude and/or behavior changes on the part of the targeted audiences.

R9.2 The communication plan should be re-evaluated using best practices identified by the IPR to provide quantifiable measurements to gauge the success of the Division's activities. Because the plan is currently being implemented, the Division should consider incorporating IPR best practices into the next communication plan. Properly developed and managed, a communication plan that incorporates accurately identified and targeted audiences and stakeholders, clear objectives, performance measurement and a monitoring system could offer important support for CMHB's mission.

When reviewing the communication plan the following items should be incorporated:

- The objectives of the communication plan should be specific, measurable and realistic. Proper attention to program evaluation can help ensure objectives are realistic. Measurement could be achieved through a number of methods such as surveys, questionnaires, focus groups and media content counts.

- Objectives should be identified as short-term or long-term. The plan should also provide for the measurement of outcomes and outputs.

- The objectives should be evaluated for appropriateness and should include provisions for the measurement of success.

Furthermore, because all plans are dynamic, a periodic review of the plan itself should be established to ensure the relevance of all its elements. The communication plan should also reflect the goals and objectives of CMHB's strategic plan for the entire organization, once developed. During the course of the audit, the Division director indicated that press coverage was beginning to be tracked and monitored.

F9.5 The Division's communication plan does not identify or prioritize all of CMHB's stakeholder groups, namely CMHB employees or the community at large. Furthermore, the communication plan only identifies six priority stakeholders, with no one stakeholder given greater priority over another. According to the plan, stakeholders are identified as groups which offer the greatest opportunity to assist CMHB in achieving the communication plan's mission. The following groups have been identified by the Division's communication plan as stakeholders for CMHB:

- Funders;

- Consumers and family members;
- Elected officials;
- Socially active faith-based organizations;
- Media; and
- Providers.

According to IPR, if a public affairs department is to be effective, it must engage in continuous scanning of stakeholders and potential stakeholders. As a result, the department can establish a base of knowledge about stakeholders, making it possible to provide valuable information to strategic decision-makers about the consequences of organizational decisions. Stakeholders should also be identified and classified as active, passive, and latent. By establishing a prioritized order for its stakeholders, CMHB could establish how its resources and efforts can best be directed.

According to IPR, strategic public relations consist of the following:

- Identifying the most strategic stakeholders with which an organization needs to develop a relationship;
- Planning, implementing, and evaluating communication programs to build relationships with these stakeholders; and
- Measuring and evaluating the long-term relationships between the organization and these strategic stakeholders.

The community at large, as well as CMHB employees are not listed as stakeholders. By omitting employees as stakeholders in the communication plan, CMHB may overlook the impact of unfavorable news coverage on employee morale. The content of local media coverage and the lack of formal internal communication was a strong theme identified in the AOS survey of CMHB employees (see **human resources** for a further discussion of the AOS employee survey). In addition, by not soliciting input from employees in the development of the communication plan, CMHB may forego valuable insight concerning CMHB's mission to serve the public.

By omitting the community at large as a stakeholder, the plan may not incorporate the opinions of those not directly involved in the mental health system. However, these individuals may vote and may be genuinely concerned with the community's mental health system. Including the community at large as a stakeholder and soliciting citizen input will allow CMHB to better fulfill the communication plan's mission "to position mental health as a permanent and priority civic issue in Cuyahoga County."

R9.3 The next communication plan should be modified to reflect the re-evaluation and prioritization of stakeholders. Stakeholder groups should be identified as groups or individuals who have something to gain from the process. All stakeholder groups should be identified and their relationships with CMHB analyzed. The community at large and employees should be considered potential stakeholders when scanning the environment. Inclusion in the stakeholder identification and prioritization process would validate the groups' influence on CMHB. Because not all stakeholders can be addressed with the same quality or amount of attention, all identified stakeholders should be prioritized as active, passive or latent. Such prioritization can help guide resource allocation and steer communication efforts which positively impact the mental health system.

F9.6 CMHB entered into a contract with an outside consultant to "augment and strengthen CMHB's efforts to improve its public image," especially as it related to the dismissal of the former executive director. However, the solutions offered by the contract do not clearly address this controversy. In addition, the communication policy that was developed and recommended pursuant to the contract was not manageable, measurable or specific.

A contract for "Coalition Building" was awarded to betpin & associates [sic] on October 1, 2001. The proposal submitted by beptin & associates states it will outline a strategy and process to deal with the issue related to the dismissal of the former executive director, as well as outline a process to educate and communicate with public officials and community representatives in regard to CMHB's policy. The consultant sought to establish an external policy that is manageable and specific, and offered the following solutions:

- Develop a plan to educate the community and public officials about the goals, objectives and problems that CMHB is experiencing. Financing needs of CMHB will be emphasized.
- Arrange meetings with public officials, community representatives, and clients.
- Establish a time and location for a broad based community meeting to heighten awareness and develop support for CMHB.
- Interview key community representatives and public officials, if necessary, on an individual basis with the purpose being to educate them about the agency and its challenges.
- Arrange subsequent meetings with community representatives and public officials to get their input and ideas.
- Prepare an agenda for a broad based community meeting to make a presentation in regard to the agency, answer questions, gain understanding and support.
- Create a process and environment for the clients, employees and community to feel a part of the organization that will make them feel valued and take ownership.

- Identify media representation that will support the agency's cause and publicize the importance of community support and help educate the community to the need and importance of the job that CMHB does.
- Assist in the training and development of the CMHB staff with emphasis on the importance of making a commitment to the organization.
- Assist in the analyzing and evaluation of this effort after 120 days.

CMHB did not define the deliverables but rather, allowed the consultant to define them. The following items represent some deficiencies evident in the contract and the contract monitoring process:

- The goals of the contract were written in such a manner that prevented adequate monitoring by CMHB for compliance and/or completion. The goals lacked details, measurements and time frames. An example of a non-specific goal of the contract is, "Arrange meetings with public officials, community representatives, and clients."

- The betpin & associates contract required a survey of community members. The survey was not technical in its development or administration. The 15 respondents, and organizations they represented, were not an accurate representation of the entire community. Also, partnerships with other organizations already in place were ignored, although this information was provided to betpin & associates before the onset of the project.

- The study listed goals that were not objectives for CMHB. Through a review of the proposal and final report, it appears betpin & associates was unclear as to the purpose of CMHB and the manner in which service is provided. This is evidenced by the following statement found in the proposal, "CMHB as a part of the Cleveland community whose goal is to provide quality services which include: early diagnosis and intervention with infants and families, physical and occupational therapy ...retirement programs for seniors." Numerous references were made to "services that CMHB provides," although CMHB does not provide any services directly, but only through the providers it monitors and supports.

- betpin & associates was paid $24,000 for a three-month period and the contract was finalized before all conditions of contract were satisfied. One of the items promised by the contract, that was not completed, was to "assist in the training and development of the CMHB staff with emphasis on the importance of making a commitment to the organization."

Although the betpin & associates contract presented its final report at the February 12, 2002 meeting of BOG's Governmental and Community Affairs Committee, no arrangements have been made to incorporate the findings of the study into the internal communication plan.

It appears that the betpin & associates contract fell short of CMHB's communication needs and accomplished little toward "outlining a strategy and process to deal with the issue (dismissal of the previous CEO), as well as outline a process to educate and communicate with public officials and community representatives in regard to the board's policy." The proposal also addressed the need to establish an external policy that is "manageable and specific" but did not establish such a policy. A successfully executed contract may have eliminated the need for an internally-created communication plan. Furthermore, CMHB does not have any plans to implement or coordinate any of the findings and conclusions of betpin & associates into the communication plan.

In addition, CMHB did not follow the County's "Policies for the Purchase or Lease of Supplies, Equipment, Construction, Services, Office supplies and Insurance." According to the policies, procurements of services that are more than $15,000 must satisfy several requirements, two of which are listed below:

- Proposals must be submitted on a completed requisition to the County Purchasing Division. The requisition must be signed by the department/division head or authorized designee to indicate that the funds are appropriated for this purpose; and

- All requisitions over $15,000 must be advertised as required by law and follow the County's RFP process.

No documentation was available to provide assurance that either requirement was met for the retention of betpin & associates (see **finance and funding** for a further discussion of purchasing).

R9.4 CMHB should use the request for proposal (RFP) process as outlined in the County's purchasing policy when the need for outside consultants is identified. The process should also include contracts for which the dollar value may be below the standard threshold for RFPs. A standard process would ensure CMHB receives the services for which it contracted and paid. The contract review process should ascertain that the contract terms contain specific language and measurable results that address or satisfy CMHB's needs. Furthermore, when contracts are issued that impact the Division, the external affairs director should be included in the contract review process to provide further assurance that the terms of contracts are met before final payment is made. See also **risk management and consumer affairs**.

F9.7 The Governmental and Community Affairs Committee does not have a committee charter to describe its purpose, establish goals and define its relationship with the External Affairs Division. The Governmental and Community Affairs Committee began in 1998 in an effort to increase awareness and provide input on legislation that addresses health care parity for mental illness. The legislative updates and other activities performed by the Division now satisfy that need. The assumed role of the Governmental and Community Affairs Committee to oversee and advise the Division may hinder the performance of everyday activities and the ability of the Division to move forward. For example, the first draft of the communication plan was written on June 29, 2001. The plan was adopted on April 8, 2002, after frequent revisions submitted by committee members. The amount of time devoted to the development of the communication plan hampered the Division's ability to take substantive action prescribed by the plan or make progress on other projects, such as website development and newsletter publications.

The State of Ohio has established the Ohio Office of Quality Services (OQS) and the Quality through Services Partnership (QStP) to transform State government into an organization where all employees work together to continuously improve how work is performed and ultimately provide value for tax dollars. According to OQS, a team, committee or task force charter should include the following:

- Background information on the assignment and why it is a high priority;
- A clear definition of the assignment in terms of what is to be accomplished, the project scope and team boundaries and limits, such as budgets; and
- A clear indication of whether the group is empowered to plan and implement the solutions or simply provide recommendations.

Measurement, as mentioned throughout this section, is an essential element of any process or process change. Measurement prevents "rushed" conclusions based on assumptions. The charter of any committee or task force should include measurement to assess the current situation, define the goals, and provide assessment of accomplishments.

R9.5 The Governmental and Community Affairs Committee should adopt a charter which describes the role and responsibilities of the committee and defines the relationship with external affairs staff and BOG. Clear guidelines should provide the limits of authority for the committee and Division staff. The charter should also define the time frame for committee accomplishments, and establish the means by which progress is measured. The task force concept, discussed further in the **organization, compliance and board governance** section, would provide a more relevant and timely method for addressing issues that impact the Division. With clearly-defined roles outlined in a charter,

committee members and Division staff would be better able to work collaboratively to improve CMHB's internal and external communications.

F9.8 The communication plan was developed without the benefit of prioritized financial and personnel allocations, due to an uncoordinated budget process between the Finance Unit and the External Affairs Division. In addition, the budget process does not serve as a management tool for the external affairs director. Currently, the director submits an annual proposed budget to the finance director, but does not receive appropriated budget figures when the budget process is complete. The external affairs director attempts to monitor Division expenditures without the benefit of monthly, quarterly or annual updates on the budget from the finance director. As seen in **Table 9-3**, actual figures are not available for any of the years listed except for the salary information derived from the Federal W-2 forms.

Table 9-3: Historical Proposed External Affairs Budgets

	Proposed 1999	Proposed 2000	Proposed 2001	Proposed 2002	% Difference 1999 to 2002
Salaries (Actual)	$65,872	$65,345	$119,064	N/A	N/A
Publications	$100	$100	$0	$100	0%
Association	$500	$500	$0	$550	10%
Printing	$34,300	$27,300	$0	$48,000	40%
Advertising	$21,000	$8,000	$0	$52,000	147%
Postage	$10,000	$10,000	$0	$15,000	50%
Equipment	$700	$700	$0	$1,500	114%
Travel	$2,250	$1,700	$0	$2,300	2%
Supplies	$500	$600	$0	$500	0%
Workshops	$1,500	$2,000	$0	$2,500	67%
Miscellaneous	$19,500	$13,000	$0	$25,000	28%
Subtotal	$90,350	$63,900	$0	$147,450	63%
Total	**$156,222**	**$129,245**	**$119,064**	**$147,450**	**N/A[1]**

Source: CMHB

[1] The change in total proposed budget from 1999 to 2002 cannot be calculated without the proposed salary figures for 2002.

The fluctuation in salaries from 1999 to 2001 is reflective of the turnover in personnel during that period. In 1999, the position for the manager of communication and community affairs position was vacant and was filled during the latter part of 2000. The position of external affairs director was held by two individuals during 2001.

Without accurate budget figures, the director is unable to determine historical costs or predict future outlays. Also, CMHB management and BOG are unable to determine if the resources committed are a factor in the success of its programs (see the **finance and funding** section for further discussion of CMHB's budget process).

R9.6 The communication plan should be developed based on accurate budget figures to ensure adequate funding is available for implementation of goals and objectives. Accurate budget figures will also facilitate the prioritization of financial and personnel resources to be used in planning. In short, the budget process should be tailored to serve as a management tool for not only the external affairs director but other CMHB managers as well. Because budgets are dynamic documents, the external affairs director should receive monthly, quarterly and annual budget updates from the Finance Unit. This will enhance the planning process and decision-making ability of the director with regards to communication activities and programs.

F9.9 The external affairs director informs interested parties of important issues affecting mental health through a tool he developed known as the "State and Federal Briefing." The "State and Federal Briefing" is circulated to CMHB's BOG, contract providers, family groups, Self-help and Peer Empowerment (SHAPE) organizations and staff. The briefing lists legislation being considered on State and Federal levels and gives a brief description of the intent of the bill and what action has been taken to date. Included in the list of contacts for CMHB's legislative awareness campaigns are other county mental health boards. CMHB's peers are notified of pertinent legislative issues and they, in turn, pass the information on through their own mailing lists.

The Division director subscribes to Gongwer News Service to stay abreast of legislative issues that may impact mental health services, consumers, providers and/or research. A tracking system has been developed to follow items of legislation and identify the voting tendencies of individual legislators. "Action Alert" faxes and broadcast e-mails are sent out to agencies, National Alliance for Mental Illness (NAMI), and other interested parties. This encourages letter, fax and phone campaigns to apply pressure to legislators who are undecided or not in favor of legislation that positively impacts mental health. The director has also drafted resolutions for proposed legislation.

Methods or processes, however, have not been established to measure the effectiveness of legislative updates or fax and e-mail alerts. Furthermore, CMHB has not determined if any changes in legislation result from these activities. During the course of the audit, the director added a tag line to fax and e-mail alerts requesting information on action taken based on the information provided. However, reaction to the reply request has been negligible.

C9.2 Through its legislative awareness program, CMHB and the director of the Division have developed a process to educate a large number of stakeholders on pertinent legislation impacting mental health.

R9.7 As part of its communication plan, the Division director should establish a formal process to track the success of the legislative awareness program. Measurement through a variety

of methods as mentioned in **F9.4** and **F9.5** should be incorporated to gauge the effectiveness of these programs. For example, the value and success of the legislative awareness program can be measured through annual surveys.

Community Outreach

F9.10 CMHB has provided outreach to two large non-English speaking populations of Cuyahoga County through the translation of the "Red Flags" booklet into Russian and Spanish. *Red Flags* is a universal prevention program designed to help students, parents and school staff recognize and respond to signs of depression and related mental illnesses. The program includes a video, curriculum and a booklet.

Although the project began in the education and training division of CMHB, it was completed by external affairs in 2001. The Division assumed responsibility for the project when the director of the Education and Training Division resigned from CMHB. Based on 1990 census figures, the need for mental health information in Russian and Spanish was evident. The population figures and the demand for mental health information were verified by the International Services Center (ICS), a non-profit resettlement and social service agency serving immigrant populations in the Cleveland area.

CMHB contracted with ICS for the two translations at a cost of $1,200. Three thousand copies, 2,000 in Spanish and 1,000 in Russian, were printed at a cost of $2,500. Sample sets containing the English and translated versions were distributed through approximately 200 key Hispanic groups and 10 Russian groups. An additional 60 requests have been received. When the Summit County Mental Health Association learned of the creation of the translated versions, it made the resource available to the citizens of Summit County through its office and also promoted it on **www.redflags.org**, a website focused on childhood depression.

C9.3 CMHB has provided exceptional outreach to accommodate two large non-English speaking populations of Cuyahoga County through the translation of "Red Flags" in Russian and Spanish. The translated publications are also promoted on **www.redflags.org**, a website maintained by the Summit County Mental Health Association, which further amplifies the accomplishment.

F9.11 CMHB does not have a speaker's bureau to accommodate the general information needs of the community. Currently, the CMHB switchboard determines how requests for speakers are directed. Calls are forwarded to the Education and Training Division if a specific request is made, and general requests for speakers are forwarded to external affairs. If the subject matter or audience requires a more technical discussion, external affairs forwards the request to a qualified staff person, appropriate contracted providers

or other agency. Requests for speakers are also received by contracted providers. Requests for topics beyond mental health may be referred to *First Call for Help*. *First Call for Help* is a free service that provides information about health, human or social services, as well as support groups and government agencies.

Requests for speakers are not coordinated by either division or reported by the contracted providers. The Division receives speaker requests about once or twice a quarter (see **human resources**).

The Stark MHB has a speaker's bureau available to accommodate requested speakers. As a community service, Stark MHB and its contracted providers are available for educational presentations to civic, social, school, religious and business organizations. The chief clinical officer provides much of the training. A comprehensive list of available topics is provided on the website and includes the following subjects:

- Anger management;
- Cultural competency in mental health services;
- Eating disorders;
- Panic attacks;
- Recognition and prevention of family violence; and
- Teen depression and suicide prevention.

In addition, as part of a mandatory annual training for union leaders, Stark MHB makes a one hour presentation, "Critical Incident Stress Management." The critical incident stress management team addresses workplace stress that may occur after events such as; industrial accidents, the death of a co-worker and even the events of September 11, 2001. Stark MHB monitors the referrals from a variety of workplaces which increase remarkably after each presentation.

R9.8 CMHB should develop an internal speaker's bureau to accommodate the general information needs of the community. A speaker's bureau would enable the External Affairs and Education and Training Divisions to better coordinate requests for speakers. In addition, a speaker's bureau could also provide an opportunity for staff to share expertise and experience. In addition, a method of tracking speaking requests should be developed to monitor the needs of the community. An annual survey of providers regarding training or speaking engagements would provide effective documentation of emerging trends and/or needs.

F9.12 The director of the Division does not plan and direct health forums or neighborhood meetings, activities which are prescribed by the director's job description. In addition,

"plan and direct town hall meetings, forums and events scheduled throughout Cuyahoga County to promote CMHB services" are included as strategies in the communication plan. The plan, however, does not specify timelines for goals to be completed or provide for measurements of success (see **F9.4**). CMHB does plan and host an annual meeting luncheon. Also, during Mental Health Month, CMHB promotes training and public health forums that are sponsored by contracted and other health providers.

The primary focus of the ADAS Board's public relations activities is community education. The emphasis on education impacts the programs and strategies that the ADAS Board implements. The public information and training division of the ADAS Board has two staff members who complete approximately 70 training sessions a year and produce commercials and a television show. Training is offered to the target populations in order of priority as follows:

- ADAS Board staff;
- Contracted providers or agencies;
- All staff in area hospitals and similar facilities who work for the treatment and prevention of substance abuse;
- Mental health professionals;
- Other professionals who provide services out of the network such as social workers, probation officers, law enforcement, teachers and nurses; and
- Citizens.

The training provided is free. Attendees are able to receive professional credit through the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). The ability to receive continuing education credits is a great incentive for attendance, as attendees need the credits to maintain their professional certifications.

R9.9 The director of the Division should plan and direct health forums and neighborhood meetings as prescribed by the job description and the communication plan. Goals to quantify these efforts, such as the number of forum attendees, number of referrals following a speaking engagement and/or the number of forums or meetings held over a period of time, should be developed to enhance the job description and communication plan.

As with the development of an internal speaker's bureau, the training sessions and public forums should be a coordinated effort between the External Affairs and Training and Education Divisions of CMHB, as well as with contracted providers. The combined effort will ensure the greatest impact of community outreach through the use of internal and external mental health experts. CMHB should also explore the possibility of joint

training ventures with the ADAS board. By collaborating with the ADAS Board, CMHB can take advantage of the ADAS Board's established procedures and programs and will present a unified effort to the community and to shared populations (see **human resources** and **planning and system development**).

F9.13 Through the Helping Hands Awards and the Kathleen Burton Memorial Award, CMHB recognizes "outstanding individuals and organizations for their extraordinary achievements in the mental health field that embody CMHB's mission, positively impact the lives of people and help end the stigma of mental illness in Cuyahoga County." The awards are presented at an annual luncheon. Nominations are solicited from the community through press releases and fax and email alerts. The Helping Hands awards honor individuals or organizations in the following five categories:

- **Media** - recognizes mass media coverage of mental health services or issues.
- **Consumer Involvement** - is awarded to a consumer or consumer operated service.
- **Interfaith or Community Partnership** - is open to clergy or laypersons associated with faith-based organizations.
- **Family Involvement -** recognizes a mental health volunteer who is a family member of a person with mental illness.
- **CMHB Agency Program** - honors a program operated by a CMHB contracted provider.

The Kathleen Burton Memorial award recognizes excellence demonstrated by a mental health professional.

The two awards are judged on the following five criteria:

- Assisting people to better control their illness and achieve their personal goals;
- Developing, conveying and providing skills and supports to help people live constructive and satisfying lives;
- Reaching above and beyond the call of duty;
- Striving to alleviate the stigma associated with mental illness; and
- Serving the mental health community in a culturally competent manner.

However, CMHB does not provide for the recognition of employees and/or BOG for service provided through a similar program. Staff and BOG could be recognized publicly for a number of attributes such as length of service, innovative ideas, customer service and/or community service. The lack of recognition by CMHB management and BOG for

meritorious service was a recurring comment in an AOS survey of CMHB employees. According to the survey, the lack of acknowledgement has contributed to low employee morale (see **human resources**).

Franklin MHB has established an employee of the month award program and also recognizes employee milestones as they occur. The "Employee of Excellence," which is also discussed in the **human resources** section, provides an opportunity for Franklin MHB to honor the outstanding performance of its employees. Similarly, Lorain MHB has also established an employee recognition program.

C9.4 CMHB has extended its community outreach efforts through the Helping Hands awards and the Kathleen Burton awards. Through the public recognition of commendable service, CMHB fosters relationships with individuals and organizations who share common goals.

R9.10 CMHB should develop an employee recognition or award program to be presented at the annual meeting. A coordinated effort between the External Affairs and Human Resources Divisions could result in an effective program that acknowledges staff and/or BOG members for exemplary service in a variety of categories. Public recognition by CMHB management and BOG would promote good will among employees, foster improved morale and be a positive statement to the community at large of CMHB's service.

F9.14 CMHB has placed a high priority on the creation of a website for this year. The website will be launched the first full week of October 2002 as part of Mental Illness Awareness Week. CMHB's website design and development is being coordinated through the Division, the Director of Management Information Services (MIS), and the Cuyahoga County Information Services Center and is hosted by Cuyahoga County. Although the website was not complete as of May 2002, it was available for some minor viewing (see **technology use and claims services**).

The U.S. Energy Information Administration, the Government Printing Office, and the Defense Technical Information Center completed a study resulting in the development of criteria that can be used to assess websites. Two types of criteria the study identified include: information criteria, which evaluates the substantive aspects of the website and ease of use criteria, which evaluates the physical movement through the site. The components of each criterion can be further broken down as follows:

Information content criteria:

- Orientation to website;
- Currency (up to date);
- Bibliographic control;
- Services;
- Accuracy;
- Privacy;
- Security;
- Retrieval/Search engine; and
- Policy Issues.
- Ease of use criteria:
- Speed;
- Feedback mechanisms;
- Accessibility;
- Design;
- Navigability;
- Video and audio; and
- Quality of links.

The study also provides performance goals and measures for Federal agency websites which may be applicable to CMHB. Some goals and their measures include the following:

- Effectiveness or how well the website meets the general governmental objectives and specific agency objectives. An agency specific measure would determine the degree to which an agency reaches new constituent audiences.

- Service quality or how well the website functions. A number of basic or agency specific measures incorporate user success rate and complaint or comment tallies.

- Usefulness or how well the website meets the needs of the users. A basic measure of the usefulness goal would be achieved through user comments, surveys and/or focus groups.

According to the study, evaluation and performance measures to describe governmental websites and resources in the networked environment are important tools for improvement. Perhaps most importantly, an ongoing program of evaluation contributes to the process of constant improvement – looking for ways to improve the usefulness, impact and benefits that can result from web-based resources and services. The following observations were made during a review of websites from peers and other mental health boards around the State:

- Franklin MHB first established its website in 2000. Archives and current newsletters, consumer advocacy council newsletters, board minutes, and printed resources are posted on the website. The speakers' bureau is also promoted on the site. The website appears uncluttered and easy to navigate. The site also contains numerous links to other resources.

- Lucas MHB's website, established in 2002, is hosted through the Lucas County government home page. Although the amount of information is not exhaustive, there are links to the contracted providers, and clients' rights information is also available.

- Stark MHB's website lists community partnerships with several other agencies. The site also has numerous local, State and national links. In addition, postcards were sent to individuals and organizations on Stark MHB's mailing list when the website became available to invite virtual visits to the new site.

Without a fully operational website, CMHB may miss opportunities to educate and provide guidance to those in need of mental health services.

R9.11 CMHB should continue to place a high priority on the development of its website. As the website is completed, the above mentioned best practices should be incorporated. CMHB should also plan for the periodic evaluation, measurement and revision of the website for content, effectiveness, efficiency, service quality and usefulness. CMHB should also review readily available resources that could be included in its website to provide additional information to its users. See the **technology use and claims services** section for further discussion of the website.

F9.15 Currently, CMHB does not publish or facilitate the publication of any newsletters to provide current, pertinent, and accurate information to consumers, contracted providers, employees and/or the community at large regarding CMHB and mental health. Historically, CMHB published a general newsletter, *Forecast*. It has not been published since 1999; although the next publication date is slated for September 2002.

CMHB does not have an employee newsletter or other type of communication tool to provide employees news about their organization. As mentioned previously, the content of local media coverage and the lack of formal internal communication was a strong theme identified in the AOS survey of CMHB employees.

Franklin and Lorain MHBs publish monthly newsletters for their contacted provider agencies. Franklin MHB's four-page newsletter, the *Network*, is geared specifically to providers and their information needs. Included in the *Network* is a CEO authored column, reminders of plan and budget submission deadlines, seminar news, frequent contact listings and initiative updates. Lorain MHB archives its *News in the Network* on its website, where it can also be viewed by any web user.

Franklin MHB also produces a quarterly newsletter written for general distribution to the community. The newsletter is also archived on its website. The newsletter provides general information about the board and its activities. Readers who desire more specific information about the board, its activities and/or mental health services are referred to the website. Franklin MHB's Consumer and Family Council also produces a newsletter available through the website featuring articles written by consumers and family members. Articles cover topics such as stress, coping with the holidays and other life events.

Without CMHB produced publications, the community, consumers, family members, contracted providers and employees are forced to rely on local media coverage to disseminate information about CMHB, its activities, accomplishments and goals.

R9.12 CMHB should publish or facilitate the publication of several types of newsletters to provide current, pertinent, and accurate information to its consumers, contracted providers, employees and the community at large regarding CMHB and mental health. The newsletters should be produced on a regular basis to establish readership and provide consistent service. Newsletters or publications should be developed to address the specific information needs of the following groups:

- Community at large;
- Consumers and their families;
- Contracted providers; and
- Employees.

By developing its own publications, CMHB would be able to influence and gain more control over the information available to the public, as opposed to relying solely on local commercial media. By providing current and past publications on the CMHB website,

similar to other county mental health boards, CMHB would also enhance the quality of information available to all interested web users.

Media Relations

F9.16 The communication plan adopted by CMHB does not effectively address the current relationship between CMHB and the local media. During a four month period, eight articles appeared in local newspapers that could be characterized as unfavorable.

Conversely, no favorable articles were published in that same time frame. Also, the status of the relationship with the local media is evident through the lack of effective action taken by the local media to CMHB's general press releases. Recently, CMHB provided two press releases regarding new leadership at CMHB. Although *Call & Post* and various *Sun* newspapers (a weekly newspaper for small communities) carried the story, the County's largest newspaper only ran an editorial and did not print a story regarding the press releases.

The communication plan's goal regarding media relations states, "Build an effective working relationship with the media as an additional tool to reach key audiences of importance to CMHB as evidenced by increased media understanding and positive attention." The three strategies of the communication plan to address media relationships are as follows:

- Meet with media representatives and conduct regular editorial meetings with key media to establish and maintain working relationships and partnerships that position CMHB as an authority on mental health issues, as well as advance the Board's mental health agenda.

- Develop and implement a plan for CMHB initiated positive media coverage through a 'Pitch Calendar' featuring news and consumer and agency success stories.

- Maintain 'transparency' and level of service in responding to media inquiries as soon as possible within deadlines to ensure accurate information concerning CMHB while preserving consumer confidentiality laws.

The strategies CMHB developed through its communication plan do not provide for goals or measurement to monitor or guide success (see **F9.4**). Numerous academic works are available concerning the process used to monitor and measure press coverage. In general, media tracking involves the measurement of several aspects of news coverage: content, favorability/unfavorability, story length, placement, size of headlines and several other factors related to gaining and retaining the public's attention.

Many government bodies such as school districts and cities are frequently faced with an adversarial relationship with their local press. Changing this relationship is essential when an entity is relying on the opinions of voters for tax or levy dollars.

The Finance Director for Dublin City Schools, for example, invested about two years of time to change his school district's relationship with the local newspaper. He met with the editors and staff writers many times to educate them about the school financial process. He continued to meet with new staff writers as they were hired. He worked to develop a relationship. Now, his office serves as a resource to provide information to the newspaper regarding local, State and Federal school finance issues, and the newspaper has supported levies and bond issues.

R9.13 The communication plan should more effectively address the current media climate surrounding CMHB. CMHB should invest the necessary resources to improve its long-term relationship with the press. CMHB should assume a proactive role with the newspapers to promote a positive image in the community. The following steps should be included in the communication plan to improve CMHB's relationship with the local print media:

- The chief executive officer, external affairs director and the BOG chairman should meet with the editors of the local newspapers. The staff writers who generally cover mental health stories should also participate. All participants in the process should understand the goal of CMHB is to redefine its role and build positive relationships.

- CMHB should also meet with new newspaper staff as necessary to ensure a continuous relationship regardless of turnover at either organization.

- CMHB should provide information that fosters understanding with regard to its mission, activities and financial position.

- CMHB should monitor and measure press coverage to determine the success of its efforts over time.

During the course of the audit, the Division director indicated that press coverage was beginning to be tracked and monitored. Notwithstanding, an effective relationship with the local media will enable CMHB to more easily garner support and build confidence among stakeholders in its ability to manage Cuyahoga County's mental health system.

F9.17 CMHB does not have a media protocol in place to address difficult situations. Due to the nature of the mental health business, it is possible to encounter many difficult situations,

such as the death of a consumer. Generally, CMHB responds to unfavorable stories after they have been published or does not respond at all. According to the director, when approached by the media about client related issues, CMHB oftentimes cannot comment because of client confidentiality mandates.

Child Protective Service agencies have a responsibility similar to that of CMHB to respect and uphold the privacy of children and families and to hold in confidence all information obtained in the course of professional service. The Public Children Services Association of Ohio (PCSAO) recommends a protocol for responding to requests from individuals external to the agency and orientation and training of staff regarding the confidentiality and information sharing. The protocol includes a statement highlighting ORC mandates regarding client privacy.

Lorain MHB does not generally release any information regarding a client related matter. However, any response to the media is made by the executive director. When there is a client related matter, Lorain MHB provides the media with the following:

- A statement relaying that "information about an individual and the situation involving an individual cannot be released because of ORC and Federal mandated health care confidentiality."

- A description of its official procedures related to incidents; for example, a requirement that Lorain MHB be notified and the process of its subsequent review.

According to a report for the Department of Energy Office of Science, issues can become crises if they are not handled well. When issues or potential issues are discussed and negotiated with the public, the result is improved relationships with the public. If a public relations professional does not communicate with the public until an issue or crisis occurs, the chance of resolving the conflict is slim.

R9.14 CMHB should develop a media protocol to address difficult situations. Such a protocol would foster a more positive long-term relationship with the media and provide the opportunity to increase the public's understanding of mental illness and the role of CMHB. The protocol should include a standard statement that addresses mandated confidentiality requirements but provides some information to enable the public to understand the process of investigation. A standard statement could be created similar to the statement provided by Lorain MHB. Every inquiry should be viewed as an opportunity to further foster understanding of mental illness and the services available through CMHB.

F9.18 Currently, CMHB does not have a comprehensive or formal written policy regarding public requests for information or statements to be made to the press. CMHB does have a policy entitled "Dissemination of Information" that addresses who may release information on behalf of CMHB. During the course of the audit, a policy for processing requests for public information was drafted. Until this policy is adopted, however, the Division director has an unofficial policy regarding the release of information. The director will answer routine matters immediately. All other information requests are required to be in writing. And, in difficult situations, the director will consult with the BOG chairman, the CEO, risk manager and/or the County Prosecutor before responding to an information request.

The Ohio Department of Job and Family Services (ODJFS) published a booklet regarding the Ohio Public Records Act to provide guidance for the requests for records. Section 149.43(B) of the Revised Code is known as the 'Public Records Act' and is the general records law governing the status of State and local records when requested by a third party. The section also requires that all public records '…be promptly prepared and made available for inspection to any person at all reasonable times during regular business hours.'

Without a formal public policy regarding the release of information, CMHB has not defined its role in the process or outlined the restrictions imposed by law and may appear uncooperative, ambiguous or even secretive.

R9.15 The director should continue to meet with the County Prosecutor's Office to write and adopt a formal policy regarding information requests. This policy should be distributed to all local media. By providing this information in advance of a record request, all parties would have a clear understanding of their roles in the process. The policy should reflect relevant sections of the ORC, OAC, ODMH guidelines, Federal statutes and specific language regarding confidentiality of client information. The policy should, in part, contain the following items:

- Requests will be filled within a "reasonable" amount of time. CMHB should work with the County Prosecutor's Office to define "reasonable" for a variety of situations.

- Requests for public information should be specific to ensure both parties understand the details of the request.

- CMHB and requesting parties should be aware that a government entity is not required to create records to satisfy a request.

The policy should be communicated to all staff, BOG and contracted providers of CMHB. Also, planned reviews of the document will ensure the items included remain relevant and new issues are effectively included.

Interagency Communications

F9.19 CMHB has not established a formal method for the creation, maintenance, review and measurement of interagency communication beyond its contracted providers. According to the communication plan, consumers and family members will be reached in the following manner, "Members of the Board of Governors and staff will reach out, develop and maintain working relationships and dialogue with consumer and family groups to effectively organize to promote and influence community mental health policies, practices and funding." However, the plan does not identify timelines or quantifiable goals to measure consumer outreach success.

As discussed in **planning and system development**, mutual agreements of understanding (MOU) are written agreements which outline the types of interaction that will take place between two organizations. Interaction may take the form or regularly scheduled meetings or developing joint programming. Each organization's responsibilities are outlined. Although not binding like a contract, it is a formal understanding. Thus far, the External Affairs Division has not been included in the development of such agreements.

The Division director and the manager of communications and community affairs serve on a number of boards, agencies, organizations and committees as part of their responsibilities and attend most of these meetings during work hours. It is unclear if any other CMHB employees serve in similar capacities or volunteer their time because community service activities are not tracked agency-wide and few respondents to the AOS survey of CMHB employees acknowledged any of their community service (see **human resources** for a complete discussion of the AOS employee survey).

Furthermore, contracted providers rated the information sharing capabilities and practices, as well as the relationship with the Division, as fair to average, according to the AOS provider survey. See the **organization, compliance and board governance** section for a complete discussion of the provider survey.

R9.16 Through the communication plan, CMHB should establish a formal method for the creation, maintenance, review and measurement of interagency communication beyond its contracted providers. Additional relationships should be formally established with a variety of government, non-profit or faith-based organizations that also interact with consumers, potential consumers or concerned family members and friends. Also, the Division should be included in the development of MOUs. Through MOUs, the

establishment of formal lines of communication and responsibility may offer contracted providers a benchmark with which to base their interactions.

Furthermore, CMHB should develop a system to track the amount of time and the number and type of agencies that its employees and BOG members serve, either as volunteers or as representatives of CMHB. Employees and BOG members should provide information concerning outside involvement whereby CMHB is represented on a formal or informal basis. This information could be used to demonstrate CMHB's commitment to the community on a very personal level. Also, the number of hours committed to community service could also be used as a qualification for the employee recognition award (see **human resources** for a complete discussion of employee recognition programs).

Conclusion Statement

The primary objective of the External Affairs Division is to increase the public's understanding of mental illness and the role CMHB plays in establishing mental health services in Cuyahoga County. Because external and internal communications are managed and coordinated through one division which reports directly to the CEO, CMHB reduces the risk of miscommunication and increases its control and accountability in this area. Also, this structure ensures internal and external communications are in line with the organizational vision of BOG and agency management. Division staffing, however, should be reviewed to ensure the assumed roles and the job descriptions of the director and manager positions provide the most effective and efficient use of the personnel and appropriately reflect their experience and expertise.

In general, the Division has established some methods for providing information, outreach and establishing effective external relationships. Through legislative updates such as, action alert e-mails and faxes and "State and Federal Briefings," the Division provides pertinent and timely information to peers, contracted providers, family groups, lawmakers, organizations and other interested parties. CMHB also recognizes outstanding service and commitment in the field of mental health by community members through its Helping Hands and Kathleen Burton Memorial awards, which are presented at the annual luncheon and meeting. Hindering the success of most programs and activities of the Division, however, is the lack of measurable goals and the lack of coordinated effort within CMHB, as well as with contracted providers and other community agencies.

Although CMHB does not have a strategic plan guiding the entire organization, a communication plan has been developed internally by the Division to guide its communication activities. The plan, however, requires review and revision to incorporate additional best practices for public relations, specifically, the objectives of the communication plan should be manageable, measurable and specific. The communication plan should also provide the basis for budget development to prioritize the allocation of fiscal and personnel resources. Periodic review and revision of the communication plan should be scheduled to reflect changing environments and technology.

Communication, as it addresses the many groups and information needs of the community, could be greatly enhanced. CMHB does not regularly publish newsletters to address the information needs of its employees, contracted providers, consumers or the general public. These publications should be developed and distributed with regularity to provide consistent, pertinent and reliable information about mental health, CMHB and its services. While all of the peers have websites tailored for their respective communities, CMHB does not have an operational website. Without sufficient communication tools, citizens of Cuyahoga County are left to receive information about CMHB from the local media. CMHB should take a proactive role to create a positive relationship with the community's major newspapers. The relationship change

will require time, effort and a genuine desire by CMHB to educate the media as well as the community.

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