OHIO AUDITOR OF STATE
KEITH FABER

Ohio Department of Mental Health and Addiction Services

Performance Audit

June 27, 2019

Efficient • Effective • Transparent

Audit Highlights

» OMHAS allocates funds to local mental health boards to support mental health programs in communities. Currently, funding is allocated based on prior year allocations rather than a need based approach.

Recommendation Allocate funds using a data-driven needs based method.

Impact Reallocation of $15,000,000 in funding.

» OMHAS operates regional psychiatric hospitals and provides 24/7 care to patients. Currently, hospitals need to mandate overtime for workers to provide appropriate levels of care.

Recommendation Adjust hiring and scheduling practices to reduce overtime.

Impact Savings of $250,000 to $990,000 annually.

» OMHAS uses contracted psychiatrists and professional staff when they do not have full-time staff to cover the needs of the patients in hospitals. The use of contracted staff is expensive and results in disjointed patient care. Improved recruitment efforts are needed to attract professional staff to OMHAS.

Recommendation Replace contracted staff with full-time staff.

Impact Savings of $655,000 annually.

» Regional Psychiatric hospitals currently employ customized training approaches for the same positions. Standardized training will allow OMHAS to deploy best practices and train staff uniformly throughout the state.

Recommendation Standardize training efforts at the regional psychiatric hospitals.

Impact Savings of $360,000 annually.

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Letter from the Auditor

To the Governor's Office, General Assembly, Director and Staff of the Ohio Department of Mental Health and Addiction Services, Ohio Taxpayers, and Interested Citizens:

The Auditor of State's Office recently completed a performance audit for the Ohio Department of Mental Health and Addiction Services (OMHAS or the Department). This service to OMHAS and to the taxpayers of the state of Ohio is being provided pursuant to Ohio Revised Code §117.46. The review was conducted by the Ohio Performance Team and provides an independent assessment of selected areas of operations in relation to industry standards and recommended or leading practices.

This performance audit report contains recommendations, supported by detailed analysis, to enhance the Department's overall economy, efficiency, and/or effectiveness. The report has been provided to the Department and its contents have been discussed with the appropriate staff and leadership within the Department. The Department is reminded of its responsibilities for public comment, implementation, and reporting related to this performance audit per the requirements outlined under ORC §117.461 and §117.462.

It is the Auditor's hope that the Department will use the results of the performance audit as a resource for improving operational efficiency as well as service delivery effectiveness. Additional resources related to performance audits are available on the Ohio Auditor of State's website.

This performance audit report can be accessed by visiting the Auditor of State's website at ohioauditor.gov and choosing the "Search" option.

Sincerely,

Keith Faber
Auditor of State
June 27, 2019

Audit Summary

Recommendation 1 Develop a data-driven methodology for the distribution of Mental Health Continuum of Care funds.

Financial Impact Redistribution could alter funding allocations to ADAMH boards by $15,002,800 and therefore redirect resources to higher-need counties.

Recommendation 2.1 Adjust the nursing and professional models to reflect the operational needs of the hospitals based on historical data. In combination with adjusting shift scheduling, this would reduce overtime, specifically mandated overtime, by better estimating leave usage.

Financial Impact The department could save between $250,000 and $990,000 annually by reducing overtime associated with current scheduling practices.

Recommendation 2.2 Improve recruitment efforts to reduce the number of contracted hours needed to provide professional services to patients and provide a better continuity of care.

Financial Impact Replacing contracted hours with full-time staff for vacant position needs in hospitals would save approximately $655,000 annually.

Recommendation 2.3 Standardize training among hospitals to reduce the variation in training staff at the regional hospitals, and enable best practices to be adopted uniformly.

Financial Impact Standard training could save up to $360,000 annually.

Recommendation 2.4 Improve the collection of exit-interview data from employees to enable the Department to determine the causes of short tenure. This information will allow the department to adjust training, hiring, and employment practices as necessary to reduce turnover.

Financial Impact N/A

Recommendation 3 Finalize an Inter-Agency Partnership Agreement with ODRC. Incorporate the framework to accurately measure programs' impact on offender relapse and recidivism.

Financial Impact N/A

Savings by the numbers

Redistributing funds, adjusting shift schedules, replacing contract workers with full-time employees, and standardizing training at regional hospitals is expected to...

SAVE UP TO:
$2 million
per year

REDIRECT:
$15 million
to higher-need counties

OMHAS Overview

Background

Responsibilities and Mission

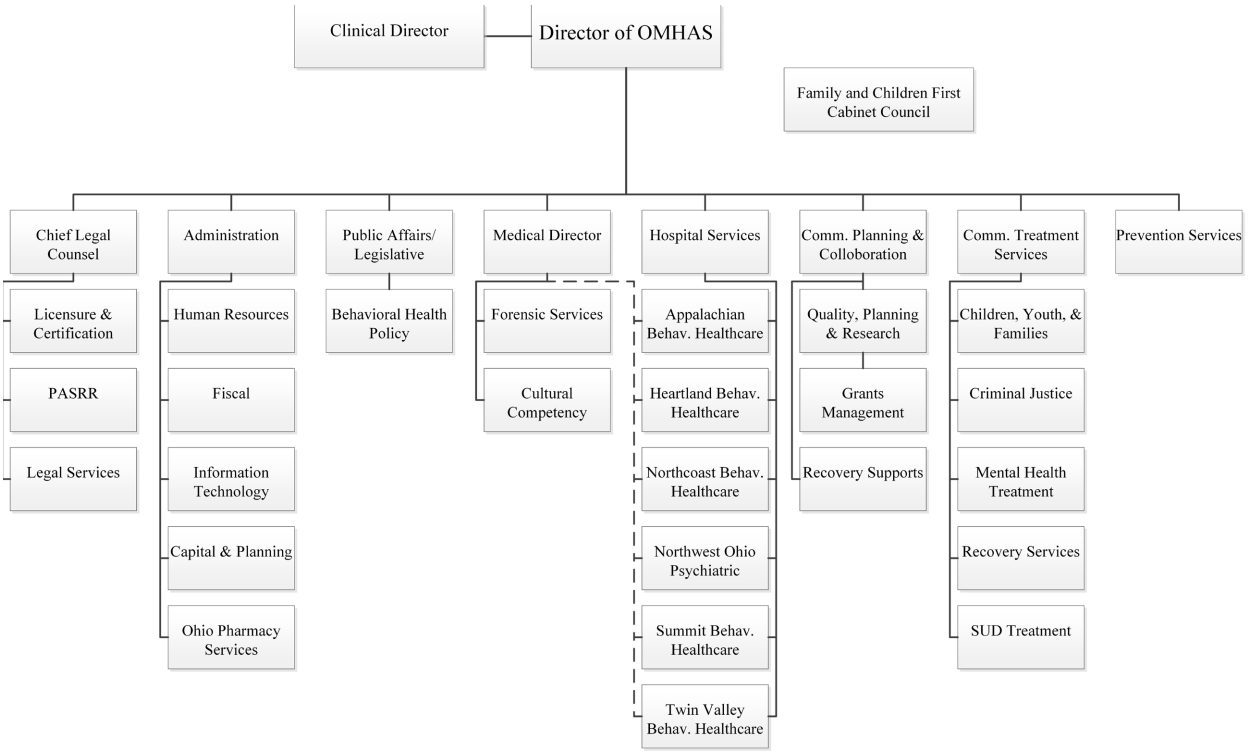
OMHAS is a cabinet-level state agency. As set forth in the Ohio Revised Code (ORC) § 5119.14, OMHAS is responsible for maintaining, operating, managing, and governing state institutions and other services for the care and treatment of mentally ill persons. As part of these responsibilities, OMHAS provides resources throughout the state for prevention programs, treatment options, and recovery support. OMHAS oversees 51 county-based mental health boards and more than 600 behavioral health agencies that provide mental health services. In addition, they operate six regional psychiatric hospitals.

The Department's mission is "to provide statewide leadership of a high-quality mental health and addiction prevention, treatment and recovery system that is effective and valued by all Ohioans."

Organizational Structure

The OMHAS director is appointed by the governor. With oversight from the Director, OMHAS carries out its statutory responsibilities and mission through the operation of the following offices and bureaus. The following organizational chart shows both the basic structure and the leadership hierarchy of the Department.

OMHAS Organizational Chart



Source: OMHAS

Audit Overview

ADAMH Board Funding

This section of the performance audit focuses on the Ohio Department of Mental Health and Addiction Services' funding of alcohol, drug and mental health boards (ADAMH or the boards) through Continuum of Care funds. Information was collected and analysis was performed to develop a profile of OMHAS general revenue funds (GRF) available for allocation. Analysis identified opportunities to redistribute funds based on need.

Recruitment, Retention, and Onboarding

This section focuses on the Ohio Department of Mental Health and Addiction Services' employee recruitment, retention, and onboarding processes. Information was collected and analysis was performed to develop an understanding of each distinct process, and identified opportunities to improve the efficiency and effectiveness of the services provided by the Office of Human Resources (OHR or Human Resources) in support of the Department's mission.

The Recruitment, Retention, and Onboarding section is divided into four sub-sections of analysis, each analyzing a distinct element of the recruitment, retention, and onboarding process:

- Nursing Model
- Recruitment Efforts
- Training Practices
- Data Collection

Prison Treatment and Recovery Services

This section of the performance audit focuses on the Ohio Department of Mental Health and Addiction Services' (OMHAS) prison treatment and recovery programming offered to eligible offenders at Ohio Department of Rehabilitation and Corrections (ODRC) facilities. Specifically, it will focus on the Bureau of Correctional Recovery Services (BCRS or Recovery Services) and the Community Transition Program (CTP), which provide alcohol and drug treatment programming for individuals who are either incarcerated in, or recently released from, Ohio's prison system.

Recommendation 1.1

ADAMH Board Funding

» Develop a data-driven methodology for the distribution of Mental Health Continuum of Care funds.

» Redistribution could alter funding allocations to ADAMH boards by $15,002,800 and therefore redirect resources to higher need counties.

Methodology

This section analyzes the OMHAS Continuum of Care fund allocations to the local ADAMH boards. Data used in the analysis was primarily sourced from OMHAS and included key information such as funding amounts, sources, destinations, and distribution methodologies. The analysis used data from FY 2019, as this was the most current data at the time the analysis was completed.[1] AOS employees interviewed key personnel associated with ADAMH board funding.

ADAMH boards are identified throughout the report by each respective board's host county name, which is the naming convention applied by OMHAS even when the ADAMH board serves multiple counties. A full cross-reference of all ADAMH Boards is provided in **Appendix 1-A**.[2]

[1] Data from FY 2015 to FY 2018 were examined as necessary to provide historical context.

[2] During the course of the audit, it was announced that the two boards within Lorain County would merge by July 1, 2019. As a result, these two boards were treated as a single board for comparison purposes, gathering the two boards' revenues into a single grouping for analysis purposes where appropriate (see **Appendix 1-A**).

Background

ADAMH Overview

OMHAS oversees the alcohol, drug and mental health boards in Ohio. Per ORC § 340.03, the main responsibilities of the boards are to plan, fund, administer, and evaluate the system of mental health and addiction services within their communities. This system encompasses a full spectrum of services, including prevention and wellness programs, crisis services, treatment services, and recovery supports such as housing and employment.

Local mental health boards and the associated State funding and local taxing authority were established by law in 1967[3]. This legislation authorized the creation of community mental health service programs in any county or combination of counties with a population of at least 50,000 residents. This law established boards to oversee each mental health program, consisting of local and Department-appointed members. In 1989, new legislation[4] gave counties the option of creating an alcohol and drug addiction services board, or establishing a single board of alcohol, drug addiction, and mental health services. While initially several counties elected to create separate boards over time, all but Lorain county have combined their mental health and addiction boards. Currently, 51 ADAMH boards serve the 88 counties in Ohio.

ADAMH boards have 14 or 18 volunteer members including clinicians, consumers, and family members of those who have received services.[5] Each board has administrative staff who work with board members to carry out the mission and statutory responsibilities of the board. The boards manage their local system of treatment and prevention services by contracting with public and private providers to offer services in accordance with identified needs and priorities. The boards are also responsible for conducting audits of programs and services to ensure that minimum standards are being met. Boards are required to submit a Community Plan to OMHAS that describes local need, assesses access issues and gaps in services, identifies strengths and challenges in the current system, and sets priorities for services. It also includes projected revenue and expenditures for the upcoming fiscal year.

Chart 1-1 shows the regional coverage of each board, labeled by the host county. (The counties represented by each host county can be found in **Appendix 1.A**). This map provides insight into how resources are being distributed and how counties are sharing services.

[3] HB648 in 1967
[4] HB317 in 1989
[5] OMHAS appoints six of the 14 members or eight of the 18 members.

Chart 1-1: ADAMH Board Regional Coverage

Source: OMHAS
Note: Although highlighted as one color, Lorain County includes two boards, the Alcohol and Drug Addiction Services Board of Lorain County and the Lorain County Board of Mental Health.

As shown in **Chart 1-1**, the 51 ADAMH boards comprise 31 single-county boards and 20 multi-county boards. The multi-county boards serve two to six counties. All boards provide both mental health and addiction services, with the exception of Lorain County, where one board provides mental health services and a separate board provides addiction services.[6]

[6] As of July 2019, the two Lorain County boards will combine into one board.

ADAMH Board Funding

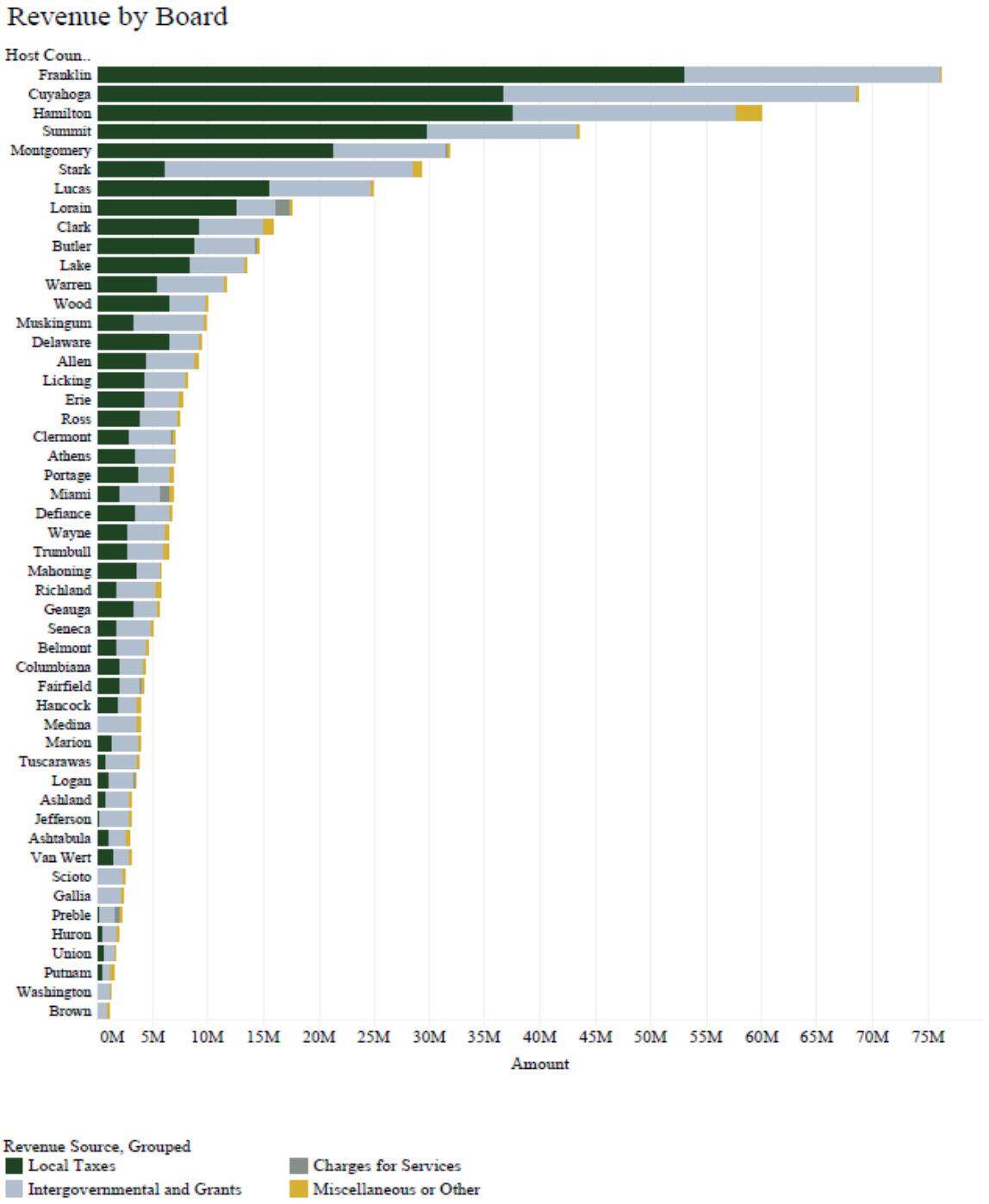
ADAMH boards are funded through local, state, and federal sources. The local taxing authority[7] for each ADAMH board allows it to levy taxes on real and personal property for operating expenses, permanent improvements, or to supplement the general fund. Six boards have no local levy support for mental health and addiction services. This includes Scioto, Brown, Gallia, Lorain ADA, Medina, and Washington.[8]

Non-local funding of ADAMH boards includes state appropriations, federal grants, and other intergovernmental sources. OMHAS distributes all state funding, as well as two federal grants: the Community Mental Health Grant and the Substance Abuse Prevention and Treatment Block Grant.

Chart 1-2 shows the main funding sources for ADAMH boards for FY 2017, listed by the host county. State funding and federal grants are represented in the Intergovernmental and Grants category. This provides context on how resources are distributed throughout the state, and how local funding compares with non-local funding.

[7] If an ADAMH board represents a single county, the taxing authority is the board of county commissioners. If an ADAMH board represents multiple counties, the taxing authority is the ADAMH board itself.
[8] Washington County passed local levy support in 2017 but had not yet collected revenue as of this analysis. Additionally, the three-county "Belmont-Harrison-Monroe Board" only receives tax levies from Belmont County. Harrison and Monroe do not have levies.

Chart 1-2: ADAMH Board Funding



Source: AOS and IPA Financial Audits
Note: Lorain County funding includes both the Alcohol and Drug Addiction Services Board and the Board of Mental Health.

As shown in **Chart 1-2**, ADAMH boards are mainly funded through a combination of local tax levies and state and federal sources. Fees and other revenue sources, represented by the Charges for Services and Miscellaneous or Other categories, minimally contribute to the total revenue.

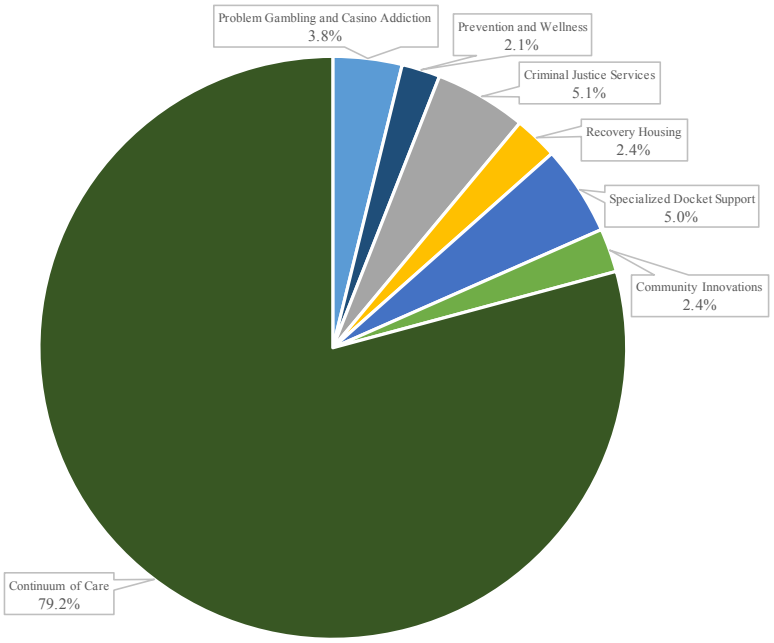
OMHAS has eight budget line items that are distributed to ADAMH boards.

- **Continuum of Care (GRF 336421 and 5TZ0 336643)** is distributed to local boards of mental health and alcohol, drug, and gambling addiction services, with a few specific earmarks to other entities. These funds are used for basic services to prevent, treat, and support recovery for behavioral health issues.[9]
- **Community Innovations (GRF 336504)** is used for targeted investments like crisis intervention projects, naloxone access, continuum of care projects including workforce development, and reimbursements to county jails for psychotropic drugs.
- **Criminal Justice Services (GRF 336422)** is used for court costs to evaluate competency to stand trial and pleas of not guilty by reason of insanity. It also funds reentry services, addiction services alternatives, medication-assisted drug treatment court programs, and mental health court programs.
- **Prevention and Wellness (GRF 336406)** is distributed to local community behavioral health boards for mental health, alcohol, and other drug prevention services. Earmarked funds support drug-abuse prevention in school settings, suicide prevention, and for boards to purchase prevention services from providers.
- **Problem Gambling and Casino Addiction (5JL0 336629)** supports efforts to alleviate problem gambling and substance abuse and related research.
- **Recovery Housing (GRF 336424)** supports access to recovery housing for individuals recovering from alcoholism or drug addiction, including peer support programs and assistance obtaining addiction services.
- **Specialized Docket Support (GRF 336425)** defrays a portion of costs to the court associated with a specialized docket, treatment services, and recovery supports.

Chart 1-3 shows the total statewide allocation of funds distributed by OMHAS to ADAMH boards in FY 2019. This chart is important for identifying which allocations are the most significant to ADAMH operations.

[9] Basic services include crisis intervention, medication assistance, hospital prescreening, counseling-psychotherapy, community support program services, alcohol and drug treatment services, diagnostic assessment, consultation, education, and residential housing.

Chart 1-3: State Funds Distributed by OMHAS



Source: OMHAS

As shown in **Chart 1-3**, 79.2 percent of state funding is distributed through the Continuum of Care allocation. This is by far the largest single source of state funding.

State funds are distributed to ADAMH boards through various allocation methods, including:

- Demographics
- Count of Counties
- Program/Service-Based

Despite requiring all boards to submit Community Plans with their projected expenditures and revenues, these plans are not used in determining funding allocations. It is also important to note that the Continuum of Care allocation is the only allocation where the authority to establish a funding formula is granted to OMHAS by the ORC.

History of Continuum of Care Funding

The Continuum of Care funding allocation has been the primary state funding source for ADAMH boards since their inception. In 1967, the legislature authorized state funding of loca-community mental health programs[10]. The state reimbursement was established at 75 percent of board operating expenditures,[11] with additional per-resident constraints. While the purpose of this funding has remained constant, the distribution principles have changed over time.

[10] ORC § 5119.62 enacted by HB 648 in 1967

[11] Adjusted operating expenditures were defined as follows: operating expenditures less federal grants, income from fees and tuition, and any salary higher than a comparable position at the Department.

Analysis

OMHAS Continuum of Care Allocations

As shown in **Table 1-1**, the Continuum of Care funding allocation is a significant source of ADAMH boards' overall funding, and accounts for 79.2 percent of state funding for ADAMH boards. Currently, Continuum of Care funds are subdivided into the following categories:

- **Alcohol and Other Drugs (AOD):** Ensures local access to quality and cost-effective alcohol and other drug treatment services based on need. ADAMH boards are required to use the funding in accordance with their stated goals and priorities.[12] This funding is used to assist people or fund services when not eligible for Medicaid reimbursement.
- **Mental Health:** Used for prevention, treatment, support, and rehabilitation services and opportunities. It is used to assist people or fund services when not eligible for Medicaid reimbursement.
- **Community Investments** (previously **Community Medication**): Provides subsidized support to indigent individuals for medications to treat mental illness and addiction, including medications used to treat opiate addiction. It is also used to support initiatives to reduce unnecessary hospitalization due to the inability to afford medication. This funding includes a specific allocation for methadone.
- **Additional Community Investment** includes resources established in FY 2018 of $7.0 million. $5.0 million of this is attributed to a new Dedicated Purpose Fund. While the $5.0 million is not 336421 Continuum of Care, it was included to capture how the funds for this single purpose were used and is, in total, referred to in this report as Additional Community Investment.

Table 1-1 shows the Continuum of Care funding by allocation type (Alcohol and Other Drugs, Mental Health, Community Investments) for FY 2015 through FY 2019. This provides context into how allocations have changed over time.

Table 1-1: Continuum of Care Funding of ADAMH Boards

Continuum of Care Category	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Alcohol and Other Drugs	$5,347,328	$5,347,328	$5,347,328	$5,347,328	$5,347,328
Mental Health	$51,491,524	$51,491,524	$51,491,524	$51,491,524	$51,491,524
Community Investments	$9,413,542	$15,150,992	$15,150,992	$15,150,994	$15,150,994
Additional Community Investment	$0	$0	$0	$7,000,000	$7,000,000
Grand Total	**$66,252,394**	**$71,989,844**	**$71,989,844**	**$78,989,846**	**$78,989,846**

Source: OMHAS

Note: Community Investments includes funds from Community Medication (FY 2015) and Community Methadone (FY 2015-19).

As shown in **Table 1-1**, total Alcohol and Other Drugs and Mental Health funds have not changed during the five years examined. Community Investments increased 60.9 percent in FY

[12] ADAMH boards submit a community plan to OMHAS every two years.

2016 when Community Medication was replaced with Community Investments. The Additional Community Investment allocation was added in FY 2018, increasing the total Continuum of Care funding by 9.7 percent.

ORC § 5119.23 requires that "the department of mental health and addiction services shall establish a methodology for allocating to boards of alcohol, drug addiction, and mental health services the funds appropriated by the general assembly to the department for the purpose of the community-based continuum of care that each board establishes under section 340.032 of the Revised Code." OMHAS methodology has been to keep allocations consistent to ensure stable funding, however, the current model lacks a data-driven method to match funding to changing needs.

Alcohol and Other Drugs and Community Investments portions of Continuum of Care

Alcohol and Other Drugs and Community Investments allocations are distributed based on population. Analysis showed that Alcohol and Other Drugs and Community Investments allocations were distributed in accordance with the funding methodology.

Additional Community Investment portion of Continuum of Care

HB 49 of the 132nd General Assembly defined how the Additional Community Investment funding would be distributed. It states that each board will receive $75,000 for each county in its jurisdiction, with a remaining amount allocated by formula incorporating the population and average number of opioid overdose deaths over a three-year period. The total allocation was $7.0 million, and with each county receiving $75,000,[13] only $325,000 remains to be distributed using the population and average-opioid-death methodology. Analysis showed that allocations aligned with the legislative guidelines for the Additional Community Investment allocation.

It should be noted that while HB 49 provided an allowance for opioid deaths, the guidance provided in HB 49 distributes funding equally by the sum of Ohio's population (11.6 million) and the statewide average opioid deaths over a three-year period (3,208). As a result, opioid deaths accounted for 0.03 percent of the remaining $325,000 Additional Community Investment funding. This accounts for a statewide total of $89 divided among Ohio's ADAMH boards, or an average of one dollar per county.

Mental Health portion of Continuum of Care

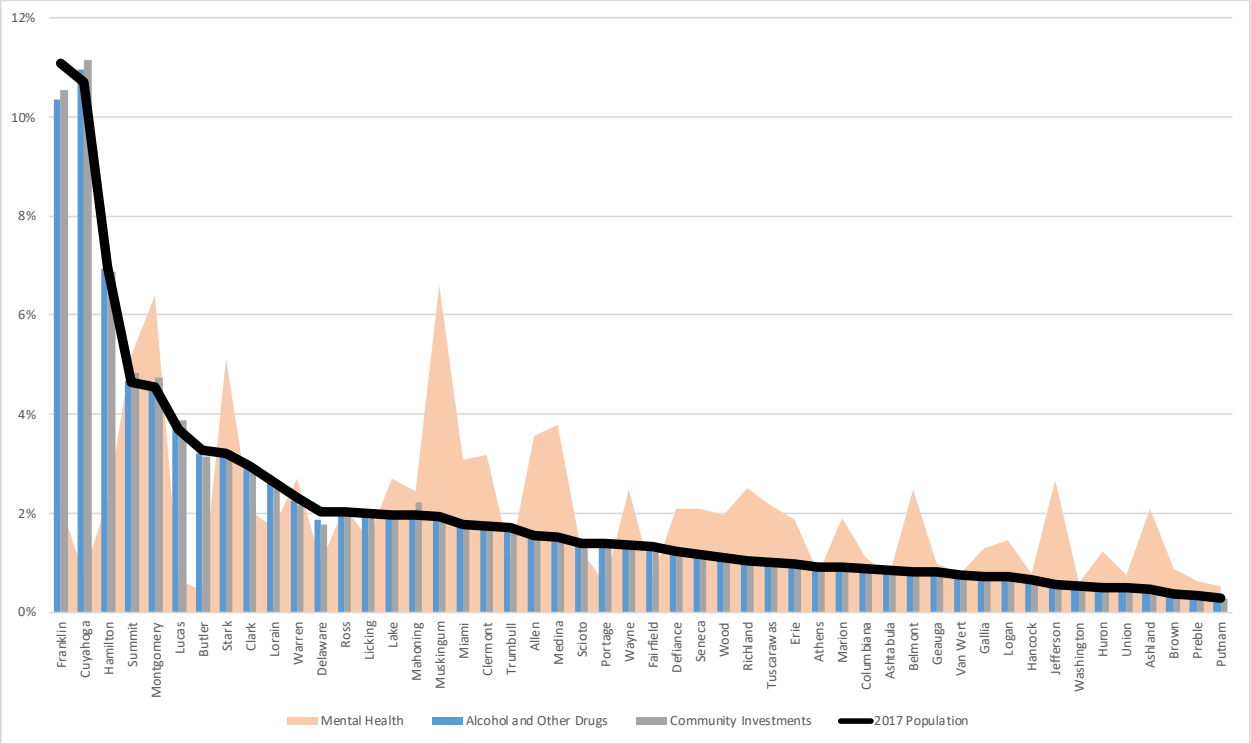
OMHAS leadership suggested that funding distributions to ADAMH boards through the Mental Health portion have remained the same for approximately 10 years. When OMHAS boards were established, this funding was allocated according to a formula as prescribed by the Ohio Revised

[13] Since Lorain County has two boards, it received a $75,000 allocation for each board.

Code. Every few years, this formula per the ORC was changed, granting OMHAS more authority to determine the methodology. Over time, OMHAS developed a practice of funding based on allocations from the previous year. Although keeping funding constant from year to year could be considered a methodology for allocating Mental Health Continuum of Care funds, it is likely that this methodology is not distributing board funds in a manner that ensures that ADAMH boards are receiving funds they may need to provide services in their ever-changing communities.

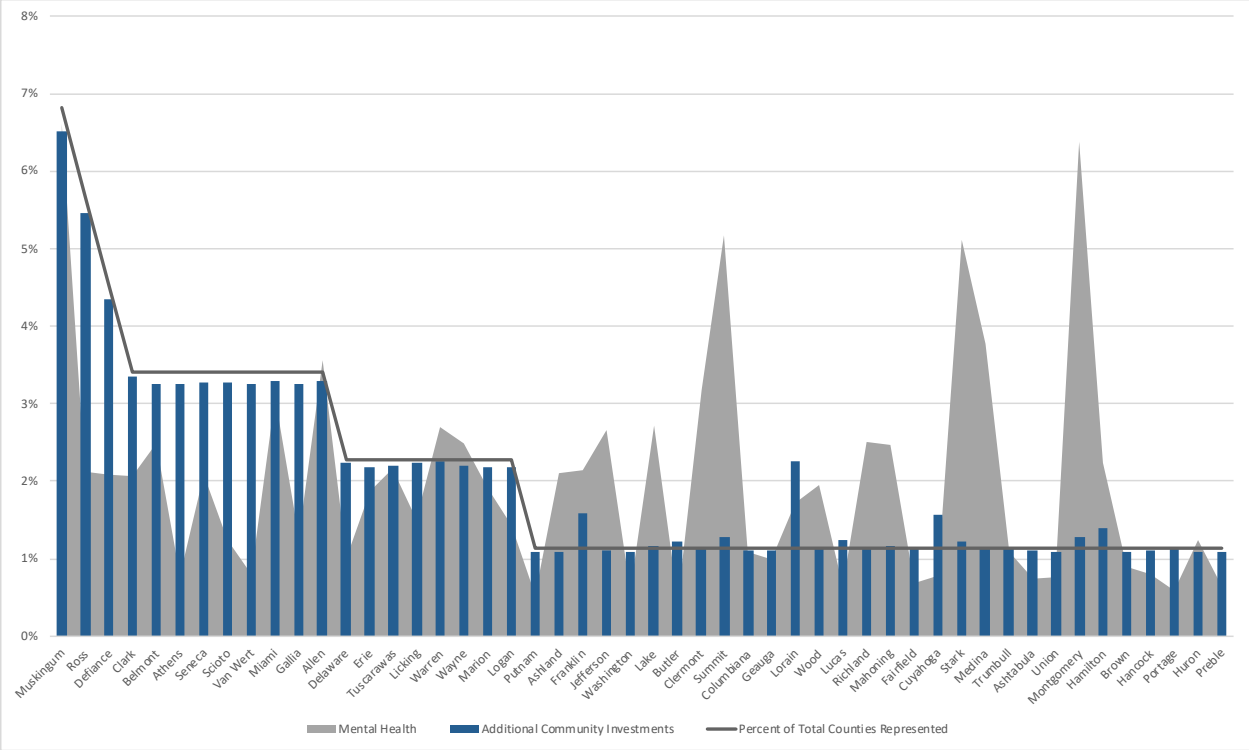
OPT compared the funds being distributed for the Mental Health portion of Continuum of Care against the three primary allocation methodologies already in use by OMHAS. These include Regional Population **(Chart 1-4),** Number of Counties Served **(Chart 1-5)**, and Average Opioid Deaths **(Chart 1-6)**.

Chart 1-4: Population Comparison with Funding



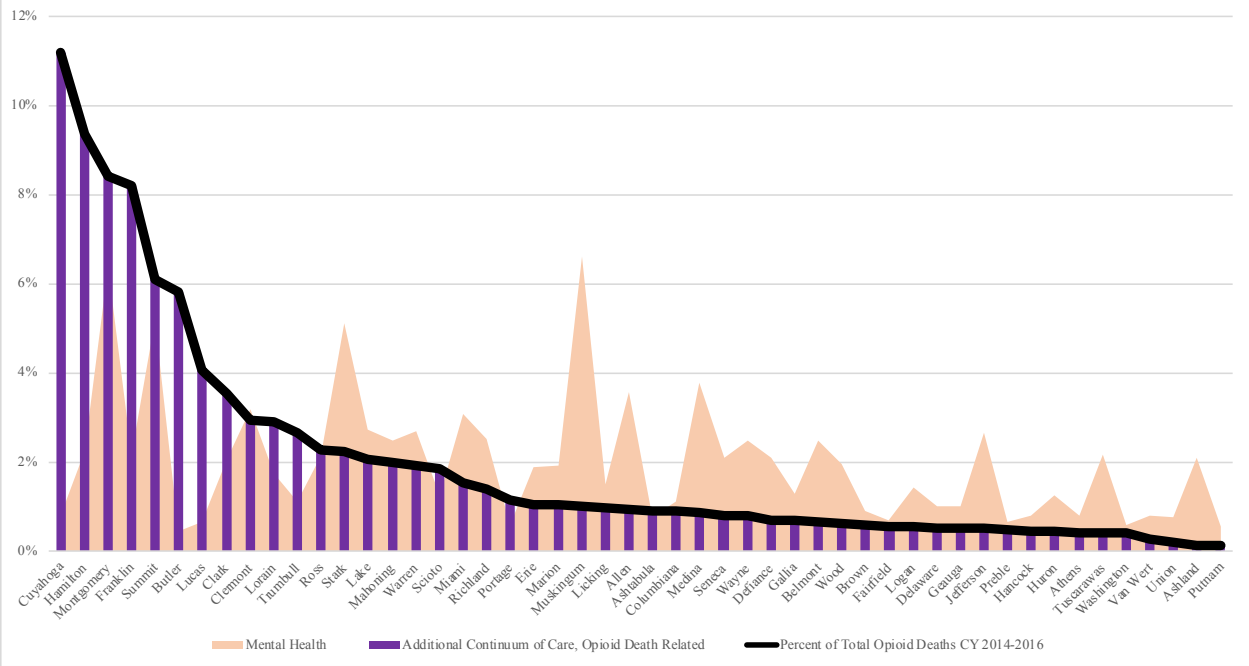
Sources: OMHAS and U.S. Census Bureau

Chart 1-5: Number of Counties Served Comparison with Mental Health Funding



Source: OMHAS

Chart 1-6: Opioid Overdose Deaths Comparison with Mental Health Funding



Sources: OMHAS and Ohio Department of Health
Note: The Opioid Death Related portion of the Additional Community Investment fund is shown for context purposes; however as stated earlier, this amounted to $89 statewide.

As shown in **Chart 1-4, Chart 1-5,** and **Chart 1-6,** no correlation could be identified between Mental Health Continuum of Care funding and the funding methodologies already deployed to other Continuum of Care funds. **Table 1-2** shows the amount of funds that would be affected by redistribution of Mental Health Continuum of Care funds based on regional population**,** number of counties served, and average opioid deaths.

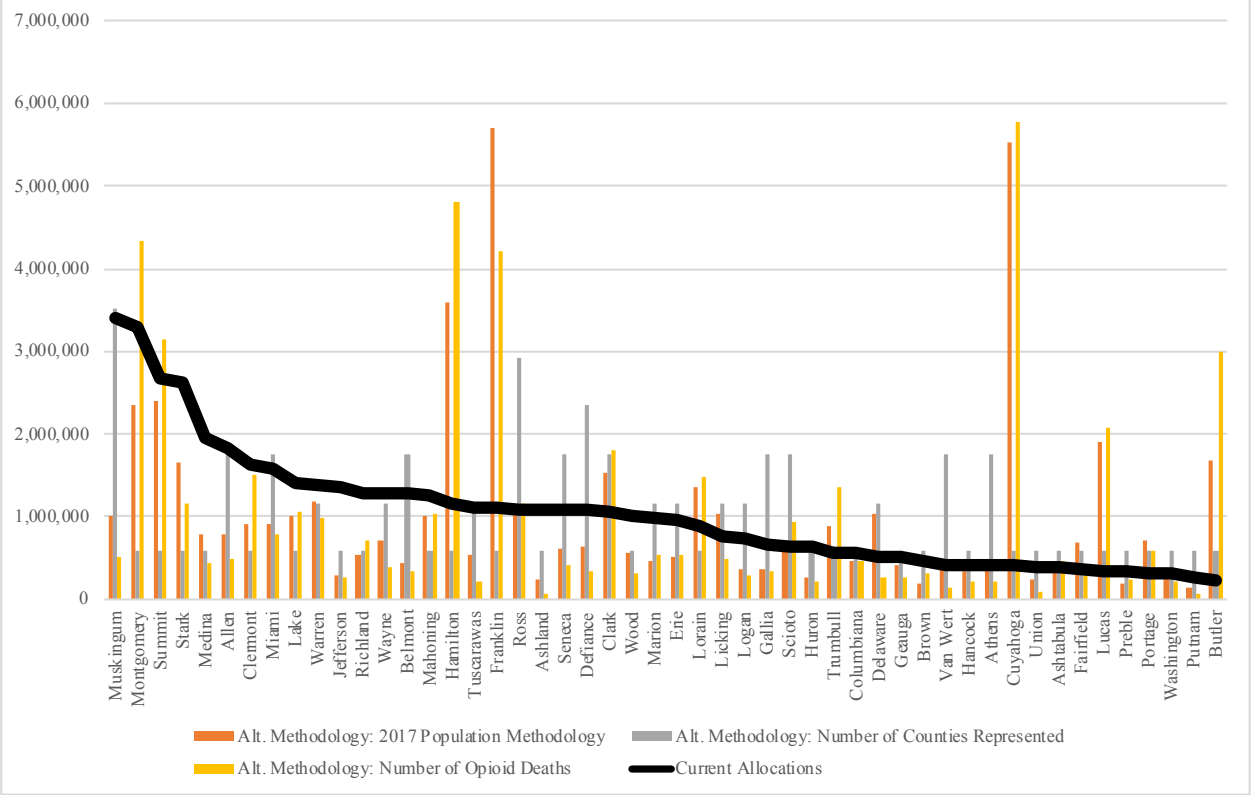
Table 1-2: Variance Between Methodologies

Metric	Funds Affected	Funds Affected as % Total
Number of Counties Served	$15,002,878	29.1%
Population of Counties Served	$18,142,099	35.2%
Opioid Deaths of Counties Served	$21,073,022	40.9%

Sources: U.S. Census Bureau, Ohio Department of Health, and OMHAS

Chart 1-7 shows the affect of redistributing funds on a per-board basis, showing the local impact of a revised Mental Health Continuum of Care methodology.

Chart 1-7: Impact of Revised Methodology



Sources: U.S. Census Bureau, Ohio Department of Health, and OMHAS

As shown in **Chart 1-7**, depending on the alternative methodology employed, there are vast differences in the current funding allocations compared with the methodologies used for other Continuum of Care funds per board. Those most affected by these methodologies include:

- **Number of Counties Served:** Ross, Athens, Van Wert, Defiance, and Scioto would gain the most funding. Montgomery, Summit, Stark, Medina, and Clermont would lose the most funding.
- **Population of Counties Served:** Cuyahoga, Franklin, Hamilton, Lucas, and Butler would gain the most funding. Muskingum, Medina, Jefferson, Allen, and Stark would lose the most funding.
- **Opioid Deaths in Counties Served:** Cuyahoga, Hamilton, Franklin, Butler, and Lucas would gain the most funding. Muskingum, Medina, Stark, Allen, and Jefferson would lose the most funding.

Conclusion

OMHAS allocates a portion of continuum of care funds to ADAMH boards based on the previous year's funding. This funding method does not account for changing conditions or needs. Revising the funding formula could allow ADAMH boards to better address critical priorities. This would likely increase the ability of OMHAS and counties to achieve these priorities, but would have an impact on the overall funding boards were receiving, both positive and negative.

Recruitment, Retention, Onboarding

Background

The Ohio Department of Mental Health and Addiction Services recruits and hires employees to carry out the mission of the organization, "to provide statewide leadership of a high-quality mental health and addiction prevention, treatment and recovery system that is effective and valued by all Ohioans."

The Office of Human Resources (OHR) is responsible for overseeing personnel and benefits, affirmative-action initiatives, education and training, labor relations, and workers' compensation. In speaking with Leadership, position-specific turnover was identified as a barrier to providing consistent care to the people served by OMHAS. Additionally, higher turnover generates more workload for OHR, both in terms of recruitment and selection of new talent and training new staff. **Table 2-1** shows the positions with the most turnover for FY 2018.

Table 2-1: Hires and Separations by Position

Category	Hires	Hires as a Percent of Total Hires	Separations	Separations as % of Total Separations
Therapeutic Program Worker	164	33.3%	131	27.8%
Psychiatric/DD Nurse	85	17.3%	73	15.5%
Licensed Practical Nurse	13	2.6%	25	5.3%
Correctional Program Coord.	37	7.5%	16	3.4%
Psychiatric Attendant	24	4.9%	16	3.4%
Social Worker 2	5	1.0%	11	2.3%
Social Worker 1	15	3.0%	9	1.9%
Custodial Worker	8	1.6%	6	1.3%
Psychiatric/DD Nurse Supv	3	0.6%	8	1.7%
Psychiatrist	11	2.2%	8	1.7%
Psychologist	7	1.4%	7	1.5%
All Other Positions	120	24.4%	161	34.2%
Total	**492**	**100%**	**471**	**100%**

Source: OAKS BI and OMHAS

As shown in **Table 2-1**, the 11 most separated positions within OMHAS account for 65.8 percent of all separations. Of these 11 positions, 10 are positions within the six regional psychiatric hospitals that OMHAS operates. Additionally, these 11 positions generally experience higher turnover than the Department average, which can be seen in **Appendix 2.1.** Therefore, these positions contribute to both the volume and rate of turnover. Therefore, the remainder of this section focuses on improvement for these position types, and necessitates a focus on hospital operations.

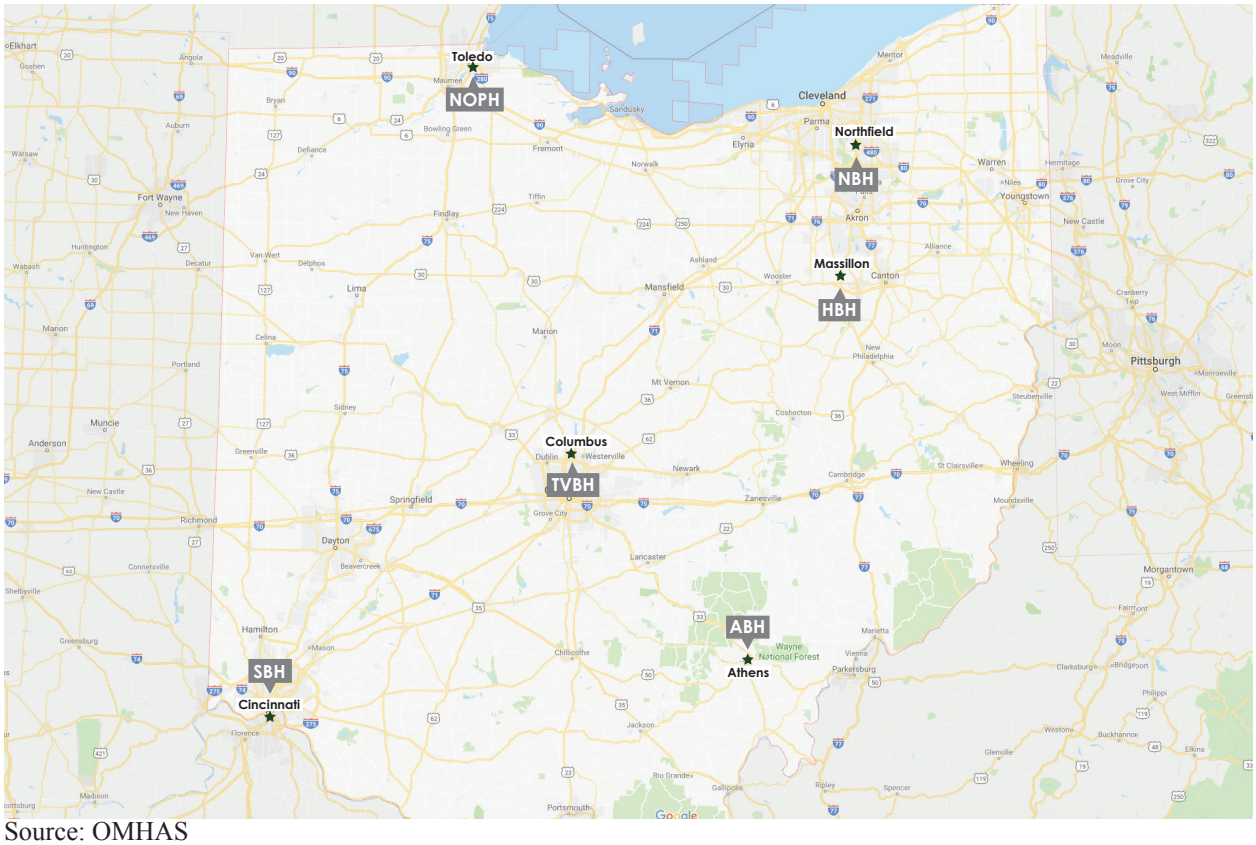
State Psychiatric Hospitals

The Department operates six regional psychiatric hospitals. State psychiatric hospitals are designed as providers of last resort for mental health services, that is, they provide short-term stabilization care for those who would not otherwise have access to private care, along with care to a forensic population.[14] The hospitals and their locations include:

- Appalachian Behavioral Healthcare (ABH) in Athens
- Heartland Behavioral Healthcare (HBH) in Massillon
- Northwest Ohio Psychiatric Hospital (NOPH) in Toledo
- Northcoast Behavioral Healthcare (NBH) in Northfield
- Summit Behavioral Healthcare (SBH) in Cincinnati
- Twin Valley Behavioral Healthcare (TVBH) in Columbus

Chart 2-1 shows the location of the regional psychiatric hospitals throughout the state.

Chart 2-1: State Psychiatric Hospital Locations



Source: OMHAS

As shown in **Chart 2-1**, regional psychiatric hospitals are located throughout the state to provide services to all constituents of Ohio.

[14] The forensic population includes patients who are awaiting trial and need services to restore competency, and patients who have been deemed unable to stand trial and need long-term psychiatric care.

Recommendation 2.1

Nursing Model

» Adjust the nursing and professional models to reflect the historical operational needs of the hospitals. In combination with adjusting shift scheduling practices within the regional psychiatric hospitals, this would reduce overtime, specifically mandated overtime, by more accurately estimating leave usage.

» Adjusting the nursing models and scheduling practices could save the state between $**250,000** and **$990,000** annually by reducing overtime associated with current scheduling practices.

Methodology

This section of the performance audit, **Nursing Model**, evaluates the effectiveness of the staffing model developed by OMHAS Hospital Services. Analysis compared current Department practices regarding the implementation of the staffing model in each of the six regional hospitals. Primary sources of data included the Ohio Administrative Knowledge System Business Intelligence (OAKS BI) application and internal information collected by OMHAS Hospital Services. Data and operations from FY 2018 will be the primary focus of analysis.

Each regional hospital has a customized approach to the care it provides to patients, which is driven by the number of specific types of patients with unique care needs that are admitted to each hospital. The hospitals are divided into units based on acuity[15]. OMHAS uses a nursing model to estimate the minimum number of staff needed at the regional hospitals. OMHAS monitors compliance with the nursing model, as well as overtime usage on a continuous basis. The nursing model attempts to take the differing needs of the units, as well as staff leave usage and other training requirements into account to determine the number of staff each hospital should employ to maintain 24/7 coverage. The hospitals schedule staff to cover each shift to these minimum standards.[16]

The nursing model is intended to calculate minimum staffing requirements, taking into account the operational need of the hospitals and leave time, such as comp time, occupational injury leave, sick leave, vacation leave, and personal leave. The model is used for direct-care staff, such as nurses and therapeutic program workers, as well as professional staff such as psychiatrists. The hospitals provide care every day of the week for 24 hours a day. To determine appropriate staffing levels, the nursing model attempts to account for all leave, training, operational needs, and the non-traditional business week by using a multiplier.

Traditional FTE of Nursing Required × **1.6** = Appropriate Staffing Level

[15] Acuity refers to the type of patient being treated in each unit, and infers different levels of care needed.

[16] The nursing model accounts for only some types of positions, and does not count nursing supervisors. These are staff that generally oversee the direct-care work provided to patients, but are available and able to do direct-care work if needed.

Appropriate Staffing Level calculates the number of employees necessary to cover shifts if all employees were traditional employees who work 2,080 hours. The following calculation converts the staffing levels calculated by the model to the minimum number of hours needed to cover the hospital shift operations.

Appropriate Staffing Level x **2,080** = Required Hours per Nursing Model

The analysis compares the minimum staffing hours required by each hospital with the actual hours worked in each hospital for FY 2018 to determine the appropriateness of the model. The analysis then investigates the results if the nursing models were improved.

Section Background

The following types of units are used to model minimum staffing for hospital services:

- Acute Care — for patients with short term stabilization needs. There is a high turnover of patients in this unit due to the short-term nature of the stays. Higher admissions and discharges lead to an increased workload for those activities associated with admitting and discharging patients.
- Restoration Unit — for patients admitted to the hospital through the court system, which is trying to restore competency to the patient so they can stand trial. This unit has less turnover than the acute unit, but still requires a higher level of staffing due to the nature of the patients. Patient stays are typically 60 days to six months.
- Forensic Unit — for patients who require care through the justice system because they have been deemed unable to stand trial due to their mental health status. Typically, these patients stay longer than 60 days.
- Moritz — for forensic patients with maximum security risks assigned through the justice system. Moritz units have a separate building facility on TVBH's campus.
- CLEAR — cares for patients w are about to be released back into the community, where patients have some access to the community. There is one CLEAR Unit, based in Cincinnati.

Table 2-2: Acuity in the Hospitals

Unit Type	ABH	HBH	NBH	NOPH	SBH	TVBH	Total
Acute	2	2	3	2	0	3	**12**
Forensic	2	3	5	3	6	3	**22**
Restoration	0	1	2	0	4	1	**8**
Moritz	0	0	0	0	0	4	**4**
CLEAR	0	0	0	0	1	0	**1**
Total Hospital Units	**4**	**6**	**10**	**5**	**11**	**11**	**47**

Source: OMHAS

As shown in **Table 2-2**, each hospital has a unique blend of unit types. This information is important in determining the number of staff to input into the nursing model, as units require different staffing levels to provide patient care. **Table 2-3** shows the minimum staffing required for each unit type to provide that patient care.

Table 2-3: Minimum Staffing Nursing Model

Unit Type	First Shift	Second Shift	Third Shift	Daily Total
Nursing Staff				
Acute	5.0	5.0	4.0	**14.0**
Forensic	4.0	4.0	4.0	**12.0**
Restoration	5.0	5.0	4.0	**14.0**
Moritz	4.0	4.0	4.0	**12.0**
CLEAR	4.0	4.0	4.0	**12.0**
Professional Staff				
Acute	N/A	N/A	N/A	**5.0**
Forensic	N/A	N/A	N/A	**3.0**
Restoration	N/A	N/A	N/A	**5.0**
Moritz	N/A	N/A	N/A	**1.5**
CLEAR	N/A	N/A	N/A	**1.5**

Source: OMHAS
Note 1: Staffing requirements vary based on the needs of the unit, including the number of beds on the unit and the type of care provided.
Note 2: Professional model staffing is based on total unit needs and not based on shift assignments, as evidenced by the N/A signifier in the table above.

As shown in **Table 2-3**, there are models for both nursing staff, which includes nurses and direct-care staff (known as Therapeutic Program Workers) and for professional staff, which includes psychiatrists, psychologists, and social workers.

Analysis

Table 2-4 shows the minimum staffing needed on each shift after taking into account the nursing model multiplier.

Table 2-4: Minimum Staffing Nursing Model with Multiplier

Unit Type	First Shift	Second Shift	Third Shift	Daily Total
Nursing Staff				
Acute	8.0	8.0	6.4	**22.4**
Forensic	6.4	6.4	6.4	**19.2**
Restoration	8.0	8.0	6.4	**22.4**
Moritz	6.4	6.4	6.4	**19.2**
CLEAR	6.4	6.4	6.4	**19.2**
Professional Staff				
Acute	N/A	N/A	N/A	**5.0**
Forensic	N/A	N/A	N/A	**3.0**
Restoration	N/A	N/A	N/A	**5.0**
Moritz	N/A	N/A	N/A	**1.5**
CLEAR	N/A	N/A	N/A	**1.5**
Grand Total	**35.2**	**35.2**	**32.0**	**118.4**

Source: OMHAS
Note: Professional model staffing is based on total unit needs and not based on shift assignments, as evidenced by the N/A signifier in the table above.

As shown in **Table 2-4**, after adding the multiplier, a total daily staffing number can be obtained for each unit type. **Table 2-5** then shows the total hours needed, based on the nursing model, for each unit type, taking into account the unit types in each hospital.

Table 2-5: Hours Needed per Nurse Model

Unit Type	ABH	HBH	NBH	NOPH	SBH	TVBH	Total
Acute	93,184	93,184	139,776	93,184	0	139,776	**559,104**
Forensic	79,872	119,808	199,680	119,808	239,616	119,808	**878,592**
Restoration	0	46,592	93,184	0	186,368	46,592	**372,736**
Moritz	0	0	0	0	0	159,744	**159,744**
CLEAR	0	0	0	0	39,936	0	**39,936**
Non-Unit Hours *	11,648	0	0	5,824	17,472	11,648	**46,592**
Nursing Subtotal	**184,704**	**259,584**	**432,640**	**218,816**	**483,392**	**477,568**	**2,056,704**
Professional Staff	33,280	49,920	83,200	39,520	82,160	72,800	**360,880**
Grand Total	**217,984**	**309,504**	**515,840**	**258,336**	**565,552**	**550,368**	**2,417,584**

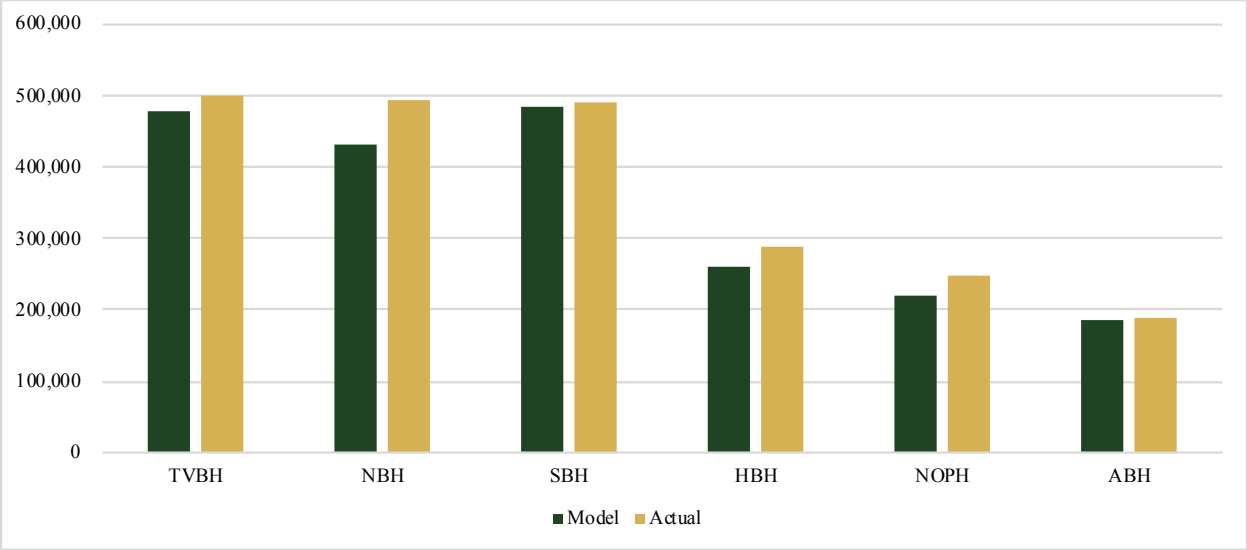
Source: OAKS
*Non-unit nurses are not part of the model and are used to provide coverage where needed. The following hospitals choose to operate with the position: ABH uses 4.0 FTE non-unit nursing positions, NOPH uses 2.0 FTE non-unit nursing positions, SBH uses 6.0 FTE non-unit nursing positions, and TVBH uses 4.0 FTE non-unit nursing positions.

Table 2-5 shows the total number of hours needed to minimally staff the regional psychiatric hospitals on a 24/7 basis with the current model assumptions. Based on the current model, approximately 2.4 million work hours are needed to minimally staff the regional psychiatric hospitals. This can then be compared with the number of work hours each hospital is reporting using payroll data.

Staffing

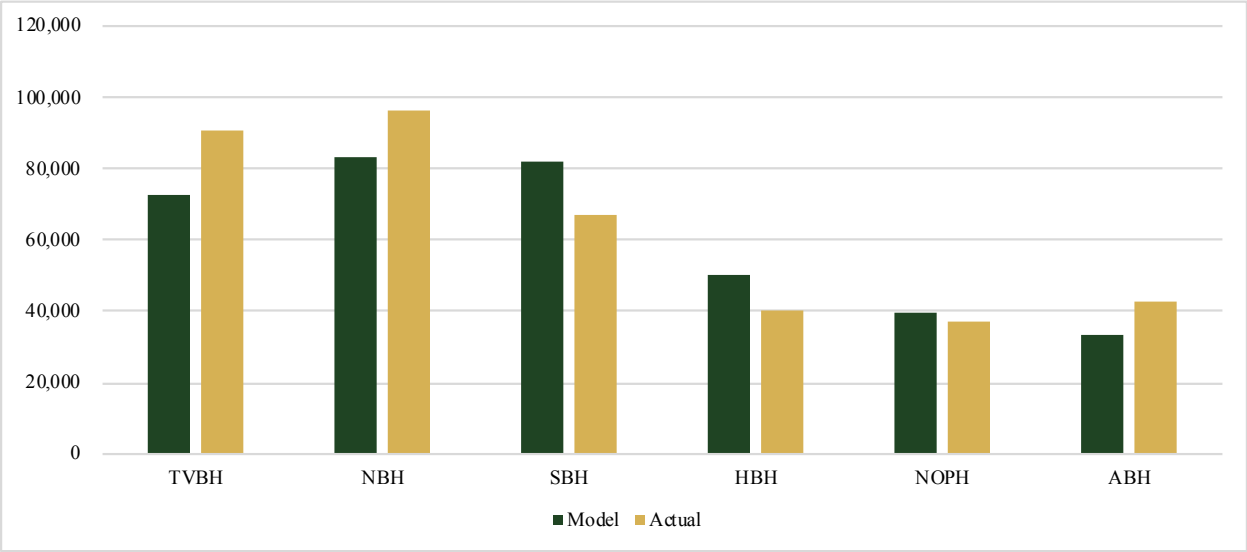
Chart 2-2 and **Chart 2-3** show the total hours worked by nursing and professional staff compared with the model in FY 2018. This includes regular, leave, and overtime hours, and provides an understanding of how the hospitals are performing in relation to the model.

Chart 2-2: Nurse Hours Compared with Model



Source: OAKS and OMHAS
Note: Hours exclude certain types of long-term leave that are not included as a part of the staff model.

Chart 2-3: Professional Staff Hours Compared with Model



Source: OAKS and OMHAS
Note: Hours exclude certain types of long-term leave that are not included as a part of the staff model.

Chart 2-2 shows that each hospital experiences higher hours for nursing staff than the model suggests. **Chart 2-3** shows that half of the hospitals are using more hours than the model suggests for professional staff hours, while the other half are using fewer hours than the model suggests (see **Recommendation 3.1 Recruitment Efforts**). Leadership identified recruiting professional staff, in particular, psychiatrists, a challenge in the current state.

This suggests that the model is not accurately estimating the number of hours needed by the positions in the nursing models. The multiplier could be adjusted to more accurately reflect the current operating environment of the hospitals. If more regular staff are available for work and shift scheduling is adjusted, hospitals could replace overtime hours with regular hours. Doing so would result in a reduction in overtime needed as well as reduce mandated overtime.

Impact Analysis

Table 2-6 shows a sensitivity analysis that reflects a range of improvement for reduced overtime if nursing model and shift scheduling adjustments result in reduced overtime.

Table 2-6: Overtime Sensitivity Analysis

Department Total Overtime Hours	231,984.96
Hospital Overtime Hours	175,152.54
Hospital Overtime Hours as a Percent of Total	75.5%
Department Total Overtime Cost	$9,366,799
Hospital Overtime Cost	$7,440,793
Hospital Overtime Cost as a Percent of Total	79.4%
Overtime Reduction Factor	10.0%
Financial Implication	$248,026.45
Overtime Reduction Factor	20.0%
Financial Implication	$496,052.89
Overtime Reduction Factor	30.0%
Financial Implication	$744,079.34
Overtime Reduction Factor	40.0%
Financial Implication	$992,105.78

Source: OAKS BI
Note: Overtime can be a financially beneficial practice when used appropriately. This analysis seeks to define the benefit if the hours worked are replaced with temporary or intermittent staff, used to cover regular workers' sick leave, which leads to mandated overtime in the hospitals.

As shown in **Table 2-6**, if OMHAS can replace overtime hours with regular hours worked[17], at a 10 percent reduction of overtime, they will realize a nearly $250,000 reduction in cost. If they were able to replace 40 percent of overtime hours worked with regular hours, OMHAS would realize nearly $1 million in savings. It is important to note that this analysis does not reduce the total number of work hours in the hospitals, but rather, shifts overtime hours to regular hours. To realize these efficiencies, hospitals will likely need to revisit their scheduling practices to have additional staff persons available to cover call-offs.

Conclusion

OMHAS's Hospital Services Department nursing model methodology could be adjusted and improved to more accurately reflect current operating practices, which will lead to reduced use of overtime. Not only is overtime costly, but mandated overtime can lead to poor morale among

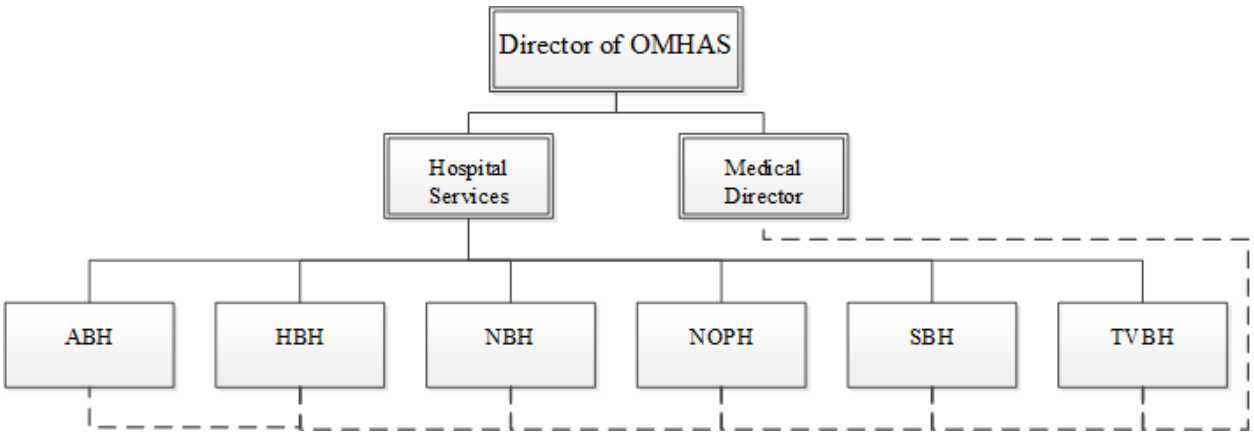
[17] This analysis assumes the use of intermittent or temporary labor pools for overtime replacement, which is already employed for these position types. If the Agency replaces overtime hours worked with full-time staff, these numbers would need to be adjusted to reflect appropriate benefits packages and reduced hours availability to compensate for paid leave usage.

workers, increasing turnover. Adjusting the nursing models to more accurately reflect the operating environments of the hospitals will assist in their efforts to hire and schedule staff, resulting in efficiencies for the Department.

Comment on Regional Psychiatric Hospital Governance and Organizational Structure

Chart 2-4 shows the Department's table of organization and lines of authority for the six regional psychiatric hospitals.

Chart 2-4 Regional Psychiatric Hospitals Table of Orgnaization



Source: OMHAS

As shown in **Chart 2-4**, OMHAS operates six regional psychiatric hospitals, located throughout the state. Per ORC § 5119.05, each hospital has its own CEO with certain authorities on behalf of the institutions. OMHAS oversees these hospitals and their budgets, however, ultimate authority over day-to-day operations of the hospitals rests with each respective hospital's governing board. However, the Office of Hospital Services is responsible for overseeing the regional hospital operations, and the Medical Director provides clinical oversight through each hospital's Chief Clinical Officer.

OMHAS operates with a decentralized structure at the regional psychiatric hospitals, meaning that each hospital's CEO has the ultimate governing authority over their own hospitals, even as OMHAS operates centrally to support the hospitals. Because OMHAS is a public institution, this structure is prescribed by state law, but this poses challenges to OMHAS to control costs and operate efficiently. Unlike private business, or even a government with a singular executive, in order to make meaningful change, each hospital CEO must be in agreement before any change can take place at all regional hospitals. As a result, OMHAS leadership must engage in coalition building to achieve these changes, particularly where shared services and operational efficiencies are concerned.

Opportunities remain to improve daily operational efficiency and effectiveness, and realizing this opportunity will help encourage long-term financial sustainability, as well as provide opportunities to improve patient care through increased programming with repurposed savings. Throughout the course of this performance audit, data and information were collected and analysis was performed that identified significant variation in the way that regional hospitals carry out day-to-day operations, negatively affecting daily efficiency. This information has been included where relevant to this performance audit report section.

Within any organization and operating environment there are barriers to change. Some may be legal, others are budgetary, and some are cultural and historical. OMHAS should consider the best governance structure to create a long-term sustainable solution to providing the best patient care possible to the community while ensuring efficient, effective, responsive service delivery.

Recommendation 2.2

Recruitment Efforts

» Improve recruitment efforts to reduce the number of contracted hours needed to provide professional services to patients and provide a better continuity of care.

» Replacing contracted hours with full-time staff for vacant positions in hospitals would save approximately $655,000 annually.

Methodology

This section of the performance audit, **Recruitment Efforts**, evaluates the effectiveness of the Department's ability to recruit staff. Analysis focused on the hires and separations in FY 2017-18. Data were obtained through the OHR administrators and the OAKS BI application and clarified through interviews with key stakeholders. Additionally, data on contracted labor for professional staff were collected from the regional hospitals.

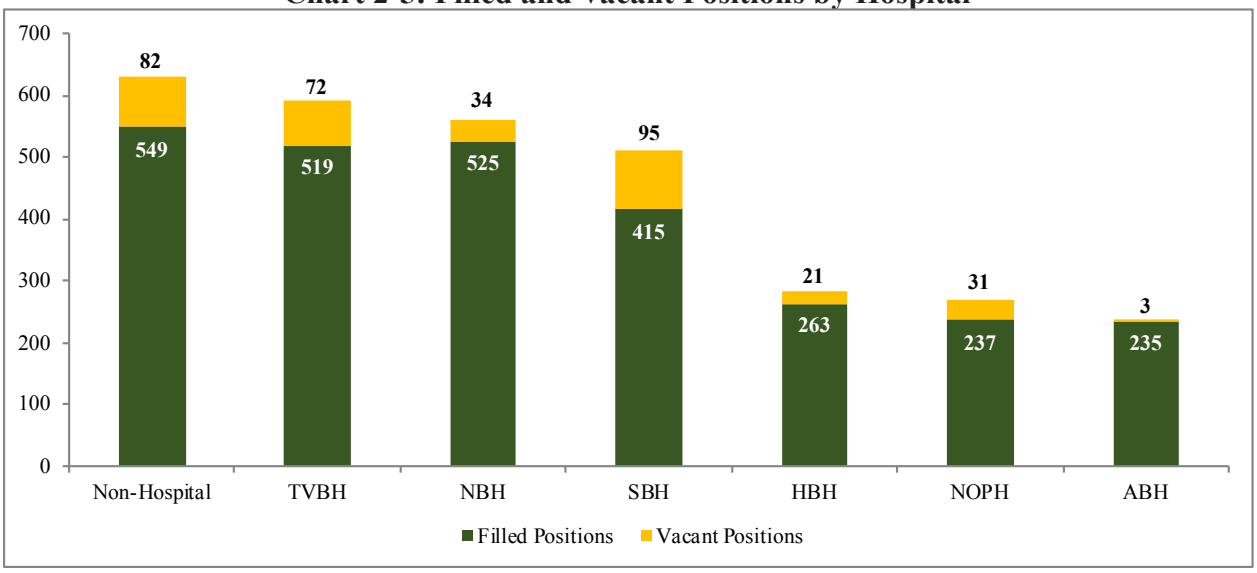
The analysis focuses on the Department's table of organization and overlays the hires and separation data[18]. Finally, the analysis shows difference in cost for contracted hours versus hiring regular staff to replace those same hours, accounting for both salary and benefits costs of regular staff.

Section Background

While OHR is responsible for hiring employees, each hospital CEO is its own appointing authority, and is responsible for their own hiring decisions. Therefore, each hospital is also responsible for its own mix of employees and their organizational structure. **Chart 2-5** shows the total number of filled and vacant positions by hospital, with all non-hospital positions grouped together.

[18] In some circumstances, the Department may employ patients during treatment as "working assistants." These positions are excluded from the analysis as they are not typical employees and are instead a part of patient-care programming.

Chart 2-5: Filled and Vacant Positions by Hospital



Source: OMHAS

As shown in **Chart 2-5**, there are vacancies in each of the hospitals and for non-hospital staff, with some locations experiencing higher vacancy rates than others at the time the table of organizations were reported.[19] While measuring the cost of these vacancies is difficult, vacancies do generate increased workload for current staff, which can lead to lower employee morale, increased overtime costs, and, in OMHAS's case, higher contracted costs.

OHR has worked to recruit staff through several recent initiatives, and has successfully negotiated the following benefits for positions that are difficult to fill:

- Geographical supplement
- Shift differential pay
- Vacation advancement
- Recruitment supplement based on experience
- Professional premiums for professional certifications
- Physician loan reimbursement
- Periodic retention supplement

Some of these benefits are available at each hospital, while others are available only in certain hospitals, such as the retention supplement.

However, notwithstanding these current efforts, many positions are still difficult to fill and this has an adverse effect on the ability of hospitals to meet the minimum staffing requirements for certain positions. One such example considers psychologists and psychiatrists, or professional staff. When the hospitals are unable to hire a regular staff member to fill these duties, they have

[19] Table of Organizations were provided as of one date in time, rather than a continuous monitoring of vacant positions.

the option to contract this work to temporary labor. This is not ideal for hospitals, as they pay a higher rate for these contracted hours. Additionally, the Office of Hospital Services mentioned that it is not ideal from a patient-care perspective, because their goal is to provide continuous care to their patients, rather than providing services from a variety of staff.

Analysis

In FY 2018, the Department contracted out approximately 12,400 hours of professional staff labor, mainly psychiatrists. The average hourly rate for contracted hours paid was $178.08. **Table 2-7** shows the total cost of contracted hours to OMHAS for all hospitals in FY 2018, compared with the cost of regular staff.

Table 2-7: Contracted Cost Comparison FY 2018

Total Contracted Costs	**$2,213,473.73**
In-House for same hours	$1,246,569.60
Fringe Benefit Cost	$311,642.40
Total Cost to Provide Service in-house	**$1,558,212.00**
Financial Impact	**$655,261.74**

Source: OMHAS and OAKS BI
Note: OMHAS's average hourly rate for psychiatrists is $100.29 with an average benefits ratio of 25.0 percent, which is the average benefits ratio actually experienced by this position type for FY 2018.

As shown in **Table 2-7**, the cost of contracting staff for 2,400 labor hours of professional staff was more than $2 million dollars. The same average cost of providing those labor hours in-house, including benefits, is approximately $1.5 million. If OMHAS can recruit additional staff to cover these hours, it can save approximately $655,000 annually.

Conclusion

The current practice of contracting professional staff when hospitals are unable to recruit sufficient levels of staffing is costly. With each hospital performing its own recruiting efforts, successes cannot be easily disseminated to the rest of the agency. Innovative efforts should be considered, new methods tested, and successes shared among the regional hospitals. Improving recruitment efforts should lead to better economic outcomes for the Department through reduced contracting costs.

Recommendation 2.3

Training Practices

» Standardize training efforts among hospitals to reduce the amount of variation in training staff at the regional psychiatric hospitals, and enable best practices to be adopted uniformly for all staff.

» Standard training for hospital personnel could save up to $360,000 annually.

Methodology

This section of the performance audit, **Training Practices**, evaluates the effectiveness of the Department's ability to train staff and evaluates the current practices of each regional hospital's training efforts. Data was obtained through the OMHAS training department and training staff at each regional hospital.

The analysis first calculates the length of time required by each hospital to train new staff by position type. Then, based on the hourly cost of each position trained, the analysis identifies the lowest cost among the hospitals as an internal best practice, and examines the impact of moving toward the most efficient training model for each position type.

Section Background

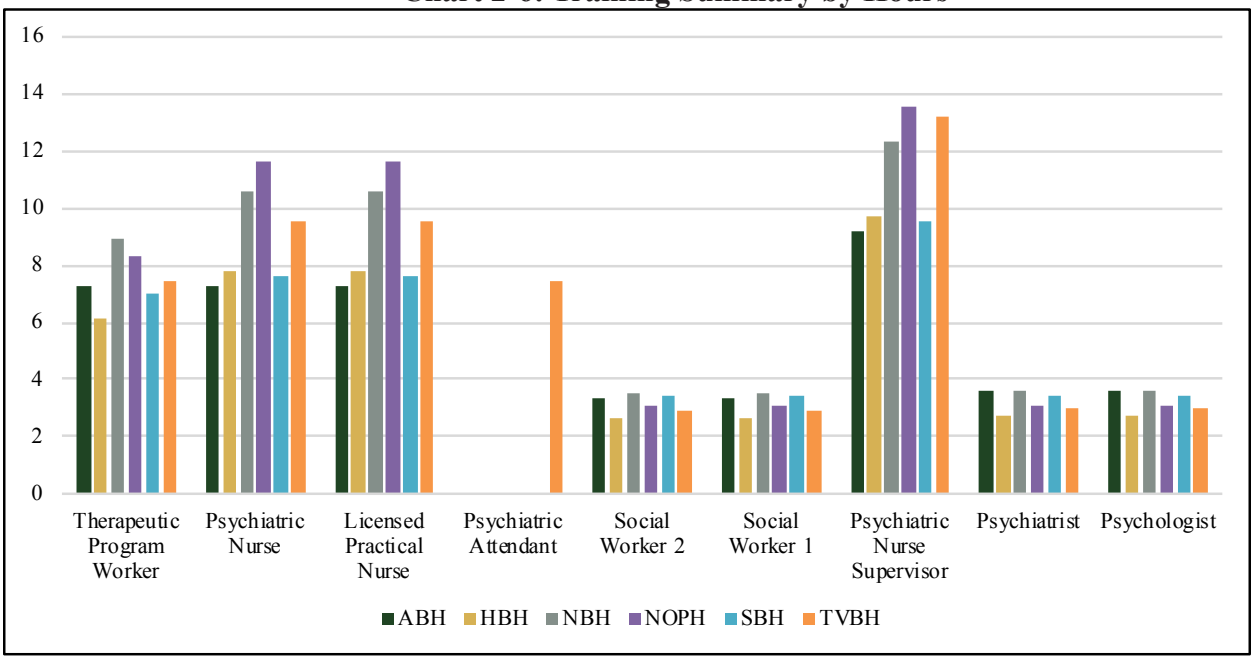
OHR oversees the training of all staff for OMHAS. However, regional hospital CEOs hire their own training staff and organize their reporting structure. The number of training staff at each regional hospital varies, but at a minimum, there is a training officer and a nurse educator. In some cases, these positions report to the same person, but not always. The varying structure can inhibit collaboration among those responsible for training individuals. As mentioned in Table 2-1, the position types most separated from OMHAS are hospital positions, and therefore this analysis focuses on the time it takes to train those positions. This time comes at a cost to the Department. This analysis quantifies this cost.

OHR has a training section that oversees the training at each of the regional hospitals. OHR tracks the training requirements needed by position type, and provides some standardized training to the regional hospitals. A training matrix is used to indicate which positions need which training requirements, which can be found in the **Appendix**. It is important to note that when standardized trainings are provided by OHR, they are not always used by the regional hospitals. The hospitals ultimately choose when and if to use the standardized training modules provided to them. The effects of such decisions are examined in the analysis.

Analysis

Chart 2-6 shows the total training hours required, by position type, in each hospital. This includes hours for orientation and any annual training requirements.

Chart 2-6: Training Summary by Hours



Source: OMHAS

As shown in **Chart 2-6**, variation in training times exists among the hospitals. In certain cases, the difference is more than two weeks. This affects the cost to the agency, but also impacts the ability of hospitals to get staff on the floor. When there is a shortage of staff, the time it takes to get a person hired and trained affects the amount of time the hospitals need to rely on overtime, particularly mandated overtime, to cover shortages. **Table 2-8** shows the base pay rates for these position types, which will be used to calculate the total cost to the agency, in wages, for newly hired employees.

Table 2-8: Base Pay Rates

Position	Base Pay Rate	Benefit Ratio
Therapeutic Program Worker	$16.43	48.2%
Psychiatric Nurse	$27.55	38.8%
Licensed Practical Nurse	$21.09	44.0%
Psychiatric Attendant	$17.28	49.0%
Social Worker 2	$22.91	42.1%
Social Worker 1	$21.01	45.7%
Psychiatric Nurse Supervisor	$33.96	35.2%
Psychiatrist	$72.96	25.0%
Psychologist	$33.32	34.0%

Source: DAS

Table 2-9 shows the wages earned by a new hire during the required training times shown in **Chart 2-6**.

Table 2-9: Wages Earned during Training for a New Hire, by Hospital

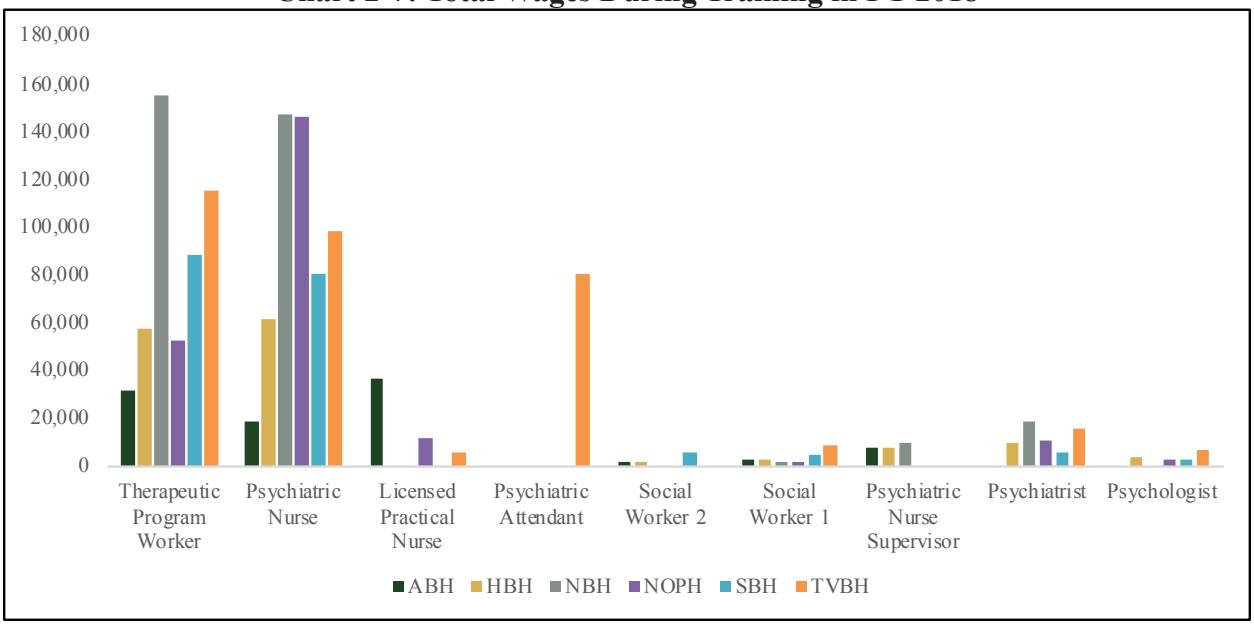
	Hospitals						
Position	ABH	HBH	NBH	NOPH	SBH	TVBH	Hospital Average
Therapeutic Program Worker	$2,878	$2,420	$3,533	$3,280	$2,752	$2,934	**$2,966**
Psychiatric Nurse	$4,825	$5,161	$7,026	$7,704	$5,055	$6,297	**$6,011**
Licensed Practical Nurse	$3,694	$3,951	$5,379	$5,898	$3,870	$4,820	**$4,602**
Psychiatric Attendant	N/A	N/A	N/A	N/A	N/A	$3,086	**$3,086**
Social Worker 2	$1,836	$1,479	$1,925	$1,680	$1,884	$1,605	**$1,735**
Social Worker 1	$1,684	$1,357	$1,766	$1,540	$1,728	$1,472	**$1,591**
Psychiatric Nurse Supervisor	$7,476	$7,889	$10,019	$11,025	$7,759	$10,751	**$9,153**
Psychiatrist	$6,322	$4,766	$6,386	$5,386	$6,054	$5,185	**$5,683**
Psychologist	$2,887	$2,176	$2,917	$2,460	$2,765	$2,368	**$2,595**

Source: OMHAS

Note: Psychiatric Attendants are only employed within TVBH's Moritz unit.

As shown in **Table 2-9**, based on position type, it costs between $1,500 and $9,100 to train new employees during their orientation and first year of annual training requirements. It is important to consider that this does not include benefits for that employee, wages earned by the training staff, or any of the time OHR incurs to hire new staff. Therefore, this is a very conservative measure of the cost of new hires to the agency. Increased turnover and therefore increased hiring needs lead to increased cost at each hospital. **Chart 2-7** shows the total wages spent on training for new hires for FY 2018.

Chart 2-7: Total Wages During Training in FY 2018



Source: OAKS
Note 1: Psychiatric Attendants are only employed within TVBH's Moritz unit.
Note 2: Psychiatric attendants are hired only for Mortiz units. Therefore, only TVBH employs this position type.

Chart 2-7 shows the total wages spent by position type. OMHAS spent more than $1.3 million on wages for new hires during their training period in FY 2018. **Table 2-10** shows the financial impact of each hospital moving to the most efficient training model, as identified in **Chart 2-7** above.

Table 2-10: Financial Impact

Position	ABH	HBH	NBH	NOPH	SBH	TVBH	Total
Therapeutic Program Worker	$7,455	$0	$72,549	$20,388	$15,713	$29,847	**$145,954**
Psychiatric Nurse	$0	$5,583	$64,149	$75,924	$5,099	$31,898	**$182,653**
Licensed Practical Nurse	$0	$0	$0	$6,347	$0	$1,949	**$8,296**
Psychiatric Attendant	N/A	N/A	N/A	N/A	N/A	$0	**$0**
Social Worker 2	$507	$0	$0	$0	$1,725	$0	**$2,233**
Social Worker 1	$954	$0	$596	$268	$1,622	$1,010	**$4,450**
Psychiatric Nurse Supervisor	$0	$559	$3,438	$0	$0	$0	**$3,997**
Psychiatrist	$0	$0	$6,078	$1,550	$1,611	$1,573	**$10,813**
Psychologist	$0	$0	$0	$380	$789	$770	**$1,939**
Total	**$8,916**	**$6,142**	**$146,811**	**$104,858**	**$26,560**	**$67,048**	**$360,334**

Sources: OMHAS and OAKS
Note: Includes wages for employees being trained and the cost of associated fringe benefits.

As shown in **Table 2-10**, the regional hospitals could save $360,000 by moving to the most efficient training model currently employed in the regional hospitals, based on FY 2018 hiring numbers. This change would have a greater impact at some hospitals, but all hospitals would realize some savings.

Conclusion

Training new staff is a vital role that OHR undertakes to better serve its clients. Decentralized structure and variation in training models at the regional hospitals provide an opportunity to examine the efficiency of such models and to make adjustments. Moving to a more standardized training model will allow the hospitals to get staff in place where needed, as well as reduce the wages spent during training.

Recommendation 2.4

Data Collection

» Improve the collection of exit interview data from employees to enable the Department to determine the causes of short tenure. This information will allow the Department to make adjustments to training practices, hiring practices, and employment practices as necessary to reduce turnover.
» Financial Impact: N/A

Methodology

This section, **Data Collection**, evaluates the effectiveness of the Department's collection of exit interview data. Data was obtained through Department HR administrators. Analysis focused on aggregating exit interview data from FY 2013-2019 to date.

Throughout the audit, high turnover was cited as a barrier to providing excellent care to the clients of OMHAS. Staff gathered data from OMHAS to attempt to determine what factors led to turnover within the agency.

Section Background

OMHAS sends an exit interview survey to employees who are separating from the Department. The survey collects a variety of information about the employees experience with the Department, and can provide valuable insight into why they are leaving. This information can be used to improve employee experiences and, ultimately, reduce turnover. The survey is sent to employees electronically by OHR after they are made aware of the separation.

Analysis

The exit interview survey was designed and implemented in CY 2013. Table 2-11 shows the exit interview data results for FY 2013-2019 to date.

Table 2-11: Exit Interview Survey Data Results

Fiscal Year	Exit Surveys	Retirement Surveys	% of Retirements	Average Salary Satisfaction	Average Orientation Satisfaction	Average On the Job Training Satisfaction
2013	138	44	31.9%	3.81	3.85	3.72
2014	70	7	10.0%	3.41	3.56	3.44
2015	68	13	19.1%	3.16	3.73	3.38
2016	92	11	12.0%	3.35	3.49	3.44
2017	23	3	13.0%	3.55	4.00	3.45
2018	34	12	35.3%	4.09	3.95	3.77
FYTD 2019	16	4	25.0%	4.00	3.92	3.83
Average	**63**	**13.43**	**20.9%**	**N/A**	**N/A**	**N/A**

Source: OMHAS

Note: FY 2019 does not include a full year of data

As shown in **Table 2-11**, the Department receives a small percentage of completed surveys each year. For example, in FY 2018, OMHAS experienced 471 separations, but received only 34 completed exit surveys, for a completion percentage of 7.2 percent. This is a missed opportunity to gain valuable insight into employee experiences with the Department.

According to *Making Exit Interviews Count,* Harvard Business Review (2016), exit interviews of varying formats can be valuable if done well. A strategic exit interview program provides insight into what employees are thinking, reveals problems in the organization, and sheds light on the competitive landscape. Done correctly, it can uncover issues related to HR, understand employees' perceptions of the work itself, gain insight into managers' leadership styles and effectiveness, learn about HR benchmarks (salary, benefits) at competing organizations, foster innovation by soliciting ideas for improving the organization, and create lifelong advocates for the organization. Additionally, making the interviews mandatory for some employees will increase the odds that some specific action will be taken. At OMHAS, this could be done when the employee is filling out their exit paperwork or turning in their badge and keys.

Conclusion

OHR distributes a survey to individuals leaving the department. This survey could provide valuable insight into the cause of turnover if implemented properly. Low rates of response from participants minimize the value of the information being collected, and hinder the Department in making meaningful improvements to its workforce. OMHAS should evaluate and improve the process by which it distributes the exit survey with the goal of improving employee experiences, increasing retention, and reducing turnover.

Recommendation 3.1

Prison Treatment and Recovery Programming

» Finalize an Inter-Agency Partnership Agreement with ODRC. Incorporate the framework to accurately measure programs' impact on offender relapse and recidivism.

» Financial implication: N/A

During the course of the audit, OMHAS and ODRC formalized their partnership agreement. The agreement was executed on May 30, 2019, laying out the terms and conditions of their partnership and data-sharing arrangement. The current Inter-Agency Partnership Agreement incorporates important elements such as policies, procedures, data and systems accessibility and ownership, roles and responsibilities, and facility access and workspace.

Methodology

This section of the performance audit focuses on the prison treatment and recovery programming offered by OHMAS to eligible offenders at Ohio Department of Rehabilitation and Corrections (ODRC) facilities. Specifically, it will focus on the Bureau of Correctional Recovery Services (BCRS or Recovery Services) and the Community Transition Program (CTP), which provide alcohol and drug treatment programming for individuals who are either incarcerated in, or recently released from, Ohio's prison system.

Data used in the analysis are from OMHAS and ODRC and include key information to analyze program participation and completion. The analysis uses data from FY 2018, the most current data at the time the analysis was completed. Data from FY 2014 through FY 2018 were used as needed to provide historical context.

Information was collected and analysis was performed to develop an operating profile of the BCRS and Community Transition Program. The analysis was conducted to identify trends in program participation and program completion rates, as well as to assess the performance of the BCRS and CTP programs.

Section Background

Prison Treatment and Recovery Programming History

Programs and services for substance-use disorders (SUD) are provided to offenders[20] through two bureaus at OMHAS.

- The Bureau of Correctional Recovery Services (BCRS) provides alcohol and other drug (AOD) programming to offenders incarcerated at each of the state's prisons.[21] These programs include group therapy, residential treatment programs, and other support and re-entry services. Offenders who have participated in BCRS programming are then eligible for additional treatment and services once released from prison.
- The Community Transition Program, a program administrated by OMHAS's Bureau of Criminal Justice, connects BCRS program participants[22] to services within the community. These services are provided within local communities by various provider agencies.

Ohio's prisons began offering alcohol and drug addiction services to offenders in 1988. In 1995, BCRS was established within ODRC, and tasked with managing prison treatment and recovery programming.[23] In 2015, the legislature transferred BCRS and its staff to OMHAS in an effort to increase the continuity of care between the prison system and the community.[24] At the same time, the legislature also made additional funding available for the establishment of the CTP. Following its establishment, the CTP began linking eligible offenders with local programming in July 2016.

Alcohol and Other Drug (AOD) Screening

As of January 2018, there were 49,437 individuals incarcerated in Ohio's 28 adult correctional institutions. Offenders are screened and assessed for needs and services when they enter prison. BCRS staff screen incoming offenders to identify individuals with substance-use disorders.[25] Those identified as needing treatment are provided access to BCRS programming.

Chart 3-1 shows the results of these screenings from FY 2014 through FY 2018. This demonstrates the need for prison treatment programs for those incarcerated.

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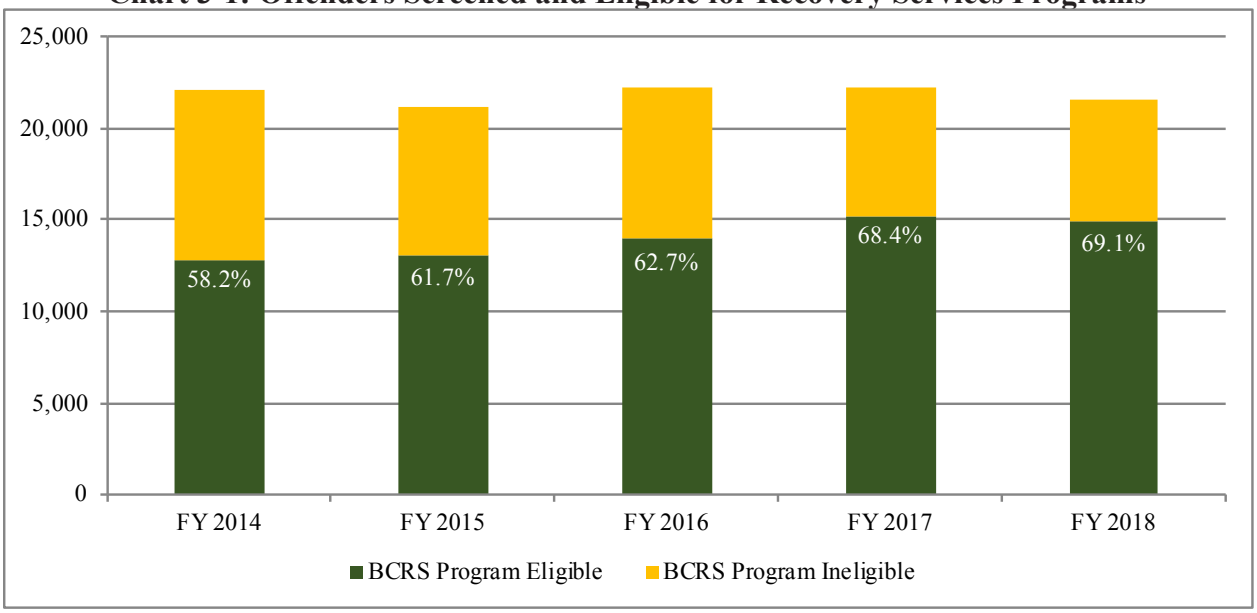
[20] For the purposes of this report, *offender* refers to an inmate or former inmate of ODRC.
[21] BCRS has a presence in all 28 correctional institutions in Ohio, which includes three private prisons.
[22] To be eligible for the CTP, an individual must participate in at least one day of BCRS treatment programming.
[23] The BCRS was established within ODRC by Executive Order 95-01.
[24] BCRS was transferred to OMHAS as part of the 131st General Assembly's budget, House Bill 64 (HB 64).
[25] Survey participants are assigned a level of care based on their Texas Christian University (TCU) score that range from an R0, indicating no need, to an R3, which is considerable need. Those with an R2 (moderate need) or R3 score are identified as having a substance-use disorder and are eligible for Recovery Services treatment.

Chart 3-1: Offenders Screened and Eligible for Recovery Services Programs



Source: OMHAS
Note: This shows offenders screened at the three reception centers and does not include new TCU screens completed at parent institutions. During FY 2018, screenings at parent institutions accounted for 1.3 percent of total screens.

Chart 3-1 shows the number of offenders screened and eligible for Recovery Services treatment programs. While the number of offenders screened has remained relatively constant, program eligibility has increased from FY 2014 through FY 2018. This demonstrates the growing demand for treatment.

Treatment

To connect offenders with the appropriate treatment,[26] OMHAS offers a range of structured treatment program options. The treatment programs and services offered at individual institutions depend on the facility's particular mission, size, security level, and staffing. Offenders are connected to these services depending on a variety of factors including their screening and assessment results, length of prison stay, where a particular program is offered, and the number of offenders awaiting programming at a particular institution. Programs range from four weeks to 12 months.[27]

[26] Offenders eligible for treatment are given an assessment that helps identify which treatment programs could be beneficial.
[27] Participation in Recovery Services programming is voluntary, but incentivized. Earned credit, or days off an individual's prison sentence, is awarded for productive program participation in certain Recovery Services programs.

Current treatment program offerings include:

- Therapeutic Community (TC)[28]
- Intensive Program Prisons (IPP)[29]
- Treatment Readiness Program (TRP)[30]
- Intensive Outpatient Program (IOP)[31]
- Recovery Maintenance Program (RMP)[32]
- Treatment Transfer Program (TTP)[33]
- Brief Intervention Program (BIP)[34]

In addition to the program offerings, BCRS staff provide AOD supplemental services. Supplemental support services are ongoing sessions and are used as part of, or in addition to, structured treatment programs. Examples of supplemental services include:

- Self-Help/Peer Groups/Alcoholics Anonymous (AA)/Narcotics Anonymous (NA)[35]
- Substance Abuse and Mentally Ill (SAMI)
- Outpatient[36]
- Recovery Dorm[37]
- Rule 39 Intervention Program[38]
- Voluntary tobacco-cessation program
-

Programming is provided to offenders prior to their release. As of January 22, 2019, more than 8,000 offenders were enrolled in BCRS programming but had not begun treatment. BCRS's internal goal is to provide treatment to offenders at least 18 to 24 months prior to release.

[28] The TC programs are run by personnel contracted by OMHAS. TCs are residential programs designed to provide a 24-hour recovery-oriented experience. There are six TCs offered at six correctional institutions in Ohio.
[29] The IPP was discontinued and phased out starting in October 2017. It's a 90-day program designed to provide intensive programming for eligible offenders in accordance with ORC § 5120.032.
[30] The TRP is a program that prepares offenders for treatment by focusing on participant motivation and readiness.
[31] IOP is operated consistent with OAC 5120-2-06, earned credit for productive program participation. It's a three-phase program that begins with the TRP and ends with the RMP.
[32] The RMP is a maintenance program following the completion of the Intensive Outpatient program.
[33] The TTP is completed within ODRC institutions prior to being transferred to halfway houses. It is a legislatively initiated program, specified in HB 64, for felony 4 or 5 drug offenders being incarcerated for the first time.
[34] The BIP targets those offenders who have a substance use history, but very short sentences which would not allow them time to complete the IOP.
[35] These are independent support groups organized by BCRS staff for substance abusers.
[36] Outpatient is a treatment service provided to offenders at the Ohio State Penitentiary (OSP). OSP is the highest security level prison with very lim ited movement, therefore programs are designed for pretreatment and motivational enhancement.
[37] A Recovery Dorm is a living space that is not Recovery Services exclusive. It's a pro-social dorm that provides services such as community services, recovery services, and religious services.
[38] Rule 39 is for offenders failing a urine screen during their incarceration, indicating drug use.

Treatment Staffing

The BCRS is responsible for tracking the progress of each offender enrolled in the above Recovery Services programs as they move through the treatment process.[39] Recovery Services clinicians[40] are responsible for updating and maintaining offenders' treatment records in the following ODRC systems: the Electronic Healthcare Record (EHR) system, Offender Risk Assessment System (ORAS), and the Department Offender Tracking System (DOTS).[41] Various imformation is gathered on each offender, including screening results, treatment plans, program enrollment, progress notes, program start and end dates, program termination or successful completion, and prison release date. This is used to measure the overall performance and outcome of the programming being offered to offenders.

Analysis

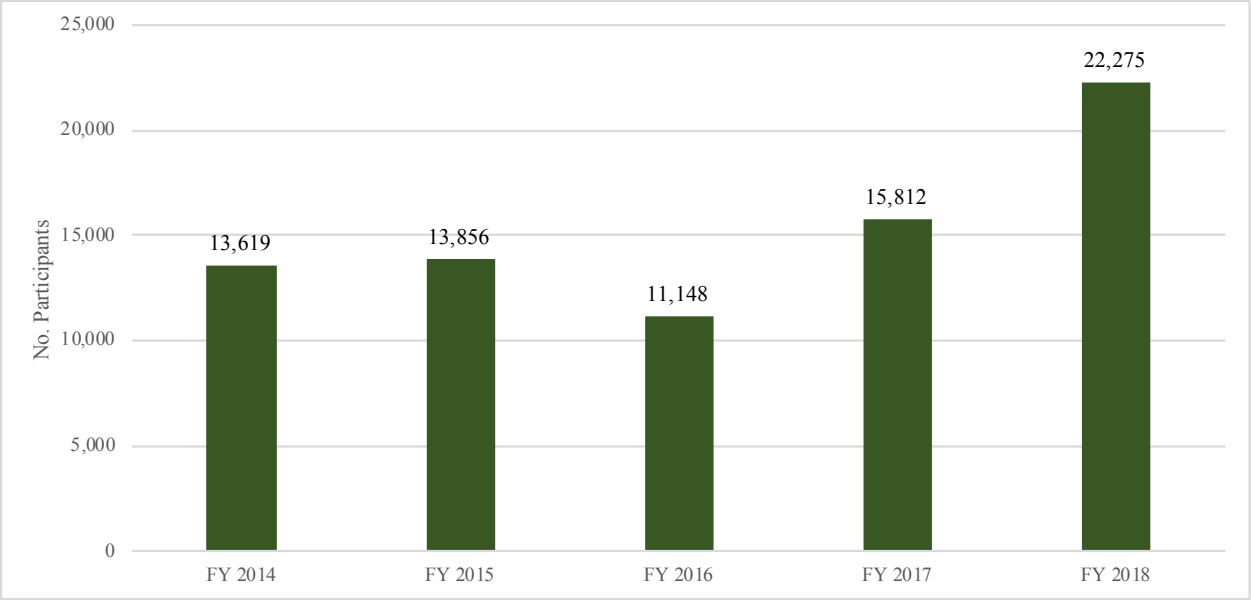
Program Participation

To measure participation in programs and services, OMHAS tracks offender engagements. Offenders can participate in more than one BCRS treatment program or service, and each time they participate, it is considered an offender engagement. From FY 2014 through FY 2018, Recovery Services had approximately 76,710 offender engagements.

Chart 3-2 shows the overall Recovery Services program participation from FY 2014 through FY 2018. This is useful for understanding the trend in participation over time.

[39] As of January 2019, BCRS had 200 employees who are responsible for carrying out the day-to-day operations involved in providing alcohol and drug treatment to offenders. Vacant positions were not included in the staffing. At the time of the analysis, there were 28 vacant positions.
[40] BCRS clinicians are categorized by OMHAS as Correctional Program Coordinators (CPCs).
[41] Their receipt, use, disclosure, transmission, maintenance, transportation, processing, or otherwise dealing with offenders' Protected Information is fully bound by the provisions of the Federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the privacy and security regulations issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164.

Chart 3-2: Overall AOD Program Participation

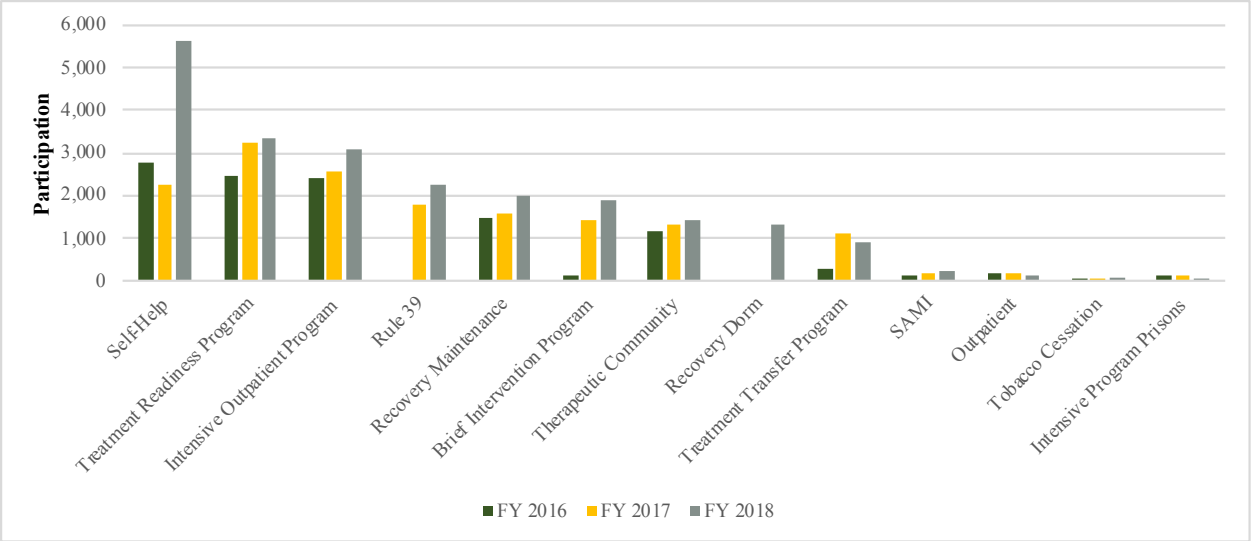


Source: OMHAS

As shown in **Chart 3-2**, aside from a slight drop in participation between FY 2015 to FY 2016, notably around the time Recovery Services transitioned from ODRC to OMHAS, participation has been increasing steadily. From FY 2014 through FY 2018, participation in Recovery Services programs increased from 13,619 to 22,275, or 63.6 percent.

Chart 3-3 shows offender participation for each individual treatment program and supplemental service from FY 2016 through FY 2018. This can help demonstrate the trend in participation for individual programs and services over time as well as identify meaningful trends or fluctuations indicating changes in program offerings or organizational needs.

Chart 3-3: AOD Programs and Supplemental Services Participation



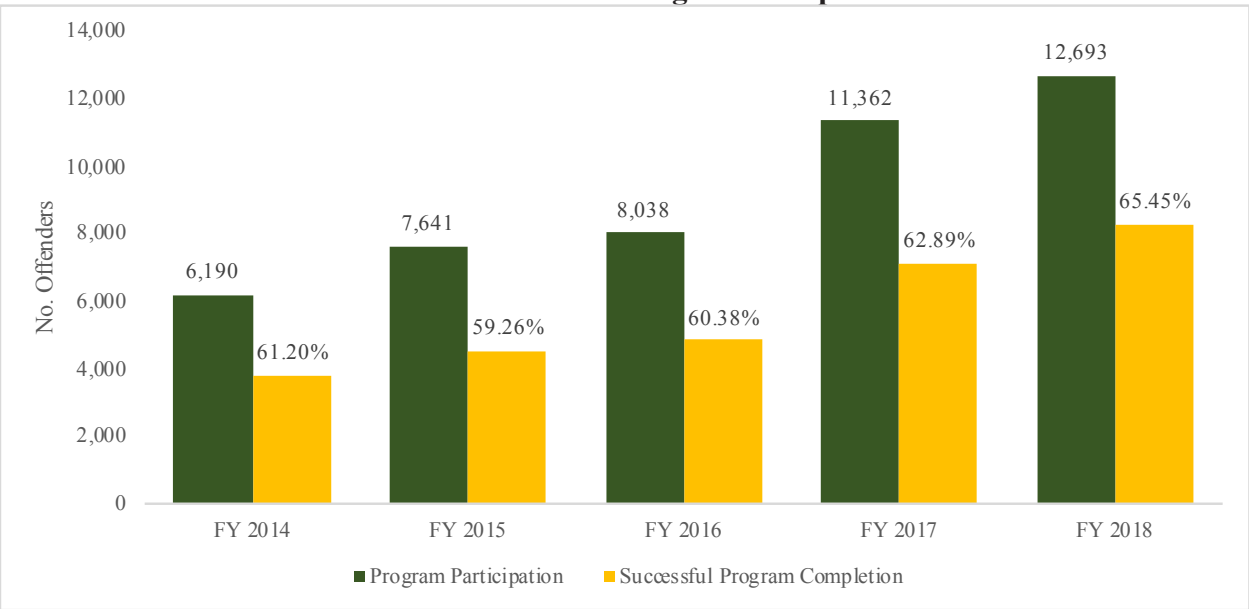
Source: OMHAS
Note 1: IPP was discontinued in October of 2017
Note 2: Rule 39 and Recovery Dorms began in 2017 and 2018 respectively.

As shown in **Chart 3-3**, the overall increase in participation identified in **Chart 3-2** was not just observed in a single program, but was a trend program-wide.[42] The Self Help/Peer Groups, the Treatment Readiness Program, and the Intensive Outpatient Program, make up 54.0 percent of the overall participation rate in FY 2018.

[42] The IPP and the TTP programs did not see an increase in participation rate from FY 2016 through FY 2018. The IPP was discontinued in October 2017 and phased out, whereas the TTP fluctuates because it is provided only to offenders who qualify under certain provisions of the ORC.

Chart 3-4 shows the number of offenders from FY 2014 through FY 2018 who enrolled and participated in Recovery Services treatment programs, and the number of offenders who successfully completed the treatment programs.[43] This demonstrates the increased progress of offenders as they move through Recovery Services programming and the increased caseload managed by Recovery Services workers.

Chart 3-4: Successful Program Completions



Source: OMHAS
Note: This shows individual treatment program participants and those that successfully complete a treatment program. It does not include participation in supplemental services.

As shown in **Chart 3-4**, as participation in Recovery Services programs has increased, so has the successful completion of the programming. From FY 2014 through FY 2018, there was a 105.1 percent increase in program participation and a 119.3 percent increase in successful program completion.

Community Linkage Services

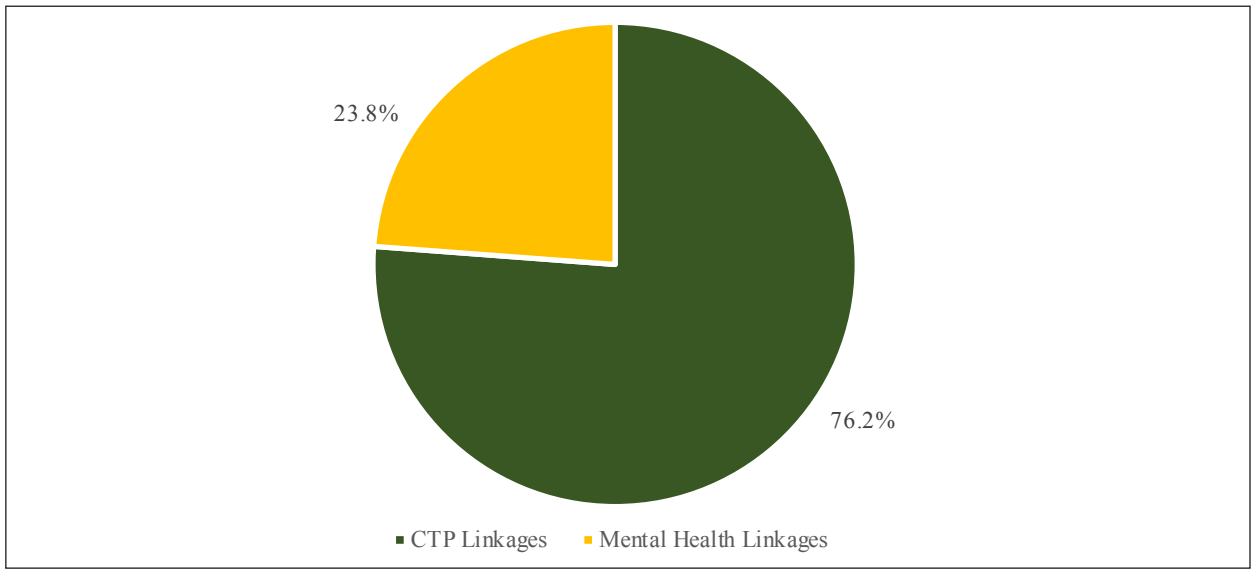
Offenders who participate in at least one day of Recovery Services programming are eligible to enroll[44] in the Community Transition Program. The CTP provides reentry services to qualified offenders leaving the prison system with connections to continued AOD treatment and recovery supports in the community.[45]

[43] The participation and completion rates include offenders that participate in, and complete, Recovery Services treatment programs. Offenders may participate in more than one treatment program. The TRP, IOP and RMP are part of a three-phase program. Offenders that complete phase one (TRP) are eligible to participate in, and complete, phase two (IOP) and phase three (RMP).
[44] For the purposes of this audit, CTP enrollment is also referred to as a linkage, or community linkage. It does not occur until an eligible individual is nearing the end of their prison sentence.
[45] CTP services are provided for one year post-release from prison and include treatment services such as Medica-

Fourteen community linkage workers are responsible for connecting all eligible offenders with community-based care.[46] Community linkage workers link offenders who have participated in Recovery Services programing, as well as those receiving mental health treatment through ODRC's Bureau of Behavior Health Services.

Chart 3-5 shows the community linkage workload for both the substance abuse population enrolled in the Community Transition Program, and the mental health population during FY 2018. This demonstrates the number and type of linkages managed by linkage workers.

Chart 3-5: Community Linkages



Source: OMHAS

As shown in **Chart 3-5**, the caseload managed by linkage workers primarily consists of the substance abuse population. Of the 4,427 community linkages that occurred in FY 2018, 76.2 percent were for the substance abuse population, while 23.8 percent were for the mental health population.[47]

BCRS Program Participation and CTP Enrollment

Chart 3-6 shows the number of individual offenders that participated in Recovery Services treatment programs, and the number of offenders that enrolled in the CTP from FY 2016 through FY 2018.[48] This shows the trend in BCRS participation and CTP linkage over time.

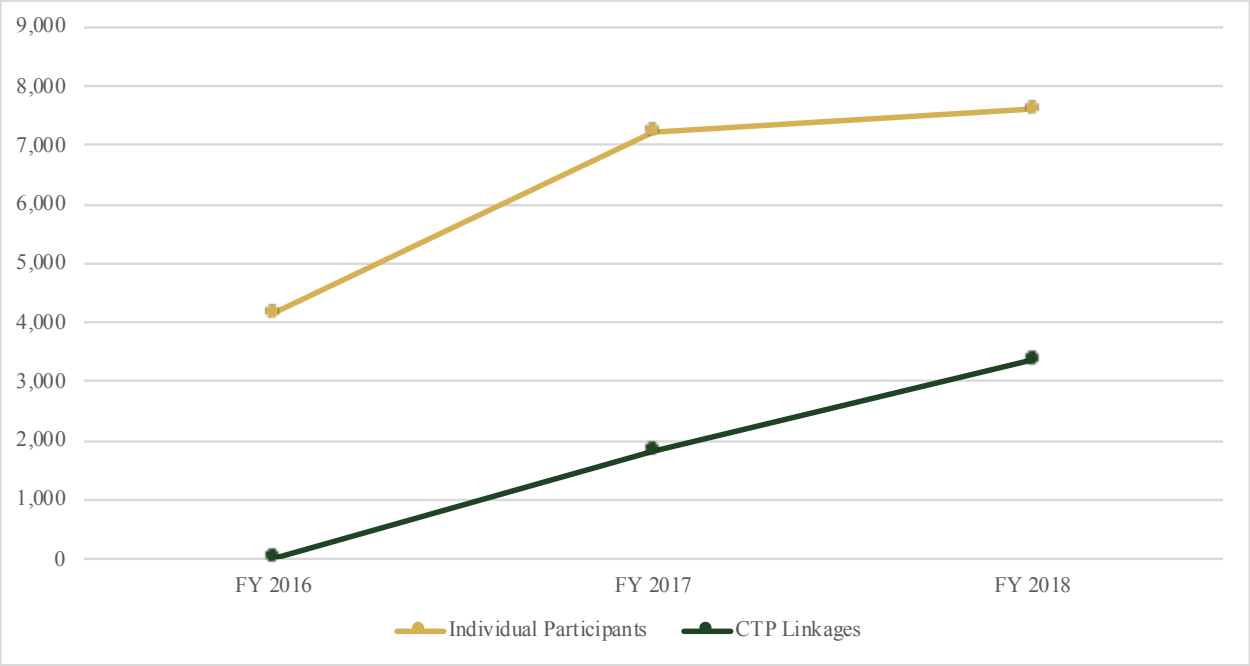
tion-Assisted Treatment (MAT) and detox services, recovery supports such as housing and employment services, and administrative services such as case management and prison in-reach.

[46] Community linkage workers are categorized by OMHAS as Correctional Program Coordinators (CPCs), but are more commonly referred to as linkage workers to differentiate between them and the Recovery Services CPCs.

[47] It is important to note that an estimated 25 percent of offenders participating in Recovery Services treatment have a co-occurring substance abuse and mental illness.

[48] BCRS program participation also includes individuals who are still incarcerated and not yet eligible for post-release services through the CTP. Any offender who participates in BCRS programming is eligible for the CTP, but

Chart 3-6: Individual BCRS Program Participants and CTP Linkages



Source: OMHAS
Note: This shows each individual program participant, and does not show overall offender engagements.

As shown in **Chart 3-6**, the number of individuals participating in BCRS programs has increased 83.0 percent over a three-year period. In addition, CTP linkages increased since the programs establishment in FY 2016. As of FY 2018, there were 5,221 CTP linkages. This chart shows program participation and CTP linkages are on an upward trend and that in FY 2018, 44.3 percent of individual offenders who have participated in AOD treatment programs have enrolled in the CTP. This information was also examined at each of the 28 institutions (see **Appendix 3-B**). With a few exceptions, the upward trend in the two metrics was also apparent at each institution.

Relapse and Recidivism

While **Chart 3-2** through **Chart 3-6** show that participation in the BCRS and the CTP programs increased significantly over the last few years, there is no clear means to measure overall program success. OMHAS uses two methods to measure the performance and success of prison treatment and recovery programming efforts. The first is a series of surveys provided to offenders in a pilot program at five institutions before, during and after completing recovery services treatment, and then six months post-release from prison. The data collected include program participation, program completion, and linkage into the community, as well as the surveys used to

they are not approached by linkage workers to enroll in the CTP until they are closer to their release date (approximately 180 days or less from release), therefore, there is not a direct correlation between BCRS program participation and CTP linkages.

assess criminogenic thinking[49] and satisfaction with the services. This method is used to provide an understanding of how certain services such as counseling, housing, employment and other factors can contribute to continued abstinence from alcohol and drugs.

The second method used to measure success is recidivism, or an individual's relapse into criminal behavior that results in re-arrest or return to incarceration. ODRC is responsible for tracking and maintaining recidivism data.

Both methods are important to measuring the overall success of the programming, which is demonstrated by an inmate's ability to successfully reenter society without relapsing into substance abuse or recidivating. Throughout the audit, the lack of current recidivism data has limited the ability to further analyze the effects that programs and services have on the rate of recidivism.

Both of these methods for measuring performance involve a significant amount of collaboration and data sharing between agencies. For the agencies to work together and share data, appropriate inter-agency agreements need to be in place prior to a formal partnership taking place. However, when the legislature transferred BCRS to OMHAS in July 2015, a formalized partnership agreement was not finalized. Since that time, daily operations have been carried out according to a draft partnership agreement between the two agencies.

According to the Government Accountability Office (GAO), an effective Inter-Agency Partnership Agreement can enhance and sustain collaborative efforts between agencies by including elements such as defining a common outcome; developing joint strategies; leveraging resources; agreeing on roles and responsibilities; reinforcing accountability; utilizing performance management systems; and developing mechanisms to monitor, evaluate, and report results.

OMHAS leadership identified three key issues that hampered inter-agency/program collaborative efforts: 1) the ownership of data and data systems, 2) incompatibility between data systems, and 3) lack of communication between agencies. These communication issues have resulted in confusion regarding agency responsibilities and duties. Furthermore, the lack of a finalized agreement hindered OMHAS's ability to gather the data and information necessary to measure the performance and success of the prison treatment and recovery programming.

Conclusion

In FY 2018, more than 49,400 offenders were incarcerated within Ohio's adult correctional facilities, and the average annual cost to house an inmate was $27,834.90. This demonstrates the number of offenders that Ohio taxpayers are paying to house in a state correctional institution, and the savings that could be realized if released offenders did not reenter the prison system.

[49] Criminogenic thinking refers to characteristic cognitive styles or belief systems that tend to precede criminal activities.

Although program participation, program completion, and linkage rates have increased during the time frame examined, OMHAS is unable to determine if its programming is improving long-term outcomes. ODRC broadly tracks recidivism rates, but does not track it on an individual basis for those who participate in recovery services programming or enroll in the CTP. Therefore, OMHAS lacks the data necessary to calculate the rate of individuals who participate in BCRS programming and relapsed or were re-incarcerated. As a result, OMHAS prison treatment and recovery programming efforts can only measure its performance based on the completion rates of the programs themselves, rather than the ongoing effects the programs may or may not have had on the inmate's ability to successfully reenter society. Collecting and analyzing outcomes-focused data is vital to measuring the success of government initiatives. It is necessary to ensure an efficient delivery of services to those who need it, and to maximize potential positive outcomes by redirecting scarce resources to where program effectiveness is demonstrated.

An Inter-Agency Partnership Agreement should incorporate requirements for collecting data that can be used as performance indicators to measure the success of the Recovery Services and CTP programs and their participants. This data should incorporate elements of both criminogenic thinking and behaviors as well as recidivism data to fully measure the effect that the programs and services have on the rate of relapse, recidivism, and, ultimately, an individual's ability to successfully reenter society.

Issue for Further Study

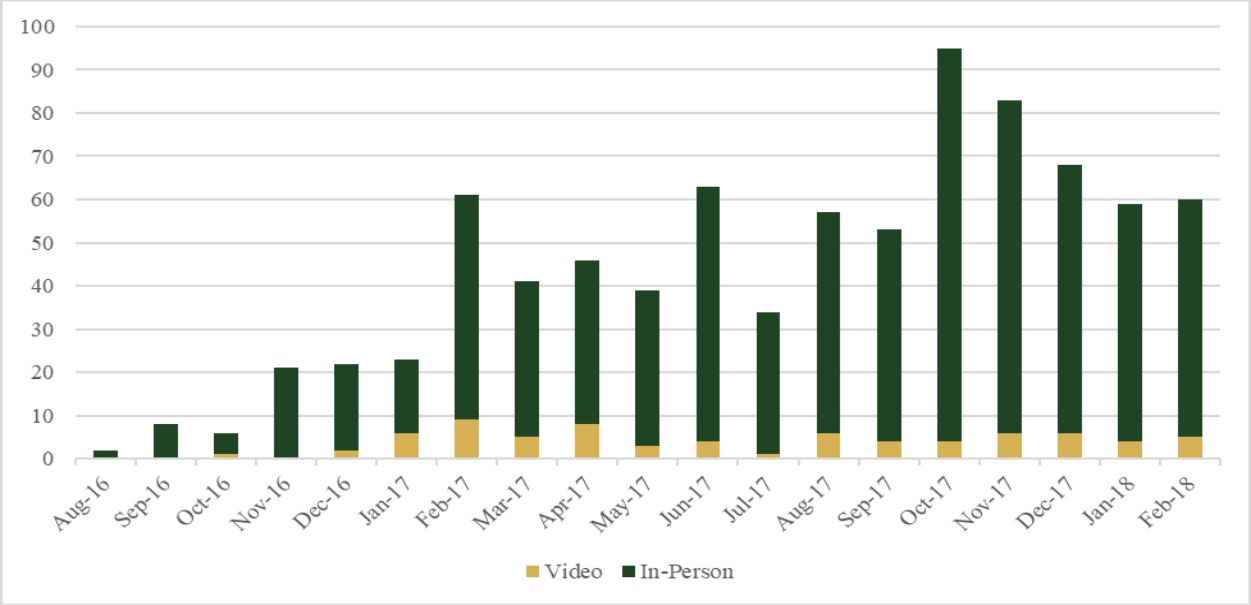
Issues are sometimes identified by AOS that are not related to the objectives of the audit, but could yield economy and efficiency if examined in more detail. During the course of the audit, OMHAS's practice of allowing service providers full discretion over whether to perform in-person or video-conferencing in-reaches was identified as one such issue.

Prison in-reaches occur when an eligible offender is nearing the end of their prison sentence and preparing to reenter the community.[50] A designated CTP provider agency will meet with an offender either in person or via video-conferencing to provide them with information regarding treatment and support services that are available to them within the community into which they are being released. A provider agency can bill $350.00 for in-reaches that occur in person, and $150.00 for in-reaches that occur via video-conferencing. The use of video-conferencing for in-reaches can be influenced by factors outside of OMHAS's control, such as the providers not having video-conferencing equipment, or the lack of available equipment in prison.

Chart 3-7 shows the number of provider in-reaches from August 2016 through February 2018. This demonstrates the trend in in-reaches over time.

[50] To be eligible, an offender must have participated in at least one day of Recovery Services alcohol or drug addiction treatment programming and be enrolled in the CTP.

Chart 3-7: Provider In-Reaches by Month



Source: OMHAS
Note 1: Provider agencies have up to one year to bill for services, therefore, February 2018 was the last month of complete in-reach data available at the time of the analysis.
Note 2: Individual offenders can receive more than one provider in-reach.

As shown in **Chart 3-7**, the number of in-reaches has continued on an upward trend. Overall, there were 841 CTP provider in-reaches between August 2016 and February 2018. Further, while in-person in-reaches have steadily increased during the time frame examined, video in-reaches have remained stagnant, typically staying under 10 per month.

Provider in-reaches have continued to rise since the program's establishment. Due to the reduced Department cost of video in-reaches, increasing the use of these services could yield significant savings if CTP in-reaches continue to grow. However, the data required to determine whether video-conferencing or in-person in-reaches are equally effective in terms of an individual's successfully reentry into a community were unavailable at the time of the audit due to the program's recent implementation. As data continue to be tracked, an analysis could yield insight into the success of these in-reaches and their associated cost.

Appendix

Appendix 1.A: Board Name and Host County by County

COUNTY	BOARD	HOST COUNTY
Adams	Adams Lawrence Scioto - Alcohol & Drug Addiction and Mental Health Services Board	Scioto
Allen	Mental Health & Recovery Services Board of Allen, Auglaize, and Hardin Counties	Allen
Ashland	Mental Health & Recovery Board of Ashland County	Ashland
Ashtabula	Ashtabula County Mental Health & Recovery Services Board	Ashtabula
Athens	Athens-Hocking-Vinton Alcohol, Drug Addiction and Mental Health Services Board	Athens
Auglaize	Mental Health & Recovery Services Board of Allen, Auglaize, and Hardin Counties	Allen
Belmont	Mental Health & Recovery Board serving Belmont, Harrison, and Monroe counties	Belmont
Brown	Brown County Board of Mental Health & Addiction Services	Brown
Butler	Butler County Mental Health & Addiction Recovery Services Board	Butler
Carroll	ADAMHS Board of Tuscarawas & Carroll Counties	Tuscarawas
Champaign	Mental Health, Drug & Alcohol Services Board of Logan & Champaign Counties	Logan
Clark	Mental Health & Recovery Board of Clark, Greene, & Madison Counties	Clark
Clermont	Clermont County Mental Health & Recovery Board	Clermont
Clinton	Mental Health Recovery Services of Warren and Clinton Counties	Warren
Columbiana	Columbiana County Mental Health and Recovery Services Board	Columbiana
Coshocton	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Crawford	Crawford-Marion Board of Alcohol, Drug Addiction, and Mental Health Services	Marion
Cuyahoga	ADAMHS Board of Cuyahoga County	Cuyahoga
Darke	Tri County Board of Recovery & Mental Health Services (Darke, Miami, & Shelby Counties)	Miami
Defiance	Four County Board of Alcohol, Drug Addiction, & Mental Health Services	Defiance
Delaware	Delaware-Morrow Mental Health & Recovery Services Board	Delaware
Erie	Mental Health & Recovery Board Erie and Ottawa Counties	Erie
Fairfield	Fairfield County ADAMH Board	Fairfield
Fayette	Paint Valley ADAMH Board	Ross
Franklin	ADAMH Board of Franklin County	Franklin
Fulton	Four County Board of Alcohol, Drug Addiction, & Mental Health Services	Defiance
Gallia	Gallia-Jackson-Meigs Board of Alcohol, Drug Addiction and Mental Health Services	Gallia
Geauga	Geauga County Board of Mental Health & Recovery Services	Geauga
Greene	Mental Health & Recovery Board of Clark, Greene, & Madison Counties	Clark
Guernsey	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Hamilton	Hamilton County Mental Health & Recovery Services Board	Hamilton
Hancock	Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	Hancock
Hardin	Mental Health & Recovery Services Board of Allen, Auglaize, and Hardin Counties	Allen
Harrison	Mental Health & Recovery Board serving Belmont, Harrison, and Monroe counties or MHRB	Belmont
Henry	Four County Board of Alcohol, Drug Addiction, & Mental Health Services	Defiance
Highland	Paint Valley ADAMH Board	Ross
Hocking	Athens-Hocking-Vinton Alcohol, Drug Addiction and Mental Health Services Board	Athens
Holmes	Mental Health & Recovery Board of Wayne & Holmes Counties	Wayne
Huron	Huron County Board of Mental Health and Addiction Services	Huron
Jackson	Gallia-Jackson-Meigs Board of Alcohol, Drug Addiction and Mental Health Services	Gallia
Jefferson	Jefferson County Prevention & Recovery Board	Jefferson
Knox	Mental Health & Recovery for Licking & Knox Counties	Licking
Lake	Lake County ADAMHS Board	Lake

Lawrence	Adams Lawrence Scioto - Alcohol & Drug Addiction and Mental Health Services Board	Scioto
Licking	Mental Health & Recovery for Licking & Knox Counties	Licking
Logan	Mental Health, Drug & Alcohol Services Board of Logan & Champaign Counties	Logan
Lorain -MH	Lorain County Board of Mental Health	Lorain
Lorain -ADA	Alcohol and Drug Addiction Services Board of Lorain County	Lorain
Lucas	Mental Health & Recovery Services Board of Lucas County	Lucas
Madison	Mental Health & Recovery Board of Clark, Greene, & Madison Counties	Clark
Mahoning	Mahoning County Mental Health & Recovery Board	Mahoning
Marion	Crawford-Marion Board of Alcohol, Drug Addiction, and Mental Health Services	Marion
Medina	Medina County ADAMH Board	Medina
Meigs	Gallia-Jackson-Meigs Board of Alcohol, Drug Addiction and Mental Health Services	Gallia
Mercer	Tri County Alcohol, Drug Addiction, Mental Health Services Board serving Van Wert, Mercer and Paulding Counties	Van Wert
Miami	Tri County Board of Recovery & Mental Health Services (Darke, Miami, & Shelby Counties)	Miami
Monroe	Mental Health & Recovery Board serving Belmont, Harrison, and Monroe counties or MHRB	Belmont
Montgomery	Montogmery County Alcohol Drug Addiction & Mental Health Services	Montgomery
Morgan	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Morrow	Delaware-Morrow Mental Health & Recovery Services Board	Delaware
Muskingum	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Noble	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Ottawa	Mental Health & Recovery Board Erie and Ottawa Counties	Erie
Paulding	Tri County Alcohol, Drug Addiction, Mental Health Services Board serving Van Wert, Mercer and Paulding Counties	Van Wert
Perry	Mental Health and Recovery Services Board serving Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry Counties	Muskingum
Pickaway	Paint Valley ADAMH Board	Ross
Pike	Paint Valley ADAMH Board	Ross
Portage	Mental Health & Recovery Board of Portage County	Portage
Preble	Preble County Mental Health & Recovery Board	Preble
Putnam	The Mental Health, Alcohol & Drug Addiction Recovery Board of Putnam County	Putnam
Richland	Mental Health & Recovery Services Board of Richland County	Richland
Ross	Paint Valley ADAMH Board	Ross
Sandusky	Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties	Seneca
Scioto	Adams Lawrence Scioto - Alcohol & Drug Addiction and Mental Health Services Board	Scioto
Seneca	Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties	Seneca
Shelby	Tri County Board of Recovery & Mental Health Services (Darke, Miami, & Shelby Counties)	Miami
Stark	Stark County Mental Health & Addiction Recovery	Stark
Summit	County of Summit ADM Board	Summit
Trumbull	Trumbull County Mental Health and Recovery Board	Trumbull
Tuscarawas	ADAMHS Board of Tuscarawas & Carroll Counties	Tuscarawas
Union	Mental Health & Recovery Board of Union County	Union
Van Wert	Tri County Alcohol, Drug Addiction, Mental Health Services Board serving Van Wert, Mercer and Paulding Counties	Van Wert
Vinton	Athens-Hocking-Vinton Alcohol, Drug Addiction and Mental Health Services Board	Athens
Warren	Mental Health Recovery Services of Warren and Clinton Counties	Warren
Washington	Washington County Behavioral Health Board	Washington
Wayne	Mental Health & Recovery Board of Wayne & Holmes Counties	Wayne
Williams	Four County Board of Alcohol, Drug Addiction, & Mental Health Services	Defiance
Wood	Wood County Alcohol, Drug Addiction and Mental Health Services Board	Wood
Wyandot	Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties	Seneca

Sources: ADAMH Boards and OMHAS

Appendix 1.B: Current Mental Health Funding by Alternate Methodology

Host County	Mental Health Funding per County	Mental Health Funding per Opioid Death	Mental Health Funding per Resident
Allen	$609,720	$60,972	$10
Ashland	$1,079,975	$269,994	$20
Ashtabula	$382,634	$13,194	$4
Athens	$135,179	$31,195	$4
Belmont	$426,089	$60,870	$13
Brown	$460,517	$24,238	$11
Butler	$230,302	$1,238	$1
Clark	$355,565	$9,440	$3
Clermont	$1,640,775	$17,455	$8
Columbiana	$563,129	$19,418	$5
Cuyahoga	$405,524	$1,130	$0
Defiance	$268,605	$48,837	$7
Delaware	$259,253	$30,500	$2
Erie	$483,102	$29,279	$8
Fairfield	$356,899	$19,828	$2
Franklin	$1,107,514	$4,211	$1
Gallia	$221,090	$30,149	$8
Geauga	$510,531	$30,031	$5
Hamilton	$1,155,015	$3,850	$1
Hancock	$407,843	$29,132	$5
Huron	$640,427	$45,745	$11
Jefferson	$1,367,955	$80,468	$21
Lake	$1,398,299	$21,186	$6
Licking	$386,616	$24,943	$3
Logan	$371,362	$41,262	$9
Lorain	$889,208	$9,561	$3
Lucas	$333,157	$2,563	$1
Mahoning	$1,267,506	$19,805	$6
Marion	$493,469	$29,907	$9
Medina	$1,943,663	$69,417	$11
Miami	$527,328	$32,285	$8
Montgomery	$3,288,146	$12,178	$6
Muskingum	$567,273	$106,364	$15
Portage	$306,969	$8,296	$2
Preble	$330,865	$22,058	$8
Putnam	$278,606	$69,652	$8
Richland	$1,295,563	$28,790	$11
Ross	$217,995	$14,931	$5
Scioto	$214,255	$10,894	$4
Seneca	$358,602	$41,377	$8
Stark	$2,630,426	$36,534	$7
Summit	$2,665,692	$13,600	$5
Trumbull	$563,169	$6,626	$3

Tuscarawas	$554,133	$85,251	$9
Union	$389,824	$64,971	$7
Van Wert	$137,635	$45,878	$5
Warren	$694,545	$22,405	$5
Washington	$304,667	$23,436	$5
Wayne	$639,843	$51,187	$8
Wood	$1,007,659	$50,383	$8

Sources: U.S. Census Bureau, Ohio Department of Health (ODH), and OMHAS

Appendix 2.A: Turnover Analysis

Position	Total Available	Hires	Separations	Separations of % of Total
Therapeutic Program Worker	677	164	131	19.4%
Psychiatric/DD Nurse	440	85	73	16.6%
Licensed Practical Nurse	107	13	25	23.4%
Correctional Program Coordinator	154	37	16	10.4%
Psychiatric Attendant	70	24	16	22.9%
Social Worker 2	53	5	11	20.8%
Social Worker 1	28	15	9	32.1%
Custodial Worker	53	8	6	11.3%
Psychiatric/DD Nurse Supervisor	67	3	8	11.9%
Psychiatrist	88	11	8	9.1%
Psychologist	52	7	7	13.5%
Other Remaining	1,292	120	161	12.5%
Total	**3,081**	**492**	**471**	**15.3%**

Sources: OMHAS and OAKS BI

Appendix 2.B: Training Matrix Page 1

Program Title	A RN/LPN TPW/PAT/HAC	B Police Security	C Physicians Dentists (Licensed Medical)	D Substantial Patient Contact	E Little or No Patient Contact
General Orientation (HCM/ Benefits/ Labor/ EEO Officer and/or MLP)					
HCM Overview - Position Description/Benefits Summary/EAP - OPERS/Deferred Compensation - Table of Organization - Benefits	X	X	X	X	X
Payroll/ Kronos	X	X	X	X	X
EEO Basics	X	X	X	X	X
Sexual Harassment	X	X	X	X	X
Workplace Violence Prevention & Response	X	X	X	X	X
Barbara Warner Workplace Domestic Violence	X	X	X	X	X
Code of Conduct/ General Work Rules	X	X	X	X	X
Drug-Free Workplace	X	X	X	X	X
Human Trafficking	X	X	X	X	
Ohio Auditor of State Fraud Reporting System	X	X	X	X	X
E-Performance	X	X	X	X	X
Ohio Ethics Law	X	X	X	X	X
The Joint Commission Reporting	X	X	X	X	X
Recognizing & Reporting Signs of Abuse & Neglect	X	X	X	X	
Introduction to MHAS (Training Staff/ CIS and/or MLP)					
Oliver's First Day: A Brief History of OhioMHAS **(Opt.)**	X	X	X	X	X
Mental Health 101 **(Opt.)**	X	X	X	X	X
Virtual Hospital Tours **(Opt.)**	X	X	X	X	X
Prevention & Wellness; Addiction & Recovery 101 **(Opt.)**	X	X	X	X	X
Intro to Recovery & Trauma Informed Care	X	X	X	X	X
Intro to RPH Service Lines	X	X	X	X	X
Computer Training	X	X	X	X	X
Patient Rights (Client Advocate/ Diversity Lead/ SAMI Staff/ Training Staff and/or MLP)					
HIPAA	X	X	X	X	X
Client Rights/Grievance or Complaint Process	X	X	X	X	
Age-Related Competencies	X	X	X	X	
Organ & Tissue Donation	X		X	X	
Sensitivity to Cultural Diversity/ Cultural Competency	X	X	X	X	X
Services to Patients with Special Needs - Deaf/HOH/Other Language/Interpreter Services - Dual Diagnosis: SAMI & M/ID	X	X	X	X	
Levels & Movement	X	X	X	X	X
Safety and Security (Safety Officer/ QA/PI and/or MLP)					
Life Safety (Fire Safety) Basics	X	X	X	X	X
Hazardous Materials Awareness	X	X	X	X	X
Emergency Preparedness- Disaster Awareness	X	X	X	X	X
Emergency Codes	X	X	X	X	X
Safety & Quality Improvement	X	X	X	X	X
Incident Reports/ Adverse Event Reporting	X	X	X	X	X
Computer Security Awareness	X	X	X	X	X

Appendix 2.C: Training Matrix Page 2

Program Title	A RN/LPN TPW/PAT/ HAC	B Police Security	C Physicians Dentists (Licensed Medical)	D Substantial Patient Contact	E Little or No Patient Contact
Clinical Safety (Master Trainer/ Crisis Response Trainer)					
Crisis Response Training*	X	X	X	X	
Seclusion/Restraint Training**	X	X	X	X	
Health and Wellness (Infection Control Nurse/ Nurse Educator/ Training Staff and/or MLP)					
Infection/Exposure Control & Prevention Strategies	X	X	X	X	X
Antimicrobial Stewardship	X		X	X	
Anticoagulation, as needed	X			(pharmacist)	
CPR/ AED	X	X	X	X	
First Aid	X	X		X	
Department/Discipline/Service Line Orientation (Department Head or Designee Responsible)					
Job Duties	X	X	X	X	X
Discipline Specific Policies	X	X	X	X	X
Service Line Specific Policies	X		X	X	
Advance Directives (Death and Dying, as applicable)	X		X	X	
Pain Management	X		X	X	
Fall Reduction	X	X	X	X	
Suicide Risk Assessment/ Suicide Guidelines	X	X	X	X	
Human Trafficking (OSHP- 3 Hours)		X		(SW's)	
Patient Care System (PCS)	X		X	X	
Computerized Physician Order Entry (CPOE)	X		X		
Computerized Treatment Plan	X		X	X	
Electronic Medical Record (EMR)	X		X	X	
Operating Emergency Medical Equipment - Portable Oxygen w Resuscitator - Portable Suction - Emergency Medication - Glucometer (Including waived testing) - Other	X X RN/LPN RN/LPN RN/LPN		X		
Direct Care Orientation (Nurse Educator Responsible)					
Therapeutic Relationship - Interpersonal Relationship	X				
Physical Care Skills and other Nursing specific skills	X				
Medical Considerations/ Change in Medical Condition - Gastrointestinal disorders in psychiatric patients - Metabolic Syndrome - Hyponatremia	X		X		
CSN Orientation (Department Head or Designee Responsible)					
CSN Specific Knowledge/Skills	X		X	X	X
Dual Diagnosis - SAMI - MIDD	X		X	X	

*Contract Medical and Direct Care personnel to receive Crisis Response Training Orientation consistent with duties and responsibilities
**Contract Medical and Direct Care personnel to receive Seclusion and Restraint Orientation consistent with duties and responsibilities

Appendix 2.D: Training Matrix Page 1

Program Title	A RN/LPN TPW/PAT/ HAC	B Police Security	C Physicians Dentists (Licensed Medical)	D Substantial Patient Contact	E Little or No Patient Contact
General Employment (HCM/ Labor/ EEO Officer and/or MLP): MLP Preferred					
EEO Basics	X	X	X	X	X
Sexual Harassment	X	X	X	X	X
Workplace Violence Prevention & Response	X	X	X	X	X
Code of Conduct/ General Work Rules	X	X	X	X	X
Drug-Free Workplace	X	X	X	X	X
Ohio Ethics Law	X	X	X	X	X
The Joint Commission Reporting	X	X	X	X	X
Recognizing & Reporting Signs of Abuse & Neglect	X	X	X	X	
Patient Rights (Client Advocate/ Diversity Lead/ SAMI Staff/ Training Staff and/or MLP): MLP Preferred					
HIPAA	X	X	X	X	X
Age-Related Competencies	X	X	X	X	
Organ & Tissue Donation	X		X	X	
Sensitivity to Cultural Diversity/ Cultural Competency	X	X	X	X	X
Services to Patients with Special Needs: - Deaf/HOH/Other Language/Interpreter Services - Dual Diagnosis: SAMI & MI/ID	X	X	X	X	
Levels & Movement	X	X	X	X	
Advance Directives (Death and Dying, as applicable)	X		X	X	
Safety and Security (Safety Officer/ QA/PI and/or MLP): MLP Preferred					
Life Safety (Fire Safety) Basics	X	X	X	X	X
Hazardous Material Awareness	X	X	X	X	X
Emergency Preparedness- Disaster Awareness	X	X	X	X	X
Emergency Codes	X	X	X	X	X
Incident Reports/ Adverse Event Reporting	X	X	X	X	X
Suicide Risk Assessment/ Suicide Guidelines	X	X	X	X	
Computer Security Awareness	X	X	X	X	X
Clinical Safety (Master Trainer/ Crisis Response Trainer)					
Crisis Response Training*	X	X	X	X	
Restraint/Seclusion **	X	X	X	X	
Health and Wellness (Infection Control Nurse/ Nurse Educator/ Training Staff and/or MLP)					
Infection/Exposure Control & Prevention Strategies	X	X	X	X	X
Antimicrobial Stewardship	X		X	X	
Medical Considerations/Change in Medical Condition - Gastrointestinal disorders in psychiatric patients - Metabolic Syndrome - Hyponatremia	X		X		
Pain Management	X		X	X	
Fall Reduction	X	X	X	X	
CPR/ AED	X	X	X	X	
First Aid	X	X		X	
Operating Emergency Medical Equipment - Portable Oxygen w Resuscitator - Portable Suction - Emergency Medication - Glucometer (Including waived testing) - Other	X X RN/LPN RN/LPN RN/LPN		X		
Other- RPH-Specific in-service/ CE Programs	TBD	TBD	TBD	TBD	TBD

*Contract Medical and Direct Care personnel to receive Crisis Response Training Orientation consistent with duties and responsibilities
**Contract Medical and Direct Care personnel to receive Seclusion and Restraint Orientation consistent with duties and responsibilities
TBD To be determined

Appendix 2.E: Training Matrix Supervisor

Program Title	A Managers/ Supervisors of RN/LPN TPW/PAT/ HAC	B Managers/ Supervisors of Police Security	C Managers/ Supervisors of Physicians Dentists (Licensed Medical)	D Managers/ Supervisors of Employees with Substantial Patient Contact	E Managers/ Supervisors of Employees with Little or No Patient Contact
Supervisor Training (Begin within 6 months of Hire) (DAS- Leaning & Professional Development)					
LEAD OHIO Foundations of Supervision: - Introduction to DiSC Behavioral Assessment - Labor Relations - Communicating for Results - Coaching for Desired Results - Goal Setting - Evaluating your Employees - Appreciating Our Differences - Leadership Skills for Supervisors	X	X	X	X	X
E-Performance for Supervisors (Part of Orientation)	X	X	X	X	X

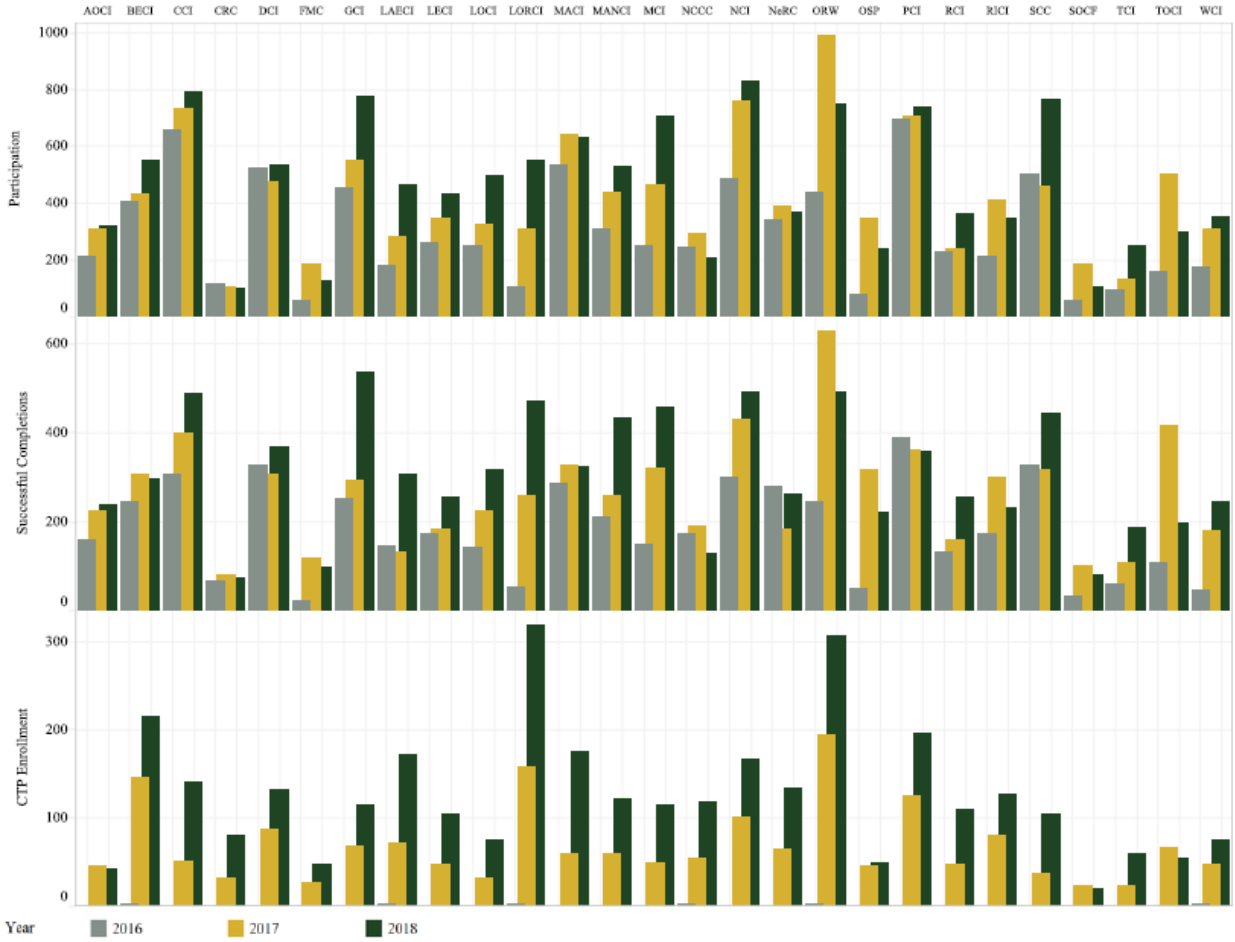
Source: OMHAS

Appendix 3.A: ODRC Facility Acronym List

Acronym	Institution Name
AOCI	Allen/Oakwood Correctional Institution
BeCI	Belmont Correctional Institution
CCI	Chillicothe Correctional Institution
CRC	Correctional Reception Center
DCI	Dayton Correctional Institution
FMC	Franklin Medical Center
GCI	Grafton Correctional Institution
LaECI	Lake Erie Correctional Institution
LeCI	Lebanon Correctional Institution
LoCI	London Correctional Institution
LorCI	Lorain Correctional Institution
MaCI	Madison Correctional Institution
ManCI	Mansfield Correctional Institution
MCI	Marion Correctional Institution
NCI	Noble Correctional Institution
NCCC	North Central Correctional Complex
NEOCC	Northeast Ohio Correctional Complex
NeRC	Northeast Reintegration Center
ORW	Ohio Reformatory for Women
OSP	Ohio State Penitentiary
PCI	Pickaway Correctional Institution
RiCI	Richland Correctional Institution
RCI	Ross Correctional Institution
SCC - H	Southeastern Correctional Complex – Hocking Unit
SCC - L	Southeastern Correctional Complex – Lancaster Unit
SOCF	Southern Ohio Correctional Facility
ToCI	Toledo Correctional Institution
TCI	Trumbull Correctional Institution
WCI	Warren Correctional Institution

Source: OMHAS
Note: The Southeastern Correctional Complex – Hocking Unit closed in 2018.

Appendix 3.B: Trends in Inmate Engagement by Facility



Source: OMHAS
Note: NEOCC was excluded as it was opened in late 2017.

Engagement Scope and Purpose

ORC § 117.46 directs that the Auditor of State (AOS) shall conduct performance audits of at least four state agencies each budget biennium. The Ohio Department of Mental Health and Addiction Services (OMHAS) was selected for FY 2017-19 Biennium, encompassing FY 2018 and FY 2019.

The Ohio Performance Team (OPT) engaged in a collaborative planning and scoping process with OMHAS leadership, which included interviews and a high-level review of data. In consultation with OMHAS, the following scope areas were selected for evaluation:

- ADAMH Board FundingRecruitment, Onboarding, and Retention
- Prison Treatment and Recovery Programming

Performance Audit Overview

OPT conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that OPT plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. OPT believes that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

Methodology

Audit work was conducted between August 2018 and June 2019. OPT staff worked closely with OMHAS staff to obtain data and conduct interviews to establish current operating conditions. This data and information were reviewed with staff at multiple levels within OMHAS to ensure accuracy and reliability. Weaknesses in the data obtained are noted within the report where germane to specific assessments.

Criteria used for comparison included OMHAS internal policies and procedures; industry standards; and government and private sector leading practices. Each section of this audit report contains the specific criteria used for comparison and detailed methodology.

The performance audit process involved sharing preliminary information with the client, which included regular status meetings. Input from the Department was considered and taken into account as appropriate. This audit report contains recommendations that are intended to provide OMHAS with options to enhance its operational efficiency and effectiveness.

Audit Objectives

» What opportunities exist to improve the efficiency and effectiveness of the ADAMH board funding in relation to industry standards and leading practices?

» What opportunities exist to improve the efficiency and effectiveness of employee recruitment and onboarding practices in relation to industry standards and leading practices?

» What opportunities exist to improve the efficiency and effectiveness of the prison treatment and recovery programming in relation to industry standards and leading practices?

Abbreviations

AA	Alcoholics Anonymous
ABH	Appalachian Behavioral Healthcare
ADAMH	Alcohol, Drug, and Mental Health Boards
AOD	Alcohol and Other Drugs
AOS	Auditor of State
BCRS	Bureau of Correctional Recovery Services
BIP	Brief Intervention Program
CPC	Correctional Program Coordinator
CTP	Community Transition Program
DOTS	Department Offender Tracking System
EHR	Electronic Healthcare Record
GAO	Government Accountability Office
GRF	General Revenue Fund
HB	House Bill
HBH	Heartland Behavioral Healthcare
HIPAA	Health Insurance Portability and Accountability Act
IOP	Intensive Outpatient Program
IPP	Intensive Program Prisons
MAT	Medication Assisted Treatment
NA	Narcotics Anonymous
NBH	Northcoast Behavioral Healthcare
NOPH	Northwest Ohio Behavioral Healthcare
OAKS BI	Ohio Administrative Knowledge System Business Intelligence
ODH	Ohio Department of Health
ODRC	Ohio Department of Rehabilitation and Corrections
OHR	Office of Human Resources
OMHAS	Ohio Mental Health and Addiction Services
OPT	Ohio Performance Team
ORAS	Offender Risk Assessment System
ORC	Ohio Revised Code
OSP	Ohio State Penitentiary
RMP	Recovery Maintenance Program
SAMI	Substance Abuse and Mentally Ill
SBH	Summit Behavioral Healthcare
SUD	Substance Use Disorder
TC	Therapeutic Community
TCU	Texas Christian University
TRP	Treatment Readiness Program
TTP	Treatment Transfer Program
TVBH	Twin Valley Behavioral Healthcare

Client Response

The following letter is the official response from OMHAS to the performance audit. Throughout the audit process, staff met with Department officials to ensure substantial agreement on the factual information presented in the report. When the Department disagreed with information contained in the report and provided supporting documentation, revisions were made to the audit report.

Promoting wellness and recovery

Mike DeWine, Governor • Lori Criss, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

June 20, 2019

Keith Faber
Auditor of State
88 E. Broad Street, 5th floor
Columbus, OH 43215

Dear Auditor Faber,

On behalf of the Ohio Department of Mental Health and Addiction Services (OhioMHAS), I would like to thank you for your staff's systematic, diligent work on our recent performance audit. Aaron Shaw and his team were respectful of our staff's time and made us feel involved and integral to the process from start to finish. I am impressed by the thoroughness of the audit and appreciate their suggested recommendations for improvement.

OhioMHAS has reviewed your suggestions to increase our efficiency both generally as a Department and specifically within each of the identified areas of the audit. We intend to use your team's suggestions as building blocks to further improve our Department.

Thank you again for the time and effort you and your staff have spent in helping promote the economy, efficiencies, and effectiveness of the agencies of the State of Ohio.

Sincerely,

Lori Criss
Director

Ohio Mental Health and Addiction Services
Performance Audit Report

June 27, 2019

88 E. Broad St.
Columbus, Ohio 43215

Phone: (614) 466-4514
Toll Free: (800) 282-0370

www.ohioauditor.gov

OHIO AUDITOR OF STATE
KEITH FABER

OHIO DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

FRANKLIN COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
JUNE 27, 2019

88 East Broad Street, Columbus, Ohio 43215
Phone: 614-466-4514 or 800-282-0370
www.ohioauditor.gov