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A. Dustin Mets, CEO
dmets@compdrug.org

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Senate Community Revitalization Committee
Testimony on SB 105
May 31, 2023

Chairman Johnson, Vice Chair Hoagland, Ranking Member Sykes, and members of the Senate Community Revitalization Committee, thank you for the opportunity to testify today on SB 105, legislation to modify county ADAMHS Boards' roles, duties, and powers, but which would significantly impact Behavioral Health providers.

My name is Dustin Mets and I am the CEO of CompDrug in Columbus, Ohio. I am an also the current President of the Ohio Association for the Treatment of Opioid Dependence (OATOD) and a Member of the 340 Review Stakeholder Workgroup. CompDrug is a fully CARF accredited, SAMHSA certified and MHA licensed behavioral health provider that contracts with and has a great relationship with the Franklin County ADAMH Board. We currently have 98 employees and 22 unfilled positions. Last year CompDrug provided prevention, outreach and treatment services to 40,588 individuals, including 1752 in our treatment programs. Our programs include the nationally recognized Youth to Youth youth-led prevention program, but CompDrug is most recognized locally for our opioid treatment program ("OTP") in Columbus. We have been treating the chronic disease of opiate addiction in an integrated medical and clinical treatment model since 1983.

I appreciate Senator Johnson's leadership and this Committee's efforts regarding the opioid epidemic and the mental health crisis in Ohio. We are acutely aware that the people we serve suffer from a chronic brain disease. Their families and communities feel the impact of a system stressed to the breaking point because of the unrelenting opioid epidemic, lingering effects of the pandemic, and labor shortages and wage pressures.

With respect to SB 105 and related efforts to improve the community behavioral health system in Ohio, I am here to offer insight on two perspectives. First, the absence of providers in opposition and secondly, a collaborative approach. Many providers are concerned to appear today, because they are currently engaging in contract negotiations with their boards regarding funding for the upcoming fiscal year. The timing of these hearings during contract negotiations is unfortunate and adds to the challenges that providers face on a daily basis, such as workforce.

As I noted, I have a good relationship with my ADAMHS board and feel it is a collaborative relationship. Most providers unfortunately do not share that experience. One of the first things I noticed when I entered the field in 2008 was the antagonistic relationships between ADAMHS boards and providers. I have always thought that to best achieve our objectively aligned mission's - boards and providers should work collaboratively to plan and provide services to those in our communities that need them most. It is a reason why I participate in committees such as the Department of Mental Health and Addiction's (MHA) 340 Review Stakeholders

Workgroup. Over the course of a year, that workgroup examined and identified the challenges and opportunities in section 340. The Summary document was just published by MHA in April 2023 and it offers an acknowledgement of the challenges and insight into the issues presented. Specifically:

> This is not a new issue, and it is one that has been the subject of conflicts, unresolved negotiations, and even lawsuits. It is why OhioMHAS convened the 340 Review Stakeholder Workgroup in 2022 to closely review Chapter 340 of the Ohio Revised Code, which governs behavioral health services in local communities. This was a significant and needed undertaking in order to lay a foundation for future considerations and decisions.

The 340 Review Stakeholder's Workgroup summary document is the first step in a collaborative process regarding resolving these contentious issues. The work of the stakeholders and community members should not be wasted and the effort at resolution of these contentious issues through a collaborative process has not yet run its course. Why? Because our citizens deserve a system that works for all and most importantly one that works for those that need our help.

For example, ADAMHS boards and providers often develop programs that are not otherwise funded by any other entity. Providers need to hire staff, educate the community on how to get services, deliver those services and then report on them. People receiving those services often are not in a position to understand who is providing the funding for those services – just that they need them.

Providers understand there are many reasons that funding may end and rely on the existing 120 day notice to provide some process of notice and negotiation. It is important to understand that when funding ends without proper planning for transition of care of those served by that funding, a cascade of events occur. Providers lose the employee providing the service, other citizens wanting to use the service now contact a number that no longer works, and the person receiving services has nowhere to go. In short, the system looks to an outsider as if it doesn't work. Is an arbitrary 120 days' notice the most effective solution? It's the only protection in law right now and absent any other protections, the people we serve suffer most without protection.

I would respectfully suggest that the next step in addressing the controversial aspects of section 340 is to have the 340 Review Stakeholders Workgroup develop recommended and agreed upon changes to the controversial aspects of 340 that would lead to a meaningful transition of care and the sunsetting of programing.

I also want to briefly cover the access to data, and efforts of the Boards to engaged in community planning. It would be very helpful if the ADMHS boards had access to aggregated **all payor** data, but that is not what the current language of SB105 provides. Most importantly, the ADAMHS boards do not require individual patient level data for anyone that they are not paying or coordinating payment for overlapping services.

For example, the ADAMHS boards do not need your federally protected personal health information (PHI) simply because you sought behavioral health services in that board's area. It

is sufficient for community planning purposes for the ADAMH board to know that thousands of Ohioans in their board area have the same diagnosis as you. In fact, ADAMHS boards already have access to county level-aggregated Medicaid data, which is more than sufficient to meet their community planning needs. As such, the current language on SB105 providing ADAMHS boards with detailed patient data is an unnecessary intrusion into federally protected health privacy. Moreover, if the need for the data is community planning, then I would assert that all payor aggregated data would provide the closest to a full picture for ADAMHS boards to fulfill their community planning duties.

Thank you for your time and consideration of my testimony. I'd be happy to answer questions.

547 East Eleventh Avenue, Columbus, Ohio 43211-2603
614.224.4506 (f)614.291.0118 **CompDrug.org**