

NN Community Services Sub-Committee Minutes
August 30, 2011

Present: Linda Abernethy, Charlie Clemons, Dale Hamilton, Kim Moody
Staff Support: Sharon Sprague
Excused: Jane Moore

The committee members clarified the original purpose of the committee to identify what services need to be available in the community when DDPC reduces services to accommodate the budget reduction of \$7,000,000 and also if DDPC closes. Four possible future states of DDPC were identified. It was suggested that looking at current hospital services and identifying missing community services to reach the four future states might be one approach the committee could take. The future states are identified on the NN Workgroup Project Plan:

- DDPC Closes
- DDPC reduces services
- A new DDPC is developed
- A Maine State Psychiatric Center is created; one hospital/two campuses

All members had concerns that key information was missing in order to assess the impact of a reduction in hospital services. Some of the information required to make sound decisions are as follows:

- What is the future for PNMI (Private Non-Medical Institute) funding and service structure; if group homes are no longer available what does that do to hospital census and discharge planning.
- Whether DDPC will be responsible for additional pay out costs for benefit time and unemployment beyond the 2.5 million. If this is the case, DDPC may not be able to safely operate an inpatient facility.
- In this fiscal climate should we assume that no additional funding is available? Maine is already number one in the nation for per capita expenditures for both inpatient and community services.
- Future impact of federal and state cuts
- What is the Commissioner's vision of the future of mental health services in general
- What is the DAFS decision regarding how much income DDPC will gain by receiving payment from other tenants?

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The committee agreed that the system is in disarray and that the larger NN work group needs to have a conversation about the mental health system as a whole. The committee agreed that the discussion could not be isolated to DDPC's future state without an examination of mental health services in the community and of the current administration's vision.

The PNMI situation was discussed and many questions rose as to how much it will change, will it exist at all, will the general fund compensate for any of disallowed costs, what level of housing replaces it, if any? Less intense placement options are needed for those who are not engaged in a rehabilitative process and want somewhere to live and get personal care needs met, including prompting to take meds. There are currently people being served in higher levels of care than they need because of lower levels of care not being available. Some clients in expensive PNMI's are aging in place due to promises made many years ago that if they left the hospital they could remain in the group home indefinitely.

Of the 60 patients DDPC typically has, on average, 12 people at any one point in time that are less acute and in transition to the community. Forty five typically required locked doors.

Currently 20 are being referred or will be referred to group homes and 6 would be appropriate for apartments with staff on site. There is only one such facility in Bangor. Twelve are planning on apartments with community supports. Four are appropriate for boarding level of care which is typically not available. Only 5 people plan to return home to family and 2 have their own homes to return to. Two will return to jail, 2 need substance abuse residential, 2 plan to live in a motel, and 2 insist on returning to the shelter. One meets nursing home level of care.

The value of apartments with staff on site was recognized. When those settings were discontinued and CRS took its place, it was to be available to DDPC patients upon discharge. It is now available to hospital patients only by waiver which takes a significant amount of time to approve, if it is approved at all. The reason for the waiver process was explained by OAMHS as being necessary because the service was costing the Department more than they had initially anticipated.

DDPC may be able to stop providing Outpatient Services if the community providers can provide more of a safety net approach. The outpatient clinic

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presently serves 140 clients, some who are extremely paranoid about receiving services elsewhere, some who are very fragile, some who cannot afford co-pays, some who have no insurance, and several people with developmental disabilities that providers, in the past, have not felt equipped to treat. An additional service through Outpatient has been to consult with providers regarding how to best provide care. Some of the issues that challenge the community to provide safety net services were identified:

- Medicare reimbursement
- Cost of no shows
- Need for more frequent appointments that the providers can schedule
- Lack of psychiatrists to provide medication management
- Lack of time and funding to assist with insurance and pharmacy (drug) assistance
- Need to accommodate walk ins

It was noted that CHCS is already losing \$300,000 per year in outpatient services due to some of these issues.

DDPC may have the potential to serve some of the RPC patients. RPC is backlogged with stable forensic patients. The Augusta area is saturated and living options are not available for a number of patients that could be transitioned into the community. Since they require an ACT Team to be able to live in the community one option is for DDPC to develop an ACT team to transition some of the stable RPC forensic patients as there are several who would like to live in the Bangor area.

Community Support Services were discussed as an example of where the system might be able to be more efficient. There are several categories of services – perhaps too many - and the case management position has become more of a broker than a hands on case worker. Instead of building a relationship with the client and follow through with providing needed services, the current system forces multiple services to be involved with a client which can be costly, confusing, and unnecessary. The required productivity rates to break even are a significant challenge as much of the work is non-billable; such as documentation, no shows, and travel. The regulatory burden hinders the ability to achieve the productivity quotas. This conversation led to the recommendation, once again, that the whole system needs to be examined. A committee member stated he wished he had more flexibility to move funding in order to provide services flexibly according to individual client needs as opposed to rigid categories of services.

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The committee acknowledged that there are a lot of community services and there may be too many different categories without flexibility to provide exactly what is needed in the most efficient manner. It also appears fragmented and providers become unclear as to 'who is doing what'. Historically the State of Maine has not had a structure to create a flexible system. The suggestion was made that providers may create greater efficiencies if they had more flexibility to move funding within their organization to better serve the individual needs of clients. It is believed that services are now driven by billing and burdensome regulations. The suggestion was made that rather than place burdensome arbitrary controls on providers, the department could set 'real' performance based measures to hold agencies accountable and begin to measure quality. There would likely be a need for a per capita cap. It was agreed that issues of control and lack of trust may have helped to force the system into an inefficient state. The committee recommended that Dale Hamilton and Linda Abernethy meet to discuss the design of a pilot to create an accountable yet flexible billing structure that would allow the shifting of monies within an agency. The pilot would allow bundled services with oversight of community partners and the department. There was recognition that this pilot would likely require a waiver from CMS.

The committee determined that this is an opportunity to create a healthier service system and help define what flexibility there needs to be. Dale and Linda agreed to meet to discuss the pilot option in more detail and report to this sub-committee on September 6 at 2:00.

Submitted by Sharon L. Sprague