

Peer Review Visit to the State of Maine
July 25-26, 2005

FINAL REPORT

Report to:

Department of Health and Human Services
Integrated Services
221 State St.
Augusta, Maine

Prepared for:

National Technical Assistance Center for State Mental Health
66 Canal Center Plaza
Suite 302
Alexandria, VA

Supported by:

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
1 Choke Cherry Lane
Rockville, MD

August 30, 2005

EXECUTIVE SUMMARY

The National Technical Assistance Center for State Mental Health (NTAC) at the National Association of State Mental Health Directors (NASMHPD) conducted a Peer Review visit with the State of Maine on July 25-26, 2005 in Augusta. NTAC is funded by the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA). The visit was conducted in partnership with the Department of Health and Human Services to review Maine's ongoing mental health system transformation activities; identify significant issues and challenges that the state faces as it seeks to transform its system of mental health care; offer advice and on-site technical assistance regarding transformation activities; and recommend any technical assistance that might further support the state's transformation efforts.

Key mental health stakeholders participated in a series of discussions facilitated by the Peer Review Team over the two-day period, focusing especially on the goals and recommendations reflected in the Final Report of the President's New Freedom Commission on Mental Health, released in July 2003. Discussions included several separate conversations with mental health consumers, including individuals who are inpatients at Riverview Psychiatric Center. The Commission's goals for the nation's system of mental health care center on prevention of mental illness; consumer and family-driven care; elimination of disparities in mental health treatment; early mental health screening, assessment and referral to services; evidence-based practices and research; use of technology to access mental health care and information.

This Peer Review Site Report reflects on a number of the state's activities in these six goal areas of mental health system's transformation, particularly within the context of the *Bates v. DHHS* Consent Decree, the recent unification of the former Departments of Human Services and Behavioral and Developmental Services into the Department of Health and Human Services, and the 2005 legislative mandate for managed care. The report identifies a series of state accomplishments designed to more effectively integrate consumer and family-driven care, especially those citizens with complex needs, including:

- The Maine Quality Forum and the Maine Youth Suicide Prevention Program;
- Funding consumer-centered services such as mental health peer specialists/mentors at Riverview Psychiatric Center, in the emergency room of a Portland general hospital, and teaching leadership and self-recovery skills to consumers through their statewide consumer organization;
- Support to families of persons with mental illness through the Quality Assurance in Prison Mental Health Services Project and the NAMI Teen Screen Project;

- A successful application for federal funding of the Co-Occurring Substance Abuse and Mental Illness State Incentive Grant Program, which will support multi-year efforts to strengthen and expand services for persons with co-occurring disorders;
- The Pathways to Excellence Program in the Governor's Office of Health Policy, which collects and reports data on the quality of healthcare and provides direct financial incentives to providers demonstrating high quality care and outcomes; and
- Development of the Enterprise Information System (EIS) to integrate clinical and administrative information for adult and child mental health and mental retardation, as well as web-based records through the Maine Health Information Network Technology program.

The report also identifies opportunities for further growth and strengthening of the state's mental health system, including:

- Providing a full range of needed and outcome-oriented mental health services throughout the state, whose rural character and geographic size present special challenges in inpatient, outpatient and crisis care;
- Ensuring continuity of care between inpatient and outpatient settings which would encourage, support and reward close collaboration among providers to ensure that consistent services are delivered, primarily in stable community settings;
- Housing and supported employment services for consumers, in continuing partnership with Maine's State Housing Authority and Division of Vocational Rehabilitation;

DHHS staff and the team discussed at some length the significant opportunity that managed care presents to continue and expand on mental health transformation efforts within a new financial and administrative framework, while continuing to ensure the services required for class members of *Bates v DHHS*.

Finally, this report offers a series of recommendations for possible future technical assistance to support Maine's mental health transformation efforts, which may be requested through NTAC and the Center for Mental Health Services.

INTRODUCTION AND BACKGROUND

Scope and Purpose of Visit

The Center for Mental Health Services (CMHS), one of three centers within the Substance Abuse and Mental Health Services Administration (SAMHSA), leads federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress has mandated CMHS' leadership role in delivering mental health services, generating and applying new knowledge, and establishing mental health policy. CMHS pursues its mission by helping states improve and increase the range and quality of their treatment, rehabilitation and support services for people with mental illnesses, their families and communities.

Within CMHS, the Division of State and Community Systems Development (DSCSD) administers the Performance Partnership Grant Program, manages CMHS' data collection and analysis efforts, and helps translate knowledge into practice. The Division provides technical assistance to states through a variety of strategies and mechanisms.¹

One of the key vehicles for technical assistance funded by CMHS and administered through DSCSD is the National Technical Assistance Center for State Mental Health (NTAC) at the National Association of State Mental Health Program Directors (NASMHPD). NTAC provides focused, state-of-the-art technical assistance and consultation to State Mental Health Agencies, state mental health planning and advisory councils, consumers, and families to help ensure that the best practices and most up-to-date knowledge in mental health and related fields are translated into action at the state and local levels.

This year, CMHS and NTAC are collaborating with a small group of states to offer innovative and specialized technical assistance in the form of peer review visits, designed to assist states in transforming their systems of care in accordance with recommendations made by President's New Freedom Commission on Mental Health.² Each visit has four primary objectives, which are to be addressed within the context of the Commission Report:

1. To create a "snapshot" view of a state's current service delivery system in key areas of mental health system's transformation.
2. To identify significant issues and challenges that the state faces as it seeks to transform its system of mental health care.
3. To provide limited on-site technical assistance in support of the state's transformation activities.
4. To recommend any follow-up technical assistance that would benefit the state's ongoing transformation efforts.

¹ CMHS Mission Statement, National Mental Health Information Center

² New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

In proposing these visits as an innovative approach to technical assistance, CMHS envisioned a “friendly” site visit, where consultants facilitate wide-ranging discussions with staff, consumers, family members, providers, and other key informants to help understand the operation of a state service delivery system and offer recommendations for its improvement. Visits are in no way intended to audit or monitor legislative or regulatory compliance (as is the case, for example, with Performance Partnership reviews). Guided as it was by the report of the President’s Commission, the scope of the visit to Maine was sufficiently broad to include virtually every area and type of service, at every level of the system. That being said, time constraints tended to focus discussions on high-priority topic areas identified as fundamental to Maine’s mental health system’s transformation.

The New Freedom Commission and Mental Health System’s Transformation

The President’s New Freedom Commission confirmed that “there are unmet needs and many barriers [that] impede care for people with mental illness” (Executive Summary). Mental illness is a “shockingly” common condition, according to the report, affecting children, adults and elderly persons from all socio-economic and demographic backgrounds, in communities, schools, and workplaces throughout the nation. In fact, “mental illnesses rank first among illnesses that cause disability in the United States, Canada and Western Europe” (page 3).

Federal, State and local mental health authorities are all too familiar with the fragmentation and gaps in care outlined by the Commission. Advances in research are not readily translated into practice. High unemployment among individuals with mental illness creates unstable and unacceptable living situations. Financing mechanisms segregate individuals and services in ways that make coordination and collaboration difficult, if not impossible. Too often, care is not consumer-centered. In the words of a leading mental health advocate:

The mental health and substance abuse systems have helped some of us, bruised some of us and failed some of us. It is changing, and much more change is necessary in how we create and deliver services, train staff, finance programs and involve consumers in their own care.³

The specific nature and scope of these and other challenges vary from state to state, community to community and system to system, depending on environmental variables such as financing, litigation, politics, consumer and family advocacy, government organization and regulation, and competing demands for scarce resources. The Commission found common ground among these unique environments by organizing its findings and making its recommendation within a framework of six goals comprising “the foundation for transforming mental health care in America” (page 5). Working within their unique circumstances and settings, states and communities have begun to use these goals as a way to understand their systems of care, to identify their highest priority transformational activities and to move toward desired outcomes.

³ Unpublished communication.

Goals of the President's New Freedom Commission on Mental Health

1 *Americans Understand that Mental Health is Essential to Overall Health.*

2 *Mental Health Care is Consumer and Family Driven*

3 *Disparities in Mental Health Services Are Eliminated*

4 *Early Mental Health Screening, Assessment and Referral to Services Are Common Practice*

5 *Excellent Mental Health Care is Delivered and Research is Accelerated*

6 *Technology is Used to Access Mental Health Care and Information*

THE PEER REVIEW VISIT

Pre-Visit Preparation

Maine's Selection as a Peer Review Site. A number of states were considered as partners for this first round of peer review visits. Maine was selected based on its expressed interest in participating in the program, the complex and challenging nature of its ongoing mental health transformation initiatives, and the potential to learn from the state's experience in ways that could enlighten future CMHS and NTAC initiatives. Once Maine was selected, Department of Health and Human Services staff joined in all aspects of the peer review planning process.

Peer Review Protocol. To ensure that on-site discussions were as consistent and as well-informed as possible, consultant staff developed a brief protocol to be used as a guide by team members during their on-site meetings with key informants. The draft protocol proposed four questions that would be posed to participants during each of the discussions facilitated by the team during its time on-site:

- What mental health systems transformation activities are currently underway in Maine?
- What significant issues and challenges does Maine face as it seeks to transform its mental health system?
- What ideas, suggestions and other technical assistance can the team offer on-site to support the state in its mental health transformation efforts?
- What recommendations can the team make for future technical assistance activities?

The protocol assigned each team member lead responsibility in specific topic areas, including creating recovery-oriented systems of care, implementing trauma-informed care, financing and delivering mental health services in a managed care

environment, reduction of seclusion and restraint, consumer and family advocacy, competence in cultural diversity, housing and employment, co-occurring disorders, workforce development and data measures. A complete list of topic areas is included in the attached “Maine Peer Review Site Visit Protocol and Prompts” (Attachment A).

Peer Review Team. The members of Maine’s Peer Review Team were selected by CMHS and NTAC based on their experience in the management, delivery and evaluation of mental health services over a period of many years, as well as for their ability to deliver effective technical assistance in a variety of state and community settings. Team members represent major stakeholders in mental health systems transformation. The peer review team included:

Gayle Bluebird, RN., Advocate for Advocacy Center for Persons with Disabilities and faculty member of NTAC Seclusion and Restraint Reduction Training Institute. A leader in the national mental health consumer/survivor movement for more than thirty years, Ms. Bluebird received federal funding to author a manual, “Participatory Dialogues”. She frequently travels the country promoting use of “Comfort Rooms” to take the place of outdated seclusion rooms.

Sarah Callahan, M.H.S.A., Deputy Director, NTAC. Leadership and management for all NTAC activities, primarily training and technical assistance to SMHAs. Former Senior Manager at AcademyHealth and Senior Policy Analyst at the National Governors Association, Center for Best Practices, both in Washington, D.C., running national programs funded through the Robert Wood Johnson Foundation to improve health care.

Bruce D. Emery, M.S.W., Team Leader. President of Strategic Partnership Solutions, Inc., in Takoma Park, MD. Over thirty years experience in mental health consultation and service delivery at local, state and federal levels. Professional mediator, clinical social worker and former Director of Technical Assistance for both the National Association of State Mental Health Program Directors and the National Council for Community Behavioral Healthcare.

Joanne Forbes, B.S.N., M.A., C.P.R.P. Director of Community Services for a state-operated mental health system in New York. Over thirty years experience in clinical, administrative and teaching positions. Expert in system change strategies, recovery and resilience orientation, supported employment, co-occurring disorders, self-help and empowerment, psychiatric rehabilitation and community organization.

David Miller, M.P.Aff. Senior Policy Associate at NASMHPD, liaison with state mental health authorities, key federal agencies, Congress, the National Governors Association, Department of Health and Human Services, and mental health advocates. Former senior staff to Governor of Texas. Currently providing technical assistance to states through SAMHSA contract to implement the President’s New Freedom Commission report.

Leslie Schwalbe. Independent behavioral health consultant and immediate past Deputy Director of the Arizona Department of Health Services (Arizona Mental Health

Commissioner). Provided behavioral health services to 140,000 members and managed annual budget of \$800+ million. More than 15 years experience financing state government agencies, providing leadership and direction to large government organizations during periods of tremendous population growth.

Teleconference Calls. During a four week period prior to the on-site visit the team convened in a series of teleconference calls to plan and prepare for the on-site visit. During these meetings, state staff articulated their assessment of the priority needs and issues facing Maine's mental health service delivery system. The calls clarified the focus of the visit, developed an agenda (Attachment B), identified key participants to be invited to meet with the team, planned logistics, and discussed any observations or questions raised by team member review of background materials. The Team Leader also communicated continually with state staff in the weeks leading up to the visit.

Background Materials. All team members were familiar with the Report of the New Freedom Commission on Mental Health and with the SAMHSA matrix which presents the Administration's national priorities for mental health and substance abuse services. In addition, team members reviewed state-specific background materials prior to the visit in order to become thoroughly familiar with Maine's mental health service system, its ongoing transformation activities and its unique issues and interests. Background materials included:

1. Adult Mental Health Services Plan (2005)
2. Transformation State Incentive Grant Application (2005)
3. Maine Road to A Transformed Mental Health System, Advocacy Initiative Network (2005)
4. Recommendations for a Rapid Response Process for Adults (2005)
5. Transition Planning for People Hospitalized at Riverview Psychiatric Center (2005)
6. State Profile Data, NASMHPD Research Institute, Inc. (2004)
7. Patient Rights Handbook published by the Disability Rights Center (2004)
8. Co-Occurring State Infrastructure Grant Application (2004)
9. MaineCare Depression Study (2004)
10. Annual Report of Maine Disability Rights Center (2004)
11. Mental Health Block Grant Site Visit Report (2001)

Additional background information was obtained through a previous site visit conducted for the Office of Mental Health and Substance Abuse Services by Joan Erney, Deputy Secretary in the Pennsylvania Department of Public Welfare. Ms. Erney consulted with Maine staff, consumers, and providers on March 14-15, 2005 regarding the possibility of the state piloting a capitated system for adults currently enrolled in the Adult Mental Health service system.

On-Site Peer Review Visit

A two-day, on-site peer review visit was conducted on July 25-26, 2005 in Augusta. Over the course of the two days, team members facilitated a series of

discussions in which consumers, family members, providers, state staff, and advocates provided their perspectives on the system's current strengths, its problems and challenges, the resources available to the system, areas where those resources failed to meet identified needs, and recommendations needed to transform and improve the system of mental health care.

Ms. Bluebird met separately with consumers from around the state. She visited Riverview Psychiatric Center to meet with a team of peer specialists working in new and unique roles as staff members and with a group of inpatients to give them an opportunity to share their perspectives on Maine's system of care. Comments from these meetings are woven into this report; a complete summary of these meetings is attached (Attachment C).

The team also met individually with Court Master Daniel Wathen and briefly with Pat Ende, Senior Policy Advisor to Governor Baldacci. Discussions focused on the actual or potential impact of the settlement agreement, the department's recent unification and the impending move to managed care on delivery and financing of services, all within the context of transforming the system of care based on the goals of the President's New Freedom Commission.

Post Visit Report and Recommendations

Team members submitted individual summaries of their observations and recommendations upon the conclusion of the visit. This report was drafted by the Team Leader and then reviewed by team members, NTAC and state staff, with subsequent review and approval by the Center for Mental Health Services.

KEY OBSERVATIONS

Mental Health System's Transformation in Maine

The environment for mental health services transformation in Maine is especially influenced by three key factors: the impact of the settlement agreement, recent unification of the Department of Health and Human Services and the implementation of managed care.

The Consent Decree and Settlement Agreement

A class action lawsuit filed in Maine Superior Court 1989 (*Bates v. Glover*, subsequently *Bates v. DHHS*) on behalf of residents of the Augusta Mental Health Institute (AMHI), was brought to address problems both at the hospital (since renamed Riverview Psychiatric Center) and in Maine's community mental health service system. The lawsuit alleged that treatment both in the hospital and in the community was inappropriate and inadequate for persons with severe and persistent mental illness. A consent decree signed by the parties in 1990 requires that the Department of Health and Human Services (formerly the Department of Mental Health and Mental Retardation,

subsequently the Department of Behavioral and Developmental Services) establish and maintain a comprehensive mental health system that recognizes and is responsive to consumers of mental health services that are part of the protected class. Planning for services is driven by a settlement agreement. Patients of AMHI as of January 1, 1998 are class members, as are individuals admitted to AMHI/Riverview subsequent to that time, during the period that the settlement agreement is being implemented.

The goals of the settlement agreement are quite broad, including reducing admissions to Riverview Psychiatric Center (formerly AMHI); improving the quality, availability and comprehensiveness of mental health care; ensuring that members participate fully in the development of their own Individualized Support Plan; and, arranging access to and use of the full resources of Maine's communities to meet the needs of class members. The settlement agreement also designates standards and procedures in areas of operation such as: treatment planning, emergency services, use of psychoactive medications, patient rights, use of seclusion and restraint, quality health and dental care, staff/patient ratios, workforce qualifications, review of all admissions to RPC for compliance with established criteria, medical records, discharge/transition from hospital to community setting.

The scope of the settlement agreement is further illustrated by its requirement that the Department of Health and Human Services develop a centralized system for planning, budgeting and developing the resources necessary to support a comprehensive system of care, a fact which further reinforces the Court's significant influence over mental health care.

Although it was anticipated that the terms of the settlement agreement would be met by September 1, 1995, it has been extended at various times throughout the ensuing years as court officials have determined that ongoing state efforts to establish and maintain a comprehensive system of mental health care fall short of expectations established by the decree. Throughout this period, the settlement agreement has been a primary motivating force behind establishment of a comprehensive array of accessible, affordable and appropriate services for persons with severe and persistent mental illness.

On July 29, 2005, Court Master Wathen issued the latest judicial decision regarding the Adult Mental Health Services Plan submitted by the Department of Health and Human Services for his review on June 30, 2005.

- | | |
|-------------|---|
| Section I | Plan Goals and Core Principles
<i>Approved as submitted</i> |
| Section II | No wrong door Services Pathway
<i>Approved as submitted</i> |
| Section III | Consumer driven Individualized support planning
<i>Approved with revisions</i> |
| Section IV | Continuity of Care: Comprehensive Service Array
<i>Disapproved</i> |

Section V	Managing the Change <i>Approved as submitted</i>
Section VI	Assuring Quality Services <i>Approved with revisions</i>
Section VI	Cost of Plan Implementation <i>Disapproved</i>
Section VIII	Riverview Psychiatric Center <i>Approved with revisions</i>

The Court Master’s decision to approve, accept with revision and disapprove sections of the proposed Adult Mental Health Services Plan and the immediate response of interested parties to this decision helps to illustrate several key observations made by the team during the visit.

- The impact of the settlement agreement and the decisions of the Court on the attitudes, perceptions and expectations of key actors in Maine’s system of mental health care over the past fifteen years can hardly be overstated. As team members have observed in other states and jurisdictions whose mental health systems have operated for significant periods of time under Court order, there may be a tendency to “manage to the decree” in order to ensure that the involvement of the Court is eventually eliminated and the service system returned to state executive oversight. The state is challenged to remain aggressively innovative and inclusive in its efforts to meet the needs of all citizens, not restricting its responsibilities to those who fall within the subgroup of individuals represented under the *Bates* decision.
- Although there is a sense of pride in the system’s evolution and accomplishments over time, it is clearly mixed with a certain degree of frustration: on the part of consumers, families and their representatives that the system continues to fall short of meeting their needs for treatment, housing, employment and other supports; on the part of the Court that its expectations for mental health systems transformation continue to be unmet, despite years of judicial orders; on the part of providers who apparently remain uncertain or unaware of their roles and responsibilities in fully meeting the terms of the settlement agreement; on the part of DHHS staff who have submitted what they believed to be thoughtful plans for meaningful systems change, only to have their efforts rejected. Fatigue, anger and resignation are the almost inevitable outcomes of these disappointments, at least in the short term. All parties will continue to be challenged to collaborate as sincere and responsible partners in the effort to transform Maine’s mental health service system and achieve compliance with the settlement agreement.
- Continuing and unanticipated challenges such as the settlement agreement’s requirement that the Department of Health and Human Services anticipate the personal circumstances and service needs of individuals who have not yet become clients of the public mental health system, and the Legislature’s decision to move the mental health system into a managed care environment in order to achieve cost reductions raise the “compliance bar” with respect to the settlement agreement.

Because the Court's purview includes responsibility for ensuring that the system is appropriately resourced, the assessment of these continually shifting and often unpredictable needs and subsequently mounting an appropriate services response that the Court will find acceptable is an especially challenging task for Department leaders.

Department Unification

On June 20, 2005, Governor John Baldacci signed Public Law 2005, Chapter 412, which created a new organizational framework for the Department of Health and Human Services. Formerly the Department of Human Services and the Department of Behavioral and Developmental Services, this newly-organized state agency operates through four primary organizational units: Finance; Operations and Support; Health, Integrated Access and Strategy; and Integrated Services.

Under Deputy Commissioner Brenda Harvey, Integrated Services consists of Adult Mental Health Services, Adults with Cognitive and Physical Disability Services, Child and Family Services, Elder Services, Substance Abuse Services, Advocacy Services, State Forensic Services, Quality Improvement, and Systems Integration Directors in each of three regions (DHHS Organizational Chart attached).

Unification into one department represents a fundamental transformation of the organization. Whereas behavioral health services previously operated in relative isolation from child welfare, elder services, public health and Medicaid management, those services are now combined under one Commissioner. Health and mental health are now in the same agency. With this merger, co-location and linkages for planning, service delivery and data sharing among a host of state agencies are underway, both centrally and regionally.

Inevitably, the Department's unification has not come without growing pains. Individual offices have over time developed their own unique cultures, languages, service approaches and expectations that are not readily integrated with one another simply because they now exist "under one roof." Anxieties have been raised about the priority of service populations and the continuation of current funding levels.

On the other hand, state staff also observe a very positive side to this fundamental organizational change: it allows the new Department to make the best possible use of scarce state personnel resources; to share strengths that have developed within individual offices with others who may not have as successfully addressed issues such as developing effective contract incentives; measuring service outcomes; supporting and engaging consumer and family networks in systems of care. The Department has expressed its complete commitment – as is reflected in new office titles and responsibilities – to integrating care in ways that benefit Maine citizens.

The Department recently demonstrated its commitment to creating stronger partnerships at the state level by submitting two grant applications for federal funding

that are specifically designed to support Maine's efforts to strengthen its bureaucratic infrastructure in order to develop a more integrated service system.

- Co-Occurring State Incentive Grants (COSIG) provide funding directly to states to enhance their infrastructure and increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment for persons with co-occurring substance use and mental disorders. These objectives are completely consistent with the principles of the settlement agreement and good practice. The grant application – developed and submitted through the Governor's Office – calls for significant changes in the way that Maine's citizens are screened for co-occurring disorders; assessed for the level of the problem's severity; comprehensively treated; and in the way that Maine's co-occurring workforce is trained, treatment plans are developed and impact of treatment services is evaluated.

On July 12, 2005, SAMHSA and Governor Baldacci announced that Maine's COSIG application had been approved for \$3.48 million over a period of 5 years.

- The State Transformation Infrastructure Grant (TSIG) Program is a cooperative agreement between state and federal authorities to support an array of infrastructure and service delivery improvement activities that help states build a solid foundation for delivering and sustaining effective mental health and related services. These grants are unique in that they will support new and expanded planning and development to promote transformation to systems that are explicitly designed to foster recovery and meet the multiple needs of consumers.

The TSIG program flows directly from SAMHSA's wish to support states in their efforts to implement recommendations of the President's New Freedom Commission Report. In FY 2005, approximately \$18.8 million will be available to fund 6 to 13 awards ranging from \$1.5 million to \$3 million in total costs per year, over a period of up to 5 years.

Although federal authorities have not yet made TSIG grant awards as of this report date, the Peer Review Team congratulates Maine for a thoughtful, innovative and well-written application. Whether or not it is funded, the application clearly reflects the state's plans and commitment to build on current health care transformation efforts in a way that creates,

an integrated, holistic health care delivery system in which mental health care is an essential aspect of health care, the consumer has a central role in health care planning, there is access to a range of quality, evidence-based interventions... the provider is accountable and measured...on the health and recovery status of consumers, and the community has a central role in...[promoting] health, resilience and recovery. (Vision Statement, Transform ME).

Managed Care

Maine is currently not a “managed care” state. Approximately ten years ago, just after the first wave of states transitioned into new managed care “carve-in” and “carve-out” financial arrangements, the leaders of the former Department of Mental Health and Mental Retardation seriously considered the possibility of moving Maine to a managed care system. Managed care consultants met over a period of months with key players to educate them and to lay out a framework for the state’s transition to managed care. Consumers, family members, providers and advocates took part in detailed discussions, provided input into planning documents and established their interests in a new managed care system. Ultimately, the decision was reached to remain within the existing “fee-for-service” model. Some participants in the team’s discussions indicated that they were both disappointed and unhappy with that decision.

One of the first acts of the Baldacci administration was to create the Governor’s Office of Health Policy and Finance, which developed a proposal for health reform encompassing universal access, cost controls and quality enhancement. That proposal resulted in Public Law 469, commonly referred to as the Dirigo Health Reform Act, which enabled creation of the Maine Quality Forum, advocating for high quality health care that is safe, effective, consumer-centered, timely, efficient and equitable. Two of the top five priorities in the new State Health Plan include depression and substance abuse. Medicaid eligibility has been broadened and affordable premiums have been subsidized to encourage employers and citizens to obtain health insurance.

A recent study determined that \$867 million was spent on Behavioral Health Services by Maine state agencies and their political subdivisions.⁴ Eighty to ninety percent (80-90%) of these expenditures were reimbursed by MaineCare, Maine’s Medicaid System. As a result, during the 2005 Legislative Session, the Maine Legislature passed a bill and the Governor signed into law a mandate requiring that the Department of Health and Human Services contract with a non-provider entity (Managed Care Organization or MCO) to provide managed behavioral health care for eligible Maine residents. Maine’s Legislature further mandated that the State of Maine save more than \$10 million as a result of implementing a managed behavioral healthcare system. The new contract for the MCO is to be in place by July 1, 2006, and the savings must occur between July 1, 2006 and June 30, 2007.

DHHS indicated during discussions with the team that the \$10 million savings mandated by the new legislation could come from the larger sum of \$867 million, which would include mental health services provided in the primary health care setting. MaineCare for physical health care is and will continue to be a fee-for-service system. Under the new system for Behavioral Health Services, substance abuse, adult mental health, children’s behavioral health (including behavioral health services traditionally provided by child welfare) will be part of the behavioral health carve-out encompassing approximately 262,000 MaineCare lives.

⁴ NASMHPD Research Institute, Other State Agency Spending for Behavioral Health Care (2005)

The Legislature provided little direction to the state in mandating this very recent move to managed care. The legislative language consists of "Savings achieved by implementing the managed behavioral healthcare services system...\$10,431,749 for SFY 2007." The team observed widespread uncertainty and anxiety among consumers, family members, providers, the Court, advocates and state staff regarding the impact of this managed care mandate on development, administration, financing and delivery of mental health services in Maine. In fact, the Court cited the fact that insufficient time for planning and implementation within a period of one year as one reason for its rejection of portions of the proposed Adult Mental Health Services Plan:

There is significant risk...that unless designed and implemented carefully, a system of managed care...is a promising, but as yet unproven approach that, in some instances, has resulted in decreased access to care, together with deficiencies in quality, appropriateness, and outcomes of care...Successful implementation of managed care will depend on careful planning, precise definition and strong oversight on the part of the Department.⁵ (Page 4)

Goal-Specific Observations

The Peer Review Team's observations and recommendations are organized within the framework of the six goals of the President's New Freedom Commission on Mental Health. Although the team facilitated discussions that spanned the range of concerns that impact mental health service delivery systems, this report emphasizes particular aspects of Goals 1, 2 and 5, which were identified prior to the visit as especially important to Maine's mental health systems transformation efforts. In this way, the team focused its limited time and attention where it seemed most needed. In the same way, this report emphasizes observations and recommendations in topic areas that perhaps have not already been proposed as part of the Adult Mental Health Services Plan submitted for consideration by the Court, grant applications or other proposals and plans made available for the team's review.

GOAL 1: AMERICAN'S UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

Public Education and Suicide Prevention

The settlement agreement requires that the Department of Health and Human Services develop public education programs to educate members of the general public regarding the myths and stigma associated with mental illness. The Maine Youth Suicide Prevention Program has been expanded to include prevention and improved access to services for individuals of all ages, as well as expanded data capacity. According to Maine's Transformation State Infrastructure Grant (TSIG) application, Dirigo Health Plan supports behavioral health projects on peer support services, PIER early identification and treatment, substance abuse, eating disorders, jail diversion, prevention

⁵ Superior Court Order Civil Action Docket No. CV-89-088 (July 29, 2005)

for Gay, Lesbian, Bisexual and Transgender Youth, as well as school-based mental programs. In addition, Adult Mental Health Services maintains a contract with NAMI for public education.

Connecting Physical and Mental Health

The majority of the state's citizens receive their mental health care from rural health centers, school-based health centers and family practitioners who estimate that behavioral health conditions account for some 40% of patient morbidity in their practices. This is similar to the Peer Review team's experience in other states, most especially those with significant rural areas where availability of trained mental health practitioners is a chronic problem. Physical health care providers are at varying levels of comfort and expertise in their ability to screen, assess and treat mental health and substance use disorders.

Of those individuals receiving services through MaineCare, 15% are diagnosed with depression. Fully 41% have a mental health, substance abuse or cognitive condition. A third of children under the age of 20 have a behavioral health condition. Based on these facts, Maine recognizes and has made a commitment to integrating physical and health care in its financing and services development activities. The State Health Plan identifies depression and substance abuse as priority areas.

Financing

The New Freedom Commission Report recognizes that mental health financing is a unique challenge facing mental health systems across the nation. Typically, "fee-for-service reimbursement systems for Medicaid...do not allow providers to bill for essential programs such as flexible case management, non-face-to-face services, or in-home visits" (page 69).

Maine is well on its way to funding the services needed by the people it serves. While median household income ranks the state currently 40th in the nation, Maine's per capita spending for mental health places it in 11th position. Many support services and evidence-based practices (EBPs) are already covered by MaineCare under its fee-for-service system, including Therapeutic Foster Care, Multi-Systemic Therapy and Assertive Community Treatment.

Managed Care

The mandated move to managed care was discussed extensively throughout the two day visit with many different stakeholders, including the DHHS Commissioner, leadership and management teams of the DHHS, consumers, family members, the Court Master, and staff of the Governor's Office. Team members oriented people to terminology and definitions used in managed-care systems using an outline provided at the beginning of the visit (Attachment D). A good deal of time was spent "de-mystifying" managed care and discussing the problems that a number of states have

encountered in shifting their mental/behavioral health systems to managed care. Discussions with the Court Master included a recent research study that describes managed care as a yet-unproven approach to health care financing.⁶

The team believes that, correctly planned and implemented, managed care presents Maine with greater opportunities than are presently available for DHHS to buy services that achieve desired outcomes for consumers of behavioral health services, especially in light of the fact that responsibility for Medicaid financing already falls with the Department. These opportunities include:

- Retaining outside experts to manage prior authorization, utilization review, claims/encounter adjudication, information systems development, expenses, the quality of client care and outcomes;
- Increasing oversight of the system by providing enhanced clinical leadership, and implementation of quality management strategies that continually strengthen practice and improve client outcomes;
- Purchasing/financing clinical practices that work and “defunding” practices that do not;
- Aligning the goals and outcomes of the *Bates v. DHHS Settlement Agreement* with the children’s settlement agreements by using managed-care tools and various funding sources.

During their discussions with the team, Maine stakeholders identified the following additional opportunities that they believe are offered by managed care:

- An increase in consumer choice of services;
- Increased consumer input into service planning, implementation and evaluation through the use of consumers employed as peer specialists and mentors;
- Strengthened utilization review to ensure appropriateness and adequacy of care;
- An expanded range of services than what is currently offered; and
- Increased support for individualized planning.

Finally, Maine stakeholders recognize that the advent of managed care does not mean that responsibility for decisions will be transferred from the state to the Managed

⁶ Carol T. Mowbry, Kyle L. Grazer & Mark Holter, *Managed Care Behavioral Health in the Public Sector: Will it Become the Third Shame of the States?*, 53 *Psychiatric Services* 157 (2002).

Care Organization. Similarly, Maine stakeholders also recognize the Court Master's fundamental decision-making authority regarding managed care implementation and system transformation.

Contracts

While Maine's ranking in per capita spending on mental health care is relatively high, compared to other states, discussions that the team facilitated during the visit suggested that there was little or no evidence available to demonstrate that individual and system outcomes match the high rate of spending.

DHHS staff state that they see managed care as an opportunity to develop and implement contracts that firmly reflect the state's responsibility to ensure that high-quality mental health services are provided. New contracts are now being considered that address provider requirements for client outcomes, incentives for exceptional care, and reductions in disparities between provider payments for the same services in similar settings.

Outcomes and Accountability

Management Information Systems

DHHS has an Office of Information Technology that is supported by the Maine Office of Information Technology. The state office's mission is to complete information system integration across all state agencies. In support of this goal, the DHHS Office of Information Technology has developed the Enterprise Information System (EIS) which is an integrated clinical and administrative information system. It basically functions as the type of electronic medical record envisioned in Goal 6 of the President's Commission Report.

DHHS participates in the "ORYX" system of data collection for its State Hospitals, maintained by the NASMHPD Research Institute, Inc. ORYX enables state inpatient and private psychiatric facilities to submit performance data from which they can then select from among 26 performance measures to compare their own performance rates with national benchmarks. Additionally, Children's service providers send data electronically to DHHS on quarterly basis. This assists DHHS in meeting some of the federal child welfare targets established under other federal funding.

The June 2005 plan that was submitted by DHHS to the Court Master to comply with the settlement agreement included a proposal to track client-specific information for all consumers. That section (Section VI) of the proposed plan was approved by the Court, with revisions. According to the plan, data will be entered from all providers and will eventually produce reports that will allow the DHHS to track scope and duration of services as well as to begin identifying trends in service utilization over time. The DHHS also plans to use EIS data to monitor timeliness of services and identify unmet needs.

Performance Standards

The settlement agreement specifies a set of performance standards that include both objective and subjective indicators and data to show how well the community mental health system is performing. There are 34 “standards” (statements of desired outcomes) and almost 80 “performance standards” (the assignment of a numerical measure to the desired outcome) that have been agreed to.

Maine also has many sources of data collection including MaineCare Data on service claims, EIS (discussed earlier), Maine Automated Child Welfare Information System (MACWIS) to track children in child protective services and foster care, and Treatment Data Systems (TDS) which tracks intake data and exit outcomes for persons receiving substance abuse services. Maine also uses many local and national survey instruments to assess the overall health of its citizens. And finally, the DHHS and its stakeholders meet monthly in a Performance Measures Workgroup to examine current data and make recommendations for future changes.

GOAL 2: MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN

One of the key vehicles through which Maine’s consumers have increasingly had a voice in mental health decision-making is the Advocacy Initiative Network of Maine, a 600-member statewide organization that has been in place for six years. The Advocacy Initiative Network currently receives \$49,000 in state funding. The group has also received two, three-year grants, one of which was a \$150,000 federal community action grant in which they take special pride, believing that it might be the only statewide consumer organization to have won a grant in this category. The network employs a full time director and two part time staff members and has used grant monies to train consumers through leadership academies. They reported to team members that 250 consumers have graduated from 13 academies that have been held throughout the state.

These academies have helped involve consumers in a number of statewide mental health forums and workgroups and trained people to serve on agency advisory boards and committees. The “Maine Road to A Transformed Mental Health System” lists some of their accomplishments:

- More than 60 consumers participated in a two-day work group to contribute to the settlement agreement plan by exploring the status of mental health services in Maine and making recommendations for solutions to existing problems.
- Forty-seven consumers from different regions participated in discussions with the Commissioner’s Implementation Advisory Team (CIAT) regarding the newly-unified Department of Health and Human Services.
- Fifteen consumers joined the Recovery Specialist Advisory Committee to guide development of a work plan for the Center for Medicaid and Medicare Recovery Specialist project.

- Approximately 300 Maine consumers attended the statewide HOPE Consumer Conference.
- The variety of services and the recovery orientation of Riverview Psychiatric Center's Treatment Mall drew praise from consumers, who expressed pride in their own understanding of and commitment to recovery principles.
- Forty-four participants participated in a series of "Crisis Service Forums" held across the state to obtain feedback from recipients of crises services regarding what works and what doesn't.

Consumers did express frustration with sometimes feeling "left out" of important discussions or notified about meetings when it was too late to make arrangements to attend. In the words of one consumer: "Even though it looks like we've done things, we still feel like we're 'crashing doors'." State staff acknowledged this frustration, affirmed their firm support of consumer-centered services, but pointed out that inviting consumers to all meetings was simply not practical. In the team's experience, this difference in perspectives is fairly common in evolving state mental health systems as they increasingly engage consumers in the decision-making process. Consumers did express optimism that, if Maine's TSIG application were funded, it would provide additional opportunities for expansion and growth for consumers.

The Office of Consumer Affairs (OCA) presents a special challenge for Maine. The OCA director reports to the Director of Adult Mental Health Services; placement at this senior level is necessary in order to adequately represent consumer interests. As in other states, though, the OCA is perceived to sometimes be forced to choose between what are perceived to be "consumer" interests and those perceived as "system" interests. Maine's Office of Consumer Affairs has seen six directors in recent years, making it difficult for the office to have a consistent positive impact on mental health services. The office has not been fully staffed. Deputy Commissioner Harvey indicated that the Department's unification has also caused a certain amount of instability and that the job is both strenuous and demanding. Consumers maintain that greater definition and clarification of the OCA director's responsibilities would help stabilize the office. Some consumers recommend that the OCA be made independent of DHHS.

In general, consumers who met with the Peer Review team attach real importance to being involved in responding to all recommendations of the President's Commission Report, not just the second goal that relates to a consumer and family-driven mental health system. The document developed by the Advocacy Initiative Network reflects this vision.

Individualized Plans of Care for Adults and Children

Individualized, consumer-driven services plans (ISP's) have been in place throughout the state for ten years. Numerous trainings have occurred since that time to train staff and providers in integrating recovery goals and outcomes into ISP's.

Consumers who are inpatients at Riverview Psychiatric Center agreed that the process of involving them in developing their own ISP's has greatly improved, pointing out that the peer specialists employed by the hospital have been especially helpful in developing their plans.

Continuity of Care

Maine is one of a number of states that are struggling with the issue of continuity of care; that is, the ability to access appropriate services in both inpatient and outpatient settings as consumers need them and only for as long as they continue to be both needed and beneficial. Discussion with participants in the site visit and the team's review of background materials suggest that the issue is in at least three parts. First, lack of sufficient access to inpatient beds that allow individuals to remain in or near their homes, benefiting from existing family and social support structures, until the need for acute hospitalization has been resolved. Understandably, this is noted as less of a problem for the areas in or surrounding Augusta and Bangor, with the availability of Riverview Psychiatric Center (formerly Augusta Mental Health Institute) and Dorothea Dix Psychiatric Center (formerly Bangor Mental Health Institute.)

DHHS clearly acknowledged the problem in its application for federal support to continue transforming the mental health system. Although Maine's per capita rate of licensed inpatient beds seems to be above-average, many of these beds are not staffed because of problems with recruiting sufficient staff to rural areas. Consequently, as the Court Master states in his communication of July 29, 2005, some individuals may have to travel up to 330 miles for hospitalization, "exacerbating the crisis ...lead[ing] to feelings of isolation and loneliness" (page 3).

A second significant problem relates to transitioning of clients from the state psychiatric hospitals once medical staff determines that no further benefit can be derived from inpatient hospitalization. At that point, discharge/transition back to the community is delayed, for some individuals, because appropriate community residential placements are not available. As a result, up to 40 individuals may remain in the hospital for 30 - 90 or more days, awaiting community placement. The lack of appropriate, stable and affordable community residential placements also tends to increase the rate of recidivism once individuals are, in fact, discharged from the Riverview or Dix Centers to return to their communities.

A new "Peer Bridger" program is being proposed by the peer specialist team at Riverview Psychiatric Center to help address the problem. Peer Bridgers would work with discharge-ready clients to learn the skills they need to live successfully in the community. After discharge, these peer specialists would work with people in their own living environments to provide peer support, teach living skills, and familiarize them with community resources.

The third aspect of the complex problems facing the continuum of care is the availability and management of crisis/emergency services. Clients awaiting evaluation

may wait in the emergency rooms of local hospitals for many hours before a qualified professional becomes available. It may not be clear who will actually provide that evaluation: in some communities, a crisis team staffed by the local community mental health center has lead responsibility. In other communities, a for-profit hospital may typically provide evaluation and perhaps subsequently admit or commit an individual to its own facility. In still other (although more rare) situations, patients may arrive at a state psychiatric hospital without having been offered appropriate emergency mental health screening and assessment intervention in their own communities. In cases where there are not clear and consistent lines of responsibility and authority for providing such critical mental health services, it is the team's experience from their work with other states that providers typically end up "doing the best they can" in difficult circumstances, with mental health consumers receiving less than adequate services from whomever steps in to accept responsibility for their care.

The State of Maine, its DHHS and system stakeholders have demonstrated in a number of ways that they clearly recognize the significant impact of these problems on their ability to strengthen Maine's continuum of mental health care and are addressing them.

- MaineCare provides reimburses for a flexible menu of services and supports that mental health consumers need to remain healthy and integrated into their communities.
- In the fall of 2004, Deputy Commissioner Harvey charged the Hospital and Crisis Services Initiative Group with examining the problem of fragmentation in the emergency services system and recommending appropriate solutions. After a series of meetings through June 2005, a number of the group's recommendations were integrated into the Adult Mental Health Services Plan which was then submitted to the Court Master for approval.
- The Amistad consumer organization in Portland provides peer services in a local emergency room when individuals present in a mental health emergency. The program is staffed with peer specialists six hours per night, seven days a week, assisting on average 3-4 persons each night. Although resistant at first, hospital staff came to understand that the purpose of the peer specialists was not simply to advocacy for consumers but to provide direct support to individuals in crisis. The involvement of peer providers is a unique way that Maine has chosen for persons to receive needed attention without a lengthy wait. This may be one of the only hospitals in the nation to hire mental health consumers for this specific purpose and could serve as a model for other states.
- The Adult Mental Health Services Plan addressed a number of ways in which the continuum of care for Maine class members requiring mental health services would be improved, if the Plan were approved.

- Both the COSIG and TSIG applications spelled out in some detail the state’s plans to more fully integrate the separate components of Maine’s mental health system into a more coherent and efficiently-functioning whole continuum of care.

The team understands these to be complex problems and acknowledges the limited time that was available during the visit to reach a complete understanding of the nature and scope of the issues and concerns related to continuity of care. Nonetheless, the team’s impression is that Maine’s system of mental health care has evolved in such a way that state hospital and community mental health service providers now tend to operate independent of one another, rather than as full partners in the continuum of care.

Two closely-related examples illustrate the team’s impressions.

1. State Hospital Transition Planning. When clients enrolled in a community-based program are admitted to Riverview Psychiatric Center or to Dorothea Dix Psychiatric Center, it does not appear to be standard clinical practice for the community-based primary therapist or specialist to maintain regular, consistent and on-site contact with either client or hospital staff during the individual’s inpatient stay. In these cases, an important opportunity is lost to maintain (or to create, in the case of individuals with no previous community mental health treatment experience) essential therapeutic ties. In addition, when hospital medical staff determine that no further benefit is to be gained from the inpatient stay, discharge/transition planning is unlikely to be as successful as it might have been had transition planning actually begun on the day of the individual’s admission. Team members could not help but wonder if a closer partnership between community and hospital staff would not decrease the incidence and stress of “difficult community placements.”
2. “Fail First” Drug Formularies: While hospitalized, clients may be successfully stabilized through a treatment regimen that includes atypical medications, leading to their being ready for discharge. However, the individual’s own mental health care coverage may not permit payment for that same medication upon his/her return to the community, without first trying and failing with medications that are included earlier on the preferred drug list. This situation presents problems in medical, surgical and psychiatric hospitals throughout the country, regardless of third party payor source (private insurance, Medicaid or, as of Jan 1, 2006, Medicare Part D). Community providers often do not have documentation available to support the prior authorization, since that documentation is in the hospital record; indeed, the community prescriber may not have received any information from the hospital regarding the new medication regimen. Closer collaboration between hospital and community staff throughout the inpatient stay could identify this problem and plan for it accordingly.

Recovery-Oriented Systems of Care

Maine enacted “Rights of Recipients of Mental Health Services” legislation in 1984, laying out basic rights of Maine’s citizens for mental health care that include

consumer rights and their roles in individualized treatment planning in inpatient, outpatient and residential settings. Consumers are included on advisory panels and planning groups. Advocacy Initiative of Maine has developed the “Roadmap for Recovery” which teaches leadership and self-recovery skills to consumers, recruits consumers to advisory boards and panels and maintains a website with links to recovery resources.

Affordable Housing and Supports

Various housing initiatives have been developed to support the housing needs of Maine’s citizens with mental illness.

- Bridging Rental Assistance Program (BRAP): Funded with \$2.7 million in state general revenue, with an increase from \$1.2 to \$2.7 million in FY 2005. The current census is 730 units. Demand for this program is very strong, with 39 individuals on a wait list for more than 90 days as of July 12, 2005.
- Shelter Plus Care: Over \$10 million of grants are under active management, between one and five year terms. Current census is approximately 750 (200 in Portland, 50 in Bangor, and the balance of 500 spread throughout the state). Maine is recognized as having a mature, well run administrative system. In fact, the U.S. Department of Housing and Urban Development has utilized Maine’s program manual as a template in designing their own Shelter Plus Care Resource Manual.
- 891 housing units have been developed in residential treatment facilities, community residential facilities and supported housing. An additional 184 units are in the process of being developed. A number of these units are shared among recipients of services other than adult mental health, including victims of domestic violence, veterans and persons who are homeless.

Despite these accomplishments, Maine’s housing situation is similar to many other states: there is not enough stable, permanent housing of the consumer’s choice. Indications are that, at the time of the team’s visit, there were 24 clients who had received maximum benefit from Riverview Psychiatric Center (Dorothea Dix Psychiatric Center inpatients were not included in this review). Community providers appear unprepared to accept those clients back into their home community, in part because of fears that they cannot be appropriately “managed” in community residential settings, because of self-injurious or aggressive behaviors. Addressing the shortage of community housing for this population of individuals was a key issue that DHHS raised in its initial discussions with NTAC regarding the focus of this Peer Review visit and potential follow-up technical assistance.

In addition, discussions brought the following housing-related issues to the surface:

- the relationship between housing and mental health services requirements is not clear to team members. Current best practice indicates that consumers should not be forced to participate in mental health services or face loss of housing;
- a need to more clearly define residential care settings, by consumer clinical needs;
- apparent differences in payment rates and service caps;
- DHHS staff are working on an overhaul of the PNMI funding formula to provide better incentives for savings in operating costs.

The adoption of managed care also offers an opportunity to generate additional policy discussions regarding gatekeeping and appropriate community placements; MaineCare issues surrounding non-categorical services (e.g., MaineCare waiver for single, childless adults), medical necessity, and categorically eligible; youth in transition to the Adult Mental Health system; the needs of elderly persons with mental illness.

Supported Employment

Both professionals and consumers in Maine recognize and value the importance of employment. The state funds limited employment support programs and noted in its report to the Court Master a positive trend in attaining employment - 15-20% of *Bates v DHHS* class members - and increasing satisfaction among clients. Maine relies significantly on the Vocational Rehabilitation Department for mental health consumer employment services. Reliance on VR appears to have led, as is the case in a number of states, to limited participation by mental health consumers and a limited connection between clinical and supported employment services. DHHS is stepping up its efforts to work more closely with DVR and intends to place additional emphasis on its supported employment activities, especially in light of the Court Master's July 29, 2005 criticism of the current system.

If funded, Maine's TSIG application is expected to track employment outcomes. The team sees particular challenges to expanding supported employment services, including the state's overall economic landscape, current federal and state disincentives and the limited use of Medicaid buy-in.

Consumers as Providers of Care

Consumers affirm that the settlement agreement and ongoing DHHS consumer-centered planning efforts have had a positive impact on the development of consumers as service providers.

- A total of 17 social clubs and peer centers are supported by state funds.
- The Amistad mental health consumer organization provides peer recovery specialists in hospital emergency rooms.

- In 2004, DHHS received funding from the federal Center for Medicaid and Medicare to develop a curriculum and certification process for Peer Recovery specialists whose services would be Medicaid reimbursable. There are now 15 peer recovery specialists working with consumers on developing Wellness Recovery Action Plans (WRAP).
- The Peer Resource Center in Bangor operating under an arrangement with the Sweetser Community Mental Health Center, includes a consumer-run drop-in center and peer-run crisis hostel that operates 24/7, serving up to two individuals per day.
- The Portland Drop-in Center operated by the Portland Coalition is the oldest consumer operated program in Maine (the program is currently being challenged by staffing and funding issues).
- A “Warm Line” available for all Maine Consumers.
- The Memorial Project for consumers who died at Augusta Mental Health Institute.
- Thirteen Leadership Academies have graduated 250 consumers.
- A five-member peer specialist team at Riverview Psychiatric Center serves all units of the hospital through Amistad. Inpatients consider the team a very positive aspect of RPC services. Although initially somewhat skeptical and cautious, staff now appear to value the services that peers provide.

Interagency Collaboration to Increase Access and Accountability

The 2005 Other State Agency (OSA) Study conducted under the auspices of the NASMHPD Research Institute, Inc. demonstrated that the need for collaboration among agencies serving persons with behavioral health issues is great. According to the study, which reviewed mental health service use and expenditures across state agencies, fully 8% of the state’s population is receiving mental health related services through education, corrections, mental health, child welfare and vocational rehabilitation systems. MaineCare provided 90% of the total funding for these services. The unification of the Department of Health and Human Services was designed, in part, to address this significant need for collaboration among state agencies.

Comprehensive State Mental Health Planning

State efforts to plan for comprehensive mental health services are ongoing and significantly influenced by the requirements of the settlement agreement plan. In addition, recent state efforts to systematically develop comprehensive and integrated services were enhanced by information provided by the Other State Agency (OSA) Study, mentioned above. DHHS staff made a very well-received presentation on their most significant findings from the OSA Study at the July 10-12, 2005 NASMHPD membership in Chicago.

Maine continues to expand its capacity to collect and analyze service and financial data, using that information to influence the planning process. The Data Infrastructure Grant (DIG) has allowed the state to make better decisions based on quality of care, although staff readily acknowledge that they're still very much "in the learning phase" in this area. DHHS is moving toward using data, information and the planning process to "buy what works" for consumers.

The state's last Mental Health Block Grant Site Review was conducted by the Center for Mental Health Services in July 2001. The date of the next visit for Performance Partnership (formerly Mental Health Block Grant) compliance has not yet been announced.

Protection and Advocacy

The Disability Rights Center (DRC) is Maine's protection and advocacy agency for persons with disabilities. While the agency serves all disabilities, attorney Helen Bailey works primarily with persons with psychiatric disabilities. The center provides legal representation, information regarding rights, advocacy skills training and works for mental health systems change, in partnership with consumers and family members. DRC promotes development and expansion of consumer-run services, particularly in the area of crisis services, including warm lines and ER departments. Implementation of consumer councils to help ensure service quality is projected for Fall 2006.

An advocacy position at Riverview Psychiatric Center has been vacant for some time. Although the hospital peer specialists attempted to fill the position on a temporary basis, there was concern that relationships with inpatients were being compromised. A Request for Proposals is being developed so that a contract can be issued to fill the position.

Seclusion and Restraint

Recent statistics on the use of seclusion and restraint at Riverview Psychiatric Center indicate that RPC is meeting its goal to reduce seclusion and restraint, with incidents at or below national norms, according to figures maintained by the NASMHPD Research Institute (Dorothea Dix Psychiatric Center statistics were not reviewed by the team). Riverview's Peer Specialists, the intensive staff training mandated for all hospital employees and participation in NTAC's National Executive Training Institute (NETI) on Seclusion and Restraint are among the factors jointly credited for much of the reduction.

Peer specialists and inpatient consumers talked with the team about the incentive "pizza parties" that they believe have also contributed to reducing incidents of seclusion and restraint. All hospital units vie for the party. Peer pressure among consumers helps inpatients self-manage their behavior; no one wants to be responsible for losing out on the party. One of the Peer Specialists brings her dog to the hospital, who is well- liked by patients. She related to the team an instance where "Cody" actually helped de-escalate the behavior of a male patient who was about to be placed in restraints.

GOAL 3: DISPARITIES IN MENTAL HEALTH SERVICES ARE ELIMINATED

Culturally Competent Care

Maine has never experienced significant immigration from members of racial or ethnic minorities. The population is, in fact, 98% white. More recently, the greater Portland area has become home to more than 3,000 people from around the world. According to materials developed in support of the TSIG application, a sizeable Somali population now calls Lewiston home. Despite the lack of diversity in its resident population, Maine is one of the few states in the nation that provides interpreter services for multiple languages through the Medicaid program. Cultural diversity training is required of all DHHS staff. Mental health-specific brochures, including those covering mental health consumer rights, are translated into five languages. Several individuals who participated in discussions with team members were quite open about their own Gay, Lesbian, Bisexual, Transgendered orientation. The TSIG application clearly spoke to the mental health needs of GLBT persons. Core competencies covering diversity are one aspect of performance evaluations for state management staff.

Access to Rural Mental Health Care

The rural nature of the state makes access to rural mental health care a pressing issue. Maine's 18 Federally-Qualified Health Centers (FQHC) are mostly located in geographic areas that experience primary health care shortages. These FQHC's may themselves have mental health and substance abuse providers on staff, or they may contract for behavioral health services with regional mental health clinics. DHHS has decided to strengthen its initiatives to integrate behavioral health into the primary health care setting as a primary strategy to increase access in rural areas.

Maine's rural nature was identified as a problem by consumers, some of whom had to travel many hours to participate in the team visit. Apparently, the vast area of the state makes it more difficult for consumer organizations to provide leadership and self-help training for their peers.

GOAL 4: EARLY MENTAL HEALTH SCREENING, ASSESSMENT & REFERRAL TO SERVICES ARE COMMON PRACTICE

Children's Mental Health

According to Maine's TSIG application, approximately 8000 children with serious emotional disturbance receive services through the adult and child divisions of DHHS. The 2004 Muskie Institute study indicated that a third of Maine's children (aged 0-20) receiving Medicaid services have a behavioral health condition. Together, Adult Mental Health Services and Child and Family Services support a menu of services oriented to the needs of children and their families, including statewide crisis outreach, Individual Support Plans (ISP), case management, family psycho-education, child psychotropic medication, Multisystemic Family Therapy, Cognitive Behavioral Therapy,

and Therapeutic Foster Care. Extensive prevention activities targeting children, youth and college age residents are offered through the Office of Substance Abuse Services.

A Memorandum of Understanding is in place between DHHS and the Department of Corrections agreeing that children with severe cognitive limitations or mental illnesses are not incarcerated. Mental health services provided to youth in juvenile facilities through the Mental Health Collaborative.

As is the case with adults with serious mental illness, the system of care for children with serious emotional disturbance suffers from uneven distribution of resources, where not all children have access to needed services throughout the state.

Co-Occurring Substance Use and Mental Disorders

Maine estimates that approximately 10,000 of its citizens experience co-occurring psychiatric and alcohol or other drug disorders. Two nationally-recognized co-occurring service programs are located in Maine: the Co-Occurring Community Collaborative of Southern Maine and Maine Medical Center's Co-Occurring ACT Team. A 2004 Community Action Grant from SAMHSA supported state efforts to develop Memoranda of Understanding with 58 agencies to develop and implement co-occurring services. In addition, a 10-member state team participated in the April, 2004 SAMHSA-sponsored Co-Occurring Policy Academy in Baltimore, MD.

The Office of Substance Abuse within DHHS contracts for services from 175 licensed adult and adolescent substance abuse programs. The Office of Adult Mental Health Services has 50 staff in central and regional offices who deliver case management services and other staff who manage mental health treatment contracts. Most substance abuse programs in the state now have consulting relationships with psychiatrists; many community mental health agencies now offer substance abuse consultation.

The state's training infrastructure includes "train-the-trainer" programs and on-line co-occurring curricula, conferences, training videos, the Adolescent Co-Occurring Training Program, the Dialectical Behavioral Therapy Training Institute and the Relapse Prevention Training Initiative.

Despite these achievements, a 2002 survey conducted by the Department of Behavioral and Developmental Services (now DHHS) noted that fully 84 percent of the stakeholders surveyed reported "a moderate to major problem with co-occurring service delivery." Resources to support mental health and substance use disorders are limited. System barriers in coordinated and integrated care include the need for greater flexibility in MaineCare's reimbursement for co-occurring services; fragmentation of services; lack of parity between mental health and substance abuse reimbursement rates; inadequate referral networks; lack of competence and training among program staff; an absence of training and education standards for co-occurring disorders, among others.

Recognizing a need to improve the system's capacity to deliver effective care to persons with co-occurring disorders, DHHS last year developed and submitted an application for SAMHSA funding of a State Incentive Grant for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG). The recent federal award of a COSIG grant to Maine is expected to significantly strengthen the state's development and delivery of services for persons with co-occurring substance use and mental disorders in the coming years.

GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED

Evidence-Based Services

Maine has convened an Evidence Based Practices (EBP) workgroup which partnered with Dartmouth University's Psychiatric Research Institute to complete a stakeholder survey on five EBP's - family psycho-education, supported employment, child medication management, dual disorders and ACT - and two promising practices - trauma-informed services and recovery. The survey demonstrated that evidence-based and promising practices are in use at various sites across that state and that the provider community is very interested in participating in further training and implementation. If funded, the TSIG will support continuation of the EBP work group; development of a policy, regulatory and funding framework for best practices; creation of training programs and evaluation tools; and development of collaboratives to extend evidence-based and promising practices throughout Maine's mental health system.

Licensure and Certification

As is the case with other states, licensing of therapists and counselors is the deciding factor regarding who is allowed to provide treatment and what the treatment may include. The basic license for substance abuse treatment is the Licensed Alcohol and Drug Counselor (LADC). Educational requirements for the LADC include specific substance abuse courses, a written test, submission of a case study completed during internship, and passing an oral exam administered by an expert panel. The LADC license does not include treating persons for a mental health diagnosis; they may treat substance abuse only. For mental health, the most common license is the Licensed Clinical Social Worker (LCSW), which requires a Master's Degree in Social Work, a clinical internship, a national clinical exam and two years post-MSW clinical experience. LCSW's are permitted to treat substance abuse if minimum substance abuse educational requirements are met. In addition, Licensed Clinical Professional Counselors (LCPC) are required to have a Master's Degree in Counseling and passing of state exams.

Trauma-Informed Care

Maine has long been a national leader in the development and implementation of trauma-informed mental health care. The team is unaware of any other state that has

made a similar level of commitment to hiring dedicated staff and putting out Requests for Proposals to deliver trauma-informed mental health services, as has Maine.

Trauma-informed services are covered under MaineCare. DHHS provides ongoing training to ensure that mental health services are provided in a trauma-informed way. Training for peer recovery specialists includes a section on trauma. Department staff developed the disaster behavioral health component of the State Emergency Plan and provide training in the psychological consequences of disaster, trauma, and bio-emergencies for primary health care providers and public health. Staff from Adult Mental Health and Child and Family Services have been leaders in implementing multiple workshops on combat related psychological issues for Maine National Guard units before and after deployment in Iraq.

The TSIG application lays out a series of innovative steps to strengthen and expand the state system of trauma-informed care, building on earlier initiatives on trauma informed assessment and treatment.

GOAL 6: TECHNOLOGY IS USED TO ACCESS MENTAL HEALTH CARE AND INFORMATION

Barriers to Access and Coordination of Care

Maine and the Department of Health and Human Services recognize that technology represents an important opportunity to provide greater access to services, especially psychiatric consultation, to children, adults and elderly persons living in rural areas of the state. In fact, team discussions included the participation of mental health staff from as far away as Aroostook County, in the northernmost portion of Maine and almost 300 miles from the meeting taking place in Augusta. However, while telemedicine has been developed to provide limited administrative and clinical services in some areas, sufficient bandwidth is not available to make this option comprehensively reliable.

RECOMMENDATIONS

Based in the findings identified above, the Peer Review Team has formulated a series of recommendations for supporting Maine in its ongoing efforts to transform the system of mental health care according to guidance provided in the report of the President's New Freedom Commission. These recommendations are based upon the team's collective knowledge and experience in the development, financing and management of public systems of mental health care. It is clear to the team that the need to consider implementing these recommendations is more immediate for some than for others; they have been duly noted. These recommendations may be considered as the basis for technical assistance requests to NTAC, NASMHPD and other technical assistance vehicles supported by CMHS, at the state's request.

Financing Needed Mental Health Services and Supports: Managed Care

Immediate Action (2-4 Weeks):

1. Request a meeting with the Center for Medicaid and Medicare Services (CMS), Region 1, to determine if a managed-care behavioral health services “carve out” will require a CMS Waiver, a MaineCare State Plan Amendment, or other written approval from CMS.
2. Determine, with the prior approval of CMS, whether a Managed Care Organization (MCO) must be purchased competitively or may be purchased through a “sole-source” or “competition impracticable” mechanism, due to the very short implementation schedule required by Maine’s Legislature.
3. Engage an actuarial firm to begin formulating capitation rates, consider whether Maine should establish separate rates for adults with serious mental illness, general mental health, substance abuse, children/youth, rural and frontier areas, and so on, and consider risk corridor limits (i.e., profit/loss ranges), and administrative allowances for the MCO.
4. Determine how non-Medicaid payments will be made to the MCO (e.g., 1/12 payment per month for Substance Abuse Prevention and Treatment Block Grant).
5. Become intimately familiar with the 42 CFR “Code of Federal Regulation” Part 438 relating to Managed Care and Medicaid.
6. Increase the managed-care knowledge among a broader spectrum of staff, providers, consumers and families in order to alleviate the fear and anxiety that often occurs with system transformation. Explain what managed care is and what it is not.
7. Hire a project manager, preferably a member of the existing DHHS management team to dedicate 100% of time to manage the project; specifically, contract development, or if necessary, proposal development.

Short-Term (4-8 Weeks):

1. Contract with outside resources to assist in the development of clinical and financial oversight strategies.
2. Determine the role of the MaineCare in oversight of the behavioral health carve out.
3. Determine structural changes necessary within DHHS, such as the role of medical leadership, reporting structures, role of regional teams, and quality assurance staff.

4. Determine delegated functions to be performed by the MCO and the monitoring strategies to be used by DHHS to oversee these delegated functions. Stakeholders have already identified that the MCO will: a) contract with providers; b) conduct utilization review; c) claims payment, and d) collect demographic data on the enrolled population.
5. Convene a “Managed Care Steering Group” and ensure that self-identified consumers and family members, Medicaid staff, substance abuse staff, financial staff, medical staff and other stakeholders truly participate in the development of the proposal/contract, within the parameters of confidentiality required under state law.
6. Develop timelines for longer term (8+ weeks) for specific contract development including the scope of work, covered services, quality management/utilization management activities, MIS requirements, financial reporting, data collection and other strategies.

Financing Needed Mental Health Services and Supports: Contracts

As part of the process of complying with the consent decree and implementing managed care, DHHS should consider the following recommendations for expanding services to buy “what works”:

1. Establish billing codes (either bundled or unbundled) to implement evidence-based practices (EBP’s) that are not currently billable services.
2. Expand the pool of services providers eligible to provide services, such as families of children who are enrolled as Family Support Partners and other non-traditional partners, such as Boys and Girls Clubs and the YMCA.
3. Determine what services and supports should be provided by state employees rather than by the managed care organization. Sufficient staff is needed “on the ground” to ensure that needs of *Bates vs. DHHS* class members are met.

In addition, future contracts will have to include more rigorous requirements for medical review, including critical incidents of mortality and morbidity; quality management strategies targeted at areas of weakness such as network sufficiency, high cost/high service utilization, appropriate assessments, and out-of-home placements for children. Internal financial controls, rigorous financial reporting standards should be clearly spelled out in order for DHHS to pre-pay the MCO and the MCO to prepay the provider network.

Outcomes and Accountability: Management Information Systems

1. While DHHS is in the midst of developing and adding elements to the EIS infrastructure, DHHS staff should make decisions regarding what information will be

transmitted to or housed by the state in the form of “service encounters,” eligibility matching files, and client demographic information.

2. Moving to managed behavioral healthcare requires the state to be more familiar with member care via electronic methods. The state, while it might rely on the MCO to have a system that tracks service utilization and other needed information, should have in place its own set of edits to ensure the accuracy of the information and, on a very regular basis, have access to any and all client data in a readable format.

Outcomes and Accountability: Performance Standards

Data collection, measurement and accountability are critical to DHHS’ success in complying with the settlement agreement, achieving successful department unification and implementing an efficient and effective system of managed behavioral healthcare. DHHS may wish to consider the following actions as staff continue to develop performance measurement systems:

1. Quickly prepare a “Question and Answer” document on managed care, DHHS unification and the settlement agreement. Follow up with other question and answer documents that address the status of the present system (e.g., the number of children being served, recent Treatment Data System (TDS) outcome data for substance abuse, etc).
2. Decide what standards and performance standards agreed to in the settlement agreement might be used for other populations, to assist in the establishment of standards across all populations. This integrated approach will be important in complying with federal requirements.
3. Decide the frequency with which performance measurement will occur, and whether measures will change over time.
4. When measurement occurs and scores are below the target, decide what interventions will occur, both from a clinical perspective as well as from a contract perspective (i.e. sanctions).
5. Determine which survey and data systems can be eliminated.
6. The state appears to be receiving and using outcome data from TDS on a regular basis. What can be done to preserve and possibly use this system as a basis for other data collection methods?
7. Ensure that the method for measurement is sustainable and withstands the tests of inter-rater reliability and statistical significance.

Mental Health Care is Consumer and Family Driven: Recovery-Oriented Systems

Maine's TSIG application reflects the state's desire to transform the system in ways that are entirely consistent with this goal. The language and concept of recovery is clearly embedded in planning documents and was apparent in discussions with the team. Recommendations to strengthen the state's efforts in this goal area include:

1. Continue capitalizing on the knowledge and vision of consumer leaders regarding the concepts of recovery/resilience. Consumers that are trained in the "recovery dialogue technique" can be effective change agents for both systems and individuals.
2. Managed care provides an opportunity to provide financial incentives for services that transcend stabilization and maintenance and embrace recovery. Staff that have received the CPRP (Certified Psychiatric Rehabilitation Practitioner) status that is offered by the United States Psychiatric Rehabilitation Association represent an excellent investment in a recovery-oriented system that the team recommends.
3. Consider orienting consumers and staff to the "Village" model in California as one way of reinforcing recovery-based clinical thinking and interventions.
4. Competitive, community-based supported employment services are measurably associated with positive, recovery-oriented outcomes. The state might consider purchasing supported employment services within the managed care menu to supplement limited funds available through VR.
5. The QSEIS (Quality of Supported Employment Implementation Scale) is an easy-to-use fidelity measure that Maine could choose to use to identify effective employment services and improve existing employment service efforts throughout the state.
6. Hold a celebration event for DHHS staff, providers consumers and family members to acknowledge their successes and strengthen communication among all constituents.
7. Convene DHHS staff and consumers to focus on the Office of Consumer Affairs: review the existing job description, revise and renew its operating strategies, and discuss its placement within DHHS. CONTAC, a CMHS-funded technical assistance center in West Virginia, could provide technical assistance in this area.
8. Contact Broward Housing Solutions (BHS) in Fort Lauderdale, FL regarding consultation in separating housing from mental health services. BHS develops new and creative housing options that are not attached to community mental health centers (Nancy Merolla: 954-764-2800).

9. The State of Tennessee has successfully expanded its consumer housing options within a constrained fiscal environment in ways that have drawn national attention. Maine might consider reviewing their website at www.housingwithinreach.org and also contacting Marie Williams, Executive Director of Recovery Services at (615) 253-3049.
10. Consumers are excited about the possibility of implementing self-directed care in Maine, a new approach being promoted by SAMHSA where individuals are in control of their money and their choice of providers, psychiatrists, etc. Instead of case managers, mentors help consumers with budget planning, choosing treatment, etc. DHHS staff and consumers might consider contacting the Florida program that is currently one of the few demonstration sites for self-directed care.
11. Contact the Peer Bridger Project in New York to further explore strategies to strengthen continuity of care (1 Columbia Pl, Albany, NY 12207, 518-436-0008 ext. 3015, Contact person: Tania Stevens).

Mental Health Care is Consumer and Family Driven: Continuity of Care

In the opinion of the Peer Review team, the task at hand is for key stakeholders to define the nature of the problem and reach a better understand of its causes. In the old social work adage: “How you define the problem dictates the solution.” If the problem is a lack of stable and affordable community housing, that will lead to a focus on developing more housing units. If the problem lies more in the nature of the provider relationships necessary to make a smooth transition from hospital back into the community, that might lead to establishing procedures for more in-hospital time by community providers. If the problem is seen as primarily involving differences in the medication or other resources available to support consumers in making the transition from the hospital to the community, that may lead to changes in the Preferred Prescription List and better communication between hospital and community staff regarding medication coverage, for example.

Typically, the most effective solutions are likely to be some combination of the above and others identified by key stakeholders who have come together to jointly identify the nature of the problems with Continuity of Care, propose and personally invest in solutions, and then take responsibility for their contributions to strengthening the system.

The team suggests that the state consider convening a “Continuity of Care Stakeholders Group” facilitated by a neutral professional to make recommendations regarding ways to strengthen continuity of care among community programs and psychiatric hospitals. The two recommendations which follow might be among those immediately addressed by the stakeholders group.

1. Creating communication mechanisms to ensure that both private and state, and psychiatric and general hospitals are familiar with an individual’s medication

coverage, so that appropriate plans can be made for the consumer's stability in community settings. Hospital staff should be provided by community providers with information on a client's insurance and prescription drug plan, so that medication decisions can be made that are consistent with best clinical practice and with a client's prescription drug coverage. If best practice indicates a medication regimen that requires prior authorization, the documentation supporting medical necessity should be provided by the hospital and the appeals process should be initiated by the hospital before the patient is discharged.

2. Consider establishing a "discharge ready protocol" that includes methods for mediating disagreements among hospital and community parties, a process for the state's involvement in disagreements and sanctions for non-compliance with clinically-appropriate community placements.

CONCLUSION

Finally, the Peer Review Team would like to offer a brief word of congratulations to consumers, family members, providers, DHHS staff, advocates and the Court for their mental health achievements and their ongoing support of the changes that are still to be made to the state's mental health system of care. In our judgment and experience, mental health systems transformation (or the transformation of any intricate bureaucracy, for that matter) is an extraordinarily complex and challenging task, which proceeds over the course of many years and includes hoped-for successes, unanticipated shortcomings and outright failures. According to Deputy Commissioner Harvey, "Sometimes you make mistakes and then you fix them." Since the signing of the settlement agreement, especially, Maine's efforts have evolved to produce successes, failures and continuing challenges. States that have never operated under a judicial order to transform their mental health service systems cannot appreciate the continuous demands of such a unique environment.

Those states have the comparative "comfort" of leading their systems evolution in ways that seem best in their own eyes and hopefully, in the eyes of consumers, families, providers, advocates, and other stakeholders. Stakeholder groups may work together to set priorities, assign resources and establish expectations, based on whatever financial, clinical, political and other exigencies exist uniquely for them. These systems may tend to evolve more slowly, as government machinery whirls and mental health concerns take their place among a host of other important priorities. The repercussions of meeting or failing to meet their goals and objectives can be quite serious, but they do not ordinarily rise to the level of judicial direction and sanction.

In contrast, Maine's settlement agreement envisions a comprehensive, responsive and consumer-centered system of mental health care – certainly, the citizens of Maine deserve no less. In Maine's unique environment, the system's actions are continually held accountable to an external (to the executive branch of government, that is) authority with responsibility to clearly rule where efforts fall short of the settlement agreement. The process is adversarial, by nature. The team urges that stakeholders guard against

“expectation fatigue”, the tendency to perceive that a system is failing because it has not yet completely fulfilled its mission – in this case, creation and maintenance of a fully responsive, comprehensive and consumer-centered system of care. Without ongoing attention to and celebration of the successes that have, in fact, been achieved, stakeholders can become mired in high levels of frustration, disappointment, resistance, and anger – even in the face of evidence that the system is steadily evolving and being transformed in positive and innovative ways.

We encourage Maine partners in mental health systems transformation to take the time to congratulate themselves for their very real achievements, even as they rededicate themselves to the challenges that lie ahead.

DRAFT

ATTACHMENT A: SITE VISIT PROTOCOL AND PROMPTS

Maine Peer Review Site Visit
July 25-26, 2005

Protocol and Prompts

The peer review team will help facilitate and serve as expert resource persons in discussions among state staff, consumers, families and providers that address the following questions:

- What mental health systems transformation activities are currently underway in the state?
- What significant issues and challenges does Maine face as it seeks to transform its mental health system?
- What ideas, suggestions and other technical assistance can the team offer on-site to support the state in its mental health transformation efforts?
- What recommendations would be the team make for future technical assistance activities?

The goals and topic areas of the President's New Freedom Commission on Mental Health President's will help focus on-site discussions. Each review team member has been tasked to assume lead responsibility in specific topic areas. This will help ensure that the team as a whole is well-informed regarding the state's services, activities, issues and challenges in each topic area and prepared to offer on-site support and assistance.

Pre-visit discussions and review of background materials review have identified three major transformation activities currently or soon-to-be underway in Maine: managed care, the consent decree/settlement agreement, and department unification. Team members will help Maine consider the implications of these and other transformation activities, raise critical issues and questions that should be considered, and propose ideas, options and experiences of other states that might help guide the state as its transformation moves forward.

The on-site schedule has been structured to allow wide-ranging discussions among various groups and the full team regarding mental health transformation activities. In-depth discussions among individual team members and constituents of high priority areas are also planned in the areas of housing, supported employment, "difficult-to-place" individuals, and consumer-operated services.

Goals and Topic Areas of New Freedom Commission Report on Mental Health

1. Mental Illness Prevention
 - a. reduce stigma
 - i. public education campaigns
 - b. prevent suicide

- c. establish connection between physical and mental health
 - d. finance needed mental health services and supports
 - i. prescription drug coverage
 - ii. accessibility of services
 - iii. affordability of services
 - iv. coordination of benefits between Medicare and Medicaid
 - v. support for evidence-based services and supports
 - vi. support for self-direction
 - vii. choice of services and supports
 - viii. outcomes and accountability
 - 1. management information systems
 - 2. quality assurance
 - 3. program evaluation
2. Consumer and Family Driven Care
- a. develop individualized plans of care for adults and children
 - i. hospital/community continuum of care
 - 1. community placement/housing of “difficult-to-manage” clients
 - b. create recovery-oriented system
 - i. consumer and family control of care
 - ii. affordable housing and supports
 - iii. supported employment and income supports
 - iv. consumers as providers
 - c. align federal programs to increase access and accountability
 - i. Medicaid financing and managed care
 - ii. better collaboration/coordination among Housing, Rehabilitation, Education, Child Welfare, Substance Abuse, Health, Criminal Justice, Juvenile Justice systems at State and Community levels to determine eligibility, policy and financing
 - d. develop comprehensive state mental health plan to coordinate services
 - i. address fragmentation and coordination issues
 - e. protect and advocate for consumers and families
 - i. end unnecessary hospitalization
 - ii. eliminate need to trade custody for care
 - iii. reduce/end use of seclusion and restraint
3. Elimination of Mental Health Services Disparities
- a. provide access to culturally competent care
 - i. set standards
 - ii. collect data
 - iii. evaluate services for effectiveness and consumer satisfaction
 - iv. develop collaborative relationships with culturally-competent providers
 - v. establish benchmarks and performance measures
 - vi. provide training
 - b. provide access to rural care

4. Early Mental Health Screening, Assessment and Referral Services
 - a. promote children's mental health
 - i. train workforce to treat young children and families
 - ii. train primary health providers to screen for emotional and behavioral problems
 - iii. eliminate barriers to coverage
 - b. improve/expand school-based programs
 - c. screen for co-occurring disorders and link with integrated treatment strategies
 - d. screen for mental disorders in primary health care and connect with treatment

5. Excellent Mental Health Care Delivery and Accelerated Research
 - a. promote recovery and resilience through accelerated research
 - b. disseminate evidence-based practices and implement them through public-private partnerships
 - c. improve/expand workforce EBP and best practice capabilities
 - i. training and education to bridge the gap between science and service
 1. medications, cognitive and interpersonal therapies for depression, prevention for children, treatment foster care, multi-systemic therapy, parent-child interaction therapy, family psycho-education, ACT, collaborative treatment in primary care
 2. consumer-operated services, jail diversion and community reentry, school mental health services, trauma-specific interventions, wraparound services, multi-family group therapy, children's systems of care.
 - ii. licensure and certification
 - d. increase knowledge base: mental health disparities, long-term effects of medications, trauma and acute care

6. Technology to Access Mental Health Care and Information
 - a. use technology to increase access and coordination
 - i. examine barriers created by restrictive licensure and scope-of-practice restrictions that impede developing technology-based services
 - b. integrate electronic health records and personal information systems

ATTACHMENT B: MAINE PEER SITE REVIEW MEETING AGENDA

State of Maine
Mental Health Systems Transformation Peer Site Visit
July 25 – 26, 2005
221 State Street
Augusta, ME

July 25, 2005

- 8:00 – 10:15 AM Team, Executive Leadership Team and Senior Staff⁷
General discussion of New Freedom Commission transformation issues and challenges to transformation presented by managed care, consent decree and department unification. Discussion framed within context of desired consumer and family outcomes: What do mental health and substance abuse consumers and families want: services, supports, seamlessness, etc. What are the challenges, issues and concerns that managed care, consent decree and unification present to achieving those outcomes?
- 10:15 – 10:30 AM Break
- 10:30 – 12:00 PM Intra-Office Collaboration: Adult Mental Health, Hospital, Substance Abuse and Children’s Staff
Finance, aligning federal funding, communication and coordination, partnerships, etc. and issues within managed care that staff need to begin addressing and ideas on how they might approach them.
- 12:00 – 1:00 PM Lunch
Team with Commissioner Nicholas and Deputy Commissioner Harvey
- 1:00 – 3:00 PM Consumer and Family-Driven Care: Staff, Consumers, Families and Providers
General issues, concerns, challenges and interests within managed care environment, consent decree, settlement agreements, transformation and unification..
Housing Discussion
- 3:00 – 3:30 PM Break
- 3:30 – 5:00 PM Continuity of Care and Service Delivery: Adult Mental Health Team
Potential implications of consent decree, managed care and unification on service delivery.
- 5:00 – 6:00 PM Recap: Team with Brenda Harvey and Marya Faust

⁷ DHHS Commissioner Jack Nicholas; Deputy Commissioners: Brenda Harvey (Integrated Services), Mike Hall (Health, Integrated Access and Strategy); Office Directors: Marya Faust (Adult Mental Health), Child and Family (Jim Beougher and Joan Smyrski); Medical Directors Elsie Freeman (Adult) and Andy Cook (Child), Kim Johnson (Substance Abuse).

- 6:00 PM Dinner Meeting with Consumers
- July 26
- 8:30 – 10:00 AM Court Master Wathen
Discussion of managed care and implications of/on consent decree. Opportunity for him to raise questions about managed care and consider how systems might be configured to adapt managed care to consent decree.
- 10:00 – 12:00 PM Consumer and Family Driven Care: Staff, Consumers, Providers, Families
Issues, concerns, challenges and interests related to individualized care planning, maintaining recovery and resilience orientation within managed care environment, affordable housing, supports, consumers as providers.
- Challenging Community Placements
- 12:00 – 1:00 PM Lunch
 Team with Trish Reilly, Pat Ende (Governor’s Office) Brenda Harvey, Jack Nicholas
- 1:00 – 3:00 PM Outcomes and Accountability: Adult Mental Health, Hospitals, Substance Abuse and Children’s Staff
Issues, concerns, challenges and interests related to evidence-based practices, quality assurance and improvement, workforce development, data systems, telehealth..
- 3:00 – 4:30 PM Intra-agency Collaboration: Mental Health, Substance Abuse, Children’s Services
Next Steps in system’s transformation.

*Maine Peer Review Site Visit
Dialogue Meetings with Consumers
Gayle Bluebird, Facilitator
July 25-26, 2005*

Several opportunities were created for separate dialogue meetings with consumers involved in statewide advocacy and members of a peer specialist team working at Riverview State Hospital. In addition, a dialogue was conducted with seven inpatients who are currently residing at the same hospital.

These meetings were considered important because they allowed for the voices of consumers (both inpatients' and former-patients') to be heard. While Maine has been successful at involving consumers at every level, there are still levels of trust and communication to be strived for. Consumers recognize and appreciate what they've accomplished such as: being part of a new workforce, having secured grants for some of their self-directed programs and initiatives, and having been invited and included at many important mental health meetings. At the same time, they are aware of the hurdles they face ahead and have a great need for someone simply to listen to their frustrations. This may have been the greatest value of the meeting with the statewide advocates, in particular, on the evening of the 25th of July, 2005.

The second meeting was a short unplanned meeting with peer specialists working at Riverview Psychiatric Center. All five team members seemed to be happy in their jobs and eager to talk about their activities. Their goal is to have their program expand into new areas of assignments and for other peer specialists to be hired for transition services to persons being discharged from the hospital.

The Dialogue with inpatients was especially important. While they may have a voice in the development of their treatment plans, they may not be given many opportunities to input their criticisms of services or to make suggestions for how they could be improved. While at present, they may not be at the top of the list for review teams, they *should* be, as their feedback may be the most important of all. They often know best what they need and how services could be designed to help them. Their voices *must* be considered important.

Dinner Meeting—July 25, 6:00 PM

Nine persons attended this meeting in the early evening with sandwiches and drinks provided by DHHS. Persons attending came from Portland, Bangor, Brunswick and Augusta. One person came from Washington County three hours away.

All of the participants, except the person from Washington County are members of the state consumer organization, Advocacy Initiative Network of Maine and know each other well, though, because of distance, do not get together often. The enthusiasm at seeing each other was like a family reunion; they wanted to spend time catching up with each other and share information. The person who came the farthest had been invited through NAMI, for which she is a member, and said she had never heard of the consumer organization.

Members of the Advocacy Network, an organization of six years, reported that they have an office in Bangor, staffed by their paid director, Melinda Davis. Some of their funds come from the mental health office in the amount of \$49,000. They have also received two other grants, one of them a federal Community Action grant that they had applied for in the amount of \$150,000. They were proud to say that they were the only state organization that had ever been funded with this particular grant. All of these funds have enabled them to hire a director and two part-time advocates. In addition to paid employees, they have many volunteers working in different parts of the state.

Two of the individuals present work for Sweetser, a large community mental health agency, located in Brunswick. While the agency is a professional provider agency, consumers provide peer directed services in a drop-in center and 24 hour respite program that is staffed 24 hrs. per day, seven days a week. The crisis program serves two persons each day and has thus far had filled beds for 60 consecutive nights since July. They pointed out that comparatively they save the state a great deal of money they estimated at \$60,000 per year. They said they would like to see similar services expanded into other areas of the state.

The network organization has had 13 leadership academies and graduated 250 consumers. Through the leadership academies they have been able to teach self-recovery skills, place consumers on boards and develop regional consumer councils in different areas of the state, an activity still in progress.

While they did not want to talk about all of their achievements, pointing instead to the report they prepared, *The Roadmap to a Transformed Mental Health System in Maine*, they did talk about a successful memorial project that had taken place at the site of the old state hospital, Augusta Mental Health Institute (AMHI). They paid tribute to the many individuals who had died at the hospital through the years, though their gravesites were not located on hospital grounds. They are currently creating an oral history project for the state and plan to create a permanent memorial at the old hospital site.

They were eager to share some of their other successes, but they seemed more interested in having an opportunity to talk about their feelings of being 'left out' at the state mental health office. They stated that they looked good on paper but deep inside they still felt left out. A current example they shared was a two-day meeting to which they had been invited but given late notice to attend, and then their invitations were limited to only certain parts, not the entire event. They felt that it was important that they be present and seated at all of the tables. "There was not a place we could not have been/should not have been," was one comment. Sometimes,

they said, they find out about meetings by “sheer will.” One person made the strong statement as follows, “It sometimes feels like you are being a party to your own abuse.”

Given the opportunity to vent led to more focused discussion on ways that they have been able to work with the department. One person said that she felt good about the transformation grant proposal and that it had been well written. Others noted at the same time that they had never received a copy of the proposal, again reinforcing their point of feeling left out. One individual remarked that she had a lot of hope that it would be funded and that if it did it would allow them to integrate more of their services into the system and would address licensing and credentialing of peer specialists.

One person stated that time needed to be taken to develop an infrastructure if the grant was approved. There needed to be time, she said, to sit down and carefully carve out a place for more consumer operated programs, social clubs, etc.

One person noted that the changing of crisis services is getting the attention of professionals who are beginning to see that peer support does work.

When asked about drop-in centers they acknowledged that the Portland Coalition is struggling to exist and has had problems with management. They reported that there had been a successful drop-in center on the grounds of AMHI but that it had closed because of budget cuts at the state level. They said there were over 1,000 members, many of whom attended frequently. Some of the innovative services included yoga classes and an arts program that were quite popular. Some people said that transportation had been a problem while others noted that there was a van available to transport people to the center and did not view transportation as a problem.

The Office of Consumer Affairs was discussed in some depth. Members stated that the office had seen six different directors and that none of them had been successful, which they attributed in part, to vagueness of the job description. They said there had been a high turnover of commissioners and that, as a result, attention to the OCA had not been sufficient. In addition, they felt that the office had never been fully staffed, but most importantly, were not sure that the office is workable or able to address the needs of consumers. One person said the OCA is in a “tough position”. They did admit that the OCA had created standards for drop-in centers and peer specialist training materials. Ultimately, they seemed to agree that the Office may need to be placed outside of the department and independent of the State. They felt that the director should be taking supervision from consumers.

A final discussion centered on the individual who came representing NAMI. Being a solitary representative put this person at a disadvantage. She countered the experiences of the persons speaking by saying that she had not shared anything similar. She said she never felt excluded by NAMI and did not feel like the other persons present. She gave an example of her experience being a good advocate in a doctor’s office when she was listened to regarding a poster that was stigmatizing or unclear in intent. She was able to get it changed. The others listened but tried to explain that there were different ways of being excluded. They wanted to know if she made decisions in her NAMI organization, to which the person admitted she did not. The individual

was able to hold her own, though clearly this level of involvement and political activity was new to her. It would be interesting to find out whether at some time later, she tried to find out more about the Advocacy Network and join.

The meeting ended at near 9:00 PM but not without everyone agreeing that they had had a good time. Perhaps they felt listened to. And perhaps they left with renewed inspiration.

Meeting with Peer Specialists, Riverview Psychiatric Center—July 27, 2005 2:00 p.m.

Meeting with the peer specialist team at Riverview Psychiatric Center had not been on the agenda but was put in place spontaneously when the team's existence was noted. This team is unique as it is believed to be one of only a few examples like it that exist in the country.

The Peer Specialist team, consisting of five full time persons (four females and one male) has been in place for approximately two years, and was initiated as part of the hospital consent decree. A main qualification for team members is their personal life experiences with mental illness. Instead of hiding their past, as they may have felt obligated to do in other life and work situations, they are encouraged to be open about their illnesses in order to be role models for the persons they work with.

All of the team members were enthusiastic about their unique positions and stated that they love their jobs. Two of them shared stories about how they became part of the team. Holly, the team leader, stated that she had been working as a social worker in the hospital when she learned about the job. While she had not disclosed her history in her previous job, she was surprised to learn that her experience as a mental health consumer would be considered an asset at this job. She stated that there are still occasions that she does not disclose, for example, at her professional organization meetings for social workers.

Peggy, one of the other specialists, stated that she previously worked in a correctional facility as a deputy. When she saw an ad in the paper requesting a consumer of mental health, she thought it was a joke but called to find out anyway. She subsequently applied for the job, was hired and has been extremely happy working in her role as peer specialist ever since.

Persons on the team do not have special training although some of them have college degrees. The state has not yet initiated certification training for peer specialists, however, training for this purpose is currently in progress. The team members pointed out that they have attended WRAP Training and are conducting WRAP groups with people they serve. Many of their duties are similar; however their jobs vary according to the unit they are assigned.

Common roles for all of them is their attendance at treatment team meetings where they provide peer support, and conduct activity groups on the Harbor Mall program. One member, who works on the admissions unit, finds that she must provide extra support to people during the admission process as this is when a patient's anxieties are highest. She works with each person to develop their individual services plan (ISP). The key ingredient for her success, she states, is her ability to listen, different only by degree from any of the other support peer specialists provide.

All of the members provide peer support. They are the principle staff who monitor the grievance process. This includes maintaining suggestion boxes, listening to each patient's complaints and helping patients to file grievances. They also assist with consumer satisfaction. They indicated that there has been a vacancy for a resident advocate position who would ordinarily review the more serious complaints and grievances.

A favorite activity among the participants is developing groups and programs for the Harbor Treatment Mall. They are free to organize groups of their own choosing according to their skills and interests. Some of the subjects include poetry, journaling, Bible study, and art classes.

One of the members proudly displayed art work by patients using the Dr. Seuss book *All the Places you'll Go*. This book was correlated to the theme of recovery and to hopes, dreams and aspirations of persons with mental illness.

Jobs differ according to whether they are working with short-term or long-term patients. Forensics patients stay for longer periods, sometimes as many as eight years, they explained. One of the biggest problems they face is finding placement for persons following their discharge. A serious lack of housing exists, particularly for anyone who has to appear before the courts. Rarely is there a discharge plan that satisfies the court which causes long stays and unnecessary waits in the hospital.

When asked how they are accepted by staff they said that at first their response was guarded; but now that the program has been in existence for two years they have proved their value and are accepted by most of the staff. Still, they note that there is some resistance in certain areas of the hospital; for instance, they believe that some of the staff may fear that peer specialists are taking some of their existing job roles.

Pet therapy day is on Wednesdays. The team is responsible for having developed an active pet therapy program and have introduced different animals; even goats! Peggy's dog, Cody, is a regular visitor and is loved by everyone, staff and patients included. Peggy told a story about how Cody provided assistance during a de-escalation, which she thinks may have been partly responsible for avoiding the use of restraint.

The time allotted for the meeting was limited as a dialogue with patients had been planned for 4:00p.m. A final question was asked about use of seclusion and restraint in the hospital. They explained that there is an incentive program in place providing units with pizza parties for good behavior and zero restraint/seclusion use. This incentive program has been a major factor in reducing incidents as none of the patients want to be responsible for causing their unit to lose out on the pizza party reward. The admissions unit still uses S/R on occasion and has (sadly) never been given a pizza party!

Quick Tour of Riverview State Hospital—July 27, 2005 4:00 PM

Though a tour of the hospital had not been planned, the opportunity arose after the patient dialogue, though it would be quick and not complete.

Peer Specialist, Peggy, took me first to forensics as she wanted to show me a room that she and the patients on the unit had created as a comfort room. The room had a TV, and comfortable chairs. Decorations on walls and shelves were done solely by the patients. Peggy said this room offers respite to two or three people at a time and is a place where she frequently meets with people.

She then showed me a patient room with the individual's permission. She said that all of the rooms are single patient rooms. Furnishings were blond wood and looked like more like a college dormitory than a hospital room. This particular room had been decorated with stuffed animals and many personal treasures and items. The person who stays in this room has been in the hospital many years, but appeared quite stable, making one wonder under what circumstances people can ever get out. (this issue had been referred to in the general meetings as a problem with judges unwilling to discharge forensic clients without proper housing and monitoring)

Nurses station was the best in appearance I had ever seen. It was low but with desk curved in a semi-circle allowing nursing staff lots of room to move. It allowed for easy patient access with staff visible at all times.

I was told that there is a Jacuzzi for the patients on this floor but it was not shown to me. I did not look at the seclusion room, though would have asked if there had been more time and if staff better understood the purpose of my visit.

The area for the treatment mall was quite impressive with rooms filled with materials reflecting interesting and stimulating activities. The arts and crafts room was visualized, while other rooms were seen as being used for writing, clay, sculpture, etc. The walls were cheery looking with artwork done by patients in abundance. A library could be seen from the outside window that looked stocked with recent literature and books. Posted on windows were lists of groups that people could choose to go to. There did not seem to be a levels system in place as none of the groups seemed to be restricted to a few.

I was told that the Café, not cafeteria is state of the art. I was disappointed that I could not have seen more, but what was seen was very impressive and would be a model for any state building a new facility. This one is only two years old. (?)

ATTACHMENT D: MANAGED CARE DISCUSSION OUTLINE

- 1) Why Managed Care?– 27 Other States are doing it for Behavioral Health Service Delivery
- 2) Regulations from Federal Government
 - a. 42CFR
 - b. Balance Budget Amendment (BBA) part 438
 - c. Medicare Modernization Act – January 2006
- 3) Covered Services – What’s Covered?
- 4) Medical/Clinical Leadership and Operations
 - a. Medication Formulary
 - b. Appointment Standards/Access to Care
 - c. Psychotropic Medications; Prescribing and Monitoring
- 5) Financing
 - a. Prepaid Capitation
 - b. Enrollment/Covered Lives
 - c. Financial Reporting
 - i. Monthly
 - ii. Quarterly
 - iii. Ad-Hoc
 - d. Audited Financial Statements - Annual
 - e. Fee-For-Service for Special Populations
 - f. At-Risk Contracting vs. Shared Risk
 - g. Fraud & Abuse
 - h. Co-Payments
 - i. Third-Party Liability and Coordination of Benefits
- 6) Quality Management/Utilization Management (QM/UM)
 - a. Management Structure and Medical Leadership
 - b. Utilization Management (UM)
 - c. Prior Authorization (PA)
 - d. Utilization Review (UR)

- e. Performance Measures (consumer surveys, access to care, appointment standards)
- 7) Member Rights
 - a. Handbooks
 - b. Notification
 - c. Grievance and Appeals
- 8) MIS
 - a. Claims Adjudication
 - b. Clean Claims
 - c. Denial
 - d. Edits and Fatal Errors
 - e. Data Queries
 - f. Eligibility and Enrollment Files
 - g. Demographic Files
- 9) Decisions for Bid Process
 - a. MCO/ASO – Service Delivery –MCO v. PIHP
 - b. Delegated Functions
 - c. Monitoring and Oversight
- 10) Project Management
 - a. Behavioral Health and Medicaid Staff Involvement
 - b. Licensing Board
 - c. Document Management
 - i. Provider Manual
 - ii. Covered Services Guide
 - iii. Policy Manual
 - iv. Technical Assistance Documents
 - d. Communication