

Maine

**UNIFORM APPLICATION
2011**

**STATE IMPLEMENTATION REPORT
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT**

OMB - Approved 08/06/2008 - Expires 08/31/2011

(generated on 12-1-2011 11.48.39 AM)

Center for Mental Health Services

Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

Table of Contents

State: Maine

Executive Summary	pg.4	Set-Aside For Children Report	pg.6
MOE Report	pg.7	Adult - Summary of Areas Previously Identified by State as Needing Improvement	pg.9
Adult - Most Significant Events that Impacted the State Mental Health System in the Previous FY	pg.11	Adult - Purpose State FY BG Expended - Recipients - Activities Description	pg.13
Child - Summary of Areas Previously Identified by State as Needing Improvement	pg.15	Child - Most Significant Events that Impacted the State in the Previous FY	pg.19
Child - Purpose State FY BG Expended - Recipients - Activities Description	pg.35	Adult - Implementation Report	pg.37
Child - Implementation Report	pg.55	Planning Council Letter for the Implementation Report	pg.84
Appendix B (Optional)	pg.86		

Please respond by writing an Executive Summary of your current year's application.

The Office of Adult Mental Health (AMH) and Office of Substance Abuse Services (SAS) is currently undergoing a re-alignment with an effort to better integrate these two systems. The Director of SAS has been appointed by the Administration as the Interim Director of AMH. The management staff of both divisions currently meet regularly and there are plans to co-locate next year. We believe this will better position Maine for a joint application in the future.

Regarding technical assistance, we have two concerns, client identifiable data and MOE. We are creating a work group and have already had several discussions with our fiscal division (Department of Audit and Financial Services) regarding the need to achieve client identifiable service encounter data, funded by the Block Grant, with a goal of piloting this project beginning Jan 1, 2011. If successful, we will be incorporating this as a requirement in all contracts beginning 7/1/2012. Secondly, regarding the MOE, we may need some technical assistance regarding what may or may not be included in this calculation.

We are involving consumers in the reviews and analysis of program and agency performance. With active participation by the Quality Improvement Council (QIC), we have modified our monitoring tool and protocols and have already scheduled two on-site visits of Agencies who receive block grant funds. We plan to conduct on-site visits of all block grant funded agencies before July 1, 2012. Another requirement coming from and supported by the QIC is our plan to build into contracts beginning 7/1/2012 is a 25% utilization of Peers and/or Peer services.

During our site visits and reviews, we will be informing agencies of our intent to re-design and re-focus the utilization of MHBG Fund in FY13. With the exception of Peer Services, the MHBG has not gone out for RFP in over a decade.

The agencies and respective service categories currently being funded with MHBG resources (and state funds as well) are:

AROOSTOOK MENTAL HLTH SERV INC	CASE MANAGEMENT
AROOSTOOK MENTAL HLTH SERV INC	MOBILE OUTREACH
AROOSTOOK MENTAL HLTH SERV INC	RESIDENTIAL TREATMENT
AROOSTOOK MENTAL HLTH SERV INC	TRANSPORTATION
CATHOLIC CHARITIES MAINE	CASE MANAGEMENT
COMMUNITY HEALTH & COUNSELING SERVICES	MOBILE OUTREACH
COMMUNITY HEALTH & COUNSELING SERVICES	RESIDENTIAL TREATMENT
COUNSELING SERVICES INC	MOBILE OUTREACH
KENNEBEC BEHAVIORAL HEALTH	MEDICATION CLINIC
SHALOM HOUSE INC	CASE MANAGEMENT
SPRING HARBOR COMMUNITY SERVICES	MOBILE OUTREACH
SPRING HARBOR COMMUNITY SERVICES	RESIDENTIAL TREATMENT
Sweetser	CASE MANAGEMENT
Sweetser	MEDICATION CLINIC
Sweetser	MOBILE OUTREACH
Sweetser	PRIVATE VENDORS
TRI-CITY MENTAL HLTH SERV	CASE MANAGEMENT
TRI-CITY MENTAL HLTH SERV	MEDICATION CLINIC
TRI-CITY MENTAL HLTH SERV	MOBILE OUTREACH
TRI-CITY MENTAL HLTH SERV	RESIDENTIAL TREATMENT

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2010	Estimate/Actual FY 2011
<u>\$5,444,159</u>	<u>\$47,990,876</u>	<u>\$43,741,734</u>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X Federal FY _____

State Expenditures for Mental Health Services

Actual FY Actual FY Actual/Estimate FY

2009	2010	2011
<u>\$123,352,714</u>	<u>\$107,725,676</u>	<u>\$93,572,727</u>

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall.

These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Based on a review of last years, 'Discussion of Strengths and Weaknesses of the Service System' it was noted the following areas needed improvement:

1. The continuing need to improve data systems and track client service utilization and outcomes across programs.

2. The staff resources to be as robust as OAMHS would like in improving quality management, developing the managed care RFP, and taking full advantage of health reform opportunities.

3. Communication always needs improvement, particularly across multiple stakeholder groups.'

We have continued to acknowledge in this year's application the need for improving data systems, particularly regarding client service utilization. Some progress has been made and a work group has been authorized to address these issues. A Service Encounter Database does exist which collects client identifiable data--however at this time we can not discern which particular service(s) provided to a particular client has been paid for using Block Grant dollars or State General Fund dollars. Based on initial discussions with agencies, it appears they have the capacity to discern and report on which funding streams pay for particular services to particular clients. This will be a topic of upcoming site visits to each funded agency.

The Office of Adult Mental Health (AMH) has re-organized as of December 2010 to make better use of existing staff resources. Currently, under a new Administration, we are re-aligning with the Office of Substance Abuse Services (SAS). The current Director of SAS is the Interim Director of AMH and there are plans to co-locate these divisions. The emphasis on integrating these services will also allow us to more seriously consider a joint application to SAMHSA in the future. Work on the Managed Care RFP has been tabled as the new Administration examines the pros and cons of this design along with Health Care Reform.

Agreeing that Communication always needs improvement, we have taken several positive steps, beginning with the planned integration of the Office of Adult Mental Health and Substance Abuse Services mentioned above. For the first time, we posted an opportunity to comment regarding the Block Grant on our website, prominently featured on our state of Maine Adult Mental Health home page. We have also taken positive steps to address concerns voiced by Consumers through the Quality Improvement Council. This has generated the action of scheduling on-site state monitoring visits to each Block Grant funded Agency along with definitive plans to incorporate Peer Services and data requirements into the contracting process beginning 7/1/2012.

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

There were three significant events impacting the mental health system in the previous FY.

1. The Office of Adult Mental Health re-organized, making better use of shrinking staff resources, in December of 2010.

2. Cost pressures on Medicaid services significantly impacting Non-Categoricals and PNMI (Private Non-Medical Institutions). CMS is moving Maine away from PNMI funded services. In FY 11 the Office of Adult Mental Health reduced it's PNMI beds, however as of today we currently have approximately 10% of all PNMI's funded statewide. This and other Medicaid reimbursed services remains an issue going forward in FY12 and FY13.

3. The migration of Medicaid data systems from one vendor to another and compliance with HIPAA coding has also presented some hurdles. These efforts have resulted in difficulties with data extraction and reporting across two systems.

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Block Grant Payments

7/01/2010-6/30/2011

Acct Period Hierarchy	2011
Approp	012192
Fund	(Multiple Items)
Bucket	(Multiple Items)

Jrnl Posting Am	Legal Name	Vend Cust Cd	Activity Nm	Program		
				2009 Grant	2010 Grant	Grand Total
	AROOSTOOK MENTAL HLTH SERV INC	VC1000005876	CASE MANAGEMENT		44,708.24	44,708.24
	AROOSTOOK MENTAL HLTH SERV INC	VC1000005876	MOBILE OUTREACH	3,327.00	9,978.00	13,305.00
	AROOSTOOK MENTAL HLTH SERV INC	VC1000005876	RESIDENTIAL TREATMENT	2,700.00	8,104.00	10,804.00
	AROOSTOOK MENTAL HLTH SERV INC	VC1000005876	TRANSPORTATION	3,540.00	10,620.00	14,160.00
	CATHOLIC CHARITIES MAINE	VC1000013796	CASE MANAGEMENT		42,932.06	42,932.06
	COMMUNITY HEALTH & COUNSELING SERVICES	VC1000017720	MOBILE OUTREACH	19,905.00	51,835.00	71,740.00
	COMMUNITY HEALTH & COUNSELING SERVICES	VC1000017720	RESIDENTIAL TREATMENT	38,224.00		38,224.00
	COUNSELING SERVICES INC	VC1000018412	MOBILE OUTREACH	21,844.00	65,531.00	87,375.00
	KENNEBEC BEHAVIORAL HEALTH	VC1000049769	MEDICATION CLINIC		60,660.00	60,660.00
	SHALOM HOUSE INC	VC1000082996	CASE MANAGEMENT		34,130.32	34,130.32
	SPRING HARBOR COMMUNITY SERVICES	VC1000085430	MOBILE OUTREACH	4,288.00	11,432.00	15,720.00
	SPRING HARBOR COMMUNITY SERVICES	VC1000085430	RESIDENTIAL TREATMENT	7,838.00	23,513.00	31,351.00
	Sweetser	VC1000088400	CASE MANAGEMENT		1,670.05	1,670.05
	Sweetser	VC1000088400	MEDICATION CLINIC		27,722.00	27,722.00
	Sweetser	VC1000088400	MOBILE OUTREACH	0.00	14,291.00	14,291.00
	Sweetser	VC1000088400	PRIVATE VENDORS		129,484.00	129,484.00
	TRI-CTY MENTAL HLTH SERV	VC1000092940	CASE MANAGEMENT		53,058.94	53,058.94
	TRI-CTY MENTAL HLTH SERV	VC1000092940	MEDICATION CLINIC	28,241.00	99,160.00	127,401.00
	TRI-CTY MENTAL HLTH SERV	VC1000092940	MOBILE OUTREACH	5,856.00	9,760.00	15,616.00
	TRI-CTY MENTAL HLTH SERV	VC1000092940	RESIDENTIAL TREATMENT	4,979.00	8,300.00	13,279.00
	Grand Total			140,742.00	706,889.61	847,631.61

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Section II.2 Service Gaps and Unmet Needs

Summary Statement on Strengths and Needs

It has been the practice of CBHS to identify system needs each year and to include the most pressing and significant of those needs in the annual Priorities section of the Block Grant Application/ Plan. Progress and outcomes for these areas and topics are accounted for in the subsequent annual plan. In this fashion CBHS keeps pace with new challenges that appear each year, and over time, has been successful in turning many of these needs into system strengths.

Sources of Data and Information used in Plan Development

Because the FY11 Block Grant Plan relies on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plan, it is useful to state the specific data sources that Maine employs.

Year End Contract Reports Children's Behavioral Health Services (CBHS) contracts with providers to deliver all community based behavioral health services. Providers report performance data, numbers served and a variety of quality improvement indicators on a quarterly basis. Contract reports show unduplicated counts of children served for the particular service component under contract. However, when different types of services are added together, the total number is a duplicated client count.

Maine Integrated Health Management Solution (MIHMS)

This is the current MaineCare claims management system that replaced the MECMS system. This system came on-line in September, 2009. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.

Enterprise Information System (EIS) this is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children's Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children's Home and Community Based Treatment and Children's Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08. An updated version of this system became operational on July 1, 2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. In addition to the standard accounting functions of accounts payable, accounts receivable, and general

ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs

Service Gaps and Unmet Needs

The Department's information systems provide data upon which service gaps, unmet needs and individuals waiting for services are determined. Currently the Enterprise Information System (EIS) generates data to track children who have requested and are waiting for Case Management Services, Behavioral Health Treatment Services and Rehabilitative Community Services and supports under the Risinger Settlement Agreement. Other data resources utilized are from the Office of Quality Improvement and APS.

Other sources of identifying needed services are from regional resource development activities and from ongoing discussions among Maine's child-serving state agencies. Some examples of the identification of needs and services that were developed in recent years resulted from discussions with the service provider community and through interdepartmental collaboration were: crisis services for children with intellectual disability and autism, transitional processes from hospitals to home and local schools, and development of specialized inpatient capacity for children with intellectual disability or autism.

CBHS regional Resource Coordinators are well positioned to detect service gaps and needs, as are CBHS community based Family Information Specialists, who because they have experienced the service system as parents raising children with behavioral or emotional needs, have special sensitivity to what is missing for families in their service area. Their insight into the needs of families resulted in the development of an intensive community treatment service (Assertive Community Treatment) or Children's ACT team in the mid-coast area.

Children's Behavioral Health Services central office staff and field management personnel routinely meet on a bi-monthly schedule to discuss current policy and operational issues as well as larger systems concerns. . As a new fiscal year begins, CBHS staff discuss possible systems needs and service gaps that are not already addressed as action targets under the current Block Grant Priorities. These needs tend to be continuing in nature due to funding constraints or institutional barriers, which would require legislative action to ameliorate. Examples are:

- Systems issue in the transition of children with intellectual disability or autism who are at risk of being found ineligible for adult intellectual disability services. The risk factor may affect children whose intellectual quotient score is at or slightly above 70. Different transitional issues face youth who seek services from the Office of Adult Mental Health Services.

- Children with Asperger's Disorder who are lost in the transition to adult services due to the lack of specific inclusion of this disability in Maine legislation.
- Services for children who are medically fragile and who have behavioral health needs.
- Lack of publicly funded treatment and rehabilitative services for children with traumatic brain injury. The Maine Legislature has expanded the former Adult Intellectual disability Services to include a wider population in the new DHHS Office of Adults with Cognitive and Physical Disabilities that include persons with brain injury, but did not change the service population under Children's Behavioral Health Services.

Other needs, such as respite care and therapeutic child care will be partially addressed through services under a new Children's Home and Community Based 1915(c) Waiver which received approval this past February. In July the proposed Maine Care (Medicaid) rule was adopted and the implementation plan finalized. Currently CBHS staff is working with families and providers to begin provision of these valuable services. It is anticipated that the service delivery system will be operational in February 2012.

Children's Behavioral Health Services has focused on extensive service development to address wait time issues in the area of case management, behavioral health treatment services and rehabilitative community services and supports over the past four years, and wait times for these services will continue to be monitored in FY12/13.

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Section II.4 Recent Significant Achievements that Address Unmet Needs and Reflect Progress toward the Development of the System of Care

The priorities that follow represent the major elements of the Children's Behavioral Health Service's work for FY11 as they were known at the time of submission of this Block Grant Application and Plan. **The detail that follows represents narrative elements for the most critical priorities that are included in the FY11 Application and they are considered as the major Goals, Targets and Action Plans for Children's Behavioral Health Services.**

1. Managed Care Initiative

Administrative Services Organization/ APS Healthcare : In September, 2007, the state entered a two-year contract with APS Healthcare (since, extended to four years) to act as an Administrative Services Organization and provide managed care services for adult and child mental health and substance abuse services. APS provides prior authorization and/or utilization review for children's mental health services, including Targeted Case Management, Outpatient Services, Home and Community-Based Treatment, Children's Assertive Community Treatment, Crisis Services, Residential and Inpatient Psychiatric Services. Children's Behavioral Health Services and APS work on collaborative models of utilization management, care management, provider relations and quality improvement that emphasize community partnership, training and technical assistance

The Managed Care Design Management Committee (DMC) met for the first time in mid-August 2010. The DMC is responsible for overseeing the Managed Care initiative; interfacing with the Stakeholder Advisory Committee; developing overall design of the program; articulating goals and objectives; directing assignments to, and coordinating various subcommittees. CBHS staff actively participated on these subcommittees, which covered issues such as quality care, operations, financial and special topics/populations.

Children's Behavioral Health successfully advocated for active youth and family involvement within the formal Stakeholders Advisory Committee (SAC). There is a representative from Youth MOVE Maine, a youth representative from the Child Welfare Services' Youth Leadership Advisory Team, a family representative from the GEAR Parent Network, which is the Maine chapter of the Federation of Families for Children's Mental Health, from the Autism Society of Maine and NAMI Maine. As directed by the legislature, this committee will provide guidance to the Director of MaineCare Services during both the initial design and then the implementation phase for the Managed MaineCare program.

FY11 Results/ Outcomes

This year the Department of Health and Human Services (DHHS) has developed a four-pronged value-based purchasing strategy to achieve target savings and improve health outcomes. Value-based purchasing means holding providers accountable for both the quality and cost of care, through:

- increased transparency of cost and quality outcomes,
- rewards for performance, and
- payment reform.

Below are the proved health outcomes:

1. Emergency Department Collaborative Care Management Initiative

Over the past year, MaineCare conducted a collaborative care management pilot with Maine General to reduce non-urgent use of their Emergency Department (ED) by MaineCare members. The pilot saved an estimated \$100,000 in reduced ED costs just from working with approximately 35 members. MaineCare has decided to expand the pilot statewide in the face of increasing ED costs and an expressed interest from hospitals in increased care management capacity. This summer, MaineCare has met with all of Maine's hospitals to discuss the initiative and to assess the care management capacity of their respective hospital systems, the members' primary care provider offices or patient centered medical home, and community care teams, where available. MaineCare will utilize the identified care management resources as the first line and, where care management services are not available; MaineCare will provide the care management resources.

2. Transition toward risk-based contracting with qualified providers; exploration of global and/or bundled payments.

MaineCare will build off its work with hospital EDs to enter into risk-based agreements with capable providers for the care management of their members. In exchange for a per member per month administrative fee, providers will collaborate with hospitals and EDs, primary care providers, specialists and other entities to achieve quality outcomes and cost savings. MaineCare will explore the possibility of phasing in alternative payment modes such as shared savings, bundled episode of care payments, or global payments

3. Leveraging and/or expansion of current initiatives and federal opportunities.

Pay for Performance: MaineCare is conducting an analysis of its Primary Care Case Management (PCCM) and Primary Care Provider Incentive Payment (PCPIP) to identify opportunities to better incent providers to deliver quality, cost efficient care. Reforms under consideration include a more stringent baseline for providers to qualify for incentive payments, and increased payments for providers who do qualify. We are also looking at shifting the emphasis on payment criteria on which the payments are made from access, where significant progress has already been made, to reduced ED utilization, attainment of clinical quality benchmarks, and the provision of cost efficient care

Transparency & Reporting: MaineCare will continue to provide quality and utilization reports to its PCCM providers. In addition, MaineCare plans to learn from the efforts of the State Employee Health Commission, the Maine Health Management Coalition and Quality Counts! to develop provider rankings to share with MaineCare members and the public.

4. Targeting Individuals with Dual Medicaid and Medicare Eligibility, Chronic or Complex conditions:

MaineCare currently has 26 multi-payer Patient Centered Medical Homes (PCMH), initiatives which have gained national recognition for the “promising trends” they show on cost and quality, as well as “greatly improved access to care.”¹ Medicare is joining the PCMH Pilot in October 2011 under the Medicare Multi-Payer Advanced Primary care practice (MAPCP) demonstration, at which point Community Health Teams (CHT) will be introduced as a strategy to improve care and reduce avoidable costs for PCMH patients, especially those with complex or chronic conditions. MaineCare plans to leverage the PCMH and CHT partnership to take advantage of the Affordable Care Act’s (ACA) Health Homes option for enrollees with chronic conditions. Implementation of the State Health Homes Option will enable Maine to receive an enhanced 90/10 federal match for the first eight quarters of the initiative. This enhanced match could in turn fund the expansion of PCMH beyond the current 26 practices. In addition, the Centers for Medicare and Medicaid (CMS) Innovation Center is testing new payment and service delivery models to achieve cost reductions and quality care for Medicare-Medicaid enrollees. MaineCare plans to pursue a model under which they could receive retrospective performance payments for achieving target Medicare savings through improved care coordination for Medicare-Medicaid enrollees under Health Homes or other primary care delivery models.

2. Quality Improvement

Children’s Behavioral Health Services (CBHS) continued in its role in ensuring quality of services delivered by contracted providers and enhanced this work with a standardized process across program areas, including residential, outpatient, case management and home and community based services.

Data systems utilized:

Maine Integrated Health Management Solution (MIHMS)

This current MaineCare claims management system replaced the MECMS system. This system came on-line in September 2009. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.

Enterprise Information System (EIS) this is an information system developed by the Office of Information Systems in the Department of Administrative and Financial Services (DAFS). The system is designed to capture consumer information for persons who are receiving services from the Division of Children’s Behavioral Health Services and the Offices of Adult Mental Health Services, Adults with Cognitive and Physical Disabilities Services, Elder Services and Substance Abuse Services. Each of these units has developed an information capacity that will serve the specific needs of that unit. EIS at present is the key data source for the enrollment of children who are referred seeking Children’s Home and Community Based Treatment and Children’s Rehabilitative and Community Services and Supports, as well as Targeted Case Management Services.

Advantage ME is the current State financial information system introduced in FY08. An updated version of this system became operational on July 1, 2011. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. It will be replacing MFASIS, TAMI for cash receipts, Sicommnet, E-Catalog and GQL Warehouse financial reporting. In addition to the standard accounting functions of accounts

payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY11 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health & Human Services for children, through the Division of Children's Behavioral Health Services and for adults, through the Office of Adult Mental Health Services. These expenditures are the source for reporting the State's general fund contributions to the Maintenance of Effort data that is required by CMHS

FY11 Results/ Outcomes

Data and Information Technology

* Maine has the capability to report specifics on individuals and service components from data received from our providers who are contractually required to submit such data reports quarterly;

* Reports are submitted to our Purchased Services Division, which monitors contracts;

* Data is utilized by CBHS and the Office of Quality Improvement to monitor fiscal and performance information;

* CBHS uses data gotten from individual and aggregate reports based on scores on the Child & Family Assessment Scale (CAFAS) for all children/youth in our Targeted Case Management and Home Based Treatment services. The CAFAS is a nationally recognized tool used to determine level of functioning in home, school and community.

*Functional Assessment Systems, the developer of the CAFAS, has developed a web based system that enhances the provider's ability to identify problem behaviors and functional ability informing the development of a strengths- based outcome-driven treatment plan incorporating the child's status ,as well as the caregiver's ability to meet the child's needs. The web-based system includes reporting functions, management options and caregiver involvement.

*Children's Behavioral Health Services, with the Office of Continuous Quality Improvement, has provided the necessary supports for implementation of this system, including purchasing of the license, and administrative oversight and training, for providers of TCM and TFC to complete the transition from paper to the web based CAFAS tool.

*Fidelity to the CAFAS was increased by the development of a cadre of certified trainers. The trainers will train the raters who rate each CAFAS subscale with a behavioral descriptor that describes the child resulting in a score. Each trainer will be re-certified annually and each rater re-certified every two years.

*All data collected is reviewed by CBHS staff with providers to address problem areas and develop remediation plans.

Children's Behavioral Health Services (CBHS) Continuous Quality Improvement (CQI) efforts include the following:

- § A stakeholder group comprised of youth, parents, providers and staff is developing a CQI process to be used across service areas. The group has established six Key Quality Areas: Accessible; Effective, Integrated and Related to the Whole Person; Participant Driven; Physically and Emotional Safe; and Strength-Focused. Work is continuing to review and improve performance measures and indicators. Prior to the work, CBHS staff worked with the youth and family members to gain a common understanding of Continuous Quality Improvement terms, including definitions of quality, performance measures, indicators, data sources, and methods, including Plan, Do, Study, Act; Lean Management; Rapid CQI; and Star-SI. The group is also looking at data sources and will work to develop indicators and performance measures that are meaningful and do not require any undue reporting or data collection burdens.
- § Assessment tool efficiencies have been achieved and effectiveness increased by transitioning from paper to web based administrations and from face to face, training to web-based training that is accessible any time. \$50,000 from the FY 10 Block Grant assisted in achieving this outcome.
- § Lean Management Principles are increasingly being used to develop new processes and to improve existing ones. For example, CBHS is implementing its first home and community based waiver. Over a two-month period, a trained Lean facilitator led a group of staff and managers in developing forms and procedures for implementing operating the waiver. The Lean process focuses on mapping out the operational steps and reducing any redundancy or waste.
- § During 2010-11, CBHS contracted providers have been required to administer a Trauma Informed System of Care Agency Assessment and a Co-Occurring Substance Abuse and Mental Health self-assessment. Contracts with over 130 providers required that they develop agency specific Continuous Quality Improvement Plans based upon the results of the assessments, which were then reviewed by CBHS. CBHS and Thrive, Maine's Trauma Informed System of Care Initiative provided feedback. There will be regular re-administrations of the assessments and ongoing review of progress on plans.
- § Data produced by APS Healthcare, the state's administrative services organization, is shared with agencies on a quarterly basis and is reviewed by CBHS staff. In addition, CBHS staff performs chart reviews at agencies and interview family and youth in services. This information is reviewed and there are annual or more frequent meetings with agencies regarding the results. Agencies are expected to engage in corrective actions with measurable outcomes in areas where there are deficiencies. CBHS district staff monitors progress and provide regular feedback to the agencies.

Children's Behavioral Health Services (CBHS) has continued to expand its role in ensuring quality of services delivered by contracted providers. These QI activities include:

- The development and use of a quality improvement tool for assessing intensive temporary residential treatment facilities, when there are clinical concerns raised during routine licensing or contract site visits. Reports are discussed and shared with provider organizations along with recommendations and standards for improvements.

- Training Home and Community Treatment Providers in the use of the Youth Outcome Questionnaire. The Youth Outcome Questionnaire (Y-OQ) is the most well developed and tested rapid clinical feedback system available. Outcome Measures, Inc., the developer of the Y-OQ, used a rigorous development process to select the questions with the greatest sensitivity to clinical change possible. The Y-OQ has been shown, in studies described in peer-reviewed articles, to be able to predict poor treatment outcome based on the trajectory of Y-OQ scores. This “early warning system” allows the clinical team (youth, parent, clinician, and supervisor) to reassess and reorient to maximize the possibility of a positive outcome.
- CBHS staff continue to oversee the further development and maintenance of quality of Evidence Based Practices throughout the state, including MultiSystemic Therapy, Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy and Multidimensional Treatment Foster Care. Residential treatment facilities are the ongoing subject of intensive quality reviews, focusing on facilities, staffing and in particular on clinical interventions and adherence to Evidence Based and Best Practice Parameters.

Included in all of these efforts is ongoing work to ensure that there is no duplication of effort with other quality oversight entities and that data is shared among these entities. CBHS continues to collaborate with the DHHS Division of Licensing; Public Service Management; APS Healthcare (the current Administrative Service Organization in Maine); the Office of MaineCare Services and Molina (Administrator of the New Health Management Information System).

Evidence Based Practices (EBP)

Over the past several years the focused work of the CBHS Evidence Based Practice Advisory Committee, the Thrive Evaluation Committee, the CBHS Medical Director and Director of Clinical Policy and Practice has resulted in an increase of children’s EBP’s that have proven their effectiveness regarding treatment outcomes.

Maine has made significant progress in disseminating the Modular Approach to Therapy for Children (MATCH). MATCH combines the common elements of the evidence based therapies for the most frequent reasons youth and parents seek psychotherapy: anxiety, depression, conduct problems, and post- traumatic stress. MATCH has great promise for being feasible to implement in community mental health clinics—instead of needing to learn four or more treatments to address the needs of the majority of clients, a therapist can learn one. Most youth seeking treatment in the community experience more than one type of these problems; the modules of MATCH can be individually tailored to specifically suit the needs and challenges of each youth.

MATCH has been the focus of one randomized controlled trial, completed by Dr. Bruce Chorpita of UCLA and Dr. John Weisz of Harvard; results will be published soon. The second RCT of MATCH has been taking place in three community mental health centers here in Maine. All clinicians in the three clinics were randomized to get training in MATCH at either the beginning or the end of the study; children were then randomized such that the effects of treatment with MATCH could be compared to the effects of treatment as usual. The treatment phase of the study has now finished, and the second wave of therapists has been trained. All 60 therapists at

the three clinics have been receiving consultation in MATCH from psychologists from the Judge Baker Children's Center (JBCC) at Harvard University. Outcome data from the study are being cleaned and will then be analyzed.

Our colleagues at JBCC have won a grant from the Any He Casey Foundation to do a third study in which fidelity measures of MATCH (questionnaires filled out by parents and youth) will be validated against fidelity measured by audio tape review and against outcome. These fidelity measures, once validated, will make dissemination of MATCH much more feasible.

Multisystemic Therapy (MST) has been disseminated to most areas of our state. CBHS is working together with DOC to monitor MST the fidelity and outcomes more closely. We will monitor the fidelity and outcomes in a joint working group that will include the MST Network Partner (the organization that provides the expert MST consultation), the providers, and CBHS/DOC. Outcomes to be monitored will include both placement status at discharge and juvenile justice recidivism and residential treatment utilization for the 12 months after discharge from MST.

There are times, unfortunately, when youth cannot be safely treated in their home. When it is serious externalizing behavior that makes the youth unsafe, the only treatment that has evidence to support its effectiveness is Multidimensional Treatment Foster care (MTFC). CBHS, in conjunction with DOC, has just developed a second MTFC program here in Maine. It is always a challenge for MTFC programs to recruit enough foster parents to be able to operate at capacity (10 beds) we are working closely with our providers to facilitate this. We will also be working with DOC, our providers, and the MTFC developers to monitor and improve fidelity and outcomes in the same way that we do with MST.

Many clinicians throughout our state have been trained in Trauma Focused Cognitive Behavioral Therapy (TF-CBT). We are in contact with the developers of TF-CBT to ensure that we will be able to utilize any certification and/or fidelity measures that have been developed in order to ensure the best fidelity and outcomes when TF-CBT is used in our state.

Infusing Trauma Informed Care Within CBHS Systems and Practice

The Maine Department Health and Human Services has established the goal that children's behavioral health services will be integrated in a Trauma Informed System of Care. This Priority is to assure that the Children's Behavioral Health Services and System will become more sensitive to the effects trauma and initiate system wide action to recognize, mitigate and eliminate causal factors of trauma for children and families who are served. In FY10 all CBHS contract agencies were required to administer a System of Care Assessment Tool that addresses the federal DHHS/SAMHSA System of Care Principles (Family Driven, Youth Guided, Culturally and Linguistically Competent care), and that the system is Trauma Informed. This assessment covers 8 components that illustrate what Trauma Informed means and is a tool to sensitize and inform contract agency staff to those principles. All agencies were required to complete the self-assessment and commit to implementing trauma informed system of care principles by January, 2010. By January 2011 each provider had to have complete an agency Quality Improvement Plan addressing specific areas of need in the FY11 CBHS contract.

Thrive's personnel and its evaluation component extended their technical assistance capacity to providers on request.

FY11 Results/ Outcomes

Contracted agencies completed the Trauma Informed System of Care Assessment Tool by January 1, 2010. The results were compiled in individual agency reports that agencies used to complete a Continuous Quality Improvement Plan by January 1, 2011. Technical Assistance to agencies was provided by Children's Behavioral Health Services, Thrive System of Care Initiative, the GEAR family organization and Youth MOVE youth organization. Thrive and CBHS distributed a guidebook regarding the competencies for agencies. Trainings on system of care principles, including Family Driven, Youth Guided, Cultural and Linguistic Competence and Trauma Informed will continue to be provided by these organizations throughout the state. The tool will be re-administered in 2012 to determine the extent of progress with agencies. Children's Behavioral Health Services is monitoring agencies for compliance with their Continuous Quality Improvement Plans as a contractual requirement. Thrive became an independent organization (501c3) in Maine as part of the System of Care sustainability plan. Thrive continued to provide technical assistance and training following the completion of the 6-year System of Care federal grant. In September the state was awarded a one year Expanding the System of Care grant for which Thrive continues to be the primary provider.

3. Transition from Youth to Adult Life

Transition has long been recognized as a crucial and, for many, a challenging time in a young person's growth and development. The Maine Children's Cabinet acknowledged this dilemma and identified transition as one of its three priorities under the previous Administration.

In Maine, the primary focus has been on a young adult's transition from one environment to another, such as from foster care to permanency or from inpatient psychiatric care back to home and community or from homelessness to safe and supportive housing. While these initiatives are important to assure health and wellness, the work has been more focused on the young person's transition to different systems rather than to successful independent adulthood.

Healthy Transitions Initiative: *Moving Forward*: Early in 2007 Children's Behavioral Health Services, the Thrive Trauma-Informed System of Care Initiative, Tri-County Mental Health Services and many other community agencies joined with the Maine Children's Cabinet to seize an opportunity to "marry" the Cabinet's Transition Priority with the Shared Youth Vision Council's interests in Trauma-Informed Services by writing a federal grant that would focus on the common goals of all parties involved in this collaboration. In September, 2009 CBHS was notified by SAMHSA that it was one of only seven national applicants to be awarded a Healthy Transitions Initiative grant.

Maine was well positioned to address the purpose of this Initiative through its response titled "***Moving Forward: Achieving Independence for Transition-Aged Youth***". The Maine Department of Health and Human Services, representing both children's and adult mental health, has joined with Tri-County Mental Health Services, the Thrive system of care Initiative which through its experience has developed solid relationships with local youth and has established credibility and trust with them, and with many other providers to implement the Transition to Independence (TIP) model in one of the neediest counties in the state, Androscoggin County.

Transition to Independence is an evidence-based practice, which emphasizes youth-directed planning and development of practical skills, which lead to independence. Maine intends to enhance TIP in two key ways. One is to train Peer Youth Specialists to support youth through the process of setting their goals and achieving their dreams. Among these will be members of Youth M.O.V.E. Maine, a local and national advocacy organization for youth, and the Somali Bantu Youth Association. The second is to assemble three community mental health agencies who will implement TIP, Tri-County Mental Health, Common Ties and New Beginnings, into a Learning Collaborative. The Learning Collaborative will serve to support the case managers who implement TIP and reinforce the initial training provided by the TIP developers.

In addition, through the program's links to the Maine Children's Cabinet and Shared Youth Vision Council, *Moving Forward* will address identified systemic issues bridging the children and adult mental health systems including the different policies, structures and eligibility criteria that exist in each system.

Moving Forward aims to increase high school graduation or GED attainment, and increase access to higher education for these youth who complete high school. Other targets include reduction of involvement with juvenile justice, and increases in employment, satisfactory living arrangements, use of the community and informal supports, and increasing the perception of personal well-being by young people whose functioning has been impaired by substance abuse or mental illness.

FY11 Results/Outcomes

Maine's Healthy Transitions Initiative, Moving Forward, continues to address the needs of youth and young adults in transition from the child serving system to successful adulthood. Some significant changes in the past year should strengthen the initiative and allow more youth to be served in Androscoggin County. Moving Forward has served **44** youth last year and the total number of referrals was **28**.

The most noteworthy change is the contract with a new lead agency. Hornby Zeller Associates has taken on the responsibility for fiscal management and program oversight and continues to be the lead evaluator for the initiative. Hornby Zeller Associates has strong ties to the other partners in Moving Forward and will utilize those relationships to further the goals of Moving Forward. Hornby Zeller Associates has continued to work on a database for information sharing and federal reporting.

Moving Forward made progress on numerous levels during its second year. Training in the Transition to Independence (TIP) model of case management was completed for staff at three local agencies collaborating with CBHS. The mission of the initiative is to provide youth and young adults with a seamless transition from the child serving system to adulthood and opportunities for meaningful participation in a system of care that empowers through leadership and advocacy. This is being accomplished by working diligently with Youth Move Maine, TriCounty Mental Health, New Beginnings and Common Ties, which are all agencies, located in the Initiative targeted geographic area.

A second round of training in TIP occurred. Invitations were sent to numerous to mental health professionals in an effort to perpetrate the use of the model across a multitude of venues and agencies. As part of this round of training the local operations coordinator has become certified to train others in the use of the Transition to Independence (TIP) model of case management.

This will allow Maine to work toward the goal of sustainability once the initiative funding ceases.

Staff at three service delivery agencies identified as partners in Moving Forward continued to serve youth in Androscoggin County. Monthly case-based review meetings are ongoing and provide support and education to case managers.

Strong collaboration continues to exist between Youth MOVE and the adult mental health Office of Community Affairs' (OCA) Intentional Peer Support program. Under the HTI, there is joint training for adult and youth peers in order to make the content more relevant to young people.

Youth Move Maine continues to be an important partner in this work and has hired a 20 hour per week and 5 hour per week staff person to work on Moving Forward. This partnership allows for the inclusion of youth voice in all that we do from policy planning to development or our website.

A state advisory council has been established with the goal of designing policy aimed at improving the seamless delivery of transition services in Androscoggin County and, eventually across Maine.

Evaluation is ongoing with Hornby Zeller Associates conducting interviews with youth, gathering program information. Cross-site evaluation between the seven states receiving the Healthy Transitions Initiative funding is in progress and Maine is actively involved in that process. SAMSHA is promulgating national evaluation standards and Maine is working with that group to include information about Moving Forward in that study

Website development is underway with a launch date in early January. A social marketing campaign will be enacted to bring information about this important initiative to more professionals, families, youth and partners so that this work can continue.

Moving Forward continues to seek ways to involve state agencies providing services to adults in the application of the model. The common goal remains the transition of youth to successful adulthood in any of its myriad manifestations.

4. Youth Leadership

This priority builds on the experience gained from seeing young people participate as peers in Maine's System of Care Initiative, hearing them while they speak, recognizing their potential, and celebrating their successes at home and on the national stage. The FY11 priority will be to infuse youth in a leadership role statewide. Leadership means moving from voice to active participation and involvement, and personal investment in the future for themselves and for their peers.

Youth Voice and Leadership: Youth MOVE Maine is a youth-led organization dedicated to modeling, teaching and supporting the youth-guided philosophy in Maine’s systems of mental health, juvenile justice, child welfare and alternative or special education. “Youth Guided” is the philosophy adopted by Systems of Care which asserts the rights of all young people to access authentic opportunities for empowerment, education and decision-making in their own lives, and in the policies and practices in youth-focused systems.

Through the Thrive System of Care grant, young people ages 14-25 with lived experience in the mental health, juvenile justice, child welfare or special education systems have been coming together as the Thrive Youth Group since 2005. Coordinating this Youth Group was a young adult with personal experience in the system of care. Members of this group were able to access peer support, training, experiential learning activities and authentic opportunities to influence state and local policies and services in Maine. In 2008, two staff with personal experience in the system of care were hired to help implement this program.

In 2009, this new regional program became Maine’s chapter of the national youth movement Youth MOVE, which stands for Youth Motivating Others through Voices of Experience. New staff was hired, all with diverse personal experiences in the systems of care, in keeping with the peer relationship model that makes Youth MOVE Maine unique. A statewide advisory council of over 60% young people under the age of 26 was developed as the governing body of Youth MOVE Maine. In this first year as Youth MOVE Maine, program leadership, members, staff and the Advisory Council worked to develop policies, governance by-laws, mission, vision and identity as Maine’s youth-led program dedicated to youth voice in the system of care. Outreach efforts to youth and stakeholders in the community, as well as training and development of products and strategies to support a more youth-guided system made that foundational year a success.

FY11 Results/ outcomes

In Youth MOVE Maine’s second year they were able to build off of the foundational work to develop a strong, sound program through leadership of the Advisory Council, partnership with community members and supportive organizations, energy and inspiration of a broader network of youth members, and dedication of staff who identify as peers and interact with youth and young adults with reverence for the unique expertise they offer through the life experiences they have had.

Key Successes to Date:

- Development of a network of four regional Youth MOVE groups in Augusta, Lewiston, Portland and Damariscotta. Each group, made up of about 12 youth ages 14-25 is dedicated to peer support and community action to develop the ability of young people to achieve fulfillment and success in their lives as they grow toward adulthood.
- Trainings for youth are offered in each region focused on the issues that matter most according to youth and young adults in the region. Trainings have included cooking classes, personal artistic expression; resume writing, meditation, among others. In May, the annual What Families and Youth Want Conference was co-hosted by Youth MOVE Maine and offered a youth-developed track developed by and for young people including trainings by young people on team planning and anti-bullying.
- Youth and young adults have had numerous opportunities to address policy, including:

- Co-chairing the Continuous Quality Improvement Workgroup for CBHS, where youth and families have co-led the development of Six Key Quality Areas to define quality services for children, youth and families, which will guide all CQI efforts.
- Development of a Youth And Family Workgroup advising CBHS from a collaborative youth and family perspective on key issues such as residential standards, implementation of the Youth Outcomes Questionnaire, CQI efforts, and more
- State and regional participation on the Shared Youth Vision Council, dedicated to reducing recidivism in Juvenile Justice and increasing successful school completion
- Developing a guide with another youth empowerment program, YLAT, to informed consent to Anti-psychotic medication for youth, which is being used as a foundation for similar national work with the FDA and SAMHSA
- Advising on peer support with the Moving Forward Healthy Transitions Initiative and Wraparound Maine
- Youth MOVE has developed as an organization to have a majority youth and young adult board, by-laws, standardized staff training, policies, procedures, a logic model and strategic plan and quality assurance measures, to ensure the program is youth-led, trauma-informed and achieving specified objectives.
- Developed strong reciprocal partnerships with other youth organizations, family organizations, state and local agencies and community collaborative/initiatives bringing youth voice into these programs and strategically working together to improve services.
- Social marketing “Shift Your Mind, Drive Your Dream” campaign, dedicated to raising awareness through info cards, kicked off with ‘resiliency cards.’ Facebook and website updated with resources and information on our program.
- Training and technical assistance offered including:
 - Webinar created with Thrive on Trauma-Informed From a Youth Perspective
 - Training co-created with other youth organizations on the Shared Youth Vision Council on best practices for involving youth on boards and collaboratives
 - Training for youth and providers at the YLAT conference on youth voice in mental and physical health care
 - Training child welfare workers on best practices in youth informed consent to anti-psychotic medication
 - Ongoing youth consultations on various boards and initiatives

5. Thrive – System of Care

This Priority addresses the transition of Maine’s Trauma Informed System of Care Initiative, Thrive, as it “turns the corner from superstar to sustainability.”

Trauma is pervasive among children, youth and families, especially those involved in public systems. These very same systems serve these trauma survivors often without treating them. Even more significant, systems are unaware of the traumas that these children, youth and families have experienced often because society does not look at behaviors through a trauma

lens. It is this lack of awareness that can result in poor outcomes and the likelihood of retraumatizing families.

Adverse Childhood Experiences and data collected in Maine by the Thrive Initiative demonstrate that trauma results in poor physical and mental health outcomes. Trauma matters because of the enormous societal cost and the preventability of these poor outcomes. Reconciling the balance between current research and knowledge about effective practices and the implementation of a trauma-informed framework requires a set of policies, practices and community education. Maine, along with other states, has undertaken this shift to become a *trauma-informed system of care* which focuses on cross system collaboration, training, education, accountability and meaningful family and youth involvement. In Maine the question is no longer, “What is wrong with you?” but instead, “What happened to you?”

Thrive – System of Care:

For the past six years Children’s Behavioral Health Services (CBHS) in partnership with the THRIVE initiative, community providers, youth and families have been transforming community mental health services in some critical ways, consistent with the System of Care principles developed at the federal level. These include giving youth who are affected by serious emotional and behavioral challenges and their families a greater voice in their treatment and to make the treatment experience “trauma-informed,” family driven, youth guided and culturally and linguistically competent. This means educating agencies who deliver these services to understand System of Care principles and the trauma that many seeking help have experienced and to avoid contributing to that trauma through the treatment process itself. Maine’s evaluation has demonstrated reductions in trauma symptoms in children, as well as reductions in use of the most expensive residential services and therefore lower treatment costs overall.

FY11 Results/ outcomes

One of the main deliverables and successes of Maine’s trauma-informed system of care has been the creation of a Trauma informed Agency Assessment created by families, youth and providers in consultation with Thrive staff. This agency assessment is now a requirement as set forth in contract language for child serving agencies contracting with the Department of Health and Human Services’ Office of Child and Family Services. Results of the first administered assessment were rolled out to provider organizations in the summer of 2010 with a requirement that providers seek out training and technical assistance on trauma, trauma informed principles and system of care principles. Agencies also created Continuous Quality Improvement (CQI) plans based on the results and submitted these plans to Children’s Behavioral Health Services for review and comment. The second re-administration of the TIAA will in July of 2012. Results will be disseminated in late summer with subsequent CQI plans to be created and submitted.

Development of the TIAA coincided with the creation of the THRIVE Guide to Trauma-Informed System of Care Organizational Development, a guide for agencies with steps to implement Trauma-Informed System of Care Practices. In addition to best practice literature, the guide includes information about CQI planning steps. Dissemination of this information is followed by a 90-minute webinar prepared by youth, family, THRIVE, and CBHS. Agency staff was required to participate and take a quiz at the end. These trainings are archived and available for agencies to use in team meetings, orientation for new employees and continuing education.

Next steps in assessment include expansion to other child serving systems. The Division of Juvenile Services met with THRIVE and CBHS in April 2010 to discuss adaptation of the TIAA for Juvenile Services staff in the community and at Youth Development Centers as well as with contracted providers. Through the expansion, Maine also intends to adapt the assessment for military families.

In addition to the above trainings THRIVE offers regional and on site trainings on Trauma, Trauma Informed, Youth Guided, Family Driven and Cultural and Linguistic principles and practices. These trainings begin the technical and adaptive process of creating change in an organization. Thrive recognizes that ongoing support outside of an initial training is necessary to sustain change which is why phases of support would be offered that identify and train “trauma informed champions”, creates agency specific strategic plans for becoming trauma informed and assesses change through continuous quality improvement and on site monitoring for those organizations who score with significant challenges.

Thrive, in partnership with the Office of Child and Family Services, continued to track agency change against these system of care trauma informed principles through a re-administration of the Trauma Informed Agency Assessment on an every other year basis. The efforts listed above would enhance an already existing system without creating additional services. Ultimately, families and youth would report increased satisfaction, safety, trust, empowerment and collaboration with their treatment providers resulting in improved treatment outcomes.

New System of Care Expansion Planning Grant: Awarded September 2011

Given the successes of the TIAA and the ongoing training needs, THRIVE and CBHS applied for an expansion grant to further embed and sustain system of care and trauma-informed principles and practices in state and local agencies. This expansion grant application, entitled “Expand ME”, will support the expansion of the trauma-informed System of Care practices developed by THRIVE¹ System of Care from three western Maine counties to the entire state, involving not just the 130 agencies who deliver mental health services but other systems as well. Thus, the geographic area is statewide, encompassing 16 Maine counties. In terms of service system expansion, the immediate focus will be juvenile justice whose leadership has participated in training and now want full integration with trauma-informed System of Care practices as well as military families where CBHS is already engaged in the Military Adjustment Program.

In order to expand the system of care CBHS will undertake an assessment to occur at two levels, one focusing on state infrastructure to sustain System of Care and the second at the agency level to assure all providers follows trauma-informed System of Care principles. The multi-stakeholder Statewide Expansion Team, including representatives from Child Welfare, Juvenile Justice, and Education, will lead the state effort. It will update the Logic Model and Strategic Plan to expand and sustain a System of Care approach across child serving entities. It will review policies, administrative and regulatory standards and make recommendations to support service improvements and coordinate funding streams. It will inform and improve the Social Marketing Communication and Education Campaign ensuring cultural and linguistic competency and family and youth voice. A statewide focus will be to modify the TIAA for juvenile justice and agencies serving military families. At the agency level, the tool will be critical to help

¹ While initially developed under the auspices of Tri-County Mental Health, THRIVE has been incorporated as a non-profit organization to continue training, technical assistance and system development both in Maine and nationally.

agencies assess their own practices and make improvements consistent with System of Care principles. The assessment includes components for agency staff, family and youth to complete, with the evaluator developing sample sizes depending on the number served by each agency. Agencies need ongoing education on the importance of assessment and planning on System of Care Principles through trainings and webinars.

Statewide Family Organizations

This year the work to form an alliance of the seven family organizations was completed. The Maine Alliance of Family Organizations (MAFO) is a statewide alliance that formed to better serve families of children with disabilities and special health care needs and to strengthen family voice. As indicated in their brochure “Family concerns, needs and voice are foundational to what we do. We believe families are the primary decision-makers regarding care of their children, and we promote the family role in influencing policies and procedures governing care for all children”. The seven family organizations are adoptive and Foster Families of Maine (AFFME); Autism Society of Maine (ASOM); GEAR Parent Network; Learning Disability Association of Maine; Maine Parent Federation (MPF); National Alliance for the Mentally Ill (NAMI) and Southern Maine Parent Awareness (SMPA). Each of the partner organizations offer trainings, support, referral, advocacy and specialized information to help families cope with the special needs of their children and obtain the services and support they need. Each of the partner organizations website contains partner web connections to facilitate family access to all available resources. Early in the alliance, MAFO produced a two-part web based video of personal family stories of the life- changing importance of family organization membership. The videos, Family Organizations: Working Together, Growing Stronger Part 1 and Part 2 can be accessed from all seven organizations websites. A copy of the MAFO brochure is in the attachment section of this application.

ⁱ Mary Takach, Reinventing Medicaid: State Innovations to Qualify And Pay For Patient-Centered Medical Homes Show Promising Results, *Health Affairs*, 30, no.7 (2011):1325-1334

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Acct Period Hierarchy	2011
Approp	013697
Fund	015
Bucket	(Multiple Items)

Block Grant Payments

7/01/2010- 6/30/2011

Jrnl Posting Am Legal Name	Vend Cust Cd	Activity Nm	Program		Grand Total
			0997	1097	
CHILD HEALTH CTR	VC1000015418	YOUTH SELF-HELP PEER SUPPORT	2,750.00	5,472.05	8,222.05
CHILD HEALTH CTR	VC1000015418	Unknown		333.84	333.84
CHILDREN'S CENTER	VC1000015436	Unknown		310.08	310.08
COMMUNITY CONCEPTS INC	VC1000017773	YOUTH SELF-HELP PEER SUPPORT		3,034.79	3,034.79
COMMUNITY COUNSELING CTR	VC1000017779	YOUTH SELF-HELP PEER SUPPORT	8,250.00	17,721.15	25,971.15
CRISIS & COUNSELING CTR INC	VC1000018712	YOUTH SELF-HELP PEER SUPPORT	70,102.23	186,984.01	257,086.24
FUNCTIONAL ASSESSMENT SYSTEMS	VC1000031514	QUALITY IMPROVEMENT		48,000.00	48,000.00
FUNCTIONAL ASSESSMENT SYSTEMS	VC1000031514	QUALITY IMPROVEMENT		833.57	833.57
HELPING HANDS FOR CHILDREN &	VC1000036127	INFORMATION & REFERRAL	12,973.90	37,282.89	50,256.79
MAINE PARENT FEDERATION	VC1000057944	INFORMATION & REFERRAL	24,775.02	54,307.66	79,082.68
NAMI MAINE INC	VC1000066700	INFORMATION & REFERRAL	19,625.00	58,875.00	78,500.00
NAMI MAINE INC	VC1000066700	Q I C	1,250.00	3,750.00	5,000.00
SOUTHERN ME PARENT AWARENESS	VC1000085298	INFORMATION & REFERRAL		44,000.00	44,000.00
TRI-CTY MENTAL HLTH SERV	VC1000092940	YOUTH SELF-HELP PEER SUPPORT	40,055.45	75,727.42	115,782.87
UNIV OF ME SYS	VC1000093516	INFORMATION & REFERRAL	10,015.78	47,556.27	57,572.05
Grand Total			189,797.38	584,353.16	774,150.54

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	11,360	11,838	12,000	12,992	108.27
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Increase number of adults with SPMI receiving services.

Target: 12,000

Population: Adults diagnosed with severe and persistent mental illness.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Number of Adults with severe and persistent mental illness.

Measure: Number of adults with severe and persistent mental illness who receive services.

Sources of Information: Data is derived from the Maine Medicaid Service Encounter Information for SFY11.

Special Issues: Data is derived from the Maine Medicaid Service Encounter Information for SFY11. In SFY11, the State of Maine transitioned mid fiscal year to a new claims system, requiring the utilization of 2 extracts of data to create data for this measure. A discrepancy was identified in the codes for SMI. This has resulted in an undercount of SMI numbers. The data will be revised and submitted for correction by Feb 2012

Significance: The number of adults with severe and persistent mental illness served reflects the overall ability of the system to meet needs for services.

Activities and strategies/ changes/ innovative or exemplary model: Mental Health System Data Epidemiology
 - Prepare current FY10 utilization data that represents most components of the adult mental health system.
 - Analyze and track specific service utilization through using performance based indicators.
 - Identify current trends in service utilization with reference to previous data.
 - Prepare service utilization data related to financial expenditure data in order to inform: Department of Health and Human Services Administration; Executive Department Administration; Relevant legislative committees--Appropriations and Financial Affairs and Health and Human Services.

Target Achieved or Not Achieved/If Not, Explain Why: The tighter Financial MaineCare eligibility requirements and more efficient services reviews by APSHealthCare, Maine's ASO, also factored into the outcome of fewer clients receiving services than originally estimated.
 Also, we have a data discrepancy issue as identified above, under 'Special Issues'.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	10.61	12.98	10	6.87	145.56
Numerator	40	47	--	34	--
Denominator	377	362	--	495	--

Table Descriptors:

Goal:	The reduced utilization of state psychiatric inpatient beds.
Target:	The 2011 target is a 10% decrease in the rate of state hospital readmissions within 30 days.
Population:	Persons with severe and persistent mental illness readmitted to state psychiatric hospitals
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Decreased 30-day readmissions to State Psychiatric Beds.
Measure:	Percentage of patients with severe and persistent mental illness re-admitted within 30 days (non-forensic patients).
Sources of Information:	DIG Uniform Reporting System Basic Table 20A.-non forensic only
Special Issues:	
Significance:	The reduction of hospital re-admissions suggests increased success living in communities of choice for individuals with severe and persistent mental illness.
Activities and strategies/ changes/ innovative or exemplary model:	Development of a Comprehensive Community-Based Adult Mental Health System. The continued transition efforts at Riverview Psychiatric Center should result in better community integration of discharged patients and lower 30 day readmission rates: - State will continue to promote recovery based planning for patients including strengthening connections with community providers; - Foster active involvement of consumers in the planning and delivery of treatment and recovery-based services; - Ongoing utilization review of admissions and discharges and treatment planning, enhanced by the involvement of APS HealthCare.
Target Achieved or Not Achieved/If Not, Explain Why:	Although this target was not met, the actual number represents a continuing and not insignificant decrease in number of consumers readmitted to state psychiatric facilities within 30 days. Within the context of and despite the recession, the rate shows consistent progress towards OAMHS' transformational goal of reducing readmissions.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	23.08	28.45	21	19.60	107.14
Numerator	87	103	--	97	--
Denominator	377	362	--	495	--

Table Descriptors:

Goal: Reduced utilization of state psychiatric inpatient beds.

Target: 10% readmissions for SFY 11

Population: Persons with severe and persistent mental illness readmitted to state psychiatric hospitals.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Decreased readmissions to state psychiatric beds.

Measure: Percentage of patients with severe and persistent mental illness who are readmitted within 180 days (non-forensic).

Sources of Information: DIG Uniform Reporting System Basic Table 20A.-non forensic

Special Issues:

Significance: The reduction of hospital days suggests increased success living in communities of choice for individuals with severe and persistent mental illness.

Activities and strategies/ changes/ innovative or exemplary model: Development of a Comprehensive Community-Based Adult Mental Health System.
- State will continue to promote recovery based planning for patients including strengthening connections with community providers;
- Foster active involvement of consumers in the planning and delivery of treatment and recovery-based services;
- Ongoing utilization review of admissions and discharges and treatment planning.

Target Achieved or Not Achieved/If Not, Explain Why: This targeted decrease was not met.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2	2	2	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: To support and improve the use of Evidence Based Practices.

Target: Two evidence based practices will be tracked.

Population: Adults with SPMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: We are not reporting on this NOM.

Maine offers: Supported Housing, , ACT, Family Psychoeducation, Integrated Treatment of Co-occurring disorders, Illness Self-management, Supported Employment and Medication Management. Only Supported Housing and ACT are currently tracked as evidence based practices.

Significance: The DIG does not currently track Supported Employment as an EBP. Supported Housing and ACT are the only two services tracked as an EPB.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	100	100	15	13.15	87.67
Numerator	2,433	2,500	--	1,725	--
Denominator	2,433	2,500	--	13,116	--

Table Descriptors:

Goal: Promotion and support of evidence-based practices.

Target: 2000 individuals receiving supported housing, representing 15% of total persons in service.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Numbers of consumers receiving supported housing.

Measure: Increase in overall numbers of consumers receiving supported housing.

Sources of Information: BRAP and Shelter Plus Care Legacy Data Base and DIG

Special Issues: Criterion section can not be edited. Eligibility criteria are persons with mental illness or substance abuse who are homeless, leaving state institutions, leaving group homes , or living in substandard housing.

Significance: Increased use of evidence-based practices (supported housing) will provide better quality services for consumers.

Activities and strategies/ changes/ innovative or exemplary model: Maine is the one of the first states in the country to develop and implement a " Housing First Model". OAMHS has developed policies and procedures regarding the administration of it's Housing programs. These have been highlighted at National Conferences and adopted by several other states.

Target Achieved or Not Achieved/If Not, Explain Why: Our target is 15% of total person in service , 2000 persons.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:]

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	67	250	43.40	17.36
Numerator	N/A	335	--	217	--
Denominator	N/A	500	--	500	--

Table Descriptors:

Goal: Promotion and support of evidence-based practices.

Target: 250 persons receiving supported employment services in SFY 2011

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Numbers of consumers receiving supported employment services.

Measure: Increase in overall numbers of individuals with severe and persistent mental illness receiving supported employment services.

Sources of Information: Contract Performance Reports and APS Healthcare prior authorization data.

Special Issues: We adjusted the target downwards to reflect actuals over the last few years.

Significance: Increased use of evidence-based practices will provide better quality services for consumers.

Activities and strategies/ changes/ innovative or exemplary model: Development of a Comprehensive Community-Based Adult Mental Health System:
- Continue to develop more reliable data regarding evidence based practices that can be used for comparison from year to year;
- Continue to track data regarding utilization, age, gender and ethnicity.
- Continue working with Maine Medical Center's Division of Vocational Rehabilitation to provide support statewide to individuals with SPMI through employment specialists working in conjunction with the Community Service Network system.

Target Achieved or Not Achieved/If Not, Explain Why: Target was not met. This is not reported and tracked as an EBP, although it is offered as a service. In FY 2011, 217 individuals received Long Term Supported Employment Services; 89 individuals were placed in competitive employment and 32 individuals secured training/education.
We adjusted the target downwards to reflect actuals over the last few years.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	100	100	900	7.30	.81
Numerator	1,178	1,141	--	997	--
Denominator	1,178	1,141	--	13,661	--

Table Descriptors:

Goal: Promotion and support of evidence-based practices.

Target: 900 individuals with severe and persistent mental illness receiving ACT services.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Numbers of consumers receiving services from ACT teams.

Measure: Increase in overall numbers of consumers receiving services from ACT teams.

Sources of Information: Medicaid (MaineCare) data

Special Issues: Data is derived from the Maine Medicaid Service Encounter Information for SFY11. In SFY11, the State of Maine transitioned mid fiscal year to a new claims system, requiring the utilization of 2 extracts of data to create data for this measure. A discrepancy was identified in the codes for SED. This has resulted in an undercount of SED numbers. The data will be revised and submitted for correction by Feb 2012

Significance: Increased use of evidence-based practices will provide better quality services for consumers.

Activities and strategies/ changes/ innovative or exemplary model: Development of a Comprehensive Community-Based Adult Mental Health System:
 - State will continue to promote and support evidence based practices by contracting for these services;
 - Continue to develop more reliable data regarding evidence based practices that can be used for comparison from year to year.
 - Continue to track data regarding utilization, age, gender and ethnicity.

Target Achieved or Not Achieved/If Not, Explain Why: Target was met. The target in raw numbers was exceeded by 97 individuals who received ACT services.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	100	N/A
Numerator	N/A	N/A	--	1	--
Denominator	N/A	N/A	--	1	--

Table Descriptors:

Goal: Family PsychoEducation is not currently tracked as an EBP.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Though offered as a MaineCare (Medicaid) Service, Family PsychoEducation is not currently tracked as an EBP.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved No target set for this indicator as not tracked as an EBP.

or

Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Currently offered in Pilot sites throughout the State; not currently tracked as an EBP.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Currently offered in Pilot sites throughout the State; not currently tracked as an EBP.

The OAMHS is functionally merging with the Office of Substance Abuse Services and we anticipate tracking this measure in the near future.

Significance:

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved No target set as not tracked as an EBP.
or

Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: This is not currently tracked as an EBP.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Wellness Recovery Action Planning (WRAP), Recovery Workbook Groups and Trauma Recovery and Empowerment Groups (TREM) are offered through MaineCare (Medicaid); these are not currently tracked as EBPs.

Significance: We are not currently tracking this measure.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved We are not currently tracking this measure.

or

Not Achieved/If Not, Explain Why:

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Medication Management is not currently tracked as an EBP, although it is provided as a MaineCare service.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues: Medication Management is offered through MaineCare (Medicaid); service is not currently tracked as an EBP.

Significance: We are not currently tracking this measure.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved or Not Achieved/If Not, Explain Why: Target not set as not tracked as an EBP.
We are currently not tracking this measure.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	81.32	82.16	90	82.88	92.09
Numerator	1,088	1,105	--	1,278	--
Denominator	1,338	1,345	--	1,542	--

Table Descriptors:

Goal: Percent of individuals with severe and persistent mental illness reporting satisfaction with services.

Target: 90% satisfaction with services.

Population: Adults diagnosed with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of consumers responding to DIG survey who report satisfaction with mental health services.

Measure: Percent of survey consumers who are satisfied with services.

Sources of Information: Data Infrastructure Consumer Satisfaction Surveys.

Special Issues:

Significance: Consumer satisfaction with services reflects quality of delivered mental health services in the system.

Activities and strategies/ changes/ innovative or exemplary model: DIG Surveyors will continue to expand the scope of their surveys to get an accurate picture of consumer satisfaction.

Target Achieved or Not Achieved/If Not, Explain Why: OAMHS will continue to track client perception of care. Target fell short by 8%. This could be related to continued economic conditions the state has been experiencing.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	7.39	5.80	2,595	5.31	.20
Numerator	805	687	--	726	--
Denominator	10,897	11,838	--	13,661	--

Table Descriptors:

Goal: Increase in community support clients employed full time or part time in competitive jobs.

Target: 19% of community support clients employed full time or part time in competitive employment (includes supported employment).

Population: Adults diagnosed with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of clients employed full time or part time in competitive employment.

Measure: Percentage of clients who are employed full time or part time in competitive employment.

Sources of Information: Resource Data Summary and DIG URS Table 4

Special Issues: We modified the percentage target to 19% to better align with national standards.

Significance: Increased employment in competitive jobs help consumers integrate into their communities.

Activities and strategies/ changes/ innovative or exemplary model: Continue to fund employment specialists statewide as well as training in employment practices for community support workers. Develop consistent data collection strategy that captures employment data across mental health recipients.

Target Achieved or Not Achieved/If Not, Explain Why: Target not met. Much work as to be done in Maine to meet the national standard of 19%. This is particularly difficult given long economic recession.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Decrease criminal justice involvement.

Target: In development.

Population: Persons receiving mental health services from the state mental health authority.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of persons arrested.

Measure: Changes in arrest overtime for persons receiving mental health services.

Sources of Information: The Maine DIG is working with the DOC/county jail systems to collect individ. level data on incarcerations for DIG (2012).

Special Issues: Current data correction has been limited, relying exclusively on annual consumer surveys likley leading to under reporting of criminal justice contacts. Individual level data of incarcerations will produce more consistent information. Intensive case managers working in jails and prisons are collecting individual arrest, recidivism and needs data which may be available in the aggregate in time for the 2012 MHBG Implementation Report.

Significance: Improved community-based systems of care should decrease consumer involvement in the criminal justice system.

Activities and strategies/ changes/ innovative or exemplary model: Data collection for this NOM continues to be in development. The challenge inherent is that data needs to be integrated across three agencies. As is noted consistently in prior reports and applications, OAMHS maintains a strong presence in state and county correctional facilities through its Intensive Case Management program and is working closely with other state agencies to refine the data collection process. It is anticipated that refinement of this process will continue through the 2011 MHBG year and that targets may be established in 2012.

Target Achieved or Not Achieved/If Not, Explain Why: NA

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	3.97	2.93	1,200	9.24	12,987.01
Numerator	433	347	--	1,200	--
Denominator	10,897	11,838	--	12,992	--

Table Descriptors:

- Goal:** Provide housing with supports to homeless person with SPMI, substance abuse and co occurring diagnosis.
- Target:** Long-term goal will be to increase the resources for homeless persons with SPMI, substance abuse and co occurring diagnosis
- Population:** Adults diagnosed with severe and persistent mental illness, substance abuse and co occurring diagnosis.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of homeless consumers receiving services.
- Measure:** Number of persons receiving housing and/or community support/case management services who are homeless.
- Sources of Information:** Legacy Housing Data Base
- Special Issues:** Despite the substantial increase in both state and federal funding for housing and supports dedicated to homeless person, demand continues outstrip supply. The state funds have increased by 1 million dollars while federal funds have also increase by nearly a million as well for FY 2012.
- Significance:** Both Nationally and in Maine, approximatley 25% of the adult homeless population are persons with SPMI. Approximately 60% of homeless persons have a substance abuse issue.
- Activities and strategies/ changes/ innovative or exemplary model:** Maine is the first state in the country to conduct a study, Cost of Homelessness benefit of Shelter Plus Care, that followed specific individuals while homeless and then housed with supports. This has been shared in Washington, DC, at the JFK Library in Boston, Mass and to the Maine Legislature. It represents a souce document that has driven a additional resources (State and Federal) to the homeless population in Maine.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target base on prior years activity.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	64.74	64.08	N/A	61.31	N/A
Numerator	863	858	--	938	--
Denominator	1,333	1,339	--	1,530	--

Table Descriptors:

Goal: Increase social supports/social connectedness for individuals with severe and persistent mental illness.

Target: This is currently in development through the DIG.

Population: Individuals with severe and persistent mental illness receiving services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults with severe and persistent mental illness who agree or strongly agree with questions 36-39 on the DIG Survey.

Measure:

Sources of Information: DIG Survey Quest:36 Otmc serv prov I have the supp from fam or friends.37.Otmc serv prov I am happy with friendships I have.38.Otmc serv prov I have people whom I can do enjoyable things.39.Other than my current serv prov I feel I belong in my community.

Special Issues: This outcome measure is in development through DIG.

Significance: Consumers, mental health is improved with increased social supports and social connectedness

Activities and strategies/ changes/ innovative or exemplary model: Follow through with development of this NOM through the DIG Survey.

Target Achieved or Not Achieved/If Not, Explain Why: N/A-currently under development through the DIG Survey.

ADULT - IMPLEMENTATION REPORT

Transformation Activities:]

Name of Implementation Report Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	52.39	45.40	40	58.86	147.15
Numerator	733	3,512	--	907	--
Denominator	1,399	7,735	--	1,541	--

Table Descriptors:

Goal: Demonstrable improvement in level of functioning

Target: 40% of individuals with severe and persistent mental illness receiving community supports will demonstrate an improvement in their level of functioning.

Population: Individuals with severe and persistent mental illness who are receiving services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Annual DIG Survey

Measure: Annual DIG Survey

Sources of Information: Annual DIG Survey

Special Issues: Ongoing discussion on best measurement tool is taking place. We are considering both the DIG Survey and/or LOCUS Scores.

Significance: Mental health services support consumers in improving their level of functioning.

Activities and strategies/ changes/ innovative or exemplary model: Follow through development of this NOM through the DIG Survey and/or LOCUS.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved using DIG survey results.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	18,664	19,664	20,057	20,029	99.86
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Increased access for children and youth served by CBHS, who receive services that address their behavioral, emotional and mental health needs

Target: Under ordinary circumstances the annual target is an increase of the served population of 2% from the prior year.

Population: Statewide number of children with ages 0 through 17 years based on unduplicated counts of those receiving specific behavioral health services from MaineCare (Medicaid).

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Total number served according to measure discussed below.

Measure: Data includes children whose behavioral health services are identified by MaineCare procedure codes that represent services appropriate to address the treatment needs of these individual children and youth. The number is reported in URS Basic Table 2A.

Sources of Information: MaineCare claims reporting system (MECMS), unduplicated count of children ages 0 through 17 years of age.

Special Issues: This NOM is a straightforward measure that depends in part on the capacity of Children's Behavioral Health Services to have adequate resources to meet service demand and a continuation of multiple service provider locations to cover all areas of the State of Maine, especially rural areas, to ensure access to services.

Significance: This data focuses specifically on children whose services are paid for by funds appropriated by the Maine Legislature to the State Mental Health Authority, specifically to address the mental, emotional and behavioral health needs of children and youth provided through community provider contracts with Children's Behavioral Health Services.

Activities and strategies/ changes/ innovative or exemplary model: Increase in access to services were attributable in large part by the stability of contracted service provider network and ability to provide services efficiently, through contractual oversight and management by CBHS personnel with assistance from the DHHS Administrative Service Organization.

Target Achieved or Not Achieved/If

Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: The State of Maine does not operate any State Psychiatric Hospitals for children or youth.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model: By order of the 1989 Augusta Mental Health Institute (AMHI) Consent Decree relating to the termination of inpatient psychiatric hospital services at the former Adolescent Unit, the Department received additional appropriations to develop community based treatment alternatives including agreements with private community psychiatric hospitals to provide those services when necessary.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: The State of Maine does not operate any State Psychiatric Hospitals for children or youth.

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Activities and strategies/ changes/ innovative or exemplary model: By order of the 1989 AMHI Consent Decree relating to the termination of inpatient psychiatric hospital services at the former Adolescent Unit, the Department received additional appropriations to develop community based treatment alternatives including agreements with private community psychiatric hospitals to provide these services when necessary.

Target Achieved or Not Achieved/If Not, Explain Why: Not Applicable

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	3	3	3	3	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Maintain or Increase number of EBP Practices in State

Target: Number of specific EBP's required to be reported under NOM for Children with SED.

Population: Children and youth who are able to benefit from EBP based on their treatment needs and evidence that the EBP is an effective treatment for their diagnosis.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number is from 0 to 3

Measure: Count 1 each for: Therapeutic Foster Care; Multi-Systemic Therapy; Functional Family Therapy

Sources of Information: Community agencies contracting for these services funded by Children's Behavioral Health Services.

Special Issues: Rate setting methodology permitting deviation from standard rates for Section 65 Home and Community Based Treatment Services (HCT) when the deviation is based on increased cost to deliver Evidence Based Services.

Significance: Evidence Based Practices, when delivered with fidelity, are proven to be effective in treatment for the individual and have a greater probability that the child's outcomes will be positive.

Activities and strategies/ changes/ innovative or exemplary model: Increase number of practices within the parameters of legislative appropriation and MaineCare rule allowing for cost deviation.

Target Achieved or Not Achieved/If Not, Explain Why: Target Achieved

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	9.43	10.72	10.72	8.35	77.89
Numerator	765	705	--	637	--
Denominator	8,110	6,576	--	7,625	--

Table Descriptors:

- Goal:** Decrease number of children and youth receiving Therapeutic Foster Care each year.
- Target:** Any decrease in the census of children placed in Therapeutic Foster Care is acceptable (as opposed to an increase). Although there are always mitigating circumstances that can cloud certainty in projecting the numerical level of decrease over a one year time frame, the most recent trend in Maine continues to be a decline of children placed in therapeutic foster care services which are supported by the Office of Child & Family Services, Child Welfare Services.
- Population:** Children and youth ages 0 through 17 years and 18-22 who are in a voluntary C5 status who are served within the DHHS/ Child Welfare Services system.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Actual unduplicated number in Therapeutic Foster Care placements, divided by number of estimated children with SED.
- Measure:** Measured by percentage of decrease of indicator.
- Sources of Information:** DHHS Office of Child & Family Services, Child Welfare Services. Numbers are tracked by the OCFs Residential Services Program Manager provided by 10 Maine community agencies under contract with DHHS/OCFS offering this service.
- Special Issues:** Reduction of children in Maine TFC has been a successful goal over the past several years. It is consistent with Child Welfare Services' objective to provide permanency for these children through adoption or Kinship care.
- Significance:** The move away from traditional custodial care, even with foster families trained with a therapeutic parental skill set, supports a national philosophy that values building life skills and learning experiences within a more traditional family environment that offers children safety, long term acceptance, stability, and the comfort of permanency.
- Activities and strategies/ changes/ innovative or exemplary model:** Continue successful efforts to place children and youth from therapeutic foster care settings to more permanent, family like environments while still meeting their behavioral health needs through available community based treatment services. Two proven avenues to accomplish this objective are the Maine Caring Families program (placement with relatives or extended family members) and DHHS adoptive programs where permanency is achieved.

Target Achieved Target achieved FY11 data is: Denominator 7,625; Numerator 637; performance

or indicator = 8.35 which is a 22.1% decrease from the actual amount in FY2011.

**Not Achieved/If
Not, Explain Why:**

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	5.65	6.31	5.98	5.65	94.48
Numerator	458	415	--	431	--
Denominator	8,110	6,576	--	7,625	--

Table Descriptors:

- Goal:** Increase number and percent of children and youth receiving Multi-Systemic Therapy.
- Target:** Children and youth who can specifically benefit from MST. Percentage target is average % of previous 2 years, or 5.98
- Population:** Specific subset of children being served under Children's Home & Community Based Treatment Services MaineCare (Sec 65)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Unduplicated numbers of children served under MST by community providers.
- Measure:** Numbers served under MST divided by estimated number of children with SED.
- Sources of Information:** Numbers in service is obtained from:
Reported by service providers actual total 431; Estimated total SED is from URS Table 16
- Special Issues:** Maintaining fidelity to this evidence based practice.
- Significance:** MST is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family and extrafamilial factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change.
- Activities and strategies/ changes/ innovative or exemplary model:** Continue to support the development, implementation and sustainability of MST EBP's for Maine children. This EBP is funded by MaineCare Children's Home & Community Based Treatment.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target not Achieved.
FY11 data is: Denominator 7,625; Numerator 431; performance indicator = 5.65. although overall there was an increased number of children who recieved MST treatment the estimate of the SED population also increase by 3.9%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2.82	4.71	4.71	4.35	92.36
Numerator	229	310	--	332	--
Denominator	8,110	6,576	--	7,625	--

Table Descriptors:

- Goal:** Maintain the number and percentage of children and youth receiving Functional Family Therapy at current levels.
- Target:** Children and Youth in the Juvenile Justice system with behavioral health needs who can specifically benefit from FFT.
- Population:** Specific subset of children being served under Children's Home & Community Based Treatment Services, MaineCare.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Unduplicated number of children served under FFT by community providers.
- Measure:** Numbers served under FFT divided by estimated number of children with SED.
- Sources of Information:** Data reported by service providers actual total 332; Estimated total SED is from URS Table 16.
- Special Issues:** Maintaining fidelity to this evidence based practice. FFT is supported jointly by Children's Behavioral Health Services and the Department of Corrections, Juvenile Services.
- Significance:** Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change and generalization.
- Activities and strategies/ changes/ innovative or exemplary model:** Continue to support the development, implementation and sustainability of FFT EBP's for Maine children. This EBP is funded by MaineCare Children's Home & Community Based Treatment (Section 65).
- Target Achieved or Not Achieved/If Not, Explain Why:** Target partially achieved. FY11 Numerator 332 Denominator Performance indicator 4.35 Percentage attained 92.36% of the FY2010 percentage. An additional 22 children received FFT services in FY2011. The SED number also increased by 21.5%.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	68.49	59.27	63.88	63.11	98.79
Numerator	765	550	--	527	--
Denominator	1,117	928	--	835	--

Table Descriptors:

- Goal:** Maintain/Improve the percentage of positive children's outcomes reported in the annual Office of Quality Improvement (OQI) Youth/Family Mental Health & Well-Being Survey.
- Target:** Maintain percentage as the average of the previous 2 years, or 57.83%.
- Population:** Children and families receiving CBHS services who respond to the annual Office of Quality Improvement Survey
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of Children/Families reporting Positive Outcomes in OQI Satisfaction Survey.
- Measure:** Denominator: Number of children/families responding to OQI Satisfaction Survey;
Numerator: Number of children/families who report positively to the Positive Outcomes of Services (questions 1-6)
- Sources of Information:** Uniform Reporting System, Table 11, specific to Questions 1-6 on the Satisfaction Survey.
- Special Issues:** The special issue for this performance indicator and all others in this section of the plan that rely on the YSS/Family Survey, upon which the main OQI survey is based, has always been the response rate from families that are sent the OQI Survey. Until FY'09, the returns were so small as to be statistically insignificant. This problem has vastly improved through the hard work of OQI staff with assistance from family organizations.
- Significance:** Child/ Youth Outcomes are an important measure of the extent to which the population served by CBHS view themselves as benefiting from the services they receive from the children's behavioral health system in Maine.
- Activities and strategies/ changes/ innovative or exemplary model:** The reported percentage of positive outcomes for FY11 (63.1%) indicates progress toward a goal of 2/3rds of individuals reporting positive outcomes.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target Not Achieved. The indicator was 98.79 % attained. There were 10 % less respondents than in FY2010.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: This is a indicator that is under development by the DHHS/Office of Quality Improvement/ Data Infrastructure Project

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure: Percent of children who reported an improvement in their school attendance since beginning to receive mental health services.

Sources of Information: URS Table 19b Profile of Change in School Attendance.

Special Issues: The data relevant to this NOM is collected by the Maine Department of Education. The Data Infrastructure Project has not been able to establish a direct connection/ collaborator with DOE on this specific work due to a recent retirement at the Department of Education. However, the Statewide Quality Improvement Council (Maine's Mental Health Planning Council for the Block Grant) has successfully recruited a member from the Department of Education effective June 2010, who will assist the OQI with identifying DOE personnel that are able to collaborate with OQI regarding the access to data that will be required, over time.

Significance:

Activities and strategies/ changes/ innovative or exemplary model: Identify Department of Education specialist qualified to obtain and analyze public school attendance data for this NOM. In collaboration with DHHS/OQI, establish baseline indicator.

Target Achieved or Not Achieved/If Not, Explain Why: Target Not Achieved
Data not yet Available

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	56.77	N/A	N/A	N/A	N/A
Numerator	109	N/A	--	N/A	--
Denominator	192	N/A	--	N/A	--

Table Descriptors:

- Goal:** Reduce recidivism for youth who are incarcerated in one year and are at risk of re-incarceration in the next year.
- Target:** Youth who are incarcerated or at risk of incarceration.
- Population:** Youth who are involved with or at risk of involvement with the Juvenile Justice system.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage of youth who do not experience recidivism.
- Measure:** Percent of youth incarcerated in Year 1 (Denominator) who were not re-incarcerated in Year 2(Numerator).
- Sources of Information:** URS Table 19a. Incarceration data for youth obtained from the Maine Department of Corrections; data analyzed and reported by the Bristol (Vermont) Observatory under contract with the Maine DOC.
- Special Issues:** Maine Data Infrastructure Group in the Office of Quality Improvement has chosen to substitute "incarceration" rather than "arrest" data for this Performance Indicator.
- Significance:** The percentage indicated will show the "success" of previously incarcerated youth who, during one year following their incarceration, do not re-offend at the level of being incarcerated.
- Activities and strategies/ changes/ innovative or exemplary model:** Baseline data is now established for FY09, to be continued in estimating/ reporting in future years.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target Not Achieved. Data is not available at this time. DHHS Office of Quality Improvement(OQI) is currently establishing a MOU with Department of Corrections(DOC)for use in calendar year 2012.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	83.38	93.54	93.54	95.47	97.98
Numerator	923	753	--	716	--
Denominator	1,107	805	--	750	--

Table Descriptors:

- Goal:** This NOM is a new addition to the Maine OQI Youth/ Family Mental Health & Well-Being Survey.
- Target:** The results in the 2010 Survey is the baseline for projecting to FY11.
- Population:** All families of children and youth responding to the 2010 (Maine) Youth & Family Survey.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Denominator is total number of respondents answering Question 28 and Question 27
Numerator is total number of respondents answering that they are living in the same place or one other place in the past 12 months.
- Measure:** Stability is measured when the child/youth is living in the same place over the past 12 months or has lived in one other place over the past 12 months. Stability is determined as the percentage of all respondents who have remained in the same place or has moved to a single other place over the year.
- Sources of Information:** 2011 OQI Maine Youth & Family Survey.
- Special Issues:** Guidance for the new Question (27), Housing, in the Maine Youth and Family Survey asks "Where is your child currently living?" with 11 check off options, and a new Question 28 "Has your child lived in any of the following places in the last 12 months?" with the same check off options. Stability is established when the response to question 28 is the same as question 27 and when there is a single added location. Allowing for up to one move over 12 months allows for a natural move factor (which can be determined by a parent seeking employment for example, or other caregiver decisions) as well as a child's return to home from a clearly temporary setting such as residential treatment, hospital or a crisis stabilization unit - although it could also indicate moving from a home to such temporary residence.
- Significance:** The observation from current data is that the surveyed population overall has experienced stability in its living situations.

Activities and strategies/ changes/ innovative or exemplary model:

Target Achieved Target achieved. NOTE: WeBGAS did not accurately compute this data as an
or increased percentage from target - Target was 93.54 and actual was 95.47, an
Not Achieved/If increase of 102.06% and not 97.98%
Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	79.13	78.31	80.64	77.31	95.87
Numerator	876	715	--	644	--
Denominator	1,107	913	--	833	--

Table Descriptors:

- Goal:** Increase percentage of children and youth who perceive positive social connectedness in their life
- Target:** Increase percentage reporting positive by .5%
- Population:** Children and youth and/or their families who complete the OQI Youth/Family Mental Health & Well-Being Survey for this functional domain.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Percentage 80.64% or greater
- Measure:** Denominator: Number of total respondents
Numerator: Number of respondents scoring positive (greater than 3.5 percent agree and agree strongly on 4 questions that have a 5 point rating system).
Reported on URS Table 9
- Sources of Information:** Annual Youth/Family Survey (OQI). Covers 4 questions on relationships that enable the person to communicate with confidence, share problems with a level of comfort, find support from others in a crisis, and knows people to do enjoyable things with.
- Special Issues:** None.
- Significance:** Children and youth scoring positive on social connectness are likely to function well in the home, school and community.
- Activities and strategies/ changes/ innovative or exemplary model:** Maintain the high level of positive social connectedness (82.15)shown in the first year of this survey domain.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. However, target was achieved at 95.9% of total. This appears to indicated that the level is slightly below what was reported in the prior year.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	69.75	60.95	61.27	64.42	105.14
Numerator	777	565	--	536	--
Denominator	1,114	927	--	832	--

Table Descriptors:

- Goal:** Improve Child's Level of Functioning by .5% each year
- Target:** Children and Youth with behavioral challenges whose functioning is addressed in the annual OQI Youth & Family Survey
- Population:** Same as above.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Percentage of children and youth indicating improvement in functioning at home, with others, ability to get along with others and cope when things go wrong.
- Measure:** Denominator is number of respondents in the annual satisfaction survey; Numerator is number of respondents that indicate positive answers to the 6 questions dealing with ability to function well on the survey.
- Sources of Information:** Results from Youth/Family Survey on Functioning Domain that includes 6 Questions that ask "My child is better able to...or my child gets along better", with emphasis on better. Reported on URS Table 9.
- Special Issues:** This NOM is very similar to the NOM on Client Perception of Care/Client Outcomes reported in Goals, Targets, Action Plans. However, the difference between these NOMS is that the percentage in this instance is derived from a different numerator which is calculated based on the weighting of each response to the specific question(s). Scoring is done on a 5 point scale, calculating the percentage of scores that average greater than 3.5 (meaning percent agree and strongly agree).
- Significance:** Improvement in ability to function in a positive fashion and to show improvement in functioning is a measure of the current value of services that are delivered in the children's system of care, especially those which focus on the behavioral, emotional and developmental needs of the child/youth.
- Activities and strategies/ changes/ innovative or exemplary model:** Ability to function is seen as the key measure of child and youth outcomes and results from participating in the system of care. The annual Youth & Family Survey asks the general questions that have value in assessing functional improvement.
- Target Achieved or Not Achieved/If** Target Achieved. The current percentage is also important to establish a higher baseline for future measure.

Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Decrease Out of Home Placements

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	5.60	4.35	4.97	4.84	97.39
Numerator	513	432	--	483	--
Denominator	9,163	9,918	--	9,991	--

Table Descriptors:

- Goal:** Decrease percentage of Out of Home Placements through Case Management Support
- Target:** Target established at 4.97% of all children served with case management services based on past 2 year trend.
- Population:** Children and youth served by CBHS with behavioral health needs specific to intensive, time limited out of home treatment services.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children placed out of home who are involved with case management services.
- Measure:** Numerator: Number of children placed out of home for time limited behavioral health treatment purposes in Fiscal Year; Denominator: Divided by the number of children authorized to receive case management services in Fiscal Year. All children placed must have a case manager.
- Sources of Information:** Children placed out of home in Fiscal Year are tracked by payment in the CBHS Room and Board account and by Clinical Care Specialists. Children authorized to receive case management services are reported by the APS Healthcare.
- Special Issues:** None
- Significance:** Over the past several years CBHS has implemented a policy on Intensive Temporary Residential Treatment Services (ITRTS) with specific clinically focused criteria and procedures that justify the need for and benefit to children that are placed out of home for behavioral health treatment. Placements are monitored by CBHS Clinical Care Specialists to assure continued need and benefit for the child.
- Activities and strategies/ changes/ innovative or exemplary model:** An original assumption in choosing the elements for this State Performance Indicator was that families and children served through the case management system would be more informed of and therefore connected to community services that are better options than out of home placement. ACT teams and the Children's Home and Community Based Treatment Services provide intensive treatment options in the home and community that will prevent unnecessary out of home placements. CBHS will continue to support families and children through case management services and the Clinical Care Specialists. When children do meet medically necessary criterion and have specific needs that can be addressed in a residential treatment setting, the emphasis will be on reducing the length of stay through focused treatment and the active engagement of the family in preparing for the child's return to the family setting.

Target Achieved Target Achieved.
or
Not Achieved/If
Not, Explain Why:

CHILD - IMPLEMENTATION REPORT

Transformation Activities:]

Name of Implementation Report Indicator: Expand Crisis to Reduce Hospitalization

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	22.83	21.10	21.96	21.11	96.13
Numerator	1,381	1,219	--	1,059	--
Denominator	6,049	5,775	--	5,035	--

Table Descriptors:

- Goal:** Maintain or expand access to crisis services to reduce hospitalization
- Target:** Maintain the percentage of hospital dispositions at 25% or less of the total number of children and youth seen by crisis workers in a face to face community setting.
- Population:** Any child or youth to 18 years experiencing crisis and seen by a trained children's crisis worker. There is no eligibility requirement for this service.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children/ youth hospitalized as a result of crisis intervention. Percentage is estimated at average of previous 2 years.
- Measure:** Data for the measure: Denominator is the total number of crisis face-to-face contacts/ assessments of children and youth who are in crisis and requesting service. Numerator is the total number of children and youth within the total seen and assessed whose disposition is to a hospital.
- Sources of Information:** Monthly statistical crisis services reports submitted to Children's Behavioral Health Services from all 9 crisis programs operating statewide on a 24/7 basis.
- Special Issues:** Crisis services are preventive by design. In this instance the data show over the past 10 years that community alternatives to hospitalization consistently represent three- quarters (75%) of the crisis dispositions made by the crisis system. Although prevention is difficult to prove, CBHS maintains that in the absence of a crisis system the number of hospital admissions for children in crisis would be substantially higher.
- Significance:** Crisis services entail intervention by trained crisis workers who are aware of available community alternatives when a child is experiencing a crisis will reduce the potential for unnecessary hospitalization.
- Activities and strategies/ changes/ innovative or exemplary model:** These services for children and youth are fully integrated with adult mental health crisis services and both are operated by the same vendor. These providers are jointly funded by adult and children's services. CBHS provides 15% of its state general funds to support these services. Over the last 10 years this statistical percentage has been steady at 25% or less hospital dispositions for all children seen by the crisis system.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target Achieved. In FY11 there was a decrease in number of hospitalizations and in percentage of hospital dispositions compared to FY10.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:]

Name of Implementation Report Indicator: Improve Functioning in Home, School ,Community

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	63	N/A	N/A	51.03	N/A
Numerator	347	N/A	--	839	--
Denominator	550	N/A	--	1,644	--

Table Descriptors:

- Goal:** Improve or Maintain Functioning measured by CAFAS in Home, School, Community
- Target:** Maintain or increase level of functioning for children tracked. New measure, baseline information for FY12 reporting
- Population:** Children and youth in school receiving case management services who are tracked over a 10-14 month time period.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children maintaining or increasing functioning measured by CAFAS over 10-14 month time period.
- Measure:** Data for the measure: Denominator is total number of children discharged from TCM tracked over a 12 month period using the CAFAS to determine degree of functioning. Numerator is number of children exhibiting stability or gains in functioning(20 points lower than at initial registration) measured by the Child & Adolescent Functional Assessment Scale (Total Youth Score) over 10-14 month period.
- Sources of Information:** DHHS/ Office of Quality Improvement - Child and Adolescent Assessment and Outcome tracking project.
- Special Issues:** This Performance Indicator was adopted by DHHS/ OQI very early in the Data Infrastructure work and has continued into be refined over time.
- Significance:** The CAFAS has been adopted for use by the Office of Quality Improvement as a standard assessment instrument that is capable of measuring a child's level of functioning. The CAFAS is also regularly employed by other professionals including DHHS/ CBHS in the utilization review process when assessing the benefits of treatment for individual children.
- Activities and strategies/ changes/ innovative or exemplary model:** The goal of treatment is to maintain or improve a child's ability to function in the normal environments of the home, at school and in the community. CBHS will continue to employ valid functional assessment instruments such as the CAFAS in the future and will expand the scope of this analysis in the future to include all of the CBHS core behavioral health services.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target Not Achieved. Baseline. Modification to the measure necessary to add a specific amount of improvement identified as a "significant" level of improvement. Significant improvement is defined as having a CAFAS score at discharge greater than or equal to 20 points lower than at initial registration. Prior information reported lower amounts of change in the CAFAS score.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Increase Crisis Outreach Interventions in Community

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	34.12	43.41	38.77	52.62	135.73
Numerator	2,064	2,507	--	2,649	--
Denominator	6,049	5,775	--	5,035	--

Table Descriptors:

- Goal:** Maintain/ Increase Percentage of Crisis Outreach Interventions in Community Settings
- Target:** 32% of crisis face to face assessments will occur in a location other than a hospital emergency room or a crisis office.
- Population:** Any child or youth up to 18 years experiencing a crisis or requesting crisis services through DHHS statewide crisis service system.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of face to face encounters occurring in a normal community environment (not hospital ER or crisis office)
- Measure:** Denominator is the number of crisis face to face assessments involving children and youth in the fiscal year. Numerator is the number of face to face assessments that occur in the home, school or other community settings.
- Sources of Information:** Information is from monthly childrens crisis provider statistical data reports from the 9 crisis programs forming the statewide crisis services system. Information is compiled by the DHHS Office of Quality Improvement.
- Special Issues:** This Performance Indicator was selected in order to assess and monitor the extent to which crisis services are responding to children and families needing the service, and at the location where the crisis occurs.
- Significance:** CBHS crisis program model emphasizes mobile crisis assessment and intervention. The data on actual location of the crisis assessment is an indicator of the extent to which the mobile outreach model is actually being practiced, i.e., face to face contacts in natural community settings.
- Activities and strategies/ changes/ innovative or exemplary model:** CBHS will continue to assess crisis services practice especially where data indicates an over reliance on hospital emergency rooms or the convenience of the crisis program office as locations where crisis assessments occur. Data from this indicator is available to all crisis providers, reported by program, each month, as an aid to comparison among programs and to self-monitor results. In FY10 all crisis programs statewide under went reconfiguration and this presented an opportunity to emphasize the necessity for true mobile services.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target Achieved. Both the number and percentage of face to face assessments increased in FY11.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Maintain Stte Expenditures to Meet MOE Requirements

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	54,445,777	47,990,876	51,218,326	43,741,734	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

Goal: Maintain State General Fund Expenditures to Meet FY11 federal Maintenance of Effort (MOE) Requirement

Target: Expend state general funds for Children's Behavioral Health Services in FY10 to achieve the average of state general fund expenditures for FY09 and FY10.

Population: Not Applicable

Criterion: 5:Management Systems

Indicator: State of Maine appropriated funds expended for Children's Behavioral Health Services, credited toward Block Grant Maintenance of Effort for FY11.

Measure: State expenditures in FY 09 (\$54,445,777) and in FY09 (\$47,990,876) equals \$102,436,653 (divided by 2) equals \$51,218,326 as the Target Measure for MOE compliance in FY11. Actual State expenditures for FY11 were \$43,741,734.

Sources of Information: Maine Department of Administration and Finance, Office of the Budget; DHHS/ Service Center/ Finance.

Special Issues: FY10-11 Budget Initiatives are designed to produce cost savings necessary to bring the state budget in line with much lower expected revenues for both years. CBHS success in these Budget Initiatives wil decrease the ability to meet its share of the MOE in FY10-11, as the federal formula stands today.

Significance: Inability to meet the State target for MOE (Total Adult Mental Health Services + Children's Beavioral Health Services)could result in financial sanctions in the amount of future Block Grant allocation to the State.

Activities and strategies/ changes/ innovative or exemplary model: CBHS success in meeting its cost savings targets in FY11 resulted in an inability to meet its federally mandated MOE target.

Target Achieved or Not Achieved/If Not, Explain Why: Target Not Achieved; See statement above.

CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Maintain or Increase Level of Services for Homeless Youth

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1,915	2,228	2,072	2,506	121
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Support Homeless Youth through Outreach Services in both urban and rural areas of Maine.
- Target:** Target for current reporting year is the average number of homeless youth served in the previous 2 Fiscal Years, or 2072.
- Population:** Children and youth up to 18 Years who are homeless and require behavioral health or other community based services.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Actual number of homeless youth served in FY11
- Measure:** Increase or decrease in total homeless youth served from Fiscal Year to Fiscal Year. The reason for selecting a current year target by averaging the 2 previous years is because of historical fluctuations in this population as reflected by numbers served. This rationale is based on the same formula as is the Block Grant MOE which corrects for unusual (+ or -) single year changes.
- Sources of Information:** Year end program information from 9 community agencies receiving state general funds for Homeless Youth Services and 3 community agencies receiving federal PATH funding. This data is reported by the Division of Purchased Services to CBHS.
- Special Issues:** Maine's geographic makeup and population distribution are essentially rural in nature. Accordingly, most of the individuals served are living in rural areas of the state. The services are largely focused on outreach for the purpose of informing homeless youth of community services available to them and to address reasons for their homelessness, including possible reconciliation with their families.
- Significance:** The rural aspects of homelessness are prevalent in Maine, which is a major reason for expanding services to areas outside of the few urban cities such as Portland, Lewiston-Auburn and Bangor.
- Activities and strategies/ changes/ innovative or exemplary model:** Some services to Homeless Youth are also provided through DHHS/ Office of Child & Family Services. CBHS has collaborated with Child Welfare Services at the regional and local levels with Homeless service providers and has effectively co-mingled funding. However, any additional funding is contingent on the Maine legislature's approval through the State appropriation process.
- Target Achieved or Not Achieved/If** Target Achieved.

Not, Explain Why:

Upload Planning Council Letter for the Implementation Report

November 4, 2011
Ms. Nichole Washington
Grants Management Officer
Division of Grants Management, OPS
SAMHSA, 1 Choke Cherry Road
Rockville, Maryland 20857

Dear Ms. Washington,

As has been the practice at the monthly Statewide Quality Improvement Council meetings,

by Maine's Mental Health Planning Council, staff provided an update on the Department's services and supports for adults with serious mental illness and for children with serious emotional disturbance at the November 4, 2011 meeting. These reviews have provided the Council members with the opportunity to serve as advocates for adults with serious mental illness, children with serious emotional disturbances, and other individuals with mental illnesses by bringing forth their own experiences and real life situations.

The Adult Committee has focused on housing priority areas and will continue in this vein for the coming year. The Adult Committee, as well as the full Council has benefited from the housing expertise of Sheldon Wheeler, Director Housing Resource Development.

Additionally ongoing support from Adult Planner Sheldon Wheeler and Assistant Planner Cindy McPherson has improved the communication conduit with the Office of Adult Mental Health Services.

Sherry Langway, DHHS / CBHS Children's Planning Council on the FY11 priority areas for C

well as an update on what the Department will be funding. Sherry's present activities of the Children's Committee has as well.

Ron Welch, Director of the Office of Adult Mental Health Services and Joan Smyrski, Director of Children's Behavior available to the Council throughout the year and provide input and updates on a regular basis, either in person or via their staff.

The Council is very pleased with this year's Review. We have worked hard to create an environment at our meetings for open communication and intend to continue our work in establishing protocols and priorities for receiving information from the Department.

The State of Maine continues to face a devastating budget shortfall that will have a deep and lasting impacts on its citizens. As the State faces these extreme and troubling fiscal times, the Council will continue to monitor, review, and evaluate the allocation and adequacy of mental health services with the State.

Sincerely,

Monica J. Elwell, Chair
Statewide Quality Improvement Council
C/o Advocacy Initiative Network of Maine
PO Box 878
Bangor, Maine 04402

CC: Mary Mayhew, Commissioner, DHHS

Joan Smyrski, Director of Children's Behavior
Guy Cousins, Interim Director of Adult Mental Health Services

Sherry Langway, Children's Services State
Sheldon Wheeler, Mental Health Planner, DHH/OAMHS

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

N/A