

Bates vs. DHHS Consent Decree Quarterly Report: August 1, 2008

Part 1: Systems Development

Of the 119 components to the system development portion of the Consent Decree Plan of October 2006, 102 have been accomplished and are no longer reported. The remaining 17 components are reported below. This number includes, per request of the Plaintiffs, reporting on 2 components (numbers 70 and 116) that OAMHS had previously designated as complete.

With this quarterly report, OAMHS deleted past reporting on components that was no longer needed to understand the current status of the component, leaving only the most current, salient reporting.

COMPONENT of Consent Decree Plan	PAGE	DUE DATE	ACTION Note: This is a cumulative report. Each action is listed by the filing date of the quarterly report. Only new attachments are included.	COMPLETED YES (X)
CHAPTER 4 – CONTINUITY OF CARE AND SERVICES				
Realignment of Services				
14. Complete contract with community hospitals with involuntary psychiatric inpatient beds	27	November 2006	<p><u>May 2008:</u> The community hospitals which were originally identified for contracts were the following: The Aroostook Medical Center (TAMC), PenBay Hospital, MidCoast Hospital, MaineGeneral Hospitals, St. Mary’s Hospital, Spring Harbor and Southern Maine Medical Center. TAMC closed its unit and the OAMHS has finalized contracts with all of the other initially identified hospitals. Subsequently P6 at Maine Medical Center was identified as accepting a very small number of involuntary admissions. OAMHS has spoken with Maine Medical Center staff and has sent a draft contract, which the hospital is reviewing through its legal staff and management.</p> <p><u>August 2008:</u> OAMHS continues to work towards obtaining a contract from Maine Medical Center P6. OAMHS has received a commitment to complete the contract by September 1, 2008</p>	

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Performance Requirements				
31. Amend MaineCare provider agreements for psychologists re: communication and info access	30		<p><u>May 2008:</u> This issue is being addressed as part of the legislative mandate to combine outpatient services into one MaineCare Section. Outpatient psychologists in private practice would then need to contract with DHHS/OAMHS in order to bill MaineCare. OAMHS contracts contain language requiring communication about the ISP and coverage and access to information after office hours.</p> <p><u>August 2008:</u> MaineCare Sections 58, 65, 100 and 111 were combined into a new MaineCare Section 65 and issued as an emergency rule as of August 1, 2008. It was decided that psychologists and private practitioners (now covered by this rule) would complete provider agreements with OMS in order to bill MaineCare and would not need to contract with DHHS.</p> <p>The following language will be included as a rider in provider agreements executed with new providers enrolling with MaineCare after 8/1/08 and included in any revisions to the provider agreement in effect at the time that all existing providers need to re-enroll.</p> <p><i>Independent Practitioners providing Behavioral Health Services pursuant to MaineCare Benefits Manual, Section 65, must comply with the following additional requirements:</i></p> <ol style="list-style-type: none"> <i>1. If the Independent Practitioner is using a crisis provider for after-hours coverage, the Independent Practitioner must have in place an explicit written agreement for after-hours coverage with the local crisis provider.</i> <i>2. The Independent Practitioner will discuss with the member sharing information with other providers of care in order to assure continuity of care, and the Independent Practitioner</i> 	August 2008

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			<p><i>will obtain authorization from the member as necessary.</i></p> <p>3. The Independent Practitioner will participate in treatment planning with other providers as requested.</p>	
Flexible Services and Housing				
34. Realign contracts to reflect realigned system	33	July 2007	<p><u>May 2008:</u> In last quarter's report, OAMHS reported (under Component #33) its intent to implement the final phase of the realignment plan submitted with the August 2007 quarterly report. This final phase called for separating the provision of support services from the physical housing units for all scattered site apartment PNMI's, through the SFY 09 contracts. As a result of a number of events outside of the control of DHHS, OAMHS has determined that it is premature to proceed with a major change in the residential service delivery on July 1, 2008.</p> <p>The most significant event is the proposed implementation of federal Medicaid rule changes related to case management and the rehabilitation option. There are a number of ways in which these rule changes would affect PNMI services, but there remain significant unanswered questions about the substance of the rule amendments and implementation requirements. Actions pending in Congress and in Federal Court may affect the content of the rules and timing of these changes. With this uncertainty, OAMHS believes that implementing phase 3 of the realignment plan at this time risks significant and repeated disruption of the mental health delivery system.</p> <p>Additionally, OAMHS has seen a number of providers in Region 1 and 3 drop both daily living support services and skills development citing a lack of referrals and the current rates. Ensuring the availability of these serves is critical for the success of the realignment, but until</p>	

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			<p>the issues in the federal rule changes are resolved providers are reluctant to re-enter these service areas.</p> <p>Given the state’s current budget, it is unreasonable for DHHS to proceed with realignment plans without knowing what federal resources will continue to be available.</p> <p>OAMHS will continue to monitor developments at the federal level, and will keep the parties informed, so that issues related to the realignment plan can be resolved as quickly as possible.</p> <p><u>August 2008:</u> The following summarizes our current PNMI residential programs and lays out our more specific plans moving forward as a result of the factors noted in our report in May, 2008. Currently there exist two general types of PNMI residential programs supported by OAMHS:</p> <ol style="list-style-type: none"> 1. On-Site Staff 24/7 Residential Treatment Facilities (RTF) <ol style="list-style-type: none"> a. Apartments with 24/7 on-site staff b. Congregate facilities with 24/7 on-site staff 2. Off-Site Staff – Scattered Sites <p>The Plan and the Working Paper on Housing and Residential Services describes four (4) models going forward:</p> <ol style="list-style-type: none"> 1. PNMI Community Residences for Persons with Mental Illness 2. Traditional Housing and Support Services 3. Supportive Housing 4. Long Term PNMI Community Residence for Persons with Mental Illness <p>PNMI Community Residences for Persons with Mental Illness and</p>	

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			<p>Long Term PNMI Community Residences for Persons with Mental Illness are included in On-Site Staff 24/7 /RTF. Off-Site Staff – Scattered Sites represent the current PNMI's which will be “unbundled” and will become either Traditional Housing and Support Services or Supportive Housing.</p> <p>The recent Federal CMS Rehabilitation Regulations have the potential of causing significant change to all PNMI's. The Federal CMS Regulations related to Case Management suggest significant change to the MaineCare community integration service which is the backbone to the Adult Mental Health System. At this time the OAMHS is proceeding as follows:</p> <ol style="list-style-type: none"> 1. Continue to work in the direction of unbundling the scattered site PNMI's by: <ol style="list-style-type: none"> a. Identifying and defining, by September 30, 2008, the service elements currently provided by community support workers as required under the consent decree and identified in MaineCare Section 17 which are not case management as defined by the CMS Case Management Regulation b. Refining the definition of daily living supports to be consistent with the proposed CMS Rehabilitation Regulation by September 30, 2008. c. Refining the definition of skills development services to be consistent with the proposed CMS Rehabilitation Regulation by September 30, 2008 d. Creating appropriate service type(s) that reflect those service elements currently provided by community support workers and which are not case management under the CMS Rehabilitation Regulation and fit the 	

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			<p>parameters of the CMS Rehabilitation Regulations.</p> <ul style="list-style-type: none"> e. Exploring personal care option for some of Section 17 services for individuals with psychiatric disabilities to assure that all services necessary to maintain community residence are available and that all services currently bundled into PNMI's can continue; and f. Reviewing crisis in-home services in MaineCare Section 65 that could be delivered as short term DLS or Skills Development <p>2. Continue operation of non scattered site PNMI's and refine the impact of the CMS Rehabilitation Regulation by:</p> <ul style="list-style-type: none"> a. Examining the amount of time spent on rehabilitation which is currently defined in personal care in the MaineCare Section 97 rules; and b. Identifying within this group of PNMI's those that fit the model of PNMI Community Residences for Persons with Mental Illness and those that fit the model of Long Term PNMI Community Residence for Persons with Mental Illness by September 30, 2008 and providing the lists of these PNMI's to the plaintiffs 	
Peer Services				
49. Begin implementation of consumer participation in licensing	35	April. 2007	<p><u>Feb. 2008:</u> At a 12/5/07 meeting with the Court Master and Plaintiffs' counsel, the Court Master agreed that it would be appropriate for the Department to present ideas for alternative ways of involving consumers in the evaluation of provider agencies' performance to the Consumer Council, and for the Council to assist in shaping of a future amendment request for this component. He approved a delay in implementation of this component to allow OAMHS to present its proposal to the Consumer Council and solicit input about methods for</p>	

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			<p>including meaningful consumer involvement as part of the quality improvement process.</p> <p>OAMHS has asked the Consumer Council System of Maine to identify participants for a workgroup to help develop a plan for involving consumers in quality improvement and the evaluation of a recovery oriented system of care. Individuals have expressed interest in participating, and the Council is expected to name the members at its upcoming February meeting. OAMHS will provide information and education for group members about types of evaluations and reviews, methods of evaluations, the difference between individual, program and system outcomes and reviews, etc. so that they can make informed recommendations. OAMHS anticipates that it will take 3-4 meetings of the workgroup (e.g., between February and May 2008) to develop recommendations that could form the basis for a Plan amendment request.</p> <p><u>May 2008:</u> The Statewide Consumer Council (SCC) has not yet named consumer representatives to participate in this work group. If SCC does not identify representatives, OAMHS will use other means to ensure that there are consumer representatives participating. As soon as the work group's proposal is ready, DHHS will seek an amendment to this plan component, including new time frames for implementation.</p> <p><u>August 2008:</u> The Statewide Consumer Council has submitted names of consumer representatives to participate in the Outcomes Workgroup. This Outcomes Workgroup will be a part of OMHS continuing work to measure the success and quality of care in the public mental health system. The workgroup will be comprised of</p>	

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			<p>consumers, providers, OAMHS and OQIS representatives. This group will engage in reviewing and selecting adult mental health behavioral/functional outcome tools. These outcome tools become the first steps in an effective outcome measurement system and will be used to:</p> <ul style="list-style-type: none"> • Guide and inform adult mental health services planning and decision-making including the appropriate level and intensity of services that may be needed; • Measure and document agency progress in identified functional outcome and strength areas; • Measure and document aggregated individual progress in identified functional outcomes and areas of strength; • Guide and inform caseload supervision and resource planning activities; • Evaluate the effectiveness of services and supports provided; and • Guide statewide services system planning and implementation. <p>The first meeting of the stakeholder group will be August 26th. The Outcomes Stakeholder group will also recommend an implementation plan which will include means for involving consumers in assisting in the administration of selected tool(s). The representatives from the Statewide Consumer Council will seek additional feedback from the CCSM during this process. Implementation of the selected tools is projected for December 2008.</p>	

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50. Provide training in spring 2007	35	Spring 2007	<u>August 2007, Nov. 2007, Feb. 2008, May 2008:</u> See Component # 49. <u>August 2008:</u> See Component #49	
51. Begin consumer participation in licensing reviews	35	June 2007	<u>August 2007, Nov. 2007, Feb. 2008, May 2008:</u> See Component # 49. <u>August 2008:</u> See Component #49	
Persons Experiencing Psychiatric Crises				
62. Issue contracts to increase number or crisis beds/staff	37	January 2007	<u>August 2008:</u> Tri-County Mental Health opened its six bed facility in May and is fully operational. OAMHS accepted the Mid-Coast Mental Health proposal for a 3 bed facility using the existing facility. OAMHS reviewed and made suggested changes to the conceptual renovation plan. A target date of September 1, 2008 was established by Mid-Coast for completion of the renovation. OAMHS expects to receive actual renovation plans to review during the first week of August. Mid-Coast has identified a contractor who will be able to complete the work during August once Mid-Coast has OAMHS approval. The target date remains as September.	
64. Create 4 observation beds in 2007	38	SFY 07	<u>Feb. 2008:</u> As DHHS/OAMHS has determined that observation beds are not financially feasible in rural, non-psychiatric hospitals (see component # 63), the Department intends to submit a request for a plan amendment related to this component and component 65 below. <u>May 2008:</u> Plan amendment request is being developed.	

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			August 2008: Amendment request submitted to court master on July 21, 2008 to delete this component and component #65 below.	
65. Evaluate utilization and effectiveness of observation beds one year after beds become available	38	SFY 08		
68. Thru CSNs, create agreements to assure all community hospitals have access to psychiatric consultation via telemedicine	39		<p><u>May 2008:</u> The New England Tele-Health Consortium, developed by ProInfoNet of Bangor and recently awarded a \$25 million Federal Communications Commission rural health care grant, has launched its effort to build a multi-state tele-health network. This network will link rural hospitals, behavioral health sites and community health care centers in Maine, Vermont and New Hampshire to urban hospitals and universities throughout New England. The consortium is close to finalizing its list of sites, which includes all but five hospitals in Maine and over 500 medical clinics in Maine, Vermont and New Hampshire.</p> <p>Dr. Stevan Gressitt, M.D., Medical Director of OAMHS, is currently negotiating a contract with the Maine Association of Psychiatric Physicians that would make psychiatric consultation available to primary care physicians throughout the state of Maine. “The Consultation Project”, developed by the Maine Association of Psychiatric Physicians (MAPP) in collaboration with the Maine Academy of Family Physicians in 2004, links volunteer psychiatrists with rural primary care practices. Financial support from DHHS will allow the project to expand statewide and will also allow for wider publicity of the project.</p> <p>Spring Harbor Hospital has submitted a USDA grant proposal that would bring tele-psychiatry to the Emergency Departments of</p>	

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			<p>Stephens, Miles and St. Andrews Hospitals and outpatient tele-psychiatry to family healthcare centers at Miles and St. Andrews Hospitals. Psychiatrists from Spring Harbor Hospital and Maine Medical Center would provide Emergency Department and Outpatient services; as well as a Nurse Practitioner providing additional Outpatient services.</p> <p>DHHS believes that these efforts meet the objectives of this plan component, and on this basis will be seeking a plan amendment.</p> <p><u>August 2008:</u> Amendment request submitted to the court master on July 18, 2007 to delete this task and amend the task to read: Execute a psychiatric consultation contract between Maine Association of Psychiatric Physicians (MAPP) and OAMHS by September 2008.</p>	
70. Provide site and web based training and info on blue papers, CD , etc	39	December 2006	<p><u>Nov. 06:</u> Some material is on the OAMHS web site and more updates including Frequently Asked Questions will be added in November and December.</p> <p><u>Feb. 07:</u> The draft of the FAQs is done and has been distributed to the mental health team for review.</p> <p><u>May 2007:</u> The material for emergency departments is posted on the OAMHS website and is being publicized through the CSNs and the MHA Mental Health Council.</p> <p><u>August 2008:</u> OAMHS agreed with the Plaintiffs to continue reporting on this component as ‘site based training’ was inadvertently missed as part of the component.</p>	X April 2007

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			<p>The feedback OAMHS received from the ED staff participating in the ED training stakeholder group as well as the MHA indicated that site bases training is not feasible due to emergency department staffing patterns and that web-based training was their preferred method to make the training available to all ED staff. OAMHS will be seeking a plan amendment to delete ‘site based training’ from this component.</p>	
73. Involve consumers in training for EDs to increase non traumatic transportation options	39		<p><u>May 2008:</u> A stakeholder workgroup comprised of consumer representatives, Emergency Department staff, Maine Hospital Association Mental Health Council members, hospital staff and crisis program representatives met in April to review and discuss the consultant’s report and draft learning objectives for the training. This group recommended priorities for learning objectives and identified desired training delivery methods. The learning objectives and information from the research are being used to draft training material. A subgroup of stakeholder group members will participate in a review and editing process. OAMHS is developing a contract with JMPA (Justice Planning and Management Associates, training consulting firm) to shape the training content into a web-based training to be completed by September 2008.</p> <p>OAMHS received comments about the consultant’s report from plaintiff’s counsel on April 30. These will be forwarded to the stakeholder group for consideration.</p> <p><u>August 2008:</u> The stakeholder group received Plaintiffs’ comments but did not provide any feedback. OAMHS has contracted with JPMH (Justice Planning and Management</p>	

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			Associates) for the technological development of the web-based training. Work continues with the stakeholder group, ED staff and consumers to refine the content of the training. Work is also underway to ensure that CMEs, CEUs and other continuing education credits are available for participation in the web-based training.	
80. Develop residential mental health services for persons with complex health needs	41	February 2007	<p><u>Nov. 2007:</u> The amendment request was submitted 10/7/07 and denied on October 25, 2007. OAMHS is considering next steps.</p> <p><u>Feb. 2008:</u> As agreed to in a meeting with the Court Master and plaintiffs' counsel on December 5, 2007, OAMHS is creating a list of consumers that have been placed from Riverview in the last year whose planning for placement was as described above (May 2007) and in the amendment. This information will provide the basis for further discussions among the parties and the Court Master.</p> <p><u>May 2008:</u> The list of consumers was provided to plaintiff's counsel on April 30, 2008, with a copy to the court master.</p> <p><u>August 2008:</u> No further activity on this component occurred in the last quarter. In the coming quarter, OAMHS will seek a meeting with the Court Master to discuss the individuals on the list provided.</p>	
82. Collaborate with MHA,ED Physicians, MSNA to provide training to lessen trauma in ED	42	SFY 2007	<p><u>August 2007, Nov. 2007, Feb. 2008, May 2008:</u> See Component #73.</p> <p><u>August 2008:</u> See Component #73</p>	

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Vocational Opportunities				
88.Update the MOA between OAMHS and BRS Expanded reporting per 3/16/07 letter to the Court Master	44	October 2006 MOA Ongoing	<p><u>May 2008, Task 2:</u> Review qualitative and quantitative data and other sources to determine the array of employment services needed, the resources currently available, and solutions to obstacles.</p> <p>A draft report of data from multiple sources was circulated to workgroup members in February. The Workgroup members felt that the draft needed additional work, particularly in making comparisons and recommendations utilizing data from different data sources. OAMHS is redrafting the report on the data to be re-circulated to the Work Group. OAMHS will move the effort to review resources currently available and solutions to obstacles to the newly forming Employment Services Networks which are being managed through the Maine Medical Center employment contract.</p> <p><u>August 2008:</u> Employment Service Networks (ESNs) have been formed in all CSNs. ESNs will be meeting monthly. Six of the 7 ESNs met in June and July. The ESN in CSN 4 has not met yet.</p>	<p>X November 2006 MOA signed</p> <p>January 2008: expanded reporting completed Tasks 1, 3, and 4</p>
CHAPTER 6 - ASSURING QUALITY SERVICES				
107. Demonstrate the ability of EIS to produce timely and accurate data	56		<p><u>Feb. 2008:</u> OAMHS continues to send monthly reports to providers about enrollments and the RDS to assure that both are up to date and do not contain duplicate clients. This monthly quality assurance process has helped develop relationships and greater responsiveness from providers, and consequently improvements in the data. The data has been cleaned for duplicates and EIS will shortly be implementing a new feature to allow only one open enrollment per client. This system change was not possible until the data had been cleaned of duplicates.</p>	

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			<p>Staff skills in using COGNOS continue to improve and OAMHS is both developing and using reports from COGNOS.</p> <p><u>May 2008:</u> The EIS now allows only one open enrollment per client. It also notifies agencies when a request is made to open a new enrollment for a client who is already enrolled in another agency. OAMHS sent a directive to all provider agencies requiring that their enrollments and RDS information be current and with no more than 15% overdue as of May 15th. OAMHS informed agencies that failure to meet the 15% standard would constitute non-compliance with their contracts and trigger enforcement actions. EIS activity suggests that providers are taking this directive seriously. Once the enrollments and RDS information are current, the transition to APS Healthcare for collection of this data will begin. The system design work and testing is in process and the transition is expected to be complete by the end of July.</p> <p>Unmet needs reports are being generated quarterly by CSN, as well as statewide. The reports for the second quarter were distributed to CSNs in March and April, and the third quarter will be distributed in June for discussion. See attached <i>March 25, 2008 CSN 5 Data Package</i>, for a sample of the data reports that have been presented to all CSNs and will be distributed on an ongoing basis.</p> <p><u>August 2008:</u> The second, third, and fourth quarter unmet needs reports will be reviewed for accuracy, among other reasons, at the August CSN meetings. The CSNs will be using these reports as part of the budget discussion scheduled for the September meetings.</p>	

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			<p>In the May 2008 narrative, OAMHS reported that providers were directed to bring enrollments and RDSs to be no more than 15% overdue by May 15th. Providers were diligent in their efforts to meet this performance requirement and enrollments were at 12% overdue, while RDSs were at 30% by the May 15th date. Any provider who failed to meet the standard received notice of that failure and contract noncompliance. OAMHS continued weekly monitoring and discussion with agencies. As of June 30, enrollments were at 5% overdue and RDSs were at 8%.</p> <p>OAMHS and APS Healthcare are preparing to move the enrollment and RDS reporting form OAMHS/EIS to be part of the prior authorization and continued stay review done by APS. Testing revealed some data issues that needed to be addressed so full implementation has been pushed from July to early September.</p>	
116. Licensing reviews of AMH agencies are current	60	Ongoing	<p><u>August 2008:</u> Reporting on this component continued for this quarter per plaintiffs' request.</p> <p>The Division of Licensing and Regulatory Services (DLRS) reports that out of 117 licensed mental health agencies, 14 licenses are not current. Of these, 11 have been reviewed but are not yet licensed and 3 have re-applied but are not yet reviewed. Of the 3 not yet reviewed, all three were scheduled to be completed by the end of August. The medical leave of one of the reviewers will cause one agency to be re-scheduled.</p>	X April 2008