Department of Health and Human Services
Maine People Living
Safe, Healthy and Productive Lives

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Department of Health and Human Services
Substance Abuse and Mental Health Services
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November 1, 2017

Daniel E. Wathen, Esq.
Pierce Atwood, LLP
77 Winthrop Street
Augusta, ME 04330

RE: Bates v. DHHS – Quarterly Progress Report for Fiscal Year 2017, Quarter 3

Dear Justice Wathen:

Enclosed, pursuant to paragraph 280 of the Settlement Agreement, please find the Substance Abuse and Mental Health Services Quarterly Progress Report for the quarter ending March 31, 2017 (FY17 Q3). This report reflects recent orders eliminating and consolidating performance standards. It also represents a re-design of the legacy reporting format to enhance consistency of presentation and documentation of compliance.

SAMHS coordinated a data integrity audit, which delayed production of this report but allowed us to include some additional information, such as the Adult Mental Health and Well Being Survey, which became available after the FY17 Q3 period being reported.

Within this report are Performance Standards under review by Counsel and Plaintiff for future reporting.

If you have any comments or concerns about the contents contained herein, we would be pleased to meet with you to discuss them.

Sincerely,

Sheldon Wheeler
Director
Office of Substance Abuse and Mental Health Services

cc: Ricker Hamilton, Commissioner, Department of Health and Human Services
Scott Lever Esq., Deputy Commissioner, Department of Health and Human Services
Phyllis Gardiner Esq., Assistant Attorney General, Office of the Attorney General
Kevin Voyvodich, Esq., Disability Rights Maine

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Substance Abuse and Adult Mental Health Services Quarterly Progress Report

Quarter Ending:
March 31, 2017

Table of Contents

SECTION ONE

Executive Summary

In 2006, the Maine Department of Health and Human Services adopted a Consent Decree Plan, approved by the Court Master, which articulates specific actions and timelines for meeting the Settlement Agreement requirements. This quarterly progress report is required by the Consent Decree Plan and paragraph 280 of the Settlement Agreement in *Bates v. DHHS*.

The Office of Substance Abuse and Mental Health Services (SAMHS) is continually improving its products and services to provide continuity of care, services close to home, as well as an array of services available in a timely manner.

SAMHS continues to focus on systemic improvement, unmet needs evaluation, and quality management improvements. The following initiatives are underway this quarter:

- Review and redevelop the current quarterly progress report to determine its effectiveness to inform key stakeholders of the Department's progress toward meeting the Consent Decree performance standards in addition to developing sustainable processes for quality and system improvement beyond the time of the Consent Decree. This review was conducted by SAMHS leadership with input from legal counsel on this case.
- The Division of Contracts Management and SAMHS are finalizing a contract development and management program. SAMHS is the division piloting this effort and upon completion will roll out the model to other DHHS divisions. This initiative encompasses the following:
  - Using templates for contracts of like kind will decrease the time to process contracts by up to 83% and ensure all requirements are consistent;
  - Amend all direct service contracts to include performance measures to track recidivism, timely access to services, employment and housing goals;
  - Create standard operating procedures for contract development and contract management;
  - Create a quarterly contract management process which addresses the "total" contract to include all deliverables, performance measures, financial indicators, required reports, waitlist data, critical incidents, and grievances associated with contracted providers;
  - Implement a corrective action process for non-compliant contracts; and
  - Create a snapshot of contract performance by agreement, provider, service group and eventually districts to be used to address unmet needs.
- Standard Operating Procedures (SOP's) have been developed within SAMHS for the Rights of Recipients Grievance Investigation process and the legislative bill tracking process.
- In April, SAMHS filled the Utilization Review Nurse position, which will focus on the Residential Treatment portfolio.

The following projects will be initiated in the next quarter (FY17 Q4):

- Develop/review processes for the invoicing, quarterly contract review, social service program manager review to ensure quality of contract management and determine unmet needs, site performance visits and annual contract performance reviews.
- Improve the timely response to critical incidents and develop criteria for reviewing data with providers.
- Training (4) Project Managers to develop protocols for all job functions to ensure annual focus on Consent Decree, Departmental, and Division goals, consistency and quality of all tasks, and continuity of services as

staffing changes. This training will occur in conjunction with SAMHS designated projects and processes as follows:

- Retooling the SAMHS Quality Management Plan to better measure the effectiveness and impact of the programs and services provided by SAMHS. This plan will collect and report SAMHS analysis of data to be distributed in final form to key stakeholders in a professional and consistent manner. It will incorporate the development and review of a strategic plan for SAMHS. It also will reflect the monthly and quarterly review of waitlists and contract data used to determine and respond to unmet needs.
- Developing a standardized system to apply for, manage, and track federal grant requirements to ensure quality performance and timely provision of services and reporting.
- Initiating a resource development project to assist leadership to develop standard operating procedures for all job functions, determine the allocation of human resources, and ensure the continuity of services as employees enter and exit employment with SAMHS.

On another note, included in this report are the results of the Adult Mental Health and Well Being Survey received on May 28, 2017 from the Lewin Group. The Lewin Group made the following observations:

- Differing survey methodologies may explain some of the changes observed between 2015 and 2017.
  - The 2015 process included providers as a main avenue of survey distribution. This methodology can imply observation which may result in a biased response, even on anonymous surveys.
  - Providers are potentially more likely to distribute surveys selectively to consumers who may have a more positive view of the services received. A phone survey features random selections.
  - In general, paper surveys feature lower inter-item variability in response. People are more likely to fill in the same answer as they go down an entire column of responses.
  - Methodological difference may explain some variation, but it will be important to continue to observe results in future survey cycles. SAMHS will continue with this methodology to maintain consistency and reduce structural bias.

Any feedback on the redesign of this report is greatly appreciated. Please send comments and suggestions to the SAMHS Quality Manager @ Michele.king@maine.gov.

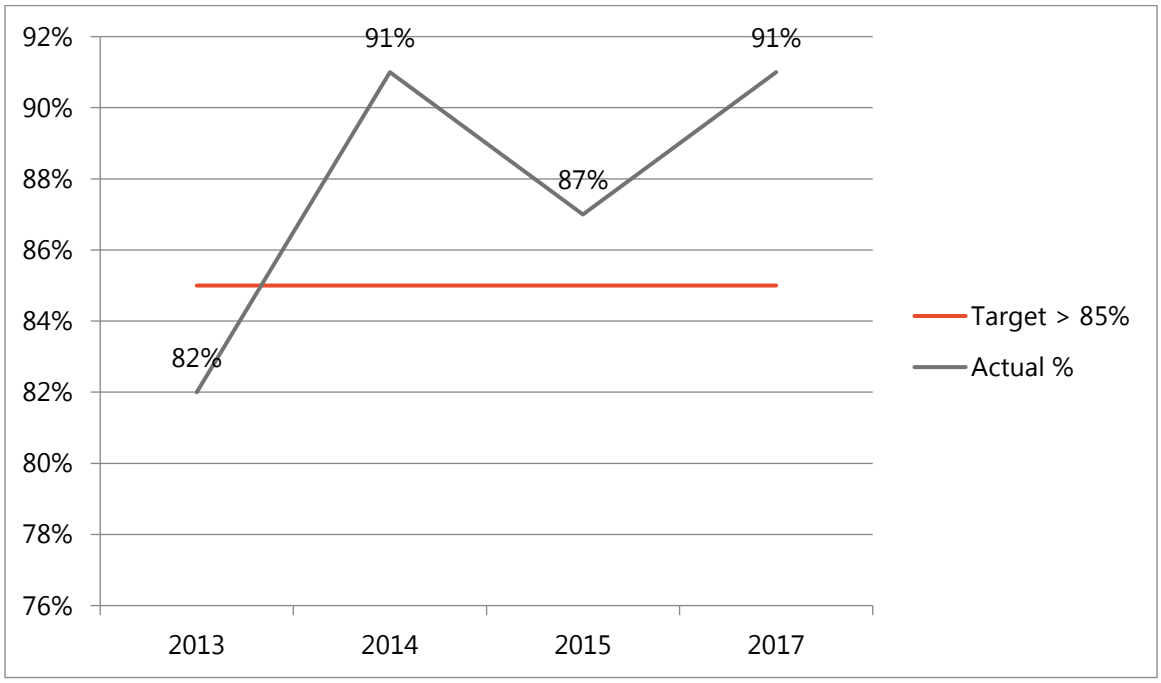
SECTION TWO

Rights, Dignity, and Respect

Standards One - Four

Performance Standard 1

Consumers report being treated with respect for their individuality.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

In previous surveys, this chart captured the "domain average of positive responses to the statements in the quality and appropriateness domain". The performance standard was modified to capture only one aspect of the previous performance standards.

See Executive Summary for explanation of survey methodology.

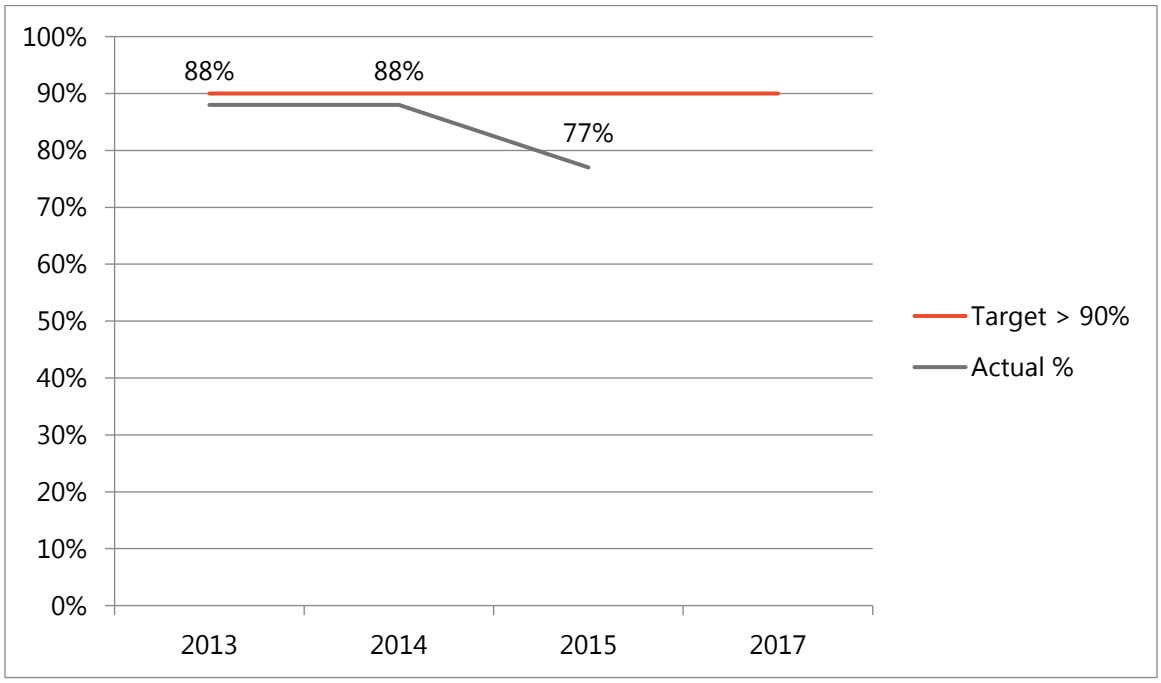
Strategies to Effect Change

In compliance, continue to monitor.

Methodological difference may explain some variation, but it will be important to continue to observe results in future survey cycles.

Performance Standard 4.2

Consumers report they have been given information about their rights.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

This measurement was inadvertently omitted from the 2017 Adult Mental Health and Well Being Survey contract.

Chart reviews indicate providers are giving information about their Rights and this is acknowledged by signature by consumers.

Strategies to Effect Change

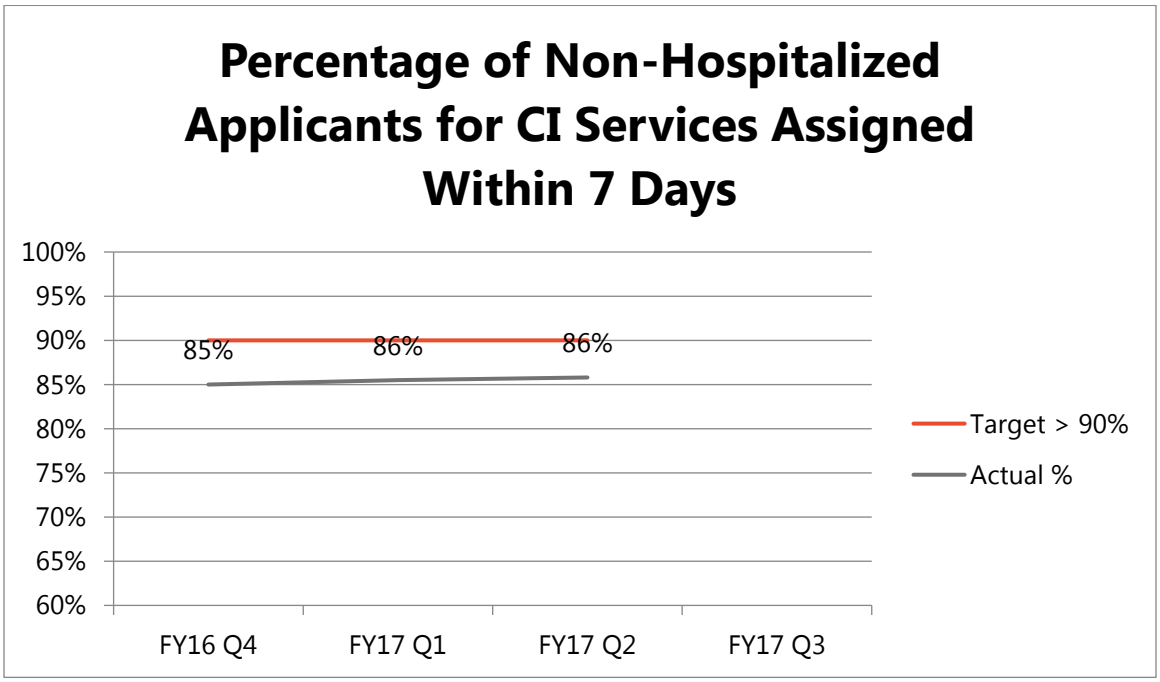
Incorporate into 2018 Adult Mental Health and Well Being Survey contract.

Community Integration, Community Support Services, and Individualized Support Planning

Standards Five - Eleven

Performance Standard 5.2-4

Percentage of Class Members who received an initial face-to-face intake or initial assessment visit by a Community Integration Provider within seven (7) calendar days of referral, regardless of source of referral.



Data Source: Kepro and DHHS Adult System Goals Measures Quarterly Report

Data Analysis

The proposed standard, "Percentage of Class Members who received an initial face-to-face intake or initial assessment visit by a Community Integration Provider within seven (7) calendar days of referral, regardless of source of referral. as stated above", is a compilation of previous performance standards 5.2, 5.3, and 5.4. As such, this data was not previously captured in this form.

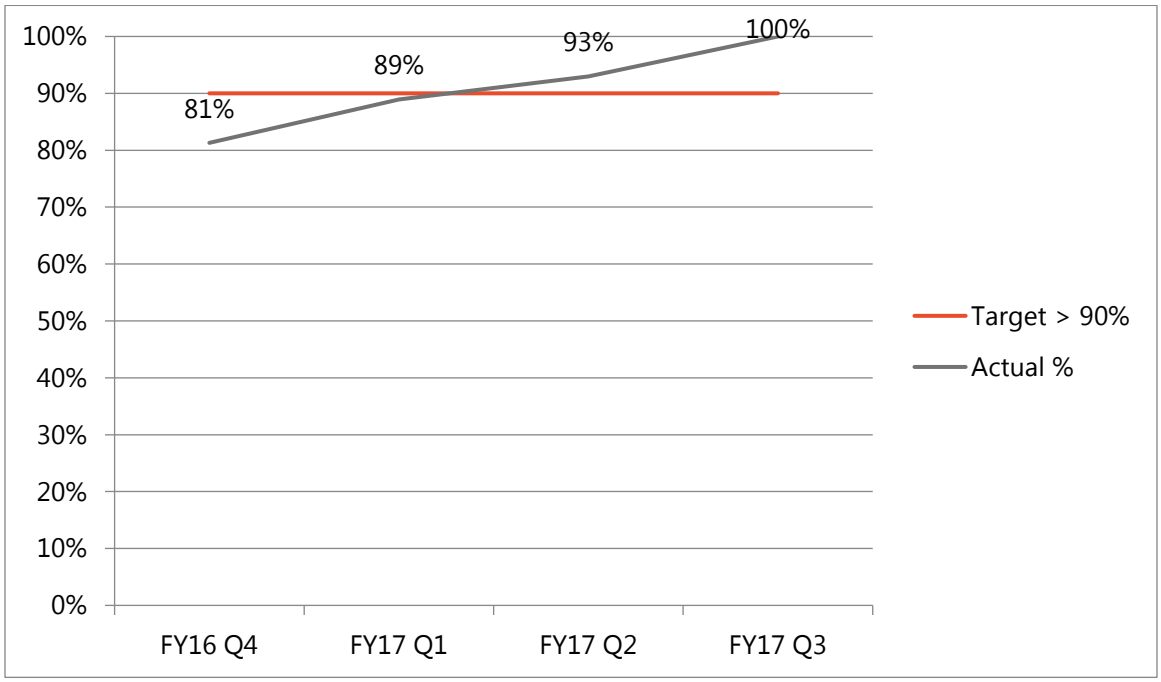
If we continue this performance standard as written, data will not be available until after 10/31/17, when Kepro expects to complete the development of a new report. In the meantime, SAMHS offers the data shown in the chart above, which is used to determine unmet needs for these services via our waitlist reporting.

Strategies to Effect Change

The Department proposes changing the standard to reflect the chart above, which represents our waitlist reporting for Community Integration Services which is reviewed monthly for each contract. The Department proposes to set the performance standard at 90%. Both proposals will need to be discussed with the Court Master.

Performance Standard 5.5

Percentage of Class Members who have their initial Individual Service Plan completed within thirty (30) days of enrollment date.



Data Source: Individual Service Plan Resource Data Summary

Data Analysis

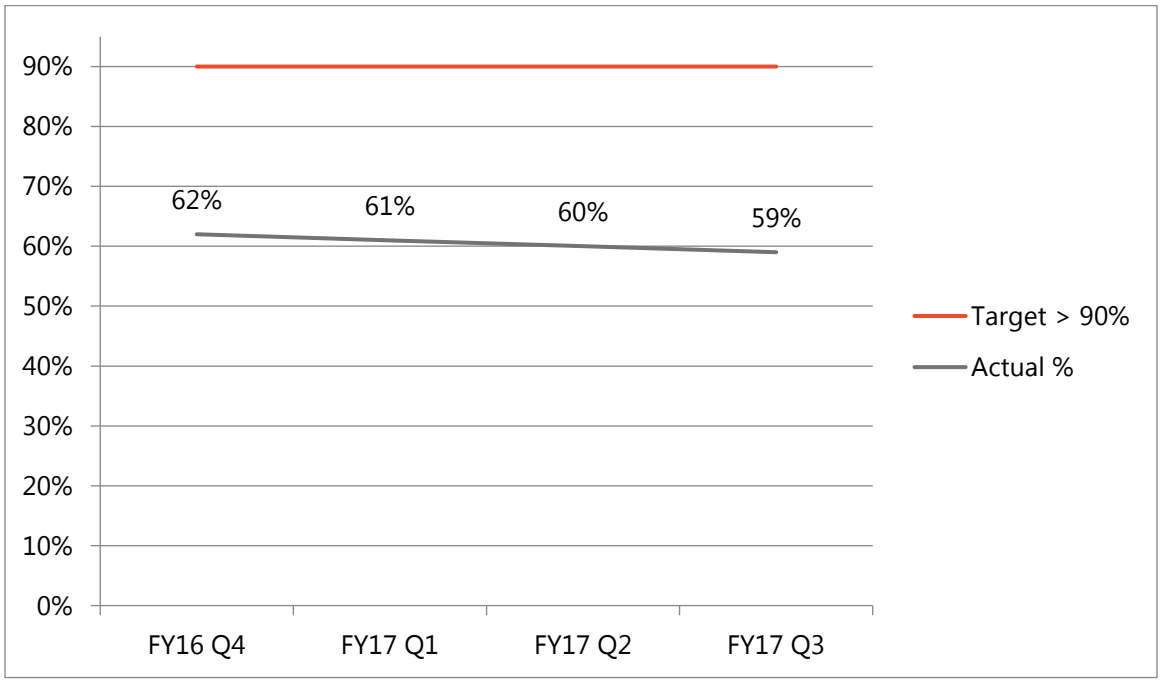
7 out of 7 new Class Members had their ISP within 30 days in Q3.

Strategies to Effect Change

In compliance; continue to monitor.

Performance Standard 5.6

90% of Class members have a ninety (90) day Individual Service Plan review completed within that time period.



Data Source: Individual Service Plan Resource Data Summary

Data Analysis

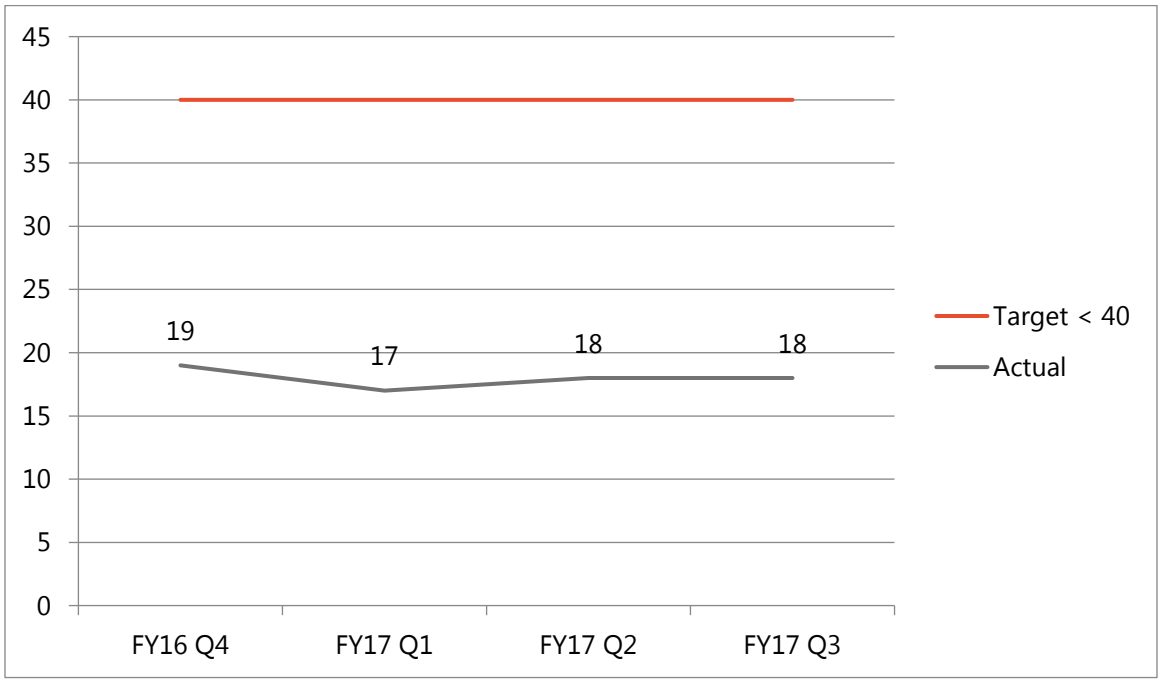
168 out of 283 Class Members had a 90-day review.

Strategies to Effect Change

Requirement is in provider contracts and enforced with new standard operating procedures for contract compliance for all recipients of mental health services.

Performance Standard 10.2

Community Integration providers with average caseloads of 1:40.



Data Source: Agency Community Support Census/Staffing (ACSCS) Report

Data Analysis

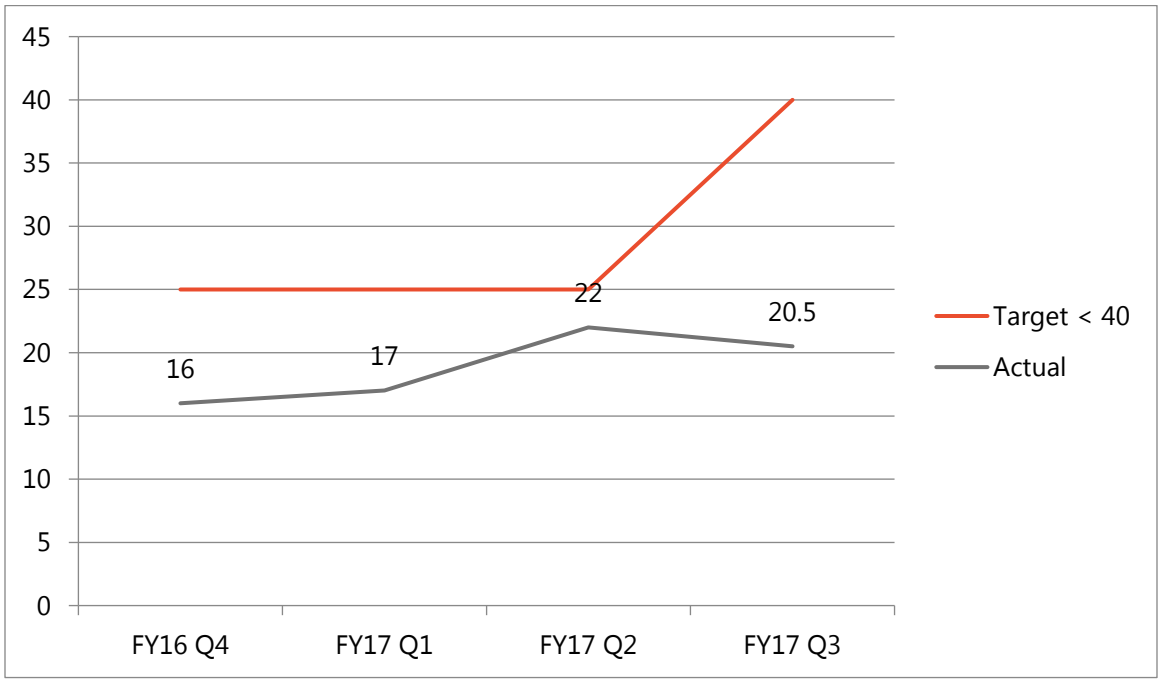
This data represents case load ratios for community CI workers. This level has been well below target for more than one year. The requirement to maintain a caseload of less than 40 is in MaineCare rule and cited in Community Integration contracts. These numbers are reported monthly and reviewed in the quarterly contract review.

Strategies to Effect Change

In compliance; continue to monitor.

Performance Standard 10.5

Office of Aging and Disability Services Case Managers with average caseloads of forty (40) or fewer.



Data Source: MAPSIS Case Counts for Workers with Class Members Public Wards

Data Analysis

The original Performance Standard was for a caseload of less than twenty-five (25) and was recorded as a percentage of those with a caseload less than twenty-five (25). This chart will now record the actual average caseload.

The target for this Performance Standard was changed from less than twenty-five (25) to less than forty (40) in 2016 to be consistent with the ratios for Community Integration Workers.

Strategies to Effect Change

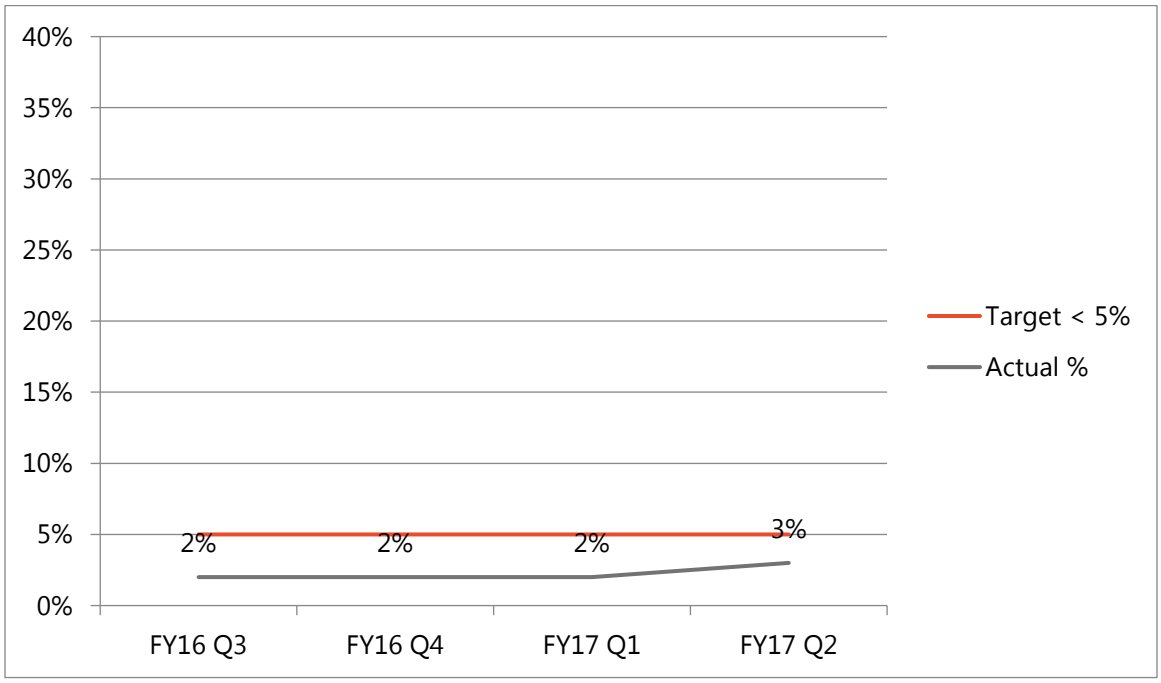
In compliance, continue to monitor.

Community Resources and Treatment Services

Standards Twelve - Fourteen

Performance Standard 12.1

Class Members with Individual Service Plans with unmet Residential Support needs.



Data Source: Individual Service Plan Resource Data Summary (data is always one quarter behind)

Data Analysis

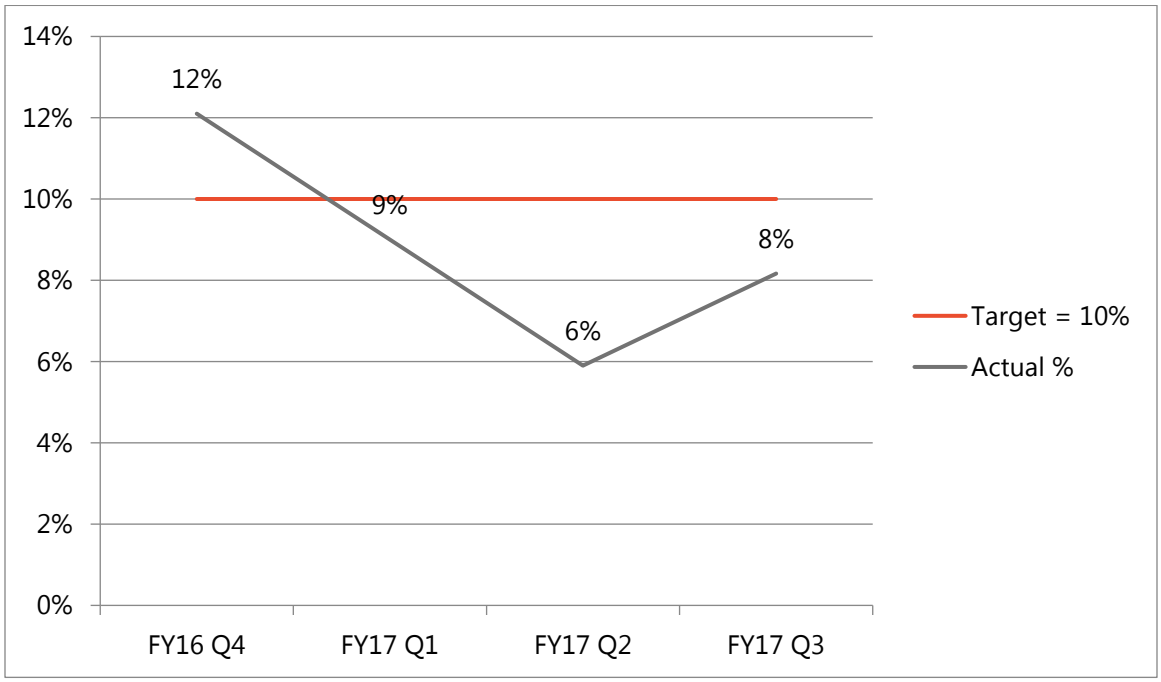
The increase is a result of a smaller population of clients. Total population in Q1 was 1,060 and Q2 was 809. Therefore, even though the number of clients with a residential need remained constant, because the population was smaller, it increased the percentage.

Strategies to Effect Change

In compliance, continue to monitor.

Performance Standard 12.2-4, 14.4-6, 21.2-4

Percentage of Class Members (excluding forensic patients) at Riverview Psychiatric Center who remained hospitalized beyond forty-four (44) days, with explanation of reason.



Data Source: Class Member Treatment Planning Review

Data Analysis

This Performance Standard was adopted in late 2016 as a substitute for previous standards 12.2 – 12.4, 14.4 – 14.6 and 21.2 – 21.4. However, no target percentage was established. The reasons given for those patients who remained hospitalized beyond the 44 days show the following:

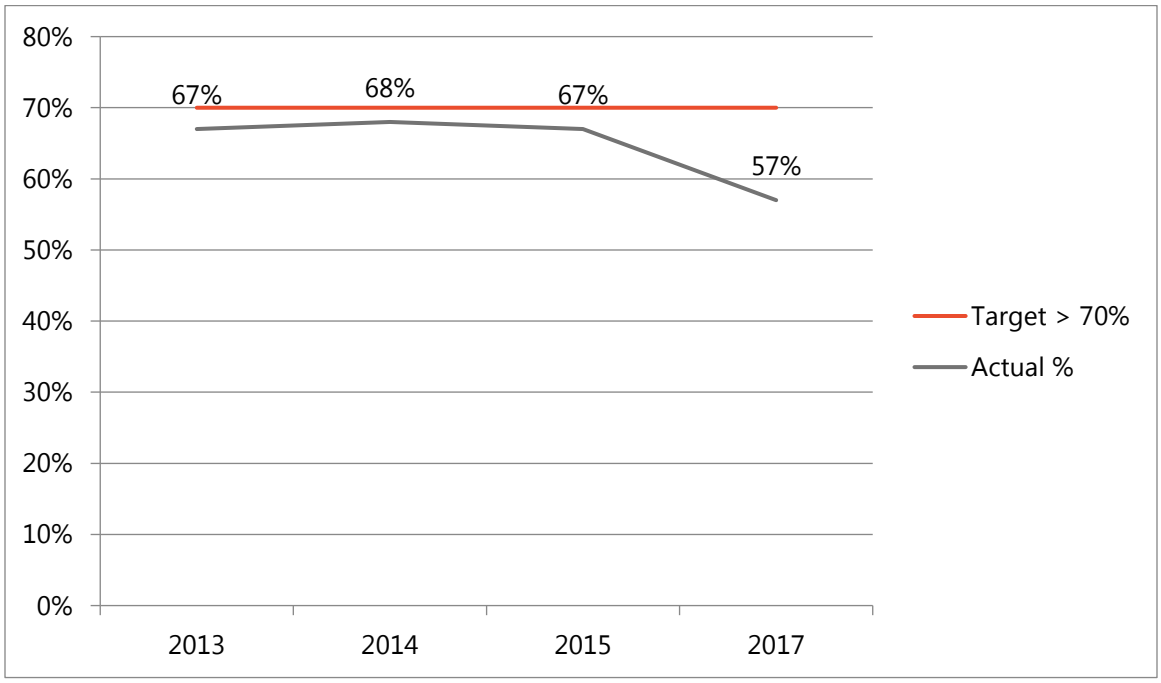
# > 44 days	Residential Supports	Housing Barriers	Treatment Barriers
FY17 Q3	0	11	0
FY17 Q2	0	6	0
FY17 Q1	0	6	1
FY16 Q4	0	7	1

Strategies to Effect Change

- SAMHS proposes a target percentage of 10% for this performance standard.
- Housing barriers are discussed in a weekly meeting with Riverview Psychiatric Center. SAMHS attendees to determine if the housing barriers are internal or external and how SAMHS can address any barriers. Analysis of the barriers to discharge and any proposed corrective actions will be included in progress reports beginning in FY18 Q2.

Performance Standard 13.1

Domain average of positive responses to the questions in the Perception of Outcomes domain.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

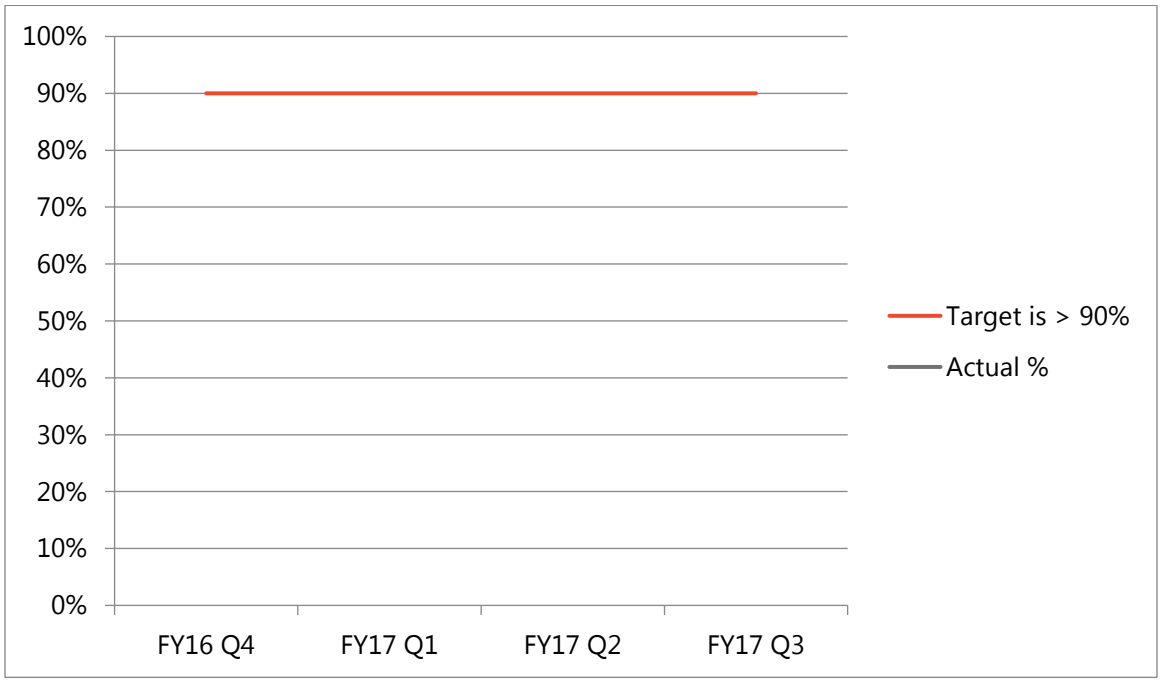
The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

Performance Standard 18.3

Community Integration and Assertive Community Treatment Workers participated in hospital treatment and discharge planning.



Data Source: Community Hospital Utilization Review Summary

Data Analysis

No data has been available since FY16 Q3 due to a vacancy in the Utilization Review Nurse position. A new Utilization Review Nurse was hired in April 2017 and data should be available in FY18 Q2 quarter.

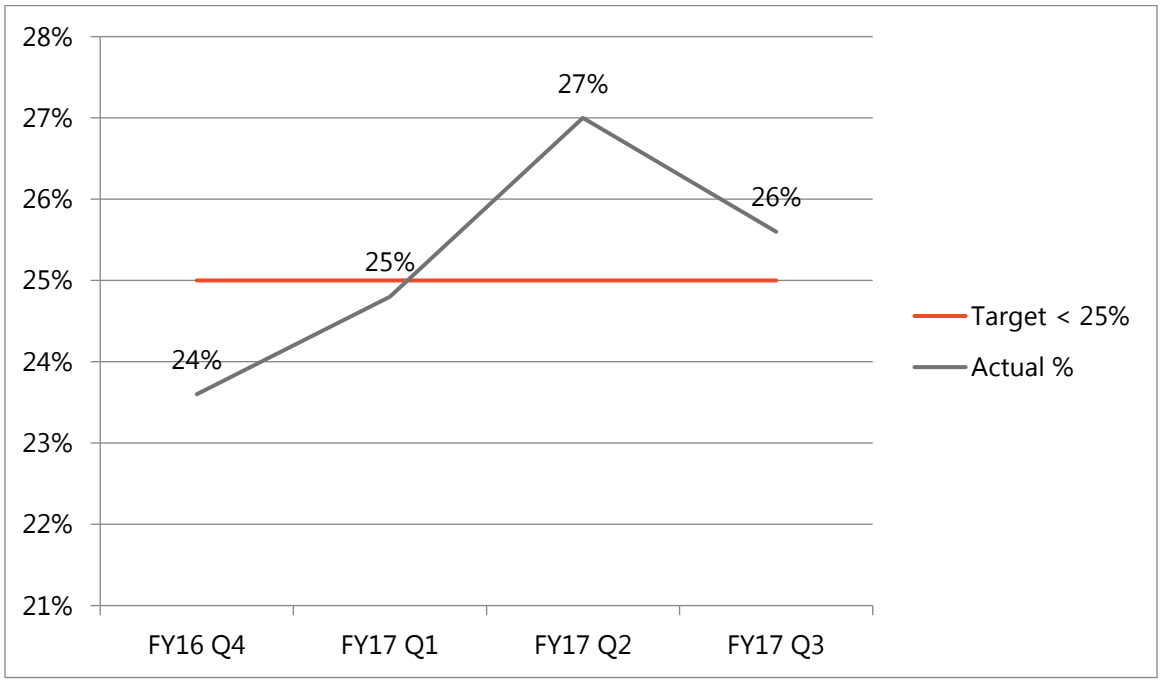
Reference to the Intensive Community Integration and Intensive Case Management positions has been removed from the standard as those positions no longer exist.

Strategies to Effect Change

SAMHS developing a job scope for the Utilization Review Nurse which will include the collection of this data. This will be complete in FY18 Q2.

Performance Standard 19.1

Face to face crisis contacts that result in hospitalization.



Data Source: Crisis Contract Performance Data

Data Analysis

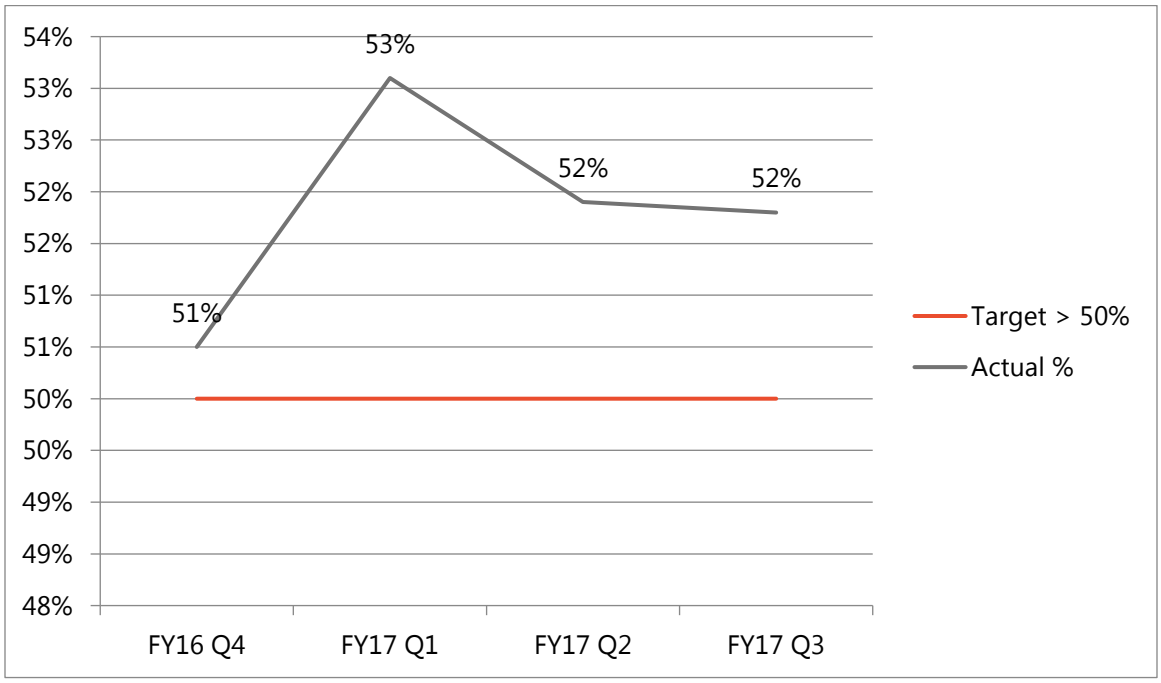
The Department is undergoing a re-design of the Crisis System through the RFP process to decrease emergency room visits and have crisis workers meet consumers where they are.

Strategies to Effect Change

New crisis contracts include performance standards to reduce inpatient psychiatric hospitalizations. These performance standards will be reviewed quarterly and enforced if providers are non-compliant.

Performance Standard 19.2

Face to face crisis contacts that result in follow-up and/or referral to community based services.



Data Source: Crisis Contract Performance Data

Data Analysis

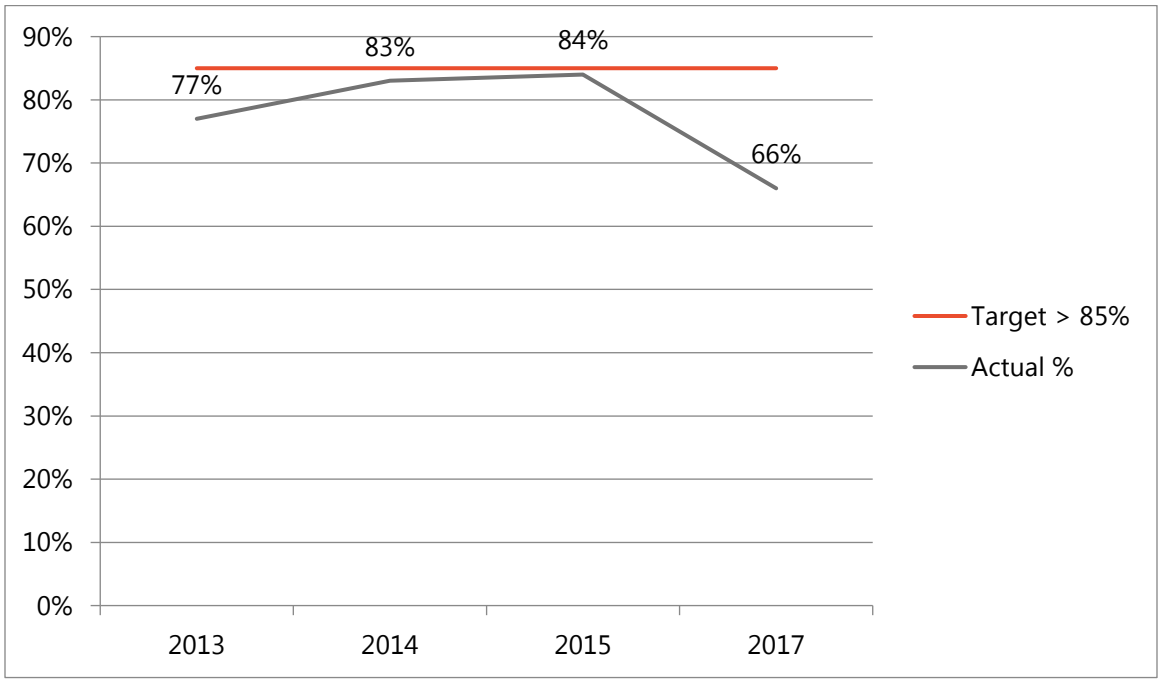
Persons engaged in crisis services, regardless of location, are encouraged to engage in community based services.

Strategies to Effect Change

New crisis contracts include a deliverable standard to require referral to community based services. The Department will continue to monitor for positive or negative changes and address as necessary.

Performance Standard 22.1

Domain average of positive responses in the Perception of Access domain.



Data Source: Adult Mental Health and Wellness Survey

Data Analysis

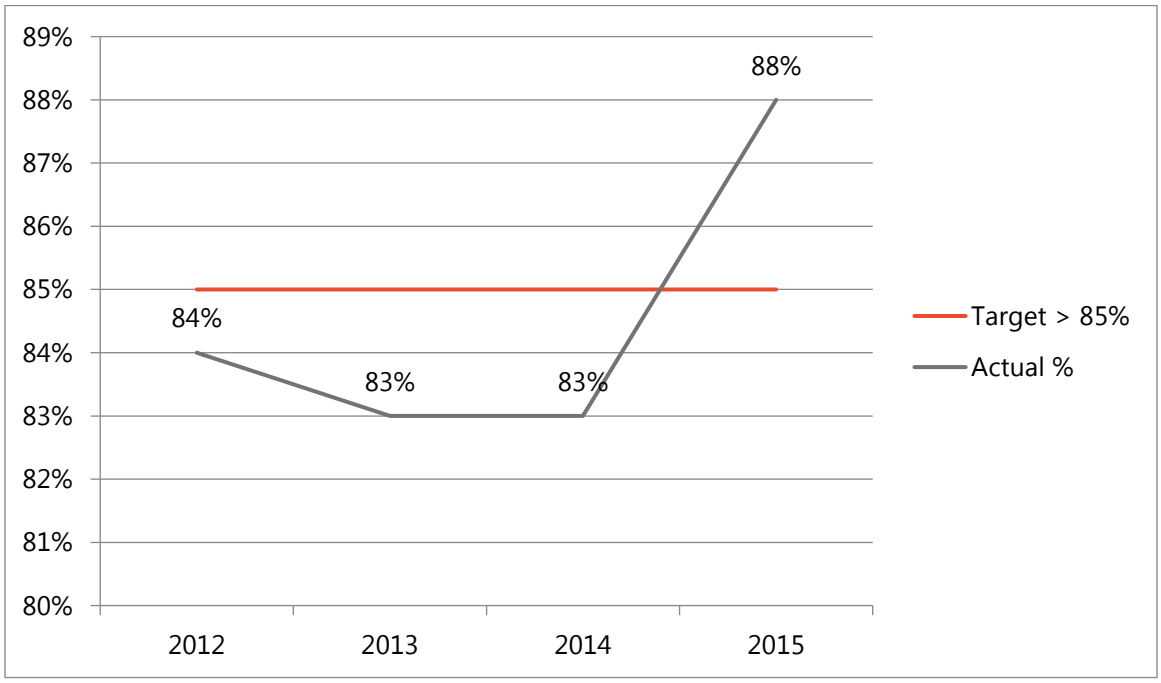
The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

Performance Standard 22.2

Domain average of positive responses in the General Satisfaction domain.



Source Data: Adult Mental Health and Well Being Survey

Data Analysis

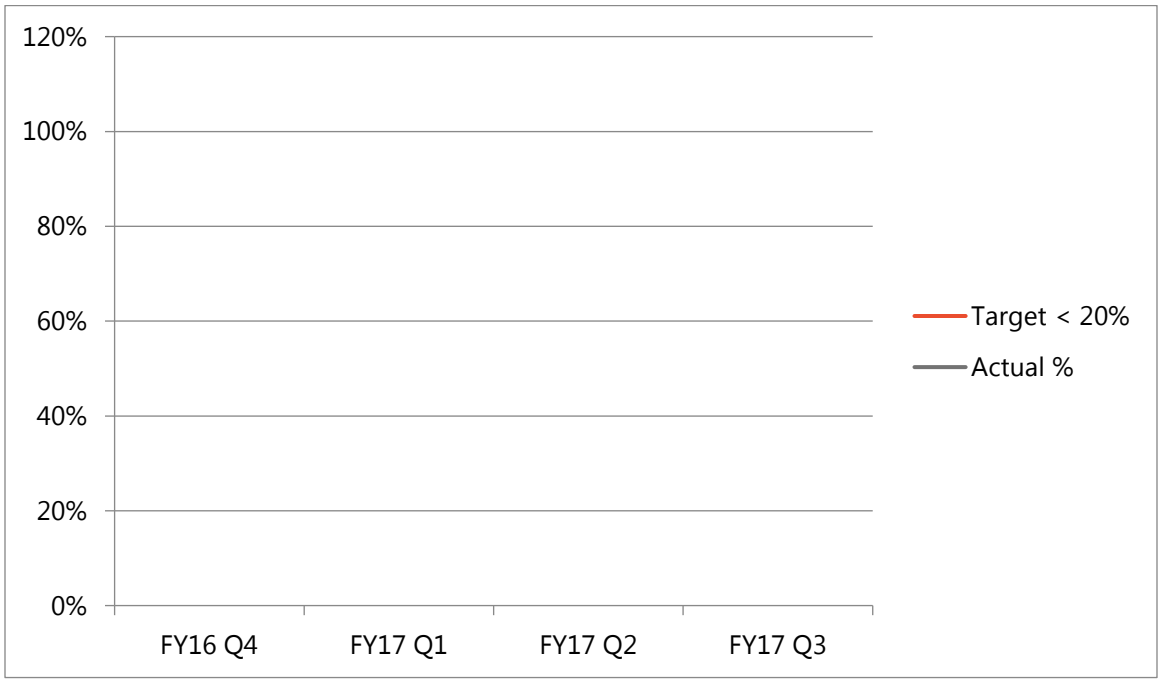
This measurement was inadvertently omitted from the 2017 Adult Mental Health and Well Being Survey contract.

Strategies to Effect Change

Incorporate into 2018 Adult Mental health and Well Being Survey contract.

Performance Standard 26.1-2

Percentage of Class Members competitively employed.



Data Source: EIS (MaineCare ID and ISP) crosswalked to OFI (MaineCare ID and wages).

Data Analysis

Two Performance Standards were combined to create this new Performance Standard. The only available data to address this standard, however, is self-reported by consumers through the Individual Support Planning process and cannot be verified. SAMHS proposes to change to this Performance Standard to one which is verifiable: "Percent of individuals with MaineCare with an active Individual Service Plan who received wages in the time frame reported".

Data to address this standard is already being collected through the Office of Family Independence, which means the Department can verify wages to determine active employment. SAMHS believes this would be a more reliable measure of performance.

In 2016, 18.8% of adults with an ISP and MaineCare ID reported some wages during the year to the Office of Family Independence. This data reflects wages at any point in 2016. Therefore, future reports that reflect quarterly information will likely fluctuate due to seasonal and/or intermittent employment.

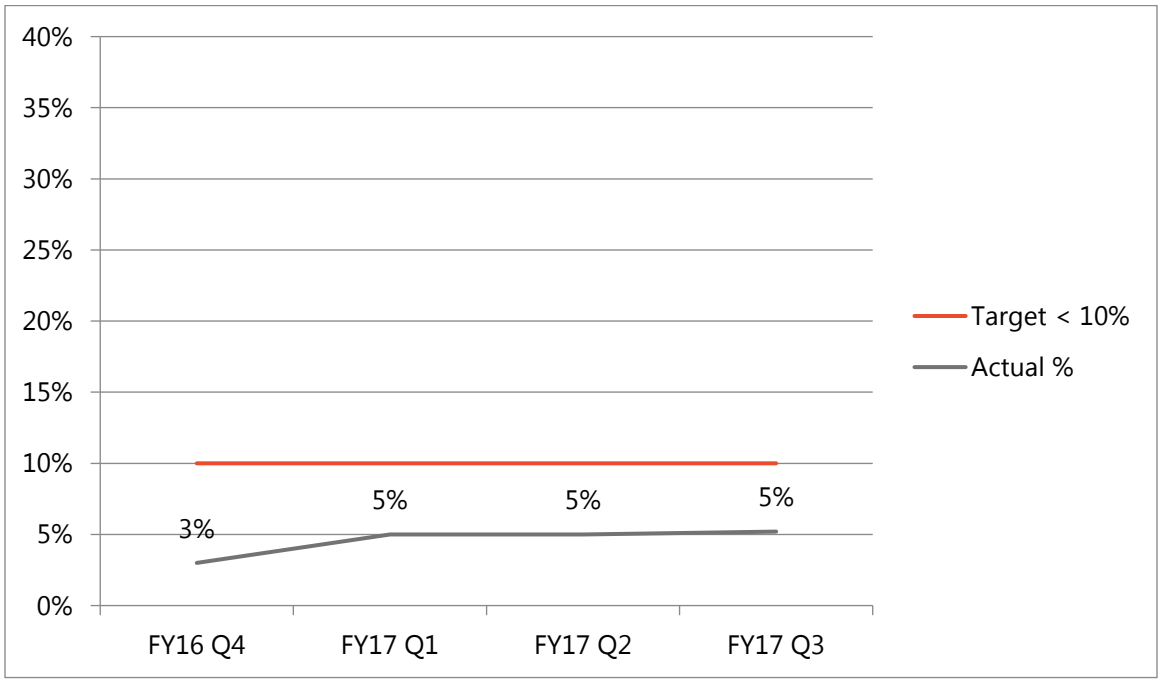
Strategies to Effect Change

Mental health contracts include a deliverable to assess for employment via the Need for Change Assessment. Assertive Community Treatment contracts also include this assessment as well as a Career Profile Assessment.

Discuss possible changes to the standard with Court Master.

Performance Standard 28

Class members with Individual Service Plans with unmet transportation needs.



Data Source: Individual Service Plan Resource Data Summary

Data Analysis

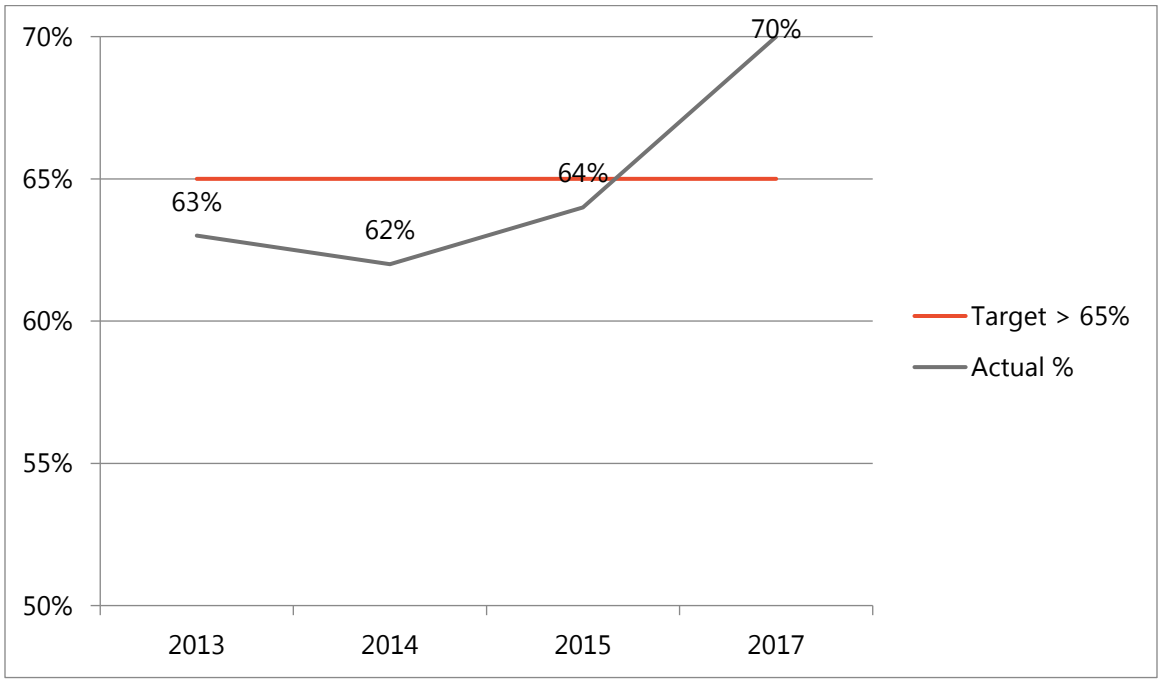
Maine is a rural state with transportation challenges that can be expected to continue.

Strategies to Effect Change

In compliance, continue to monitor.

Performance Standard 31.2

Domain average of positive responses in the Social Connectedness domain.



Data Source: Adult mental Health and Well Being Survey

Data Analysis

The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

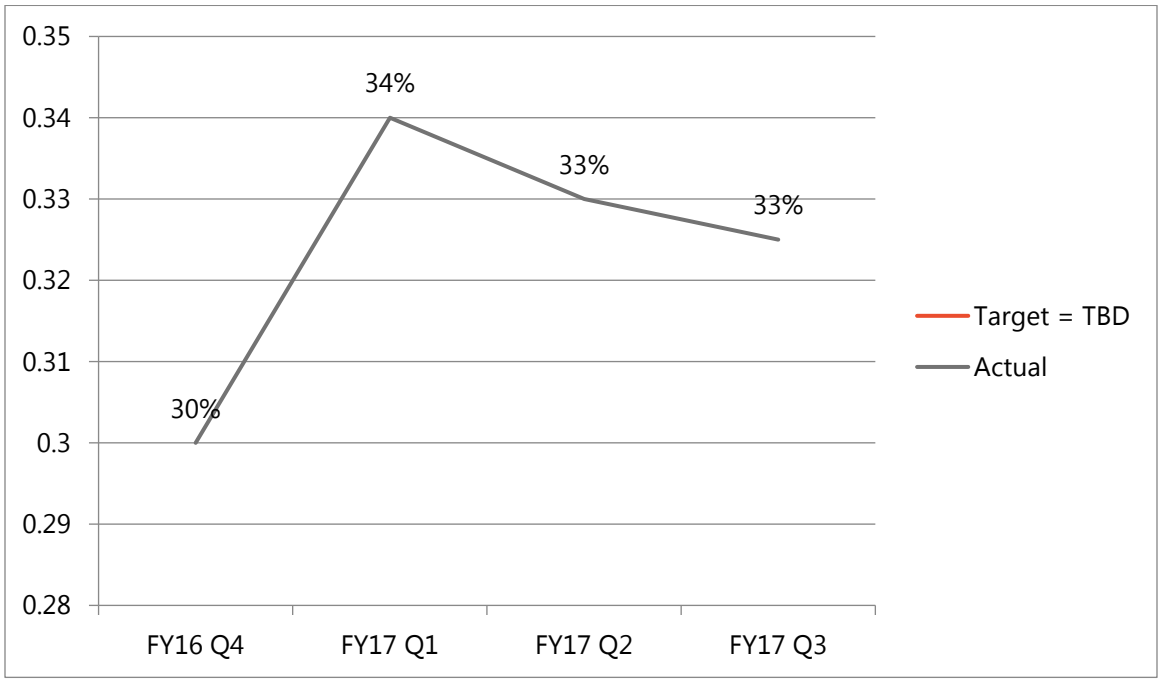
Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

System Outcomes: Supporting the Recovery of Adults with Mental Illness

Standards Thirty-Two and Thirty-Three

Performance Standard 32.1-3

Class Members who demonstrate functional improvement on LOCUS or ANSA between baseline and 12-month recertification.



Data Source: Level of Care Utilization System (LOCUS) and/or Adult Needs Survey Assessment (ANSA)

Data Analysis

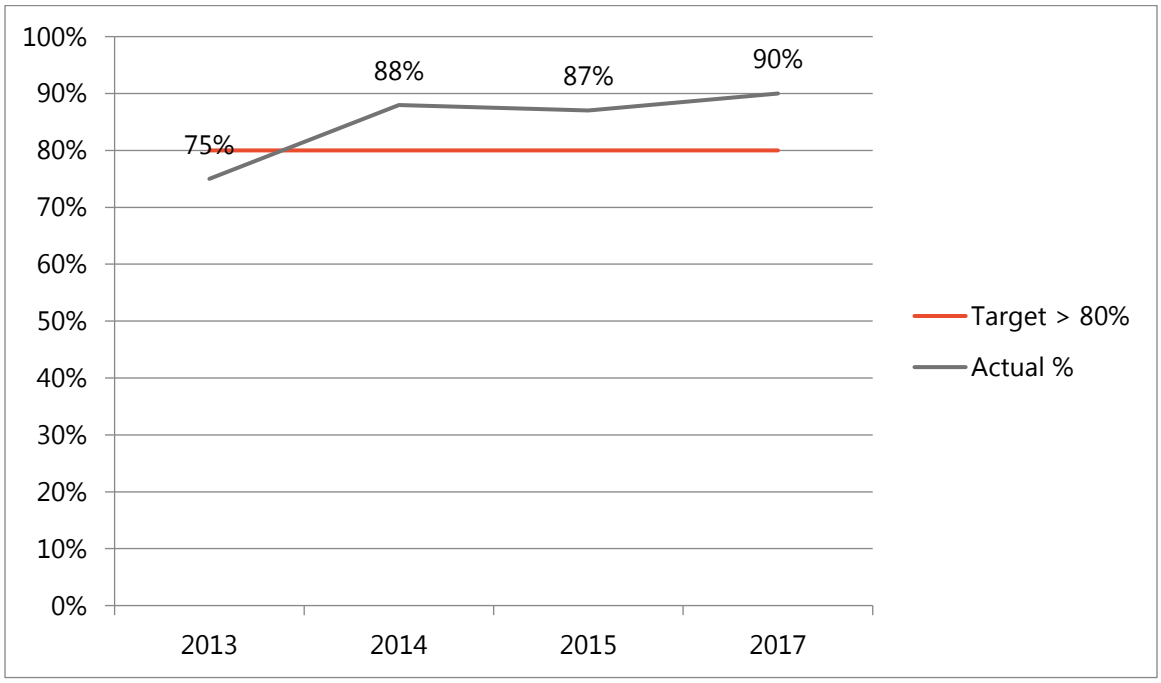
This Performance Standard replaces three (3) previous performance standards (32.1, 32.2 and 32.3). The data shown above represents Performance Standard 32.1 which is in-line with the new Performance Standard.

Strategies to Effect Change

The Department currently collects data using the LOCUS measure, but is moving toward replacing the LOCUS with the Adult Needs and Strengths Assessment (ANSA).

Performance Standard 33.2

Consumers report agency staff believes they can grow, change and recover.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

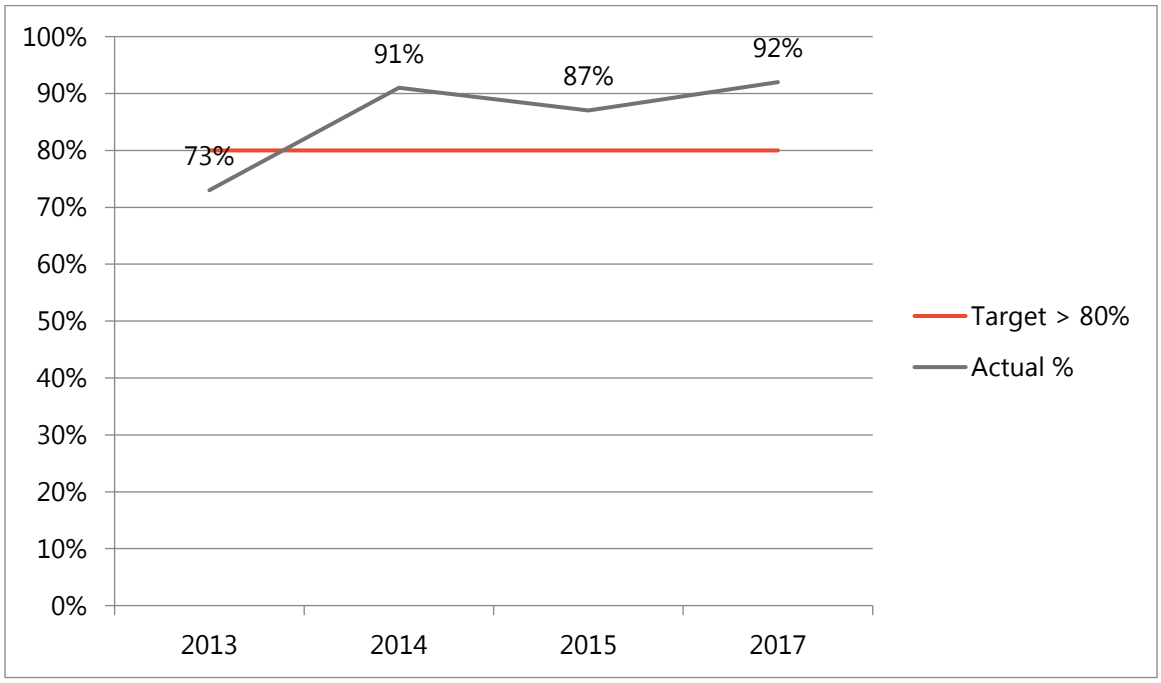
The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

Performance Standard 33.3

Consumers report agency services and staff supported their recovery and wellness efforts and beliefs.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

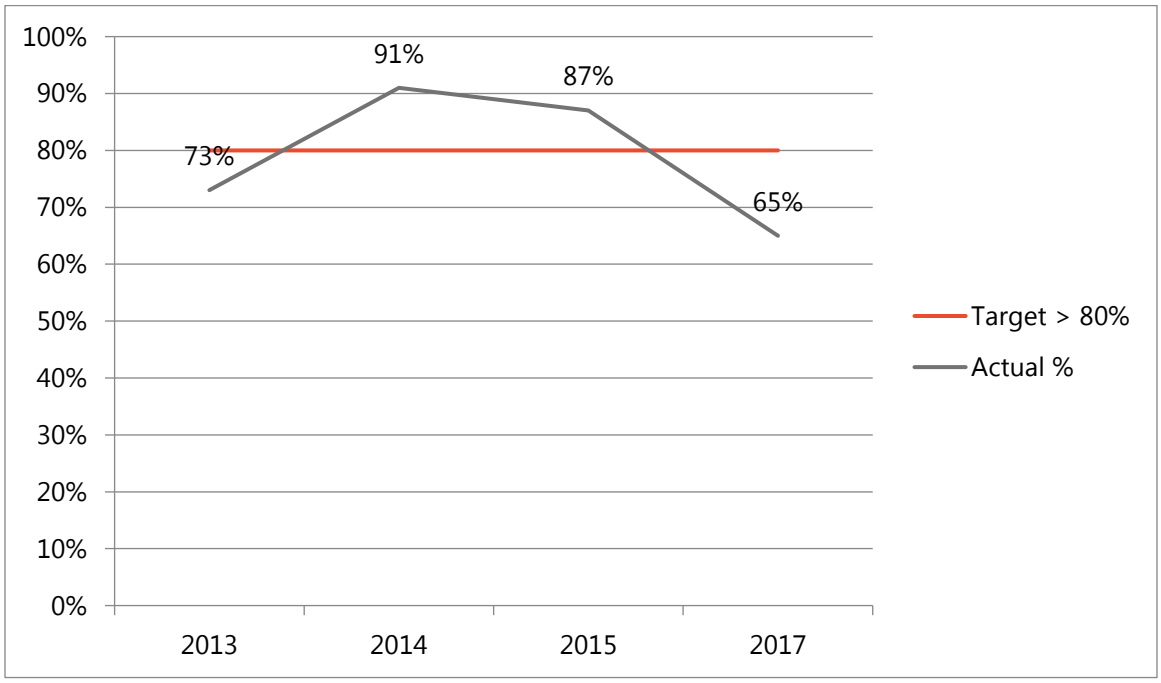
The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

Performance Standard 33.6

Consumers report service providers offered mutual support or recovery-oriented groups run by peers.



Data Source: Adult Mental Health and Well Being Survey

Data Analysis

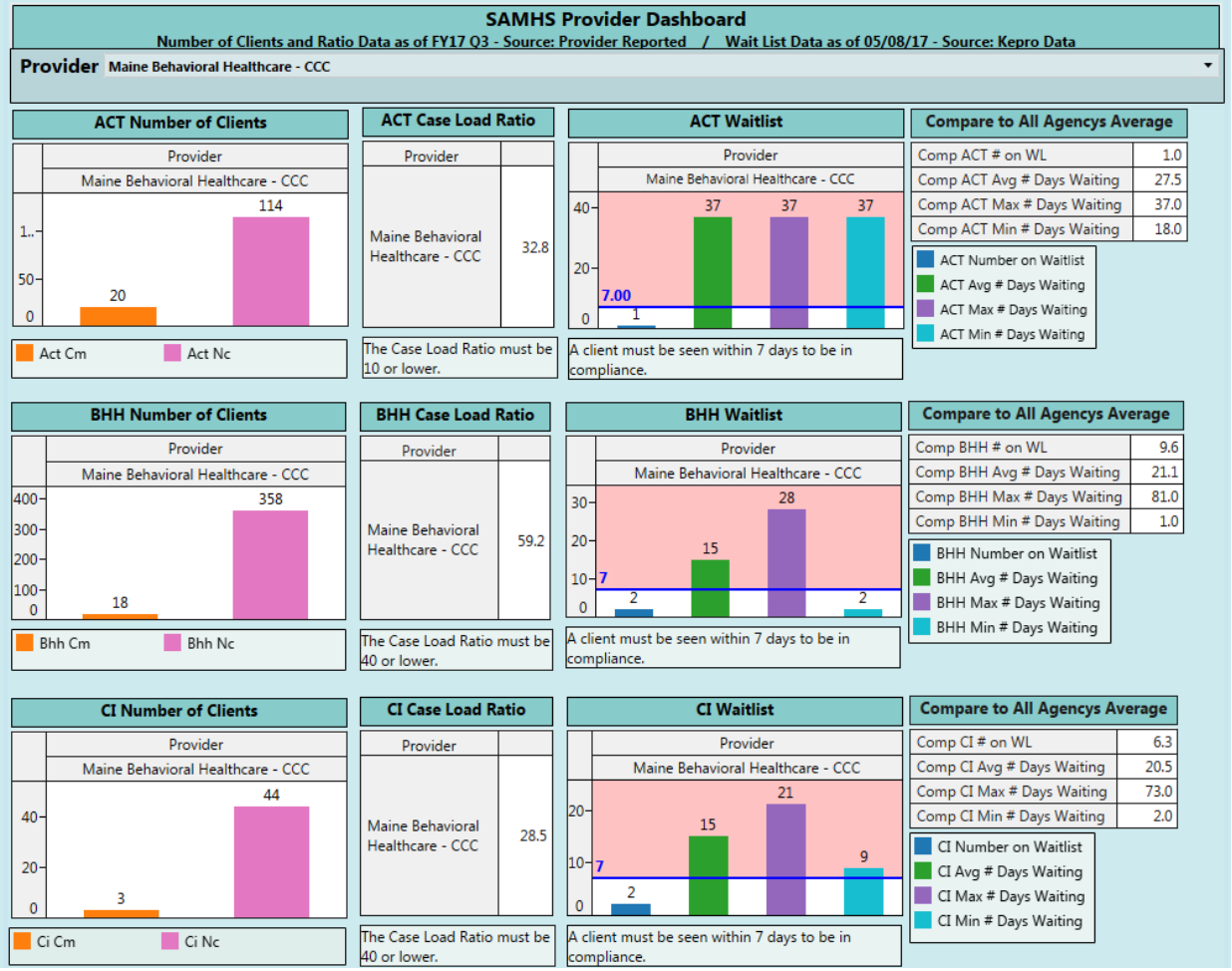
The changes in survey methodology explained in the Executive Summary may explain some of the variation in the data this year.

Strategies to Effect Change

Although the methodological differences may explain some variation, it will be important to continue to observe results in future survey cycles.

SECTION THREE

Analytics Tool



Data Analysis

With the new data collection tools that are available, SAMHS can now analyze waitlist data and staffing ratios. Assertive Community Treatment, Behavioral Health Homes, and Community Integration Services all have waitlist tracking capability. A standard protocol has been developed for services with a waitlist. It requires the program manager to:

1. Verify numbers are accurate from the Quarterly ACSCS report sent by Data Team.
2. If the data is accurate, contact the provider for corrective measures. Possible corrective measures include, but are not limited to:
    a. If case load ratios are less than 40 (ACT is 8), increase caseloads per worker within standard;
    b. If CIW caseloads are high, pull a KePro report to look at clients, services, and hours to determine if they should be in BHH (if there is capacity);
    c. If it is a staffing issue, what is the plan and is it reasonable;
        i. If the plan is not accomplished in timeframe established, discuss the issue with Social Service Program Manager to develop other resources in the area.

The dramatic reductions in the Community Integration waitlist are a testament to the efficacy of this process.

	2015	2016	April 10, 2017
# C.I. Waitlist	560	260	50

Strategies to Effect Change

- Phase Ⅱ – For services nearing capacity or having staffing issues, scatter graph by client zip code to determine possible locations for development of new services.
- Phase Ⅱ – Perform asset mapping of mental health services to understand capacity and unmet needs.
- Provide ANSA training to providers to assist in more effective assessments which lead to improved service planning to include addressing unmet needs.
- Recommend removing unmet needs from RDS feed as these new tools prove effective.

BRAP Waitlist Monitoring Report

The Bridging Recovery Assistance Program (BRAP) has been established in recognition that recovery can only begin in a safe, healthy, and decent environment; a place one can call home. The Office of Substance Abuse and Adult Mental Health Services also recognizes that recovery is achieved on an individual basis which is not predicated by length of time but rather individual progress, successes and the necessity for rental assistance for persons with mental illness where length of assistance and amount of services are measured in need rather than in months.

BRAP is designed to assist individuals who have a psychiatric disability with housing costs until the individuals are awarded a Housing Choice Voucher (aka Section 8 Voucher), another federal subsidy, or until the individuals have an alternative housing placement. All units subsidized by BRAP funding must meet the U.S. Department of Housing and Urban Development's Housing Quality Standards and Fair Market Rents. Following the ***Housing First*** evidence-based program model, initial BRAP recipients are encouraged, but not required, to accept the provision of services to go hand in hand with the voucher.

BRAP Waitlist

As of the end of the 3rd Quarter of FY2017, there has been no waitlist for the BRAP program. Due to the lack of a waitlist, qualified individuals who have applied waited an average of 4-5 business days before being awarded a voucher and able to start looking for housing.

Graph: Detail by Priority Status to include those persons waiting longer than 90 Days, and showing change relative to last report.

Reporting Periods	16'-Jun	16'-Sept	16'-Dec	17'-Mar	% Change relative to Last Report
Total Number of Persons on Waitlist	0	0	0	0	No Change
Priority 1—Discharge from a psychiatric hospital, or State Funded Residential treatment facility	0	0	0	0	No Change
Priority 2—Homeless (HUD Transitional Definition)	0	0	0	0	No Change
Priority 3—Sub-standard Housing	0	0	0	0	No Change
Priority 4—Discharge from a Jail/Prison	0	0	0	0	No Change
Total number of persons on waitlist more than 90 days	0	0	0	0	No Change

BRAP Vouchers Awarded in 3rd Quarter of FY 2017

As of the close of the 3rd Quarter of FY 2017, a total of **386** new BRAP vouchers have been awarded.

Of those awarded, the total can be broken down into the priorities as follows:

- Priority #1: **75** individuals discharged from psychiatric hospitals or a state funded residential treatment facilities/PNMI have been awarded BRAP vouchers.
- Priority #2: **239** individuals who meet HUD's transitional homeless definition have been awarded BRAP vouchers.
- Priority #3: **14** individuals identified as living in sub-standard housing have been awarded BRAP vouchers.
- Priority #4: **25** individuals who were leaving a jail or prison have been awarded BRAP vouchers.
- No-Priority: **33** individuals who did not fit into specific program priorities but were coming from circumstances that warranted a situational waiver have been awarded BRAP vouchers.

Current BRAP Vouchers Awarded/Housed

The current BRAP census, as of March 31, 2017, shows a total of **1,224** vouchers awarded, with **225** of those awarded but have not found housing.

Graph: Award detail by Priority Status, including persons in between apartments and never housed

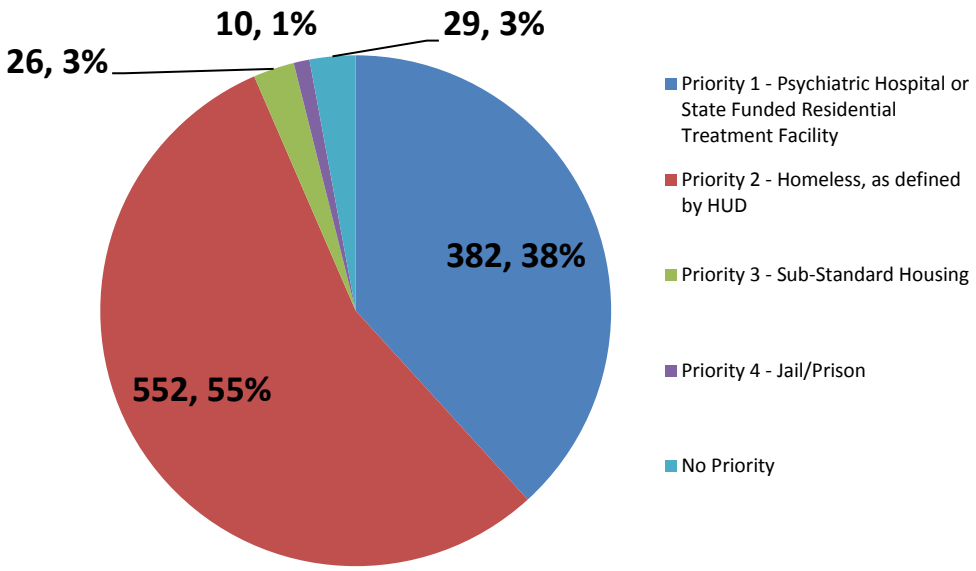
BRAP Vouchers currently awarded, as of March 31, 2017	1,224

Total number on BRAP Waitlist	0

Total number of persons Housed on BRAP	999
Priority 1 – Psych. Facility/PNMI	382
Priority 2 – Homeless (HUD)	552
Priority 3 – Substandard Housing	26
Priority 4 – Jail/Prison	10
No Priority	29

Total number of persons Awarded and looking for housing	225

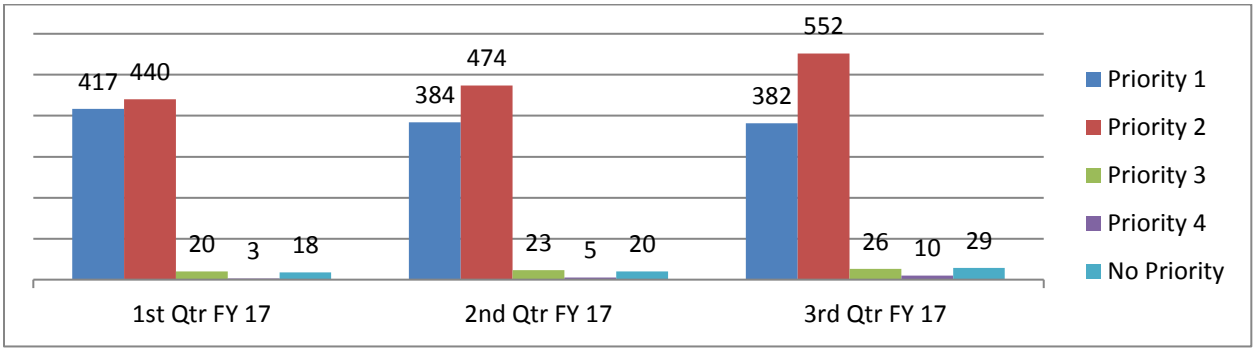
Graph: Currently Housed detail by Priority Status



Graph: Detail by Priority Status, Individuals currently housed, and showing change relative to last report

Reporting Periods	16'-Sept 1st Qtr. FY 17	16'-Dec 2nd Qtr. FY 17	16'-Dec 2nd Qtr. FY 17	% Change relative to Last Report
Total Housed	898	906	999	10% ↑
Priority 1—Discharge from a psychiatric hospital, or State Funded Residential treatment facility	417	384	382	.50% ↓
Priority 2—Homeless (HUD Transitional Definition)	440	474	552	16% ↑
Priority 3—Sub-standard Housing	20	23	26	13% ↑
Priority 4—Discharge from a Jail/Prison	3	5	10	100% ↑
No Priority-Waiver	18	20	29	45% ↑

Graph: Number of individuals awarded and housed by Priority



All Individuals Housed on BRAP

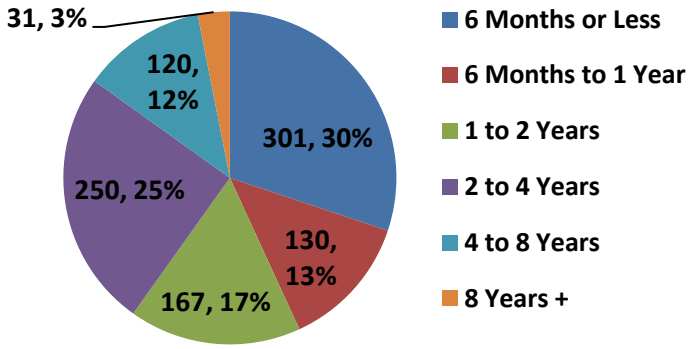
As of March 31, 2017, the current census shows a total of **1,519** individuals, including household members, in active housing.

- Of the total **1,519** individuals who are currently housed, **999** are the awarded heads of households, with an additional **520** household members, which can be broken down as follows:
  - Adults (18+): 104
  - Minors (17 and below): 416

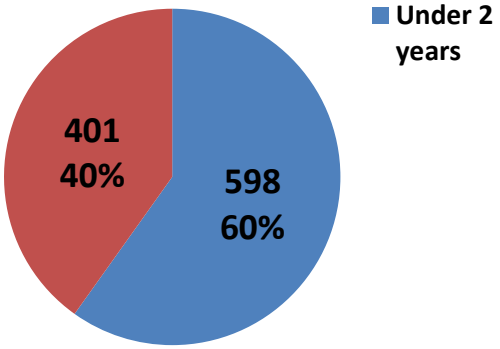
Length of Stay for those Housed on BRAP

The number of individuals housed on the BRAP program for longer than 24 months has decreased from 43% to 40% of the total persons housed on the program, with the shortest length of time housed being just under 1 month and with the longest amount of time staying housed on the program up to a period of 16 years or more.

Detail by Length of Stay of 2 years



Detail by Length of Stay



Other Housing Programs

In addition to the BRAP program, SAMHS manages the PATH program, which is directed towards outreach, and which is responsible for engaging and enrolling literally homeless individuals into housing and mainstream resources with a focus on the literally homeless individuals who are eligible for Sec.13 and 17 in the Maine Care Manual and would be prioritized for BRAP and Shelter Plus Care.

Lastly, SAMHS administers a substantial number of Shelter Plus Care vouchers, funded by the U.S. Department of Housing and Urban Development, more than any other state on a per-capita basis. The census of those housed under Shelter Plus Care, as of March 31, 2017, is 799 plus their family members. This program has seen significant growth over the last decade, which is the direct result of SAMHS aggressively applying for, and receiving, new grants annually. However, there has been no increase in HUD funding over the past two years, causing a zero increase in grants funded through the federal government. Because if this lack of additional funding, SAMHS is focusing vouchers, when they become available through turnover, on the Chronic and Long Term homeless populations throughout the state who generally qualify for this program.

The BRAP program was recently put out as a Request for Proposal (RFP). The results of this RFP were a single provider selected to administer the program state wide.

Shalom House Inc., based in Portland, was the selected provider. Shalom has been the Centralized Administrative Agency for this program since inception and has selected each of our existing LAAs (Local Administrative Agencies) to continue to administer the program in each of their respective areas around the State of Maine.

****The changes to the eligibility of Sec.17 have had a significant effect on how many persons have accessed BRAP this past quarter. In light of this and to allow an avenue of access the program has created a BRAP enrollment form which allows a potential applicant to qualify for the program prior to actually receiving Sec. 17 services. This should prove to decrease any perceived barriers which may have resulted from the changes. Educating the community providers and potential applicants is a priority of SAMHS as well as our Providers*.

SECTION FOUR

Psychiatric Center Performance Improvement Report