Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

In Focus

A Brief Overview Of The Department's Services, Core Functions And Measurable Outcomes

June 2005 to July 2006

Department of Health and Human Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	3,757
Total Funding FY '06:	$3,192,488,703
General Fund:	$934,686,342
Federal Fund:	$1,676,542,861
Special Revenue:	$413,095,202
Block Grant:	$165,764,298

Brenda M. Harvey
Commissioner

Introduction

The Department of Health and Human Services seeks to meet its customers needs so that they experience every employee as responsive, caring and part of a well-managed organization.

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Maine Department of Health and Human Services Governing Principles *adopted January 6, 2006*

Vision
Maine people living safe, healthy, and productive lives

Mission
Provide integrated health and human services to the people of Maine
to assist individuals in meeting their needs, while respecting the rights and preferences
of the individual and family, within available resources.

Foundational Values
Honesty, Respect, Integrity, Responsibility, Accountability, Compassion, Empathy, Fairness

Guiding Principles
•Treat consumers with dignity and respect
•Deliver services that are individualized, family-centered, easily accessible, preventative, independence-oriented, interdisciplinary, collaborative, evidence-based and consistent with best and promising practices.
•Value and support departmental staff as a critical connection to the consumer.
•Engage staff, stakeholders, providers and customers in a collaborative partnership that continuously seeks excellence in service design and delivery.
•Balance centralized accountability with regional flexibility.
•Align systems, actions, and values toward a common vision.

Department Goals
Protect and enhance the health and well-being of Maine people
Protect and care for those who are unable to care for themselves
Promote independence and self sufficiency
Provide effective stewardship for the resources entrusted to the department

Department Outcomes
High Performing Staff
Integrated Services
Efficient and Effective Administration
Excellent Provider Partnerships
Superior Customer Service

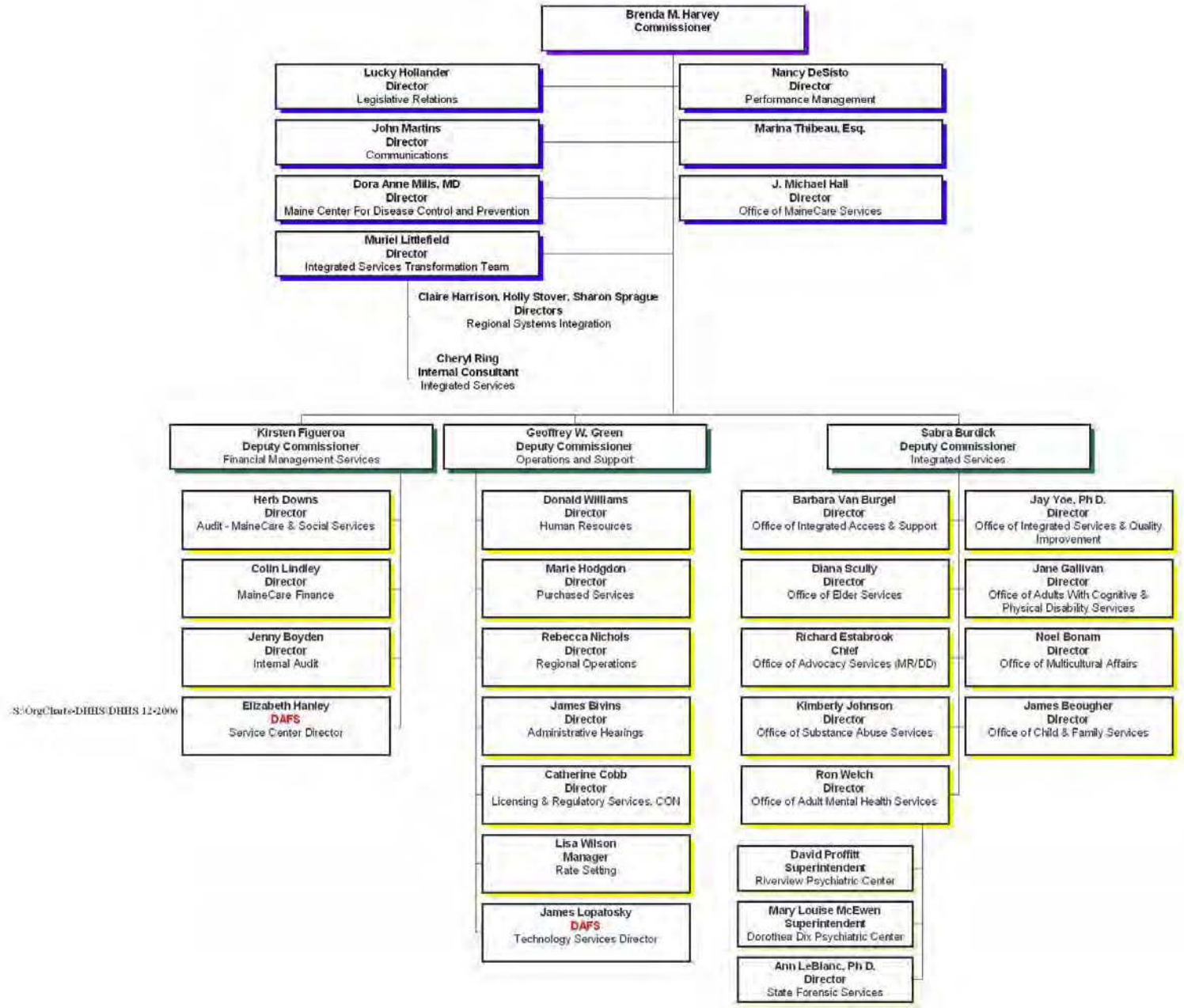
Program Objectives

Program Performance Indicators

Staff Performance Expectations

Maine Department of Health and Human Services

revised December 2006



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Commissioner's Overview

The Department of Health and Human Services (DHHS) resulted from Governor Baldacci's first Inaugural proposal to create a new agency by combining the resources of the Department of Human Services (DHS) and the Department of Behavioral and Developmental Services (BDS) into a new agency. Governor Baldacci's guiding direction was to create a system of health and human services where access is facilitated, care is coordinated and costs are contained.

Transformation to achieve the goals outlined in the legislation is a monumental task and requires continuous attention to detail while simultaneously developing and holding the big picture. This work happens over years, in sequenced steps with all stakeholders. This is a dynamic process that allows for and encourages reshaping and redesign during the flow of implementation. This document outlines the accomplishments thus far and identifies DHHS' targets for change.

Core Functions

- ❑ Protect and enhance the health and well-being of Maine people
- ❑ Promote independence and self sufficiency
- ❑ Protect and care for those who are unable to care for themselves
- ❑ Provide effective stewardship for the resources entrusted to the department

Performance Goals

Performance Goal:	**DHHS Governing Principles,** established in 2006, guide the work of all employees toward our overall vision: *Maine people live safe, healthy and productive lives*.	**What We Have Learned:** Governing Principles provide the foundation for common culture. The DHHS Governing Principles have been widely distributed throughout the Department and form the basis of the DHHS communications strategy.
Form one culture within the Department of Health and Human Services.		

Promote Common Culture

"How Am I Helping To Meet The Needs Of My Customers So That They Experience Me As Responsive, Caring, And Part Of A Well-Managed Organization?"

Guide Interactions With Each Other

We Assume Best Intentions + We Assess Impact + We Interact Respectfully
+ This Results In A Caring and Responsive Culture

Performance Goal:	**DHHS System Outcomes:**	**What We Have Learned:**
Measure the Department's performance toward its vision, mission, guiding principles and goals.	▪ DHHS staff perform with a high level of efficiency and effectiveness; ▪ Providers in partnership with DHHS value the partnership / benefit from the partnership; ▪ Consumers and providers have easy access to DHHS services; ▪ Internal and external customers are very satisfied with DHHS systems and services; ▪ DHHS administrators operate systems that are efficient, effective and promote equity in service delivery.	DHHS is in the process of surveying consumers, staff and providers and will continue to do so on a regular basis. This feedback will be used to make informed changes and infrastructure alignments. *This process will be shared with the Legislature in a separate legislatively mandated report*.

Performance Goal:	**DHHS System Level**	**What We Have Learned:**
Increase the focus on communications to manage organizational change.	Through conducting interviews with key personnel and conducting an employee survey, the Department is gathering information to provide a baseline assessment of current communications initiatives. This data will help guide future communications initiatives to support and sustain the DHHS Governing Principles.	Communication styles within the Department are diverse, as are the values placed on existing communications vehicles. The Commissioner's Weekly Update has been very well received by many employees. The DHHS *In Focus* newsletter celebrated its first year of publication. DHHS web assets are being redesigned. Our strategic communications plan is evolving.

Performance Goal:	**DHHS System Level**	**What We Have Learned:**
Invest in staff, the Department's most important resource, as a critical component for success.	**Staff is the critical connection**: By increasing our support to staff through quality training and professional development, the Department will strengthen its connection to external customers and improve the retention of valued, competent and committed staff. Organizational climate is key to improved outcomes for clients. Empowering staff with information, clear role definition and expectations, authority, accountability and rewards is central to creating a supportive organizational climate in the Department. Supporting staff during this period of large-scale change continues to be a critical management function, as staff learns to work differently.	The Department is developing a unified human resources development plan to align performance measures with strategic direction. Positive culture thrives on performance measurement.

DHHS Financial Management

FY 2006 Department of Health and Human Services Budget

UNIT_TITLE	General Fund -010	Federal Fund - 013	Special Revenue - 014	Block Grant - 015	Trust Fund - 018	Grand Total	Head count
OMB	$ 21,041,977	$ 20,782,911	$ 1,517,364	$ 1,580,716	$ -	$ 44,922,968	441.5
MaineCare	$ 450,102,967	$ 1,455,919,913	$ 178,584,356	$ 24,701,966	$ -	$ 2,109,309,202	251.0
MeCDC	$ 13,320,638	$ 65,272,508	$ 30,321,248	$ 5,204,792	$ 2,400,000	$ 116,519,186	377.5
Substance Abuse	$ 11,248,860	$ 9,893,006	$ 6,255,856	$ 6,893,244	$ -	$ 34,290,966	34.0
Child and Family	$ 128,902,826	$ 26,478,970	$ 10,927,751	$ 48,787,846	$ -	$ 215,097,393	598.5
Integrated Access and Support	$ 77,843,980	$ 78,737,801	$ 135,027,683	$ 76,433,770	$ -	$ 368,043,234	856.5
Adult Mental Health	$ 90,636,034	$ 8,425,598	$ 39,723,030	$ 1,217,022	$ -	$ 140,001,684	743.1
Adults with Cognitive and Physical	$ 118,614,519	$ 1,065,379	$ 10,623,959	$ 944,942	$ -	$ 131,248,799	349.8
Elder	$ 22,974,541	$ 9,966,775	$ 113,955	$ -	$ -	$ 33,055,271	105.5
Grand total	$ 934,686,342	$ 1,676,542,861	$ 413,095,202	$ 165,764,298	$ 2,400,000	$ 3,192,488,703	3757

DHHS
Employs 3757 staff
Manages $3.2 billion
Serves virtually all Maine people

Financial Management

Core Functions

Service Center:

- Quarterly and annual financial reports
- Grant management
- Federal cash draws/8 letters of credit
- Accounts payable/receivable
- Support programs
- Budget preparation
- Legislative support/fiscal note preparation
- Work programs
- Budget monitoring and analysis
- Audit responses/corrective action plans

MaineCare Finance

- Financial oversight of $2.1 billion MaineCare expenditures, budget and reporting
- Leadership and direction for 15 staff
- Direct all MaineCare accounting and cash management
- Direct preparation of MaineCare biennial budget
- Oversee MaineCare payment cycles and collection processes
- Direct forecasting, tracking and reporting of MaineCare costs

Internal Audit

- MaineCare cost settlement audits and settlement processes
- Assure MaineCare funds are spent on allowable costs
- Assure compliance of MaineCare reimbursement with state regulations
- Review financial statement audits
- Complete community agency agreement closeouts
- Provide response to agency corrective action plans
- Provide MAAP agreement training to community agencies
- Oversee state and federal audits
- Respond to audit findings correctly and timely

Performance Goals

Performance Goal:		**What We Have Learned:**
Manage the resources entrusted to the Department in an efficient and effective manner.	DHHS financial management has entered into a modernization process that will result in: ▪ Organizational-wide performance metrics ▪ Documented processes ▪ Formal and regular communication ▪ Clearly defined roles organization-wide ▪ Management tools that help monitor issues The fundamental issues to be addressed are: ▪ Planning and Budgeting Management ▪ Financial Analysis & Reporting ▪ Performance Management & Advice ▪ Stakeholder Management ▪ Risk Management & Control ▪ Compliance	Our financial management system needs to be modernized in order to efficiently and effectively manage a $3.2 billion budget which finances the safety net for Maine people. Modernization requires knowledgeable staff, business process improvements and time.

Operations and Support

Performance Goal:	**What We Have Done:**	**What We Have Learned:**
Co-locate departmental offices where there were more than one office serving the area.	Facilities have been combined in ten locations; Sanford, Bath, Lewiston, Farmington, Rockland, Skowhegan, South Paris, Caribou, Fort Kent; Houlton, and locations in the planning stage are Augusta and Portland.	Co location has improved service integration.

Performance Goal:	**Administrative services**	**What We Have Learned:**
Combine services and resources and adjust to diminishing resources.	▪ Management of administrative functions, including contracting, auditing, licensing, rate-setting and human resources has been consolidated to standardize processes and maximize efficiency. ▪ Rate-setting processes and methodologies are being standardized. ▪ The Administrative Processes Oversight Committee (APOC) was established, with provider representatives, to develop recommendations and oversee implementation. Recommendations were reported to the Legislature in January 2006, and implementation is in progress.	Administrative oversight is directly related to cost and performance of our services and to customer outcomes.

Performance Goal:	**Licensing and Regulatory Functions**	**What We Have Learned:**
Ensure that regulatory functions efficiently and effectively support public policy objectives.	• A joint work group with hospitals has been established to reform hospital licensing processes and roles. • A consolidated intake and tracking process has been established for all complaints regarding licensed service providers. • The Certificate of Need process has been strengthened by increasing staff support and establishing a formal role for the Maine Quality Forum.	Administrative oversight is directly related to cost and performance of our services and to customer outcomes.

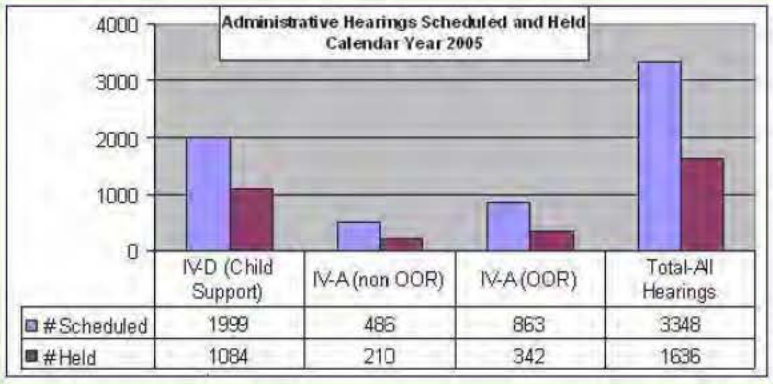
Performance Goal:	**Business Process Improvement**	**What We Have Learned:**
Provide the right service at the right time for the right price. Adopt organizational management strategies to reduce inefficiencies.	DHHS is challenged to provide enhanced and integrated services to its customers with fewer resources. The Department is committed to using LEAN Principles in order to ensure services and programs are mapped, evaluated and redesigned as necessary to promote process improvements, enhance customer value, reduce cost and eliminate duplication and/or unnecessary policies processes.	Analyses have taken place to reduce wasted steps in vital records, adoption, child care and 12 other DHHS business processes, allowing for streamlining and standardized processes.

Performance Goal:	**What we have done**:	**What We Have Learned:**
Redesign the DHHS website to be: ▪ Useful: *It has the information people need and want.* ▪ Usable: *Information is easy to find.* ▪ Credible: *Users trust the site because reputation and past experience has proven it to be accurate, compete and up-to-date*.	DHHS has analyzed its current and potential web presence and has a plan to create business efficiencies and improve customer service through a redesigned web presence. Project management has begun. The design phase has started for Child and Family Services and Children's Behavioral Health, with the Office of Integrated Access and support to follow. Other areas will be phased in as resources allow.	A professional trusted website will: 1. Present DHHS as a unified competent entity. 2. Improve customer services. 3. Create business efficiencies.

Administrative Hearings

Performance Goal:

Improve cycle time for Administrative Hearings.



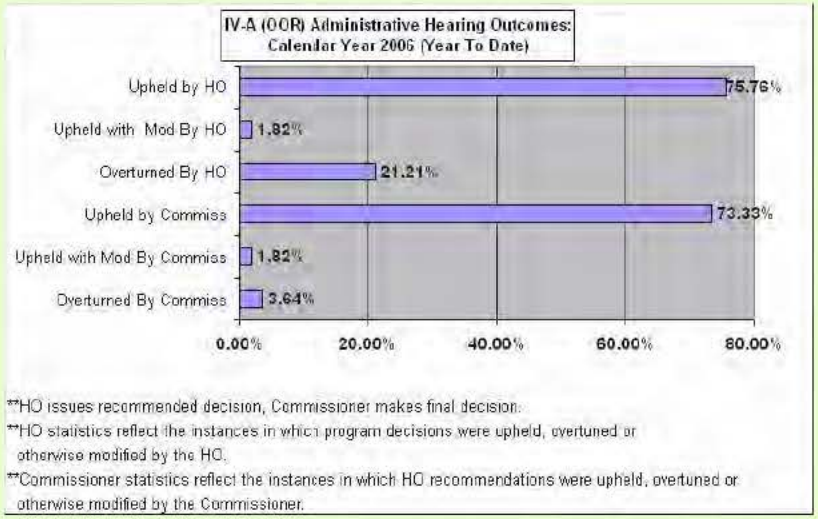
What We Have Learned:

Backlogs of administrative hearings have been eliminated and cycle time for decisions on appeals has been reduced by approximately 50 percent.

95 percent success rate in holding hearings and issuing final decisions within the statutory and regulatory deadlines.

Performance Issue:

Analyze Hearings Officers' decisions.



What We Have Learned:

25 percent of Department decisions are overturned by the Hearings Officers and the Commissioner upholds these determinations about 75 percent of the time.

Quality Improvement

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The primary role of DHHS Quality Improvement is to inform and promote innovations and integrative approaches to service delivery and policy development. Guided by the Department's mission, vision and values, the Office of Quality Improvement (OQI) is built on a foundation that emphasizes consumer and family involvement, outcome measurement, standardized data collection, strong collaborative relationships with internal and external partners and the use of data to inform policy and decision-making. The core functions are designed to support and enhance the quality and integrity of services provided to DHHS customers (i.e., consumers, family members, contracted service providers).

Core Functions

- **Design and implement Department-wide Performance Management and Review System**.
- **Evaluation of service effectiveness for priority population**s using standard consumer and family outcome tools.
- **Perform ongoing data management and statistical analysis of service trends and outcomes**.
- **Drive policy development and decision-making through ongoing reporting and feedback of quality improvement information.**
- **Enhance awareness and skills through ongoing trainings and consultation on quality improvement topics**, including: service reviews, service evaluation design and implementation, focused research presentations, data interpretation, statistical analysis and sampling.
- **Develop and implement standard procedures and protocols to review evidence-based treatments and service approaches.**
- **Develop high quality useful reports** that are driven by service area/office priorities and are responsive to the needs of multiple audiences, including: policy makers, program staff, consumer, families and other community partners.
- **Turn Data into Action** to guide system improvements, programs, system planning and decision-making.
- Many of the initiatives outlined in this report were guided by the Office of Quality Improvement.

Highlights and Successes

- There is greater access to data/information sources internal and external to the Department for use in quality improvement work. The Office of Quality Improvement accesses and uses a diverse range of data sources from across the Department and state government to assess human service system trends and quality.
- The Office of Quality Improvement is being re-organized to better meet the diverse needs of the unified department. This reorganization provides opportunity to enhance and focus the data analytic, training and technical assistance activities of the Office of Quality Improvement.
- DHHS unification efforts have provided opportunities for establishing collaborative relationships with other DHHS Offices and the design and implementation of integrative quality improvement projects.

- Quality Improvement plays a lead role in the development of a Department-wide performance management system to establish outcome-oriented performance objectives and to identify performance measures to uniformly assess the effectiveness of Department services.

- The Office of Quality Improvement lends ongoing support to other offices in the Department on the development and implementation of and training on standard consumer outcome assessment tools. The Office of Quality Improvement has trained more than 3,500 state and community agency providers in adult and children's behavioral health assessment tools since 1999.

- Maine received Federal SAMHSA Data Infrastructure Grant to establish common state mental health data elements and to implement national outcome measures for children and adults experiencing mental health challenges.

- The Office of Quality Improvement participates in the National Core Indicators Project to establish common data and outcome indicators for assessing service quality for adults with cognitive and developmental disabilities. This is a joint project with the Office of Adults with Cognitive and Developmental Disability Services.

Multicultural Affairs

Noel Bonam
Director

The primary role of the Office of Multicultural Affairs is to function as a resource to all state agencies and to all communities served to improve services to minority and multicultural populations in the state of Maine.

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Multicultural Affairs

In order to improve services to minority and multicultural populations in the state of Maine, the Department of Health and Human Services, with the support of the Office of the Governor, strategically established the Office of Multicultural Affairs (OMA). The office provides support to state agencies, non-governmental organization, and community partners in order to develop sustainable projects and initiatives that will address the needs of multicultural community.

The Office implements the recommendations of the Multicultural Affairs Sub-Cabinet that was established by Executive Order, in acknowledgement of the need to provide strategic planning, policy development and program implementation for services to Maine residents who belong to cultural, racial and ethnic minorities. These services assist recipients in achieving economic, education and social self-sufficiency. The Office promotes mutual cooperation, exchange and understanding among the various populations served which will be vital to the provision of meaningful, effective service delivery.

Core Functions

The core functions of the Office are designed to support and enhance the quality and integrity of services provided by the Department of Health and Human Services, other state departments and service providers across the state.

- ❑ **Function as a resource for state departments and for multicultural communities**
- ❑ **Training, education and technical assistance**
- ❑ **Regular Dissemination and Feedback:** particularly related to cultural, racial and ethnic communities in Maine to increase consumer engagement at all levels of service delivery.
- ❑ **Support the Multicultural Sub-Cabinet and State Advisory Council on Multicultural Affairs**

Highlights & Successes

The Office of Multi-Cultural Services is leading an inter-departmental collaborative to address issues of access to services.

- **The Language Access Resolution Agreement** is in compliance with the Federal Department of Health and Human Services' Office of Civil Rights Language Access Resolution Agreement:

    1. Trained 2000 DHHS employees on the DHHS Language Access Policy; the remaining employee sessions are scheduled through spring 2007.
    2. Language in contracts clarifies responsibilities of all DHHS contractors/provider agencies.
    3. Developed appropriate language access resources and services.

- **The Maine Multicultural Resource Guide** is posted on line and updated as new information arrives. http://www.maine.gov/dhhs/bds/mhservices/MulticulturalResource/Contents.html

- **The Domestic Violence Interview Pictorial Booklet** is a tool for law enforcement, domestic violence advocates and interpreters. The booklet is available on line at: http://www.maine.gov/dhhs//bds/mhservices/MulticulturalResource/DV/index.html

- **The mental health support services staff training curriculum** has been revised to be culturally and linguistically appropriate and accessible to deaf staff working in mental health group homes as case managers.

- **Eight refugee and immigrant mental health collaborative** meetings were held in Portland and Androscoggin Valley, which highlighted four major work areas:

    1. To address language barrier in service delivery for persons with limited English proficiency;
    2. To address cross-cultural communication between service providers and service recipients from diverse cultures;
    3. To ensure networking among services providers, members of the different ethnic groups and service recipients;
    4. To reach out to the different ethnic groups.

- **Trained 15 facilitators of peer support groups.** Provide ongoing support and mentoring for three of these support groups in the greater Portland area, in partnership with the National Alliance On Mental Illness.

- **Secured resources to run a focus group** in the refugee and immigrant community on integrated mental health and substance abuse treatment.

Integrated Services

From a broad perspective, a truly integrated service delivery system provides formal, publicly funded services as a supplement to existing natural supports and community networks. In areas where supports do not exist, DHHS takes responsibility to address those gaps seriously and augment local connections. DHHS also understands the importance of collaborating with other Departments to assure services for shared customers are provided seamlessly. Integrated services bridge traditional programs to simplify access to a wide range of benefits and coordinated services to improve the health, safety and productivity of Maine citizens.

Core Functions

DHHS programs are working together to address the complex needs of Maine citizens.

Principles of Integrated Services:

1. Consumer/family-centered and individualized;
2. Strengths-based;
3. Consumer/family driven to the extent possible;
4. Consumer/family members are always part of the team;
5. One comprehensive plan addressing all supports and services;
6. Maximizes natural supports.

Thus far, the priorities in support of integrating services have been to create a management structure that reflects an integrated model, which includes: implementing policy changes across boundaries; reforming data systems to increase the flow of information; and coordinating intake and eligibility processes system-wide.

Given the breadth of DHHS and the multitude of services it provides, it is critical to ensure that the complexity often associated with delivering the right services to the right people at the right time isn't passed along to consumers. It is recognized, however, that access to services is currently dispersed across an array of entry points, with multiple intake processes.

Given a new management infrastructure and additional federal resources to support the creation of an integrated system (approximately $2.9 million in federal funds), the following goals represent cross-system initiatives, linking all service areas in support of a vision to "speak with one voice" and deliver services from a "one-stop" approach:

- **Streamlining multiple existing intake and eligibility** processes is critical to developing a "one-stop system."
- Operating with **common customer service standards** includes establishing new assessment protocols and revising confidentiality laws, rules, and protocols (to the extent possible) to develop a uniform approach to sharing consumer and/or family information.
- One feature of an integrated service system is that families and individuals are **empowered to customize service options** against requirements

defined by the Department and within the available resources. Increasing the consumer's ability to choose and have some control over long-term supports is a well-established goal of integrating services.

- A workgroup made up of Department staff, consumers, judges, and family members is meeting to **improve the current guardianship process**. Changes along this service stream extend beyond the Department's boundaries and include making notable changes with probate court protocols.

MaineCare Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	251
Total Funding FY '06:	$2,109,309,202
General Fund:	$450,102,967
Federal Fund:	$1,455,919,913
Special Revenue:	$178,584,356
Block Grant:	$24,701,966

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Program Introduction

MaineCare is a health insurance program funded jointly by the federal government's Center for Medicare and Medicaid Services (CMS) and the state. MaineCare provides for Maine's children and adults who are elderly, disabled or with low incomes.

Maine Care Services

Over the past five years, the Legislature and the Department of Health and Human Services have added categories of services to the MaineCare program in an effort to reduce the number of people in Maine without health insurance. Today, 270,000 Mainers rely on MaineCare for access to needed medical care and health services.

Core Functions

- ❑ Quality and performance management, fiscal and operational performance
- ❑ Third party liability insurance research and recovery
- ❑ Claims intake and processing, including suspensions and adjustments
- ❑ Healthcare management, clinical, pharmaceutical and authorization management
- ❑ Policy development, legislative analysis
- ❑ Customer service for members and providers

Performance Goals

- ❑ Improve the management of the MaineCare health insurance program
- ❑ Promote access to appropriate medical care and health services
- ❑ Improve system outcomes

Performance Goal:	**Office of Maine Care Services**	**What We Have Learned:**
Improve the management of the MaineCare health insurance program funded jointly by the federal Center for Medicare and Medicaid Services and the state.	The Office of MaineCare Services has been restructured. The MeCMS system has been stabilized and future planning is underway.	The Department needs to partner with CMS to get to a certified Maine Management Information System. A plan is to be reported under a separate format.

MaineCare CASELOAD

	Traditional Medicaid	SCHIP Medicaid Expansion	SCHIP " Cub Care"	Medicaid Expansion Parents ≤ 150% FPL	Non-Categorical Adults ≤ 100% FPL	Medicaid Expansion Parents >150% FPL	SUBTOTAL	DEL\MaineRX Drug Programs	TOTAL
Jul-01	160,039	6,629	3,593	10,410	0	0	**180,671**	55,916	**236,587**
Aug-01	159,946	6,686	3,601	10,957	0	0	**181,190**	59,265	**240,455**
Sep-01	160,408	6,877	3,612	11,243	0	0	**182,140**	62,468	**244,608**
Oct-01	161,379	7,209	3,707	11,522	0	0	**183,817**	65,282	**249,099**
Nov-01	162,219	7,456	3,931	11,758	0	0	**185,364**	92,728	**278,092**
Dec-01	163,662	7,690	4,068	12,188	0	0	**187,608**	109,411	**297,019**
Jan-02	166,222	7,963	4,137	12,665	0	0	**190,987**	109,384	**300,371**
Feb-02	167,920	8,194	4,218	13,060	0	0	**193,392**	110,143	**303,535**
Mar-02	169,974	8,484	4,346	13,543	0	0	**196,347**	110,898	**307,245**
Apr-02	171,777	8,698	4,401	13,800	0	0	**198,676**	111,401	**310,077**
May-02	173,222	8,913	4,243	13,922	0	0	**200,300**	112,140	**312,440**
Jun-02	173,613	9,029	4,130	14,052	0	0	**200,824**	111,726	**312,550**
Jul-02	174,393	9,208	4,069	14,330	0	0	**202,000**	112,071	**314,071**
Aug-02	175,329	9,199	4,065	14,425	0	0	**203,018**	112,430	**315,448**
Sep-02	176,047	8,442	4,061	13,147	0	0	**201,697**	112,897	**314,594**
Oct-02	181,134	8,294	4,079	13,500	2,846	0	**209,853**	111,811	**321,664**
Nov-02	184,050	8,328	4,307	14,245	5,571	0	**216,501**	110,778	**327,279**
Dec-02	185,859	8,415	4,449	14,379	7,774	0	**220,876**	109,864	**330,740**
Jan-03	190,665	7,954	4,575	13,727	10,036	0	**226,957**	108,851	**335,808**
Feb-03	190,905	8,414	4,619	14,665	11,535	0	**230,138**	107,025	**337,163**
Mar-03	192,472	8,504	4,684	14,778	12,845	0	**233,283**	102,669	**335,952**
Apr-03	193,887	8,413	4,752	14,778	13,719	0	**235,549**	98,551	**334,100**
May-03	195,694	8,023	4,697	14,387	14,591	0	**237,392**	94,175	**331,567**
Jun-03	195,499	7,943	4,720	14,400	15,007	0	**237,569**	90,373	**327,942**
Jul-03	196,151	7,944	4,701	14,300	15,538	0	**238,634**	86,277	**324,911**
Aug-03	196,291	8,221	4,709	14,396	15,853	0	**239,470**	82,078	**321,548**
Sep-03	198,110	8,056	4,808	14,195	16,248	0	**241,417**	80,212	**321,629**
Oct-03	200,419	7,940	4,890	12,064	16,854	0	**242,167**	80,055	**322,222**
Nov-03	199,704	8,011	4,853	12,900	17,176	0	**242,644**	79,810	**322,454**
Dec-03	198,172	8,281	4,804	13,639	17,458	0	**242,354**	79,806	**322,160**
Jan-04	201,189	8,225	4,693	13,542	18,344	0	**245,993**	102,052	**348,045**
Feb-04	201,928	8,369	4,712	14,110	19,086	0	**248,205**	103,667	**351,872**
Mar-04	201,924	8,916	4,577	15,428	19,859	0	**250,704**	104,290	**354,994**
Apr-04	202,258	9,169	4,491	15,952	20,262	0	**252,132**	101,574	**353,706**
May-04	202,690	9,408	4,449	16,393	20,552	0	**253,492**	99,767	**353,259**
Jun-04	202,923	9,483	4,484	16,681	20,901	0	**254,472**	98,977	**353,449**
Jul-04	203,722	9,634	4,481	16,942	21,376	0	**256,155**	98,914	**355,069**
Aug-04	203,765	9,684	4,489	17,054	21,712	0	**256,704**	98,879	**355,583**

Sep-04	204,625	9,816	4,397	17,486	22,194	0	**258,518**	98,761	**357,279**
Oct-04	205,195	9,985	4,454	17,657	22,623	0	**259,914**	98,662	**358,576**
	Traditional Medicaid	**SCHIP Medicaid Expansion**	**SCHIP " Cub Care"**	**Medicaid Expansion Parents ≤ 150% FPL**	**Non-Categorical Adults ≤ 100% FPL**	**Medicaid Expansion Parents >150% FPL**	**SUBTOTAL**	**DEL\MaineRX Drug Programs**	**TOTAL**
Nov-04	205,862	10,011	4,420	17,904	23,072	0	**261,269**	98,588	**359,857**
Dec-04	207,217	10,064	4,372	17,821	23,669	0	**263,143**	98,515	**361,658**
Jan-05	207,966	10,150	4,225	18,116	24,383	0	**264,840**	98,514	**363,354**
Feb-05	208,138	10,087	4,127	17,972	24,925	0	**265,249**	98,611	**363,860**
Mar-05	209,545	10,067	4,000	18,078	24,460	0	**266,150**	98,942	**365,092**
Apr-05	210,550	10,040	3,899	18,070	23,333	0	**265,892**	96,318	**362,210**
May-05	210,394	10,165	3,816	18,270	22,021	611	**265,277**	95,006	**360,283**
Jun-05	210,096	10,047	3,942	18,354	20,556	1,631	**264,626**	92,697	**357,323**
Jul-05	209,973	10,073	4,076	18,339	19,248	2,442	**264,151**	90,084	**354,235**
Aug-05	209,974	10,145	4,200	18,319	18,029	3,075	**263,742**	90,018	**353,760**
Sep-05	209,806	10,106	4,262	18,447	16,895	3,766	**263,282**	91,875	**355,157**
Oct-05	210,191	10,220	4,360	18,587	15,933	4,040	**263,331**	93,247	**356,578**
Nov-05	210,502	10,254	4,498	18,607	15,087	4,288	**263,236**	89,773	**353,009**
Dec-05	210,666	10,200	4,505	18,453	13,634	4,340	**261,798**	90,360	**352,158**
Jan-06	211,114	10,417	4,504	18,669	12,972	4,545	**262,221**	89,237	**351,458**
Feb-06	212,099	10,408	4,482	18,671	12,462	4,749	**262,871**	88,944	**351,815**
Mar-06	213,767	10,111	4,568	18,500	11,824	4,907	**263,677**	86,548	**350,225**
Apr-06	213,195	10,276	4,504	18,749	11,430	5,010	**263,164**	85,735	**348,899**
May-06	213,410	10,235	4,489	18,776	11,058	5,091	**263,059**	84,463	**347,522**
Jun-06	213,643	10,270	4,509	18,876	10,795	5,108	**263,201**	84,780	**347,981**
Jul-06	212,833	10,325	4,483	18,920	10,872	5,048	**262,481**	84,119	**346,600**
Aug-06	212,515	10,310	4,504	18,824	16,123	5,100	**267,376**	78,888	**346,264**
Sep-06	212,686	10,264	4,505	18,730	18,091	5,005	**269,281**	76,213	**345,494**
Oct-06	212,938	10,343	4,530	18,891	19,249	5,090	**271,041**	74,707	**345,748**
Nov-06	212,796	10,292	4,533	18,918	20,249	5,129	**271,917**	73,691	**345,608**

DHHS Eligibility Descriptions:

• Traditional Medicaid includes adults and children in receipt of a financial benefit (TANF, IV-E); aged and disabled persons in receipt of a financial benefit (SSI, SSI Supplement), institutionalized persons (NF), and others not included below.

• SCHIP (State Child Health Insurance Program) Medicaid Expansion Children (M S-CHIP) are children with family incomes above 100% and up to and including 150% of the Federal Poverty Level (FPL).

• SCHIP "Cub Care" Children (S S-CHIP) are children with family incomes above 150% and up to and including 200% of FPL.

• Medicaid Expansion Parents are persons who function as the primary caretakers of dependent children and whose income is above 100% and up to and including 150% of FPL; and beginning May 2005, up to and including 200% of FPL.

• Non-Categorical Adults are persons who are over 21 and under 65, not disabled, not the primary caretakers of dependent children, and whose income is not more than 100% of FPL.

• DEL\MaineRX Drug Programs include persons eligible for Medicaid, but not for "full benefits" (e. g., QMB, SLMB, QI) who meet the criteria for participation in DEL and/ or Maine Rx; and persons who meet ONLY the criteria for participation in DEL and/ or Maine Rx.

Highlights and Successes

- **MaineCare Primary Care Case Management (PCCM)** is a voluntary managed care model and is available to all MaineCare members who receive TANF, families with children, State Children's Health Insurance Program members and childless adults. More than 160,000 MaineCare members have a "medical home" providing or managing most of their care. The medical home is important for members to receive appropriate preventive care and on-going management of chronic conditions.

  - 85 percent of Maine's primary care professional capacity participates in the PCCM program making the PCCM provider to patient ratio an average of one provider for every 135 patients.
  - 60 percent (165,000) of MaineCare members have a medical home that provides them with preventive services, 24/7 service and referrals to specialty services.
  - 90 percent (144,000) of MaineCare PCCM participating members have chosen their own primary care physician, increasing the likelihood that they will follow advice of their physician (national average is 75 – 80 percent).

- **Improved performance of the MeCMS claims processing system**
  - MaineCare's Claims Management System processes 1.7 million claims from nearly 7,000 providers annually. Problems identified in the days following implementation of a new computer system in January 2005 are well-documented. Progress has been made in stabilizing the system and implementing corrections that now allow claims to be processed.
  - The September 2006 performance for turnaround time revealed that 89.2 percent of fresh claims received were processed within 14 calendar days and 91.6 percent processed within 30 calendar days.
  - The Office of MaineCare Services will continue to monitor adjudication rates, turnaround time for processing claims and the quality of processing.

- **Improved customer service**
  - The Office of MaineCare Services' customer service function has been reorganized and staffing has increased. The Division of Customer Service now operates distinct units for billing and information, provider relations, provider enrollment and member relations. Every Maine county is assigned a team of provider relations representatives that assists providers with questions and training on issues related to policy, billing and claims.
  - The billing and information unit has reduced its abandoned call rate to less than 7 percent, from a high of more than 30 percent during the first quarter of 2006. The unit receives an average of 6,600 calls per month.
  - Recently the unit added two positions dedicated to training. This will allow staff to ensure that all providers receive the most current information available. An upgrade of the current phone system will enhance the customer service process, along with implementing call and contact tracking software.

Integrated Access and Support

Funding At a Glance

Total Staff (Full-Time Equivalencies):	856.5
Total Funding FY '06:	$368,043,234
General Funds:	$77,843,980
Federal Funds:	$8,737,801
Special Revenue:	$135,027,683
Block Grants:	$76,433,770

Barbara Van Burgel
Director

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Program Introduction

The Office of Integrated Access and Support (OIAS) assists Maine citizens to meet their basic needs while providing opportunities to achieve their maximum potential independence, employability, safety and health.

Integrated Access and Support

Integrated Access and Support serves more than 400,000 Maine citizens each month with 26,000 to 28,000 served in person, in local offices.

The services provide temporary cash assistance, employment and training, food, medical coverage, Social Security Disability determination and child support collection assistance.

Core Functions

- **Temporary assistance for Needy Families (TANF)** provides temporary, time-limited financial assistance to needy, dependent, deprived children and their parents to meet their basic needs while being cared for in their homes. The average payment is $381 monthly. Maine citizens may apply for these other TANF-funded programs:

  - Families may qualify for a payment of up to $50 monthly when certain housing costs equal or exceed 75 percent of their income. The payment is referred to as the Special Needs Housing Allowance.
  - Families may volunteer to receive Alternative Aid instead of TANF if they only need short-term assistance to retain or obtain employment. This vendor-payment assistance is available once a year.
  - The Emergency Assistance Program assists families by preventing a crisis, such as an eviction from their home or a utility disconnect. The once-a-year program pays vendors directly.
  - Transitional Services provide families leaving TANF for work with the work supports they need to maintain employment. These services include child care subsidies, transportation assistance and child support collection.
  - Additional Support for People in Retraining and Employment (ASPIRE) provides assistance to TANF parents in developing individual employment plans that will support their family. ASPIRE support services assist TANF families in preparing for, obtaining and retaining employment. Support services such as child care and transportation are needed to participate in ASPIRE programs. Types of ASPIRE services available: career/life planning, job skills training, job search assistance, job placement and support services necessary to successfully complete the individual employment plan such as transportation, child care and certain other services.

- **The federally-funded Food Stamp Program** serves as the first line of defense against hunger. An average benefit is $177 monthly and food stamp benefits are paid exclusively with federal dollars. Low-income families can buy nutritious food with Electronic Benefit Transfer (EBT) cards. Food Stamp recipients spend their benefits to buy eligible food in authorized retail food stores. The amount of food stamps is based on the U.S Department of Agriculture's Thrifty Food Plan, which is an estimate of how much it costs to buy food to prepare nutritious, low-cost meals for the specific size household. This estimate is changed every year to keep pace with food prices.

- **Child Support Enforcement** assists welfare and non-welfare families with establishing paternity and securing financial and medical support, while its Recovery unit collects overpaid assistance/benefits and support services. While TANF families receive a share of the child support collected on their behalf, the Department also retains a share to help offset the cost of providing assistance.

- **Fill-the-Gap**, Maine's TANF program's budgeting methodology, allows TANF families to get some or all of the child support collected for the family. When the Department collects current child support from the parent who does not live with the TANF family, the TANF family gets up to the first $50 monthly as a Pass Through Payment. When the Department collects more that $50 in current or arrearage child support, the TANF family may receive a supplemental TANF payment, referred to as a Gap Payment. The average payment is about $100 monthly.

- **MaineCare** provides many categories of health care coverage and payment for some prescription drugs. The Office of Integrated Access and Support is responsible for determining eligibility and implementing the program, while the Office of MaineCare Services handles billing and other related functions.
  - DEL and Maine RX programs provide assistance with the cost of prescription drugs.
  - Children and Young Adults health coverage (some with premiums) for newborns through age 20.
  - Health coverage for pregnant women, elders, and the people who are disabled; people age 21 and over who have dependent children living in the home.
  - Health coverage for adults who are between age 21 and 64 who have no dependent children living in the home, have not been determined to be disabled, and do not meet qualifications for another MaineCare benefit package. (Non-categorical)
  - Home and Community-Based Benefits for People with Mental Retardation provides health coverage for mentally retarded or autistic adults 18 and over.
  - Home and Community-Based Benefits for the Physically Disabled provides health coverage for adults who have physical disabilities and the capacity to direct their own services.
  - Home and Community-Based Benefits for the Elderly and Adults with Physical Disabilities.
  - Health coverage for people who are living with HIV/AIDS, pregnant women who are presumptively eligible and inmates in jails.
  - Emergency health coverage only for non-citizens who have no documents from Homeland Security.
  - Health coverage for residents of nursing homes.
  - Health coverage for residents of residential care facilities.

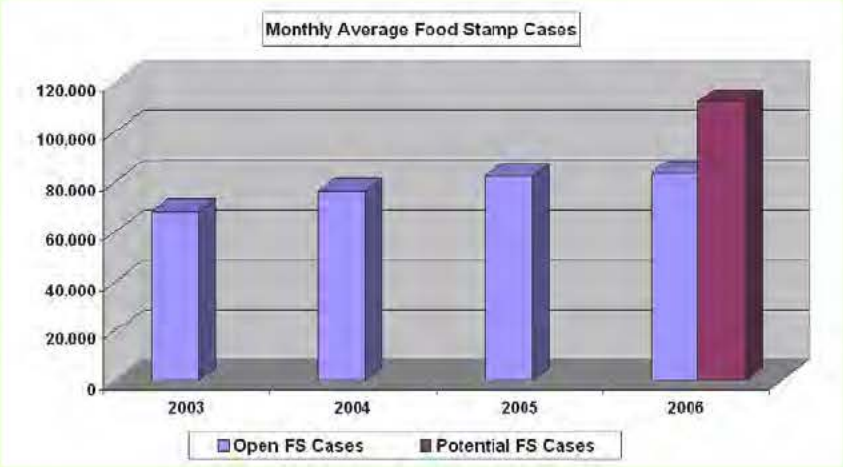
- **Disability Determination**
  - **For TANF and MaineCare Benefits**: The Medical Review Team (MRT) determines disability status of clients for TANF disability programs and disability-related MaineCare programs. Disability determinations are based on providers' medical records and consultation with physicians contracted by the Department. Applicants found eligible get health care coverage.
  - **For Social Security Disability Benefits**: The Disability Determination Services (DDS) Unit processes applications filed for Social Security disability benefits based on Social Security rules and regulations. Applicants found to be disabled receive monthly cash benefits from the federal Social Security Administration.

Performance Goals

- ❑ Protect and enhance the health and well being of Maine people.
- ❑ Promote independence and self-sufficiency
- ❑ Provide effective stewardship for the resources entrusted to the department: maintain and/or improve the cost effectiveness of child support and eligibility determinations.

Performance Goal:

Increase the percentage of potentially eligible people receiving food stamps to 75 percent.

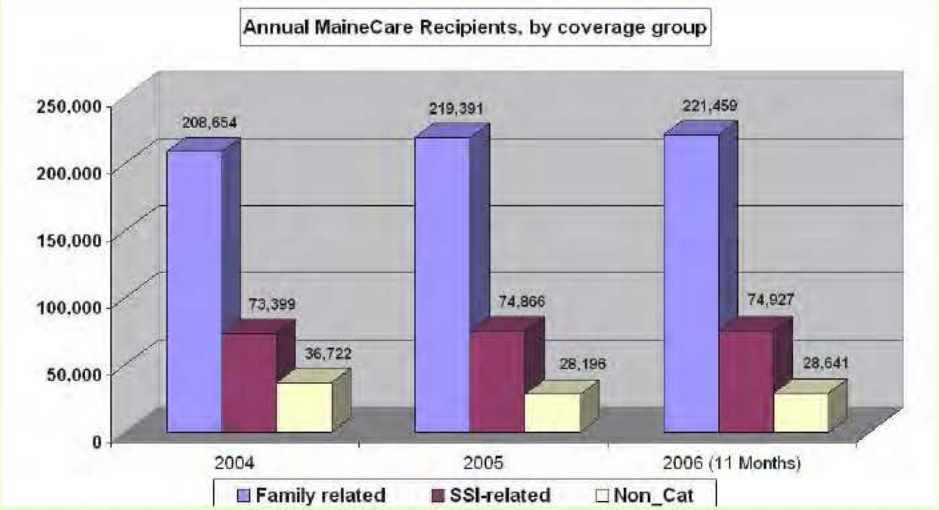


What We Have Learned:

There is potential to reach additional people eligible for Food Stamps. National access and penetration rate is 60 percent, Maine's is 72.3 percent. The Food Stamp Program also plays a vital role in Maine's economy, bringing $169,291,080 in federal funds to markets and stores throughout Maine in 2006.

Performance Goals:

Assure access to health care coverage through MaineCare.

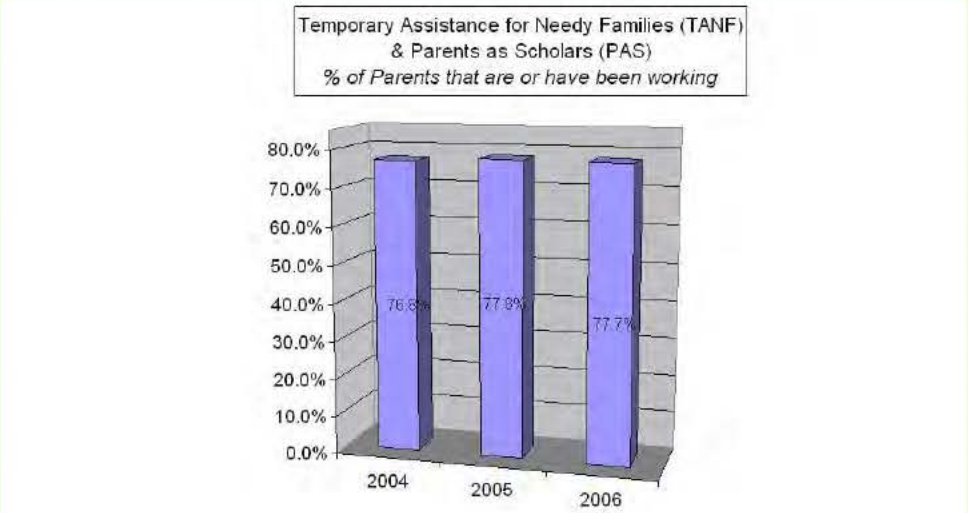


What We Have Learned:

The number of MaineCare recipients show a slight increase over the past three years.

Performance Goal:

Increase the number of TANF parents employed and transitioning to financial independence from cash benefits.

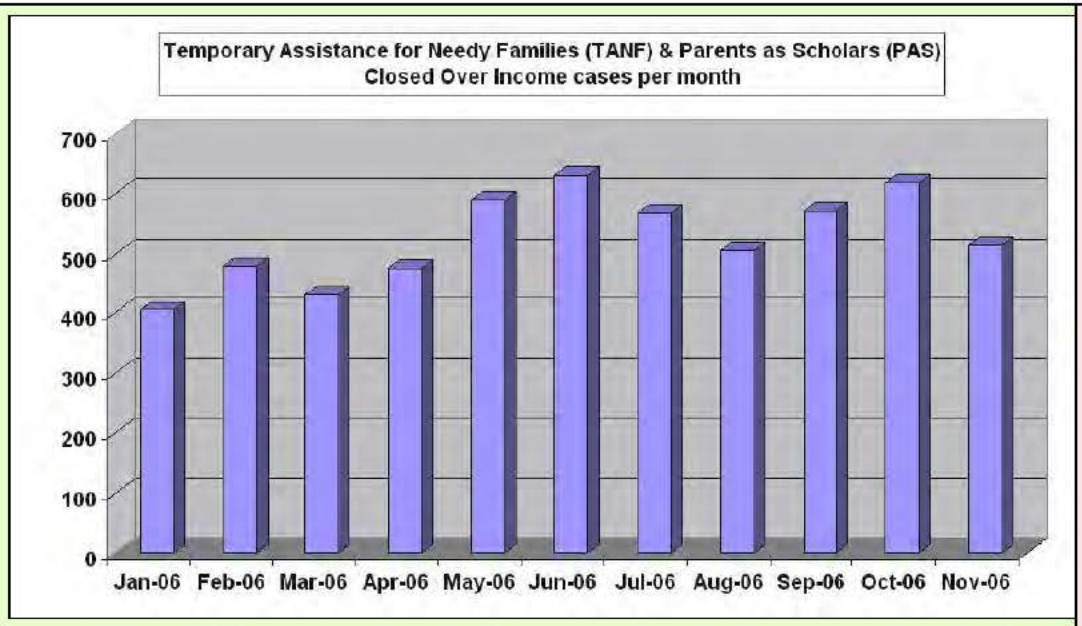


What We Have Learned:

The percentage of parents that are or have been working during the past 3 years has remained stable.

Performance Goal:

Promote Independence and self-sufficiency.

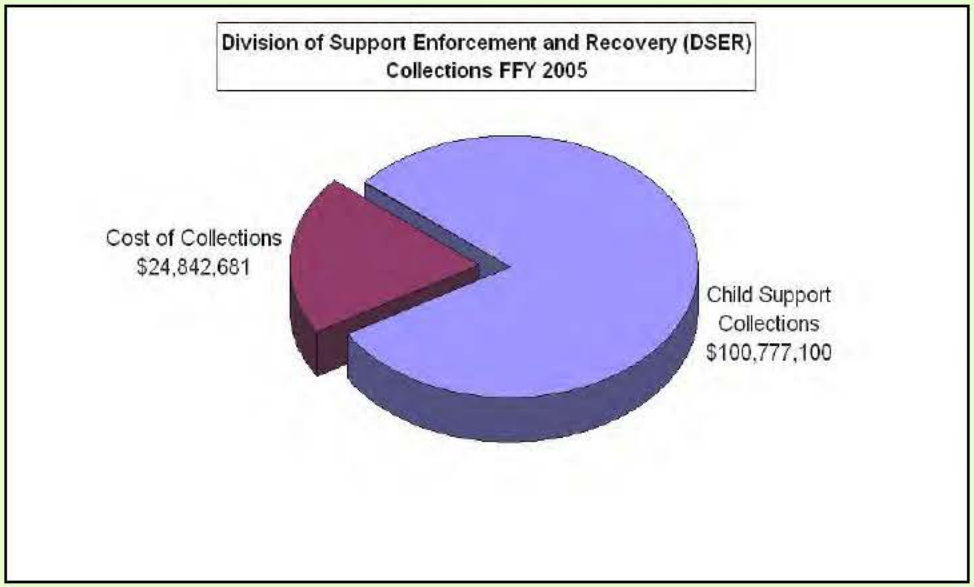


What We Have Learned:

There has been an increase in the number of cases closed due to increases in non-welfare income, (e.g. wages), January through November of 2006.

Performance Goal:

Maintain and or/improve the cost effectiveness of child support and eligibility determinations.



What We Have Learned:

During FFY 2005 the cost of collections was $24,842681 while child support collections totaled $100,777,100.

Maine has a return of $4.27 for each $1.00 dedicated to collection of child support payments.

Highlights & Successes

- The TANF caseload decreased 35.8 percent, from a high of 23,268 in December 1991 to 13,654 in October 2006.

- The welfare reform law abolished the AFDC program in 1996 and established the TANF program. Prior to 1996, the average monthly cost for providing cash assistance to the AFDC caseload was $7.6 million, which equals approximately $10 million in 2006. In calendar year 2006, the average monthly cost of the TANF caseload was $5.2 million. In nominal dollars, this is a cost reduction of 31.6 percent. But if you take inflation into account, this is a cost reduction of 48 percent.

- In early 2005, the TANF/ASPIRE Program received a cash award of $2,563,677 for its FFY 2003 work participation performance. Maine ranks fifth highest in the nation in job retention for former TANF recipients, contributing to its receipt of a High Performance Award from the federal government for the last four years. Awards for TANF and ASPIRE come from the US DHHS Administration for Children and Families.

- In June 2005, Maine's ASPIRE Program was presented an award by the United States Small Business Administration's 2005 Women in Business Champion Award.

- The average length stay on TANF is 21 months.

- In FFY 2005, the TANF Program received a cash award of $3,032,827 for continued participation by TANF/ASPIRE recipients in the Food Stamp Program; and in prior years, the TANF Program has received bonus awards for continued access in the MaineCare Program.

- In FFY 05, Maine's Food Stamp Program was awarded $739,296 for increasing access to the Food Program in FFY 2004. In FFY 06, Maine's Food Stamp Program was awarded approximately $440,475 for increased access to the Food Stamp Program in FFY 06. Food Stamp funding comes from the USDA Food and Nutrition Service.

- For the last five years, Maine has had the highest Child Support collections per TANF case in the New England region and the highest percentage of TANF cases with support orders. A 2005 report indicates that in FFY 04, the Child Support Enforcement Program collected $108 million in child support and distributed more than $90 million directly to Maine families.

- The Parents as Scholars program has helped thousands for TANF-eligible parents obtain post secondary degrees which can lead to well paying jobs. Graduates earn nearly 50 percent more than those without a degree and report that the aspirations of their children are increased. This program has won several awards.

Maine Center for Disease Control and Prevention

Funding At a Glance

Total Staff (Full-Time Equivalencies): 377.5

Total Funding FY '06:	$116,519,186
General Fund:	$ 13,320,638
Federal Fund:	$ 65,272,508
Special Revenue:	$ 30,321,248
Block Grant:	$ 5,204,792
Trust Fund:	$ 2,400,000

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Program Introduction

The Maine Centers for Disease Control and Prevention is Maine's state public health agency. As such, it provides public health expertise and services toward advancing the Department of Health and Human Services' goal of protecting and enhancing the health and well-being of Maine people, as well as the State Health Plan's goal of Maine becoming the healthiest state in the nation. MeCDC strategic planning themes are:

- ❑ Excellence in Public Health
- ❑ Efficient Public Health Structures
- ❑ Effective Communication

Maine Center for Disease Control and Prevention

The Maine CDC provides public health expertise and services toward advancing DHHS's goal of protecting and enhancing the health and well-being of Maine people as well as the State Health Plan's goal of Maine becoming the healthiest state in the nation.

Core Functions

2006-2007 Maine CDC Focus Areas:

- ★ **Pandemic Influenza** (leading the State's pandemic influenza public health preparedness efforts)
- ★ **DHHS Integration** (pursuing new opportunities to integrate public health functions to serve the public more effectively)
- ★ **State Health Plan** (helping to implement areas of the Plan)
- ★ **Communication** (improving internal and external communication)

Public health service is different from the practice of medicine. Instead of working with each individual person, as health care providers do, public health approaches health by working with groups (populations) of people – "population health". In other words, instead of treating people with food poisoning, we inspect public places where food is prepared to help prevent outbreaks, we track reportable diseases such as food poisonings, and we investigate reports to stop ongoing spread of the disease.

The Maine CDC's overall public health goals are longer and healthier lives for all of Maine people, with a focus on addressing health disparities. Our goals and objectives for the decade are found in Healthy Maine 2010 on our web site, www.mainepublichealth.gov.

Today, the Maine CDC is organized into five divisions:

1. Chronic Disease
2. Environmental Health
3. Family Health
4. Infectious Disease
5. Public Health Systems

The Maine Center for Disease Control and Prevention includes the following programs:

Minority Health
Environmental Health
Medical & Epidemiological Consultation
HIV, STD & Viral Hepatitis
Immunizations
Infectious Disease Epidemiology
Maternal & Child Health
Public Health Nursing
Special Health Needs
Youth Development
Data & Information systems
Public Health Information
Health Systems Resources
Public Health Emergency Preparedness
Public Health Laboratory
Cancer Control
Disease Prevention & Management
Healthy Maine Partnerships

Public health uses evidenced-based approaches to protect and improve the health of the public. In practice, the Maine CDC is working every day to carry out the 10 essential public health services:

1. Understand health issues at the state and community levels *(Or "what's going on in our state/community? Do we know how healthy we are?")*

2. Identify and respond to health problems or threats *(Or "Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?")*

3. Keep people informed about health issues and healthy choices. *(Or "How well do we keep all people and segments of our State informed about health issues?")*

4. Engage people and organizations in health issues. *(Or "How well do we really get people and organizations engaged in health issues?")*

5. Plan and implement sound health policies. (Or "What policies promote health in our State? How effective are we in planning and in setting health policies?")

6. Enforce public health laws and regulations. (Or "When we enforce health regulations are we up-to-date, technically competent, fair and effective?")

7. Make sure people receive the medical care they need. (Or "Are people receiving the medical care they need?")

8. Maintain a competent public health and medical workforce. (Or "Do we have a competent public health staff? How can we be sure that our staff stays current?")

9. Evaluate and improve programs. (Or "Are we doing any good? Are we doing things right and doing the right things?")

10. Support innovation and identify and use best practices. (Or "Are we discovering/using new ways to get the job done?"

Since public health is a set of strategies, we work with many partners to accomplish our work. For instance, we work closely with virtually all other state agencies, as well as a large number of statewide and local private and public organizations.

Performance Goals

Public Health Infrastructure

Performance Goal:	**Public Health Infrastructure**	**What We Have Learned:**
Ensure that state and local health agencies have the infrastructure to provide essential public health services effectively.	Maine is one of few states without a statewide public health infrastructure. As a result, we do not have public health professionals in every area of the state to address health issues such as assisting with pandemic influenza preparedness.	As part of the State Health Plan approved by the Legislature, the Governor's Office of Health Policy and Finance in 2005 convened the Public Health Work Group (PHWG) to develop a statewide public health infrastructure within existing resources. LD 1614 was subsequently enacted in 2006, directing the PHWG to address the need for a statewide system of comprehensive community health coalitions.

Health Disparities

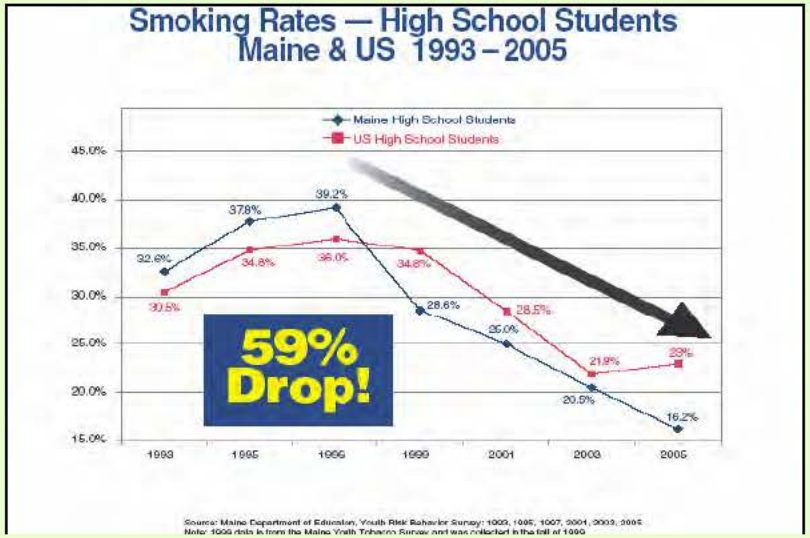
One of the overarching public health goals for this decade (Healthy Maine 2010) is to eliminate health disparities, which are discrepancies in health status for which there is not a biological basis. For instance, it is known that those who are from a racial or ethnic minority, who are poor, who have low educational opportunities, or who are a sexual minority have poorer health status than others; yet, there is no biological reason for most of these discrepancies. Additionally, gender, age, and geographical residence can also affect one's health status in non-biological ways.

This past year, an Office of Minority Health was created to assure state government and health systems are addressing the disparities faced by Maine's growing racial minority population. We continue to face challenges in assessing the health of Maine's minority populations as well as analyzing existing data with respect to some populations facing disparities. Without adequate assessments we are unable to provide effective interventions.

Maine is a leader in addressing our number one underlying killer – tobacco addiction.

Performance Goal:

Reduce tobacco use by adolescents (students in grades 9-12).

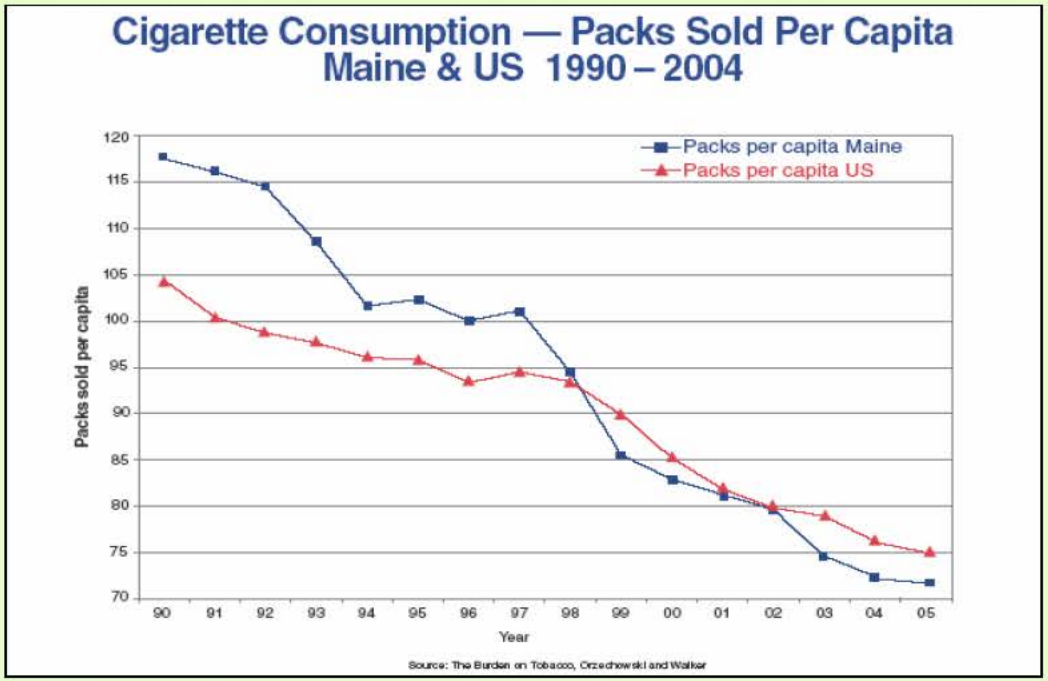


What We Have Learned:

Since 1997, we have seen a 60 percent decrease in our youth smoking rates and since 1990, a 40 percent reduction in our adult cigarette consumption.

Performance Goal:

Reduce tobacco use.



What We Have Learned:

The amount of cigarettes purchased has decreased dramatically since 1990 and has fallen below the national average.

This success is a direct result of policies and funding over the last few years supported by Maine's Governors and Legislatures. Examples include:

- ❑ Smoke-free laws;
- ❑ Cigarette tax increases;
- ❑ Enforcement of Maine's tobacco laws; and
- ❑ Funding from Maine's share of the National Tobacco Settlement (Fund for a Healthy Maine) for a comprehensive approach.

We continue to face challenges to these successes, especially because of the ongoing mass marketing by the tobacco industry. Some challenges include:

- ❑ Significant numbers of Maine children are exposed to secondhand smoke at home and in cars, contributing to our high rates of asthma and other childhood diseases (about one-third of adolescents are exposed to secondhand smoke 1-6 days per week at home or in cars);
- ❑ Nationally, youth tobacco addiction rates are starting to increase;
  - ❑ Non-cigarette products such as snuff and cigars are gaining in popularity;
  - ❑ Almost one-third of Maine young adults (who are also commonly parents of young children) are tobacco addicted; and
  - ❑ One in five adults are tobacco addicted, and about 50,000 Maine adults suffer from tobacco-related disease.


AMERICAN LUNG ASSOCIATION

2005 STATE OF MAINE TOBACCO CONTROL

Report Card

SUBJECT	GRADE
Tobacco Prevention and Control Spending	A
Smoke-Free Air	A
Cigarette Tax	A
Youth Access	A

Maine Is First State to Receive Straight A's

The American Lung Association salutes Maine for having the best grades in the nation. Maine scores an A on tobacco prevention and control spending, smoke-free air, cigarette tax, and youth access

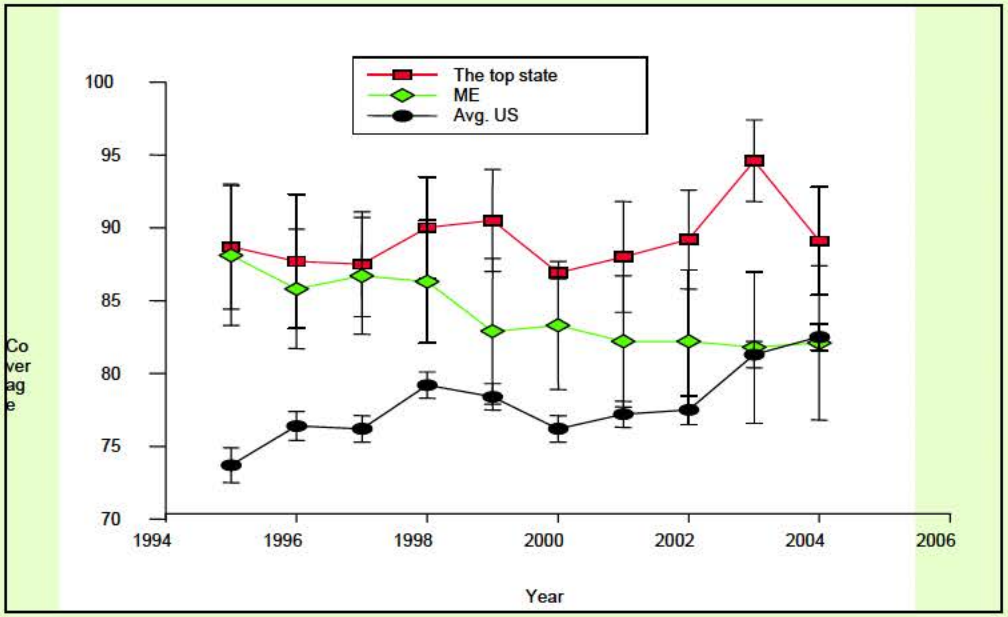
We are proud of Maine's accomplishments, including the first-in-the-nation straight A report card from the American Lung Association, and we continue to work with many partners across the state to address this tragic toll on the health and well-being of Maine people and communities.

Childhood Vaccinations

Increase of Childhood Vaccines and Price in the US		
Year	Number of vaccine	Cost of vaccine ($)
1985	7	$45
1995	10	$155
2005	14	$584

Performance Goals:

- Prevent disease, disability and death from infectious diseases, including vaccine-preventable diseases.
- Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.



What We Have Learned:

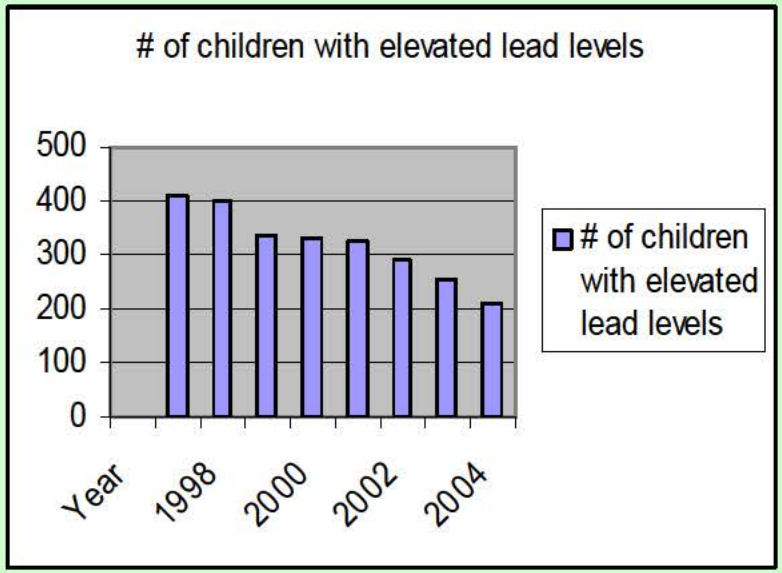
In the mid-late 1990s Maine enjoyed some of the highest childhood immunization rates in the country, with about 90 percent of our two-year-olds fully vaccinated. However, since then, rates have decreased to below the national average, to a rate of about 80 percent.

Promote health for all through a healthy environment - lead poisoning

In 2005, the Maine Legislature passed legislation creating the *Lead Poisoning Prevention Fund* from an assessed manufacturer's fee on paint sold in Maine (PL 2005 c.403). The funds are earmarked for public education and outreach efforts designed to prevent lead exposure before lead poisoning occurs. Together with our Childhood Lead Poisoning Prevention grant from the U.S. Centers for Disease Control and Prevention, these funds will afford us the opportunity to implement projects intended to prevent lead exposures in young children.

Performance Goal:

Eliminate childhood lead poisoning by the year 2010.



What We Have Learned:

The number of identified children aged 0-72 months with confirmed elevated blood lead levels or above the CDC threshold has declined from 412 children in 1997 to 211 children in 2004. This decline occurred while screening rates increased between 2000 and 2004.

In 2004, 50 percent of one-year-olds and 25% of two-year-olds were screened for lead exposure. Lead poisoned children are found in all regions of the state. Children in the most rural areas are as likely to be lead poisoned as their urban counterparts.

Lead poisoning, continued

Performance Goals:		**What We Have Learned:**
▪ Increase blood lead testing rates among one- and two-year old children with MaineCare coverage. ▪ Reduce the proportion of children who are lead-poisoned.	The Maine Childhood Lead Poisoning Prevention Program conducts home lead inspections for all children with confirmed high blood lead levels.	Lead paint can still be found in homes built prior to 1978; most frequently it is found in pre-1950 homes. Approximately half of the lead- poisoned children reside in rental housing, while half of the lead- poisoned children live in old homes where renovation or remodeling work that disturbs old lead paint is being done.

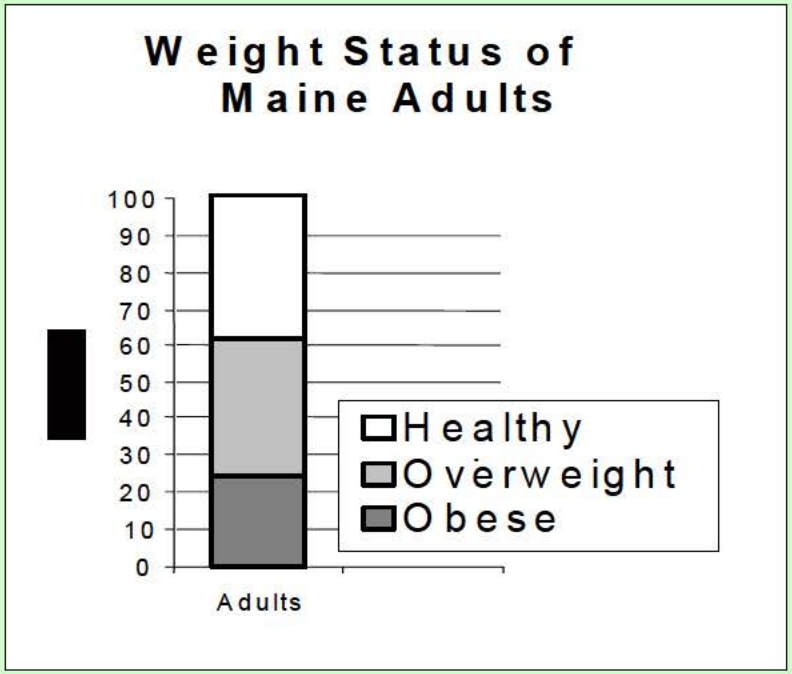
Pandemic Preparation

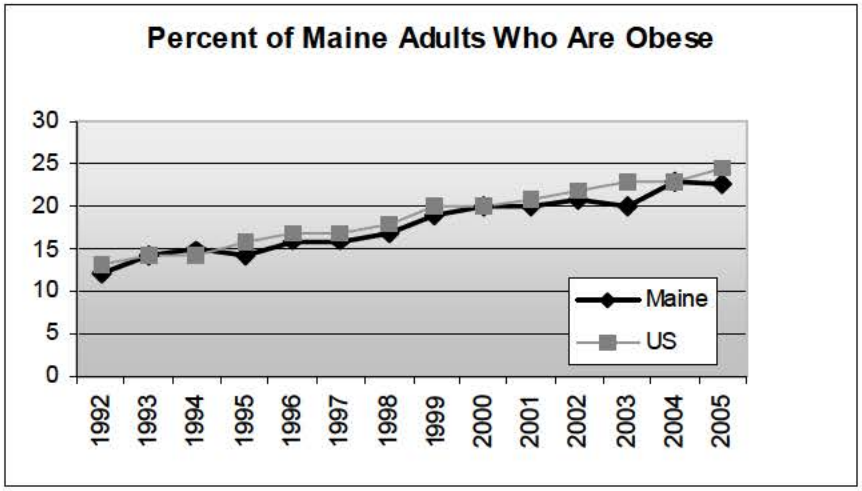
Performance Goal: Improve our preparedness for public health emergencies.	Since the September 11, 2001 attacks, one of our highest priorities has been to improve our preparedness for public health emergencies such as attacks with a weapon of mass destruction or a pandemic (worldwide epidemic). For 2006-2007, our priorities include: ▪ Updating the state pandemic influenza plan; ▪ Assisting counties and hospitals to develop pandemic influenza plans; ▪ Exercising state, county, and hospital plans.	**What We Have Learned:** With the spread of a strain of H5N1 avian influenza virus, we have been preparing for the arrival of this virus in birds as well as the possibility that it could evolve to a human pandemic. This work involves collaboration and coordination with many partners, including the Maine Emergency Management Agency (MEMA), Departments of Agriculture and Inland Fisheries and Wildlife, Maine Emergency Medical Services (Maine EMS) and behavioral health experts at Maine DHHS.

Decrease Obesity

Performance Goal:

Improve access to comprehensive, high quality health care services and effective prevention interventions.





What We Have Learned:

Obesity is one of the most serious and increasing public health threats in the United States today, as obesity and overweight rates have almost doubled since 1992. With 61 percent of Maine adults overweight or obese, our burden of chronic diseases are expected to increase unless we address underlying physical activity and nutrition challenges we face. Indeed, obesity contributes significantly to chronic diseases that account for the leading causes of premature death – cardiovascular disease, diabetes, cancer and chronic lung disease.

Obesity, continued

Diseases Associated with Obesity/Overweight

- Heart Disease
- Stroke
- Type 2 Diabetes
- Cancer
- Chronic Lung Disease
- Sleep Apnea
- Osteoarthritis
- High Blood Pressure
- Infertility
- Pregnancy Complications
- Gout
- Bladder Control Problems
- Psychological Disorders
- Depression
- Low Self-Esteem
- Eating Disorders

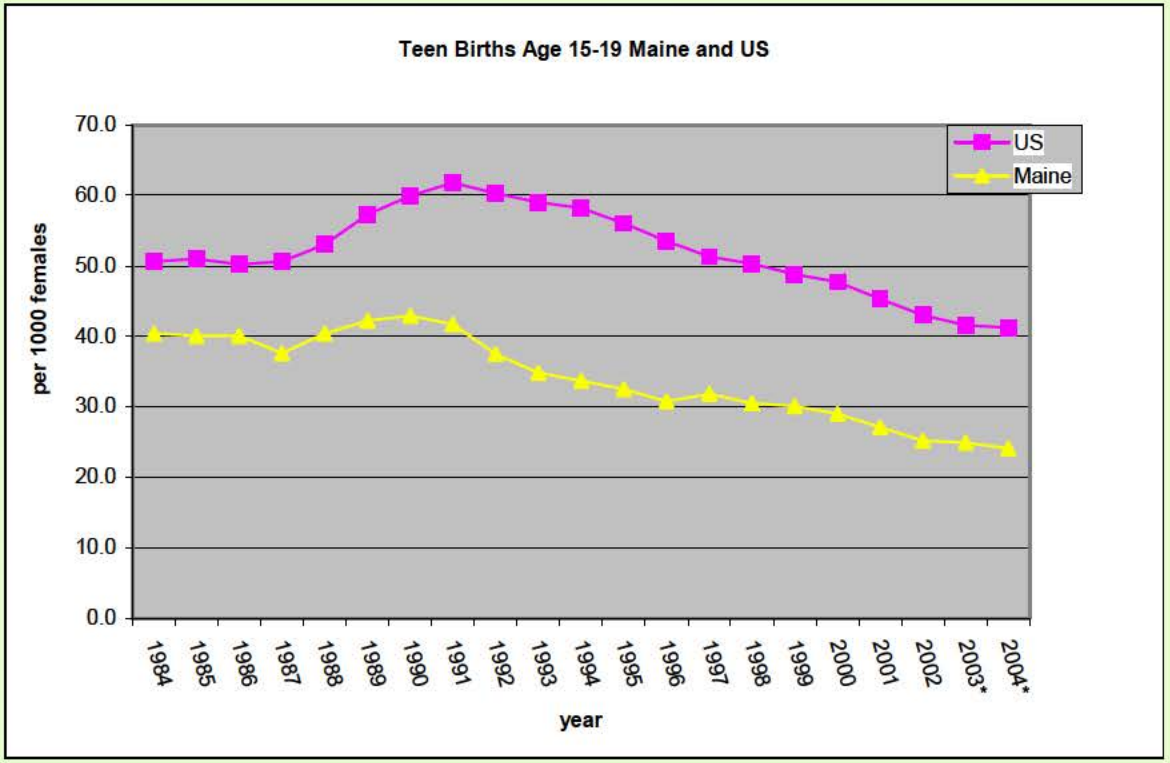
Youth rates of obesity are of particular concern. About one-third of Maine youth are at an unhealthy weight, including 36 percent of kindergarteners. The current generation of young people in the United States may be the first generation to not live as long as their parents if the current trends in obesity continue.

The Maine CDC's Physical Activity and Nutrition Program was created two years ago with funding from the Federal CDC. The program worked with many partners across the state to develop Maine's Physical Activity and Nutrition Plan, which was released in 2006. The plan proposes using a comprehensive approach, with strategies similar to those successfully implemented to address tobacco in Maine. For example, current priorities include: facilitating the construction of walking and bicycle paths; improving physical activity and nutritional opportunities in schools; increasing available data on youth obesity; and reducing the amounts of advertising seen by youth for unhealthy foods.

Improve pregnancy planning and spacing, prevent unintended pregnancy and improve the health of women and infants

Performance Goal:

Reduce pregnancies among adolescent females.



What We Have Learned:

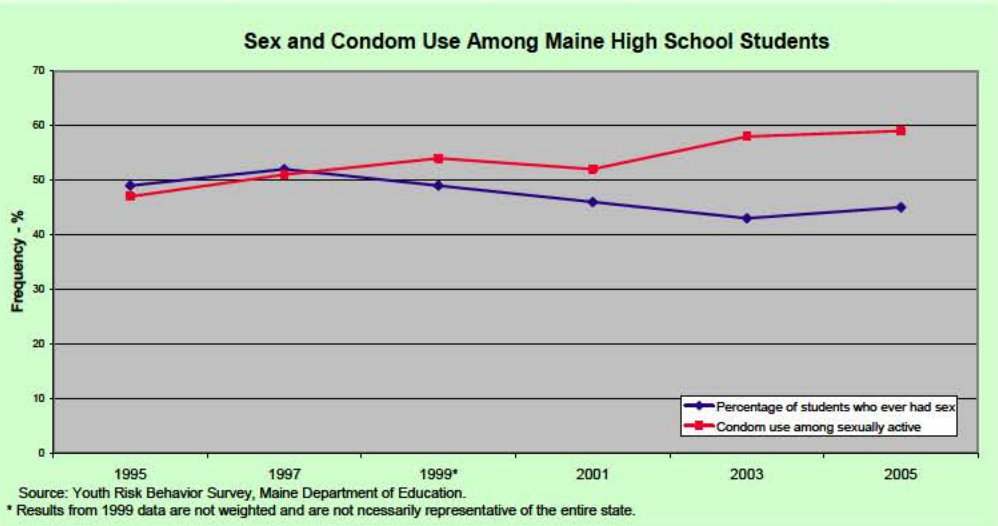
Twenty years ago Maine had one of the highest teen pregnancy rates in the country. Maine now **has one of the five lowest teenage birth rates in the country.** This rate has declined faster than any other state since the 1990s. Over the last 20 years Maine has cut its teen pregnancy rates in half.

The Healthy Maine 2010 goal of 16.3 pregnancies per 1000 women ages 15-17 has not yet been met. However, with a current rate of 17.1, we are on track if current reductions continue. For older teens, reductions in pregnancy rates have not been as great.

Pregnancy, women and infant health, continued

Performance Goal:

Reduce pregnancies among adolescent females.



Source: Youth Risk Behavior Survey, Maine Department of Education.
* Results from 1999 data are not weighted and are not ncessarily representative of the entire state.

What We Have Learned:

The decline in Maine's teen birth and pregnancy rate can been attributed to our longstanding support for family planning services for teens and low-income women, and our support and implementation of comprehensive family life education in the context of a comprehensive K-12 health education curriculum. With support from state and community programs, adolescents in Maine continue to show improvement in delaying sexual behavior and using birth control when they are sexually active.

Pregnancy, women and infant health, continued

One in three (33.5 percent) births in Maine are unintended, even though Maine has one of the highest rates of birth control use for women 18 and over who are at risk of becoming pregnant (88 percent). The majority (77 percent) of youth under age 20 report that their pregnancy was unintended.

In the coming years, we believe this percent will decrease as more teens receive comprehensive health education and develop aspirations that encourage the delay of childbearing. Among young adults (ages 20-24), about half of all births are unintended, accounting for more than one-third (37 percent) of the unintended births in Maine. We believe that these numbers will decrease as more young women access preventive family planning services.

Although we have made substantial progress in reducing teen pregnancy rates, the poor health and social outcomes for teen parents and their children, coupled with health care and social services costs to the state, teen pregnancy, remains a public health issue.

In order to continue the progress we must:

- Continue to track trends in outcomes and use data to better understand our accomplishments and challenges in reducing risk factors and increasing supports for healthy choices in youth.
- Facilitate the adoption of comprehensive family life education in more schools.
- Better address the needs of older teens and young adults who are at greater risk of unintended pregnancy.

Identify and Respond to Factors Contributing to Infant Mortality

The infant mortality rate is a sensitive public health indicator of social health and well-being. The most common causes of infant death in Maine are birth defects, prematurity, and Sudden Infant Death Syndrome (SIDS). Nearly every year, one Maine woman dies from a pregnancy-related cause. An average of four women die per year during or just after pregnancy, mostly due to injuries and cancer. Even when we know 'what' is associated with infant and maternal deaths, we often cannot answer the other 'why', 'how', 'who', and 'when' questions that could lead us to creating stronger and more humane policies, systems, and services for women and infants.

As specified in Chapter 467 (H.P. 984 – L.D. 1420), the Maine CDC is establishing a Maternal and Infant Mortality Review (MIMR) Panel to reduce morbidity and mortality, strengthen community resources and enhance systems and policies to improve the health of women, infants, and families. The MIMR panel will review cases so that we will recognize emerging patterns that represent opportunities to prevent future maternal and infant deaths, reduce morbidity and increase the availability of prevention services. The panel will present an annual report to DHHS and the Legislature that will identify factors contributing to maternal and infant deaths in Maine, determine the strengths and weaknesses of current health care and other systems, and make recommendations to DHHS to decrease the rate of death and morbidity.

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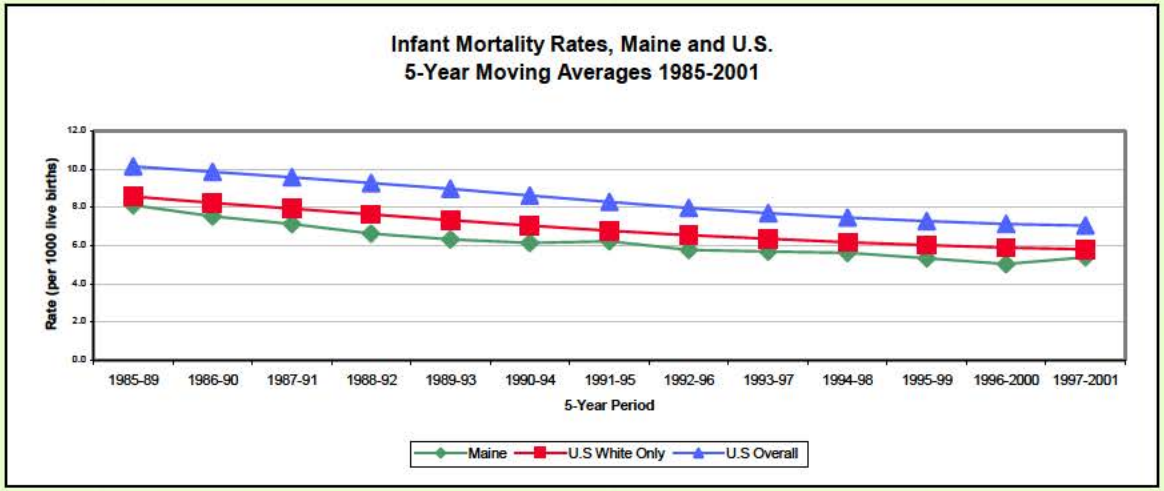
Performance Goal:

Reduce infant deaths.



What We Have Learned:

Although infant mortality has declined in Maine and the U.S. the rates remain relatively high in relation to other developed nations.

Prematurity, a known risk factor for infant mortality and morbidity, has increased steadily in Maine.

Reduce injuries, disabilities and deaths due to unintentional injuries, suicide and violence (behavioral risks)

Performance goals include:

- Increase the use of safety belts.
- Continue promoting child passenger safety laws and federal funding for child passenger safety activities.
- Increase the proportion of Maine adults with diabetes who have taken a course or class managing diabetes.
- Increase the proportion of adults with diabetes who have a hemoglobin A1c test at least once a year.
- Reduce hospital emergency department visits for asthma.
- Increase the proportion of persons with asthma who receive formal patient education as an essential part of the management of their condition.
- Reduce coronary heart disease deaths.
- Reduce stroke deaths.
- Increase the proportion of adults in Maine who have had their blood cholesterol checked within the preceding five years.
- Reduce the overall cancer death rate.
- Reduce the proportion of adults who are overweight or obese.
- Reduce the proportion of adolescents who are overweight or obese.
- Reduce tobacco use by adolescents (students in grades 9-12).
- Reduce the proportion of low-income pregnant women who smoked during the last three months of pregnancy.
- Reduce the proportion of children with dental care experiences in their primary teeth.
- Increase the proportion of children who have received dental sealants on their molar teeth.

Death Record Closure Process Improvement

Death Records are received by the Office of Vital Statistics where they are reviewed and sent to a variety of other entities for data verification, data entry, record keeping, and error correction**.** The existing process needed to be streamlined to be more responsive to customer demands at a time when staffing levels have been reduced and volume is high. In addition, the process needed to be able to respond to policy changes and to coordinate between the two units that handle the data in the death certificates.

Documents and data were handled numerous time and multiple files waited to be processed. There were many steps in the process of filing death certificates and some were unneeded or duplicative. The process also needed to be standardized to prevent errors and to make it easier to cross train staff. After the Value Stream Mapping session, the process reduced customer lead time from 90 days to five days and reduced the number of processing steps from 23 to 11. Customers of this process have praised the Vital Statistics office for the improved timeliness in acquiring death certificates from the State of Maine.

The Maine Public Health and Environmental Testing Laboratory (HETL)

The Maine Public Health and Environmental Testing Laboratory (HETL) has gone through significant change in the past five years. New instruments, remodeling of some of its antiquated work place, new scientists, and new computer systems provide significant improvements to the lab. Many of these changes are in response to National security issues after 9/11/01, increased concern for emerging infectious diseases/surveillance, new methods for monitoring and reporting environmental health surveillance, and modern drug enforcement objectives. The Health and Environmental Testing Laboratory provides Maine critical public health laboratory functions such as emergency testing for such biological threats as anthrax and meningitis as well as chemical threats, such as drinking water contaminants. These emergency functions have been greatly enhanced since 9/11 with Federal bioterrorism funds. The HETL provides a unique function within this system and supports the role of public health in Maine through a cost-effective allocation of scarce resources that focuses on keeping the public healthy and productive.

Substance Abuse Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	34.0
Total Funding FY '06:	$34,290,966
General Fund:	$11,248,860
Federal Fund:	$9,893,006
Special Revenue:	$6,255,856
Block Grant:	$6,893,244

Kimberly Johnson
Director

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Program Introduction

The Maine Office of Substance Abuse (OSA) is the single state administrative authority responsible for the planning, development, implementation, regulation and evaluation of substance abuse services. OSA provides funds for services through contracts with agencies statewide and provides oversight and technical assistance to contracted agencies.

Substance Abuse Services

Throughout 2006 the office continued to improve its public substance abuse prevention, intervention and treatment system while strengthening its basic supportive administrative and clinical infrastructure.

Core Functions

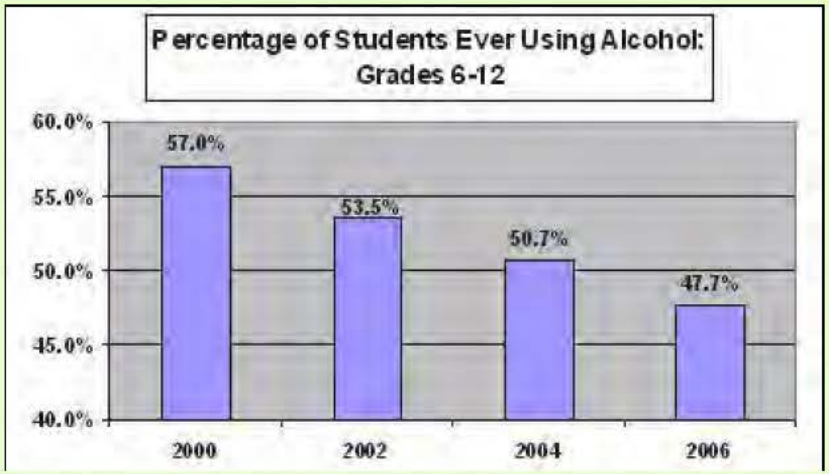
- Substance abuse prevention uses research-based concepts, tools, skills, and strategies, which reduce the risk of alcohol and other drug-related problems.
- Prevention programs cover all segments of the population at potential risk for drug and alcohol use and abuse, but a primary focus is on underage youth who have not yet begun to use or are experimenting.
- Intervention programs target high risk populations and intervene using education, information dissemination and brief therapy to prevent progression of abuse.
- Treatment services use evidence-based practices such as medication and cognitive behavioral therapy to treat addiction to alcohol and drugs.

Performance Goals

Prevention

Performance Goals:

- Prevent substance use in high school students.
- Reduce alcohol use by Maine high school students.

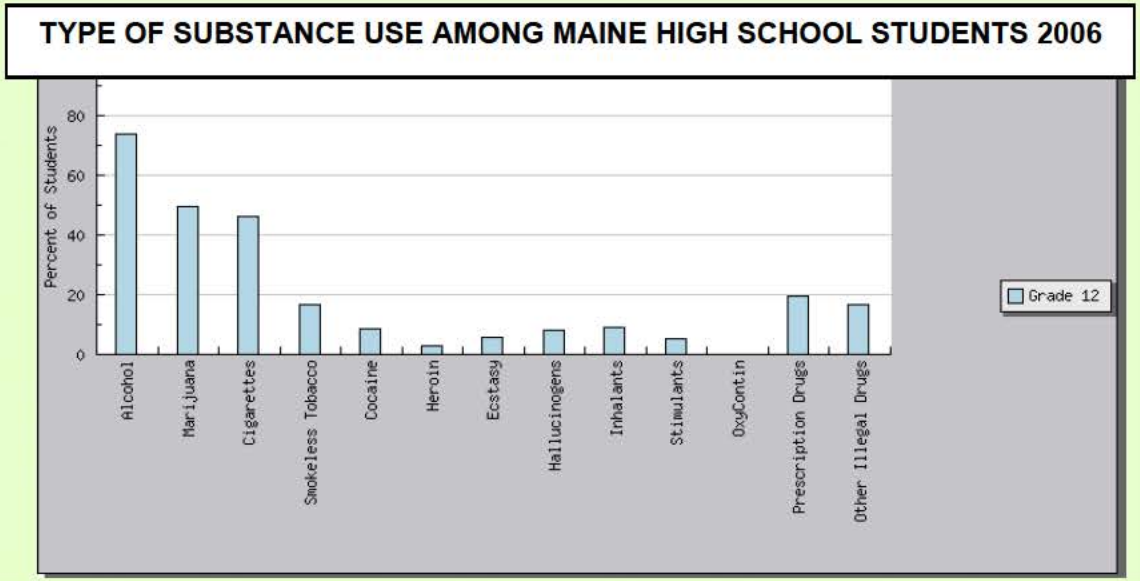


What We Have Learned:

The number of students in grades 6-12 who reported they had ever used alcohol decreased from 57 percent in 2002 to 47.7 percent in 2006.

Performance Goals:

- Prevent substance use in high school students.
- Reduce alcohol and drug use by Maine high school students.

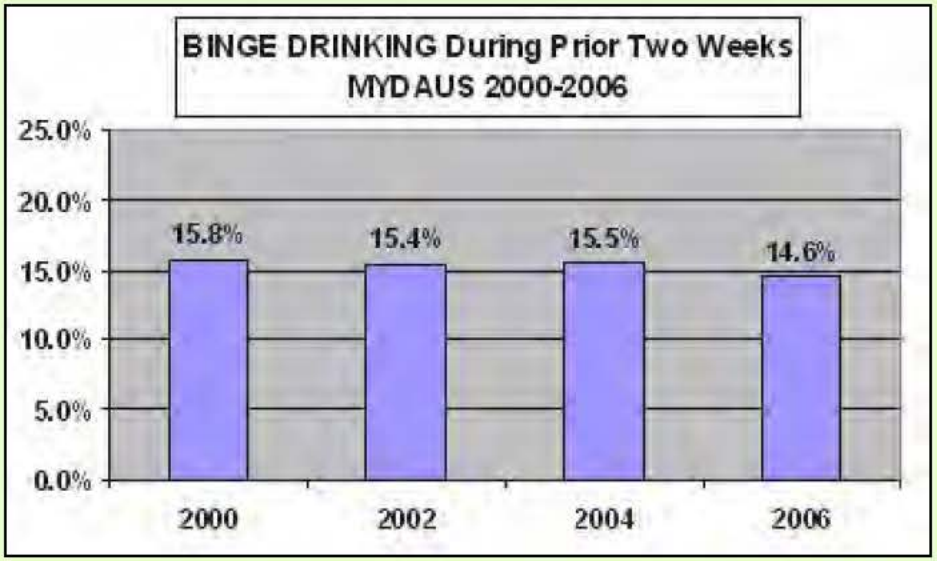


What We Have Learned:

According to the 2006 Maine Youth Drug & Alcohol Use Survey results, alcohol continues to be Maine's #1 youth drug problem. All drug use has decreased from 2004.

Performance Goals:

- Prevent / reduce substance use in high school students.
- Reduce the incidence of binge drinking by Maine high school students.



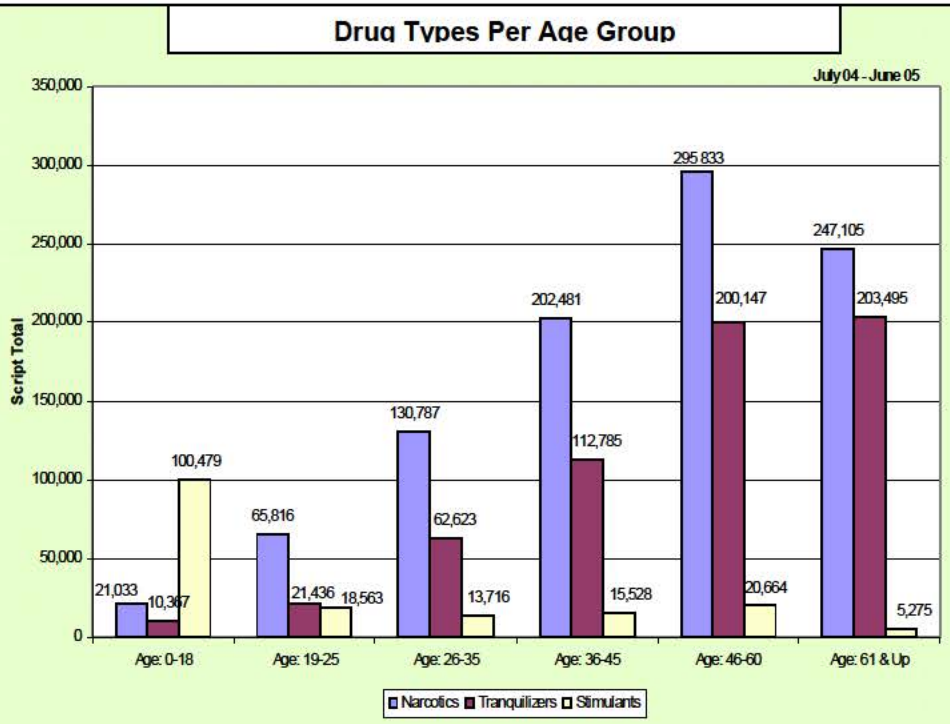
What We Have Learned:

The percentage of high school students reporting episodes of binge drinking in the past two weeks has decreased from 15.8 percent in 2000 to 14.6 percent in 2006.

Intervention Services

Performance Goal:

Reduce prescription drug abuse through providing information to medical providers and general public.



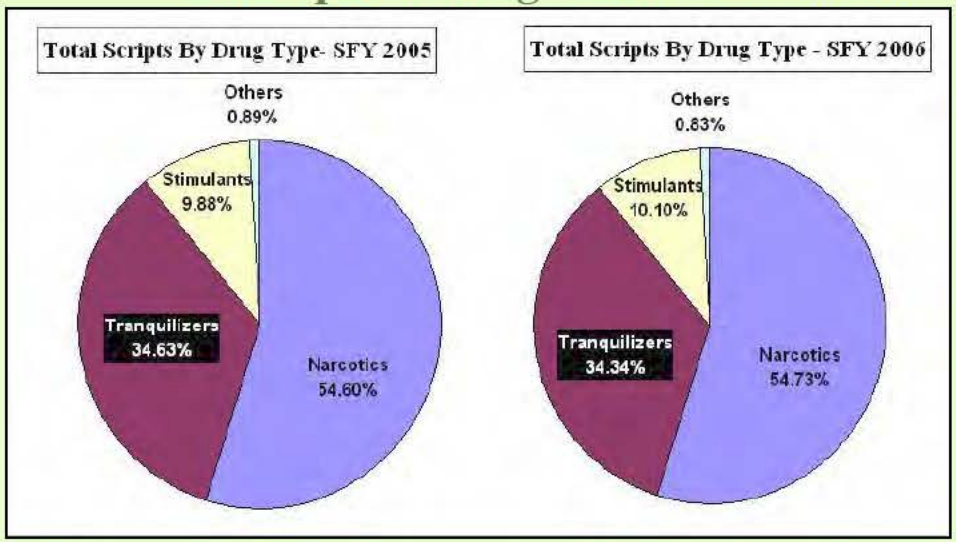
What We Have Learned:

The Prescription Monitoring Program (PMP) in SFY 2006 added more pharmacies to its program including Togus VA, and collected 1,977,415 prescriptions for Schedule II, III & IV drugs. This yielded an average of 1.50 prescriptions per person regardless of age. To date, 409,000 different individuals have at least one record in the PMP data base.

Prescription Drug Abuse Prevention

Performance Goal:

Reduce prescription drug abuse through providing information to medical providers.



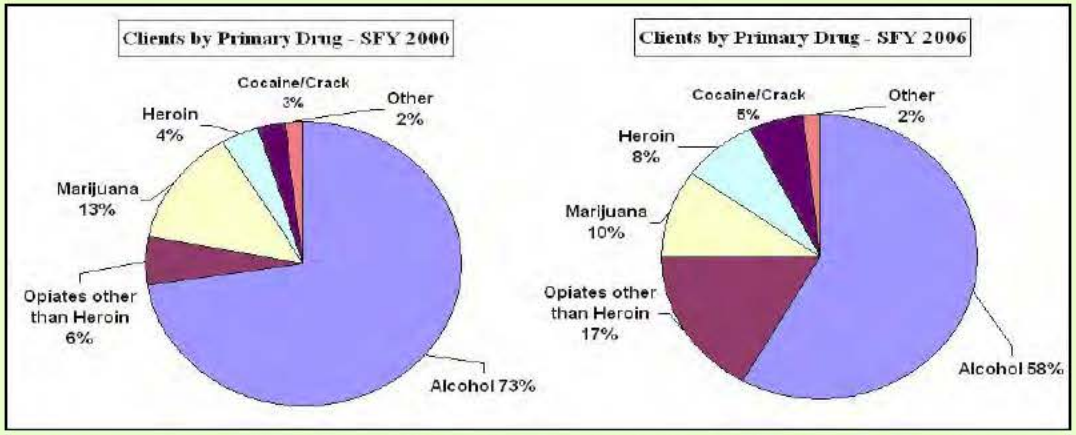
What We Have Learned:

PMP drug type data collected in SFY 2006 -- narcotics (54.73 percent), tranquilizers (34.34 percent), stimulants (10.10 percent), and others (0.83 percent).

Treatment Services

Performance Goal:

Increase access to treatment.



With 18,744 admissions accounted for, approximately 12,630 individuals received treatment services in Maine.

What We Have Learned:

Since 2000, admissions for alcohol abuse has gone from 73 percent to 58 percent, admisions for opiates including heroin and prescription drugs have increased from 10 percent to 25 percent. The proportion admitted for marijuana has dropped from 13 to 10%.

Highlights and Successes

A second parent media campaign targeting underage drinking has been in the market research and design phase, to launch in the fall of 2006

- **Community summits on underage drinking**. These summits were part of a national effort sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and were an overwhelming success. The Governor and First Lady, the Office of Substance Abuse (OSA), the Maine Association of Prevention Programs (MAPP), the Maine Environmental Substance Abuse Prevention Center (MESAP) and the Attorney General's Office all partnered to support local communities as they planned these summits with the statewide theme: "Underage drinking is a community problem; it needs a community solution." These meetings increased awareness of community norms around underage drinking and have already led to local action and policy change.

- **Maine's Prescription Monitoring Program (PMP)** has completed its second year, receiving an outstanding evaluation from the University of Southern Maine's Muskie School of Public Service. Authorized by the legislature in 2003 and administered by the DHHS Office of Substance Abuse, the PMP is aimed at the rapidly growing problem of prescription drug addiction in Maine. The Maine PMP continues to find recognition among other states, as well as with our Canadian neighbors. Several representatives from various locales have visited the OSA office to learn about the new web portal built and implemented by the Office of Information Technology. In the month of June 2006 alone, prescribers and pharmacists requested over 900 reports from the new online portal which allows them to access patient history data. OSA was also asked to present on this new enhancement at the National Meeting for PMP's hosted by the National Alliance for Model State Drug Laws (NAMSDL).

- **Maine Meth Watch Program** aims to prevent the spread and manufacturing of methamphetamine. The Office of Substance Abuse was legislatively directed to create a program to educate retailers and the general public about the dangerous drug and the way it is manufactured. A broad-based steering committee, formed in January 2006, has begun statewide educational activities.

- **Co-occurring State Incentive Grant (COSIG**), a SAMHSA funded project, is implementing a program for building, delivering and sustaining effective substance abuse treatment and mental health services to people with co-occurring substance abuse and mental health disorders through needs assessments, capacity building, strategic planning, evidence-based programming, monitoring and evaluation. The program will fund nine agency pilot sites to implement new co-occurring approaches over the three-year course of the grant. With these dual disorders affecting an estimated 10,000 people, this work will be extremely important in establishing the groundwork necessary to remove barriers to integrated treatment.

- **21 community prevention programs grants** were awarded from the SAMHSA Prevention & Treatment Block Grant.

- **Two Prevention Centers of Excellence, 8 Unified Governance Structure Sites, six Needs/Resources Assessments were established**, (11 county grants beginning September 2006) funded by SAMHSA/CSAP SPF-SIG.

- **DOJ/OJJDP Enforcing Underage Drinking Laws Program** -- 15 Law Enforcement Agencies, 13 Maine Youth Voices Groups, the majority of Maine's Colleges & Universities engaged in the HEAPP Statewide Initiative.

- **179 Local Education Agencies, nine targeted prevention programs provided** (ended June 2006, five new grants began September 2006) - USED Office of Safe and Drug-Free Schools – Maine Safe and Drug-Free Schools & Communities Program. **Funded treatment services**: Diagnostic evaluation, alcohol and drug detoxification, outpatient & intensive outpatient, medication assisted, short- and long-term residential, and adolescent outpatient and residential treatment, services for pregnant and parenting women, treatment for co-occurring mental health and substance abuse disorders, juvenile and adult drug treatment court services and juvenile & adult treatment in Maine Department of Corrections (MDOC) correctional facilities.

- **Developing a network of evidence-based treatment services for adult criminal justice referrals** in collaboration with MDOC and the Judicial Branch.

- **Developing a system of screening and assessment for parents and a system of treatment services** to meet the needs of these families in collaboration with the Child Protective System.

- **The Driver Education and Evaluation Program (DEEP)**, offering programs for individuals who have had one or more alcohol and/or other drug-related vehicle offense(s) provided services to 7,786 residents.

Child and Family Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	598.5
Total Funding FY '06:	$215,097,393
General Fund:	$128,902,826
Federal Fund:	$26,478,970
Special Revenue:	$10,927,751
Block Grant:	$48,787,846

James Beougher
Director

Program Introduction

The formation of the Office of Child and Family Services served as an opportunity to create a seamless system of care for vulnerable children and their families. Numerous recommendations made over the past few years have led to policy and practice changes that yield more consistent approaches to services, particularly for families that are served by multiple programs. Children's behavioral health services, child welfare services and early childhood services are now together under one policy and management structure.

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Child and Family Services

The Office of Child and Family Services has three divisions:

1. Children's Behavioral Health Services
2. Child Welfare Services
3. Early Childhood Services

The Office of Child and Family Services is moving to a system of care that is child-centered and family-focused, with the needs of the family and child dictating the mix of services. The Office of Child and Family Services has developed an integration plan that includes a single system of behavioral health services for children. In the near future, all authorizations for assessments will be made through the unified behavioral health system. In order to support seamless services for families involved with the Office of Child and Family Services, eight local collaborative work groups with special training in services integration have been convened. These groups include representatives from early childhood, substance abuse, behavioral health, child welfare, and other key child and family support services. In a further effort to assure seamless services, the legislature appropriated funding to support community inclusion for children who are involved with multiple systems. The RFP for that process has been released and services will begin in eight communities across the state by the end of this budget year. This system will be overseen by an interdepartmental oversight group of the Children's Cabinet.

Core Functions

- ❑ Protect and enhance the health and well-being of youth and families.
- ❑ Provide effective safety response and timely access to an array of services to meet individual child and family needs.
- ❑ Support and enhance youth, family and community participation in system and service planning/decision making.
- ❑ Utilize resources to maximize efficient and effective services to meet the needs of children and families.
- ❑ Increase opportunities for children/youth to live in a family within their community.

Children's Behavioral Health Services

Children's Behavioral Health Services provides leadership in the development of a comprehensive system of care that ensures that each child develops to his/her full potential. The system of care strengthens the capacity of families, promotes natural helping networks, and develops community resources to meet behavioral, developmental, and treatment needs of children.

- Services are based on the family's and child's strengths
- Families and youth are full participants in all aspects of planning and delivery of services.
- Children receive services in the least restrictive, most normative environment that is clinically possible.
- Natural and community-based supports with each family are fostered.

Funding At a Glance

Total Staff (Full-Time Equivalencies):	64
Total Funding FY 07:	$50,439,575
General Fund:	$48,457,466
Federal Fund:	$733,732
Special Revenue:	$311,413
Block Grant:	$936,964

Core Functions

- ❑ **Children with Special Needs** –Advocate for and support children with special needs.
  - Children (birth - age 5) with developmental disabilities or severe developmental delays.
  - Children (birth – age 20) with emotional/behavioral disorders.
  - Children (birth - age 20) with mental retardation or autism.
- ❑ **Comprehensive system of care** – Develop a system that ensures, within the available resources, that each child develops to his/her fullest capacity.
- ❑ **Available services**– Ensure access to a wide array of services and supports for children with behavioral health needs up to their 21st birthday.
- ❑ **Community support** – Support the development and enhancement of parent/youth organizations and other supports such as respite.
- ❑ **Quality improvements** – Enroll clients, monitor contracts, review providers, outcomes and involve families in evaluating care.
- ❑ **Local services** – Provide information and referrals for children with behavioral health care needs in three regional offices.

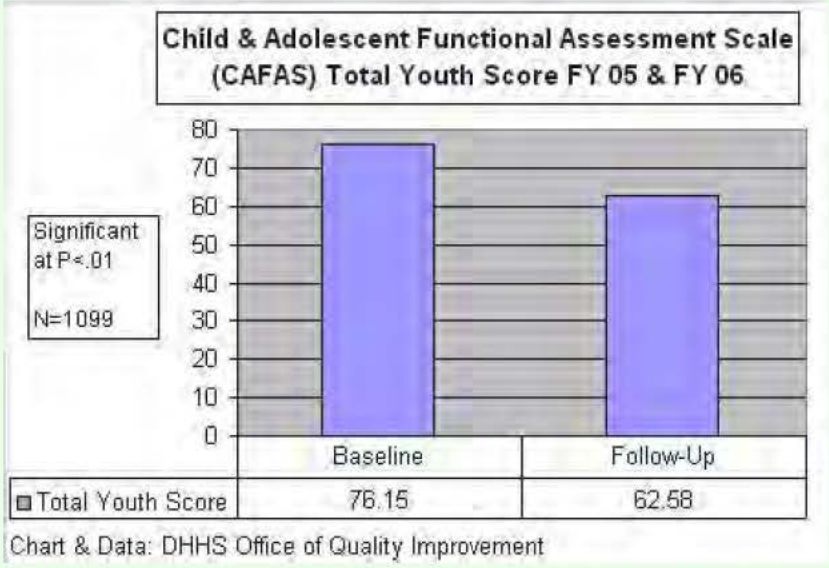
The Division of Children's Behavioral Health serves more 21,000 children annually. These individuals received one or more of the following community-based services:

- Outpatient Treatment Services (13,000)
- Case Management Services (7,200)
- Crisis Services (5,838)
- Medication Management (5,167)
- Wraparound/Flex funds (2,179)
- In-home Services (2,614)
- Respite Services (2,228)
- Homeless Youth Services (1,485)
- Intervention Services (1,033)

Children's Behavioral Health Performance Goals

Performance Goal:

Improve behavioral/functional status (increase in percentage of children/youth with stable or improved functioning as measured by decreased scores on CAFAS functional assessment between baseline and follow-up).

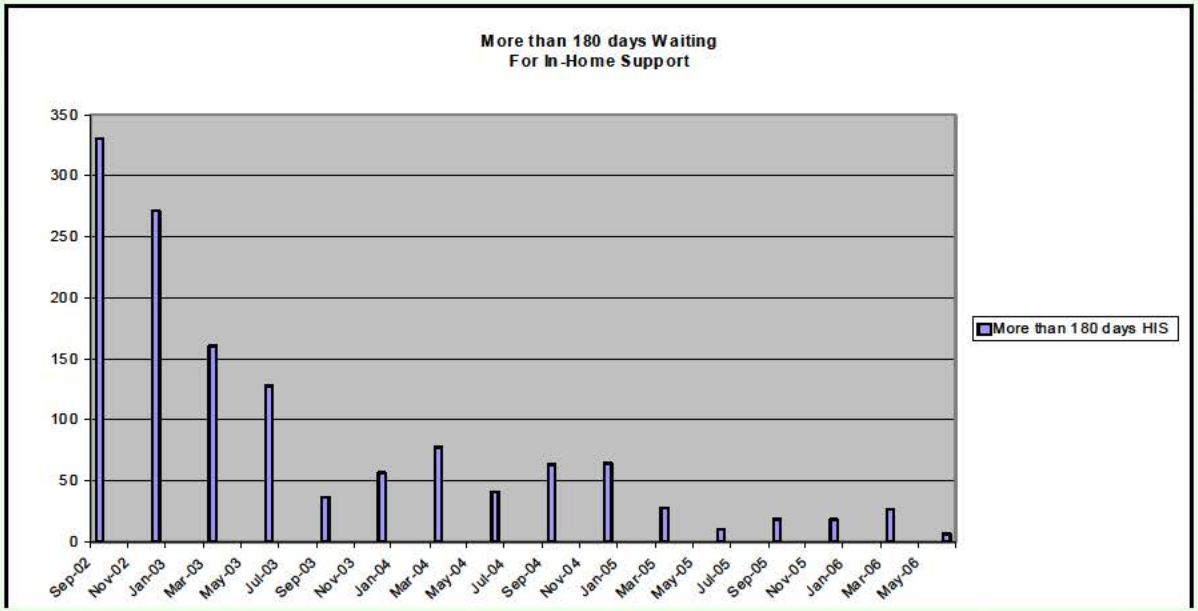


What We Have Learned:

Over a 12-month period, children in Targeted Case Management showed significant improvement in behavioral and emotional functioning, as evidenced by a reduction in the CAFAS score.

Performance Goal:

Provide effective safety response and timely access to an array of services to meet individual child and family needs.

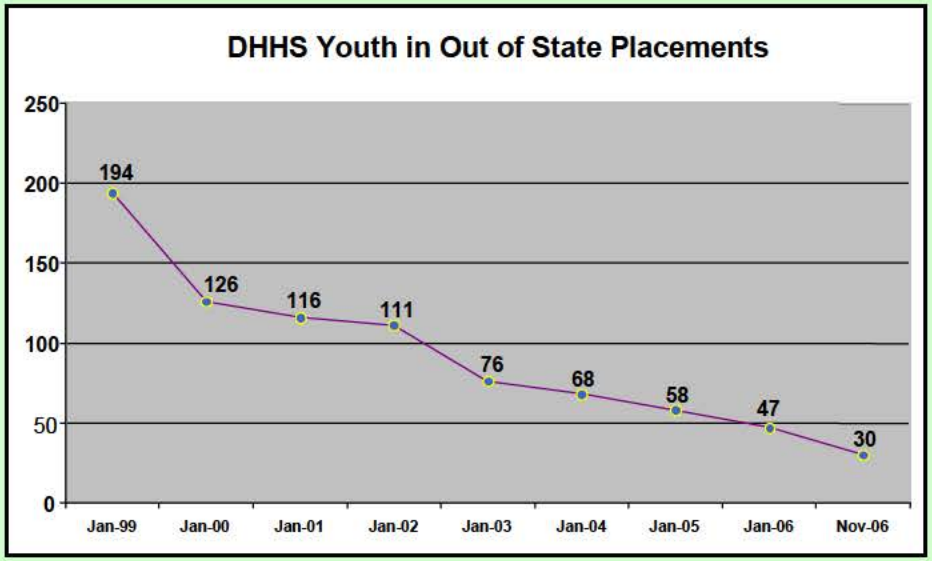


What We Have Learned:

Reduction of the number of children waiting over 180 days for in-home services from 325 children in 2002 to zero children on December 15, 2006.

Performance Goals

- Increase opportunities for children/ youth to live in a family within their area.
- Reduce use of restrictive out-of-home placements.
- Reduce number of children placed out of their home districts.



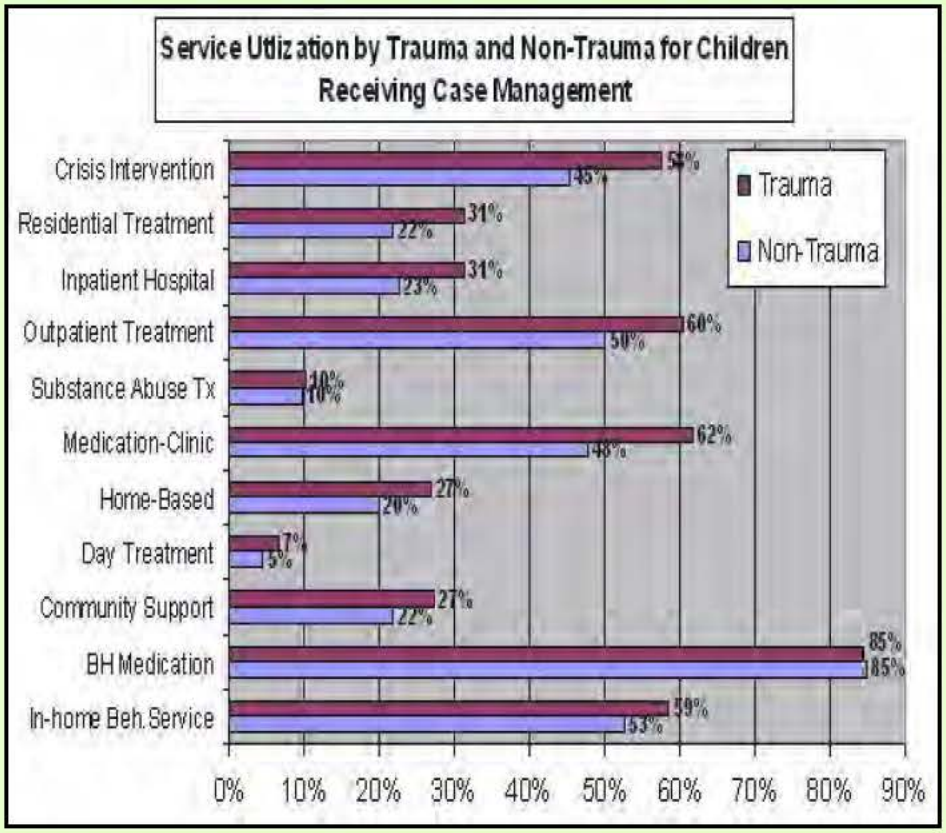
What We Have Learned:

Children's Behavioral Health and Child Welfare reduced out-of-state (residential and hospital) placements by 80 percent from 270 children in 1998 to 30 children in 2006.

The Influence of Childhood Trauma on Public Mental Health Service Use and Expenditures

Performance Goal:

Determine the influence of childhood trauma on public mental health service use and expenditures.



What We Have Learned:

Compared to children who have not experienced trauma, trauma survivors were;

- Younger.
- At significantly higher risk of harm to self and others.
- More likely to experience higher-levels of environmental stress and have fewer supports.
- Less likely to exhibit behavioral/functional stability or improvement.
- More likely to use high-end mental health services, including: inpatient psychiatric hospitalization, residential/group treatment and crisis intervention services at significantly higher cost.

Children's Behavioral Health Highlights and Successes

- **Services for children and families**
  Children's Behavioral Health ensures that services for children with behavioral health needs are available from contracted providers to all children from birth up to their 21st birthday. Staff are working with Adult Behavioral Health to ensure, when necessary, there is a smooth transition to adult services. A major focus is to ensure the right treatment, at the right time, for the right intensity and duration.

- **Federal grant award for a trauma-informed system of care – The Thrive Initiative**
  $9 million dollar federal grant over six years to implement a trauma-informed system of care in Androscoggin, Franklin, and Oxford Counties. Activities are underway to enhance inter-agency collaboration, evaluate services, reduce stigma related to mental illness, and to implement evidence-based practices. Parents and youth are integral members of the governance council and subcommittees.

- **New intensive in-home treatment services**
  The new Child and Family Behavioral Health Treatment and Community-based Treatment for children without permanency will utilize functional assessment measures, thereby allowing staff to track improvement and to enhance individual treatment outcomes. The new service emphasizes a team approach, active family involvement with a clinician, encourages evidence-based practices, and requires service management by prior authorization and utilization review.

Early Childhood Services

The Maine Early Childhood Initiative has been approved and federally funded to promote system change. Many on the Task Force on Early Childhood believe that establishing a Division of Early Childhood is one of the most prominent victories of the Early Childhood community in the past year. The Division provides leadership to state government, ensuring that Maine's early childhood services system addresses the needs of young children, shares common standards for quality and respects the diversity and uniqueness of all Maine's children and their families. The Division of Early Childhood ensures the seamless integration of early intervention and prevention programs into the family-centered practices of the Office of Child and Family Services.

Core Functions

- **Early childhood service system**- Develop a model for a unified statewide approach to early childhood services, such as home visiting, Head Start (0-5 years old), child care (0-15 years old) and parenting education.
- **Prevention-** Train early childhood providers to support the delivery of effective quality, prevention-focused services.
- **Education-** Work with caregivers and families, in their own environments, to support the early development of children in a positive way.

Population served by the Division of Early Childhood:

- 110 nationally accredited child care programs.
- The licensed capacity for child care is 49,862. 7,817 of those slots are in programs that hold a Quality Certificate (see pg. 66).
- 720 licensed centers and 1,732 certified family child care homes.

More than 6,700 Maine families received consumer education and referral services from local child care Resource and Referral agencies (Resource Development Centers *or* RDCs) in 2005. These referrals include those accessed via the RDC websites.

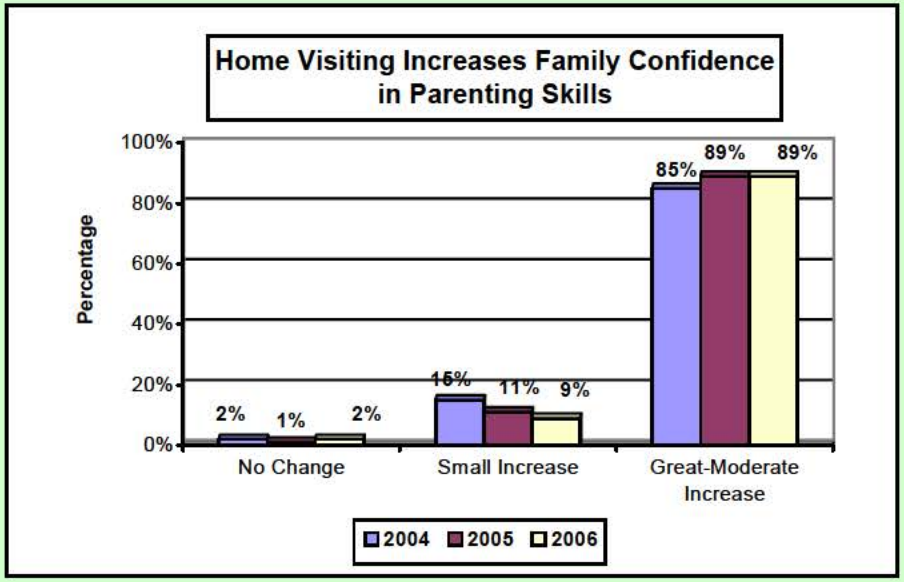
Early Childhood Performance Goals

Home Visiting

- With the support of the Governor's Children's Cabinet and the Braselton Institute in Boston, the Early Childhood Initiative is working to integrate the principles of Touchpoints practice statewide using the existing home visiting network. The model focuses on integration within early care and education, health and social services delivery systems and curricula.
- For both 2005 and 2006, 89 percent of families report a moderate to great increase in their confidence in parenting ability. Other outcomes include well child visits, immunizations, health insurance and access to a primary care provider, all well above the state average. As a result of their participation, families have changed their behaviors to reduce or eliminate their children's exposure to secondhand smoke, demonstrated strong parent-child attachment, and shown improvements in overall home safety from enrollment to the most recent visit.

Performance Goals:

- Support and enhance youth, family, and community participation in system and service planning/decision making.
- Increased active participation of parents.
- Increased percentage of children whose family strengths are maintained or improved.



What We Have Learned:

In both 2005 and 2006, 89 percent of families receiving home visiting services report a moderate to great increase in their confidence in parenting ability.

Enhancing the professional development of the early care and education workforce

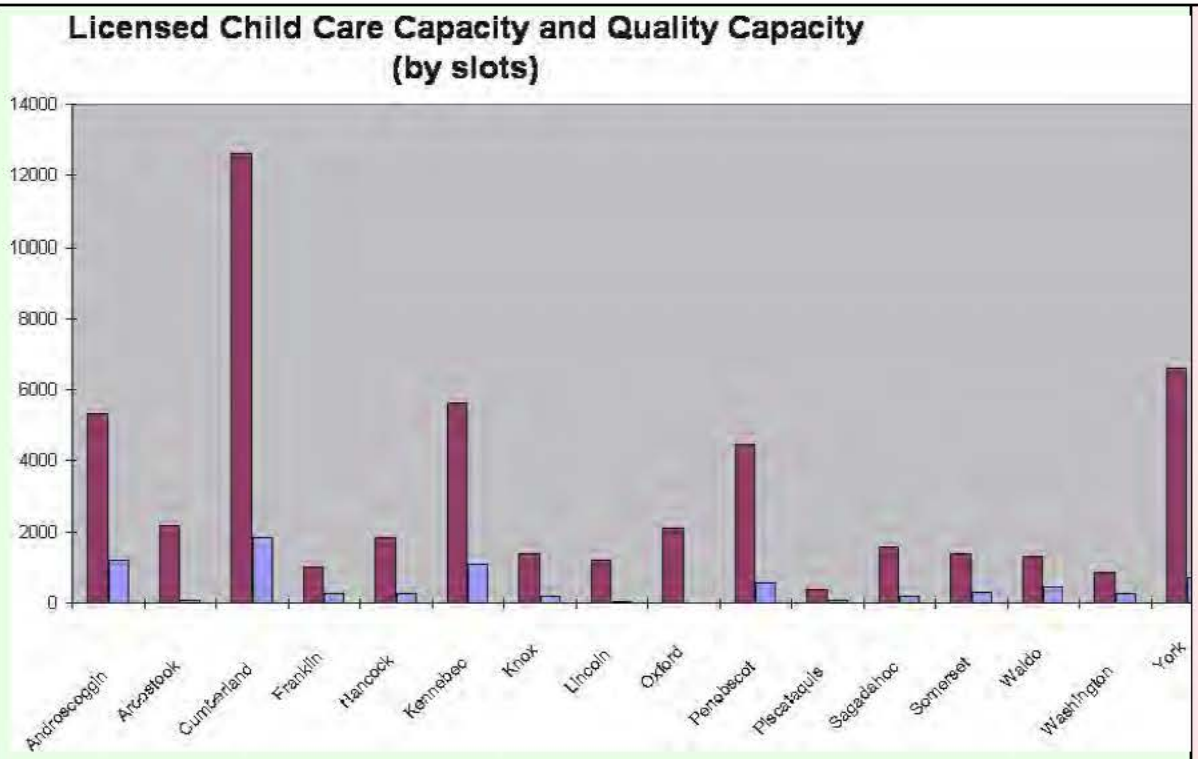
The Maine Roads to Quality professional development system serves as the coordinating entity for early care and education training opportunities. Maine Roads to Quality works in conjunction with the Resource Development Centers to disseminate training to providers. DHHS has articulation agreements with the community college system in Maine to award credit to providers who have completed the Maine Roads to Quality 180 hour training series.

Improving the quality of child care

The Early Childhood Services Division has designed a Quality Certificate to recognize programs that have met standards that exceed licensing requirements. Parents who purchase child care from a provider with a Quality Certificate receive a double Dependent Care Tax Credit on their Maine Income Tax. In an effort to support providers seeking national accreditation and the Quality Certificate, DHHS has funded the Maine Roads to Quality (MRTQ) Accreditation Facilitation Project since 2000. Since that time, the number of programs achieving national accreditation has risen from 15 to 110. An expanded Quality Rating System to acknowledge providers who meet progressive quality indicators will be piloted in early 2007 to better inform parents as they select child care.

Performance Goals:

- Increase the number of Child Care/Head Start programs that receive quality certificates.
- Increase percentage of subsidized children served in child care/Head Start programs with quality certificates.



What We Have Learned:

The number of child care programs reaching national accreditation has risen from 15 to 110.

Child Welfare Services

Child Welfare Services joins with families and the community to promote long-term safety, well-being and permanent families for children. Our work is guided by a practice model. This practice model emphasizes child safety, first and foremost, and is based on the following beliefs:

- Parents have the right and responsibility to raise their own children;
- Children are entitled to live in a safe and nurturing family;
- All children deserve a permanent family;
- How we do our work is as important as the work we do.

Funding At a Glance	
Total Staff (Full-Time Equivalencies):	535
Total Funding FY 07:	$174,797,089
General Fund:	$90,584,631
Federal Fund:	$25,745,238
Special Revenue:	$10,616,338
Block Grant:	$47,950,882

In 2002, Maine's senior Child Welfare managers began to look at the outcomes for children under the State's supervision. From that review, a plan for reform began to evolve. The organization realized in 2002 that reform was needed: children were in care for too long; too many youth were in residential settings; and policies did not lead to engagement with youth or families. Casey Strategic Consulting agreed to support the reform process and provided extensive assistance over the course of four years.

Core Functions

- ❑ **Child Safety** – Child safety is first and foremost.
- ❑ **Preservation of Families** – Parents have the right and responsibility to raise their own children.
- ❑ **Child Well-being** – Children are entitled to live in a safe and nurturing family.
- ❑ **Permanency** – All children deserve a permanent family.
- ❑ **Local Service** – Staff provides services in 16 offices across the State.
- ❑ **Transition to Adulthood** – Foster children are ensured opportunities for education, driver's education programs, tuition waivers for college, job skills training and certification programs and independent living skills.
- ❑ **Education** – Staff works with community agencies to identify the signs of abuse and neglect, to know of local services available and to call DHHS as mandated reporters when necessary.

Child Welfare Performance Goals

Safe and responsible reduction in the overall number of children in foster care

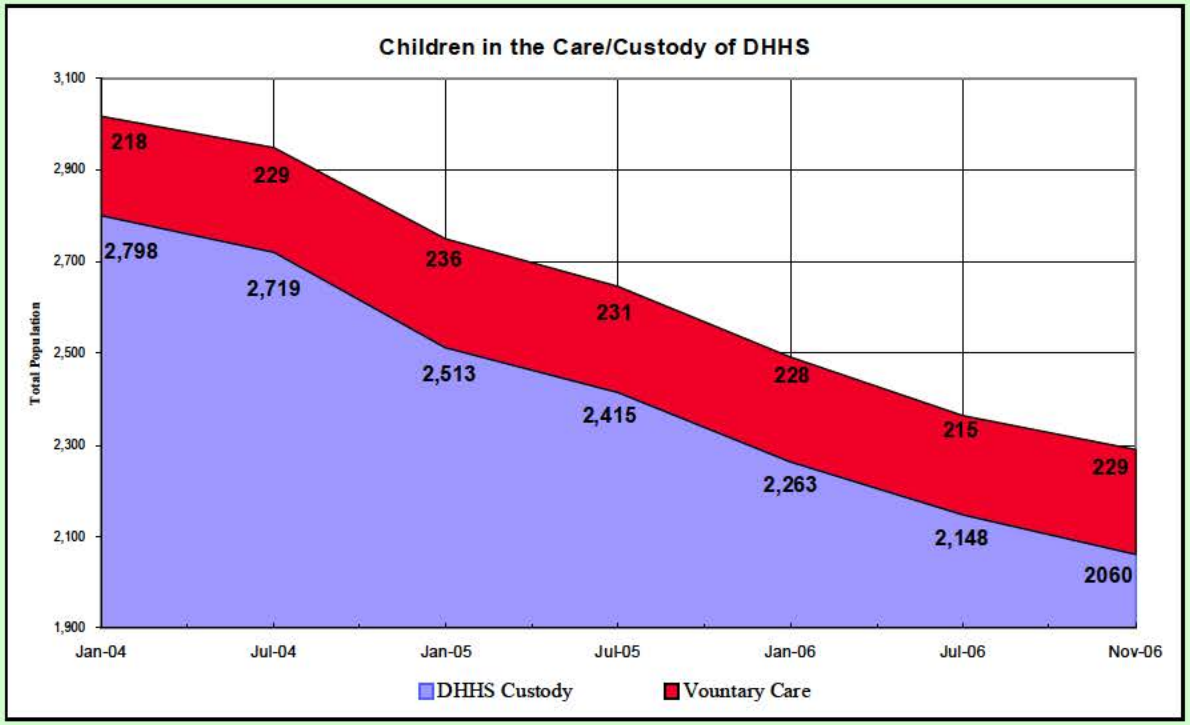
In the past three years, Maine's overall foster care population has been reduced by more than 23 percent. This has been accomplished by more effectively engaging families in safety plans to prevent the need for removal and by achieving permanency for more of the children.

Population served by the Division of Child Welfare Services:

- 2,300 children in foster care as of November 2006.
- 2,700 children receiving post-adoption services as of November 2006.
- In 2005, 5,324 reports of child abuse and neglect involving 10,707 children assigned to a caseworker for a safety assessment.
- In 2005, 2,617 appropriate reports of child abuse and neglect were assigned to a Community Intervention Program.

Performance Goals:

- Increase opportunities for children/youth to live in a family within their community.
- Reduce number of children placed outside of their home.



What We Have Learned:

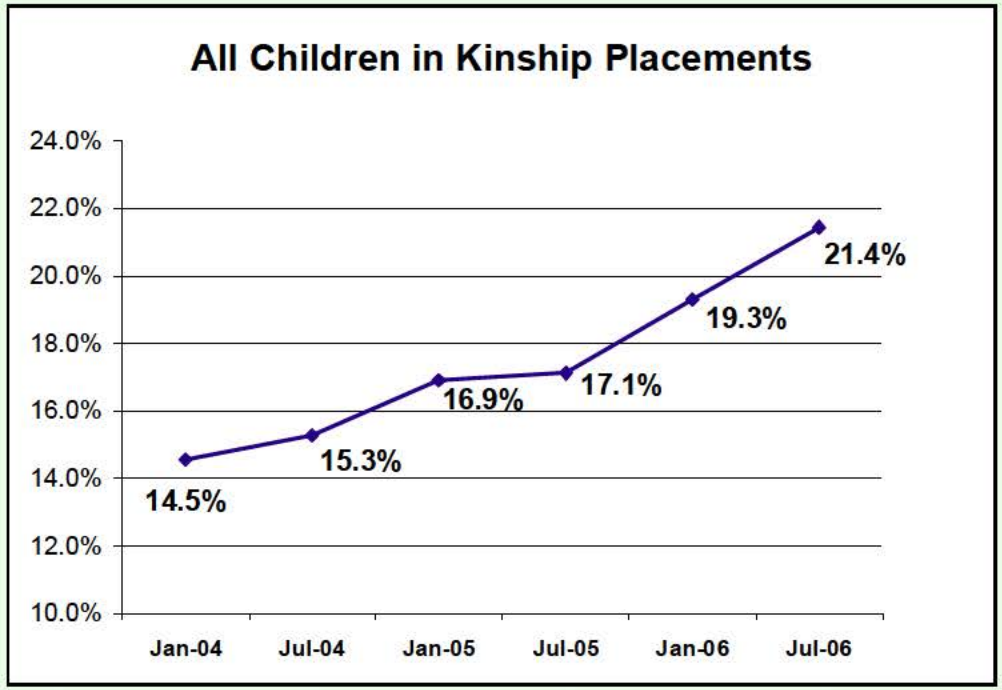
The number of Maine's overall foster care population has been reduced by more than 23 percent over the past three years.

Kinship Commitments

Maine's new Relative Placement and Kinship Care Policy (effective November 2005) clarifies the importance of relative placements and emphasizes the preservation of family relationships and familial bonds. Important family connections are identified early in the assessment process. If it becomes necessary to remove a child from his/her parents, relatives are sought as the first option for placement. This has resulted in an increase in the overall percentage of foster children placed with kin as well as a much higher percentage of the new children entering care being placed with relatives.

Performance Goals:

- Increase opportunities for children/youth to live in a family within their community.
- Increase the number of kinship placements for children.



What We Have Learned:

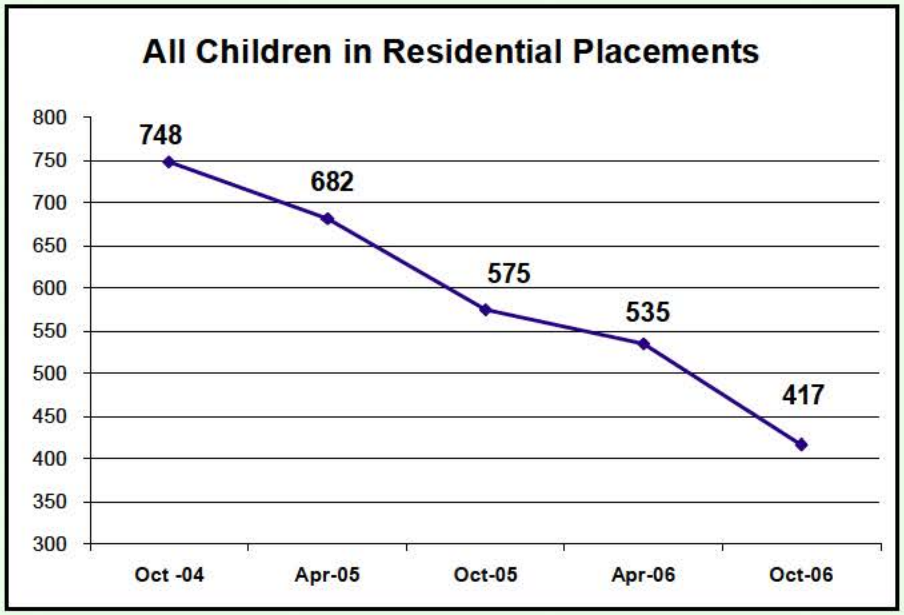
Over the past three years the percentage of foster children placed with kin has risen from 14.5 percent of placements in January 2004 to 21.4 percent of placements in July of 2006.

Reducing Children placed in Residential Care

The Office of Child and Family Services has refocused efforts to find a family for each child with relatives or foster or adoptive families. Between July 2004 and December 2006, the number of children in a residential setting has been reduced from 770 to 399 children.

Performance Goals:

- Increase opportunities for children/youth to live in a family within their community.
- Reduce the use of restrictive out-of-home placements.



What We Have Learned:

The number of children in residential placements has decreased over the past two years by 331, from 748 in October 2004 to 417 in October 2006.

Child Welfare Highlights and Successes

- **Improvement in Timely and Effective Safety Response to Reports of Child Abuse and Neglect:** Through new policy expectations and more effective management strategies, Child Welfare has significantly increased the number of assessments assigned to child protective staff, as well as the timeliness of completing them. This assures a consistent approach to child safety. Before the new policy, staff could take as long as two weeks to see alleged child victims face to face. With the new policy (effective August 2005) staff takes, at the most, 120 hours/ five days (including weekends/holidays) to see children face-to-face.

- **Family Team Meetings:** Every child in state care now has a family group conference, called a Family Team Meeting, where the family plans for their child's needs for safety and permanency. These meetings include a variety of professionals as well as the family's natural support system.

- **Federal Program Improvement Plan passed:** The division of Child Welfare has successfully completed all 92 actions steps of the Program Improvement Plan that was designed to address the 2003 Federal Child and Family Services Review and implemented between August 2004 and August 2006. There were six national standards to be met as well: We met four targets; reduction in repeated maltreatment (Maine is at 5.7 percent; national average is 6.1 percent); reduction in repeat maltreatment of children in foster care (Maine at .48 percent; national is .57); reduction in re-entry into foster care (Maine is at 7.3 percent, the federal standard is 8.6); and adoptions completed within 24 months (Maine is striving to achieve a 32 percent target). Remaining standards are: reunification of children with their families (goal is 42.8 percent); and children in stable placements (goal is 83.5 percent).

- It is our hope that we will achieve these standards by September, 2007.

- **Child Protective Intake Unit**: Through targeted scheduling, Child Protective Intake Unit increased the availability of workers to speak with callers immediately about suspected child abuse and neglect, lowering the average wait time for callers to less than one minute and voice mail to fewer than two per day.

- **Child Welfare Accreditation:** Child Welfare Services (CWS) is actively moving toward national accreditation through the Council on Accreditation. These standards will strengthen the agency, provide accountability of resources and improve the quality of services statewide.

- **Tribal–State Collaboration:** Maine is becoming a model state for Tribal-State relationships. CWS has been working with Maine's tribes to reduce the number of tribal children in custody and increase collaborative prevention work. An Indian Child Welfare Summit held in March was attended by Tribal and State Child Welfare Directors, as well as by Assistant Attorneys General and court representatives.

Adult Mental Health Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	743.1
Total Funding FY '06:	$140,001,684
General Fund	$90,636,034
Federal Fund:	$8,425,598
Special Revenue:	$39,723,030
Block Grant:	$1,217,022

Ronald Welch, Director

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Program Introduction

The DHHS Office of Adult Mental Health Services (OAMHS) is the designated State Public Mental Health Authority for adults.

A primary responsibility of the Mental Health Authority is to develop and maintain a comprehensive system of mental health services and supports for persons age 18 and older with severe and persistent mental illness.

Core Functions

- ❑ Manage the delivery of community support, vocational, peer, residential, outpatient treatment, medication management, crisis, inpatient treatment and other mental health services. These services are provided by 205 private provider organizations under contract with OAMHS.

- ❑ Provide a safety net of adult mental health services for people with major mental illness who cannot otherwise be served by community service networks including :
  - Backup emergency hospital beds for people requiring medical stabilization, assessment or treatment;
  - Intermediate and long-term treatment for people who need long-term structured care;
  - Forensic services;
  - Intensive Case Management for individuals who have experienced difficulty connecting with other community services, are in jails, prisons or on probation, are homeless, or who have been hospitalized for extended periods of time.

- ❑ Operate two state psychiatric hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, which provide inpatient care and treatment for people with severe mental illness, on both a voluntary and court committed basis.

- ❑ Additionally, the State Forensic Service conducts court-ordered psychological and psychiatric evaluations in adult and juvenile criminal cases, providing a comprehensive assessment of matters pertaining to competence and criminal responsibility.

Performance Goals

- ❑ Provide effective and appropriate services to meet the needs of persons with serious mental illness.

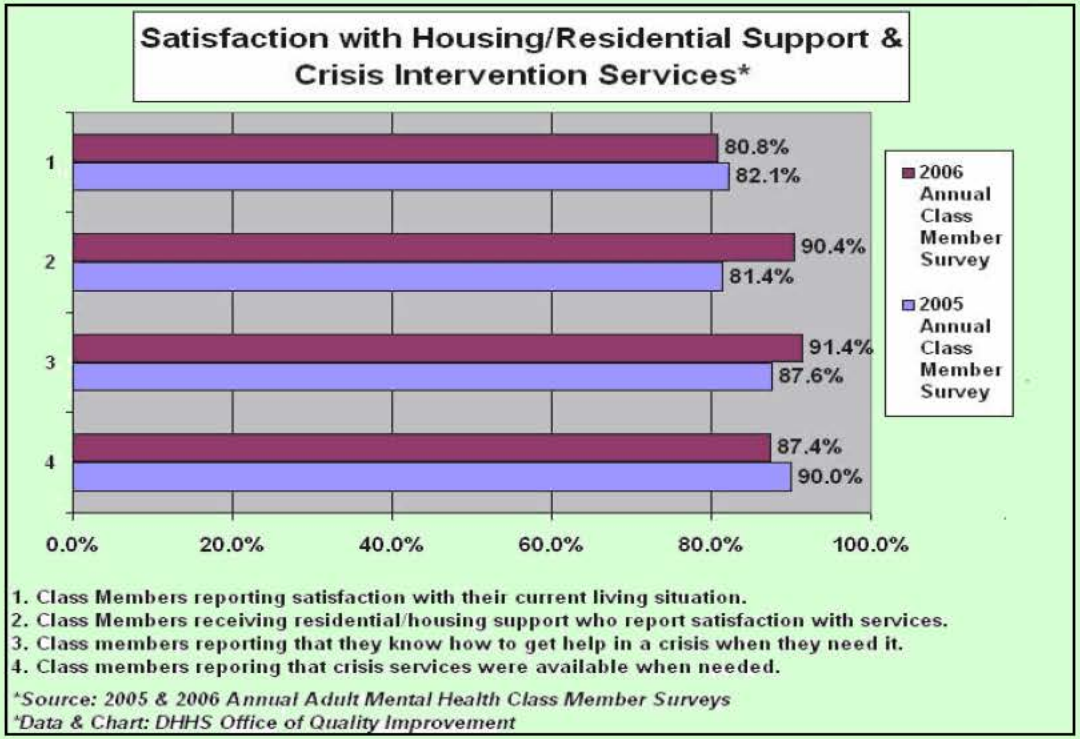
- ❑ Insure the general health and safety of persons with serious mental illness.

- ❑ Promote access to effective and appropriate services and increased continuity of care.

- ❑ Support consumer engagement and inclusion in community life, including school, work, housing, social, spiritual and recreational opportunities.

Performance Goals:

- Provide effective and appropriate services to meet the needs of persons with serious mental illness.
- Increase percentage of consumers who report satisfaction with access to mental health services.



1. Class Members reporting satisfaction with their current living situation.
2. Class Members receiving residential/housing support who report satisfaction with services.
3. Class members reporting that they know how to get help in a crisis when they need it.
4. Class members reporing that crisis services were available when needed.

**Source: 2005 & 2006 Annual Adult Mental Health Class Member Surveys*
**Data & Chart: DHHS Office of Quality Improvement*

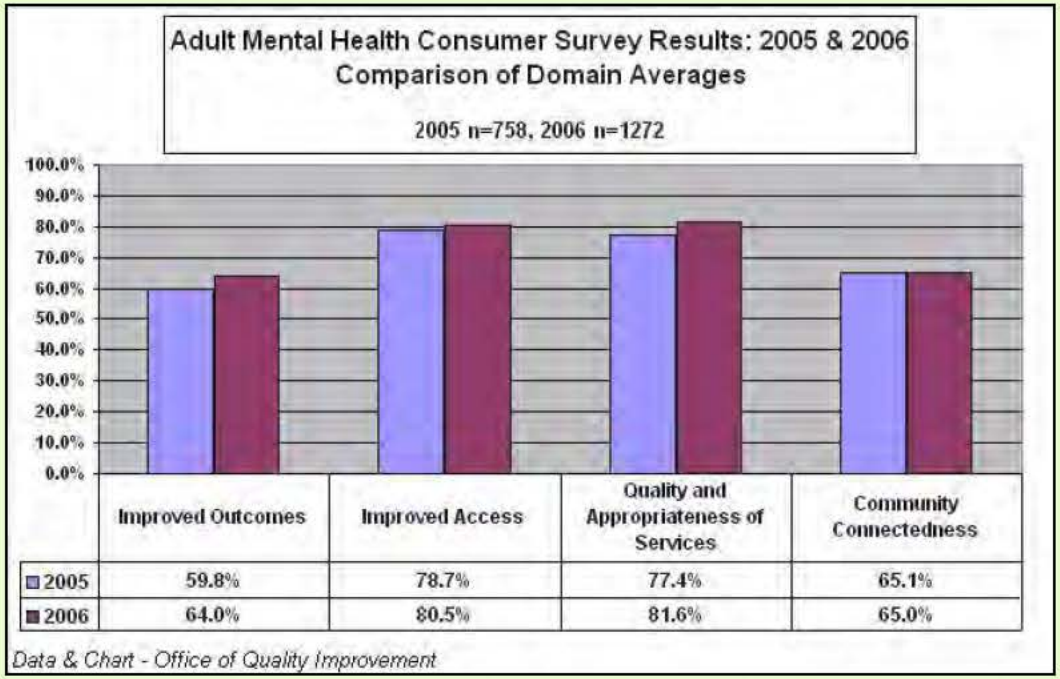
What We Have Learned:

Satisfaction rates with current living situation and crisis intervention services has remained stable from 2005 through 2006.

Class member satisfaction with housing support services increased by 9% from 81.4% in 2005 to 90.4% in 2006.

Performance Goals:

- Support consumer engagement and inclusion in community life, including school, work, housing, social, spiritual and recreational opportunities.
- Increase percentage of consumers who report satisfaction with access to mental health services.
- Provide effective and appropriate services to meet the needs of persons with serious mental illness.
- Increase percent of consumers reporting higher degree of community connectedness and belonging.



	Improved Outcomes	Improved Access	Quality and Appropriateness of Services	Community Connectedness
2005	59.8%	78.7%	77.4%	65.1%
2006	64.0%	80.5%	81.6%	65.0%

Data & Chart - Office of Quality Improvement

What We Have Learned:

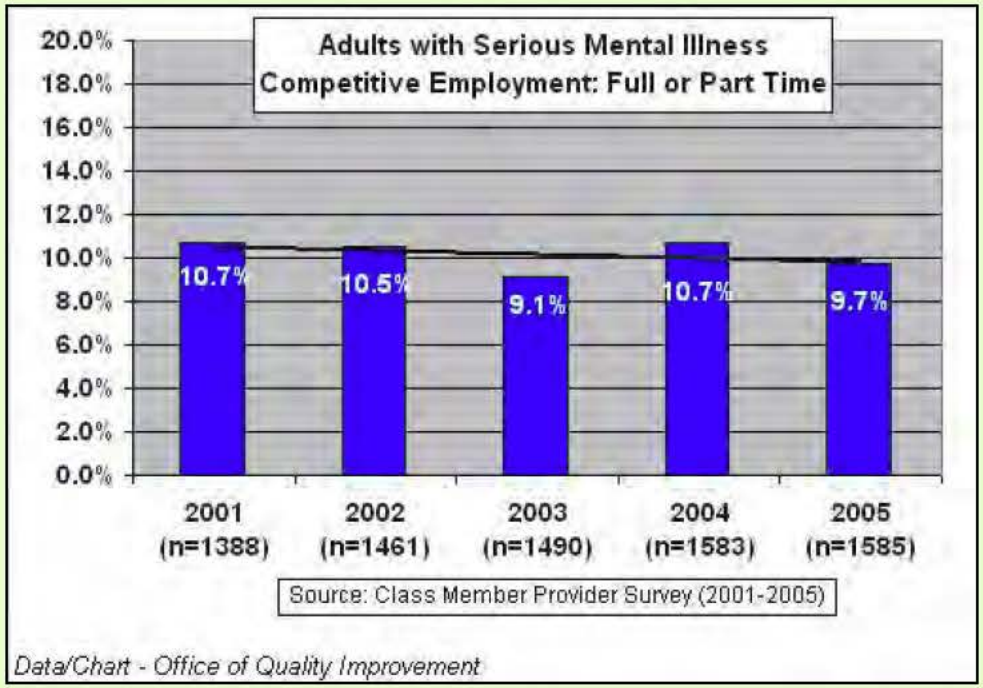
A comparison of results from the 2004 and 2005 Adult Consumer Survey demonstrate that overall consumer satisfaction rates across survey domains have remained consistent or have shown a slight increase.

Employment

OAMHS increased the number of employment opportunities for mental health consumers by providing financial support for increased employment related services, such as more benefits specialists to advise SSI/SSDI recipients regarding how to work and earn wages without jeopardizing benefits. Certified employment specialists work in community mental health agencies providing job development services and employment supports.

Performance Goals:

- Support consumer engagement and inclusion in community life, including school, work, housing, social, spiritual and recreational opportunities.
- Increase percent of consumers who are employed in competitive community employment situations.



Data/Chart - Office of Quality Improvement

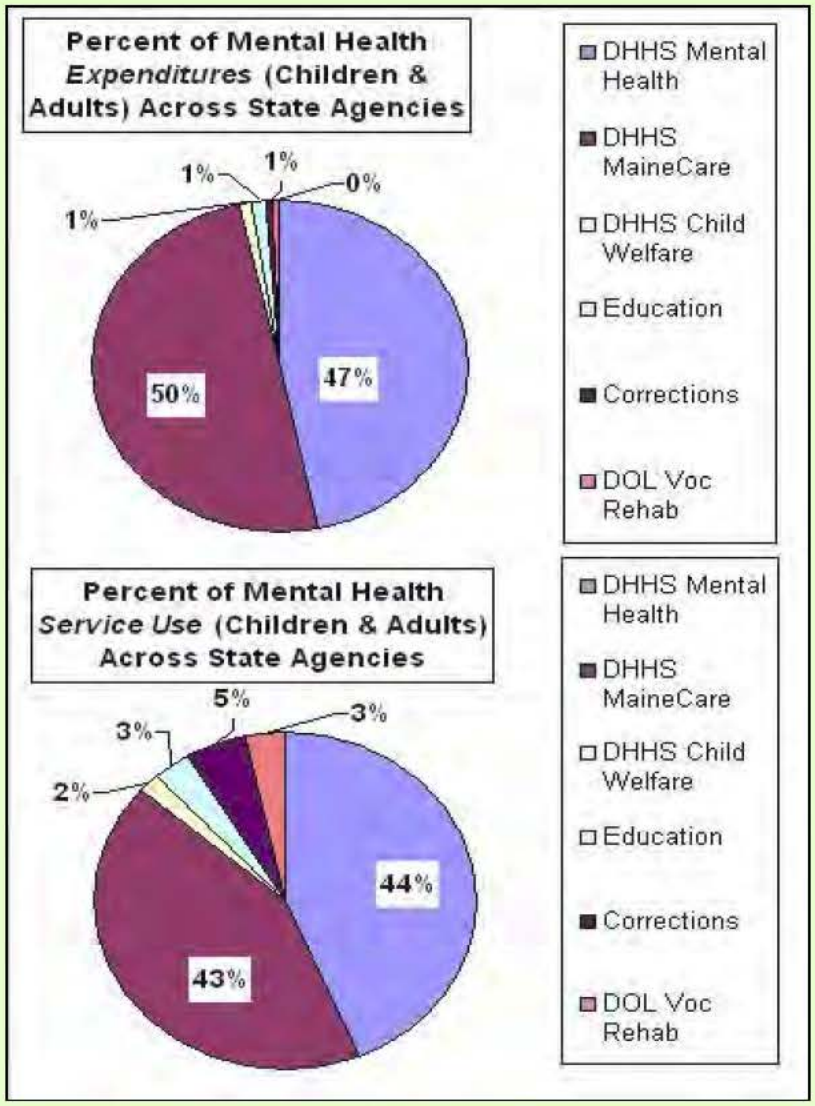
What We Have Learned:

During the past five years, the employment rate for adults with serious mental illness has remained somewhat stable, remaining between 9.1 percent and 10.7 percent.

Mental Health Service Use: Expenditures Across State Government

Performance Goal:

Determine mental health service expenditures across state government.



What We Have Learned:

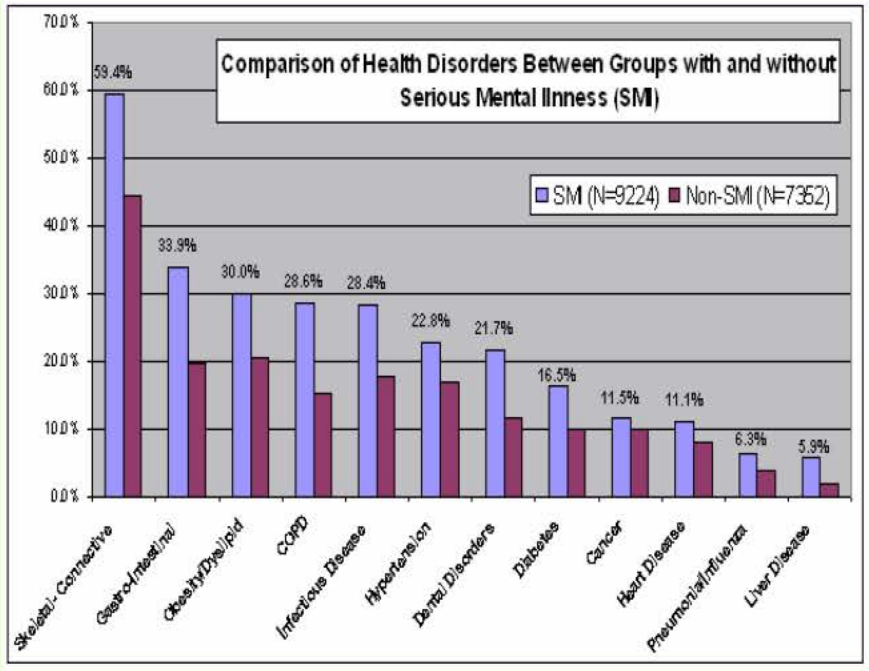
Other State Agency Study:

- 554.1 million dollars expended in FY 2004 across state government on public mental health services
- 75,609 children & adults received services in FY 2004 (6 percent of population).
- Over half (53 percent) of expenditures were for high-cost residential and psychiatric inpatient services and used by 15 percent of the service users.
- MaineCare was primary funding source of mental health services accounting for 84 percent of service users and over 90 percent of mental health expenditures.

The Poor Health Status of Persons with Serious Mental Illness

Performance Goal:

Determine the health status of persons with serious mental illness.



What We Have Learned:

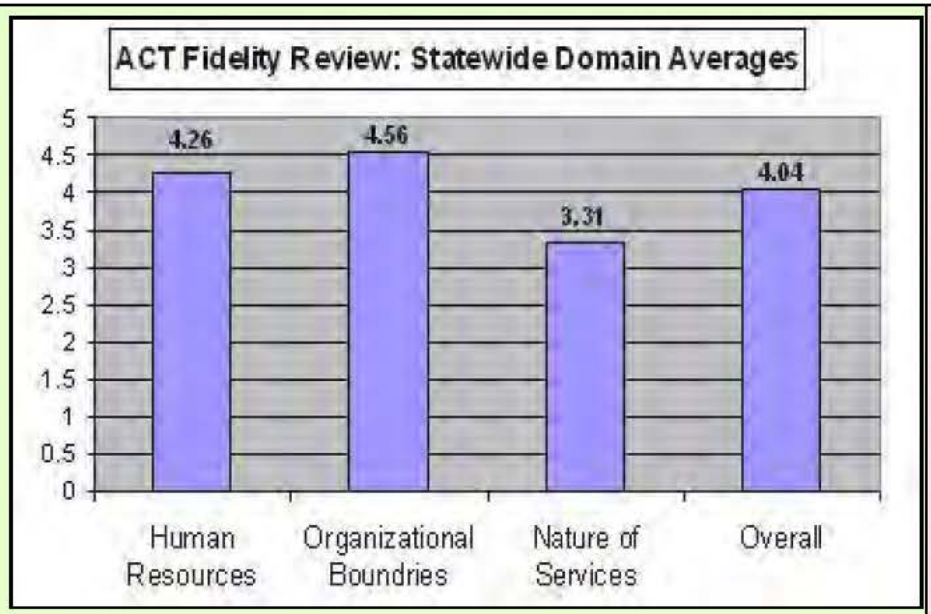
Compared to MaineCare members who do not have Serious Mental Illness (SMI), those with SMI:

- Are at higher risk for chronic medical conditions, such as diabetes and coronary heart disease.
- Are less likely to be receiving the same quality of health care.
- Are more likely to have at least two medical illnesses (46 percent vs. 27 percent) and more likely to have 3 medical illnesses (28 percent vs. 15 percent).
- Have an annual average medical expense was $4,000.00 per year less than the non-SMI group ($22,745 as compared to $26,890), despite having more medical illnesses.
- Have almost twice the prevalence of diabetes risk but are less likely to receive best diabetes care (hemoglobin A1c lipid profile, etc). They use more inpatient and ER and less outpatient services, have higher costs for care ($5,360 vs. $3,930 per year) and have more short and long term complications than other MaineCare members.

Assertive Community Treatment in Maine: Evaluating Fidelity, Service Use, and Outcomes

Performance Goal:

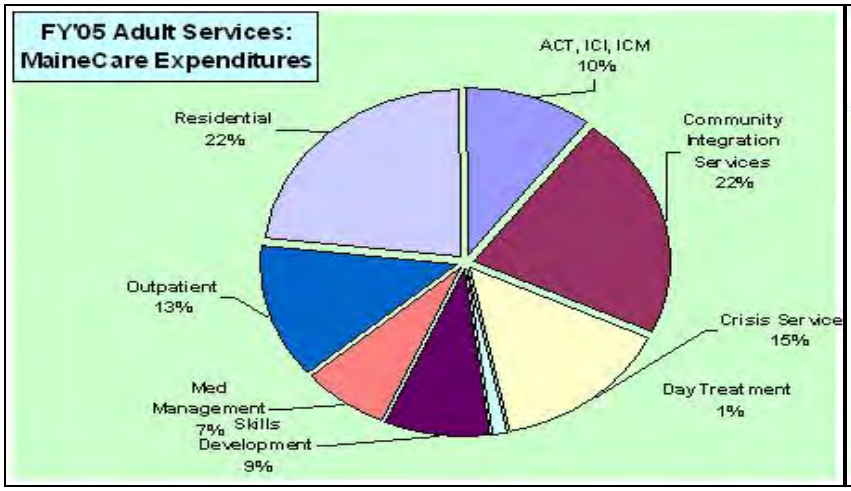
Determine the fidelity of Maine's Assertive Community Treatment (ACT) program to the national model.

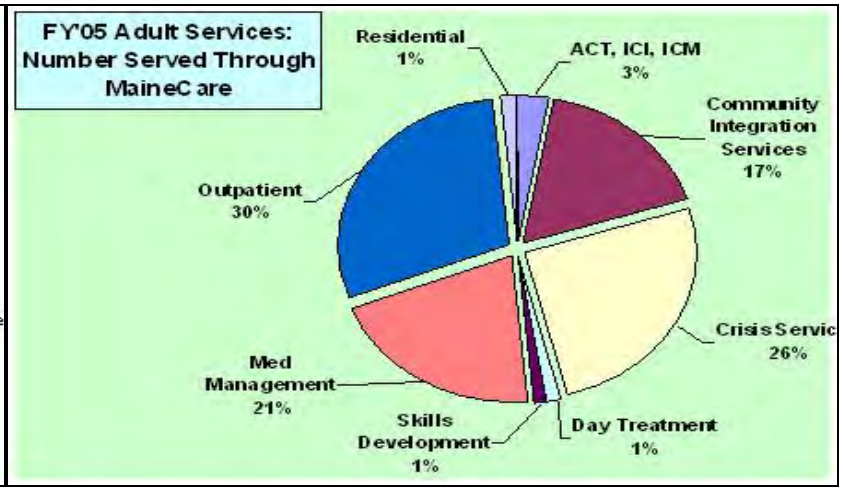


What We Have Learned:

- The higher an ACT team scored on the fidelity scale, the more closely it complied with nationally recognized ACT service guidelines.
- Fidelity Ratings are based on a scale of 1 to 5, 5 being the highest.
- Based on preliminary findings of the ten ACT teams in the state, Maine's fidelity scores showed high correspondence with established service guidelines.

Highlights and Successes





- In October of 2006 the DHHS Adult Mental Health Services Consent Decree work plan was approved by Court Master Daniel E. Wathen. The plan calls for numerous widespread improvements to the adult mental health system in Maine and includes an aggressive schedule for achieving those improvements.
  - The Bates vs. the Department of Health and Human Services Consent Decree serves 4,028 consumers. A total of 1,599 of the class are in community support, including ACT, community integration, ICI and intensive case management services. 114 Class members have asked to be removed from contact. 529 class members are out of state.
- Expanded access to peer support services beyond peer centers and social clubs through contracts for the provision of peer services in emergency departments and a statewide consumer-operated warm line. The warm line provides an alternative for consumers who are not in crisis but are seeking peer support and/or resource information.
- Developed a training curriculum for *Peer Recovery* Specialists and is establishing a training and certification system to make certified Peer Recovery Specialists available in a variety of settings including Assertive Community Treatment teams, emergency departments, warm lines and peer centers. OAMHS will also develop quality standards and outcome measurements to ensure quality peer support services and gather evidence to evaluate their effectiveness.
- Collaborated with Children's Behavioral Health Services to train the mental health workforce in disaster mental health response; provided technical support to initiatives in three counties linking local emergency preparedness efforts with disaster mental health responders.

- Creating a coherent system that will assure continuity of care between community support services, crisis services and all community hospitals. This is being achieved, in part, by a system design change that includes dividing Maine into seven Community Services Networks comprised of the mental health providers, including hospitals, in each region. All core services and functions will be coordinated to reflect a collective responsibility to all consumers in the network area.

- Held the first Maine Diversion and Re-Entry Summit in October of 2006, in collaboration with the Department of Corrections. This summit involved 125 participants including law enforcement and mental health personnel, diversion attorneys and prosecutors. Objectives included providing an overview of current diversion/re-entry services, selected best-practice diversion models, identification of future directions and developing contacts among the various professions. (Note: "Re-entry" refers to re-entry into the community from incarceration).

- Established two Progressive Treatment Programs (one associated with Dorothea Dix Psychiatric Center and one with Riverview Psychiatric Center) in response to legislation passed by the 122nd Legislature. The program involves court-ordered assignment of involuntarily hospitalized persons to specialized outpatient Assertive Community Treatment teams. The intent is to increase the length of successful tenure in the community for people with a history of severely impaired functioning.

Dorothea Dix Psychiatric Center

Dorothea Dix Psychiatric Center (DDPC) is part of a comprehensive network of community-based mental health services in Northern and Eastern Maine that includes community mental health centers, community hospitals and independent mental health providers. DDPC is dedicated to reducing the burden of mental illness on individuals in their care, on their family members, and the community. DDPC collaborates with individuals with severe and persistent mental illness and with their community and personal supports to provide respectful, compassionate and effective psychiatric care and treatment in the least restrictive, safest and most therapeutic environment. DDPC focuses on enhancing symptom management, promoting skill development, increasing knowledge and challenging people to use their strengths to lead more hopeful and autonomous lives.

Core Functions

DDPC In-Patient Services

DDPC has two 12 bed admission units. They serve as DDPC's front door, taking 250-325 admissions a year from other inpatient facilities, emergency departments, crisis services, jails, and community providers. The major treatment focus is in-depth assessment and stabilization of acute psychiatric and behavioral symptoms. Psychosocial rehabilitation services are provided both on and off the unit. About half of those admitted are discharged directly to the community, with a mean length stay of 26 days.

For those who need extended hospitalization, DDPC has two 18-bed extended care units that focus on continued stabilization and psychiatric rehabilitation. These units take patients transferred from the admission units to address issues that prevent discharge to a less restrictive setting. There is a wide range of clinical presentations – some patients require further medication adjustment; some have skill deficits requiring extensive training and rehabilitation; some need extensive discharge planning and arrangement to meet special needs.

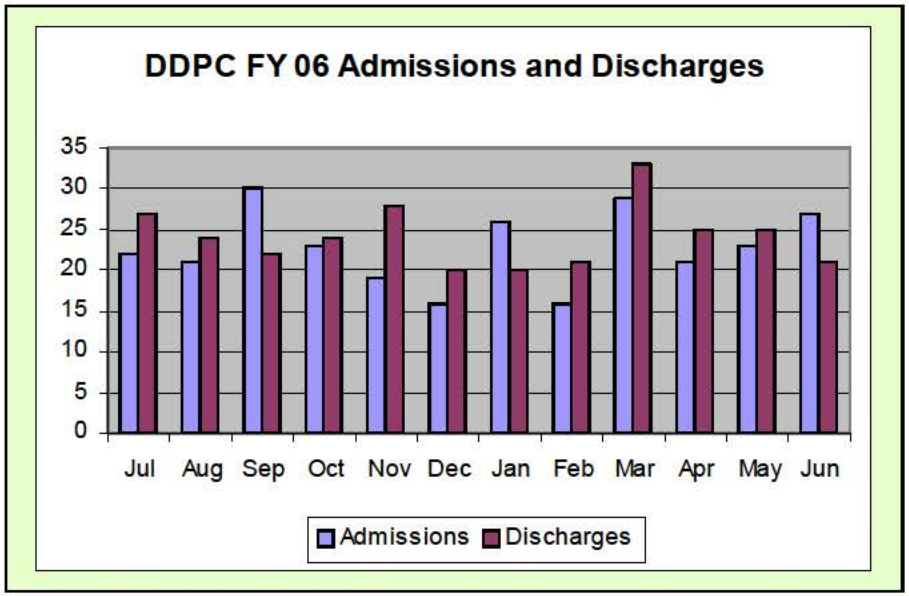
Wilson Treatment Mall offers psychosocial rehabilitation and psycho-educational groups for DDPC inpatients. It is attended by more than 90 percent of the inpatients. Groups are run by all clinical disciplines and address such issues as learning about coping skills, mental illness, treatment, managing symptoms, substance abuse, effective communication and leisure skills.

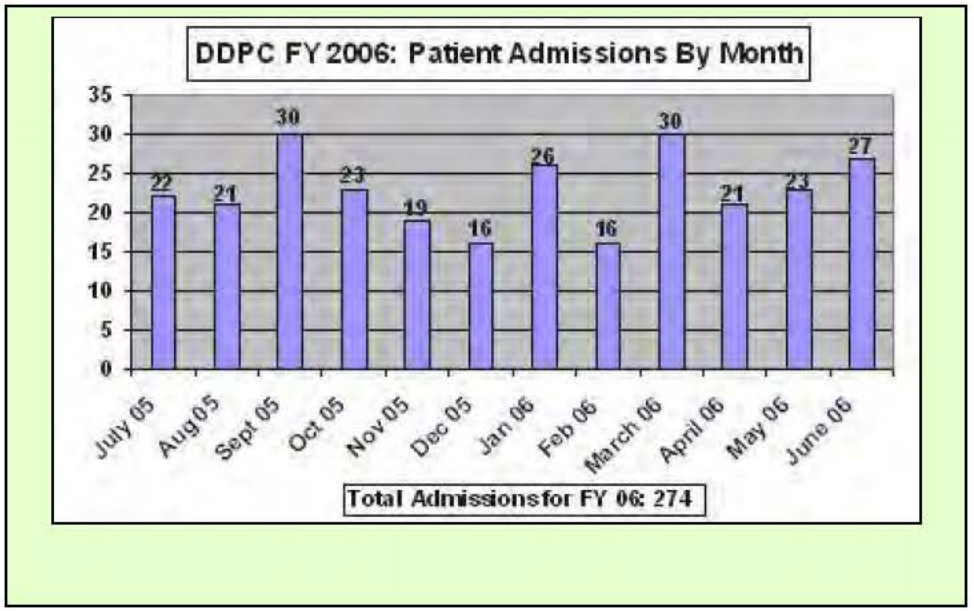
DDPC Outpatient Services

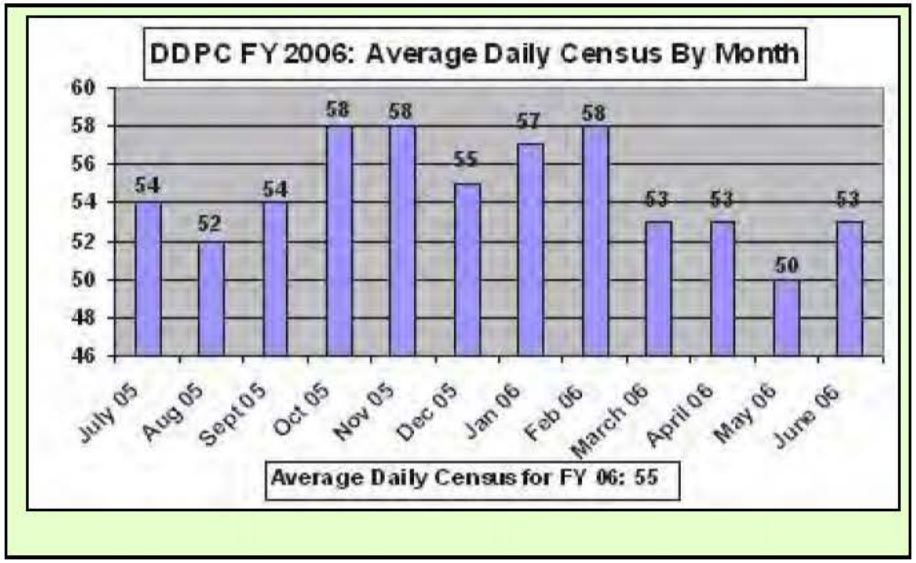
CLASP (Community Link and Support Program) focuses on engaging psychiatrically diagnosed individuals in a holistic treatment program, then in a supportive manner, linking them to the appropriate community based services and activities. This program includes a Dialectic Behavioral Treatment program.

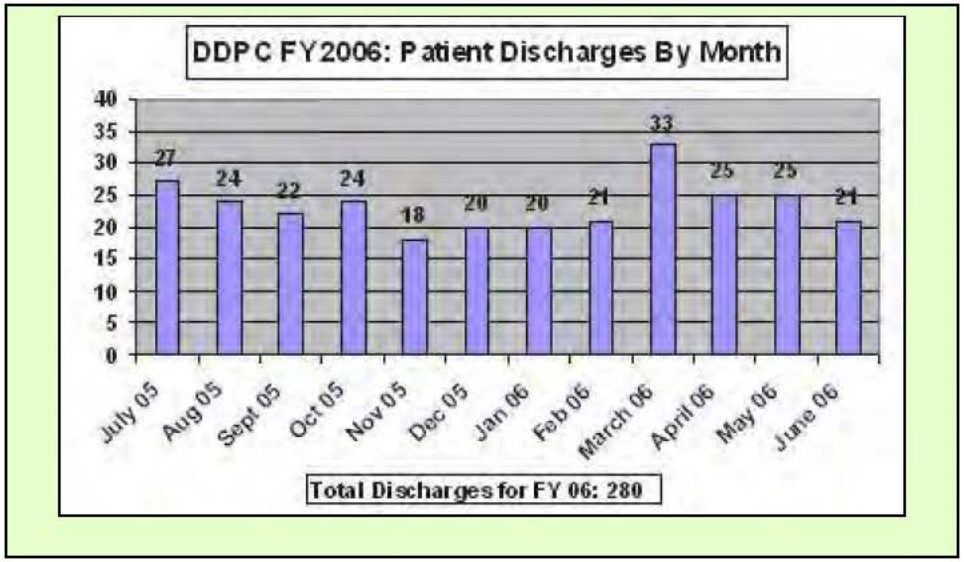
STARS (Senior Treatment and Respite Services) day program is comprised of the Geriatric Continuing Treatment Program and the Alzheimer's Day Treatment/Respite Care Program.

Outpatient Pharmacology Clinic provides psychiatric assessment, monitoring and medications for those who are unable to obtain services from community providers. The Dental Clinic provides dentistry services to adult clients of DHHS and Department funded agencies that are unable to receive these services in the community. Its goal is to provide both inpatients and outpatients with services until they can access community dentists. Its services are integrated with the hospitals in terms of total patient care.


DDPC FY 06 Admissions and Discharges
35
30
25
20
15
10
5
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Admissions
Discharges


DDPC FY 2006: Patient Admissions By Month
35
30
25
20
15
10
5
0
22
21
30
23
19
16
26
16
30
21
23
27
July 05
Aug 05
Sept 05
Oct 05
Nov 05
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Total Admissions for FY 06: 274


DDPC FY 2006: Average Daily Census By Month
60
58
56
54
52
50
48
46
54
52
54
58
58
55
57
58
53
53
50
53
July 05
Aug 05
Sept 05
Oct 05
Nov 05
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Average Daily Census for FY 06: 55


DDPC FY 2006: Patient Discharges By Month
40
35
30
25
20
15
10
5
0
27
24
22
24
18
20
20
21
33
25
25
21
July 05
Aug 05
Sept 05
Oct 05
Nov 05
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Total Discharges for FY 06: 280

Highlights and Successes

- ❑ **No** deficiencies found in an unannounced Center for Medicare and Medicaid survey.
- ❑ Implemented Centers for Medicare and Medicaid Services Prospective Payment System to assure accurate billing.
- ❑ Provided jail diversion planning to assure mentally ill inmates receive adequate support and care.
- ❑ Hosted a program to assist police and correction officers in recognizing and de-escalating individuals with mental illness.
- ❑ Participated in the Region III Provider Collaborative which identifies opportunities for quality improvement and methods to improve access and quality of care.
- ❑ Actively participated in disaster preparedness in conjunction with the Penobscot County Emergency Management Agency.
- ❑ Worked with the Maine CDC to prepare for a possible Flu Pandemic.
- ❑ Implemented a "Hand-Off" communication system regarding patient risks, conditions and anticipated changes in condition between shifts and on/off unit staff. Research shows that improved provider communication is strongly correlated with better patient outcomes and error prevention.
- ❑ Invested in Technology for a Patient-Care Environment: DDPC patients can now receive e-mail in the Computer Café and access the Internet to explore their interests. Staff is encouraged to take computer classes and clinical staff has online access to educational materials to meet continuing education requirements.
- ❑ Implemented the Pyxis Medication System to deliver medications to Nursing Units in a manner that reduces the chance for medical errors. The Pharmacy, Medical and Nursing Staff have online access formularies that provide information on drug interactions, dose ranges, possible side effects and medication availability to staff.
- ❑ There will be a contracted Assertive Community Treatment Team targeted for patients of the hospital.

Riverview Psychiatric Center

The main focus at Riverview Psychiatric Center (RPC) is supporting the recovery of persons experiencing severe and persistent mental illness. It is the goal of RPC to assist clients in obtaining self-selected and valued community roles and return to their families and communities. There, they will fully participate in Maine's culture, lifestyle and citizenry in a manner that reflects their aspirations and desires.

The Riverview Psychiatric Center (RPC) is mandated to treat adults who require intensive 24-hour psychiatric service statewide. RPC is dedicated to reducing the burden of mental illness on individuals in their care, their family members and the community.

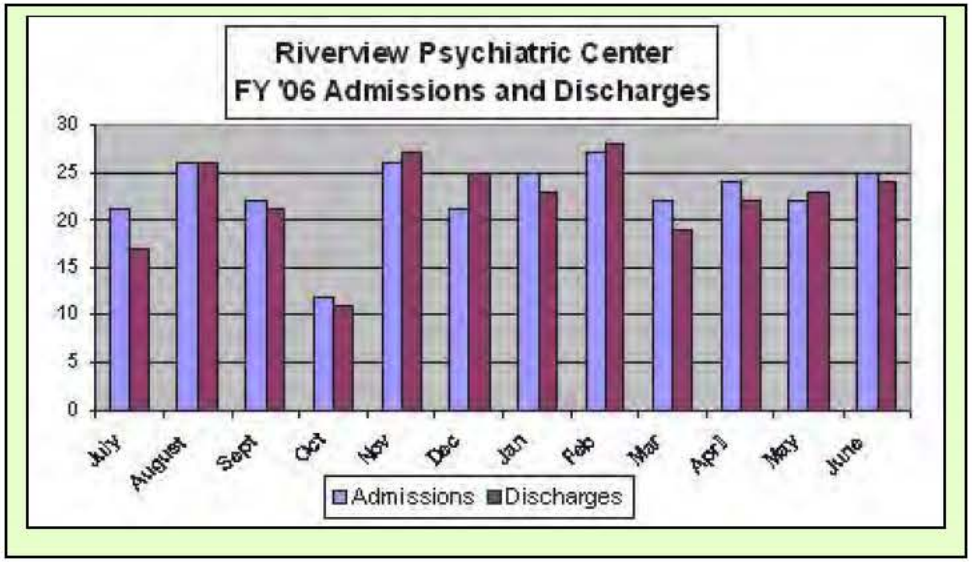
RPC is mandated and equipped to provide care and treatment. Its clients may require a secure setting, extended observation, care and treatment and those who require certain highly specialized programs not available elsewhere.

Core Functions

In-Patient Unit
RPC has 92 licensed psychiatric beds. "Lower" and "Upper Kennebec" are civil admission units. Lower Kennebec is the regular non-forensic civil admission unit, with a total of 24 beds, with six considered Special Care beds. Clients coming into the hospital usually are admitted to one of these six beds. As they progress in treatment, they may transition into one of the 18 remaining beds on the regular unit. Upper Kennebec is an extended care civil admission unit with 24 client beds. Clients on this unit are engaged in intense psychiatric rehabilitation and transition planning.

The hospital also has two Forensic units. Lower Saco has a total of 20 beds and serves forensic clients coming from jails or prisons in Maine for treatment, evaluation, or to be restored to competency to stand trial. Upper Saco has a total of 24 beds and serves extended stay clients, generally found "not criminally responsible" that are committed to the hospital for treatment and rehabilitation under the care of the DHHS Commissioner.

In-Patient Services
RPC has two outpatient clinics, one within the hospital and one at 63 Preble Street in Portland. The clinics offer outpatient "safety net" psychiatry services, dental services, medical services and podiatry services. In the fall of 2006, Riverview implemented a Forensic Assertive Community Treatment service. A residential service setting for forensic clients is also maintained on the AMHI/Eastside campus.


Riverview Psychiatric Center
FY '06 Admissions and Discharges
30
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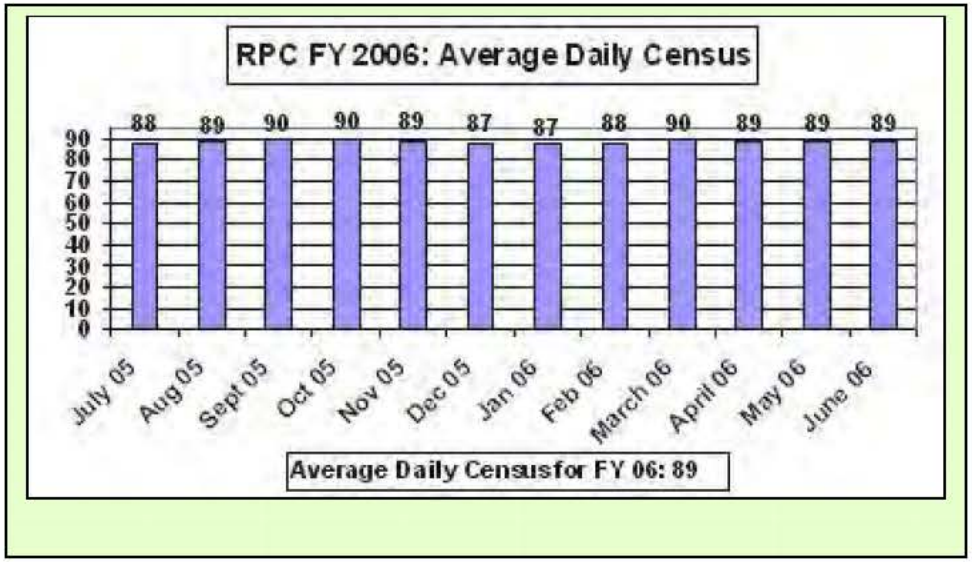
June
Admissions
Discharges


RPC FY 2006: Average Daily Census
88
89
90
90
89
87
87
88
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80
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50
40
30
20
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July 05
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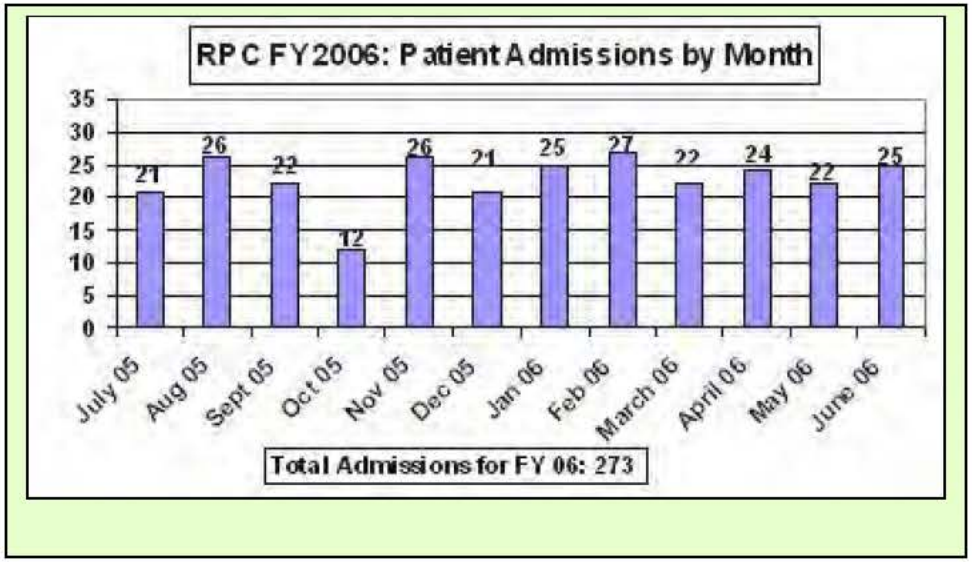
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Average Daily Census for FY 06: 89


RPC FY 2006: Patient Admissions by Month
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22
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July 05
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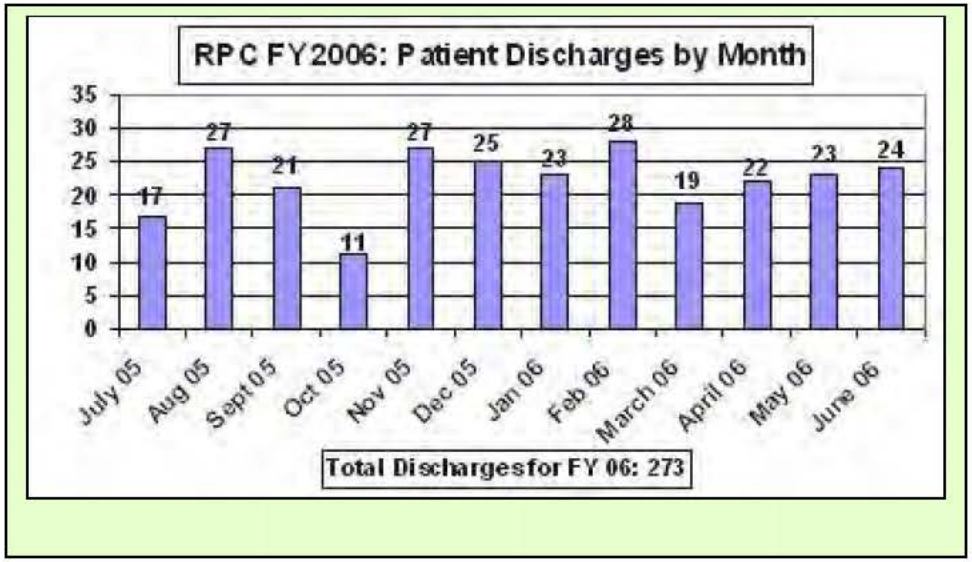
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Total Admissions for FY 06: 273


RPC FY 2006: Patient Discharges by Month
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28
19
22
23
24
July 05
Aug 05
Sept 05
Oct 05
Nov 05
Dec 05
Jan 06
Feb 06
March 06
April 06
May 06
June 06
Total Discharges for FY 06: 273

Highlights and Successes

- ❑ Implemented a continuous quality assessment and improvement process with quarterly reports posted at www.state.me.us/dhhs/riverview/departments/leadership.
- ❑ Reduced greatly the utilization of seclusion and restraint. Staff injuries and mandated shift work have also decreased.
- ❑ Established the 72-hour rapid assessment and stabilization bed system on the forensics unit to better meet the needs of jail administrators with respect to inmates with mental disorders.
- ❑ Reduced the population of over 30 days post-discharge readiness at the hospital.
- ❑ Reduced daily pharmaceutical costs through consultation and collaboration between pharmacists and physicians.
- ❑ Passed an unannounced Center for Medicare and Medicaid survey with **no deficiencies**, an announced DHHS survey and a Joint Commission on the Accreditation of Healthcare Organizations unannounced verification survey.
- ❑ Increased staff and community education on topics concerning mental health.
- ❑ Initiated collaboration with community partners in providing substance abuse services.
- ❑ Contracted with the Disability Rights Center to establish advocacy services within the hospital.
- ❑ Expanded the Peer Specialist Program and Vocational Services.
- ❑ Enhanced the physical plant on the forensic unit resulting in improved safety.
- ❑ Launched an automated billing system.
- ❑ Implemented discharge transitional and consultation services to community providers.
- ❑ Initiated healthier diet specific to diabetic risk and introduced exercise equipment to the care milieu.

State Forensic Service

The State Forensic Service (SFS) conducts court-ordered psychological and psychiatric evaluations in adult and juvenile criminal cases. Examinations are conducted either by one of two psychologists employed by the SFS, or by one of 48 psychiatrists and psychologists located throughout the state who contract with the SFS. The goals of the State Forensic Service are to provide thorough, impartial examinations by experienced, well-trained experts in a timely fashion, while controlling the cost of such assessments.

Core Functions

Stage I
Stage I evaluations are meant to provide a brief examination of a defendant's competency to stand trial and to identify any mental or emotional issues that may pertain to criminal responsibility. Stage I evaluations usually take 30-45 days for completion from the receipt of the court order, unless appointments are missed.

Stage II
Stage II evaluations provide a comprehensive assessment of matters pertaining to competence and criminal responsibility. Stage II evaluations are ordered when it was not possible to provide the Court with sufficient information on the basis of a Stage I evaluation. The Stage II exam allows a more extensive review of records, additional psychological testing, if indicated, psychiatric assessment and interview of collateral contacts, such as treaters and family members. Stage II evaluations are ordinarily completed within 60 day.

Stage III
When it is not possible to assess matters of competence or criminal responsibility on an outpatient basis, the court may order this period of inpatient assessment. The defendant is observed and assessed for up to 60 days on the forensic unit of the Riverview Psychiatric Center. When the evaluation is complete, the defendant is released from the hospital and a report is submitted to the court by the SFS.

Incompetent to Stand Trial
Defendants found Incompetent to Stand Trial and committed to the forensic treatment unit in the custody of the DHHS Commissioner, are examined 30 days after admission, 60 days later and again no more than a year after admission, or sooner, if there is a significant change in status. A report is submitted to the Court regarding the defendant's progress toward restoration of competence after each examination.

Not Criminally Responsible
The Director of the State Forensic Service and the Chief Forensic Psychologist examine persons found Not Criminally Responsible at the time of any petitions for any level of release and provide relevant court testimony with special attention to community safety issues.

Post Conviction Review
The State Forensic Service conducts examinations as part of post conviction reviews when issues of competence and criminal responsibility are raised.

Bindover Examinations
Bindover evaluations are requested when there is the possibility that a juvenile may be tried as an adult. Bindover evaluations include a thorough assessment of cognitive and emotional factors, treatment alternatives, and risks.

Pre-sentence Evaluations
Pre-sentence evaluations provide information for sentencing. Reports emphasize factors which may increase or decrease the risk of repeat offending, and identify treatment possibilities. Pre-sentence evaluations are sometimes ordered when mental health treatment is being considered as a condition of probation. These evaluations take about two months to complete.

Juvenile Predisposition, **Pre-adjudicatory Evaluations**
These diagnostic evaluations provide information about the juvenile's history and functioning, factors that may increase or decrease risk, or affect success in treatment. They take about two months to complete, depending on how quickly records are obtained. Brief juvenile evaluations are available to answer narrower- focused questions posed by the Court, with the intention of minimizing the time a juvenile is detained while awaiting disposition, when possible. Since October, 2005 pre-sentence, pre-adjudicatory, and pre-dispositional evaluations conducted by the State Forensic Services have been limited to charges of Class A crimes, murder, and sex offenses.

Training
The State Forensic Service offers annual training by national experts in forensic psychology and psychiatry, open to any professionals in the field, including attorneys, judges and probation officers. Training on specialized topics is offered by local experts approximately once a year. The Director and Chief Forensic Psychologist provide training at no cost to other state and local agencies, schools and hospitals, the Maine Medical Center psychiatry resident program, the University of Maine School of Law, and the University of Maine at Farmington. The SFS offers a pre- or post-doctoral fellowship rotation for Togus Veteran's Administration Medical Center trainees. For the first time this year, a forensic psychiatry rotation is in place, in collaboration with Maine Medical Center.

Examinations Conducted by the State Forensic Service
August 31, 2005 – August 31, 2006

Type of Examination	Number
Incompetent to Stand Trial follow-up	53
Bindover	10
Brief Juvenile	18
Not Criminally Responsible	39
Stage I and related	223
Pre-adjudicatory	31
Pre-dispositional	33
Pre-sentence	25
Probation	1
Stage II	59
Stage III	40

Cognitive and Physical Disabilities Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	349.8
Total Funding FY '06:	$131,248,799
General Fund:	$118,614,519
Federal Fund:	$1,065,379
Special Revenue:	$10,623,959
Block Grant:	$944,942

Jane Gallivan
Director

Program Introduction

The Office of Adults with Cognitive and Physical Disabilities Services provides leadership and is an active partner in Maine's comprehensive system of support to individuals with cognitive and physical disabilities.

Office Information

Mailing Address:

DHHS Office of Adults with Cognitive and Physical Disabilities Services
Marquardt Building, 2nd Floor
State House Station #11
Augusta, Maine 04333-0011

Phone number:
207 287-4242

Fax number:
207-287-9915

TTY:
800-606-0215

Director's e-mail address:

jane.gallivan@maine.gov

Cognitive and Physical Disabilities Services

At the foundation of this system is the belief that all individuals, through self-determination, can achieve a quality of life consistent with the community in which they live. Supports must be flexible and designed in a manner that recognizes people's changing needs throughout their lifetimes.

Core Functions

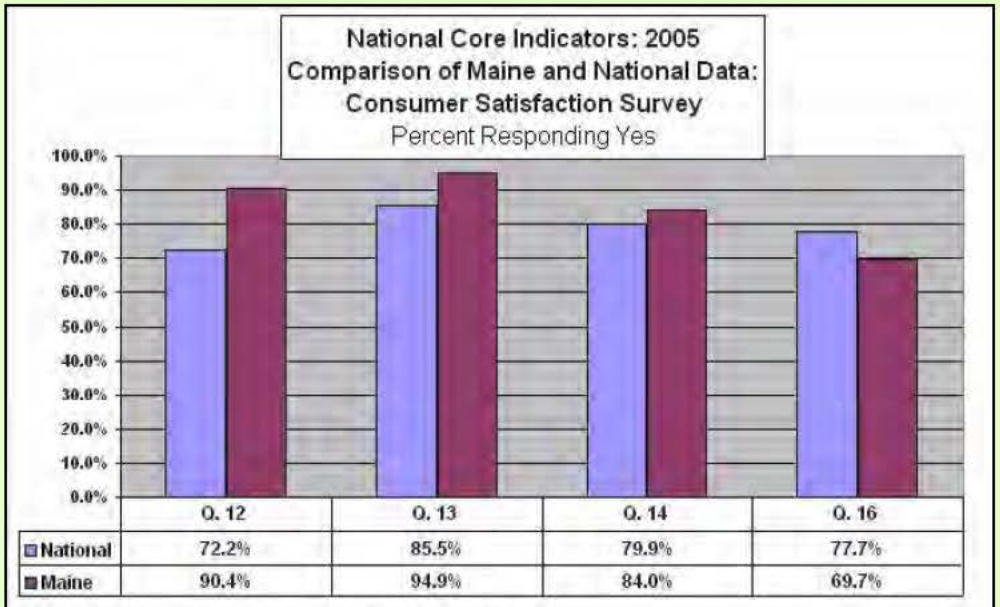
- **Case Management** coordinates a variety of services and supports for an individual based on the person's need and personal choice. An Individual Support Coordinator (I.S.C.) will work with the person and their family through an individual planning process.
- **Person-Centered Planning** is a flexible approach to planning with and for someone, based upon the needs, desires and preferences of the person, with input from family and other members of his or her planning group.
- **The Quality Improvement/Quality Assurance** system for this Office provides ongoing review of activities – ensuring health and safety, achieving individual needs met, measuring people's involvement in their communities and monitoring the many requirements which govern the Department's delivery of services.
- **Crisis Services** in each region provide assistance to individuals, families, guardians and providers. The crisis team works to help individuals remain in their homes and local communities during and after crisis incidents. The team can provide outreach support, consultation, education and in-home services. Each of the regional crisis teams also operates a residential service for short-term stabilization. Crisis services are available 24 hours a day through a toll-free hotline.
- **Public Guardianship is provided** for incapacitated persons with mental retardation when no private individual is able to act as a private guardian. The authority of guardianship is delegated to the Department's Guardianship Program Manager.
- **Representative Payee**: If it is determined (by the Social Security Administration, Veterans Administration, or similar entity) that an individual needs assistance in conducting their financial affairs, and that there are no family members or other responsible individuals in a person's life to do so, our office can provide that service.
- **Adult Protective Services** has the responsibility to investigate allegations of abuse, neglect and exploitation of persons with mental retardations. Investigations are conducted by regional investigators and approved agency investigators. Agency investigators must be nominated by the Executive Director, must undergo a criminal record check and must be cleared by Child Protective Services.
- **The Office of Advocacy** supports those served by the Department in all matters pertaining to rights and dignity. Using available resources, advocates represent people in grievance proceedings and intercede on their behalf to uphold their rights. The office also acts as an information resource regarding the rights of all people served by the Department.

Performance Goals

- ❑ People are included their communities
- ❑ People are safe and healthy
- ❑ People's needs are met
- ❑ The system is effective and efficient

Performance Goals:

Determine the percent of consumers responding positively to community inclusiveness.



	Q. 12	Q. 13	Q. 14	Q. 16
National	72.2%	85.5%	79.9%	77.7%
Maine	90.4%	94.9%	84.0%	69.7%

Q. 12 - Do you have friends you like to talk or do things with?
Q. 13 - Do you have a best friend or someone you are really close to?
Q. 14 - Can you see your friends when you want to see them?
Q. 16 - Can you see your family when you want to?

Data & Chart - Office of Quality Improvement

The National Core Indicators Project: The aim of the project is to develop nationally recognized performance and outcome indicators that will enable the Office of Adults with Cognitive and Physical Development Disabilities to benchmark the performance of Maine against the performance of other states.

What We Have Learned:

Maine exceeded the national averages for each of the Questions;

Question 12, ranking 2nd.

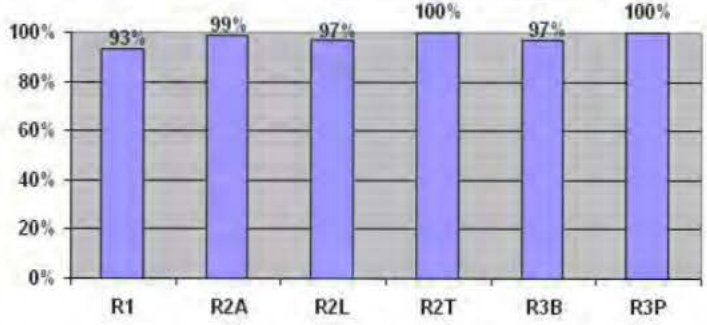
Question 13, ranking 1st

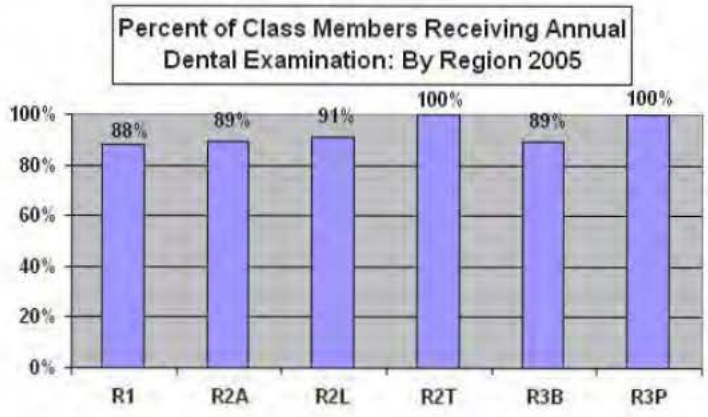
Question 14 ranking 8th.

Maine fell below the national average for responses to Question 16. However, when comparing the number of individuals who responded No or Sometimes to that very same question, Maine was above the National average.

Performance Goals:

Determine the percent of consumers who receive annual physical and dental care check-ups.





Region Key:
Region 1: York & Cumberland Counties
Region 2A: Kennebec & Somerset Counties
Region 2L: Androscoggin, Franklin & Oxford Counties
Region 2T: Knox, Lincoln, Sagadahoc & Waldo Counties
Region 3B: Hancock, Penobscot, Pisctaquis, and Washington Counties

What We Have Learned:

In 2005, every region reported that 93 percent or more of consumers had an annual physical.

In 2005, every region reported that 88 percent or more of all class members had an annual dental examination.

Highlights and Successes

- Mental Retardation Services re-designed its Home and Community Based Waiver for Adults with Mental Retardation and autistic disorder. The redesigned waiver was approved by the Centers for Medicaid and Medicare (CMS) July 1, 2006. The redesigned waiver has many new definitions, for example: residential training and personal supports are now "Home Supports", and day habilitation services is now "Community Supports." Participation from a variety of stakeholders, including individuals, family members, advocacy groups and providers was invited. The primary function of the redesign is to support the new published rate setting system with clear definitions that will have consistent rates associated with them. Currently, 2,666 people with mental retardation and/or autism are served on this waiver. 212 people are in the ICF-MR program and 219 in the PNMI program.

- Mental Retardation Services has created a new published rate setting system. CMS has informed DHHS the previous method of negotiated rates is no longer acceptable. With federal funding from the CMS Money Follows the Person grant, Mental Retardation Services did an extensive evaluation of five years of claims and utilization data, together with a survey or provider actual costs to develop new published rates. Those rates are now being tested in a xi-month pilot with 18 provider agencies participating to study the viability of the rates created from the data analysis. The final rates will be determined at the end of the pilot.

- Substantial progress has been made in achieving compliance with the Community Consent Decree. Under the direction of Clarence Sundram, Special Court Master, the Department and the plaintiffs have developed a system of certifications of compliance. Mental Retardation Services is collecting data for each indicator to assure that the outcomes are being measured to achieve compliance.

- Freeport Towne Square, consisting of two six- bed waiver homes, was successfully transitioned from a state-operated facility to Independence Association, a private non –profit provider agency. The completion of the closure of the homes is ongoing, with each individual having a transition plan to move into a new residence. This transition completes the elimination of all state-operated residential services for adults with mental retardation.

- Mental Retardation Services has successfully developed a community case management system to serve more than 500 adults who live at home with their families or on their own in their own homes or apartments through non- profit agencies. This service has focused specifically on family supports and allowed state case management to focus on those living in agency-run facilities.

- Strive U graduated its first class of students. This program provides post-secondary educational experience to young adults with developmental disabilities in the realms of residential, employment, and community skills with the goal of enabling its graduates to live and work as full community members with maximum independence, productivity, and dignity.

- Adult Protective Services for individuals with mental retardation has been transitioned to Mental Retardation

Services. A collaborative relationship is emerging with the provider agencies that assist with adult protective investigations and Adult Protective Services. The draft rules and procedures have been consolidated into one document which went through the public hearing process and is close to being finalized into rule.

- Speaking Up For Us (SUFU) has continued to grow as the major self-advocacy organization funded by Mental Retardation Services. Leadership of SUFU represents Maine at national conferences, speaks at public forums and provides testimony on a variety of topics at the legislature. Maine has received recognition for many training programs that include self-advocates as trainers.

- Maine was ranked second in the county for individuals being included in their communities in a recent report funded by the National Cerebral Palsy Foundation.

- Mental Retardation Services, in collaboration with the Maine Chiefs of Police, developed an on-line course for law enforcement titled “Awareness of People with Mental Retardation”. As of July, 326 law enforcement personnel have completed the course.

- The Guardianship program within Mental Retardation Services, has worked closely with Elder Services guardianship program to share resources and expertise. This has been a very positive experience.

- Mental Retardation Services participates in the CMS Real Systems Transformation Grant to explore alternatives to guardianship. This project holds great promise to examine and improve the guardianship system for adults in Maine.

- Mental Retardation Systems is in the process of completing an Independence Plus waiver application to begin self-directed services. This new waiver will allow individuals to design and directed their own supports and services, hire staff, provide training to those staff and manage the budget for these services. Starting on a very small scale, it the goal is to begin this new program in July.

- A position has been transferred to Office of Adults with Cognitive and Physical Disabilities to assist in the creation of a single state agency for Brain Injury.

Advocacy Services

The Office of Advocacy has provided assistance or information through more than 11,000 contacts with people with mental health difficulties and/or mental retardation through investigations of alleged rights violations, review of aversive programming, and representation of clients at person centered plan meetings and Pupil Evaluation Team meetings.

The Office of Advocacy is the designated investigatory agent for alleged violations of the rights of persons with mental retardation under 34-B MRSA Section 5606. There are six and one half community advocate positions for persons with mental retardation. One community advocate also serves persons at the Elizabeth Levinson Center. One chief advocate supervises all of the advocates. The community advocates: (1) investigate allegations of alleged violations of rights pertaining to persons with mental retardation; (2) approve and monitor the utilization of aversive behavior modification plans; (3) represent clients at person centered planning team meetings at which programs for treatment, services, goals and habilitation are planned, developed and recorded; (4) seek ways to implement and enforce the rights of persons with mental retardation under the Community Consent Decree, state and federal law; and (5) review policies and actions of the department's regional offices and suggest ways to deliver high quality care to persons with mental retardation. The Office of Advocacy administers a small contract under which limited civil legal services may be provided to clients and patients of the department.

A major goal of the office is to be able to provide to the department suggestions which will not only impact upon individual client's lives, but will also aid the department and clients in general, through helpful systematic changes.

Office of Elder Services

Funding At a Glance

Total Staff (Full-Time Equivalencies):	105.5
Total Funding FY 06:	$33,055,271
General Fund:	$22,974,541
Federal Fund:	$9,966,775
Special Revenue:	$113,955

Diana Scully
Director

Program Introduction

The Office of Elder Services strives to promote optimal independence for older citizens and adults in need of protective and supportive services.

Office Information

Mailing Address:

Office of Elder Services
442 Civic Center Drive
State House Station #11
Augusta, Maine 04333-0011

Phone number:
207-287-9224

Fax number:
207-287-9229

TTY:
800-606-0215

Director's e-mail address:
Diana.scully@maine.gov

Elder Services

The Office of Elder Services oversees a variety of community services and supports that help older people remain independent. These resources are provided through a collaborative network comprised of Maine's five Area Agencies on Aging and many others. The Office also manages long term care assessments and home-based services for people with long-term needs. Maine has been a leader in the nation in reducing its reliance on nursing facilities and increasing home care and other community alternatives. The Office helps dependent and incapacitated adults. Abuse, neglect and exploitation have no boundaries; elders and adults of all cultural and socio-economic groups and all levels of physical and mental functioning are affected.

Core Functions

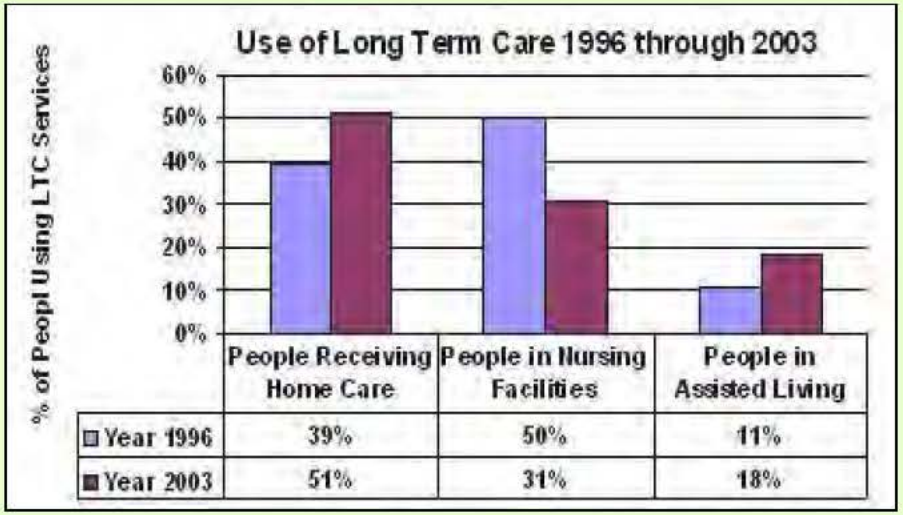
- **Maintain an up–to–date information system related to Maine's aging population and incapacitated and dependent adults** by: conducting research on the causes and nature of problems relating to Maine's aging population and incapacitated and dependent adults; collection, maintenance and dissemination of knowledge relating to Maine's aging population and incapacitated and dependent adults; maintaining an inventory of the types and quality of facilities, programs, and services operated under public or private auspices for Maine's aging population and incapacitated and dependent adults; conducting a continuous evaluation of the impact, quality and value of facilities, programs and services, including their administrative adequacy and capacity.
- **Prepare and administer a comprehensive state plan** relating to Maine's aging population and incapacitated and dependent adults.
- **Function as the organizational unit of state government solely responsible for administering: The 1973 Act of Maine's Elderly, The Priority Social Services Act of 1973, The United States Older Americans Act of 1965, and the Adult Protective Services Act of 1981.**
- **Help communities mobilize resources to benefit Maine's aging population, incapacitated and dependent adults** through coordination of information, technical assistance and consultation to state, regional and local governments and to public and private nonprofit agencies, institutions, organizations and individuals.
- **Develop and implement an educational program**, convene and conduct conferences of public and private non profit organizations concerned with the development and operation of programs for Maine's aging population and incapacitated and dependent adults.
- **Support and maintain legal services**.
- **Administer a program of protective services** including a public guardianship/conservatorship program which is designed to protect incapacitated and dependent adults, other than adults with developmental disabilities, from abuse, neglect, exploitation, and physical danger.
- **Support and maintain** Long Term Care Ombudsman Program.
- **Administer long term care services** that reduce reliance on nursing home care and offer more choices for consumers and families to achieve a balanced array of services. Assure an adequate number of direct care workers.

Performance Goals:

Adult protective investigations of abuse, neglect and exploitation may also include determining the need for guardianship	2,446
Protective care management. This service is provided to adults not under public guardianship or conservatorship in order to reduce or eliminate danger and to coordinate services	84
Public guardianship and conservatorship, includes authorized medical and psychiatric care, placement decisions, financial management, assessments, advocacy, service planning and coordination, etc to incapacitated adults.	853
Nursing facilities -members reimbursed by MaineCare	7,888
Assisted living, adult family care homes and residential care (PNMI) reimbursed by MaineCare	3,888
Office of Elder Services Homemaker services (HMKR)	2,267
Long Term Care assessments by Goold Health Systems	15,335
LTC MaineCare & state funded home care programs, including 2 waivers, consumer directed programs, the state funded Home Based care program for OES and DOL, Private Duty Nursing/Personal Care program	4,135

Goals:

Determine the performance availability of community based support services for older adults and those with disabilities to support people in living in the least restrictive setting.

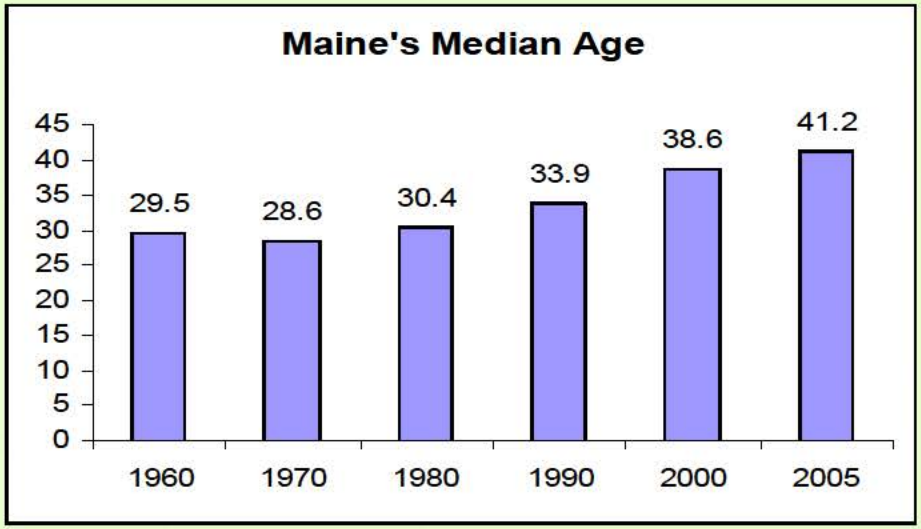


What We Have Learned:

From 1996 through 2003, the number of older adults residing in nursing facilities has decreased by 19 percent, while the percentage receiving home increased by 22 percent and those receiving Assisted living increased by 7 percent.

Performance Goal:

Determine the extent of population demographic shift.

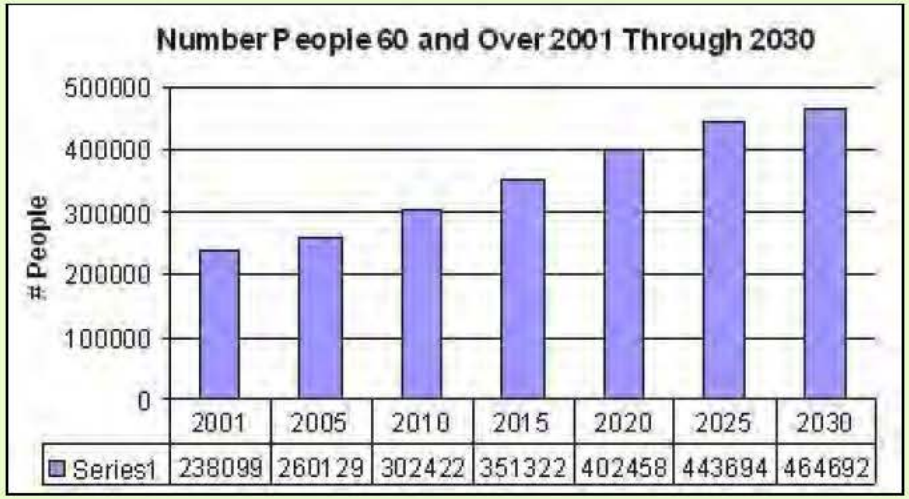


What We Have Learned:

Population estimates indicate a significant demographic shift in Maine. By 2025, one in five Mainers will be a senior citizen. It is estimated the percentage of Maine citizens aged 65 to 74 will grow by 97 percent and those aged 75 to 84 will grow by 55 percent. While our population of seniors grows, our youth and younger adults will continue to decline.

Performance Goal:

Determine the effect of the aging population on our work force.



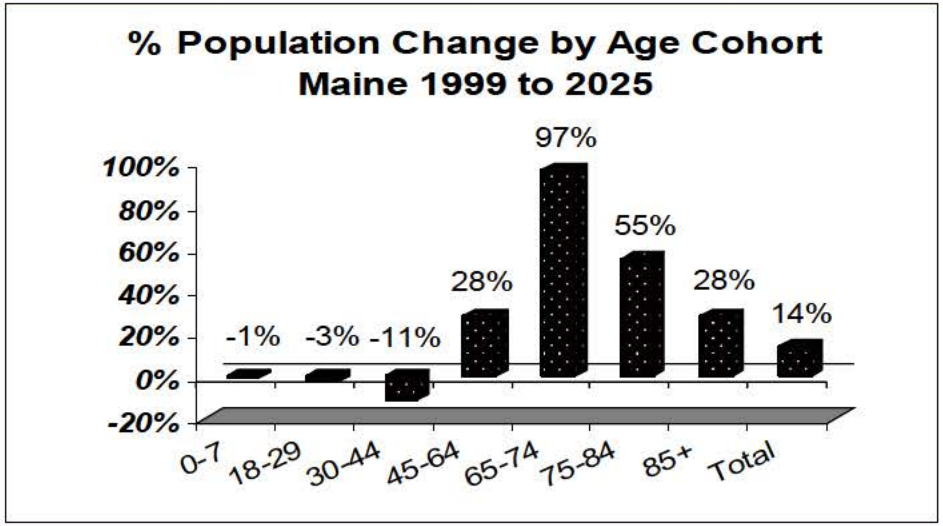
What We Have Learned:

The aging population is growing while the direct support workforce is decreasing.

As the baby boom generation enters retirement age, New England employers will become increasingly dependent on older workers (those aged 55 and above) to meet the demand for skilled workers.

Performance Goal:

Determine the effect of the population aging on services.



What We Have Learned:

This significant change in demographics will dramatically affect the way in which the State of Maine, DHHS and OES approach, plan and develop resources and services for Maine's elders.

Highlights and Successes

- **Received additional federal and private funding** to support expansion of several community programs.
- **Received federal funds from the Administration on Aging** to extend the development of aging and disability resource centers throughout much of Maine.
- **Received additional federal funds from CMS** to reward the excellence of Maine's state health insurance assistance program.
- **Received private funding from AARP** to expand the Money Management Program.
- **Continued development of the Maine Adult Services Information System** has made possible a comprehensive financial account management system for adult protective services workers and about 800 public wards and protected persons, and for 2000+ people with mental retardation.
- **The first worldwide Elder Abuse Prevention Day** was recognized in June 2006 with the Governor issuing a proclamation and holding a press conference.
- **Increased awareness of elder abuse** through ongoing community education and awareness campaigns through continued collaboration with community organizations and financial institution.
- **The Blaine House Conference on Aging** was re-convened by the office of Elder Services in September 2006 after a 16 year hiatus. Approximately 300 people participated, including almost 200 elder delegates. The 25 action resolutions adopted will guide public and private partners in building on the strengths and addressing the needs of Maine's elders. Conference proceedings and related materials can be found on the web: http://www.maine.gov/dhhs/beas/bhcoa_2006.htm

Pressures Affecting the Department As A Whole

1. **Integrating Systems within a complex organization** takes time, focus and resources.

2. **Information Technology forms the foundation of many of DHHS operations**. It underlies our ability to deliver services; assimilate and share knowledge; manage finances and other resources; direct and monitor program performance and maintain public trust by virtue of authentic accountability**.** [1] DHHS Information Technology Services faces a dual integration challenge. Synchronizing data within multiple data systems presents major challenges and significantly impacts to our ability to create ”one door”. Added to the challenge of the newly integrated Department of Health and Human Services, Information Technology for the entire state government recently became a centralized function.

3. **The Federal Deficit Reduction Act** and increasing federal requirements for oversight and outcome measures create fear and anxiety that the services and programs fought for and developed over the past quarter century are in jeopardy. These fears spread among clients, their families, provider agencies and our employees, who all fear the loss of services. As public policy makers shift to more consolidation, accountability and efficiency, we need to keep the people we are trying to help in the center of our work and be compassionate to those who are adversely impacted by change.

4. **Health Issues remain an enormous pressure for the State. Specific to DHHS:**
   - Increased need to account for healthcare expenditures and health outcomes requiring more care management.
   - The costs of healthcare services continue to rise.
   - Current resources diverted to improve our preparedness for public health emergencies such as attacks with a weapon of mass destruction or a pandemic (worldwide epidemic).
   - Our childhood vaccine program is primarily funded with Federal dollars, with some contribution from Maine HMOs to purchase vaccine for children they insure. Over the past several years, we have sustained Federal cutbacks in the face of increasing costs of vaccines. As a result, we are no longer able to provide adult vaccines and some recommended childhood vaccines.
   - Keeping up with increases in health care and medication costs and providing access to newer forms of birth control that reduce user errors, such as the OrthoEvra Patch and Nuva Ring;
   - Health disparities, for which there is not a biological basis;
   - Dental services are needed for customers with special needs;
   - Increasing need for geriatric health and mental health services in light of the aging of Maine’s population;
   - Increased need for mental health services in our jails.

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1. OPEGA Guidance: Statewide Planning and Management of Information Technology

5. **Community Support Services are the linchpin to help people to have a richer fuller life.** Moving toward more and more community support services represent the future we want to develop. Keeping our eye on this "prize" will mean an ever-increasing shared understanding of our goals and sacrifices to get there. Some challenges include:
   - Employment and community inclusion for consumers with special needs. Young adults transitioning from high school would like to work and finding appropriate jobs and the funding to support job coaching is a challenge;
   - Childcare and after-school programs are needed to provide a safe and supervised environment for the children, allowing their parents/caregivers to be fully employed;
   - Affordable and accessible housing across the state is needed. Individuals who have only SSI /A for income cannot afford housing. The demand from all low-income individuals has stressed Section 8 and other housing resources.

6. **Maine's aging population will challenge our service systems and our future workforce.**

DHHS Resources

*Note – many of the following publications are available free of charge on the Department of Health and Human Services website, online at www.maine.gov/dhhs

Source of Publication	Publication Name
Maine Developmental Disabilities Council 139 State House Station Augusta, ME 04333-0139 Phones: 207-287-4213 / 1-800-244-3990 Voice & TTY Fax: 207-287-8001	Five Year State Plan Position Papers DD Dispatch (published 3x annually) Five-Year State Plan "Why Bother?" (Educating Maine's Legislators) Breaking Diagnostic News to Parents (booklet) Breaking Diagnostic News to Parents (checklist) "What About Lindsay?" (video)
Elizabeth Levinson Center 159 Hogan Road Bangor, ME 04401 Telephone (207) 941-4400 or 1-800-227-7706 (TTY) 1-800-606-0215	Elizabeth Levinson Center Brochure
Maine Center for Disease Control and Prevention 286 Water Street State House Station 11 Augusta, ME 04333-0011 General Information / Receptionist: 287-8016 TTY: 800-606-0215	Healthy Maine 2010 Annual Vital Statistics Report Annual Infectious Disease Report Maine Epi-Gram Monthly Public Health Fact Sheets Maine Cancer Registry Report Behavioral Risk Factor Surveillance System Report www.mainepublichealth.gov, Maine CDC's Web site, contains many updates and reports Various educational materials for nutrition, mothers' and children's' health, newborn screening, fact sheets, newsletters and resource lists are available from the Division of Community & Family Communicable Disease Control and reporting rules, educational materials about selected infectious diseases, and the Epi-Gram, the Division newsletter, are available through the Division of Disease Control
Office of MaineCare Services	Annual MaineCare Report

442 Civic Center Drive 11 State House Station, Augusta, Maine 04333-0011 Main Number: (207) 287-9202 TTY: 1-800-606-0215	MaineCare Benefits Manual; All Chapters -Book One - Acute/Hospital-Based Services -Book Two - Free Standing Rehabilitation & Other Facilities Hospital Cooperation Act Program Manual Regulations Governing the Licensing and Functioning of End Stage Renal Disease Units/Facilities Regulations Governing the Licensing of Ambulatory Surgical Facilities Rules and Regulations Governing Personal Care and Support Workers Rules and Regulations Governing the Functioning of the Maine Registry of Certified Nursing Assistants Directory of Health Facilities by County - Volume 1 Hospitals, Ambulatory Surgical Ctrs., Comprehensive Outpatient Rehabilitation Facilities End State Renal Disease Facilities Federally Qualified Health Ctrs. Home Health Agencies, Home Health Care Svcs. Hospices, Portable X-Ray Svcs. Rehabilitation Agencies, Rural Health Clinics, Temporary Nurse Agencies, Personal Care Agencies Directory of Health Facilities by County - Volume II Skilled Nursing Facilities Nursing Facilities Multilevel Facilities Intermediate Care Facilities for People with Mental Retardation
Office of Elder Services Maine Health and Human Services 11 State House Station 442 Civic Center Drive Augusta, Maine 04333 Voice: (207) 287-9200 (800)262-2232 Fax: (207)287-9229 TTY: (800)606-0215	Resource Directory for Older People in Maine Taking Charge of Your Health Care: Advanced Directives (7/00) Abuse, Neglect, & Exploitation in Licensed Facilities (training manual) (Avail. on OES website) Abuse, Neglect & Exploitation - The problem, reporting law, where to report Adult Guardianship Conservatorship Questions and Answers (Available on OES website) Prescription Drug Assistance Guide for Maine Elders & Adults with Disabilities (11/05) A Consumer's Guide to Long Term Care Insurance (7/06) Aging: Taking Care of Business (Available on OES website) Home Care: Where to Find It (Available on OES website) Reporting for Financial Institutions: Fighting Financial Exploitation Medicare & You (2006 and 2007) Choosing A Medigap Policy Medicare Savings Program brochure (2006). "Help to Pay Medicare Part B Premium" Prescription Drug Coverage - Your Guide to Medicare (10/05) Guide to Medicare Preventive Benefits (8/04)

Division of Environmental Health Key Plaza Building 286 Water St. 3rd Floor 11 State House Station Augusta, Maine 04333-0011 TEL: (207) 287-5338 TTY: (800) 606-0215 FAX: (207) 287-3165	Copies of rules - Free except Subsurface Wastewater and Radiation Site Evaluation in Maine Technical Guidance Manual - Subsurface Wastewater Systems Subsurface Wastewater Enforcement Manual Radon in Air and Water Water Supply Water Testing Guide Boys/Girls (Youth Camps) Compressed Air Maine Food Code Lodging Rules Trailer & Tenting/RV Campgrounds Tattoo Electrology Board of Certification of Water Treatment Operators Well Drillers & Pump Installers Rules Body Piercing Micropigmentation Mass Gathering Top Ten Tips for a Healthy Septic System
Office of Child and Family Services 221 State Street Augusta, Me 04333 Phone: (207) 287-5060 FAX: (207) 287-5031 TTY: (207) 287-5048	Annual Statewide Child Welfare Services Plan A Guide to Child Protective Services Thinking about Adoption, a Guide to Adoption Services in Maine State Plan for Independent Living Initiatives Child Death & Serious Injury Report Treatment Resource Guide Bi-annual Child Care Development Fund Plan The State of Early Education in Maine annual report The State of Head Start in Maine annual report The Bi-annual Child Care Market Rate Study The Cost/Quality Study of Center-based and Family Child Care Services (every 3-5 years) The Early Childhood Systems Planning Initiative Plan
Division of Licensing & Regulatory Services Certificate of Need Unit 41 Anthony Ave. Augusta, ME 04333 Tel. 287-5807	Monthly Project Summary Certificate of Need Procedure Manual Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities Regulations Governing the Licensing and Functioning of Intermediate Care Facilities for Persons with Mental Retardation Regulations for the Licensure of General and Specialty Hospitals

	Regulations Governing the Licensing and Functioning of Hospice Programs Regulations Governing the Licensing and Functioning of Home Health Care Services Maine Certificate of Need Procedure Manual Maine Certificate of Need Monthly Project Summary Health Care Facility/Agency Space and Needs Guidelines
Office of Substance Abuse Riverview Psychiatric Center Complex Marquardt Building, 3rd Floor #11 State House Station Augusta, ME 04333-0011 Tel. 207-287-2595 TTY: 1-800-606-0215 Fax: 207-287-4334 The Information and Resource Center may be contacted directly for these publications, videos and other materials (telephone 1-800-499-0027). The are available online at www.maine.gov/dhhs/bds/osa	State Plan for Alcohol and Other Drug Abuse Services in Maine Maine Alcohol and Drug Services (a directory of treatment services) Support Groups for the State of Maine (a regularly up-dated list of support groups in Maine) The Book List (lists books in the Information and Resource Center (IRC) of OSA) Alcohol, Tobacco and Other Drug Video Catalog (a catalog of the 1500+ videos in the IRC) Annual Applications Utilization Reports Independent audit reports on the substance abuse portion of the Federal Substance Abuse and Prevention and Treatment Block Grant (available for review at the Office) Maine Youth Drug and Alcohol Use Survey Evaluations of Maine's Statewide Drug Treatment Court Inhalant abuse in Maine, One Maine Evaluation
Adult Mental Health Services Marquardt Building, 2nd Floor State House Station #11 Augusta, Maine 04333-0011 Phone number: 207-287-4243 Fax number: 207-287-7571 TDD: 800-606-0215	Adult Mental Health Services Plan-Consent Decree Plan Pursuant to Paragraphs 36, 37, 38 279 of the Settlement Agreement in Bates v. DHHS, Revised June, 2005 2006 Application for Federal Community Mental Health Services Block Grant Biennial Report to Maine Legislature on Mental Health Services to Deaf Persons Department of Corrections/Department of Health and Human Services Joint Plan of Action, submitted to the Commission to Improve Sentencing, Supervision, and Management of Prisoners, 2005 Grievance Process Guide for Recipients of Mental Health Services In Their Own Words, Maine Trauma Advisory Groups Report 1997 Intentional Peer Support, Recovering, Learning and Growing Together, 2005 Mental Health Support Specialist Curriculum, 2005 The Rights of Recipients of Mental Health Services
Riverview Psychiatric Center 250 Arsenal Street 11 State House Station Augusta, Maine 04332-0011	Guide Program description Brochure Mission Vision Values pamphlet Client Handbook WEB site with links to several hospital publications

Telephone Number (207) 624-4600	
Dorothea Dix Psychiatric Center 656 State Street Bangor, Maine 04401 Tel. 941-4025	DDPC Overview (free to citizens, patients and staff) Patient's Handbook -DDPC (free to citizens and patients) Staff Handbook - (free to staff) Patients' Rights Manual (free to citizens, patients) Employee Benefits (free to staff) Bi-Weekly Newsletter (free to citizens, patients, and staff)
Office of Chief Advocate Riverview Psychiatric Center Campus SHS #11, 3rd Floor Greenlaw Building Augusta, ME 04333	Copies of the AMHI Consent Decree and the Community Consent Decree Rights of Recipients of Mental Health Services Mental Retardation Services Grievance and Appeal Process Adult Guardianship and Conservatorship Questions & Answers The Office of Advocacy maintains a library of information regarding clients' rights. These materials are available for on-site use and in many cases are available for loan to individuals involved in service provision for clients of the department.
Children's Behavioral Health 221 State Street, # 11 State House Station Augusta, Maine 04333 Tel. 287-5060	Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment (free)