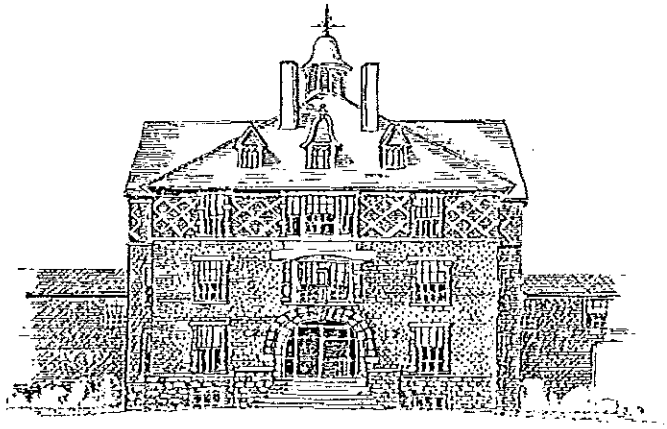

PUBLIC LAW 2011
CHAPTER 380
PART NN

Report to the Commissioner Mary Mayhew

The Future Role and Structure of the *DOROTHEA DIX PSYCHIATRIC CENTER*

November 2011

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

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707
Fax (207) 287-3005; TTY: 1-800-606-0215

March 14, 2012

Senator Earle L. McCormick, Chair
Representative Meredith N. Strang Burgess, Chair
Joint Standing Committee on Health and
and Human Services
#100 State House Station
Augusta, ME 04333-0100

Senator Richard W. Rosen, Chair
Representative Patrick S. A. Flood, Chair
Joint Standing Committee on Appropriations
and Financial Affairs
#100 State House Station
Augusta, ME 04333-0100

Dear Senators McCormick and Rosen, Representatives Strang Burgess and Flood, and Members of the Joint Standing Committees on Health and Human Services AND Appropriations and Financial Affairs:

Attached, please find the report developed by the legislatively mandated Part NN Workgroup charged with determining the future role and structure of Dorothea Dix Psychiatric Center.

After a series of meetings and a review of preliminary data, the consensus of the group was that a state-wide assessment of the mental health system is necessary before making long-term decisions regarding the future of the Bangor facility.

DHHS has begun that preliminary analysis and will continue its effort to provide care to those with serious and persistent mental illness in the most effective and efficient manner. I appreciate the efforts of all members of the Work Group who gave of their time and energy over several months to this important process.

I believe this information will provide useful background information as our work moves forward.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

Attachment

Public Law 2011, Chapter 380, Part NN
NN Work Group Report
Executive Summary

Introduction and Purpose of the NN Work Group:

The 125th Maine Legislature passed Public Law 2011, Chapter 380, Part NN requiring the establishment of a work group to develop a plan and suggest implementing legislation regarding the future role and structure of the Dorothea Dix Psychiatric Center (DDPC) to be effective June 30, 2012. The plan required detail of personnel transfers, position counts and other responsibilities, if applicable, to other programs within the Department of Health and Human Services (DHHS). The work group was to develop a comprehensive plan focused on the attainment of recovery milestones, such as improved health status, increased independence, improved life satisfaction and integration into the full community, for persons with serious and persistent mental health conditions through the delivery of high-quality, efficient services. The law included as Appendix A required specific representation to form the work group and was to be chaired by the Commissioner of Health and Human Services.

Membership of the NN Work Group:

The following members comprised the NN work group:

A. Senator Nichi S. Farnham: A member of the Senate representing Bangor
B. Representative Sara Stevens: A member of the House of Representatives representing Bangor
C. Mary Mayhew: The Commissioner of the DHHS
D. Linda Abernethy: The Superintendent of DDPC
E. Mary Louise McEwen: The Superintendent of Riverview Psychiatric Center
F. David F. Emery: Designee for the Commissioner of Administrative and Financial Services
G. Lisa Hall: A DDPC staff member who is a member of the Maine State Employees Association
H. Patrick Murphy: A DDPC staff member who is a member of the American Federation of State, County and Municipal Employees
I. The following members were invited by the Commissioner of Health and Human Services to participate in the work group:
    - Dennis King, Chief Executive Officer of Spring Harbor Hospital
    - Daniel B. Coffey, Chief Executive Officer of Acadia Hospital
    - Jane Moore, a member of the Consumer Council System of Maine
    - Kim Moody, Executive Director of the Disability Rights Center
    - Carol Carothers, Executive Director of the National Alliance on Mental Illness Maine
    - Gregory P. Disy, Chief Executive Officer of Aroostook Mental Health Services
    - Dale Hamilton, Executive Director of Community Health and Counseling Services, Inc.
    - Richard M. Brown, Chief Executive Officer of the Charlotte White Center
    - Vicki Rusbult, designee for the President of the Eastern Maine Development Corporation
    - Simonne Maline, Executive Director of Consumer Council System of Maine

Non-voting Support Staff:

- Work Group Facilitator: Helen Wieczorek
- Office of Adult Mental Health Services Representation: Ronald Welch and Guy Cousins
- DDPC staff to the work group: Jenny Boyden, Bill Dunwoody, Sharon Sprague, Melissa Hayward (recorder).

Work Group Process:

In developing recommendations and suggesting implementation of legislation, the work group's charge was to develop a plan that:

A. Establishes recovery outcomes to be tracked;
B. Ensures that the transitional needs of patients are effectively met;
C. Includes the provision of essential community living supports for housing, vocational and non-vocational involvements and health care;
D. Includes support for other critical community-based resources and treatment services;
E. Focuses on integrating all health care;
F. Ensures that adequate capacity exists locally for inpatient hospitalizations;
G. Ensures that adequate essential community care services to support outcomes are available;
H. Ensures that community and family education is optimized to support integration;
I. Ensures that the delivery of high-quality, efficient service is achieved.

NN Work Group Recommendations:

The work group submits the following three recommendations:

Recommendation #1:

That an ongoing, time-limited process be implemented to develop a plan that examines the strengths and opportunities of the mental health system of the region. This includes:

- Needs of the consumers and families
- Existing services
- Other services needed and costs
- Decision process
- Recommendations for the role of DDPC

Recommendation #2:

In order to respond to Public Law 2011, Chapter 380, Part NN, Sub-section 5 A-I, the following information is required:

A. Establish recovery outcomes to be tracked:
    - The Office of Adult Mental Health must establish a standard set of recovery outcomes for persons receiving treatment and performance measures for providers.
B. To ensure that the transitional needs of patients are effectively met:
    - It is not clear what the word "transitional" means in this piece of legislation. The following questions assume that the word "transition" refers to transitions throughout the services continuum.
    - What is the current reality of transitional needs? What is happening at these key transition points? How can we structure services in a way to better meet needs?

- We need re-admission data. How long do people wait at the ER for a bed?
- What would be the ideal transitional plan if money were not driving the services? If all of the silos were not funded differently, would we be able to have a more efficient system?
- What are the current limitations of the system?
- We need information on the overall wait lists for the various services and a list of what services exist in this area?

C. Includes provision of essential community living supports for housing, vocational and non-vocational involvements and health care:
   - There is a high level of uncertainty around the future and funding of the Private Non-Medical Institutes.
   - What is the area's current capacity for affordable housing options? What are the housing needs? Who gets stuck in a higher level of care because of housing needs?
   - This group recommends a needs assessment of housing options and vocational availability, if one is not already available.
   - What do clients want for vocational services as part of their plans? What are current evidence based vocational models? How does the state currently spend its resources on vocational services?

D. Includes support for other critical community-based resources and treatment services:
   - Are there other resources in the area that could provide the same or similar services (i.e. oral health, FQHC, etc)?
   - What is the data on transportation availability?
   - What psychiatric services are and are not being provided in correctional settings?
   - What are the forensic needs?

E. Focuses on integrating all health care:
   - What is the data on the existing impact of current primary care integration activities and their impact on people with mental illness?
   - What are the models of integrated care?
   - What are the best practices?
   - How integrated are mental health and substance abuse services? Are there integrated models of payment?

F. Ensures that adequate capacity exists locally for inpatient hospitalizations:
   - Would a private institution provide the longer term care that DDPC provides?
   - What are the laws for involuntary admissions/ treatment?
   - Do the laws hamper the "right way" to treat patients?
   - What is the cost of transferring beds from one model to another (clearly define services and how they differ)?
   - Would the cost of forensic beds be the same if operated elsewhere?

G. Ensures that adequate essential community care services to support outcomes are available:
   - Is there a population that is unable to access services due to funding?

H. Ensures that community and family education is optimized to support integration:
   - What peer and family support services exist and at what cost? How does the state currently spend its funding for peer and family services?
   - What is the evidence based array of services that should be in place?
   - Is there a way to evaluate programs in terms of outcomes?
   - There's a need to evaluate any current or proposed models against resources to determine if additional gaps will develop.
   - There needs to be a review of how families are informed about caring for their loved ones at home and any barriers to involving families in that discussion.

I. Ensures that the delivery of high quality, efficient service is achieved:
   - What are the Department's expectations on performance based contracting issues and the development of a standard set of outcomes?
   - What will the Department do with the buildings on the Bangor campus?
   - What are the full cost implications?

Recommendation #3: That the DHHS Commissioner determine the next steps and this work should inform a more comprehensive state-wide review of the mental health system.

NN Work Group Attachments:
These attachments were working documents of the Work Group. They were ***not*** accepted by the Work Group and may contain inaccuracies.

- ➔ DRAFT Report from the "Close DDPC" sub-committee
- ➔ DRAFT Report from the "Keep DDPC Open" sub-committee
- ➔ NN subcommittee report (written by DDPC staff) which incorporates suggestions/recommendations from the Close and Open reports
- ➔ Report offered by David Emery, DAFS Deputy Commissioner, focused on facilities utilization options and internal DHHS discussion of potential funding structure

REPORT OF THE SUBCOMMITTEE TO CLOSE DOROTHEA DIX PSYCHIATRIC CENTER

TABLE OF CONTENTS

THIS IS DRAFT FOR DISCUSSION PURPOSES ONLY
Dorothea Dix Psychiatric Center (DDPC) Closure Proposal

Executive Summary

The Subcommittee recommends that Dorothea Dix Psychiatric Center (DDPC) close by July 1, 2012, or as soon as reasonably possible based on the transition needs of patients and concrete and visible signs that the infrastructure to provide needed community supports are in place. The subcommittee cannot stress strongly enough that closing the hospital without shifting funding to other service areas, expanding the availability of community programs, enhancing fidelity to evidence-based models, and expanding inpatient capacity at Acadia would do more harm than good.

For over one hundred years, DDPC has served as the safety net for people who have acute treatment needs. DDPC has served a group of individuals that no one else has been willing to or has the capacity to serve. *There will need to be a very strong plan in place that addresses the needs of this vulnerable population, those who are ill now, and those who will become ill in the future. And, the infrastructure and actual services that are needed to successfully close the hospital must be in place, before it can be successfully closed.*

The recommendations are based in the three pillars of AIM – improved health, cost effectiveness, and patient involvement. The report articulates a vision that changes how people with serious and persistent mental illness with acute needs receive care, how those services are funded, and how they are measured.

THIS IS A FIRST DRAFT, FOR DISCUSSION PURPOSES ONLY. THIS DRAFT HAS NOT ADDRESSED THE NEED FOR A TIMELINE WITH MILESTONES AND ANY LEGISLATION NEEDED TO IMPLEMENT THE RECOMMENDED CHANGES.

Introduction

State revenue shortfalls, antiquated facilities, consent decrees, and changes in practice have led many states to consider closing and/or to close state psychiatric hospitals. Between 1997 and 2005, a number of studies (see attached chart) document the impact of these attempts. A 2010 report by Allegheny HealthChoices, Inc. describes the State of Pennsylvania's effort to close Mayview State Hospital and to do so by maximizing the resources for people being discharged into the community, including a transfer of hospital resources (see attached report).

In 2011, the Maine State Legislature posed the same question: can Maine close one of its psychiatric hospitals, and if so, what steps are needed? Public Law 2011, Chapter 380 did two things: (l) reduce funding for Dorothea Dix Psychiatric Center by $2.5 million starting in July of 2012 (a 25% reduction in funding) and (2) created a work group to "develop a plan and suggest implementing legislation regarding the future role and structure of the Dorothea Dix Psychiatric Center, including the transfer of personnel, position counts and other responsibilities, to other programs within the Department of Health and Human Services." In addition the work group was charged with "developing a comprehensive plan that is focused on the attainment of recovery milestones, such as improved health status, increased independence, improved life satisfaction and integration into the full community for persons with serious and persistent mental health conditions through the delivery of high-quality, efficient services." (PART NN of Public Law 2011, Chapter 380.)

Maine spends a great deal on the provision of care for people with mental illness: $62,272,243 in paid claims for community-based Section 17 services, $59,636,407 on PNMI funded supported housing, and $142,059,806 on inpatient psychiatric care provided by the state's two psychiatric hospitals and the two private IMDs. In 2009, Maine ranked first in per capita spending on mental health and 5th on inpatient psychiatric hospital beds. This subcommittee recognizes that because DDPC pays for costs unconnected to the provision of psychiatric care, which contributes to a cost per day that is almost twice as much as any other psychiatric bed in the state.[1] .

The committee sees this work group as an opportunity to realign current expenditures, redefine particular systems of care (care management, residential care, and crisis), increase flexibility in rules governing delivery and financing of care, ensure fidelity to performance and outcome standards for all services, and focus care on specific client needs. The recent de-appropriation of DDPC funds provides a timely opportunity for the State and region, in partnership, to consider these needs and to improve client care while saving several million dollars.

[1] Information distributed to the work group shows cost per day for Riverview as $841.41, Acadia $871.04, Spring Harbor $873.65, and DDPC $1,172.56. Total annual cost for 64 beds at Dorothea Dix in 2010 was $28,353,757.

This report and the recommendations it contains include ideas and principles discussed in the Work Group established by the Maine Legislature to review the future role of DDPC.

This report is organized to match the specific requirements included in Part NN. We begin by describing the assumptions that the committee used when drafting recommendations and describe the information that was presented to the committee about the role that DDPC plays in the system of care in northern Maine and the gaps that DDPC staff feel the hospital fills as well as the gaps that exist when they discharge patients which contribute, in some cases, to re-admission. The report then makes recommendations under each sub-heading included in the legislation, the last of which, asks for the delivery of high-quality efficient service. In this section, we recommend a system re-design. The final section of the report describes next steps, including any legislation that is needed.

Assumptions

1. The subcommittee believes that adequate preventive care (supported housing, medication management, ACT, and so on) would reduce reliance upon inpatient treatment. Based on this, the committee believes Maine does not need four Institutes for Mental Disease (IMDs) and recommends that DDPC close by July 2013, or as soon after as is reasonably possible to transition patients to other facilities and build community services that meet local needs. The imperatives requiring this change include:

a. The current cost per day for DDPC is the most expensive inpatient psychiatric hospital of the four IMDs operating in Maine.

b. Given the legislated annual twenty-five percent reduction of $7,000,000 in DDPC's State funding (combination of general fund and disproportionate share hospital (DSH) dollars), the remaining bed capacity will be so reduced that diseconomies of scale (fixed and administrative costs) will likely result in even higher unit costs at DDPC.

c. With a realignment of the systems of community psychiatric care and modest expansion of inpatient bed capacity at both private IMDs sufficient capacity can be guaranteed. Closing DDPC will save the State over $[redacted] million in general funds and a significant portion of the $15 million DSH funds could be redirected to the two other private IMDs for the care of adult inpatients. A thorough analysis of DSH allocations and limitations on its use, as well as detail regarding the costs involved with system redesign is needed before the final chapter of this report can detail next steps, milestones, and timelines.

2. Unless there is a re-alignment of reimbursement streams and rethinking of the rules, policies, practices, and performance standards governing current funding requirements and service delivery so that financial incentives exist, the system of care will continue to be fragmented. A thorough clinical assessment of client/population needs will assist in program

development that can then drive the highest and best use of very good community and regional resources.

3. Service delivery is complicated by over thirty (30) separate community providers of mental health services in northern Maine not counting the independent practitioners. Navigating this fragmented system and understanding the different cost structures, program specifications, and different services can be difficult, costly, and leave people without care. Chasms of miscommunication, separate and independent organizations, and misunderstandings about who provides what service, where, and at what cost can create difficulty for families and people with mental illness. There is a need to better connect, collaborate, and perhaps consolidate the management of care.

This report, prepared by a subcommittee of the full NN work group, makes recommendations and offers a plan for closing Dorothea Dix Psychiatric Center at the earliest by July of 2013. The committee members want to stress their strong belief that this action creates an opportunity to re-design service delivery in northern Maine to reflect best practice. There is a real need to create a system that based on prevention and offers adequate access to community supports including Assertive Community Treatment, supported housing, vocational and pre-vocational support, medication management, case management, crisis prevention and intervention, peer and family programming, and other care which supports and sustains recovery.

Services provided by Dorothea Dix Psychiatric Center (DDPC)

In the last ten years, DDDPC has assumed a critical role in the provision of specialized psychiatric care for northern Maine and as an over-flow destination for other hospitals across Maine. In addition to taking over-flow forensic patients, DDPC has also specialized in treating people with serious and persistent mental illnesses who are not able to re-stabilize during the shorter stays offered at Maine's IMDs (Acadia Hospital and Spring Harbor Hospital) or by the other hospital-based inpatient psychiatric hospital bed providers located across Maine. A number of funding barriers (including, but not limited to the allocation of disproportionate share dollars and the process for court approval for involuntary treatment) prevent Maine's private hospitals from routinely offering hospitalization for longer than 30 days. In fact, the average length of stay for DDPC patients is 60 days vs. 14 days for the IMDs. DDPC also provides outpatient services including northern Maine's only DBT day program, a dental clinic, and serves as the only location from which people in northern Maine who are part of Maine's Progressive Treatment Program (Maine's version of outpatient commitment) can be admitted. Although Community Health and Counseling Center provides the ACT team for this program, patients who are court committed return to DDPC when they are deemed to be out of compliance with their treatment plan.

There is a clear recognition that should the 60 beds and the outpatient services offered by DDPC close, the resulting service- gap would create additional pressure on a system that is already overloaded. Patients testified to the work group that Dorothea Dix offers recovery-focused treatment that is not available in the private hospitals; families testified that DDPC provides a quality of care and length of stay that is not available elsewhere. And, service providers indicated that the loss of 60 inpatient psychiatric beds would create significant hardship for all: families, people with mental illness, jails, and the service providers in northern Maine. Any attempt to close the hospital will, therefore, require the shift, over time, of funds now spent on DDPC to other mental health services. Any attempt to close the hospital will also require the establishment of needed preventive care such as ACT, supported housing, peer and family services, and other programs that help to prevent hospitalization and cost less than inpatient psychiatric care.

Identified Service and Other Gaps

The Part NN Work Group subcommittee recognizes that there are service gaps for people with psychiatric illness that lead to a need for hospitalization. Testimony before the group documented the following gaps:

- Inadequate access to ACT services, including ACT programs that because of funding cuts, no longer meet fidelity standards (i.e., are not available 24-7, lack psychiatry, lack vocational, substance abuse, and peer staff);
- Inadequate access to a full array of supported housing alternatives, including transitional housing that can ease patients from inpatient settings back into the community;
- Waiting lists for medication management, case management, therapy, and other clinic- and home-based care considered crucial to community tenure and the development of and support for consistent recovery;
- Appropriate community-based services that can meet the needs of people whose illness is of such severity that they do not recognize they are ill and cycle between psychoses, treatment, homelessness, jail, and the hospital.

The subcommittee also believes that there are funding barriers that prevent community service providers from offering the full array of services that include:

- Reimbursement and payment structure changes over the last six years that have reduced funding for ACT teams and reduced rates for some services to such an extent that service delivery cannot be maintained. (ACT teams cost approximately $10,000 per person, per year considerably less than the cost of inpatient care at DDPC which is approximately $1,300 per day.)

- Disincentives caused by MAP rules that do not recognize frugality, and require unspent funds to be returned;
- Funding streams that are compartmentalized and do not allow flexibility to meet individual needs;
- Funding streams that are separate and prevent the provision of integrated care – both mental health and substance abuse and the provision of physical health treatment;

Flexible funding models that focus on innovative support for patients living in the community and/or transitioning from inpatient care are needed. Community agencies receive grant funds that are allocated by service silos and contain restrictions on how funding may be used. A better model may be one that allows innovation and preserves the intent of grant funds. Pilots should be allowed that are tied to specific performance-based outcomes that measure individual recovery goals. A priority would be to test more flexible models of care on individuals with a history of multiple hospitalizations and discharges. State audit and finance departments should be asked to review changes in MAP rules to permit greater flexibility in grant funding and grant funding that assists care to be more integrated. Changes to MaineCare and a shift from fee-for-service models, that are based on the quantity of services provided, to rewarding quality outcomes and higher value should be made. The plan to close DDPC must address these gaps as well as funding and regulatory barriers if it is to be successful. Psychiatric hospitalization is often the end result of the inability to receive adequate care in the community.

Report Format. In preparing its report and recommendations, the Work Group was charged with addressing the following items: (a) Tracking Recovery Outcomes, (b) Transitional Needs, (c) Essential Community Living Supports, (d) Critical Community Based Resources and Treatment, (e) Integrating all HealthCare, (f) Adequate Hospital Inpatient Capacity, (g) Community Care that supports Outcomes, (h) Community and Family Education is optimized to support integration, (i) Delivery of high-quality efficient service

A, Recovery Outcomes to be Tracked; Community Care that supports Outcomes

Existing service contracts for mental health service providers include a significant number of measures, many based in the terms of the AMHI Consent Decree. Providers must meet all of the nine pages of requirements included in Rider E as well as maintain licensure with the State and comply with all of those licensure standards. Agencies must also comply with MAP rules and with those established by the Medicaid program. Medicaid audits match every service plan with every bill – and compare the treatment plan goals with the service note. Some agencies also must meet certification standards, for example, hospitals are licensed by JCA. In short, there are multiple regulations that absorb considerable time, cost money, detract from the time available for the delivery of care, and are at best duplicative, and at worst, contradictory. It would be

wrong to add new outcome measures to what already exists; it would be cost effective to reduce the current amount of documentation, streamline what is necessary, and collect data that measures recovery outcomes. The Office of Substance Abuse has been collecting outcome data for each person treated for substance abuse for a number of years. The data they collect measures things like, completion of treatment, employment status, and sobriety; they collect data that measures recovery outcomes. The mental health system, however, collects data focused on consent decree requirements. Though those are important, they do not measure treatment or recovery outcomes. Length of stay in emergency departments, time for assignment of a case manager – measures that are consent-decree driven are in place; measures that are based on recovery principles like social supports, employment, reduced crisis and use of emergency rooms, and other measures of recovery that are part of the Program Fidelity Assessment Common Ingredients Tool, the Integrated Behavioral Health Project Survey, and the Peer Outcomes Protocol are not collected.

Recommendation One: The committee recommends the following:

- A group of providers be tasked with reviewing and consolidating contract and licensing requirements to assure that they are based on recovery outcomes, are not-duplicative, and that they reduce paperwork. That they present recommendations to the Commissioner of DHHS by July 1, 2012 and that they be proposed in rulemaking and adopted within 6 months.
- A group of consumers, families, and providers be tasked with reviewing the current outcome data collection forms and the system currently in place for substance abuse service delivery, and use that to develop an integrated, mental health, substance abuse, and physical health recovery outcomes process to be adopted and implemented no later than September of 2012.. Peer-developed and tested measures like the POP and FACIT should be used to guide this process.
- The Commissioner of DHHS will establish pilots for local case management and alternative funding models such as bundled paymentglobal budget allocation, capitation payments, or contracted rates to create incentives for more coordinated, cost effective service delivery and a continuum of care using the accountable care type of organization model, or a highly integrated behavioral health network, and measure outcomes from those pilots. Before considering movement to a risk model, the pilot should be designed to build a database for use in a "shadow" risk model for future consideration.
- Core services and flexible funding to provide them must integrate dental, physical, and behavioral health

B. Transitional Needs

The Work Group reviewed information about patient recidivism at DDPC between 2010 and 2011. 30 patients had multiple admissions, many because services in the community did not meet their needs, were not available, and/or because their co-occurring substance use disorder affected their recovery and their provider's willingness to treat them. 12 people were discharged and readmitted within six months and some people had over 20 re-admissions. The subcommittee believes that the lack of appropriate and adequate transitional services, including specialized services that recognize and respond to the needs of individuals with a history of multiple readmissions related to co-occurring substance use disorders and/or inability to recognize that they are ill must be in place, if DDPC is to be closed without forcing people into jail and onto the street. The subcommittee recommends a ward-by-ward approach, with active discharge planning, phasing in closing of the hospital over a year, and developing individualized plans for existing long-stay patients and those with histories of multiple admissions and re-admissions. Please see the section on delivery of high quality effective service later in this report for more details about this transition process.

Recommendation Two: Funds be shifted from Dorothea Dix to pay for needed transitional programming and:

- Transition plans. A transition plan must be developed for each long-stay and multiple admission patients. A community support plan that is developed by a team composed of the resident of DDPC, their family or other natural supports, an advocate or chosen representative, and assigned clinicians must be part of the transition plan. These teams should model those described on page 2, Toward Recovery and Hope, Allegheny Health Choices.
- Peer and Family mentors. All transition plans should include the assignment of a community mentor (either paid, or a volunteer) who can assist people to transition successfully and to offer support during non-traditional hours. These mentors need to be adequately trained.
- Advocacy. Transitions can be difficult, particularly when resources are scarce. People can fall through the cracks, be placed only because a placement exists, even if that placement does not meet their needs or does not reflect their choice. For this reason, we recommend that an advocate be a part of all transition planning.
- Medication. Continuity of stabilizing medications must be insured between the hospital and the community.
- Case Management. Case managers who are mobile and involved in supporting recovery are an essential part of community life, and the foundation of the consent decree. They must be assigned in a timely fashion, have appropriate training, be mobile, and be part of transitional programming.
- Progressive Treatment Program. The PTP program in northern Maine is currently based on re-admission to DDPC. The subcommittee recognizes that the PTP program continues

to be un-evaluated and that outpatient commitment (Maine's version is PTP) remains divisive, so much so, that legislation that was introduced last year relative to PTP in Maine was carried forward. One of the provisions of the 2009 statute governing PTP was a requirement that DHHS evaluate the program in terms of its effectiveness and this has not been done. Nonetheless, at this moment in time, should DDPC close, there would need to be a decision about to do with the current program participants. The subcommittee makes this recommendation without taking a position on the value or lack thereof, of Maine's PTP program.

- Gatekeeper. Acadia should be responsible for coordinating the use of inpatient psychiatric beds in northern Maine, in the same way that Spring Harbor coordinates admission in southern Maine.
- Forensic needs. There has been long-standing difficulty for northern Maine jails to obtain inpatient beds for inmates who have been deemed to need it. The closing of DDPC, which has provided a place for forensic admissions when Riverview cannot, will exacerbate an existing problem. The transition plan between Acadia and DDPC must address capacity for inmate hospitalization.

C. Essential Community Living Supports (housing, vocational, non-vocational, healthcare)

Maine is fortunate to have developed the necessary and broad array of community-based supports including case management, intensive case management, living skills support, peer centers, in-home supports, ACT, and so on. Availability of these community-based treatments is crucial to a comprehensive system of care, continuity of care, and to reduced use of emergency rooms, hospitals, jails, and other high cost services. We must maintain these services and assure that people can access care early and in the least restrictive site possible so that they do not fall into more costly and restrictive levels of care because they could not get help more quickly. In addition, there is a need for enhanced and improved team work and continuity of care. The increased focus on Medicaid as the only payment source, a service system that is clinic based and only available during business hours, and non-integrated services that force people out when they are ill all lead to the eventual use of hospital and emergency care. The committee recommends.

This section cannot be complete without addressing the need for preventive crisis intervention and post-crisis intervention that is mobile and includes outreach to those who do not know they are ill and may reject help when it is truly needed. People with mental illness and their families need crisis assistance that is responsive, mobile, and designed to both prevent hospitalization and to assist transitioning out of the hospital. A number of barriers prevent this from happening, and sometimes, the crisis service serves more as a gatekeeper for hospitalization and less as an early

intervention team or a "step-down" from the hospital team. The subcommittee recognizes that people can remain in a locked hospital setting longer than needed, only because there is inadequate access to needed transitional services.

Recommendation Three:

- ACT. The subcommittee recommends that at least one additional ACT team and an assessment of ACT team availability in northern Maine. These teams must have full fidelity to the model in terms of 24-7 availability and range of staff (ie., psychiatry, substance abuse, vocational, etc.) Although the subcommittee recognizes that some teams may have full fidelity to the ACT model, there are others that may not, or may not be able to meet all standards because of funding. Changes in how ACT teams bill, rate reductions, and other policy issues have affected, in some cases, fidelity to the model and must be addressed. A rate should be developed that pays for ACT service delivery that has fidelity. ACT teams must have forensic capacity. The state must clearly articulate ACT fidelity standards and create measures to evaluate adherence to them.
- Supported housing. The DDPC area currently offers a full range of supportive housing options, but funding, staffing, and non-integrative philosophies and licensing standards can hinder the delivery of services to those with complex needs. The subcommittee recommends that DHHS create tiered rates for housing providers. An enhanced rate should be provided to housing service providers who (1) offer integrated care which includes accommodations and treatment for people who have co-occurring substance use disorders and policies that allow for relapse to the use of substances, (2) include peer, family, and mentoring support services in their programming as mechanisms to support recovery and reduce reliance on more costly interventions, and (3) offer graduated options for increasing supports or decreasing supports as needed and based on recovery status. Supported housing must continue to include a full mix of options: independent living with case management and on-site staff at a variety of levels. There are housing models that cost less by working with local landlords to rent to patients and that use peers to provide support in the home (Oxford House model). These models should be pursued. In addition, the group wants to highlight the crucial importance of housing. There is research that shows people who have adequate housing, with an emphasis on adequate, fare better, use fewer services, and enter institutional care less often.
- Peer and Family Support. People with mental illness and their families need support. Peer support and recovery centers, skill building groups, and family supports must be available. There are areas of northern Maine where these services are not available. Peers that are located in emergency rooms have been shown to reduce admissions. Peer centers must offer skill building, vocational, and social supports. They must be funded so that they can offer these services, particularly those that help people return to work or to volunteer jobs. There must be more than one model of peer support available and, if the

state is to insist that all peer service providers follow a single model, training and supervision for that model must be readily available and at low to no cost. Families must be linked with family support organizations that can assist them to cope with the illness in their family and identify and obtain assistance when something is going poorly. 65% of the 60 patients leaving DDPC are released to a family setting. If families are to be "residential service providers", they need support to do so. Peer and family programs constitute less than 1% of spending – it is recommended that spending allocations reflect their value as a significant contributor to recovery and reduced use of inpatient care.

- Crisis. The committee recognizes that there is a current process underway that creates HCCs, and creates a two tiered payment system and single call center approach to the delivery of crisis services. The committee recommends that the Commissioner examine the existing re-organization that is underway, how it is progressing, and clearly articulate in measurable terms, the expectations for outcomes connected to the delivery of crisis services, including prevention and for lack of a better term "step down" and "step up" crisis services that help keep people out of the hospital and help them transition out of the hospital. The current crisis reorganization does not include responding to the needs of families, and this, too, must be part of any system review and modification.
- Vocational support. 99% of people with serious and persistent mental illness are unemployed. The system itself creates barriers to employment (i.e., loss of MaineCare, billing structures, etc.). There are a variety of models that are evidence-based and help people return to work. The clubhouse is one model and it should be expanded. The outcome measures and MaineCare reform changes that are recommended earlier in this report, must include a vocational measure and dis-incentives for work must be removed.
- Advocacy. Maine and the nation have recognized the need for advocacy. Each state has a protection and advocacy organization, a body of laws and rules that define patient rights, and mechanisms to protect the health, safety, and quality of care provided to people with mental illness and other disabilities. The committee sees adequate advocacy for peers and families as a crucial part of any system of care and recommends that it continue in its current capacity for peers and be strengthened for families.

D. Critical Community-based Resources and Treatment

The successful closing of DDPC will depend on access to critical community-based resources and treatment. As noted earlier, Maine has developed and implemented the array of resources and treatments that are needed. There are gaps in services (i.e., areas where there are no ACT teams, no Peer Centers, for example). The section above recommends the expansion of services as well as pilots to test improved delivery of preventive care. The subcommittee cannot stress enough that it is policy and funding that forces practice change. Service providers will offer treatments when they are required to do so and when they receive adequate financial incentives

to do so. Currently, DDPC provides a crucial safety net for northern Maine because there are financial incentives for the state to provide this level of care and there are regulatory barriers for community organizations to do so. We must assure that intensive, home-based treatment and outreach follow those patients who need it when they leave the hospital. DDPC has filled a safety net service for over 100 years. Once it is gone, that safety net service must be available. The committee cannot state strongly enough that closing DDPC without consideration of the evidence about what leads to readmission and addressing those factors will be folly. The recommendations in this report ask providers to track different outcomes (work, completion of treatment, social supports, reduced use of crisis care, etc.) That is just one part of assuring change. By asking them to track different outcomes – delivery of care will follow. The recommendations here also suggest that financial incentives be used to encourage practice change. That, too, is part of assuring change. ACT team rates must support fidelity to the model so that participants receive that level of intensive care. Agencies that provide integrated care should receive enhanced rates because integrated care produces better outcomes. In short, the critical community based resources and treatment that are necessary to support recovery and reduce use of hospital-based care must be supported by policy and by funding.

E. Integrating all healthcare

Healthcare is siloed. Siloed care delivery is inefficient and ineffective. People with mental illness and substance use disorders need to have holistic care. Maine has made progress in integrating care – both in terms of integrating mental health and substance abuse treatment and integrating physical healthcare with behavioral healthcare. And, there are many types of integration; not one model fits all. Integration must occur and a variety of models must be supported. But many barriers remain – those that are based in funding streams and over-regulation and those that are based in training and practice. Practice is strongly influenced by payment and regulation. The committee recommends:

Recommendation Four:

- Any provider agency that is accredited by an external organization (JAC, CARF) be exempt from obtaining state licensure;
- Offer a single integrated license and enhanced payment rates for providers who obtain a single license and provide mental health, substance abuse, and physical health services within a single integrated practice.
- Create payment reform pilots and financial incentives to integrate care.
- Encourage a variety of evidence-based, best-practice, and innovative models.

F. Adequate Hospital Inpatient Capacity

Acadia Hospital is now licensed for 100 beds, but staffed for 68, 36 for adults and 32 for children. Space currently utilized for partial hospitalization outpatient services for children would need to be returned to inpatient capacity for adults thus requiring some capital investment. Other options could be considered that would free up additional space for adult patients. Spring Harbor Hospital is also licensed for 100, but staffed for 88, 48 of which are for adults. Disproportionate share funds from the federal government allocated to state facilities create a dis-incentive for private hospitals to provide care for adults with mental illness. Therefore there is existing capacity for at least 44 adult inpatient psychiatric hospital beds between Spring Harbor and Acadia. Additional recommendations about hospital capacity are below as well as in other sections of this report.

The committee recommends that the issue is not just inpatient capacity, the issue is capacity and quality. Hospital beds that do not provide active treatment options and those that do not recognize and practice to recovery standards also "lack capacity". As the shift occurs from DDPC to private psychiatric hospitals, the state must clearly articulate the standards that must be in place and the means to hold providers accountable to those standards. This will involve regulation, licensure, policy, payment incentives, and outcome measures, and advocacy designed to assure compliance. Unless this occurs, those who have been served at DDPC will be harmed.

Recommendation Five: The committee recommends that the assessment described later in this report estimate how many of the 44 adult inpatient psychiatric beds are needed and make them available. In addition, the committee recommends (1) that the state make available to the IMDs, the legal assistance they need to help them utilize existing involuntary admission and treatment laws, and (2) require that the IMDs provide, when clinically necessary, the same level of care and longer-term stabilization that is currently offered by DDPC, including the array of treatment options that they offer, and (3) that the state articulate standards and outcome measures that govern the provision of inpatient services, that include recovery principles, peer and family engagement, and active discharge planning, and that are required to access and continue to maintain DSH and other state funds.

G. Essential Community Care Services to Support Outcomes.

Much of this report has already addressed the essential services that are needed to support recovery-based outcomes and the transitional needs of people served at DDPC. These include access to the array of services articulated earlier. The report has also addressed the need to modify the outcome measures that are collected to more closely reflect recovery outcomes and less on consent decree requirements. The subcommittee believes it is the role and responsibility of the DHHS to clearly articulate the outcomes that they expect to be produced and to hold contract agents accountable relative to those outcomes.

H. Community and Family Education is optimized to support integration

There is no doubt that mental illness and substance use are among the most stigmatized and misunderstood of conditions. We recognize the signs of a heart attack; we recognize the signs of a stroke – but many of us are not aware of the signs of the onset of mental illness. Further, we do not know where to find help. We dial 911 and ask police officers to intervene long after earlier and easier interventions could have prevented the need for this level of intervention. Despite the fact that 65% of DDPC patients are discharged to their families, there is little preparation for families, families are often not provided with even the most basic information about their loved one's transitional needs, and families do not know what they can and cannot do. Funding for adult family support services has been cut by 34% in the last six years and less than one percent of all funding is spent to help families. The PIER program showed that adequate community education and awareness can reduce the incidence of mental illness in a community. Misunderstandings, myths, and lack of education include:

- Inconsistent application of confidentiality laws.
- Inconsistent application of guardianship, advance directives, peer representatives, and other laws related to informed consent..
- Licensing and contractual obligations require all providers to refer families to family support services, but it is rare that this occurs.
- Although education is readily available to help families and the community, most people do not know how to access that information.
- Most people do not understand the criminal justice system nor are they able to identify and address the risk factors that lead people with mental illness to jail.
- Many providers continue to practice concurrent treatment or single treatment, rather than integrated treatment for substance abuse and mental illness.

Recommendation Six:

- DHHS should undertake a comprehensive and ongoing educational program to assist all stakeholders to understand confidentiality and guide their practice to improve continuity of care. Regulations and licensing requirements must insist on improved understanding and incentives for improved practice must be developed and implemented.
- DHHS should review funding for peer and family supports and shift funding to those programs.
- Maintain the existing ride along program for law enforcement and Crisis Intervention Teams (CIT) for police departments and continue to improve northern Maine's pre-booking diversion options. Educate the community about these options.

I. Delivery of high-quality efficient service

Existing regulations and funding streams contribute to ineffective care. Some policies discourage cost containment by penalizing organizations with unspent funds, requiring them to return those funds, and reducing future allocations. Fee for service encourages the delivery of more service, rather than the delivery of effective service. Service delivery is not always based on individual assessment of client needs, but on what services are available. People living in York county can be hospitalized in Aroostook County because of bed shortages. In addition, many of the outcome measures that we use and the data that we collect are based on consent decree requirements and not on patient recovery. Changes in how we evaluate effectiveness and the ability to use that data to fund what works are needed. As noted earlier, the subcommittee makes the assumption that closing DDPC presents an opportunity to realign the system of care in northern Maine so that more efficient and effective services can be delivered to those who need them. The Institute for Healthcare Improvement (IHI) calls for new designs must be developed to simultaneously accomplish three critical objectives, or what is called "The Triple Aim: improve the health of the population, enhance the patient and family experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of care. The recommendations of this subcommittee are designed based on those aims.

Steps for Closing DDPC and realigning community services

Close DDPC by July 2013, or some reasonable later date (immediately saving the State over $__ million in general funds).

Recommendation Seven:

Inpatient Capacity. Acadia is willing to assist the State Department of Health and Human Services to carry out an orderly and thoughtful transition to realign the system of psychiatric care for the northern Maine region. The committee sees the following as part of this first step:

- Redirect savings from the closure of DDPC to the following:
    - Expand Acadia inpatient capacity by at least __ beds to handle more acute needs clients residing in northern Maine. Require that Acadia expand the level of programming (skill building groups, treatment mall choices; routine access to the outside, etc.) and maintain an in-house advocate to help peers and families. (i.e., mimic some of the current recovery oriented and oversight related features that will be lost when DDPC closes).
    - Independently evaluate the needs of existing DDPC patients and their families and assess their discharge needs. Once this has been done, expand/convert residential programs to meet the needs that have been identified and transition these individuals to the community. Included in this assessment must be options for community living

that bring services to where people are living, rather than requiring people to up-root themselves and move to a new setting in order to obtain services. Included also, must be supports and assistance to those families who are providing significant levels of care for DDPC patients.

- Detail the specific needs for people currently served by DDPC including the array of services mentioned earlier, especially their housing needs.

Assessment Strategy. Acadia Hospital recently engaged an independent consultant to perform a comprehensive assessment of its inpatient and outpatient care models including program development, staffing, workflow, treatment plans, discharge efforts, funding streams, policies, and organizational efficiency. This assessment will consider current and future needs and systems of services required to support Acadia clients. Acadia proposes to include DDPC patients in a population assessment described below. Further, Acadia will request that Maine DHHS permit Acadia's independent psychiatrist consultant to perform a population assessment of DDCP's current inpatient population to gain an understanding of the clinical needs and challenges for program planning purposes. This information is needed before Acadia may fully develop a detailed proposal to assist DHHS in the transition of patient care associated with the closing of DDPC. Acadia will then be able to include the transition of DDPC patient population in a revised clinical and business plan. The estimated time frame and the components of Acadia's assessment are as follows:

1. Population Assessment: October – November, 2011. Define populations currently served, admission criteria, and needs of clients/referral sources.
2. Program Development: November – December, 2011. Based on the clinical needs of the populations served, develop programs of treatment.
3. Mission and Vision: December 2011 – March 2012. Refresh for the future.
4. Staffing Model: January – February, 2012. Based on population served, the programs offered, and industry standards, develop staffing expectations.
5. Workflow: February - April 2013. Working in interdisciplinary teams, examine, modify, and streamline workflow tasks and forms (including the electronic medical record) to maximize staff efficiency and patient experience.
6. Treatment Plan Development: March - May2012. Using interdisciplinary teams and refined workflow, design an efficient treatment planning process and forms which meet patient needs, staff planning needs, and all regulatory requirements.
7. Treatment Plan Training: May – July 2012. Through combination of didactic training, modeling, and mentoring, works with staff on formalizing the treatment planning process including the use of and modification of treatment plan forms.
8. Reassessment of Programming, Workflow, and Treatment Planning: July – September 2012.

Important Note: As a condition of entertaining a transition of DDPC patients to Acadia (privatization), Acadia will require a non-revocable guarantee and commitment by DHHS and the State of Maine to provide mutually agreeable adequate funds for the new model of care whereby Acadia will be responsible for acute needs patients, and to provide the necessary capacity of supported housing options and a plan for their development, so that the hospital can serve their needs and rely upon service delivery that supports discharge as soon as possible.

To address significant concerns discussed within the Dorothea Dix Work Group, and based on data gained from assessment of the patient population at DDPC, Acadia will explore the following:

1. Of all clients currently at DDPC and Acadia that could/will be discharged within three months, determine what would be needed for each client to be safely discharged into a community setting (including some that would require long term residential care).
2. Of the clients currently at DDPC and Acadia, determine what would have been needed to in the community to prevent (if appropriate) clients from inpatient hospitalization.
3. For clients currently at DDPC and Acadia who need continuing inpatient hospital care, determine whether the clients require biological or psychosocial treatment, or both.

This process will include community providers in a team approach that assesses specific client needs and preferences, history, family input, treatment relationships, care outcomes and the development of a thorough recovery and support plan and, a robust recovery oriented system of care.

- The Dorothea Dix Work Group reviewed a multitude of discharge alternatives, barriers to discharge, and challenges around the shortage of adequate housing capacity. Part of the savings from closing DDPC will need to be invested to increase supported housing capacity and options. Current gaps include insufficient first floor accommodations and the need for apartments with staff on site 24/7, apartments with Community Rehabilitation Services (CRS), apartments with daily living support and/or skills development, group homes, boarding homes/assisted living, and supports that are mobile and increase or decrease based on personal need, preference, and recovery. The DHHS must convene and support an ongoing mechanism for the existing members of the service community who will be affected by the closure of DDPC (jails, peers and families, other service providers, the city of Bangor, Penobscot Community Health Care (PCHC), Sweetser, Tri-County National Alliance for

Mental Illness (NAMI), regional hospitals, NFI-North; VOA, Charlotte White Center, OHI , Community Health and Counseling Center (CHCS) Northeast Occupational Exchange (NOE), Catholic Charities, all peer advocacy programs, and other providers based outside the region but connected by clients served such as Spring Harbor, KVMHC, Health Reach, Goodwill of Northern NE, etc.) to work together to develop a collaborative partnership. Collaborators will have letters of agreement defining areas of specialization, mutual referral agreements, and mechanisms to ensure cross-service optioning for all consumers. Maximum consumer choice and minimum service duplication are desired characteristics of this effort at each service entrance. Whenever possible, the client will be given choice of service provider. Assistance will be provided to the client in identifying the purpose of the service, establishing measureable goals, assisting in recognizing services not effective at attaining desired outcomes, and in determining future service decisions, The group will review programs offered in other areas, such as The Home Team in Portland to determine the most effective way to provide intervention before a crisis and create a local collaboration to implement these interventions in northern Maine. Flexible funding models emerged as an idea from a subcommittee of the Dorothea Dix Work Group focused on exploring innovative ways to support patients in their transition from inpatient psychiatric care to supportive community resources. It is expected that collaborative planning among many community resources, such as those listed above, can reduce unnecessary psychiatric admissions and readmissions.

Implementing Legislation and next Steps

The next step for this committee is the development of milestones and action steps, along with any necessary legislation related to this report.

Public Comments

Public comments were received in response to the first draft circulated by this subcommittee and include:

- A Bar Harbor physician expresses dismay at the closure of DDPC – seeing state hospitals as the real safety net and placement of last resort for the most difficult to treat members of our society. He recommends that real replacement services be in place before, or if, the hospital is to be closed.
- A family member expresses support for DDPC and talks about the care that was provided there for her daughter – that was lifesaving and restorative. Making Augusta the only place that treatment from the state is available would be a terrible thing for northern Maine.

DRAFT

PUBLIC LAW 2011
CHAPTER 380
PART NN

DOROTHEA DIX PSYCHIATRIC CENTER

SUBCOMMITTEE REPORT TO KEEP DDPC OPEN

OCTOBER 2011

EXECUTIVE SUMMARY
KEEP DDPC OPEN

If the state is *not* willing to accept an increased risk to our least fortunate and to our community, the bottom line is that DDPC must remain open to serve the small number of individuals with severe, chronic psychotic disorders, most diagnosed with schizophrenia, who have: 1) brain illnesses that are highly resistant to treatment; or 2) a lethal combination of no insight, refusal of all community services and ongoing symptoms that pose a high risk of danger to themselves or to the community. Hospitalization and rehospitalization is expected for this fragile group of affected individuals even with an ideal community system in place due to the chronic nature of the brain illness that can worsen with each acute episode. Because of the complex, biopsychosocial needs of the group of people we serve at DDPC, adequate time in a safe, secure setting for their illnesses to respond to treatment and for necessary services to be arranged such that they can safely transition to the community is an absolute necessity--not a luxury.

The Dorothea Dix Psychiatric Center (DDPC) is a specialized psychiatric care facility that provides inpatient and outpatient services for patients suffering from severe and persistent mental illness that are refractory to the care normally provided and available in the community and at private psychiatric hospitals. The hospital employs approximately 250 providers of mental health care, therapeutic services, social services, psychiatric services, psychological services and support services who have years of experience in this specialized care and who have refined their ability to delivery services to this unique population utilizing a body of knowledge acquired by lengthy exposure to patients with these severe, persistent and refractory mental illnesses.

Services provided by DDPC ensure the continuity of a safety net that protects individuals in our society who have often been deemed a danger to themselves or others by a court of law and are committed for care that may require longer-term treatment, medication management, and reintegration into society. This process can be lengthy and complicated depending upon the individual needs of the patient, his or her existing support mechanisms, or support systems (both service focused and financial) that are available in the community. DDPC also serves those residents of Maine in a sizeable geographic area that would have no other options for access to this specialized care.

DDPC is part of a comprehensive system of mental health services that includes the Riverview Psychiatric Center, the State's primary provider of forensic services to the residents of Maine. The demand for forensic services is continually rising. This demand is placing further stress on the system's capability to provide services to the patients with severe, persistent, and refractory mental illnesses in southern Maine. The demand for services is growing, not diminishing.

Society at large has an obligation to ensure that the needs of those who are incapable of providing for themselves are offered the opportunity to enjoy the same rights that are afforded to all other citizens of the US and residents of the State of Maine. This "safety net" has traditionally been granted through the delivery of services by the public, as private organizations are not obligated by this mandate and have the option to make service delivery decisions based purely on the financial feasibility of the proposition. While there is a need to maintain a high degree of fiscal accountability, the focus of the State's mental health system must be on the sustainability of the safety net for those who are incapable of providing for their individual needs. To accomplish this objective it is essential that the services provided by the Dorothea Dix Psychiatric Center remain intact and that operational efficiencies be found to ensure that the services are provide in a manner that supports the fiscal needs of the taxpayer.

Proposed recommendations for change that maintain the "safety net" while improving overall fiscal efficiency are as follows:

1. Adopt the recommendations of the 2009 BGS Master Plan on the DDPC facilities, including the transition of other eastern Maine departments into the facility.
2. Leverage existing space at DDPC to relieve the forensic bottleneck that is being created by the growing population of NCR clients, especially those with ties to the eastern Maine area. This would also require the initiation of a forensic ACT team.

3. Provide support for the creation of comprehensive care centers that offer integrated medical, psychiatric, therapeutic, and social services.
4. Establish a task force to investigate options for public/private partnerships that will leverage the expertise of DDPC staff and provide alternative outpatient and continuing care services to the population served.
5. Support the development of local peer and family networks as a means of offering guidance and assistance to clients in the community in an attempt to identify and advocate for alternative, less invasive intervention when appropriate.
6. A 2009 SMHA report indicated that Maine ranks #1 in the total expenditures for community based programs. Due to this level of funding it is not reasonable to expect further expenditures for community services, rather, an in-depth study of current expenditures should be initiated that evaluates the efficiency of the current funding structure, identifies duplicative or gratuitous services, and recommends shifting existing funds to new recovery based service models.

Public Law 2011, Chapter 380, Part NN
NN Work Group Report
DRAFT

Introduction:
The 125th Maine Legislature passed Public Law 2011, Chapter 380, Part NN requiring the establishment of a work group to develop a plan and suggest implementing legislation regarding the future role and structure of the Dorothea Dix Psychiatric Center (DDPC) to be effective June 3, 2012. The plan required detail of personnel transfers, position counts and other responsibilities, if applicable, to other programs within the Department of Health and Human Services (DHHS). The work group was to develop a comprehensive plan focused on the attainment of recovery milestones, such as improved health status, increased independence, improved life satisfaction and integration into the full community, for persons with serious and persistent mental health conditions through the delivery of high-quality, efficient services. The law included as *Appendix A* required specific representation to form the work group and was to be chaired by the Commissioner of Health and Human Services.

Membership:
The following members comprised the NN work group:

A. Senator Nichi S. Farnham: A member of the Senate representing Bangor
B. Representative Sara Stevens: A member of the House of Representatives representing Bangor
C. Mary Mayhew: The Commissioner of the DHHS
D. Linda Abernethy: The Superintendent of DDPC
E. Mary Louise McEwen: The Superintendent of Riverview Psychiatric Center
F. David F. Emery: Designee for the Commissioner of Administrative and Financial Services
G. Lisa Hall: A DDPC staff member who is a member of the Maine State Employees Association
H. Patrick Murphy: A DDPC staff member who is a member of the American Federation of State, County and Municipal Employees
I. The following members were invited by the Commissioner of Health and Human Services to participate in the work group:
    - Dennis King, Chief Executive Officer of Spring Harbor Hospital
    - Daniel B. Coffey, Chief Executive Officer of Acadia Hospital
    - Jane Moore, a member of the Consumer Council System of Maine
    - Kim Moody, Executive Director of the Disability Rights Center
    - Carol Carothers, Executive Director of the National Alliance on Mental Illness Maine
    - Gregory P. Disy, Chief Executive Officer of Aroostook Mental Health Services
    - Dale Hamilton, Executive Director of Community Health and Counseling Services, Inc.
    - Richard M. Brown, Chief Executive Officer of the Charlotte White Center
    - Vicki Rusbult, designee for the President of the Eastern Maine Development Corporation
    - Simonne Maline, Executive Director of Consumer Council System of Maine

    - Work Group Facilitator: Helen Wieczorek
    - Office of Adult Mental Health Services Representation: Ronald Welch and Guy Cousins
    - DDPC staff to the work group: Jenny Boyden, Bill Dunwoody, Sharon Sprague, Melissa Hayward (recorder).

Work Group Process:
In developing recommendations and suggesting implementation of legislation, the work group's charge was to develop a plan that:

A. Establishes recovery outcomes to be tracked;
B. Ensures that the transitional needs of patients are effectively met;
C. Includes the provision of essential community living supports for housing, vocational and non-vocational involvements and health care;

D. Includes support for other critical community-based resources and treatment services;
E. Focuses on integrating all health care;
F. Ensures that adequate capacity exists locally for inpatient hospitalizations;
G. Ensures that adequate essential community care services to support outcomes are available;
H. Ensures that community and family education is optimized to support integration;
I. Ensures that the delivery of high-quality, efficient service is achieved.

The NN work group met six times from August 12 through November 18. Please refer to *Appendix---* for work group minutes, the public comments from the DHHS website, and the public statements provided in person during each session.

Several presentations were provided to the NN work group regarding the characteristics and needs of people with SPMI, the DDPC physical plant, financial information regarding hospital and community costs, and the services provided by the mental health system.

DDPC Patients: Who they are, what brought them to DDPC, their lengths of stay
Dr. Michelle Gardner, Acting Medical Director of DDPC presented information to the subcommittee regarding the need for specialized services to treat the most severe of the persistently mentally ill and described the extent to which staff at DDPC work to address the biopsychosocial needs of the patients using all available tools to minimize rapid re-hospitalization risk and improve quality of life.

Dorothea Dix Psychiatric Center accepts referrals for admissions from all over the state of Maine. Based on analysis of the hospital census of 61 inpatients on 9/23/11: 33 % of admissions were direct transfers from Acadia Hospital, 23% were transfers from other psychiatric units, 14% were direct admissions from the community (ACT, PTP, walk-ons), 27% were admissions directly from Emergency Departments and 3% from the Department of Corrections (jail/prisons).

Dorothea Dix Psychiatric Center specializes in the treatment of people with the most severe and treatment resistant brain illnesses. Eighty-seven percent of the patients at DDPC suffer from schizophrenia/schizoaffective disorder with symptoms dominated by delusions and/or hallucinations that affect their ability to function and/or cause them to be potentially dangerous. Schizophrenia affects 1% of the general population (approximately 13,284 people in Maine) and DDPC specializes in that 10% (approximately 1,328 people in Maine) whose symptoms have become so persistent, resistant and unremitting over the course of their illness that it can take months to respond to treatment and for the individual to be safely discharged to a less restrictive setting.

Schizophrenia, like any other medical illness has a range of severity and dysfunction. Those patients with the most severe symptoms of the illness experience the following: 1) high risk of danger to themselves and others such that the court involuntarily commits them to a psychiatric hospital for lengthy periods; 2) no insight into their illness and need of treatment; 3) refuse of all treatment services. Those with the most severe form of schizophrenia is a small but significant group who do not routinely participate in research studies for the following reasons: 1) refusal to participate in the study; 2) inability to participate in the study due to inability to give informed consent. Alternatively, they do participate in the study but are a small component of the overall group, therefore their negative outcomes are insignificant to the overall findings. The quantity of these negative outcomes is not as large as the quality of the impact to the community through finances and fear. These negative outcomes are the stuff front page stories are made of that enhance public hysteria and stigma.

The majority of patients with these disorders do not even recognize that they are sick and in need of treatment. In fact, one of the symptoms can be lack of insight into the illness itself. So treatment is often delayed at the outset necessitating additional time in the hospital to recover and additional court processes for involuntary treatment. Furthermore, the majority of these patients never develop insight even with treatment and then will often refuse community treatment making assertive community treatment (ACT) not even an option. Be aware that large studies yielding good outcomes with ACT are not done solely with patients involuntarily committed to a hospital, with severe schizophrenia, without insight, who pose a high risk of danger and refuse all community services and supports. To make a wise decision, you must compare apples to apples.

Even with court-ordered outpatient treatment to the Progressive Treatment Program (PTP), these individuals still may refuse to allow arrangement of adequate housing within the 20-mile radius of the PTP and/or refuse to apply for entitlements/insurance necessary for them to access many supports, medications and other treatment options. On 9/23/11, 50 out of the 61 inpatients at DDPC had received an order from the district court for continued involuntary hospitalization due to clear and convincing evidence that they posed a potential danger to themselves or others as a result of their mental illness and that adequate community resources were unavailable to meet their needs.

Those with no insight, severe symptoms and high risk of danger who refuse community services are either hospitalized to protect themselves and the community long enough for them to become safe for discharge *or* the community must accept an increased risk of morbidity and mortality even in an ideal community system. A vote to close DDPC is a vote to accept a higher risk of danger to the community and to those with the severest forms of brain illness.

Overview of the Public Mental Health System/Services in Maine:
The State Mental Health Association's (SMSA) (*Appendix---)* FY 2009 report ranks Maine first in the nation for mental health actual dollars and per capita expenditures which include state mental hospital inpatient services, community-based programs, and state mental health support activities.

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates, based on national prevalence data, that 56,376 people in Maine have a serious mental illness with 27,144 having severe and persistent mental illness. The Office of Adult Mental Health Services (OAMHS) defines a person with SPMI as:

- Being age 18 or older;
- Having a primary diagnosis of Axis I or Axis II of the multi-axial assessment system of the current version of the *Diagnostic and Statistical Manual of Mental Disorders*;
- Having a functional level that severely limits the person's ability to lead a normal productive life. Specific clinical assessments are done to determine an individual's functional level.

The number of adult MaineCare recipients receiving MaineCare funded mental health services rose from a rate (per thousand) of 29.08 in 2006 to 36.09 in 2010, reflecting a 24.1% increase over the last five years. There was a two-fold increase in people using mental health services between 2009 and 2010 compared to earlier years. Maine currently has approximately 12,000 people enrolled in mental health services. The rate of people using services is often used as a measure at the state and national level to assess access and availability of public mental health services.

Total expenditures for adult mental health services in Maine were $289,423,423 in fiscal year 2010:

- DDPC: $28,332,708;
- RPC: $33,066,519;
- Office of Adult Mental Health: $37,096,776;
- MaineCare – Acute Care Hospital Psychiatric Beds: $11,005,028;
- MaineCare - Private Institute for Mental Disease (IMD) Inpatient Services: $33,665,171;
- MaineCare - Private IMD Outpatient Services: $15,596,766;
- MaineCare - Section 17 Community Support Services: $62,272,243;
- MaineCare – Section 65 Behavioral Health Services: $8,751,806;
- MaineCare – Section 97 Private Non Medical Institutions (appendix E): $59,636,407.

State Run Inpatient Care
The two state run inpatient service facilities, DDPC and RPC, provide care and treatment for voluntary and court-committed patients.

Dorothea Dix Psychiatric Center:

Dorothea Dix Psychiatric Center (DDPC) is a 64 bed psychiatric hospital with four inpatient treatment units that serves approximately 300 patients per year. Fifty-one percent of admissions come from Penobscot County; 23% are from Aroostook, Hancock, Washington and Piscataquis counties; with the remaining 26% coming from all other Maine counties or out of state. Because over 50% of DDPC patients are homeless, the average 60-day length of stay at DDPC can be further prolonged by the need for stable housing alone. Since the patients with severe brain disorders struggle to make it in optimal circumstances, DDPC staff make every effort to engage the patients in securing stable housing before discharge so that they are less likely to need rapid re-hospitalization and more likely to meet their life goals. Only if a patient requests discharge to a shelter does DDPC discharge to shelters. Even then, the patient is encouraged to work with DDPC staff to arrange a planned discharge to a shelter with coordination between DDPC and shelter staff about the bio-psychosocial needs of the patient. As the patient will allow, DDPC staff work to engage natural supports, communicate with the patient's providers throughout the hospitalization and attempt to address those factors that contribute to hospitalization and life dysfunction as opposed to just trying to medicate symptoms.

In addition to accepting patients in transfer from other hospitals, admitting patients directly from emergency departments and the community, DDPC also accepts direct admissions of inmates from jails and prisons who are suffering acute psychiatric symptoms such that they need hospital level of care. DDPC currently provides a small outpatient medication management clinic for those whose needs have not been met in the community (eg: too many missed appointments so they are terminated from clinics; behavior that has been too disruptive to be tolerated in other clinics; patients too mistrustful to negotiate rotating providers; patients in need of an appointment within 1-2 weeks of discharge and/or more frequently than the community can provide in order to minimize readmission during the fragile post-discharge period. Both inpatient and outpatient, DDPC's goal is to provide a safety net for the patients, their families and the community while supporting patients in their recovery.

DDPC also oversees two dental clinics: one that operates on-site four days per week and one in Ashland, two days per month. The Dental Clinics primarily serve Pineland Consent Decree members and AMHI Class members.

The 2012 budget for DDPC totals $27,021,676: 41% from the General Fund, 51% from Disproportionate Share (DHS), and 8% from reimbursements. Based on the State accounting system, $21 million of the $28 million of 2010 DDPC expenditures were Personal Services (staff). Please refer to *Appendix* --- for DDPC's projected 2013 budget which includes the reduction of $2.5 million in general fund dollars.

Riverview Psychiatric Center:

Riverview Psychiatric Center (RPC) is a 92 bed psychiatric hospital with four inpatient treatment units that serves approximately 300 people per year. Fifty-five percent of admissions come from Cumberland, York, Androscoggin and Knox counties, 21 % from Kennebec County, and the remaining 24% from other Maine counties and out of state. The average length of stay is 89 days.

Forty-eight of the beds are for civil patients and 44 are for forensic patients. RPC is the State of Maine's only forensic psychiatric hospital providing psychiatric services to Maine residents who are in the criminal justice system. Those who have been arrested and/or charged with crimes may be court-ordered for admission to RPC for forensic evaluations of competency to proceed to hearing, criminal responsibility, or mental condition relevant to other issues. They may also be committed to the custody of the Commissioner of Health and Human Services for observation at RPC to enhance the forensic team's ability to perform necessary evaluations. If found incompetent to proceed with the hearing, the patient will he held for up to one year, or sometimes longer, with the goal of restoration to competency. If found not criminally responsible, the person could be remanded by the court to RPC for their sentence. Various models are being explored to determine if people who are Not Criminally Responsible (NCR) and not typically in need of acute inpatient care can be housed at a lower cost as they do not require a hospital setting.

RPC oversees two dental clinics, one in Portland and one at RPC. The Dental Clinics primarily serve Pineland Consent Decree members and AMHI Class members.

The 2012 budget for RPC totals $33,130,979: 38% from the General Fund; 56% from DSH; and 5% from reimbursements.

Financial:
The Legislatively approved FY13 budget for DDPC ($24,543,522) includes a General Fund reduction of $2.5 million as identified in PL 2011, Chapter 380, Part A. The loss of General Fund results in the loss of $4.3 million of DSH funding. After adjusting for the reduction to DSH funding, the FY13 budget will be approximately $20.3 million. This legislated budget reduction will result in an estimated cost per patient day between $1087 and $1148 based on a daily census of 51. The details of the budget reduction plan are not available at this time as the plan must be proposed in the Supplemental Budget. Details of the Supplemental Budget will be released in January 2012.

The Center for Medicaid and Medicare Services (CMS) allots approximately $34 million to the State of Maine for Institute of Mental Disease (IMD) Disproportionate Share (DSH). RPC and DDPC receive all of the IMD DSH funding authorized to the State of Maine. IMD DSH funding is part of the Medicaid program. Hospitals receive DSH funding to offset the cost not covered by Medicare, Medicaid, other third party insurers and patient revenue collections. In order to be eligible to receive DSH funding each hospital must show that the number of inpatient days for Medicaid eligible clients, those under nineteen or over sixty-five, is at least 1% of the total inpatient days. No hospital can receive a DSH payment that exceeds the hospital's unreimbursed costs of Medicaid and uninsured patients.

MaineCare uses the General Fund appropriations and Third Party Reimbursement as the state match for drawing the Medicaid IMD DSH funding. The federal match assistance percentage (FMAP) is determined annually by CMS. Additionally, each hospital has a separate IMD DSH limit based on their allowable expenditures. The hospitals must file Medicare Cost Reports annually.

The DSH funding no longer accessed by DDPC is available for other IMDs. The Affordable Care Act currently includes language reducing DSH funding, beginning in 2014. It is unclear if the reductions are to include both the Acute Care and IMD DSH funding, creating an uncertainty as to whether DSH will be here to support DDPC or the community in the future. Future reductions in federal funding may cause an increasing burden for General Fund dollars.

DDPC pays the cost of water and sewer for all tenants including Inland Fisheries and Wildlife. DDPC is billed for all of the electric costs of campus tenants. DDPC maintenance staff responds to mitigate emergencies for tenants. DDPC plows and mows the entire campus. DDPC provides housekeeping services to the regional office staff in the Pooler Pavilion and maintains the keyless entry system. The private security company contracted by DDPC provides outdoor security rounds for the entire campus. The cost of providing these services to other tenants adds $93 to the per diem rate. Please see *Appendix* --- for more detailed financial information.

Physical Plant:
There was considerable discussion about the age of the DDPC campus and whether the current buildings are the right space to achieve the best patient outcomes. Some work group members expressed concern about the "institutional" feel of the buildings and the impact on patient recovery. Others members expressed the view that many patients and families enjoy the older buildings and that there are many positive aspects in providing clinical care at the DDPC campus. Currently there is no funding to move the services of DDPC off campus.

The Bureau of General Services (BGS) Master Plan of 2009 describes several options to make more efficient use of the campus. Currently the state leases approximately 125,000 square feet for other state agencies in the Bangor area for a cost of $1.2 million annually. BGS leases space to other state departments on the DDPC campus at a cost of $5 - $6 per sq foot versus the fair market value of $15 per square foot. This is low considering that DDPC provides heat and electricity to all tenants. By December of 2011, DDPC plans to utilize 46.6% of the campus with 25% (110,313 sq ft) vacant and the remainder occupied by 11 other state agencies, including the Wellness Center. DDPC is currently decreasing their footprint as the hospital downsizes from four

units to three, a capacity reduction from 60 patients to 51 due to the FY13 budget reduction. In order to create a more secure and recovery focused community treatment center, other treatment spaces are currently being relocated closer to patient units. This move is consistent with the master plan which included maintaining hospital services and freeing up 90,000 square feet as the psychiatric services of DDPC decrease their footprint allowing maximum use of the building for other state agencies. The building can easily accommodate the 44,000 square feet required by the DHHS Griffin Road complex in current vacant space. Other state agencies are currently considering utilizing the vacant space.

The master plan also recommended that the Pooler Pavilion, now occupied by DHHS regional staff, Department of Corrections, the Advocacy Initiative of Maine and the Wellness Center should be vacated and demolished.

Subcommittees:
Four sub-committees were formed to discuss various aspects of the work group's plan: Community Services, Financial, Close DDPC, and Keep DDPC Open

Community Services Subcommittee:
The Community Services Subcommittee examined how community services could be altered to more efficiently serve people with SPMI. With the 25% total budget reduction at DDPC for FY13 budget, the subcommittee anticipated that the system will need to find innovative ways to support patients in their transition from the hospital to the community. With an expectation that other community resources will be impacted by the state budget, the subcommittee recommended that they system work collaboratively to provide innovative services which reduce unnecessary admissions to the hospital.

The Community Services Subcommittee recommended that a pilot initiative be developed that is consistent with the value based purchasing initiatives of DHHS, including a systemic focus of the reductions, and allowing flexibility with funding. The pilot would be operationalized with community partners and incorporate the following:

- A flexible funding structure that moves away from a fee for service structure and allows grant funding to have flexible utilization to fill service gaps.
- Increased utilization and integration of peer/family supports.
- Increased coordination of services for the 'high-end' users.
- Utilization of a care management structure to connect Dorothea Dix, the pilot site and primary care.
- Involvement of state audit and finance offices to review language requiring legislative action or changes in MAAP rules.

Please refer to *Appendix* --- for the Community Services Subcommittee reports.

Financial Subcommittee:
A Financial Subcommittee was formed to examine side by side costs of the four Institutes for Mental Disease (IMD): RPC, DDPC, Acadia, and Spring Harbor. Based on 2010 Medicare Cost Reports Per Diem cost (less Clinic costs and taxes) for the 4 IMD's:

RPC	DDPC	Acadia	Spring Harbor
$1,005.89	$1,373.08	$1,145.19	$1,085.60

The subcommittee also examined DDPC cost estimates adjusted for campus-wide services. Distributing costs proportionately among tenants on the DDPC campus would have a $93 impact on DDPC's cost per patient day. The largest component of the hospital's per day cost is personal services, responsible for $21 million of the $28 million dollar budget. To achieve any significant savings, changes will be required in the staffing of DDPC. Please refer to *Appendix* --- for the Financial Subcommittee documents.

Close DDPC Subcommittee: See attached report.

Keep DDPC Open Subcommittee members: Lisa Hall, Chair; Rep. Sara Stevens, Simonne Maline, Linda Abernethy, Mary Louise Mcewen, and Patrick Murphy. Content experts: Mary Ann Turowski, Dr. Michelle

Garduer, Katharine Storer, Lonnie Gould; DDPC staff: Sharon Sprague, Bill Dunwoody, Jenny Boyden, Melissa Hayward, recorder. Guests: Joe Baldacci, Richard Green.

The DDPC subcommittee recommends that the hospital remain open due to the lack of local capacity to provide specialized treatment to people with SPMI. Costs incurred by the psychiatric center can be offset by following tbe recommendations outlined in the 2009 BGS Master Plan. In addition to costs offset by state offices relocating to the DDPC campus, the center will be operating with a 25% reduction of their current budget beginning FY13 bringing the cost per patient day in line with the other 3 IMDs.

The subcommittee considered several DDPC closure impact issues that led to their decision:

Trans-institutionalization:
According to the *Oxford Dictionary of Sociology*, trans-institutionalization is a process whereby individuals, supposedly deinstitutionalized as a result of community care policies, in practice end up in different institutions, rather than their own homes. For example, the mentally ill who are discharged from, or no longer admitted to, mental hospitals are frequently found in prisons, boarding-houses, nursing homes, and homes for the elderly.

At a 2009 juvenile justice summit, Florida Judge Steve Leifman reported that in 1963, 500,000 people with SPMI resided in state psychiatric facilities. According to the US Department of Health and Human Services & Department of Justice Statistics, less than 50,000 people with mental illness were housed as prisoners in 1969. As deinstitutionalization efforts that began in the mid 1950's continued through the 70's to remove people with mental illness from state psychiatric hospitals the nation's homeless population also grew. By 2009 only 50,000 people with severe and persistent mental illness remained in psychiatric facilities but 500,000 people with SPMI were housed in jails with another 500,000 on parole. When people come out of a state psychiatric facility they are not felons and have all of their rights intact. When released from jail with a felony record, it is more difficult to secure employment, housing, and various financial benefits. The three most common reasons for arrests of people with SPMI are disorderly conduct, verbal threatening, and trespass; all pretty much victimless crimes.

Privatization: Other states have gone through privatization and initially saw a decrease in cost but there is no research that shows that the safety net population needs are addressed and some states are beginning to see that privatization was not successful. Jail rates are rising and homeless shelter population is increasing. There are no studies that identify the safety net population before privatization to see where they end up 1-3 years after privatization. They are a population that disappear into jails and shelters or onto the street and perhaps, die.

According to Bruce A. Wallin's publication: *Privatization of state services in Massachusetts: Politics, Policy, and an experience that wasn't prepared for the economic policy institute*, executive branch officials admit they moved too fast, without proper evaluation of alternative care providers, to close public hospitals in efforts to save money. The state realized only half of the predicted savings. "The most costly in both fiscal and huuan terms was the inability of the state to find homes for many of the mental health patients displaced due to the state hospital closings. While partially reimbursable by the federal government's Medicaid program, the cost to the state of maintaining many of these patients in private hospitals was considerably over budget, while reinforcing a medical orientation that may detract from community support objectives. Mental health advocates have charged that other privatizations have resulted in denial of needed care, inappropriately short hospital stays, over-reliance on medication, lesser trained staff, high staff turnover, loss of ability to track patients, and a reluctance to respond to requests for information. Advocates also criticize the impact on patients of hours waiting in emergency rooms for beds. Some private hospitals have simply refused to admit more than the contracted number of patients, something state facilities would not have done." Further, it was recommended that privatization be treated as an experiment so that a proper evaluation can be made. If not effective "privatization should be easily reversible. Efficiency and lower cost must be balanced by effectiveness..."

A March 2011 report by the National Alliance on Mental Illness, *State Mental Health Cuts: a National Crisis*, states that Mary Lou Sudders, who is the former commissioner of mental health in Massachusetts, says that cuts of this magnitude (referring to one quarter of the beds in the state's psychiatric hospitals slated for elimination) will "freeze up the entire public mental health system, so that no one will be able to transfer into Department of

Mental Health inpatieut beds, and individuals coming out of the hospitals will be at risk of being in the streets or highly marginalized settings."

Psychiatric Services, August 2011 issue features an editorial, "Storm Clouds Over the Public Mental Health Safety Net" taking issue with the loss of the public safety net. According to Marvin S. Swartz, M.D., Duke University Medical Center the "maximization of Medicaid reimbursement and its attendant privatization of service providers has shifted funding away from the public safety net for persons not eligible for Medicaid, shifted the policy balance away from state mental health authorities with expertise in and commitment to these consumers, eliminated public hospital beds, and neglected the public mental health workforce. With many states confronting sizable budget shortfalls, Medicaid, even with its allure of leveraging for states, has become a seductive target for cuts in eligibility, optional services, or provider reimbursement, pitching the burden of care back to the now frayed public mental health safety net."

A report of the Treatment Advocacy Center, *The Shortage of Public Hospital Beds for Mentally Ill Persons,* states that a consensus of experts polled for the report suggests that 50 public psychiatric beds per 100,000 population is a minimum number. "The consequences of severe shortage of public psychiatric beds include increased homelessness; the incarceration of mentally ill in jails and prisons; emergency rooms being overrun with patients waiting for a psychiatric bed; and an increase in violent behavior, including homicides, in communities across the nation." Maine currently has 12.5 beds per 100,000 population.

The Journal of the American Academy of Psychiatry and the Law states that "the drift toward criminalization will continue without a well-reasoned and determined national mental health system that includes, but is not limited to, adequate state and community inpatient care facilities."

For private hospitals to receive DSH funding, the state would have to provide the General Fund dollars needed as the matching requirement. It would not cost more or less than providing the same funding to DDPC. The budgeted General Fund savings included in Public Law 2011, chapter 380, Part A will lead to approximately $4.3 million in available DSH funding. In order to provide that DSH funding to either of the private psychiatric facilities, the State would have to appropriate the $2.5 million in General Fund back to the Medicaid program. All hospitals receiving DSH funding must ensure that the DSH does not exceed their cost of uncompensated care. The federal government applies a cap to the amount of DSH each state receives each year. This can be an incentive for private facilities to not serve people with uncompensated care after the State has utilized all of its DSH funding. Private hospitals have a financial incentive to reduce their losses.

Additionally, public input and sub-committee dialogue indicates major concerns with the private sector's lack of expertise required to engage, assess, treat, and connect with natural supports and community agencies to assist patients with SPMI. There are many non-billable hours involved in the kind of work that needs to be performed to talk to patients' family, providers, and attend system meetings that involve issues of homelessness, unmet needs, and efforts toward building relationships with community partners for the sake of improving the system and assisting the treatment needs of individual patients.

Concern has been expressed that the rapid cycling of acute patients in the private hospital setting will interfere with the treatment focus and time needed to stabilize medication issues with non-responsive patients many of whom are medically compromised as well as a younger population who need diagnoses sorted out and transition assistance to move from the children's service world to the adult system.

Public Input to the Committee:
Public input from Bangor citizens is tbat the "jail is already full and there are already people with mental illness on the streets and 800 people in the shelters in Bangor." The subcommittee was urged to look beyond narrow parameters as DDPC is a vital service to the city. Concern was expressed about how DDPC closure would impact the city as a whole (shelter, police, jail, general assistance) and urges the Bangor city council to come forward in opposition of any closure or downsizing of the facility.

Many public comments expressed preference for care provided at DDPC as opposed to other hospitals. In particular, it was noted that "Acadia has had their own challenges and that they do not have the real resources to absorb the burden the way DDPC does. There is a role for public benevolent care."

A psychiatrist noted that "closing DDPC is like closing a cardiac care unit without the input of a cardiologist." Criticism was expressed regarding the lack of clinical representation on the NN work group.

Much of the public sentiment was captured by the following quote; "People in this hospital work with patients that the private sector does not want and don't want them no matter how much you pay them."

A mother is concerned about the dental clinic. Her son would never be able to go to a regular dentist. They have worked as a team to get him to go to the dentist. Both she and her son have been hospitalized. The services in the community do not coordinate well with discharge from the hospital. She needed a case worker and a daily living support worker. She had to call several agencies to find out who did that and then meet with different people to see if there was a fit. Additionally, they were using non-traditional therapy for her son that was strength based and works on reasoning. She stated that the agency just dropped her son because they didn't know he had Medicare.

And finally, from a DDPC practitioner: "DDPC is a therapeutic environment. The grounds are beautiful and promote a connection to the community with the walking trails and fields. Patient discharge survey results indicate no significant difference from DDPC to RPC for environmental factors; both are satisfactory. The building and grounds provide ample space for treatment to occur and for comfortable visitation with family, friends, and community supports".

Barriers to Discharge:

- Discharge data for the first quarter of 2011:
  - 79 discharges;
  - 28% (22 people) returned to family;
  - 28% (22 people) went to apartments;
  - 20% (16 people) were referred to PNMIs;
  - Less than 1%:
    - 5 returned to jail;
    - 1 stepped down to crisis unit;
    - 2 referred to a boarding home;
    - 7 returned to their own homes;
    - 1 discharged to shelter at their insistence;
    - 2 discharged to a medical hospital;
    - 1 refused to disclose plans.
- Typically over 50% of DDPC patients are homeless.
- The majority of DDPC patients prefer to live in their own apartments but several are referred to group homes for the benefit of having 24 hour staff. Preferred resources are supervised and supported apartments. Region III lost 4 such programs within the last few years as they were replaced by Community Rehabilitation Services which is not accessible to hospital patients without a waiver. The service has also been replaced with patching together several separate community support services, each having its own staff which becomes intrusive to the clients, cumbersome to arrange, and costly. There is no outcome data to show effectiveness of this kind of patchwork service.
- Negotiation of placement options with the patient, family, guardians, and community providers;
- Many have lost benefits and refuse to sign paperwork;
- Unwillingness to participate in a safe discharge plan;
- Lack of affordable rents;
- Legal and eviction histories ;
- Histories of assaultiveness and/or fire setting;
- Denial of illness/lack of insight ;
- Time needed to sort out diagnoses and medications;

- Patients hope that families will change their mind and they can return home;
- Rejection from PNMIs for problematic histories or lack of rehab potential;
- Six month wait lists for gero-psych beds;
- DDPS social workers have a bigger work load as community providers provide less assistance with discharge plans;
- Desire to stay for feeling of safety, companionship, warmth, recreation, no worries about taking medications;
- Rejections from residential options due to substance abuse issues.

Recidivism:

- Clinical reviews of patients who have high recidivism rates reveal the following common factors: social isolation, denial of illnesses, substance abuse, unresolved trauma issues, vicious cases of schizophrenia, or low cognitive functioning. that does not qualify for developmental services, and a young and rambunctious profile.
- Systemic issues identified that promote higher rates of recidivism include among others, few recreation and socialization opportunities on a poverty income, transportation, a crisis system that does not accept patients in crisis if they are homeless, providers who accept rejection from their patients quite readily – then patients isolate and decompensate, group homes can be too rigid, few services for low cognitive functioning, the current funding structure does not provide any incentive to work with difficult to locate or engage clients, providers terminate services due to no shows, fragmented services, and lack of true Dialectical Behavior Therapy (DBT) and Assertive Community Treatment (ACT) programs.

Specialized Care:

DDPC embraces the following definition of recovery, used in treatment programs and individual care, taken from the OAMHS Recovery Guidelines: ***A journey of healing and transformation that enables a person to live a meaningful, satisfying, and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of the illness while holding a positive sense of identity.***

People with SPMI deserve the best specialized care possible just as a cardiac patient will receive specialized services in a cardiac unit. It is not expected that all hospitals will have the expertise to treat serious cardiac problems. Inpatient care for people with SPMI requires expertise in diagnosis, time to evaluate courses of medications, treat co-occurring medical issues, engage the patient in quality discharge plans, and link with the community prior to exiting the hospital. A comment made by an NN member was that we cannot afford the time to treat people in this manner. The Keep DDPC Open subcommittee challenges that comment by insisting that time be taken to effectively treat people with severe and persistent mental illness including the provision of quality discharge planning or the cost will be greater elsewhere (emergency rooms, corrections, violence toward others, and loss of life.)

The DDPC treatment philosophy is the consideration of biopsychosocial factors that keep people coming into the hospital. Treatment and discharge planning are focused on decreasing future readmissions and improving quality of life. The sixty day average length of stay allows for the development of therapeutic relationships based on trust, respect, compassion and hope for recovery. DDPC encourages patients to work towards the life they want to have and teaches the skills needed to follow their recovery path. For some, stabilization and return to baseline functioning is a slow non-linear process that requires the expertise of a multi-disciplinary staff. Frequently the issue for many of the patients is one of putting the pieces of their life together and progressing towards their goals. It is not simply symptom management and putting them back into the same situation. Med management is a very incomplete approach to treatment.

DDPC specializes in a population that does not have insight into their illnesses. Decision makers need to consider the lack of community capacity to deal with those that do not clear in fourteen or sixty days depending upon the severity of the illness. There is a whole component that happens here that does not happen in your run of the mill private sector. DDPC specializes in working with people who do not have enough insight to

recognize that they even need recovery. DDPC has an excellent record of retaining high quality psychiatrists who are committed to providing services to this population which provides greater continuity of care, a factor critically important for people with chronic mental illness.

A primary mission is treating patients that have been deemed potentially dangerous. We are accepting people from Acadia who are committed for longer than 30 days. Only 4 people currently have less than a 30 day commitment.

NN Work Group Recommendations: In order to meet A-I below, the only option is to keep DDPC open. We recommend that the following be explored and investigated:

A. Recovery outcomes to be tracked:
Recovery oriented care is the treatment and rehabilitation that practitioners offer in support of the person's own recovery journey. There are a number of recovery guideline models (ROSI, RAS, FACIT, POPS) that propose various recovery oriented systems and person centered indicator measures. The subcommittee recommends that the OAMHS consider various outcome tools and ensure that the following domains (by Saltzer) be incorporated as measures to be used by the hospital and the community to evaluate success in promoting long-term recovery:

- Civic and/or Community Engagement
- Education
- Employment or purposeful activity
- Friendships
- Health and Wellness
- Housing
- Family Roles
- Recreation and Leisure
- Religion and Spirituality
- Transportation

The subcommittee suggests that a nationally recognized recovery tool (selected by the OAMHS management team that includes superintendents and is consistent with Maine state recovery guidelines for recovery-oriented care) be used upon admission to the hospital, at each treatment plan meeting, at discharge, and in the community to measure recovery outcomes. The use of the tool in both the hospital and the community promotes a feedback loop and increased continuity of care and progress towards community integration. Positive outcomes include reduced hospitalizations, less need for paid community supports, increased natural supports and life satisfaction. Outcomes can be tied to performance based contracting with community agencies with financial incentives as a motivating force, allowing greater flexibility of funding when performance indicators have been met. The state should be contracting with agencies that have demonstrated an ability to provide recovery based services in an efficient manner.

Development of performance indicators, based on recovery concepts, applicable to the state's mental health administration is also imperative.

B. Transitional Needs of Patients are Effectively Met:

- If DDPC closes the transitional needs of the patients will not be met.
- The reduction in census at DDPC due to the FY13 budget reduction is occurring in a timely manner to allow for quality discharge planning to occur. The committee does have recommendations for changes in the community system that will better accommodate the needs of DDPC patients and people in the community that require mental health services.
- A specialized transition service is the use of trained peer advocates to help bridge patients into the community and continued support as the client engages in various domains listed above to achieve long term recovery. It is important for community providers to establish relationships with clients prior to hospital discharges. Providers need to maintain their relationships with clients rather than close their case when they are hospitalized.

- Closing DDPC does not address the impact on RPC with its growing forensic population. RPC will not be in a position to absorb any overflow from emergency rooms or other IMDs. Consideration should be given to the development of a DDPC ACT team to relieve the bottleneck of RPC's forensic population as the RPC Team is full, the Augusta area is saturated with NCR/forensic community placements and NCR referrals are increasing. Only state run ACT teams and state psychiatrists are allowed to provide oversight to the NCR population. A DDPC ACT Team could be an extension of the RPC ACT team, providing more efficient use of resources.
- Our local ACT team is only able to support people within a 12 mile radius and is unable to meet the national fidelity standards for psychiatric leadership which is essential when serving the most challenging and potentially dangerous mentally ill in the community. Our local ACT team provides supervised medication administration for only one dose of medications daily, so patients who are on medications twice daily are left to their own devices to take one of the doses, which could lead to noncompliance. Also, supervised medication administration is Monday through Friday for most ACT patients, with few patients having 7 day per week administration. Although the ACT team tries to accommodate dosing schedules as ordered, their schedule constraints often dictate dosing times. So, patients have to deal with sedation during waking hours from medications that should be given at bedtime. Also, participation in ACT is voluntary and most clients from DDPC are not willing to engage willingly with this level of service despite their clinical needs.
- ACT has little value for many of DDPC patients considering that the majority of our patients are involuntary, not believing they are sick and thus unlikely to volunteer to be in an ACT Team. Although the Progressive Treatment program has its limitations, it could better meet the needs of DDPC patients were there more availability over a larger geographic area. The Progressive Treatment Program can accommodate up to twice daily medication administration 7 days per week and, given the lack of insight into the need for treatment in this population, PTP is critical. With the court-ordered treatment plan, the clients have more motivation to work with the entire outpatient treatment team beyond medication management such that they may make more progress than ACT patients who may not take advantage of all that ACT has to offer. However, to make PTP work, there needs to be tight coordination and communication with the receiving hospital so that patients who violate their court-ordered treatment plan can be rapidly and seamlessly admitted and transitioned back to the community.
- With the medication management piece alone, providing ACT or PTP to people in such a large geographic area is beyond challenging. Also, ACT and PTP teams need to provide more assertive engagement, psychosocial rehab and peer support opportunities to foster the right interpersonal match.
- Measures can be used to assess a successful transition to the community but it is important to remember that recovery is nonlinear. Hospitalization is an expected part of nonlinear recovery. Success for some would be admission to the hospital at an earlier point requiring shorter stays.

C. The Provision of Essential Community Living Supports: housing, vocational and non-vocational involvements and health care:

1) Housing:
   - Most patients have to be talked into going to a Private Non-Medical Institute (PNMI), more commonly referred to as a group home. The subcommittee recommends that a third of the existing PNMIs be converted into supported apartments. This housing model allows people to have their own independent space, keep more of their income, receive support on as needed basis as opposed to having to live with a group of people and be with staff 24 hours per day. This model of care is also more successful with many of the younger male population who are rowdy and often reactive to others in close quarters. Trained peer specialists in some of the supported apartment programs are recommended. In one apartment program the night receptionist is not a mental health provider and is able to provide support to people who may need someone to talk to in the middle of the night.
   - The Department may want to consider requesting that Eastern Maine Development Corporation, Maine State Housing, and city governments inform them regarding the availability of housing that might be utilized in the same fashion as Waterworks, the apartment complex that has very successfully served many people with SPMI who otherwise would have had to reside in more restrictive care or be discharged to a situation putting them, and perhaps others, in jeopardy.

- The subcommittee also recommends that PNMI's make it a priority to locate in one floor buildings as many of the psychiatric patients that require that level of care also have medical issues that necessitate living on one floor.
- Currently, there are many mixed messages regarding the requirements of people who can live in a PNMI. The expectation of having to meet rehabilitation goals and move on to independent living in order to be accepted into the PNMI is inconsistent. The subcommittee recommends that services be provided according to functional levels as opposed to diagnoses and the PNMI's current milieu.
- DDPC will continue to provide Social Work, Psychiatric and Occupational Therapy assessments, progress reports, and recommendations to community providers upon discharge. The information will match the performance indicator domains measuring both the hospital's and community agencies performance in engaging the patient/client in meaningful and productive recovery plans.

2) Vocational: Historically, Region III has not received a proportionate share of mental health resources. Consideration needs to be given to the provision of a Club House for at least the Bangor area.

3) Non-vocational: Loneliness is a common characteristic of people with chronic mental illness. They are frequently rejected by family and friends and have little opportunity to form healthy relationships. Ideally, individuals of all functional levels and avenues of recovery will be welcomed at a local Club House/Peer Center. The feeling of belonging and peers modeling their experiences will support them in moving forward. Additionally, not everyone wants or needs group non-vocational involvement; providers and peers need to work with people individually to support their integration into the fabric of their chosen community using the recovery domains as a guide. Expect community providers and peers to be proactive and persistent in their efforts. Never give up.

D. Support for Other Critical Community-based Resources and Treatment Services:

- The DDPC Dental clinic is a community service housed and supported by the hospital. It is vital that these specialized services continue as most of the clients are unable to receive the specialized care from community providers who are not equipped to treat the special needs of people with developmental disabilities and severe and persistent mental illness.
- Outpatient services will need to accommodate the following issues: the transition of several DDPC outpatients to community services is currently underway as part of the efforts to have people receive services in the community whenever possible. DDPC is a safety net service and would like to see all patients successfully treated in the community. In order for people to be successfully transitioned, the community providers will need to make greater allowances for no-shows, provide engagement processes for people who are very paranoid about using other providers, maintain as much consistency as possible with providers delivering the services, providing support with pharmacy assistance needs, and navigating insurance issues. Given the lack of psychiatric resources, it appears likely that psychiatrists will need to consult with their clients primary care providers to a greater extent in the future, rather than maintaining full responsibility for medication management. An NN work group member reports that in the current funding structure, adding more providers to an agency creates a financial loss. In order to accommodate the needs of the clients, the committee discussed the need for flexible grant dollars that could provide the necessary initial support required to engage clients and help them become receptive to primary and psychiatric care in a new setting.
- Currently DDPC provides the only true DBT treatment, an evidence-based practice that outpatient members state has decreased, for some, eliminated hospitalizations. The program provides flexibility so that people are not arbitrarily dismissed if they miss sessions.

E. Integrating all health care:

- DDPC patients are getting integrated health care by having their medical and psychiatric illnesses addressed at admission, during their inpatient stay, discharge, and quality hand off information is provided to the community. The doctors at DDPC take the time to talk to other providers.
- In the community the medical home for the safety net population becomes the mental health service provider - not the PCP. The medical provider should be on site at the local community mental health center so that when the person shows up for mental health services and also have a medical issue they can walk down the hall to the medical provider, or vice versa. The only local provider demonstrating this model is PCHC. At the Summer Street clinic, the provider stops what they are doing (psychiatrist or medical doctor) to engage the client demonstrating the kind of flexibility required to effectively treat people with SPMI. This model is our recommendation for satisfying integrated care needs. The medical record needs to be an open medical record to be able to communicate between the medical provider and the psychiatrist. Sharing of information is hindered by state regulations that impact continuity of care. If you do not have providers under one roof you at least need the intensive case manager to provide the old fashioned case management service; intensive outreach, hands on support, stay ahead of insurance changes, responsibility for linkages between all providers, support in a recovery focused plan.
- Currently the case management service has become more of a broker and other services that promote dependency are billed at a high cost to the state. The most effective way to begin integrated care is to start the services while in the hospital with a more aggressive case work model of care that ensures hands on support for the client and is accountable for the coordination of services and communication between providers.

F. Adequate capacity exists locally for inpatient hospitalizations:

- A poll of state emergency rooms would likely indicate a need for more psychiatric beds, not less.
- When DDPC had over 60 patients a day they continued to run a wait list most of the time. Currently, with a decrease in census, there are patient referrals from emergency rooms and other hospitals whose needs cannot be met. Three months projected refusals would be 90 people, as we average 30 referrals a month. Where are those 90 people going? Perhaps the street, jail, home? Are they violent? RPC is feeling the crunch of the DDPC downsizing as they are now getting calls from emergency rooms that they usually do not get.
- DDPC can demonstrate an economy of care by continuing to provide evidence based care and enhance recovery. Staff at DDPC work with people who are so ill that they are frightening to some or considered too complex for routine treatment. If the hospital closes, DDPC's specialized skilled labor force will no longer be able to provide care to the people that need it.
- RPC cannot absorb the overflow due to the increased demands from the Department of Corrections who is currently requesting that RPC provide an entire unit to treat their population. RPC does not anticipate a release to a community residence of any of the current NCRs for another year. For the past 10 years there have been an average of 5 new NCRs per year. The demand for RPC beds for Title 15 forensic evaluations continues with 40 admissions from January to July 2011. Of the 44 forensic beds at RPC, 33 are not going to be available for the foreseeable future due to the status of the clients occupying them.
- The subcommittee recommends consideration be given to an examination of the forensic population and the role of the 2 state hospitals. One consideration is for DDPC to provide a forensic unit to relieve the bottleneck at RPC so that they can maintain an adequate amount of civil beds for their catchment area.
- Another area for study is creation of treatment and housing on RPC grounds or in the community for NCR clients that may not need hospital level care, but may be appropriate for community programs.
- The 2009 BGS Master Plan calls for a need of 75 beds, especially with the growing number of forensic patients. There is no other inpatient provider north of Augusta skilled in the provision of inpatient psychiatric treatment to people with SPMI.
- PTP clients need to be able to be hospitalized in a state psychiatric facility. If DDPC closes all PTP clients will be forced to live in a 20 mile radius of Augusta.
- Acute stays at private hospitals are not long enough to treat many people with SPMI.

G. Adequate Essential Community Care Services to Support Outcomes:

- A redesign of the community system can achieve greater efficiencies and provide more effective recovery based services;
- Reduce the number of PNMIs by at least a third and use the financial savings to provide client preferred and more economical supported housing. In addition to qualified staff, the use of peers as paid staff and peer support should be part of the new service system design.
- Eliminate the duplication of community support services by going back to the 'old fashioned' case management model that allows billable hours for engagement, support, attendance at psychiatric and medical appointments, skill building, and linkage to vocational and educational pursuits. Consideration should be given on the best way to incorporate and support peer case management models in community support services.
- Consider contracting with a single mental health service center in each county reducing administrative costs with multiple providers. This would create greater efficiencies and, if performance based contracting was appropriately designed, aid in the goal of integrated care and accountability.
- By eliminating the duplication of community support services funding should be saved that can be put toward evidence based practices such as ACT and DBT.
- By eliminating duplication, some of the community support services that foster dependence (such as an over-use of Daily support and Living Skills) can be replaced with educational, vocational, and high quality case management.
- Consider utilizing a functional level when authorizing services as opposed to diagnoses.
- ACT Teams that operate according to ACT fidelity standards are effective evidence-based services. Since they have only a 20 mile radius (the local community ACT Team has a radius of only 10 miles), they can be a part of the Region III service system but a full service community health agency in each county is a better approach to service the rural nature of Region III.

H. Community and Family Education is Optimized to Support Integration:

- All patients receive information on the Consumer Advisory Council and NAMI upon admission.
- Local NAMI members have expressed an interest in participating in DDPC programs to help support the patients.
- The DDPC Rehabilitation Department is working with the Office of Adult Mental Health Community Partnerships to train DDPC staff in peer support and recovery based treatment.
- The location of the facility is important as the families need to be close to where their family member is hospitalized.
- The DDPC Admissions Service is always available to the community and family members for resource guidance and to consult for all patients discharged from DDPC or for those seeking admission.
- The DDPC Social Work Department conducts At Risk discharge meetings to create tighter community plans and work in a proactive manner to help prevent re-hospitalizations.
- DDPC's new Community Center Program will be offering a family support group.

I. Delivery of High-quality, Efficient Service is Achieved

Maine is currently ranked as the highest cost per capita community mental health expenditures. The subcommittee believes that a system redesign does not necessarily require more funding. The department may want to consider adopting the Substance Abuse and Mental Health Administration's Federal Action Agenda; strategies for planning, leadership, financing, and service development guided by the following five principles:

- Focus on the desired outcomes of mental health care to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and the delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.

- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Ensure that The New Freedom Commission on Mental Health's recommendations promotes innovation, flexibility, and accountability at all levels of government.

At DDPC treatment will continue to be evidenced based and recovery oriented in order to provide the most effective and efficient inpatient treatment. We will remain committed to revising our practices as research becomes available and as fiscal challenges arise.

Current and projected treatments include (see Appendix for more details on specific practices):

- Dialectical Behavior Therapy
- Acceptance and Commitment Therapy
- Cognitive Behavioral Therapy
- Wellness Recovery Action Planning
- Motivational Interviewing
- Pre-vocational and Vocational Services
- Sensory Integration
- Personal Futures Planning (Dr. Beth Mount)

Additionally, a new centralized treatment and activity center will be developed based on the concepts of psychosocial rehabilitation, recovery oriented care and ICCD Clubhouse Models (as applicable to inpatient settings). The center (to be named by the patients) will provide group and individual treatment as well as diversional and social opportunities for all patients, available 12 hours each day. The goal will be to offer treatment and activities appropriate and beneficial to individuals on all levels of the stability and recovery continuum. The goal of services offered is to promote easy transition into community settings such as: clubhouses, support groups, neighbor's kitchen, local adult enrichment classes and area career centers. Patients will play an integral role in determining weekly offerings and in finding presenters (staff, volunteers, patients).

Subcommittees Recommendations for Changes in the Mental Health Service Delivery System October 2011

So as not to lose the great ideas generated by subcommittees to create a more recovery focused community mental health system, the Keep DDPC Open and the Close DDPC subcommittee recommendations are listed below. The NN Work Group recommends that these ideas be explored further by a neutral analyst for effectiveness and efficiency.

Keep Open A

A. Recovery outcomes to be tracked:

Recovery oriented care is the treatment and rehabilitation that practitioners offer in support of the person's own recovery journey. There are a number of recovery guideline models (ROSI, RAS, FACIT, POPS) that propose various recovery oriented systems and person centered indicator measures. The subcommittee recommends that the OAMHS consider various outcome tools and ensure that the following domains (by Saltzer) be incorporated as measures to be used by the hospital and the community to evaluate success in promoting long-term recovery:

- Civic and/or Community Engagement
- Education
- Employment or purposeful activity
- Friendships
- Health and Wellness
- Housing
- Family Roles
- Recreation and Leisure
- Religion and Spirituality
- Transportation

The subcommittee suggests that a nationally recognized recovery tool (selected by the OAMHS management team that includes superintendents and is consistent with Maine state recovery guidelines for recovery-oriented care) be used upon admission to the hospital, at each treatment plan meeting, at discharge, and in the community to measure recovery outcomes. The use of the tool in both the hospital and the community promotes a feedback loop and increased continuity of care and progress towards community integration. Positive outcomes include reduced hospitalizations, less need for paid community supports, increased natural supports and life satisfaction. Outcomes can be tied to performance based contracting with community agencies with financial incentives as a motivating force, allowing greater flexibility of funding when performance indicators have been met. The state should be contracting with agencies that have demonstrated an ability to provide recovery based services in an efficient manner.

Development of performance indicators, based on recovery concepts, applicable to the state's mental health administration is also imperative.

Close A. Recovery Outcomes to be tracked

- A group of providers be tasked with reviewing and consolidating contract and licensing requirements to assure that they are based on recovery outcomes, are not-duplicative, and that they reduce paperwork. That they present recommendations to the Commissioner of DHHS by July 1, 2012 and that they be proposed in rulemaking and adopted within 6 months.
- A group of consumers, families, and providers be tasked with reviewing the current outcome data collection forms and the system currently in place for substance abuse service delivery, and use that to develop an integrated, mental health, substance abuse, and physical health recovery

outcomes process to be adopted and implemented no later than September of 2012. Peer-developed and tested measures like the POP and FACIT should be used to guide this process.

- The Commissioner of DHHS will establish pilots for local case management and alternative funding models such as bundled payment, global budget allocation, capitation payments, or contracted rates to create incentives for more coordinated, cost effective service delivery and a continuum of care using the accountable care type of organization model, or a highly integrated behavioral health network, and measure outcomes from those pilots. Before considering movement to a risk model, the pilot should be designed to build a database for use in a "shadow" risk model for future consideration.
- Core services and flexible funding to provide them must integrate dental, physical, and behavioral health

Keep Open B

B. Transitional Needs of Patients are Effectively Met:

- DDPC inpatient bed reduction from 61 to 51 and subsequent hold on admissions has caused the patient, and the system as a whole, difficulty and delay with transitioning from primary to secondary or tertiary care. Based on feedback from emergency rooms, primary and secondary inpatient hospitals and the Bangor community at large during public comments.
- The reduction in census at DDPC due to the FY13 budget reduction is occurring in a timely manner to allow for quality discharge planning from DDPC to occur. The committee does have recommendations for changes in the community system that will better accommodate the needs of DDPC patients and people in the community that require mental health services.
- A specialized transition service is the use of trained peer advocates to help bridge patients into the community and continued support as the client engages in various domains listed above to achieve long term recovery. It is important for community providers to establish relationships with clients prior to hospital discharges. Providers need to maintain their relationships with clients rather than close their case when they are hospitalized.
- RPC will not be in a position to absorb any overflow from emergency rooms or other IMDs. Consideration should be given to the development of a DDPC ACT team to relieve the bottleneck of RPC's forensic population as the RPC Team is full, the Augusta area is saturated with NCR/forensic community placements and NCR referrals are increasing. Only state run ACT teams and state psychiatrists are allowed to provide oversight to the NCR population. A DDPC ACT Team could be an extension of the RPC ACT team, providing more efficient use of resources.
- Although ACT is an evidence-based practice, there are limitations to the effectiveness of the service which may be due to regulatory practices. The current regulations and practice needs to be re-assessed to determine what changes might make ACT a more effective and efficient service.
- ACT has little value for many of DDPC patients considering that the majority of our patients are involuntary, not believing they are sick and thus unlikely to volunteer to be in an ACT Team. Although the Progressive Treatment program has its limitations, it could better meet the needs of DDPC patients if there were more availability over a larger geographic area. The Progressive Treatment Program can accommodate up to twice daily medication administration 7 days per week and, given the lack of insight into the need for treatment in this population, PTP is critical. With the court-ordered treatment plan, the clients have more motivation to work with the entire outpatient treatment team beyond medication management such that they may make more progress than ACT patients who may not take advantage of all that ACT has to offer. However, to make PTP work, there needs to be tight coordination and communication with the receiving hospital so that patients who violate their court-ordered treatment plan can be rapidly and seamlessly admitted and transitioned back to the community.
- With the medication management piece alone, providing ACT or PTP to people in such a large geographic area is beyond challenging. Also, ACT and PTP teams need to be able to provide more

assertive engagement, psychosocial rehab and peer support opportunities to foster the right interpersonal match.

- Measures can be used to assess a successful transition to the community but it is important to remember that recovery is nonlinear. Hospitalization is an expected part of nonlinear recovery. Success for some would be admission to the hospital at an earlier point requiring shorter stays.

Close B. Transitional Needs of Patients are effectively Met

Funds be shifted from Dorothea Dix to pay for needed transitional programming and:

- Transition plans. A transition plan must be developed for each long-stay and multiple admission patient. A community support plan that is developed by a team composed of the resident of DDPC, their family or other natural supports, an advocate or chosen representative, and assigned clinicians must be part of the transition plan. These teams should model those described on page 2, Toward Recovery and Hope, Allegheny Health Choices.
- Peer and Family mentors. All transition plans should include the assignment of a community mentor (either paid, or a volunteer) who can assist people to transition successfully and to offer support during non-traditional hours. These mentors need to be adequately trained.
- Advocacy. Transitions can be difficult, particularly when resources are scarce. People can fall through the cracks, be placed only because a placement exists, even if that placement does not meet their needs or does not reflect their choice. For this reason, we recommend that an advocate be a part of all transition planning.
- Medication. Continuity of stabilizing medications must be insured between the hospital and the community.
- Case Management. Case managers who are mobile and involved in supporting recovery are an essential part of community life, and the foundation of the consent decree. They must be assigned in a timely fashion, have appropriate training, be mobile, and be part of transitional programming.
- Progressive Treatment Program. The PTP program in northern Maine is currently based on re-admission to DDPC. The subcommittee recognizes that the PTP program continues to be un-evaluated and that outpatient commitment (Maine's version is PTP) remains divisive, so much so, that legislation that was introduced last year relative to PTP in Maine was carried forward. One of the provisions of the 2009 statute governing PTP was a requirement that DHHS evaluate the program in terms of its effectiveness and this has not been done. Nonetheless, at this moment in time, should DDPC close, there would need to be a decision about what to do with the current program participants. The subcommittee makes this recommendation without taking a position on the value or lack thereof, of Maine's PTP program.
- Gatekeeper. Acadia should be responsible for coordinating the use of inpatient psychiatric beds in northern Maine, in the same way that Spring Harbor coordinates admission in southern Maine.
- Forensic needs. There has been long-standing difficulty for northern Maine jails to obtain inpatient beds for inmates who have been deemed to need it. The closing of DDPC, which has provided a place for forensic admissions when Riverview cannot, will exacerbate an existing problem. The transition plan between Acadia and DDPC must address capacity for inmate hospitalization.

Keep Open C

C. The Provision of Essential Community Living Supports: housing, vocational and non-vocational involvements and health care:

1) Housing:
   - Most patients have to be talked into going to a Private Non-Medical Institute (PNMI), more commonly referred to as a group home. The subcommittee recommends that a third of the existing PNMIs be converted into supervised and supported apartments. This housing model allows people to have their own independent space, keep more of their

income, receive support on as needed basis as opposed to having to live with a group of people and be with staff 24 hours per day. This model of care is also more successful with many of the younger male population who are rowdy and often reactive to others in close quarters. Trained peer specialists in some of the supported apartment programs are recommended. In one apartment program the night receptionist is not a mental health provider and is able to provide support to people who may need someone to talk to in the middle of the night.

- The Department may want to consider requesting that Eastern Maine Development Corporation, Maine State Housing, and city governments inform them regarding the availability of housing that might be utilized in the same fashion as Waterworks, the apartment complex that has very successfully served many people with SPMI who otherwise would have had to reside in more restrictive care or be discharged to a situation putting them, and perhaps others, in jeopardy.
- The subcommittee also recommends that PNMIs make it a priority to locate in one floor buildings as many of the psychiatric patients that require that level of care also have medical issues that necessitate living on one floor.
- Currently, there are many mixed messages regarding the requirements of people who can live in a PNMI. The expectation of having to meet rehabilitation goals and move on to independent living in order to be accepted into the PNMI is inconsistent. The subcommittee recommends that services be provided according to functional levels as opposed to diagnoses and the PNMI's current milieu.
- DDPC will continue to provide Social Work, Psychiatric and Occupational Therapy assessments, progress reports, and recommendations to community providers upon discharge. The information will match the performance indicator domains measuring both the hospital's and community agencies performance in engaging the patient/client in meaningful and productive recovery plans.

2) Vocational: Historically, Region III has not received a proportionate share of mental health resources. Consideration needs to be given to the provision of a Club House for at least the Bangor area.

3) Non-vocational: Loneliness is a common characteristic of people with chronic mental illness. They are frequently rejected by family and friends and have little opportunity to form healthy relationships. Ideally, individuals of all functional levels and avenues of recovery will be welcomed at a local Club House/Peer Center. The feeling of belonging and peers modeling their experiences will support them in moving forward. Additionally, not everyone wants or needs group non-vocational involvement; providers and peers need to work with people individually to support their integration into the fabric of their chosen community using the recovery domains as a guide. Expect community providers and peers to be proactive and persistent in their efforts. "Never Give Up" needs to be the motto in delivering services to people with SPMI.

Close C.: The Provision of Essential Community Living Supports: housing, vocational and non-vocational involvements and health care:

- ACT. The subcommittee recommends at least one additional ACT team and an assessment of ACT team availability in northern Maine. These teams must have full fidelity to the model in terms of 24-7 availability and range of staff (i.e. psychiatry, substance abuse, vocational, etc.) Although the subcommittee recognizes that some teams may have full fidelity to the ACT model, there are others that may not, or may not be able to meet all standards because of funding. Changes in how ACT teams bill, rate reductions, and other policy issues have affected, in some cases, fidelity to the model and must be addressed. A rate should be developed that pays for ACT

service delivery that has fidelity. ACT teams must have forensic capacity. The state must clearly articulate ACT fidelity standards and create measures to evaluate adherence to them.

- Supported housing. The DDPC area currently offers a full range of supportive housing options, but funding, staffing, and non-integrative philosophies and licensing standards can hinder the delivery of services to those with complex needs. The subcommittee recommends that DHHS create tiered rates for housing providers. An enhanced rate should be provided to housing service providers who (1) offer integrated care which includes accommodations and treatment for people who have co-occurring substance use disorders and policies that allow for relapse to the use of substances, (2) include peer, family, and mentoring support services in their programming as mechanisms to support recovery and reduce reliance on more costly interventions, and (3) offer graduated options for increasing supports or decreasing supports as needed and based on recovery status. Supported housing must continue to include a full mix of options: independent living with case management and on-site staff at a variety of levels. There are housing models that cost less by working with local landlords to rent to patients and that use peers to provide support in the home (Oxford House model). These models should be pursued. In addition, the group wants to highlight the crucial importance of housing. There is research that shows people who have adequate housing, with an emphasis on adequate, fare better, use fewer services, and enter institutional care less often.
- Peer and Family Support. People with mental illness and their families need support. Peer support and recovery centers, skill building groups, and family supports must be available. There are areas of northern Maine where these services are not available. Peers that are located in emergency rooms have been shown to reduce admissions. Peer centers must offer skill building, vocational, and social supports. They must be funded so that they can offer these services, particularly those that help people return to work or to volunteer jobs. There must be more than one model of peer support available and, if the state is to insist that all peer service providers follow a single model, training and supervision for that model must be readily available and at low to no cost. Families must be linked with family support organizations that can assist them to cope with the illness in their family and identify and obtain assistance when something is going poorly. 65% of the 60 patients leaving DDPC are released to a family setting. If families are to be "residential service providers", they need support to do so. Peer and family programs constitute less than 1% of spending – it is recommended that spending allocations reflect their value as a significant contributor to recovery and reduced use of inpatient care.
- Crisis. The committee recognizes that there is a current process underway that creates HCCs, and creates a two tiered payment system and single call center approach to the delivery of crisis services. The committee recommends that the Commissioner examine the existing re-organization that is underway, how it is progressing, and clearly articulate in measurable terms, the expectations for outcomes connected to the delivery of crisis services, including prevention and for lack of a better term "step down" and "step up" crisis services that help keep people out of the hospital and help them transition out of the hospital. The current crisis reorganization does not include responding to the needs of families, and this, too, must be part of any system review and modification.
- Vocational support. 99% of people with serious and persistent mental illness are unemployed. The system itself creates barriers to employment (i.e., loss of MaineCare, billing structures, etc.). There are a variety of models that are evidence-based and help people return to work. The club house is one model and it should be expanded. The outcome measures and MaineCare reform changes that are recommended earlier in this report, must include a vocational measure and disincentives for work must be removed.
- Advocacy. Maine and the nation have recognized the need for advocacy. Each state has a protection and advocacy organization, a body of laws and rules that define patient rights, and mechanisms to protect the health, safety, and quality of care provided to people with mental illness and other disabilities. The committee sees adequate advocacy for peers and families as a

crucial part of any system of care and recommends that it continue in its current capacity for peers and be strengthened for families.

Keep Open D

D. Support for Other Critical Community-based Resources and Treatment Services:

- The DDPC Dental clinic is a community service housed and supported by the hospital. It is vital that these specialized services continue as most of the clients are unable to receive the specialized care from community providers who are not equipped to treat the special needs of people with developmental disabilities and severe and persistent mental illness.
- Outpatient services will need to accommodate the following issues: the transition of several DDPC outpatients to community services is currently underway as part of the efforts to have people receive services in the community whenever possible. DDPC is a safety net service and would like to see all patients successfully treated in the community. In order for people to be successfully transitioned, the community providers will need to make greater allowances for no-shows, provide engagement processes for people who are very paranoid about using other providers, maintain as much consistency as possible with providers delivering the services, providing support with pharmacy assistance needs, and navigating insurance issues. Given the lack of psychiatric resources, it appears likely that psychiatrists will need to consult with their clients' primary care providers to a greater extent in the future, rather than maintaining full responsibility for medication management. An NN work group member reports that in the current funding structure, adding more providers to an agency creates a financial loss. In order to accommodate the needs of the clients, the committee discussed the need for flexible grant dollars that could provide the necessary initial support required to engage clients and help them become receptive to primary and psychiatric care in a new setting.
- Currently DDPC provides the only true DBT treatment, an evidence-based practice that outpatient members state has decreased, and for some, eliminated hospitalizations. The program provides flexibility so that people are not arbitrarily dismissed if they miss sessions.

Close D Support for Other Critical Community-based Resources and Treatment Services:
The successful closing of DDPC will depend on access to critical community-based resources and treatment. As noted earlier, Maine has developed and implemented the array of resources and treatments that are needed. There are gaps in services (i.e., areas where there are no ACT teams, no Peer Centers, for example). The section above recommends the expansion of services as well as pilots to test improved delivery of preventive care. The subcommittee cannot stress enough that it is policy and funding that forces practice change. Service providers will offer treatments when they are required to do so and when they receive adequate financial incentives to do so. Currently, DDPC provides a crucial safety net for northern Maine because there are financial incentives for the state to provide this level of care and there are regulatory barriers for community organizations to do so. We must assure that intensive, home-based treatment and outreach follow those patients who need it when they leave the hospital. DDPC has filled a safety net service for over 100 years. Once it is gone, that safety net service must be available. The committee cannot state strongly enough that closing DDPC without consideration of the evidence about what leads to readmission and addressing those factors will be folly. The recommendations in this report ask providers to track different outcomes (work, completion of treatment, social supports, reduced use of crisis care, etc.) That is just one part of assuring change. By asking them to track different outcomes – delivery of care will follow. The recommendations here also suggest that financial incentives be used to encourage practice change. That, too, is part of assuring change. ACT team rates must support fidelity to the model so that participants receive that level of intensive care. Agencies that provide integrated care should receive enhanced rates because integrated care produces better outcomes. In short, the critical community based resources and treatment that are necessary to support recovery and reduce use of hospital-based care must be supported by policy and by funding.

Keep Open E

E. Integrating all health care:

- DDPC patients are getting integrated health care by having their medical and psychiatric illnesses addressed at admission, during their inpatient stay, at discharge, as well as quality hand off information is given to their community providers. The doctors at DDPC take the time to talk to other providers.
- In the community the medical home for the safety net population becomes the mental health service provider - not the PCP. The medical provider should be on site at the local community mental health center so that when the person shows up for mental health services and also has a medical issue he/she can walk down the hall to the medical provider, or vice versa. The only local provider demonstrating this model is Penobscot Community Health Center. At the Summer Street clinic, the provider stops what they are doing (psychiatrist or medical doctor) to engage the client demonstrating the kind of flexibility required to effectively treat people with SPMI. This model is our recommendation for satisfying integrated care needs. The medical record needs to be an open medical record to be able to communicate between the medical provider and the psychiatrist. Sharing of information is hindered by state regulations that impact continuity of care. If you do not have providers under one roof you at least need the intensive case manager to provide the old fashioned case management service; intensive outreach, hands on support, stay ahead of insurance changes, responsibility for linkages between all providers, support in a recovery focused plan.
- Currently the case management service has become more of a broker and other services that promote dependency are billed at a high cost to the state. The most effective way to begin integrated care is to start the services while in the hospital with a more aggressive case work model of care that ensures hands on support for the client and is accountable for the coordination of services and communication between providers.

Close E: <u>Integrating all healthcare</u>

Healthcare is siloed. Siloed care delivery is inefficient and ineffective. People with mental illness and substance use disorders need to have holistic care. Maine has made progress in integrating care – both in terms of integrating mental health and substance abuse treatment and integrating physical healthcare with behavioral healthcare. And, there are many types of integration; not one model fits all. Integration must occur and a variety of models must be supported. But many barriers remain – those that are based in funding streams and over-regulation and those that are based in training and practice. Practice is strongly influenced by payment and regulation. The committee recommends:

- Any provider agency that is accredited by an external organization (JAC, CARF) be exempt from obtaining state licensure;
- Offer a single integrated license and enhanced payment rates for providers who obtain a single license and provide mental health, substance abuse, and physical health services within a single integrated practice;
- Create payment reform pilots and financial incentives to integrate care;
- Encourage a variety of evidence-based, best-practice, and innovative models.

Keep Open F

F. Adequate capacity exists locally for inpatient hospitalizations:

Keep DDPC open to continue providing specialized care to people with severe and persistent mental illness.

- A poll of state emergency rooms would likely indicate a need for more psychiatric beds, not less.
- When DDPC had over 60 patients a day they continued to run a wait list most of the time. Currently, with a decrease in census, there are patient referrals from emergency rooms and other hospitals whose needs cannot be met. Three months projected refusals would be 90 people, as we average 30 referrals a month. Where are those 90 people going? Perhaps the street, jail, home?

Are they violent? RPC is feeling the crunch of the DDPC downsizing as they are now getting calls from emergency rooms that they usually do not get.

- DDPC can demonstrate an economy of care by continuing to provide evidence based care and enhance recovery. Staff at DDPC work with people who are so ill that they are frightening to some or considered too complex for routine treatment. If the hospital closes, DDPC's specialized skilled labor force will no longer be able to provide care to the people that need it.
- RPC cannot absorb the overflow due to the increased demands from the Department of Corrections which is currently requesting that RPC provide an entire unit to treat their population. RPC does not anticipate a release to a community residence of any of the current NCRs for another year. For the past 10 years there has been an average of 5 new NCRs per year. The demand for RPC beds for Title 15 forensic evaluations continues with 40 admissions from January to July 2011. Of the 44 forensic beds at RPC, 33 are not going to be available for the foreseeable future due to the status of the clients occupying them.
- The subcommittee recommends consideration be given to an examination of the forensic population and the role of the 2 state hospitals. One consideration is for DDPC to provide a forensic unit to relieve the bottleneck at RPC so that they can maintain an adequate amount of civil beds for their catchment area.
- Another area for study is creation of treatment and housing on RPC grounds or in the community for NCR clients that may not need hospital level care, but may be appropriate for community programs.
- The 2009 BGS Master Plan calls for a need of 75 beds, especially with the growing number of forensic patients. There is no other inpatient provider north of Augusta skilled in the provision of inpatient psychiatric treatment to people with SPMI.
- PTP clients need to be able to be hospitalized in a state psychiatric facility. If DDPC closes, all PTP clients will be forced to live in a 20 mile radius of Augusta.
- Acute stays at private hospitals are not long enough to treat many people with SPMI.

Close F: Adequate capacity exists locally for inpatient hospitalizations

The committee recommends that the assessment described later in this report estimate how many of the 44 adult inpatient psychiatric beds are needed and make them available. In addition, the committee recommends (l) that the state make available to the IMDs, the legal assistance they need to help them utilize existing involuntary admission and treatment laws, and (2) require that the IMDs provide, when clinically necessary, the same level of care and longer-term stabilization that is currently offered by DDPC, including the array of treatment options that they offer, and (3) that the state articulate standards and outcome measures that govern the provision of inpatient services, that include recovery principles, peer and family engagement, and active discharge planning, and that are required to access and continue to maintain DSH and other state funds.

Keep Open G

G. Adequate Essential Community Care Services to Support Outcomes:

- A redesign of the community system can achieve greater efficiencies and provide more effective recovery based services;
- Reduce the number of PNMIs by at least a third and use the financial savings to provide client preferred and more economical supervised and supported housing. In addition to qualified staff, the use of peers as paid staff and peer support should be part of the new service system design;
- Eliminate the duplication of community support services by going back to the 'old fashioned' case management model that allows billable hours for engagement, support, attendance at psychiatric and medical appointments, skill building, and linkage to vocational and educational pursuits. Consideration should be given on the best way to incorporate and support peer case management models in community support services.

- Consider contracting with a single mental health service center in each county reducing administrative costs with multiple providers. This would create greater efficiencies and, if performance based contracting was appropriately designed, aid in the goal of integrated care and accountability.
- By eliminating the duplication of community support services funding should be saved that can be put toward evidence based practices such as ACT and DBT.
- By eliminating duplication, some of the community support services that foster dependence (such as an over-use of Daily support and Living Skills) can be replaced with educational, vocational, and high quality case management.
- Consider utilizing a functional level when authorizing services as opposed to diagnoses.

Close G: Adequate Essential Community Care Services to Support Outcomes
Much of this report has already addressed the essential services that are needed to support recovery-based outcomes and the transitional needs of people served at DDPC. These include access to the array of services articulated earlier. The report has also addressed the need to modify the outcome measures that are collected to more closely reflect recovery outcomes and less on consent decree requirements. The subcommittee believes it is the role and responsibility of the DHHS to clearly articulate the outcomes that they expect to be produced and to hold contract agents accountable relative to those outcomes.

Keep Open H
H. Community and Family Education is Optimized to Support Integration:
- Currently all DDPC patients receive information on the Consumer Advisory Council and NAMI upon admission.
- Local NAMI members have expressed an interest in participating in DDPC programs to help support the patients.
- The DDPC Rehabilitation Department is working with the Office of Adult Mental Health Community Partnerships to train DDPC staff in peer support and recovery based treatment.
- The location of the facility is important as the families need to be close to where their family member is hospitalized.
- The DDPC Admissions Service is always available to the community and family members for resource guidance and to consult for all patients discharged from DDPC or for those seeking admission.
- The DDPC Social Work Department conducts At Risk discharge meetings to create tighter community plans and work in a proactive manner to help prevent re-hospitalizations.
- DDPC's new Community Center Program will be offering a family support group.

Close H: Community and Family Education is Optimized to Support Integration
- DHHS should undertake a comprehensive and ongoing educational program to assist all stakeholders to understand confidentiality and guide their practice to improve continuity of care. Regulations and licensing requirements must insist on improved understanding and incentives for improved practice must be developed and implemented.
- DHHS should review funding for peer and family supports and shift funding to those programs.
- Maintain the existing ride along program for law enforcement and Crisis Intervention Teams (CIT) for police departments and continue to improve northern Maine's pre-booking diversion options. Educate the community about these options.

Keep Open I
I. Delivery of High-quality, Efficient Service is Achieved
Maine is currently ranked as the highest cost per capita community mental health expenditures. The subcommittee believes that a system redesign does not necessarily require more funding. The department may want to consider adopting the Substance Abuse and Mental Health Administration's Federal Action

Agenda; strategies for planning, leadership, financing, and service development guided by the following five principles:

- Focus on the desired outcomes of mental health care to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and the delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Ensure that The New Freedom Commission on Mental Health's recommendations promote innovation, flexibility, and accountability
- At DDPC treatment will continue to be evidenced based and recovery oriented in order to provide the most effective and efficient inpatient treatment. We will remain committed to revising our practices as research becomes available and as fiscal challenges arise at all levels of government. Current and projected treatments include but are not limited to:
  - Dialectical Behavior Therapy
  - Acceptance and Commitment Therapy
  - Cognitive Behavioral Therapy
  - Wellness Recovery Action Planning
  - Motivational Interviewing
  - Pre-vocational and Vocational Services
  - Sensory Integration
  - Personal Futures Planning (Dr. Beth Mount)

- Additionally, a new centralized treatment and activity center will be developed based on the concepts of psychosocial rehabilitation, recovery oriented care and ICCD Clubhouse Models (as applicable to inpatient settings). The center (to be named by the patients) will provide group and individual treatment as well as diversion and social opportunities for all patients, available 12 hours each day. The center will offer treatment and activities appropriate and beneficial to individuals on all levels of the stability and recovery continuum. The goal of services offered is to promote easy transition into community settings such as: club houses, support groups, neighbor's kitchen, local adult enrichment classes and area career centers. Patients will play an integral role in determining weekly offerings and in finding presenters (staff, volunteers, patients).

Close I: Delivery of High-quality, Efficient Service is Achieved

Existing regulations and funding streams contribute to ineffective care. Some policies discourage cost containment by penalizing organizations with unspent funds, requiring them to return those funds, and reducing future allocations. Fee for service encourages the delivery of more service, rather than the delivery of effective service. Service delivery is not always based on individual assessment of client needs, but on what services are available. People living in York County can be hospitalized in Aroostook County because of bed shortages. In addition, many of the outcome measures that we use and the data that we collect are based on consent decree requirements and not on patient recovery. Changes in how we evaluate effectiveness and the ability to use that data to fund what works are needed. As noted earlier, the subcommittee makes the assumption that closing DDPC presents an opportunity to realign the system of care in northern Maine so that more efficient and effective services can be delivered to those who need them. The Institute for Healthcare Improvement (IHI) calls for new designs to be developed to simultaneously accomplish three critical objectives, or what is called: *The Triple Aim*: improve the health of the population, enhance the patient and family experience of care (including quality, access, and

reliability), and reduce, or at least control, the per capita cost of care. The recommendations of this subcommittee are designed based on those aims.

Dorothea Dix Working Group (Part NN)

As we discussed, I have been trying to develop a conceptual strategy to allow the closure of the Dorothea Dix Psychiatric Hospital while at the same time addressing certain important psychiatric care delivery issues, as well as operating within the required $2,500,000 reduction of Dorothea Dix operating costs included in the current budget.

This is a tall order.

I have been concerned that our Working Group meetings have neglected (to this point, at least) to focus on the numbers; that is, have not begun to craft, in concrete terms, a plan to redistribute patients from Dorothea Dix to other facilities, or to determine how the new structure would be funded given State and Federal regulatory and financial constraints.

The following paper is a 20,000-foot view of a possible direction for the Group's consideration. I would appreciate and value your input:

The Physical facility:

A fundamental concern is the fact that the Dorothea Dix Psychiatric Center is the most expensive of the four hospitals to operate:

Dorothea Dix	$1373 /patient day
Acadia	$1145
Spring Harbor	$1086
Riverview	$1006

In addition, despite certain renovations, the Dorothea Dix physical plant (e.g., the massive building) is old, inefficiently configured and extremely difficult to heat. According to the Bureau of General Services, the savings from closing and decommissioning the building *entirely* would save approximately $1,100,000 in operation and maintenance expenditures.

Moreover, it is well-known that an older building such as the Dorothea Dix facility will deteriorate rapidly without minimal heat and maintenance, thereby rendering it useless within a very few years, severely reducing its value to the State either as a site for future renovation and use, or for sale to a potential purchaser from the private sector. One cost estimate for minimal heating of the facility sufficient to retard such deterioration is roughly one-third of the current operations and maintenance cost, or about $400,000 per year.

In-Patient Capacity:

A significant factor in any proposal to close the Dorothea Dix Psychiatric Center is the obligation to insure the continued care at the appropriate level for current Dorothea Dix patients. This can only be done by transferring them, in some fashion, to the other existing facilities. Currently, the four hospitals are licensed and occupied as follows:

	Licensed Capacity	**Current Occupancy**
Dorothea Dix	64	61
Acadia	100	70
Spring Harbor	100	88
Riverview	92	92
	====	====
TOTAL	356	311

Removing the Dorothea Dix Psychiatric Center from the equation, the available licensed in-patient capacity is reduced to 292 beds, causing a shortfall of 19 beds, assuming that the three remaining facilities operate at full capacity. Obviously, the true need is for some additional capacity greater than 19, since at any given time the demand for beds could easily exceed the current occupancy of 311 for at least a short period of time.

Additionally, closure of Dorothea Dix will require that certain patients needing longer-term and/or acute care will have to be housed at Riverview. This makes sense given that the Riverview facility is particularly well-suited to managing certain complex and demanding cases, as well as housing Maine's forensic patients.

Residential Housing at Dorothea Dix:

The Riverview Psychiatric Center currently houses some 20 – 24 patients (more or less) that live and sleep at the facility but are free to work, attend class or otherwise participate within the Greater Augusta community during the day. These patients are candidates for relocation to an appropriate residential facility, or group home, so long as the State requirements for monitoring and supervision are met. Such relocation is problematic in the Greater Augusta area since the market for suitable residential facilities is now saturated.

One possible use for the Dorothea Dix facility would be to establish a supervised residential housing unit to occupy one or more of the wings currently used by the hospital. Some patient rooms could probably be used with little modification, essentially converting them to small apartments (possibly by joining adjacent rooms into a single unit in some cases). The advantage would be safe housing with the possibility of supervision on a campus that is attractive, accessible and familiar to at least some of the probable residents. Making such a residential facility available would relieve pressure on neighborhoods resistant to the group home concept and would expand the availability of suitable housing.

The potential exists for at least 60 such apartment units at the Dorothea Dix facility, and probably more, given available funds and demand. Depending upon the model adopted, the resulting facility operations and maintenance could be significantly less than the current cost of $1,100,000 (possibly as low as $650,000, yielding an operations and maintenance savings of about $450,000). This would depend upon a wing (or wings) in operation with all services (i.e., heat, electricity) for housing; and the remainder operating in minimal maintenance mode.

Secure Management of Violent Patients:

Another collateral issue with some bearing on a comprehensive practical solution is the necessity to manage a number of violent forensic patients. Some are held at Riverview; others are temporarily held in county jails throughout the state. Many are initially admitted to non-psychiatric medical facilities and are then transferred to Riverview as space allows. This particular class of patient often poses a significant threat to the Riverview staff, and there have been any number of incidents during which staff has been assaulted, even injured, while trying to control these patients. It is also true that county jail personnel cannot be expected to understand the psychiatric issues, indicated treatment regimens or patient management techniques of the disparate population that regularly end up in jail. It is true that in many cases, the jail experience often exacerbates the symptoms and complicates treatment outcomes. Clearly it is desirable to remove these persons from the jail environment as quickly as possible to a facility where they can be stabilized and where violent or antisocial behavior will not pose a threat to medical and other hospital staff, or to other psychiatric patients.

Several states provide for a psychiatric ward co-located with a correctional facility, whereby staff specially trained to restrain violent patients in as humane and non-threatening a manner as possible can assist medical and psychiatric professionals. Such an arrangement in Maine would free the Riverview staff from this threat, allowing them an enhanced capability to treat the non-violent patients without disruption. It would also provide a facility for law enforcement officials and non-psychiatric medical facilities and emergency rooms (with appropriate review) to assign violent patients rather than to rely upon the county jail system.

It should be possible to establish such a facility at the Maine State Prison complex in Warren. Specifically, there is now available a 50-bed unit at the so-called "Super Max" facility, recently depopulated but entirely serviceable.

For this idea to be implemented, certain changes to existing Maine law would be needed, specifically addressing the proposed co-location of a new satellite unit of the Riverview Psychiatric Center (as I envision it) at the Prison site. This change would clearly create and define the Satellite Center as 'hospital jurisdiction' for purposes of treatment, as opposed to 'prison jurisdiction' in the sense that patients would not be considered as inmates of the prison, but rather, as hospital patients. This would allow the administration of medical care, medicine, psychiatric treatment, etc., in a secure environment.

Possible Realignment Strategy:

The following is a conceptual outline of how such a plan might look if implemented:

	Now	Realignment
Dorothea Dix Psychiatric Center	61	0
Acadia Hospital	70	97
Spring Harbor Hospital	88	97
Riverview Psychiatric Center	92	89
Dorothea Dix Residential Facility	0	44 (24 + 20) [a]
Riverview Satellite Facility at the Prison	0	20 (8 + 12) [b]

This pattern assumes the following:

- Approximately 24 'residential' patients are relocated from Riverview to apartments at the new Dorothea Dix Residential facility (or, of course, other 'mix and match' assignments can be made, as determined to be appropriate for the individuals, the result being a net shift of 24 'residential' beds from Riverview to apartments at the new Dorothea Dix Residential Facility (See Note [a] above);

- An additional 20 apartments (more or less) are also available at the new Dorothea Dix Residential Facility for use by other persons with psychiatric histories, as needed (See Note [a] above);

- Eight violent patients are relocated from Riverview to the new Riverview Satellite Facility at the Maine State Prison (See Note [b] above);

- Space is provided for as many as 12 transfers of violent patients from the three remaining Psychiatric Centers, county jails or from non-psychiatric medical facilities (See Note [b] above);

- Acadia expands its occupancy from 70 to 97, leaving approximately three beds for expected occupancy fluctuations;

- Spring Harbor expands its occupancy from 88 to 97, leaving approximately three beds for expected occupancy fluctuations;

- Riverview Psychiatric Center reduces its occupancy from 92 to 89, leaving approximately three beds for expected occupancy fluctuations. Beds released from the transfer of approximately 24 low-risk residential patients to the new Dorothea Dix Residential Facility will initially be used primarily for Dorothea Dix Psychiatric Center patients that are deemed to benefit from longer-term care patterned after the Dorothea Dix treatment model. Nonviolent forensic patients will also be housed at Riverview.

Scoring:

Savings and costs will have to be carefully determined by recalculating the figures against known reimbursement formulas, Federal and State regulations, etc., to assure that all costs are borne appropriately and that costs of operating a Riverview Satellite Psychiatric Center in Warren, and operating a Dorothea Dix Residential Facility are, indeed, cost-effective options. There is a high level of confidence that significant savings can be achieved by terminating the hospital operations of the Dorothea Dix Psychiatric center; and that there will be at least $450,000 of savings in operations and maintenance even with the implementation of a residential facility.

NOTE: These figures will have to be calculated and reviewed by DHHS and Budget staff before these assumptions can be validated.

A small group of DHHS staff met on October 27, 2011 to comment of the funding structures involved based on the proposals included in the DAFS report. The ideas included are good but we are not sure there would be any General Fund savings. The financial information included on the first page is based on fiscal year 2010. DDPC has submitted a proposal to the Commissioner to be included in the supplemental budget outlining our plan to reduce the General Fund budget by $2.5M. This results in a reduction of DSH funding as well. If accepted by the Legislature, the FY13 per patient per day cost for DDPC should be in the same range as the other 3 IMDs. That $2.5M has already been booked by the Legislature. The savings cannot be counted again. This will leave the DDPC FY13 General Fund budget at approximately $10M. Savings from closure and any other proposal would have this as a starting point for General Fund.

Shifting some inpatient capacity to Acadia and Spring Harbor is an option. We would need to amend the Medicaid State Plan to enable us to pay Disproportionate Share funding to the private IMDs, with Riverview still being the first priority. The current rate structure for Acadia and Spring Harbor would have to be reviewed and changed to accommodate the new process. Under the Affordable Care Act, there is also a DSH Demonstration Waiver that is being pursued with the private hospitals (at least Spring Harbor). We would need to make sure we are not double counting the same beds here as they are proposing to use somewhere else. Acadia and Spring Harbor are currently paid on a percentage of charges. Given the added capacity, increased acuity and length of stay, Audit concerned that the costs could exceed the funding available. Payments to Acadia and Spring Harbor would be General Fund (from the remaining $10M identified) and DSH.

Residential Housing at Dorothea Dix: In order to develop residential housing at DDPC, there would be some significant costs associated with construction and abatement (asbestos and lead paint). When renovating (reconstructing) the facility will no longer be "grandfathered" on current code requirements, including ADA and egress. Whether the facility would continue to be state property or be sold and run by a private entity should also be considered. If the property remains state property (even if run by a private company) clients living in the facility would not be able to collect SSI or SSDI. We currently have this problem with clients who live in PNMIs on the AMHI campus. The Social Security Administration will not pay their benefits while they are living on a state campus. That leaves the client with no funds. If the property were sold to a private company the SSI issue would not be a problem. Unless there is some grant funding available, construction costs would be General Fund. Given the current flux of the PNMI system, I am not sure how we would propose to fund the ongoing costs of residential housing. Medicaid is clear that they do not fund room and board.

Secure management of violent patients: I have reached out to the Central New York Psychiatric Center, Dixon Psychiatric Unit, and the State of California's Vacaville Psychiatric Program and Salinas Valley

Psychiatric Program. I've also contacted the American Correctional Association and National Association of State Budget Officers regarding the potential funding of psychiatric units. The State of Texas had their funding structure on their website. Their Department of Criminal Justice is funded primarily (94%) with General Fund money ($3 Billion annual budget for the Department). The remainder of their funding was revenues from prison industries and educational programs. The Director of Administrative Services for the Central New York Psychiatric Center responded to my inquiring and indicated that they are also funded with 100% General Fund money. I suspect that will be the case everywhere. According to our auditors, DSH protocols state that "the costs incurred for individuals for which the State or local government is responsible on a basis other than indigency should not be included in calculating the hospital specific limit. This would include costs for care for which the State makes payments on the basis of status as State employees, prisoners or other wards of the State." I also have a copy of a CMS letter that states: "Inmates of correctional facilities are wards of the State. As such, the State is obligated to cover their basic economic needs (food, housing, and medical care) because failure to do so would be in violation of the eighth amendment of the Constitution. Therefore, because these individuals have a source of third party coverage, they are not uninsured, and the State cannot make DSH payments to cover the costs of their care." If the people in this satellite unit were not prison inmates, we would be able to claim the expenses as part of our DSH calculations. Setting up a satellite unit of the hospital would also subject that area to the review of The Joint Commission as part of our hospital accreditation.

Present at the meeting:
Chris Pierce, DHHS Deputy Commissioner
Guy Cousins - Director OSA & OAMH
Colin Lindley - Director Medicaid Finance
Sue MacKenzie - DHHS Audit
George Cooper - DHHS Director Program and Fiscal Coordination
Jenny Boyden - RPC/DDPC