The Maine Long-Term Care Ombudsman program

P.O. Box 128 • Augusta, Maine 04332
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INCLUDE VITAL HOME CARE COORDINATION SERVICES IN THE BUDGET

HOME CARE COORDINATION SERVICES

Providing elderly and disabled Maine citizens the choice to stay in their homes.

One of the key themes that emerged from the Blaine House Conference on Aging was that seniors want to stay in their homes for as long as they can. Home care coordination services make that choice possible and answer the question "what do I do now?" when help is needed.

Elder Independence of Maine (EIM) connects 2,950 elderly and disabled consumers throughout the state with home care services.

1/3 of these consumers are eligible for nursing facility services but choose to remain in their homes.

Elder Independence of Maine (EIM) has been nationally recognized for achieving quality outcomes and cost-effective home care coordination services.

No rate increase means further cuts to staff, unmanageable caseloads and the beginning of the dismantling of the quality system EIM has established.

Funding needed: Approximately $575,000 for each of the fiscal years 2007-08 and 2008-09.

-More-

MEALS ON WHEELS

A vital source of good nutrition and social contact.

Volunteer drivers for Meals on Wheels provide vital food and social contact to Maine's seniors and disabled in need.

The delivered food provides good nutrition and, for many isolated seniors, the Meals on Wheels delivery provides their only social contact.

Unfortunately, rising motor fuel prices have increased the travel cost for the volunteer drivers.

To ensure the continued viability of the Meals on Wheels program, funds are needed to reimburse the Meals on Wheels volunteer drivers for increased travel expenses resulting from increased motor fuel costs.

Funding needed: $75,000 in fiscal year 2007-08 and $75,000 in fiscal year 2008-09.

VOLUNTEER MEDICAL RIDE NETWORK

Providing access to essential health care services.

This network provides transportation for seniors who have no other resource to travel to essential medical appointments (e.g., kidney dialysis treatment, radiation and/or chemo treatment or related follow-up for cancer and cardiac care).

For example, the Aroostook Agency on Aging currently has 57 volunteer medical ride drivers. Many of these volunteers are older people relying on a fixed income. In August 2005 there were 128 volunteer drivers; however, **in the aftermath of the gasoline price spike following Hurricane Katrina, the number reduced to 74 drivers by November 2005.**

Unfortunately, with continued high motor fuel costs, the number of volunteer drivers has dwindled.

Assuring mileage reimbursement would make it easier to recruit much-needed volunteer drivers and expand the network.

Funding needed: A one-time appropriation of $50,000 in fiscal year 2007-08 for direct grants to local area agencies on aging to support the volunteer medical ride network.

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VERNON L. MOORE

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March 17, 2007

Senator Margaret Rotundo, Chair
Appropriations and Financial Affairs Committee
446 College Street
Lewiston, ME 04240

Dear Senator Rotundo:

I am writing to you again with two purposes. First, I continue to ask you to not recommend nor vote for cuts to community mental health funding. Second, I offer you a series of questions to raise with representatives of the Department of Health and Human Services who may testify or present material to your committee or you about proposed cuts to the state's funding for community mental health services for people with chronic mental illness.

I have learned that members of the Appropriations and Financial Affairs Committee may have been led to believe several assumptions that are contrary to the reality of community mental health clients, board members and staff. If this is the case, I ask that you lead the Committee to separate truth from assumptions. Actions taken by your committee based on these assumptions will prove harmful to thousands of chronically mentally ill citizens of Maine and their families and communities. I also have learned that members of the Committee may not pleased with proposed compromises that have been offered. I share their displeasure with the "compromises". However, my displeasure may be for different reasons than members of the Committee. I think the proposed compromises and any cuts to community mental health funding are insensitive, mean spirited, unneeded and unwise. They are not compromises. They are veiled threats and forced choices that give the allusion of compromise. The problems that will ensue from any cuts to community mental health funding will far exceed in cost any "savings" realized from the cuts.

Assumptions and Questions to Ask:

Tough choices have to be made and we all must share in the burden. Please ask the questions: What is the tough choice about which people have become so enamored? For whom is it a tough choice? Is it a tough choice for those who are calling for cuts to the budget? Will they suffer the way people with chronic mental illness will suffer? Will they risk losing their homes, their loved ones, their jobs, their freedom and safety and other rights? How much of the burden are "we" sharing? What other tough choices have been considered?

CEO and other community mental health salaries are excessive. Please ask for comprehensive data to support this assumption. Are industry standards being applied or are personal agenda driving this assumption? Please look at a wide distribution of salaries in the community mental health and not-for-profit sector and not just a few hand-picked salaries. Also look at the credentials, years of experience and scope of responsibility of those who are supposed to have excessive salaries.

Community mental health agencies are not efficient and have fat that can be trimmed. If you look, you will find that the assumptions that community mental health agencies are inefficient and there is room to cut overhead budgets are misguided if not mean spirited. Please ask for evidence to support these assumptions. Also ask for an accounting of all the non-funded or loss-leader services (social clubs, payee services, etc.) that are provided by community mental health agencies. Many of these services, which are very effective, are covered within overhead budgets.

A for-profit managed care agency can save the state money, make a profit for itself and not affect service delivery to Maine citizens with chronic mental illness. I ask you to request and encourage all other legislators to request a thorough analysis of what financial and social impacts the cuts to mental health funding will have on those with chronic mental illness and their families, friends and employers, and police departments, emergency rooms, hospitals in their communities and the state. Please request a base line of all mental health costs in the state and compare the base line to all costs for mental health services in the state one year after the proposed cuts are enacted. I propose this action as a mechanism to get data about the efficiency and effectiveness of the proposed cuts for you, the legislature and the citizens of Maine. The downside of waiting a year to measure the differences is that many of Maine's most vulnerable citizens will have suffered unnecessarily for an action that will not save money. The cuts will cost more due to the increase in hospitalizations, emergency services and demands on other state and community resources.

Rates for community mental health services are excessive and inconsistent within the state and with rates outside the state. I ask you to make sure and to encourage all other legislators to make sure the comparisons of rates are comparisons of apples to apples. Make sure the comparison rates, especially the low rates, you have been presented for Community Support, Psychiatry or Crisis services are paying for the same level of needed comprehensive services as the higher rates. Ask about supply of professional mental health providers, proximity of services, economy of scale, etc. I think you will find that the assumptions that rates are too high are misguided if not mean spirited.

I remain ready to further discuss all of the above issues with you. I also encourage you to seek input from others who have expertise in community mental health design, delivery and finance, especially those not employed by state agencies.

I close by asking you again to seek what is true and to not vote for any cuts to community mental health funding. To all of the people with chronic mental illness, their families and communities, you will show that you are willing to make the tough choice.

Sincerely,

Dr. Vernon L. Moore, Chair
Board of Directors
Counseling Services, Inc.

Maine Elder Issues Partnership

Secretariat: 207-729-5607 ElderIssues@GoodGroupDecisions.com

Distributed at the request of Representative James Campbell

Wednesday, February 28, 2007

Dear Legislator:

We are a diverse group of Maine organizations acting together to represent the interests of Maine's elderly citizens, and we are greatly concerned that the budget does not provide a rate increase for home care coordination services for long term care consumers served in the community. This marks the 2nd year in a row without such an increase. No rate increase means further cuts to staff and essentially the beginning of the dismantling of the current system. As you consider the budget, we urge you to address this critical issue.

As you may know, one of the key themes that emerged from the Blaine House Conference on Aging was that people want to be able to stay in their homes for as long as they possibly can. Home care coordination services play a key role in making that possible.

Elder Independence of Maine (EIM), working as part of Maine's Long Term Care System, connects people throughout Maine with important home care services. A division of SeniorsPlus, an area agency on aging, EIM has been nationally recognized for achieving quality outcomes by highly cost-effective means for coordinating the care consumers receive in their own homes rather than in a more costly, institutional setting. In fact, 1/3 of EIM's clients are at nursing facility level of care but can choose to safely stay at home instead. EIM provides daily care management services for over 3,000 consumers statewide. They coordinate the delivery of in-home services through a network of 200 contracted providers. EIM's care management system, built over ten years, gives Mainers a choice in determining their future.

<u>Without a rate increase for EIM</u>:

1. Current case loads of 100 would go higher, resulting in:
   - taking longer to return phone calls
   - less room for proactive work for consumers – such as anticipating issues
   - less collaboration with other entities involved in consumer care
   - consumers waiting longer for start of services

2. Quality oversight of the EIM Provider Network would be reduced:
   - EIM used to audit 20% of providers, now they audit 5%. Without a rate increase, this will be reduced further, allowing for only reacting to complaints, instead of ensuring that providers are abiding by program regulations.

3. It will be difficult, if not impossible, to maintain the level of service for those consumers who are nursing facility level of care, but choose to stay at home in their community. The

result would be a much greater chance of those consumers going to a nursing facility prematurely, leaving where they really want to be for a more expensive setting.

4. It will lead to a further dismantling of this managed-care blended care management system that has been built over ten years.

While EIM has served as a model over the years for the rest of the nation, we are now at a crucial point. Insufficient funding over the past four years has severely compromised the work of EIM. Given that, in addition to being the oldest state in the nation, Maine's population is aging faster than any other state's, this is not the time to allow home care coordination services to wither on the vine. Instead, we need to build on those efforts that have proven successful.

We are pleased to note that Rep. Campbell has introduced "An Act to Preserve Quality Home Care Coordination Services for Long Term Care Consumers Served in the Community". We support this legislative proposal which provides $518,415 for home care coordination services for consumers of the state funded home based care program. It also provides $57,064 in matching funds for home care coordination services for the MaineCare home care programs. This funding will help make EIM whole and continue the quality service Mainers depend upon.

As you consider the budget, please help us protect and strengthen a home care coordination system that answers the question, "what do I do now?" when help is needed.

Thank you for your attention to our request.

Sincerely,

Maine Elder Issues Partnership

The Maine Elder Issues Partnership is a partnership of Maine organizations concerned with advocating, educating, and communicating the needs of older Maine citizens.

This letter is written on behalf of the following member organizations (next page also):

- AARP
- ALDA-Maine
- Alpha One
- Community Concepts, Inc.
- Community Counseling Center
- Consumers for Affordable Health Care
- Disability Rights Center
- Eastern Agency on Aging
- Global Wellness and A Woman's Touch
- Home Care and Hospice Alliance of Maine
- Home Care for Maine
- Joint Advisory Committee on Select Services for Older Persons
- Keeping Seniors Home, a program of Western Maine Community Action
- Legal Services for the Elderly
- Maine Adult Day Services Association
- Maine Alzheimer's Association
- Maine Assisted Technology Program
- Maine Association of Area Agencies on Aging
- Maine Association of Retirees
- Maine Center for Economic Policy
- Maine Council of Senior Citizens
- Maine Equal Justice Partnership
- Maine Health Care Association
- MaineHealth's Partnership for Healthy Aging
- Maine Long-term Care Ombudsman Program
- Maine Personal Assistance Services Association (PASA)
- Maine State Nurses Association
- Maine Women's Lobby
- Mid-Coast Hospital
- Moose Ridge
- National Senior Service Corp (NSSC)
- Office of Elder Affairs, Portland Health and Human Services Department
- PROP (People's Regional Opportunity Program)
- Residential Resources
- Sandy River Home Resources
- Senior Spectrum
- SeniorsPlus, Agency on Aging
- Southern Maine Agency on Aging
- Tri-County Mental Health Services
- Village Elders
- Washington Hancock Community Agency

Testimony Against LD 499: An Act Making unified Appropriations and Allocations for the Expenditures of State Government, General Fund, and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2008 and June 30, 2009.

February 23, 2007

Senator Rotundo, Representative Fischer, Senator Iranian, Representative Perry, members of the Appropriations and Health and Human Services Committees:

I am Vanessa Broga, I'm a Licensed Social Worker and Family Caregiver Specialist with Senior Spectrum, the Central Maine Area Agency on Aging. Where I am not able to attend today, I am writing to testify against the proposed budget presented in LD 499.

As a social worker with over ten years of experience working with the elderly and their families, I have seen first hand the impact that limited APS resources have had, and the increasing severity of this issue. As a professional and mandated reporter, I have felt the frustration and lack of response when it comes to investigating these cases. It is concerning when professionals reach a point where they have to make themselves "savvy" at how to report a case to APS, so that it is assigned, and are faced with learning the "ins and outs" of just how many professionals and individuals need to call and make a report on a case before it is opened to APS services. The severity of this issue has recently increased to the point where cases may be accepted by APS, but are not being investigated in a timely manner, or at all due to inadequate staffing and resources as reported by the workers.

This was the case in two recent reports, one of which I made to APS. Both cases presented multiple risk factors concerning the primary caregiver, and both cases when reported to aps were opened to services, but not responded to in a timely manner. When visits were attempted, and failed, they were not followed through on due to a lack of adequate staffing and resources to see the individuals.

Most notably was the case which I reported on, regarding a couple in their late 70's, where the husband was the primary caregiver for his wife with Alzheimer's. The case involved numerous risk factors, concerning the health, safety, and welfare of this couple that had been noted by me, the family, and adult day staff. The wife had a history of wandering from the home, and had become combative with her husband who had multiple health issues himself and who was caring for her. The caregiver had reached a point where he was completely exhausted, had started sleeping in a chair in front of his door (as he was extremely hard of hearing and could not hear her leave the home) to keep her from leaving. The caregiver had refused outside resources and to self pay for any type of assistance. There was a history of alcohol use by the caregiver, refusal on his part to stop driving, and concerns of misuse of his wives medications. The family had exhausted all outside resources and there was no legal representative for the care recipient.

It is extremely important in light of cases such as this, that there are adequate resources and staffing in place, to ensure that these situations are adequately investigated, and in a timely manner.

It is with the above concerns that I oppose the proposed budget presented in LD499.

Maine Health Care Association

O.F.P.R.
2007 FEB 26 PM 1:02

The Honorable Karl W. Turner
Maine State Senate
3 State House Station
Augusta, Maine 04333

February 26, 2007

Dear Senator Turner:

At Friday's public hearing on LD 499, you asked an earnest question on how and why anyone would choose to enter or remain in the nursing home business. I don't think my answer provided an adequate response, and would like to elaborate a little further.

In truth, few people are choosing to enter the long-term care profession. I can tell you that there are nursing facilities that were being openly marketed when I arrived at Maine Health Care Association five years ago and remain available to purchase today. An exception has been the recent purchase of the Sandy River facilities by the Genesis Corporation. This is a bit of an aberration in itself, as the reputation of Maine's certificate of need process, high staffing requirements, and relatively low reimbursement rates have cooled acquisition interest from most national chains.

The last five years have been a difficult time for providers, but there have been just enough positive developments to keep the doors open at most facilities. These include:

1. In 2003, facilities benefited from an infusion of funding that accompanied the nursing home provider tax. This was the biggest single factor in halting a rise in closures and receiverships at that time. However, time has eroded the value of this program.

2. An upturn in Maine's unemployment rate from 3.3% in 2000 to 5% in 2003 temporarily eased staffing pressures.

3. A substantial Medicare rate increase during the same period encouraged Nursing homes to offer more medical rehabilitation services. This year however, Medicare payment rates have declined slightly and competition for rehab services has increased from Maine's rural hospitals.

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4. For some providers, interim payments resulting from MECMS issues have resulted in being temporarily overpaid for services. This has clouded the true financial picture, at least until recoupment is accomplished.

5. The minimal cost of living adjustments received in the past two years have helped facilities to limp along with 2% increases, but have not come close to meeting true cost increases. Meaningful rate relief is required to ensure their economic viability.

As I mentioned on Friday, a few facilities are fortunate to have a parent organization such as a hospital, church, or municipal government that can subsidize operational losses. For most however, options consist of things like deferring maintenance, extending credit terms, or increasing personal debt. In every case, closing the doors of the facility is considered to be a last resort and a decision that cannot be taken lightly. For the providers, these are places that represent a lifetime of work.

As part of the public hearing on Friday, I distributed a letter from Philip Cyr, an independent nursing home owner who describes in detail the problems he faces at the Katahdin Nursing Home in Millinocket. Mr. Cyr has explored every option, including the sale of his facility, but now wrestles with the prospect of closing his 95% MaineCare facility in the near future.

It is impractical to try to fully address the complex financial problems of Maine's long-term care providers in three minutes of testimony. I encourage the Appropriations & Financial Affairs Committee and the Health & Human Services Committee to take the time to learn about the challenges our providers face. I would welcome the opportunity to participate in such discussions.

Yours truly,

Richard A. Erb
President & Chief Executive Officer

cc: The Honorable Margaret Rotundo
The Honorable Joseph Brannigan
The Honorable Jeremy Fischer
The Honorable Anne Perry
Members of the Appropriations & Financial Affairs Committee
Members of the Health & Human Services Committee

NAMI Maine ☆☆☆

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MEMO
FROM: CAROL CAROTHERS
TO: APPROPRIATIONS AND HEALTH AND HUMAN SERVICES COMMITTEES
DATE:February 23, 2007
RE: QUESTIONS

1. **Please provide information on the grading system for mental health services systems – Question was to Carol Carothers, NAMI-Maine.**

Attached is a copy of the grading information from NAMI national's Report Card : the grading reports for the grade "B" states, including Maine.

2. **Please provide information on the SAMHSA rating system for care – Question was to Carol Carothers, NAMI-Maine.**

3. **Please provide information on the criteria for determining whether mental health care is effective – Question was to Carol Carothers, NAMI-Maine**.

Questions two and three are similar, how we can measure the outcomes of the care that is being provided by Maine's mental health providers? The most recent comprehensive effort to describe what is and isn't working in mental health and substance abuse and what to do about it is the Institute of Medicine's book, *"Improving the Quality of Health Care for Mental and Substance Use Conditions"*, published in 2006. Numerous recommendations (400 pages worth) about what should be done to improve the quality and safety of mental health and substance abuse treatment (behavioral health) are made. They make two broad statements:

1. **Problems no different**. The problems in the mental health/substance abuse treatment arena are *no different* from those in the general health care system – a need to improve safety, access, and to adopt treatments that are evidence-based in a timely fashion. And, there are complicating factors in the delivery of mental health and substance abuse care not found in the general health care arena including:
    a. Greater stigma attached to these diagnoses
    b. More frequent coercion of patients into treatment
    c. A less developed infrastructure for measuring and improving the quality of care
    d. The need for more linkages among multiple providers, organizations, and systems
    e. Less widespread use of information technology
    f. The separation of the "market" (i.e., mental health and substance abuse are usually carved out of the regular medical system and not treated equally).
2. **Integration needed**. There is an inherent interaction between the mind and body and mental health and substance abuse treatment *must be integrated* into general medical treatment. They see the separation of treatment for behavioral health from general medical care as a primary contributor to the nation's poor health care outcomes. In fact, they express concern about

managed care carve outs because they impair the link between medical and behavioral health data collection.

Attached are materials that provide more specific information:

- A chart showing SAMHSAS national outcome measures for mental health and substance abuse treatment. The chart shows the criteria we should be using to decide if service delivery is effective.
- A list of the evidence-based practices supported by SAMHSA.
- SAMHSAS goals for mental health system transformation.
- NAMIs Grading the States Standards for a Quality Mental health System.

NAMI Maine respectfully suggests the following as you pursue the current budget proposal:

- **Do not compromise community-based, mobile, safety net mental health services**. When these services are not available when and where they are needed, tragedies occur. Cutting the intensive case manager program by 50%, compromising the provision of other community-based services, and failing to make ACT teams that are faithful to the model more available can only mean more people are in jail or emergency rooms.
- **Obtain an independent evaluation**. Any hope of understanding the outcome of your decisions will require the collection of accurate evaluation data. We strongly recommend that the contract with a managed care entity include provisions for *independent* evaluation and a report back to the legislature. This evaluation should use the SAMHSA outcome measures as the basis for understanding the impact of the delivery of behavioral healthcare in Maine and include information about how savings were achieved.

FIVE "B" STATES - QUESTION #1

Executive Summary

This report is the first comprehensive survey and grading of state adult public mental healthcare systems conducted in more than 15 years. Public systems serve people with serious mental illnesses—such as schizophrenia, bipolar illness, and major depression—who have the lowest incomes.

The report confirms in state-by-state detail what President Bush's New Freedom Commission on Mental Health called a fragmented "system in shambles."

Nationally, the system is in trouble. Its grade is no better than a D.

Too many state systems are failing

Only five states receive a B: Connecticut, Maine, Ohio, South Carolina, and Wisconsin.

Seventeen states receive Cs, 19 states get Ds, and eight get Fs. That's without the pluses and minuses.

Those states that are failing are: Iowa, Idaho, Illinois, Kansas, Kentucky, Montana, North Dakota, and South Dakota.

Nationally, the system is in trouble. Its grade is no better than a D.

This report includes tables that indicate each state's overall grade as well as its grade in each of four categories: Infrastructure, Information Access, Services, and Recovery.

Each state grade is based in part on a "take-home test," in which survey questions were submitted to state mental health agencies during October and November 2005. All but two states responded. Colorado and New York declined. They have been graded "U" for "Unresponsive."

NAMI wishes to commend Alabama, Louisiana, and Mississippi for their participation, which came in the wake of the twin catastrophes of Hurricanes Katrina and Rita.

Based on the surveys and publicly available information, states were scored on 39 criteria. Consumer and family advocates also provided information through interviews that contributed to state narratives.

The "Consumer and Family Test Drive" represents a unique, innovative measurement. Access to services depends on access to information. NAMI therefore had consumers and family members navigate the Web sites and telephone systems of the state mental health agency in each state and rate their accessibility according to how easily one could obtain basic information.

To some degree, this exercise was like a "pop quiz." Over 80 percent of the states scored less than 50 percent of the total points.

In one case, an agency employee told a consumer: "No, I will not help you."

Those states that received excellent Test Drive scores were Indiana, Michigan, Ohio, South Carolina, and Tennessee.

Those that received the lowest Test Drive scores were Alabama, Arkansas, Missouri, New Mexico, and South Dakota.

For each state, grades in each category and scoring of the 39 criteria appear in the "State Narratives" section of the report.

The narratives provide context. Common themes

emerge. In every case, they relate to choices. None are predestined. Some reflect choices made by governors and legislatures, sometimes without full appreciation of the nature of serious mental illnesses.

The report offers several basic policy recommendations:

- Increase funding tied to performance and outcomes
- Invest in proven. cost-effective practices (i.e., evidence -based practices)
- Improve data collection
- Increase access to information
- Involve consumers and families in all aspects of the system
- Eliminate discrimination

Each state narrative also includes a list of specific "Innovations" and "Urgent Needs" to help advocates and policymakers further define agendas for action. An overall list of innovations provides an opportunity for states to learn from one another. Just a few include:

- California's Proposition 63 to finance mental health services
- Low-income housing financed by real estate transaction fees in Illinois
- A telephone triage system in jails financed through DWI fines in Kentucky
- A public-private joint venture in Massachusetts to replace a mental health center
- A prescription feedback system in Missouri that has reduced hospitalizations and unnecessary poly-pharmacy
- A purchasing collaborative in New Mexico

Creative action is needed. Progress is needed. As the grade distribution in the report demonstrates, the United States still has a long way to go to achieve a "New Freedom" for people living with serious mental illness—a freedom based on recovery and dignity.

NAMI wishes to commend Alabama, Louisiana, and Mississippi for their participation, which came in the wake of the twin catastrophes of Hurricanes Katrina and Rita.

Maine

Grade: B-

Category Grades

Infrastructure	D
Information Access	C-
Services	B
Recovery Supports	A

Spending, Income, & Rankings

PC Spending/Rank	$127.92	7
PC Income	$27,373	35
Total MH Spending/Rank	$167 *(in millions)*	33
Suicide Rank		20

Recent Innovations

- Mental health parity law
- Inclusion of full mental health parity for the uninsured in Dirigo Health
- Progress in improving conditions in county jails

Urgent Needs

- Reduce long waitlists for community services
- Relieve crowding in emergency rooms
- Access to crisis and inpatient beds
- Mitigate the too-rapid implementation of managed care

Maine is a study in contradictions. On the one hand, the state has wisely invested in practices that are proven and cost-effective, such as Assertive Community Treatment (ACT) and supported employment. It has also been a leader in including mental health parity in its program to expand access to health insurance. However, budget cuts have contributed to significant gaps in services and poor outcomes. Additional cuts would reverse Maine's progress and devastate an already stretched system of mental healthcare.

Maine has taken several positive steps to improve its mental health services. Most importantly, it has invested in evidence-based practices (EBPs). It received a federal grant to expand use of these cost-effective services in the state. Both the Department of Corrections and the Department of Mental Health are focused on EBPs and are moving the Medicaid system to reimburse these services. The state has seven ACT teams, 24 supported employment programs, three Family Psychoeducation programs, and 59 programs for integrated mental illness and substance abuse treatment. The state has also developed a Peer Recovery Specialist training program.

Maine has also been a leader in the fight for insurance parity, passing one of the first state parity laws. Governor Baldacci deserves credit for including full parity in Dirigo Health, his signature program to provide health insurance to the uninsured. Many states have been shortsighted in limiting or excluding mental health care in their efforts to expand eligibility for insurance. The governor's recognition that true health insurance must include mental as well as physical healthcare should be a model for other states. Baldacci has also positioned Maine to be the first state to provide wrap-around services for the Mainers who were dual eligible for Medicare as part of the Medicare Part D rollout.

Maine has worked to reduce involvement of individuals with mental illness in the criminal justice system, which is a significant problem in the state. The Department of Behavioral and Developmental Services has developed a joint action plan with the Department of Corrections, and they have begun implementation. The state also has 11 jail diversion programs.

Despite these examples of progress, significant problems remain. Funding for mental health services has declined. Most recently, the legislature proposed slashing

$26 million from the adult and children's community mental health services. At the same time, individuals with serious mental illness in Maine are experiencing long waitlists for community services, crowded emergency rooms, involvement with the criminal justice system, and a shortage of state hospital beds, with hospitals turning away, in the first four months of 2005, 57 percent of those eligible for admission. This is a significant increase over 2004's average of 46 percent of those seeking admission.

The state mental health and Medicaid agencies are working on a transition from a cost-based, fee-for-service model to a behavioral, managed care design. It remains to be seen whether the new system for managed care can lead to cost savings without compromising quality. Significant concerns exist as to the quality of the planning and the timeline for implementation of this significant change. Advocates fear an undue emphasis on cost containment in the state in response to a study by the Muskie Institute claiming that behavioral health costs are rising much more rapidly than other healthcare costs. Although the methodology has been criticized, the report has been used by some policymakers to support cutting funds.

Budget cuts could also jeopardize the state's ability to meet its legal obligations. The Maine mental health system continues to operate under a 1990 consent decree to address deficiencies in the care of current and future patients at Augusta Mental Health Institute (AMHI). AMHI has been replaced by a new facility, but the case continues because the judge found that the state was not meeting class members' needs for community, emergency, and hospital services. The court master and others have expressed concern about the impact of managed care on the mental health system.

Maine has been a leader in both parity and employing evidence-based practices. But the state still falls short in providing an adequate mental health system. If the implementation of managed care focuses on cost cutting, the situation will get worse. For progress to continue, Maine must build upon its strengths, develop a consistent vision and the political will necessary to stop the budget cutting, and focus on filling the existing gaps in services.

Score Card: MAINE

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Connecticut

Grade: B

Category Grades

Infrastructure	A
Information Access	C+
Services	C+
Recovery Supports	B+

Spending, Income, & Rankings

PC Spending/Rank	$151.03	5
PC Income	$40,990	2
Total MH Spending/Rank	$525 *(in millions)*	15
Suicide Rank		47

Recent Innovations

- Recovery as a vision and goal, prior to the President's New Freedom Commission
- Corporation for Supportive Housing, a joint private/public partnership
- Mental Health Jail Diversion specialists in all arraignment courts
- Training institute with Yale

Urgent Needs

- Aggressive examination and solution to the nursing home crisis
- Housing
- Fidelity to ACT
- [illegible] concerns at CVH

Connecticut is recognized nationally for explicit promotion of a recovery model of care which focuses on individual strengths and enhancement of the ability to function. The vision is commendable, but the state is not yet fully engaged in making it a reality. It can do better.

Credit for the vision belongs to Commissioner Thomas Kirk, Jr., who issued a policy statement in 2002 that recovery was to become the overall goal of the Department of Mental Health and Addiction Services (DMHAS). Consumer and family advocates in the state generally find his leadership to be open and respectful of their involvement, but question whether the policy statement will actually translate into better services—and most of all, outcomes.

One innovation has been the creation of a training institute with Yale University for mental health workers. DMHAS includes requirements in its contracts that program staff be competent in recovery models—but the approach has not yet taken hold at the grassroots, nor been applied comprehensively. The state has increased funding for vocational support and developed pilot consumer-run programs, but the latter so far have been only that, small pilots, with no apparent plans to reproduce or expand them.

Over the past few years, the state has moved to improve cultural competency within the system, which in turn influences treatment effectiveness. The state has promoted cultural competency. It currently plans to increase bilingual and bicultural personnel to reduce culturally-specific barriers to treatment.

Long emergency room wait times for hospitalizations are a problem. Additional inpatient adult hospital beds are not the solution, but the state also should not reduce the supply. They are still the only intermediate level of inpatient care. The core problem is lack of ready access to outpatient care, along with shortages in decent, safe, affordable housing and effective outreach and crisis intervention services. Some state hospital beds have been made available through a new fund that last year served 42 people by supporting tailored discharge plans for people requiring intensive services who otherwise could not have left the hospital.

Grave concerns over the quality and safety of Connecticut Valley Hospital have recently surfaced. The

state's largest psychiatric facility is being investigated by the US Department of Justice for concerns about safety and the use of restraint and seclusion. Additionally, the Judge David Bazelon Center has initiated a review of whether people with serious psychiatric illnesses are inappropriately admitted to locked nursing home beds in Connecticut. Issues in both settings require urgent action.

Twenty-nine Assertive Community Treatment (ACT) teams are available statewide, but previously have not met federal standards. The state is moving now to improve fidelity to standards in order to obtain Medicaid funds for the service.

Housing is a problem. As a small state with the country's highest average per capita income, safe, decent, affordable housing for people with serious mental illnesses often is limited. The state has worked to address the problem. Approximately 2,300 units of supported housing have been added since the 1990s, and another 500 are anticipated. The state also has worked to make creation of smaller group homes easier through zoning exemptions, but ultimately, in order to meet overall needs, more investment by the legislature is needed.

There has been an increase of approximately 40 percent in the number of people with serious mental illnesses who have been placed in nursing homes. DMHA is considering the use of a state Medicaid waiver to move younger adults into more appropriate settings in the community. The state needs to move forward quickly to do so.

Criminalization of people with serious mental illnesses is also a problem. Based on information provided by the Connecticut Department of Corrections, Connecticut's adult prison population of people identified with a moderate to serious mental illness has gone from 2,200 in 2000 to 3,700 in 2005, from 12 percent of the total prison population to nearly 20 percent. Pre-booking crisis intervention teams (CIT) have been started in several towns with the help of federal grant funds. Jail diversion programs exist in all 20 arraignment courts in the state, but only about 40 percent of people with serious mental illnesses can be diverted, in large part due to lack of community housing and services.

Connecticut is one of seven states to receive a SAMSHA Transformation Grant. It has an excellent opportunity to examine how it can build on its successes and address some of the more disturbing trends related to incarceration and inappropriate nursing home placements.

Connecticut is moving forward and compares favorably to other states. But the state must not become complacent or content to stay in place. Many people still are not getting the help they need. One in five Americans experience mental illness at some point in their lives. Every person in the state is potentially vulnerable to a swift reversal of fortune. If it happens, the state needs a mental healthcare system that is ready, willing, and able to help them truly recover.

Score Card: CONNECTICUT

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	9	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Ohio

Grade: B

Category Grades

Infrastructure	B
Information Access	A
Services	B
Recovery Supports	B

Spending, Income, & Rankings

PC Spending/Rank	$62.03	37
PC Income	$28,430	26
Total MH Spending/Rank	$709 *(in millions)*	9
Suicide Rank		30

Recent Innovations

- Strong state-level leadership in various branches of government
- Consumers and family play a prominent role in the system
- Impressive implementation of EBPs, decriminalization, and criminal diversion initiatives
- Productive dialogue between advocates and criminal justice system leaders

Urgent Needs

- Gaps in funding must be closed
- Parity legislation urgently needed
- Insufficient services, especially acute shortages of beds and staff

Ohio is home to some of the strongest leaders in improving the nation's mental healthcare system, and a pace-setter for states with large county-based systems.

As the state with the electoral votes that decided the 2004 presidential election, it may be no exaggeration to say that in the field of mental health, too, as goes Ohio, so goes the nation.

The director of the Ohio Department of Mental Health (ODMH), Michael Hogan, Ph.D., is one of the nation's longest serving mental health agency heads. He served as chair of the President's New Freedom Commission on Mental Health in 2002-2003. U.S. Senator Mike DeWine and U.S. Representative Ted Strickland have nurtured the growth of mental health courts and criminal diversion programs nationally. State Supreme Court Justice Evelyn Lundberg and Corrections Director Reggie Wilkinson also have forged new policies, programs, and partnerships to change the shape of treatment in the state's criminal justice system.

In addition, consumer and family participants in policy and service decisions within the system play important leadership roles.

Unfortunately, gaps and unmet needs still exist. It is a sad commentary on public mental health systems when even a state like Ohio is still not fully able to bring treatment and recovery to people with serious mental illnesses.

Leaders alone are not enough. Quality services cost money. New funds are entering the Ohio system through a federal Transformation State Incentive Grant (TSIG) and recent budget increases. ODMH received a 3 percent increase in 2005 and again in 2006—the largest increase for any state department. In a period of intense competition for funds, it was an encouraging signal that Governor Taft and the General Assembly recognize the importance of mental health in the state's overall healthcare equation.

Looking beyond the public health system, Ohio advocates are hoping that the same vision will extend to passage of a mental health insurance parity law. Lack of parity is a strange blot on Ohio's record of national leadership, compared to the 36 other states that have passed such laws.

Parity is important in helping to stem the flow of people with private insurance into the public system—as well as being central to eliminating stigma and discrimi-

...When middle class families lack mental health ...its under private health insurance plans, they often ...down assets and end up in the public system, or ...without treatment. Ultimately, costs are passed on to the state. More emergency room visits and hospitalizations result. In some cases, costs are shifted to the criminal justice system. The legislature's inaction on parity comes with a price.

ODMH plans to use increased funds to maintain current levels of hospital beds and staff, while offering Safety-Net Emergency Funds to community service boards, based on financial hardship. Even so, the system presently is overwhelmed by not enough money or staff. There are long waitlists for services and housing. ODMH's support of 27 residency and training programs at state universities are intended to ease the workforce shortage, but by themselves, they aren't enough.

Medicaid funds many services. Federal waivers allow boards to manage provider contracts autonomously, but autonomy comes with a price—they must provide matching funds. Many boards therefore limit investment in services that are non-Medicaid reimbursable, in order to maximize federal funding. The result is minimum access to recovery-oriented services that may not be reimbursable, such as early intervention, housing, em...yment, consumer-run programs, and culturally co...tent services. In addition, recent changes in Medicaid eligibility requirements will drop nearly 20,000 adults from the rolls. Taken together, Ohio's toughest challenge will come in finding the funds to sustain services and innovations in the future.

Other states would do well to take notice of Ohio's approach to implementing evidence-based practices (EBPs) and decriminalization of mental illness. Coordinating Centers of Excellence (CCOEs) and Networks, located around the state, instill best practices through a three-phase model of engaging practitioners, providing training in specific EBPs, and offering follow-up reinforcement. The state recently made Assertive Community Treatment (ACT) a reimbursable service under Medicaid. The CCOE approach will allow the state to upgrade intensive case management services using ACT teams.

The commitment of Ohio leaders to criminal diversion and re-entry programs for people with mental illnesses is unique—these successes represent real partnerships that have brought together diverse communities and centers of power. In May 2005, the Criminal Justice CCOE, along with the Ohio Supreme Court, Capital University Law School, and NAMI Ohio, co-sponsored the first national conference on Crisis Intervention Teams (CIT) and the third national conference on Mental Illness and the Criminal Justice System, drawing participants from around the nation.

The challenge for Ohio is to apply the same kind of commitment and cohesion to other dimensions of the mental healthcare system—with the support from the legislature and other community leaders.

Score Card: OHIO

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

South Carolina

Grade: B-

Category Grades

Infrastructure	B
Information Access	A
Services	D+
Recovery Supports	B

Spending, Income, & Rankings

PC Spending/Rank	$67.18	32
PC Income	$24,811	43
Total MH Spending/Rank	$276 *(in millions)*	24
Suicide Rank		35 *(tied with Iowa)*

Recent Innovations

- Public-private partnerships to build capacity
- CMHC and primary healthcare facility collaborations for general healthcare services, including reciprocal agreements for "on-site staffing"
- Investment in consumer-run businesses

Urgent Needs

- Funding
- Close scrutiny of proposed Medicaid reforms
- Additional crisis care capacity
- Integrated treatment

Ask people familiar with South Carolina to rate the state's mental health system, and the answer you get is "average."

Still, the state has significant problems. Specifically, it has fared poorly in providing access to crisis and acute care treatment. Over the past several years, the South Carolina Department of Mental Health (DMH) has reduced the number of inpatient psychiatric beds it operates.

While these reductions originally represented a desire to provide more care in a community setting, in recent years the cuts have been budget-driven. DMH bed reductions went too far, leaving hospital emergency departments and local jails as the only alternative for many patients who need a state psychiatric hospital bed. Nearly 50 percent of DMH acute care beds, those intended for short stays, are now occupied by long-term patients who were displaced when the state started the process of closing the last of its long-term psychiatric hospitals.

DMH's waiting list for its forensic facility also has reached a length that is unacceptable, from both a legal and a patient care point of view. A recent surge in emergency admissions from jails (e.g., suicide risks) has decreased available beds for court-ordered, pre-trial evaluations and restorations to competency for trial.

While DMH to its credit appears to realize the shortcomings in the system, prospects for relief are uncertain. Governor Mark Sanford recently released his executive budget that funds a mere 30 percent of what the department requested. If the governor prevails, the crisis in hospital emergency rooms and jails will continue.

Since 2001, DMH has lost $30 million in funding—dropping below its 1998 level, even as the cost of programs increased by more than $45 million. Advocates support selling state-owned land near the primary state hospital and dedicating proceeds to the improvement of mental health services—but the governor instead is pushing to put them in the state's general fund.

The state also is taking aim at Medicaid.

South Carolina enjoys a federal match rate of approximately 70 percent on Medicaid expenditures, but is seeking reforms that would impose a cap on expenditures for each Medicaid beneficiary. Some analysts consider the proposals "the most radical changes ever made in a state Medicaid program." If a strict cap is adopted, the

state stands to suffer significant economic consequences—it would be prohibited from seeking additional funds in the event of a natural disaster, public health emergency, advances in medical technology and medicines, or expanding long-term care for an aging population.

Concern also exists as the state soon will be drafting reforms aimed at people with serious mental illnesses. Currently, the state plan goes beyond federal requirements to support Assertive Community Treatment (ACT) and peer specialists. There is no guarantee that these critical services will remain intact.

The state's existing Medicaid program also provides open access to medications for people diagnosed with mental illnesses—in spite of executive and legislative threats during the past two years to restrict access.

Open access is essential for effective treatment and recovery. To date South Carolina has held the line in preserving that commitment. Advocates see the issue as critical.

Despite its average reputation, South Carolina has made some commendable improvements in the system of care—which is all the more reason to protect it from radical reforms. Despite difficult budget cuts, DMH has demonstrated commitment to providing evidence-based practices (EBPs). Through agency leadership and consistent stakeholder advocacy, the state has developed and implemented ACT, supported employment programs, housing initiatives, and other programs that meet fidelity standards.

Another significant achievement was the legislature's passage of mental health insurance parity in 2005, which the governor chose to allow to become law without his signature.

Police and judges have supported better services and diversion programs for people with mental illnesses. Expansion of mental health courts and recent legislation authorizing diversion from incarceration for minor offenders with mental illness are promising developments.

DMH deserves credit for incorporating the findings of President Bush's New Freedom Commission into its operational approach—moving toward a focus on recovery and involvement of consumers and families in meaningful roles. The agency has adopted a strategic plan that lays the groundwork for significant, cost-effective improvements in the years ahead.

The wild card is whether the state's elected officials will support it.

Score Card: SOUTH CAROLINA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	0	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Wisconsin

Grade: B-

Category Grades

Infrastructure	C
Information Access	D
Services	B+
Recovery Supports	B+

Spending, Income, & Rankings

PC Spending/Rank	$90.98	20
PC Income	$29,336	21
Total MH Spending/Rank	$498 *(in millions)*	17
Suicide Rank		28 *(tied with Alabama)*

Recent Innovations

- Statewide expansion of CSP
- CCS for clients between CSP and traditional outpatient care
- Broad community services reduce need for state hospitalization

Urgent Needs

- Outcome studies of CSPs and managed care
- Stronger CCS focus; commitment and monitoring over time
- State support and coordination for counties with underdeveloped service systems

Wisconsin is nationally distinguished as the birthplace of both NAMI and Assertive Community Treatment (ACT), and known locally for its strong network of consumer advocates, but its mental healthcare system still has weaknesses, as well as strengths.

The system is county-based. Some advocates believe it is too decentralized, with the state not providing enough financial support—particularly to counties with underdeveloped systems. At the same time, the state has limited ability to control care locally and quality of services varies across the state.

The Bureau of Mental Health and Substance Abuse Services (BMHSAS) is located inside the Division of Disability and Elder Services, which itself is a subdivision of the Department of Health and Family Services. Finances for mental healthcare are primarily controlled elsewhere—by the Division of Healthcare Financing and by the individual counties. This structure leaves BMHSAS facing barriers to controlling mental health expenditures, along with a bureaucratic view that counties are the state's primary customers—rather than people with serious mental illnesses.

Nonetheless, the county-based system is effective at reducing demand for state hospital admissions. Every system requires balanced options. Broad community services in Wisconsin get credit for the fact that no significant waiting lists exist for state inpatient hospital care.

The vision shown by the state leadership has been mixed with disappointments. To his credit, Governor Jim Doyle recently vetoed legislation that would have increased co-pays on Medicaid prescriptions and placed artificial limits on the total number of prescriptions. On the other hand, the governor vetoed a requirement that the state's new SSI managed care programs report on progress and outcomes to the legislature—effectively eliminating oversight of changes, and an opportunity to spot design errors in pilot programs.

In reporting on ACT use, BMHAS states that its community support programs (CSPs) are the equivalent of ACT. This is not true—a disappointing misconception for the state in which ACT began.

- ACT inspired CSPs, but they are not equivalent. CSPs do not meet ACT national standards. ACT teams have no more than 8-10 clients per staff member; 75 percent or more of services are

delivered outside program offices; and peer specialists are required. Wisconsin's CSP standards require only that 50 percent of services be delivered outside the office and the client ratio is 1:20. There are no requirements for peer specialists.

- Although CSPs are not the same as ACT, they do have some of the right ingredients and are well supported by the state. They deserve close study of their actual effectiveness. CSPs are present in all but 10 rural counties, and the state goal is to add programs in one county per year for the next three years. At last count there were approximately 80 certified CSPs, serving 5,500 persons with serious mental illness at a cost of about $10,000 per client.

- The state has created a new Medicaid benefit—Comprehensive Community Services (CCS)—designed to help consumers who don't require the intensity of CSP, but still need more assistance than general outpatient treatment provides. Unfortunately, the population served by CCS is poorly defined, with only vague definitions of the individuals to be served and no system-wide outcome measures. Advocates are concerned that these factors will cause the program to be simply eliminated, before it ever is adequately and uniformly implemented.

Overall, Wisconsin has a strong foundation built on community services. As the state continues to move forward, it is a model for the nation.

Score Card: WISCONSIN

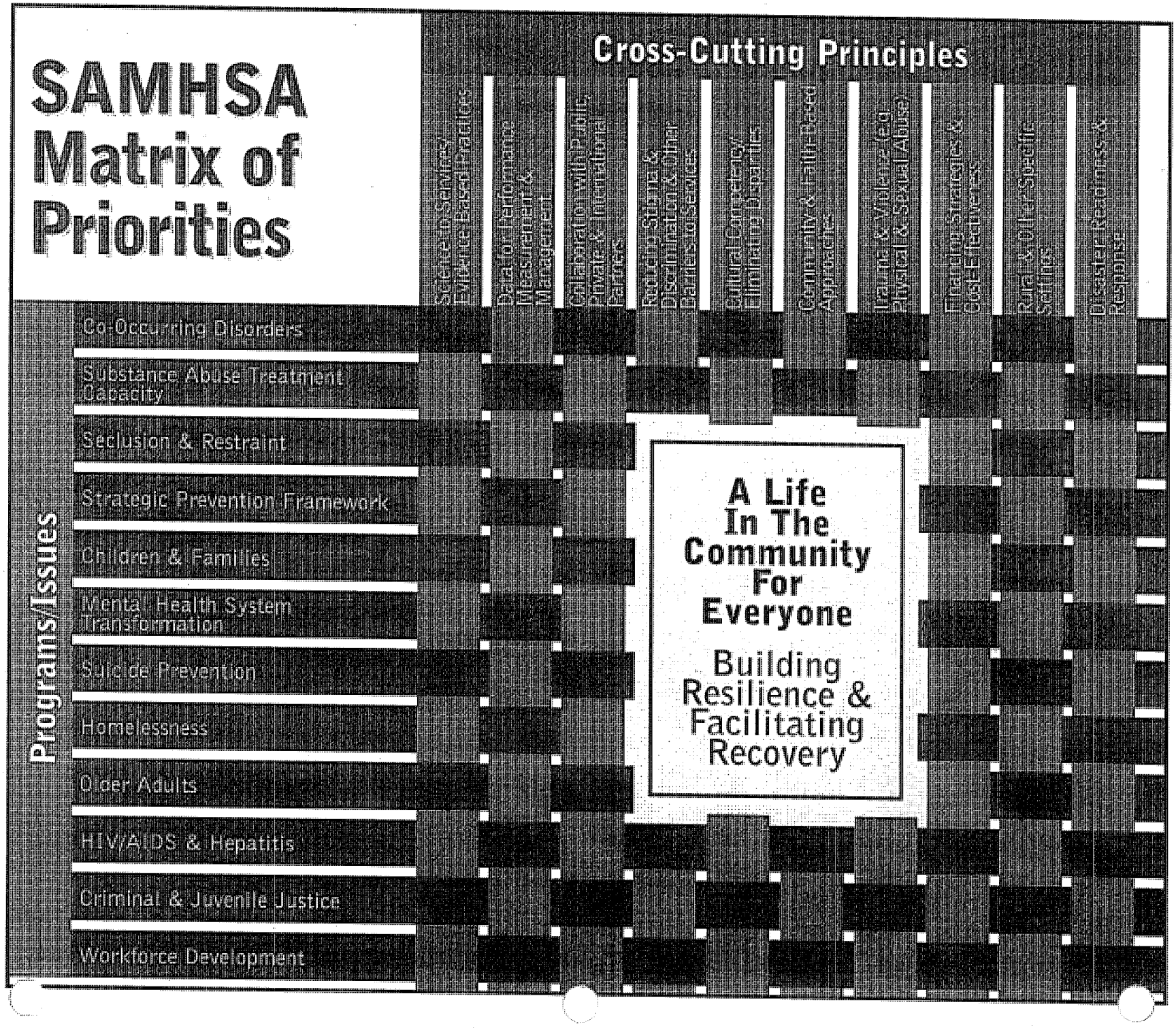
Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	3	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

SAMHSA GUIDELINES + PRIORITIES QUESTION #2

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.


SAMHSA
Matrix of
Priorities
Cross-Cutting Principles
Science to Services/ Evidence-Based Practices
Data for Performance Measurement & Management
Collaboration With Public, Private & International Partners
Reducing Stigma & Discrimination & Other Barriers to Services
Cultural Competency/ Eliminating Disparities
Community & Faith-Based Approaches
Trauma & Violence (eg. Physical & Sexual Abuse)
Financing Strategies & Cost Effectiveness
Rural & Other Specific Settings
Disaster Readiness & Response
Programs/Issues
Co-Occurring Disorders
Substance Abuse Treatment Capacity
Seclusion & Restraint
Strategic Prevention Framework
Children & Families
Mental Health System Transformation
Suicide Prevention
Homelessness
Older Adults
HIV/AIDS & Hepatitis
Criminal & Juvenile Justice
Workforce Development
A Life In The Community For Everyone
Building Resilience & Facilitating Recovery

SAMHSA Action Plan
Mental Health Systems Transformation
Fiscal Years 2006 and 2007

PURPOSE	*Ensure that mental health services and treatments 1) are consumer and family-centered and 2) focus on increasing consumers' ability to successfully manage life's challenges, on facilitating recovery and on building resilience. This purpose is consistent with the goals of mental health system transformation outlined in the Federal Mental Health Action Agenda.*
PERFORMANCE MEASURES	**Long Term Measures** ▸ *Increase the number of States that are transforming their public mental health system consistent with the Federal Mental Health Action Agenda goals (Data Source: MHBG, Baseline: TBD, 2007)* **Annual Measures** ▸ *Increase the number of States with a comprehensive Mental Health System Transformation (MHST) Plan (MHSIG, Baseline: 7, 2006)* ▸ *Increase the number of evidence-based practices implemented by States (Data Source: Uniform Reporting System, Baseline: 2.8, 2005)* ▸ *Increase the percentage of adults (SMI) and children (SED) served by States who are receiving evidenced-based practices (Data Source: Uniform Reporting System, Baseline: a) adults: 9.8% b) children: 2.0%; 2005)* ▸ *Increase the number of Prototype Individualized Plans of Care that are generally available to providers and consumers by making them available at the SAMHSA website (Baseline: TBD, 2006)*
POLICY AND PROGRAM PARAMETERS — Including drivers	▸ *Mental Health: A Report of the Surgeon General was published in 1999 and provides the scientific basis for transforming the delivery of mental health services* ▸ *The goals and recommendations incorporated in Achieving the Promise: Transforming Mental Health Care in America, the final report of the President's New Freedom Commission on Mental Health, was published in 2003 and establishes parameters for transforming the mental health system*

	▸ T*ransforming Mental Health Care in America the Federal Action Agenda: First Steps: July 2005, unprecedented collaborative efforts of six cabinet level departments, developed specific steps to assist in Transforming Mental Health Care.* ▸ *Recommendations of the Institute of Medicine, Improving the Quality of Healthcare for Mental and Substance Use Conditions, November 2005.*
KEY ACTIVITIES - FY 06-07	▸ *Monitor the extent to which the Mental Health Systems Transformation SIG addresses those population groups prioritized on the SAMHSA matrix that are appropriate and relevant to the programs within the matrix area.* ▸ *Complete 3-year implementation plan for NOMS for MHBG and mental health discretionary grant programs.* ▸ *Increase the number of candidate mental health promotion and service programs that apply for review in the National Registry of Evidence-based Programs and Practices (NREPP).* ▸ *Establish a prototype electronic health record that helps providers and consumers better manage mental health care and that will protect the privacy and confidentiality of consumers' health information.* ▸ *Establish the Transformation Action Initiative (TAI) to support the implementation of mental health systems transformation technical assistance and provide "one stop" access to technical assistance services for States that will align, consolidate and minimize duplication among technical assistance providers.*

As Matrix Lead, I agree to the incorporation of the concepts, strategies, and goals outlined in this Action Plan into my performance contract.

Submitted by: A. Kathryn Power, *Matrix Lead* **Date:** 04/26/06

Approved by: Charles G. Curie, *Administrator* **Date:** 05/16/06

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File Date: 6/29/2006

About Evidence-Based Practices: Shaping Mental Health Services Toward Recovery

Printed versions of the Toolkits are currently out of stock. All of toolkits can be downloaded directly from our web site.

The Substance Abuse and Mental Health Services Administration (SAM its Center for Mental Health Services (CMHS) are pleased to introduce Evidence-Based Practice Implementation Resource Kits to encourage tl evidence-based practices in mental health. The Kits were developed as several SAMHSA/CMHS activities critical to its science-to-services strat expect to identify additional practices for future Kits.

The Kits contain many useful resources, including:

- Information Sheets for all stakeholder groups
- Introductory videos
- Practice demonstration videos
- Workbook or manual for Practitioners

Each of the six Resource Kits is described below.

Illness Management and Recovery

The Illness Management and Recovery program strongly emphasizes h people to set and pursue personal goals and to implement action strat their everyday lives. The information and skills taught in the program i

- Recovery strategies
- Practical facts about mental illness
- The Stress-Vulnerability Model and strategies for treatment
- Building social support
- Using medication effectively
- Reducing relapses and coping with stress
- Coping with problems and symptoms
- Getting needs met in the mental health system

Assertive Community Treatment

The goal of Assertive Community Treatment is to help people stay out hospital and to develop skills for living in the community, so that their

illness is not the driving force in their lives. Assertive community treati services that are customized to the individual needs of the consumer, (by a team of practitioners, and available 24 hours a day. The program needs related to:

- Symptom management
- Housing
- Finances
- Employment
- Medical care
- Substance abuse
- Family life
- Activities of daily life

Family Psychoeducation

Family Psychoeducation involves a partnership among consumers, fam supporters, and practitioners. Through relationship building, education collaboration, problem solving, and an atmosphere of hope and cooper family psychoeducation helps consumers and their families and suppor

- Learn about mental illness
- Master new ways of managing their mental illness
- Reduce tension and stress within the family
- Provide social support and encouragement to each other
- Focus on the future
- Find ways for families and supporters to help consumers in their

Supported Employment

Supported Employment is a well-defined approach to helping people w illnesses find and keep competitive employment within their communit Supported employment programs are staffed by employment specialis frequent meetings with treatment providers to integrate supported em with mental health services. The core principles of this program include

- Eligibility based on consumer choices and preferences
- Supported employment as an integrated treatment
- Continuous follow-along supports
- Help with moving beyond the patient role and developing new er related Roles as part of the recovery process

Co-occurring Disorders: Integrated Dual Diagnosis Tr

Integrated Dual Diagnosis Treatment is for people who have co-occurri disorders, mental illness and a substance abuse addiction. This treatm approach helps people recover by offering both mental health and subs abuse services at the same time and in one setting.

This approach includes:

- Individualized treatment, based on a person's current stage of re
- Education about the illness
- Case management
- Help with housing
- Money management
- Relationships and social support
- Counseling designed especially for people with co-occurring disor

NAMI STANDARDS FOR QUALITY QUESTION #3

Standards for a Quality Mental Health System: A Vision of Recovery

The starting point for conducting a comprehensive evaluation of state mental health services is to define what a good public mental health system looks like. This section of the report outlines the standards NAMI used to conduct this evaluation.

In setting forth these standards, we acknowledge that no State Mental Health Authority (SMHA) has unilateral control over all elements of mental health services in its state. In a number of states, responsibility for administering community mental health services is vested at county levels, with the state responsible for such functions as running hospitals, setting standards for community services, setting rates, and monitoring provider performance.

Today, it is widely understood that a diagnosis of a serious mental illness need not relegate a person to a lifetime of suffering or dependency.

Moreover, multiple state agencies, not just the SMHA, affect in some way the provision of mental health services. These agencies include corrections, housing, vocational rehabilitation, Medicaid, and others.

Despite these factors, our assumption in conducting this evaluation is that the SMHA plays the most critical role in organizing and implementing the statewide system of services and coordinating the various funding streams that help support these services. As the state agency directly responsible for mental health services, the SMHA therefore ultimately must be held accountable for how these services are organized and delivered.

Based on NAMI's review, we have determined that high quality state mental health systems are characterized by the following 10 elements.

1. Comprehensive services and support
2. Integrated systems
3. Sufficient funding
4. Consumer- and family-driven systems
5. Safe and respectful treatment environments
6. Accessible information for consumers and family members
7. Access to acute care and long-term care treatment
8. Cultural competence
9. Health promotion and mortality reduction
10. Adequate mental health workforce

1. Comprehensive Services and Supports

Today, it is widely understood that a diagnosis of a serious mental illness need not relegate a person to a lifetime of suffering or dependency. With appropriate services and supports, people with serious mental illnesses can and do recover and lead lives that are productive and meaningful. Moreover, the term "recovery" does not mean simply relieving or controlling medical symptoms.

It focuses more broadly on the process of restoring "self-esteem and identify and on attaining meaningful roles in society." Recovery also does not necessarily refer to "curing" mental illness, but rather describes a process of restoring consumers' independence, self-sufficiency, dignity, and personal fulfillment.

Serious mental illnesses affect people in a wide variety of ways. Therefore, the specific services needed and the intensity of those services will vary from person to person. However, a high quality mental health system should, at a minimum, include the following services.

> Housing is the cornerstone of recovery for people with serious mental illnesses.

A. Affordable and supportive housing.

Housing is the cornerstone of recovery for people with serious mental illnesses. Without stable housing, it is very difficult for consumers to benefit from other services. Supportive housing is an approach that combines affordable housing with supportive services to help people with serious mental illnesses achieve stable and productive lives. Supportive housing has proven effective in alleviating homelessness and aiding recovery.

Unfortunately, supportive housing options are in short supply in most parts of the country due to federal cuts in vital programs such as Section 8 and Section 811, and the prohibitive costs of housing. Nationally, the average monthly cost of a one-bedroom rental apartment exceeds the total amount of monthly income under Supplemental Security Income (SSI). Thus, even though SMHAs may not be directly responsible for funding housing programs, NAMI believes that it is very important for these agencies to be integrally involved in strategies to develop supportive housing opportunities for consumers at both state and local levels.

B. Access to medications.

Significant progress has been made in the past several decades in discovering medications that alleviate and help to control the most profound symptoms of serious mental illnesses such as schizophrenia, bipolar disorder, and major depression. Medication decisions are best made on an individualized basis, taking into consideration factors such as consumers' past treatment history, side effect profiles, and other clinical concerns. A high quality mental health system should include full access to approved psychiatric medications and should enable clinicians, in partnership with consumers, to make informed medication decisions tailored to the individual. The system also should include mechanisms for providing physicians with feedback about prescribing patterns and ongoing education about best practices.

C. Assertive Community Treatment (ACT).

ACT is the most studied and widely adopted model for addressing the needs of people with serious mental illnesses who require multiple services at a high intensity and level of support. ACT programs are characterized by inclusion of all key service components (mental health, substance abuse, etc.) under one administrative entity; low staff-to-client ratios; services that are available on a 24-hour, seven-day-a-week basis; a client-centered program philosophy that encourages the provision of services at whatever location that client prefers; and a mobile crisis management capability. While relatively expensive, ACT programs have a track record of success in reducing far costlier hospitalizations and other adverse consequences of lack of treatment.

> While relatively expensive, ACT programs have a track record of success in reducing far costlier hospitalizations and other adverse consequences of lack of treatment.

D. Integrated Dual Diagnosis Treatment (IDDT).

IDDT is an evidence-based program designed for people with co-occurring mental illnesses and substance abuse disorders. It is characterized by both mental health and substance abuse treatment provided at the same time and in one setting. Research results demonstrate that integrated approaches to mental health and substance abuse treatment are more effective and produce better outcomes than non-integrated approaches.

E. Illness Management and Recovery.

Illness management programs are intended to educate consumers about their mental illness so they may make informed decisions and generally manage the course of their illness effectively. These programs generally are conducted by professionals and are distinguished from illness-self-management programs which are conducted by peers. While these programs provide strategies for minimizing symptoms and preventing relapse, many go further and try to help recipients achieve personal goals and recovery. Research conducted on these programs provides promising indications that they are successful in increasing consumer knowledge and fostering recovery.

Jails and prisons have become de facto psychiatric treatment facilities.

F. Family psychoeducation.

Family psychoeducation programs are designed to educate and inform family members about the mental illness of a loved one and to participate in a meaningful and informed way, in partnership with consumers and providers, in helping to prevent relapse and to foster recovery. Studies show a reduction in relapse and re-hospitalization rates among consumers whose families have participated in family psychoeducation programs.

G. Supported Employment.

Supported employment is an evidence-based approach to helping consumers find and maintain competitive employment. Unlike the traditional approach to vocational rehabilitation, which involved job training and subsequent job placement, supported employment follows a "place and train" model. People with mental illnesses are helped to find a suitable job and are provided with job coaching and related services designed to help them keep it. Research on supported employment demonstrates its effectiveness in improving employment outcomes for consumers.

H. Jail Diversion.

Jails and prisons have become de facto psychiatric treatment facilities. It is conservatively estimated that 16 percent of all inmates—more than 300,000 people—in U.S. jails and prisons suffer from serious mental illnesses. Jail diversion programs are collaborations between criminal justice and mental health systems designed to link individuals (primarily non-violent offenders diagnosed with serious mental illnesses or co-occurring mental illness and substance abuse disorders) with appropriate services instead of incarceration. Jail diversion strategies include pre-booking diversion initiated prior to arrest, and post-booking diversion, which is initiated following arrest and is often under the ongoing supervision of courts.

I. Peer Services and Supports.

The provision of services by peers is a growing trend in the mental health field. These services include case management, drop-in centers and clubhouses, outreach programs and consumer-run businesses. The benefits of these services are two-fold: first, they provide meaningful work for consumers employed as peer specialists and peer counselors, and second, there is emerging evidence that peer services produce positive outcomes. In recognition of this, peer specialists are now included as part of recommended staffing for ACT teams.

J. Crisis Intervention Services.

A quality mental health system must have mechanisms in place to respond in a timely and compassionate manner to people with serious mental illnesses in crisis. Too often, these responsibilities are left to law enforcement. Mobile crisis intervention services should be available on a 24-hour, seven-day-a-week basis. Acute care hospital beds and/or crisis residential services must be available for individuals identified as needing that level of service.

The provision of services by peers is a growing trend in the mental health field.

The list set forth above represents NAMI's judgment about what constitutes the essential elements of high quality mental health services. It is by no means an exhaustive list. Other services that should be available include psychiatric rehabilitation, clubhouses or drop-in centers, and supported education.

2. Integrated Systems.

To achieve recovery, people with serious mental illnesses require multiple services, ranging from psychiatric treatment to housing to rehabilitative services. Typically, these services are furnished by different providers accessing different sources of funding, and therefore operating under different rules. The result is a mental health system that, in the words of President Bush's New Freedom Commission on Mental Health, "looks more like a maze than a coordinated system of care."

Complex, uncoordinated mental health service systems serve no one's interest—not providers, not families, and certainly not consumers. One important element of quality in a mental health system is the extent to which the various services required by individual consumers—and the funds used to pay for these services—are provided in the most user-friendly manner possible. This requires close collaboration among the systems responsible for providing the various services.

One method being tried involves integrating diverse funding streams into one general fund. However, even without blended funding, it is possible to coordinate services to design effective service systems at local levels. Coordination must occur, for example, between SMHAs and regional or local mental health systems and providers to facilitate seamless transitions from inpatient to outpatient services. And, coordination also must occur among the myriad state agencies offering services for people with serious mental illnesses.

As the entity most knowledgeable about the services consumers need and how best to deliver them, SMHAs should be at the center of these integration efforts. Moreover, SMHAs should be aware of all services for consumers, even those for which they are not directly responsible. For example, SMHAs should be involved in the design of jail diversion or supportive housing initiatives, even though they may not be directly responsible for funding these services. Similarly, SMHAs should be aware of where these programs and services exist at local levels.

There is increasing awareness that short-term savings accrued through cuts in public mental health funding lead to increased long-term public costs associated with hospitalizations, incarcerations, and other costly consequences of lack of treatment.

3. Sufficient Funding

In recent years, many states faced with budget deficits have cut mental health services funding and/or increasingly relied on Medicaid to pay for community mental health services. Today, Medicaid is the largest single payer of public mental health services. Since Congress has recently enacted cuts to the federal portion of Medicaid, burdens on states are likely to increase even more.

Continuing disparities in mental health coverage in health insurance is also a factor. Although 36 states have enacted parity laws, the lack of a federal parity law is an impediment to achieving true equity in coverage of mental illnesses in private health insurance. And, costs not picked up by private insurance frequently are shifted to state mental health systems.

There is increasing awareness that short-term savings accrued through cuts in public mental health funding lead to increased long-term public costs associated with hospitalizations, incarcerations, and other costly consequences of lack of treatment. NAMI's research for this project reveals that a few states have increased mental health funding in recent years, even in the face of overall budget deficits.

Funding is not the only solution. Funds allocated for services that don't work or systems that don't effectively coordinate mental health services are wasteful and inefficient. However, the provision of high quality mental health services cannot be achieved without adequate funding. The sad reality today is that few states are funding public mental health services at levels sufficient to enable all or even most who need those services to receive them.

4. Consumer and Family Driven

Historically, consumers have had little involvement in the services they receive or the settings in which they receive them. Some consumers continue to have negative experiences with the treatment system, which deters many from continuing to participate in services. Families, too, often have been discounted as having any role to play despite the fact that, in many cases, families function in a primary caregiving role.

In recent years, there has been some progress in creating systems that are responsive to the concerns of consumers and family members. For example, successful efforts in many states to reduce the use of restraints and limit consumers' seclusion in hospitals can be directly traced to the efforts of consumer advocates.

A system that is truly consumer- and family-driven is characterized by meaningful involvement of consumers and families in the design, implementation and evaluation of services. Consumers and family members should be regarded as true partners in this enterprise, not as mere advisors whose feedback can be ultimately discounted. Mental health systems should operate in a transparent manner, welcoming and supporting monitoring and feedback from consumers and family members. One promising development in a few states is the emergence of consumer and family teams responsible for monitoring the quality of psychiatric treatment facilities and other mental health services.

5. Safe and Respectful Treatment Environments.

As discussed above, many consumers have had painful experiences with the treatment system. These experiences—such as being put into restraints or seclusion, suffering abuse and assault, or encountering a general disregard of one's concerns while in a treatment facility —reduce trust and willingness to participate in future treatment. Inpatient psychiatric treatment facilities and community treatment or residential programs are unsafe and even dangerous in some parts of the country.

As any consumer of healthcare services would expect, people with serious mental illnesses should be treated with dignity and respect while in inpatient or community treatment programs. Adequate staffing must be maintained and program staff should receive training on crisis de-escalation techniques in order to avoid the use of restraints or seclusion. Consumer complaints of abuse and neglect should be investigated promptly, the findings shared with the consumer, and steps taken to remedy any problems that are identified. All deaths or serious injuries that occur in psychiatric treatment programs must be reported and investigated.

6. Accessible Information for Consumers and Family Members.

Being diagnosed with mental illness is a traumatic and unsettling experience for consumers and their families. At such times, accurate information about the specific diagnosis, treatment options and community resources is vitally important. Unfortunately, this information is frequently unavailable.

NAMI believes that SMHAs play a critical role in disseminating information to the public about mental illnesses and where people diagnosed with these illnesses can go for help. As reliance on the Internet increases, this information should be available on the SMHA website. Moreover, SMHAs should develop written materials and resources and provide training to their employees about how to respond effectively to inquiries from the public.

> Families, too, often have been discounted as having any role to play despite the fact that, in many cases, families function in a primary caregiving role.

7. Access to Acute and Long-Term Care Treatment.

As efforts to transform state mental health systems from institutional to community-based care continue, adequate resources must be maintained for the provision of acute or long-term psychiatric treatment for those who need it. These resources should include acute care beds, group homes or other 24-hour residential programs for people who require continuous care on a long-term basis. The use of nursing homes or unlicensed and unregulated board and care homes to address the needs of previously institutionalized individuals is not appropriate.

8. Cultural Competence

Communities throughout the country are becoming more diverse, with a rich mix of racial and ethnic groups. Mental health services should be designed and delivered in a culturally competent manner. A number of states have made significant strides in developing culturally competent services, some of which are highlighted in this report. Awareness of the need for cultural and language competence should be incorporated in all aspects of mental health planning and service delivery, including staff recruitment, staff training, development of resource materials, and service delivery.

9. Health Promotion and Mortality Reduction

Studies have shown that people with schizophrenia and other serious mental illnesses have a higher risk of medical disorders such as diabetes, hypertension, and heart disease than people without mental illnesses. There are a number of possible contributing factors, including high rates of smoking among people with mental illnesses, reduced physical activity and fitness levels, and the side effects of psychiatric medications. NAMI believes that a high quality mental health system must promote the overall health of those it serves through the integration of primary medical care with psychiatric treatment. Health-promoting activities such as exercise, smoking-cessation programs, and dietary education must be offered and data about medical risk factors and health mortality rates collected.

10. Adequate and Qualified Mental Health Workforce

There is a significant shortage of qualified mental health personnel across the country. This shortage pervades all aspects of the field, from psychiatrists to caseworkers and other direct service personnel. NAMI believes that SMHAs should work in partnership with other relevant agencies and institutions (e.g., universities) on initiatives to ensure an adequate supply of qualified mental health personnel. These initiatives should consider strategies such as educational subsidies, loan forgiveness programs, continuing education, competitive salary and benefit structures, and inclusion of consumers and family members within the mental health workforce.

Policy Recommendations

1. Increase funding tied to performance and outcomes.

In recent years, most states either have reduced funding of services for people with serious mental illnesses or have level-funded these programs. The impact of inadequate funding has been devastating—we now see overflowing emergency rooms with no place for people to go, increased numbers of people with serious mental illnesses in jails and prisons, and large numbers of people without access to desperately needed services.

State legislators and policymakers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society. These cuts affect systems in a very negative way. Corrections systems, indigent care systems, emergency medicine, or homeless service providers are left to pick up the pieces.

State legislators and policymakers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society.

At the same time, NAMI understands and supports the importance of linking public-sector mental health expenditures with positive outcomes. Thus, we believe that states should be able to demonstrate that mental health services funded through Medicaid, the Federal Mental Health Services Block Grant, or state dollars achieve positive outcomes such as reduced symptoms, increased independence, employment, housing, and increased consumer satisfaction. States also should be able to show that these expenditures reduce negative outcomes such as hospitalizations, homelessness, criminal justice involvement, and suicides.

If a state mental health system is unable to demonstrate the positive impact of the services it funds, legislators and policymakers are justified in raising questions about the value of the funding. We believe that the federal government, through the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), and other agencies administering services and programs that affect people with serious mental illnesses, should provide technical assistance to ensure that such funds are being used appropriately and achieving positive outcomes.

As a last resort, non-performance by a mental health system may be a justifiable reason to reallocate mental health funds to other systems and programs that bear the burdens of failed mental health policies and services, such as jail diversion programs, homeless shelters, and emergency rooms.

2. Invest in evidence-based and emerging best practices.

In the section of this report entitled "Standards for a Quality Mental Health System—A Vision for Recovery" we have described the elements of what we believe constitute high-quality services for people with serious mental illness. Unfortunately, the research we conducted in preparing this report revealed that the services discussed in that section are in short supply, or even non-existent, in many parts of the country.

This is not acceptable. If services with an established research base of demonstrated effectiveness are not translated into practice, the cynicism of policymakers may be justified. On a more positive note, SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD) are engaging in efforts to promote the widespread adoption of evidence-based and emerging best practices. And state mental health authorities in some states are taking leadership in working with other agencies and systems on jail diversion, supported housing, employment, and other critical services.

NAMI understands and supports the importance of linking public-sector mental health expenditures with positive outcomes.

3. Improve data collection, reporting, and transparency of information.

In preparing this report, we tried to find existing data that would help give advocates and consumers information about state mental health systems and how well they were performing. We found very little. The data that exist are not designed to allow easy state comparisons and are not linked to consumer outcomes.

SAMHSA, as the agency with responsibility for oversight of mental health services, must develop uniform outcomes measures and insist that states provide data on these measures as part of their block grant reporting requirements. This information should be accessible and transparent and be used to guide the development of priorities by state legislators and policymakers.

Our research for this report also revealed that state mental health authorities are, by and large, not doing well in providing easily accessible information about mental illnesses and mental health resources to their customers—consumers and family members. This is another area that requires significant improvement. In this day of enhanced information technology, it is reasonable to expect states to fulfill their fundamental obligation to provide easily accessible and understandable information about the services they provide.

4. Involve consumers and families in all aspects of the system.

Although lip service is given to the importance of consumer- and family-driven systems, we found very few examples where this important principle actually is being translated into practice. The examples we did find are exemplary and should be replicated in all states.

For example, in recognition of growing evidence about the effectiveness of peer services and supports, Georgia is the first state that reimburses certified peer counselors in its Medicaid program. Other states should follow Georgia's lead.

Another example is the use of independent, third-party, consumer- and family-monitoring teams used to conduct inspections and monitor conditions in psychiatric treatment facilities. These teams have proven effective in the past in states such as Delaware, New Hampshire, Oklahoma, and Pennsylvania. All states should similarly involve consumers and family members in oversight and monitoring activities.

States are required under the Federal Public Health Services Act to include consumers and family members on state mental health planning councils. We strongly believe that the involvement of consumers and family members must extend significantly beyond an advisory function. Unfortunately, on an overall basis, involvement of consumers and families in various aspects of the mental health system (planning, implementation, and evaluation) is token at best. Some states and systems apparently find it difficult to break away from outdated, paternalistic attitudes toward the people they are charged with serving.

The federal Medicare program also contains provisions that discriminate against people with mental illness.

5. Eliminate discrimination.

People with serious mental illness encounter stigma and discrimination in all aspects of their lives. Overcoming this discrimination requires not only community education, but also the change of certain federal policies that reinforce this discrimination.

For example, Congress continues to sanction discrimination against people with serious mental illness by failing to enact a federal law requiring that mental illnesses be covered on a par with all other medical disorders in health insurance policies.

> SAMHSA, as the agency with responsibility for oversight of mental health services, must develop uniform outcomes measures and insist that states provide data on these measures as part of their block grant reporting requirements.

The federal Medicaid program contains a provision that similarly encourages discrimination toward people with serious mental illness. Since its inception, there has been a provision in federal law prohibiting the use of federal Medicaid dollars to pay for services in an "institution for mental disease" (IMD), defined as a facility with 16 or more beds, at least 50 percent of which are used for psychiatric treatment. This provision serves as a barrier not only to reimbursing care in psychiatric hospitals, but also to implementing Medicaid-reimbursable home- and community-based waivers of the kind that have been very helpful in facilitating recovery among people with developmental disabilities, and other Medicaid populations.

Finally, the federal Medicare program also contains provisions that discriminate against people with mental illness. For example, while Medicare covers 80 percent of the costs of outpatient treatment for traditional medical disorders, it covers only 50 percent of the costs of outpatient psychiatric treatment.

NAMI calls upon Congress and the President to set an example for the rest of the nation by moving swiftly to change these discriminatory policies. Outdated laws that reinforce stigma and faulty assumptions about mental illnesses should not be allowed to continue.

Innovations

A Sample of State Innovations and Best Practices, as viewed by NAMI

During the development of this report, programs and policies emerged that represented sound examples of innovation and commitment to providing high-quality services to people living with mental illness. They are shining examples of high quality. The following list is not comprehensive, but it demonstrates the pioneering approach that is necessary to change fundamentally America's mental health system. There is an urgent call for our nation to take steps to make these programs the norm—not the exception.

Financing

- Proposition 63—Voters recognize need to creatively fund services. (California)
- Combining multiple funding sources to streamline care and decision-making. The jury is out, but the effort will teach others. (New Mexico)
- Local municipalities taking the lead to address mental health concern in their communities through special tax districts or unique bond proposals. (Arizona and Colorado)

Housing

- Tremendous progress in developing housing, which rose from almost none in NAMI's 1990 report to among the best today. (Tennessee)
- Transaction fees on real estate transactions to promote rental housing assistance. (Illinois)
- Passage of legislation that dedicates $200 million to create 10,000 units of new supported housing in the next 10 years. (New Jersey)
- Initiative to develop more than 36,000 supportive housing units. (New York)
- Cooperative ("Bridges") program between the state mental health authority and the housing finance agency to provide $650,000 in housing subsidies for people with serious mental illnesses. (Minnesota)

Five states received excellent scores in our survey for their work in employment.

Restraint and Seclusion Reduction

- The leadership of the National Association of State Mental Health Program Directors (NASMHPD) drives a national culture change.
- Significant reductions in use of restraint and seclusion in a forensic setting at North Texas Hospital (Texas) and Taylor Hardin Secure Medical Facility. (Alabama)
- Regulations enacted in 2006 to codify a preventive approach and discourage the use of restraint and seclusion in all facilities, both acute and tate-run. (Massachusetts)

Jail Diversion

- A culture of jail diversion that penetrates almost the entire state. (Ohio)
- Legislation mandating a telephonic triage system to screen jail inmates for mental illness and to provide linkages to treatment. (Kentucky)

- Extensive post-booking jail diversion programs in arraignment courts. (Connecticut)
- TAMAR (Trauma, Addictions, Mental Health, and Recovery) Project for the treatment of female consumers in detention centers. The program also helps their children. (Maryland)

- Prison education program run by NAMI Indiana and supported by the state DMHA and Department of Corrections to educate prison guards and staff about serious mental illnesses. (Indiana)
- Mandatory jail diversion strategies for every county authorized through HB 2292. (Texas)
- Statewide implementation of police crisis intervention training (CIT). (Georgia and Texas)

Employment/Vocational Success

- Five states received excellent scores in NAMI's survey for their work in employment. (Connecticut, Maine, Missouri, New Mexico, and Vermont)
- A rural state is dedicated to employment opportunities, reporting an impressive 41 percent employment rate for consumers. (South Dakota)

Disaster Response

- Quick response and triage to continue service provision and ensure safety of consumers during and after Hurricane Katrina. (Mississippi, Louisiana, Alabama, and Texas)
- Mutual aid support from many states across the country.

Academic/State Collaboration

- Partnerships with SMHAs and universities to establish centers promoting the implementation of EBPs. (Ohio, Hawaii, and Indiana)
- Collaboration to promote the mental healthcare workforce with Yale University. (Connecticut)

Creative Use of Public Land

- Public/private collaboration to rebuild a community mental health center. (Massachusetts)
- Reinvestment of funds from the sale of a state hospital to create increased housing options for individuals with mental illnesses through the Community Mental Health Housing Fund. (Oregon)
- Establishment of the Alaska Mental Health Trust Authority to generate revenue for the state's mental health services. (Alaska)

Mortality Studies

- NASMHPD medical directors are investing in this important issue as a priority.

One state reinvested funds from the sale of a state hospital to create increased housing options for individuals with mental illness.

Multicultural Outreach

- State leadership to encourage and monitor county-based efforts to ensure culturally competent care. (California)
- Efforts to ensure the mental health workforce has appropriate linguistic skills, and that materials are properly translated. (Arizona)
- Establishment of subcommittees—specifically on ethnic/cultural minorities and sexual minorities—to focus on the impact that legislation, public policies, and practices have on the treatment of multicultural and/or minority groups in institutional, residential, and community settings. (Washington)

Co-Occurring Systems Change

- Development of a consumer- and family-driven process to evaluate every level of the system to integrate services for co-occurring disorders. (Oklahoma)
- Leadership to integrate treatment for substance abuse and mental illness, resulting in statewide adoption of integrated dual disorder treatment. (Delaware)
- State-funded program to incorporate mental health treatment principles into a traditional 12-step model, "Double Trouble in Recovery." (Georgia)

Capacity Response

- Using the state's authority to generate new inpatient beds to address a profound need among the population. (Arkansas)

Best Information

- Several states score as top performers on NAMI's Consumer/Family Test Drive. (Tennessee, Ohio, Indiana, South Carolina, and Michigan)
- Several states provide most accessible SMHA Web sites. (South Carolina, Alaska, Minnesota, New York, Tennessee, Texas, Massachusetts, Michigan, Oregon, and California.)
- Web site publication of a report containing data comparing performance in the provision of mental health services with neighboring states. (Nevada)

Parity Laws

- Model parity law that includes substance abuse. (Connecticut, Maryland, Minnesota, Vermont, and Oregon—to take effect in 2007)
- Inclusion of mental health parity in a statewide program to expand health insurance to uninsured populations. (Maine)

Clinical Approaches to Medication Access

- Program to provide clinical feedback to doctors on prescribing patterns that save money and improve outcomes. (Missouri)

Peer Support/Peer Run Programs

- A culture infused with recovery principles. (Vermont)
- Policies to promote recovery and ensure that it is a part of the state's mission and treatment planning. (Connecticut)
- Medicaid reimbursement of certified peer counselors. (Georgia)

Health Promotion

- Development of a program that provides identification and intervention for diabetes, hypertension, and other cardiac risk factors among individuals with serious mental illnesses. (New Hampshire)

Community System of Care

- Comprehensive systems of care with demonstrated linkage between service providers and integrated service approaches. (Vermont and Wisconsin)

Engaging Rural Constituents

- Use of audiovisual technology to eliminate long-haul vehicle transport for persons in need of emergency orders of detention. (Oklahoma)
- "Deliberate and Deliberative" approach to system redesign to improve local service capacity and access within specific budgetary constraints. (Nebraska)

John Elias Baldacci
Governor

Maine Department of Health and Human Services

Commissioner's Office

221 State Street
#11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

February 14, 2007

Senator Joseph C. Brannigan, Co-Chair
Representative Anne C. Perry, Co-Chair
Joint Standing Committee on Health and Human Services
Cross Office Building, Room 209
Augusta, ME 04333

Senator Margaret Rotundo, Co-Chair
Representative Jeremy R. Fischer, Co-Chair
Joint Standing Committee on Appropriations and Financial Affairs
State House, Room 228
Augusta, ME 04333

Dear Senators Brannigan and Rotundo, Representatives Perry and Fischer, and Members of the Joint Standing Committees on Health and Human Services and Appropriations and Financial Affairs:

On behalf of the Department of Health and Human Services I am pleased to provide this report pursuant to Public Law 2005, Chapter 683, section C-11 which appropriated funds to make grants to Androscoggin Home Care and Hospice and the Hospice of Southern Maine. These grants were used to support newly built or to be built in-patient hospice facilities.

While the role of the Department was rather small in scope, we were very happy to have facilitated the grant process that enabled these resources to become available to citizens in Maine who are near the end of their life. Should you have any questions about the report, please feel free to contact me or Diana Scully, Director of the office of Elder Services.

Thank you.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

Enclosure

Maine Department of Health and Human Services
Public Law 2005, Chapter 683, Section C-11
Report to the Joint Standing Committee of Health and Human Service and the Joint Standing Committee of Appropriations and Financial Affairs
February 7, 2007

This report is being submitted pursuant to Public Law 2005, Chapter 683, Section C-11 which appropriated funds for grants to Androscoggin Home Care and Hospice and Hospice of Southern Maine to support newly built or to be built in-patient hospice facilities. (Law 2005, Chapter 683, Section C-11 amended Public Law 2005, Chapter 519, Part GGG-1 to clarify that a competitive bidding process was not required in awarding these funds).

As required by the legislation, both Hospice of Southern Maine and Androscoggin Home Care and Hospice submitted detailed plans to the Department of Health and Human Services by July 1, 2006, including but not limited to information on construction, expected costs, and services to be offered from the facilities. Grant agreements were executed with both entities as of September 1, 2006. Androscoggin Home Care and Hospice and Hospice of Southern Maine were each awarded $125,000. A brief update on these projects, including how the grant funds are being utilized, is set forth below.

Androscoggin Home Care and Hospice:

Hospice House of Androscoggin Home Care and Hospice opened November 2005 in Auburn, Maine. A seven patient suite wing opened in November followed by a second seven patient suite wing in March 2006, one month ahead of schedule.

The total project cost for Hospice House of Androscoggin Home Care and Hospice was $3,864,124 paid for by a combination of a community fundraising campaign that raised $1.6 million, and long term financing. The appropriation from the State of $125,000 is being used to pay down the balance of the loan. The additional funds applied to the principal will save approximately $70,000 in interest over the 15-year amortization period.

A review of first year operations (November 2005-October 2006) found that:

- 261 patients received care at the Hospice House. Eighty-six (86) percent were age 60 and above. The average stay was 10 days,
- Patients came from 52 different towns throughout central, western and southern Maine. The majority (76%) were from Androscoggin County.
- Ninety-three percent of the patients were in need of in-patient hospice care for pain and symptom management. A small number received respite services and others were at the Hospice house for a short time due to a caregiver crisis at home.
- Of those cared for at the Hospice House, 50% had a terminal diagnosis of cancer. Other diagnoses included general debility, respiratory conditions, renal and heart

failure. Eighty-two percent of the patients cared for passed away at Hospice House.

Hospice of Southern Maine:

Construction on the Gosnell Memorial Hospice House began in September 2006.

The estimated cost to build and prepare the facility for occupancy is $5,200,000. In addition, the cost of startup and information technology is estimated to be $600,000. Hospice of Southern Maine has raised $5,500,000 in cash and pledges (the greater part to be received over the next five years) to create the facility. The expenses of the capital campaign are $500,000, leaving $5,000,000 to build the facility. The appropriation from the State of $125,000, along with the procurement of two loans, is being used to cover the gap in funding.

- The facility will be an 18 bed hospice facility in Scarborough, Maine that will serve approximately 700 patients per year and their families.
- The project is on target to complete the building phase in July 2007 and it is anticipated that patients will be admitted beginning in August.
- Once fully occupied, Hospice of Southern Maine anticipates employing 36 full time equivalents to staff the facility.

Further information on these projects, including photographs and the grant application materials, is available from the Office of Elder Services.

working/going to school, whose child care costs are covered, in part, by the Child Care and Development Fund/state child care funds/Fund for a Healthy Maine.

The cost of (1) TANF Transitional Child Care has increased each year as more families go to work and leave TANF. A recent LEAN management Value Stream Mapping Process recommended that TANF Transitional Child Care Subsidy Management be moved from the 11 Voucher Management Agencies under contract with DHHS to the TANF Direct Payment System. This would save TANF an estimated $1,053,000 in FY2008 and '09 for administrative costs currently paid to the voucher management agencies, reducing duplication of administrative costs and the incidence of eligibility errors. From the client perspective, TCC participants will get their services from one agency and one worker; from the child care provider's perspective, they will interface with fewer agencies and workers.

7. Please provide information on the State Supplement to Social Security account, including fiscal history, carry forwards and cuts in the 06 and 07 budget years.

State Supplemental Income is a program operated by the Department in conjunction with federal Social Security Administration's Supplemental Security Income (historically the Aged, Blind and Disabled Program). In the 1970's, when the federal Social Security Administration agreed to operate and fund the Aged, Blind and Disabled Program(which prior to this was a totally state operated and funded program), states were required to provide a supplemental payment to this population as a Maintenance of Effort. Over the years, States are allowed to reach their Maintenance of Effort level through continuing the same individual benefit level or by spending $1 more each calendar year for the entire eligibility population (aggregate method).

From the 1970s until 2002, Maine maintained the MOE level by spending $1 more each calendar year. In 2002, Maine changed from the aggregate method to the individual method which provides the State the ability to have "carry" over funds. In SFY 06, these carry over funds were used to eliminate a budget shortfall for the Department of Health & Human Services.

The State Supplemental Income Maintenance of Effort is also required to preserve the federal match for Medicaid.

The estimated expenditures in SSI for SFY 07 provide for an estimated unexpended balance of $101,596, unexpended balance in SFY 08 of $1,656,938 and in SFY 09 of $1,088,264.

Estimated State Supplemental Payment Expenditures
Mar-07

	SFY 07	SFY 08	SFY09
Budget Amount	$9,167,196	$8,167,196	$8,167,196
Chapter 12, Part B	($214,443)		
Chapter 519, Part A	($1,000,000)		
Chapter 519, Part A	($2,200,000)		
Sub Total	$5,752,753	$8,167,196	$8,167,196
Balance forward	$0	$101,596	$656,938
Est Expend		$6,611,854	$7,735,870
Unexpended Balance		$1,656,938	$1,088,264
Move to TANF for MOE		($1,000,000)	($1,000,000)

Estimated a 15-17% increase in expenditures based on increased aging and historic pattern.

Estimated a 15%-17% increase in expenditures based on increased aging and historic pattern.

8. See attachment #7 for an overview of programs administered by the Office of Integrated Access and Support.

DHHS Reductions in Cooperative Agreements							
Total reduction		$1.4 Million					rev10- 5/22/07
We working with the Universities on the $1.4 million cut and are taking the opportunity to reframe our agreements and relationships. Currently the spread of reductions is 69% in Training; 19% in technical assistance and 13% in research and evaluation.							
			Total		WorkForce Develoment	Technical Assistance	Research
Center for Learning							
	OACPD		$ 40,533		$ 40,533		
	AMHS		$ 212,673		$ 127,604	$ 85,069	
Child and Family			$414,201		$414,201		
Behavioral Health Science Institute							
	CF		$ 42,649		$ 42,649		
	OACPD		$ 15,443		$ 15,443		
OIAS			$ 79,225		$ 79,225		
OMS	Information		$ 13,000			$ 13,000	
	Policy Research		$ 115,798				$ 115,798
	TA & Training		$ 54,504		$ 27,252	$ 27,252	
	Research Institute		$ 77,847			$ 77,847	
DHHSTI	Technology		$ 75,000		$ 75,000		
OSA			$ 79,275		$ 79,275		
Commissioner			$ 83,995		$ 27,998	$ 27,998	$ 27,999
	Total		$ 1,304,143		$ 929,180	$ 231,166	$ 143,797
Current project reduction			$ 95,857		$ 31,952	$ 31,952	$ 31,953
			$ 1,400,000		$ 961,132	$ 263,118	$ 175,750
			100%		69%	19%	13%

Figueroa, Kirsten

From: Harper, Sandra J
Sent: Friday, February 16, 2007 1:10 PM
To: Leet, Tim
Cc: Nolan, Christopher; Figueroa, Kirsten
Subject: LD 499 Funding mechanism for Attorney General

The Biennial budget contains a proposal to change the funding mechanism for the provision of legal services by the Office of the Attorney General for the DHHS.
The proposal transfers all positions working full time on DHHS matters and their related costs to one account in the Office of the Attorney General. It changes the current system of funding for these positions from one based primairly on legislative fund transfer and partially on invoicing to a system in which the DHHS receives internal bills for all the legal services.
1. This proposal creates one consistent method of payment for legal services within both Departments. Currently with the exception of DHHS all state Departments and Agencies that fund legal services provided by the Office of the Attorney General do so using the internal billing system. DHHS primarily transfers funds to the Office but also uses the internal billing system for another 12.1 FTE. Current policy from the Bureau of the Budget and the Controller' Office direct that if an agency is providing services to another agency it should be recorded as an expenditure not as a transfer. This change will move funding into compliance with this policy.
2. The current appropriation/ allocation budget structure within the Office of the Attorney General is not in alignment with the way the Department receives FFP. In other words the Office may have a General Fund position which is eligible for FFP at 50%. To maximize FFP to the state DHHS collects information on all positions providing services to the DHHS funded through either fund transfer or the AG General Fund and calculates FFP based on time studies rather than the position's actual budgeted account. By moving to the new system all positions will be in the same account. This will insure that all positions and information will be treated in the same way and will eliminate the incongruity created by a budget structure which is not aligned with the accounting processes collecting FFP.
3. Under this proposal DHHS would pay for their legal services through an All Other expenditure. This then would provide the proper accounting for the cost of a program because the legal services would be recorded as part of the program's expenses. Currently only the legal services paid for through the internal billing system are picked up in that fashion.

The biennial budget reflects this proposal in the following way:
LD 499 pgs 82, 83, 84, and 75. This shows the consolidation of the DHHS related legal services into the DHS program 0696 Other Special Revenue account.
LD 499 pg 323. This shows the appropriation of General Fund All Other to DHHS Departmentwide program 0640. This appropriation is made up of two components:
1. the continuation of the $1,689,361 appropriated in the FY07 Emergency Budget to provide the correct amount of match for the FFP. This annualizes in FY08 at $1,742,096 and in FY09 $1,814,301.
2.the value of the General Fund deappropriation (pg 82)of the Office of the Attorney General match for DHHS of $1,301,162 in FY08 and $1,370,681 in FY09.
Thus the request for DHHS $3,043,258 in FY08 and $3,184,982 in FY09.

Please let me know if you would like any additional explanation of this funding mechanism. Thanks.

Figueroa, Kirsten

From: Harper, Sandra J
Sent: Wednesday, May 23, 2007 9:52 AM
To: Dionne, James K.
Cc: Figueroa, Kirsten; Schneiter, Ellen; Leet, Tim
Subject: response to Approps request

Jim, I made a chart that I think will get to what you were asking me for yesterday. Numbers are estimates and represent the Office of the Attorney General perspective, of course. I can't speak to the DHHS accounts. I am sure that Kirsten can provide you with whatever you need from that end. If anything more.

Funding for DHHS related services in the Office of the Attorney General

		FY07	FY08	FY09	
AG Program 0696 costs					
	Match or General Fund seed for FFP				
	AG General Fund	1,212,392	1,301,162	1,370,681	Current Services (
	AG General Fund		-1,301,162	-1,370,681	transferred to DHI
	DHHS Departmentwide		1,301,162	1,370,681	transferred from A
	DHHS supplemental continuation	1,689,361	1,742,096	1,814,301	Needed to continu
	subtotal GF match	2,901,753	3,043,258	3,184,982	DHHS Departmer
	FFP	1,768,979	1,916,666	2,008,614	
	Subtotal program 0696	4,670,732	4,959,924	5,193,596	
AG Program 0310 costs	billed through REs				
	DHHS seed for FFP	558,776	586,764	620,686	
	DHHS FFP	683,568	718,822	761,404	
	Subtotal program 0310	1,242,344	1,305,586	1,382,090	
Total	**Seed or GF Match**	3,460,529	3,630,022	3,805,668	
Total	**FFP**	2,452,547	2,635,488	2,770,018	
	Grand total	5,913,076	6,265,510	6,575,686	