# L.D. 1838
# Briefing Book

An Act to Include Mental Retardation, Developmental Disability and Substance Abuse Services in the Community Service System of the Department of Mental Health, Mental Retardation, and Substance Abuse Services and to Consolidate Those Advisory Bodies to the Department.

**Prepared by:**
**Department of Mental Health, Mental Retardation, and Substance Abuse Services**

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## Overview

In April, 1996, Governor King signed into law a bill passed by the Legislature known as **"An Act Redefining the Community Services Structure of the Mental Health System (L.D. 1704, P.L. 1995, Chapter 691)."** This law authorized the development of Quality Improvement Councils (QICs); established seven geographic areas for local service planning; prescribed essential elements of local network services; mandated the development of Local Service Networks (LSNs); defined the roles and responsibilities of QICs and LSNs; and, mandated the establishment of a statewide QIC.

Section 3607 of Chapter 691 required the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) to establish nine quality improvement councils to oversee the delivery of mental health services to children and adults under the authority of DMHMRSAS. Seven of the councils were defined by geographic area (known as area or local councils); the remaining two councils, known as institute councils, were established for the Augusta Mental Health Institute and for the Bangor Mental Health Institute.

The seven geographic areas, each required to have a quality improvement council (QIC) and a local service network (LSN) are:

- **Aroostook**: Aroostook County;
- **Northeast**: Hancock, Washington, Penobscot, and Piscataquis counties;
- **Ken-Som**: Kennebec and Somerset counties;
- **Coastal**: Knox, Lincoln, Sagadahoc, and Waldo counties;
- **Western**: Androscoggin, Franklin, and Oxford counties;
- **Cumberland**: Cumberland County; and
- **York**: York County.

Because the purpose of the new law was to provide local input into the service delivery system, and because it was most important that the input represent the range of persons who are served by and/or otherwise interact with the local service system, categories of membership on the councils were established in law as follows, collectively referred to as system stakeholders:

- Consumers of mental health services;
- Family members of adult consumers of mental health services;
- Parents of consumers of mental health services under age 18;
- Providers of mental health services;
- Representatives of the community at large.

When the legislature enacted Chapter 691 in 1996, it established local structures dedicated specifically and only to mental health services. In the fall of 1997, Commissioner Peet requested that system stakeholders gather to look at expanding the QICs and LSNs to include mental retardation/developmental disability services as well as substance abuse services. By this time, quality improvement groups (QIGs), consisting of stakeholders in the mental retardation/developmental disability service system, had begun meeting informally in most of the seven network areas, but they had no statutory authority for their activities.

From September, 1997 through February, 1998, three facilitated day-long meetings were held at which representatives of existing QICs and QIGs, as well as persons representing the substance abuse service system, came together to craft a model for local collaborative quality councils. The model and these legislative changes drawn from it contain many compromises and reflect the wishes of the majority, but not all, of those present at the restructuring meetings. The model was explicated in a position paper on Collaborative Quality Councils issued by the Department in April, 1998 (see Appendix) following additional stakeholder input through a draft-review-revision process. This bill will give statutory authority for stakeholders of all Department services to participate in their local quality councils, and will include in the local service networks providers of services to persons with mental retardation and/or developmental disabilities and providers of services to persons receiving substance abuse services.

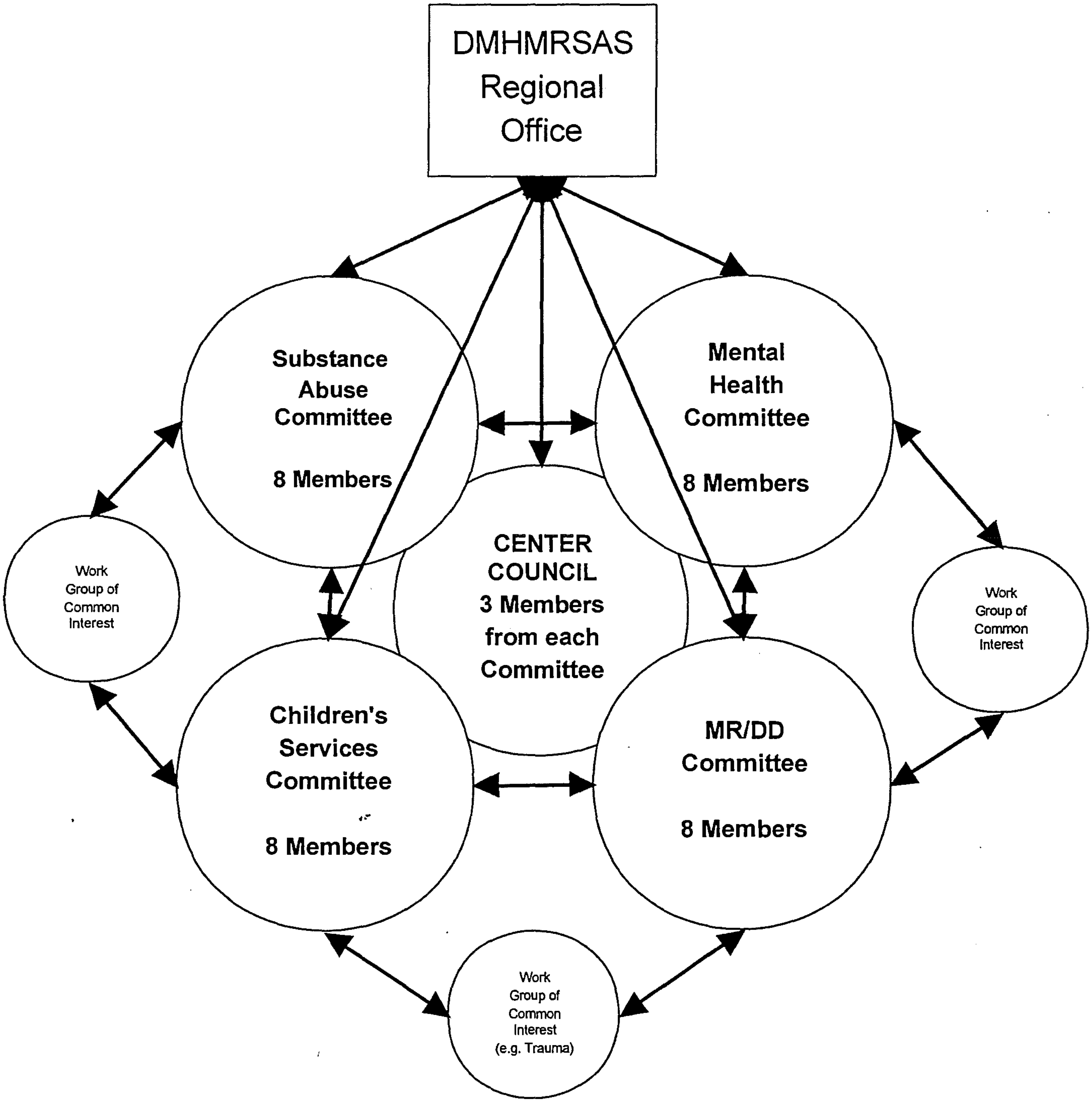
In order to further the restructuring of the Department and to bring down artificial barriers to services created by unnecessarily strict separation of adult and children's mental health, mental retardation, and substance abuse systems, the Department proposes to eliminate certain advisory committees which exist now to advise the Commissioner on statewide planning and implementation, and have become, since enactment of the QIC legislation, duplicative in nature. The functions of these groups will be assumed by the Statewide Quality Improvement Council, which is reflective of all constituencies served by the Department.

The attached diagram of the Network Quality Councils, as well as the table of committee membership, is included herewith to aid in understanding the changes being proposed in L. D. 1838. In addition, this book also contains copies of information supplied to QIC's and LSN's over the last two years as the Department has worked in concert with its stakeholders to further define and refine local systems of care for persons served by DMHMRSAS. That information is divided into four general sections, as follows:

- Quality Improvement Councils, Roles and Responsibilities
- Local Service Networks, Roles and Responsibilities
- QIC Collaborative Model Design
- Related Quality Assurance/Quality Improvement Information

Questions regarding any of the information contained herein should be directed to Nancy L. Essex, DMHMRSAS Director of Community Systems Development; she may be reached at (207) 287-4205.

# NETWORK QUALITY COUNCILS



Work Groups can exist among any combination of committees. The above are examples only.

# Network Quality Council Membership

| Stakeholder Category | Mental Health Committee | Children's Committee | MR/DD Committee | Substance Abuse Committee |
|---|---|---|---|---|
| Consumers | 3 | 2 (adolescents) | 3 | 3 |
| Family Members | 2 | 0 | 2 | 2 |
| Parents | 0 | 3 | 0 | 0 |
| Service Providers | 2 | 2 | 2 | 2 |
| Community | 1 | 1 | 1 | 1 |
| **TOTALS** | **8** | **5** | **8** | **8** |

<u>**Definitions Per Statute:**</u>

- **Consumer:** (As proposed by L.D. 1838) An adult or child recipient or former recipient of publicly funded mental health, mental retardation, developmental disability or substance abuse services.
- **Family Member:** A relative, guardian or household member of an adult consumer.
- **Parent:** A parent or a person who has acted in that capacity or assumed that role for a consumer under 18 years of age.
- **Service Provider:** (As proposed by L.D. 1838) A person or organization providing publicly funded services to consumers or family members under the authority of the department.
- **Community Member:** Persons who represent the composition of the community at large.

# 119th MAINE LEGISLATURE

## FIRST REGULAR SESSION-1999

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Legislative Document No. 1838

H.P. 1277 House of Representatives, March 11, 1999

### An Act to Include Mental Retardation, Developmental Disability and Substance Abuse Services in the Community Service System of the Department of Mental Health, Mental Retardation and Substance Abuse Services and to Consolidate Those Advisory Bodies to the Department

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Submitted by the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to Joint Rule 204.

Reference to the Committee on Health and Human Services suggested and ordered printed.

Joseph W. Mayo

JOSEPH W. MAYO, Clerk

Presented by Representative KANE of Saco.
Cosponsored by Senator PARADIS of Aroostook and
Representatives: BRAGDON of Bangor, BROOKS of Winterport, FULLER of Manchester, POWERS of Rockport, SNOWE-MELLO of Poland, Senators: MacKINNON of York, MITCHELL of Penobscot.

**Be it enacted by the People of the State of Maine as follows:**

**Sec. 1. 5 MRSA §12004-I, sub-§59,** as enacted by PL 1987, c. 786, §5, is repealed.

**Sec. 2. 5 MRSA §12004-I, sub-§61,** as amended by PL 1989, c. 73, §1, is repealed.

**Sec. 3. 5 MRSA §12004-I, sub-§63,** as enacted by PL 1987, c. 786, §5, is repealed.

**Sec. 4. 34-B MRSA §1209-A,** as amended by PL 1989, c. 503, Pt. B, §161, is repealed.

**Sec. 5. 34-B MRSA §1210,** as amended by PL 1993, c. 410, Pt. CCC, §13, is repealed.

**Sec. 6. 34-B MRSA §3604, sub-§5,** as enacted by PL 1995, c. 691, §6, is repealed.

**Sec. 7. 34-B MRSA §3604, sub-§5-A** is enacted to read:

**5-A. Exclusion.** Beginning October 1, 1999, an organization that receives a grant from or enters into a contract with the department for the provision of services under the authority of the department must be a participating member of the local service network, as described in section 3608, for the region of the State subject to that grant or contract.

**Sec. 8. 34-B MRSA §3607,** as amended by PL 1997, c. 683, Pt. B, §22, is further amended by repealing and replacing the headnote to read:

**§3607. Quality councils**

**Sec. 9. 34-B MRSA §3607, first ¶,** as repealed and replaced by PL 1997, c. 683, Pt. B, §22, is amended to read:

The department shall establish 7 local quality ~~improvement~~ councils, called ~~area~~ network quality councils, to evaluate the delivery of ~~mental-health~~ services to children and adults under the authority of the department ~~or--who--have--a--major--mental illness,~~ and to advise the department regarding quality assurance, systems development and the delivery of mental health, mental retardation, developmental disability and substance abuse services to children and adults under the authority of the department. The department shall also establish 2 institute councils to evaluate the delivery of mental health services at the 2 state mental health institutes and advise the department regarding quality assurance, operations and functions of the mental health institutes.

**Sec. 10. 34-B MRSA §3607, sub-§1, ¶¶A-1 and A-2** are enacted to read:

A-1. "Center council" consists of representatives elected from each of the 4 population-specific committees of the network quality council that is responsible for decisions or recommendations that pertain to the network quality council as a whole or 2 or more of its committees.

A-2. "Committee" or "population-specific committee" is a group of members who have responsibility for decisions or recommendations that pertain to the specific population to which the work of the committee is dedicated.

**Sec. 11. 34-B MRSA §3607, sub-§1, ¶B,** as amended by PL 1997, c. 371, §2, is further amended to read:

B. "Consumer" means a an adult or child recipient or former recipient of publicly funded mental health, mental retardation, developmental disability or substance abuse services ~~or-an-adult-who-has-or-had-a-major-mental-illness~~.

**Sec. 12. 34-B MRSA §3607, sub-§1, ¶¶C and H,** as enacted by PL 1995, c. 691, §7, are amended to read:

C. "Council" means a network quality ~~improvement~~ council or an institute council approved by the commissioner pursuant to subsection 2, paragraph D. A local council consists of the center council plus its 4 population-specific committees.

H. "Service provider" or "provider" means a person or organization providing publicly funded ~~mental---health~~ services to consumers or family members under the authority of the department.

**Sec. 13. 34-B MRSA §3607, sub-§1, ¶I** is enacted to read:

I. "Stakeholders" collectively refers to those people identified in paragraphs A, B, D, F and H.

**Sec. 14. 34-B MRSA §3607, sub-§2,** as enacted by PL 1995, c. 691, §7, is repealed and the following enacted in its place:

**2. Councils established.** There is established an approved network quality council for each area designated in subsection 3, referred to in this section as "local council," and for the Augusta Mental Health Institute and the Bangor Mental Health Institute, referred to in this section as "institute council." The councils operate under the authority of the department. Each council consists of members chosen pursuant to paragraphs B and C.

A. The councils shall assist the department and providers with systems planning and needs assessment at the local level and community education and quality improvement activities that must be implemented at the local level. The councils shall perform program assessment through service evaluation teams, as described in paragraph E.

B. Each network quality council consists of the following 4 population-specific committees of 8 members each, whose membership takes into consideration local geographic factors.

(1) A mental health committee, which advises the department regarding issues germane to adult mental health services, consists of 3 adult mental health consumers, 2 family members of adult mental health consumers, one community member and 2 mental health service providers.

(2) A mental retardation and developmental disabilities committee, which advises the department regarding issues germane to adult mental retardation services and developmental disability services, consists of 3 consumers of mental retardation or developmental disabilities services, 2 family members of persons with mental retardation or developmental disabilities, or both, 2 mental retardation or developmental disabilities service providers and one member of the community.

(3) A children's services committee, which advises the department regarding issues germane to mental health services, mental retardation services and developmental disability services and substance abuse services to persons under 18 years of age, consists of 2 adolescent consumers of mental health services, mental retardation services, substance abuse services or developmental disability services, 3 parents of consumers of such services, 2 providers of such services and one member of the community.

(4) A substance abuse committee, which advises the department regarding issues germane to adult substance abuse services, consists of 3 consumers of substance abuse services, 2 family members of consumers of substance abuse services, 2 substance abuse service providers and one member of the community.

The department shall adopt rules for committee membership. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

C. Each institute council consists of 16 members whose membership takes into consideration local geographic factors. The membership on each council consists of 4 consumers of mental health services, 4 family members of such consumers, 4 community members and 4 mental health service providers.

D. The councils shall adopt bylaws that establish the terms and qualifications of membership, the selection of members succeeding the initial members and the internal governance and rules. The commissioner shall approve the bylaws of each council, prior to designating it as an approved network quality council.

E. Under the supervision of each council, a service evaluation team of nonprovider members shall periodically review programs funded with public money. The results of the review must be reported to the council, the local service network and the regional director for the department and must be considered in funding decisions by the department. To the extent possible, there must be one service evaluation team per population-specific committee.

F. Each network quality council must have a center council, consisting of a maximum of 12 members. Each of the 4 population-specific committees shall select 3 persons from its membership to be members of the center council. The center council shall meet as frequently as the needs of the network quality council dictate.

**Sec. 15. 34-B MRSA §3607, sub-§§3 and 4,** as enacted by PL 1995, c. 691, §7, are amended to read:

**3. Areas.** ~~An area~~ A local council shall operate in each of the following geographic areas:

A. Aroostook County;

B. Hancock County, Washington County, Penobscot County and Piscataquis County;

C. Kennebec County and Somerset County;

D. Knox County, Lincoln County, Sagadahoc County and Waldo County;

E. Androscoggin County, Franklin County and Oxford County;

F. Cumberland County; and

G. York County.

**4. Accountability.** Each ~~area~~ local council is accountable to the regional director. The institute councils are accountable to the director of facility management within the department.

**Sec. 16. 34-B MRSA §3607, sub-§5,** as amended by PL 1997, c. 371, §4, is further amended to read:

**5. Duties.** By ~~October 1, 1996~~ March 1st of each year, each network quality council shall submit to the department a plan for the development, coordination and implementation of a local ~~mental health~~ system ~~for the delivery of services to~~ of services for children and adults under the authority of the department and ~~to~~ for their families. ~~This plan must be updated every 2 years. By October 1, 1998, the updated plan of each council must include provisions for the development, coordination and implementation of a local mental health system for the delivery of services to children and adults who have a major mental illness.~~ The department shall determine required elements of the plan, including but not limited to ~~the following:~~ core services within each network.

~~A. Case management, including advocacy activities and techniques for identifying and providing services to consumers at risk. Case management services must be independent of providers whenever possible;~~

~~B. Medication management, outpatient therapy, substance abuse treatment and other outpatient services;~~

~~C. In-home flexible supports, home-based crisis assistance, mobile outreach, respite and inpatient capacity and other crisis prevention and resolution services;~~

~~D. Housing, in-home support services, tenant training and support services, home ownership options and supported housing; and~~

~~E. Rehabilitation and vocational services, including transitional employment, supported education and job finding and coaching.~~

**Sec. 17. 34-B MRSA §3607, sub-§6,** as enacted by PL 1995, c. 691, §7, is amended to read:

**6. Regional directors; responsibilities.** Each regional director is responsible for the operation of the ~~area~~ local councils within the region and for dispute resolution within those ~~area~~ local councils. Each regional director shall receive reports from the councils, consider the recommendations of the councils and report periodically to the commissioner on their performance.

**Sec. 18. 34-B MRSA §3608,** as amended by PL 1997, c. 423, §§1 and 2, is further amended to read:

**§3608. Local service networks**

The department shall establish and oversee networks to participate with the ~~area~~ local councils, as defined in section 3607, subsection 2, in the delivery of ~~mental health~~ services to children and adults under the authority of the department. A network consists of organizations providing ~~mental health~~ services funded by the General Fund and Medicaid in the corresponding area specified in section 3607, subsection 3. The local service networks must be established and operated in accordance with standards that are consistent with standards adopted by accredited health care organizations and other standards adopted by the department to establish and operate networks. Oversight must include, but is not limited to~~,~~ : establishing and overseeing protocols~~,~~ ; quality assurance~~, writing and~~ mechanisms, including outcome measures; contract monitoring ~~contracts for service, establishing outcome measures~~ ; and ensuring that each network provides an integrated system of care. The department may adopt rules to carry out this section. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. This section may not be construed to supersede the authority of the Department of Human Services as the single state Medicaid agency under the Social Security Act, Title XII or to affect the professional standards and practices of nonnetwork providers.

**1. Responsibilities.** Each network shall perform the following responsibilities:

~~A. Deliver and coordinate 24-hour crisis response services accessible through a single point of entry to adults with mental illness and to children and adolescents with severe emotional disturbance and their families;~~

B. Ensure continuity, accountability and coordination regarding service delivery;

C. Participate in a uniform client data base;

D. In conjunction with the regional director and the ~~area~~ local council, conduct planning activities; and

E. Develop techniques for identifying and providing services to consumers at risk.

2. **Accountability.** Each network is accountable to the ~~area~~ local council and the regional director.

3. **Public outreach.** Each network shall solicit the participation of interested providers to serve on the ~~area~~ local council, the network or advisory committees.

4. **Participation.** State-operated direct service programs shall participate in the activities of the networks.

5. **Data collection.** The department shall collect data to assess the capacity of the local service networks, including, but not limited to, analyses of utilization of ~~mental-health~~ services and the unmet needs of persons receiving publicly funded ~~mental health~~ services.

**Sec. 19. 34-B MRSA §3609,** as enacted by PL 1995, c. 691, §7, is amended to read:

**§3609. Statewide quality improvement council**

Each network quality council and institute council shall designate a member and an alternate to serve on a statewide quality improvement council to advise the commissioner on issues of system implementation that have statewide impact. The commissioner shall appoint other members to serve on the council. The council shall review plans submitted to the council by the department pursuant to federal and state mandates and shall submit to the department any comments or recommendations regarding these plans.

**Sec. 20. 34-B MRSA §6241,** as amended by PL 1995, c. 560, Pt. K, §§73 and 74, is repealed.

**Sec. 21. Repeal.** That section of this Act that repeals the Maine Revised Statutes, Title 34-B, section 3604, subsection 5 takes effect October 1, 1999.

## SUMMARY

The purpose of this bill is to further the restructuring of the Department of Mental Health, Mental Retardation and Substance

Abuse Services to eliminate artificial barriers to services by an unnecessarily strict separation of adult and children's mental health, mental retardation and substance abuse systems. This bill gives statutory authority for stakeholders of all department services to participate in their local quality councils and includes providers of services to persons with mental retardation or developmental disabilities, or both, and persons receiving substance abuse services in the local service networks. This bill eliminates population-specific committees that exist to advise the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services on implementation of statewide planning. The functions of these groups will be assumed by the statewide quality improvement council whose membership will be reflective of all constituencies served by the department.

# Quality Improvement Councils
# Roles and Responsibilities

This section contains copies of the following information supplied to all QIC's to assist them in understanding their roles and responsibilities. Information is arranged in chronological order by date of issue, beginning with the earliest information at the front of the section.

| Document Title | Issue Date |
|---|---|
| Summary of Public Law 1995, Chapter 691 | May, 1996 |
| The Quality Improvement Council | May, 1996 |
| Draft Model Bylaws for Quality Improvement Councils | July, 1996 |
| Clarifying Memo from Kenneth Dym | August 15, 1996 |
| Clarifying Memo from Kenneth Dym | September 16, 1996 |
| Clarifying Memo from Kenneth Dym | January 28, 1997 |
| Guidelines for QIC Network Plans | August, 1997 |
| Clarifying Memo from Nancy Essex | December 11, 1997 |
| DMHMRSAS Progress Report to Legislature | January 1, 1998 |
| Clarifying Memo from Nancy Essex | February 6, 1998 |
| Service Evaluation Team Position Paper (w/memo) | December 28, 1998 |

# SUMMARY of
# Public Law 1995, Chapter 691
# (Formerly L.D. 1704)

## An Act Redefining the Community Services Structure of the Mental Health System

This legislation creates new community structures designed to perform important and active roles in Maine's emerging community-based system of mental health services. The structures include entities called Quality Improvement Councils (council) whose membership is drawn from among all stakeholders in the local area, and Local Service Networks that consist of all service providers under contract or grant to the Department of Mental Health, Mental Retardation and Substance Abuse Services, including state operated direct services.

### Quality Improvement Councils

The law establishes 9 Quality Improvement Councils that operate under the authority of the department Seven local councils are accountable to DMHMR&SAS Regional Systems Directors. Separate institute councils for the Bangor and Augusta Mental Health Institutes are also created. Local councils are established within the following geographic areas (counties):

A. Aroostook
B. Hancock, Washington, Penobscot and Piscataquis
C. Kennebec and Somerset
D. Knox, Lincoln, Sagadahoc and Waldo
E. Androscoggin, Franklin and Oxford
F. Cumberland
G. York

### Council Membership

Membership on each local council consists of 24 members apportioned as follows: 4 adult consumers, 4 parents of children, 4 family members, 6 service providers and 6 community members. The two institute councils consists of 16 members, with 4 adult consumers, 4 family members, 4 providers and 4 community members. The commissioner appoints the initial membership and reviews each council's bylaws as a condition to formally approving each council. All councils are expected to hold their initial meeting by June 15, 1996.

### Council Duties

Local councils are charged with assisting the department and service providers with systems planning and needs assessment at the local level. Councils also will engage in community education and quality improvement activities that must be implemented at the local level. Under the supervision of each council, program evaluation teams will periodically review each program funded by the department and report results to the council and to the regional director. Evaluation results must be taken into account in funding decisions made by the department.

### Local Plan

Every two years, beginning on October 1, 1996, councils are charged with submitting a plan to the department. The plan must address the development, coordination and implementation of a local mental health system for the delivery of publicly funded services to children and adults and to their families. The department is responsible for determining the scope of the plan, which must include at a minimum several core elements. Those elements are: case management and advocacy; medication management and outpatient services; responsive crisis prevention and resolution services; housing services and supports; and rehabilitation and vocational services.

(Over)

## Statewide Quality Improvement Council

The law establishes a statewide council to advise the commissioner on issues of system implementation that have statewide impact. The statewide council is made up of a member from each of the 9 local and institutional councils, and other members that the commissioner may appoint.

## Local Service Networks

The legislation defines a local service network as persons and organizations providing mental health services under contract or grant from the department in the local service area outlined in this legislation. Each network is charged with soliciting the participation of interested providers to serve on the area council, the service network or such advisory committees as may be formed. State operated direct service programs will participate in the activities of the local networks.

## Responsibilities of Networks

Local service networks are accountable to the department's regional director and to the corresponding quality improvement council. The network will play an important part in area planning activities, in conjunction with the area council and the regional director.

Networks are required to deliver and coordinate 24 hour crisis response services accessible through a single point of entry for adults and children and their families. In addition, networks are charged with ensuring continuity, accountability and coordination of services, to participate in a uniform client data base and to develop techniques for identifying and providing services to consumers at risk.

## Timelines and Reports

The commissioner shall report to the legislative committee having jurisdiction over health and human services matters by January 1, 1997 and January 1, 1998 on the operation of quality improvement councils and local service networks. The report will include recommendations for improving the system's operations and may suggest legislation necessary to accomplish the purposes of this law.

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# THE QUALITY IMPROVEMENT COUNCIL

In April, 1996, the Governor signed into the law a bill earlier passed by the Legislature known as "An Act Redefining the Community Services Structure of the Mental Health System." Among other provisions contained in the Act is Section 3607: **Quality Improvement Councils**. Specifically, by law, the Department of Mental Health, Mental Retardation, and Substance Abuse Services "shall establish 9 quality improvement councils to oversee the delivery of mental health services to children and adults under the authority of the department." Seven of the councils are geographically defined (Aroostook, Northeast, Kennebec-Somerset, Mid-Coast, Western, Cumberland, and York), and one each is for AMHI and BMHI. The seven geographic councils have 24 members each: 4 adult consumers, 4 family members, 4 parents, 6 community members, and 6 service providers. Each institute council has 16 members: 4 consumers, 4 family members, 4 community members, and 4 providers.

*The Councils have the following responsibilities:*

- Assist the Department and local providers with systems planning, needs assessment, community education, and quality improvement activities
- Through the program evaluation team (PET), review Department funded programs
- By October 1, 1996, submit a plan to the Department for the "development, coordination, and implementation of a local mental health system for the delivery of services" to adults and children and their families. The plan must contain provisions for five core services:
    1. Case management
    2. Outpatient services including medication, substance abuse, and outpatient therapy
    3. Crisis services
    4. Housing
    5. Rehabilitation and vocational

The Act also states, in Section 3608, that the Department shall establish **Local Service Networks** to participate with the area councils in the "delivery of mental health services to children and adults."
*The local service networks have the following responsibilities:*

- Deliver and coordinate 24-hour crisis response services
- Ensure continuity, accountability and coordination regarding service delivery
- Participate in a uniform client data base
- Conduct planning activities
- Develop techniques for identifying and providing services to consumers at risk

Finally, the Act, in Section 3609 creates a **Statewide Quality Improvement** Council, designed to "advise the commissioner on issues of system implementation that have statewide impact.

5/96

D-R-A-F-T M-O-D-E-L B-Y-L-A-W-S

# ____________________________QUALITY IMPROVEMENT COUNCIL

## BY-LAWS

## Article I

## Name, Mission and Definitions

Section 1. The Name of this organization shall be the ____________Quality Improvement Council, otherwise known as the ____________QIC, also referenced in these bylaws as "the council."

Section 2. The ___________QIC defines its area of geographic coverage to include the following Maine Counties:_________________________________________.

Section 3. The fundamental mission of the council is derived from Maine Public Law (1995), Chapter 691, An Act Redefining the Community Services Structure of the Mental Health System. The mission is to assist the Department of Mental Health, Mental Retardation and Substance Abuse Services to plan for, to evaluate and to oversee the delivery of mental health services to children and adults under the authority of the Department.

Section 4. For purposes of these bylaws the following terms are defined:

a. "Commissioner" means the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, or her designee.

b. Community members" means persons who represent the composition of the community at large.

c. "Consumer" means a recipient or former recipient of publicly funded mental health services.

d. "Family member" means a relative, guardian or household member of an adult consumer.

e. "Network" means a local service network consisting of persons and organizations providing mental health services under contract or grant from the department.

f. "Parent" means a parent or person who has acted in that capacity or assumed that role for a consumer under 18 years of age.

g. "Regional Director" means the DMHMRSAS regional director for the region the council is located.

h. "Service provider" or "provider" means a person or organization providing publicly funded mental health services to consumers or family members.

## Article II

## Membership of the Council

Section 1. The council membership shall consist of 24 members.

Section 2. Membership shall be apportioned as follows: 4 Consumers, 4 Parents, 4 Family Members; 6 Service Providers; 6 Community Members.

Section 3. The council shall establish a policy addressing expectations of membership to participate in the business of the council, including a policy on attendance.

## Article II

## Quorum and Voting

Section 1. In matters that require a formal vote, each member shall have one vote. A person who is asked to represent an absent council member may participate in discussion but may not vote.

Section 2. At any meeting of the council, a majority of the membership then in office shall constitute a quorum for the transaction of business.

Section 3. The vote of a majority of the membership present at a meeting at which a quorum is present shall be the act of the council, unless the vote of a greater number is required by these bylaws.

Section 4. Members present at a meeting at which a quorum was once present may continue to do business and take action at the meeting notwithstanding the withdrawal of enough members to leave less than a quorum.

Section 5. Any meeting may be adjourned by a majority of the votes cast upon the question, whether or not a quorum is present.

locals choose who goes - they chose succession

Commissioner replaces members initially appointed by her taking into consideration the overall make-up of the Council

## Article III

## Terms of Appointment, Vacancies, Resignation and Removal

Section 1. Appointment to membership of the council shall be made by the Commissioner. The term of initial appointment shall be a for a period of two years. Members shall be limited to two consecutive terms of service, but may be reappointed following a one year period of absence.

Section 2. Vacancies occurring during the period of initial appointment shall be filled as they occur, taking into consideration local geographic factors and qualifications for membership as defined by category of membership in PL 691.

✓ Section 3. The council may recommend individuals by category of membership to fill vacancies that occur during the initial period of appointment. Names of persons or organizations nominated for such appointment shall be forwarded to the Regional Director. The Commissioner shall make all appointments filling vacancies during the initial period of appointment.

Section 4. Appointments made to the council following the initial 2 year term shall be as follows: One third of the membership for a term of one year; one third membership for two years; the remaining membership for a 3 year period. Members appointed during the initial period may succeed themselves on the council for one additional term. The Commissioner shall make appointments for membership for the period following the initial appointment period.

Section 5. Any member may resign their appointment by delivering a written resignation to the Chair.

Section 6. Any member may be removed from office in accordance with the council's policy on expectation of membership participation, including the policy on attendance.

Section 7. Vacancies that occur through resignation or removal from office shall be recorded by the Secretary, by category of membership, and reported to the regional director in order to initiate action to restore the council to its full membership.

## Article IV

## Officers

Section 1. The proceedings and activities of the council will be managed through a Chairperson who shall be selected by the council membership for a term of one year. The Chair shall preside at council meetings. In the absence of the Chair, a Vice-Chair, also selected by the council membership, shall assume those duties.

Section 2. Recording Secretary and Treasurer. The council shall elect a secretary and treasurer for a term of one year. The duties of the Secretary shall include assuring that a written record of council meetings and a list of active membership and vacancies are maintained. The Treasurer shall authorize payments for approved council expenditures and maintain a record of council expenses against the council's operating resources. The council may combine the functions of the secretary and treasurer in a single officer.

Section 3. The council shall agree on procedures or guidelines to assure fair and open participation by all members during the proceedings of the council, its committees, and in the general conduct of its business which shall be open to the public. The council shall establish other elements of governance as it deems necessary.

## Article V

## Council Relationship to Department of MHMRSAS

Section 1. The formal relationship between the council and the Department is established by P.L. 631.

a. The council operates under the authority of the department.

b. The council is accountable to the regional director, who is in turn responsible to the Commissioner.

c. The regional director is responsible for the operation of the council and for dispute resolution within the council.

d. The council shall submit reports to the regional director, who shall consider the recommendations of the council and report periodically to the commissioner on the council's performance.

Section 2. The working relationship between the council and the Department is based on mutually held commitment to support the activities of the council that it undertakes on behalf of persons receiving and providing mental health services in the local area.

<u>Section 3.</u> The department shall commit funds in order to support the operations of the council. The council shall develop an annual budget for this purpose.

a. The council shall identify its needs for operational support necessary to conduct its business. These needs shall be made known to the regional director.

b. Individual council members may identify their individual needs or supports that will enable them to carry out their duties as members of the council. These needs shall be made known to the regional director.

## Article VI

## Committees of the Council

<u>Section 1</u>. The council shall establish standing or ad hoc committees in order to carry out its responsibilities. Interest from the membership to serve on committees shall be solicited by the Chair, who may appoint a Chair, from among the council's membership, for each committee so established.

<u>Section 2.</u> The council may solicit the participation of interested persons from the local area who are not members of the council to serve on committees of the council.

<u>Section 3.</u> Each committee established by the council should have a written charge in order to focus its work and deliberation. Ad hoc committees should be established with an expected time frame for its operation.

<u>Section 4.</u> A record of the proceedings of committee meetings shall be maintained. Minutes or other documentation of the work of committees shall be forwarded to the Secretary of the council and distributed to membership and other interested parties as determined by the council.

## Article VII

## Conflict of Interest

<u>Section 1.</u> If a member of the council has a conflict of interest, or an appearance of a conflict of interest, in business before the council, the member shall declare such interest and abstain from discussion or voting on the business or motion. The Secretary shall record such declaration and abstention in the minutes.

<u>Section 2.</u> Any member of the council may call upon any other member to disclose any possible conflict of interest. Such possible conflict may be discussed by the council and a vote taken on whether a conflict exists. The decision of this vote shall be binding.

<u>Section 3.</u> A member of the council having a conflict of interest and therefore unable to act or do business before the council is still considered present and included in the quorum. A member who cannot vote on one piece of business has the right to take full part in other business before the council at the same or other meetings.

## Article VIII

## Selection to Statewide QIC

Section 1. The council shall designate a member and an alternate to serve on a Statewide Quality Improvement Council to advise the Commissioner on issues of system implementation that have statewide impact. The term of this designation shall be for one year.

## Article IX

## Specific Responsibilities of the Council

Section 1. By October 1, 1996, the council shall submit to the department a plan for the development, coordination and implementation of a local mental health system for the delivery of services to children and adults under the authority of the department and to their families.

Section 2. The department shall determine required elements of the plan and shall provide direction, technical assistance and support to the council so that it may be able to accomplish these tasks by October 1, 1996 and every two years thereafter.

Section 3. The council shall review each program funded by the department on a periodic basis. Such reviews shall be conducted under the supervision of the council. The council shall report the results of program evaluation to the regional director, who must take these reports into account when making funding decisions.

Section 4. The council shall engage in active public outreach in order to gain the participation of interested consumers, families, parents, community members and service providers to assist the council in meeting its responsibilities and/or to serve on the council, the service network or advisory committees.

## Article X

## Bylaw Amendments

Section 1. The council may amend its bylaws by two-thirds vote of its membership. Proposed amendments must be read at the meeting prior to the vote and there shall be a written thirty (30) day notice of such proposal to amend the bylaws prior to the vote.

Section 2. Bylaw amendments must be reviewed and approved by the Commissioner.

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

**TO:** Chairperson, QIC

**FROM:** Kenneth Dym, Program Manager,
Mental Health Services

**RE:** Updated information

**DATE:** August 15, 1996

Over the past few months, QIC members have posed a number of questions regarding the function, operations, and purpose of the QIC's. This memo is the first of a series of written messages addressing these questions. Should you have any questions, if anything is unclear, please do not hesitate to contact the staff person who is facilitating your QIC, your regional director, or myself.

**Regarding the Network Plan:**

The plan remains due on October 1, 1996. If a QIC can complete the entire document by that date, terrific! However, if the QIC can submit, what we are terming, Phase I of the Network Plan, that is also acceptable. Phase I consists of the following:

- The specified data listed on the plan. See attached sheets for an outline of what data needs to be collected.
- A detailed work plan outlining specifically how the entire Network Plan will be developed. Phase I should describe how each of the substantive questions will be answered. For example, under Medication Management, question 8 asks, "How are clients educated about their medications," who will develop the response. Will a subcommittee be established, will their be a literature search to find out how other locations have dealt with this problem, etc. Also, what will the timelines be? When will a complete response be submitted?

**Regarding reimbursement:**

- Mileage should be reimbursed at the current State rate of 22 cents per mile.
- Child care should be reimbursed at cost.
- The QIC can provide light snacks and beverages at meetings. Meals will not be reimbursed.

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- The QIC budget should cover such administrative items as copying, postage, and typing (although in-kind contributions are welcome).
- A stipend of $25 per QIC meeting (but not committee meetings) will be available to any QIC member who, without the stipend, could not afford to attend the meeting. These stipends should be arranged individually by the QIC member and the Regional Director.

**Regarding Membership Issues:**

- QIC's should consider making recommendations to the Commissioner regarding new members. As per the by-laws, these should go through the Regional Directors. QIC's can establish membership/nominating committees as a way of expediting the process.

c:\qicmemo-info-0815

# DATA ELEMENTS
# REQUIRED WITHIN
# THE NETWORK PLAN

The following data is required for each area:

## CASE MANAGEMENT

1. List who provides the service:
2. Number of clients currently receiving services:
3. How long have clients been receiving services:

## MEDICATION MANAGEMENT

4. List who provides services:
5. Number of clients receiving services:
6. How long have clients been receiving services:

## CRISIS MANAGEMENT

7. List who provides services:
8. Number of clients who used the service last year:
9. Average wait time in ER's for screening and triage:
10. Number of hospital bed days used by service area residents last year:

## HOUSING

11. List who provides service:
12. Number of clients receiving housing supports:
13. Length of stay in each setting:

## REHABILITATION AND VOCATIONAL SERVICES

14. List who provides services:
15. Number of clients receiving services:
16. How long have they been receiving services:
17. How many people obtained jobs last year:

## CHILDREN:

18. List who provides services:
19. Number of clients receiving services:
20. How long have they been receiving services

## OTHER

21. Number of people with special needs, e.g.
    a. Dual diagnosis (MH/MR/DD)
    b. Dual diagnosis (MH/SA)
    c. Migrant workers
    d. Native Americans
    e. Non-English speaking people

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GOVERNOR

MELODIE J. PEET
COMMISSIONER

KENNETH DYM
PROGRAM MANAGER
MENTAL HEALTH SERVICES

# MEMO

**TO:** Chairperson, QIC

**FROM:** Kenneth Dym KD

**RE:** Information Update

**DATE:** September 16, 1996

The QIC's continue to move forward, each one in its own fashion and at its own speed. At this point most of the QIC's have adopted by-laws and elected officers. Each QIC is currently developing a service plan to address the needs in their communities. No doubt, this is a complicated process. First, there has to be a needs assessment, then a determination of the gaps, and finally, a proposal for what would be useful, helpful, and feasible. Phase one of the plans are due October 1.

Over the past number of weeks, I have received a number of suggestions and questions. Let me comment on a few of them:

1. **Training**: As the QIC's meet and discuss the various issues, we realized an in-service training program might be useful to some members of the QIC. Possibly topics could include: managed care, how to read a budget, what goes into a contract, quality assurance/quality improvement. To that end, Mike McClellan will be working with the QIC's to develop a training program. Over the next few weeks, he will be contacting each QIC to determine if: a) they have training needs, b) what topics should be presented, and c) what would be the best way to offer the training.
2. **State-wide QIC**: There remains great interest in setting up the state-wide QIC. The Commissioner, Melodie Peet, has asked me to serve as the facilitator of this group. Each QIC has designated a representative and an alternative to the state-wide QIC. In addition, the Commissioner has made some appointments. I will try to set up the first meeting of the State-wide QIC by mid-October.
3. **State-wide meeting of QIC's**: As the QIC's complete phase I of the service plan, it would probably be a good idea to pull together a few people from each QIC (maybe the chair and vice-chair?) to come together for a state-wide meeting. Each QIC could have the opportunity to share where they are at, what has worked well, what obstacles remain,

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HONE: (207) 287-4271 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

and where each is going. The meeting, as I envision it, would allow QIC members the chance to interact, assess their own process, and learn from others. I have asked Ned Vitalis to work with the QIC's to set up this meeting, which we will try to hold in mid to late October.

The QIC's are clearly in the developmental stage. This can be exciting -- everything is new -- but also frustrating -- why aren't they moving faster, what don't we have more answers? I will be sending out these updates on a regular basis to keep people informed. But please, if you have questions, or suggestions, please do not hesitate to let us know. Speak to the staff member facilitating your group, or contact me directly (287-4271).

Thanks and hear from you soon.

c.c. Melodie Peet, Commissioner

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STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
& SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE J. PEET
COMMISSIONER

KENNETH DYM
PROGRAM MANAGER
MENTAL HEALTH SERVICES

# MEMO

**TO:** Chairperson, QIC

**FROM:** Kenneth Dym

**RE:** Roles and responsibilities of the Quality Improvement Council

**DATE:** January 28, 1997

The Commissioner has asked me to clarify the roles and responsibilities of the Quality Improvement Council as described in Section 7, Paragraph 3607.2a of the law, LD 691.

The Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services has the ultimate responsibility for policy and the program direction of the Department. She carries out these responsibilities through the delegation of authority to Associate Commissioners, Regional Directors, and other high level assistants. The Commissioner has the responsibility for developing policy and for assuring program compliance and quality. To do so, she relies on information, advice, and recommendations from those to whom she has delegated authority, including the Quality Improvement Councils.

The Regional Directors, deriving their authority directly from the Commissioner, have the responsibility for operationalizing Department policy and programming in the local service networks.

The Quality Improvement Councils, through wide community representation, are designed to expand the range and quality of advice available to the Commissioner. While advice and recommendations may be elicited on additional issues over time, the specific areas referred to in the law are: systems planning, needs assessment, community education and quality improvement. Consequently, I believe this is where the Quality Improvement Councils, at this point, should focus their energies.

No doubt the tasks are large and at times have perhaps appeared too vaguely defined. One possible way for a Quality Improvement Council to carry out its responsibilities is to establish subcommittees charged with specific tasks. For example, one Council has created subcommittees on community education, finances, psychiatric recruitment, and children's services. People from the Quality Improvement Council serve on the subcommittee as well as other interested individuals from the community.

As stated , it is the intent of this memo to clarify the roles and responsibilities of the Quality Improvement Councils. Should there be further questions, please do not hesitate to contact me (287-4271) or the Regional Director working with your specific Council.

Thank you.

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State of Maine
Department of Mental Health, Mental Retardation,
and Substance Abuse Services

# GUIDELINES FOR QIC NETWORK PLANS

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## *Introduction*

Public Law 1995, Chapter 691, requires each QIC to submit a "plan for the development, coordination and implementation of a local mental health system for the delivery of services to children and adults under the authority of the department and to their families." Original plans were due 10/1/96 and by law are to be updated every two years. However, because of the extensive nature of the information required in the plan and because the councils were just getting started, in September of 1996 the department instructed the councils that by 10/1/96 they could submit a "Plan for a Plan" that would outline the steps the council would take to prepare a comprehensive plan and asking the councils to set a date by which their full plan would be submitted.

A year later, it would appear that the planning process outlined in the legislation is somewhat "out of synch" with the current activities of the department. Clearly it is the department which is spearheading the development of regionalized systems of care as part of the preparation for the move to managed care. Additionally, the Children's Task Force is working on the development of a comprehensive system of care for children in response to LD 1744. To require the councils to submit plans for the development and implementation of a system of care at this time seems both redundant and superfluous.

Therefore, as will be reflected in proposed legislation next session, councils are being asked to submit annual plans of a different, but similar nature. Plans are due no later than October 1st of each year and are to be submitted to the Regional Directors.

## *PLAN REQUIREMENTS*

Plans should be brief, concise, and to the point, and need to fully address <u>all</u> of the following points outlined (I through V).

Revised 8/97

## I. QIC Membership/Organization

A. List the current members of the council and provide their stakeholder category, geographic area (if applicable), and the service population(s) they represent (e.g. Jane Doe, family member, Brown County, adult mental health and substance abuse). In addition, show each member's date of appointment to the council and the expiration date of their term of office.

B. List the current office holders by name and title, and give the expiration date of their term of office. (These people also should be shown as council members above.) For the chair and vice-chair, provide their mailing address, E-Mail address (if any), and phone number.

C. Give the council's standard meeting days, times, and location.

D. Explain any difficulties encountered in maintaining a full council membership during the past year and steps taken by the council to address those difficulties.

## II. LSN Membership/Organization

A. Provide a brief narrative update on the status of the Local Service Network (LSN), addressing such issues as:

- LSN's stage of formal organization.
- Meeting dates, times, location.
- Office holders, if any.
- Mission/vision.
- Membership - list by individual name and their organization.
- Barriers, if any, encountered to date in working together as a network of providers and steps being taken to address removing or reducing those barriers.

If no formal LSN has been organized, give the names, addresses, and phone numbers of at least three people who would be interested in beginning the work of organizing the LSN.

## III. QIC Operation

A. Explain the council's accomplishments during the fiscal year ended June 30th. Address the following: 1) educational activities sponsored, 2) RFP design/evaluation participation, 3) program evaluation activity, 4) needs assessment, and 5) any other major activity undertaken by the council during the year. If a Program Evaluation Team (PET) has been formed, provide the names and stakeholder category of the team participants.

B. Explain any difficulties encountered in the operations of the council and the steps taken to address those difficulties.

## IV. Network Services

The following services are deemed crucial to an effective and responsive system of care:

- **Case Management** (including advocacy services).
- **Medication Management and Other Outpatient Services** (including therapy, substance abuse treatment, and other services).
- **Crisis Prevention and Resolution** (including in-home flexible supports, homebased crises assistance, mobile outreach, respite, and inpatient care).
- **Housing** (including in-home support services, tenant training and support services, home ownership options, and supported housing).
- **Rehabilitation and Vocational Services** (including transitional employment, supported education, job finding and coaching).

A. With respect to these services, provide a brief narrative that addresses the following questions/issues relative to your network area: 1) What service areas need improvement? 2) Upon what is this determination based? 3) What specific improvements are needed? 4) What is necessary to bring about these improvements? 5) What role will the QIC play in bringing about the needed improvements?

B. One of the principles of the system of care under development is that all people in need will be provided services in a timely manner and they will not be discharged from service discriminately. This is known as a "No Reject/No Eject" system. Other than an increase in system resources, what are some of the ways in which this principle can be operationalized in your network area?

## V. Plan for the Next Year

A. In priority order, explain what the QIC sees as its **five** (5) major goals for the following twelve months and indicate objectives/tasks it will utilize to accomplish them.

**State of Maine**

Department of Mental Health,
Mental Retardation, and
Substance Abuse Services
40 State House Station
Augusta, ME 04333-0040

Nancy L. Essex, Director of Community Systems Development
Phone: (207) 287-4205
FAX: (207) 287-4291
email: Nancy.Essex@state.me.us

# *Memorandum*

*To:* QIC Chairs
*From:* Nancy L. Essex, Director of Community Systems Development
*cc:* Regional Directors, Facility Operations Director
*Date:* December 11, 1997
*Subject:* QIC Education Plans

*Last winter/spring the Department asked each QIC to develop an Education Plan. However, we were remiss in that we did not provide you with a full explanation of what those plans should entail, nor did we let you know that the plans would be submitted to the Court Master to demonstrate compliance with the AMHI Consent Decree. Additionally, there was a lack of clarity all the way around regarding when the plans were due and to whom they should have been submitted. For all of the above, I sincerely apologize.*

*I am writing now because the Court Master has informed us that he has not approved the Department's Education Plan, a part of which are the plans from the QICs. Please be assured that the QICs are in no way responsible for this. To those of you who submitted plans, we very much appreciate your efforts; a couple of the plans were quite good.*

*So, it is necessary for those QICs that submitted Education Plans to now revisit them, and for those QICs that did not submit one to now do so. Enclosed you will please find what I hope are clear guidelines for the creation of QIC Public Education Plans. These guidelines explicate the tenets of the Consent Decree upon which educational activities must focus. If upon review of these guidelines you think the plan that you originally submitted meets those guidelines, all you would need to do now is put it into the uniform format (see sample enclosed) which we will be using for submission of these plans to the Court Master. As the guidelines explain, QIC Plans must be submitted to me no later than March 1, 1998. This is a firm deadline. And please note that your plan needs to cover both those educational activities that you have already done as well as those you plan to accomplish by December 31, 1998.*

*Thank you for your understanding. Again, I apologize for any inconvenience this may cause, and I encourage you to avail yourselves of the technical assistance being offered, should you need it. Please do not hesitate to contact me should you have any questions.*

# GUIDELINES FOR QIC PUBLIC EDUCATION PLANS

## *Purpose*

Public Education Plans need to specifically address the terms of the Consent Decree, as outlined below. While it is acceptable for the councils to address the ways in which they will educate the public about the QICs, that is not the purpose of these plans.

## *Plan Objectives*

QIC Public Education Plans must address, *specifically*, the ways in which they will accomplish the following objectives:

Objective 1: Educate the public regarding:

a) Mental illness
b) Myths and stigma of mental illness
c) Rights of consumers and their families

Objective 2: Target community members and employees of public service agencies so that they can interact with persons with mental illness without prejudice and foster the full integration of persons with mental illness into their home communities.

Examples of the groups to which the public education programs shall be offered may include, but are not limited to:

- Schools
- Libraries
- Area agencies on aging
- General Assistance offices
- Shelters
- Governmental agencies
- Civic groups
- Law enforcement agencies

When targeting groups in your Plan, please provide the names of those groups, organizations, and agencies to whom you plan to focus your efforts.

## *Plan Timelines*

The Plan needs to state the time frames in which your QIC will accomplish *each* task explicated in the plan. Plans should address educational activities already accomplished, as well as those to be undertaken during calendar year 1998.

### *Technical Assistance*

Should you want assistance in creating your Public Education Plan, you need only ask any of the following staff, all of whom will make themselves available to help you: your Regional Director, your Mental Health Team Leader, your Children's Team Leader, or Nancy Essex. A sample plan format is enclosed to help you with this task. You do not need to use this form unless you want to, but please put your plan in this format.

### *Plan Submission and Approval*

Plans must be submitted to Nancy Essex, DMHMRSAS Director of Community Systems Development, 40 State House Station, Augusta, ME 04333-0040 **no later than March 1, 1998.** Plans which meet the criteria as stated in this document will be approved and incorporated into the Department's Education Plan for submission to the Court Master for final approval. Plans which do not meet the criteria as stated in this document will be returned and guidance about what needs to be changed or added will be provided. Questions about the plan should be directed to Nancy Essex at 287-4205.

# ____________________ QIC Public Education Plan

For the Period Beginning on ______________ and Ending on December 31, 1998

| Objectives | Activities or Tasks | Target Audience * For Each Activity/Task | Person Responsible | Date of Activity |
|---|---|---|---|---|
| **Objective 1(a):** Educate the public regarding mental illness. | | | | |
| **Objective 1(b):** Educate the public regarding the myths and stigma of mental illness. | | | | |
| **Objective 1(c):** Educate the public regarding the rights of consumers and their families. | | | | |

* Target community members and employees of public service agencies so that they can interact with persons with mental illness without prejudice and foster the full integration of persons with mental illness into their home communities.

# RESTRUCTURING OF THE MENTAL HEALTH SERVICE DELIVERY SYSTEM

## DEPARTMENT OF MENTAL HEALTH,
## MENTAL RETARDATION AND
## SUBSTANCE ABUSE SERVICES

# A PROGRESS REPORT

JANUARY 1, 1998

SUBMITTED TO:

JOINT STANDING COMMITTEE ON HEALTH & HUMAN SERVICES

IN ACCORDANCE WITH
PUBLIC LAW 1995, CHAPTER 691

ANGUS S. KING, GOVERNOR

MELODIE J. PEET, COMMISSIONER

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# I. EXECUTIVE SUMMARY

In April, 1996, the Governor signed into law a bill earlier passed by the Legislature known as "An Act Redefining the Community Services Structure of the Mental Health System (L.D. 1704 - P.L. 1995, Chapter 691)" referred to in this document as Chapter 691. This law authorized the development of Quality Improvement Councils (QICs); established seven geographic areas for local service planning; prescribed essential elements of local service plans; defined roles and responsibilities of QICs, LSNs and Regional Offices; mandated the development of Local Service Networks (LSNs) in each region; mandated the establishment of a statewide QIC; and required that annual reports be submitted to the Legislature by January 1st 1997 and January 1st 1998. Chapter 691 was developed as part of a major restructuring effort in the state's mental health, mental retardation and substance abuse service system.

During the first year, in accordance with Chapter 691, nine QICs were established and representatives to the statewide QIC were designated; by-laws were developed; local service plans were submitted; parameters for the development of Local Service Networks were established; Program Evaluation Teams were formed; and a framework for ongoing program evaluation and quality improvement was constructed.

During the second year, a Central Office position was established to provide oversight and support for QICs and LSNs; revised guidelines were issued for QIC planning, membership, and public education activities; and draft access standards for LSNs were developed. The statewide QIC began meeting regularly; local QICs began some program evaluation activities; and a conceptual model was agreed upon for the integration of PET activities into an overall QA/QI framework. LSN development activities continued in preparation for managed systems of care. In addition, baseline data were gathered on systems integration/coordination and on service utilization in both the adult and children's service systems; and the first steps were taken towards the development of consumer and family outcome measures.

# II. BACKGROUND AND CONTEXT

L.D. 1704 (PL 1995, Chapter 691) was developed in the context of a major restructuring effort in the state's mental health, mental retardation, and substance abuse service system. During 1995, the following issues emerged as critical for the development of an effective community mental health system in Maine:

### Structural Issues

- No fixed point of accountability at any level of the system below the Commissioner's Office
- State hospitals not well integrated into community system of care
- Lack of incentives for providers to function as integrated networks of care

### Financial Issues

- Maldistribution of resources between hospital and community
- Separation of fiscal and programmatic control in the Medicaid behavioral healthcare budget

### Programmatic Issues

- Fragmentation of crisis response systems
- Lack of "safety net" in the community for high risk and hard-to-serve individuals
- Underdevelopment of some elements of an effective community mental health system

### Quality Improvement Issues

- Professional skill deficits in some areas
- Lack of data and technology to support quality improvement
- Attitudinal barriers and discrimination against people with mental illness

In response to the identification of these problems, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS, or "The Department") embarked on a series of initiatives to restructure the mental health system. These initiatives included a Productivity Realization Task Force Plan which reorganized the Department's central office and regional structures; consolidated 15 existing and fragmented, regional administrative structures into three; increased the shift of resources toward direct care; reallocated more than $1 million to fulfill obligations under the AMHI Consent Decree; and established a consolidated regional office management structure for service coordination and administrative accountability.

In addition, the Department established a set of "Core Services" required in all local service delivery systems; developed a new Office of Quality Improvement, and began a multifaceted strategy to improve the clinical capacity of the community mental health system, including recruitment of psychiatrists as Medical Directors for each regional office.

Chapter 691 was designed to provide a vehicle for the establishment of Local Service Networks to work under the jurisdiction of the regional offices. It was also designed to increase the participation of a wide range of "stakeholders" in the planning and oversight of local mental health systems, through the establishment of "Quality Improvement Councils" (QICs).

Figure One illustrates the structure of the mental health system prior to the enactment of Chapter 691.

Figure Two illustrates the design of the mental health system as defined by Chapter 691.

## Figure 1: Structure of Mental Health System Before PL Chapter 691

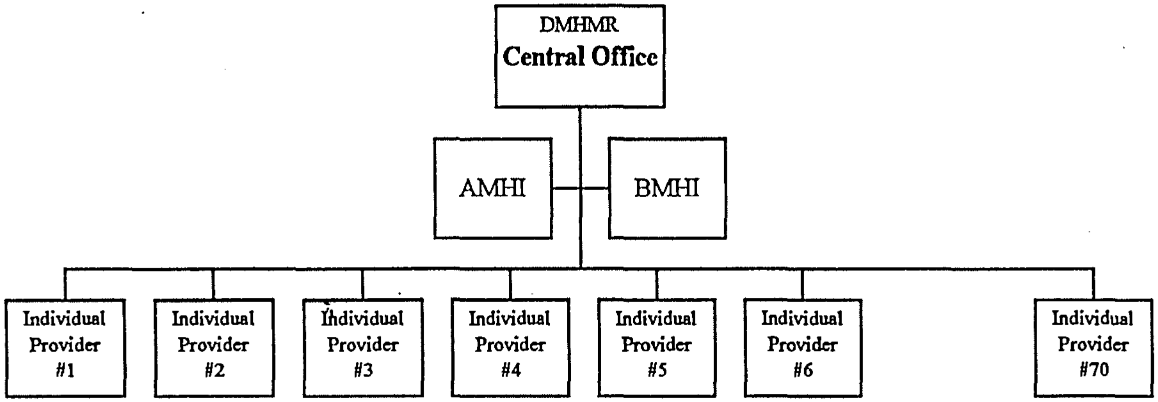
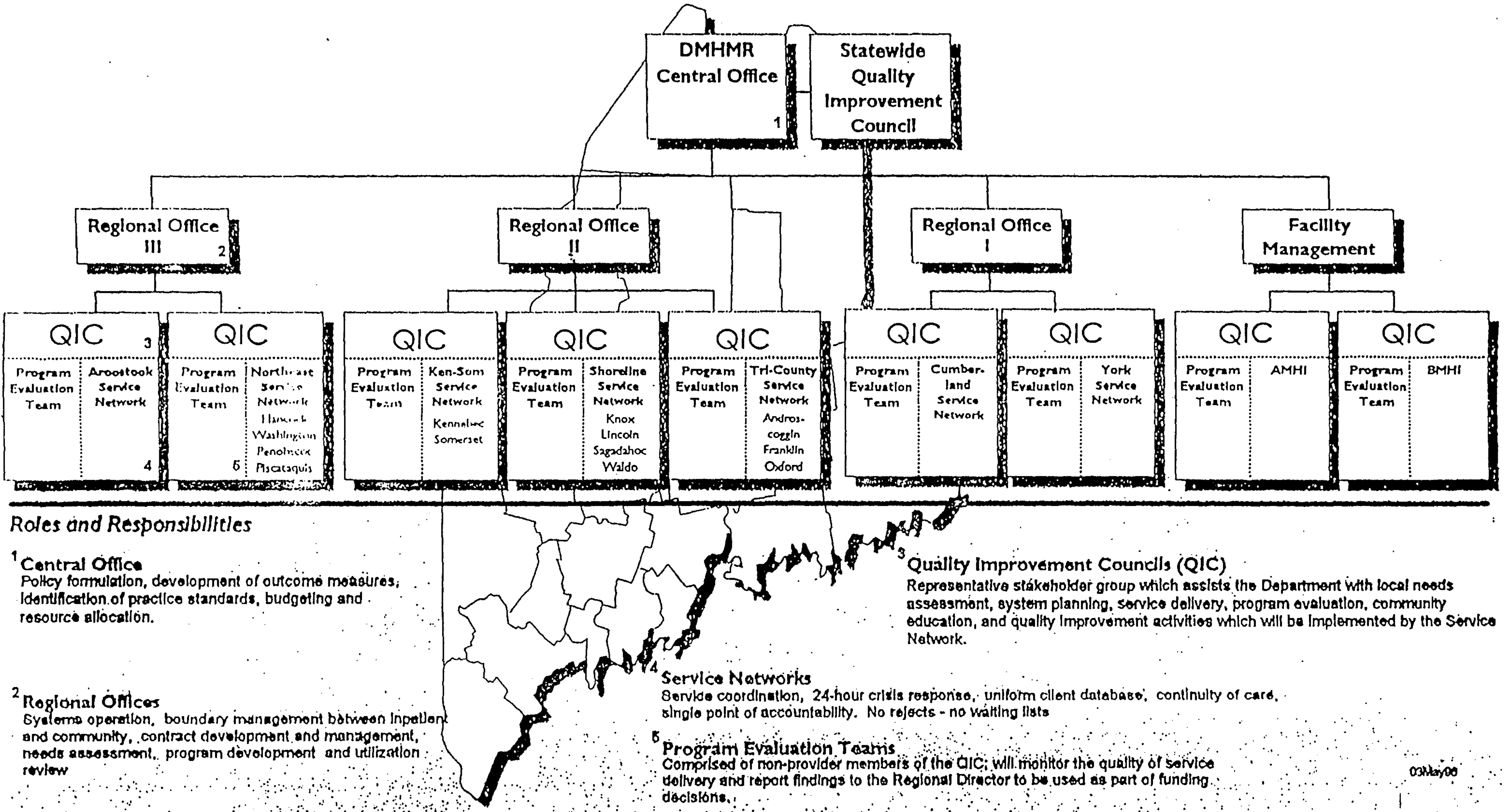


Figure 2: Structure for the Delivery of Mental Health Services in Maine

AS DEFINED BY PL CHAPTER 691



*Roles and Responsibilities*

**[1] Central Office**
Policy formulation, development of outcome measures, identification of practice standards, budgeting and resource allocation.

**[2] Regional Offices**
Systems operation, boundary management between inpatient and community, contract development and management, needs assessment, program development and utilization review

**[3] Quality Improvement Councils (QIC)**
Representative stakeholder group which assists the Department with local needs assessment, system planning, service delivery, program evaluation, community education, and quality improvement activities which will be implemented by the Service Network.

**[4] Service Networks**
Service coordination, 24-hour crisis response, uniform client database, continuity of care, single point of accountability. No rejects - no waiting lists

**[5] Program Evaluation Teams**
Comprised of non-provider members of the QIC; will monitor the quality of service delivery and report findings to the Regional Director to be used as part of funding decisions.

03May00

# III. IMPLEMENTATION OF CHAPTER 691

In April, 1996, the Governor signed into the law a bill earlier passed by the Legislature known as "An Act Redefining the Community Services Structure of the Mental Health System (L.D. 1704 - PL 1995, Chapter 691)." This law authorized the development of Quality Improvement Councils (QICs); established seven geographic areas for local service planning; prescribed essential elements of local service plans; mandated the development of Local Service Networks (LSNs) in each region; defined roles and responsibilities of QICs, LSNs and regional offices; mandated the establishment of a statewide QIC; and required that annual reports be submitted to the Legislature by January 1st 1997 and January 1st 1998.

Section 3607 of Chapter 691 states that the "Department of Mental Health, Mental Retardation, and Substance Abuse Services shall establish nine quality improvement councils to oversee the delivery of mental health services to children and adults under the authority of the DMHMRSAS." Seven of the councils are defined by geographical area ("Area Councils") (Aroostook, Northeast, Kennebec-Somerset, Mid-Coast, Western, Cumberland, and York), and the remaining two councils are defined as "Institute Councils", one each for the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institue (BMHI). Each of the seven geographic councils have 24 members including: 4 adult consumers, 4 family members, 4 parents, 6 community members, and 6 service providers. Each institute council has 16 members: 4 consumers, 4 family members, 4 community members, and 4 providers.

**Quality Improvement Councils have the following responsibilities:**

- Assist the Department and local providers with systems planning, needs assessment, community education, and quality improvement activities;
- Establish Program Evaluation Teams (PETs) that will assist the Department and local providers in the design and implementation of uniform program evaluation procedures to assess the quality and effectiveness of Department funded programs;
- Develop a plan for the Department outlining the "development, coordination, and implementation of a local mental health system for the delivery of services" to adults and children and their families. The plan must contain provisions for five core services:

  1. Case management
  2. Outpatient services including medication, substance abuse, and outpatient therapy
  3. Crisis services
  4. Housing
  5. Rehabilitation and vocational services

The law also calls for the development of Local Service Networks that will participate with the area QICs in the "planning and delivery of mental health services to children and adults."

**Local Service Networks have the following Responsibilities:**

- Deliver and coordinate 24-hour crisis response services;
- Ensure continuity, accountability and coordination regarding service delivery;
- Participate in the development and implementation of a uniform client data base;
- Conduct planning activities;
- Develop techniques for identifying and providing services to consumers at risk;

Finally, the Act, in Section 3609 creates a **Statewide Quality Improvement Council**, designed to "advise the commissioner on issues of system implementation that have statewide impact."

## IV. SUMMARY OF PROGRESS

### Year I

During Year I, the following progress was made.

- *3607 - Section 2, a.b.c:* Seven area Quality Improvement Councils and two institute Quality Improvement Councils were formed by 6/1/96. The first statewide meeting was held in Augusta on 6/15/96.
- *3607 - Section 2.d:* By-laws were adopted by each QIC.
- *3607 - Section 2.e:* QIC's took the first steps in forming program evaluation teams, and requested technical assistance.
- *3607 - Section 5:* On October 1, 1996, Quality Improvement Councils submitted initial "plans for the development, coordination, and implementation of a local mental health system...."
- *3607 - Section 8:* Quality Improvement Councils began public outreach activities, including announcing their meetings in local newspapers, printing up flyers and distributing them, and inviting the participation of interested community members.
- *Section 3608:* Local Service Networks began to form in two areas. In addition, in all QIC's providers were asked to begin to develop those elements necessary to include in a local service network, such as: a uniform client data base and assessment forms, uniform quality assurance procedures, etc.
- *Section 3609:* Each area and institute Quality Improvement Council nominated a member and an alternative to serve on the statewide Quality Improvement Council.

## Year Two: QICs

### *Legislative*

L.D. 1326, An Act to Clarify the Responsibilities of the Institute Councils of the Augusta Mental Health Institute and the Bangor Mental Health Institute, was approved which refined the definition of the major responsibilities of the seven network area councils: 1) to evaluate the delivery of mental health services, and 2) to advise the Department regarding quality assurance, systems development, and the delivery of mental health services to children and adults under the authority of the Department. The act further refined the responsibilities of the institute councils: 1) to evaluate the delivery of mental health services at the two state mental health institutes, and 2) to advise the Department regarding quality assurance, operations and functions of the mental health institutes. This act became Chapter 365 when enacted (See Appendix A).

L.D. 1526, An Act to Redefine the Community Services of the Mental Health System, was approved which expanded definitions in chapter 691 to include an "adult who has or had a major mental illness." This act holds the Department responsible for services to persons who have or have had a major mental illness, regardless of the source of funding for those services (See Appendix A).

### *Evaluation Activities*

Chapter 691 calls for each quality improvement council to form a program evaluation team (PET) to review each program funded by the Department on a periodic basis. During the year, two of the network area councils developed their own approaches to evaluating the mental health programs in their network area, while the remaining councils awaited guidance from the Department. The Cumberland QIC devised protocols and conducted a site visit to one of the programs in its network area that was having problems. While the result of this effort was a reduction in the problems identified, the QIC determined that the effort was well beyond what could reasonably be expected of a group of volunteers. The York QIC developed a survey and measured consumer satisfaction with the new, collaborative crisis intervention service. As a result of this, recommendations were made for improvements that have been incorporated in the contract.

Clarity from the Department regarding PET expectations was provided at a statewide meeting of QIC members on November 24, 1997. (See Appendix D and the section of this report on evaluation activities for more information.) Following the November 24th meeting, many councils expressed the need for more technical assistance before beginning to organize their PETs and activities. Each year beginning in 1998, the Department will provide facilitation training to all team members. Other trainings are in the works, such as how to construct and analyze satisfaction surveys.

### *Director of Community Systems Development*

In response to the expressed needs of the Quality Improvement Councils, as well as those of the existing Local Service Networks, the Department redefined an existing position and dedicated it to providing technical assistance and guidance to these bodies, in addition to being responsible for regulatory reform necessitated by changes in the delivery of mental health, mental retardation, and substance abuse services as the Department prepares for the move to Managed Care. The Director of Community Systems Development, a former local QIC Chair with extensive experience in quality assurance and system of care development, began work on December 1, 1997. Much of the QIC work that was anticipated to be completed in year two was stalled due to the departure of the Mental Health Program Manager in late April and the reassignment of QIC duties originally assigned to that position to the newly created position. Pending the decision to redefine an existing line, the Department contracted over the Summer and Fall for some technical assistance.

### *Network Plans*

Guidelines were issued in July revising the elements required in QIC Network Plans. The new guidelines make the planning process more meaningful to both the councils and the Department. (See Appendix B.)

### *Education Plans*

Last winter/spring the Department asked each QIC to develop an Education Plan. Due to a lack of clarity on the scope and purpose of the plans, the Department issued new guidelines for the creation of QIC Public Education Plans (See Appendix B). These guidelines explicate the tenets of the Consent Decree upon which educational activities must focus.

### *Membership Applications*

As the law stipulates, the Commissioner makes all appointments to the local and institute QIC's, as well as the at-large members of the Statewide QIC. In August, the Department standardized the process by which new QIC members are nominated by the councils and presented to the Commissioner for formal appointment (See Appendix B). It is the intent of the Department that the membership of each QIC reflect the diversity of its network area. To that end, QICs are now being asked to implement a membership policy that enables them to select candidates who can represent groups, agencies, families, and organizations that currently do not occupy a seat on the council.

### *Statewide QIC*

The Statewide QIC began meeting monthly in February, 1997. Bylaws have been approved and officers elected. The group is still in the process of clarifying and operationalizing its responsibility to advise the Department on issues having a statewide focus. Attendance at meetings has been sporadic. In order to assist this body in achieving its stated mission, the Commissioner has assigned the Director of Internal Operations and the Director of Community Systems Development to attend all meetings.

### *Formation of Quality Improvement Groups (QIGs)*

At a meeting sponsored by the Department, stakeholders in the field of mental retardation met at Sugarloaf to discuss services for individuals with mental retardation. A major reason for that meeting was to describe the QICs and to begin a parrallel process in the mental retardation field. During the year, therefore, stakeholders in the field of mental retardation began meeting to discuss issues similar to those discussed by QICs. These local groups have been referred to as

Quality Improvement Groups (QIGs). Support to these groups have been provided by Departmental staff.

### *Integration of Local Quality Activities*

Quality Improvement Councils are mandated for mental health services only. However, the Department and many of its stakeholders want local quality activities to focus on all of the services under the purview of the Department. To that end, two day-long meetings of stakeholders were held in the fall of 1997 to design a model for local quality activities that would enable equal participation for all disability groups. Reports from the September 24 QIC/QIG retreat and November 24 meetings highlight what happened and what still needs to happen to bring to fruition a fully integrated, collaborative system of quality activities in each network area (See Appendix C). Appropriate legislation to achieve necessary changes to the structure to Chapter 691 will be sought at the appropriate time.

### *Highlights of Specific QIC Activities This Year*

QICs have been actively involved in helping the Department's regional offices interview and select key personnel, For example, in Region I members from both the York and Cumberland QICs participated in the hiring of the Medical Director as well as the new supervisor in children's services; they will also be involved in the hiring of the new financial team leader and the quality assurance director. QICs have sponsored public education forums across the state to reduce the stigma and myths associated with mental illness. They have also reviewed the Department's Strategic Plan and provided feedback on it, as well as the Children's Plan in response to L.D. 1744. Finally, QICs have actively participated in the creation of new Requests for Proposals for the development of new services; non-provider QIC members have participated on proposal review panels and contributed to decisions regarding the awarding of the contracts.

## Year Two: LSNs

### *Legislation*

L.D. 1814, An Act to Improve the Delivery of Mental Health Services in Maine, was approved, clarifying the Department's oversight responsibility for the Local Service Networks (LSNs) (See Appendix A).

### *LSN Development*

The development of statewide Local Service Networks has been held up while elements which will be required of the networks are designed and piloted. Two network areas have been designated as the primary points of system development activities during the past year, both of which were chosen because of the fragmentation in the delivery of mental health services for adults with severe and persistent mental illness. In Cumberland County, an advisory group of the Cumberland QIC has been meeting regularly since summer to define the following six key elements of a coordinated system of care: 1) Access, 2) Target Populations, 3) Services, 4) Care Management, 5) Quality Assurance, and 6) Financing. While this group is not an official LSN, many of the members of the group are providers under contract to the Department and

belong to a providers' group in the area. The Department will be working closely with these groups in the coming months to have them formally designate a LSN for Cumberland County.
In the Kennebec-Somerset area, providers and other interested system stakeholders have been meeting biweekly since July 1, 1997 to restructure their local service delivery system. Activities have focused on defining core services of an integrated system, creating protocols for movement of consumers within the network system, clarifying roles and responsibilities of inpatient psychiatric services vis-a-vis the community system, piloting the Uniform Intake Form (see below) and creating and piloting a network Release of Information form. This summer this group formally recognized itself as the Ken-Som LSN.

Both of the above referenced activities have been under the direction of Department consultants who are working on the design of a managed care system. Since the networks are vital to a Medicaid managed system of care, network development and managed care development activities go hand-in-hand. It is not possible to speak of one without addressing issues relative to the other. The Department has worked hard to ensure close coordination of its many initiatives which involve networks and/or managed care.

In addition to the network development activities in Cumberland and Ken-Som, a group of stakeholders (mostly providers) in the Western area has been meeting since before Chapter 691 became law. They identify themselves as the Western LSN, and will be the next network area into which formal system development work will be expanded. A group of providers in the Coastal area is in the process of organizing, calling themselves the Coastal LSN, and they, too, will soon begin formal system development work. To date and as far as the Department knows, no other LSNs are in the process of forming in the other three network areas (York, Northeast, and Aroostook); the Director of Community Systems Development is responsible for working with providers and local stakeholders to establish working LSN's in these areas by the end of 1998.

In addition to the system development activities explicated above, other initiatives having direct impact on the local service networks are in the development phase and/or ready for implementation. These are as follows, and will be discussed briefly below: 1) Uniform Intake and Assessment Instruments, 2) Access Standards, 3) Level of Care Criteria, and 4) Case Management Standards.

### *Uniform Intake and Assessment Instruments*

A Uniform Intake form has been designed by a work group of system stakeholders, the purpose of which is to gather initial demographic and other information at the first point of system face-to-face contact. The form was piloted during the months of July - September in the Ken-Som LSN. Feedback was received and the work group has revised the piloted form. It will now be sent out for final comments prior to being implemented statewide by April 1, 1998. Uniform clinical assessment instruments are beginning to be developed for each service population served by the Department (mental health, children, mental retardation, substance abuse). These should be ready for piloting by LSNs sometime in 1998.

### *Access Standards*

The Department is committed to assuring that services are available and accessible in a manner consistent with progressive standards of care. This means that local service networks will have to assure that persons are afforded access in a manner consistent with the acuity of their need and in a manner that assures equal access. A work group in the Cumberland area is currently refining access standards originally drafted by the Managed Care Steering Committee. The focus of these standards is on availability, scheduled appointments and waiting time, location, architectural barriers, cost, education, family supports, cultural competency, and choice. A draft of the standards under consideration can be found in Appendix B.

### *Level of Care Criteria*

Determination of the appropriate amount and mix of needed services is crucial to a networked system of care. Criteria by which service decisions will be made are in the process of being developed, and networks will be required to implement them once they are finalized.

### *Case Management Standards*

Case management is considered the glue that holds a system of care together. Another work group of stakeholders is developing standards and networks will be required to implement them once they have been finalized. There is no draft yet on these.

# V. EVALUATION OF THE MENTAL HEALTH SYSTEM – RESTRUCTURING INITIATIVE

The system reorganization effort authorized by Chapter 691 is guided by the following underlying goals:

- Increase mental health service capacity in local communities adequate to meet the needs of consumers and family members and reduce reliance on institutional care;
- Increase the level of collaboration and coordination among provider agencies to ensure the efficient delivery of services and reduce fragmentation and duplication of service efforts;
- Increase the level of accountability among providers in meeting the needs of consumers and family members;
- Provide services that are individualized and based on the needs of individual consumers and family members;
- Increase the involvement and participation of consumers and family members in the planning, delivery and evaluation services;
- Increase consumer and family member satisfaction with services.

In order to assess the impact of the system reorganization effort and the progress made toward achieving the above goals, the Department, in collaboration with the Muskie Institute at the University of Southern Maine is conducting an ongoing statewide evaluation of the system implementation process. In this evaluation a number of service system and client level outcomes will be used to monitor the development of an integrated service delivery system.

## INTERAGENCY/ORGANIZATIONAL SYSTEM BASELINE ASSESSMENT

Inter-organizational service delivery was evaluated to assess the interagency/organizational climate, collaboration/coordination among provider agencies, and interagency/organizational relationships. A survey instrument, developed in collaboration with the Edmund S. Muskie School of Public Service at the University of Southern Maine, was used to assess these system dimensions. The survey was administered to key stakeholders (i.e., local network providers, consumers, parent/family members, community members, Quality Improvement Council (QIC) members, Quality Improvement Group (QIG) members, and other interested parties. These data will provide a baseline local system assessment which will establish a benchmark for comparison of additional survey results over time.

The survey was mailed to over 870 individuals. To date 38% of the surveys have been returned, which represents a typical response rate for survey research. Additional surveys are still being received, and approximately 60% of the responses have been entered into the database. This report presents a preliminary evaluation based on results entered to date. A final report will be prepared by the end of February, 1998, and will include a more rigorous statistical evaluation as well as a breakdown of responses by the respondents title/position, disability group, and Local Service Network. A detailed analysis of the open-ended questions (where respondents had the opportunity to write additional opinions on the strengths/weakness of the system) will also be presented. A summary of the preliminary findings is presented below. Results were rated on a scale from 1 (very low) to 4 (very high); the average response has been reported.

### *Collaboration Among Local Service Network Providers*

- The level of cooperation among local service providers was rated positively (average 3.1).
- Overall communication was considered moderate to low (average 2.7).
- The most common written response noted the collaboration among provider agencies as a positive aspect of the local service system.

### *Relationship Between DMHMRSAS, Providers, and QICs/QIGs*

- Communication between the Department and providers, QICs, and QIGs was rated moderate to low (average 2.7, 2.6, and 2.8, respectively).
- The most common written response noted that communication with DMHMRSAS was an area needing improvement.

### *Stakeholder Perception of System Development Efforts*

- The use of evaluation data to assess system effectiveness and public education efforts were rated low by the respondents (average 2.2 and 2.3).
- Availability of transportation, respite, psychiatric, and interpreter services received a low rating (average 2.3 - 2.4)
- Positive responses were received for the overall quality of treatment services (average 3.5), provider staff training and knowledge (average 3.4), and the tailoring of services to individual and family needs (average 3.3).
- The most common written response noted the support and understanding of provider staff as a positive aspect of the local service system.

### *QIC/QIG - Perception of Participation*

- The respondents' perception of their participation in the QIC or QIG process was generally favorable (moderate to high). These positive responses include satisfaction with participation in the QIC/QIG process (average 3.8), shared goals and values of members (average 3.5), and the willingness to listen to others (4.0).

- The most common written responses noted the opportunity to hear different opinions and perspectives and the consumer and family involvement as positive aspects of the QIC/QIG process.

### *QIC/QIG - Effectiveness in Influencing Change*

- While QIC/QIG members expressed satisfaction with the group process, they were less satisfied with their effectiveness as a group (quality of planning activities - average 2.6, and effectiveness in making changes to the system - average 1.8).

### *Perceived Barriers to Local System Development*

- The most common written responses noted the role and authority of the QICs and QIGs need to be better defined.

- An increase in both system capacity and funding was noted as necessary for system development.

## SERVICE CAPACITY/UTILIZATION BASELINE

An evaluation of service utilization was performed using FY1996 Medicaid claims data as well as other secondary data sources (e.g., hospital admission data) in order to assess trends in service use. These data will be used to establish baseline utilization rates, which will serve as benchmarks to compare changes in service use over time. These analyses examined service use across the several core service areas (i.e., inpatient hospital services, residential/group services, and community-based services), as well as the distribution of service utilization across Local Service Networks. Inpatient and outpatient service utilization rates were evaluated separately for children (0 - 17 years) and adults (18 - 64 years). The results of these analyses are graphically displayed in Appendix E. A summary of selected findings is presented below.

### *Inpatient Utilization*

- Seventy-five percent or $51,366,165 of the total annual Medicaid expenditures go toward serving children in the most costly and restrictive out-of-home treatment alternatives including inpatient psychiatric hospitals and residential treatment centers.

- Annually 539 children and youth between the ages of 0 and 17 years are placed in instate psychiatric hospitals on an annual basis at a per child cost of $25,565 and 74 children and youth are placed in out-of-state inpatient psychiatric hospitals at a per child cost of $81,516.

- The average daily census for adult inpatient psychiatric hospitals in Maine is twice that for Vermont/New Hampshire/Rhode Island (3.4 vs. 1.5 per 10,000 population).

### *Length of Stay for Inpatient Hospitalization*

- The average length of stay for children in out-of-state psychiatric inpatient facilities is more than 4 times longer than inpatient stays in Maine (i.e., 133 days - out-of-state versus 32 days instate).

- 22% of the adult involuntary admissions involve a length of stay greater than one month.

### *Utilization of Outpatient Community Mental Health Services*

- Twenty-five percent or $17,298,082 of the total annual Medicaid expenditures go toward serving children in community care settings (outpatient, case management, crisis, and home based services).

- Adult community housing supports (supervised apartments and supported housing) has shown a growth in available housing units of more than 33% from 1996 to 1997.

- The utilization for adult outpatient community mental health services in Maine is 1/3 less than that for Vermont/New Hampshire/Rhode Island (101 vs. 154 users 1.5 per 10,000 population).

- The total number of adult recipients for Intensive Case Management and ACT services has increased more than 5 times from 1996 to 1997.

### *Inpatient/Outpatient Utilization Patterns Across Local Service Networks*

- Children residing in the Northeast, Kennebec-Somerset, and Western local service networks are more likely to receive services in inpatient hospital and residential treatment settings than children residing in other areas of the state.

- Children residing in Cumberland County tend to use community-based services such as outpatient clinical, case management, outpatient emergency services, in-home family services, and substance abuse services less frequently than children in other areas of the state.

- Adults residing in the Northeast, Kennebec-Somerset, and Western local service networks are more likely to receive services in inpatient hospital settings than those residing in other areas of the state.

- Adults residing in York County tend to use community-based services such as outpatient clinical, case management, crisis services less frequently than those in other areas of the state.

- Involuntary adult admissions are higher on average in the Northeast, Kennebec-Somerset, and Cumberland local service networks than for the other areas of the state.

### *Areas for Further Evaluation*

This study was designed to be longitudinal to allow for follow-up assessments. Future evaluations will examine the changes in utilization over time for the core service areas. In addition, measurement systems will be developed to look at other mental health indicators, such as the delivery of services to people who are homeless and mentally ill and those in the correctional system.

## Quality Improvement Activities

In order to effectively manage the re-organized community-based system of care for children and adults, the Department is currently developing an integrated management information system and accountability structure that includes common data collection tools and procedures, including uniform intake and screening protocols and common procedures for monitoring consumer, family and system outcomes. The proposed management information and accountability system will include the following core components:

- **Comprehensive Service Use and Encounter Information**. This component forms the core of an integrated management information system and would capture comprehensive service use and encounter data on all clients served by the Department. This information is essential for assessing service use and expenditure patterns and trends and monitoring local service system capacity. The DHS/BMS MMIS Medicaid Claims data system currently captures a large portion (approximately 60% to 70%) of behavioral health related service encounters. However, in order to obtain a comprehensive picture of service use within local systems, the Department is working with DHS to expand the Medicaid claims data system to incorporate all non-medicaid reimbursable service encounters.

- **System for Tracking Consumer and Family Outcomes**. The final component of the proposed accountability system is a system for assessing and tracking key consumer and family outcomes.

  Through on-going work in developing performance-based contracts, DMHMRSAS, in collaboration with DHS and other system stakeholders (i.e., consumers, family members, service providers) has identified key performance goals and outcome indicators for each program area across all service population (i.e., adult mental health, children's services, mental retardation services, substance abuse services) and has selected from this list of outcome domains the following "core outcome measures" for adult and child services:

  **Adult Mental Health Services**

  - Coping and Recovery

- Quality of Life (progress toward goals)
- Consumer Satisfaction
- Community Tenure
- Employment in integrated settings
- Involvement with law enforcement and correctional system

**Child & Adolescent Services**

- Child and family behavioral and emotional strengths
- Progress toward individualized goals
- Youth and family satisfaction
- Restrictiveness of living arrangement
- Progress in school
- Involvement with law enforcement and correctional system

The Department is developing uniform measurement tools and data collection methods for each of the above outcome areas. Over the past six months, the Department's Office of Quality Improvement has collected and compiled a number of measurement tools in each of the above outcome areas that have been used by other state systems and in mental health services research projects. The Department is currently forming an Outcome Development Group to review and select core outcome measures to be used system wide. Implementation of the outcome tracking system is anticipated in May of 1998.

### Consumer and Family Assessment Teams and the Role of Local Program Evaluation Teams

As an approach to the data collection and feedback of consumer and family satisfaction and outcome information, the Department is proposing the development of Consumer and Family Assessment Teams. These teams will include mental health consumers and family members trained as interviewers and in group facilitation. These Teams will collect evaluation information in the following ways: 1) by conducting dialogue sessions with consumers and family members in DMHMRSAS program/service sites; 2) conducting individual interviews with consumers and family members, and 3) conducting consumer/family speakouts. A more detailed discussion of the proposed Consumer Assessment Team Approach can be found in Appendix D. The focus of these evaluation activities is to assess consumer and family satisfaction with the services and the service delivery system. In addition to data collection activities, these teams will be responsible for summarizing and disseminating this information to the Department, Quality Councils and other stakeholder groups to be used to guide local service system and statewide planning efforts. The Department's approach to the development of Consumer and Family Assessment Teams is guided by a nationally known organization called "Consumer Satisfaction Team" (CST) based in Philadelphia. This organization pioneered the concept of consumer satisfaction teams. The DMHMRSAS has been in contact with this CST to provide consultation and technical assistance with the development, training, and implementation of Consumer and Family Assessment Teams in Maine.

The Program Evaluation Teams (PETs) that were established through this legislation (PL 691) and include non-provider members of each QIC will perform the following evaluation and planning activities:

1. Participate in the development of statewide core consumer and family outcomes and outcome tracking procedures;
2. Participate in the development and implementation of Consumer and Family Assessment Teams;
3. Conduct consumer/family dialogue sessions in 3 to 4 program sites per year and provide feedback local provider agencies, QICs, DMHMRSAS and other stakeholder groups;
4. Review and summarize local consumer/family, program, and system level information for use in local, regional, and statewide planning efforts;
5. Identify annual local service system improvement priority areas based on review of local system, program and consumer/family level information.

# VI. CONCLUSION

As referenced in this report, the development of the Local Service Networks and the refinement of the local quality systems is a part of the Department's preparation for the move to a managed system of care. On November 21, 1997, after months of review and comment by many system stakeholders, the Department issued a Request for Comment (RFC) on Network Manager Services. Following receipt of questions and comments (deadline for comments is January 22, 1998), the Department, in consultation with its stakeholders, will determine the requirements for its network managers and will then issue an RFP to procure those services, anticipated to be awarded by January 1, 1999. At the same time the RFC comments are being collected, the Department is preparing its 1915 waiver for submission to HCFA, which, when granted, will enable the Department to go forward with its behavioral health carve out under managed care.

Organization and coordination are the keys to bringing sweeping system changes to fruition. The next two years will be watershed years for this Department, as it brings together into a cohesive system the many system change initiatives currently under way. Quality Councils and Local Service Networks will be vital to the successful transition to the new system, as they grapple with operationalizing new system elements. One of the many daunting tasks will be operationalizing the access standards once they are finalized. The major goal of the emerging system is to assure persons are afforded equality of access in a manner consistent with the acuity of their need. This includes providing services in a timely manner, and eliminating waiting lists. Because of the breadth of these and other changes in the service delivery system, the Department has a affirmative obligation to assist agencies in the development of policies, protocols, and procedures to implement and incorporate these and other standards into their program design and operations. Since the Department is changing from a funder of services (under a grantor arrangement with providers) to a purchaser of services (fee-for-services provided), this will require most agencies to shift allocation of their resources and to collaborate more closely with other agencies in the system. The majority of this collaboration and coordination will take place in the Local Service Networks and the Quality Improvement Councils.

Years one and two of the implementation of Chapter 691 saw the building of the foundations of the emerging managed local systems of care with the creation of the QICs and the LSNs. While much of the work in year two focused on stakeholders getting used to organizing and working together in new ways, in year three they will be faced with even more challenging tasks as members work together to respond to the needs of the citizens of Maine. The framework established by Chapter 691 and developed during the past two years will allow the Department to manage services more effectively and to evaluate their performance through an ongoing, consumer and family-directed quality improvement process.

**State of Maine**

Department of Mental Health,
Mental Retardation, and
Substance Abuse Services
40 State House Station
Augusta, ME 04333-0040

Phone: (207) 287-4205
FAX: (207) 287-4291
email: Nancy.Essex@state.me.us

# *Memorandum*

| | |
|---|---|
| *To:* | *Local QIC Chairs* |
| *From:* | *Nancy L. Essex, Director of Community Systems Development*<br>*Cathy Bustin-Baker, Director of the Office of Consumer Affairs* |
| *cc:* | *Leslie Cosgrove, AMI*<br>*Andy Blanch, Associate Commissioner*<br>*Pat Hunt, Statewide QIC Chair*<br>*Regional Directors* |
| *Date:* | *February 6, 1998* |
| *Subject:* | *Accessing Education Monies* |

As you know, the Alliance for the Mentally Ill (AMI) is administering disbursement of the additional $5,000 each local QIC has been granted for educational activities. The two institute QIC's are expected to partner with their local QIC's in these endeavors (AMHI with Ken-Som and BMHI with Northeast and Aroostook).

These monies are to be used only for the specific activities shown below. While QICs may certainly undertake other educational activities and are encouraged to do so, the following are the only types of activities for which the $5,000 may be used. In order for the Alliance to conform with the terms of its performance-based contract with the Department, the QICs need to provide AMI with certain information regarding the expenditure of these funds. To ensure that the funds are being spent for the purposes intended, the Office of Consumer Affairs (OCA) needs to review and approve all expenditures (of these specially earmarked funds) by each Quality Improvement Council. This memo sets forth the guidelines under which each council's $5,000 allocation may be spent, as well as how to to go about obtaining OCA approval and AMI payment. Please note that this approval is for the expenditure of the funds and is not to be confused with approval of your Education Plan by the Court Master. That Plan is still due to Nancy Essex by March 1, 1998.

## Requirements For Expenditure of the $5,000

- The education/information provided by each QIC must have a lasting impact on consumers and their families, as well as the local community;
- The planning and delivery of the education/information must involve a significant number of local consumers and their families; and
- Education/information efforts must increase direct interaction between consumers, families, providers, and the community at large. (This means activities must involve face-to-face interaction with consumers and families; therefore, any media activities should be

incorporated into a broader effort that involves direct participation of consumers, families, providers, and the community.)

## How to Get Approval from the Office of Consumer Affairs

- Submit your request, in writing, to Cathy Bustin-Baker giving a description of the educational activity, by whom it is to be delivered, who the intended audience is, the anticipated delivery date, the number of persons to be educated/informed, and an itemized budget of all costs for which funding is being sought. The request may be comprehensive, covering all activities for which the QIC will be seeking expenditure of these funds, or a separate request may be made for each specific activity as it is planned. Requests for the use of these monies must be received by the OCA no later than 15 working days (3 weeks) prior to the date of the activity.

- Upon receipt of a completed request in writing, the Director of OCA, or designee, will determine if the planned activity meets these guidelines. If it does, the Director of OCA will notify, within five (5) working days (one week), the requesting QIC and AMI of approval of the request. If the Director of OCA, or designee, determines that the planned activity falls outside these guidelines, s/he will notify the requesting QIC, in writing, within five (5) working days of the reason(s) the request is being denied. The OCA will make every effort to work with the requesting QIC, if it desires, to restructure the proposed activity so that it may be funded under this initiative.

## How to Get the Money from AMI

The Alliance issued its guidelines for this via memo to QIC Chairs on October 24, 1997. These are reiterated here so that all guidelines for these monies are contained in the same document.

Invoices need to be submitted to AMI with a cover letter containing the following information:

1. Date activity was approved by the Office of Consumer Affairs;
2. Date, time, place(s) where the education or information was provided;
3. Target audience;
4. The topics discussed; and
5. The number of people involved/attended.

The Office of Consumer Affairs is available for technical assistance, ideas, and other resources that the QICs may desire to aid them in conducting these activities. OCA staff are usually booked weeks in advance, so make your request for their assistance as early as possible.

Should you have any questions regarding any of the above, please don't hesitate to contact Cathy at 287-4209 or Nancy at 287-4205.

**State of Maine**

Department of Mental Health,
Mental Retardation, and
Substance Abuse Services
40 State House Station
Augusta, ME 04333-0040

Phone: (207) 287-4205
FAX: (207) 287-4291
email: Nancy.Essex@state.me.us

# *Memorandum*

*To:* *QIC/QC Chairs*
*From:* *Nancy L. Essex, Director of Community Systems Development*
*cc:* *EEMT, Jay Yoe, QI Managers*
*Date:* *December 28, 1998*
*Subject:* *SET Position Paper*

Enclosed you will please find the finalized version of the Department's position paper on service evaluation teams. A very special thanks to those of you who reviewed the draft of this document and provided valuable feedback on both the paper and the SET process.

The Department is now ready to begin development of the survey instrument(s) which will be used statewide by the SET's. A meeting will be held on **Thursday, January 28th from 1:00 - 2:30 PM** in the Department's 4th Floor Conference Room to begin this process. Involvement of a wide variety of stakeholders who are interested in survey instrument construction is being sought for this meeting. It is especially important that consumers and family members participate in this development process. Providers, although not eligible to participate on SET's, are welcome to participate in the development of the instruments, since it is their services which will be evaluated.

Please solicit volunteers for the survey development committee from your council. In order for us to be able to plan the meeting as well as assure, to the extent we are able, that representatives of all stakeholders groups are present at the meeting, ***please notify me at the above number by Monday, January 25th of the names of those who will be attending the meeting representing your council.***

A number of survey instruments have already been developed throughout the state and nation for use in measuring client satisfaction. Department QI staff have been gathering copies of other forms for the committee's perusal. Meeting participants are encouraged to bring with them copies of satisfaction survey forms which they feel could also be used to guide the committee's work.

Please feel free to contact me with any questions pertaining to the position paper or the meeting on January 28th .

Maine Department of Mental Health, Mental Retardation,
and Substance Abuse Services

Position Paper

# SERVICE EVALUATION TEAMS

December 28, 1998

## Introduction

The primary goal of the Department's Quality Improvement (QI) system is to improve the overall quality and integrity of services and supports that are provided to its customers (consumers and family members, service providers, and Department staff), and to ensure that programs and services are responsive to consumer and family needs. This is accomplished through:

- Routine monitoring of system capacity and growth,
- Ongoing tracking of program and agency performance,
- Incorporating best practice standards into the service delivery process, and
- Using evaluation information to inform individual, system, and program planning activities as well as decision-making.

The Department's QI system is driven by its mission, vision, and values, and is built on a foundation that includes a focus on consumer involvement and outcomes, collaboration with key organizations and with system stakeholders. The QI system is designed to continually improve performance over time, in addition to identifying and correcting specific problems. In order to accomplish this, QI activities have been established to monitor and improve the service delivery system in four general categories:

- Health, Safety, and Consumer Rights,
- Organizational Performance,
- System Capacity, and
- Consumer and Family Outcomes.

In 1995, the Maine legislature created quality improvement councils (QICs) charged with, among other things, having a service evaluation team of non-provider members whose responsibility it is to periodically review programs funded by the Department. The results of the reviews must be reported to the council and the regional director for the Department, and must be considered in funding decisions by the Department.

Service Evaluation Teams (SETs) need to be viewed as one piece of the QI system in each region. Predicated on the Department value that folks who have used a service (and their families) need to evaluate that service, SETs primary responsibility is the measurement of the satisfaction (or lack thereof) that consumers experience as a result of receiving Department sponsored services. This involves:

- Development of the survey instrument(s),
- Determination of the services to be evaluated,
- Participation in data gathering activities, and
- Review of analyzed results.

In addition to conducting consumer satisfaction surveys, SETs will routinely receive a number of analyses and QI reports specific to the services delivered in their network area.

Most of this information will consist of analyses of data from quarterly reports submitted by contracted providers.

The Department is very aware that doing consumer satisfaction surveys is a labor intensive activity. While it wants to encourage SET members to do as much of the work as it wants to and is able, the Department is prepared to lend as much assistance as necessary to assure that SET efforts are successful and are not a burden to the SET, the quality council, or to individual council members.

## Satisfaction Survey Instrument

A standardized satisfaction survey instrument will be developed as soon as possible under the direction of the Department and with the active participation of representatives of all Department stakeholder groups (consumers, family members, parents, providers, community members). Separate instruments may need to be developed for clinic-based services and for residential-based services, as well as for the four distinct populations served by the Department. The use of a standard satisfaction assessment tool allows for comparisons to be drawn across a wide spectrum (by program, by providers, by network, by region, for example). A committee has already been working on a draft satisfaction survey for mr/dd services, and QI staff have been gathering samples of other survey instruments in use across the country, all of which could serve as guides for further survey instrument development.

To assure that respondents are given an opportunity to fully express themselves with respect to their experiences with the program being evaluated, the survey instrument must contain a combination of both closed-ended and open-ended questions. Closed-ended questions are those that offer a number of responses from which the respondent is expected to select the one response that most closely matches their feelings. (Example*: My appointments are scheduled at a time convenient for me.* Answers from which the respondent must choose are: *1) Strongly Agree, 2) Agree, 3) Neither Agree Nor Disagree, 4) Disagree, 5)* Strongly Disagree.) Open-ended questions are those to which the respondent supplies the full answer. (Example: *How do you think we can improve to serve you better?)*

In general, survey forms which contain from eight to twelve closed-ended questions and one or two open ended questions work well, as they usually can be filled out in five to ten minutes.

## Data Gathering and Methodology

Each SET needs to establish the criteria it will use to determine which of its network's programs are to be evaluated each year. Services provided directly by the Department as well as services provided by agencies under contract to the Department are eligible for evaluation. It is suggested that no more than three or four separate programs be evaluated in any given year.

Each SET needs to determine how the survey will be conducted. Some choices include conducting one-on-one interviews, having recipients fill out a survey form, conducting focus groups, or a combination of any of these. If the survey is to be done by interview or focus group, wherever possible consumer members of the SET should conduct the interviews and facilitate the focus groups.

Interviews may be done by phone or in person, with respondents' answers being recorded on the survey form either by the interviewer or by another member of the SET present at the interview. It is expected that council members will be fully reimbursed by the council for any out-of-pocket expenses incurred during the data gathering process, and, if council resources and bylaws permit, stipends be paid to non-provider members participating in this process.

People are asked to fill out a survey form usually in one of two ways. They can either be mailed a form and supplied with an envelope in which to return the completed survey, or they can be handed the form when they receive a service and be requested to complete it and drop it in a sealed receptacle before leaving, or if the service is delivered off-site, they can be given a postage-free envelope in which to return it.

Focus groups can be open-ended, whereby participants are asked to talk about their experience with the service being evaluated. Or, focus groups may be structured, using the survey instrument as a guide. The latter method allows for much easier data analysis and comparison, as each participant in the focus group can be asked to discuss their experiences and also complete the survey form.

SETs have a range of choices in selecting the persons to be surveyed. The first decision is whether to survey persons after their service has ended, whether to survey persons while they are in service, or a combination of both. (Obviously, when surveying crisis services, it is advised that recipients be surveyed after their crisis has been stabilized, rather than while they are receiving crisis services.) The next decision involves determining how the persons to be surveyed will be chosen. Options include surveying everyone provided service during a specified period of time (for example, all served in one week), or surveying everyone served by a program after they are discharged from the service. There are pros and cons to each of these methods; the QI Managers in each region are available to provide technical assistance to the SETs to assist them with these decisions.

It is the Department's desire that primary consumers of services always be surveyed, as well as parents/guardians of children and those adults who clinically lack capacity to make reasoned decisions. Surveying family members of adult consumers who do not lack capacity should only be done with the permission of the adult consumer.

In addition to paying stipends and reimbursing members of the SET for any out-of-pocket expenses connected with SET activities, it is also expected that any other expenses incurred by the SETs as they carry out these tasks will be paid from the quality council's annual allocation of funds. Careful attention needs to be paid to the costs associated with various kinds of data gathering when the SET considers the survey method it will employ. (For example, mailing survey forms to recipients and providing them with a postage-free envelope in which to return the survey form can be an expensive enterprise, especially if the number of persons to be surveyed is high. And, mailed surveys rarely result in more than a 15% - 20% response rate.) Surveys which are designed to garner the highest possible number of responses are considered optimal, as the greater volume of data increases the credibility of the results.

Regardless of the method used, respondents are to be guaranteed anonymity, meaning survey responses and comments shall never be associated with any one person, either verbally or in writing by anyone involved in the survey process. Further, SET's shall assure consumers when they elect to complete a survey that their responses will not result in withholding of services. Paper surveys may be encoded with information that enables identification of certain elements that may be used in data analysis, such as the agency providing the service, the service delivery site, the professional responsible for the service, the client's age and sex (but never the client's name). When the survey is done by interview, this information can be elicited directly from the respondent.

## Data Analysis, Reporting, and Use of Results

The regional QI Manager is responsible for coordinating the analysis of the survey data and preparation of the survey report. Following review by the SET, the report is to be shared with the quality council, the agencies whose clients were included in the survey, the Department's regional office, the Department's Office of Quality Improvement, the Local Service Network, and shall be made available for review by those who participated in the survey by placement in agency waiting rooms and other public areas respondents are known to frequent.

When a survey report reveals areas needing improvement, the data will be reviewed by the QI teams at both the regional and central office of the Department. Members of the SET along with regional office staff shall meet with representatives of the agency identified as needing improvement to discuss ways in which the agency will work to bring about noted improvements. The SET shall monitor improvement activities until it is satisfied that there has been satisfactory improvement in the area(s) in question.

## The Service Evaluation Team
## A PROCESS EXAMPLE

This is provided as one example of the decisions and methods that may be used to conduct a consumer satisfaction survey. It is not provided as **the** model by which the Department expects service evaluation to take place, but rather as **one** way it may be done. This example presumes that the uniform survey instrument development process has been completed. The steps in the satisfaction surveying process may be broken down as follows:

1. Determine service to be evaluated;
2. Select persons to be surveyed;
3. Determine method for gathering data;
4. Determine survey date(s);
5. Determine variables by which analyses will be conducted;
6. Determine SET members' role in data gathering;
7. Conduct survey;
8. Data entry, data analysis, report generation;
9. Dissemination of the survey report;
10. Meet with service to discuss areas identified as needing attention;
11. Monitor service improvement activities.

This is not intended to be a complete list for every type of satisfaction survey; there may be other steps each SET identifies during its own process.

### 1. Determine Service to be Evaluated

The SET has decided that it wishes to evaluate medication management services as provided by the Good Meds Clinic. This decision is based on a number of factors, not the least of which has been the number of complaints the regional office has received regarding the difficulties adult consumers are having getting adequate time with their psychiatrists; they frequently feel rushed during their appointments. It was decided to focus only on the medication management services provided by this one agency, rather than on all medication management services provided in the network area, because of the need to identify if there really is a problem with this one service, and if so, what the problem or problems may be.

### 2. Select Persons to be Surveyed

The SET has decided they want feedback from current adult consumers of this service, and they want to survey as many consumers as is feasible.

### 3. Determine Method for Gathering Data

Because of the situation noted above, the SET decides to conduct their data-gathering on-site by asking recipients in the waiting room to complete the survey form while they wait to be seen. In order to do this, they need the cooperation of the administration of the Good Meds Clinic, so a meeting is arranged between members of the SET, the regional QI Manager, and staff of the clinic. At that meeting, they agree that SET members may be present in the clinic's waiting room for five consecutive afternoons from 1:00 - 5:00 to conduct the survey. Clinic psychiatric staff are to have been informed by their administrator that the survey is taking place, so that they can be patient if a consumer is a few minutes late for an appointment.

### 4. Determine Survey Dates

In consultation with the Good Meds Clinic, the SET decides that the survey will take place during the week of November 16th, a week where there are no holidays and most staff of the clinic will be at work (instead of off at a conference or on vacation).

### 5. Determine Variables by Which Analyses will be Conducted

In order to try to pin point where a problem may exist, it is decided to look at the data from the following: 1) Gender - is this a problem for only one or both sexes? 2) Provider - both psychiatrists and physician assistants are employed at the clinic to provide medication management services. Is there a difference in the way consumers perceive they are treated by one or the other? 3) Primary Diagnosis - are persons with more severe conditions afforded greater personal service with their meds, for example? In order to gather this information, the survey form will have the following three questions added to it:

- Sex: ☐ Male ☐ Female
- Who are you here to see today? ____________________
- What is your primary diagnosis? ____________________

From the staff information provided by the clinic, the person entering the data from the surveys will then know by the name given above if the consumer was being seen by a psychiatrist or a PA and will enter a code for whichever it is. Likewise, from the information given on diagnosis, the person entering the data will enter a predefined code for the response provided.

### 6. Determine SET members' role in data gathering

Since it has been decided that SET members will be present in the clinic's waiting room, assignment of days and times needs to be made so that all of the hours in the survey period are covered. A backup system should be in place in case a SET member is unable to be present at the specified time. SET members will be trained in how to elicit consumer participation in the survey and how to keep track of surveys given out so that an accurate response rate can be calculated.

### 7. Conduct Survey

As noted above, SET members will be present in the clinic's waiting room each day of the week of November 16th from 1:00 - 5:00. They will have with them a supply of survey forms, clip boards, pens, and a sealed box for responses. As consumers arrive for their appointments, the SET member will ask them to please complete the survey and deposit it in the box and return the clip board and pen. Consumers who need assistance filling out the form will have the questions read to them by the SET member, who will record the responses on a survey form and deposit it in the collection box. At the end of the survey week, the last SET member will remove the box of survey responses and deliver it according to SET protocols on data entry.

### 8. Data Entry, Data Analysis, and Report Generation

It is the responsibility of the QI Manager for each region to coordinate data entry and analysis, as well as preparation of the formal survey report.

### 9. Dissemination of the Survey Report

Once the SET has received and reviewed the report and had an opportunity to have all its questions answered with respect to the survey process, the regional QI Manager will then disseminate the formal report to the entire QIC, the regional director and team leaders, the LSN, the Department's Office of Quality Improvement, the administration of the Good Meds Clinic, and shall make copies of the report available to those who participated in the survey by placement in the clinic's waiting room where the survey was conducted.

### 10. Meet with Service to Discuss Areas Identified as Needing Attention

Should the survey results indicate a clear problem area, members of the SET along with regional office staff meet with representatives of the Good Meds Clinic to discuss the results of the entire survey (the outstanding and the problematic) and come to agreement on ways in which the clinic will work to bring about noted improvements. Suppose, for example, the survey shows that a number of the people surveyed are dissatisfied with one particular psychiatrist. In essence, the SET wants the identified psychiatrist to be counseled by his/her supervisor to improve his/her doctor-patient relationships. The clinic agrees to increase supervision with a focus on this issue. The SET notes that it will follow up in three months to see if there has been improvement.

### 11. Monitor Service Improvement Activities

At the conclusion of three months, the SET has another meeting with the administration of the Good Meds Clinic. They learn that the psychiatrist was very concerned about the survey results and has been working on his/her doctor-patient relationships. The SET is pleased to hear this, but wants to verify this on its own, so it requests that the Good Meds Clinic let it do a brief follow up survey. It is agreed that members of the SET will be present on two afternoons to talk informally with consumers who are there to see the identified psychiatrist. Following this activity, the members of the SET report that they are satisfied that the problem identified in the survey report has been rectified.

It is hoped that the above has been helpful in understanding what is involved in conducting satisfaction surveys. Questions about this process should be directed to the regional QI Manager.

# Local Service Networks
# Roles and Responsibilities

This section contains copies of the following information supplied to all LSN's to assist them in understanding their roles and responsibilities. Information is arranged in chronological order by date of issue, beginning with the earliest information at the front of the section.

| Document Title | Issue Date |
|---|---|
| Network Plan | May, 1996 |
| Network System of Care Development Plan | January, 1998 |
| What is an LSN? | March, 1998 |
| Access Standards (pilot version) | April, 1998 |
| Target Populations for Mental Health Services | September, 1998 |
| Local Service Network Update | March, 1999 |

# NETWORK PLAN

I. Overview Of Process
   A. Stakeholders involved
   B. Schedule of meetings

II. Mission / Vision /Values

III. Network Membership

IV. Plan For the Provision of Mental Health Services For Children and Adults

   A. Case Management (includes advocacy services)

      1. List who provides the service
      2. Describe the relationship among case management components and provide an analysis of the case management function
      3. Number of clients currently receiving services
      4. How long have they been receiving the service?
      5. Describe the relationship between network providers and other related agencies such as Vocational Rehabilitation, police, housing authority, schools, jails
      6. What is the plan to reach those who are at risk or difficult to serve?
      7. Is there a waiting list for service? If so, what is the strategy for eliminating it?
      8. Program goals Year 1; Year 2

   B. Medication Management and Other Outpatient Services (includes outpatient therapy, substance abuse treatment, other services)

      1. List who provides the service
      2. Describe the relationship among the programs and the providers
      3. Number of clients currently receiving services
      4. How long have they been receiving the service?
      5. Describe the relationship between network providers and other related agencies
      6. What is the plan to reach those who are at risk or difficult to serve?
      7. Describe the role and extent of brief and group therapies as part of the outpatient service continuum?
      8. How are clients educated about their medications?
      9. Is there a waiting list for services? If so, what is the strategy for eliminating it?
      10. Program goals Year 1; Year 2

C. Crisis Prevention and Resolution (includes in-home flexible supports, home-based crisis assistance, mobile outreach, respite, inpatient)

1. List who provides the service
2. Describe the relationship among programs and providers
    a. Describe the single point for intake and service planning
    b. How is 24 hour coverage assured
3. Number of clients who used the service last year?
4. What is the process used to prescreen for all potential hospital admissions?
5. What is the average wait time in ERs for screening and triage?
6. Describe the relationship between crisis providers and hospital, police, sheriffs, etc.
7. What is the plan to reach people earlier in the development of crisis?
8. How many hospital bed days were used by service area residents last year?
9. Program goals Year 1; Year 2

D. Housing (includes in-home support services, tenant training and support services, home ownership options, supported housing)

1. List who provides the service
2. Describe the relationship among the housing providers and clinical service providers
3. Number of clients receiving housing supports
4. Length of stay in each setting?
5. What efforts are going to help people move to the housing of their choice?
6. What is the plan for outreach and engagement to homeless persons?
7. What criteria are used to govern admission to group homes?
8. Is there a waiting list? if so, what is the strategy for eliminating it?
9. Program goals Year 1; Year 2

E. Rehabilitation and Vocational Services (includes transitional employment, supported education, job finding and coaching)

1. List who provides the service
2. Describe the relationship among the programs and providers
3. Number of clients receiving services?
4. How long have they been receiving the service?
5. How many people obtained jobs last year?
6. Describe the relationship between network providers and other related agencies, e.g. Voc Rehab, Dept. of Labor, Adult Ed programs, Community colleges.
7. Is there a waiting list? If so, what is the strategy for eliminating it?
8. Program goals Year 1; Year 2

V. What Mechanisms Will Be Used To Assure A Smooth Transition Between The Child And Adult Systems Of Care?

VI. What Strategies Will Be Used To Insure Integration With Larger Community Systems Such As Schools, Criminal Justice, Welfare, Etc.?

VII. Each Geographic Area Has Some Populations Of People With Special Needs Living Within It's Boundaries (E.G. Migrant Workers, Native Americans). What Unique Program Interventions Are Contemplated Or Ongoing To Address These Needs?

VIII. What Is The Strategy For Meeting The Needs Of Rural Residents Of The Service Area? ?

IX. Are There Sub Area Issues That Require Attention?

X. What Process Is In Place For Assessing Risk For Each Person Served By The ? System?

XI. What Mechanisms Will Be Used To Assure Ease Of Access, Coordination, Continuity Of Service And Accountability?

XII. Describe How The QIC Will Evaluate Consumer Satisfaction And Progress Towards Meeting Network Principles. ?

ISSUED AT CASTINE, MAY 1996

Maine Department of Mental Health, Mental Retardation, and
Substance Abuse Services

# Network System of Care Development Plan

## Introduction

The goal of the Department of Mental Health, Mental Retardation, and Substance Abuse Services is to create in each of the seven identified network areas a system of care that is comprehensive, integrated, and responsive to and accountable for addressing the needs and desires of the individuals it serves. A major objective of the system will be to better utilize federal and state resources. A single system of care, properly structured, will assure service integration, efficient use of available funds, and achieve desired service outcomes. Since the change to such a system requires many steps, the process will be phased in over several years. Initial network system of care development activities will focus on services for adults with mental health care needs, and children's services will follow closely thereafter. Substance abuse services and services for persons with mental retardation and developmental disabilities will be added later. Providers and other stakeholders from all four service populations are encouraged to participate in all network development activities, even when those development activities may not be specifically for the population with which they are involved.

Network system of care development began in the summer of 1997 in both Cumberland County and the Kennebec-Somerset area. These were chosen as the pilot network development sites because the need for a system of care was greatest in these two areas due to the fragmentation of the existing service delivery system. Network development will proceed in the remaining areas of the state based on the development work accomplished in Cumberland and Ken-Som, with all seven network areas having working Local Service Networks (LSNs) by December 31, 1998.

## Guiding Principles

Certain principles provide the foundation for development of a system of care. These guiding principles, developed by system stakeholders, are:

- **The program approach should be consumer-centered.** DMHMRSAS will seek consumer as well as provider participation in the development, implementation, and ongoing assessment of the system, both through the formal Quality Council mechanism as well as various types of informal review mechanisms.

- **The fundamental goals of the program approach should be to create incentives for fostering independence, improving functional ability and recovery, where possible, and supporting an individual in achieving his/her highest level of functioning.** The system of care must link acute, long term, and other services across a spectrum of settings and assure that high-quality, consumer-centered, cost-effective care is delivered.

- **The system should assure well coordinated and high quality care management.** The current delivery and financing system does not promote consumer choice and participation in decision making, does not promote integration of services by providers, and does not adequately promote rehabilitation, recovery, and independence. The system must change the role of the consumer in his/her care, as well as change the structure of the delivery and financing system to assure better integration of services.

- **The system of care should incorporate a comprehensive array of medical, dental, mental health, substance abuse, social support, housing, peer support, and vocational services.** Long-term and acute care services should be integrated into a single system of care, so that access for consumers is improved and transition across the array of services is seamless.

- **The system of care should provide timely access to cost-effective, high-quality, and appropriate service in the least restrictive environment.** The integration of services will allow for services to be individually tailored and provided when they are needed. Consumers will benefit from improved access to and coordination of services, more effective care arising from prevention and early intervention, and more responsive care delivered without rigid, predefined service restrictions.

## Goals

The goals of the network system of care are as follows:

- Ensure accountability across the service system by developing a unified system of care which establishes a single point of accountability for each person served and which reflects the principles and values of the Department.

- Ensure an effective case management system which assures that persons are not excluded from services, places priority on persons with long-term and multiple problems, and supports mobile, on-site and in home services.

- Ensure consumers and their families (where appropriate) are involved in the design and development of the system of care.

- Ensure access, enrollment assignment, and treatment processes are easily understood by consumers, their families, providers and other community caregivers, and health and safety personnel.

- Ensure adults with mental illness can be served appropriately within their home community and in the settings of their choice.

- Ensure consumers are provided prompt treatment and crisis services by development of access and practice standards.

- Ensure consumers returning to the community from an institutional setting are provided necessary supports from community providers in order to minimize the human consequences and cost impact of repeat or long-term hospitalization.

- Ensure that the operation of the single system of care reflects the principles which guide it by establishing responsibility through contract terms, rules, protocols, and a review process which includes review by the local quality councils and the stakeholder-based Program Evaluation Team (PET) process.

## Working Assumptions

1. The system of care will be consistent with the standards and practice of the managed care system (Medicaid) being developed by DMHMRSAS in coordination with DHS and with the guidance of the statewide Managed Care Steering Committee.
2. The system of care will introduce new requirements for care management, including access and central enrollment.
3. The system of care will introduce case management practice standards.
4. Both state operated and community operated services will meet these criteria and will be provided under the same system,
5. Agencies providing case management services will be required to provide needed psychiatric services for persons receiving case management services. Consumers will always have the right to select their own psychiatrist.
6. The system of care will be phased in so that the structures developed can be modified and improved over time and so the system will not be overwhelmed by change.
7. The changes listed in items #2, 3, 5, and 6 above will be developed by both the Regional and Central Offices of DMHMRSAS and will include a review process by both offices and the local quality council prior to the implementation of any new service or major change in the system. The Regional Director in collaboration with Central Office staff will establish the schedule for implementation.

## Development Activities

Therefore, working in concert with DMHMRSAS, network system of care development needs to address the following major elements:

### ***Access Standards***

Assuring access to service is the cornerstone of a comprehensive system of care. Standards will be developed that address the following categories of services: 1) Crisis, 2) Inpatient, 3) Outpatient (including all kinds of outpatient services, such as medication clinic, ACT, community support, geriatric, etc.), 4) Residential, 5) Vocational, and 6) Peer Support. There are ten access domains, for which standards will be developed. These are:

- **Availability**: This refers to assuring access to an adequate number and type of providers for the full range of services and social support needs, including specialty services such as services for persons with multiple needs.

- **Scheduling**: This refers to the linkage, waiting time and convenience for appointments for urgent and routine outpatient treatment and for assignment to case management, and in office waiting time and scheduling of appointments during hours that take into account family obligations and work and other commitments.

- **Location**: This refers to locating services within reasonable distances and at sites that are accessible via public transportation. This includes locating services to take into account natural travel use patterns where people live and receive services.

- **Architectural Accommodation**: This refers to provider requirements for complying with the Americans with Disabilities Act of 1990 requirements and physical access to services, including street level access or wheelchair accessible ramps into facilities; wheelchair access to lavatories; elevators that are operable from a wheelchair and by persons who are visually impaired; and accessible examining rooms, tables, diagnostic and/or other equipment. This also includes a requirement for providers of services to document, investigate, and correct all physical access problems.

- **Communication Accommodation**: This refers to provider requirements for translation and interpretation services for persons who only use English as a second language or use a non-primary language for communication, such as sign language. This refers to providers making assistive technology available as requested and needed. This also refers to making communication accessible to persons who have limited reading skills by making all written materials accessible at the fourth grade reading level and verbal when necessary.

- **Cost**: This refers to the out-of-pocket costs for obtaining services not reimbursed as well as the costs associated with reaching services; these costs must be scaled to a person's income and ability to pay.

- **Information**: This refers to the provision of information for potential service recipients to assure they can make informed choices about seeking services and outreach to assure services are available to potential users of services and to ensure continuity of services.

- **Family Support**: This refers to providing the option for home delivered care, to provide after hours appointments and to ensure all direct services personnel are knowledgeable about the full range of medical conditions and other support service needs experienced by older persons and adults with disabilities who live with or are dependent upon their family by their affirmative choice. This also includes assuring the service recipient or their designee (for example, family member, friend, or advocate) is referred to support services, medical services and/or other resources when needed.

- **Cultural Competence**: This refers to each provider's demonstrated capacity to appropriately serve persons of all cultures. This includes policy and practice that reflects knowledge in and sensitivity to cultural issues and employment practices. This includes demonstrating evidence of cultural sensitivity training.

- **Choice**: This includes consumers being able to select the provider and/or individual practitioner of their choice. For some services funding is only available for a single service provider in a local area. Under those circumstances, provider choice may be limited. However, under the proposed Medicaid managed care plan, Network Managers will be charged with the responsibility to provide choice. This also includes providers furnishing a list of alternatives for service recipients when the recipient requests a change in service treating professional and providers not making one service contingent on the acceptance of another service unless related to the imminent danger of the recipient.

Access Standards, predicated on the above, will be developed by a group of system stakeholders for use everywhere in the state. Once finalized, networks will need to operationalize the standards.

### *Case Management Practice Standards*

Case Management, the glue that holds a system of care together, needs to be provided in a consistent and systematic manner, regardless of who is providing the service. To this end, the Department, in concert with its stakeholders, will adopt and/or develop practice guidelines. These guidelines should include definitions for case management, admission and discharge criteria, assignment to case management provider (by level of intensity of service), transition between levels of case management, and outcomes. Once finalized, networks will need to operationalize the standards.

### *Care Coordination*

In order to assure system integration, a single point of accountability must be established through designation of a Care Coordination Agency (CCA). The Care Coordination Agency will be accountable for assuring access to services through development of referral agreements and triage protocols. The CCA will serve as the central point of contact for screening, intake and referral. Care coordination, specifically, involves the following:

- Implementing protocols and instruments for screening, intake, and assessment for all new admissions into the system. This includes field testing and monitoring the standardized instruments and protocols which will be developed by DMHMRSAS in concert with system stakeholders.

- Monitoring the access persons have into services and, where needed, managing the triage of persons into appropriate care.

- Overseeing the implementation of Access Standards as approved by DMHMRSAS. This includes providing information on the standards to providers, advocates, and consumers regarding how they are to be used and how they will be monitored.

- Developing the criteria for how each standard will be measured and reported and how the implementation will be monitored.

- Developing the processes for implementing Case Management Practice Standards, including field testing, establishing protocols for use, and training staff on their use.

- Assigning levels of care and conducting concurrent and retrospective reviews of case management services.

- Developing quarterly reports on the implementation of the tracking and referral process, Access Standards, and Case Management Practice Standards for presentation to the Regional Office, provider agencies, and local quality councils.

- Developing a database for tracking screenings, admissions, referrals, case management assignments, and other access information as needed for use in monitoring services utilization and for assuring each person entering the system receives the help they need.

***Psychiatric Services***

Research has shown that consumers have better outcomes when they are able to access their psychiatric services through their case management provider. Therefore, agencies who provide case management services will be required to also provide medication management services.

In addition to putting into place the elements identified above, each network will need to have protocols and procedures for how its service providers work collaboratively together. This includes development of such things as:

- Directory of network services;
- Protocols for the movement of consumers within the network system;
- Clarifying the relationships between psychiatric inpatient facilities and the community system; and
- Preparing the environment for the implementation of an improved system of care.

## Time Frames

**Access Standards, Case Management Practice Standards, Care Coordination Agency:** Development should be completed so that pilot implementation in Cumberland and Ken-Som can begin April 1, 1998. Statewide implementation will proceed beginning in Fiscal Year 1999.

**Psychiatric Services:** In Cumberland and Ken-Som agencies not already providing both case management and medication management services will be expected to have in place the mechanisms that enable the provision of both services so that pilot implementation can begin on July 1, 1998. Statewide implementation will proceed during Fiscal Year 1999.

ISSUED 1/98

# WHAT IS AN LSN?
# (Local Service Network)

**According to Maine Law (34-B MRSA § 3608):**

The Department of Mental Health, Mental Retardation, and Substance Abuse Services is responsible for establishing and overseeing Local Service Networks to participate with the area councils in the delivery of mental health services to children and adults under the authority of the Department. A network consists of organizations providing mental health services funded by the General Fund and Medicaid in the corresponding network area. The Local Service Networks must be established and operated in accordance with standards that are consistent with standards adopted by accredited health care organizations and other standards adopted by the Department to establish and operate networks. Department oversight must include, but is not limited to, establishing and overseeing protocols, quality assurance, monitoring contracts, establishing outcome measures, and ensuring that each network provides an integrated system of care.

**Networks:**

As provided by law, Local Service Networks are to be established as follows:

- York (York County)
- Cumberland (Cumberland County)
- Western (Androscoggin, Franklin and Oxford Counties)
- Coastal (Knox, Lincoln, Sagadahoc, and Waldo Counties)
- Ken-Som (Kennebec and Somerset Counties)
- Northeast (Hancock, Washington, Penobscot, and Piscataquis Counties)
- Aroostook (Aroostook County)

**Responsibilities:**

1. **Tasks.** Each network shall perform the following:
   A. Deliver and coordinate 24 hour crisis response services accessible through a single point of entry to adults with mental illness and to children and adolescents with severe emotional disturbance and their families;
   B. Ensure continuity, accountability and coordination regarding service delivery;
   C. Participate in a uniform client data base;
   D. In conjunction with the regional director and the area council, conduct planning activities;
   E. Develop techniques for identification and providing services to consumers at risk.

2. **Accountability.** Each network is accountable to the Department's Regional Director and to the local quality council..

3. **Public Outreach.** Each network shall solicit the participation of interested providers to serve on the area council, the network, or advisory committees.

4. **Participation.** State-operated direct service programs shall participate in the activities of the networks.

March, 1998

5. **Data Collection.** The Department shall collect data to assess the capacity of the local service networks, including, but not limited to analyses of utilization of mental health services and the unmet needs of persons receiving publicly funded mental health services.

## WHAT ARE THE MAJOR FUNCTIONS OF THE LSN?

- Coordinating comprehensive care plans which span agency boundaries;
- Resolving clinical disputes among agencies;
- Conducting ongoing area-wide needs assessments based on direct feedback from consumers and family members;
- Developing ongoing program development plans for the network area;
- Taking responsibility for outreach to all people in need of service who are currently not receiving services;
- Implementing policies of DMHMRSAS at the local level;
- Participating in all coalitions and initiatives which contribute to the value of community inclusion for those individuals served by the network.

## WHAT ARE THE BENEFITS OF AN LSN?

- Increased coordination of services, reduced duplication and fragmentation of services;
- Enhanced opportunities for blended funding;
- Increased accessibility to services;
- Improved communication between service recipients, providers, and DMHMRSAS;
- Decreased costs per episode of care;
- Enhanced accountability for fiscal and clinical outcomes.

Maine Department of Mental Health, Mental Retardation, and
Substance Abuse Services

# ACCESS STANDARDS

## I. AVAILABILITY

This refers to assuring access to an adequate number and type of providers for the full range of services and social support needs.

A. **Staff qualifications** - For all services: Personnel files of all direct service staff will contain evidence of either: 1) one of the following licenses/certifications: LSW, LMSW, LCSW, LPC, LMFT, LCPC, RNC or RNCS. If the service is clinical in nature, only the LMSW Conditional Clinical, LCSW, LMFT, LCPC Conditional, LCPC or RNCS will be accepted; or 2) MHRT I or above for residential services and MHRT II or above for non-clinical services or other certification or eligibility standards that may be established by the Department.

B. **Job knowledge** - For all services: All providers will develop and have documented evidence of an orientation and training program that will insure that staff have sufficient knowledge of the duties of their positions and significant issues related to the service provided and the individuals served. This will include available traditional and non-traditional services. Personnel files will contain evidence of staff completing orientation and engaging in training.

C. **Staff availability**

1. **Crisis services**: Providers will have documented evidence, including staffing schedules, of 24 hour availability of professional staff for telephone, face-to-face and mobile interventions for individuals needing crisis services. Agency policies and procedures will delineate the criteria upon which appropriate venue for service delivery is assessed, minimally including client choice and need. Such determination will be documented in client records.

2. **Outpatient/community and housing services**: Providers will have 24-hour on-call service available, either directly or through cooperative agreement, that will include at a minimum: 1) access to the direct service provider or designee in order to provide pertinent clinical and medical information, particularly the medications the client is receiving; 2) access to staff qualified to provide triage. Such triage shall determine if crisis or emergency room services are indicated and, if not, will offer strategies for the client to wait until regular business hours to receive services. The above will be documented through on-call schedules and agency policies and procedures. Off-hour interventions will be documented in client records.

## II. SCHEDULED APPOINTMENTS AND WAITING TIME

This refers to the linkage, waiting time and convenience for appointments for urgent and routine outpatient treatment and for assignment to case management, in office waiting time and scheduling of appointments during hours that take into account family obligations, work and other commitments.

**A. Emergency services** - Crisis and emergency service providers will develop policies and procedures as well as staffing schedules sufficient to insure that all individuals seeking and in need of crisis/emergency services receive services within 1 hour of request or referral. The provider will develop a means of documenting the time period from referral to service provision. The provider will aggregate this data and report it to the local regional office on a monthly basis. In instances in which the established time frames are not met, reasons for the failure to do so will be provided.

**B. Outpatient/community services** - Outpatient/community service providers will develop policies and procedures as well as staffing schedules sufficient to insure that all individuals seeking and in need of these services will receive them in the following manner:

**1. For routine services**, which will be indicated by the client demonstrating either: a) some distress, but the preconditions for the distress and the associated stressors are easily identifiable; or b) some impairment in judgment, impulse control and/or functioning. Existing clients will be seen within seven (7) days and new clients within five (5) days.

**2. For urgent services**, which will be indicated by the client demonstrating either: a) distress and upset but not in immediate danger of harming him/herself or others; or b) significant evidence of impaired judgment, impulse control and/or functioning. All clients will be seen within one (1) day.

For all of these individuals, in-office waiting time will be less than one hour. The provider will develop a means of documenting the time period from referral to service provision, as well as in-office waiting time. The provider will aggregate this data and report it to the local regional office on a monthly basis. In instances in which the established time frames are not met, reasons for the failure to do so will be provided.

**C. Vocational services** - Vocational service providers will develop policies and procedures as well as staffing schedules sufficient to provide appointments for all individuals newly seeking services within seven (7) days of the request. The provider will develop a means of documenting the time period from referral to service provision. The provider will aggregate this data and report it to the local regional office on a monthly basis. In instances in which the established time frames are not met, reasons for the failure to do so will be provided.

**D. Housing/residential services** - Housing and residential service providers will attempt, within the limits of available resources, to insure that individuals needing such services are placed into them within 30 days of the request. The provider will develop a means of documenting the time period from referral to placement. The provider will aggregate this data and report it to the local regional office on a monthly basis. In instances in which the established time frames are not met, reasons for the failure to do so will be provided.

## III. LOCATION

This refers to locating services within reasonable distances and at sites that are accessible via public transportation. This includes locating services that take into account natural travel patterns where people live and receive services.

**For all services -** The agency will insure that services are available for all clients within one (1) hour commuting time of his or her residence. In instances in which agency offices are further than one hour from the client's residence, accommodations, such as home visits or appropriate, centrally located meeting sites that can protect client confidentiality, will be arranged. Instances in which this standard is not met will be reported to the local regional office on a monthly basis, including the reasons for inability to meet the standard.

## IV. ARCHITECTURAL ACCOMMODATION

This refers to provider requirements for complying with the Americans with Disabilities Act of 1990. This also includes a requirement for providers of services to document, investigate, and correct all physical access problems.

**For all services -** The agency will comply with the Americans with Disabilities Act in all service delivery sites. In instances in which the agency is incapable of complying at a given site, the agency will accommodate the individual with the disability by acting to insure that the full array of services is available to the individual. All instances in which the agency is unable to accommodate a client will be reported to the local regional office on a monthly basis, including the reasons for the inability to provide the accommodation.

## V. COMMUNICATION ACCOMMODATION

This refers to provider requirements for translation and interpretation services for persons who only use English as a second language or use a non-primary language for communication, such as sign language. This refers to providers making assistive technology available as requested and needed, as well as making communication accessible to persons who have limited reading skills by making all written materials accessible at the fourth grade reading level, and verbal when necessary.

**A. For all services -** The agency will maintain a list of translation and interpretation services for individuals who do not communicate in English or who may be hearing impaired, that will contain instructions for accessing such services. The agency will insure that a lack of ability to communicate in spoken English is not an obstacle to receipt of services. If the agency is unable to access an appropriate interpreter or translator, the agency will refer the individual to a provider who is capable of providing accessible and appropriate services to the individual. Additionally, the agency will obtain or develop a means of access to assistive technology for individuals for whom such assistance is needed. All instances in which the agency is unable to accommodate a client will be reported to the local regional office on a monthly basis, including the reasons for the inability to provide the accommodation.

**B. For all services -** The agency will insure that all written materials are available at a 4th grade reading level in order to be accessible to the widest range of clients. Verbal and other translations will be made available for nonreaders. All instances in which the agency is unable to accommodate a client will be reported to the local regional office on a monthly basis, including the reasons for the inability to provide the accommodation.

## VI. COST

This refers to the out-of-pocket costs for obtaining services not reimbursed and the costs associated with reaching services. These costs must be scaled to a person's income and ability to pay.

**For all services -** The agency will have documented evidence of the means by which out of pocket expenses are scaled to the client's income, in the form of a sliding fee scale or another such mechanism.

## VII. INFORMATION

This refers to the provision of information for potential service recipients to assure they can make informed choices about seeking services and outreach to inform potential users of services that are available.

**A. Crisis and Outpatient/community services** - The agency will develop policies and procedures for the provision of outreach services, including the means by which these services and individuals and sites will be targeted for such efforts. The agency will also provide documented evidence, including work schedules and contact notes, of the means by which outreach efforts and follow-up are conducted to offer services to persons outside the service system who are identified as the target population in Department policies and procedures.

**B. For all services -** All providers, in written material and face to face client contacts, will provide information about available and needed services, as well as how crisis services may be accessed.

## VIII. FAMILY SUPPORT

This refers to providing families who support both children and adults with information and assistance to help the family in its support role. This is only done at the request of the service recipient (adult services) or parent/guardian (child services). Information and assistance refers to ensuring all direct service personnel are knowledgeable about the full range of medical conditions and other support service needs experienced by older persons and adults with disabilities. This also includes assuring the service recipient of their designee (family, friend, or advocate if so designated) is referred to support services and/or other resources when needed. *This is listed as a family support because many families have physical care responsibilities and may not be fully aware of treatment and support options that would lessen the burden on the family and ultimately on the service recipient.*

**A. For all services -** All providers will develop policies and procedures governing the means by which family support services will be offered and provided as appropriate and needed. This will include, as documented by staff schedules, the availability of off hour appointments for family members to be able to meet with agency staff.

**B. Vocational services -** Providers will develop policies and procedures governing the means by which they will assist clients in obtaining child care services, in order to be able to work a regular schedule. Such efforts will be documented in client records.

**C. Housing and residential services -** Providers will insure that, among the range of residential options available to clients, are those that will accept children, in order to serve clients who are parents.

**D. For all services -** All providers will develop policies and procedures as well as in-service and training programs to insure that all direct service personnel are aware of the full range of support and medical services that may be needed by individuals with disabilities. Direct service personnel, with the consent of the client and/or parent or guardian, will provide such information to families, friends or significant others and will document such efforts in the client record.

## IX. CULTURAL COMPETENCE

This refers to each provider's demonstrated capacity to appropriately serve persons of all cultures. This includes anti-discrimination, sensitivity practice which demonstrates knowledge in and sensitivity to cultural issues and employment practices. This also includes evidence of cultural sensitivity training.

**A. For all services -** All service providers will develop anti-discrimination policies that will be implemented subject to the approval of the DMHMRSAS Equal Opportunity Officer.

**B. For all services -** All providers will develop written grievance procedures, consistent with those delineated in the *Rights of Recipients of Mental Health Services* and/or the *Rights of Recipients of Mental Health Services who are Children in Need of Treatment*, to address complaints relating to beliefs, values and other cultural norms.

**C. For all services -** All providers will develop policies and procedures as well as an in-service training program for staff regarding sensitivity to cultural issues and treating clients with dignity and respect, addressing the following specific areas: beliefs, values, traditions, lifestyle practices, laws, formal and informal rules of behavior, spirituality, poverty, infantilization, rural marginalization, the experience of feeling invisible, powerlessness, patienthood and disability. Personnel files of all staff will contain documentation of completion of this training.

## X. CHOICE

This includes consumers being able to select the provider and/or individual practitioner of their choice. For some services, funding is only available for a single service provider in a local area. Under those circumstances, provider choice may be limited. This also includes providers furnishing a list of alternatives for service recipients when the recipient requests a change in treating professional, as well as providers not making one service contingent upon the acceptance of another service, unless related to the imminent danger of the recipient.

**A. For all services -** All providers will develop policies and procedures governing the means by which clients will be informed of the full range of choices of providers available to them, including follow-up options for crisis clients and information about peer support services and how to access them.

**B. For all services -** All providers will develop policies and procedures governing the means by which clients may exercise choice of service delivery personnel within the agency, including the means by which a change of direct service person may be effected. All client complaints in this area will be reported to the local regional office on a monthly basis, including the outcome and a description of any actions the agency may have taken.

**State of Maine**

Department of Mental Health,
Mental Retardation, and
Substance Abuse Services
40 State House Station
Augusta, ME 04333-0040

Phone: (207) 287-4205
FAX: (207) 287-4291
email: Nancy.Essex@state.me.us

# *Memorandum*

*To:* *Regional Directors, Mental Health Team Leaders, Children's Team Leaders*
*From:* *Nancy L. Essex, Director of Community Systems Development*
*cc:* *EEMT*
*Date:* *September 3, 1998*
*Subject:* *Target Populations for Mental Health Services*

Enclosed you will please find the target population definitions for adult and children's mental health services; these were approved by EEMT at its meeting on August 27, 1998. Target population definitions for substance abuse services and for mr/dd services are currently under consideration and will be forthcoming shortly. The Department is issuing the mental health target population definitions at this time primarily because of our work with the LSNs, which is focused presently on the development of community-based systems of care for mental health services, both for adults and for children. As this development work continues, we must be able to give providers and other stakeholders clarity regarding for whom Department policies and directives are applicable. Everything we are preparing for "roll-out" through the LSNs (uniform referral and assessment instruments, case management standards, access standards, critical incident reporting, level of care criteria, etc.) requires clarity of the Department's target populations.

In issuing the enclosed, the Department is drawing a clear distinction between a target population definition for *services* and a target population definition for *data collection.* In addition, as part of each of the mental health target populations (adults and children), there is an identified *priority population* which is expected to be expedited into service.

The process of defining these target populations did not involve an evaluation of the Department's priority populations, which are included (sometimes only by reference) in existing provider contracts. In addition, the adult priority population criteria is contained in the Medicaid rule for Community Support Services (Section 17). It is the Department's intention to re-evaluate shortly the mental health priority population criteria; stakeholder involvement in this process will be vital and will be sought through the LSNs and the QICs.

Please deliver all of this information (Target Population definitions, Priority Population criteria, and this memo) to your LSNs and QICs at your earliest opportunity. We anticipate that the issuance of this will be the beginning of a process that will bring clarity regarding who the Department expects its providers to serve; toward that end, we anticipate that this will raise a number of questions. Please direct those questions to me. Further clarifying memos will be issued if warranted.

Thank you for your help with this.

Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services —

# Target Populations
# Mental Health Services

Stated below are the populations targeted to receive mental health services supported by public monies (Medicaid and DMHMRSAS general fund dollars) in the state of Maine. Within the target populations there may be additional criteria for persons who are to be given priority servicing. Although the department is issuing this criteria in order to clarify who it intends its system of care to serve, the department does not guarantee funding for any specific service. However, this in no way affects existing entitlements.

## Target Population For Services

PURPOSE: Identify the populations for which public monies for mental health services are earmarked.

### Adult Mental Health (except Crisis Services)

All adults (18+) in need of mental health care, with priority given to:

- Department's designated priority population (as currently defined)
- Medicaid recipients

With the exception of:

- Persons paying full fee on their own or through a combination of a third party payer and applicable co-payments and deductibles.

### Children's Mental Health (except Crisis Services)

All children (through age 20) in need of mental health care, with priority given to:

- Department's designated priority population (as currently defined)
- Medicaid recipients

With the exception of:

- Persons paying full fee on their own or through a combination of a third party payer and applicable co-payments and deductibles.

### Crisis Services

- Everyone who presents, regardless of age or presenting condition.

## Target Population For Data Collection

PURPOSE: To gather information on persons served by agencies and organizations receiving public monies for the provision of mental heatlh services.

### All Populations

- Data shall be reported to the department on all persons served for mental health services, regardless of the source of payment for those services.

**Department of Mental Health, Mental Retardation, and Substance Abuse Services**

# Adult Mental Health Services Priority Population Criteria

The individual meets the priority population criteria only when
I **and** IV, **plus** II **or** III are present.

I. Is age 18 or older or is an emancipated minor, **and**

II. Is a Class Member (patient at AMHI on or after 1/1/88), **or**

III. Has a severe and disabling mental illness, defined as (must have **either** A or B; if B, must also have at least **one** of 1 through 8):

A. Axis I classification of major mental illness in combination with sufficient severity of illness to cause disturbances in role performance or severe functional impairment. *Note: Individuals with a concurrent substance abuse diagnosis may be included here; individuals whose only diagnosis is substance abuse are not eligible. Individuals with an Axis I adjustment disorder diagnosis or a V code diagnosis are not considered to have a major mental illness, and therefore, do not meet this criterion.*

B. Axis II personality disorders or Axis II mental retardation (mild or moderate). Individuals whose only diagnosis is mental retardation are not eligible. Individuals must also meet the criteria for severe functional impairment by having at least **one** of the following psychiatric signs or symptoms:

1. Attempted or threatened suicide;
2. Confusion, disorientation, memory loss, or lack of judgment which impairs behavioral functioning;
3. Active hallucinations which impair behavioral functioning;
4. Delusional or disorganized thoughts which impair behavioral functioning;
5. Bizarre behavior with severe disturbances of mood or affect;
6. Severe psychomotor retardation, agitation, or hyperactivity;
7. Grossly inappropriate or grossly blunted affect;
8. Manifest inability to care for self, creating conditions either threatening to life or limb or likely to result in severe deterioration of medical condition(s).

(continued)

IV. **<u>And</u>** (Must have at least **<u>one</u>** of A through K):

A. Is currently receiving active discharge planning while in a state psychiatric hospital or has been discharged therefrom in the last six months; or

B. Is currently receiving active discharge planning from another inpatient unit or has been discharged therefrom in the last six months; or

C. Has had a period of hospitalization for mental illness of at least six months' duration in the last eighteen months; or

D. Has had two or more periods of hospitalization for mental illness in the last twelve months; or

E. Has had four or more emergency face-to-face incidents with emergency mental health providers in the last twelve months; or

F. Is currently residing in a living arrangement financially supported by the Department of Mental Health, Mental Retardation, and Substance Abuse Services; or

G. Is homeless; or

H. Is in current crisis; or

I. Is likely to deteriorate clinically to a point of needing immediate institutionalization in the absence of prompt community support services interventions; or

J. Is currently receiving the medication clozaril or its general equivalent or will be receiving the medication in the next 30 days; or

K. Has had a history of hospitalization for mental illness and a level of functional ability such that continued community support services are needed.

Department of Mental Health, Mental Retardation, and Substance Abuse Services —

# Children's Mental Health Services Priority Population Criteria

I. Diagnosis: DSM-IV or mental retardation, except primary diagnosis of substance abuse.

II. Functional Impairment/Symptoms (Must have A+B **or** A+C):

A. Separation from Family: Has been removed from family or is at clear risk of (e.g., on waiting list for) out-of-home placement such as inpatient psychiatric facility, residential center, nonpublic school, therapeutic group or therapeutic foster home, crisis or emergency shelter, or corrections facility; or is homeless; and requires case management services to be returned to family, community, or less restrictive treatment setting.

B. Functional Impairment: Must have substantial impairment in **two** of the following (present 6 months or more or based on a specific diagnosis that is likely to continue a year or more if not treated):

1. Developmentally appropriate self care;
2. Ability to build or maintain satisfactory relationships with peers or adults;
3. Self-direction, including behavioral control;
4. Capacity to live in a family or family equivalent;
5. Inability to learn not due to intellect, sensory or health factors.

C. Symptoms. Must have **one** of the following:

1. Psychotic symptoms;
2. Suicidality: attempt in past 3 months; significant ideation within past month;
3. Aggression: at risk of causing injury to person or significant damage to property;
4. Victim of current abuse.

Priority shall be given to children who are:

1. At risk of admission to an inpatient psychiatric facility;
2. Reside in a DMHMRSAS funded community treatment home;
3. At risk for out-of-home placement for mental health reasons;
4. Homeless;
5. Unable to maintain in home or at school without other agency treatment provision;
6. Residing in out-of-home placements for mental health reasons.

# Local Service Network Update

Copies of Overheads
Prepared For
DMHMRSAS Provider Meetings
March 15 - 19, 1999

# *DISABILITY GROUPS INCLUDED IN LSN's*

- **Adult Mental Health**
- **Children's Mental Health**
- **Mental Retardation/Developmental Disabilities**
- **Substance Abuse**

**LSN's consist of *agencies or organizations* that meet the following requirements for each disability group.**

## ADULT MENTAL HEALTH SERVICES

- All agencies having a contract of at least $25,000 per year with DMHMRSAS;
- All licensed mental health agencies receiving at least $25,000 per year from Medicaid for these services;
- Community hospitals receiving at least $25,000 per year from Medicaid for these services;
- AMHI and BMHI;
- DMHMRSAS direct care services;
- The standards of the LSN will apply to entities that receive less than $25,000 annually, but their formal participation will not be required.

## CHILDREN'S MENTAL HEALTH SERVICES

- Agencies receiving $25,000 per year or more via a DMHMRSAS contract or in Medicaid funding;
- The standards of the LSN will apply to entities that receive less than $25,000 annually, but their formal participation will not be required.

## *MR/DD SERVICES*

- **Agencies receiving $25,000 per year or more via a DMHMRSAS contract or in Medicaid funding;**
- **The standards of the LSN will apply to entities that receive less than $25,000 annually, but their formal participation will not be required.**

## *SUBSTANCE ABUSE SERVICES*

- **Agencies receiving $25,000 per year or more via a DMHMRSAS contract or in Medicaid funding;**
- **The standards of the LSN will apply to entities that receive less than $25,000 annually, but their formal participation will not be required;**
- **Prevention programs are NOT required to participate.**

Those agencies or organizations not required to participate in the LSN are welcome to do so voluntarily.

# *LSN ESSENTIAL TASKS*

- Ensure access to care;
- Ensure continuity and coordination of care (including crisis and inpatient care);
- Provide clinical coordination for every recipient;
- Develop, in concert with DMHMRSAS, standards of care which are consistently applied throughout the LSN;
- Develop and maintain an information system which enables agencies to provide the following data to DMHMRSAS and each other as necessary:
  - ☑ Demographic data;
  - ☑ Cost per episode of care;
  - ☑ Average length of stay;
  - ☑ Cost per service;
  - ☑ Accurate waiting list data;
  - ☑ Diagnostic data;
  - ☑ Data necessary to provide case management services.

# *LSN STRUCTURE*

- **Local Service Network (policy committee)**

  This is the overall group that is currently meeting as the LSN in most areas. Expected participants:

  - ☑ Agency CEO's
  - ☑ DMHMRSAS Regional Director

- **Clinical Care Coordinating Committee**

  Responsible for assuring care coordination among agencies and for development and implementation of clinical standards. Expected participants:

  - ☑ Agency clinical directors;
  - ☑ DMHMRSAS Regional Medical Directors;
  - ☑ DMHMRSAS Regional Team Leaders.

- **Information Services Committee**

  **Responsible for the development and implementation of the information system. Participants:**

  - ☑ **Agency MIS directors;**
  - ☑ **DMHMRSAS MIS representative(s).**

- **Quality Assurance Committee**

  **Responsible for developing, implementing, and monitoring QA activities of the network, including reviewing and making recommendations to the network on QIC Service Evaluation Team reviews. Expected participants:**

  - ☑ **Agency QA staff;**
  - ☑ **DMHMRSAS Regional QI Managers.**

## ***DMHMRSAS REGIONAL OFFICE RESPONSIBILITIES***

- **Coordinate LSN activities:**
  - **Bring issues to policy committee to assure the network acts on critical issues and that needed standards are developed and implemented;**
  - **Assure LSN has a Chair to work in concert with the Regional Director and staff regarding the coordination of LSN activities.**

## ***DMHMRSAS CENTRAL OFFICE RESPONSIBILITIES***

- **Assure consistency across networks;**
- **Assist Regional Director and staff, as requested.**

# *<u>OTHER IMPORTANT STUFF</u>*

- <u>Agencies which provide services statewide</u>:
  - ☑ Participate in LSN where services are provided;
  - ☑ An agency with <u>multiple service locations</u>:
    - Agency program manager in each service location will be <u>invited</u> to the local LSN;
    - Location of the agency's administrative office will determine the LSN in which the agency is <u>required</u> to participate.

- <u>Out-of-state owned agencies</u> would send their local director or manager to participate in the appropriate LSN (policy committee), instead of the CEO of the entire organization.

- DMHMRSAS regional offices will develop a "contract" with its own direct care services that hold those services to the same standards, outcome measures, reporting and accountability requirements as all other member agencies of the network.

- The LSN statute has been interpreted to mean that agencies belonging to the LSN may share information with each other on <u>common clients</u> without obtaining written permission from the client or guardian. The Department sees this as critical for coordination of care. It is anticipated that most of this sharing of information will take place in private meetings or phone conversations between staff of the agencies. In the event that a particular case needs to be discussed in an LSN meeting, such discussions are not to take place at the policy table, but rather at the clinical care table. While the case is being discussed, the meeting shall be closed.

- <u>Local Service Networks and the Quality Councils</u>:

    - LSN's are <u>not</u> committees of the QC's;

    - LSN member agencies services can be evaluated by the Service Evaluation Teams (SET) of the quality councils;

    - Agencies are expected to cooperate fully with the SET and the regional QI Manager regarding evaluation data gathering;

- LSN will receive written report of SET evaluation results - report is for information purposes only and not for LSN action, unless a problem is identified which is specific to the entire system of care rather than one specific agency or program;

- LSN will receive written Plan of Correction, if needed, following SET evaluation, also for information purposes only.

# QIC Collaborative Model Design

This section contains copies of the information generated during the stakeholder meetings which DMHMRSAS held to design a new structure for the QIC's that would be inclusive of all services under the auspices of the Department. Information is arranged in chronological order by date of issue, beginning with the earliest information at the front of the section.

| Document Title | Issue Date |
|---|---|
| Highlights from QIC/QIG Retreat of 9/24/97 | October, 1997 |
| Highlights from QIG/QIC Collaboration Meeting #2 | December, 1997 |
| Highlights from QIC/QIG/SAQIC Collaboration Meeting #3 | March, 1998 |
| DMHMRSAS Position Paper: Collaborative Quality Councils | April, 1998 |
| QIC/QC Membership Report | December, 1998 |
| DMHMRSAS Changes Made to QIC/LSN Legislation | February, 1999 |

**State of Maine**
**DMHMRSAS**

State of Maine

Phone: 287-4226
FAX: 287-4291

# *Memorandum*

*To:* *QIC/QIG Retreat Participants, QIC Chairs, QIG Chairs, and Lynn Duby, OSA Director*

*From:* *Melodie J. Peet, Commissioner*

*cc:* *Regional Directors's, Team Leaders, Lisa Burgess*

*Date:* *Thursday, October 9, 1997*

*Subject:* *Retreat Followup*

Enclosed you will please find the highlights of the retreat held on September 24th, when representatives from the QIC's and QIG's gathered at Echo Lake Lodge for the day. The outcome of that gathering was consensus on a model/structure for the collaboration among local quality improvement committees for all of the Department's constituent groups.

As a result of achieving agreement on a collaborative model, many new questions and issues have been raised which now need to be addressed by system stakeholders. Once the local quality system design is completed, legislative approval will be required. As you read the enclosed, please keep in mind that at this time no assumptions should be made regarding the membership of the area councils or the population-specific committees. Several ideas have been offered, but the decisions on this will be part of the follow-up work. You should know, however, that it is the intention of the Department to incorporate the work and membership of the existing QIC's and QIG's whenever the new structure is implemented.

In order to move forward with the positive energy generated at the Echo Lake retreat, we will be holding another day-long gathering soon to begin to address these issues. Currently, we are trying to find a date in November and a location suitable for the number we anticipate will want to attend. You should be hearing more about this shortly.

Thank you for your commitment to work together to improve services for all persons served by the Department. I look forward to seeing you in November as we continue to define and refine our systems of care.

NE/b
neretreat.lwp

# Highlights from QIC/QIG Retreat
## September 24, 1997

Facilitator: **Jacqui Clark**

Sponsored by:
State of Maine
Department of Mental Health, Mental Retardation, and
Substance Abuse Services

## Group-Generated Thoughts/Ideas
## Morning Session

### *Role of QIC* (Quality Improvement Council)

- Represent needs of population regarding mental illness
- Advise DMHMRSAS regarding mental illness
- Educate general public regarding mental illness
- Fine tune Program Evaluation Team (PET) process
- Review plans (both provider and DMHMRSAS)
- Develop services for unmet needs
- Advocate from QIC perspective
- Develop collaborative local relationships
- Review Strategic Plan and understand resources

### *Role of QIG* (Quality Improvement Group)

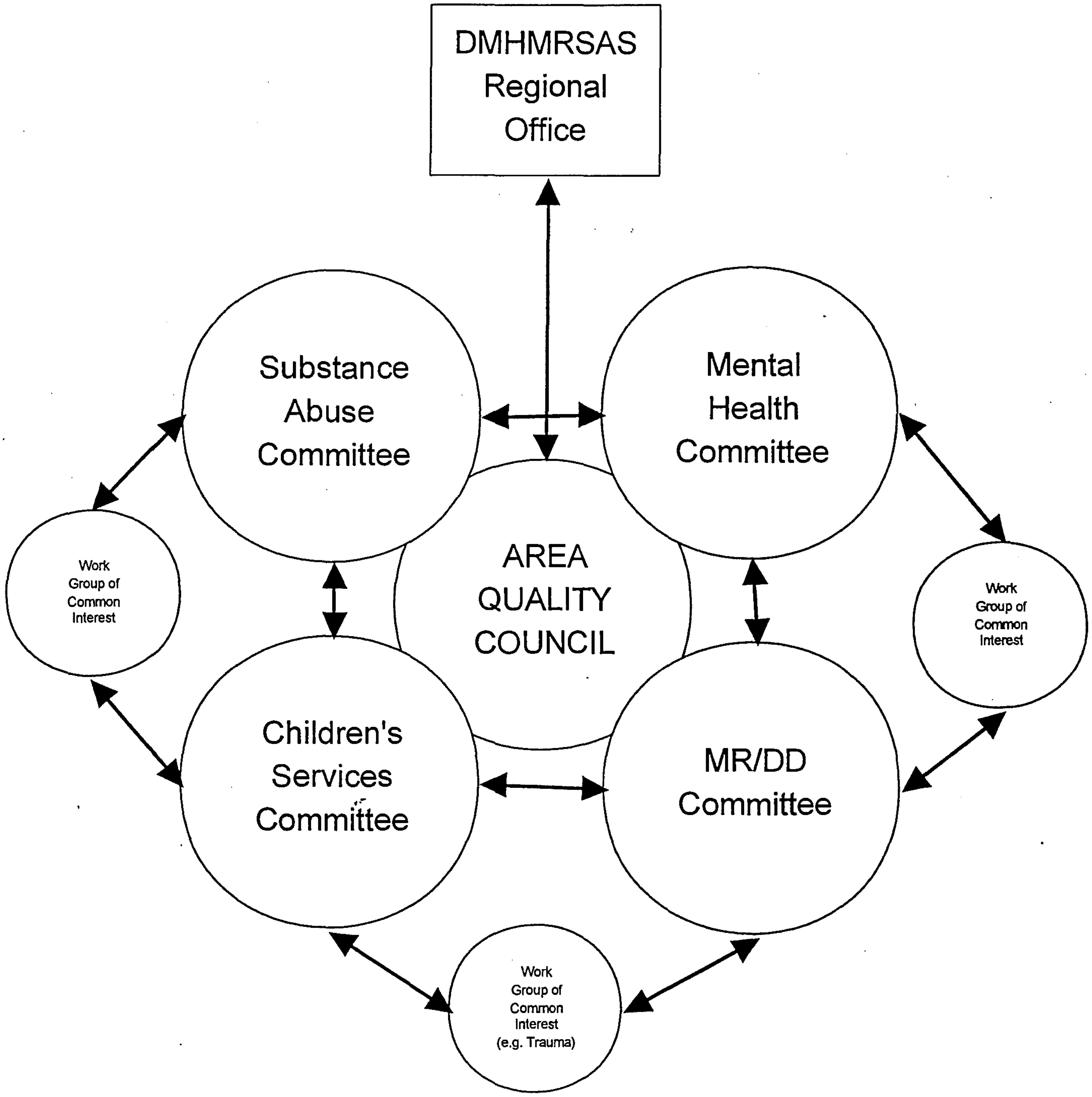
- Forum for stakeholders
- Understand how system works
- Data gathering and analysis regarding quality of life
- Define quality for MR/DD services
- Develop visible presence in DMHMRSAS
- Review DMHMRSAS Strategic Plan
- Educate families and providers with peer advocacy
- Foster family and consumer involvement
- Collaboration with QIC

### *Risks and Gains of Collaboration*

| * **Risks** | * **Gains** |
|---|---|
| * Mental health will dominate | * Opportunity to overcome complexities of multiple diagnoses |
| * Fear of loss of control | * Stronger organization with enhanced access |
| * Lack of communication between stakeholder groups | * Stakeholders income knowledge and share resources |
| * Too overwhelming | * Bigger 'chorus' |
| * Find quality leadership | * Increased possibility of needs being met |
| * Loss to some; others gain at their expense | * Respect for diversity/shared knowledge |
| * Lack of knowledge regarding decision-making | * Legal recognition of new structure |
| * Bureaucratic chaos | * Vision of people as citizens |
| * Loss of separate cultural identity (kids, adults, etc.) | * |

## MODEL STRUCTURE SELECTED FOR COLLABORATION OF NETWORK QUALITY IMPROVEMENT ACTIVITIES

QIC/QIG Retreat 9/24/97



Work Groups can exist among any combination of committees. The above are examples only. Institute councils will be included in the Network areas of which they are a part.

# Issues/Questions/Concerns/Suggestions
# From Afternoon Groups
# During Selection of (Common) Model

## *Region I*

- Does each group have its own bylaws?
- Will trauma be added on?
- Funding streams are defining structures.
- How does this relate to LSN's?
- Need funding and administrative staff support.
- Need to have enforceable communication flow.
- Need to look to technology for enhancing communication.
- Shared fears about Managed Care.
- Quality Council membership - from each of the four committees, one family member, one consumer, one provider, and one community-at-large member, plus four at-large members will make a council of 20.
- Role of Quality Council - makes recommendations to DMHMRSAS through Regional Director.
- Committees:
  - ◊ will have formal membership, to be determined by each council
  - ◊ team leader participation
  - ◊ open participation (with guidelines)

## *Region II*

- Model allows for addition of sub-committees
- Inclusive membership
- AMHI and BMHI need to be included
- Allows for early response - serve people regardless of their label
- Moves toward isolation of services; representation may be a minority
- Balanced
- Caution! Need to reach down to grassroots system
- Quality Council needs to represent all and the committees advise the QC
- Equality of all four service areas
- Everything independent, but connected
- Connection to DMHMRSAS needs to be illustrated
- Equal authority
- Model builds on what's out there and builds something new
- Promotes ease of transition
- Need to allow for trauma survivors' inclusion
- Roles and Responsibilities:
  - ◊ direct linkage to LSN
  - ◊ possible chartering of special issues
  - ◊ providers must belong to LSN
  - ◊ committees have authority to make decisions

- Membership:
  - ◊ From each committee, one parent, one provider, one consumer, one community-at-large to Quality Committee
  - ◊ Area Quality Council - service provider rep. (i.e. housing, employment)
  - ◊ Unlimited number of members on committees
  - ◊ Add institution as a committee connected to mental health committee and Area Quality Council
- Linkages:
  - ◊ Area Quality Council ➔ LSN
  - ◊ Committees ➔ Area Quality Council
- Tech support from Regional Office?
- Where does AMHI go? LSN issue!?
- Division of funds
- Chartering of special issues possible
- After today, what?

## *Region III*

- Distance between Madawaska, Bangor and Calais creates the need for separate quality entities
- Strong communication between Assistant and Regional System Directors
- Rethink membership in QIC's, especially Aroostook to include all constituencies
- Communication regarding DMHMRSAS issues needs to flow between Regional Office and QIC's.
- Strengthen the partnership between local QIC's and Regional Office
- Need to consider travel time and using technology (i.e. teleconferencing - how to include families and consumers)
- Support the committee process
- Training and education to improve knowledge base of QIC members
- Recommend three Quality Councils in Region:
  - ◊ Aroostook
  - ◊ Northeast
  - ◊ Downeast
- BMHI will not have own QIC, but will have representation on Quality Council and serve as an equal committee
- Membership:
  - ◊ Quality Council - recommended by committees, appointed by DMHMRSAS
  - ◊ Committee - open to all interested with commitment and responsibility
  - ◊ Committee - chaired by Quality Council member
  - ◊ Work Group - volunteers and DMHMRSAS consultants
- Lots of public input
- Preserve unique identity
- Learn to work together on common issues/needs
- Communication: QC < - > Regional Office < - > Central Office
- Quality Council recommends policy, gathers and shares information on quality improvement, etc.

## *Questions Jacqui Gathered and Presented to Commissioner*

- How many councils does the department want to deal with?
- What does the department want as the councils' primary role?
- How can the councils be of the most help?
- What behavior/activity is most valued?
- What kinds of technical support, staff support, and money are available?
- In addition to locally generated agenda items, who will direct agenda issues to the councils/committees?
- More understanding is needed regarding the LSN's and how the systems interact or are integrated.

## *Where We Go From Here* (Tasks and persons responsible)

- Transcribe today's work and distribute to attendees (Nancy Essex).
- Consider rescheduling October 9 QIC Conference to be inclusive (Department staff).
- Generate good gossip about today's structure/ideas (all present).
- Consider how to tackle implementation issues and get feedback (Nancy Essex to organize - will include participation of all stakeholder groups).
- Next QIC and QIG meetings, talk about this retreat (members present).

# Highlights from QIG/QIC Collaboration Meeting #2
Augusta Civic Center
November 24, 1997

**Facilitator: Jacqui Clark**

**Sponsored by:**
**State of Maine**
**Department of Mental Health, Mental Retardation,**
**and Substance Abuse Services**
**With the assistance of:**
**Muskie Institute Center for Public Sector Innovation**

***The tasks undertaken at this meeting were in follow-up to a meeting in September, where a model structure for the collaboration of local quality activities was created; it is attached to the last page of this document for your reference.***

## Morning Task #1: Locus of Decision - Making

| | Model #1 | Model #2 | Hybrid |
|---|---|---|---|
| Tables Voting | 2 | 4 | 7* |

* Includes those who previously voted "no decision" but informed us that they concurred with the hybrid model after it had been created..

**Model #1**: (Population-specific) Committees (outer circles/pedals) make recommendations to the Council (center circle), which then makes decisions.

**Model #2**: Committees make decisions and report them to the Council.

**Hybrid Model**: Committees make decisions specific to their particular population; council makes decisions on issues affecting more than one committee or the entire council.

***Comments from Table Reports Following Their Discussions of Decision-Making Models***

- ➩ Functions need clarity.
- ➩ Build on the work the QICs and QIGs have done so far.
- ➩ Name: Network Quality Council (NQC).
- ➩ Term limits - no person may serve longer than two years.
- ➩ Prioritizing should remain in committees.
- ➩ Work Groups should be a formal part of the Quality Council.
- ➩ Balance membership.
- ➩ Commissioner appoints committee members.
- ➩ Quality Council coordinates the "work" in the committees.
- ➩ Quality Council - reviews and coordinates stuff from the committees; committees make recommendations to the Council.
- ➩ Committees do population-specific work. Quality Council handles issues not population-specific.
- ➩ Committees pick Quality Council - coordinating body. Shared decision-making.
- ➩ All stakeholders should be involved in all decisions.
- ➩ Ongoing clarity needed regarding roles and responsibilities.
- ➩ 'Decision-making' vs 'Recommending' (to the Department). [Don't set up false expectations.]
- ➩ Committees need to be primary "recommenders" regarding issues specific to each population.
- ➩ Committees have equal representation, while being open to having additional participants.
- ➩ Need appeal process under Model #1.
- ➩ Watch burn-out.
- ➩ Need flexibility of membership.
- ➩ Committee work should include advocating, assessing service needs, and determining best practices.
- ➩ Model needs to relate to Managed Care.

***Following creation of the Hybrid Model of Decision-Making, the following were offered as possible functions for the committees and the center circle.***

| **Committees** (Outer Circles)<br>Focus is on population-specific issues. | **Council** (Center Circle)<br>Focus is on collaboration and overview. |
|---|---|
| • Form recommendations on specific topics for use by center circle. | • Amplify recommendations to Department using committee recommendations and facilitating input from other committees. |
| • Consider Best Practices. | • Facilitate work among committees. |
| • Identify areas needing system attention for the Quality Council agenda. | • Direct agenda topics to appropriate committees. |
| • Local advocacy. | • Speak for Network area. |
| • Recommend representation on RFP review committees. | • Communication conduit into/throughout entire Quality Council membership. |

**Network Quality Councils** - Process Considerations
- Roles clarified ongoing.
- Use facilitation, and as needed, mediation.
- Center circle is made up of committee members.
- Department uses nominees from area and assigns them to appropriate committee.
- Additional community members welcome on work groups, as needed.

### Potential Norms
- Network Quality Councils recommend membership; Commissioner appoints.
- Network Quality Councils give advice to the Department based on broad, community consensus. Power is in the strength of the local stakeholder consensus.

*Following lunch, participants broke into groups by Region. The ambitious agenda for discussion in the Regions included: 1) Consideration of the Hybrid Model (Does it work? What changes are needed? Are there additional functions to be considered?); 2) Network Quality Council Membership (numbers, how to incorporate members of existing QIGs and QICs); 3) Location of the Program Evaluation Teams in the model; and, 4) Location of the Local Service Network (LSN) in the local model. What follows are the regional reports back to the entire group.*

## Region I

The group was unable to complete the assigned tasks. Much of the discussion focused on various perspectives of how the collaboration model could work, with those currently sitting on the QICs expressing strong concern that their hard work will end up having been for naught, while representatives of the QIGs as well as Substance Abuse providers expressed strong concern that their voices are not being heard and that local council activities will be dominated by mental health issues.

# Region II

Some thoughts preliminary to the greater discussion . . . . . . .

- Should we have a geriatric circle to address those specific services?
  - ◊ *This could be addressed through work groups with cross-disability representatives, as with Trauma.*

- Difficult to involve family/parents and consumers without support; need to consider how to do this well, so that it is not merely "lip service."
  - ◊ *Allow them to decide membership.*
  - ◊ *Department provide financial and technical support.*
  - ◊ *Department provide direction and clarity on tasks requested of them.*
  - ◊ *Training.*
  - ◊ *Simplify language for better communication.*

- Committees may vary in their way of operations and membership.
- What is the relationship to the Managed Care company?
- The Children's Committee needs to have a direct connection to the local children's resolution committees.

**Network Quality Council - Recommended Functions**

- Amplifies recommendations of committees to Department.
- Facilitates discussion and additional input.
- Directs agenda items/topics to appropriate committees.
- Speaks for Network area.
- Communication conduit for system.
- Encompass wider vision.

**Network Quality Council - Recommended Membership**

Need the best facilitators and coordinators sent from the committees. The intent is to have broad stakeholder representation, but not a number specific to particular stakeholder groups. Suggest six members from each of the four committees, making the Council consist of 24 members.

**Committees - Recommended Functions**

- Form recommendations on specific topics.
- Consider best practices.
- Identify areas needing attention for center circle.
- Local advocacy.
- Recommend representation on RFP reviews.
- Quality improvement activities.

**Committees - Recommended Membership**

Committee membership should encompass broad representation, with the largest percentage being consumers, family members, and parents.

- Four consumers
- Equal representation of the following:

- ◊ family/parents
- ◊ community-at-large
- ◊ providers
- ◊ Department representatives
- ◊ Technical Staff to do support work needed

Committees should be of a size so as to make the tasks workable - maybe an open number, rather than a specific limit on the number of members?

## Region III

Concurs basically with Region II. They expressed frustration, however, as they now have more questions with no answers. Concern that the end process will not disenfranchise consumers/parents, especially about where the system is going and what this "puzzle" looks like. It's hard to make recommendations when it feels as though the sands are shifting. The group did achieve consensus on the following:

- Each disability group meet as frequently as possible.
- Central group meet quarterly, with possibly longer meetings.
- Financial resources must be directed to:
  - ◊ Help with the barriers of geography by providing travel costs and technology.
  - ◊ Provide adequate staff support.
  - ◊ Provide stipends for individuals not already paid to be present.
- Set standards for PET, but do NOT conduct the activities.
- Need more education as to what LSNs are.

## Where We Go From Here

Because no clear consensus emerged from today's work, it was determined that the final recommendations that will be made to the Department will be determined as follows:

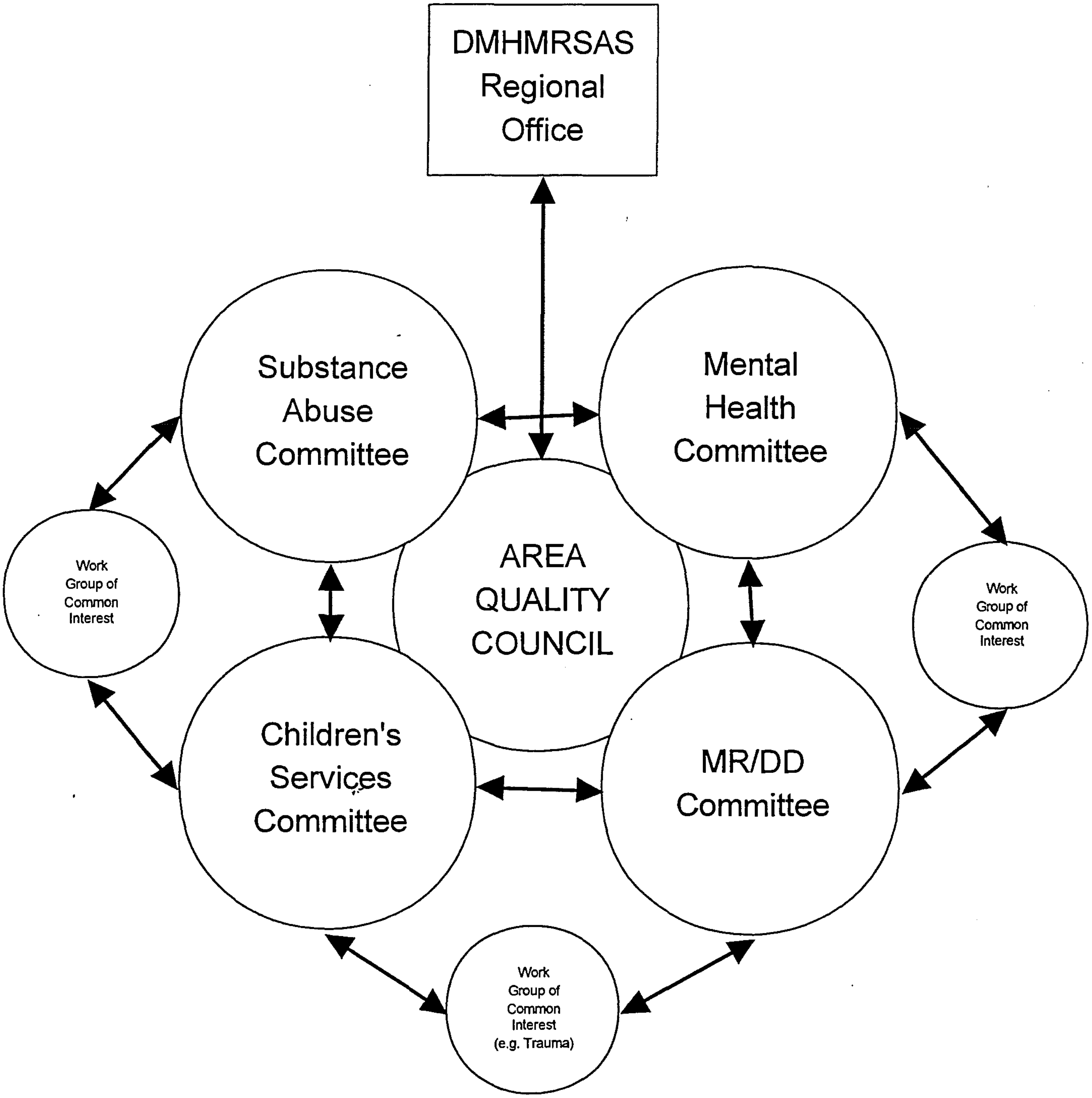
- Regional "Bubbling Up" - One or more meetings in each Region of stakeholders representing all four Department service populations, **<u>by the end of January</u>**.
  - ◊ Include attendees from today and Echo Lake.
  - ◊ Build local consensus.
  - ◊ Nominate two stakeholder representatives from each of the four service populations to serve on a statewide committee. (That's a total of ***eight*** stakeholder reps from each Region.)

- This committee, to be convened by Nancy Essex, will meet **<u>by the end of February</u>** to determine final recommendations to be made to DMHMRSAS.

- Final Recommendations Report to Regional groups**, <u>by the end of March</u>**, for feedback.

- Final Report issued by DMHMRSAS, **<u>by the end of April.</u>**

**MODEL STRUCTURE SELECTED**
**FOR COLLABORATION OF**
**NETWORK QUALITY IMPROVEMENT ACTIVITIES**
**QIC/QIG Retreat 9/24/97**



Work Groups can exist among any combination of committees. The above are examples only. Institute councils will be included in the Network areas of which they are a part.

# Highlights from QIC/QIG/SAQIC Collaboration Meeting #3
Comfort Inn, Augusta
February 25, 1998

Facilitator: Nancy Essex

Sponsored by:
State of Maine
Department of Mental Health, Mental Retardation,
and Substance Abuse Services

# REDESIGNING LOCAL QUALITY COUNCILS

**Purpose of Today:** To determine recommendations to be made to DMHMRSAS regarding the restructuring of the local quality system to be inclusive of all populations served by the Department.

**What has been determined** prior to today (the September 24, 1997 meeting at Echo Lake Lodge and the November 24, 1997 meeting at the Augusta Civic Center) by system stakeholders:

- "Petal" Structure
- Decision-Making Responsibilities
  - ◊ Center: What affects the council as a whole <u>or</u> what affects two or more of its "petals"
  - ◊ "Petals": What affects only that specific population to which the committee's work is dedicated

## I. "Petal" Membership

The first question to be answered was, "Do we want the membership of each "petal" to be a fixed number or open to any number who want to participate?" A motion was made and seconded that the number of members in each "petal" should be fixed. Following discussion, the vote was: Fixed number of members - 27, Open membership - 1. **Therefore, it is recommended each "petal" have a fixed number of members.**

## II. Number of Members per "Petal"

A motion was made and seconded that each "petal" shall consist of the following twelve (12) members: Four (4) primary consumers (including youth on the children's "petal"), and two (2) <u>each</u> providers, parents, family members, and representatives of the community-at-large. Following discussion, which included clarification that the definitions of the stakeholders listed above would be as contained in existing QIC legislation, the vote was: For the proposal - 18, against the proposal - 11. **Therefore, it is recommended each "petal" consist of 4 consumers, 2 providers, 2 parents, 2 family members, and 2 community-at-large members.**

## III. Existing QIC Members

Concern for what will happen to existing members of QICs was raised. Because the QICs are the only local groups which currently exist in statute, it was felt that the state has an obligation to accommodate those who have worked so diligently for the past 20 months to bring the concept of local quality improvement to fruition. The following recommendation was moved and seconded: **Existing voting members of Quality Improvement Councils be voting members in the new structure.** The vote was: For the recommendation - 16, against the recommendation - 8. The recommendation was accepted.

IV. **Quality Council (inner circle) Membership**

A motion was made and seconded that the inner circle consist solely of consumers and family members. Following discussion, the vote was: For - 2, against - 25. The motion did not pass. Another motion was made and seconded that five (5) persons from each "petal" shall constitute the membership of the inner circle, with the selection of the five to be determined by each "petal." Following discussion and clarification that the distribution of the five need not be equal among the stakeholders, the vote was: For - 25, against - 5. **Therefore, it is recommended each "petal" select five persons from its membership to be members of the Quality Council.**

V. **Transition from Existing Structure to New Structure**

With the understanding that the Commissioner of DMHMRSAS will continue to appoint all members in the new structure, it was moved and seconded that the existing Quality Improvement Councils, Quality Improvement Groups (mr/dd stakeholders), and Substance Abuse Quality Improvement Councils (currently under development) recommend to the Commissioner which "petal" existing members will now become members of, with the understanding that only QIC members would be guaranteed a seat. Following discussion, the vote was unanimous. **Therefore, it is recommended existing QICs, QIGs, and SAQICs select where existing members will sit (which "petal").**

VI. **Filling out the "Petals"**

It was moved and seconded that the members of each "petal" shall coordinate and facilitate recommending to the Commissioner additional members to fill out the "petals." Following discussion, the vote was unanimous. **Therefore, it is recommended each "petal" recommend additional members to fill any vacancies remaining after assignment and appointment of members currently serving on a QIC, QIG, or SAQIC.**

VII. **Implementation Date**

It was moved and seconded that the implementation date of the new quality system be July 1, 1998. The vote was unanimous. **Therefore, it is recommended the switch to the new, collaborative local quality councils take place on July 1, 1998.**

VIII. **Location of Institute Councils in the Model**

A motion was made and seconded that the BMHI council be a "petal" of the Northeast Quality Council and the AMHI council be a "petal" of the Ken-Som Quality Council. Following discussion, which included determining no one was present from the AMHI QIC, the motion and second were withdrawn under the premise that those present were uncomfortable making decisions regarding AMHI with no one here representing that council. Another motion was made and seconded that the BMHI QIC become a "petal" of the Northeast Quality Council. Members from the Northeast and BMHI QICs in attendance feel very strongly that this is the best structure for their area. Following extensive discussion, the vote was: For - 11, Against - 15. Most present were uncomfortable with this. Not being comfortable moving forward on this at this time, it was moved and seconded that we defer further deliberation on the location of institute councils in the model until we address the issue of the Statewide Council. The vote was: For - 15, Against - 6. The discussion was deferred. When brought up again later, it was **decided that the Commissioner would be approached by Nancy Essex for further direction on how to locate the institute councils in the new model.**

IX. **Location of Program Evaluation Teams (PETs) in the Model**
It was moved and seconded that there be one PET per Quality Council, consisting of four (4) non-provider representatives from each "petal" who would review all providers, including state-run services. Conceptually, this would be a group of stakeholders who would be trained, but only those interested and available would participate in any single evaluation. Following discussion, the vote was: For - 25, Against - 3. **Therefore, it is recommended each Quality Council have one Program Evaluation Team consisting of four non-provider representatives from each "petal." It was further recommended that the name of these evaluative teams be changed, so as not to be confused with the Pupil Evaluation Teams in the school systems.**

It was moved and seconded that the PETs also evaluate the relationship between their Quality Council and DMHMRSAS, including both Regional Office and Central Office relations. Following discussion, where it was noted that the state often appears to not understand the amount of work it is asking volunteers to undertake, the vote was: For - 20. Against - 7. **Therefore, it is recommended that the responsibilities of the Program Evaluation Teams include evaluation of the relationship between the Quality Council and the Department of Mental Health, Mental Retardation, and Substance Abuse Services.**

X. **Location of Local Service Networks (LSNs) in the Model**
Following a brief discussion, it was recommended that this is better decided elsewhere. **Therefore, no recommendation is offered on this.**

XI. **Statewide Quality Council**
It was moved and seconded that there be a Statewide Quality Council to address issues of statewide impact. Following brief discussion, the vote was unanimous. It was then moved and seconded that the statewide body use the same model as the local councils. Following discussion where it became clear that there was much ambiguity in the motion, the motion was voted down. With the understanding that the changes that will take place in the quality system will be subject to periodic evaluation and review, and that the Commissioner is looking for ways to better utilize various advisory bodies, it was moved and seconded that the Statewide Quality Council remain as it is presently, with one representative from each of the local and institute councils and at-large members appointed by the Commissioner. Following discussion, the vote was: For -16, Against - 7. **Therefore, it is recommended that the Statewide Quality Council consist of one representative from each local and institute Quality Council, as determined by each council, and an unspecified number of at-large representatives appointed by the Commissioner.**

Having completed the work for today, the meeting was adjourned at 3:30 PM.

## Other Stuff You Should Know

- When the new system is implemented, the existing QICs, QIGs and SAQICs will no longer exist, since they will be folded into the new model.
- QICs, because they exist in statute, are provided an annual allotment of $10,000 to assist them in accomplishing their assigned tasks. Most QICs use their funds to reimburse non-provider members for travel costs, dependent care expenses, and other out-of-pocket costs of participating on the council. In addition, many councils also provide a stipend to non-provider members for attending council meetings. Under the new system, each **Network Quality Council** will be allotted $10,000 annually for use by the council and its committees.
- The Department plans to seek legislative approval for the redesigned local quality system during next year's legislative session.

## What Happens Next?

This report is being distributed to those in attendance on February 25th as well as to the chairs of the Quality Improvement Councils and Quality Improvement Groups for distribution to its members. **DMHMRSAS will accept feedback/comments on the recommendations contained in this report until 5:00 PM Friday, April 3, 1998**. Following receipt of comments, DMHMRSAS will issue its final report on the new local quality structure by April 30, 1998. Assuming the recommended implementation date of July 1, 1998 is accepted by the Department, councils will then have two months to transition to the new structure.

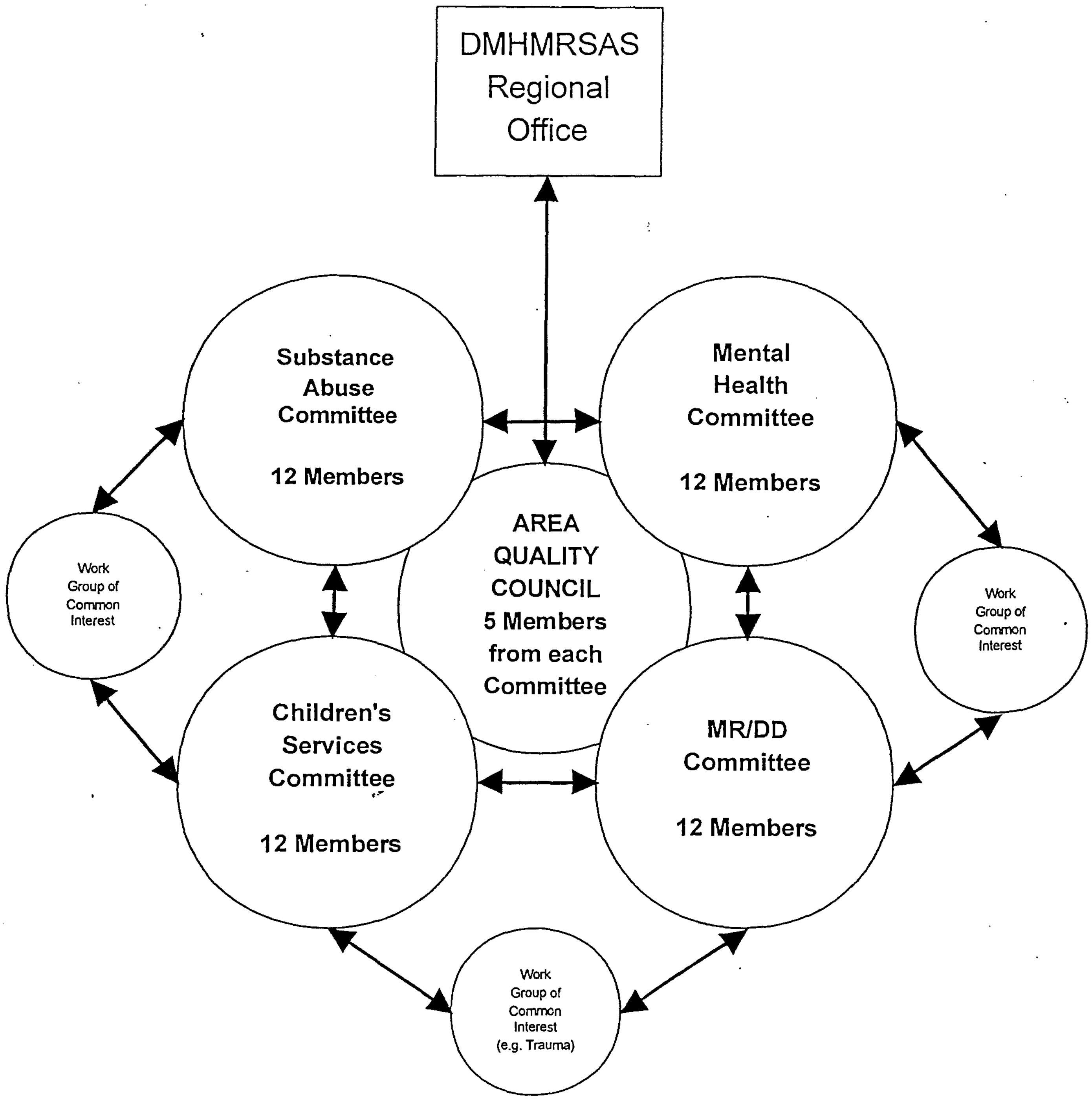
**Address Comments/Feedback to:**

**Commissioner Melodie J. Peet**
**Department of Mental Health, Mental Retardation, and**
**Substance Abuse Services**
**40 State House Station**
**Augusta, ME 04333-0040**

**Please indicate *Quality Council* on the envelope.**

Questions should be directed to Nancy L. Essex, Director of Community System Development, at 287-4205.

# MODEL STRUCTURE SELECTED FOR COLLABORATION OF NETWORK QUALITY IMPROVEMENT ACTIVITIES



Work Groups can exist among any combination of committees. The above are examples only.

Committee Membership: 4 Consumers, 2 Parents, 2 Family Members, 2 Providers, 2 Community-at-Large

Maine Department of Mental Health, Mental Retardation,
and Substance Abuse Services

POSITION PAPER

# COLLABORATIVE QUALITY COUNCILS

April 30, 1998

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Committee Structure and Membership

## *Introduction*

Quality Improvement Councils are mandated in state statute for mental health services (adults and children) only. However, the Department and many of its stakeholders want local quality activities to focus on all of the services under the purview of the Department. To that end, three day-long meetings of stakeholders were held in the fall of 1997 and winter of 1998 to design a model for local quality activities that would be inclusive of all disability groups. Recommendations from those meetings were published in early March and the Department accepted comments on those recommendations through April 3, 1998. This report explicates the Department's conceptualization of a collaborative local quality system and is predicated upon both the recommendations from the three collaboration meetings as well as comments and feedback received during the comment period. The Department gratefully acknowledges the contributions of over 100 individual stakeholders from across the state who gave of their time, energy, experience, and expertise to restructure the local quality system.

Somewhere during the design discussions, a flower metaphor emerged when referring to the new model; population-specific committees were called "petals" and the whole was called a flower. It is felt we need to get away from this language. Therefore, the following terminology will be used in this report:

Quality Council: refers to the entire body of a local or institute council (previously referred to as the flower).

Committee: refers to those groups whose work focuses on one distinct population, such as adult mental health (previously referred to as a petal).

Center Council: refers to the group of representatives from the four committees.

Work Group: refers to those groups whose work focuses on a combination of two or more distinct populations, such as dual diagnoses (mh and sa or mh and mr/dd).

Stakeholders: the definitions employed will be those as stated in the statutes which currently govern the Quality Improvement Councils and are shown here for clarification purposes:

- Community members: persons who represent the composition of the community at large.
- Consumer: a recipient or former recipient of publicly funded mental health services. In this report, consumer will also apply to a recipient or former recipient of publicly funded substance abuse or mental retardation/developmental disability services.
- Family member: a relative, guardian, or household member of an adult consumer.
- Parent: a parent or a person who has acted in that capacity or assumed that role for a consumer under 18 years of age.

- Provider: a person or organization providing publicly funded mental health services to consumers or family members. In this report, provider will also apply to persons or organizations providing publicly funded substance abuse or mental retardation/developmental disability services.

### *Decision-Making Responsibilities*

Responsibility for making decisions and/or recommendations within the Quality Council shall be vested as follows:

- Committees: responsible for what only affects that specific population to which the committee's work is dedicated.

- Center Council: responsible for what affects the council as a whole or what affects two or more of its committees.

### *Committee Structure and Membership*

**Structure**

Each Quality Council shall consist of the following four committees and as many work groups as the council deems necessary:

- Mental Health Committee: issues germane to adult mental health services.

- Substance Abuse Committee: issues germane to adult substance abuse services.

- MR/DD Committee: issues germane to adult mental retardation and/or developmental disability services.

- Children's Services Committee: issues germane to mental health services, mental retardation and/or developmental disability services, and substance abuse services for persons under the age of 18.

**Membership**

Each committee shall have 12 voting members. Additionally, committees are encouraged to elicit the informal participation of other interested stakeholders to assist them with their work. A person may be a formal member of only one committee at a time. Committee members shall be appointed by the Commissioner of the Department upon the recommendation of that committee. Because of the differences in the four populations to which the Department's work is dedicated, it was felt each committee needed to have a slightly different configuration of stakeholders, as follows:

|  | Mental Health Committee | Children's Services Committee | MR/DD Committee | Substance Abuse Committee |
|---|---|---|---|---|
| Consumers | 4 | 2 (adolescents) | 2 | 4 |
| Family | 3 | 0 | 4 | 2 |
| Parents | 0 | 4 | 0 | 2 |
| Providers | 3 | 3 | 3 | 2 |
| Community | 2 | 3 | 3 | 2 |
| **Total** | **12** | **12** | **12** | **12** |

For purposes of staff membership on committees, schools will be considered providers (of children's services). Providers may not occupy a community-at-large seat on a committee if they provide the services to which that committee's work is dedicated. And, due to potential or existent conflicts of interest, Department employees may not serve on any committee, regardless of their stakeholder designation, after June 30, 1998.

**Geriatric Services**

During the comment period, a number of letters were received from the geriatric service community requesting a separate committee dedicated to geriatric services. It was decided that having a separate geriatric committee would not be prudent for the following reasons:

- geriatric services are not one of the disability groups for which the Department has primary responsibility (the DHS Bureau of Elder and Adult Services has this statutory responsibility);
- services for geriatric persons have not been legislatively mandated, as they have for children's services; and
- geriatric services may cross three of the four disability groups which have separate committees, thus making geriatric services, like trauma services, appropriate for a work group of representatives from various committees.

This determination should not be construed to mean that the Department sees geriatric services, trauma services, or any other services which cross disability lines as being any less important than those services for which committees exist. To the contrary, these types of services can be perceived as more complex *because* they cross disability lines and, therefore, require the participation of stakeholders from impacted disability groups.

**Department Staff**

It is the expectation that Team Leaders will represent the Department at meetings of the Committees and the Regional Director will represent the Department at Center Council meetings.

**Meeting Frequency**
Committees shall meet as frequently as they deem necessary to accomplish their work.

### *Existing QIC Members*

The Department agrees with the recommendation that existing voting members of the Quality Improvement Councils become voting members in the new system, with the understanding that this will be done **wherever possible.**

### *Center Council Membership*

The Department agrees with the recommendation that each committee select five persons from its membership to be members of the Center Council, thus making the Center Council consist of a maximum of 20 members. In order to assure equitable consumer and/or parent/family member representation on the Center Council, the following shall be required:

- <u>Adult Mental Health Committee Representatives</u> - at least three of the five must be consumers.
- <u>Children's Services Committee Representatives</u> - at least three of the five must be either a consumer or a parent.
- <u>MR/DD Committee Representatives</u> - at least three of the five must be either a consumer or a family member.
- <u>Substance Abuse Committee Representatives</u> - at least three of the five must be either a consumer, or a family member, or a parent.

### *Filling out the Committees*

The Department concurs with the recommendation that the QICs, QIGs and SAQICs may select which committee their existing members will serve on, *provided that the person has or has had direct experience with the population to which the committee of choice is dedicated,* except, of course, community-at-large members. This means that a stakeholder who has had no connection to the substance abuse system, for example, would not be seen as appropriate for appointment to that committee.

Each existing local QIC, QIG, and SAQIC shall notify the Commissioner, in writing, <u>no later than June 30, 1998</u> which committee of the local quality council each of its members wishes to join, if they wish to continue serving on their quality council. Members will then be considered for appointment by the Commissioner and letters of appointment shall follow closely thereafter.

### *Institute Councils*

Institute Quality Improvement Councils will continue as they currently exist in statute, as separate bodies with different statutory responsibilities. Membership categories and numbers will remain as is. Each of the institute councils shall notify the Commissioner no later than June 30, 1998 which of its members wish to be reappointed for terms commencing July 1, 1998.

### *Evaluation Teams*

To avoid further confusion with the educational system, a new name has been selected for these teams - Services Evaluation Team (SET).

The recommendation of a standing SET consisting of 16 non-provider members (four from each committee) was not favored by the Department. This seems too cumbersome and time consuming for volunteer members of the council. Therefore, the Department would like to see the following with respect to these activities:

- SET's will be predicated on the Department value that folks who have used a service (and their families) need to evaluate that service.

- SET activities will consist primarily of consumer satisfaction surveys, although they will also be privy to QA/QI information from the Regional Office. The expectation is that this satisfaction measuring process will also include some random interviews with consumers by consumers. These activities need to utilize a standard satisfaction tool which allows for variation by service, but which will also allow for comparison across services. Such tool(s) are to be developed with stakeholder participation.

- The SET needs to be seen as just one piece of an entire QA/QI process in each region. The QA position in the regional office will be responsible for providing TA and data analysis services for the SET's. The QA/QI efforts need to be coordinated so that consumers don't get bombarded with satisfaction surveys (by individual providers, QC's, central office, regional office, etc.)

- Only non-providers may serve on an SET.

- There will be one SET per committee.

The Department concurs with the recommendation that the Services Evaluation Team also evaluate Department-run services, as well as the relationship between the Quality Council and the Department.

### *Local Service Networks (LSNs)*

As prescribed in current law, there shall be one LSN per designated network area. Adult and children's mental health providers will be required to participate now; substance abuse and mr/dd providers are welcome to participate until such time as they, too, are required by law to do so.

### *Statewide Quality Council*

The Statewide Quality Council will remain as it exists in current statute, meaning that there shall be one representative and alternate from each local council and one representative and alternate from both institute councils, as well as an unspecified number of at-large representatives appointed by the Commissioner. Local and institute councils shall select their representatives and alternates. There is no change in the roles and responsibilities as assigned to the Statewide Council under existing statute.

### *Implementation of Restructured System*

Quality Improvement Councils were created by the legislature, which must formally legislate any changes to the councils' structure as prescribed in law. Because quality system redesign efforts were not begun until after the due date for bills to be considered by the 118th legislature, the changes called for in this document have not been legislated. The Department will use the stakeholder-defined restructured system as set forth in this document when seeking legislative approval from the 119th legislature next year. ***In the interim, existing QICs, QIGs, and SAQICs may transition to the new structure, with the understanding that the ultimate determination of the changes to the system rests with the legislature.***

There are many operational issues which are impacted by this decision, not the least of which is the annual $10,000 allocation to the QICs. Because the QIGs and SAQICs do not exist in statute, access to the $10,000 must be through the existing QIC, **or through the new collaborative quality council**, whichever is in operation in each network area. The Department will recognize one or the other, but not both, as the "official" local quality council during this interim period.

### *Local Quality Council Roles and Responsibilities*

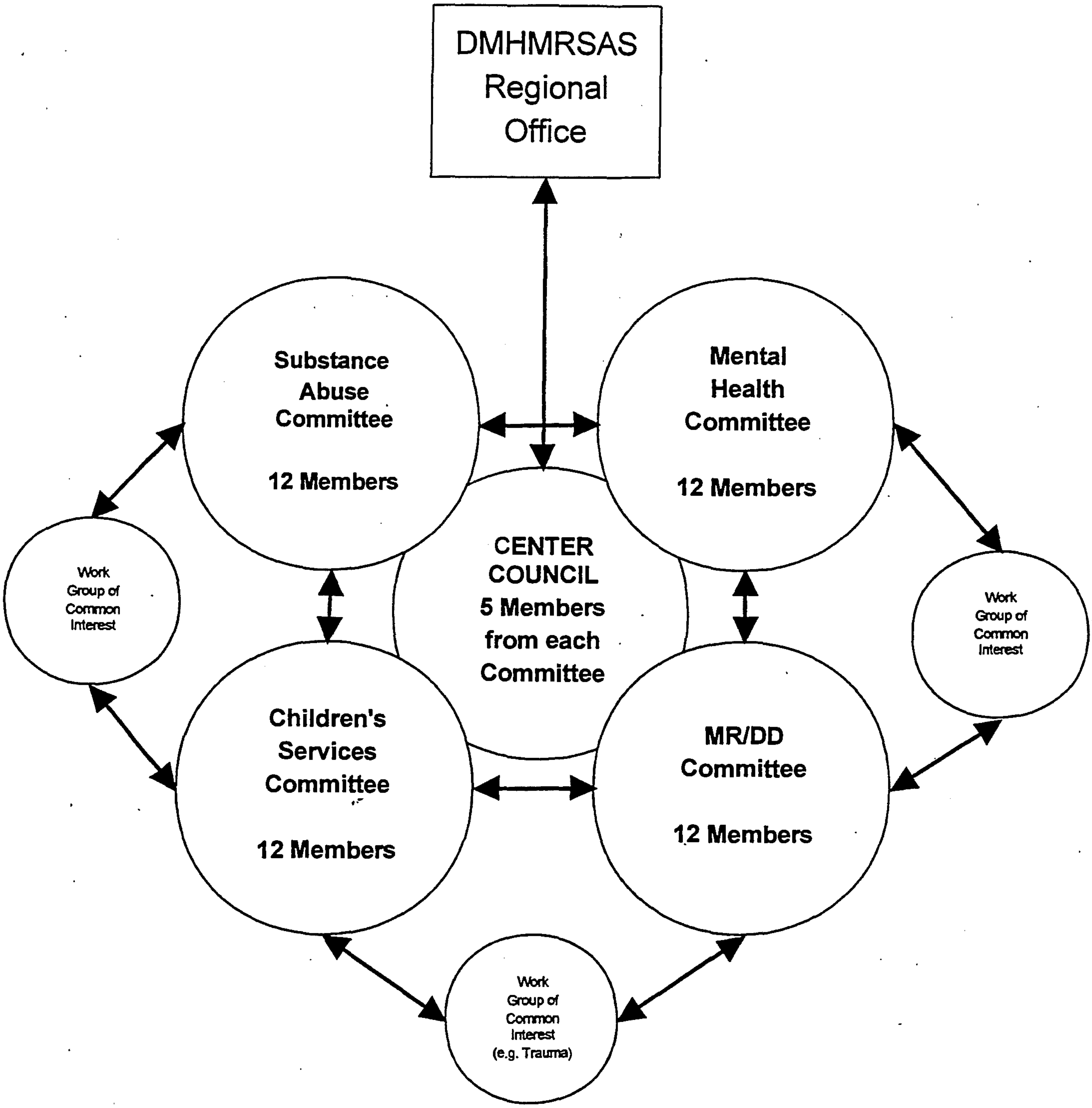
The Department is not seeking any change in the roles and responsibilities as assigned to the local quality councils in the originating legislation, which are as follows:

- Advising the Department on system planning and needs assessment (capacity development);
- Community public education activities; and
- Local quality improvement activities (service evaluation).

### *Department Oversight and Technical Assistance*

As stipulated in the legislation, each local quality council is accountable to the Regional Director for the region of the state in which the council is located, and the institute councils are accountable to the Department's Director of Facility Management. System clarification and technical assistance can also be obtained from Nancy Essex, Director of Community Systems Development.

# MODEL STRUCTURE SELECTED FOR COLLABORATION OF NETWORK QUALITY IMPROVEMENT ACTIVITIES



Work Groups can exist among any combination of committees. The above are examples only.

Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services

# QIC/QC Membership Report

As of December 10, 1998

As of this date, five of the seven local councils have begun to organize in a way that is broadly consistent with the collaborative quality council model. These councils are referred to as ***Quality Councils*** (QCs). The structure of the other two local councils, the two institute councils, and the statewide council all remain unchanged and as stipulated in current state law. These councils are referred to as ***Quality Improvement Councils*** (QICs).

This first report is being issued in response to a number of requests for the data contained herein; it is intended to be revised periodically, as council membership changes frequently. Membership data are reported only for occupied seats on the councils. As of this date, there are 221 council members; Table I below shows the distribution among the ten councils by stakeholder designation.

## Table I: Council Membership Distribution

| Councils | Total Members | Consumer Members | Parent Members | Family Members | Provider Members | Community Members |
|---|---|---|---|---|---|---|
| **Institutes** | | | | | | |
| AMHI | 10 | 2 | n/a | 3 | 3 | 2 |
| BMHI | 15 | 4 | n/a | 3 | 4 | 4 |
| **Subtotal** | **25** | **6** | **n/a** | **6** | **7** | **6** |
| | | | | | | |
| **Locals** | | | | | | |
| Aroostook | 26 | 5 | 4 | 4 | 6 | 7 |
| Coastal | 33 | 9 | 1 | 6 | 11 | 6 |
| Cumberland | 23 | 6 | 3 | 2 | 8 | 4 |
| Ken-Som* | 16 | 3 | 3 | 1 | 6 | 3 |
| Northeast | 30 | 4 | 1 | 5 | 13 | 7 |
| Western | 30 | 5 | 2 | 7 | 12 | 4 |
| York* | 24 | 4 | 4 | 4 | 6 | 6 |
| **Subtotal** | **182** | **36** | **18** | **29** | **62** | **37** |
| | | | | | | |
| **Statewide**** | 14 | n/a | n/a | n/a | n/a | 14 |
| | | | | | | |
| **TOTALS** | **221** | **42** | **18** | **35** | **69** | **57** |

* Indicates Quality Improvement Council (statutory model)

** Reflects only at-large members (does not include representatives from the other nine councils)

Five local councils are in transition to the collaborative model. All have had difficulties attracting the full complement of 48 members each and are still working to increase membership. The Cumberland council has moved to a modified collaborative model, remaining with the existing statutory membership of 24, but organizing into the four population-specific committees. Table II on the next page shows the membership of the collaborative councils by committee.

## Table II: Committee Membership Distribution

| Council | Total Members | Ment Health Committee | Children Committee | MR/DD Committee | Sub Abuse Committee |
|---|---|---|---|---|---|
| Aroostook | 26 | 10 | 5 | 1 | 10 |
| Coastal | 33 | 13 | 5 | 8 | 7 |
| Cumberland | 23 | 6 | 6 | 6 | 5 |
| Northeast | 30 | 11 | 4 | 8 | 7 |
| Western | 30 | 10 | 6 | 10 | 4 |
| TOTALS | 142 | 50 | 26 | 33 | 33 |

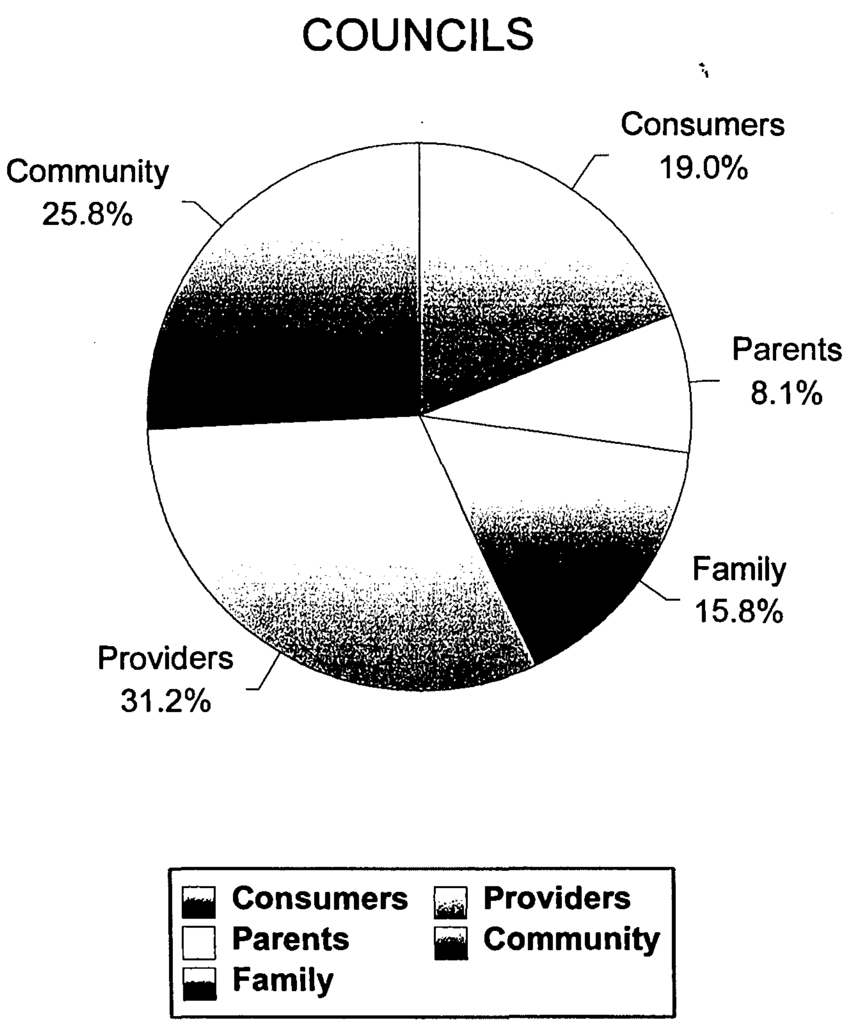
If all council seats were filled, there would be 48 members in each of the quality councils, 24 members in each of the local quality improvement councils, and 16 members in each of the institute quality improvement councils. The statewide council has no statutory limit, but for purposes of this report the existing at-large membership will be considered full membership. Table III below shows the number and percentage of vacancies on each council.

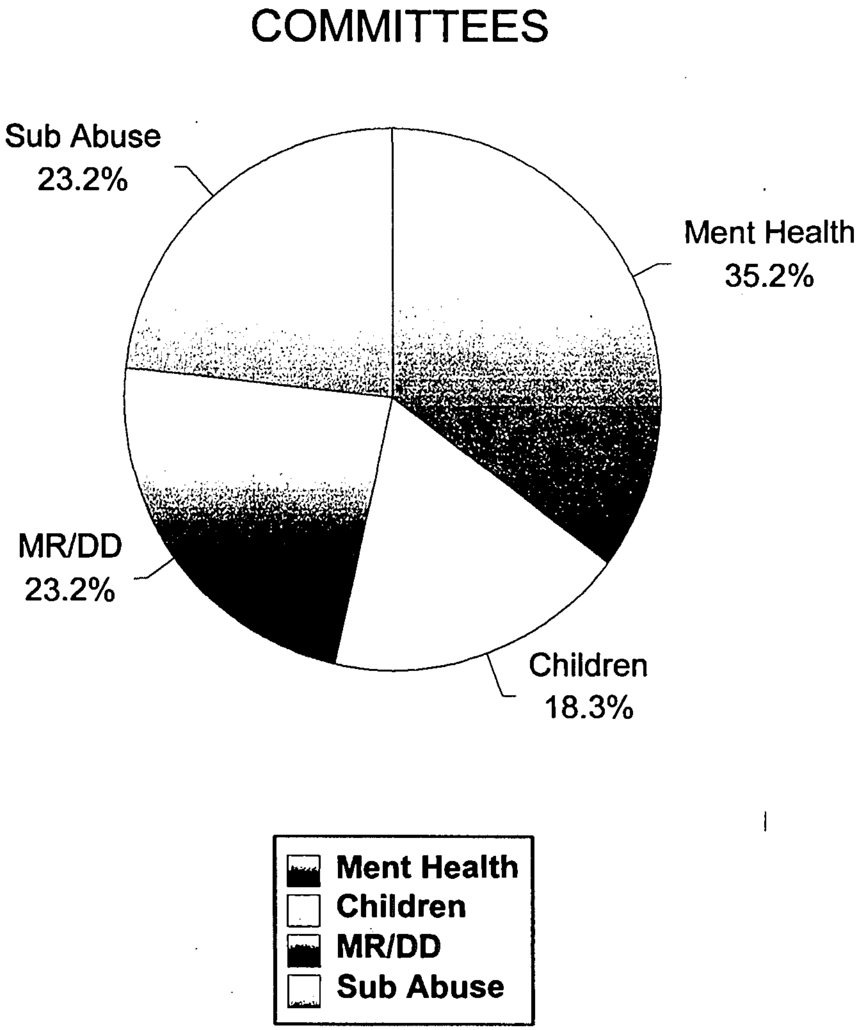
## Table III: Council Membership Vacancies

| Council | Full Membership | Current Membership | Vacancies | Percentage of Vacancies |
|---|---|---|---|---|
| AMHI | 16 | 10 | 6 | 38% |
| BMHI | 16 | 15 | 1 | 6% |
| Ken-Som QIC | 24 | 16 | 8 | 33% |
| York QIC | 24 | 24 | 0 | 0% |
| Aroostook QC | 48 | 26 | 22 | 46% |
| Coastal QC | 48 | 33 | 15 | 31% |
| Cumberland QC * | 24 | 23 | 1 | 4% |
| Northeast QC | 48 | 30 | 18 | 38% |
| Western QC | 48 | 30 | 18 | 38% |
| Statewide | 14 | 14 | 0 | 0% |
| TOTALS | 310 | 221 | 89 | 29% |

* Cumberland QC is limiting itself to 24 members until the law changes.

# QC/QIC Membership
# As of 12/10/98





# DMHMRSAS Changes Made to QIC/LSN Legislation

The Department of Mental Health, Mental Retardation, and Substance Abuse Services has made some changes to the legislation submitted to restructure the local quality improvement councils. These changes are being made in response to the large number of comments the Department has received regarding the size of the restructured collaborative quality councils; many perceive them to be too large and unwieldy. The five quality councils that have attempted to restructure to the collaborative model have had difficulty recruiting and retaining twelve persons to serve on each of the four committees, despite months of effort. The Department, therefore, has reduced the number on each population-specific committee to eight, thereby reducing the total number of council members from 48 to 32. This is still an increase over the current membership of each local council, which is 24. This reduction in the number of persons on each of the four committees led to a similar reduction in the number of persons on the Center Council. Finally, the Service Evaluation Team section (§3607, sub-§2(E)) has been amended to remove the four guidelines listed under subsection 2(E); these were seen as too prescriptive for law and are better suited to guidelines and/or rules and are covered in the Department's position paper on Service Evaluation Teams.

## *Population-Specific Committee Membership*

| | **Mental Health Committee** | | **Children's Committee** | | **MR/DD Committee** | | **Sub Abuse Committee** | |
|---|---|---|---|---|---|---|---|---|
| | Old | New | Old | New | Old | New | Old | New |
| Consumers | 4 | 3 | 2 | 2 | 2 | 3 | 4 | 3 |
| Family | 3 | 2 | 0 | 0 | 4 | 2 | 2 | 2 |
| Parents | 0 | 0 | 4 | 3 | 0 | 0 | 2 | 0 |
| Providers | 3 | 2 | 3 | 2 | 3 | 2 | 2 | 2 |
| Community | 2 | 1 | 3 | 1 | 3 | 1 | 2 | 1 |
| **Totals** | **12** | **8** | **12** | **8** | **12** | **8** | **12** | **8** |

## *Center Council Membership*

Changed from 20 (five persons from each of the four population-specific committees, with specific representative categories from each committee; example, as originally conceived: At least three of the five representatives from the mental health committee must be consumers), to 12 members made up of three (unspecified) representatives from each of the four population-specific committees.

Issued 2/22/99

# Related Quality Assurance/Quality Improvement Information

This section contains copies of quality assurance/quality improvement information supplied to all QIC's and LSN's to assist them in understanding their roles and responsibilities. Information is arranged in chronological order by date of issue, beginning with the earliest information at the front of the section.

| Document Title | Issue Date |
|---|---|
| • Position Paper: QA/QI Activities | August, 1997 |
| • The Role of Quality Councils and Program Evaluation | November, 1997 |

Not included herewith is the latest draft (2/18/99) of the DMHMRSAS Quality Improvement Plan. This plan has been supplied to the legislative Oversight Committee for the Children's System, as well as to all QIC's, LSN's, and other interested system stakeholders. Anyone wanting a copy of this extensive plan may obtain one by contacting the following:

James T. Yoe, Ph.D.
Office of Quality Improvement
DMHMRSAS
40 State House Station
Augusta, ME 04333
Phone: (207) 287-8982

State of Maine
Department of Mental Health, Mental Retardation,
and Substance Abuse Services

# Position Paper:
# Quality Assurance/Quality Improvement Activities

## *Background*

Two years ago the system for delivering mental health, mental retardation, and substance abuse services for adults and children in Maine was marked, in many areas, by fragmentation and an emphasis on responding to the immediate demands of consent decrees for people with mental illness and mental retardation. Services for people with substance abuse issues were administered through the Office of Substance Abuse, then an independently organized agency operated under the auspices of the Governor's Office, and a substantial percentage of the State's resources for children with special needs were supporting inpatient psychiatric care, often out of state. Throughout 1995, community discussions led to a new and strong commitment to involve consumers and families in reforming Maine's service system and to create a system that is committed to offering the services people want and need. These discussions formed the basis of the creation of the Quality Improvement Councils (QIC's) and the Local Service Networks (LSN's).

In 1995, the Department's administration was organized in the following population-specific compartments: the Division of Mental Health, the Division of Mental Retardation, and the Bureau of Children with Special Needs. While mental retardation and children's services maintained a regional presence, all planning for adult mental health services was centralized in Augusta and community services were provided through contracts with private organizations. The planning for people with dual diagnoses (mental health and substance abuse) was fragmented between the Department and the Office of Substance Abuse, then located in the Governor's Office.

In 1996, the reorganization of the service system was formally launched when the Office of Substance Abuse was transferred to the Department on July 1 and population-specific Divisions/Bureaus were eliminated in favor of regional offices covering all populations served by the Department. These new structures provide a regional Department presence which works with local system stakeholders (consumers, family members, providers, and the community at large) in identifying regional service needs, quality improvement activities, and related issues.

Quality Assurance and Quality Improvement activities are not limited to one point in time, nor are they the responsibility of any one entity. The Department and service providers are all responsible in one way or another for monitoring the quality of their work. However, specific responsibility for quality improvement activities at the local level is vested in the Quality Improvement Councils, through their Program Evaluation

Teams (PETs) which are charged with reviewing each program funded by the Department on a periodic basis, the results of which must be considered in subsequent funding decisions by the Department. These program level findings, combined with system and client outcome information, will be used to assess the overall effectiveness of each local service network. Public Law 691, which created the QIC's and the LSN's, is specific to adult and children's mental health services. In many instances substance abuse providers are already participating on area councils; while participation by substance abuse providers has been encouraged, councils are still focused on mental health issues and active participation by consumers, parents, and family members of persons with substance abuse disorders has not occurred. At the same time, in some areas of the state, mental retardation providers, consumers, and family members have formed separate councils, referred to as Quality Improvement Groups (QIGs).

*Moving Ahead*

The Department is interested in creating coordinated Quality Councils (QC's) that identify areas and approaches of common interest and concern of all the populations served by the Department, and at the same time respect the differences in service types and issues that exist between the various populations. Already, process and client outcomes are being developed for all populations as part of the Department's performance-based contracting initiative.

In order to create a unified quality system, the Department will host a meeting of representatives from all the QIC's and QIG's in September of 1997. Working with the Department, the group will be charged with recommending an integrated model that will include subcommittees reflecting the particular interests of each population group. As a result, the work already accomplished in the separate groups will not be lost and a new coordinated and unified structure will be developed.

Under the newly developed quality system and within the developing managed care system, network providers will report uniform client descriptive information along with progress in achieving designated client outcomes to the network manager on a quarterly basis. The network manager will forward this information to the local Quality Council and to the Department. Additionally, the network manager will make the Quality Council aware of any issues and concerns as they arise with and about providers. These activities will be in addition to and will compliment the program-specific evaluative activities of each council.

The Quality Council will also conduct, in conjunction with the Department's Program Division, regular needs assessments and make recommendations to the Department about capacity development. It is important to note again that pieces of this work will need to be accomplished in subcommittees representing the interests of the separate population groups. Other pieces will need to be done jointly, reflecting common areas of interest or concern.

In order to begin this process, the Department, through the Regional Directors, will host joint meetings of the local QIC's and QIG's beginning in October of 1997, with the goal that full integration will be achieved by July 1, 1999.

# DMHMRSAS Quality Improvement Agenda

## The Role of Quality Councils & Program Evaluation Teams

November 24, 1997

# Current Quality Improvement Activities

- ☐ Development of Uniform Intake & Assessment protocols & procedures
- ☐ Development of Uniform Consumer & Family Outcomes & Tracking Procedures
- ☐ Local Service System Survey
- ☐ Individual Support Plan Record Review & Consumer Interview Process
- ☐ Housing Initiatives Study
- ☐ Service System Capacity Assessment - Medicaid Analyses
- ☐ Design & Development of Consumer/Family Dialogue & Assessment Teams

# Quality Council /Program Evaluation Team Quality Improvement Activities

- ☐ Participate in development & implementation of uniform intake & assessment protocols and procedures

- ☐ Participate in the selection & development of statewide core consumer & family outcomes and tracking procedures

- ☐ Participate in development & implementation of Consumer/Family Dialogue process & procedures & in development of Consumer/Family Assessment Teams

- ☐ Conduct consumer/family dialogue sessions in 3 to 4 programs per year and feedback information to local provider agencies, Quality Councils, DMHMRSAS, and other Planning groups

- ☐ Review & summarize local consumer/family, program, and system level information for use in local, regional & statewide planning efforts (e.g., Service capacity/utilization data, local system stakeholder survey results, Individual Support Plan record review & consumer interview data, consumer & family outcome information, results of consumer & family dialogues, results of focused research & evaluation projects, etc.)

- ☐ Identify annual local service system improvement priority areas based on review of local system, program & consumer/family level information

# Goals of Consumer & Family Dialogue & Assessment Team Process

☐ To provide regular feedback on what is working well and areas needing improvement in DMHMRSAS funded agencies and programs and in local service networks from the experience of service recipients and their families

☐ Links program development and system improvement efforts to consumer and family experiences and needs

☐ Supports and encourages consumer and family interaction and participation in service system development activities

☐ Empowers and provides a voice for consumers and family members

| Maine Consumer/Family Assessment Team Approach (Draft) | | | | |
|---|---|---|---|---|
| **Activity** | **General Approach** | **Participants** | **Who Collects** | **Products and Feedback** |
| Consumer/Family Dialogue Sessions<br>(Focus on Program Quality) | Semi-structured facilitated discussion with group of 10 to 15 consumers from selected DMHMRSAS Program/service sites within each Local Service Network. Focus on consumer experiences in selected program areas (i.e., what is positive or working well, barriers and problem areas, suggestions for improvement etc.). Dialog sessions would be conducted in a minimum of three program sites per year and separate sessions will conducted with consumers and family members. | Consumers of Service (all disability groups)<br>Family Members | Non-provider members (consumers/family members) of each local Quality Council. Each QC will establish a four member dialogue team consisting of two facilitators, a time keeper and a session recorder. | Dialogue teams will produce reports summarizing content of dialogue sessions, and report findings to service provider, Local QC, and DMHMRSAS for use in program and service system planning and QI activities. |
| Individual Consumer/ Family Member Satisfaction Interviews<br>(Focus on individual experiences within service system and specific program area) | Will involve individual face to face or phone interviews using a standard format to assess individual satisfaction with services, living arrangement, quality of life and degree of involvement in service and support planning, etc. | Consumers of service (all disability groups)<br>Family members | Consumer Interviewers as part of Statewide Consumer/ Family Assessment Teams (CFAT)<br>Interviews may be conducted in consumer's home, service location or other community setting. | Aggregate satisfaction information will be reported back by CFAT representatives to local service providers, local Quality Councils, DMHMRSAS, and other stakeholder groups for use in planning and quality improvement activities. |
| Consumer/Family Speakouts<br>(Focus on Local Service Network) | Town meeting like forum designed to assess the quality of services (e.g., system access, service availability, individualized services, quality of care, care coordination, etc.) within each DMHMRSAS Local Service Network. Speakouts will be held on an annual basis with each disability group and involve 25 to 30 consumer or family member participants. Speakout discussions will be guided by a trained facilitator and a set of focused questions. Separate speakouts will be conducted for consumers and family members. | Consumers of service (All disablity groups)<br>Family members | Consumer and family members as part of Statewide Consumer and Family Assessment Teams (CFAT) | Written reports will be produced summarizing speakout dialogues. This information will be shared with Local QC, DMHMRSAS, and other system stakeholders for use in planning and quality improvement activities. |

| **Consumer/Family Dialogues: Implementation Plan** | |
|---|---|
| **Task** | **Description of Activity** |
| Establish Local Dialogue Teams | Each Quality Council will select a team consisting of 4 non-provider members. Each team will consist of 2 facilitators, 1 timekeeper, and 1 recorder |
| Establish Dialogue Design Team | A design team will be established by the Department to review and finalize Dialogue process and procedures. This team will consist of QC representatives (provider & non-provider members), Department representatives (Director of QI & OCA), other consumer & family member representatives. |
| Train Dialogue Teams | Each year, the Department will provide facilitation training to all Dialogue team members |
| Selection of Agencies/Programs to be Assessed | The Quality Councils in conjunction with the Department will develop an annual schedule of programs to be assessed. |
| Recruit Consumers and Family Member Participants | Consumers and family member dialogue participants will be recruited using a sign-up procedure at each service site and 10 to 15 participants will be selected for each Dialogue session. |
| Conduct Dialogue Sessions | Each QC will conduct 3 to 4 dialogue sessions per year. Separate dialogue sessions will be conducted with consumer and family members. Each dialogue session will last 60 to 90 minutes and will be guided by a set of core questions and discussion guidelines. All responses will be recorded by two recorders including one member of the Dialogue Team and one volunteer from participant group. |
| Reports and Feedback of Dialogue Information | Each dialogue team will prepare a written report summarizing each dialogue session. These reports will be shared with the provider agency, the Local Quality Council, DMHMRSAS, dialogue participants and other designated groups. Immediately following each dialogue session, the Team will hold a debriefing meeting with agency and program administrators summarizing the session. |