Commissioner's Report:

Establishment and Implementation of the Maine Department of Health and Human Services

Pursuant to Public Law 2003, Chapter 689, Part B

January 31, 2005

(Updated as of 2/8/05)

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Executive Summary

The new Department of Health and Human Services (DHHS) was established by Public Law, Chapter 689, as of July 1, 2004, by combining and reorganizing the former-Department of Human Services (DHS)and the former-Department of Behavioral and Developmental Services (BDS).

The enabling legislation authorized the Commissioner of DHHS to consolidate administrative functions as well as adult protective functions. It also required the Commissioner to report on a number of other issues, including:

A. Bureau structure,
B. Administrative structure and functions,
C. Program and service delivery functions,
D. Advisory boards; and
E. The child welfare ombudsman program."

This report represents Commissioner Nicholas's submission to the Governor and Legislature regarding the "establishment and implementation of the Department of Health and Human Services", pursuant to law.

The Commissioner's recommended structure accomplishes the following outcomes:

A Renewed Focus on Customer Service

Fundamental to the changes in DHHS is a renewed commitment to customer service. *Customer service* is broadly defined and includes internal and external customers. Internal customers are Department staff. External customers include individuals receiving services, their families, community providers, citizens working to improve public health, other departments of State government and the Legislature.. An overarching philosophy of customer service will provide a common identity across the Department's diverse programs unifying it and moving toward a culture of shared customers and shared mission.

Internal Customers: Department Staff

Investing in staff, the Department's most important resource, is a critical component for success. By supporting staff through quality training and professional development, the Department strengthens its connection to external customers and improves the retention of valued, competent, and committed staff. Organizational climate is key to improved outcomes for clients and communities. Empowering staff with information, clear role definition and expectations, authority, accountability and rewards is central to creating a supportive organizational climate in the new Department. Supporting staff during this period of large-scale change will be a critical management function, as staff become familiar with the new organization.

Services That Are Easy to Use and Work Well Together

Improving access to services and information is crucial to the organization of DHHS. By adopting a policy of "No Wrong Door", the Department takes the responsibility for resolving the fragmentation of existing services and creating a system designed to be responsive to customers and communities, regardless of where the client seeks services in the organization. DHHS must adopt and operationalize a core set of principles to support the integration of strengths-based services across life domains. Streamlined eligibility processes, cross-trained staff, multiple points of access, co-location of services, increased use of technology and integrated data systems are all strategies that hold promise for effectively facilitating access to the Department's services and information resources.

Multiple Strategies to Achieve Integration

Integrated service delivery is the new Department's most important opportunity, and should be the marker of success as restructuring is implemented. If access has not been streamlined for consumers, if coordination has not been strengthened across providers, if collaboration has not been fostered within communities, if efficiency and effectiveness are not improved, if the Department does not offer greater value to Maine citizens, little will have been gained from this monumental effort. Creating a true continuum of services including prevention, intervention and, long term supports, will ensure that all citizens can access the level of service appropriate to their needs. By giving voice and choice to its customers (by having a strong customer orientation) the Department can tailor services to individual and family strengths and needs, supporting rather than supplanting natural supports. An enhanced commitment to the achievement of positi8ve outcomes for DHHS' customers is a hallmark of this reform.

Consolidated Case Management Services

Consolidated case management is another change recommended to improve both efficiency and effectiveness. The use of multi-disciplinary teams brings a variety of programmatic perspectives and expertise to create and carry out comprehensive, strengths-based plans. Greater consumer involvement in the development of plans is necessary to achieve desired goals of independence and self-determination. Through increased collaboration and communication among Department staff and contracted providers, the Department will maximize effectiveness and reduce redundancies among those providing service and support.

While there are many strategies to achieve service integration, the Department needs to continue to make the administrative changes necessary to support the new approach. In the past, both Departments have suffered from internal organizational divisions that created silos, fragmenting rather than integrating services. The new Department's structure should contain as few organizational units as needed to organize its primary functions effectively. The fewer the units, the fewer the boundaries where programs can collide. Historic traditions of service delivery by population, diagnosis, or funding stream are outmoded and ineffective. Further development of statewide structures and consistent policies will enable the regions to employ the most effective strategies for their communities. Optimally, the organizational structure of DHHS will maintain an appropriate balance between centralized authority and regional flexibility. The most effective efforts at integrating services in other states are those in which the local community creates and carries out the detailed implementation plans combining various strategies, partners and methods. Ideally, the Department will create an administrative structure and provide leadership that supports and enhances an integrated service delivery system for both prevention and interventions at the local level.

Re-engaging Communities

The Department's structure must support integration, but the reality is that all health promotion and service delivery is local. Improved relationships with community prevention and service providers can energize the Department's efforts. Creating true partnerships means including them in planning and policy development with formal mechanisms for input and communication. In turn, the Department must expect quality service and accountability from providers, and reward exemplary practice.

A Commitment to Providing the Best and Learning to Do Better

Quality assurance and improvement efforts need to be aligned with stated Departmental outcomes. All customers and communities provide rich data for the Department to measure and improve its performance. Critical feedback from consumers, advocates, ombudsmen, and providers needs to be systematically incorporated in performance improvement efforts. Becoming a "world class organization" means staying abreast of best practices. Functioning as a learning organization, dynamic and flexible and able to respond to changing environments, means constantly examining best practices against the status quo and being responsive to an ever-changing environment. The

Department needs to create a capacity for research and re-design consistent with these values and closely linked to quality improvement strategies and outcomes.

Communicating Effectively Inside and Outside the Department

Organizational change of this magnitude demands an increased focus on communication. To enhance understanding about the Department's initiatives and related progress, the Department must provide honest and timely information. An open and transparent communication plan is essential to this goal and it must be operationalized through communication structures that effectively link policy to program delivery. Communication up, down and across the Department is key to improved coordination and efficiencies. Increased innovations in the use of technology can advance many of these objectives.

Summary

This new structure and approach to service delivery will provide consistent, effective high-quality services based on standardized, evidence-based, best-practices parameters with uniform oversight. The new system will bring increased strength-based collaboration with all programs which are involved with an individual and his or her family – from primary prevention all the way to long-term care. In addition, the new system:

- Supports, strengthens, and integrates primary prevention efforts for all programs across the Department;
- Integrates mental health and physical health with social services throughout the entire department;
- Recognizes the value and importance of population-based public health efforts in making Maine people healthier and in reducing health-care costs; and
- Eliminates the "silo" approach to services by breaking down barriers to a holistic approach to these services.

Introduction[1]

Purpose of this Report

Effective July 1, 2004, the Governor and the Legislature created a new Department of Health and Human Services (DHHS) by combining and reorganizing the Department of Human Services (DHS) and the Department of Behavioral and Developmental Services (BDS). The creation of the new Department provides an unprecedented opportunity to improve the health and well being of all Maine citizens through more coordinated and responsive systems. The intent of the new Department is to deliver services that are both more effective and efficient. DHHS employs 4,000 people, has a budget which represents almost half of state government's budget and serves virtually all Maine citizens through a diverse array of health and human services. Not only are the challenges presented by this degree of organizational change complex, but also the opportunities are unprecedented.

The purpose of this report is to comply with a provision of the Department's enabling legislation[2], requiring the Commissioner to "convene working groups to study five particular issues, and to submit his recommendations to the Governor and to the Joint Standing Committee on Health and Human Services by January 31, 2005 regarding:

A. Bureau structure,
B. Administrative structure and functions,
C. Program and service delivery functions,
D. Advisory boards; and
E. The child welfare ombudsman program."

Accordingly, this report represents Commissioner Nicholas's submission to the Governor and Legislature regarding the "establishment and implementation of the Department of Health and Human Services", pursuant to law.[3]

Following receipt and review of the Commissioner's report, the Joint Standing Committee on Health and Human Services matters may report out legislation to the 122nd Legislature[4].

Unification Council and the Commissioner's Implementation Advisory Team

Almost two years ago, Governor Baldacci took the first step to create the new Department by signing an Executive Order establishing the "Advisory Council for the Reorganization and Unification of the Department of Human Services and the Department of Behavioral and Developmental Services". In January 2004, the Council released its report, containing one hundred recommendations. In summary, the Council found that the merger of the two departments into a single Department of Health and Human Services was "absolutely essential",[5] noting that the two former departments of Human Services and of Behavioral and Developmental Services "serve common clients, use common funding sources (Medicaid and General Fund), use common service agencies, and employ people with similar skills and job descriptions."[6]

The Council report was presented to the 121st Maine Legislature during a second special session, and based upon the Council's recommendations, the Legislature passed and the Governor signed *Public Law 2003 Chapter 689*. This law, which took effect July 01, 2004, established the new Department of Health and Human Services as a cabinet-level department with responsibility for all programs within the former Departments of Human Services and Behavioral and Developmental Services. The law mandated specific attention to:(a) improved client-centered services, (b) increased efficiencies, and (c) improved relations with community organizations.

The law required that by January 31, 2005, the Commissioner of DHHS submit to the Governor and Legislature a transition report, including recommendations and any necessary legislation to create the new Department

In preparation for the report due by January 31, 2005, the Commissioner convened a "Commissioner's Implementation Advisory Team" in June 2004 to advise him on the five items which are the subject of the report, as noted above, and more. The Commissioner's Implementation Advisory Team used the recommendations of the Unification Council as the basis of its work.

The "Commissioner's Implementation Advisory Team" ("CIAT") is comprised of five members of the initial Governor's Advisory Council for the Reorganization and Unification of DHS and BDS, paired with DHHS leadership .

Members of the CIAT (in alphabetical order) are:

- Richard Batt - Franklin Community Health Network
- Meg Baxter - United Way of Greater Portland (Chair);
- Christine Gianopoulos - DHHS
- Kim Johnson - DHHS
- Brenda Harvey - Deputy Commissioner Programs
- Patrick Ende - Senior Policy Advisor for Governor Baldacci
- Andrea Paul - DHHS
- Cheryl Rust - Small business owner;
- Paul Saucier - University of Southern Maine, Muskie School of Public Service;
- Susan Savell - DHHS
- Rebecca Wyke - Commissioner Department of Administrative & Financial Services

This group co-chaired five Working Groups, which, collectively included 83 members, representing consumers, DHHS staff, parents, advocates, providers, business owners and the general public[7]. The five Working Groups were organized according to the desired outcomes for the work of the CIAT; i.e.

- Superior customer Service
- Integrated Service Delivery
- High-Performing Work Force
- Effective Provider Partnerships; and
- Effective Administration

The Work Groups were expertly staffed by members of the Muskie School for Public Service, led by Nadine Edris, the School's Director of the Center for Learning[8]. The Commissioner's charge to the Work Groups is included in the Appendices, as well as the organizational chart for the CIAT.

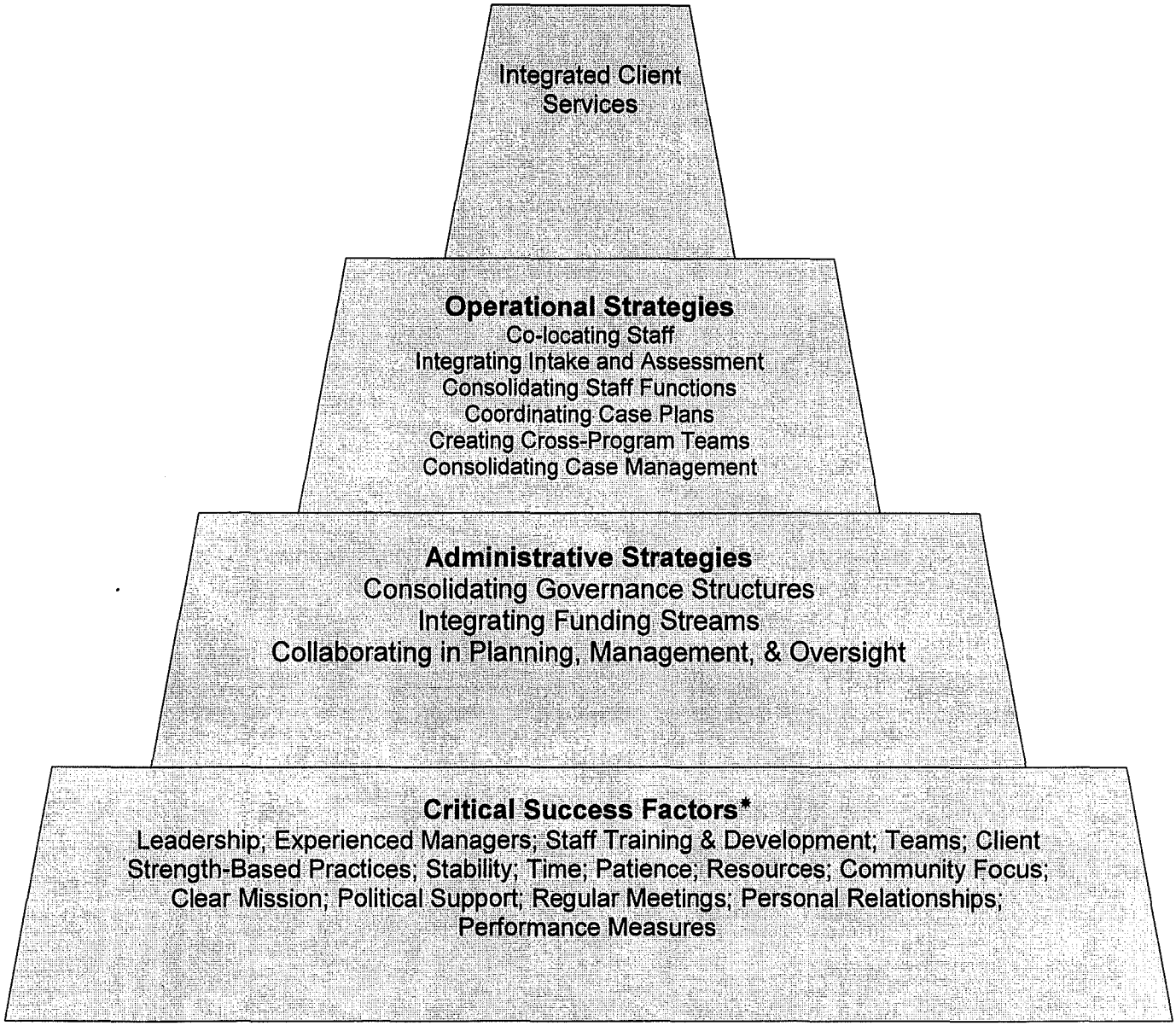
All together, the Working Groups devoted 2,275 hours over the course of six months to generate some 45 recommendations to the Commissioner. The process included vigorous debate, discussion and analysis from multiple perspectives. The effort was informed by literature on best practice, social science research, the experience of other states, and direct experiences and opinions of many stakeholders. Honest and open dialogue characterized the deliberation of recommendations. The report of the CIAT and its Work Groups to the Commissioner is posted at http://www.maine.gov/dhhs/dhhsnews/ciat.htm.

The Commissioner has expressed his deep appreciation for the work of Meg Baxter, Chair of the Advisory Team, the others members of the CIAT, the members of the Work Groups, and the Muskie Staff, particularly citing the hard work and careful thinking they brought to the process. The Commissioner has studied the recommendations carefully and has sought the advice and counsel of the Governor and members of the Executive Management Team, DHHS staff, and others, in crafting his final analysis of recommendations.

Critical Success Factors

As noted in the CIAT's advisory report to the Commissioner, "(c)reating the CIAT as an approach was based in part on the need to integrate the lessons of other states and to incorporate a "best-practice" approach to implementation derived from the literature of organizational change and consolidation in both the private and public sectors. In particular, the CIAT relied on Mark Ragan's extensive research culminating in an analysis of 12 states, which led to several conclusions or lessons about what it takes to increase the odds for a successful merger or organizational change effort. Chief among those were a series of "critical success factors" that he found to be persistent indicators of success when attempting to integrate client services. As seen on the following graphic, these critical success factors were the foundation for the operational and administrative strategies employed by several of the states, and provide the foundation for many of the CIAT recommendations.

["Strategies and Critical Success Factors in Integrated Human Service Systems". From: Building Better Human Service Systems, Mark Ragan, June 2004]



* The value of Ragan's model is the focus it brings to the 'soft' process skills that will make or break the effort to create the new DHHS. While operational and administrative policies, procedures, and structures are the framework for success, process skills such as communication, tolerance, patience, team-building, and cultural sensitivity led by a visionary leader and empowered supervisors are the cement that will build and sustain the new department. This is why these success factors are considered to be ***critical***.

In many ways, Ragan's critical success factors are a function of an organization's internal climate- a measure of employee morale, attitude, and satisfaction with one's situation (James and Sells 1981).A three-year study published in1998 found that organizational climate rather than inter-organizational coordination (including low conflict, cooperation, role clarity, and personalization) was the primary predictor of positive service outcomes (in this case, children's improved psycho-social functioning)

and a significant predictor of service quality (responsiveness, comprehensiveness, and continuity), (Behar 1985; Glisson and Hemmelgarn 1998).

Over the past five years, federal, state, and local governments have been developing approaches to link organizational goals to intended results oftentimes in customer-centric terms and occasionally beyond the boundaries of individual agencies. Abramson, Breul, & Kamensky Four Trends Transforming Government, IBM Center for The Business of Government 2003

Critical success factors are in part a function of the degree to which organizational climate is managed and acknowledged during the introduction and adoption of processes different than those used by supervisors and staff in the past. Several of the recommendations generated by the Work Groups indicate an acknowledgement of the importance of the provider of services in the context of his or her organization. Hence, recommendations having to do with training and professional development are aimed at enhancing not just skills, but in reinforcing the "helping" and quality work service ethic.

Merger and change have potentially devastating effects on the morale and productivity of an organization's staff. In part, this is due to the (a) disruption of work routine and social networks, (b) threat of losing one's competence in a new work structure, and (c) perhaps most importantly, the clash of cultures that results from combining two ostensibly different agencies with differing organizational climates, comprised of staff who differ by educational preparation, salary, discipline, and philosophy (Heifetz and Lipsky 2004; Smith 1996)."

Leadership Framework for the new Department

In keeping with an empowered and collaborative approach, and consistent with the critical success factors identified by Ragan, the executive leadership at DHHS have adopted a leadership model to guide DHHS's decision making process and to support a common sustainable culture for the new Department of Health and Human Services. The model is predicated on leadership principles and commitments detailed in the "Leadership Challenge" (by Kouzes and Posner), as follows:

1. **Model the Way**
    - 1.1. Find your voice by clarifying your personal values.
    - 1.2. Set the example by aligning actions with shared values.
2. **Inspire a Shared Vision**
    - 2.1. Envision the future by imagining exciting and ennobling possibilities.
    - 2.2. Enlist others in a common vision by appealing to shared aspirations.
3. **Challenge the Process**
    - 3.1. Search for opportunities by seeking innovative ways to change, grow, and improve.
    - 3.2. Experiment and take risks by constantly generating small wins and learning from mistakes.
4. **Enable Others to Act**
    - 4.1. Foster Collaboration by promoting cooperative goals and building trust.
    - 4.2. Strengthen others by sharing power and discretion.
5. **Encourage the Heart**
    - 5.1. Recognize contributions by showing appreciation for individual excellence.
    - 5.2. Celebrate the values and victories by creating a spirit of community.

Vision and Mission

Another critical success factor identified by Ragan and other researchers, both in the public and private sectors, is the importance of establishing a common vision,values and mission in the success of implementing large organizational change initiatives (Ragan 2004; Smith 1996; Fullan 2003; Heifetz and Lipsky 2004).

As one of his first actions, the Commissioner set the following **vision** to guide the development of DHHS:

> "To create a quality, best-in-class, consumer-driven agency that supports, assists, enables, and empowers people to achieve responsible and full lives of maximum independence and self-determination by strengthening individuals and families, building healthy communities, and supporting healthy lifestyles"

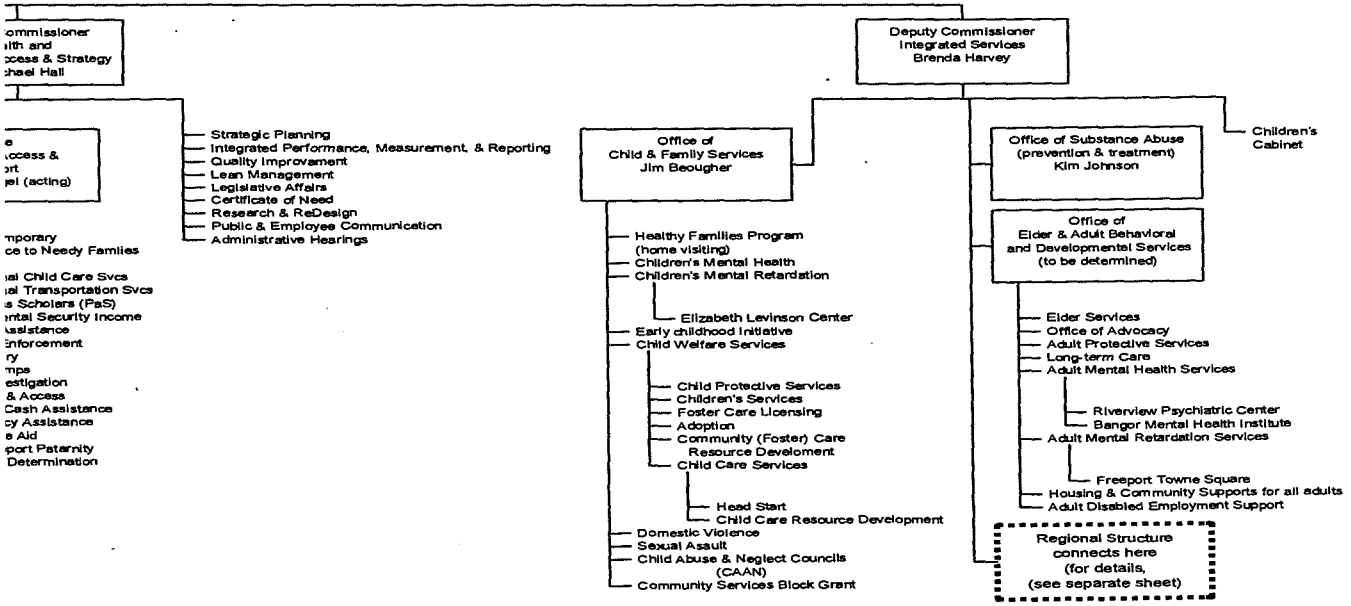
The department's current operating **Mission** comes from the department's enabling legislation; i.e.[9]

> "The mission of the department is to provide health and human services to the people of Maine so that all persons may achieve and maintain their optimal level of health and their full potential for economic independence and personal development. Within available funds, the department shall provide supportive, preventive, protective, public health and intervention services to children, families and adults, including the elderly and adults with disabilities. The department shall endeavor to assist individuals in meeting their needs and families in providing for the developmental, health and safety needs of their children, while respecting the rights and preferences of the individual or family."

Organizational Structure Recommended

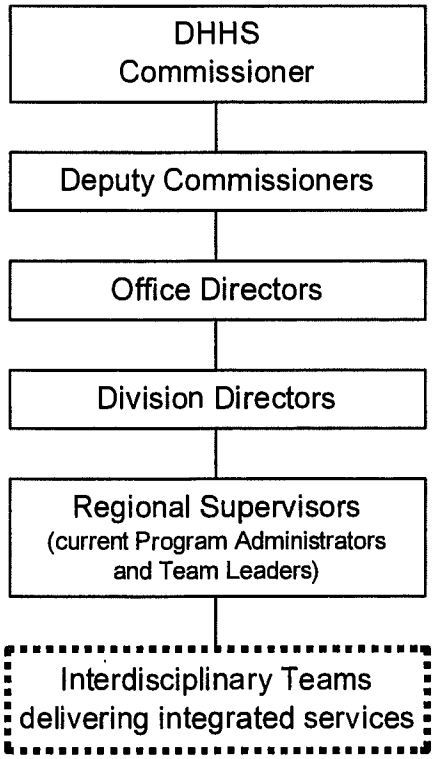
The Commissioner recommends the following core organizational structure and regional structure for the Department of Health and Human Services, as depicted in the following two pages.

This chart shows integration of functions and responsibilities only. It does **not show staffing configuration**. Details of staffing configuration to achieve this functional integration will be determined by forming Work Groups, including DHHS staff, ***after*** the Legislature approves the functional organization of DHHS this session.



Several Regional Structures Considered

1. **Structure Recommended by the CIAT-** The structure for Regional Operations recommended by the CIAT's Effective Administration Work Group may be broadly depicted as follows:

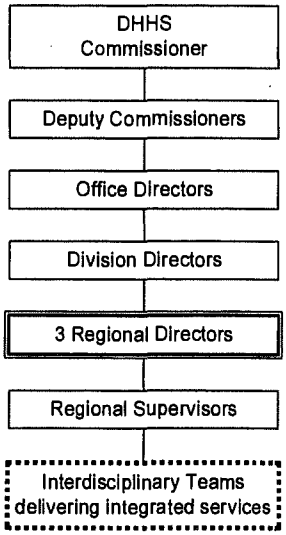


The Effective Administration Work Group recommended this structure for the following reasons:

a. "the new Department's structure should contain as few organizational units as needed to organize its primary functions effectively;
b. creates an administrative structure in the regions that provide leadership , and supports and enhances an integrated service delivery system at the local level
c. Re-engaging Communities - The Department's structure must support integration, but the reality is that all service delivery is local. Integrating a wider range of service providers in local systems can streamline access and enhance outcomes for the Department's customers. Improved relationships with community service providers can energize the Department's efforts. Creating true partnerships means including them in planning and policy development with formal mechanisms for input and communication. In turn, the Department must expect quality service and accountability from providers, and reward exemplary practice.

2. **Second Structure considered** – the Commissioner also considered the implications of adopting the same type of regional structure now employed by the former-Department of Behavioral and Developmental Services. That structure places a second level of administration in each region represented by a Regional Director in each of the three regions. These Regional Directors would have line-authority, with staff reporting to each.

In broad terms, this second regional structure could be depicted as follows:

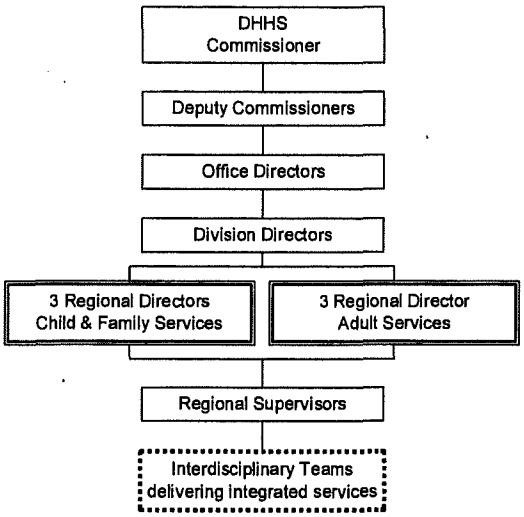


This second structure was not recommended by the Commissioner for the following reasons:

a. With the confluence of services from both legacy departments, Regional Directors in that system would have an unmanageable scope of responsibility and accountability.
b. This structure has an inherent disadvantage of disconnecting *policy and practice*, which would reside with the Office Directors, from *service delivery*, which would reside with the Regional Directors, Regional Supervisors, and front-line staff.

3. **Third Structure considered** – In order to capture the benefits of retaining Regional Directors, while making the position manageable, consideration was given to doubling the number of Regional Directors to six, and deploying two in each region, dividing responsibilities between child & family services, and adult services. These two Regional Directors in each of the three regions were contemplated to have had direct line authority for staff in their area.

In broad terms, this third regional structure could be depicted as follows:



This structure has the added disadvantage of doubling a layer of administration between service providers and Division Directors. The doubling would also require establishing three new positions.

In the final analysis, then, the Commissioner chose to **endorse the regional structure originally suggested by the Commissioner's Implementation Advisory Team.** At this time, the Commissioner considers the Regional Structure proposed to be ***transitional.*** The Commissioner intends to review the effectiveness of this structure periodically and make any adjustments needed consistent with the vision, mission, and guiding principles.

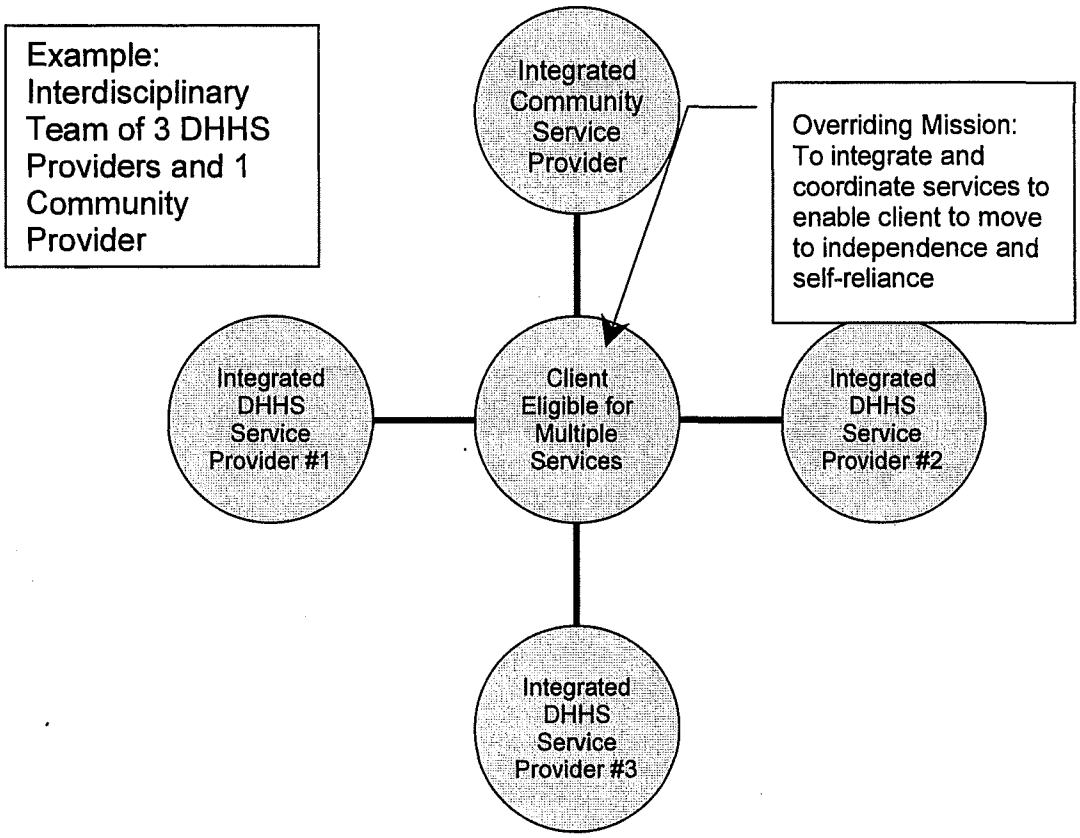
Also, the Commissioner notes his intent to ensure that a formal mechanism and process is established across the organization to guarantee and require that communication, collaboration, and cooperation occurs. He intends to inculcate a philosophy, culture, and practice of communication, collaboration, and cooperation that is sanctioned, understood, encouraged, and required by DHHS leadership at all levels of the organization.

How the Regional Structure Works

1. **Service Navigators:** The Service Navigators in the regions do not exist currently and will be created using existing Eligibility Specialist positions and with existing funds *(i.e. not additional positions, and not new funding)*
   A. Service Navigators will be trained to connect people who are eligible for multiple services with the needed service providers within the Department.
   B. For people eligible for multiple services, the Service Navigators will "hand-off" these clients to the correct service providers
   C. The Service Navigators will also be responsible for "following" the client into and through the system, to ensure that the correct services are provided.
   D. Service Navigators will not actually provide the service, but the navigators will be accountable for their clients' experience in the system
2. **System Integration Managers** – three current positions, now called "Regional Directors" will be re-named and re-constituted as "System Integration Managers"
   A. These will be pivotal and challenging positions in the regions

B. These System Integration Managers will serve as the link between the regional operations and the core operations of the organization.
C. They will serve as natural liaisons with DHHS provider linkages in the communities

3. **Integrated Systems Team Leaders -** The Integrated Systems Team Leaders in the regions do not now exist . The Integrated Systems Team Leaders will be created using existing Caseworker positions with existing funds *(not additional positions, and not new funding)*
   A. The ISTLs will have, as their sole job, the task of convening, from current staff throughout the organization, a team of people to provide the needs for which the client is eligible.
   B. The ISTLs will have the authority to call together service providers to be members of the Interdisciplinary Team from any place in the organization
   C. The ISTLs have no permanent staff reporting to them; the members of the Interdisciplinary Teams will continue to report to their usual supervisor.
4. The **Interdisciplinary Teams** themselves- serve as "Designer Teams" for the client – whose sole mission is to meet the specific needs of that particular client by providing all the services for which that client is eligible in an integrated fashion. These Teams will focus on cross-system needs for consumers and families in an integrated case management model that will include prevention and treatment, as well as renewed emphasis on substance abuse intervention in order to overcome barriers to success.
   A. Each member of the team is responsible for providing his or her service, AND for delivering that service in concert with the larger mission of empowering the client to live independently with self-determination.
   B. These teams ebb and flow depending upon the needs of the client.
   C. Each team dissolves when the need for the team dissolves
   D. Members of the Interdisciplinary Teams will continue to report to their usual supervisor – the Integrated Systems Team Leader does not have line-authority over the members of the Interdisciplinary Teams.



Comparison between
Commissioner's Recommended Organization
and
the Organization Recommended by the CIAT

Features that are the same:

1. **Flat Structure** - the new Department's structure contains as few organizational units as needed to organize its primary functions effectively;
2. **Integrated Services-** creates an administrative structure that provides leadership, and supports and enhances an integrated service delivery system, both within the core department, in the regions, and with community providers at the local level. As recommended by the CIAT, Integrated Services Operations are based on an integrated case service system model in order to build services around the individual or family to the benefit of the recipient rather than to the convenience or benefit of the service provider. Also, Integrated Services Operations, as consistent with the CIAT recommendation, will function with:
    a. a team approach;
    b. consolidated and collaborative approach,
    c. links with agencies outside the department, both public and private,
    d. a focus on the functionality of the whole system; and
    e. and move from gate-keeping to networking.

Integration is also achieved via the Deputy Commissioner for Integrated Services, who oversees a regional and district structure that includes an Integrated System Team Leader. As noted below, the Integrated System Team Leader coordinates the functional care management and treatment functions of an interdisciplinary team, which could include the myriad services of child protective, substance abuse, adult MH, adult MR child MH, child MR, Aspire/TANF, public health, etc.)

Integrated communication, collaboration, and cooperation will also occur throughout the department and supersede formal reporting relationships by means of coordinating teams, cross-functional task forces, informal organizational networking, and a culture which encourages and insists on teamwork and interdepartmental cooperation.

3. **Provider Partnerships** – Effectively integrates a wide range of local service providers into DHHS's system of service delivery in order to streamline access and enhance outcomes for the Department's customers.
4. **Regional Structure** – the Commissioner is recommending the structure of regional organization and service delivery as recommended by the CIAT.

   The new regional structure is not merely a passive combining of the two existing regional structures from the legacy departments. Instead, it is a fresh approach, whereby staff from both legacy departments are integrated and re-aligned according to the type of service they now provide.
5. **Scope** - Manageable and appropriate scope of authority
6. **Planning and Strategy** - Focused emphasis on planning and strategy
7. **"No Wrong Door"** – Allows, facilitates, and even requires, the implementation of easy access to services
8. **Emphasis on OD** - Human Resource and organizational development position in the Commissioner's Office is consistent with CIAT recommendation to support a high-performing work force.
9. **Research & Redesign** – as recommended by the CIAT, a "Research and Redesign" function is included in the responsibilities of the Deputy Commissioner of Health, Integrated Access, and Strategy.
10. **Quality Improvement** – Quality Improvement is also specifically cited within the purview of the Deputy Commissioner of Health, Integrated Access, and Strategy
11. **Public Information** – an Office of Public and Employee Communication is situated with the Health, Integrated Access, and Strategic Operations.
12. **Unit Titles** – Commissioner's recommended organization employs the same titles as recommended by the CIAT's Effective Administration Work Group (i.e. "Office" and "Division")

Features that are different

1. **Operations and Support organization** – The CIAT had recommended placing rate-setting functions, contract processing, purchased services, and child support enforcement payment processing within the jurisdiction of the Office of Finance.

   In order to ensure a manageable scope of control and authority, the Commissioner recommends that these functions be placed under the jurisdiction of a Deputy

Commissioner of Operations and Support. This allocation of responsibility will also ensure needed focus on finance, accounting, budget issues, and cash management

2. **Office of Substance Abuse** – The CIAT recommended that the prevention, intervention, and treatment services of the current-Office of Substance Abuse be completely integrated throughout the new DHHS organization. Accordingly, the CIAT recommended dissolving the current-office and embedding its functions strategically throughout the department.

   The Commissioner's recommended structure recognizes the value of integrating substance abuse prevention and treatment services with all other services provided by DHHS, as the CIAT recommended. However, the Commissioner also recognizes public, legislative and staff sentiment for the expert capacity the current "intact" office has developed over the years. Accordingly, the Commissioner's organizational chart takes a hybrid approach of retaining an intact Office of Substance Abuse, but placed within Integrated Services Operations. In this way, the best of past work is retained, while, at the same time, ensuring integration of these services with all other services offered by the department. Also, the current Office of Substance Abuse has no staff in the regions; placing the Office of Substance Abuse within Integrated Services Operations will enable OSA to have ready access to regional staff.

3. **State Health Officer** – the CIAT had recommended that an "Office of Health" be created and report directly to the DHHS Commissioner.

   The Commissioner appreciates and agrees with the CIAT's focus on prevention and population-based public health services. His recommended structure enhances the CIAT's recommendations by:

   a. Employing a structure that is parallel to that used by the national Center for Disease Control. This parallel structure will assist the state in attracting additional federal monies for health services and will facilitate integration and coordination with federal health programs.

   b. The new name, too, also reflects its relationship with the National Center for Disease Control, as well as connotes that the Center has the authority to report directly to the Governor in the case of a state-wide health emergency, which is a distinction from other Offices within the department.

   c. Some may be disappointed that the State Health Officer is not slated to report directly to the Commissioner. However, the Commissioner's structure is in keeping with the guiding principle of integration and with maintaining a manageable scope of authority. The State Health Officer remains an appointed position by the Commissioner, (as do all Deputies and Division Directors), so that relationship and connection endures.

Consistent with the Guiding Principles and Major Themes:

The Commissioner's recommended organization is consistent with and enhances the DHHS Guiding Principles and the Major Themes with which the Commissioner had charged the CIAT originally; i.e.

Guiding Principles:

1. Deliver services that are:[10]
    A. integrated,
    B. individualized,
    C. family-centered,
    D. easily accessible,
    E. preventive,
    F. independence-oriented,
    G. interdisciplinary,
    H. collaborative,
    I. evidence-based and
    J. consistent with best practices.
2. Improve the health and well-being of Maine residents, 11
3. Treat consumers with respect and dignity;12
4. Treat service providers with professionalism and collegiality;13
5. Value and support department staff as the critical connection to the consumer;14
6. Involve consumers, providers, advocates and staff in long-term planning;15
7. Use relevant, meaningful data and objective analyses of population-based needs in program planning, decision making and quality assurance;16
8. Continually maximize capability and customer value while minimizing cost and waste;17
9. Balance centralized accountability with regional flexibility for effective problem-solving; [18]
10. Align systems, actions, and values to continually progress toward our common vision.19

Major Themes

These major themes those with which the Commissioner charged the CIAT with at one of its first meetings. These themes constitute the foundational underpinnings of the CIAT's work, as well as the recommendations of the Commissioner.

Focus on client-centered opportunities

- Refine and reorganize programs and human enterprise that are comprehensive and serve the best interests of consumers and customers.
- Ensure the resulting system is easily accessible.
- Build a system that supports self sufficiency, family stability, child safety and community well-being

Build a common organizational culture

- Engage all staff in the crafting of a departmental vision, mission, guiding principles and core values.
- Integrate service delivery.
- Break down silos
- Emphasize teamwork and collaboration

Build a best practices organization that achieves high performance

- Communicate up, down and sideways.
- Allow employees to participate in goal setting and achievement of measurable performance outcomes.
- Use formal teams frequently to problem solve and achieve results in operations
- Empower employees, through teams, to make improvements in work processes within the scope of their jobs and responsibilities.
- Focus on and reward customer service.
- Recognize staff achievements and opportunities for growth.

Implement lean management

- Seek the most efficient form of work processes
- Eliminate waste, or those processes that do not add value to the organization.
- Design and implement improved processes that meet client needs that are value added
- Maximize service delivery and always measure results currently and over time.
- Make the most effective use of tax payer dollars.

Other Recommendations

The Commissioner chose to endorse and include in his report virtually all of the recommendations suggested by the CIAT. The exceptions are the three recommendations noted earlier on page 21. The recommendations themselves appear below. However, much more information and background on these recommendations are available in the CIAT's report to the Commissioner, and may be accessed at
http://www.maine.gov/dhhs/dhhsnews/ciat.htm

Effective Administration - structure and functions

The Commissioner endorses eight of the nine recommendations made by the Effective Administration Work Group of the CIAT, which appear below. The Commissioner has recommended some differences from the core organizational chart, as well as the organization of public health services, which are articulated elsewhere in this report.

Recommendation – High-Performing Executive Team

Consistent with statute requirements and the mission of providing "supportive, preventive, protective, public health and intervention services", develop a high performing executive team, reporting to the Commissioner.

Recommendation – Integrated Service Delivery

"The single most important factor that affects the outcome of integrating services is leadership." Create an administrative structure and provide leadership that supports and enhances an integrated service delivery system at the local consumer level. Administrative and operational strategies to include consolidating program administration and functions; developing a common intake, assessment, and case navigation process; integrating staff with varied expertise into teams; and blending funding streams.

Recommendation – HR Leadership

Acknowledging that staff (the human resources) of DHHS represent the "core" strength of the organization, and believing that an intentional and significant investment in staff is critical to the success of organizational transformation, combine Organizational Development and Human

Resource systems in order to create an internal HR capacity that links productivity, service, quality, and pride. Develop HR leadership as a strategic role in support of achieving overall Department goals and assuring effective flow of internal communication throughout.

Recommendation – Research and Redesign

Becoming and remaining a "world class organization" means staying abreast of best practices. Functioning as a learning organization, dynamic and flexible and able to respond to a changing environment, means constantly examining best practices against the status quo and being responsive to an ever-changing environment. Create a capacity for "Research and Redesign" consistent with these beliefs and closely linked with quality improvement strategies and outcomes.

Recommendation – Quality Improvement

Adopt a quality improvement system that is outcome-based, one that requires establishing priorities, documenting accomplishments, and measuring performance at all levels of the organization as well as with external service providers. Standardize for cost efficiencies, fairness, equity, and capacity building and make decisions based on the use of relevant, meaningful data; support an objective analysis of needs and successful outcomes. Institute a process of continuous improvement based upon the principles of "Lean Management". At the center, routinely solicit feedback about services from staff, those receiving services, and others supporting or impacted by the service delivery system.

Recommendation – Public Information

Change of this magnitude commands a commitment to informing the public about DHHS strategic planning efforts and performance results. In order to enhance understanding about Department initiatives and related progress build confidence in and awareness about DHHS services through the use of honest and timely communication. Create an Office of Public Information under the direction of the Deputy Commissioner with a direct working relationship with the Governor's office and a primary focus on external communication, in charge of public relations and media management.

Recommendation – Contract Management

Recognizing contract management plays an essential role in supporting DHHS structural consolidations, reassign this administrative function in a manner that enables optimal service delivery and supports quality improvement initiatives. Retain the "contract processing payments" function under the direction of the Associate Commissioner of Finance, establish "contract standards" under the direction of the Deputy Commissioner of Strategic Planning and Performance, and locate "contract management" within Integrated Services and Operations or within the Health area as appropriate.

Recommendation – Continuing Role of the CIAT

Advisory Boards to DHHS are recognized as "highly visible Boards that play a key role in advising the Commissioner on long term systems planning and provide guidance on how to improve public/private partnerships." In this regard, the Effective Administration Workgroup recommends the following: 1.) Continue the existing Commissioner's Implementation Advisory Team (CIAT) with a focus on measuring DHHS progress relative to the stated outcomes of *integrating services*, achieving true *provider partnerships*, providing *superior services*, creating and retaining a *high performing staff*, and operating under an *effective administration*. Include regional representation. 2.) Create a high profile best practices advisory board comprised of national experts to review DHHS services and administrative initiatives and outcomes, provide

feedback and advice to the Commissioner and his direct reports. 3.) Work proactively with the Governor's office and legislative committee oversight.

High-Performing Work Force

(For complete text of these recommendations, please see CIAT report posted at http://www.maine.gov/dhhs/dhhsnews/ciat.htm)

Recommendation – Vision and Mission

Within the next three months, articulate and communicate a short, inspiring vision and mission to all staff. The vision and mission need to connect the concept of an engaged, valued and proud workforce with high performance. In addition, communicate one unified set of values (4 or 5) for all of DHHS, built on the foundational value work currently occurring and supplemented by Senior Management. Over the next year the vision, mission and values needs to be operationalized into all aspects (training, performance management, communication, recruitment, hiring and retention) to unify and integrate the new DHHS culture

Recommendation – Strategic Human Resource Management

Elevate strategic Human Resource Management to the highest level and have one person responsible for developing and implementing a three year Human Resource Strategic Plan. This person would be part of the Executive Senior Management team

Recommendation – Staff Retention and Attraction

Implement comprehensive strategies to retain and attract highly competent and engaged staff in public employment

Recommendation – Leadership Training

Demonstrate a commitment to core mandatory leadership training and integrated, accessible professional training and continuing education for all staff. Provide training in change management and cross systems knowledge and skills to facilitate the transition to the new department

Recommendation – Performance Management

DHHS embraces a strength-based performance management and cultural accountability system to support the development of high performing staff and the provision of quality services

Recommendation – Communication

The establishment of a transparent and open communication plan that helps with the transmission of relevant and timely information throughout DHHS. The development of a consistent and comprehensive technology system that has the ability to "talk" internally with all of DHHS and externally with provider partnerships to support staff in doing work that is important and valued by customers

Superior Customer Service

(For complete text of these recommendations, please see CIAT report posted at http://www.maine.gov/dhhs/dhhsnews/ciat.htm)

Recommendation – Customer Service

DHHS will adopt a customer service philosophy. All existing and new staff (all employees of the Department) are trained in customer service skills and are held accountable to customer service standards through the performance evaluation process. Customer service standards are

published so that customers understand what they can expect in their interactions with the Department.

Recommendation – Easily Accessible

The Department is easily accessible and inviting to customers. This applies to the physical space, hours of operation, the Department's website, and phone system. The Department is culturally competent and inviting to the diverse range of groups it serves. Application for Department services is made available in multiple modes including by phone and through the internet.

Recommendation -"No Wrong Door"

Regardless of which program or part of Department consumers access, they experience the Department as one unified department. Regardless of where a person enters the Department, intake processes are conducted or a specific appointment is made for the person to move to the next stage of the process. The staff who makes first contact with a customer needing assistance owns the responsibility of making an appropriate referral and stays with the customer until the correct contact is found.

Recommendation – Customer Feedback

The Department leads an ongoing collaborative effort to collect and act on feedback from internal and external customers to support enhanced performance.

Recommendation – Advocacy Organizational, Ombudsman Programs, Grievance Appeals

Advocacy organizations, ombudsman programs, and the grievance/appeals process are critical sources of feedback. The Department needs a systematic way of gathering and acting on this feedback.

Recommendation – Legal Advocacy

Legal advocacy (including the advocacy of the Long-term Care Ombudsman) is free from conflict-of-interest. In order to provide legal advocacy (e.g. investigating violations of rights), individuals and agencies must be free to take positions in opposition to those of the Department. If stakeholders do not have absolute confidence in the fairness of advocacy systems, their effectiveness is compromised

Recommendation – Appeal Process

Customers have confidence that the Department's appeal process results in fair and impartial decisions.

Integrated Services

(For complete text of these recommendations, please see CIAT report posted at http://www.maine.gov/dhhs/dhhsnews/ciat.htm)

Recommendation - Minimize Need for Department Services.

1. Integrate services across all levels of services, and across all life domains, for all categories of customers.
2. Adopt and operationalize a core set of principles to support the integration of strengths-based services across life domains

Recommendation - Ensure Infrastructure Maximizes Effective Delivery of Services.

3. Expand existing regional public health infrastructure to achieve state health plan and other public health goals
4. Enhance existing service delivery system to offer low barrier access to services for individuals and families.

   (Note: In this recommendation, the Commissioner makes a special note of the Integrated Services Work Group's conception of *Community Prevention and Resource Centers, or PARCS,* as an important part of the community infrastructure the Work Group envisions. Although the Commissioner does not, at this time, specifically endorse the implementation of PARCS pending further study and discussion, the Commissioner commends the Work Group for an innovative and far-reaching idea, intended to maximize the effective delivery of services and enhance access to services.]

5. Integrate public health with service delivery infrastructure at regional and community level through system of community based coalitions.

Recommendation - Ensure Service System Absorbs Complexity.

6. Develop integrated intake and assessment process that efficiently and effectively streamlines appropriate linkage to services
7. Streamline the financial eligibility process with distributed access to eligibility determination tools
8. Streamline navigation of the service system with a highly trained systems navigator, comprehensive planning process, and integrated delivery of services.
9. Develop consistent process and uniform requirements for the Department and its partners to share information in compliance with federal and state law.

Recommendation - Allow Customized Delivery of Services.

10. Expand consumer control over service through individualized budgeting and consumer directed services.
11. Braid and blend funds as necessary and where permitted to achieve desired outcomes for individuals and families.

Recommendation - Align Systems and Service Delivery with Desired Outcomes.

12. Align incentives with desired outcomes
13. Align quality management and performance measurement with desired outcomes.
14. Allocate resources equitably based on functional need to achieve desired outcomes, where clinical need irrelevant
15. Allocate responsibility for integrating services to minimize duplication and maximize effectiveness
16. At the systems level and for service delivery, establish the necessary collaborative relationships to promote all aspects of well-being.
17. Ensure that the Department has the functional capacity necessary to achieve desired outcomes

Provider Partnerships

(For complete text of these recommendations, please see CIAT report posted at http://www.maine.gov/dhhs/dhhsnews/ciat.htm)

Recommendation – Advisory Council

DHHS to establish the Provider Partnerships Advisory Council to formalize a collaborative approach to increasing provider input and improving communication and business processes between DHHS and providers.[20]

Recommendation - Feedback

DHHS to establish a policy, which requires the development of a provider input system for ongoing and ad hoc feedback between consumers, providers and key DHHS staff to provide input into rulemaking, policy and program changes.

Recommendation - Communications

DHHS to develop a protocol that responds quickly, clearly and consistently to provider requests for information. DHHS to provide DHHS internal staff and providers with written policy clarifications which are clear and can be counted on to be a definitive answer.

Recommendation – Business Processes

DHHS to establish realistic time frames and coordinated, consistent, timely business processes between DHHS and providers.

Recommendation – Articulate goals

DHHS to define and articulate shared goals and intended outcomes for the program, consumers and larger community being served. DHHS to measure performance in achieving these goals.

Recommendation – Incentive Plan

DHHS to develop an incentive plan for providers who achieve or exceed clearly identified, expected outcomes

Advisory boards and the child welfare ombudsman program

Advisory Boards

The department's enabling legislation had contemplated some degree of integration and consolidation of existing advisory boards, councils and commissions that now serve the legacy departments. As a first step in achieving this goal, the Department, and Muskie Staff, worked together to create a comprehensive inventory of existing Councils, Boards and Commissions serving both departments and to determine statutory mandates of these Boards (pursuant to Unification Council recommendation B3). That inventory is included as an Appendix of this report. As the next step, the Commissioner will create a special panel to review and consider integration opportunities and present its recommendation to the Commissioner.

Child Welfare Ombudsman Program

The Commissioner strongly supports the continuation of the Child Welfare Ombudsman Program, particularly given the rapid pace of realignment of the system.

The CIAT's Superior Services Work Group did not offer any specific recommendation in this regard. The Work Group did research other states' approaches on child welfare ombudsman and found that states have radically different approaches to ombuds, including:

- one general ombuds program for all of state government.

- one ombuds for all programs of a single department, or
- a program-specific ombuds (like child welfare)

Given the size of the department, the Chair of this Work Group surmised that there may be some logic to having an ombuds for the entire department, as a "general trouble shooter" who would help customers in their interactions with the Department. Also, the Chair notes that one of the common features of ombuds programs that make them distinct from advocacy is that ombuds programs are generally not independent - they are designed as internal mechanisms to help customers rather than overseers of services.

In summary, the Commissioner appreciates the research done by the Work Group and intends to explore all options available to continue a strong and vibrant ombudsman program.

The Commissioner considers worthy of further research the Chairs' observation that DHHS should have an ombudsman program for the entire department to help all DHHS customers with issues regarding program and service delivery. Such an approach would require a review of the current constituent services function, evaluation of capability of resolve diverse issues and location (inside of outside of DHHS). In the meantime, the Commissioner recommends continuation of the Child Welfare Ombudsman Programs as a grant, rather than as a competitive contract, through the Office of the Commissioner.

Other Statutory Considerations

Chapter 689 also required the Commissioner to consider the following issues::

The unique needs of special populations:

The Commissioner notes that his recommended organization will meet the needs of special populations, and all DHHS clients, in a more comprehensive way than is now possible by enabling the integration of all services for which a client is eligible. No longer will a person who wishes services from DHHS have to become an expert in either the bureaucracy or the law and rules on eligibility. The new structure is designed so that DHHS "Service Navigators", System Integration Managers, Integrated Systems Team Leaders, and Interdisciplinary teams will determine, on behalf of the client, services for which the client is eligible and, upon approval of the client, will take responsibility for delivery of the full panoply of services to that client, in an integrated fashion.

Integration of former-Bureau of Family Independence with Children and Families unit[21]*,*

In regard to integrating the Bureau of Family Independence into a new bureau of children and families, the Commissioner notes that none of the stakeholders who provided information to the CIAT and to the Commissioner supported this idea. In addition, the TANF Advisory Council, and others, advised that placing TANF within the child and family services unit would serve to discourage clients from accessing TANF, which would be an undesirable outcome.

Employment status of Division Directors.[22]

In regard to Division Directors, DHHS currently has a total of 18 unclassified (appointed) employees. Also, the number of "Division Directors" is 33 filled, 4 vacant, and one undesignated line and incumbent. All but three Division Directors are currently classified employees within the Maine Management Services - but are not appointed.

The Commissioner will review the final organizational structure approved by the Legislature. At that point, it will be clear which positions report directly to the Commissioner and should be appointed. It will also be clear which lines will be major policy influencing and should also be unclassified.

Pay Equity

Several pay equity issues have arisen in connection with the unification of the former-DHS and BDS. It is expected that other pay equity issues may arise as job duties in merged work units become clearer, especially after the new bureau structure is implemented. Within this fiscal year, the Commissioner will form a Task Force on Pay Equity, including representatives from DAFS's Bureau of Human Resources and Bureau of Employee Relations, and union representation, to continue to review job classifications, determine classification appropriateness, and recommend reclassifications as appropriate.

The review of classifications of employees performing case management responsibilities within the merged Department affects the largest number of employees within DHHS. There are currently 453 Human Services Caseworkers who have appealed their current pay grade assignment. They believe that the annual pay differential of $ 1,930.00 when compared to MH&MR Caseworkers is not appropriate. (There are currently 161 MH&MR Caseworkers employed within the Division of Mental Retardation Services.) The issue has been submitted to binding arbitration and a decision is expected by the end of January. As part of the arbitration process, Department staff provided testimony clarifying Human Services Caseworker job responsibilities.

The merger of employees from throughout the former BDS and the former-DHS Community Service Center into the consolidated Purchased Services Division affects approximately 20 employees. Analysis of employee job duties with the Division Director is ongoing. A recommendation concerning job classification and pay range, and submission of documentation to the Department of Administration and Financial Services' Bureau of Human Resources will occur by mid-February.

The HR unit and the Division of Technology Services are in the process of reviewing operational requirements relating to IT staff availability after 5:00 p.m. and on weekends. The Information Technology staff at BDS were not required to be available beyond normal business hours. Former DHS staff are paid to be "on call" after hours. The merger of these work groups requires that we review our practices and expectations of employees and incorporate all staff into a rotational system of IT coverage that is fair and equitable to the entire unit.

An apparent equity issue has also been identified with the consolidation of senior administrative support staff from the two legacy departments in the Commissioner's office. Analysis is currently being conducted.

Adult Protective Functions

Chapter 689 also authorizes the DHHS Commissioner to consolidate Adult Protective Functions.

APS Background:

The Department of Health and Human Services, through the Bureau of Elder and Adult Services (BEAS) and through Adult MR Services, administers Adult Protective Services program and is responsible for receiving and investigating reports of abuse, neglect and exploitation of incapacitated and dependent adults. Protective Services are intended to reduce or eliminate danger, preserve the adult's rights and resources and to maintain the adult's physical and mental well-being. These services may include seeking public guardianship or conservatorship. BEAS and Adult MR Services received a combined total of 3,563 adult protective referrals in SFY04.

The Department, both BEAS and Adult MR Services, acts as public guardian and/or conservator for over 1400 individuals in the State. Public guardianship appointments are made to provide

continuing care and supervision of incapacitated adults, and public conservatorship appointments are made to protect, preserve, manage and apply estates of incapacitated adults. A public guardian or conservator is only appointed when there is no suitable private individual available. Upon appointment, DHHS maximizes self-reliance and independence of the adult, as appropriate to the adult's needs.

Case management services are provided to adults under public guardianship and/or conservatorship. These services are designed to ensure comprehensive planning, provision and coordination of services to enhance quality of life and promote self-care whenever possible.

For adults under public conservatorship, the Department is responsible for completing Inventories and Accountings required by the Probate Court. Their assets may include retirement pensions, Certificates of Deposit, U.S. savings bonds, stocks and bonds, real estate, tangible personal property, life insurance, mortuary trusts and special need trusts. Estate management activities include property management, sale of real estate /motor vehicles and other property, and filing tax returns. The Public Guardian and /or Conservator manages approximately six million dollars in assets.

Many adults with mental retardation benefit from assistance with managing their monthly income, and through Adult MR Services a representative payee program is offered for approximately 2000 individuals. A representative payee is responsible for paying the person's daily expenses, saving any money that is left after paying expenses, maintaining written records of all payments, notifying Social Security of any changes, and completing written reports. The public guardian may also act as representative payee when the adult no longer is able to manage their own finances.

The committee of BEAS and Adult MR Services staff began reviewing the foundational data for each program including procedures, organizational structure, staffing, resources, estate management, provider agency's role and data systems. BEAS and Adult MR Services are engaged in ongoing discussions around a substantiation registry, staff training, court practices, estate management and utilization of resources.

Staffing resources are key to the consolidation of the two programs. BEAS staff include: Centralized Intake Unit, 7 Case Aides, 53 Regional Caseworkers, 8 Regional Supervisors, 3 Protective Program Administrators, 1 Program Specialist; 1 Financial Services Specialist; 1 Director of Regional Operations. Adult Mental Retardation Services staff include: 3.5 APS caseworkers, 1 APS manager, 1 paralegal, 1 Public Guardianship manager,135 regional Individual Support Coordinators and 11 Case management Supervisors. Individual Support Coordinators primary role is case management of mental retardation services and guardianship responsibilities are part of case management. As the consolidation moves forward Individual Support Coordinators and supervisors need to be identified for guardianship responsibilities.

APS Plan to Proceed with Consolidation

Each legacy department operates separate and distinct programs for investigating abuse, neglect and exploitation of dependent or incapacitated adults. There are distinct differences in the manner in which the services are provided, even though both programs operate under the same state laws. The same can be said about public guardianship programs.

A Task Force has been created from both legacy departments to identify work processes, the resources available to the combined Department to carry out both protective and guardianship functions, data systems differences, pay equity, and values/cultural differences that impact service delivery. The Task Force meetings have been highly productive, and it was relatively simple to identify short-term measures that can begin the integration process and improve upon work processes. Longer-term integration issues are not viewed as barriers to combining these

functions, but rather reflect the need to carefully unravel these functions as they are currently integrated in the former BDS. For example, case managers in Adult Mental Retardation Services carry out functions of the guardian at the same time that they provide overall case management duties.

The status and plans to merge these processes are as follows:

- Guardianship/Conservatorship
    - Former-BEAS's specialized court workers will begin by assisting Adult MR Services staff in preparation of petitions for emergency guardianship by, for example, reviewing affidavits in support of those petitions. This will reduce Adult MR Services reliance on Assistant Attorney Generals, and build upon former-BEAS's expertise. There are approximately 50 Adult MR Services emergency guardianships/year.
    - Adult MR Services' paralegal assistant (as soon as the vacancy is filled) will be integrated with former-BEAS's specialized court workers to enhance/coordinate the preparation of court documents. Former-BEAS has templates of court documents heretofore not used by Adult MR Services staff. This will increase the efficiency of the guardianship/conservatorship process.
    - Adult MR Services' staff will have access to former-BEAS's network of contract attorneys. This requires, however, the identification of funding to support the additional work required.
    - A pilot project will begin by March 1, 2005 to separate the guardianship and case management functions of Adult MR Services workers. This will help determine the number of caseworkers who will be needed to devote to specialized guardianship work for persons with developmental disabilities. This approach will allow an examination of the work process without disrupting client entry into the case management system. This model will reduce the conflict of interest inherent in the Adult MR Services system, and the results will be shared with the community consent decree court master. According to an earlier pilot project conducted by Adult MR Services, it was estimated that a ratio of 1:70-85 is necessary to carry out guardianship duties. However, former-BEAS's experience is that this ratio has not allowed sufficient time for visitation and other services to be provided. With other case management functions for persons with mental retardation, it is important to identify what duties are considered guardianship-related. There are approximately 700 persons with mental retardation under public guardianship, and a similar number of former-BEAS. As soon as the project is complete, a new organizational chart for a combined Adult Protective Services Program incorporating Adult MR Services guardianship will be developed.
    - Immediately, measures will be taken to allow Adult MR Services access to safety deposit boxes in place for BEAS to secure assets of wards after hours.
    - Umbrella insurance and bonding insurance needs of both agencies shall be reviewed. Adult MR Services has an umbrella insurance policy and BEAS does not. The former-BEAS was self-insured for risk. Both have bonding insurance. The expiration dates for the bonding insurance should be reviewed so that one policy can cover all activities. An Assistant Attorney General will be consulted to determine the need for umbrella liability insurance for the combined guardianship program.

- As a long-term goal, BEAS/Adult MR Services will work together to terminate conservatorship for 300 Adult MR Services cases that have no assets to manage. These appointments date back to the 1970's when guardianship and conservator appointments were combined. The Adult MR Services guardianship system has not accounted to the Probate Court and a unified approach to the court system will be developed to resolve this outstanding issue.
- Another long-term goal will be to determine how BEAS's MAPSIS and Adult MR Services' EIS will relate with regard to managing guardianship/conservatorship cases. It is important to maintain the connection between guardianship reporting and the Adult MR Services reportable events system.
- Finally, Adult MR Services has a special expertise with regard to guardianship for persons with mental retardation, such as communication and interview techniques. While it is expected that specialization in MR Services may be advantageous within a combined guardianship/conservatorship program, nonetheless it will be necessary to cross train staff with regard to all special needs populations.

- Representative Payee
  - Adult MR Services has an extensive representative payee system for approximately 3,000 persons with mental retardation who live in both licensed settings and supported living environments. Adult MR Services has a manager and 6 account clerks who are responsible for managing resident accounts and complete required reporting to the Social Security Administration. Adult MR Services provides this service whether or not the individual is under public guardianship. BEAS does not provide this service to the general public, providing this on a much more limited basis, relying instead on licensed facilities for many people in community settings. There is no statutory prohibition against licensed facilities serving as a representative payee, and it likely that some of these functions could be subsumed by licensed facilities where many consumers serviced by Adult MR Services reside. This may result in cost savings that can be used to support the guardianship/conservatorship program, and to pay for needed increases in contract attorney services. There shall be an ongoing effort to reduce the number of people for whom DHHS acts as representative payee during the next fiscal year.
  - A complete review of the Adult MR Services and BEAS system should be undertaken to determine the best and most cost effective way to deliver this service, and combine banking services/systems. Emphasis on customer service with regard to banking activities, opportunities for electronic bill paying and improving cost efficiency of the present Adult MR Services system for authorizing personal spending on behalf of consumers should be completed by June 30, 2005.

- Asset Management/Conservation
  - There are usually few assets to manage for individuals with mental retardation, and generally when special or protected trusts are involved, the establishment and management of these trusts are similar between the legacy departments. All asset management functions should be consolidated as soon as possible. BEAS has established systems that interact with MaineCare's third party liability unit, and BEAS charges the consumer's assets for these services.

- Adult Protective Services
    - Adult MR Services maintains a small Adult Protective Services Unit comprised of a director and 3.5 FTE investigators. This unit is independent of other Adult MR Services functions except for the EIS data system, and should be immediately combined with the BEAS Adult Protective Services Unit. This will allow the programs to work closely together to develop a working relationship and to move forward with determining how to best enhance the Adult MR Services protective functions.

DHHS Support & Operations

Chapter 689 authorizes the DHHS Commissioner to consolidate certain administrative functions, including internal auditing; external auditing; financial management; human resources; information technology and data collection and management; facilities management; contracting; licensing; permitting and inspecting; training; administrative appeals; communications and legislative relations; rate setting; and rulemaking.

Human Resources :The HR departments of the two legacy departments have been consolidated under the management of a single Director, reporting to the Deputy Commissioner for Operations and Support. All HR staff will be physically co-located by the end of January, 2005.

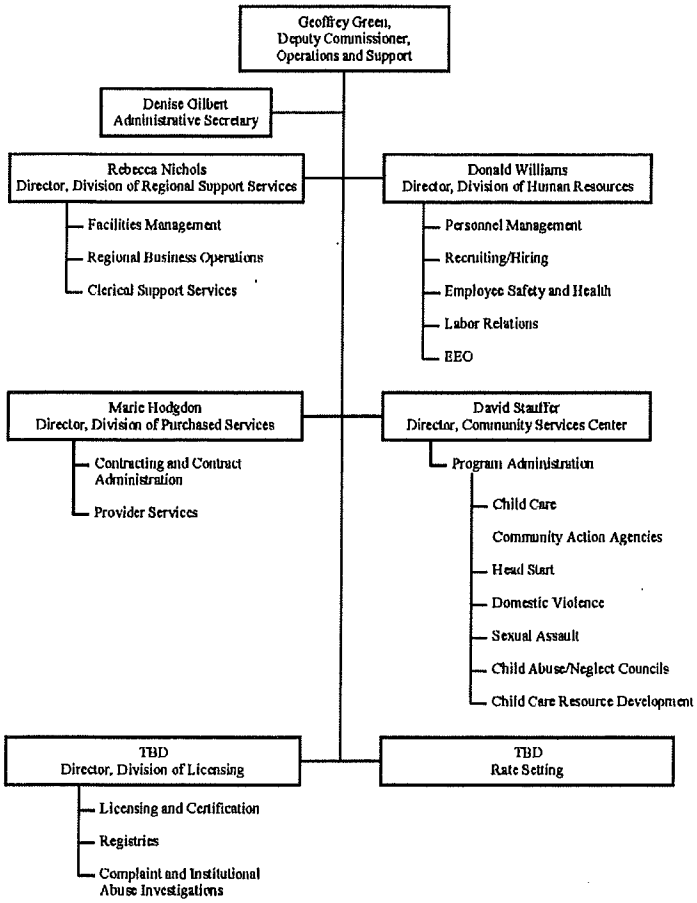
Facilities Management :Facilities management is now consolidated under a single Director, reporting to the Deputy Commissioner for Operations and Support. A comprehensive plan for consolidation of office facilities throughout the State has been developed and implementation is in progress.

Contracting :All contracting functions will be consolidated under a single Director, reporting to the Deputy Commissioner for Operations and Support. Phase 1, which implemented during the month of November 2004, will merge the contracting operations and personnel of the former-BDS and the former DHS Community Service Center. This will encompass most of the contracting performed by DHHS. Phase 2 will bring the contracting functions currently performed in the bureaus under the consolidated contract management structure.

Licensing, permitting and inspecting: Planning is currently underway to consolidate these functions, which are currently performed in several bureaus and departments. The plan was finalized during the month of November 2004, and restructuring of licensing functions into a consolidated organization should be completed by March 2005.

Rate setting :Planning for the consolidation of rate setting functions has begun. The objectives are to establish consistent policies, streamline the processes, and maximize cost-effectiveness. As an interim measure, all rate changes are subject to review and approval by the Deputy Commissioner for Operations and Support.

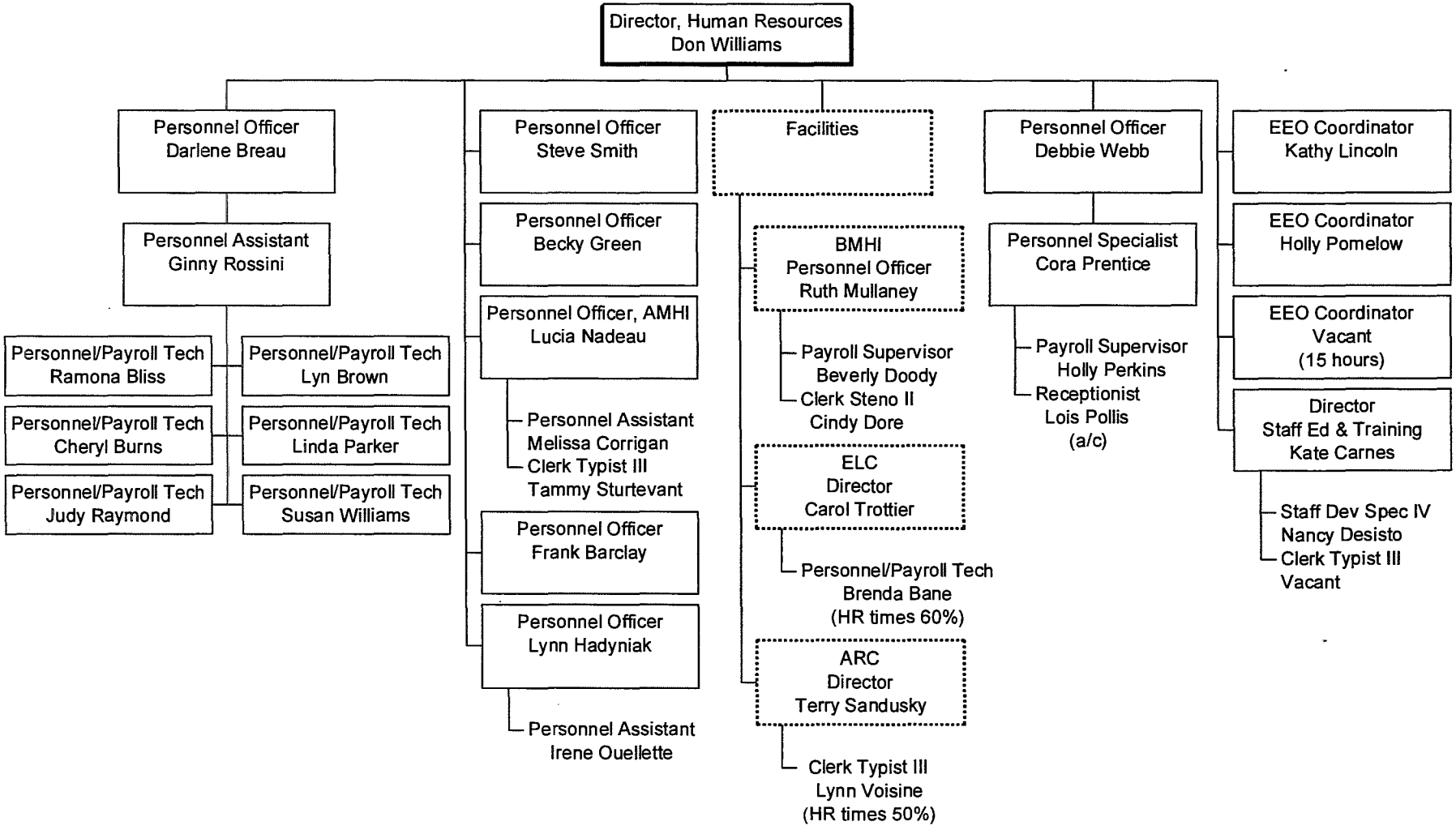
Department of Health and Human Services
Operations and Support



DHHS Human Resources

The Human Resources Department provides oversight into all areas of human resources and employee relations management. Specific areas of responsibility include recruitment and retention, classification, compensation, payroll and benefit administration, labor relations, worker's compensation, performance management, employee orientation, and supervisory training activities. These activities are managed within the scope of civil service and other human resource related laws, rules, and collective bargaining requirements.

Human Resources Organization for DHHS



Office of Management & Budget

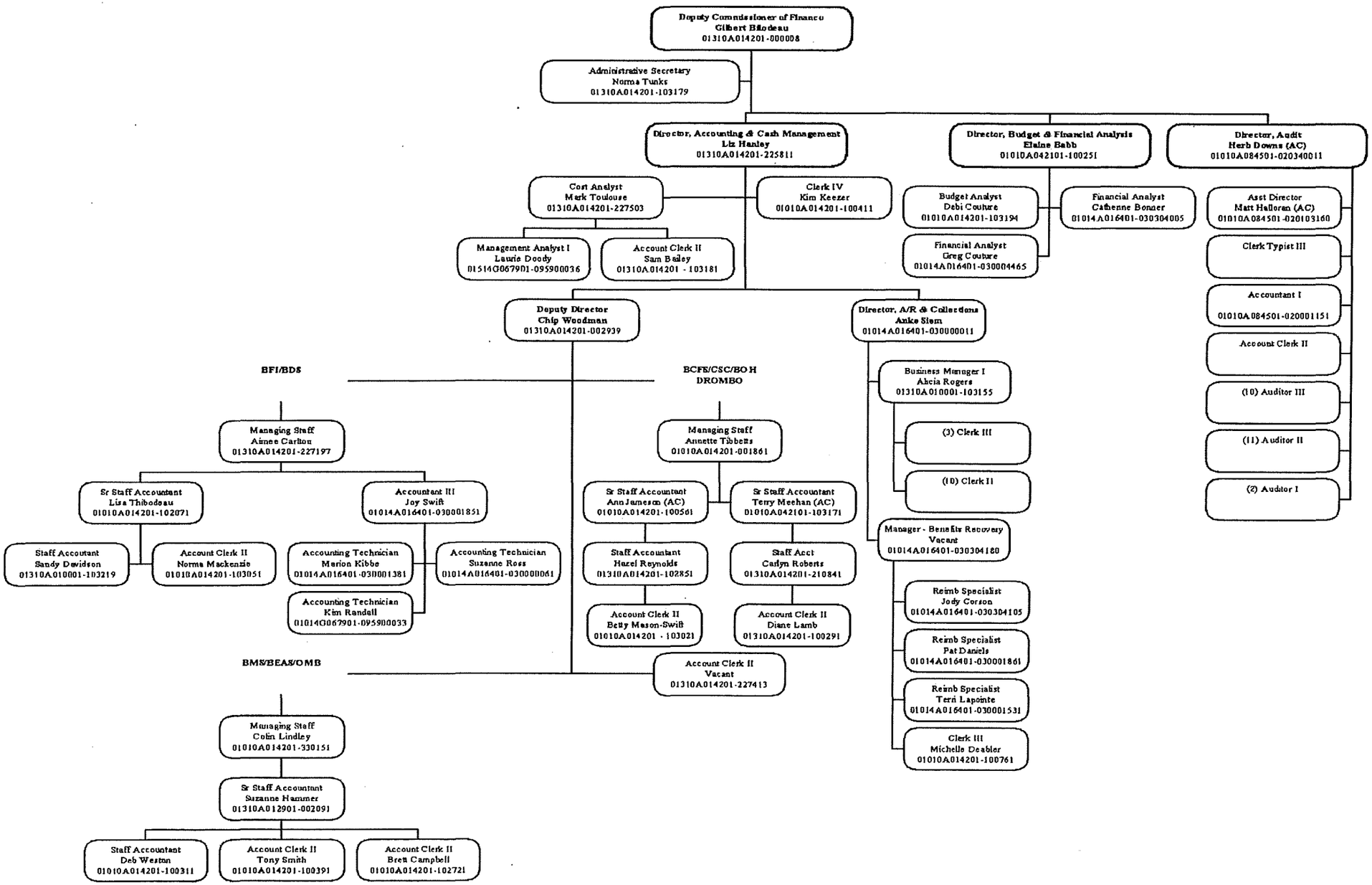
The Department's Office of Management & Budget is responsible for delivering financial management services of the highest quality to executive management and program staff in support of effective and efficient program operations. The Office seeks to deliver services of a high standard by which other agencies measure themselves.

The Division of Budget and Financial Analysis is led by a Director who is supported by three financial analysts. This unit's charge is to work with management and program staff to build an effective budget to meet program needs. The unit constantly monitors budget activity and provides key financial analysis tools to management in support of carrying out the Department's mission and goals.

The Division of Accounting and Cash Management is led by a Director and Assistant Director who are supported by three Managing Staff Accountants. This unit is charged with supporting the professional accounting and cash management activities of the Department. The unit provides expenditure reporting & cash management services and acts as the liaison for resolving audit findings issued by the State's Department of Audit.

The Division of Audit is led by a Director and Deputy Director who are supported by a team of auditors charged with ensuring that all funds distributed to sub-recipient agencies and other entities are effectively monitored for appropriate use. The unit issues audit findings and provides a key measure of the successful delivery of service to our clients.

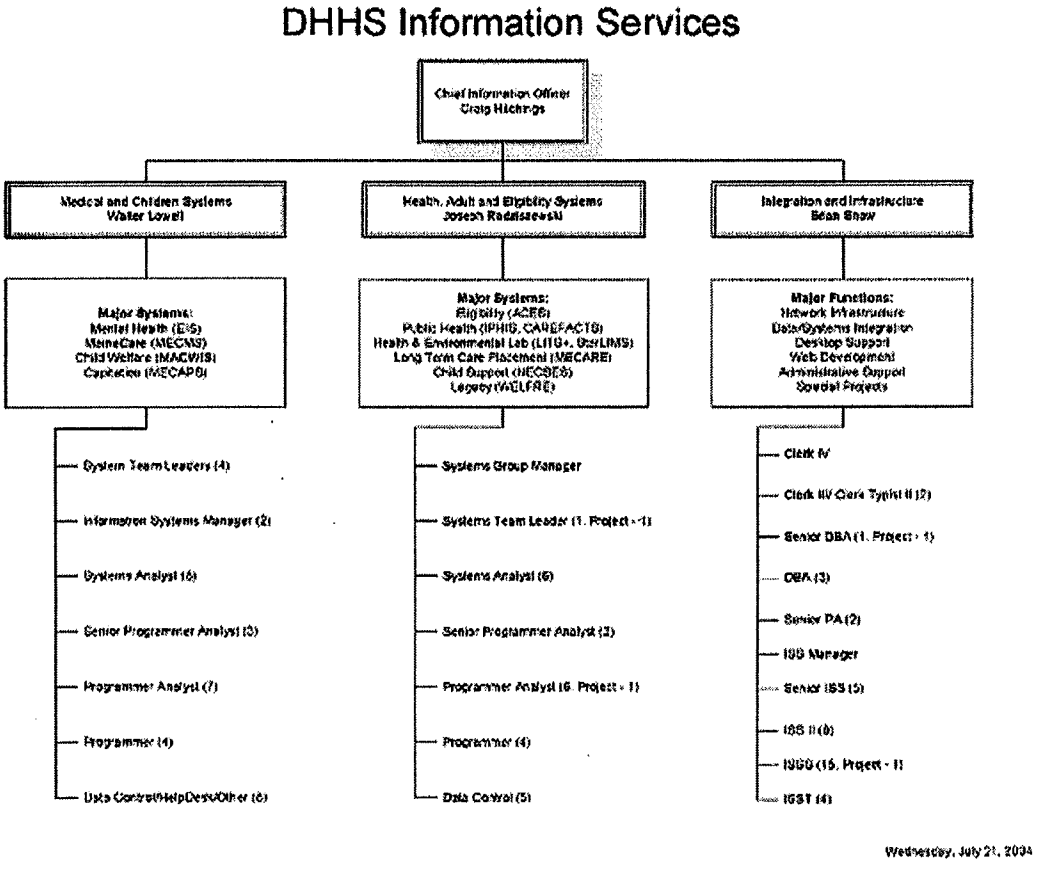
Department of Health & Human Services
Office of Management & Budget
January 2005



Office of Chief Information Officer

The Division of Technology Services in the former DHS and Office of Information Services in the former BDS began consolidating in July 2004 in compliance with the statute's mandate, to best support the Department's mission. Since the organizational structure is focused on service provision, the draft organization below will be finalized once the DHHS structure is approved by the Legislature. A services-based structure will afford senior IT managers more insight into, and direct access to, the programs they support. The leaders of the former BDS and DHS technology staffs now report to the DHHS CIO and are supporting the migration to a consolidated structure.

The combined 110+ IT staff have worked as a team to establish foundational values, identify challenges, and help develop the blueprint for the construction of the merged IT group and implementation plan. Pending approval of the final DHHS structure, the focus is on completing the infrastructure IT component which consists of network and desktop support, web development, and database administration. The approach to providing these services will not change with the final DHHS structure.



Quick Reference to Enabling Legislation

1/31/05 REPORT—STATUTORY AMENDMENTS

Statutes describing the organizational structure of the Department of Health and Human Services are now found in the Maine Revised Statutes Annotated in titles 5, 22, 22-A and 34-B. To the extent that the Legislature decides to redesign the current bureau and program structures and reallocate responsibilities for programs, client populations or subjects of governmental concern within the Department, some sections of these statutes will have to be repealed, amended or replaced. The attached outline is offered as a quick reference to the current structure of the Department and as a guide to Legislative consideration of the need to change the statutes to reflect any new structure.

Title 22 describes the "old" Department of Human Services.[1] In most sections, the delegation of authority is to the commissioner or to the Department[2] without reference to any particular bureau or program. If the Legislature determines that the commissioner will continue to be so empowered, there is no need to amend these provisions. In fact, the Legislature may determine that it is better practice to indicate their preference for the new organizational structure in unallocated language and leave in provisions that promote flexibility to establish and change the precise structure of the Department over time. This can be done by leaving in place the current law, stating that "[t]he commissioner may employ any bureau and division heads, deputies, assistants and employees who may be necessary to carry out the work of the department." In addition, current law states that "[t]he commissioner shall have the power to distribute the functions and duties outlined in this Title among the various bureaus so as to integrate the work properly and to promote the most economical and efficient administration of the department."

Similarly, title 34-B describes the "old" Department of Behavioral and Developmental Services. Sections 1202 through 1205 generally describe the organizational structure and the appointment of a deputy commissioner, associate commissioner for administration, associate commissioner for systems operations and other officials with specified duties and obligations to report. Other sections describe the Office of Advocacy, the Office of Substance Abuse, the Office of Advocacy and Consumer Affairs, the State Forensic Service, and various officials within the state institutions. As noted above, these could all be rewritten to assign the functions generally to the commissioner or the Department without specifying a bureau or lower level official with responsibility.

However, if the Legislature determines that the new codified statutes should explicitly describe the new sub-structure and/or identify specific employee titles and responsibilities, the sections of titles 22 and 34-B requiring amendment or replacement are identified on the attached chart. Those sections that establish an employment position by title, or prescribe the responsibilities or qualifications of the person to hold that title, or specify a bureau by name must be amended if the title, responsibilities, qualifications, or bureau name is changed or shifted.

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[1] Title 5, sections 20001-20078-A, describe the Office of Substance Abuse. Other statutory sections may delegate powers or responsibilities to the Department, but these titles describe most of its current organizational structure.

[2] Legislation has already replaced references to the "Department of Human Services" with the "Department of Health and Human Services" in all codified Maine statutes. References to the "Department of Behavioral and Developmental Services" still appear. Some substantive rewriting will be required to make sensible the deletion of references to BDS, as noted in the outline. These include provisions that affect confidentiality of departmental records and the availability of administrative hearings, so that the operations of the two merged departments can be condensed in an effective and efficient manner.

Even though the consolidation and integration legislation enacted last year clearly acknowledged the continuing validity of the rules previously adopted by DHS and BDS, it may be confusing to the public, after the Legislature adopts a new departmental structure, when those rules continue to refer to departments, divisions, bureaus or programs that are renamed or reorganized. It would be helpful if the Legislature also enacted one item of unallocated language to reaffirm that all of the Department's current rules remain valid and effective until otherwise amended or repealed, even though they may refer to various bureaus, divisions, programs or departmental position titles that no longer exist after the Legislature has made its restructuring choices.

In addition, plans are underway to revise the accounting structure of the two legacy departments and create a new accounting structure for the Department of Health and Human Services.

Bureau or Program	Title & Section(s)	Topic Area [need to delete]
Bureau of Health	5:19251-19254	Community-based AIDS organizations, refers to BOH.
Office of Substance Abuse	5:20001-20050	Substance abuse prevention and treatment, refers to OSA as single administrative unit.
	5:20003	Substance abuse. [Refers to Commissioner, BDS]
	5:20005	Substance abuse, refers to OSA, limits use of funding, Director of OSA.
	5:20006-A	Substance abuse, refers to Director of OSA, powers and duties.
	5:20072-20078-A	Substance abuse, establishes DEEP in OSA.
Commissioner's Office	22:1	Refers to a Deputy Comm'r; Director, BCFS; Director, BEAS; Director, BOH; Director, BFI; Director, BMS; Asst. Deputy Comm'rs; 3 Regional Executive Managers. Identifies appointment process. Sets qualifications for Director, BOH.
	22:6-A	Describes 5 service regions. [Refers to BDS]
	22:6-B	[Describes co-location with BDS]
	22:6-C	Community Services Center. [Refers to BDS]
Bureau of Medical Services	22:18	BMS administers Private Health Insurance Premium Program.
	22:42(8)	Rules and records, refers to BMS, BFI.
	22:48	MaineCare provider relations, refers to Director, BMS.
Bureau of Health	22:271, 272	Tobacco tax, refers to BOH.
	22:565	Refers to Director, BOH; Director, Health and Environmental Testing Laboratory
	22:567	Laboratory, refers to Director, BOH.
	22:663	Refers to State Nuclear Safety Inspection Office and State Nuclear Safety Inspector (classified, qualifications)
	22:663-667	Describes responsibilities of State Nuclear Safety Inspector.
	22:772-775, 784	Radon registration act, refers to Division of Health Engineering
	22:812	Communicable diseases refers to State Forensic Unit. [Refers to title 34-B]
	22:815	Communicable diseases, refers to BOH. [Refers to title 34-B]
	22:819	Communicable diseases, [refers to title 34-

Bureau or Program	Title & Section(s)	Topic Area [need to delete]
		B, rights of mental health patients]
	22:835	Blood-borne pathogen testing, refers to BOH.
	22:1319-A	Lead poisoning control, refers to State Health and Environmental Testing Laboratory
	22:1341	Hypodermic exchange, refers to BOH.
	22:1406	Cancer data review, refers to BOH.
	22:1407	Cancer prevention and control, refers to BOH.
	22:1444	Browntail moth control, refers to Director, BOH.
	22:1471-B	Board of Pesticides Control, refers to appointment of director
	22:1533	Detection of genetic conditions, refers to Division of Maternal and Child Health
	22:1580-A	Smoking at employment, refers to BOH.
	22:1653	Exposure to diethylstilbestrol, refers to BOH.
	22:1674	Public rest rooms, refers to Division of Health Engineering.
	22:1686, 1688	Public rest rooms in eating places, refers to Division of Health Engineering.
	22:1689-B	Water Well Program, refers to Division of Health Engineering.
	22:1691-1692-A, 1696, 1696-C, 1696-F, 1696-I	Environmental health, refers to BOH.
	22:1697-1699	Hypertension, refers to BOH.
	22:1700	Asthma prevention and control, refers to BOH.
	22:1701	General public health, refers to BOH.
Bureau of Medical Services	22:1717(1)	Personal care agencies, refers to Division of Licensing & Certification.
	22:1719	Nonstate mental health institutions. [Refers to BDS and title 34-B]
	22:1816	Hospital, NF inspections, refers to BMS.
Bureau of Health	22:1951	Maternal and child health, refers to BOH.
	22:1961-1962	School nurse consultant, refers to BOH, Director, Public Health Nursing Program, sets qualifications.
	22:1971	School nurse consultant, refers to BOH.
	22:2001	Disabled children, refers to BOH.
	22:2092	Refers to Director, Division of Dental Health.

Bureau or Program	Title & Section(s)	Topic Area [need to delete]
	22:2093, 2097, 2123	Refers to Division of Dental Health.
	22:2127(2)	Dental services, refers to BOH.
	22:2660-B	Public drinking water program, refers to BOH, Division of Health Engineering.
Bureau of Medical Services	22:2692	Rx Drug Advisory Committee, refers to Director, BMS.
Bureau of Health	22:2701-2704, 2706-2706-A, 2709	Vital statistics, establishes Office of Health Data and Program Management, identifies State Registrar of Vital Statistics and states qualifications and duties, refers to deputy state registrar.
	22:2710	Domestic partner registry, refers to Office of Health Data and Program Management.
	22:2761, 2764-2767	Birth registration, refers to State Registrar.
	22:2803-2804	Marriage records, refers to State Registrar.
	22:2842	Death registration, refers to State Registrar.
	22:2882-2883	Disposal of dead bodies, refers to Superintendent, BMHI and Superintendent, AMHI.
	22:3087	Head injury survivors, refers to BOH.
Bureau of Elder and Adult Services	22:3174-I	MaineCare coverage of NF care, refers to BEAS.
Bureau of Child and Family Services	22:3291	Confidentiality in personnel, licensure matters, refers to BCFS, BMS, directors.
Bureau of Elder and Adult Services	22:3472	Adult protective services, refers to BEAS. [Refers to BDS]
Bureau of Child and Family Services	22:3739	Child Care Advisory Council, refers to BFI, Children with Special Needs, Director of OSA.
	22:3740	Office of Child Care and Head Start, refers to Division of Purchased and Support Services.
Bureau of Family Independence	22:3762	TANF. [Refers to BDS]
	22:3789-B	Interdepartmental Welfare Reform Comm., refers to Director of OSA, BFI.
	22:3789-C	Uniform application committee, refers to BFI.
Bureau of Child and Family Services	22:4066	Foster care, refers to BCFS.
	22:4088	Out-of-home abuse investigating team, refers to BCFS, Community Services Center
	22:4099-C	Youth in need of services, refers to OSA. [Refers to BDS]
	22:4100	Quality child care, refers to Office of Head

Bureau or Program	Title & Section(s)	Topic Area [need to delete]
		Start and Child Care
Bureau of Elder and Adult Services	22:5104	Elder services, refers to BEAS, Director of BEAS.
	22:5104-A	Elder services, refers to "bureau"
	22:5105	Establishes BEAS as separate and distinct unit, director's qualifications.
	22:5106	BEAS powers and duties.
	22:5115-5116, 5118	Grants to agencies on aging, refers to "director"
	22:5304	Administration, refers to BCFS, BEAS, Director of BEAS, Director of Bureau of Resource Development.
	22:5305	Administration, refers to "bureau"
Bureau of Child and Family Services	22:5308	Establishes BCFS as separate and distinct unit.
	22:5309	Describes Director of BCFS, sets qualifications.
	22:5310	Describes BCFS powers and duties.
	22:5312	Head Start, refers to Division of Purchased and Support Services.
	22:5321-5324	Community services, refers to Division of Purchased and Support Services, Director.
	22:5325	Community action agency, refers to "bureau"
	22:5327-5329	Block grants, refers to Division of Purchased and Support Services.
Bureau of Elder and Adult Services	22:6108	Priority social services for elderly, refers to BEAS.
	22:6113	Priority social services for elderly, refers to Office of Resource Development, Services for Aging.
	22:6202	Adult day care, refers to BEAS.
Office of Substance Abuse	22:7246-7252	Prescription monitoring, refers to OSA, director of OSA.
Bureau of Child and Family Services	22:7802	Licensing, refers to consolidation of licensing within BCFS.
Bureau of Elder and Adult Services	22:7861	Assisted housing programs, refers to BEAS.
Commissioner's office	22:7933	Receiver for hospitals, etc., refers to "acting commissioner"
	22:8104	Interagency licensing of children's homes. [Refers to Comm'r, BDS]
Bureau of Medical Services	22:8752-8754	Sentinel events reporting, refers to BMS, Division of Licensing and Certification. [Refers to title 34-B]
Bureau of Health	22:8941	Birth defects, refers to BOH.

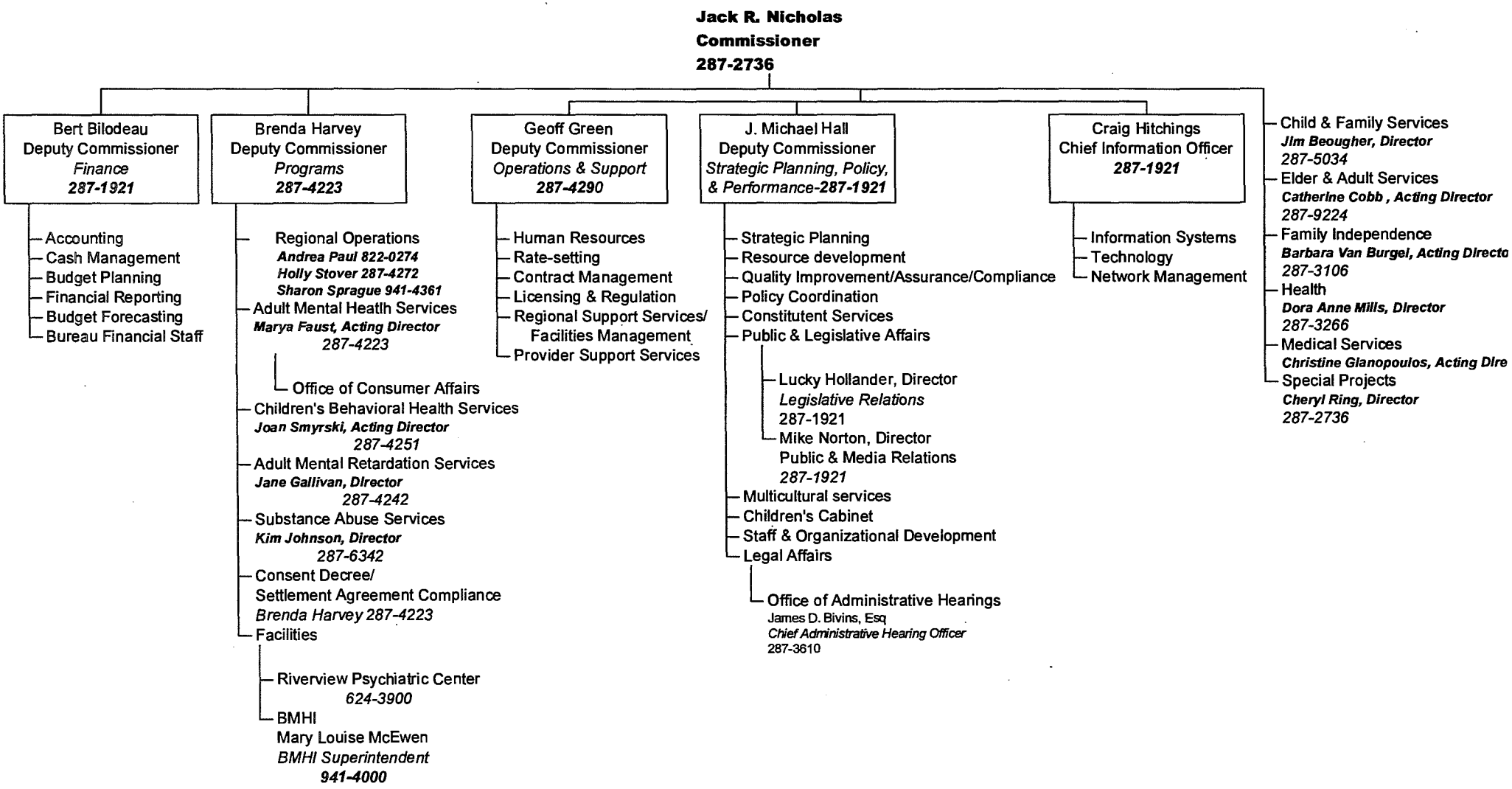
Bureau or Program	Title & Section(s)	Topic Area [need to delete]
Behavioral and Developmental Services	34-B:1201	Establishes BDS, refers to Commissioner, BDS.
	34-B:1201-A, 1201-B	Describes 5 services regions. [Refers to co-location with DHS]
	34-B:1202	Refers to deputy commissioner.
	34-B:1203	Duties generally, refers to OSA.
	34-B:1204	Powers, refers to deputy comm'r, associate comm'r for administration and qualifications, associate comm'r for systems operations and qualifications, other associate comm'rs, superintendent of AMHI, superintendent of BMHI, director of ELC, assistant to the comm'r, regional directors, director of OSA, deputy comm'r, clinical directors and qualifications, physicians and qualifications.
	34-B:1205	Advocacy, refers to Office of Advocacy, Office of Advocacy and Consumer Affairs, describes chief advocate.
	34-B:1207	Confidentiality. [Refers to DHS]
	34-B:1212	Establishes State Forensic Service, duties, qualifications of members.
	34-B:1217	Consent decree applicability, refers to BMHI.
	34-B:1219	Strategy for preventing imprisonment of mentally ill persons, refers to BMS, OSA.
	34-B:1221	Plans for homeless, refers to "regional housing coordinator"
	34-B:1401, 1404, 34-B:1405, 1408, 1409	State institutions, refers to "chief administrative officers" and "acting" chief administrative officers.
	34-B:3201, 3202	Mental health, refers to BMHI and AMHI, superintendents of each, qualifications, appointment, duties.
	34-B:3607	Quality improvement councils, refers to "regional director" and "director of facility management" in 2 mental health hospitals.
	34-B:3801	Hospitalization, refers to BMHI and AMHI.
	34-B:3861, 3870	Hospitalization, refers to "chief administrative officer of a state mental health institute."
	34-B:5401	Mental retardation services, refers to Aroostook Residential Center and Freeport Towne Square.
	34-B:5405	MR services, refers to Freeport Towne Square, identifies manager, duties.
	34-B:5471	MR service agreements, refers to "individual support coordinator of the

Bureau or Program	Title & Section(s)	Topic Area [need to delete]
		planning team" and "regional director or designee."
	34-B:5474	MR services, refers to director of the Elizabeth Levinson Center.
	34-B:5606	MR services, refers to Office of Advocacy, investigations, obligation to write reports.
	34-B:6001	Autism, refers to Division of Mental Retardation.
	34-B:6251	Children's services, refers to the Elizabeth Levinson Center.
	34-B:6252	Children's services, refers to ELC, director, qualifications, duties.
	34-B:13003	Receiver for facilities, providers, refers to "acting commissioner."
	34-B:15001, 15002	Children's services, establishes Children's Mental Health Program, structure, purpose, supervision, identifies director.
	34-B:15004	Children's Mental Health Oversight Committee. [Refers to Commissioner, Human Services]

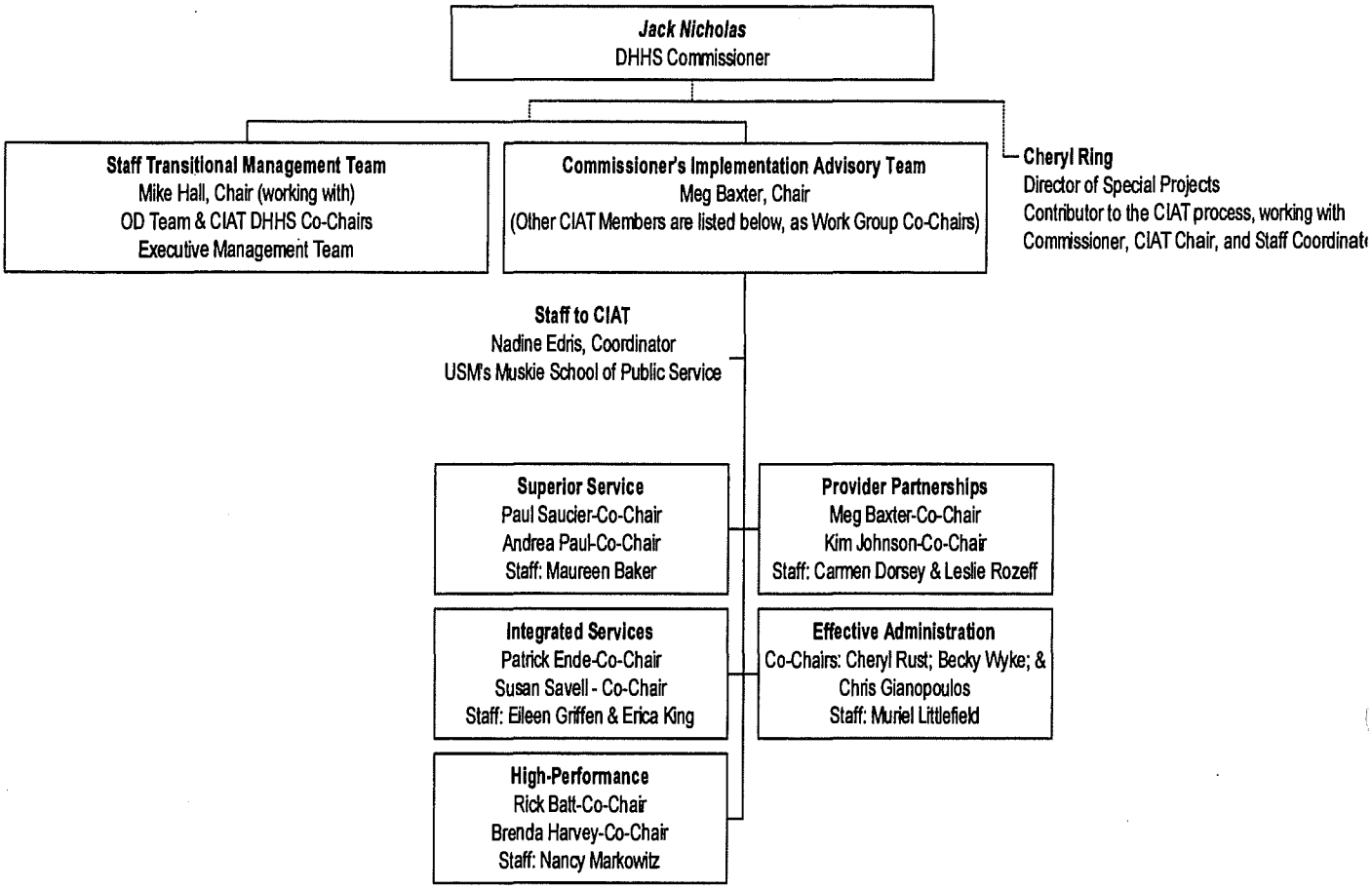
Appendices

Organization as of July 1, 2004

This organizational arrangement is ***interim*** pending the Legislature's consideration of the report on organization and structure issues due from the Commissioner on January 31, 2005. After consideration of the Commissioner's report, the Joint Standing Committee on Health and Human Services may choose to report out legislation governing the organization and services of the new department (pursuant to PL 689 §A-3)



Organization of the Commissioner's Implementation Advisory Team



Inventory of Advisory Boards and Commissions

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
Advisory Committee On Mental Retardation	Department of Mental Health, Mental Retardation and Substance Abuse Services		Y	The committee advises the department in assessing present programs, planning future programs and developing means to meet the needs of persons with mental retardation in the State.
Advisory Committee on Radiation	Division of Health Engineering	Clough Toppan	Y	The committee shall make recommendations to the commissioner and furnish advice that is requested by the department on matters relating to the regulation of sources of radiation including enforcement actions, regulation revision and the establishment of fees. The committee may also make recommendations and reports to the joint standing committees of the Legislature.
Birth Defects Program Advisory Committee	Division of Family Health	Ellie Mulcahy	N	The committee provides input to the department through the programs on issues related to identification, treatment, and services for children with birth defects.
Board of Dental Examiners			Y	The Board of Dental Examiners, established by Title 5, section 12004-A, subsection 10, and in this chapter called the "board," consists of 8 members, appointed by the Governor as follows: five members of the dental profession, one dental hygienist, one denturist and one representative of the public. [2001, c. 260, Pt. B, §1 (amd).]
Board of Licensing of Dietetic Practice			Y	There is established, within the Department of Professional and Financial Regulation, the Board of Licensing of Dietetic Practice. The board consists of 5 members appointed by the Governor, including 2 public members who are residents of this State, who do not hold a license to practice dietetics and who have no direct or indirect financial interest in the practice or delivery of dietetic services. Two board members must be dietitians. The professional members must at all times be holders of valid licenses under this chapter, except for the members of the first board, each of whom must fulfill the requirements for licensing under this chapter. [1995, c. 402, Pt. A, §28 (amd).]
Board of Licensure on Medicine			Y	The Board of Licensure in Medicine, as established by Title 5, section 12004-A, subsection 24, and in this chapter called the "board," consists of 9 individuals who are residents of this State, appointed by the Governor. Three individuals must be representatives of the public. Six

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
				individuals must be graduates of a legally chartered medical college or university having authority to confer degrees in medicine and must have been actively engaged in the practice of their profession in this State for a continuous period of 5 years preceding their appointments to the board. A member of the board may be removed from office for cause by the Governor. [1997, c. 680, Pt. C, §1 (amd).]
Board of Osteopathic Examination and Registration			Repealed	
Board of Osteopathic Licensure			Y	The Board of Osteopathic Licensure, as established by Title 5, section 12004-A, subsection 29, and in this chapter called the "board," consists of 9 members appointed by the Governor. These members must be residents of this State. Six of these members must be graduates of a school or college of osteopathic medicine approved by the American Osteopathic Association and must be, at the time of appointment, actively engaged in the practice of the profession of osteopathic medicine in the State for a period of at least 5 years, and 3 of these members must be public members. Consumer groups may submit nominations to the Governor for the members to be appointed to represent the interest of consumers. A full term of appointment is for 5 years. Appointment of members must comply with section 60. A member of the board may be removed from office for cause by the Governor. [1997, c. 50, §1 (amd).]
Cancer Registry Advisory Committee	Maine Cancer Registry	Dr. Molly Schwenn		
Cancer Registry Data Review Committee	Maine Cancer Registry	Dr. Molly Schwenn	Y	The committee is appointed and convened by the Bureau of Health to review and advise the administrators of the statewide cancer-incidence registry established in section 1404 on the release of identifiable data as requested by researchers for the purposes of cancer prevention, control and research. The committee is composed of not fewer than 3 members, representing training and experience in the fields of medical or public health research or disease prevention and control. The committee must be guided by rules adopted by the Bureau of Health providing for the protection of the confidentiality of all cancer case data reported to the registry.
Center for Tobacco	Partnership for a	MaryBeth		

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
Independence Scientific Advisory Committee	Tobacco-Free Maine	Welton		
Child Abuse Action Network				The Maine Child Abuse Action Network (CAAN) is the entity designed by the Governor to receive Children's Justice Act funds which are provided by the Administration for Children and Families of the Department of Health and Human Services.
Child Abuse and Neglect Councils			Y	Maine Association of Child Abuse and Neglect Councils" means the statewide organization composed of a majority of the child abuse and neglect councils. The association shall establish standards of practice by which it may evaluate the effectiveness of each individual council's strategies to combat child abuse and neglect and also maintain a statewide network that works to develop statewide plans and effective implementation strategies. [1993, c. 142, §2 (amd).] A child abuse and neglect council shall assess and monitor the extent and causes of child abuse and neglect in its county and carry out the following activities: Coordinate services, utilizing community, state and federal resources to ensure that direct services are being provided to children and families; [1993, c. 142, §3 (new).] Provide training to professionals who deal directly with children and families; and [1993, c. 142, §3 (new).] Provide education and awareness concerning child abuse and neglect and its prevention. [1993, c. 142, §3 (new).] [1993, c. 142, §3 (new).]
Child Care Advisory Council	Community Services Center	Carolyn Drugge	Y	The council advises the department and Legislature regarding child care services in the State; to encourage the development of coordinated child care policies to promote quality, uniformity and efficiency of services.
Child Death and Serious Injury Review team	Division of Child Welfare	Sandra Hodge		The purpose of the panel is to review cases of child fatalities and serious injuries, particularly those revolving around child abuse, to improve the present systems and foster education to both professionals and the general public.
Child Welfare Advisory Committee	Bureau of Child and Family Services		Repealed	The committee advises department on development of policies and programs which affect the well-being of children and their families for whom the department has responsibility, as well as those programs which prevent the maltreatment of children within the State.
Childhood Lead Poisoning Prevention Program Advisory	Childhood Lead Poisoning Prevention Program	MaryAnn Amrich	N	The Advisory Council advises on lead poisoning issues that are out in the community. The Council provides feedback and recommendations to any initiatives that are going to be taken with federal money. In

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
Council				addition, the council is drafting a plan to eliminate childhood lead poisoning by 2010, which is in the statute.
Children With Special Needs Advisory Committee	Department of Mental Health, Mental Retardation and Substance Abuse Services		Repealed	The committee advises the department in assessing present programs, planning future programs and developing means to meet the needs of children in need of treatment and their families.
Committee to Advise the Office of Public Health Emergency Preparedness	Bureau of Health	Sue Dowdie		
Court Improvement Project				
Dental Advisory Committee	Bureau of Medical Services			
Family Advisory Council	Division of Family Health	Toni Wall		
Family Support Councils:	Department of Mental Health, Mental Retardation and Substance Abuse Services		Repealed	The councils advise the department regarding statewide development and implementation of family support services.
Foster and Adoptive Parent Advisory Committee	Bureau of Child and Family Services		. Y	
HIV Advisory Committee	Division of Disease Control	Sally Lou Patterson	Y	The council advises the department and other state agencies on prevention of HIV; crises that may develop related to HIV; services for persons with HIV and those family members or other providing support and care to persons with HIV; HIV-related policy, planning, rules or legislation; and fiscal matters related to HIV.
Immunization Advisory Work Group	Division of Disease Control	Sally Lou Patterson		
Joint Advisory Committee (Newborn Screening and Children with Special	Division of Family Health	Ellie Mulcahy	N (but by regulation)	The committee provides input to the department through the programs on issues related to screening and treatment of children for disorders included on their screening panel. The committee makes decisions on what disorders to test for and they identify gaps in services.

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
Health Needs Program)				
Juvenile Corrections Liaison				
Law Enforcement Liaison				
Levels of Care Committee			N	Meets twice monthly to look at ways to assess each child in the care of DHHS as well as children entering care. Several subcommittees formed to look at screening tools, develop levels of care child functioning definitions, define expectations of providers, perform pilot assessments, and policy development.
Long-term Care Steering Committee	Bureau of Elder and Adult Services		Repealed	The committee provides input on all policies and initiatives, laws and rules concerning long-term care and assisted living in order to ensure that long-term care and assisted living programs reflect the needs of the elderly and individuals with disabilities.
Maine Board of Pharmacy			Y	There is established, within the department, in accordance with Title 5, chapter 379, the Maine Board of Pharmacy. The board has all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act. [1997, c. 245, §6 (amd).]
Maine Care Advisory Committee	Bureau of Medical Services			
Maine Youth Suicide Prevention Program Steering Committee	Maine Injury Prevention Program	Cheryl DiCara	Y	Guide the work of the Maine Youth Suicide Prevention Program whose mission it is to: increase public awareness that suicide is preventable, provide suicide prevention training to those who come in close contact with youth, disseminate data and information resources statewide, provide guidance to various agencies and groups on effective suicide prevention methods and practices.
MBCHP Clinical Advisory Group	Maine Breast and Cervical Health Program	Sharon Jerome		
MBCHP Program Advisory Group	Maine Breast and Cervical Health Program	Sharon Jerome		
Mental Health Rights Advisory Board	Department of Mental Health, Mental Retardation and Substance Abuse Services		Repealed	The board advises the department on the implementation of its rules concerning the rights of recipients of mental health services.

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
Newborn Hearing Program Advisory Board	Division of Family Health	Ellie Mulcahy	Y	The board shall oversee the program and advise the commissioner on issues relating to the program and shall recommend procedures for hearing screening, evaluation, treatment and intervention services. Beginning January 1, 2001, the board shall report each year to the joint standing committees of the Legislature having jurisdiction over health and human services matters and education matters on the program, the percentages of children being screened and evaluated and those children being offered and receiving intervention and treatment services. The report must be made available to the public.
Nursing Home Administrators Licensing Board			Y	The Nursing Home Administrators Licensing Board, as established by Title 5, section 12004-A, subsection 23, and referred to in this section as the "board," consists of 7 members appointed by the Governor. T
Partnership for a Tobacco-Free Maine Advisory Council	Partnership for a Tobacco-Free Maine	MaryBeth Welton	N	The Partnership For A Tobacco-Free Maine (PTM) is the primary program responsible for tobacco prevention and control throughout the state of Maine.
Physician Advisory Committee	Bureau of Medical Services		N	Established in June 2000 with the intent of giving physicians ongoing input into Maine PrimeCare program. Co-chaired by MaineCare's agency's director and Maine PrimeCare director.
Public Health and Health Services Block Grant Advisory Committee	Offices of Health Data and Program Management	Sue Dowdie		gives stakeholder review and input for the yearly allocation of the so-called "Prevention Block" of funds for public health
Refugee Advisory Council	Community Services Center	Pierrot Rugaba	N	Maine Refugee Advisory Council advises DHHS on Maine's Refugee Resettlement Plan and advocates for refugees statewide.
Ryan White Title II Advisory Committee	Division of Disease Control	Sally Lou Patterson	N (mandated by cooperative agreement with Health Reso	Advise the HIV/STD program on the sources provided by the Ryan White Title II grant- provides a place for community input.

Name of Board	Bureau/Program Affiliation	DHHS contact	In statute (Y/N)	Purpose
			urces and Servi ces Admi nistrat ors-grant ers).	
State Board of Nursing			Y	The State Board of Nursing, as established by Title 5, section 12004-A, subsection 25, consists of 9 members who are appointed by the Governor. A full-term appointment is for 4 years. Appointment of members must comply with section 60. Members of the board may be removed from office for cause by the Governor. [1993, c. 600, Pt. A, §120 (amd).]
Substance Abuse Services Commission	Department of Mental Health, Mental Retardation and Substance Abuse Services	Kimberly Johnson	Y	The committee advises the Office of Substance Abuse and the Legislature in the development of policies and programs for substance abuse services and treatment.
TANF Advisory Board	Bureau of Family Independence	Wendy Rose	Y	The council advises the Commissioner regarding education, training, job opportunities, quality employment and business opportunities, postsecondary education programs and other matters affecting TANF recipients.
The Cancer Prevention and Control Advisory Committee		Dr. Molly Schwenn	Y	to serve as an advisory body to the department on the operation of the Cancer Registry Program and on the development and maintenance of a coordinated statewide approach to cancer prevention and control.
Therapeutic Network Team				
Wabanaki Child Welfare Coalition				
Youth Leadership Advisory Team	Bureau of Child and Family Services		N	team of Maine youth in care (in state custody), ages 14-21, engaged in the education of the government, general public, caregivers, and peers regarding the needs of children and young adults in the child welfare system

Name of other Boards, Programs or Advocates
AARP
ABI (Traumatic Brain) Council
Alz Assn
American Lung Association
Association of Area Agencies on Aging
Board of Water Treatment Operators
Community Health Promotion Program Stakeholder Group
Consumers for Affordable Health Care
DD Council
Diabetes Control Program
Disability Rights Center
Drinking Water Commission
Drinking Water Program
DV groups
Eating and Lodging Program
Elder Abuse Task Forces
Environmental Public Health Tracking Grant Consortium
Family Health Promotion Council
Friends of the Fund for Healthy Maine
Health and Environmental Testing Laboratory
Healthy Maine Partnerships
Hepatitis C Working Group
HIV/STD Prevention Materials Review Committee
hospice council
Infectious Disease Workgroup
JAC
Legal Services for the Elderly
LITCOP
Maine Asthma Council
Maine Asthma Program Management Team
Maine Cardiovascular Health Council
Maine Cardiovascular Health Program Stakeholder Group
Maine Children's Alliance
Maine Coalition on Smoking or Health
Maine Council of Senior Citizens
Maine Dental Access Coalition
Maine Equal Justice
Maine HIV prevention Community Planning Group

Name of other Boards, Programs or Advocates
Maine Nutrition Network
Maine Parent Federation
Maine Youth Action Network
Physician Task Force on Lead Screening
Pine Tree Legal services
Plan Development Workgroup (Olmstead Decision)
Radiation Control Program
School Oral Health Program Directors
State Independent Living Council
TB Elimination Subcommittee of the American Lung Association of Maine
Triads
Wastewater and Plumbing Control Program
Well Drillers and Pump Installers Board
West Nile Virus Working Group
Young Advisors and Educations of Maine

DHHS- At A Glance

- Provides health and human services for all people in Maine
- 4,000 employees
  - 2,700 from former-Department of Human Services
  - 1,300 from former-Department of Behavioral and Developmental Services
- FY 2004 total expenditures for both legacy departments (July 1, 2003 to June 30, 2004)
  - Block Grant Funds.....$137,561,214.97
  - Bonds.....$1,420,000.00
  - Federal Funds.....$1,584,239,887.12
  - General Funds.....$804,097,083.91
  - Other Special Revenue Funds.....$254,469,098.22
  - **TOTAL**.....**$2,781,787,284.22**
- Contact Information for DHHS

Constituent Services for DHHS

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Highlights of DHHS Enabling Legislation

1. ***Effective Date -*** The new Department of Health and Human Services was established by Public Law, Chapter 689, as of July 1, 2004
2. ***Legacy Departments -*** The new department is a combination of the former Department of Human Services and the former Department of Behavioral and Developmental Services
3. ***Authority -*** The enabling legislation authorized the Commissioner to consolidate administrative functions and adult protective functions. However, the Commissioner is not permitted to establish a bureau structure for the new department until that structure has been approved by the 122nd Legislature.[23]
4. ***Report Due –*** The Commissioner must submit a report, including recommendations and any necessary legislation, to the Governor and the Joint Standing Committee on Health and Human Services by January 31, 2005. The report must include:
    A. Bureau structure, including the number, title and functions of bureaus and divisions within bureaus
    B. Administrative structure and functions,
    C. Program and service delivery functions
    D. Integration and consolidation of existing advisory boards, councils and commissions that serve the Department of Human Services and the Department of Behavioral and Developmental Services; and
    E. The child welfare ombudsman program
5. ***Legislation -*** Following receipt and review of the report, the Joint Standing Committee on Health and Human Services may report out legislation to the 122nd Legislature.
6. ***Child development services and juvenile justice services -*** By January 31, 2006, the Commissioner must submit a report, in conjunction with the Commissioner of Education and the Commissioner of Corrections, to the legislative Health and Human Services committee to review the delivery of child development services and juvenile justice services. Following receipt and review of the report, the committee may report out legislation to the Second Regular Session of the 122nd Legislature

Internet Sites for More Information

Please feel free to access these web sites for more detailed information about programs and services offered by DHHS.

Former-DHS programs and services: http://www.maine.gov/dhhs/

Former-BDS programs and services: http://www.maine.gov/dhhs/bds/

Creation of DHHS and the Commissioner's Implementation Advisory Team: http://www.maine.gov/dhhs/dhhsnews/dhhsnews.htm

[1] Note: selected language from the report to the Commissioner from his Implementation Advisory Committee may appear herein verbatim, with or without specific attribution

[2] P.L.2003 Chapter 689 Part B §B-1, sub-§10

[33] Public Law 2003, Chapter 689, Part B, §B-1, sub-§10, as passed at the Second Special Session of the 121st Legislature.

[4] P.L.2003 Chapter 689 Part B §B-1, sub-§10

[5] Report of the Advisory Council For the Reorganization and Unification of DHS and BDS. January 5, 2004. page 3

[6] "Report of the Advisory Council for the Reorganization and Unification of DHS and BDS. January 5, 2004. page iv.

[7] for a list of Work Group members, see http://www.maine.gov/dhhs/dhhsnews/ciat.htm

[8] http://muskie.usm.maine.edu/

[9] Public Law 2003, Chapter 689. 22-A MRSA. §202 sub-§1

[10] Title 22-A §202.2.**G**

[11] Title 22-A §202.2.**A**

[12] Title 22-A §202.2.**B**

[13] Title 22-A §202.2.**C**

[14] Title 22-A §202.2.**D**

[15] Title 22-A §202.2.**E**

[16] Title 22-A §202.2.**F**

[17] from lean management principles

[18] from CIAT Work Groups and Leadership Framework

[19] from CIAT Work Groups and Leadership Framework

[20] This Recommendation outlines a structure to provide oversight and direction of several recommendations by the Provider Partnerships work group.

[21] Public Law 2003 Chapter 689 Part B. §10

[22] to PL 2003 Ch 689 Part B, §10 B 4

[23] Public Law 2003 Chapter 689. §A-3