REPORT TO THE COURT

February 12, 1999

Bates, et al. v. Peet et al., Kennebec County Superior Court, Docket No. CV 89-88

Gerald Rodman, Master

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I. SUMMARY

This Report focuses on three topics: 1) progress highlights for specific programs, 2) the emerging quality improvement program of DMHMRSAS, and 3) funding considerations.

In Section II of this Report I highlight progress regarding specific programs and initiatives. Progress has been made through the addition of more housing opportunities. The addition of Mobil Psychogeriatric services for Kennebec/Somerset Counties and a 24-hour per day, 365-day per year, statewide peer phone support line for trauma survivors are also gains. Additionally, the Department of Mental Health Mental Retardation and Substance Abuse Services reports that its Intensive Case Managers, in cooperation with the Maine Correctional Center, have been working collaboratively on identifying class members and developing comprehensive release plans. DMHMRSAS reports that in Region I, the collaborative team has worked with approximately 65 individuals, with no recidivism for any of the individuals released.

Also, the Department of Human Services has initiated long-awaited rulemaking to allow for individuals with acquired brain injury to receive in-home services and which increases the range of services available to Medicaid patients. Other programs are in the early stages of development or consideration but hold promise for progress. These include setting up formal review processes for

every seclusion and restraint episode occurring in hospitals in order to assist staff in devising alternative interventions. Likewise, contracts have been entered into for the provision of transportation services and DMHMRSAS is reexamining the proposed Medicaid managed care program. Citing potential problems for consumers, the Department is reviewing alternatives so that class member's Individualized Support Plans (ISPs) and other consumer plans become central to the managed care initiative.

Some initiatives have been slow to develop. For example, the Request for Proposal (RFP) for in-home support services has not yet been issued. Also, the Consumer Information Centers (CICs) are yet to be developed. Additionally, the public education initiative has slipped backwards. This appears to be due to instability in the Quality Improvement Councils (QICs). On balance, however, Defendants have demonstrated overall progress in implementing the Consent Decree.

In Section III of this Report I review the emerging quality improvement program, focusing on quality improvement tools which are currently utilized or are in early stages of utilization. This includes: the Case Management Application (CMA) system, the computerized database for Individualized Support Planning (ISP) data; class member surveys; performance indicators (as required by provider contracts and service agreements); and "targeted outcome studies", such as DMHMRSAS's housing study. These quality

improvement tools are already producing interesting and potentially useful information.

At this point, it can not be ascertained whether the emerging system will meet all Settlement Agreement requirements for the monitoring and evaluation of each component of a comprehensive mental health system. It is clear, however, that significant progress has been made. In the past, progress has been measured by quantifying the incremental additions of services to the mental health system. It has not been possible, however, to ascertain on a broad basis what progress had been made relative to specific class member needs. Class member specific outcomes were also not ascertainable. The emerging quality improvement system marks a shift to a more scientific, data-informed approach to meeting class member needs and to evaluating Consent Decree compliance.

Section IV of this Report regards funding. Currently, the Governor's Part II budget for fiscal years 2000/2001 includes $3,427,669 for each fiscal year for DMHMRSAS. These funds, however, replace money previously available through the "tax and match" program. As such, if appropriated, these funds will allow for continuation of programs but do not represent additional funding. No other major funding initiatives are included in the Governor's Part II budget for DMHMRSAS. Among other things, the Department had sought Part II funding of $477,138 for both FY'00 and FY'01 to meet identified, unmet class member needs. Also, the

Department sought specific appropriations for three initiatives related to their plan for serving victims of trauma. This includes $175,000 per year for three regional trauma specialists and $300,000 per year for a trauma safe house in Region I. These initiatives are currently specified in the approved Implementation Plan to the Consent Decree. The Department also sought $210,000 per year to expand coverage for trauma treatment. Expanding coverage is also a component of the approved plan. (DMHMRSAS's budget request was for three trauma out-patient service centers, the approved plan, however, provides the Department latitude in selecting strategies to expand coverage for trauma treatment.) Other unfunded areas which may impact upon Consent Decree obligations include services designated for substance abuse purposes, including residential services, interim services and detoxification services.

Moreover, as previously reported to the Court, DMHMRSAS's Community Development - Mental Health account is currently slated to expire on June 30, 1999. The Department has relied heavily on its authority to carry balances from one biennium into another in order to fund Consent Decree related programs through this account. The absence of additional funding and the lapse of the mental health community development account may pose a significant challenge to the Defendants' achieving Consent Decree compliance. The budget process is ongoing, however, and it should not be assumed at this time that funds will not be made available for

Consent Decree related purposes. On the positive side, the Part I budget includes cost of living adjustments (COLAs) for community mental health (2.9%) and community mental health - Medicaid (6%). The 6% Medicaid COLA adjustment is a significant benefit.

II. PROGRESS HIGHLIGHTS

Housing

Under the Bridging Rental Assistance Program (BRAP), a total of 1353 individuals are reported to have received subsidies as of September 30, 1998.[1] This includes 658 class members who have been served at some time since the inception of the program. Fifty-one (51) class members were newly served under BRAP for the quarter ending September 30, 1998. There were a total of 492 class members being served by BRAP as of September 30, 1998. (DMHMRSAS Quarterly Report of 11/15/98, Housing, Outcome 3, task #8.)

Under the 1995 General Obligation Maine State Housing Authority Bond there has been development activity regarding 173 units/beds as of September 30, 1998 (114 units/beds completed, 41 units/beds under construction, 18 units/beds under purchase and sale options). This represents an increase of 18 units/beds since June 3, 1998. The total development goal for this bond issue is 200 units/beds. (DMHMRSAS Quarterly Report of 11/15/98, Outcome 3, task #14).

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[1] The quarterly reporting for housing follows the calendar year and therefore does not correspond precisely with the Quarterly Reports filed by Defendants.

There has been some concern regarding the status of 70 housing vouchers under the Shelter Plus Care Program. The vouchers are for use in Cumberland County through the City of Portland (30 vouchers) and the Maine State Housing Authority (40 vouchers). The federal Department of Housing and Urban Development (HUD) determined not to award grant applications for renewal of these vouchers in late December 1998. DMHMRSAS's Housing Coordinator, William Floyd, stated that the vouchers could be renewed if applications are approved during the next federal year cycle (beginning 10/1/00). Mr. Floyd stated that this did not currently affect the availability of the 70 vouchers or require the State to pick up the cost of the vouchers. The risk, as I understand it, is that if the vouchers are approved for the next fiscal year, the total number of vouchers approved may exceed a cap forcing reduction in the number of available vouchers in subsequent federal fiscal years.

On the positive side, Mr. Floyd stated that approximately 400 additional units of Section 8 Housing have been made available to the State, for individuals with disabilities (through the Augusta Housing Authority, Westbrook Housing Authority, and Maine State Housing Authority) over the course of the past year. He estimates that more than 50% of these housing units may be available to individuals with mental illness. (Telephone conversations with William Floyd, 1/28/99, 2/3/99.

Residential Support Services

In its May 1998 Quarterly Report DMHMRSAS reported that "current work is underway to better define these services and the levels and types provided. This includes: short-term, long-term intensive, and crisis". In the November 1998 Quarterly Report it is reported that a statewide RFP for in-home support services is being finalized and that in the meantime services are negotiated and developed on an as-needed basis for individual clients. (Outcome 1, task #3). However, DMHMRSAS's Consent Decree Operations Manager, Lisa Wallace, reported in a telephone conversation of 2/2/99 that the RFP has not yet been issued.

Individualized Support Plan Development and Revision

Outcome 2, task #4 of this section is to "implement ISP record review and consumer interview procedures on representative samples from each provider agency and ICM office". The November 1998 Quarterly Report states that four rounds of quarterly record reviews have been completed and two administrations of the ISP consumer interview have been completed with a third to be completed by the end of November 1998. In the second round, 74 interviews were completed statewide (August 1998 Quarterly Report). These are discussed in this Report in Section III, Quality Assurance.

Vocational Services

The contract for statewide and regional vocational initiatives, which had previously been delayed, has been finalized

with Maine Medical Center. A director and three coordinators, one for each region, have been hired. (Outcome 1, task #5, November 1998). As of November 1998, Region III was also negotiating a contract with an expected completion date of December 1, 1998, to provide similar services in that region (November 1998 Report, Outcome 1, task #9).

Recreational/Social/Avocational Opportunities

Outcome 1, task #6, is to "Provide opportunities for members of social clubs and consumer organizations to self-identify training, development and technical assistance needs and provide for meeting those identified needs". It is reported in the August 1998 Quarterly Report that $20,000 in training money has been provided to AMISTAD, through a contract with DMHMRSAS, for AMISTAD to act as the fiduciary agents for clubs as they make their decisions regarding training priorities.

Pursuant to Outcome 1, task #15, Consumer Information Centers (CICs) are to be developed. It is reported in the November 1998 Quarterly Report that, subsequent to a series of delays, the RFP was released and five proposals received. None of the proposals met specifications, however, and this initiative remains incomplete (telephone conversation with Lisa Wallace, 2/2/99). As this is a recent development, DMHMRSAS will need some time to rethink its strategy regarding CICs.

Treatment Services

Outcome 1, task #5 is to develop contracts for timely assessment and referral of class members needs in the Maine Correctional system and to continue development of regional relationships between DMHMRSAS, Department of Correction Probation and Parole, social services and mental health personnel. DMHMRSAS reported in its August 1998 Quarterly Report that the Maine Correctional Center and the Department's intensive case managers have worked collaboratively on identifying class members and developing comprehensive release plans. The Department reports that in Region I, the collaborative team has worked with approximately 65 individuals, with no recidivism for any of the individuals released.[2]

Pursuant to Outcome 1, task #6, DMHMRSAS is to "develop access standards which will address at least: a) easy access to out-patient services, b) a no eject/no reject policy, and c) eliminating the waiting list". It also requires that LSNs operationalize and implement these access standards. In August 1998 the Department reported that full implementation of the access standards was expected in fiscal year 1999 (ending June 30, 1999).

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[2] DMHMRSAS also reports that it is working in cooperation with the Department of Corrections pursuant to 34-B, M.R.S.A., Section 1220. This legislation requires that the Department designate at least one individual within each of the state's seven areas to act as liaison to the district courts and superior courts and to the Department of Corrections in its administration of probation and parole services and the Intensive Supervision Program under 17-A, M.R.S.A., Section 1261. (See DMHMRSAS's Quarterly Report of November 1998, Treatment Services, Outcome 1, task #5b.)

In November 1998 the Department stated that the revised and final version of the access standards would be released in late November 1998 and that providers are required to provide information on the implementation of those access standards on a quarterly basis. Some provider reports have now been submitted to DMHMRSAS. (Letter of February 11, 1999, Greason to Rodman.)

Outcome 1, task #9 regards recruiting and filling medical director positions in the State's three regions. In accordance with the November 1998 report, a psychiatrist has been recruited in Region III and is to start in January 1999. This will result in a medical director for each of the State's three regions.

Trauma Treatment Services

Outcome 1, task #8 regards initiating funding and implementation of treatment options, services and resources for persons with histories of traumatic abuse. Under this task, at item "B", it is reported that the 24-hour per day, 365-day per year peer phone support line for trauma survivors has been implemented statewide. This phoneline is established in collaboration with the Maine Coalition Against Sexual Assault and its 10 local Rape Crisis Centers.

Trauma Treatment Services Strategic Action Plan

The Department has requested $210,000 in its Part II Budget Request for expanding Medicaid coverage for trauma treatment.

(Outcome 2, task #1.) It also sought funding for a trauma specialist in each of the state's three regions (Outcome 3, task #5). As reported in the Funding section of this Report, no funding for these initiatives is currently included in the Governor's Budget.

Outcome 3, task #4 regards the development of intensive residential treatment options as an alternative to hospitalization for clients with trauma disorders. The Department reports in its November 1998 report that the grant for this program was not awarded and that alternative strategies are being explored. DMHMRSAS filed a proposed amendment to its Trauma Treatment Services Plan on December 31, 1998 which sought to terminate this specific proposal and replace it with a proposal to develop alternate plans. For the reasons stated in my Review of the Proposed Amendment, this request was denied. (See February 4, 1999 Review of Proposed Amendment to Trauma Treatment Services Plan.)

Outcome 3, task #3 regards the development of three regional safe houses to provide longer term residential support for consumers in crucial phases of treatment for trauma disorders. The safe houses were originally to have been implemented by July 1998. DMHMRSAS has also sought an amendment to this provision of the Plan (request of December 31, 1998). In this request, the Department states that the bid for safe houses was over the budgeted figure. The Department, therefore, has proposed to proceed with the

development of a safe house in Region III by May 1999 and in Region II by April 1999. It has also sought to expand the Region II residential facility from 6 to 8 beds. The Department requested additional Part II funding in order to develop a safe house in Region I sometime in fiscal year 2000 (see request of December 31, 1998, page 1). In its requested amendment the Department did not make clear its ultimate commitment to the development of the Region I safe house. I approved the amended dates for the development of the safe houses in Regions II and III and required that the Department maintain its commitment to develop the Region I safe house in fiscal year 2000. (See February 4, 1999 Review of Proposed Amendment to Trauma Treatment Services Plan.)

Substance Abuse Services

Quarterly Reports indicate that DMHMRSAS is still in the process of integrating substance abuse initiatives under its umbrella. The Office of Substance Abuse had previously been located within the Executive Department. Developing an integrated database by blending OSA and DMHMRSAS initiatives is the goal of Outcome 1, task #5. The November Quarterly Report indicates that DMHMRSAS's MIS office is in the process of setting up a work station to begin joint programming efforts between the Divisions of Mental Health and Substance Abuse Services within DMHMRSAS.[3]

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[3] The Office of Substance Abuse was originally under the jurisdiction of the Department of Human Services when it was known as the Office of Alcohol and Drug Abuse Prevention (OADAP). It became an independent office of the Executive in 1991 and was transferred to the Department of Mental Health and Mental

Outcome 39, task #1, requires that notification be given to class members of their right to receive services of a community support worker or other individualized support services upon admission to a substance abuse treatment facility. The status section of this task indicates that the final draft of new licensing regulations is nearing completion. They will be made available to the Licensing Task Force for review in late February 1999 (telephone conversation with Lisa Wallace, 2/2/99).

Geriatric Services

The Mobil Psychogeriatric Services for Kennebec/Somerset Counties are reported to be fully operational pursuant to Outcome 4, task #7, (May 1998 Quarterly Report). Development of the other two Mobil Psychogeriatric Services for Bath/Brunswick (tasks #1-#3) and Cumberland County (tasks #8-#10) had previously been reported as completed.

Special Populations

Outcome 2 regards the development of community services and housing/residential options for individuals with specialized needs. Defendants had previously reported that qualified bidders withdrew

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Retardation in 1996. Defendants requested, by letter of April 16, 1998, that Substance Abuse Services tasks reported upon by DHS be reported upon by DMHMRSAS, or be eliminated if they were completed or no longer applicable. By letter of April 28, 1998, I approved the transfer of reporting responsibility. The transferred tasks are listed in the November 1998 Quarterly Report at pages 58-60 (Outcomes 36, 38, and 39). The list of tasks which Defendants believed to be completed or no longer applicable are listed in the chart on page 57 of the November 1998 Quarterly Report.

their bids "due to the inability to operate small homes within the routine cost limits contained in the Principles of Reimbursement". In August 1998 it was reported that the Bureau of Medical Services (DHS), was changing its payment method and preparing amendments to the Principles of Reimbursement which would be retroactive to July 1998. In the November 1998 Quarterly Report, Defendants report that the amendments which were to have been retroactive to July 1, 1998 have been postponed by the Bureau of Medical Services until April 1999. (Outcome 2, task #2.)

Outcome 2, task #16, regards implementing a statewide treatment approach for class members with acquired brain injuries. A key feature has been the development of rules regarding such things as rates of reimbursement and determination of medical eligibility criteria for home-based services for these individuals. Defendants reported in the November 1998 Quarterly Report that BMS had initiated rule making in November 1998. The new rule will "allow individuals with brain injury the option of receiving necessary services in a home or community setting instead of a nursing facility. This rule increases the range of services available to Medicaid patients with brain injury". (Cover memorandum of 11/18/98 to Notice of Agency Rule Making - Proposal.)

Transportation

In Region II, contracts have been awarded to four entities: Western Transportation, Shoreline MHC, Mid-Coast MHC, and The Peer

Center (November 1998 Report, Outcome 1, task #14). In Region I, contracts have been entered into with Regional Transportation Inc. and York County Community Action Corporation. In Region III, Aroostook Transportation Services is under contract to provide services in Aroostook County. (Letter of February 11, 1999, Greason to Rodman.)

Clients' Rights

Outcome 1, task #3 is to reduce the overall use of seclusion, restraint and protective devises. The official implementation date of the new "Clinical Protocol for Prevention of Seclusion and Restraint Informed by the Client's History of Trauma" was October 1, 1998. Members of the nursing staff of BMHI and AMHI are working with committees in the hospitals to set up formal review processes for every seclusion and restraint episode in order to assist the staff in devising alternative interventions. The next phase is to implement the protocol in community hospitals throughout the state. One training with Maine Medical Center was planned for November 12, 1998. (November 1998 Quarterly Report).

Public Education

Defendants' Revised Public Education Plan of January 13, 1998/April 1, 1998 was partially approved on April 27, 1998. The partial approval was due to the absence of plans from York and Aroostook QICs. The Public Education Plan was supplemented with the submission of plans from the York and Aroostook area QICs and

approved on June 4, 1998. I noted in my reviews of both April 27, 1998 and June 4, 1998, that the plan I approved defined an evolving program and it was my expectation that the programs of the individual QICs, particularly those which were weak, would be strengthened and that this would be reflected in Defendants' quarterly reporting.

It appears that the public education initiative has slipped backwards. It is reported at Outcome 1, task #12 of the November 1998 Report that "QICs have been very busy reorganizing and expanding their membership. To the Department's knowledge, no public education activities have taken place by QICs this quarter".

Managed Care

In the May 1998 Quarterly Report DMHMRSAS noted that, based upon comments received, it was revising its managed care model. The stimulus for the proposed revision was the system's administrative inefficiencies which would result in less money available to support direct care. In the August 1998 Report, the Department announced a more broad-based reexamination of the current Medicaid managed care model. The Department cited "potential problems for consumers".

In the November 1998 Report the Department stated that it was considering alternatives for managing care and that the "priority goal of this review is to locate models which will make consumers

and their care plan/ISP the central focus and will streamline administrative processes". It appears that the goal of having managed care be ISP-centric improves the potential for the Medicaid managed care program to be consistent with Consent Decree values and requirements. DMHMRSAS further states in its November 1998 Report that "work on a 1915(b) waiver for Medicaid-funded services, if that is the appropriate tool, will resume when a clearer picture of models that are possible for managing care while also supporting the Department's values and goals have emerged". The Report also states that DHS's Bureau of Medical Services expects to implement an interim plan for Medicaid services for managing acute behavioral health services, probably through an HMO.

Management Information Systems and Quality Assurance

See this Report, Section III.

Downsizing

Outcome 1, task #10 regards negotiating "resource development for remaining long-stay patients". Defendants report that the Level III Safety Net project "has been delayed due to funding availability, but program development continues to undergo revisions". The goal of the Level III project has been to develop a 6-bed facility for patients who have been difficult to discharge from AMHI. (November 1998 Quarterly Report.)

In other activities relating to downsizing, Defendants report

that DMHMRSAS assisted in bringing 6 new psychiatrists to Region III. The Department also has contracts with psychiatrists to provide medication consultation to individuals with mental retardation and psychiatric illness in Regions I and II. Additionally, agreement was reached with Maine Medical Center for the provision of expert inpatient consultation for clients of the Department who are not responsive to current treatment or who otherwise could benefit from the service. (May 1998 Quarterly Report, Outcome 1, task #12.)

III. QUALITY ASSURANCE

Defendants' Quality Assurance Program is outlined generally in its May 3, 1996 Plan ("Final Consolidated Plan For Implementing Settlement Agreement to AMHI Consent Decree") beginning at page 123. The May 1996 Plan responds to Defendants' observation that "there is a lack of data and technology to support quality improvement" (May 1996 Plan, preface, page iii). In my Review of Specific Planning Initiatives which were submitted subsequent to the May 1996 Plan, I noted concerns regarding Defendants' ability to assure the quality of its specific programs. Specific reference was made to Settlement Agreement ¶36 which requires, among other things, that each component of the comprehensive mental health system be capable of being evaluated on an ongoing basis for its

"quality and effectiveness".[4]

In November 1998 DMHMRSAS produced a detailed overview of its quality assurance functions (DMHMRSAS Quality Improvement Plan - DRAFT - November 23, 1998, attachment #1, hereinafter "Draft Plan"). The Draft Plan, at this point, does not have a formal status under the Consent Decree. It is, however, a useful tool for discussing the quality assurance system and is also useful as a reference document. As such, the Draft Plan is the single most useful document for organizing a discussion of quality assurance.

At this point, it can not be ascertained whether the emerging system will meet all Settlement Agreement requirements for the monitoring and evaluation of each component of a comprehensive mental health system. It is clear, however, that significant progress has been made. In the past, progress has been measured by quantifying the incremental additions of services to the mental health system. It has not been possible, however, to ascertain on a broad basis what progress had been made relative to specific class member needs. Class member specific outcomes were also not ascertainable. The emerging quality improvement system marks a shift to a more scientific, data-informed approach to meeting class member needs and to evaluating Consent Decree compliance.

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[4] My observation regarding the need for more comprehensive quality assurance initiatives is outlined in my December 16, 1997 Memorandum regarding Treatment Planning at pages 4-6. This concern was also raised in my Review of March 18, 1998 regarding the Revised Trauma Treatment Services Plan.

The Draft Plan discusses quality improvement activities across several domains. The initiatives described in the plan are in widely varying stages of implementation. Some elements of the plan, such as the Systems Infrastructure Development Initiative (SIDI), are part of an effort to develop an integrated information system, which will impact this Consent Decree but go beyond it in scope. SIDI is an information system that covers the Department's complete client base, including not only people with mental illness, but also people with mental retardation and children with special needs. Most of the activities, however, bear directly upon qualitative evaluation of progress relevant to class members. A draft summary of quality improvement activities is also presented in chart form (draft Quality Improvement Monitoring Activities - revised 12/14/98), (attachment #2 to this Report).

As is clear from the discussion which follows, the quality assurance system is an emerging system. There is, however, considerable documentation of the operation of the system which provides visual reference for the specific data generated by the system. I have included a substantial number of these documents in the attachments to this Report to assist the Court in understanding the system's current and emerging capabilities. First, I turn below to a brief discussion to the structure of the quality assurance system.[5]

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[5] For the purposes of this Report I use the terms "quality assurance" and "quality improvement", interchangeably.

The structure of the quality improvement system is outlined generally in figure #1 on page 4 of the Draft Plan (attachment #1). Regional Quality Improvement Teams are included in each of the State's three regional offices. There is also a Central Office Quality Improvement Team which is responsible for reviewing information coming from the regions, as well as other data, and is responsible for making recommendations to DMHMRSAS's Executive Management Team. Advisory roles are to be played by Network Quality Councils which will interact with the Regional Quality Improvement Teams and the Statewide Quality Council which will in turn interact with the Central Office Quality Improvement Team. (Responsibilities associated with various components of this system are outlined in the Draft Plan at pages 4-8.)

Central to the operation of the Quality Improvement System is the Management Information System (MIS) which is "currently being developed to consolidate existing data systems, address system-wide information needs, and support the Quality Improvement System." (Draft Plan, page 6). Responsibility for data summary and analysis lies with the Central Office Quality Improvement Team. The Central Office Quality Improvement Team will produce quarterly and annual reports which are to be reviewed regionally and also forwarded with the recommendations to the management teams at both the central and regional offices. (Draft Report, pages 6, 11.) Also, within each of the two state hospitals there is a Director of Quality Assurance (Draft Plan, page 8).

The quality improvement system is informed by a number of data sources. Among the major data sources are: Individualized Support Plans (ISPs), surveys, performance indicators, and grievances and complaints. Each of these areas is discussed briefly below. (I do not follow the format of the Draft Plan or any other planning document. I also do not discuss each item which is a part of the quality assurance system. The areas outlined below are major components of the system for which current, useful documentation is available.)

ISP's

Pursuant to Settlement Agreement ¶72, "the ISP is the principal tool through which class members' needs are identified". ISPs follow a uniform format and data from ISPs are tracked through the "Case Management Application" (CMA). The standard ISP form is attachment #3 to this Report. The CMA is a computerized database. Until recently, data entered in the CMA has been lifted from existing ISPs. Data entry is in the beginning phases of transitioning to "real-time" entry. Under this initiative, information will be entered directly into the Case Management Application system as the information becomes available. The first step in this process is training intensive case managers to enter data. The data will be entered at the regional level. This training was reported to be imminent (meeting of 12/21/98).

"Unmet needs data collected through the CMA on AMHI class members and non-class members are analyzed by CO MIS [Central Office Management Information System] staff on an annual basis to determine how well the system is performing, what budget adjustments (if any) are needed, and what unanticipated needs may have emerged during the year". (Draft Plan, page 26.) DMHMRSAS's "Unmet Needs Summary - June 1998" is attachment #4 to this Report. The summary breaks out needs over 13 areas (e.g., dental, psychiatric, substance abuse, trauma). Attachment #5 is the unmet needs data extrapolated for all class members as of August 1998. Using this unmet needs data, DMHMRSAS has computed the total cost of unmet needs for all class members as $477,138. Unmet needs are defined as those that "can not currently be met with existing resources" (see footnote, attachment #5). The funding implications of this data are discussed in Section IV (Funding) of this Report.

ISPs themselves are reviewed through the "record review" process. Record reviews are performed by Consent Decree Coordinators (CDCs) "using a standard protocol on a randomly selected sample of ISPs in each region". The standard ISP Document Review form is attachment #6 to this Report. This information is entered into a database and aggregated for each region on a quarterly basis. Attachment #7 is the ISP Quarterly Review for the first quarter of FY'99. This is the fourth quarter for which the data has been accumulated.

Interviews And Surveys

Pursuant to the draft Quality Improvement Plan, interviews of class members with ISPs are to be conducted twice a year by trained consumer interviewers. These interviews are conducted pursuant to a standard protocol. These interviews are designed to gauge how the ISP process is working for the class member. (Draft Plan, page 26).

The Standard ISP Consumer Interview form is attachment #8. The results of the interviews are tabulated for each question asked. The "crosstabs" tabulation for the three sample rounds which have been performed is attachment #9. The cross tabulation indicates that 88.9% of individuals found the ISP between moderately to very useful in helping them reach their goals. Over forty percent (40.3%) of class members interviewed stated that the ISP has made a difference in their life either "a good deal" or "very much". Over eighty percent (88.6%) would recommend ISPs to others "almost always" or "definitely". These results seem to confirm the utility and value of ISPs.

An independent survey is also conducted of class members in general. The purpose of this survey is to find out how mental health needs are being addressed and how all rights are being protected under the Consent Decree. The survey is broken into two components. One is a survey of class members living in the community and the other is a survey of class members who are at

AMHI. As of January 1999, the hospital survey had been completed, but the results not yet tabulated. The community survey had not yet been completed. The hospital version of the class member interview form is attachment #10 to this Report.

This survey is not specific to the ISP process, but is a broad-based survey which seeks specific information regarding a wide variety of services, among other things. These include advocacy services, psychological counseling, substance abuse services, psychiatric services, crisis services, vocational services, dental care, transportation, and trauma services (see Interview Form, page 2 for a complete listing).

This survey appears to be specifically geared to meet Defendants' obligations under Settlement Agreement ¶279, which states: "Defendants shall perform an annual random statistically significant review of class members residing both at AMHI and in the community to measure Defendants' compliance with this agreement in meeting individual class members' needs and in protecting their rights under this agreement".

Organizational Performance

Performance indicators are incorporated into all contracts and service agreements with provider agencies. These are discussed in the draft Quality Improvement Plan, pages 22-24. These indicators include specific things such as: number of substantiated

grievances, waiting time for assignment of case manager, waiting time for receipt of psychiatric services and number of individuals hospitalized within 24 hours of a face-to-face crisis intervention. Specific adult mental health performance indicators are listed on page 23 of the Draft Plan, with detailed descriptions of these indicators appearing in Appendix D to the Draft Plan.

Each provider is to report on a quarterly basis regarding outcomes for each indicated area. Included within the Quarterly Report is the provider's Quality Improvement Plan. DMHMRSAS has set up a database for entry of the information contained in the reports, but as of December 1998 no entries had yet been made (meeting of 12/21/98). A sample report (Shalom House, Inc. - Performance Standards and Outcomes - Adult Mental Health Performance Indicators, Quarterly Report, 7/1/98 - 9/30/98) is attachment #11 to this Report.

Critical Incidents and Grievances

Critical incidents are defined as those which have a serious or potentially serious impact on clients, staff, volunteers, or visitors of DMHMRSAS operated programs, facilities or agencies. Critical incidents are either Level I (requires immediate action) or Level II (requires prompt attention). Level I instances are to be reported to the DMHMRSAS Regional Director or Facilities Operation Director within 4 hours. Level II incidents are to be reported within 24 hours. DMHMRSAS currently has a database for

these reports. The regional offices of the Department have the computer capacity to transmit data to DMHMRSAS's Central Office, but were not yet up to speed on data entry as of December 1998 (meeting of 12/21/98). Aggregate Critical Incidence Reports are now produced by DMHMRSAS, a Critical Incidents Quarterly Summary Report is attachment #12 to this Report.

DMHMRSAS maintains a database for all Level II and Level III grievances. Level II grievances are those which have been appealed to a DMHMRSAS Program Manager (community programs) or the Superintendent's office (inpatient facility). Level III grievances are those that have been appealed to the Commissioner of DMHMRSAS. (Draft Plan, pages 20-21.) Settlement Agreement ¶27 requires that Defendants submit semiannual reports of grievances and complaints which have been appealed. DMHMRSAS's Grievance Process Summary Report of December 1, 1998 is attachment #13 to this Report.

Quality Improvement Councils

Quality Improvement Councils (QICs) are obligated to have a Service Evaluation Team of non-provider members. Service Evaluation Teams are responsible for periodic review of programs funded by the Department. The general role of the QICs is outlined in the Draft Plan at pages 9-11. DMHMRSAS has developed a position paper regarding Service Evaluation Teams (December 28, 1998). The Department sees the Teams' primary responsibility as "measurement of the satisfaction (or lack thereof) that consumers experience as

a result of receiving Department sponsored services". The Consumer Satisfaction Surveys proposed by the Department are outlined in more detail in the Service Evaluation Team Position Paper which is attachment #14 to this Report. At this point, it appears as though most QICs are not highly functioning organizations (meeting of 12/22/98).

Pursuant to the Draft Plan, local system's annual priorities are to be generated by each Local QIC (Draft Plan, page 10). Most QICs have not submitted this material. The "Network Plan" for the Kennebec/Somerset QIC of October 1, 1998 is attachment #15 to this Report.

Other Quality Assurance Related Items

Annual capacity studies are currently done to track the development of service capacity for core services. According to the Draft Plan, page 32, "wherever possible, parameters will be determined through comparison with 'exemplary' service systems in states that are similar to Maine". DMHMRSAS's Mental Health System Capacity Study - September 1998, is attachment #16 to this Report. Charts included within the study show increased outpatient mental health services, case management services, crisis beds, and housing. Community housing, which includes supervised apartments and supported housing units has grown from 375 units in 1975 to 1268 units in 1998. (The Capacity Study is systemwide and includes all service recipients, the numbers therefore will include, but are

not limited to class members.) The data also indicates, however, that Maine lags behind the other northern New England states in its availability of case management and outpatient services.

Another source of information is Medicaid claims data. During the past year DMHMRSAS has worked with DHS in order to enable DMHMRSAS to access and use Medicaid claims data. (Draft Plan, page 32.) Attachment #17 to this Report is a recently run Medicaid claims data study for women with affective disorders.

"Targeted outcome studies" are discussed in the Draft Plan, page 33. These studies tend to have a research orientation and are "reserved for specific areas where important policy questions about efficacy and cost-effectiveness need to be answered". DMHMRSAS has completed Phase I of the Department's Housing Study which is a targeted outcome study. The findings of the Phase I Study (Maine Housing Alternatives Project - Phase I Study Findings) is attachment #18 to this Report. A more detailed description of the study is found in the Maine Housing Alternative Projects, §A, "Descriptions of Housing Models and Process Evaluation: Methodologies and Results". (This document is not attached to this Report.)

The housing study contains much useful information. For example, a high percentage of residents in all forms of housing indicated that they had privacy (with a high of 95.8% for supported

housing). Also, in supervised apartments and supported housing individuals tend to feel that they could stay in housing even if they did not accept services (88.9% and 85.3% respectively). On the other hand, a very low percentage of people in supported housing reported having social activities (15.4%), and a high percentage felt isolated (47.2%). Overall, people felt that their housing quality was good, although supervised apartments and supported housing was ranked higher than group homes.

IV. FUNDING

Attachment #19 is DMHMRSAS's Part I requested funding for FY'00/FY'01 (General Fund - Mental Health). The Department sought a total of $70,378,977 for FY'00 and $73,251,526 for FY'01. The Governor's budget (119th Maine Legislature, L.D. 618) seeks approximately $66,664,360 in FY'00 and $69,130,575 in FY'01. (The Governor's Part I General Fund - Mental Health proposed budget is approximated by the budget summary which is attachment #20 to this Report.) Most of the difference in these two proposed budgets regards funding to replace "tax and match" funds. "Tax and match" funds had become a routine source of funds for DMHMRSAS. However, those funds have expired. The Department's requested budget included $3,427,669 in each of FY'00 and FY'01 to replace the loss of the "tax and match" funds. Requested funds are not included in the Governor's Part I Budget, but this precise amount ($3,430,169) is included in the Governor's Part II Budget (119th Maine

Legislature, L.D. 617) under the designation "Mental Health Services - Community". While designated as a supplemental appropriation (Part II) these funds will be necessary to maintain existing obligations.

On the positive side, the Governor's Part I Budget does include a modest Cost Of Living Adjustment (COLA) of 2.9% for Community Mental Health and a significant 6% COLA adjustment for Community Mental Health - Medicaid. The Medicaid COLA is reflected in the increase from FY'99 funding of $23,833,657 to proposed expenditures of $25,190,060 in FY'01. (See attachment #20.)

Regarding the Part II Budget request, other than the previously discussed "tax and match" replacement funds, the Governor's Budget seeks no new major appropriation of funds for mental health. DMHMRSAS's own Part II Budget request (attachment #21 to this Report) did seek additional funds which are not reflected in the Governor's Budget. Among other things, the Department sought $477,138 for both FY'00 and FY'01 to meet identified, unmet class member needs (attachment #21, line 20).[6] The process and methodology for arriving at this figure is discussed in this Report in Section III at pages 23, 24.

The Department also sought specific appropriations for three

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[6] The Department also sought $500,909 for each fiscal year for non-class member unmet needs (attachment #21, line 19).

initiatives related to their plan for serving victims of trauma. This includes $175,000 per year for three regional trauma specialists, $300,000 per year for a trauma safe house in Region I, and $210,000 per year for support for three trauma outpatient service centers. The total funding for the upcoming biennium sought by the Department for identified, unmet class member needs and the trauma program is $2,324,276. The absence of these funds may pose a significant challenge to the Defendants achieving Consent Decree compliance in these areas.[7] Among other unfunded areas which may impact upon Consent Decree obligations are services designated for substance abuse purposes, including residential services, interim services and detoxification services. These are identified in attachment #21 at lines 28-30.

I have previously reported to the Court that DMHMRSAS has relied heavily on its authority to be able to carry balances from one biennium into another. As previously reported, its Community Development - Mental Health account is currently slated to expire on June 30, 1999 (P.L.1997, c.24, Part VV, Sec.11). In 1998 the balance carried in this account was $447,819 (see attachment #22). If this carrying authority is not extended, additional stress will be placed upon the Department's ability to fulfill its obligations.

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[7] DMHMRSAS did receive a supplemental appropriation in the Mental Health Services - Community account in the amount of $405,757 for FY'99. (119th Maine Legislature, L.D.50, pg. 21.) This funding may be used to assist the Department in meeting its obligations to provide for identified, unmet class member needs for the duration of FY'99, but is a one time appropriation and not available beyond FY'99 (fiscal year ending June 30, 1999).

It should be noted that the processing of the budget for FY'00/FY'01 is ongoing. The information presented above indicates the current status of the budget. At this time, it should not be assumed that funds will not be made available for Consent Decree related purposes.

February 12, 1999
Date

Gerald Rodman, Court Master