Maine Department of Health and Human Services

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October 10, 2006

Arthur F. Mayo, III, Chair
Hannah Pingree, Chair
Joint Standing Committee on Health and Human Services
Cross Office Building
Room 209
Augusta, ME 04333

Dear Senator Mayo, Representative Pingree, and the Members of the Joint Standing Committee on Health and Human Services:

Enclosed is a status update to Resolve Chapter 188 related to Community-Based Therapeutic Living Settings for Adults with Mental Illness. Incorporated in this report is a section related to flexible services and housing which is the overarching framework for our work going forward. We previously forwarded Consent Decree plan amendments that describe this framework.

Within this framework we have begun to look at a model of shared living which has been used within the Department by the Office of Adults with Physical and Cognitive Disabilities Services. This model is described in the enclosed report. However, we have more work to do before we can conclude that it should be part of an array of services for people with mental illness.

Our staff has discussed this direction with Representative Burns, the sponsor of LD 183, and he is supportive of efforts thus far.

Finally, we have included the costs per day of the various PNMI models for which we currently contract.

Sincerely

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

Enclosure

REPORT TO JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES REGARGING LD 1983 RESOLVE CHAPTER 188 DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A MODEL FOR COMMUNITY-BASED THERAPEUTIC LIVING SETTINGS FOR ADULTS WITH MENTAL ILLNESS

On August 16, 2006 the Department of Health and Human Services submitted to the Daniel E. Wathen, Court Master in Bates v. DHHS Consent Decree Plan Amendments. Amongst those amendments was a section on flexible services and housing which outlines our direction in relation to community-based therapeutic living settings for adults with mental illness and the action steps are to be undertaken. That section of the plan follows:

Flexible Services and Housing

Recognizing that recovery from mental illness is not linear, the Office of Adult Mental Health Services (OAMHS) will realign its service system to focus on providing services to consumers in their chosen, permanent home at the level of intensity, duration and type to meet the individual consumer's need. Services will be flexible and "wrapped around" the consumer. Services may be provided on a very intermittent basis or up to twenty-four (24) hours per day seven (7) days per week. Consumers will not lose their home because they no longer need or want services. The current link between services and housing will be broken. At the center of this model directing the service array is the consumer and community support worker. The community support worker will lead the array of providers working as partners with the consumer necessary to meet consumer needs. As consumer needs change, the community support worker will arrange to increase or decrease services.

To accomplish this realignment, changes in licensing and MaineCare regulations will be necessary as the level and intensity of services which are needed are not allowed in certain regulations and licensing. Currently, two chapters of MaineCare cover the services to be changed – Chapter 17 and Chapter 97. Chapter 17 only allows services up to 16 hours per day and expects that they will be rapidly reduced and Chapter 97, which allows for 24/7 service is for only residential services (PNMI).

This realignment will result in the elimination of two types of "residential service" in Licensing– supportive housing and community residential - leaving only residential treatment, which will be a transitional service.

Since many of the services currently provided to consumers are bundled with residential services, these changes will be implemented to minimize the impact on current services to consumers and align finances such that providers will be able to make the transition. Further, while appearing to be a simple change, it is such a fundamental change that all parties need to be involved in shaping the change.

OAMHS will also develop a residential and housing database that will be accessible to consumers, providers and OAMHS, which will identify all programs, capacity and current vacancies.

With the realignment as noted above the only residential treatment that will remain is a group home model or a "bundled" service. This service is currently in existence in MaineCare and is defined as follows: This service includes providing or arranging for comprehensive treatment to include psychiatric and other specialized services, training and support (including housekeeping/home maintenance and meal planning/preparation); transportation; interpersonal relationships, self advocacy and assertiveness training; health maintenance and

safety practices; financial, personal and legal affairs management, contingency planning and decision making; basic academic, work and recreational skills; and utilization of community services and resources. Services are provided by specific levels of credentialed staff. Service is typically provided in a group home living arrangement.

Actions undertaken by OAMHS:

Housing Database

- By November 2006 Beacon Health Strategies will have their initial web-based PNMI data base system operational;
- By January 2007 negotiate with Beacon Health Strategies to provide a replica of this data-base for use with the state information system;
- By May 2007 introduce a pilot data base for one of the Community Service Networks with all fields populated; The OAMHS Regional Housing Coordinators will take the lead on provider education and utilization of this system to ensure occupancy levels are documented accurately in a timely fashion. Regional Housing Coordinators will continue to utilize the existing OAMHS electronic reporting system as a fail safe until such time as the new database is operational without problems, errors, or system breakdowns;
- By July 2007 a useable database will be in place and available to providers, consumers and OAMHS staff statewide for use.

Realignment of Housing and Support Services

- By October 2006 establish a work group lead by OAMHS and including consumers, providers, MaineCare, and licensing representatives to identify and develop solutions to resolve the practical issues faced by the community support worker in implementing the system of flexible services and provider coordination;
- By February 2007 have an implementation plan for the realigned system to include changes to contracts for FY 2008 and revision of licensing and MaineCare regulations;
- Contracts for FY 2008 reflect the realigned system.

Housing

OAMHS continues to expand the array of housing options available to consumers. In 1996 there were less than 50 units developed with the support of the Department, today there are more than 900. Rental assistance vouchers have witnessed similar growth. In 1995, the Bridging Rental Assistance Program started with less than 40 vouchers, today more than 4,250 cumulative vouchers have been issued. Shelter Plus Care, a federally funded rental assistance program targeting homeless persons with mental illness, has grown from an initial grant of $300,000 in 1998 to more than $25,000,000 today.

OAMHS applied to the U. S. Department of Housing and Urban Development (HUD) in March 2006 for new Tenant Based Shelter Plus Care rental assistance vouchers and for continuing Sponsor Based Shelter Plus Care vouchers, totaling $900,000. These vouchers can be utilized at the discretion of the sponsor (the non-profit agency that owns or leases the property) in any unit or building that is owned or sub-leased by the sponsor. These vouchers are unique in that they represent a hybrid between the traditional project based voucher programs and tenant based vouchers. These vouchers will reduce the potential financial risk for sponsors and will likely result in increasing the availability of housing stock.

OAMHS has been very active in building collaborative partnerships with a myriad of stakeholders. Maine was one of the first states in the nation to develop an Action Plan to End Homelessness. Maine's Shelter Plus Care program is used as a model in New Hampshire, and our manuals are being used as foundational documents in Arizona, as well as a component of a HUD initiative to create a national Shelter Plus Care desk reference and program guide.
The demands for rental assistance continue to grow in the Bridging Rental Assistance Program (BRAP) as well. The overall housing market has tightened dramatically over the last five years.

Action to be undertaken by OAMHS:

- Carefully monitor BRAP to assure no waiting or minimal waiting lists.

Shared Living Model
Within our plans related to the Consent Degree outlined above we are exploring other community based therapeutic living settings. One such model is based on the DHHS Mental Retardation concept of *Shared Living.* This model is also known as the Individual Service Option (ISO) model. For purposes of discussion, we will refer to this as Shared Living (SL). Much of the information below represents excerpts from the work already completed by the Office of Adults with Cognitive & Physical Disabilities.

The model described below and on the following pages represents our initial understanding of a Shared Living concept that clearly needs to be clinically reviewed, have standards and certifications established, terms defined, and receive buy-in, feedback and input from consumers, providers, and interested parties. In addition, the funding of such a model will need to be further explored as it pertains to cost neutrality within the Adult Mental Health System. There is much work yet to be done.

The Shared Living model of service delivery represents an alternative living setting. Some of the flexible features are:

- A family or individual (Direct Support Provider) provides support in their existing home to a person with a disability OR;
- The person with the disability owns or leases their own home and the Direct Support Provider moves in with them to provide support OR;
- A home is purchased or leased by the Provider agency and the Direct Support Provider and individual with disabilities share the home

Direct Support Providers (individuals and families) will be supervised and supported by Designated Community Support Provider Agencies that currently provide residential and supportive services to people with mental illness under MaineCare Chapters 17, 65, and 97. The Direct Support Providers will not support more than two people with disabilities in one home and commonly will support only one. There can be a high degree of flexibility in this model, depending upon the needs of the consumer and the resources available. It is important to note that although these living and service arrangements are not licensed by DHHS they would have to meet a series of both physical and treatment standards—yet to be developed by Adult Mental Health. Some examples of the diversity within this model are:

- An individual or family provides support in their existing home to the person with a disability. (Usually this is Adult Foster Care/sub-contractor relationship with the Designated Community Support Provider Agency.)

- The consumer owns or leases their own home and the Direct Support Provider moves in with them to provide support. (Typically a Companion Employee of the Designated Community Support Provider Agency.)

- A home is purchased or leased by the Designated Community Support Provider Agency and the Direct Support Provider and the consumer share the home. (This could be either sub-contractor or companion employee relationship.)

The Direct Support Provider, whether individual or family, must have a desire to welcome a new consumer who is in need of support, understanding and inclusion into the local community. They will be the major component of an individual's support team and must be willing to participate with other members of the person's team in planning, coordinating and responding to his or her needs and desires. The Direct Support Provider will ensure an environment which is supportive of the consumer's rights and personal development and will provide opportunities for informed decision-making, development and maintenance of relationships with family and friends, and meaningful participation within the household. They will fulfill the requirements and obligations negotiated and agreed upon among DHHS, the Provider Agency, and the consumer.

The role of the Designated Community Support Provider Agency is critical to the quality of the services. Agencies will be required to provide an array of services, some of which may be:

- Recruit, interview, procure criminal/motor vehicle records, conduct reference checks, then contract with or hire the person wishing to provide this model of service. Is also responsible for any staffing.
- Assure that services being provided are supportive of the values of inclusion, both in the home/family life and in the community.
- Provide orientation and training (initial and on-going) to Direct Support Providers (and other members of the family, if appropriate/necessary.)
- Provide specialized training (behavioral, medical, therapeutic, intervention) depending upon specific needs of the consumer.
- Provide supervision/support to the Direct Support Provider, and any assigned staff members, on a regular basis.
- Provide quality assurance/improvement oversight. This usually includes unscheduled/unannounced visits as well as scheduled support.
- Assure documentation, record retention and reporting requirements are adhered to.
- Assure that all applicable Certification Standards, Licensing Regulations, and State and Federal laws are followed.
- Provide health and safety guidelines and see that they are followed.
- Facilitate, implement, and monitor the Individual Support Plan.
- Assist the Direct Support Provider and consumer to use Respite appropriately.
- Investigate allegations, submit reports and take action as necessary.
- Negotiate budgets and adjustments, if necessary. Submit bills to MaineCare.
- Provide emergency, on-call support.

This model is not intended to replace any existing models of housing and service delivery. Depending upon the level of expertise, training, credentialing and commitment of the family/individual providing the service and the level of support from the Agency, it is an option that may be made widely available within our community based service delivery system. In order to capitalize on strengths and expertise available throughout Maine, this concept will involve a unique blend of support driven by the needs of each person served and the community in

which he or she lives. An individual or family with whom the consumer lives will provide the core elements of support, in all cases. This individual or family must have a strong commitment to the person served and meet all the requirements and standards required by the this program model.

DHHS will provide: resource coordination, crisis intervention, and technical assistance to the Designated Community Support Provider Agency; case management to the individual; and financial support as resources allow. Advocacy, grievance processes, and adult protective services are also available if necessary as they currently exist in our existing models of housing and services.

Reimbursement:

Payment for services identified above is usually comprised of three major components:

1) Room and Board: the individual's portion of any rent or mortgage payment and their contribution to the cost of food. Unlike the following two categories, R&B is not a Medicaid reimbursable expense.
2) Direct support payments: funding associated with the provision of direct support to the consumer by the Direct Support Provider (Individual and/or family). This amount is negotiated among the Direct Support Provider, the Designated Community Support Provider Agency and DHHS. Under the current model in MR, the most common source of funds for this service is the Home and Community Based Waiver program—as indicated previously the feasibility of this funding approach will need to be thoroughly explored before we can formerly endorse this model within the Office of Adult Mental Health Services.
3) Administrative costs: these will vary depending upon the arrangements between the Direct Support Provider and the Designated Community Support Provider Agency. As is the case above, under the MR model, the final amount approved by DHHS is usually covered as a Waiver expense. Funding of these expenses within OAMHS will also need to be thoroughly researched.

   The total cost per unit per year for this model within MR is currently estimated between $40,000 and $50,000.

PNMI Cost Per Day

Below are estimated costs of our existing PNMI categories for FY2007. We have broken out average projected expenses in FY2007 of our current cost centers surrounding: 1601 Residential Treatment Facilities, 1602 Community Residential Facilities, and 1603 Supportive Housing. As noted above our Consent Decree Plan Amendments would eliminate the categories of 1602 and 1603 into a new design which would have a different reimbursement methodology.

For accounting and contracting purposes, the FY2007 categories and projected average estimated PNMI costs per unit per year are listed below. Please note that these do not represent consumer specific costs as they are based on agency and department budget projections as derived from the contracting process:

1601 Residential Treatment Facilities are defined as:

Provide or arrange for comprehensive treatment, training and support, including housekeeping/home maintenance and meal planning/preparation; transportation; interpersonal relationships, self advocacy and assertiveness training; health maintenance and safety practices; financial , personal and legal affairs management, contingency planning and decision making; basic academic, work and recreational skills; utilization of community services and resources. A transitional group home living arrangement.

- The average cost per unit per year, including Treatment, R&B, and Tax for these facilities in FY2007 is estimated at: $94,612.

1602 Community Residential Facilities are defined as:

> Provide or arrange a supervised living arrangement for comprehensive treatment, training and support, including housekeeping/home maintenance and meal planning/preparation; transportation; interpersonal relationships, self advocacy and assertiveness training; health maintenance and safety practices; financial , personal and legal affairs management, contingency planning and decision making; basic academic, work and recreational skills; utilization of community services and resources. Either a group or independent, permanent living arrangement

- The average cost per unit per year, including Treatment, R&B, and Tax for these facilities in FY2007 is estimated at: $81,478

1603 Supportive Housing

> Supported living arrangement with support provided in limited amounts, duration or period of availability.

- The average cost per unit per year, including Treatment, R&B, and Tax for these facilities in FY2007 is estimated at: $42,163