

MEMO

To: Joint Finance Committee
From: Brian Hartman, on behalf of the following organizations:

Disabilities Law Program
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities

Subject: Division of Substance Abuse & Mental Health FY 12 Budget
Date: March 2, 2011

Please consider this memo a summary of the oral presentation of Brian J. Hartman, Esq. on behalf of the Disabilities Law Program ("DLP"), Developmental Disabilities Council ("DDC"), Governor's Advisory Council for Exceptional Citizens ("GACEC"), and the State Council for Persons with Disabilities ("SCPD"). We are addressing one (1) overarching aspect of DSAMH's budget, the need to accelerate efforts to reallocate resources from DPC to community programs.

Historically, Delaware has had one of the highest rates of psychiatric hospitalization in the Nation. [Attachment "A"] This has resulted in a disproportionate amount of resources being dedicated to DPC versus community programs. In its 2007 report, the Governor's Task Force on DPC noted that "Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%."¹ This distorted allocation of funding has been improving, but at a slow pace:

DSAMH GF Appropriation: DPC & Community Mental Health

	FY08	FY09	FY10	FY11	FY 12 (Gov. Proposed)
DPC	58% (40,802.1)	57% (41,467.4)	56% (40,475.4)	56% (40,042.1)	52% (36,892.1)
Community Mental Health	42% (29,298.2)	43% (31,846.5)	44% (32,448.3)	44% (31,785.2)	48% (33,877.6)

¹Governor's Task Force on the Delaware Psychiatric Center, Final Report (December 18, 2007) at 49-50. [Attachment "B"] The Task Force was co-chaired by the State's former budget director, Pete Ross, and the current DHSS Secretary, Rita Landgraf.

The Governor's proposed FY12 budget allocates only 48% (\$33,877.6 million) of the mental health budget to community support vs. 52% (\$36,892.1 million) to DPC.² Of the 14,000+ clients served in DSAMH contract and state-operated programs, 52% of funds are spent on an institution serving roughly 160 individuals in January, 2011.

The anomaly historically reinforced by this institutional bias is that Division clients unnecessarily spend many years in DPC simply because there is a lack of funded community options. According to the latest CMS statistics, for DPC patients who reach the threshold of 1 year in the facility, the average length of stay is 7.8 years (2,857 days), almost 3 years beyond the national average. [Attachment "D"].

In November, 2010, the Department of Justice issued a compelling report which highlighted the same concerns. The report included the following findings:

DPC is violating the ADA by unnecessarily institutionalizing individuals who are appropriate for community-based treatment. Olmstead, 527 U.S. at 607. Based on the information we reviewed during our tours of DPC, including our review of patient records and interviews with statewide leadership and hospital staff and administrators, it is clear that the vast majority of individuals confined at DPC could be - and have a right to be - living in community settings with appropriate services and supports. DPC staff has already determined that over 70 percent of the individuals being treated at DPC are clinically ready to leave the hospital and to be served in more integrated settings.

At 5 [Attachment "E"] The report concluded that many DPC patients could be diverted or moved to community settings with proper planning and a major reallocation of resources.

Recommendations

The U.S. Department of Justice report is a "shot across the bow" which should serve as a catalyst for revamping Delaware's mental health system. The U.S. DOJ is aggressively enforcing the ADA's community integration mandate nationwide [Attachment "F"]. Although the proposed FY12 budget contemplates transferring 25 DPC patients to the community, we believe this number could be increased if DHSS were granted flexibility and fluidity in moving funds between institutional and community contexts to target resources in a cost-effective manner. [Attachment "G"] For example, the proposed FY12 budget reflects a reduction of \$3.150 million in DPC funding but only an increase of \$2.092.4 million in community funding, a difference of more than \$1 million. If current and prospective cost savings at DPC were reallocated dollar-for-dollar to support community services, the State could expeditiously achieve ADA compliance.

²The relevant excerpt from the Governor's proposed FY 12 budget (H.B. No. 25) is included as Attachment "C".

Joint Finance Committee

Page 3

March 2, 2011

We also recommend reassessing use of Money-Follows-the-Person grant funds to facilitate discharge of DPC patients to the community. The original MFP grant application contemplated annually moving 5 institutionalized persons with mental illness, including DPC patients, to the community using MFP funds. [Attachment "H"]. DPC patients with TBI or intellectual disabilities in certain age groups may be prime candidates for MFP screening. Delaware appears to underutilize Medicaid subsidies for both institutional and community mental health services. [Attachment "I"].

Thank you for your consideration of our comments.

Attachments

8g:paimi/fy12mhjfbud

F:pub/bjh/legis/budget/2011/fy12mhjfc

State Psychiatric Hospitals: History and Trends

Gina Eckart

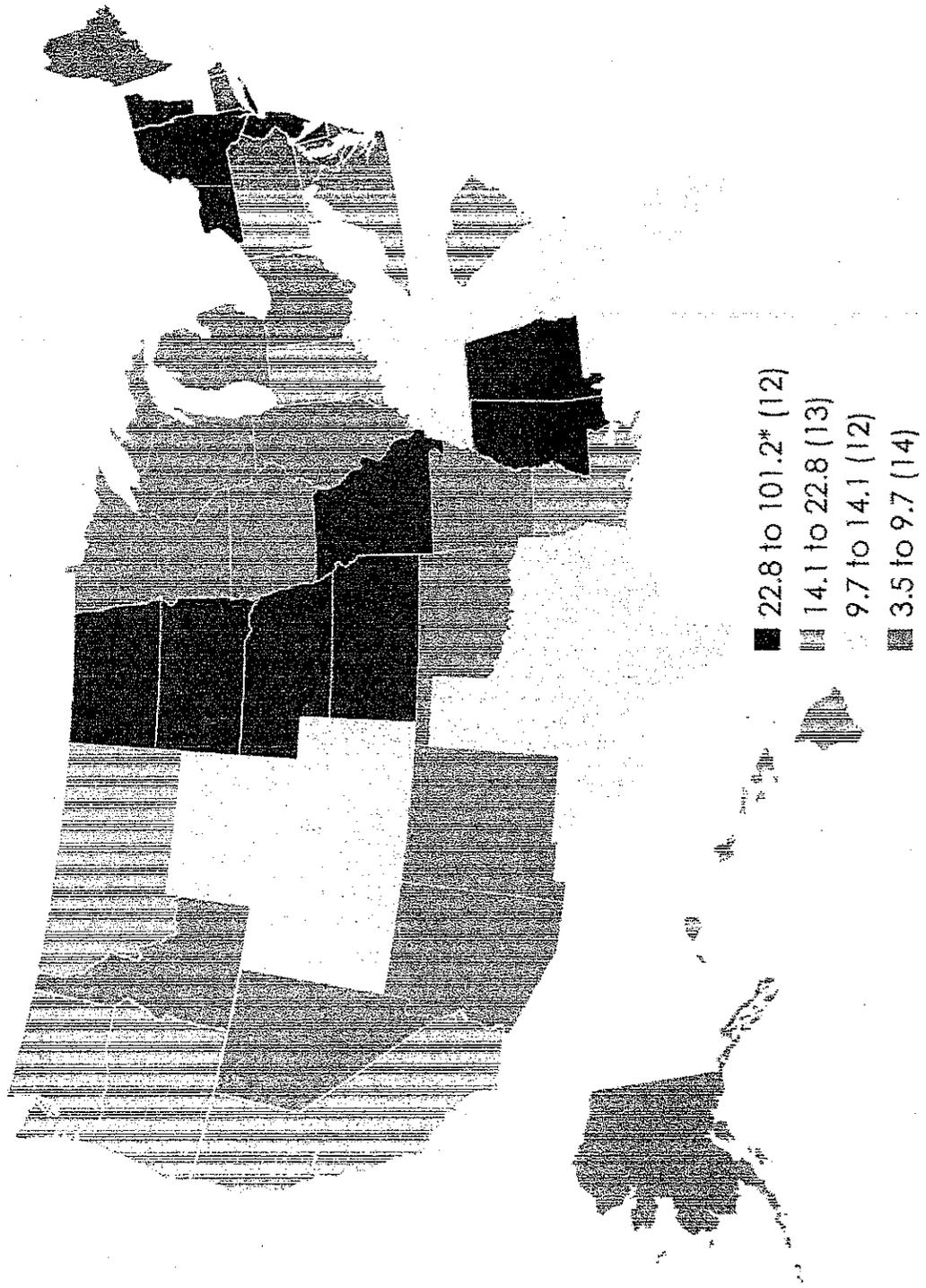
Division of Mental Health and Addiction
Commission on Mental Health Presentation

September 7, 2010

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

EXCERPT

State Psychiatric Hospital Residents per 100,000 Population (2007)



* Includes District of Columbia

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

*Governor's Task Force
On the
Delaware Psychiatric Center*

Final Report

December 18, 2007

Task Force Members:

*Senator Margaret Rose Henry
Kevin Ann Huckshorn, R.N.; MSN,
Rita Landgraf (Co-Chair)
Representative Pam Maier
Dennis Rochford
Harold Rosen, M.D.
Peter Ross (Co-Chair)
Yvonne Stringfield, Ed.D; R.N.
Gary Wirt, Ed.D*

Created by:

*Executive Order 100
August 17, 2007*

Staff:

*Brian Posey; AARP
Lisa Schieffert, DHSS
Keith Warren, Office of the Governor
Andrea Summers, Office of Highway
Safety, Dept. of Safety and Homeland
Security*

- The Task Force recommends that a utilization review (UR) process be initiated that is managed by an independent community contractor not otherwise involved in the DSAMH system of care. This UR process should mirror the kind of UR performed by other community hospitals and managed care insurers and would provide the state with daily reports regarding people admitted to DPC who no longer meet criteria for this level of care. The above recommendations should alleviate this scenario and would afford the state a comprehensive planning process, which is cost-effective and ensures that the appropriate level of care is provided.
- For DPC to better reflect their actual length of stay, data needs to be analyzed based by patient population inclusive of Forensic Unit (Mitchell), Long Term Care Unit (Carvel), Acute Care Unit (K-3) and Intermediate Care Units (K-S). The average aggregate length of stay for resident adult patients at DPC in 2006 was 2,130 days compared to the national average of 869 days. CMHS reports that in 2006 Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%.

III. Funding Considerations

A. National and Historical Perspective

As states steadily shift from a delivery system focused on inpatient services to one of community-based service, this movement has been reflected in their mental health budgets. A national study (NASMHPD Research Institute, 2005) shows dramatic changes in the allocation of total state mental health agency expenditures in the United States between 1993 and 2003. For example:

In 1993

- 48% of mental health budget expenditures were allocated to state psychiatric hospital inpatient services
- 49% of expenditures were allocated to community-based services

By 2002

- 29% of expenditures were allocated to state psychiatric hospital inpatient services
- 69% of expenditures were allocated to community-based services

Delaware's allocation of resources today is similar to that of the U.S. in 1993. In 2005, Delaware's spending on community-based services for the same time was 45%. It is difficult to know what Delaware's total community costs are as the state's Medicaid service costs are not included. It may be that with the addition of these Medicaid community mental health expenditures that DE's community funding is higher than 45%, which would change these ratios. Most states include Medicaid expenditures when reporting these costs.

- The Task Force recommends that an explanation regarding why inpatient service costs are not being shared by Medicaid needs to be provided. It should also be noted that the 45% of spending on community-based care includes funds to support the involuntary commitments to community psychiatric hospitals such as Rockford Center, Meadowwood and Dover Behavioral Health. The use of state general revenue funding for private psychiatric beds in the community needs to be reviewed. Medicaid generally pays the cost of psychiatric care when that care is provided in a general medical facility.
- The Task Force recommends that all efforts need to be taken to access these federal dollars to help support these very expensive hospital beds. Also, the actual per bed day costs need to be described in order to assure that the state is not over-paying for these beds. Costs per bed should reflect the costs paid by managed care providers for these same services for their covered populations.

B. Recent Delaware Budgetary Practices

- The Task Force recommends that Delaware's budgetary allocations for community support services keep closer pace with the ongoing need, and that the community support service system receive inflationary increases to sustain their current level of services. The Task Force recommends a dedicated % of increase be provided to providers on an annual basis that is reflective of inflationary measures and/or the CPI. Between 2001 and 2007, private providers received less than 4% in contractual increases. During this same timeframe, the consumer price index increased by approximately 30%. Rates for services, many of them set in 2001, have not be re-evaluated for increases. Providers have indicated this lack of increase has a direct impact on the delivery of service. Many have increased the number of individuals being served assigned to a staff member, resulting in a less intensive service for those with the most significant conditions. DE community mental health providers testified that they have not been able to provide cost of living increases for their employees for many years and that these same employees are still limited to mileage reimbursement that is almost 50% less than the federal rate. *Such erosion of community-based services can lead to increased use of unnecessary hospital care.* The non-state community providers have voiced that since 2001, community-based services have actually eroded. The Legislature last appropriated funds for group homes in the FY01 and FY02 budgets. Funds for supervised apartments were included in FY01, 02, 06, 07 and 08 budgets. As a result, *the Division's inventory of supported housing is limited to fourteen (14) group homes (serving 114 residents) and eight (8) supervised apartment programs. The combined capacity of the entire residential system is only two hundred nine (209) clients statewide.*
- The Task Force supports the movement of the 35 patients to community-based services and the dedicated funding associated with this movement to adequately support those transitioning from DPC to community. This movement will bring the community residential placements to 244 and hospital census 210, if average

APPROPRIATENESS DOMAIN: Length of Stays in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers for Children Settings, FY 2009

STATE: Delaware

Setting	Demographic	State						US						States Reporting
		Length of Stay (Days)						Length of Stay (Days)						
		Discharged Clients		Resident Clients with LOS 1 yr or less		Resident Clients with LOS Over 1 year		Discharged Clients		Resident Clients with LOS 1 yr or less		Resident Clients with LOS Over 1 year		
		Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	
State Hospitals	All	-	-	-	-	-	-	196	71	106	84	2,058	1,392	5
	Children	-	-	-	-	-	-	97	78	77	68	608	534	36
	Adults	228	17	52	19	2,857	1,068	155	47	91	62	1,791	1,117	51
	Age NA	-	-	-	-	-	-	26	17	42	35	704	504	2
Other Inpatient	All	-	-	-	-	-	-	34	14	28	15	526	434	3
	Children	8	6	8	6	-	-	13	7	35	29	722	706	23
	Adults	16	12	17	12	676	711	26	9	35	30	870	697	33
	Age NA	-	-	-	-	-	-	3	3	2	1	-	-	2
Residential Treatment Centers	All	-	-	-	-	-	-	357	306	150	140	718	554	2
	Children	203	187	161	161	462	471	184	155	138	121	610	550	28
	Adults	574	375	172	160	1,933	1,092	450	331	145	144	1,124	831	18
	Age NA	-	-	-	-	-	-	174	168	182	177	400	400	1

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS/DIG Table 6.

Table 6 State Notes:

Hospital	None
Other Inpatient	None
Residential	None
Community	None
Overall	None

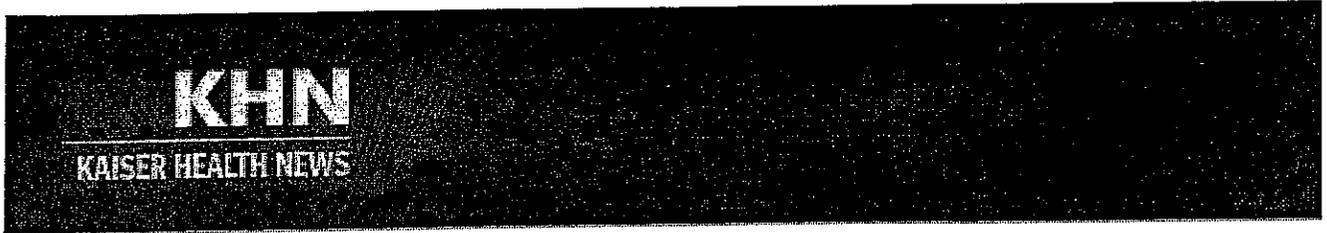
decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607. In so holding, the Court explained that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. It also recognized the harm caused by unnecessary institutionalization: "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601.³ As the Third Circuit Court of Appeals has made clear, the ADA "favor[s] integrated, community-based treatment over institutionalization." Frederick L. v. Dept. of Public Welfare, 364 F.3d 497, 491-92 (3rd Cir. 2004).

1. Individuals Remain Unnecessarily and Inappropriately Institutionalized in DPC in Violation of the ADA

* DPC is violating the ADA by unnecessarily institutionalizing individuals who are appropriate for community-based treatment. Olmstead, 527 U.S. at 607. Based on the information we reviewed during our tours of DPC, including our review of patient records and interviews with statewide leadership and hospital staff and administrators, it is clear that the vast majority of individuals confined to DPC could be—and have a right to be—living in community settings with appropriate services and supports. DPC staff has already determined that over 70 percent of the individuals being treated at DPC are clinically ready to leave the hospital and to be served in more integrated settings. The percentage of individuals ready for discharge likely is even higher, according to our experts, due to DPC's inappropriate discharge assessment process, as discussed below. In fact, during an interview, the State's Director of the Division of Substance Abuse and Mental Health Services ("DSAMHS") acknowledged that "pretty much everyone at DPC would be appropriate for community placement."

DPC maintains and keeps current a central roster, entitled "DPC Discharge Assessment," which lists all individuals in DPC and their status with respect to discharge. This list indicates which individuals are ready for release and summarizes barriers to discharge.

³ Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").



Justice Dept. Pushes For Services To Move Patients Out Of Mental Hospitals

TOPICS: MENTAL HEALTH, STATES

By ANDY MILLER

OCT 21, 2010

ATLANTA – A sweeping agreement this week between the Justice Department and the state of Georgia highlights an aggressive new campaign by the Obama administration to ensure that people with mental illness and developmental disabilities can get services in their communities and not be forced to live in institutions.

The settlement, announced Tuesday, will be used "as a template for our enforcement efforts across the country," said Thomas Perez, assistant attorney general for the Civil Rights Division at Justice, in a statement announcing the accord.

The agreement ends three years of legal wrangling over Georgia's mental health system. National consumer advocacy organizations called the Georgia settlement unprecedented, with Curt Decker, executive director of the National Disability Rights Network saying in an interview that the agreement "sends a message to the rest of the country."

The Justice Department action demonstrates broader enforcement of the landmark 1999 Olmstead decision by the Supreme Court. The court in Olmstead – also a Georgia case – ruled that under the Americans With Disabilities Act, unnecessary institutionalization of people with disabilities is a form of discrimination.

The action follows decisions by Justice to file briefs and join Olmstead-related lawsuits in several states, including New York, North Carolina, Arkansas, California and Illinois. "We will continue to aggressively enforce the law, and we hope other states will follow Georgia's example," Perez said.

As part of the accord, Georgia agreed to specific targets for creating housing aid and community treatment for people with disabilities, who in the past have often cycled in and out of the state's long-troubled psychiatric hospitals. The state said it will set aside \$15 million in the current fiscal year and \$62 million next year to make the improvements.

The state agreed to:

ATTACHMENT F

-- End all admissions of people with developmental disabilities to the state hospitals by July 2011.

-- Move people with developmental disabilities out of hospitals to community settings by July 2015.

-- Establish community services, including supported housing, for about 9,000 people with mental illness. These individuals, Perez said, "currently receive services in the state hospitals, are frequently readmitted to state hospitals, are frequently seen in emergency rooms, are chronically homeless or are being released from jails or prisons."

-- Create community support teams and crisis intervention teams to help people with developmental disabilities and mental illness avoid hospitalization.

Georgia Gov. Sonny Perdue said the agreement "moves us towards our common goals of recovery and independence for people with mental illness and developmental disabilities."

Lewis Bossing, a senior staff attorney at the Bazelon Center for Mental Health Law, a Washington, D.C.-based advocacy organization for people with mental illness, said the "ground-breaking" settlement capped a flurry of federal legal activity in disability cases during the past 18 months. Bossing said the Justice Department, by spelling out an array of community services required to meet Olmstead criteria "will make it more likely that states will change the way they do business with people with disabilities."

Over the past year and a half, Department of Justice attorneys:

-- Filed a brief in support of North Carolina litigation seeking to keep two individuals with developmental disabilities in community settings. A proposed cutoff of funds jeopardized the housing for the two. Perez said in an April statement about the case, "We will not allow people with disabilities to be a casualty of the difficult economy."

-- Filed a motion to intervene in a lawsuit in New York seeking supported housing units for thousands of residents of "adult homes."

-- Filed briefs in existing lawsuits in Florida, Illinois and New Jersey against what the agency called "unnecessary institutionalization" of people with disabilities.

The Justice Department began probing the Georgia mental hospitals in 2007 after a series in the Atlanta Journal-Constitution found dozens of patients died under suspicious circumstances in the state-run facilities. The newspaper also chronicled abuse by hospital workers; overuse of medications to sedate patients; and discharge of many patients to homeless shelters.

The state agreed to improve the hospitals in a January 2009 agreement with the Justice Department, in the final days of the Bush administration. But a coalition of consumer groups filed a brief in opposition to that settlement, saying it failed to improve hospital discharge planning and services in the community.

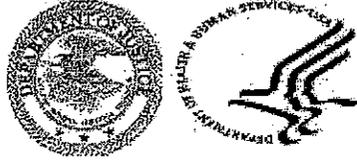
The Justice Department later backed away from the original terms of the deal and eventually added the Olmstead issues in a separate complaint in January. Last month, the federal judge in the case ratified the original hospital agreement, but let the Olmstead portion proceed, which culminated in the second agreement. The community services pact will have an independent monitor to assess its progress.

Change can't happen soon enough for Rhonda Davidson. She was discharged from a Milledgeville, Ga., mental hospital when the state closed her unit earlier this year. While Davidson, who has schizophrenia, has found a group home in metro Atlanta to live in, she has not received the treatment program and employment help she needs, says her attorney, Sue Jamieson of the Atlanta Legal Aid Society. This agreement should help accelerate that help for Davidson and others, Jamieson said.



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DEPARTMENT OF JUSTICE



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JUSTICE DEPARTMENT OBTAINS COMPREHENSIVE AGREEMENT REGARDING THE STATE OF GEORGIA'S MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SYSTEM

WASHINGTON - The Justice Department today announced that it has entered into a comprehensive settlement agreement that will transform the state of Georgia's mental health and developmental disability system and resolve a lawsuit the United States brought against the state. The lawsuit alleged unlawful segregation of individuals with mental illness and developmental disabilities in the state's psychiatric hospitals in violation of the Americans with Disabilities Act (ADA) and the Supreme Court's landmark decision in *Olmstead v. L.C.*

The U.S. District Court for the Northern District of Georgia will retain jurisdiction to enforce today's settlement agreement, which supersedes a 2008 agreement between the state and the Office for Civil Rights of the U.S. Department of Health and Human Services (HHS) concerning Georgia's provision of community services for individuals with mental illness and developmental disabilities. In light of today's agreement and the progress the state has made in complying with an earlier agreement regarding the conditions in the psychiatric hospitals, the United States has agreed to withdraw its motions to enforce that earlier agreement.

More than a decade ago, in *Olmstead v. L.C.*, the Supreme Court found that one of Georgia's state hospitals was impermissibly segregating two individuals with disabilities in that hospital when they could have been served in more integrated settings. The Supreme Court ordered states to serve individuals with disabilities in the most integrated settings appropriate to their needs.

"The *Olmstead* decision strongly affirmed that people with disabilities have a right to live and receive services in the most integrated setting appropriate for them as individuals," said Thomas E. Perez, Assistant Attorney General for Civil Rights. "Under this agreement, the state of Georgia will provide services in the community to hundreds of people with developmental disabilities and thousands of people with mental illness. The promises of the ADA and *Olmstead* will finally become a reality for individuals in Georgia with mental illness and developmental disabilities."

“Georgia is the home of the Supreme Court’s *Olmstead* decision,” said Sally Quillian Yates, U.S. Attorney for the Northern District of Georgia. “With this agreement, the state begins to make good on *Olmstead*’s promise to end the inappropriate segregation of people with disabilities in state hospitals that set apart from the community.”

“The expansion of community living opportunities is critical to protecting the civil rights of individuals with disabilities under *Olmstead*, said Georgina Verdugo, Director of the Office for Civil Rights at HHS. “The specific requirements and timelines in this agreement will ensure that Georgians with mental illness and developmental disabilities have the services they need to live full lives in the community and achieve their goals.”

The Justice Department began its investigation in 2007, and found that preventable deaths, suicides and assaults occurred with alarming frequency in the state hospitals. In January 2009, the department entered into a settlement agreement with the state of Georgia regarding conditions in the hospitals. Further investigation found that the state also failed to serve individuals with mental illness and developmental disabilities in the most integrated setting appropriate to their needs, in violation of the ADA and the *Olmstead* decision. In January 2010, the department filed a freestanding complaint under the ADA and a motion for immediate relief seeking to protect individuals confined in the hospitals from continued segregation and from threats of harm to their lives, health and safety. The department subsequently entered into extensive settlement negotiations with Georgia, the Office for Civil Rights and local mental health advocates.

The agreement signed today resolves the ADA lawsuit. The agreement expands community mental health services so that Georgia can serve individuals with mental illness and developmental disabilities in the most integrated setting appropriate to those individuals’ needs. Under today’s agreement, over the next five years, Georgia will increase its assertive community treatment, intensive case management, case management, supported housing and supported employment programs to serve 9,000 individuals with mental illness in community settings. The agreement will also increase community crisis services to respond to and serve individuals in a mental health crisis without admission to a state hospital, including crisis services centers, crisis stabilization programs, mobile crisis and crisis apartments; create at least 1,000 Medicaid waivers to transition all individuals with developmental disabilities from the state hospitals to community settings; and increase crisis, respite, family and housing support services to serve individuals with developmental disabilities in community settings.

The Civil Rights Division enforces the ADA which authorizes the attorney general to investigate whether a state is serving individuals in the most integrated settings appropriate to their needs. Please visit www.justice.gov/crt to learn more about the *Olmstead* decision, the ADA and other laws enforced by the Justice Department’s Civil Rights Division.

The agreements in this case protecting the rights of individuals with mental illness and developmental disabilities in Georgia are due to the efforts of the following Special Litigation Section attorneys: Judy Preston, Acting Chief; Mary Bohan, Deputy Chief; Timothy Mygatt, Special Counsel; Robert Koch, Max Lapertosa, Richard Farano, Aaron Fleisher, Jeffrey Murray, Jennifer Mondino, David Deutsch, Emily Gunston, Samantha Trepel, and Amin Aminfar, Trial Attorneys. In addition, the division received support and assistance from Aileen Bell-Hughes and Mina Rhee, Assistant U.S. Attorneys for the Northern District of Georgia.

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Delaware Psychiatric Center: We can't fix it alone, Landgraf says

Cooperation of lawmakers, unions key, she says

By SEAN O'SULLIVAN - The News Journal - November 12, 2010

The state can reform the Delaware Psychiatric Center to meet standards demanded by federal civil rights officials in a report released this week, but it will require the cooperation of the Delaware General Assembly and state employee unions, Delaware Health and Social Services Secretary Rita Landgraf said Thursday.

At least two state legislators also said they are willing to consider the budget flexibility that Landgraf said she needs, with one, Helene Keeley, D-Wilmington North, saying Landgraf's proposals seem "100 percent right on the money."

A nonprofit provider of community-based services - that likely will be called on by the state to help meet federal demands - praised Landgraf's outline and said it could be ready in as little as 90 days to begin accepting additional patients from DPC if the proper funding and support is in place.

This is all in response to a 21-page letter from the U.S. Department of Justice's Civil Rights Division released Wednesday that summarizes a three-year investigation of the psychiatric center - started after a 2007 report in The News Journal about abuses at DPC - and concludes that the psychiatric hospital continues to unnecessarily warehouse the mentally ill instead of offering individual screening and treatment in a community setting.

Failure to reach an agreement with federal officials to correct the deficiencies could result in a civil rights lawsuit against Delaware, the letter indicated.

Landgraf said she can make some changes without outside help, but added she will need the cooperation of Delaware legislators to grant her more flexibility in her budget. Currently, money is tied to the institution and the program - with some

\$42 million set aside to operate DPC's hospital facilities and \$60 million earmarked for community programs, she said.

But Landgraf said she would like to see a more flexible model that ties funding to individual patients, similar to what is being done in states like Virginia, Arizona and Vermont. This allows dollars to ebb and flow with the needs of treatment, either in the hospital - where costs are higher - or in a community setting like a group home - where costs are lower.

At least 70 percent of the 170 non-criminal patients currently at DPC "could be and have a right to be living in community settings with appropriate services and supports," the federal report said.

This is where Landgraf would like to see some of DPC's work force and resources moved. "I value my work force, but we need to figure out how to utilize the work force differently," she said.

What Landgraf and federal officials would like to see is more of what is taking place at a group home operated by the nonprofit Connections Community Support Programs Inc. in Llangollen Estates, near New Castle. Five residents, ages 25 to 70, live with around-the-clock staff at the home.

Every morning, two of the five residents get on a DART Paratransit bus and head off to jobs.

The other residents, who are older or have more intensive medical needs, are allowed to follow their own pursuits, said Chris Devaney, chief operating



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officer at Connections. On Thursday, some played Nintendo Wii golf while one focused on writing, he said.

Landgraf said this shift of patients from DPC to the community could save the state money in the long run because it costs about \$100,000 less on average to house someone in the community rather than the hospital.

Catherine McKay, president and CEO of Connections, said the savings could be even greater, depending on the patients and their needs.

If she receives the budgetary flexibility, Landgraf would then need cooperation from the unions that represent the 505 state employees at DPC to "reallocate" them from jobs at the hospital to nonprofit providers, like Connections.

Landgraf did not say Thursday how many or what percentage of DPC employees would need to be moved.

Michael A. Begatto, executive director of the American Federation of State, County and Municipal Employees Council 81, which represents most state employees, could not be reached for comment Thursday.

Such a shift of employees has been done before in Delaware and at DPC.

McKay said that in the 1980s, when Delaware first set about moving patients into community settings, the state's contract with a predecessor of Connections required that state employees whose jobs were being eliminated be given the first "right of refusal" for all new jobs created by the contract.

Rep. Greg Lavelle, R-Sharples, said he will certainly be willing to hear out Landgraf on her plans. Lavelle said he hopes this is a sign that the Markell administration is taking a different approach to DPC than the Minner administration, which Lavelle said "just stuck their heads in the sand."

Keeley thinks the department and the unions could work together on the issue. "As long as they [union members] are well informed and are sitting at the table when the decisions are being made, it may not be as difficult as many think," she said.

McKay warned that Landgraf's proposal would work only if the state properly funds the community

programs.

"Since 2002, community programs have been cut or held stable," McKay said, adding that underfunding of community programs was one issue raised in the federal letter to the state.

Landgraf said there is some tension from the threat of a lawsuit by federal officials, but said that may present a moment of opportunity for reform.

"Reform usually doesn't happen in good times," she said, adding it often takes a force, like litigation, to bring it about. "I would like, as a public servant, to do it without litigation. I don't want to be caught up in other costs," she said. "We can do this. It is a matter of political will with all of us."

Contact Sean O'Sullivan at 324-2777 or sosullivan@delawareonline.com.

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Aiding psychiatric patients must be joint effort

November 12, 2010

This week's highly critical federal report on the state's "warehousing" of the mentally ill is another jolting reminder of the continuing problem of abuse and delay at the Delaware Psychiatric Center.

The report details how continuing violations and threats to the health and safety of the patients are the result of layers of bureaucracy that hamstringing improvement efforts.

The report's authors agree with the state Department of Health and Social Services that better patient care and cost savings can come from more community-based placements.

The impediments to this change must be removed quickly, not just to avoid action by the federal government, but mostly to improve the lives of the hospital's patients.

The Markell administration has made some progress since the last federal investigation, but more needs to be done.

This is more than just an administration problem. The state's legislators, whose votes determine the DHSS budget, must do their part to make sure genuine reform takes place.

But the report and comments from officials indicate the challenge goes beyond budgets. A large problem is the hospital's culture. Bureaucratic layers insulate some employees from oversight and thwart change. Despite the acknowledged need to shift to community-based homes for the patients, too many people have a stake in keeping a large, central facility in operation.

That bureaucratic block must be broken. The General Assembly must be behind efforts like that to improve the welfare of the patients.

Moving the patients who should be out of the institution and in community homes requires a thorough, open transition that involves the entire

community. It would be counterproductive to solve the problem of hospital culture only to be stymied by a resistant, suspicious community.

The burden of providing humane care must be shared by all of us.

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EXCERPT

Money Follows the Person Rebalancing Demonstration
Response to Request for Additional Information
State of Delaware

The Money Follows the Person project, "Finding a Way Home", reflects Delaware's commitment to fostering self-determination with strong community partnerships and participation among older persons and persons with disabilities. Delaware's Money Follows the Person initiative will allow the State to serve Medicaid beneficiaries and provide a platform for others to receive services and supports in the most community-integrated setting possible, while ensuring the beneficiary's health and safety, many reasons including: 1) it is expensive for the State to support people in institutions who do not want to be there; 2) support the *Olmstead* decision of providing service in "the most integrated setting possible;" and 3) it is their preference.

Section III. Issues Raised through Independent Review

Question 1

How do the institutions you plan to transition individuals from meet the definition of a "qualified institution" in the MFP solicitation? See especially "residential settings of 4 or more".

Response

The following excerpt from Delaware's grant application included in Section III, Demonstration Design, Objective 6, and Target Population stated "In addition, DDDS will also offer transition services to its current HCBS Waiver recipients living in residential settings of 4 or more who chose to live in smaller less restrictive settings." This statement is not accurate, and unfortunately was overlooked when we edited the application. These residential settings operated by DDDS are not "qualified institutions" as defined in the MFP solicitation.

The individuals included in the MFP grant application will transition from Medicaid funded service providers meeting the definition of "qualified institutions" defined in the MFP solicitation. Delaware will transition consumers from State of Delaware public long-term care institutions, nursing homes and hospitals including:

- Hospital for the Chronically Ill - LTC intermediate and skilled care hospital
- Emily P. Bissell Hospital - LTC intermediate and skilled care hospital
- Governor Bacon Health Center -- LTC intermediate care facility
- Delaware Psychiatric Center -- IMD (consumers under 21 & over 65)
- Private Nursing Homes
- Private Nursing Homes providing MR services
- Hospitals providing MH services

*

seemed suitable for clients transferring from an ICF-MR. Costs were trended forward to 2008 using a medical inflation factor of 4.1% (based on medical component of the CPI). This same annual inflation factor was applied to obtain projections for 2009 through 2011.

- Clients with Mental Illness: Not Applicable. Delaware does not have a home and community-based waiver program for mentally ill clients at risk of institutionalization.

Qualified Services - State Plan Option for HCBS

- ~~Personal Assistance Services for All Groups:~~ Delaware proposes to provide all target groups with Personal Assistance services as needed to support their stay in the community.

Delaware's Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) currently uses State funds to finance Personal Assistance Services for a small number of elderly and disabled clients. (Total population served in July 2005 to June 2006 was 72 clients.) To develop projections, average annual cost per recipient for this program (roughly \$12,000 in Fiscal Year 2006) and other estimates from an Independence Plus waiver application were used, along with an assumption that most clients in each population category would need to use this service. Costs for 2009-2011 were inflated using a medical inflation factor of 4.1%

- * • HCB Demonstration Services for Persons with Mental Illness: Aside from personal assistance services, Delaware plans to provide two other services - respite care and homemaker/personal care services - to clients with serious mental illness who are in the 18-20 and 65+ age brackets. In addition, Delaware will cover the cost of short-term IMD care for clients ages 18 to 20 who relapse after moving to the community and need readmission to an IMD. Projected costs for respite and personal care/homemaker services are based on average per capita costs in July 2004-June 2005 for these services under Delaware's waiver program.

**Money Follows the Person Demonstration
Budget Proposal**

Instructions: Please fill in only the cells highlighted yellow. All other cells will autopopulate. Please DO NOT alter any formulas.

State Name **DE** State FMAP* **0.5** Enhanced **0.75**

* FFY 2007 FMAP should be expressed as a decimal. (If the FMAP is 68.32%, it should be .6832.)

Populations to be Transitioned (unduplicated count)** *

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis
FFY*** 2007					
FFY 2008	8	5	7	5	
FFY 2009	8	5	7	5	
FFY 2010	8	5	7	5	
FFY 2011	8	5	7	5	
Total	32	20	28	20	0
	100				

Populations for Dual Diagnosis:

** Unduplicated Count - Each individual is only counted once in the year that they physically transition.

*** All population counts and budget estimates should be based on the Federal Fiscal Years indicated.

Demonstration Budget

Total	Rate	Total Costs	Federal	State
Qualified HCBS****		3642212	2731659	910553
Demonstration HCBS****		3132751	2349563.25	783187.8
Supplemental****		0	0	0
Administrative - Normal*****		2210961.6	1105480.812	1105481
Administrative - 75%*****		657500	493125	164375
Administrative - 90%*****		0	0	0
State Evaluation		80000	40000	40000
Total		9723424.6	6719828.062	3003597

Per Capita Service Costs	67749.63
Per Capita Admin Costs	28684.62
Rebalancing Fund*****	1613741

**** Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services were defined in the RFP.

***** Administration - Normal should include all costs that adhere to CFR Title 42, Section 433(b)(7)

Administrative - 75% should include all costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10)

Administrative - 90% should include all costs that adhere to CFR Title 42 Section 433(b)(3)

***** The Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings realized because of the enhanced FMAP rate that could be reinvested into rebalancing benchmarks.

REQUIRED ATTACHE MENTS (Final Version)
Money Follows the Person

7-07

State Profile and Summary of Project

Name of State: Delaware

Primary Contact Name and Title: Joyce Pinkett, Administrator

Year of Demonstration: 2008

(submit a separate form for each year the State purposes to transition individuals)

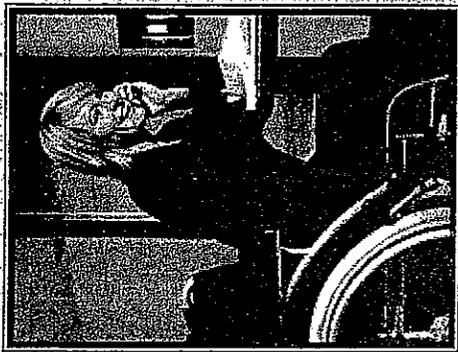
Populations to be transitioned (unduplicated count)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
Estimated number of individuals to be transitioned	8	5	7	5	(fill in)
Statewide (SW) or Not Statewide (NSW)	SW	SW	SW	SW	
Qualified Institutional Settings*	A-B	A-B-C revised	A -B	A-D revised	
Qualified Community Settings**	A-B-C	A-B-C	A-B-C	A-B-C	
Qualified HCB Services	Emergency response installation & fees Adult Day Care Respite Care Homemaker Service	Staffed/supervised apartments Case Management Clinical Support Pre-Vocational training Respite Care Transportation	Emergency response installation & fees Day Care Respite Care Homemaker Service	Case Management Pre-Vocational Training	
HCB Demonstration Services	Home Accessibility Adaptations Assistive Technology Community	Home Accessibility Adaptations Assistive Technology Community	Case Management Home Accessibility Adaptations Assistive	Community Transition Services Day Treatment Mental	

<p>HCB Demonstration Services</p>	<p>Transition services Habitat Services Training and counseling Services for Unpaid Caregiver Personal Assistance Service</p>	<p>Transition services Habitat Services Training and counseling Services for Unpaid Caregiver Personal Assistance Service</p>	<p>Technology Community Transition services Habitat Services Training and counseling Services for Unpaid Caregiver Personal Assistance Service</p>	<p>Health Services</p>	
<p>Supplemental Demonstration Services</p>					

* Please indicate one or more from the list. Do not list names of actual facilities. **a).** Hospital; **b).** Nursing Home; **c).** ICF/MR; **d).** IMDs)

** Please indicate if participants are moving to: **a).** Homes owned or leased by the individual or the individual's family member; **b).** Apartment with individual leases, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or individual's family has domain and control; **c).** Residences, in a community-based residential setting, in which no more than four unrelated individuals reside.

Delaware Health and Social Services
 Division of Medicaid & Medical Assistance
 Eddi Ashby, MFP Project Director
 Phone: (800) 372-2022 ext. 59288
 Fax: (302) 255-4425
 E-mail: eddi.ashby@state.de.us



State of Delaware
 Delaware Health and Social Services
 Division of Medicaid & Medical Assistance
 Herman Holloway Campus — Lewis Building
 P.O. Box 906
 NEW CASTLE, DELAWARE 19720-0906
 MFP BR0 (rev09/2008)



Delaware Health and Social Services
 Division of Medicaid & Medical Assistance
 Herman Holloway Campus—Lewis Building
 Eddi Ashby
 MFP Project Director
 P. O. Box 906
 New Castle, DE 19720
 Phone: (800) 372-2022 ext. 59288
 Fax: (302) 255-4425



MONEY FOLLOWS THE PERSON

"Finding A Way Home"
 Money Follows the Person



DELAWARE HEALTH
 AND SOCIAL SERVICES
 DIVISION OF MEDICAID & MEDICAL ASSISTANCE

What is the Money Follows the Person Demonstration Program?

The Money Follows the Person Demonstration (MFP) is a special project developed by the federal government to assist you in moving from a Long Term Care (LTC) facility, (nursing home or state hospital) to a residential setting in the community, such as:

- A home owned or leased by you or your family
- An apartment with an individual lease that includes living, sleeping, bathing, and cooking areas
- A residence in which 4 or fewer unrelated individuals reside (such as Adult Foster Care or Shared Apartment)

Who is eligible to participate in the MFP Program in the State of Delaware?

For you to participate in the MFP Program, you must:

- Have lived in a LTC facility for at least 3 months
- Be Medicaid eligible prior to discharge
- Have health needs that can be met through services available in the community
- Voluntarily consent to participation by signing a consent form
- Be eligible for one of the following Home and Community Based Waiver Services (HCBS) as of the first day of your transition
 - **Elderly And Disabled (E&D)**: Individuals meeting medical requirements & must also be aged or disabled.
 - **Developmental Disabilities (DD)**: Individuals meeting eligibility & medical requirements

How Does the Money Follows the Person Program Work?

The MFP Program will assist you in transitioning from a LTC facility by providing:

- Information to help you make an informed choice regarding transition and participation in the MFP Program

- Support to transition and help in arranging services in the community
- Post-discharge follow-up by a Transition Coordinator to ensure your move is satisfactory and your needs are being met

The MFP Program will assist you with locating a place to live and in arranging for medical, rehabilitative, home health, or other services you may need in the community.

Your Social Security or other income will pay for your rent and other basic necessities, while the MFP Program will pay for your services in the first year of transition. The Medicaid Program will pay for medical services.

You will be part of the MFP program for 365 days; after that, you will receive your services through other state programs.

If you are eligible to participate based on the criteria in this brochure, you will assist in developing your own plan of care.

What Services are Available through the MFP Program?

You will receive services as available through regular Medicaid and the HCBS waiver you selected, as well as the following:

- **Demonstration services**
 - **Community Transition Services** such as household setup expenses (e.g. security and utility deposits, etc.)
 - **Counseling** which assists with basic living skills such as budgeting, nutrition and transit travel.
 - **Education and Training on Community Services and Medical Care** such as workshops that inform you of the services that can be accessed in the community.
 - **Assistive Technology** provides the necessary assistive devices for individuals to function within the community.
 - **Personal Assistance Services** provides assistance with any instrumental daily living activities. (e.g. grooming, meal preparation and recreation, etc.)
 - **Home Accessibility Modifications** can provide the necessary accessibility needs in the home.
 - **Respite Care** offers short term care assistance when your regular care provider is not available.
- **Supplemental services**
 - **Transition Coordinator** will assist you in developing a transition plan that will follow you throughout the 12 month MFP Program.

What are Home and Community Based Waiver Services (HCBS)?

HCBS are services that are available to individuals who move from a LTC facility into the community. These services are provided in addition to medical services you may need, and help you to live independently in the community. Delaware has three (3) HCBS waivers.

For participation in the Money Follows the Person demonstration, you must be eligible for either the Elderly and Disabled (E&D) waiver, or the Developmental Disabilities (DD) waiver as of the first day of your transition.

Services Available through the Waiver Programs Elderly & Disabled (E&D) Waiver

- Case Management
- Personal Care Services
- Medical and Social Day Care
- Respite Care
- Emergency Response System
- Orthotics and Prostheses
- Adult Day Service
- Day Habilitation
- Assisted Living
- Cognitive Services
- Specialized Medical Equipment & Supplies

Developmental Disabilities (DD) Waiver

- Case Management
- Habilitation Services
- Prevocational Services
- Supported Employment Services
- Day Habilitation Services
- Respite Services
- Clinical Support

If you would like more information about the MFP Program, please call 1-800-372-2022 ext. 59288.

STRUCTURE DOMAIN: State Mental Health Agency Controlled Revenues by Funding Sources, FY 2007

STATE Delaware

Funding Source	Ambulatory/Community			State Hospital		
	State Revenues	Percent Total (State)	Percent Total (US)	State Revenues	Percent Total (State)	Percent Total (US)
Medicaid	\$14,010,210	32.3%	57.3%	\$746,934	1.6%	25.3% *
Community MH Block Grant	\$639,972	1.5%	1.6%	-	-	0.0%
Other SAMHSA	-	-	0.2%	-	-	0.0%
other Federal(non-SAMHSA)	\$1,942,029	4.5%	3.3%	\$1,732,933	3.6%	3.4%
State	\$26,825,046	61.8%	31.1%	\$44,140,500	92.8%	67.5%
Other	-	-	4.7%	\$957,200	2.0%	2.9%
Total	\$43,417,257	100.0%	100.0%	\$47,577,567	100.0%	100.0%

Note:

Data from NRI's Funding Sources and Expenditures of State Mental Health Agencies, FY 2007 reports - State Mental Health Agency Controlled Expenditures and Revenue, Table 24, 25, and 26.

This table does not show Revenues for state central office including Research, Training, and Administration expenses.

More information on the State Mental Health Agency's Revenues & Expenditures as well as State Footnotes can be found on the NRI website: <http://www.nri-inc.org/projects/Profiles/RevenuesExpenditures.cfm>