Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

Resolve 2023, chapter 98

Tuesday, September 17, 10:00 am

Room 209 (Health and Human Services Committee room)
Cross State Office Building, Augusta ME

AGENDA

10:00 am	Welcome, *Chairs Senator Duson and Representative Craven*
10:10 am	Legislative Review of DHHS • 129th Commission to Study Long-term Care Workforce Issues, *staff* • GOC's Review of Child Welfare, *DHHS* • Review - State Government Evaluation Act, *staff*
11:30 am	Discussion – possible recommendations and additional information needed, *commission members*
BREAK	
1:00 pm	Next Steps

Future meeting dates: October 9, October 30.

	RECOMMENDATION	2024 AAAA report to HHS	Prior to 2024 report or other source
	Reimbursement for Current and Future Structural Costs		
1	Immediate: Increase wages for starting direct care workers to no less than 125% of the minimum wage.	Nursing homes and residential care homes (PNMI-Cs) have been engaged by the department for rate setting reforms which are expected to be implemented in January 2025 for nursing facilities and subsequently for PNMI-Cs. The Department has been working with partners to gather feedback. In December 2023, the Department issued $19 million in one-time Medicaid (MaineCare) payments to Maine nursing facilities to support their continued recovery from the pandemic. The payment initiative prioritized direct care staffing levels to promote access and quality. In response to the healthcare worker challenges exacerbated by the COVID-19 pandemic, DHHS submitted and received approval of its Home and Community Based Services Improvement Plan under Section 9817 of the American Rescue Plan Act through the Centers for Medicare & Medicaid Services (CMS). A key component of the plan was to provide retention and recruitment bonus payments for new and existing direct support workers and their supervisors across several MaineCare sections of policy. As of June 2023, initial reporting from provider agencies showed that more than 24,000 workers received an average of $3,429 in bonuses over the reporting period between July 1, 2021 and December 31, 2022. The initial reporting data suggests that the payments helped to stabilize and grow Maine's Home and Community Based Service workforce. Effective January 1, 2023, the Department updated the rates for MaineCare Benefits Manual, Chapter II, Sections 12, 18, 19, 20, 21, 29, 67, 96 and 97, Appendix C to ensure rates continue to support the requirements of Part AAAA of PL	PL 2021, c. 398, Pt AAAA requires essential support workers (direct care) paid by MaineCare to be paid 125% of the minimum wage. In effect, January 1, 2022 and January 1, 2023 (depending on the MaineCare service).

		2021, c. 398, of 125 percent of minimum wage for essential workers. The Department also implemented rates resulting from rate studies for Sections 13, Targeted Case Management and 26, Day Health Services and is in the process of finalizing rates from a rate study for Section 2, Adult Family Care Homes to ensure compliance with both PL 2021 c. 398, Part AAAA for Section 2 and 26, and PL 2021 c. 639 for Sections 2, 13 and 26.	
2	Immediate: Direct the Department of Health and Human Services to explore limiting reimbursement rates for temporary staffing agencies that provide direct care worker services for long- term services and supports.		
3	Immediate: Increase reimbursement rates to reflect current and future structural additions to provider costs, including increases in minimum wage, paid time off, electronic visit verification requirements, background checks and potentially fingerprinting.		See new rate setting process under PL 2021, c. 639?
	Alternative Rate Reimbursement Methodologies		
4	Intermediate / Long-term: Direct the Department of Health and Human Services to identify ways to consolidate tasks currently performed by multiple staff in both home and community-based and residential settings.		
5	Intermediate / Long-term: Direct the Department of Health and Human Services to explore options		Related to PL 2021, c. 639 rate setting system?

	to develop alternative reimbursement methodology that includes the following: • Accounts for acuity level of clients of home and community-based services, for both older adults and individuals with an intellectual disability or autism similar to the way case-mix is used in nursing facilities; • Allows additional reimbursement for merit or longevity pay increases for direct care workers; • Allows for increased reimbursement for specialized care including dementia care, bariatric care or behavioral needs; • Reimburses for ongoing training including for agency or nursing facility personnel taken off-line to conduct training of employees; and • Includes direct care workers as paid staff in any multi-disciplinary care planning team with a reimbursement rate to recognize the value of that work.		
	Rate Review		
6	<u>Intermediate:</u> Support legislation to enact a Rate Setting Commission that is independent of the Department of Health and Human Services that		Public Law 2021, c. 639 (LD 1867) was enacted in 2022 and took effect August 8, 2022. Enacts a new stand-alone section of Maine law (22 MRSA §3173-J) that codifies the processes and principles for the

	evaluates reimbursement rates for all long-term services and supports.		MaineCare Rate System. These processes and principles include setting a schedule for regular rate review and adjustment, to be reviewed annually in consultation with the Technical Advisory Panel; reviewing relevant state and national data to inform rate amounts and payment models, with an emphasis on models that promote high value services by connecting reimbursement to performance; and formalizing a clear and transparent process for rate determination that includes public notice and comment.
	Direct Care Workforce Recruitment and Retention		
7	Immediate: Direct the Department of Labor, in coordination with the Department of Economic and Community Development and the Department of Health and Human Services, to develop and implement a multimedia public service campaign that promotes direct care worker jobs as a career choice. Ensure that the campaign materials include new Mainers, men, younger people including high school students, older people and individuals with disabilities.	In April 2022, the *Caring for ME* campaign launched (initially by DoL then transferred to DHHS) which targeted direct care and support workers interested in the areas of behavioral health, aging, intellectual disability, brain injury and physical disability. DHHS 2023 report: The campaign created videos that spotlight HCBS workers in Maine and ran ads in a mix of digital and traditional media outlets. Additional marketing efforts will begin in early 2024.	Maine Long Term Care Ombudsman Program formed and supports the Direct Care and Support Advisory Council. In 2023, this council was actively involved in several presentations to state lawmakers, advocacy organizations, and other partners. Council members continue to provide leadership and support to present ideas that help strengthen Maine's HCBS workforce. See also: Essential Support Workforce Advisory Committee within DoL. Enacted in 2022 in PL 2021, c. 688.
8	Immediate: Direct the Department of Labor to conduct job fairs through the State focused on direct care workers for all long-term care settings.	DOL continues to conduct targeted health and Long-Term Services and Supports (LTSS) job fairs, which will be further developed in conjunction with the ongoing media campaigns. LTSS providers have been participating in statewide job fairs, as well as customized connections (i.e., reverse job fairs) to specifically identified individuals who	

		have direct care employment goals; In FFY 2023, CareerCenters around the state hosted 407 hiring events. Among them more than 95 percent featured employers hiring positions in direct care jobs. As part of a broader healthcare workforce attraction campaign, DHHS has contracted with Live and Work in Maine to develop health career exploration and outreach tools aimed at encouraging graduating high school students and younger workers to enter the healthcare profession. This strategy is part of a public/private partnership with the Maine Hospital Association, Maine Primary Care Association, and the Maine Health Care Association. This campaign has created 22 career exploration videos, a job board, and a career toolkit distributed across all high schools in Maine. The multimedia advertising strategy includes radio, video, traditional and social media, resulting in 58,533 job views for positions in the healthcare sector, and 699 applications to healthcare jobs posted on the Live and Work in Maine job board. This campaign will continue in 2023 with a wider target audience.	
9	Long-term: Direct the Department of Health and Human Services to offer direct care training programs in languages other than English and for ESL individuals	To support recruitment efforts for non-English speaking Mainers, DHHS continues to work with the Department of Education (DOE) to expand Bridge English as a second language (ESL) course that tie into direct care credentials such as Certified Nursing Assistant (CNA), Personal Support Specialist (PSS) and others.	
10	Long-term: Direct the Department of Health and Human Services to explore options, including those models outlined by PHI and NCSL, for supportive supervision and mentoring for direct care workers.		

	Workforce Development Initiatives		
11	Intermediate / Long-term: Direct the Department of Labor to work with the Department of Education, Maine's institutes of higher education, and Maine's Career and Technical Education Centers to develop and target education and certification programs for direct care workers, including high school vocational education programs including the following: • Apprenticeship programs for direct care workers; • "Earn as you learn" programs for direct care workers; and • Pre-apprenticeship program for Maine's Career and Technical Education Centers.	The Maine DOL has been expanding healthcare pre-apprenticeship and registered apprenticeship programs. The Maine Apprenticeship Program currently has 11 registered sponsors in healthcare, including Maine DHHS, MaineGeneral Health, Northern Light Health, and MaineHealth. The Maine Apprenticeship Program is also engaged with CVS to establish a registered apprenticeship program in Maine, with a focus on serving individuals with disabilities. Through the Maine Jobs & Recovery Plan (MJRP) funds and a US Department of Labor grant, MaineHealth has expanded their Medical Assistant apprenticeship program to three additional locations. It has also established a Clinical Career Awareness Pre- Apprenticeship, in partnership with Southern Maine Community College. Three other certified pre-apprenticeship programs have also been established through the use of MJRP funds – a CNA Pre-Apprenticeship in partnership with Lewiston Adult Education and Clover Manor, a Medical Assistant Pre-Apprenticeship in partnership with Portland Adult Education (PAE) and Northern Light Health (NLH), and a Healthcare Office Pre-Apprenticeship in partnership with PAE and NLH. These pre-apprenticeships are focused on increasing representation to historically marginalized populations, particularly multi-lingual learners. To date, over 60 pre-apprentices have been enrolled in these programs, with a goal of over 600 to be served through the grant period, which ends December 31, 2024. Supported by Maine Jobs & Recovery Plan funding, DOL hired two full-time healthcare career navigator positions to assist individuals statewide interested in healthcare careers get connected to training and job opportunities. Since the inception of the Maine Jobs Plan, healthcare navigators have worked with 1,250+ individuals who are referred from a	

		variety of sources, including the Caring For ME campaign, and has connected 385 individuals to free training, job opportunities and other services. These positions also focus on helping out-of-state and foreign-trained workers navigate the complex credentialing landscape and connect to healthcare careers, in partnership with ongoing efforts. In addition to our Maine Jobs & Recovery Plan funding, DOL has made investments in the "Caring Economy" through the QUEST grant. QUEST is a dislocated worker grant created in direct response to the COVID-19 pandemic. The grant can help workers reach their employment or educational goals by providing help with services and supports such as childcare, transportation, education and training, and apprenticeships. QUEST has a specific focus on the care economy, green energy, and infrastructure and is administered by the local area workforce boards throughout the state. In Federal Fiscal Year 2023, 102 folks were trained in healthcare including CNA, MA, Home Health, and Personal Care, representing 44 percent of the investment. DHHS is engaged with the University of Maine System (UMS) and MCCS to align learning standards with provider needs. One pilot at the University of Maine at Fort Kent has enabled UMFK nursing students to earn certification as a Personal Support Specialist (PSS) in year 1, a Certified Nursing Assistant (CNA) in year 2, and a Certified Residential Medication Aide (CRMA) in year 3 as they work on their nursing degrees. This allows nursing students to engage in paid work in different capacities along the continuum as they move through their degree program. This model is being expanded to other colleges across Maine.	
12	<u>Intermediate / Long-term:</u> Recommend to the Joint Standing Committee on Innovation,		PL 2021, c. 346 enacted the Maine Health Care Provider Loan Repayment Program. Geared towards certain health care

	Development, Economic Advancement and Business that it amends LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program, to specify that direct care workers be considered eligible health care providers and direct care occupations be included for priority consideration by the Maine Health Care Provider Loan Repayment Program Advisory Committee that is proposed in the bill.		professionals, including behavioral health and oral care. The program is administered by FAME. Prioritizes the provision of access to services (e.g. population served, Medicaid clients etc), educational debt obligation, and workforce needs. Program continues as long as funding exists (additional funding added in 2024).
13	Intermediate / Long-term: Direct the Department of Health and Human Services to work with Maine's institutions of higher education and Career and Technical Education Centers to develop worker pools of students, including students with disabilities, interested in working as a direct care worker on a part-time and/or flexible schedule basis.	As part of the COVID-19 response, the UMS was formally engaged as a partner to coordinate students who would be available to increase the worker pool. Job postings for short-term/crisis staffing needs were sent directly through the Maine Responds system. Permanent and longer-term needs are sent to the Career Services offices across the MCCS and UMS. The process to connect with students is outlined in the DHHS Recruitment and Retention Toolkit.	
14	Intermediate / Long-term: Require all healthcare degree programs that require practicum experience to include practicum requirements and rotations in the long-term services and support sector.		
	Qualifications and Training		
15	Immediate: Direct the Department of Health and Human Services to examine qualification requirements for entry-	DOL and DHHS are working closely with the Department of Education (DOE), Maine Community College System (MCCS) and the University of Maine System (UMS) partners to coordinate a centralized approach to healthcare	

	level direct care workers to align qualifications across settings wherever possible without compromising consumer safety.	training opportunities and training funding via Healthcare Training For ME (launched in April 2022). The funding is a combination of approximately $7 million in tuition remission funding from the Maine Jobs & Recovery Plan as well as MCCS funding. The focus is working with employers to connect incumbent health care workers in entry level jobs with training funding to support attaining certifications and credentials to move up the career ladder and to improve retention and quality of care. Though not exclusively focused on direct care, priority occupations for training funding support include CNA, CNA-M, CRMA and home health aide, among others. The Tuition Remission program has funded more than 700 healthcare workers. Training certificates funded by this program includes 303 individuals with certificates in MHRT-C, ACRE, CNA, Fading Supports, PSS, CRMA, RBT, CADC, Footcare Nurse Specialist, and Certified Dementia Care. Currently, Behavioral Health Professional (BHP) and Direct Support Professional (DSP) certifications are fully funded by DHHS. With one and a half years remaining in the project, the team has reached 47 percent of its goal to serve 1,500 individuals. The MCCS has also funded healthcare training, resulting in 2,772 unique enrollments since the inception of Healthcare Training for ME, and 2,552 individuals have completed their studies notably for this report including CNA, Medical Assistant, and Phlebotomists. DHHS continued development of the Worker Portability and Advancement initiative, which is creating a base credential usable by individuals in at least two current roles, the Personal Support Specialist (PSS) and Direct Support Professional (DSP). The base credential will enable a direct care and support worker to perform entry-level work across multiple groups of people and aspire to pursue additional expertise to advance in the field. Throughout 2024 the Department will meet with partners to receive input and test the new curriculum as it prepares to launch it.	

		To address the significant challenge of finding Direct Support Professionals (DSP) who are able to communicate and care for individuals who use American Sign Language (ASL), DOL and DHHS worked together to record the DSP training in ASL. Those trainings are now being made available through the College of Direct Support. This curriculum version will better meet the needs of potential DSP's who are ASL users.	
16	Immediate: Direct the Department of Health and Human Services to immediately reconstitute, update and implement the Maine Direct Service Worker Training Program.	DHHS is in the process of developing the Worker Portability and Advancement initiative, which creates a base credential usable by individuals in at least two current roles, the Personal Support Specialist (PSS) and Direct Support Professional (DSP). The base credential will enable a direct care and support worker to perform entry-level work across multiple groups of people and aspire to pursue additional expertise to advance in the field. The new base credential curriculum is based on Maine's Direct Service Worker Training Program pilot program and has since been updated and presented at multiple stakeholder meetings to receive stakeholder feedback.	LTCWF Commission received DHHS letter in 2019 stating it would delay the end date of the program for 4 months. The letter explained that a new curriculum was necessary to resolve conflicts with Board of Nursing delegation rules, and had already been implemented.
	Expanding Use of Existing Support Systems		
17	Intermediate: Direct the Department of Health and Human Services to remove as many barriers to family members and guardians being paid caregivers as possible and allowable under federal law and regulations.	In October 2022, DHHS and the five Area Agencies on Aging implemented Respite for ME, funded through the Maine Jobs & Recovery Plan. Preliminary reporting on the Respite for ME grants show that over 406 unique individuals participated on the program with $543,516.44 grant funds expended. Funds were used for respite services, assistive technology/devices, and for home modifications and repairs. In late 2023, the individual grant amounts increased from $2,000 to $5,171.	

	Adult Day Services		
18	Intermediate: Direct the Department of Health and Human Services to review the hours allowable for adult day health services, respite services and other similar programs for adequacy in allowing individuals to remain at home with family members as long as desired by both the caregivers and the individuals receiving services.		
	Assistive technology and environmental modifications		
19	Immediate: Direct the Department of Health and Human Services to raise the caps and create more flexible cost models for assistive technology and environmental modifications for members receiving home and community-based services	In July, 2023 the benefit cap for assistive technology increased from $1,000 to $1,500 and the cap for environmental modifications increased from $3,000 to $4,500 for section 19 waiver services.	
	Other Recommendations		
20	Intermediate: Direct the Office of Aging and Disability Services within the Department of Health and Human Services to convene a work group of stakeholders within the department that includes providers, advocates and consumers, to determine how to expand the consumer-directed options to individuals with developmental disabilities or autism and examine if consumer-directed options are fully utilized for all populations eligible for home and community-based services.	Self-direction has been expanded to participants of Section 18 (Brain Injury Waiver), 20 (Other Related Conditions) and 29 (Supportive Services for Individuals with Intellectual Disabilities waiver) through modifications to the waivers through the emergency use of the Appendix K option during the federal public health emergency. DHHS pursued and obtained changes to its waiver policies to allow these options to continue. Self-Direction is currently offered in Maine Care Section 19 (Older Adults waiver), Section 96 (Private Duty Nursing) and Section 12 (Consumer Directed Attendant Services). The Department also allows self-direction in its state funded Section 69 (Independent Support Services), Section 63 (Home Based Services and Supports).	

21	Long-term: Direct the Department of Health and Human Services to convene a stakeholder group of providers to explore methods to pool workers across providers and care settings or programs, including developing a method to provide benefits to the workers.		Early in the pandemic, DHHS asked provider associations to encourage staff sharing among their members. The associations did not believe this approach would deliver value due to the considerable effort that would be needed to design and operate such a system. They also cited competition among members as a barrier to sharing staff. (2022 report)
22	Long-term: Direct the Department of Health and Human Services to explore creating a HIPAA- compliant digital platform to connect direct care workers, providers, self-directing consumers and family members. The department must include providers in its exploratory effort.		DHHS worked with ADvancing States to pilot a candidate matching platform called Connect to Care Jobs. The platform was designed to allow director care workers and providers to match open positions with available candidates. It was rolled out in phases with SNFs first. It was determined that not enough candidates were creating profiles. DHHS, in consultation with DoL, made the decision to focus energies on candidate attraction to the Maine JobLink instead. (2022 report)
23	Intermediate: Direct the Department of Health and Human Services to explore options for increasing income levels for direct care workers who are receiving various public assistance benefits and ensure that department's case workers communicate this information to their clients.	The Department, in partnership with the Administration for Children and Families (ACF) and the American Public Human Services Association (APHSA), in addition to the Federal Reserve Bank of Atlanta, launched a Benefits Cliff Tool Pilot in February 2022. The pilot enables workers to receive coaching and the tool allows workers to see how starting in entry level healthcare jobs can provide a pathway to greater economic mobility while helping them plan for how it will or will not impact their benefits. The first pilot was completed in 2022, in partnership with state agencies and community organizations. Feedback from staff and families was positive, with the tool helping to spur discussion about careers and wage increases. In 2023, Maine DHHS and MDOL joined ACF and APHSA to launch a broader uptake of the tool. At the same time, the Federal	

		Reserve Bank of Atlanta expanded the project to offer a suite of tools, including: o A calculator that enables participants to evaluate their overall net income gain with wage increases; o The benefit cliff tool piloted in 2022; and o An in-depth budget and career planning tool. In 2023, over 150 staff across multiple agencies participated in training on how to use the tools, including several staff from the Department.	
24	Intermediate: Direct the Department of Health and Human Services to study public assistance programs across the spectrum to determine where higher income levels might be allowable under federal and state laws and rules and consider developing programs that provide more flexibility of increased hours among direct care workers and report findings to the Joint Standing Committee on Health and Human Services for statutory action.	See above. Families Forward (through the Fedcap TANF ASPIRE program) now offers a Health and Human Services career development On Ramp program. Participants learn about career ladders in both fields and how they intersect. Beginning in May 2023, the Office for Family Independence (OFI) began redetermining eligibility for an estimated 17,000 households, representing approximately 31,000 members each month. (Unwinding) The Department has many steps to prepare for the end of the continuous coverage. In 2020, the Department extended transitional MaineCare from 6 months to 12 months to individuals who lost MaineCare assistance due to earnings. This extends the individual's full MaineCare benefits for one year following the increased earnings that put them over the limit. MaineCare income limits are set per coverage group, such as parents and caretakers, pregnant women, childless adults, etc. Increasing income levels for direct care workers, or any other specific employment type, is only an option if the income limits for all MaineCare applicants in the coverage group are increased.	

25	Intermediate: Improve communication and navigation of maximum income levels to individuals receiving public assistance	The Department's Office for Family Independence (OFI) continues to host monthly community partners meetings with MaineCare provides, local advocacy groups, etc. as a forum to share information such as upcoming changes to public assistance rules or process or respond to inquiries questions from agencies who support our applicants and members.	
26	Intermediate: Direct the Division of Licensing and Certification in the Department of Health and Human Services to convene a work group to develop proposals for projects in nursing homes focused on best practices for recruitment and retention of direct care staff using Civil Money Penalty Reinvestment Program funds and submit those proposals to the Centers for Medicare and Medicaid Services.	DHHS decided that pursuing a Lifespan Respite Care grant from the federal Administration for Community Living would not be feasible and has instead received approval from CMS to fund a pilot program under Section 9817 of the American Rescue Plan Act.	
27	Intermediate: Direct the Department of Health and Human Services to consider applying for a grant under the Lifespan Respite Care program grant offered by the ACL within the federal Department of Health and Human Services, or working with any appropriate organization that is eligible.	See above.	
28	Intermediate: Direct the Department of Health and Human Services to investigate and apply for any grant opportunities that improve the quality of long-term care services and supports.	As part of a federal CDC Health Disparities Grant, DHHS launched a pilot to increase and expand capacity of health-related training programs. This Initiative seeks to address health care workforce shortages by expanding the network of rural clinical preceptors, providing access to clinical learned placement systems and expand clinical placements through a public and private partnerships within the Building-ME Network. This initiative has streamlined	In 2021, the Maine Health Access Foundation (MeHAF) provided a grant to the Maine Long-term Care Ombudsman Program (LTCOP) to conduct discussion groups with direct care and support workers who work in nursing homes, residential and home-based settings. As part of Section 9817, under the American Rescue Plan Act,

		clinical placements by using a "Common Preceptor" form and "Clinical Site Directories" to efficiently match academic institutions with rural sites available for clinical placement. Additionally, through the development of new rural clinical preceptorships, as well as the expansion of current rural clinical preceptorships, approximately 380 clinical placements will occur with providers in rural and underserved communities.	OADS has contracted with LTCOP to continue this effort through an initiative that has supported the creation of a Direct Care and Support Worker Advisory Council. Members of the Council include direct care and support staff providing in-home care, working in assisted living and residential care homes, and nursing facilities. The purpose of the Council is to build leadership and advocacy skills as well as to inform and makes recommendations to policy makers about workforce initiatives. DHHS received a federal Money Follows the Person (MFP) Capacity Building grant award that includes a workforce development component.
29	Immediate: Enact an ongoing, independent Oversight Committee to review progress in implementing the recommendations of this Commission, address barriers to implementation, and make new recommendations as needed.	PL 2021, c. 398 (biennial budget), Pt AAAA-7 requires annual reports for 5 years from DHHS on departmental efforts and progress in implementing Commission recommendations. Reports include data related to unstaffed hours. Requires DHHS to include stakeholders in policy discussions relating to recommendations.	

Implementation of the Government Oversight Committee's February 2024 Recommendations – 9/17/2024 OCFS update

Recommendation	Status	Notes
Front Line Staff		
Recruit and retain more case aides	Ongoing	The Legislature approved the budget initiative to increase pay for these positions in recognition of the complexity and critical nature of this work. The vacancy rate in these positions recently dropped from 25% to ~10% and OCFS continues to work diligently to recruit and retain these staff.
Address burnout, turnover, vacancies, and workload	Ongoing	OCFS has undertaken a number of initiatives to both directly and indirectly address workload, burnout, and turnover. These including increasing the pay for caseworker and supervisor positions, establishing Supervisor Trainer positions to support new and established staff's training needs, working to strengthen internal management structure and support for frontline staff both through a reorganization of the child welfare division and a comprehensive review of decision-making processes at all levels of OCFS, and establishing ongoing discussion between child welfare leadership and frontline staff. These efforts have already decreased the vacancy rate by about 50%.
Provide specific coaching/mentoring opportunities	In Progress	OCFS sought and was granted in the budget 8 new Supervisor Trainer positions, one per District. These staff will provide in-district support for training and onboarding of new staff as well as supporting opportunities for ongoing training for more established staff.
Increase and enhance ongoing training opportunities, including job shadowing	In Progress	*See above*: the work of the Supervisor Trainer positions will include enhancing and increasing job shadowing opportunities (among other things). OCFS is also partnering with the Cutler Institute on training development, working with subject-matter experts on specific curriculum topics, and continuing to survey new workers at the completion of Foundations Training and implement changes based on their input and recommendations.
Create special teams to deal with complex cases	In Progress	OCFS is in the process of establishing a cross-office complex case protocol. Much of this work is already being done in an informal manner but the protocol will formalize the process and the various members of the team OCFS staff can access when working on complex cases.
Services for Families		
Improve family team meetings	In Progress	OCFS is currently considering the best path forward to both improve Family Team Meetings and create a process for ongoing evaluation and improvement. OCFS is reviewing the current model and the many changes that have occurred within it since it was implemented in 2002 and seeking the input of national partners with expertise in child welfare to ensure that any framework that OCFS implements has had success in other jurisdictions.
Resource Families and Other Placement Support		
Ensure placement options exist other than in hotels or hospital emergency departments	Ongoing	OCFS hired a dedicated hotel and emergency department coordinator and is engaged in the national dialogue regarding this topic as it is being experienced in jurisdictions throughout the country. Some of the solutions will continue to be pursued in partnership with other DHHS offices as we seek to ensure there are appropriate behavioral health treatment opportunities, including residential where appropriate, for all youth (including youth in State custody).
Improve home-based therapeutic and other resource family resources and supports	Ongoing	This is and will continue to be an ongoing effort between OCFS, other DHHS offices, and community partners who provide these services and supports. This includes therapeutic foster care investments in the 2024 supplemental budget.

Expand financial support to resource families and ensure timely reimbursements for appropriate expenditures	Ongoing	OCFS has established a workgroup to review and ensure the process for addressing any delay in reimbursement to resource parents is quickly and efficiently addressed.
Department Management, Plans, and Reporting		
Task the new director with an improvement plan containing short, medium, and long-term strategies and metrics with regular public updates on progress and challenges	In Progress	OCFS is currently working to develop this plan, working from a comprehensive list of over 200 recommendations OCFS has received from the Legislature, Citizen Review Panels, and other partners. A comprehensive child welfare improvement plan is in development and OCFS intends to begin providing regular updates on the status of action items in the plan in January of 2025.
Require outcomes data	In Progress	*See above* re: improvement plan.
Require specific public reporting on any hospital, hotel, or Department office stays	Under Discussion	OCFS is considering inclusion of these metrics in its work and is currently reviewing whether such metrics could accelerate appropriate placements for children.
Improve culture and job satisfaction	Ongoing	OCFS has undertaken several initiatives to both directly and indirectly address workload, burnout, and turnover. These including increasing the pay for caseworker and supervisor positions, establishing the Supervisor Trainer positions to support new and established staff's training needs, working to strengthen internal management structure and support for frontline staff both through a reorganization of the child welfare division and a comprehensive review of decision-making processes at all levels of OCFS, and establishing ongoing discussion between child welfare leadership and frontline staff. These efforts have already decreased the vacancy rate by about 50%.
Courts		
Improve access to courts for children and families	Outside of OCFS	OCFS works in partnership with the courts but cannot control the specific level of access for cases involving children and families.
Improve child and family access to legal services	Outside of OCFS	This is the role of the Maine Commission on Public Defense Services.
Statute		
Initiate a review of statutes relevant to child protection	Ongoing	OCFS plans to propose changes to the Child and Family Services and Child Protection Act in the upcoming session. OCFS has consistently brought forward bills to improve the statutes where appropriate and ensure we adapt to changes in federal law and policy, as well as best practice.
Technology		
Fix issues with critical Department technology (Katahdin)	Ongoing	The Information Services (IS) team has established a process to regularly survey supervisors and caseworkers about their experience with Katahdin, as well as meeting with District offices to discuss experiences and concerns. The IS team has engaged in focus groups with both staff and external partners, collaborated with the Training Unit to address training-related concerns, and worked with OCFS' Quality Assurance staff to identify system-related feedback they have gathered in their work. In conjunction with this information gathering the IS team is constantly working on updates, enhancements, and improvements to the system to address established child welfare priority items (many of which are the result of the feedback work outlined above).

Child Safety		
Address Department struggles to determine the safety of children at the beginning of involvement during child protective investigations and when deciding whether or not to reunify children with their parents	Ongoing	This is being address via multiple pathways to ensure the greatest success possible. Many initiatives touch on this including efforts to update and improve Foundations Training, provide training support via the new Supervisor Trainer positions, update policy and practice expectations, support strong supervisory oversight through the Supervisory Framework, efforts to comprehensively review decision making processes and establish a framework to support and empower staff to make well-supported decisions, the implementation of Safety Science reviews of critical incidents, among others.
Share Safety Science recommendations with stakeholders and implement systemic recommendations	Ongoing	OCFS has an established annual Safety Science report, and the latest version will be published in the coming months.
Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations	In Progress	As part of OCFS' efforts to review and update policy we are ensuring that consultation with child abuse pediatricians is a practice expectation at all appropriate junctures.
Join the National Center for Fatality Review and Prevention's Case Reporting System	Completed	OCFS announced they had joined the National Partnership for Child Safety and National Center for Fatality Review and Prevention's Case Reporting System in early 2024. Work is currently underway to establish the formal MOU required to share OCFS data with the NCFRPC
Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with the Department	Completed	In the last contract renewal, the organization that provides Maine's child abuse pediatrician services received a substantial increase. The program now has two certified child abuse pedestrians on staff as well as other clinical staff to provide support.
Management, Plans, and Reporting		
Review and assess informal policies and practices	In Progress	OCFS is working methodically to review and update all existing policies which includes reviewing related informal practices that may have been established over the years and determining whether they need to be included in the policy. Recognizing that no policy can address the myriad situations staff encounter and that policy is intended to support good decisions and casework, OCFS is comprehensively reviewing decision making processes at all levels of OCFS to establish a framework to support and empower staff to make well-supported decisions.

Services for Families		
Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring	In Progress	A bill to fund an outside evaluation of the Family Team Meeting (FTM) process did not become law last session. As such, OCFS is currently considering the best path forward to both initially improve Family Team Meetings (FTMs) and create a process for ongoing evaluation and improvement. OCFS is seeking the input of national partners with expertise in child welfare to ensure that the framework OCFS implements has had success in other child welfare jurisdictions while also reviewing the current model and the many changes that have occurred within it since it was implemented in 2002 to help establish a path forward to meaningful improvement.
Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families as well as housing and transportation	Ongoing	This is and will continue to be an ongoing effort between OCFS, other DHHS offices, and community partners who provide these services and supports. OCFS has been a partner with CDC in launching https://bethereforme.org/ which provides support to parents and caregivers in connecting to existing resources and support.
Greater supports for new mothers with substance use disorder	Completed	Maine MOM program and OCFS' efforts around the Plan of Safe Care for infants and their caregivers when infants are born affected by substances.
Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment	Outside OCFS	This recommendation is directed to the Maine CDC which oversees public health nursing.

EXCERPTS

§952. Scope

"system of periodic review of agencies and independent agencies of State Government in order to evaluate their efficacy and performance"

"The financial and programmatic review must include, but is not limited to, a review of agency management and organization, program delivery, agency goals and objectives, statutory mandate and fiscal accountability."

§955. Committee schedule

Program evaluation report - due no later than November 1st prior to 2nd regular session;

Committee report - due no later than March 15th of the 2nd regular session;

- May include legislation to implement recommendations;
- May establish follow-up review of agency progress including progress reports and public hearings

§956. Program evaluation report

Must include:

1. Enabling or authorizing law or mandate, including any federal mandates;
2. A description of each program administered by the agency
   - Established priorities, including the goals and objectives;
   - Performance measures or other benchmarks used to measure progress; and
   - Agency assessment on success in meeting its goals and objectives, and reasons for not meeting them and the corrective measures taken;
3. Organizational structure;
4. Financial summary;
5. Areas where agency has coordinated with other state and federal agencies to achieve objectives;
6. Identify constituencies served:
7. Efforts on use of alternative delivery systems;
8. Emerging issues;
9. Any other information requested by the committee of jurisdiction;
10. A comparison of related federal laws and regulations to the state laws;
11. Policies for collecting, managing and using personal information and evaluation of adherence to practice principles of notice, choice, access, integrity and enforcement;
12. List of reports, applications and other similar paperwork required to be filed with the agency by the public;
13. List of reports Legislature requires agency to prepare or submit;
14. List of organizational units and programs; and
15. Identification of enabling or authorizing statutes that may require legislative review to align the statutes with federal law, other state law or SCOTUS decisions.

§957. Committee analysis and recommendations; authority

Committee may conduct an analysis and evaluation that may include, but need not be limited to, an evaluation of the program evaluation report required

Craven Recommendations

From: Craven, Margaret
Sent: Thursday, September 12, 2024 11:21 AM
To: Westphal, Lynne; Broome, Anna
Subject: Fw: Bill we discussed last week in cape elizabeth
Attachments: rationale for Children's Ombudsman 091124.docx

Hi Lynne and Anna,

Please find an attachment from Rep. Mathieson, for legislation she is planning on submitting this session. Could you please forward to the entire commission for their review.
Thank you.
Margaret

From: Mathieson, Kristi
Sent: Wednesday, September 11, 2024 7:45 PM
To: Craven, Margaret
Subject: Bill we discussed last week in cape elizabeth

Hi Margaret,
Attached is a draft rationale of the bill I submitted second session of the 131'st legislature (did not go through leg council as an emergency bill) but I will be resubmitting this session. The vision is an independent expert who can take the time to be fully informed about best practice, evidence-based approaches, and most importantly, what works for children and their families - according to children and their families. With unique and carefully protected access to all children's information the ombudsman may be the only person with the full story. With independence, the ombudsman can explain the nature of the problem and propose solutions without restrictions an administrator must work within: administration priorities or limits on budget requests, etc. Strengthened independence will also build trust with all parties - something Maine sorely lacks right now. NH has done a great deal of good work establishing an independent ombudsman department. I attached the rationale for the bill but am still working on language with stakeholders.

Happy to discuss in more detail
Kristi

Representative Kristi Mathieson (she/her)
District 151 Kittery

Please be advised that this email is subject to the Freedom of Access Act.

Proposal: Legislation to enhance independence and expand jurisdiction of the Child Welfare Ombudsman.

Action: This bill would repeal Title 22 § 4087-A Ombudsman program and replace with a new separate chapter in Title 5, Administrative Procedures and Services § 24, Protection and Advocacy Agencies, solely dedicated for the purpose to establish the Office of the Children's Ombudsman

Title 22 § 4087-A mandates *"ombudsman services to children and families of the state regarding child welfare services provided by the Department of Health and Human Services..." and to... "promote the best interests of the child...answer inquiries and investigate, advise and work towards resolution of complaints of infringement of the rights of the child and family involved."*

Rationale:

- The limited jurisdiction of Title 22 § 4087-A discriminates (by exclusion) certain children. For example children who are in custody or supervision of the Department of Corrections or Education or any other agency that is or should be serving children do not have protections of their rights like children who are suspected of or determined to be abused or neglected. Similarly, children receiving services from other State agencies than DHHS do not have a voice in the development, implementation and assessment of essential services.
- The US Department of Justice (DOJ) recently found Maine in violation of the Americans with Disabilities Act for over-institutionalizing children with disabilities.[1] Children's lack of access to mental health services and over reliance on institutional placements with high risk of incarceration, violates children's rights, exacerbates trauma, and interrupts potential for rehabilitation. Appointment of an independent ombudsman to oversee juvenile justice reforms would be a sign of good faith to the DOJ and potentially avoid fines, federal oversight and class action.
- A recent investigation and series of reports by New Hampshire's Child Advocate demonstrates the importance and urgency of having an independent and informed lens examining all placements of children by the state. Concerns rose by the Child Advocate after a visit to Bledsoe Youth Academy in Tennessee described a culture of abuse that included bullying, threatening, and berating children; verbal and physical aggressiveness; harsh punishments and forced work akin to human trafficking.[2] All New Hampshire children were returned to New Hampshire. The extreme conditions found so recently underscore the urgency of a situation of Maine juvenile justice-involved children and youth who have no independent resource to check on them and assure their safety.
- Maine leaders are currently contemplating significant change in juvenile justice services. An independent voice with access to both children, their records, system infrastructure, experts and science will serve as a valuable and essential resource to all parties for making the most effective, efficient decisions.

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[1] Office of Public Affairs, U.S. Department of Justice (2022). Justice Department finds Maine in violation of ADA for over-institutionalization of children with disabilities (June 22). https://www.justice.gov/opa/pr/justice-department-finds-maine-violation-ada-over-institutionalization-children-disabilities

[2] State of New Hampshire Office of the Child Advocate (2023) Issue Briefing and Update: Concerns for Out of State Placement: Bledsoe Youth Academy; Update Follow up on Out of State Residential Facility: Bledsoe Youth Academy. https://www.childadvocate.nh.gov/documents/reports/OCA-Bledsoe-Issue-Briefing.pdf https://www.childadvocate.nh.gov/documents/reports/OCA-Bledsoe-Issue-Briefing-Update.pdf

September 2024: Blue Ribbon Commission to Study the Organization of and Service Delivery by Maine's Department of Health and Human Services

The Commission submits these recommendations to address gaps in the care and wellbeing of all Maine children receiving services and supports from any of the offices in the Department of Health and Human Services.

1. **Problem: While the mission of the Maine Department of Health and Human Services is "to provide health and human services to the people of Maine so that all persons may achieve and maintain their optimal level of health and their full potential for economic independence and personal development" , its structure (a group of offices that offer a variety of largely siloed services) and transactional interface resulting in a disjointed, transactional experience, with multiple programs with multiple doors and rules. These unsynchronized programs create real risks for children to fall through gaps. DHHS needs to add processes to assume a whole person approach that includes some services as well as the framework necessary for our children to grow and thrive by not falling through a gap.**

   Solution: Develop a management structure with holistic leadership of all children's programs. The function of such leadership should be to shift from an eligibility-based service to a whole person approach, ensuring strong oversight and coordination of all DHHS activities impacting the health and wellbeing of Maine's children, including children with developmental disabilities, behavioral health needs, brain injury, complex medical needs. This management structure should not only ensure that services are effective, efficient, and in the least restrictive environment but also that the safety net for Maine's children is whole.

   An Approach: The Department should identify a position within the Commissioner's Office to lead the transition from an eligibility- based system to a whole child approach. The position should be devoted to the oversight and coordination of all DHHS activities impacting the health and wellbeing of Maine's children with developmental disabilities, behavioral health needs, brain injury, special healthcare needs, etc. This role should holistically integrate initiatives among the offices of MaineCare, Behavioral Health; Child and Family Services, Maine Center for Disease Control and Prevention (Children and Youth with Special Healthcare Needs), other offices as appropriate, and ensure that Maine's EPSDT (Early and Periodic Screening,

Diagnostic and Treatment) obligation is met. This position should embrace the role of realizing the National Blueprint for Change that "Families should have timely access to the integrated, easy-to-navigate, high-quality health care and supports they need, including but not limited to physical, oral, and behavioral health providers; home and community-based supports; and care coordination throughout the life course."[1] This role should have authority to gather the appropriate data from the various agencies and internal offices to develop and monitor metrics for change. Further this position should be designated the responsibility for coordination of systemic policies with partner Departments such as DOE and DOC to ensure the maximized health and wellbeing of children.

[1] stateofmaine.sharepoint.com/teams/MeCDC-MCH-BlueprintforChange/Shared Documents/Forms/AllItems.aspx?id=%2Fteams%2FMeCDC-MCH-BlueprintforChange%2FShared Documents%2FGeneral%2FSystems Lens Blueprint Domains_%2Epdf&parent=%2Fteams%2FMeCDC-MCH-BlueprintforChange%2FShared Documents%2FGeneral&p=true&ga=1

Adapted From HealthFirst, Colorado EPSDT Policy:

(https://hcpf.colorado.gov/sites/hcpf/files/EPSDT%20Policy%20Statement%20June%202023%20%28For %20Providers%29.pdf)

EPSDT benefits under federal law, requires States to cover any service for members aged 20 or younger that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the State Medicaid Plan.

Even if the service will not cure the member's condition, it must be covered if it is medically necessary to improve or maintain the member's overall health.

This means that EPSDT benefits include medically necessary treatments that a recipient under 21 years of age needs to stay as healthy as possible, and the State program must provide or arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment.

EPSDT makes short-term and long-term services available to all members under 21 years of age, without many of the limits Medicaid imposes for services for members over the age of 21.

The services must be prescribed by the member's treating provider(s) and prior authorization may be required for some services.

EPSDT Fast Facts

1. No Medicaid Wait List for EPSDT Services.
2. No Monetary Cap on the Total Cost of EPSDT Services.
3. No Upper Limit on the Number of Visits, Hours, or Units under EPSDT. For Medicaid limits to be exceeded, providers must document why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition.
4. There is no requirement to make special requests for EPSDT coverage.

EPSDT describes a core set of Medicaid benefits for individuals under the age of 21. Members and their providers are not required to cite or mention EPSDT to have requests reviewed under the EPSDT medical necessity standard.

EPSDT

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic, age-appropriate intervals

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and

Treatment: Control, correct or ameliorate health problems found.

2. **Problem: Maine has stuck kids. Kids stuck in emergency departments with nowhere to go. Kids stuck at home living in sometimes exponentially deteriorating situations because there are no community supports available to them. Kids out of state are unable to get services in Maine, leaving them far away from their families and communities. Kids in crisis. Yet, even at this point, there is little that can be offered to get them unstuck and out of crisis. Maine is currently not fulfilling either Olmstead or EPSDT obligations for all Maine's children. Because of the transactional, siloed approach to care, the safety net has been allowed to erode and holes have grown large enough that some children fall through.**

   Solution: Harness the will and apply the resources, including leadership and funding, to address the needs of these vulnerable children.

   An Approach: Designate a person within the Commissioner's office who has sufficient decision-making authority to coordinate and solve multifactorial problems impacting children such as kids at risk of being, or actually stuck in, Emergency Departments and institutional settings. This leader should coordinate among departments to find solutions quickly that will remove stuck kids from deteriorating situations. This should be a leadership function because solutions can only be found utilizing the services of a combination of offices and programs within DHHS….i.e., a child in an ED will likely need services from MaineCare, Behavioral Health; Child and Family Services, Maine Center for Disease Control and Prevention (Children and Youth with Special Healthcare Needs), and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) .

3. **Problem: Title V is a partnership with Maternal Child Health AND Children with Special Healthcare Needs programs, legislated as separate under the Social Security Act but funded jointly through the MCH block grant[2] , intended to ensure that "Families, regardless circumstance, can access high-quality, affordable, community-based service that support the medical, behavioral, social, and emotional well-being."**

[2] Fast Facts https://amchp.org/title-v/

Over many years, these programs have been stripped of authority to fulfill their charge and funding has been diverted to other public health priorities. In recent years the goals of both the federal charge and the authorizing Maine statute[3] have been ineffective, or at best, minimally realized.

Solution: Ensure funding that is meant to be for CYSHN is allocated to the work within the approved State Plan. Reorganize the program so that it can effectively accomplish its current goal to assist the Department in implementing cross office initiatives such as the Health Resources and Services Administration's Maternal and Child Health Bureau National Blueprint for Change [4]

An Approach: The Title V Children and Youth with Special Healthcare Needs (CYSHN) program should be disentangled from the MCH program, yet remain within the Maine CDC as required by the Social Security Administration[5]. Reallocate funding to support Maine's goals outlined in the "Systems Lens Blueprint Domains" document, especially, Principle 3 sets a goal that "Service sectors increase the ability of CYSHCN and their families to access services by addressing administrative and other processes that hinder access." [6] This program should support the Commissioner's office to realize the work to transition from an eligibility- based system to a whole child approach.

4. **Problem: There is not a seamless continuum of care available to serve Maine children with complex medical and developmental needs, including but not limited to intellectual disability, autism spectrum disorder, cerebral palsy, complex medical disorders, neurological disorders, or brain injury. Children with developmental disabilities often have to wait until they have behavioral health needs to access community services when, if they had received services earlier, behavioral health needs may never have presented. At higher levels of need, the State offers Children's Residential Care Facilities (CRCF) through the Private Non-Medical Institutions (PNMI) model. However, children who have the need for these types of facilities and have nursing needs are not eligible for that model of care. When community-based**

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[3] https://legislature.maine.gov/statutes/18-C/title18-Csec9-401.html

[4] https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn/blueprint-change.

[5] According to Social Security Administration MCH and Children with Special Healthcare Needs programs must be in the State Health Agency https://www.ssa.gov/OP_Home/ssact/title05/0509.htm

[6] State of Maine CDC Systems Lens Blueprint Domains .pdf

services are available for children, they are delivered through a behavioral health model which may not be appropriate to address developmental issues and does not address medical needs. There is no centralized referral nor quality monitoring system for children's in-home nursing care (as there is for behavior health community services,) impacting children's access to integrated care.

Solution: Develop a process to study, design, plan, and continuously work to improve a system of care to meet the needs of Maine people with disabilities. This process should be dynamic and iterative.

An Approach: Given the urgency of stuck children with disabilities in Maine and the EPSDT obligation the Department should begin a process to develop a continuum of care model that serves children, with adequate, appropriate, and available care to meet their needs in the least restrictive setting. The continuum of care should include structures to meet the needs of children and youth with any combination of disabilities including developmental, behavioral health, brain injury, substance affected, neurological, and complex medical needs. The Department should consider if different types of children's waivers such as a medically complex children's waiver as an addition to Maine's menu of options.

5. **Problem: The Department will be offering lifespan waiver slots to eligible 14-year-olds in 2025. The Office of Aging and Disability Services has limited experience and authority in coordinating care among the systems that serve children.**

   Solution: Build capacity to focus on cross department and cross agency coordination to ensure smooth support for eligible transition aged youth.

   An Approach: The Office of Aging and Disabilities Services should create a position for an Associate Director for Youth with Disabilities. This position should support the lifespan waiver and, among other duties, focuses on cross department and cross agency coordination to ensure smooth support for eligible transition aged youth.

6. **Problem: DHHS services for children are focused on only some children: those with behavioral health needs, children with intellectual disabilities, and some children with autism. Children with complex medical needs, neurological disorders, brain injuries, and other developmental disorders are served only through what they can access through fragmented systems of care, if they are fortunate. Maine does not know what the gaps of these children are because they are often invisible unless they fall into crisis or develop a behavioral health problem. For example, Maine has no system of monitoring, home-based nursing services, leaving families to navigate, if they are able, many waitlists at different agencies.**

   Solution: Adapt, reorganize, or expand DHHS to ensure that all children with disabilities have a system of supports to meet their needs.

   An Approach: Either create a new program to serve children with developmental needs or expand CYSHN to include monitoring and supporting services for children and youth with complex medical and developmental needs who require support such as nursing services, section 28, and developmentally focused services.

7. **Problem: Children and youth involved in Juvenile Corrections system are not receiving appropriate behavioral health care.**

   Solution: Ensure that children involved in the juvenile justice system get their behavioral health needs met through increased access to services.

   An Approach: The Office of Behavioral Health Services should expand its capacity to support youth who are also involved in juvenile corrections to ensure that adequate, appropriate, and effective behavioral health care is available to youth involved in Juvenile Community Corrections as well as those involved in institutional levels of care.

8. **Problem: Inadequate rates are frequently cited as a very significant barrier to provision of high-quality health and human services. Rate setting is a commonly used set of practices to determine rates. However, there isn't a feedback loop to determine if the rates set were adequate. I.e., if a rate was established with the hope that more providers would offer the service to members, there is no analysis to see whether the amount actually did meet the need and created more capacity.**

   Solution: Create a quality assurance loop to examine whether the changes to the rate structure impacted the service.

   An Approach: Regularly report to the legislature the impact of rate setting initiatives on service delivery program quality, and when appropriate, capacity. If quality and/or capacity has not measurably increased, a plan to improve the service should be developed.

Blue Ribbon Commission to Study the Organization of and Service Delivery by Maine's Department of Health and Human Services

DRAFT by Commissioner Allina Diaz

Problems:

1. Families don't feel heard, are/feel stigmatized.
2. Families need more resources, so that they essentially have less contact with the department.
3. People using services in Maine do not feel like they have any power or autonomy, and are often being re-traumatized when they encounter the system.

Recommendation/Solutions:

1) Create more opportunities for families to give input. Identifying solutions that will make the most impact requires this feedback. This could include listening sessions, surveys, or additional DHHS staff charged with community engagement. Special attention should be paid to communities of color, immigrant communities and other underserved groups.
2) Create more avenues for filing grievances, use and expand constituent services to hear from participants, address concerns, and track issues.This should include multiple departments including organizations that are contracted by DHHS.
3) Provide more economic resources that reduce toxic stress in the home. If people can't meet their basic needs they are focused on survival and have less opportunity to reach their potential. The housing crisis and cost of goods, particularly groceries, are having a growing impact on low-income and working families. In the current economy a growing number of people are experiencing the impacts of financial stress.
    a) Support Services for families–due process, education. Families should know what resources are available to them, and how to apply. If they are denied services they should be able to access due process. Participants deserve an official denial and a path forward if they do not agree with the decision.
4) Improve pay and employment for current DHHS staff, work on retention.
5) Implement ongoing training for staff to promote cultural understanding and competency, including issues of implicit bias, to build a climate of equity and inclusion. Establish a culture based on trauma informed practices. Train Staff on:
    a) General Trauma Theory (trauma informed and culturally and linguistically appropriate services)
    b) The impact of trauma on families and youth, including behavior and relationship.
    c) What are Trauma Informed Principles
    d) Impacts of trauma work on staff

https://nhchc.org/wp-content/uploads/2019/08/thrive-guide-to-trauma-informed-organizational-development.pdf

6) Invest in the technology that the department needs to make changes to the way services are administered.
7) Review how TANF grant funds are spent and allocate more money to go directly to families, in flexible funds. Increase flexible funds to families.
8) Consider how to bring in more revenue to meet the demand of need by families in Maine.
9) Improve inter and intra-departmental communications to make Department processes more efficient and reduce the potential for clients' emotional burden and trauma.
10) Improve language access, translation of resources, and quality of interpretation in appropriate dialects.

Recommendations for the Maine Blue Ribbon Commission to Study the Delivery of Services of the Department of Health and Human Services:

1. Enhance Support for Frontline Staff
   - Expand Training Programs: Align training with national best practices, especially in child welfare and behavioral health service.
   - Incorporate Frontline Feedback: Prioritize the experiences and opinions of frontline staff in policy-making to ensure practical, on-the-ground improvements.

2. Improve Substance Use Disorder Services
   - Streamline Service Access: Develop a comprehensive, coordinated approach to intervention, treatment, and recovery to reduce fragmentation and improve outcomes.
   - Expand Peer Support Services: Increase the availability of peer and family support at all levels of care to enhance the recovery process for individuals with substance use disorders.

3. Strengthen Child Welfare Practices
   - Focus on Early Intervention: Implement programs supporting early screenings and interventions for children at risk of adverse experiences to prevent escalation into more serious welfare cases.
   - Standardize Safety Plans: Establish clear guidelines for the use and monitoring of safety plans during child welfare investigations to ensure consistent and effective protection of children across the states.

4. Expand Behavioral Health Services
   - Develop Comprehensive Crisis Services: Advance a robust crisis continuum that provides timely, effective responses and reduces the reliance on hospitals or criminal justice interventions.
   - Promote Continuity of Care: Ensure continuous, lifespan-focused behavioral health care, particularly for adults with intellectual and developmental disabilities and serious mental illnesses.

5. Address Systemic Challenges in Child Welfare
   - Reduce Investigation Delays: Increase the efficiency of child welfare investigations by ensuring that all necessary investigative activities are promptly completed and that risks to children are recognized and acted upon.
   - Accelerate Permanency Decisions: Avoid delays in filing petitions for termination of parental rights when warranted, to expedite permanency for children in state custody.

6. Expand Housing and Transportation Services
   - Support Housing Initiatives: Facilitate access to supportive housing, both for short-term recovery and long-term stability, especially for individuals involved in behavioral health services.
   - Enhance Transportation Accessibility: Improve transportation services to ensure that individuals can access necessary health and social services across the state.

7. Invest in Workforce Development
   - Recruit and Retain Healthcare Workers: Position Maine as a desirable location for healthcare professionals through competitive initiatives that address recruitment, skill development, and retention.

Draft Recommendations from Rep. Dan Shagoury for the Blue Ribbon to Study the Organization of and Service Delivery by the Department of Health and Human Services

Submitted by Rep. Dan Shagoury

I would suggest the following recommendations:

Mental Health Services

We received a very encouraging report from DHHS on its work concerning Certified Community Behavioral Health Clinics (CCBHC). By June 2024, Maine, alongside nine other states, was awarded a grant to launch the CCBHC model at five geographically diverse locations across the state. This model emphasizes tailoring services to meet the unique needs and cultural concerns of the communities served, with a minimum scope of practice across nine key areas.

While DHHS was working on implementing the CCBHC model of service, a 2022 investigation by the Department of Justice (DOJ) revealed significant deficiencies in Maine's mental health, child protective, and correctional systems. The DOJ's findings resulted in a lawsuit against the State of Maine this past week, outlining systemic issues, including lengthy waitlists for community services, underfunded crisis services, and prolonged institutionalization of youth.

The CCBHC model offers a comprehensive pathway to address many of the systemic concerns raised by the DOJ in its investigation and subsequent lawsuit. Maine can improve its behavioral health system and meet the needs of its most vulnerable populations by ensuring adequate funding, increasing access to crisis and community-based services, and expanding evidence-based programs. The recommendations outlined below help address the DOJ lawsuit and foster a sustainable, community-focused approach to mental health care across the state.

The Certified Community Behavioral Health Clinics (CCBHC) Model

The CCBHC model mandates the provision of services in the following nine areas through direct services or formal partnerships:
1. Crisis Services
2. Outpatient Mental Health and Substance Use Services
3. Person and Family-Centered Treatment Planning
4. Community-Based Mental Health Care for Veterans
5. Peer Family Support and Counseling Services
6. Targeted Case Management
7. Outpatient Primary Care Screening and Monitoring
8. Psychiatric Rehabilitation Services
9. Screening, Diagnosis, and Risk Assessment

This model is designed to create a comprehensive and culturally responsive behavioral health system to meet the needs of diverse populations across Maine.

The DOJ Investigation and Lawsuit Against the State of Maine

In June 2022, the DOJ completed an investigation into the State of Maine's handling of institutionalized youth, particularly regarding the intersection of the mental health, child protective, and correctional systems. Key issues identified by the DOJ included:

1. Lengthy Waitlists for Community Services
2. Low Provider Pool due to Low Payments and Burdensome Documentation
3. Law Enforcement as Primary Responders for Mental Health Crises
4. Lack of Access to Wraparound (WRAP) and Assertive Community Treatment (ACT) Programs
5. Insufficient Support for Foster Parents, Leading to Prolonged Institutionalization

Following the investigation, the DOJ filed a lawsuit against the State of Maine on September 9, 2024. The lawsuit calls for the following accommodations:
1. Ensure access to community-based services through individualized screening and planning.
2. Address behavioral health waitlists.
3. Provide timely crisis services, particularly mobile crisis providers.
4. Fund and train a pool of providers, including foster parents.
5. Revive previously funded programs that support foster children.

Recommendations:

- Ongoing Funding for CCBHCs - DHHS should develop a plan to ensure sustained funding for all CCBHCs across the state. The nine required areas of the CCBHC model align with the DOJ's identified areas of concern, including reducing waitlists, providing timely crisis services, and maintaining robust behavioral health services.

- Enhancing Crisis Services – DHHS should develop a plan to increase accessibility to crisis services, particularly mobile crisis teams and crisis receiving centers. The 2024 legislative session saw the Health and Human Services Committee address these concerns with increased funding for crisis centers in Penobscot, Aroostook, and Lewiston. Continued investment in these services is necessary to divert individuals from law enforcement, the criminal justice system, and hospitalization.

- Expanding Family Caregiver and Peer Support Models – DHHS should focus on developing and expanding family caregiver and peer support models. Providing adequate reimbursement rates and benefits for these support roles ensures that caregivers are equipped to assist in recovery, ultimately expanding the system's capacity to serve individuals in their homes and communities.

- Increasing Service Accessibility in Rural Areas - The DOJ's lawsuit highlights the limited access to care in rural areas of Maine, which increases the risk of institutionalization for those living in underserved regions. DHHS should develop a plan to provide preventative, community-based services in rural areas to reduce the need for higher levels of care and institutionalization.

- Implementing Evidence-Based Services - The DOJ noted the lack of evidence-based programming, such as wraparound services and ACT programming, throughout the state. Maine currently has only one Child ACT provider in the southern area, with limited geographic coverage. The state does have additional Adult ACT providers. However, there continues to be a lack of providers for much of the state. Although Multi-Systemic Therapy is also an evidence-based program, some limited providers have implemented it with fidelity to the model and significant restraints due to travel and geographic needs.

The DOJ noted that many programs are offered throughout the state; however, due to the lengthy waitlists, many young people are placed in higher and institutional levels of care while awaiting services. Providing evidence-based, preventative, and community-level services assists in maintaining individuals in their communities with their families and friends, supporting them through their recovery.

Concerning older Mainers

Maine is the oldest state in the union, and the number of Mainers over 65 is expected to grow over the next 30 years, and with it the need for caregivers. The state has done an admirable job of reducing and eliminating the wait lists for services on the programs it oversees, but this only addresses part of the problem. Even though the state has authorized payment for services, this does not mean that these services are actually available to consumers. Many of these consumers are not getting their authorized hours of service because the caregivers aren't available to provide it. This results in worsening health results for consumers and increased burnout for existing caregivers.

Recommendation:

- DHHS should consider: taking any unspent money resulting from these unfilled hours and roll it over into a permanent account aimed at improving caregiver recruitment and retention.

Transportation for other than medical care is a problem facing older Mainers. Lack of transportation for things like grocery shopping, laundry and social activities, such as attending church, can cause things like poor nutrition and depression. Medicaid rules allow for transportation for non-medical transportation of this nature, and this is done in NY.

- DHHS should undertake a pilot project using the New York model (as was proposed in LD 17 from the 130th Legislature) to see if it would work in Maine.

Concerning the recommendations of the Government Oversight Committee concerning Child Protective Services

Child Protective Services was the subject of an in-depth examination from the Government Oversight Committee, who made numerous recommendations for improving their operation. To their credit, the Department has already begun acting on many of those recommendations , particularly those concerning frontline staff.

- I would endorse all of the unanimous recommendations, as well as the following recommendations:
    - I5 – Join the National Center for Fatality Review and Prevention's Case reporting System
    - B1 – Increase access to mental health, behavioral health, substance use disorder, domestic violence and other services for families as well as housing and transportation

- B4 – Greater supports for new mothers with substance use disorder
- B7 – Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment
- B5 – Increase access to low-barrier wraparound services , with peer support and flex funds
- B6 - Expand financial assistance to low-income families.

General Recommendations

The following are recommendations aimed to improve overall operations and results from DHHS:

- DHHS should automatically enroll people into all the programs they qualify for within the Department, and make every effort to set up systems to automatically enroll them, or simplify their enrollment in applicable programs outside of DHHS (ie., LIHEAP).
- DHHS should establish a position within the Commissioner's Office with the authority to develop and implement individualized systems of care for difficult cases

I have also consulted with Commission member Nancy Cronin, who will submit her own recommendations, which I am in agreement with.

Closing the Gap: Maine's Direct Care Shortage and Solutions to Fix It

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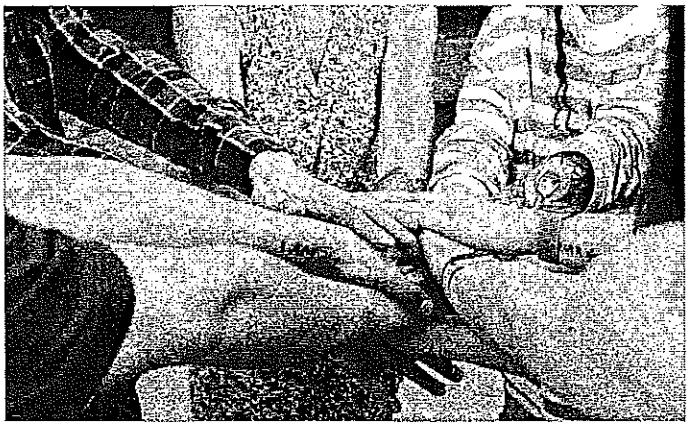
AARP estimated that 166,000 people in Maine provided 155 million hours of unpaid care in 2021. A significant portion of these caregivers are presumably employed. Further research into the impacts of informal caregiving on overall worker productivity and labor force participation is warranted, but it appears to have a significant — and underappreciated — impact on our economy. In the same way that employers and policymakers recognize the importance of child care to the workforce, caregiving, especially unpaid care, must also gain greater consideration and support.

Together we can close Maine's care gap



An all-hands-on-deck approach is needed, but for these efforts to succeed, the state must lead with bold policy.

Addressing direct care workforce challenges will require an all-hands-on-deck approach. Employers need to implement family-friendly policies that allow workers to juggle their work and family demands; municipalities and counties need to provide innovative solutions like adult day drop-in services; people in Maine must raise their awareness of the issue and volunteer in their communities. But for these efforts to succeed, the state must lead with bold policy that both honors the fundamental value of the people who need and provide these supports and recognizes why the economic case for investment is so important. Specific opportunities to pursue include:

Collaboration and engagement

- Expand membership of the Essential Support Workforce Advisory Committee to sufficiently represent the interests and perspectives of workers, clients, and other impacted groups
- Collaborate with high schools and institutions of higher education to create meaningful pathways for students to engage in this workforce
- Elevate direct care access and workforce issues in Maine's economic development priorities
- Prioritize culturally relevant recruitment and training pathways for New Mainer communities

Data collection

- Improve public data collection and reporting systems and engage stakeholders in data design
- Annually survey agencies and workers to measure job vacancies, turnover rates, and working conditions
- Engage Maine Health Data Organization to regularly measure the direct care gap for all payers
- Track and report health outcomes of people on waitlists or who are receiving a fraction of their approved care

Reimbursement, compensation, and innovation

- Raise reimbursement for the labor portion of direct care in all settings to at least 140% of the state minimum wage
- Ensure workforce investments are focused on improving long-term retention and include pass-through polices and clear guidelines to optimize worker benefit
- Prioritize timely reimbursements, including when rates change
- Create a universal worker training and credentialing system that provides workers portable and stackable credentials

- Fund innovation grants to help employers pilot programs to explore best practices for worker recruitment and retention
- Pursue innovative policies to provide benefits to direct care workers, including health, retirement, and education. Examples could include:
  - Create a state-subsidy for direct care workers to purchase insurance on the state's marketplace
  - Create public higher education benefits for direct care workers and their immediate family members
  - Explore direct care worker's access to the Maine Public Employee Retirement System

Conclusion: public and private support is necessary to fix this problem

Maine's direct care system is failing thousands of older adults, people with disabilities, and individuals with behavioral health challenges. This report finds more than 23,500 hours of approved home care for older adults go undelivered every week. Yet when accounting for data inadequacies and people who do not qualify for public programs, this figure certainly underestimates the true scale of the problem. While MECEP's 2023 report on direct care work identified the myriad economic costs of undervaluing direct care workers, this report aims to estimate the scale of the care gap Maine people face. To reduce the high rate of turnover and attract more than 2,300 more workers into direct care, MECEP recommends raising reimbursement to at least 140% of state minimum wage and exploring innovative ways to provide care workers health, retirement, and higher education benefits. Fundamentally, we urge state leaders to more deeply engage consumers and care providers in efforts to close our direct care gap.