

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature



A Review of the Closure of the Mississippi State Hospital's Community Services Division

PEER received a complaint from a citizen who was concerned about the Mississippi State Hospital's contract with Key Behavior Essentials (doing business as Guided Steps Healthcare) to assume responsibilities of the hospital's Community Services Division on May 1, 2014. Subsequent to the complaint and during the course of the review, the hospital voided its contract with Guided Steps; PEER then focused the review on the division's closure and the transition of clients to other providers.

According to officials of the Department of Mental Health (DMH), the department's and hospital's staffs perceived that the Community Services Division was outside the hospital's primary mission and believed that redirecting resources from community mental health services to acute inpatient care at the Mississippi State Hospital (MSH) was the best use of resources.

To implement a transition of clients from the division to other mental health care providers, in December 2013, MSH contracted with Guided Steps Healthcare. However, the department did not ensure that Guided Steps complied with some of the requirements for provider certification and did not verify during the application process that Guided Steps' Executive Director met the education requirements for a certified provider.

Neither DMH nor MSH could provide evidence that their staffs were involved in the development, review, or approval of the plan that Guided Steps created to facilitate the transition of MSH Community Services clients. Although MSH designated a staff member as being responsible for tracking the transition of these clients, MSH had no system in place for tracking and MSH could not readily determine where clients were located or where they were going.

Due to Guided Steps' "failure to comply with DMH Operational Standards" and "inappropriate and unethical conduct," the department terminated Guided Steps' certification, which resulted in MSH terminating its contract with Guided Steps on April 12, 2014. Regarding the transition of clients after the contract was terminated, DMH maintained that contract termination should not change the transition process and that MSH Community Services staff would continue to provide placements for clients.

In providing community-based mental health services in the future, the state should recognize the continuing significance and obligation of the Rose Isabel Williams Mental Health Reform Act of 2011 to involve representatives of all sectors of the state's mental health system in planning for and delivering community-based mental health services. Also, when contracting with private providers for community-based services, the Department of Mental Health should exercise due diligence and prudent contracting practices.

June 10, 2014

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms, with one Senator and one Representative appointed from each of the U. S. Congressional Districts and three at-large members appointed from each house. Committee officers are elected by the membership, with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) <http://www.peer.state.ms.us>

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
NANCY ADAMS COLLINS
Chair
KELVIN E. BUTLER
VIDET CARMICHAEL
THOMAS GOLLOTT
GARY JACKSON
SAMPSON JACKSON II
PERRY LEE



REPRESENTATIVES
BECKY CURRIE
Vice Chair
MARGARET ELLIS ROGERS
Secretary
RICHARD BENNETT
KIMBERLY L. CAMPBELL
STEVE HORNE
RAY ROGERS
PERCY W. WATSON

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

www.peer.state.ms.us

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

June 10, 2014

Honorable Phil Bryant, Governor
Honorable Tate Reeves, Lieutenant Governor
Honorable Philip Gunn, Speaker of the House
Members of the Mississippi State Legislature

On June 10, 2014, the PEER Committee authorized release of the report entitled **A Review of the Closure of the Mississippi State Hospital's Community Services Division.**

A handwritten signature in cursive script that reads "Nancy Adams Collins".

Senator Nancy Adams Collins, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Letter of Transmittali

Executive Summary vii

Introduction1

 Authority1

 Problem Statement1

 Scope and Purpose2

 Method2

Background3

 Mississippi’s Structure for Mental Health Service Delivery3

 Significant Events Affecting Mississippi’s Public Policy on
 the Delivery of Mental Health Services4

Why did the Mississippi State Hospital close its
Community Services Division? 12

 What was the role of the Mississippi State Hospital’s
 Community Services Division in delivering mental health
 services in Mississippi? 12

 Why did MSH close its Community Services Division? 14

How did the Department of Mental Health and the Mississippi
State Hospital plan to handle the transitioning, tracking, and
future care of clients formerly served by the Mississippi State
Hospital’s Community Services Division? 17

 How did MSH plan to transition clients out of the MSH
 Community Services Division? 17

 Did the Department of Mental Health and the Mississippi State
 Hospital exercise due diligence in the decision to contract for
 the transition of clients formerly served by the Mississippi State
 Hospital’s Community Services Division?..... 19

 What was the plan for transitioning and tracking clients formerly
 served by the Division of Community Services? 32

 How did DMH and MSH plan to handle the transition of MSH
 Community Services Division clients after the contract with
 Guided Steps was terminated? 36

Table of Contents (continued)

How should the state provide community-based mental health services in the future? 37

 Follow Mandates of State Law 37

 Utilize Prudent Contracting Practices 38

Recommendations 40

Appendix A: State-Operated Facilities for Behavioral Health and Treatment of Intellectual and Developmental Disabilities, 2014..... 41

Appendix B: Mississippi’s Regional Community Mental Health Centers, 2014 43

Appendix C: Additional Information on the U. S. Department of Justice’s 2011 Findings Regarding Mississippi’s Mental Health System and the State’s Subsequent Response..... 45

Appendix D: Other States’ Efforts in Changing Their Structures for Delivery of Community-Based Mental Health Services 51

Agency Response 54

List of Exhibits

1. Mississippi State Hospital’s Community Services Division Programs and Services, as of April 30, 2014..... 13
2. Number of Clients Transitioning Out of the Mississippi State Hospital Community Services Division, by Program, as of February 19, 2014 18
3. Profile of Guided Steps Healthcare 25
4. Department of Mental Health Obligations and Status Information as of February 2014, By Program/Project, for Funds Provided by SB 2874, 2013 Regular Session..... 49

A Review of the Closure of the Mississippi State Hospital's Community Services Division

Executive Summary

Introduction

The PEER Committee received a complaint from a citizen who was concerned about the Mississippi State Hospital's contract with Key Behavior Essentials (doing business as Guided Steps Healthcare) to assume the responsibilities of the hospital's Community Services Division on May 1, 2014. Subsequent to PEER's receipt of the complaint and during the course of the review, the Mississippi State Hospital (MSH) voided its contract with Guided Steps Healthcare.

Because the hospital terminated the contract during the course of the review, PEER focused on the closure of the Mississippi State Hospital's Community Services Division and the transition of those clients to other providers. Also, despite the voided contract, questions remained regarding the state's community-based mental health care service structure.

Background

In Mississippi, the Board of Mental Health sets statewide mental health policy and the Department of Mental Health administers policies and implements programs. Behavioral health and intellectual and developmental disabilities programs are delivered statewide through state-operated programs and facilities, regional community mental health centers, and other non-profit service agencies and organizations. The Mississippi State Hospital is one of the state-operated facilities for delivery of behavioral health services.

Four events in recent years have had a significant impact on Mississippi's public policy regarding delivery of mental health services:

- the U. S. Supreme Court's 1999 *Olmstead v. L.C.* decision regarding states' obligations under the Americans with Disabilities Act to move toward a

system of community-based care for persons with mental disabilities;

- the 2001 Mississippi Access to Care (MAC) plan, which was Mississippi's formal response to the *Olmstead* decision;
- requirements of the Rose Isabel Williams Mental Health Reform Act of 2011 regarding strategic planning for delivery of mental health services; and,
- results of a 2011 investigation by the United States Department of Justice of Mississippi's mental health service delivery system.

Pages 4 through 11 in the report explain the significance of these events and their relationship to the closure of the MSH Community Services Division and future delivery of community-based mental health services.

Conclusions

Why did the Mississippi State Hospital close its Community Services Division?

For approximately thirty years, the MSH's Community Services Division provided community mental health services to persons eighteen years and over residing in Mississippi who had a serious mental illness.

According to DMH officials, the following were primary reasons for closing the division:

- the department's and hospital's staff perceived that the Community Services Division was outside the hospital's primary mission; and,
- MSH's appropriations had experienced recurring annual decreases in recent years and the department believed that redirecting resources from community mental health services to acute inpatient care at MSH was the best use of resources for the department.

PEER notes that because MSH is not eliminating any of the division's positions and plans to transfer its employees to MSH inpatient care positions, the department has forgone the opportunity to redirect the resources yielded from closure of the division into providing community-based mental health care.

How did the Department of Mental Health and the Mississippi State Hospital plan to handle the transitioning, tracking, and future care of clients formerly served by the Mississippi State Hospital's Community Services Division?

In December 2013, MSH contracted with Guided Steps Healthcare to implement a transition of clients from the Community Services Division to other mental health care providers. However, the department did not ensure that Guided Steps complied with some of the requirements for certification as a provider and did not verify during the application process that Guided Steps' Executive Director met the education requirements for a certified provider. Also, under the terms of the contract, Guided Steps received additional benefits or incentives beyond the actual value of the contract.

Neither DMH nor MSH could provide evidence to PEER that DMH staff or MSH Community Services Division staff were involved in the development, review, or approval of the plan Guided Steps created to facilitate the transition of MSH Community Services clients. Although MSH designated a staff member as being responsible for tracking the transition of MSH Community Services clients, MSH had no system in place to track these individuals and MSH could not readily determine where clients were located or where they were going.

Due to Guided Steps' "failure to comply with DMH Operational Standards" and "inappropriate and unethical conduct," the department terminated Guided Steps' certification, which resulted in MSH terminating its contract with Guided Steps on April 12, 2014. PEER concurs that this was good cause for terminating the contract.

Regarding the transition of these clients after the contract with Guided Steps was terminated, DMH maintained that termination of the contract should not change the transition process. MSH Community Services staff would continue to perform their duties of providing placements for individuals.

How should the state provide community-based mental health services in the future?

In providing community-based mental health services in the future, the state should recognize the continuing significance and obligation of the Rose Isabel Williams Mental Health Reform Act of 2011 to involve representatives of all sectors of the state's mental health system in planning for and delivering community-based mental health services. Also, when contracting with private providers for community-based services, the Department

of Mental Health should exercise due diligence and prudent contracting practices.

Recommendations

1. Using existing resources, DMH should develop a client tracking and management information system, in conjunction with the community mental health centers, to track patients within the state's mental health system.
2. DMH should adopt formal, written procedures that require department-certified mental health facilities and providers (e. g., MSH) to procure personal services contracts of \$50,000 or less that, at a minimum, comport with best practices in order to ensure fair and open competition.
3. The Governor should make appointments to the Strategic Planning and Best Practices Committee created by MISS. CODE ANN. Section 41-4-10 (1972) so that the committee can continue the collaborative efforts of strategic planning with the Board of Mental Health, the community mental health centers, and other interested parties. To inform the Governor of the need for such appointments, the PEER Committee will forward a copy of this report to his office for review. Because certain minor, technical corrections are needed to perfect Section 41-4-10, the Legislature should consider making these changes during the 2015 session. Appointments need not wait for these changes to be made.
4. Any future decisions of the Department of Mental Health or the Board of Mental Health to realign agency services in light of the department's and board's concept of the department's proper mission should be submitted to the Strategic Planning and Best Practices Committee for guidance on such recommendations and their impact on the operations of community mental health centers and other providers of mental health services in Mississippi.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
<http://www.peer.state.ms.us>

Senator Nancy Collins, Chair
Tupelo, MS

Representative Becky Currie, Vice Chair
Brookhaven, MS

Representative Margaret Rogers, Secretary
New Albany, MS

A Review of the Closure of the Mississippi State Hospital's Community Services Division

Introduction

Authority

The PEER Committee reviewed the closure of the Mississippi State Hospital's Community Services Division and the contract between the Mississippi State Hospital and Key Behavior Essentials DBA "Guided Steps Healthcare" to transition clients from the division to other providers. The Committee acted in accordance with MISS. CODE ANN. Section 5-31-51 et seq. (1972).

Problem Statement

The PEER Committee received a complaint from a citizen who was concerned about the Mississippi State Hospital's contract with Key Behavior Essentials (doing business as Guided Steps Healthcare) to assume the responsibilities of the hospital's Community Services Division on May 1, 2014.

The complainant was concerned about:

- the types of and adequacy of services this company was planning to offer seriously mentally ill patients;
- the contractual issues and how those issues would help or hurt patients;
- the availability of "safety nets" for those patients who might "fall through the cracks;"
- the reasons for not utilizing existing community mental health centers to perform the duties included in the contract; and,
- the resulting employment status of Mississippi State Hospital's Community Services Division's staff.

Subsequent to PEER's receipt of the complaint and during the course of the review, the Mississippi State Hospital voided its contract with Guided Steps Healthcare (see page 27).

Scope and Purpose

Although PEER's initial objective for this review was to critique the Mississippi State Hospital's contract with Guided Steps Healthcare, because the hospital terminated the contract during the course of the review, PEER focused on the closure of the Mississippi State Hospital's Community Services Division and the transition of those clients to other providers. Also, despite the voided contract, questions remained regarding the state's community-based mental health care service structure.

The report addresses the following questions:

- Why did the Mississippi State Hospital close its Community Services Division?
- How did the Department of Mental Health and the Mississippi State Hospital plan to handle the transitioning, tracking, and future care of clients formerly served by the Mississippi State Hospital's Community Services Division?
- How should the state provide community-based mental health services in the future?

Method

During the course of this review, PEER:

- interviewed the executive directors of the Mississippi Department of Mental Health and the Mississippi State Hospital;
- interviewed staff of the Mississippi Department of Mental Health and the Mississippi State Hospital's Community Services Division;
- interviewed the executive directors of selected community mental health centers;
- interviewed selected staff of the Legislative Budget Office, State Personnel Board, and the Attorney General's Office;
- interviewed the Executive Director of Guided Steps Healthcare;
- reviewed documents provided by the Mississippi Department of Mental Health, the Mississippi State Hospital Community Services Division, and Guided Steps Healthcare;
- conducted a literature search on best practices in choosing a contractor and on nationwide community mental health policy; and,
- conducted research on the *Olmstead* decision and subsequent actions of the U. S. Department of Justice.

Background

This chapter will address:

- Mississippi's structure for mental health service delivery; and,
- four events of significance to Mississippi's public policy regarding delivery of mental health services.

Mississippi's Structure for Mental Health Service Delivery

In Mississippi, the Board of Mental Health sets statewide mental health policy and the Department of Mental Health administers policies and implements programs. Community mental health centers, governed by regional commissions, also deliver services at the local level. A variety of non-DMH-certified mental health providers, who are certified by other bodies, provide mental health services to individuals.

The Board of Mental Health and Department of Mental Health

The Board of Mental Health sets statewide mental health policy and the Department of Mental Health administers policies and implements programs for mental health care.

In Mississippi, policy for the publicly funded system for the delivery of mental health services is set by the Board of Mental Health and administered through the Department of Mental Health.

MISS. CODE ANN. Section 41-4-3 (1972) establishes the Board of Mental Health. The board is composed of nine members who serve staggered terms. The members of the board are appointed by the Governor and are confirmed by the Senate. Board members include a physician, a psychiatrist, a clinical psychologist, a social worker with experience in the mental health field, and one individual from each of Mississippi's congressional districts.

The Department of Mental Health is headed by an Executive Director and has bureaus to administer its behavioral health and intellectual and developmental disabilities programs throughout the state. These services are delivered through:

- state-operated programs and facilities (see Appendix A, page 41, for a list of the state-operated facilities for behavioral health and intellectual and developmental disabilities);
- regional community mental health centers (see following section); and,

- other non-profit service agencies and organizations that make up a small part of the service delivery system, are certified, and may also receive funding through the Department of Mental Health to provide community-based services (i. e., Catholic Charities).

Also, some other providers not certified by DMH and which do not receive funding from the department are certified by other entities (e. g., Brentwood Behavioral Care) to provide mental health services to individuals.

The Role of the Community Mental Health Centers

Community mental health centers are autonomous public bodies governed by regional commissions that include representatives from each county in their service area. They are independent from, yet regulated by, the Board of Mental Health and Department of Mental Health.

The Regional Commission Act of 1966 authorized the creation of locally governed community mental health centers (CMHCs). These centers are autonomous public bodies governed by regional commissions that include representatives from each county in that service area and who are appointed by their respective boards of supervisors. They are independent from, yet regulated by, the Board of Mental Health and the Department of Mental Health. (See Appendix B, page 43, for a list of the regional community health centers and a map showing their service areas.)

The Department of Mental Health contracts with CMHCs (and other certified service providers) to provide community-based services. The fourteen regional centers make available a range of community-based mental health, substance abuse, and in some regions, intellectual and developmental disabilities services.

Significant Events Affecting Mississippi's Public Policy on the Delivery of Mental Health Services

Four recent events have had, and will continue to have, a significant impact on Mississippi's public policy regarding delivery of mental health services.

Four events in recent years have had a significant impact on Mississippi's public policy regarding delivery of mental health services:

- the U. S. Supreme Court's 1999 *Olmstead v. L.C.* decision regarding states' obligations under the Americans with Disabilities Act to move toward a system of community-based care for persons with mental disabilities;
- the 2001 Mississippi Access to Care (MAC) plan, which was Mississippi's formal response to the *Olmstead* decision;

- requirements of the Rose Isabel Williams Mental Health Reform Act of 2011 regarding strategic planning for delivery of mental health services; and,
- results of a 2011 investigation by the United States Department of Justice of Mississippi's mental health service delivery system.

***Olmstead's* Emphasis on Community-Based Care**

In the 1999 case *Olmstead v. L.C.*, the Supreme Court held that unjustifiable institutionalization of persons with any disability, including mental illness or developmental disability, is discrimination under Title II of the Americans with Disabilities Act. The *Olmstead* decision notes that states are obligated to develop and implement plans to move toward a system of community-based care for persons with mental disabilities.

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.*, 527 U.S. 581 (1999), that unjustified segregation of qualified individuals¹ with disabilities, including mental illness and developmental disabilities, constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA).² The court held that public entities are obligated to develop and implement plans to move toward a system of community-based care for persons with mental illness and developmental disabilities when:

- such services are appropriate;
- the affected persons do not oppose community-based treatment; and,
- community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Title II of the ADA, which serves as the basis for the *Olmstead* decision, prohibits public entities, including state governments and health care services funded and administered by state agencies, from excluding from participation or denying people with disabilities “the benefits of the services, programs, or activities of a public entity, or subject[ing] to discrimination by

¹“Qualified individuals,” the ADA explains, are persons with disabilities who, “with or without reasonable modifications to rules, policies, or practices. . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12101 - 12213 (2000).

²The ADA is a civil rights law enacted by Congress “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. § 12101 (b)(1).

any such entity.” Congress enacted the act because it found that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.”

The Mississippi Access to Care (MAC) Plan

The Mississippi Access to Care (MAC) plan, completed in 2001, was Mississippi's formal response to the Olmstead decision.

Subsequent to the *Olmstead* decision, Governor Ronnie Musgrove appointed the Division of Medicaid as the lead agency to develop, in coordination with the departments of Mental Health, Rehabilitation Services, Human Services, Education, and Health, a comprehensive, effective plan for addressing the issues related to the *Olmstead* decision. Those six agencies, as well as various advocacy groups, consumer groups, consumers, providers, and other organizations, formed a statewide work group called Mississippi Access to Care (MAC) in October 2000.

In an effort to provide the MAC work group with additional structure and focus, the Mississippi Legislature passed House Bill 929, 2001 Regular Session, which mandated development of a comprehensive plan to provide services to people with disabilities in the most appropriate integrated setting. The bill specified items the plan should address--e. g., an estimate of the number of people with disabilities in the state who need or will need services and an estimate of the amount of appropriations necessary to accomplish the proposed plan.

In September 2001, the departments submitted the MAC Plan to the Legislature. According to the plan, its overall purpose “is to create an individualized service and support system that enables individuals with disabilities to live and work in the most integrated setting of their choice. It is our vision that all Mississippians with disabilities will have the services and supports necessary to live in the most appropriate and integrated setting possible.”

The Rose Isabel Williams Mental Health Reform Act of 2011

The Rose Isabel Williams Mental Health Reform Act of 2011 included a mandate for the Department of Mental Health, the community mental health centers, and other interested parties to jointly develop a plan for statewide mental health service delivery.

For many years, mental health policy in the state of Mississippi has been driven by two legally separate entities or groups of entities--the Department of Mental Health and the community mental health centers. The Division of Medicaid also plays a role in mental health policy as the primary payer source for community mental health services. As noted on page 3, the

Department of Mental Health is a state agency governed by an appointed board, while the community mental health centers are governed by local boards and are separate and distinct from the governance of the Department of Mental Health.

In an attempt to bring the stakeholders together for the best interests of all Mississippians, the Legislature enacted Senate Bill 2836, Regular Session 2011, known as the Rose Isabel Williams Mental Health Reform Act of 2011. This legislation envisioned bringing the department, the community mental health centers, and other interested parties together to collaborate on planning for the development of mental health services for the people of the state and the determination of best practices for the delivery of these services.

In this act, the Legislature made clear the legislation's purpose by providing:

(1) The goal of the Rose Isabel Williams Mental Health Reform Act of 2011 is to reform the current Mississippi mental health delivery system so that necessary services, supports and operational structures for all its citizens with mental illness and/or alcohol and drug dependence and/or comorbidity, whether children, youth or adults, are accessible and delivered preferably in the communities where these citizens live. To accomplish this goal, this act provides that initially certain core services as defined in subsection (2) of this section should be available to residents of each county in the state. These services may be provided by community mental health/intellectual disability centers. In order to determine what services are available, the State Department of Mental Health is directed to survey the community mental health/intellectual disability centers, and the community mental health/intellectual disability centers are directed to report what services they are currently providing in each county. This act does not require any community mental health/intellectual disability center to provide any service. This act is not independent authority for any program not otherwise authorized.

(2) The State Board of Mental Health is authorized and empowered to promulgate regulations to ensure that core adult mental health services, child mental health services, intellectual/developmental disability services, and substance abuse prevention and treatment/rehabilitation services are provided throughout the state through the regional mental health/intellectual disability commissions and centers or through other providers. The State

Board of Mental Health is directed to give priority to crisis services and crisis stabilization unit services provided twenty-four (24) hours a day, seven (7) days a week, where trained emergency-crisis response staff triage referrals and respond in a timely and adequate manner to diffuse a current personal crisis situation.

Of critical importance to this legislation was the joint planning mandate involving the Department of Mental Health, the community mental health centers, and other interested parties who were to develop a plan for statewide service delivery. Specifically, Section 4 of this act, amending CODE Section 41-4-7, directed the Board of Mental Health to establish a Strategic Planning and Best Practices Committee composed of members of the Board of Mental Health, community mental health center directors, appointees of the Attorney General, and other providers. The Chair of Psychiatry at the University of Mississippi Medical Center was also to be a member. This committee was to assist in the development of strategic planning for services set out in law and was to assist in developing performance measures. The legislation also established provisions addressing the Board of Mental Health's power to establish a minimum program of services to be provided by community mental health centers and to require such centers to offer the program as a pre-condition to receiving state funds. The law contained a July 1, 2013, repealer on the committee.

During the 2013 session, the Legislature made several changes to this committee. Codified as Section 41-4-10, the new committee was established and empowered as follows:

There is hereby established a Strategic Planning and Best Practices Committee (committee) for the purpose of improving and coordinating mental health services in the state. The committee shall consist of eleven (11) members appointed by the Governor as follows:

(a) Two (2) members of the State Board of Mental Health;

(b) The Chairman of the Department of Psychiatry at the University of Mississippi Medical Center;

(c) The Executive Director of the Division of Medicaid in the Office of the Governor;

(d) Two (2) directors of community mental health centers that are members of the Mississippi Association of Community Mental Health Centers;

(e) One (1) representative of a nonprofit mental health advocacy group;

(f) One (1) consumer or family member of a consumer of mental health services;

(g) One (1) representative from a separate, private, nonprofit provider of a continuum of mental health services;

(h) Two (2) individuals knowledgeable in the field of mental health and/or with experience in business management or public administration.

All appointed members of the Strategic Planning and Best Practices Committee shall be appointed to three-year terms and may be reappointed.

The committee shall meet and elect a chairman, who shall not be a member of the Mississippi Board of Mental Health or the State Board of Health. The committee shall meet upon the call of the chair.

The Lieutenant Governor may designate one (1) Senator and the Speaker of the House of Representatives may designate one (1) Representative to attend any meeting of the Strategic Planning and Best Practices Committee. The appointing authorities may designate alternate members from their respective houses to serve when the regular designees are unable to attend the meetings of the committee.

The committee shall work with the Mississippi Department of Mental Health and the Regional Community Mental Health and Intellectual Disability Commissions to produce the state strategic plan as required in Section 41-4-7(d).

The Department of Mental Health shall provide professional and technical support to the committee, including the services of the department's medical director, and its planning staff. Additionally, the committee shall be authorized to seek grants from public and private sources to conduct the necessary studies and evaluations to support the committee in carrying out its responsibilities. The committee may also seek the assistance of the state institutions of higher learning, the State Department of Health, the Division of Medicaid, the State Department of Education, any community mental health center, and any other state agency whose expertise may be helpful to the committee.

This section shall stand repealed from and after July 1, 2017.

These 2013 changes gave the Governor the power to appoint the members of the committee and made clear that the

committee is to cooperate with the Board of Mental Health and the community mental health centers in developing a strategic plan.

Thus the Legislature devised a mechanism for bringing the separate mental health service delivery participants together to devise a plan for the delivery of services, which would preferably be delivered in the service recipients' own communities.

The U. S. Department of Justice's Findings Regarding Mississippi's Mental Health Service Delivery System

In 2011, the U. S. Department of Justice found Mississippi to be in violation of Title II of the Americans with Disabilities Act by failing to provide services to Mississippians with mental illness and developmental disabilities in the most integrated setting appropriate.

On December 22, 2011, the U. S. Department of Justice (DOJ) found Mississippi was violating Title II of the Americans with Disabilities Act by failing to provide services to Mississippians with mental illness and developmental disabilities in the most integrated setting appropriate. The DOJ recommended that the state implement certain remedial measures, including the development of adequate, safe, community-based services for people with mental illness or developmental disabilities who are unnecessarily institutionalized or at risk of unnecessary institutionalization.

In response to the DOJ's findings:

- DMH requested additional funds in its FY 2013 appropriation to expand community-based services; however, those funds were not appropriated.
- Negotiations are ongoing between the U. S. DOJ, the Department of Mental Health, and multiple relevant state agencies. As of April 2014, DOJ has not filed a lawsuit against DMH for violation of Title II of the Americans with Disabilities Act.
- The Legislature appropriated a total of approximately \$10 million in additional funds for FY 2014 and \$16.1 million for FY 2015 to expand community-based services to improve the state's compliance with the Americans with Disabilities Act as interpreted by *Olmstead*. (See Appendix C, page 45, for additional information on obligation of the additional funds.) These funds are to be shared by the DMH, Mississippi Department of Education, and Mississippi Department of Rehabilitation Services to implement or improve community-based mental health services. However, these funds represent only a temporary, partial approach to the problem and not a strategically planned, comprehensive move toward community-based mental health service delivery.

See Appendix C, page 45, for additional detail on the DOJ's findings and the state's subsequent response.

Why did the Mississippi State Hospital close its Community Services Division?

According to DMH officials, one reason MSH closed its Community Services Division was because the division's function did not comply with the mission of the Mississippi State Hospital. The department and hospital officials also agreed that closing the division would help financially sustain MSH's acute inpatient operations.

This chapter will address the following:

- What was the role of the MSH's Community Services Division in delivering mental health services in Mississippi?
- Why did MSH close its Community Services Division?

What was the role of the Mississippi State Hospital's Community Services Division in delivering mental health services in Mississippi?

For approximately thirty years, the MSH's Community Services Division provided community mental health services to persons eighteen years and over residing in Mississippi who had a serious mental illness.

The Mississippi State Hospital (MSH) is located on a 350-acre campus in Whitfield, fifteen miles southeast of Jackson. MSH serves an area covering fifty-one of the state's eighty-two counties that includes approximately 1.6 million people.

In addition to residential psychiatric services and nursing home services, MSH has operated a Community Services Division that ceased to function on May 1, 2014. For approximately thirty years, the MSH Community Services Division provided community mental health services to persons eighteen years and over who reside in Mississippi and who had a serious mental illness (according to the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*).

MSH's Community Services Division provided outpatient mental health services for individuals admitted to both the case management and residential programs with the goal of promoting successful independent functioning and recovery while enhancing the resilience of individuals receiving services. The length of enrollment in programs varied depending on the individual's needs, wishes, and personal goals. When individuals were discharged from MSH CS, the division made referrals for continued service needs when necessary. See Exhibit 1, page 13, for a list and brief descriptions of the programs and services that were available through the Mississippi State Hospital's Community Services Division.

Exhibit 1: Mississippi State Hospital's Community Services Division* Programs and Services, as of April 30, 2014

| Program | Description |
|--|---|
| Support and Therapeutic Services | Included case management, nursing, psycho-educational counseling, transportation, psychosocial rehabilitation, community living, community integration, and psychiatric medication evaluation/monitoring. Services were available during regular office hours Monday-Friday, with the exception of community living, which was available twenty-four hours a day, seven days a week. |
| MSH CS Community Living Services (CLS) | CLS consisted of two group homes, Villa Hope (a fifteen-bed facility) and Crossroads (a ten-bed facility). Both facilities accommodated both men and women. CLS also included MICARE (Mental Illness and Chemically Addicted Recovery Environment), a transitional substance abuse rehabilitation and treatment home that accommodated twelve male adults. |
| MSH CS Community Integration Program (CIP)** | CIP served individuals who received services from MSH Inpatient Services or Jaquith Nursing Home. This program provided both day and overnight services. The overnight program accommodated sixteen male and female adults. Depending on the number of individuals participating in the overnight program, CIP provided day programming that could accommodate up to twenty individuals. |
| Project for Assistance and Transition from Homelessness (PATH) | PATH was a case management program for homeless and mentally ill individuals. Also known as the Jimmy Stubbs House, this program offered intensive outreach, psychiatric medication monitoring, and case management services. PATH also provided "drop-in" services, including access to laundry and bathing facilities, referral and information services, and other basic therapeutic services. |

* The Mississippi State Hospital closed this division on May 1, 2014.

**MSH's CIP is the only community program that will continue after the elimination of MSH's Community Services Division

SOURCE: Mississippi State Hospital.

Why did MSH close its Community Services Division?

According to DMH officials, the following were primary reasons for closing MSH's Community Services Division:

- *the department's and hospital's staff perceived that the Community Services Division was outside the hospital's primary mission; and,*
- *MSH's appropriations had experienced recurring annual decreases in recent years and the department believed that redirecting resources from community mental health services to acute inpatient care at MSH was the best use of resources for the department.*

In 2013, DMH and MSH officials agreed to close the MSH CSD and transition the clients it served to other providers. According to DMH officials, the elimination of the CSD would help MSH align more closely with its budget and not sacrifice the quality of services provided.

DMH and MSH Officials Perceived that the Division was Outside of MSH's Mission

One reason given by DMH and MSH for the closure of the MSH Community Services Division, which had been established approximately thirty years ago, was that the division's function did not comply with the mission of the Mississippi State Hospital.

DMH and MSH officials stated that one reason for the closure of the Community Services Division was because its function did not comply with the mission of MSH, which the staff believes to be a focus on inpatient mental health care. DMH staff related to PEER that although the Community Services Division at MSH began approximately thirty years ago, the hospital should have never started providing such services. According to DMH, MSH only began providing community mental health services because no other entities were providing the services in the area. DMH and MSH officials stated that they believed that redirecting resources from community mental health services to acute inpatient care at MSH was the best use of resources for the department.

According to DMH, the decision to contract for the services provided by the MSH Community Services Division was not presented to the Board of Mental Health, because it did not believe that board action was required for the contract or the elements therein.

DMH and MSH Officials Agreed that Closing the Division Would Provide Additional Resources for Inpatient Care

DMH officials assert that one of MSH's reasons for seeking closure of the State Hospital's Community Services Division was so that MSH could financially sustain its acute inpatient operations after recurring decreases in the hospital's annual appropriations. The hospital is not eliminating any of the division's positions and plans to transfer its employees to MSH inpatient care positions. Because DMH did not

require the hospital to execute a process for eliminating positions, the department has forgone the opportunity to redirect the resources yielded from closure of the division into providing community-based care.

DMH's officials stated that the Mississippi State Hospital, like other public entities, has struggled due to the lingering effects of the recession and a reduction in its legislative appropriations over the last few fiscal years. DMH and MSH stated that the reason for transitioning the functions of the Community Services Division to other providers was due in part to recurring budget cuts for the State Hospital since 2008 that have impacted acute inpatient care. Appropriations bills for fiscal years 2008 through 2014 show that the Mississippi State Hospital's appropriations declined from approximately \$139.2 million to \$122.8 million during that period, a decline of twelve percent.

DMH and MSH planned to close MSH's Community Services Division, which employed fifty-three staff as of March 4, 2014. Rather than eliminating those positions through a reduction in force (RIF)³ and redirecting the funds associated with these positions to provide additional community mental health services as envisioned by the MAC Plan (see page 6) and the Rose Isabel Williams Mental Health Reform Act, the department chose to transfer the employees to MSH acute inpatient care positions.

If the Mississippi State Hospital had filed a RIF plan that documented a "shortage of funds" as its justification and the plan had been approved, the hospital could have reduced the number of employees that would have been necessary to absorb the amount of the budget reductions. Instead, the hospital retained the division's staff and planned to move them into inpatient care positions at MSH. By doing so, the hospital in effect eliminated the services of the division but retained the costs associated with its staff, did not improve its financial position, and the department could not use those resources to move toward providing additional community-based services.

MSH was not required to file a RIF plan with the State Personnel Board (SPB) in this situation because it planned to transfer positions to another unit within MSH and not eliminate positions. According to MSH and SPB staff interviews, SPB had

³MISS. CODE ANN. Section 25-9-127 (1972) and State Personnel Board policies make provision for a reduction in force (RIF) procedure when an agency needs to eliminate positions due to:

- shortage of funds or work;
- material change in duties or organization; or,
- a merger of agencies.

One advantage of an SPB-approved RIF for employees is that it provides certain protections for permanent state service employees, including preferred consideration for re-employment by that agency or another agency. Also, it provides the agency with a legally defensible method of reducing its personnel expenses.

no knowledge of the decision to transfer more than fifty positions from the Community Services Division to acute inpatient care until the *Clarion Ledger* published an article about the transfer.

Due to the fact that a RIF plan was not required because no positions were eliminated, the method MSH followed to transfer Community Services Division employees was left completely to the agency's discretion. As of March 4, 2014, the division's employees had received little communication from MSH managers regarding what positions would be available for them to transfer to and whether those positions would be suitable for these employees' backgrounds and experience.

How did the Department of Mental Health and the Mississippi State Hospital plan to handle the transitioning, tracking, and future care of clients formerly served by the Mississippi State Hospital's Community Services Division?

In December 2013, MSH contracted with Guided Steps Healthcare to implement a transition of clients from the Community Services Division to other mental health care providers. The Department of Mental Health did not ensure that Guided Steps complied with some of the requirements for certification as a provider and did not verify during the application process that its Executive Director met the education requirements for a certified provider. Also, under the terms of the contract, Guided Steps received additional benefits or incentives beyond the actual value of the contract. DMH maintained that the termination of the Guided Steps contract should not change the transition process and that MSH Community Services staff would continue to perform their duties of providing placements for individuals.

This chapter will address the following:

- How did MSH plan to transition clients out of the MSH Community Services Division?
- Did the Department of Mental Health and the Mississippi State Hospital exercise due diligence in the decision to contract for the transition of clients formerly served by the Mississippi State Hospital's Community Services Division?
- What was the plan for transitioning and tracking clients formerly served by the Community Services Division?
- How did DMH and MSH plan to handle the transition of MSH Community Services Division clients after the contract with Guided Steps was terminated?

How did MSH plan to transition clients out of the MSH Community Services Division?

In December 2013, MSH contracted with Guided Steps Healthcare to implement a transition of clients from the Community Services Division to other mental health care providers.

In December 2013, the Mississippi State Hospital entered into a contract with Guided Steps Healthcare (Guided Steps) to “ensure a safe, therapeutic and orderly transition of services” from January 6 through June 30, 2014, in assuming the care of individuals currently being served by MSH's Community Services Division. Guided Steps' Mississippi coverage areas

included Hinds, Madison, Yazoo, Claiborne, Rankin, Warren, Copiah, and Simpson counties, including those individuals who were formerly served by the Community Services Division. According to PEER’s analysis, this was 120 individuals as of February 19, 2014 (see Exhibit 2, below).

According to the contract, MSH was to pay Guided Steps Healthcare the Medicaid rate for services rendered to individuals who did not have a pay source via third party payer, such as Medicaid, or an agreed-upon rate if the services were not reimbursable, for an amount not to exceed \$45,000, for the period May 1 through June 30, 2014.⁴ The contract provided “incentives” that would allow the provider to expand its business in the state by delivering adult community mental health services in order to carry out the responsibilities under the contract (see page 31 for a discussion of the incentives). MSH planned to continue to pay salaries and benefits for MSH Community Services Division staff (fifty-three employees as of March 4, 2014) until April 30, 2014 (see page 31).

Due to Guided Steps Healthcare’s “failure to comply with DMH Operational Standards” and “inappropriate and unethical conduct,” the department terminated Guided Steps’ certification, which resulted in MSH terminating its contract with Guided Steps on April 12, 2014 (see page 27). PEER concurs that this was good cause for terminating the contract.

Exhibit 2: Number of Clients Transitioning Out of the Mississippi State Hospital Community Services Division, by Program, as of February 19, 2014

| Program | Number of Individuals (18 and Over) |
|-----------------------------|--|
| Community Living Services | 13 |
| MICARE | 3 |
| Community Case Management | 61 |
| PATH Case Management | 12 |
| Psychosocial Rehabilitation | 31 |
| Total | 120 |

SOURCE: Department of Mental Health.

⁴Although the December 2013 contract period was from January 6 through June 30, 2014, the contractual amount of \$45,000 was payable for services rendered by Guided Steps Healthcare only between May 1 through June 30, 2014. For the period from January 6 to May 1, 2014, MSH Community Services Division clients were to receive discharge planning services, placements for new services, and help to secure a pay source. The period from May 1 to June 30, 2014, was the time when services with Guided Steps would begin and the money associated with the contract would be utilized.

Did the Department of Mental Health and the Mississippi State Hospital exercise due diligence in the decision to contract for the transition of clients formerly served by the Mississippi State Hospital's Community Services Division?

The Department of Mental Health did not ensure that the contractor, Guided Steps Healthcare, complied with some of the requirements for certification as a provider and did not verify during the application process that Guided Steps' Executive Director met the education requirements for a certified provider. Also, under the terms of the contract, Guided Steps received additional benefits or incentives beyond the actual value of the contract.

PEER does not find fault with the decision to separate MSH's institutionalized care services from community care by transitioning those community services to another provider. However, in making such a change in the delivery of services, DMH and MSH must have an accountable process to choose and vet a contractor that could best render the needed community mental health services for those clients affected.

To determine whether DMH and MSH exercised due diligence in contracting with Guided Steps Healthcare, PEER addressed the following questions:

- Did DMH's Bureau of Community Mental Health Services provide the already established community mental health center system with the opportunity to assist in the transition or to provide services to clients of the former Community Services Division?
- Did DMH adhere to its own certification process for the contractor (Guided Steps Healthcare)?
- Did the department verify the credentials of Guided Steps' Executive Director during the provider application process?
- Did DMH and MSH ensure that the contract with Guided Steps Healthcare protected the state's interests and the interests of clients?

Did DMH's Bureau of Community Mental Health Services provide the already established community mental health center system with the opportunity to assist in the transition or to provide services to clients of the former Community Services Division?

Despite the implications of the Olmstead decision, the MAC Plan, and the Rose Isabel Williams Mental Health Reform Act of 2011, the department chose not to provide the already established community mental health centers with the opportunity to assist in the transition of service delivery.

PEER notes that providers--the community mental health centers--already exist and are positioned to provide the types of services needed for these clients. According to DMH's 2013 annual report, the state's community mental health centers

(CMHCs) are the primary providers with whom DMH contracts to provide community mental health services in the state.

When PEER inquired as to why the CMHCs were not involved in the transition, DMH staff related to PEER that the department did not contact the CMHCs--specifically, Regions 8 and 9, which serve Hinds, Madison, Rankin, Copiah, Lincoln, and Simpson counties--to transition clients from the MSH Community Services Division because the CMHCs had declined opportunities offered by the department in the past and these interactions led the department to believe the CMHCs "would not be interested" in the current venture.

Staff from Regions 8, 9 and 12⁵ confirmed to PEER that neither MSH nor DMH approached them about becoming a provider for the MSH Community Services clients. The executive directors of regions 8 and 9 informed PEER that they would have been willing to facilitate the transition of community services and able to provide any of the services that MSH Community Services clients needed.

The Board of Mental Health's response to the 2008 PEER report (*Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis*) stated:

The Executive Director has shown his commitment to partnering with the CMHCs to provide mental health services through the creation of the new Bureau of Community Mental Health Services [...] In addition, the members of the newly formed Association of Community Mental Health Centers are in regular dialogue with our staff about plans for future services.

According to DMH staff, the Bureau of Community Mental Health Services, which began in June 2007 after restructuring of the DMH bureaus, has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's disease and other dementia. The bureau certifies community-based programs, including CMHCs' programs and other providers' programs that possess a DMH certification. DMH allows programs to have the autonomy to administer all its activities as long as they follow the DMH operational standards for DMH-certified programs. The bureau makes site visits to certify facilities, sends out information on funding opportunities to agencies, and provides trainers who go to facilities and train staff on specific work-related topics. The bureau did not have any involvement in the closure of the Community Services Division.

⁵ Region 8 serves Copiah, Lincoln, Madison, Rankin, and Simpson counties; Region 9, Hinds County; and, Region 12, Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Perry and Wayne counties.

The local CMHCs' acknowledgment of no prior knowledge related to this contract, or even MSH's decisionmaking process leading to the ultimate decision to eliminate the Community Services Division, demonstrates the insufficient communication between DMH and the CMHCs. When PEER questioned regions 8 and 9 CMHC staffs about their interest and ability in transitioning MSH Community Services clients, their response was that they were not only willing, but they were able to serve these individuals.

Did DMH adhere to its own certification process for the contractor (Guided Steps Healthcare)?

The Department of Mental Health requires that a DMH-certified mental health provider obtain provider certification, certification of the services it seeks to provide, and certification of the program locations at which the services will be provided. DMH did not ensure that Guided Steps complied with some of the requirements for certification as a mental health care service provider.

The Department of Mental Health requires that DMH-certified mental health providers obtain provider certification, certification of the services it seeks to provide, and certification of the program locations at which the services are provided. DMH-certified providers must comply with the department's operational standards, regulations, and other requirements and must submit documentation of specified requirements.

According to DMH Operational Standards, new service providers interested in DMH certification must complete DMH provider orientation prior to seeking certification, submit the required DMH application and supporting documentation, and adhere to the timelines and procedures for application.

DMH certification for all new service provider organizations is a two-step process:

- The service provider must obtain DMH provider certification.
- The DMH-certified provider must then apply for DMH certification of the services it seeks to provide and the applicable program locations at which the services are provided. (Not all services require a physical program location.)

DMH issues provider, service, and program certifications for a three-year certification cycle unless stated otherwise at the time of certification. DMH providers must comply with current DMH Operational Standards, special guidelines, DMH regulations, the DMH Record Guide, and requirements of DMH Provider Bulletins. Certification is based on the following:

- provision of applicable required services in all required locations for desired certification option;
- adherence to DMH standards, DMH grant requirements (if applicable), guidelines, contracts, memoranda of understanding, and memoranda of agreement;

- compliance with DMH fiscal management standards and practices;
- evidence of fiscal compliance/good standing with external (other than DMH) funding sources;
- compliance with ethical practices/codes of conduct of professional licensing entities related to provision of services and management of the organization; and,
- evidence of solid business and management practices.

Providers must maintain current and accurate data for submission of all reports and data, within established time frames, as required by DMH according to the DMH Manual of Uniform Data Standards (i. e., standards designed to promote consistency in the collection, processing, submission, and reporting of data within DMH).

Providers must also put in place quality management strategies that, at a minimum:

- allow for the collection of performance measures as required by DMH; and,
- develop a Quality Management Committee with responsibility for the oversight of collection and reporting of DMH-required performance measures, written analysis of serious incidents, periodic analysis of DMH-required client level data collection, and oversight for the development and implementation of DMH-required plans of compliance.

Applicants must include the following enclosures with their applications:

- proof of legal status of organization;
- proof of incorporation in Mississippi;
- proof of physical location in Mississippi;
- policy and procedure manual for their organization;
- site-specific permits, licenses, inspection reports, other similar documents;
- a staffing plan that includes job descriptions with qualifications;
- a record of staff training and/or staff training plan(s); and,
- floor plan(s) for their physical location(s) with dimensions for all included sites and service areas.

DMH did not ensure that Guided Steps complied with some of the requirements for certification as a mental health care service provider. The department certified Guided Steps and MSH entered into a contract with the company despite the fact that Guided Steps did not have a permanent adult program location or a staff that could provide all of the services required of a DMH-certified provider. Also, DMH did not verify Guided Steps' references, require a plan to transition MSH Community Services

clients, or a plan to ensure that clients without pay sources would continue to receive services.

As explained below, DMH did not ensure that Guided Steps complied with some of its own requirements for certification as a mental health care service provider--specifically, proof of physical location, a staffing plan, and evidence of solid business and management practices.

- *Proof of Physical Location (where transitioning clients would receive services)*--As noted previously, DMH requires that applicants for certain certifications include proof of physical location in Mississippi for providing services. Although not every type of service provider would have to have a physical location for service provision, Guided Steps would because it sought to become certified to provide substance abuse, outpatient prevention, IDD, community support, day treatment, and emergency/crisis services for both the child and adult populations.

At the time that DMH certified Guided Steps, Guided Steps did not have a location in place at which it would offer adult community mental health services. DMH planned to allow Guided Steps to use the state-owned facility on Capers Avenue in Jackson while it was transitioning clients and included this stipulation in the contract. The contract stated that Guided Steps would have to provide documentation that it had secured a new location by June 30, 2014.

- *Staffing Plan*--The DMH application process requires that a staffing plan be submitted. DMH Operational Standards state:

Other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center must provide the following core services in each county in the CMHC's entire catchment area:

Adult Mental Health Services:

- *Outpatient Therapy*
- *Community Support Services*
- *Psychiatric/Physician Services*
- *Emergency/Crisis Services*
- *Psychosocial Rehabilitation*
- *Inpatient Referral*
- *Peer Support Services*
- *Targeted Case Management Services*

- *Support for Recovery/Resiliency Oriented Services*

PEER could not determine from the personnel documentation provided (i. e., organization chart) by DMH that Guided Steps would be able to provide all of the required adult core services (see page 7).

- *Evidence of Solid Business and Management Practices--As noted previously, one of the requirements for DMH certification is “evidence of solid business and management practices.”*

DMH staff noted that it considered Guided Steps’ presence as a certified provider in Louisiana as determinant of its ability to offer services in Mississippi. DMH staff requested budget information from Guided Steps and noted that they had concerns with the budget, noting that it did not seem “reasonable or achievable” and requested a revised budget.

Also, DMH was never able to make contact with any of the references listed on Guided Steps’ application. The questions that would have been posed to the recommenders were related to whether Guided Steps had established a reputation to provide quality mental health services to clients, but DMH was never able to make contact with these individuals. DMH documented that on January 4, 2013, calls were made to Guided Steps’ listed references. None of the calls were answered and DMH staff left messages. When PEER questioned DMH about why the references of this interested provider were never contacted, the response was that such references were “subjective” and that in lieu of checking these, the Division of Certification utilizes other licensing/certifying entities (such as other state agencies) to check information on the provider.

Since Guided Steps also reported providing services in Louisiana, the Division of Certification utilized the provider search for Magellan Health Services to determine that Guided Steps Healthcare was an approved provider of mental health services in Louisiana.⁶ PEER notes that such a check only confirms that an organization was initially approved as a provider, not whether the organization has provided quality services.

Guided Steps’ limited history in other states would have made it difficult to determine its ability to provide quality services in Mississippi. Key Behavior Essentials had previously operated in North Carolina and Georgia, but Key Behavior Essentials DBA Guided Steps Healthcare is no

⁶According to Louisiana’s Secretary of State’s Office, Key Behavior Essentials is not currently “in good standing” due to its failure to submit an annual report. As noted on page 1 of this report, the contract under discussion was between the Mississippi State Hospital and Key Behavior Essentials DBA Guided Steps Healthcare.

longer affiliated with those agencies. The only agency on which to base Guided Steps Healthcare's ability to provide quality services is in Louisiana.

MSH did send a staff member to New Orleans to observe Guided Steps' delivery of services there. Although the MSH staff member did not provide documentation to support his observations, he stated that he interviewed three Guided Steps staffers at the New Orleans location regarding their knowledge of mental health services and delivery, their efforts to provide services in the community for those they served, and their passion for and knowledge of these individuals and that he was "very impressed with their [Guided Steps'] program."

According to DMH officials, Guided Steps was an available "willing provider" to handle the transition. DMH hoped that other private providers would be encouraged to apply for DMH certification to provide community mental health services in the future.

According to DMH officials, two private providers, Guided Steps Healthcare and Marion Counseling Services, received DMH provider certification in April 2013. In December 2013, MSH contracted with Guided Steps Healthcare as the provider to transition clients from the MSH Community Services Division to its services or the services of other providers. Neither DMH nor MSH provided to PEER an explanation of how Guided Steps was selected for further consideration of the contract--i. e., site review (see page 20)--as opposed to Marion or any other private provider. (See Exhibit 3, below, for a profile of Guided Steps Healthcare.) DMH staff mentioned that they liked Guided Steps' "enthusiasm, passion, and willingness to serve the community mental health population." According to DMH staff, the department hoped that by using Guided Steps Healthcare for the transition and to provide services for some of the clients, that other providers would be encouraged to come forth and apply for DMH certification to provide community mental health services to these individuals.

Exhibit 3: Profile of Guided Steps Healthcare

Key Behavior Essentials DBA Guided Steps Healthcare is a for-profit organization that renders a variety of mental health services to both children and adults.

Key Behavior Essentials first began in Raleigh, NC, on October 30, 2008. On July 30, 2013, the company filed an Article of Dissolution with the North Carolina's Secretary of State's Office, citing that the company no longer had members. In 2010, Key Behavior Essentials DBA Guided Steps Healthcare began operating in New Orleans, Louisiana. Guided Steps currently renders community mental health services in Louisiana for the child and adult populations.

Guided Steps stated that it would provide a variety of services, including:

| | |
|------------------------------|--|
| Individual Psychotherapy | Crisis Management Services |
| Family Counseling | Day Treatment (Child) |
| Group Therapy | Psychosocial Rehabilitation (Adults) |
| Children's Therapy | Assertive Community Treatment (Adults) |
| Intensive Outpatient Therapy | Parent Counseling |
| Community Support Services | Peer Support Services |
| Targeted Case Management | |

Guided Steps aims to help clients address the following issues:

| | |
|--|-------------------------------|
| Attention Deficit Disorder | Eating Disorders |
| Attention Deficit Hyperactive Disorder | Grief and Loss |
| Oppositional Defiant Disorder | Mood and Anxiety Disorders |
| Conduct Disorder | Obesity |
| Bipolar Disorder | Obsessive-Compulsive Disorder |
| Bulimia | Panic Disorder |
| Depression | Self-Esteem Issues |
| Stress Management | |

Guided Steps received its certification from the Mississippi Department of Mental Health in April 2013. The timeline below shows Guided Steps' entry into Mississippi's mental health market.

| Date | Event |
|-----------|--|
| 6/4/2012 | Guided Steps submitted documentation to DMH's Bureau of Quality Management, Operations and Standards to provide the following: <ul style="list-style-type: none"> • Child/Adolescent Day Treatment • Child Case Management • Child/Youth Mental Health Services • Individual Therapeutic Supports • Outpatient Services • Adult Mental Health Services PACT • Adult Case Management • Clinical Diagnostic Assessment |
| 4/29/2013 | Guided Steps received DMH/P certification for the Dunbarton Street location |
| 5/13/2013 | Guided Steps received certification to provide specific services at the Dunbarton Street location: <ul style="list-style-type: none"> • Prevention and Early Intervention • Respite Care Services • Intensive Outpatient Services for Children and Youth |

| | |
|------------|---|
| 9/3/2013 | Guided Steps was certified to provide Day Treatment Services for Children and Youth at Winter Street location (grades K-12) |
| 9/3/2013 | Guided Steps was certified to provide Day Treatment Services for Children and Youth at Dunbarton Street location (grades 3-12) |
| 12/31/2013 | Guided Steps closed its Winter Street location due to potential breaches in confidentiality ⁷ |
| 1/13/2014 | Program change: Guided Steps was certified to provide Day Treatment Services for Children and Youth at the Dunbarton Street location (grades K-8) |

*Guided Steps shared its facility with other organizations that would use adjoining rooms for practices, meetings, and other events. Guided Steps felt that it could not successfully conduct its sessions when other events were taking place. These events disturbed them and potentially jeopardized Guided Steps' confidentiality that is promised during therapy sessions.

SOURCE: DMH.

As of February 2014, Guided Steps stated that it had filled the following positions on its staff:

- Clinical Director;
- Director of Adult Services;
- Director of Children's Services;
- Administrative Director;
- Corporate Compliance Officer; and,
- Office Manager.

As noted previously, effective April 12, 2014, the Department of Mental Health terminated Guided Steps' certification due to Guided Steps' failure to comply with DMH Operational Standards and "inappropriate and unethical conduct by the provider." The Mississippi State Hospital voided the contract with Guided Steps because it was no longer a DMH-certified community mental health provider.

⁷Guided Steps shared its facility with other organizations that would use adjoining rooms for practices, meetings, and other events. Guided Steps felt that it could not successfully conduct its sessions when other events were taking place. These events disturbed them and potentially jeopardized the confidentiality that is promised during therapy sessions.

Did the department verify the credentials of Guided Steps' Executive Director during the provider application process?

DMH did not verify during the provider application process that Guided Steps' Executive Director had a master's degree in a mental health or related field, which is the department's education requirement for certified mental health care providers. Thus DMH did not ensure that community mental health care clients were protected.

As stated previously, mental health care providers certified by DMH must comply with current DMH Operational Standards. Those standards stipulate the following:

The provider must have one full-time Executive Director who has a minimum of a Master's degree in a mental health or related field with a minimum of three (3) years administrative experience in programs related to mental health, intellectual/developmental disabilities, or substance abuse services and/or programs OR a minimum of a Bachelor's degree in nursing and current licensure as a Registered Nurse (RN) for DMH/H Providers only that primarily serve as providers of In-Home Nursing Respite Services and Home and Community Supports.

DMH's certification application specifically asks whether the Executive Director of the potential provider has a master's degree in a mental health or related field. On Guided Steps' application, signed by its Executive Director, this item was marked "yes."

PEER sought information from DMH's staff to determine whether it could verify the credentials of Guided Steps' Executive Director, but the department's staff could not do so. Subsequently, PEER contacted Guided Steps' Executive Director to ask for verification, including the signing of a transcript release, which would have allowed PEER to request an official transcript from the university from which the Executive Director claimed to have received a degree. Following PEER's request for information, the department sought further information from Guided Steps to ensure that the Executive Director had the necessary credentials. As a result of the department's follow-up efforts, its staff determined that the certified provider had violated certain departmental operating standards regarding certification and MSH terminated its agreement with Guided Steps on April 12, 2014.

While ultimately DMH's process ensured the desired end that only properly credentialed staff and organizations were certified by the department, it appears that this end was only achieved after PEER became involved in the process and sought to document independently the credentials of Guided Steps' Executive Director. The Department of Mental Health did not verify the credentials during the application process and thus did not assure that the provider complied with the department's operating standards and possessed the qualifications that had been previously determined by the

department as being necessary for a mental health care service provider.

Did DMH and MSH ensure that the contract with Guided Steps Healthcare protected the state's interests and the interests of clients?

Neither DMH nor MSH used a competitive process to select the contractor for the Community Services transition. Under the terms of the contract, Guided Steps received additional benefits or incentives--use of state buildings, equipment and staff--beyond the actual value of the contract. Essentially, this allowed Guided Steps to expand its business in the state in preparation for fulfilling the terms of the contract by using state resources, as opposed to its own resources.

No Competitive Selection of Contractor

Although the amount of the contract with Guided Steps Healthcare fell below the threshold for the Personal Service Contract Review Board's requirement for competitive selection, neither the Department of Mental Health nor the Mississippi State Hospital could provide evidence to PEER that they had obtained "adequate and reasonable competition" when selecting the contractor, which is required for contracts of any amount.

Mississippi's state agencies are required to follow regulations of the Personal Service Contract Review Board (PSCRB) when arranging contracts for personal services. As required by MISS. CODE ANN. Section 25-9-120 (1972), the PSCRB has established rules and regulations for state agencies' solicitation and selection of contractual service personnel when such agencies are not excluded statutorily from the scope of the board's authority. As one of the behavioral health programs of the Department of Mental Health, MSH is subject to the requirements of the PSCRB.

MSH's contract with Guided Steps was for the amount of \$45,000. The PSCRB requires state agencies to employ competitive practices to obtain personal services contracts for contracts of \$50,000 or more; thus, the contract was not subject to PSCRB's approval.

However, even for contracts of \$50,000, the PSCRB's regulations require the following:

The Agency Head shall adopt operational procedures for making small purchases of \$50,000 or less. Such operational procedures shall provide for obtaining adequate and reasonable competition and for making records to properly account for funds and to facilitate auditing of the Purchasing Agency.

In this context, "obtaining adequate and reasonable competition" should, according to best practices, include (at a minimum) ensuring fair and open competition and documentation of how the agency justified the contract

decision. This should be the practice of a public body regardless of specific requirements for contractor selection. However, when PEER inquired regarding how Guided Steps was selected as the contractor, neither DMH staff nor MSH staff could provide an explanation of the selection process other than the fact that Guided Steps Healthcare was a “willing provider.”

DMH and MSH officials acknowledged that the hospital neither employed a formal process in procuring the contract nor maintained any documentation that identified other vendors who were considered for procurement or explained the basis on which the hospital decided to contract with Guided Steps.

When entities do not exercise fair, open, and competitive procurement practices, they risk criticism. If a third party questions an outcome such as a contractor’s selection, the lack of a competitive selection system leaves the entity open to criticism that favoritism, as opposed to competitiveness, was the basis for the selection.

Terms of the Department’s Contract with Guided Steps

The terms of the contract between the Mississippi State Hospital and Guided Steps Healthcare provided “incentives” that would allow the provider to carry out its responsibilities.

The Mississippi State Hospital executed a contract with Guided Steps Healthcare, a recently certified provider, to facilitate a transition of clients from the Community Services Division to other mental health care providers, including Guided Steps. The terms of the contract provided “incentives” that would allow the provider to expand its business in the state to deliver adult community mental health services in order to carry out the responsibilities under the contract.

Per the contract:

- Guided Steps could use MSH’s Community Services Division vehicles, if permitted by the Department of Finance and Administration’s Bureau of Fleet Management, and assume liability for personal or property damage, until June 30, 2014, after which Guided Steps was to purchase vehicles necessary to carry out its programs and services.
- Guided Steps could bill other entities⁸ for services provided through a Program of Assertive Community Treatment (PACT)⁹ beginning January 6, 2014. These PACT teams were to provide individualized care and services for individuals who resided in MSH Community Services group homes and were being transitioned out.

⁸The contract identified “Magnolia Health Plan, United Healthcare Community Plan, Medicaid, etc.” as billable entities.

⁹This billing option is available through Medicaid for any certified provider that provides PACT team services.

- Guided Steps could use MSH Community Services computers and printers, if approved by the Department of Information Technology Services, to provide network services from May 1 through June 30, 2014, and furnish its own computers, printers and network services after June 30, 2014.
- Guided Steps could use MSH Community Services buildings and equipment and pay utilities and maintenance costs until June 30, 2014.
- Guided Steps was exempt from all costs associated with the operation of MSH Community Services group homes until June 30, 2014.
- MSH was to continue to employ staff and pay salaries and benefits for MSH Community Services staff until April 30, 2014.

PEER notes that according to DMH officials, the Personal Services Contract Review Board's rules and regulations did not require that the Board of Mental Health approve the contract between Guided Steps and MSH because the contract was for an amount less than \$50,000 (as noted on page 29 of this report). Also, DMH officials stated that "the State Board of Mental Health has given the Executive Director the necessary authority for the administration and all its activities and divisions."

Contract Incentives Would Have Provided Additional Benefit to Guided Steps

The incentives that Guided Steps received under the terms of its contract with the Mississippi State Hospital (e. g., use of state buildings, equipment, and staff) provided additional benefit to Guided Steps beyond the actual value of the contract. Essentially, the contract would have allowed Guided Steps to expand its business in the state to deliver adult mental health services in preparation for fulfilling the terms of the contract by using state resources, as opposed to its own resources.

Under the terms of MSH's December 2013 contract with Guided Steps, the company was set to receive more than the actual value of the contract (\$45,000) due to additional benefits or incentives. These incentives would have permitted Guided Steps essentially to expand its business in the state to deliver adult mental health services in preparation for fulfilling its responsibilities under the contract by using state resources, as opposed to its own resources. PEER believes that this type of contract is not good public policy, because it uses taxpayer dollars to fund private enterprise.

As noted previously, if approved by appropriate state agencies such as the Department of Finance and Administration and the Department of Information Technology Services, the terms of the contract permitted Guided Steps to use all buildings, equipment, vehicles, and staff of the MSH Community Services program for specific time frames. Guided Steps was responsible only for building/equipment utilities and

maintenance and vehicle liability insurance. (As of February 25, 2014, the Department of Finance and Administration had not yet permitted vehicle usage to Guided Steps.)

The contract would have allowed Guided Steps to use the MSH Community Services facilities on Capers Avenue from May 1, 2014, through June 30, 2014. According to DMH's estimates, costs and utilities for the facilities on Capers Avenue for that period would have been approximately \$18,800.

In addition to use of the group home and equipment, the contract allowed Guided Steps to utilize MSH Community Services program staff until April 30, 2014, to help transition clients as well as to secure third-party pay sources for clients.

The contract also permitted Guided Steps to bill other entities for services provided by its PACT teams. Although DMH could not determine an estimate of the amount Guided Steps Healthcare could invoice, according to DMH, PACT team services would require prior authorization from and must be submitted to the Division of Medicaid. According to the Mississippi Division of Medicaid Administrative Code, as of July 1, 2013, PACT teams may bill \$27.50 per fifteen-minute unit per person. PACT services are limited to 1,600 units (fifteen-minute units) per state fiscal year and forty units per day. Billing PACT teams is an option available through Medicaid for any certified provider that provides PACT team services.

As a result of the incentives provided by the December 2013 contract, Guided Steps received additional benefits beyond the actual value of the contract. In essence, the contract would have allowed Guided Steps to expand its business in the state by delivering adult community mental health services in preparation for fulfilling the terms of the contract by using state resources, as opposed to its own resources.

What was the plan for transitioning and tracking clients formerly served by the Division of Community Services?

Neither DMH nor MSH could provide evidence to PEER that DMH staff or MSH Community Services Division staff were involved in the development, review, or approval of the plan Guided Steps created to facilitate the transition of MSH Community Services clients. Although MSH designated a staff member as being responsible for tracking the transition of MSH Community Services clients, MSH had no system in place to track these individuals and MSH could not readily determine where clients were located or where they were going.

Development of the MSH Community Services Client Transition Plan

Neither DMH nor MSH could provide evidence to PEER that DMH staff or MSH Community Services staff were involved in the development, review, or approval of the plan Guided Steps created to facilitate the transition of MSH Community Services

clients. Because of DMH's and MSH's presumed lack of involvement in the development of Guided Steps' transition plan, the needs and wants of MSH's Community Services clients did not appear to be the top priority.

Due to the elimination of a service of this magnitude, PEER expected to receive an overarching plan developed by MSH and DMH that outlined the necessary actions for the closure of MSH's Community Services Division--i. e., client transition action plans, staffing plans, and contract requirements that ensured continued services for clients. Because such a plan was not developed, PEER sought to determine MSH's and DMH's involvement in the development of Guided Steps' transition plan, which would indicate the degree to which clients' needs were considered. Neither DMH nor MSH could provide evidence to PEER of DMH staff or MSH staff meeting with Guided Steps during the development of Guided Steps' transition plan, including what elements of the plan were discussed. MSH gave Guided Steps full responsibility to transition MSH's Community Services clients out of the program, although MSH Community Services staff could have been instrumental in planning the transition due to their knowledge of the clients.

In a meeting with the Community Services Division staff, PEER inquired about any research that might have been conducted to help MSH determine how to facilitate a transition of this scale. MSH administration was not aware of any such research.

Many of the clients transitioning out of the division have been receiving care from the MSH Community Services Division for years and because of DMH's and MSH's presumed lack of involvement in the development of Guided Steps' transition plan, the needs and wants of MSH's Community Services clients did not appear to be the top priority.

When PEER requested documentation regarding a transition plan and specific transition action steps, Guided Steps provided PEER with a quality assurance plan for the Capers transition. This plan included the following nine goals:

- Goal #1: Ensure Consumer Access to Provider and Appropriate Care
- Goal #2: Timeliness of determination for care
- Goal #3: Patient safety: Improve consumer safety and identifying potentially high-risk behavior that may threaten consumer safety and monitoring/trending information
- Goal #4: Adhering to the legal and ethical standards that govern our business of providing care to clients
- Goal #5: Quality Management activities that involve consumers, provider and community in the ongoing evaluation and improvement of services
- Goal #6: Training and licensure: monitor and ensure compliance with CARF/State training and licensure standards

- Goal #7: Monitor service delivery of professionals providing direct service of care
- Goal #8: Personnel record compliance
- Goal #9: Ensure compliance with CARF accreditation

Each listed goal included targeted activities, key measures, responsible persons, and the date due. When DMH staff were asked about what involvement they and MSH had with the above plan (and applicable supporting documentation), the response was:

“There were multiple staff at MS DMH, MSH hospital leadership and MSH Community Services staff who had multiple discussions with [Guided Steps] about multiple elements of the transition plan. All of the individuals involved, all of the conversations that were had, and all the elements of those conversations are not known. You will have to ask [Guided Steps] to find out exactly who he talked with and the content of those discussions.”

DMH’s and MSH’s inability to recall meetings, or the details of those meetings, and document their involvement in the development of the transition plan demonstrates that the department might not have had the needs of Community Services Division clients as its highest priority in making the decision to eliminate the division. DMH and MSH officials could not provide information to PEER related to any plan created by DMH or MSH that was geared directly toward the needs of the transitioning clients. Many of the MSH Community Services Division clients had received services from that division for several years. Undergoing a transition such as this would be understandably difficult for any person, especially for persons suffering from mental illness.

No Statewide Mental Health Patient Tracking System

Although the Mississippi Access to Care Plan and PEER’s 2008 report on the delivery of mental health services both recommended implementing a system for tracking the state’s mental health clients, DMH has not done so. To date, the hospital has relied on emails among Community Services Division staff and the MSH staff member identified as the transition coordinator to track clients transitioning out of the division. DMH

The 2001 Mississippi Access to Care Plan (MAC Plan) recommended that Mississippi develop an ongoing, comprehensive data collection system for the identification of individuals with disabilities who are receiving or are in need of services and supports. The MAC plan noted that this system should include a multi-agency tracking system for persons who are receiving services, waiting on services, and who have left institutions.

In its report *Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis*, released in June 2008, the PEER Committee made the following recommendation:

The Board of Mental Health should consider developing a patient tracking and management information system, in conjunction with the fifteen regional community mental health centers, to track patients within the state mental health system and to yield usable performance information for managing the Department of Mental Health and for providing mental health services throughout the state.

The Board of Mental Health's response to PEER's 2008 report said that DMH had contracted with the Department of Information Technology Services (ITS) to begin the process of building an enhanced, system-wide patient tracking and management information program. PEER contacted ITS and its staff could not find any contract for such system during that time frame. DMH does utilize a system called CDR (Central Data Repository, created around 2004) that all facilities feed data into and that is able to develop specific reports to send to the federal government; however, it is not a statewide patient tracking system as was mentioned in the response to PEER's 2008 report. According to DMH officials and as evidenced by DMH's documentation reflecting changes, updates, and revisions to CDR, DMH is actively working with ITS to pursue this statewide tracking system.

Until February 18, 2014, MSH had decided that a designated person would follow only residential clients leaving the MSH Community Services Division's care for one year after transition. Subsequent to that date, after PEER's inquiry, MSH decided to follow all transitioning clients, but had no system in place in order to be able to track these individuals.

The contract between Guided Steps Healthcare and Mississippi State Hospital stated:

MSH will identify a transition coordinator for the specific purpose of following all individuals discharged from MSH CS group homes for a period of one year after discharge. The transition coordinator will regularly follow-up with the individuals and assist them with accessing any additional mental health services that they need.

In a meeting with MSH Community Services Division leadership, PEER inquired why MSH was planning to track only the division's group home clients (approximately sixteen individuals) post-transition when MSH was providing services to approximately 120 individuals at the beginning of the transition. MSH did not have an answer as to why only residential individuals would be followed. The following day, PEER learned that MSH had decided to follow and assist all transitioning individuals for one year after the transition. However, MSH did not identify how it would track these individuals without a system in place to do so. MSH staff relied on emails sent back and forth among Community Services Division staff and the staff member identified as the transition

coordinator. After some clients had already been discharged from MSH Community Services care, PEER was told that MSH would develop a way to track these individuals mid-transition.

MSH relied on Guided Steps to find providers for those clients with the inability to pay for their community mental health services. Guided Steps made it clear to PEER that from a business standpoint, it would not be able to provide services to clients who were unable to pay or who did not have an eligible pay source, such as Medicaid.

The inability to track transitioning individuals makes it impossible for the transition coordinator to complete her job function successfully and the department cannot ensure that former Community Services Division clients are receiving adequate services or any services at all.

DMH and MSH would have been better equipped to facilitate a smooth transition had it followed previous recommendations regarding tracking of mental health clients.

How did DMH and MSH plan to handle the transition of MSH Community Services Division clients after the contract with Guided Steps was terminated?

DMH maintained that the termination of the Guided Steps contract should not change the transition process. MSH Community Services staff would continue to perform their duties of providing placements for individuals.

According to DMH, the termination of the contract with Guided Steps would not change the transition process because MSH employees would continue to transition the individuals served by MSH's Community Services Division. DMH states that the only change in this process would be that no referrals would be made to Guided Steps. According to DMH, treatment professionals would continue to seek alternate providers for the individuals.

All former MSH Community Services Division clients should have been transitioned prior to May 1, 2014. If not, MSH stated that residential clients would go to the Newton residential facility for services.

After the contract termination, Guided Steps was to find placements for clients it had previously accepted for service delivery. However, Guided Steps would no longer seek pay sources for clients.

How should the state provide community-based mental health services in the future?

In providing community-based mental health services in the future, the state should recognize the continuing significance and obligation of the Rose Isabel Williams Mental Health Reform Act of 2011 to involve representatives of all sectors of the state’s mental health system in planning for and delivering community-based mental health services. When contracting with private providers for community-based services, the Department of Mental Health should exercise due diligence and prudent contracting practices.

Follow Mandates of State Law

In the future, the Department of Mental Health should recognize the continuing significance and obligation of the Rose Isabel Williams Mental Health Reform Act of 2011 in planning for and delivering community-based mental health services.

As noted previously, the Legislature recently enacted a major mental health reform initiative entitled the Rose Isabel Williams Mental Health Reform Act of 2011. The goal of the act is for the state to provide core mental health services to those who need them, ensuring that such services are “accessible and delivered preferably in the communities where these citizens live.”

The act established a mechanism for joint planning that involves the Department of Mental Health, the local community mental health centers, and other participants in the state’s mental health system. Community mental health centers participate in the planning of core services and then must agree to provide these services to be eligible to receive public funds in the future in compensation for service delivery.

The act also directed that the Department of Mental Health survey the community mental health centers, which are to report to the department which services they are capable of providing. The act authorizes the Board of Mental Health to promulgate regulations to ensure that core services are provided through the community mental health centers or other providers.

While the reform act contemplates that the department might use private providers to provide services anywhere in the state, and does not guarantee to the community mental health centers a monopoly within their service area, the act presumes that they are, and will continue to be, vital to the provision of mental health services in their geographic area.

In view of the recognized role of community mental health centers in law, any future contracting with private providers

that would make “cherry picking”¹⁰ possible would appear to conflict with an ongoing cooperative effort between the department and the community centers to provide services to the state’s population in need. Actions that could impair a community mental health center would not be consistent with the cooperative ideal set out in the 2011 reform legislation.

As of June 30, 2013, the centers and other participants specified in law collaborated with the department in a joint strategic planning effort to identify the appropriate core services and measures to ensure effective service delivery. In doing so, the critical providers of mental health services collaborated in setting out a set of services that should be delivered to the state’s citizens in need of such.

According to DMH staff, the reconstituted Strategic Planning and Best Practices Committee (whose composition was changed by the 2013 amendment to the Rose Isabel Williams Mental Health Reform Act [see page 8]) has not yet been appointed by the Governor.

Utilize Prudent Contracting Practices

In the future, the Department of Mental Health should exercise due diligence when contracting with private providers for community-based services.

If the department determines that some community mental health centers are not equipped to provide some of the services needed in a particular area, it may choose to contract with providers in the future. DMH related to PEER that other states (i. e., Georgia, Tennessee, Florida, Louisiana, and Alabama) have contracted with private providers to provide community mental health services. These states cite various reasons for the decision to transition or privatize their community services programs (e. g., allows states to control costs, boosts efficiency, gives incentives to private providers to offer appropriate services). See Appendix D, page 51, for a description of other states’ efforts in changing the delivery structure of mental health services.

If the department uses private providers, PEER suggests the following:

- *The Department of Mental Health should utilize a competitive process to identify potential contractors, thus ensuring the best “bang for the buck”--As noted previously, the department did not seek competition, via solicitations of bids or a request for proposals, to consider what was available in the market with regard to potential private community mental health providers when contracting with Guided Steps Healthcare (see page 29).*

¹⁰“Cherry picking” is a practice whereby a provider offers only the most highly profitable services and/or offers services to only those individuals with pay sources, thereby potentially excluding seriously mentally ill clients from necessary care.

- *The Department of Mental Health should require private providers to document compliance with the department's certification requirements and operational standards--DMH should ensure that private providers adhere to all requirements outlined in the department's operational standards and policies when procuring a professional contract and certifying a new agency.*

For example, to verify the credentials of future providers, DMH should:

- request to see the original copy of the executive director's degree, transcript, or professional certification and keep documentation on file that the original was witnessed;
- contact the degree-granting academic institution to verify educational credentials or request a letter directly from the institution to the hiring organization stating educational qualifications;
- contact the professional association or agency that licenses or regulates the profession to check the candidate's professional certification or credentials; and,
- use a staffing checklist with a section that refers to proof of education, which attests that human resources personnel witnessed the original document.

In the case of the Guided Steps Healthcare contract, DMH did not exercise due diligence to obtain documentation showing that Guided Steps was qualified to perform the duties of the December 2013 contract in accordance with its terms (see pages 21-25). Lack of such diligence in the future could subject clients to receiving care from a provider whose staff does not possess the minimum qualifications that have been previously determined by the department as being necessary for a mental health care service provider.

- *The Department of Mental Health should require private providers to adhere to the same quality standards for services as are required for the community mental health centers--In the future, the department's contracts with providers should include quality standards and accountability measures for the contractor in order to ensure that the clients' best interests are a priority.*

Recommendations

1. Using existing resources, DMH should develop a client tracking and management information system, in conjunction with the community mental health centers, to track patients within the state's mental health system.
2. DMH should adopt formal, written procedures that require department-certified mental health facilities and providers (e. g., MSH) to procure personal services contracts of \$50,000 or less that, at a minimum, comport with best practices in order to ensure fair and open competition.
3. The Governor should make appointments to the Strategic Planning and Best Practices Committee created by MISS. CODE ANN. Section 41-4-10 (1972) so that the committee can continue the collaborative efforts of strategic planning with the Board of Mental Health, the community mental health centers, and other interested parties. To inform the Governor of the need for such appointments, the PEER Committee will forward a copy of this report to his office for review. Because certain minor, technical corrections are needed to perfect Section 41-4-10, the Legislature should consider making these changes during the 2015 session. Appointments need not wait for these changes to be made.
4. Any future decisions of the Department of Mental Health or the Board of Mental Health to realign agency services in light of the department's and board's concept of the department's proper mission should be submitted to the Strategic Planning and Best Practices Committee for guidance on such recommendations and their impact on the operations of community mental health centers and other providers of mental health services in Mississippi.

Appendix A: State-Operated Facilities for Behavioral Health and Treatment of Intellectual and Developmental Disabilities, 2014

State-Operated Facilities for Behavioral Health

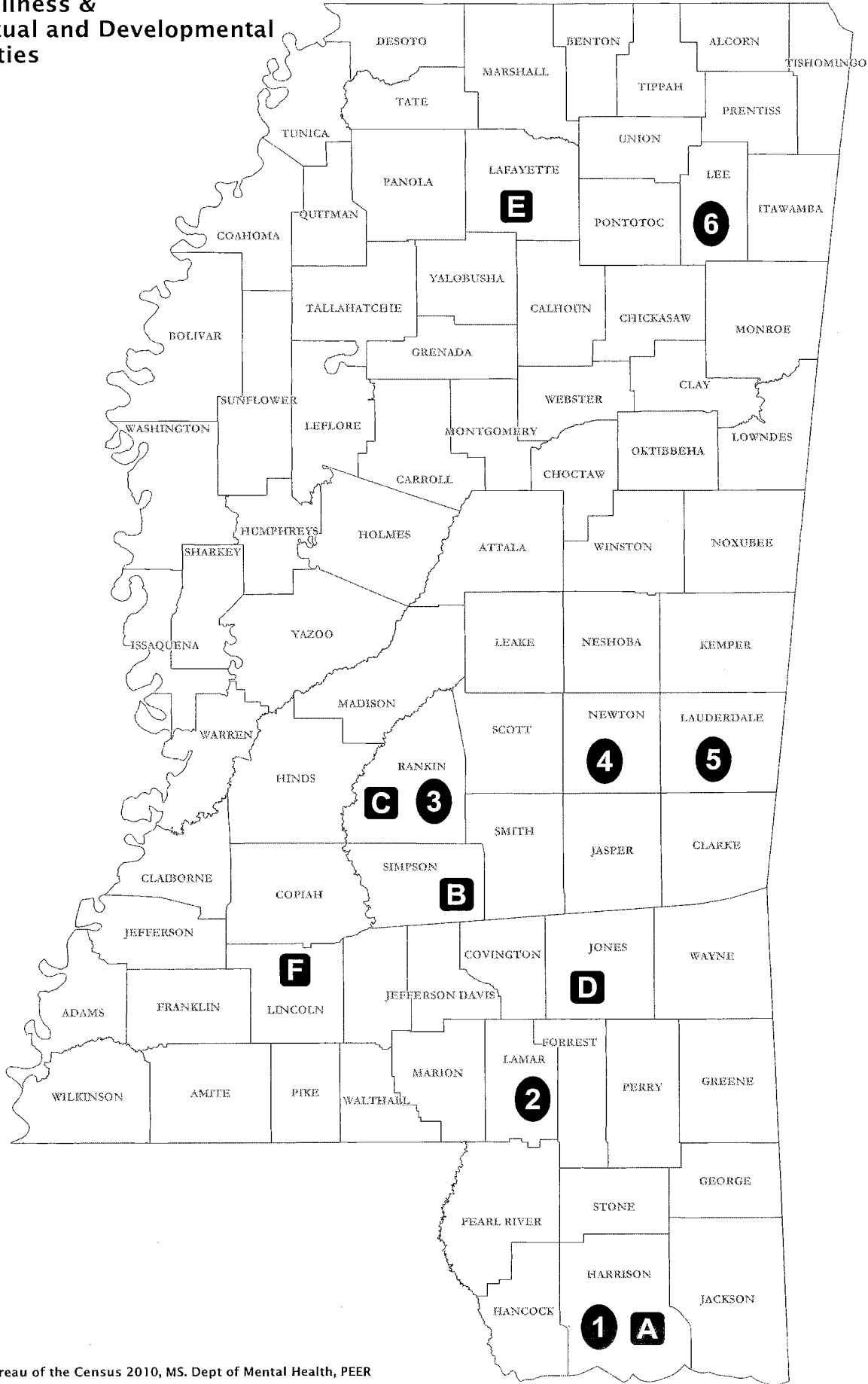
These programs are administered by DMH and offer residential and/or community services for mental health, substance abuse, and Alzheimer's disease and other dementia.

1. Specialized Treatment Facility, Gulfport
2. South Mississippi State Hospital, Purvis
3. Mississippi State Hospital, Whitfield
4. Central Mississippi Residential Center, Newton
5. East Mississippi State Hospital, Meridian
6. North Mississippi State Hospital, Tupelo

State-Operated Facilities for Treatment of Intellectual and Developmental Disabilities

- A. South Mississippi Regional Center, Long Beach
- B. Boswell Regional Center, Magee
- C. Hudspeth Regional Center, Whitfield
- D. Ellisville State School, Ellisville
- E. North Mississippi Regional Center, Oxford
- F. Mississippi Adolescent Center, Brookhaven

**State Facilities for Delivery of Services:
Mental Illness &
Intellectual and Developmental
Disabilities**



Source: US Bureau of the Census 2010, MS. Dept of Mental Health, PEER

Appendix B: Mississippi's Regional Community Mental Health Centers, 2014*

Region 1: Region 1 Mental Health Center, Clarksdale

Region 2: Communicare, Oxford

Region 3: Region III Mental Health Center, Tupelo

Region 4: Timber Hills Mental Health Services, Corinth

Region 6: Life Help, Greenwood

Region 7: Community Counseling Services, West Point

Region 8: Region 8 Mental Health Services, Brandon

Region 9: Hinds Behavioral Health Services, Jackson

Region 10: Weems Community Mental Health Center, Meridian

Region 11: Southwest MS Mental Health Complex, McComb

Region 12: Pine Belt Mental Healthcare Resources, Hattiesburg

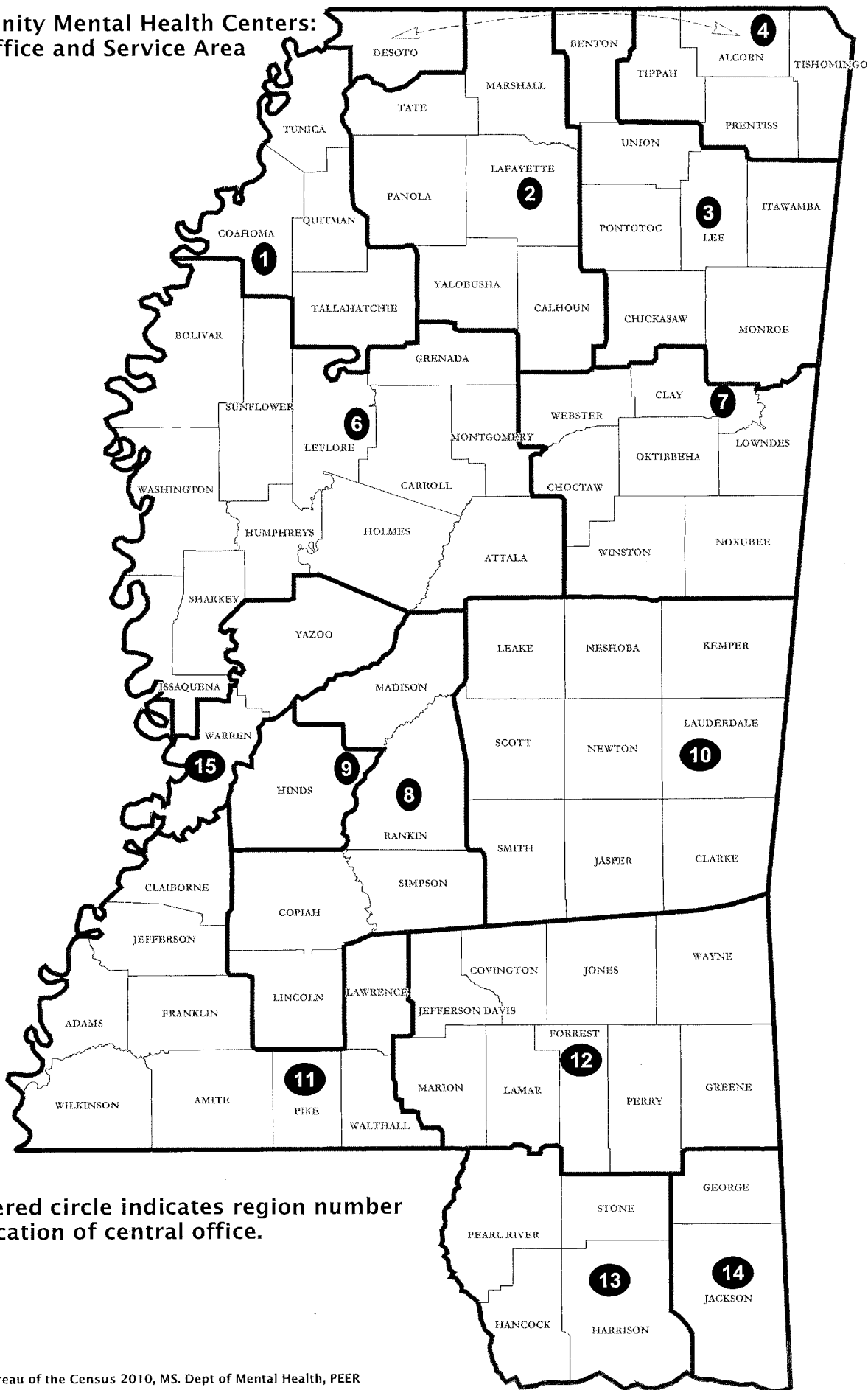
Region 13: Gulf Coast Mental Health Center, Gulfport

Region 14: Singing River Services, Gautier

Region 15: Warren-Yazoo Mental Health Services, Vicksburg and Yazoo City

*As of February 2014, Region 6 took over Region 5 due to Region 5's financial struggles.

**Community Mental Health Centers:
Main Office and Service Area**



Numbered circle indicates region number and location of central office.

Source: US Bureau of the Census 2010, MS. Dept of Mental Health, PEER

Appendix C: Additional Information on the U. S. Department of Justice’s 2011 Findings Regarding Mississippi’s Mental Health System and the State’s Subsequent Response

Title II of the Americans with Disabilities Act includes the “integration regulation,” which mandates that a “public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” Thus Mississippi is obligated to provide a mental health system with services, programs, and activities to address mental health needs in the most integrated setting that is appropriate.

The U.S. Department of Justice’s Findings Regarding Mississippi’s Mental Health System

On December 22, 2011, the U. S. Department of Justice found that the state was violating Title II of the Americans with Disabilities Act by unnecessarily institutionalizing Mississippians with disabilities, including mental illness and developmental disabilities.

On February 25, 2011, the U. S. Department of Justice (DOJ) notified Governor Haley Barbour of an impending investigation of the state’s mental health delivery system to determine whether the state was in compliance with Title II of the ADA, as interpreted in *Olmstead*, requiring individuals with disabilities, including mental illness or developmental disabilities, to receive services and supports in the most integrated settings appropriate to their needs.

As noted in this report, on December 22, 2011, DOJ issued a Findings Letter to Governor Barbour that concluded that the state fails to provide services to qualified individuals with disabilities, including mental illness or developmental disabilities, in the most integrated settings appropriate to their needs, in violation of the integration mandate of the ADA. Key findings of the letter include:

- Mississippi serves too many in institutions and not enough in their homes and communities and has never fully funded or implemented its own *Olmstead* Plan (i.e., the MAC Plan).
- DOJ found, “This has led to needless and prolonged institutionalization of adults and children with disabilities who could be served in more integrated settings in the community with adequate services and supports.”

- Compared to other states, Mississippi serves the highest percentage of individuals with developmental disabilities in large institutions.
- Mississippi spends more money proportionally on institutional care, and less on community services, than any other state. Our state is still in the process of opening new and expensive institutions, which runs counter to well-established professional and legal dictates.
- The state's reliance on unnecessary institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Focusing on community services and supports would permit the state to support people with disabilities in settings appropriate to their needs in the most cost-effective manner.
- The lack of sufficient community services has forced families struggling to support loved ones with disabilities to choose between living without needed services and placing loved ones in institutional care. It also leads to individuals with disabilities being forced to obtain needed services at inappropriate and costly venues, such as emergency rooms or institutions. For some, the lack of community services, especially crisis intervention, leads to homelessness and incarceration.
- Mississippi has not taken full advantage of Medicaid support for community services. These programs would facilitate the transition of persons with disabilities to community settings with ongoing services supported by a generous federal contribution.

DOJ recommended that the state implement certain remedial measures, including the development of adequate, safe, community-based services for people with mental illness or developmental disabilities who are unnecessarily institutionalized or at risk of unnecessary institutionalization.

DMH's Response to the ADA's Integration Mandate and the U. S. DOJ's Findings Letter

The Department of Mental Health responded to the Olmstead decision and DOJ findings by requesting additional funds in its appropriation for FY 2013 in order to expand community-based services; however, the additional funds were not appropriated.

According to DMH, in an effort to move Mississippi's mental health system forward and place even more individuals with mental illness or developmental disabilities in their communities, the department requested an additional \$49.8 million in its appropriation for FY 2013 to expand community-based services; however, additional funds were not appropriated. These additional funds, according to DMH, would help the state move forward with more community placement of individuals through expanding services delivered by community service providers and enrolling more individuals on

the IDD waiver program, which would allow individuals to receive services in their communities. DMH asserts that these have been goals since the inception of DMH's strategic plan in 2009.

DMH has not developed any estimates of cost savings that might be derived from moving institutional residents to community-based services. DMH asserts that, "Because the additional demand for inpatient psychiatric care remains after an individual is discharged, there are no cost savings achieved when an individual who is inpatient is transferred to a community based service." PEER notes that some of this demand for inpatient care could be due to the scarcity of community-based options.

Negotiations Between the U.S. DOJ, DMH, the Mississippi Attorney General's Office, and Relevant State Agencies

Since the DOJ's findings were released, the Department of Mental Health, Mississippi Attorney General's Office, and other stakeholders have been in negotiations regarding a potential settlement agreement, but have not yet been successful.

Since the release of the December 2011 findings letter, the Mississippi Attorney's General Office entered into negotiations with the U. S. Department of Justice in an effort to reach a written, enforceable settlement agreement that would set forth remedial actions to be taken within a specified period to address each outstanding area and also preclude costly and lengthy litigation with the federal government.

According to DMH, after receiving DOJ's findings letter, DOJ met on February 22-23, 2012, with DMH and the executive directors of Region 8 CMHC and the ARC to negotiate terms for a settlement agreement. Subsequent interactions with DOJ consisted of conference calls, emails, and face-to-face meetings, as well as the inclusion of various state agencies, including the Governor's Office, the Division of Medicaid, the Department of Rehabilitation Services, the Department of Education, and the Attorney General's Office.

Negotiations between these groups consisted of proposals, followed by counter-proposals, which, according to DMH, did not materialize into a settlement agreement. The last meeting between DOJ, DMH, the Attorney General's office, and other relevant state agencies occurred on February 13, 2013.

Legislation to Provide Additional Funds for Community-Based Mental Health Services

*The Legislature appropriated \$10 million for FY 2014 and \$16.1 million for FY 2015 to expand community-based mental health services to improve compliance with the *Olmstead* decision.*

Senate Bill 2874, 2013 Regular Session, appropriated \$10 million, and Senate Bill 2880, 2014 Regular Session, appropriated \$16.1 million for FY 2014 and FY 2015, respectively, to DMH “to expand those community based services that will improve the State of Mississippi’s compliance with the *Olmstead* decision of the United States Supreme Court.” The bills grant DMH the authority to transfer funds that “are necessary to implement or improve those community services that are more appropriately addressed by the Mississippi Department of Education and/or the Department of Rehabilitation Services.”

DMH has obligated approximately \$9.7 million of the \$10 million appropriated for FY 2014, thus leaving the agency with approximately \$300,000 to award to the departments of Education and Rehabilitation Services. The balance, according to DMH staff, has been reserved, because the obligations are estimates. According to the department, if obligation estimates are too low, funds held in reserve will be able to offset those increases in actual costs. PEER notes, however, that although the department states that it is holding the remaining \$300,000 in reserve, as of February 2014, it had not obligated funds for three proposed programs/projects.

According to DMH, obligations for the \$10 million for FY 2014 will continue into FY 2015 and be funded via appropriations by Senate Bill 2880.

DMH has obligated funds to establish two Programs of Assertive Community Treatment (PACT) Teams¹¹ and to hire three staff to serve as quality liaisons with other staff from the Bureau of Quality Management Standards and Operations, as well as current and new providers.

Exhibit 4, page 49, outlines DMH’s proposed obligations for the \$10 million appropriated for FY 2014, as well as progress made on each obligation as of February 2014.

¹¹PACT Teams are individual-centered, recovery-oriented, mental health service delivery models for facilitating community living, psychological rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses.

Exhibit 4: Department of Mental Health Obligations and Status Information as of February 2014, By Program/Project, for Funds Provided by SB 2874, 2013 Regular Session

| Program/Project | Amount | Status (as of February 2014) |
|---|----------------------------------|---|
| Mobile Crisis Teams | \$4,000,000 | Fourteen CMHCs responded to the Funding Opportunity Announcement ¹² (FOA) and have been awarded. |
| Two PACT Teams | \$1,200,000 (\$600,000 per team) | One PACT Team will serve Regions 8 and 9 and one team will serve Regions 13 and 14. |
| Three “out of home” regional crisis beds for individuals with IDD | \$1,000,000 | DMH has expanded the number of “out of home” crisis beds to 6 due to greater demand for additional beds |
| 200 IDD Waiver Slots | \$2,000,000 | 178 waiver slots have been added to the Home and Community Based Waiver (HCBW) and the department anticipates adding the remaining 22 slots by the end of FY 2014. |
| | \$200,000 | Budgeted for Burns & Associates ¹³ to conduct an IDD rate study for waiver rates. |
| | \$77,025 | DMH has trained 61 individuals throughout the Public Mental Health System via the Mandt System, which is a program designed to build healthy workplace relationships by reducing incidents and violence in the workplace. |
| Targeted Case Management/Community Support Specialist | No award | DMH is working with the Division of Medicaid to determine the amount of funding for this project. |

¹²A *Funding Opportunity Announcement* (FOA) is a publicly available document by which an agency announces its intentions to accept applications for the awarding of grants or cooperative agreements, usually as a result of competition. According to DMH, the department has only announced one FOA to establish Mobile Crisis Teams. According to DMH, the FOAs were provided to the CMHCs with the right of first refusal.

¹³Burns & Associates is a health care consulting firm that works with public sector clients on strategic planning, financial model development, evaluation and audit, rate setting and support of operations of health care programs.

| | | |
|--|-----------|--|
| Retain fifteen Peer Support Specialists | \$900,000 | Per the Funding Opportunity Announcement, each Mobile Crisis Team must be staffed with a Peer Support Specialist. |
| “Supported Employment” for Individuals with ID/DD and MI | \$15,000 | DMH is working with the Department of Vocational Rehabilitation to determine the amount of funding necessary for this project and plans to develop a memorandum of understanding with the Department of Vocational Rehabilitation once an amount is agreed on. |
| “Wrap around” services for children | No award | DMH is currently working with the Division of Medicaid to determine the amount of funding needed for this project. |
| Outreach education to individuals and families regarding community integration and housing transition | No award | DMH required that 10% of the Mobile Crisis Team grant award be utilized to provide marketing and outreach to educate the public on the availability of services. |
| Training for service providers on recovery model, person-centered planning and System of Care Principles | \$165,000 | Since July 1, 2013, DMH has spent \$135,000 for person-centered thinking training, which will provide 24 training sessions, 46 training days, and 40 slots for individuals to be trained in each of the training sessions. |
| Quality Assurance | \$135,464 | Since June 2013, 2 staff have been hired and a third is being sought for the Bureau of Quality Management Standards and Operations to serve as quality liaisons with other bureau staff as well as current and new providers. |

SOURCE: Department of Mental Health SB 2874 (Obligations) as of February 2014.

Appendix D: Other States' Efforts in Changing Their Structures for Delivery of Community-Based Mental Health Services

Alabama

The Alabama Department of Mental Health maintains an extensive network of Alabama's DMH-certified providers who provide a variety of services for the community mental health population instead of operating their own community mental health programs.

In 2011, Alabama became one of thirteen states to close all of its residential institutions for persons with intellectual disabilities and the only state to reach that milestone in the Southeast.

According to the 2012 Alabama Department of Mental Health's Annual Report, the closing of the state's last residential institution for persons with intellectual disabilities in December 2011 not only transitioned Alabama to a system of community-based care (i. e., integrating residents into society rather than segregating them in institutions), but it:

- provided vastly improved treatment options for those directly served;
- provided a significant and measurable reduction in the financial demands placed on the state's resources;
- allowed Alabama DMH to close three aging institutions at a net savings to the state in excess of 20 million dollars, with no reduction in levels of service; and,
- provided far greater access to additional federal dollars not available in state institutional settings as a result of providing services through community partners such as local mental health centers, local crisis care centers, and local hospital psychiatric units.

Currently, not only does the Alabama DMH no longer operate developmental disability facilities within the state, but the department no longer runs any community programs for individuals with developmental disabilities. Instead, the Alabama DMH maintains an extensive network of providers who are Alabama DMH-certified that provide a broad network of care, treatment, programs, and services that specifically enable persons with mental illnesses, developmental disabilities, or substance abuse disorders to reside in communities.

Alabama DMH provides oversight for these providers through five community service regional offices that ensure that providers follow departmental rules and regulations. The

Alabama DMH's Office of Community Programs serves as a liaison between the DMH and community mental health providers in an effort to enhance treatment for consumers. The office works to ensure that quality standards are implemented and maintained throughout the community provider network.

Louisiana

Louisiana transitioned the majority of its mental health programs to an out-of-state private provider. The Louisiana Behavioral Health Partnership oversees the provider and ensures quality service delivery for mental health individuals.

Due to difficulties in transforming its behavioral health delivery system to a community-based system due to funding difficulties and high rates of institutionalization, in March 2012 Louisiana transitioned the bulk of the state's behavioral health systems to the Behavioral Health Statewide Management Organization (SMO), Magellan Health Services, Inc., a private provider located in Avon, Connecticut, with offices in Baton Rouge and Shreveport.

The Louisiana Behavioral Health Partnership, which is managed by the Louisiana Department of Health and Hospital, Office of Behavioral Health, oversees SMO, Magellan Health Services. Magellan manages behavioral health services for Medicaid and non-Medicaid eligible populations served by the Office of Behavioral Health, the Department of Children and Family Services, the Department of Education, and the Office of Juvenile Justice and funded through state general funds and block grants, including services for individuals with co-occurring mental health and addictive conditions.

According to DHH, Magellan "is improving access, quality and efficiency of behavioral health services for children not eligible for the Coordinated System of Care (CSoc), and adults with Serious Mental Illness (SMI) and Addictive Disorders [and] developing a qualified provider network to offer a full array of services to meet the needs of people with behavioral health challenges." DHH also believes that Magellan will provide citizens with increased access to care and availability of services, greater involvement in care decisions, and a more integrated life in the community.

According to the Department of Health and Hospital, selecting Magellan as the SMO was necessary to assist with the state's system reform goals to:

- foster individual, youth, and family-driven behavioral health services;
- increase access to a wider array of evidence-based home- and community-based services that promote hope, recovery, and resilience;
- improve quality by establishing and measuring outcomes;

- manage costs through effective utilization of state, federal, and local resources; and,
- foster reliance on natural supports that sustain individuals and families in homes and communities.

Georgia

The Georgia Department of Behavioral Health and Developmental Disabilities operates six regional offices that contract with, monitor, and oversee private providers.

The Georgia Department of Behavioral Health and Developmental Disabilities system of services is administered through six regional offices, which also operate a community-based system of care for clients served. These regional offices administer the hospital and community resources assigned to the region. The regional offices:

- oversee statewide initiatives;
- develop new services and expand existing services as needed;
- monitor the services being received by consumers to ensure quality and access;
- investigate and resolve complaints; and,
- conduct special investigations and reviews when warranted.

The regional offices oversee contracts and monitor the performance of private providers who serve people living with developmental disabilities and behavioral health challenges. The community-based system allows clients to receive care in the least restrictive setting possible while helping them to obtain a life of independence and recovery. Each regional office provides planning for and coordination of its provider network; offers technical assistance; and serves as the point of contact for consumers who have questions about accessing services.

SOURCES: Alabama Department of Mental Health Annual Report (2012), Alabama DMH website and Alabama DMH Region 1 Community Service Office; Louisiana DHH website, dhh.louisiana.gov; Georgia DBHDD website, <http://dbhdd.georgia.gov/>.

Agency Response

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Edwin C. LeGrand III - Executive Director

June 5, 2014

Max K. Arinder, Ph.D.
Executive Director
PEER Committee
P.O. Box 1204
Jackson, Mississippi 39215-1204



Re: Mississippi Department of Mental Health and Mississippi State Hospital's Response to PEER's draft report regarding Mississippi State Hospital's Community Services Division

Dear Sir:

Thank you for the opportunity given to the Mississippi Department of Mental Health and Mississippi State Hospital to respond to the matters raised in PEER's draft report regarding the closure of Mississippi State Hospital's Community Services Division. Below I have stated the underlying facts regarding this closure and the Department and State Hospital's response to PEER's recommendations.

Underlying Facts

Mississippi State Hospital (hereinafter, "MSH"), is an acute care hospital providing inpatient mental health, substance abuse, and nursing home services under the administration of the Mississippi Department of Mental Health (hereinafter, "DMH"). Approximately thirty (30) years ago, MSH opened a Community Services Division (hereinafter, "CSD") in Jackson, Mississippi. At the time, MSH was encountering great difficulty arranging for follow-up care for individuals being discharged from the hospital. The CSD was created to provide some form of temporary transitional services to those individuals.

In the years since the establishment of the CSD, Mississippi has undergone a massive transition toward providing more community services. As of December of 2013, the State spent approximately fifty-one (51%) of its mental health dollars per year toward community services. Also, seventy-one percent (71%) of the individuals DMH serves with intellectual/developmental disabilities are now served in the community. Though the U.S. Department of Justice (hereinafter, "DOJ") began an inquiry into Mississippi's mental health system in 2011, DMH's commitment to expanded community services began prior to DOJ's involvement in the state and will continue.

At the same time as the state has expanded its commitment toward community services, the general fund dollars received by MSH have declined by fifteen percent (15%) since FY2008. MSH's primary mission is as an acute care hospital tasked with serving individuals in need of acute inpatient mental health services.

DMH allocates its resources for community mental health services to providers whose primary mission is to provide community services, not inpatient acute care. As MSH's general fund appropriation declined, DMH directed MSH to live within its means, and that included a refocus on MSH's core mission of inpatient acute mental health services. Transition of the individuals CSD serves to other community providers, redirecting CSD resources back into hospital operations, and movement of CSD staff to needed and hard-to-fill positions at the hospital were necessary outcomes of that refocus. Also, the Department of Finance and Administration had indicated the rent charged for CSD facilities may be increasing from a nominal \$10 total per year, to \$12 per square foot per year (the Capital Facilities customary rate) for space in an area of Jackson that had deteriorated and was demonstrably unsafe for CSD staff and the individuals they served. No money was "saved" by the closure of the CSD; rather, the closure of CSD allowed MSH to reduce the cost of their current operations in order to live within their appropriation.

DMH and MSH were disappointed that PEER included in the draft report certain editorial comments disparaging DMH and MSH staff's motives and commitment toward the individuals we serve. Such opinions and comments are not in keeping with what should be a factual and qualitative audit. PEER began its review of the CSD's closure in the midst of the transition process. Because of this, DMH and MSH believe some opinions were mistakenly clouded by the fears of transitioning employees and advocates unconnected with the transition process. In some instances, PEER staff questioned actions as they were being conducted and planned, rather than evaluating and reviewing those actions after the fact. As a result of the timing of this review, DMH and MSH staff were required to direct an inordinate amount of time and staff resources toward answering PEER staff inquiries, rather than more properly directing those resources toward the task at hand.

PEER Report Recommendations

1. Using existing resources, DMH should develop a client tracking and management information system, in conjunction with the community mental health centers, to track patients with the state's mental health system.

RESPONSE: In response to a 2008 PEER Report, DMH amended the Plan of Action connected to an existing Central Data Repository contract with the Mississippi Department of Information Technology Services ("ITS") to pursue this goal. DMH is actively working with ITS to create and implement a statewide tracking system. Documentation reflecting this work was provided to PEER staff.

2. DMH should adopt formal, written procedures that require the department certified mental health facilities and providers (e.g. MSH) to procure personal services contracts of \$50,000 or less, that, at a minimum, comport with best practices in order to ensure fair and open competition.

RESPONSE: DMH and the programs it administers will adopt formal, written policies and procedures that comply with Mississippi State Personnel Board policy with regard to contracts of less than \$50,000.

3. The Governor should make appointments to the Strategic Planning and Best Practices Committee created by MISS. CODE ANN. Section 41-4-10 (1972) so that the committee can continue the collaborative efforts of strategic planning with the Board of Mental Health, the community mental health centers, and other interested parties. To inform the Governor of the need for such appointments, the PEER Committee will forward a copy of this report to his office for review. Because certain minor, technical corrections are needed to perfect Section 41-4-10, the Legislature should consider making these changes during the 2014 session. Appointments need not wait for these changes.


RESPONSE: Stakeholders from all sectors of the public mental health system and recipients of services are currently involved in the DMH strategic planning process and advisory councils. Their input is encouraged, welcomed, and is regularly incorporated into DMH's strategic plan and ongoing operations. DMH welcomes collaboration with these various stakeholders, and the agency currently maintains and supports various advisory committees for the very purpose of encouraging such collaboration.

4. Any future decisions of the Department of Mental Health or Board of Mental Health to realign agency services in light of the department's and board's concept of the department's proper mission should be submitted to the Strategic Planning and Best Practices Committee for guidance on such recommendations and their impact on the operations of community mental health centers and other providers of mental health services in Mississippi.

RESPONSE: As was stated in response to the PEER recommendation above, the input from committees of concerned stakeholders is encouraged, welcomed, and is regularly incorporated into DMH's strategic plan and ongoing operations. However, volunteers serving on the committee created by Section 41-4-10 will have no responsibility or accountability for the outcomes of their decisions, and should not be charged with dictating the policy, practices, and procedures for providing public mental health services in the State of Mississippi. Certainly DMH would welcome the committee's input and feedback regarding significant realignments which might negatively affect community mental health providers. The Board of Mental Health is the authority given the responsibility to govern the operations of the Department of Mental Health and the programs it administers. That responsibility is not properly ceded to an advisory committee.

Thank you for the opportunity to present the agency response to the draft report. Should you have any questions, need a more complete answer to any of the issues addressed above, or need any assistance whatsoever, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Edwin C. LeGrand, III". The signature is written in a cursive style with a large, stylized initial 'E'.

Edwin C. LeGrand, III
Executive Director

PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Administration

Tracy Bobo
Larry Landrum
Rosana Slawson
Gale Taylor

Corrections Audit

Lou Davis

Reapportionment

Ben Collins

Evaluation

Kim Cummins
Matthew Dry
Lonnie Edgar
Barbara Hamilton
Matthew Holmes
Angela Norwood
Jennifer Sebren
MeriClare Steelman
Jenell Ward
Ava Welborn
Sarah Williamson
Julie Winkeljohn
Ray Wright

Performance Budgeting

Brian Dickerson
David Pray
Linda Triplett