



STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES *A HEALTHCARE SERVICE AGENCY*

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GOVERNOR

THOMAS A. KIRK, JR., Ph.D.
COMMISSIONER

Memorandum:

TO: Public Health Committee

FROM: Thomas A. Kirk, Jr., Ph.D.
Commissioner

DATE: March 16, 2009

SUBJECT: **S.B. 1120, An Act Imposing a Moratorium on the Rebidding of Purchase of Service Contracts Pertaining to the Delivery of Health and Human Service Contracts by or on Behalf of State Agencies**

Sen. Harris, Rep. Ritter and distinguished members of the Public Health Committee, thank you for the opportunity to submit written testimony on **S.B. 1120, An Act Imposing a Moratorium on the Rebidding of Purchase of Service Contracts Pertaining to the Delivery of Health and Human Service Contracts by or on Behalf of State Agencies.**

In considering the pros and cons of this bill, I believe it is important to share with you the extraordinary work that has occurred over the last few years, its purpose, desired outcomes, and state/private nonprofit participants. I say this because the current fiscal climate is so challenging that it could have one conclude, and not surprisingly so, that this process has always been about saving money. That is simply not the case. Rather, at least for DMHAS, it stems from a continuous quality improvement and strategic planning/review process dating back to at least 2006. Further, we did not proceed because of the contracting bill. In fact, we had developed our three- to five- year quality improvement game plan by March 2007. It resulted from findings such as the following:

1) For too many people, repetitive use/admission into acute care and crisis services is the rule, rather than a format of treating mental illness and substance use conditions as continuing care disorders for which carefully integrated and often new combinations of services would be more effective and appropriate. And, yes, it can have implications for funding — but from the perspective of how we allocate our resources, whatever amount that may be, not whether we should spend more or less. Some of the costly inpatient and acute care resources would not be as necessary if we introduced (a) some models that have been tested in other states, (b) other modalities based on solid professional literature, as well as ideas resulting from the experience, and (c) innovative approaches suggested by one or more sectors of the current DMHAS public/private healthcare system.

- 2) The symptom profile of persons presenting for care at emergency rooms and other entry portals often involves co-occurring mental illness and substance use disorders. Rather than being solely the responsibility of a local mental health or a substance abuse treatment agency, a more effective service model needs to focus on integrated care and access to a broader array of services than previously has been the case. DMHAS, through a five-year, \$4 million federal grant focused on co-occurring disorders, has implemented a standardized screening for co-occurring disorders and worked closely with state and community providers to increase access to effective, integrated care. The DMHAS “Alternative to Hospitalization” initiative begun as early as FY 06, and now in concert with a dozen community hospitals, is one such model — not the total solution, yet a contributor.
- 3) While Connecticut is a relatively small state in terms of geography and service areas, new ideas as to what would work best for one area may be quite different from that which would be best for another area. Some of the variance may be due to the demographics of the residents, how the service system evolved or any of a host of other factors. We need to pay more attention to and build on those variations.
- 4) Recommendations that were included in the Hospital Strategic Task Force Report (January 2008). This Task Force was co-chaired by Secretary Genuario and Commissioner Vogel, and members included representatives from community hospitals, the Connecticut Hospital Association, DPH and DMHAS, and other stakeholders. One of the key recommendations centered on identifying “High Demand Service Areas” and then concentrating on new intervention models. Our proposed procurement strategies will reflect that emphasis.
- 5) Results derived from an intensive and comprehensive survey (2006) by DMHAS of our service recipients who, though on outpatient status, were “not making it” in the community for various reasons. One such group of approximately 135 persons had inpatient readmissions for 120 or more days during the year, at an estimated state cost of \$17 million. More effective community-based service models can be identified for some of these individuals. A similar survey was completed for inpatient service recipients. Again, our strategy will help to address the survey results.
- 6) A review was done of requests for proposals being used by Iowa, Massachusetts, New Jersey, Delaware and other states to introduce new or refined service models based on the latest literature. These RFPs are often not based primarily on new money, but rather on better outcomes from the allocation of existing funding. We can learn from others and build on their lessons.
- 7) Very careful study of the ongoing experience of regional planning and service models in the New Haven and greater Hartford areas. Since May of 2008, DMHAS staff have had and continue to have weekly, but no less frequently than bi-monthly, work sessions with direct and supervisory care representatives of local hospitals, and private nonprofit mental health and substance abuse agencies, to compile extensive patient flow and entitlement data, and develop proposed integrated service models to ease emergency room demand and promote greater flexibility — and better patient outcomes — in the use of acute care contract, mobile crisis and case management resources.

8) Responses to Requests for Information released by DMHAS, e.g., October 2008, to hear from care providers about their ideas as to what would work best in their communities. Over 12 responses, each based on collaborations involving at least 5 to 6 local, state and private agencies, resulted from an RFI for acute care/mobile crisis/case management.

The bottom line is this: DMHAS and a broad cross section of stakeholders have been working since at least 2006 to identify service gaps, solicit ideas, and conduct research, both locally and nationally, in the development of the next tier of innovative service models that will enhance the quality of outcomes in our public/private behavioral healthcare system. The results to date have been quite impressive. Our overarching goals have included: shifting further to a recovery-oriented service approach and supports that result in more sustained benefits from clinical care; driving toward a continuous care, long-term model, rather than repeated acute care and inpatient episodes; increased refinements in regional, data-driven service planning and system design; and stimulating innovation, flexibility and efficiency in service delivery. In the pursuit of these goals, we are committed to ensuring patient safety, continuity of care and what is best for the individuals and families we serve. In addition, we have included in our assessments and planning significant factors such as siting, bond obligations, operational feasibility, Certificates of Need, and implications for other state agencies.

We believe the proposed bill will delay efforts to build on work we have done over at least the last three years and that the procurement restrictions will hinder our goal of transitioning to the next tier of quality care and service delivery. Based on the responses to RFIs and reprocurement proposals released by DMHAS within the last year or so, many current private nonprofit service providers are ready to partner with other colleagues, as well as DMHAS, in these initiatives. For the foregoing reasons, we oppose passage of S.B. 1120.

Thank you for the opportunity to submit testimony to the Committee on this bill.