STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A HEALTHCARE SERVICE AGENCY

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GOVERNOR

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COMMISSIONER

Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health & Addiction Services Before the Appropriations Committee February 20, 2009

Good morning, Senator Harp, Representative Geragosian, and distinguished members of the Appropriations Committee. I am Thomas A. Kirk, Jr., Ph.D., Commissioner of the health care services agency known as the Department of Mental Health and Addiction Services.

I am pleased to be here to discuss the Governor's proposed Biennial Budget for FY 2010 and FY 2011. As Connecticut grapples with its budgetary problems, the Department remains committed to its core mission of promoting wellness and preventing illness for many, many thousands of youngsters and adults, and to designing and implementing an innovative, quality-focused and cost-contained system of care, annually yielding sustained recovery for over 90,000 adults with serious psychiatric and substance use conditions.

I believe that the financing, service design and outcome strategies that DMHAS has progressively developed since 2000 — with critical support from the Governor, the Legislature and federal agencies— will not merely help the DMHAS health care system to withstand the current difficult economic storm; rather, these tested strategies will significantly accelerate our progress over the next few years and validate our four-step System Enhancement Model: Innovation, Improved Outcomes, Reinvestment, and Savings.

Consider components of the Governor's Recommended Biennial Budget for DMHAS with notation as appropriate to the points noted above.

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1) It provides $3.3 million in each year of the biennium to support a caseload growth of 5% for the General Assistance Behavioral Healthcare Program (GABHP). As an indication of the quality and cost containment of the GABHP, using FY03 as a baseline, there has been a 46% increase in the number of persons benefiting from the program through FY08, with only a 12.4% increase in costs over the same five-year period. Also, as the result of various quality improvement strategies introduced since FY2003, we were able to eliminate $65 million in projected service claims through FY08, compared with our FY03 service and funding models. More people helped ... better outcomes ... greater value for the dollars spent.

2) The Governor's proposed budget also provides funds for expected caseload growth over the biennium in the challenging, yet highly touted, Young Adult Services (YAS) program— the service bridge for teenagers aging out of the DCF service system and into DMHAS. Specifically, the proposed YAS funding includes $7.7m for SFY 2010 and $10.6m for SFY 2011. These funds will support 185 youth each year transitioning from DCF. The highly respected Institute of Medicine and the National Research Council released a report last Friday recommending that the mental health of youngsters should be a national priority and that the focus should include targeting high risk youth (i.e., foster care, juvenile justice, youth with depressed parents, etc.). Connecticut began the YAS initiative in 2000.

3) In addition, the Governor's budget increased funding for individuals with Acquired or Traumatic Brain Injury, such as those presently awaiting discharge from Connecticut Valley Hospital (CVH). Funding of $2m (comprised of $900,000 annualization and $1.1m in new funding) is proposed for SFY 2010 and an additional $1.7m in SFY 2011 for additional community placements. These funds would support a total of 17 placements over the biennium.

4) Further, the Governor's proposed budget will fund service and housing dollars for 144 persons with Mental Illness placed through the Medicaid Waiver in the amount of $1.2m in SFY 2010 and $2.9m in SFY 2011. These funds include service dollars for adults with serious mental health illnesses as part of the DSS Money Follows the Person program.

Proposed Service Redesign recommendations included in the Governor's budget are the following:

1) Migrating Cedarcrest Hospital (CRH) to the Connecticut Valley Hospital Campus (CVH). This proposal calls for the reduction of 98 full-time and six part-time staff. We anticipate that this migration can be achieved without any layoffs through management of direct care vacancies. The current bed redesign plan recommends moving 64 beds to the CVH campus, 10 to DMHAS's Greater Bridgeport Mental Health Center and adding two new 15-bed community residential programs for persons with psychiatric disabilities. This plan is consistent with the Department's overall service design and bed planning that has been taking place during the past several months and which included several key concepts:

a) Ongoing evaluation of the programming for persons in inpatient beds at CRH and CVH is underway, allowing for the establishment of units that could more appropriately treat the current population of persons now in the hospital beds, as well as indications for staffing patterns.

b) Establish a length of stay that is of intermediate duration, i.e., up to 18 months' length of stay. The ability to utilize beds on the CVH campus, as well as the establishment of two community-based residential programs that are highly structured, will assist with the appropriate and timely discharge of persons from inpatient status.

c) The movement of CRH beds and staff into CVH will allow for one administrative structure that will increase our ability to uniformly staff inpatient units, including establishing a common overtime utilization procedure. This does not necessarily mean that each unit will be staffed in the same manner; staffing patterns will be determined by program design and clinical needs of the individuals receiving care on each unit.

The department is acutely aware of the impact of this proposal on patients, families, staff and communities and will develop a process for all stakeholders to have input during this transition. A transition team and process will be led by Deputy Commissioner Pat Rehmer, along with the

leadership of CRH and CVH. That forum will be the venue for input from all key stakeholder representatives, with a special focus on patients and their families.

I expect that you will hear from some advocates that we do not have enough community residential services, such as the 30 beds proposed. From others you may hear that we do not have enough hospital beds. I believe that the Governor's budget gives us an opportunity to move some persons into the community who are clinically stable and ready for a non-hospital service placement. Further, it gives us the opportunity to redefine services and allocate our hospital beds so that they are more accessible and appropriate to the level of care needed for the people whom we serve.

2) The Governor's recommended budget for DMHAS also proposes to merge administration of CVH and River Valley Services (RVS). This proposal will result in the reduction of three (3) management positions, with no reduction in the community services currently provided by RVS.

3) The Governor's budget also proposes reductions in research support to Connecticut Mental Health Center in the amount of $1.2m in each year of the biennium which will not involve any loss of services.

Other modifications to the DMHAS budget are the result of net savings through service model enhancements which the Department anticipates achieving over the biennium through reprocurement initiatives, often after first formally seeking ideas from service providers and other stakeholders through the Request for Information process. I and senior members of my staff have met with board representatives of Connecticut NAMI and with various trade organizations to discuss these efforts and to solicit their input. The model enhancements will improve the service system, while yielding savings in several service categories (case management: $1m SFY2010 and $2.5 million SFY 2011; mobile crisis services, crisis respite, and acute psychiatric inpatient services: $700,000 SFY 2010 & 2011; methadone maintenance: $250,000 SFY 2010 & 2011; and ambulatory detoxification services: $100,000 SFY 2010 & 2011). These savings represent only 0.6% on a base of $34 million; thus

leaving significant funding to support improved service models based on the input from local stakeholders, the latest professional literature and approaches tested and implemented elsewhere in the country.

Times are tough. They offer the opportunity for innovation and enhanced service models. They raise questions we might not ordinarily ask, but maybe should have, in better fiscal times. From my perspective, the key policy issues/questions relevant to some of the above notes are:

- Do we want: (a) to spend on bricks and mortar or (b) invest in people living in communities with natural supports?
- Should we focus on: (a) the cost of disability and disease or (b) investing in recovery and healthcare?
- Are we talking about: (a) spending more or less or (b) spending differently?
- Should the funding associated with the DMHAS budget be described as: (a) an expense or (b) a well informed and effective healthcare investment?

My answer to each of these four questions is "b."

Thank you again for the opportunity to address the Committee today. I will be happy to take any questions you may have at this time.