

November 6, 2009
Provider Meeting
Region1 Children's Behavioral Health Services

Present:

- Mike Parker, CBHS
- Sandra Kennedy, Milestones Family Services
- Donna Lynes, Milestones Family Services
- Brian O'Leary, Milestones Family Services
- Gary Grover, Back to Basics
- Sylvie Demers, CSI Inc.
- Pat Proulx-Lough, Tri-County Mental Health Services
- Rhonda Juneau, Growing Opportunities
- Andra Spearrin, MAS Home Care of Maine
- Ken Johnson, MAS Home Care of Maine
- Muriel Blanc, MAS Home Care of Maine
- Pamela Wing, MAS Home Care of Maine
- John Regan, CAFÉ
- Melissa Maurais, CAFÉ
- Alison Patin, Affinity
- Emilee Taplin-Lacy, Affinity
- Jim Pease, Casa
- Bethanie Jacques, Casa
- Rachel Posner, CBHS
- Jennifer Dondero, CBHS
- Bob Barton, CBHS
- Carla Stockdale, APS Healthcare
- Doug Patrick, CBHS
- Roger Wentworth, Sweetser
- Thomas Riddell, Sweetser
- Doug DuBois, Port Resources
- Durinda Chace, Spurrwink
- Louise Haddock, YI
- Becky Ryan, Living Innovations
- Heather Borst, Connections for Kids
- Terri Thompson-Porter, Connections for Kids
- Beth Blanchette, KidsPeace
- Clarice Dunn, CBHS
- Kelsey Holt, Woodfords Family Services
- Ellen Martzial, Woodfords Family Services
- Karri White, Infinite Horizons
- Laura Harvey, Independence Association
- Colleen Gilliam, Independence Association
- Ellen Tims, CBHS
- Michelle Armstrong, CBHS
- Lisa Salger, CBHS
- Patricia Sands, Pine Tree Society
- Carolyn Cheney, Pine Tree Society
- Kathy Kosnow, PROP

New Graduate Program

There is a new LCPC program through University of Southern NH. They have a small site in Brunswick. Some of the program will probably be web based. We will invite Susan Maslack for another provider meeting.

Crisis Plans

CBHS staff sees a range of crisis plans from agencies providing various services. Some are very specific, & others are very general. The plans vary in the amount of parent involvement in developing the plan. There are many other differences as well. Providers were encouraged to share their experience in developing crisis plans, & what works (& doesn't). Discussion:

- Most helpful to families have been very detailed crisis plans with specific steps. Families need it very spelled out step-by-step. That's easier to follow than just "call 911," and parents don't really want to do that.
- Focus on antecedents, look at earlier steps
- Some families don't define "crisis" as we do. Need to define crisis for families. E.g. medical crisis vs. behavioral crisis. These are different categories, and might lead to different responses. Families might have a different definition than we do.
 - There may be different definitions. What does the family define as a crisis, as a time when they really need others to be involved? This is individual for each family.
 - A good plan is 90% *not* what you do in a crisis. 90% is what early warning signs are, & what to do when those early warning signs appear.
 - The plan also addresses how to put in supports. What is helpful, and what is not helpful? Learn from what has been tried before and has not worked.
- Does CBHS have a format, a list of questions that should be included in the plan?
 - We can help with this, and send out questions. But of course the plan has to be individualized for each family.
- Needs to be a living document. Not put on the back burner.
- Plan needs to be different for each family. A crisis is defined by the family, not by the provider.
- Many of the questions that are asked for Reportable Events might be helpful for crisis plans.

Changes in Targeted Case Management Rules

Doug Patrick reported that we have completed the comment period for the proposed TCM rule and expect the final rule to be out in a week or so. Check the MaineCare website for adopted rules & proposed rules.

http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html

Regarding single case manager: generally the new rule, like the emergency rule, has a requirement to move to a single case manager. There are some specific guidelines about when those activities should occur, and there is a provision for a transition period. There is a process for transitioning from one CM agency to another, or from one CM area to another.

Carla Stockdale from APS Healthcare added that APS is managing TCM as a non-concurrent service, in a similar way to the way APS manages concurrent services for adults. APS allows up to a 30 day transition period. For example, a child may have an authorization in place for one service, then a request comes in for another service, and APS sees that they can't legally overlap. The authorization for the second one (newest service) is shortened to a 30 day authorization. At the time of the continued stay review for the second service, if the first service hasn't ended, generally the second service won't be reauthorized until the first service discharges.

This is basically how this will be done under the new CM rules. It will be up to the providers to know and manage what can be done under CM as a single service. APS cannot tell the second agency who else the client is receiving services with. It would be up to the agency to coordinate that with the member (child/family). In general, case managers would have a sense of who else the child is receiving services from.

Question:

- Will the case management client enrollment form be coming with the final rules?
The emergency rule talks about a client enrollment form.
 - That has been eliminated in the final rule.

Doug Patrick indicated that the proposed rule, & the emergency rule, set forth areas of case management. There will be one comprehensive case manager who will be responsible for all areas of the child's care. Primary areas: child welfare, mental health, developmental disabilities, medical, homeless. There is some room for transition between case managers. For over a year there has been a policy in place regarding Child Welfare clients, and whether a contracted community case manager can continue to work with a child when a child becomes involved in CW, or whether a referral can be made to community CM for a child already involved with CW.

There have been questions about other areas of case management. Essentially, for a child in ACT or in a PNMI, it's very important to document that you're not duplicating the same types of activities—for example, both aren't documenting that they're coordinating outpatient services. A child can have CM while in PNMI. There can be overlap with an ACT team, but there must be documentation that they are working on different activities. Deadline to move to single case manager is November 1, 2009.

Questions:

- Case where a child was given up to State custody, & had a CM for a number of years. The child was not allowed (by CW caseworker) to see the child again.
 - That needs to be brought to the attention of the Child Welfare Supervisor or Program Administrator. This is not intended to happen this way. There should be a planful transition, not an abrupt one. The policy talks about discussion of the transition within the team.
- Regarding a case that "fell through the cracks": this provider has had several meetings with families where he has learned that this will be the last meeting for the

case manager, since CM will be ending. The family is now turning to the Section 24 provider for help with IEPs, and with a range of other issues. The family's need is still there. The family has trouble voicing their need (e.g. to APS) and turns to the people they know (Section 24 provider). Another Section 24 provider agreed that this is a current challenge.

- Where people no longer have case managers, refer them to DHHS. In York County, refer to Michelle Armstrong, and in Cumberland County, Lisa Salger. CBHS staff will refer the family to appropriate services, such as advocacy for educational services. Also, prior to the end of the CM service, the case manager needs to help the family with what types of supports might be helpful for when CM ends.
- CM services can be reinstated if there is additional disruption or something has changed in the family, and they need case management again. The goal of CM is to promote self-sufficiency with the families, and there is a need for strong discharge planning when case management is going to end.
- However, the parents may not be educated, they may have been given information upon discharge from case management but didn't understand it, they don't know how to pursue it, etc. So they turn to the people they know when they're in distress, such as Section 24 providers.
 - Some families will struggle more with this than others.
 - We're always looking toward independence. Self-sufficiency is the goal of case management, rather than being an ongoing service. Please direct families to CBHS staff for assistance.
 - One issue is self sufficiency for the family. Another issue has to do with MaineCare. MaineCare is health insurance, like Blue Cross. What would private health insurance pay for? Medicaid is a medical insurance program. Straight State dollars could pay for various things, but unless funding is specifically appropriated to the Department, the Department can't provide that. There are limited resources.
 - Part of the process is having an exchange of meaningful information with APS so APS can find those situations where there is more information that should be considered in making a decision about whether or not to continue services. Also: connection with community resources (MPF, GEAR etc.) should be ongoing, so that the case manager doesn't do everything, and the end of case management doesn't mean starting afresh.
 - In APS's experience, practices in the system haven't caught up with the policy change yet. For the first time since APS has been doing reviews, the policy shift in case management has meant that many children won't be able to get the service. APS's job is to apply level-of-care criteria, look at the whole clinical picture, and understand the comprehensive needs of the child/family. For the first time, TCM has experienced partial authorizations. APS's Medical Director has been sensitive to not issuing straight denials, but instead issuing 30-60 day partial authorizations to allow some transition time. APS looks at scores, eligibility, intensity of service, frequency of service. Is there a lot of work going on, or is the service in place "just in case"? There have been situations where all the information hasn't been presented, and the

service is reinstated when more information is presented. There are nuances in the needs of the different populations that are served under TCM. APS doesn't just look at the CAFAS score, but looks also at the activity & intensity of what CM is doing. Under the new regulations, CM is meant to be an episodic service, not an ongoing one.

APS doesn't want to direct treatment, but is available to consult on cases.

Carla Stockdale answered some questions for APS:

- Will criteria that are currently being applied to TCM be applied in the future to Section 24? Also: for a family that has had years of case management, & once children's CM ends the Section 24 provider finds out that the parents are mentally incompetent--is it possible that CM from an adult point of view can go in so the family is not completely left alone?
 - APS is not currently reviewing Section 24. DHHS (CBHS) manages Section 24 services. A revision of Section 24 is out for comment (proposed Section 28). There are no plans for APS to review Section 24 or Section 28, so current staff will continue to review that service.
 - The point of the service is always to move toward independence. But as some goals are accomplished, there are often more goals. CBHS is scrutinizing plans somewhat more closely than we have before. CBHS has to manage resources well. Section 24 is a very expensive service. There are about 371 children in Section 24 services in southern Maine. A reduction of one hour per week for all the children in Section 24 services would reduce annual spending by approximately \$577,000.
 - Regarding adults with mental health issues or cognitive limitations—please help the families to access adult services, and if there is anything that CBHS staff can do to help with linkages to adult services, please call.
- Can the discharge plan from case management include a plan for a follow up call, for example once a month for 3 months, to check in with the family?
 - One agency says they're already doing this. It's not billable to MaineCare. But it also provides an opportunity to reassess about whether the service needs to be opened again.
- CAFAS training will no longer be available on line?
 - CBHS is working with the CAFAS developers on this. There may be a round of face-to-face trainings, and the Department is also looking into revised on-line training. The developers are working on new technology for the CAFAS.
 - Youth Outcome Questionnaire (Y-OQ) is being looked at as an option for assessment. It hasn't been determined yet whether it will be used for case management. The first pilot is with HCT providers to see if this will be a useful option.

Loss of MaineCare

CBHS has been asked who notifies whom about the loss of MaineCare. Providers should call monthly to make sure the MaineCare is still active. If the child doesn't have MaineCare, providers should close the service. CBHS can't pay straight dollars for the

service. Case managers who learn that the child no longer has MaineCare should contact other providers.

The phone number to check MaineCare status is 1-800-321-5557 (Option 8) or 624-7539 (Option 8).

Question:

- Situation where parent didn't pay the premium, so the child's MaineCare ends. Could the State provide a technological fix, for example through MIHMS, to automatically notify that a family has lost MaineCare?
 - Sylvie Demers from CSI has some information about a service that CSI's billing department uses for this purpose. She'll send the information. This might be a service that CSI pays for.

APS

Carla Stockdale indicated that there have been regular call-ins with TCM agencies. There will be a call-in with PNMI providers about the newly posted Section 97 rules (November 19). APS is trying to do joint call-ins with the Department regarding rule changes. There are also quarterly service-specific conference calls, to talk about trends in the service area, answer questions etc.

Section 24 and Section 28 updates

The Section 28 rule has been proposed. That means that Department staff can't comment on it at present, but providers & others can. Providers should have gotten notification of the rule being posted. We're looking to transition Section 24 to Section 28.

Section 29 is closed. This is an adult day habilitation service (day programming) for individuals age 18 and up who are out of school. There is overlap between ages 18 and 21 when individuals can get children's & adult services. Bob emphasized that these are different services. Section 24 is not the same service as Section 29.

CBHS has data on the average number of hours at each Section 24 agency. Those hours can be skewed by one child being served who has very high needs. Averages per agencies range from 12.25 to 26 hours/week, so there is a big variation. Bob asked agencies to look at what is *needed*, not necessary what is desired by the family. Bob commented that there are children who get blocks of hours—3 hrs/day, or 4hrs/day, or 5 hrs/day for example. Do all of the objectives really add up to these round numbers? Section 24/28 is a skill teaching program, not a support program. CBHS is also concerned about the social implications of having a one-to-one staff, and the reliance over time on staffing rather than natural supports.

Many plans have been sent in with reductions in hours, as the child has gained skills.

Questions:

- Comment regarding Bob's observation about planning daily for the child's service: take for example a child with autism who needs regularity, needs a person to come at a predictable time consistently?

- If that's what the child needs, yes, this should be individualized. Planning should start with the child's needs, and those needs should dictate the number of hours, days/week, etc. But the vast majority of plans are in 5-day multiples. Also, think about the number of objectives that are being worked on. Can the staff member keep a large number of objectives straight? Can the child?
- Will consideration of expected level of staff education (in the new Section 28) be considered in rate setting?
 - The Department as a separate rate setting unit that will set rates. There will be a standard rate, one rate for the one-on-one service, and a rate for the group service.
- Regarding group service for social skills etc. Are there HIPAA issues? If a group of children is put together, some parents might like the idea, but others might not? There are considerations regarding the setting, the other children involved, etc. What if the group involves children that are served from different providers, how would that work? How would the treatment plan look for group services?
 - In mental health services, there have been groups for a while, so we can learn from their experience. There will need to be a release-of-information.
 - Regarding how to document group services on a treatment plan, CBHS will need to get back to agencies with more information.
- Where could the group activity occur? In the community, or in someone's home?
 - Agencies need to be aware of problems that might occur in having the group in someone's home. There are liability issues to consider.
- In a group, the worker would be responsible for more than one client?
 - Please see the proposed regulations. There are proposed ratios in the rules. Please make a comment if you'd like.

Many thanks. The Section 24 treatment plans look good. Providers are doing a great job. Thanks for providers' hard work in helping meeting the criteria in the Risinger lawsuit.

Reportable Events/Critical Incident Reports

The Reportable Events form should be familiar. When there is an incident with a child (see form for types of incidents), send a copy of this form. It's pretty self-explanatory. This is for pretty serious incidents—restraints, injuries, medication errors, rights violations, etc. If a child has fallen down & scraped a knee & the mother cleaned it & put on a Band-Aid, don't fill out this form. This is for more serious incidents—incidents in public, serious aggression, etc. CBHS does track these incidents. Restraints are of particular interest. If there are 3 restraints in a 2 week period, there must be a treatment team meeting to determine whether the child needs a behavior plan. If this comes up for an agency, contact CBHS for assistance. This form is for incidents that occur when agency staff are present.

Providers may be familiar with 2 different forms. The Reportable Events form is used by both CBHS and by the Office of Adults with Cognitive & Physical Disabilities (OACPD) for individuals with developmental disabilities. Mental Health providers are more familiar with the Critical Incident form. This is similar, for example, regarding restraints.

On the Critical Incident form, please also inform the Department of serious incidents that you believe we should know about, and call CBHS if you have any questions about whether or not to fill out the form in a particular situation.

The reports for children with developmental disabilities go to Mike Parker. CBHS doesn't expect to see those as much from CM providers as from Section 24 providers. Please send these within 24 hours if possible.

The Critical Incident forms are on the website, and come to Rachel. Please call if you think you might have something to report, but aren't sure.

http://www.maine.gov/dhhs/ocfs/cbhs/provider/word/critical_incident_form.doc

Question:

- Providers who also do adult services have EIS access, and can put these directly into EIS. Would that be OK for a children's Reportable Event?
 - No, our systems are different. Please send in the paper version.