

**DHHS Children's Behavioral Health Services
Districts 1 and 2 (Region 1)
Provider Meeting Minutes
March 2, 2010**

Present:

- Mike Parker (CBHS)
- Nancy Givren (Community Counseling)
- Dawn Willard-Robinson (Pine Tree Society/Pine Tree Camp)
- Kinsey Tinelli (Bridges of Maine)
- Hannah Welch (Bridges of Maine)
- Ellen Williams (Connections for Kids)
- Gary Grover (Back to Basics)
- Terry Valente (Affinity)
- Leah Cunha (Affinity)
- Debbie Papps (CSI)
- Melissa Maurais (Café)
- Ellen Tims (CBHS)
- Michelle Armstrong (CBHS)
- Doug DuBois (Port Resources)
- Ellen Martzial (Woodfords)
- Melissa Ridlon (Providence Service Corp.)
- Katherine Bate (Community Care)
- Jana Colby (CBHS)
- Clarice Dunn (CBHS)
- Sally Hunt (CBHS)
- Brenda Smith (YAI)
- Kane Loukes (YAI)
- Roger Wentworth (Sweetser)
- Kim Proulx (MAS Home Care for Maine)
- Pamela Wing (MAS Home Care for Maine)
- Ken Johnson (MAS Home Care for Maine)
- John Beaman (KidsPeace)
- Becky Ryan (Living Innovations)
- Lisa Salger (CBHS)
- Buzz Sawyer (CBHS)
- Nichole O'Farrell (Christopher Aaron Counseling Center)
- Mariah Rackliff (Christopher Aaron Counseling Center)
- Corinne Whitling (Providence Service Corp.)
- Bob Barton (CBHS)
- Jim Allen (CBHS)
- Doug Patrick (CBHS)
- Rachel Posner (CBHS)

Introductions

Availability of Targeted Case Managers (Bob)

There are times when children are referred to services, or are in services such as Section 24, and do not have TCM. If the provider (such as Section 24 or HCT) feels the child needs TCM, the child can be re-referred to TCM, even if TCM was closed in the past. The burden of case management activities should not fall onto the providers of other services.

Discussion about experience with TCM—since regulations changed over the summer, partial authorizations & denials have increased from APS, in accordance with the changed MaineCare regulations. A provider of TCM commented that it's quite inconsistent what will go through (be approved by APS) and what will not go through. Another provider commented that a case might close, but it can be opened again if the need can be demonstrated. The criteria are more stringent than they have been.

Section 24 & Section 28 updates (Bob and Doug)

Looking for start of Section 28 April 1. There's a call-in scheduled for March 26 from 1-2:00 p.m. Phone number is 1-888-560-3504; you will need to enter a passcode to access the conference call. The passcode is 146499. The forms will be ready for the providers by that date. The process for prior authorization will be finalized at that time also. There will also be a call-in for case managers about Section 28 following the call-in for Section 28 providers. The call-in is designed to have everyone statewide hear a consistent message, and to make it easier for people to attend. CBHS plans to do regular call-ins in the early stages of implementation of Section 28.

Section 28 has changes from Section 24. The final draft of Section 28 will have some changes from the draft the providers saw earlier.

Some items under discussion in the new regulations:

- Custodial care—if someone has been working on an objective for a very long time, at some point does this become more a supervision issue than a teaching issue? (e.g. crossing the street for an 18 year old who has been working on this for many years)
- Parent participation—this is an important component of Section 28 services.
- Chapter 1 requirements are especially important. Chapter 1 MaineCare does not allow provision of academic, socialization, recreation and vocational training, and requires the services meet the MaineCare definition of Medical Necessity.

Doug gave some background. Originally the expectation was that the rule would be adopted by January. The rule-making process took longer than expected. The rule is currently in the Commissioner's office. (UPDATE- The rule is now posted on the web)

Bob indicated that he met recently with OACPD (adult developmental services). He learned that Section 29 is basically closed for the foreseeable future. (UPDATE- OACPD may have some *LIMITED* ability to place some people on this waiver in July) This may mean an increase in referrals to Section 28 for young adults. We will all need to be

careful to make sure that the Section 28 requirements are met, despite the young person's need for other services that are not available.

The Section 21 adult waiver is also closed. Bob heard that adult services hope that in July 2010 they may be able to add *one* new individual to the waiver. (*UPDATE- there will probably be some ability to add more individuals to the section 21 waiver this July but not as many as have been identified as eligible for the service*) We will all have to work hard on reasonable transition plans. There are currently some young adults getting a high number of Section 24 hours who will turn 21, and at that time not have any services available in the adult system.

Waiver (Mike and Doug)

After several years of not having waiver services available for children, the good news is that a new policy is under development. The process involves application to the Federal CMS for a waiver. A group working on this includes parents, providers, staff from CBHS and MaineCare, and advocates putting together pieces of the application that will be submitted to the Federal government. The next piece of work is putting together a MaineCare policy with details of what services will be offered. Those rules will go through the rule-making process (for public comments). The current draft application includes the following service menu:

- home and community support services provided either in the child's natural home setting (family, foster family, etc), or in a small agency run waiver group home
- respite
- environmental or home accessibility adaptations
- consultation services
- communication aids
- some transportation

New waivers are approved for a 3 year period. The Department is asking CMS to approve 40 "slots" for the first year, and thereafter 20 for the second, and 20 for the 3rd year bringing the total to 80.

Any changes that may be necessary to the waiver may be addressed by submitting a request for an amendment. Focus will be on the highest need children, who may be in an institution, or a PNMI, and children who are at home with significant need for intensive services.

Implementation is projected by Jan 1, 2011. We will be giving updates over the coming months, and will be in touch with people who might be interested in doing these services.

Question about Section 29: It's frightening that an individual in the children's part of the system could get many hours of services, and then at age 21 suddenly not have services available.

People can advocate, through professional organizations etc., if they disagree with the current budget. Unfortunately, there is only so much money to go around, so

together we can work on providing the amount of services that are needed, but not more.

Also, people can keep in touch with OACPD (adult services) and let them know which clients are in need, and what services they need. And if you anticipate that something may become an Adult Protective issue, please call that agency, since Adult Protective provides the basic safety net. Calls to adult services—OACPD or Adult Protective--can be made proactively, in anticipation of need. Also, let CBHS regional staff know about individuals in transition about whom you have concerns. CBHS meets regularly with OACPD in the region and can flag that individual for the OACPD staff. Please work on getting an eligibility determination as soon as that is possible.

Adult MH (Carlton Lewis and Janice Teasenfitz)

Carlton Lewis is Team Leader for Adult MH and Janice Teasenfitz is acting Supervisor for the Forensic team.

Adult MH uses Section 17 to cover community services, and Section 97 residential services. An adult has to qualify for Section 17 services in order to then qualify for Section 97 residential.

Section 65 services:

- Outpatient mental health services, similar to children's services
- Psychiatric medication management

Section 17 includes:

- Community Integration—which is similar to TCM in children's services. Provides CM and support services. This is the entry-level service for Section 17 services.
 - Class Members are entitled to community integration services. The average amount of community integration services is about 1.5 hours/week
- ACT-Adult ACT is similar to children's ACT. This is a comprehensive resource of services including clinician services, med management, substance abuse services, etc. Clinical eligibility determines the duration of ACT services.
- Community rehabilitation services—new this year. It was developed for individuals primarily who are stepping down from 24/7 residential settings and need a more intensive service than ACT may provide. They most likely would receive these services in independent apartment settings. This service involves a team approach with a community integration worker and daily living support services to assist with daily medication dispensing, and other supports, up to 12 hours of available face-to-face service per day.

All of these services are authorized through APS HealthCare.

Adult MH Services has a Homeless Outreach team of Intensive Case Managers, who do outreach to shelters (such as Oxford Street), the streets (e.g. Preble Street). The goal is to connect with individuals with mental illness and help get services for them.

There is also Adult MH staff at correctional facilities, working with individuals with severe & persistent mental illness, and individuals with co-occurring mental illness & substance abuse problems. ICMs work closely with the facilities and with the Probation Department and with Maine Pre-trial Services in Region 1.

Referral procedure for someone coming out of children's services? Referrals are made directly to community services for community integration, ACT etc. The individual has to have Categorical MaineCare and meet the Section 17 eligibility criteria. The community agencies do the eligibility determination. The provider agencies are listed on the Adult MH website. (<http://www.maine.gov/dhhs/mh/mh-system/home.html>)

Question: is there ever a time when it is in the young adult's best interests to transition to adult services at age 18 rather than remain with children's services?

This is an individual decision. Sometimes the adult system staff knows more about the challenges that are facing the young adult (work, etc.) than the children's system staff know.

Carlton commented about the transition for some young people, for example from a locked PNMI in the children's system to the adult system where no similar facilities exist. Adults can walk away from facilities, with no one able to tell them they have to stay. The rules change substantially. Expectations are different, for example, at a child vs. an adult hospital unit.

Eligibility for children's services is broader than for adult MH services. There are individuals who have been served in children's services who will not be eligible in adult services.

What is the eligibility for adult MH services?

The requirements are in section 17. Requirement of Axis I diagnosis. Very few individuals with Axis II diagnosis will qualify.

(<http://www.maine.gov/dhhs/oms/rules/adopted.shtml>)

Is there a way that an adult can have case management from OACPD and Adult MH Services?

If someone has a primary diagnosis of mental retardation that is typically where they would receive case management. But it can happen.

Behavioral Health/Corrections (Buzz Sawyer)

Buzz is a psychiatric social worker at Long Creek, for hold-for-court girls. Jasmine Savio is the other psychiatric social worker at Long Creek. Buzz and Jasmine are both LCSWs who work at the facility for CBHS. They do risk assessments, meet regularly with youth for check-ins and stabilization, and facilitate contact with the family, JCCOs, and any providers. They participate in any planning/coordination to transition the youth out of the facility. The Dept. of Corrections also has mental health staff at the facility

When someone comes to Long Creek, or is held at Long Creek, it is because there is a crime involved. There may be a crime, or a probation violation. They come to LC because of the risk involved; because there is no place else for the youth to go; or as a sanction. LC is not a crisis bed, or a psychological testing unit, or a safety net, or the placement of last resort. LC is not a place to let the youth “cool their heels” or “teach them a lesson.”

When a youth is held, there are 2 business days before they must go to Court. Exceptions are if the youth comes right to LC from Court, ordered directly to LC by the Judge. Court decides the status of the child: for a short “shock” sentence, or Hold For Court, with or without Right To Release; or Commitment up to the age of 21 years old.

When detained, a youth can connect with providers. There is a team meeting to identify needs, create a plan, and schedule a time for the child to go home. The psychiatric social workers’ role.....

Challenges: during the first 72 hours is the time the youth may be at the most risk for self-harm. There are 15 minute checks during that time. Other stressors include the fact that the youth doesn’t know when they’re getting out. The other youth in the facility are also stressors for each other. Some of the youth are very trauma-reactive. Some youth have medical difficulties. Youth with serious mental illness typically don’t go to LC, but it happens occasionally. There are also times when youth with MR/PDD are at LC, and they present serious challenges. They have difficulty recognizing danger and reading social cues. They have trouble understanding the rules at LC. The other youth may also try to manipulate the youth with MR/PDD. The immigrant and refugee population has also presented a challenge to LC staff. Accessing support systems can be a challenge. Services such as counseling and case management may not be familiar to the family.

What role could the LC people play? What role could providers play?

The DOC system won’t help with some of our more vulnerable youth. It puts them at risk of exploitation or abuse, and exposes them to more intrusive and/or criminal type behaviors.

The Refugee & Immigrant program at Community Counseling can be an option to assist for immigrant and refugee youth who come to LC.

Buzz commented that within a team, a lot of power seems to gravitate to the JCCO. Unfortunately, the team planning process sometimes hinges on the personality and /or philosophy of the individuals, rather than being standardized in terms of roles. Case managers can be very helpful within teams to ensure that behavioral health needs are met, and appropriate treatment is determined.

Encouraged CMs, and supervisors of CMs, to offer their behavioral expertise within the teams. Others, such as JCCOs, have different roles within the teams. It is often difficult

for CMs with behavioral health training to push back within teams when they disagree. Case managers should feel comfortable in being an equal member of the treatment team, and not subservient to another state agency. It is important to remember that the primary mission of Corrections is the safety of the community and of the individual.

Please feel free to call the CBHS staff at the facility for assistance, if a youth with whom you are involved end up at the facility.

Can section 24/28 services be provided to someone who is at LC?

No. Usually youth are in and out of the facility rather quickly. Remember, we're talking here primarily about detention, not commitment which is for a longer period of time. Providers can maintain contact with youth in the facility, and with the LC staff, for the short time there; and help with coordinating care.

Buzz says, ideally the work of the community providers prevents the youth from landing in the facility at all. But if the youth does end up at LC, it would be important for the staff at LC to hear about the youth's needs. Encourage all case managers to contact the Psychiatric Social Worker for DHHS when a member of their caseload is detained.

Pine Tree Camp (Dawn Robinson)

Dawn is the director at Pine Tree Camp, which provides residential camping experiences for children and adults with disabilities. Children's sessions can at times be until age 20, depending on the transition needs. Sessions are divided up into 7 different 6-day sessions. All the July sessions are for children. Sessions are divided according to the children's ability levels, and how the peer groups will work best. Also offer a small day camp program for children 5-12, since some families weren't comfortable yet with having the child go to a residential camp. The camp is in Rome, Maine, about 25 minutes from Augusta. It's a traditional summer camp program, but everything is accessible. There are accessible hiking trails, accessible camping-out experiences, etc. A lot of times teams don't start to think about summer camp this early, but she encouraged people to apply early. 90-100 campers per session. 1 to 3 staff to camper ratio. Cabins are set up with 6 staff and 15-18 campers per cabin. One cabin is a year-round unit, with separate bedrooms, which allows the child to come with a parent or caregiver, and/or provide an option for some children who would be too challenged with the larger groups.

Dawn brought some information to distribute.

e-mail her at ptcamp@pinetreesociety.org

All of the information including the application are on-line.

www.pinetreesociety.org

Cut off is June 15 for applications

Question: Payment, funding?

Sliding fee scale for tuition. This is on the brochure and website. There should be some sort of financial commitment from the family; but they do not turn people away because of inability to pay.

Does PT Camp accept individuals with mental health disabilities?

Depends on the individual's needs. It doesn't necessarily depend on diagnosis, but on whether or not this would be a good fit.

PT Camp has the first accessible tree house in the State of Maine! Adults love it as much as the kids.

I TRT Process

Rachel reported that Michelle has gotten some calls from case managers looking for the "other" residential program (not ITRT), the one where the child can stay in the "group home" for quite a while, maybe years. There is actually only *one* ITRT process, and lengths-of-stay are individualized for each child's needs based on continued medical necessity.

Doug indicated that, once the children's waiver is available, there will be a small number of children who need residential care for their developmental disabilities & will be able to be served on the new waiver.

Jim indicated that ITRT is also not an option when parents feel the child can no longer live at home, yet the child does not meet medical necessity criteria.

HCT

Jana Colby reminded CM agencies that all referrals for 65HCT go to Michelle Armstrong, who processes the referrals, then sends them to Jana for matching a family to an agency.

Recently, Jana has received calls from both Case Managers and HCT agencies that are trying to get their families into 65HCT service. But matching of children to agencies is governed by the Central Enrollment process, so that the child waiting longest is served first if there is more than one family in a town where the service is being requested. Even if the agency really wants to pick up a particular child, a child who has been waiting longest should get precedence.

Family preference?

We will honor family choice, but have an obligation if/when an opening with another agency becomes available before there is an opening with the preferred provider, to offer that opening to the family. The family can choose to take that opening, or remain on the wait list for the preferred provider.

Other

Please, on faxes to CBHS (our FAX# 822-2358), attention the fax to someone at CBHS. We will make sure that it gets to the right person. Also put on the fax face sheet the number of pages to the fax, that way we can make sure that we have received all the information. THANK YOU

Section 24 plans: When faxing Treatment Plan and Meeting Signature pages please have the child's name on the top of the page. Without the child's name on the page it is

sometimes difficult to match the page with the correct plan as the parent's signature may not be legible and their last name may not match the child's last name.

Also CBHS now has a support staff member who will be helping to process the Section 24 paperwork. When plans and reviews are e-mailed to Clarice, please copy kate.russell@maine.gov.

Update from Providence: Providence is now providing CM out of all of its offices. Referral process is directly to Providence.

Providence is also rolling out Trauma-Focused CBT in the home.