

**Community Service Network 1 Meeting – Aroostook County
Presque Isle Inn & Convention Center
November 15, 2006**

Minutes

Present: Mary B. White, Lorraine Chamberlain, Greg Disy, and Wes Davidson, AMHC; Eric Morin, ESM; Lloyd Chase, CMS; Peter Sirois, NMMC; Debra Henderlong, Allies, Inc.; Mary Louise McEwen, DDPC; Annette Adams, Acadia Hospital. Presenters from OAMHS: Ron Welch, Don Chamberlain, Marya Faust, Darren Morgan. Muskie School: Janice Daley, Elaine Ecker.

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I. Welcome and Introductions	Darren Morgan, Region III Team Leader, welcomed everyone to the meeting and introductions were made around the table. He briefly went over the meeting materials and explained the format of the meeting, i.e. that questions may be posed at any time during the presentations. Any questions requiring significant time to answer will be recorded in the “parking lot” and addressed during that part of the meeting.
II. Overview of the Mental Health Plan approved by the Court Master on October 13, 2006.	<p>Ron Welch, Director of DHHS Office of Adult Mental Health Services (OAMHS), presented an overview of the Consent Decree Plan, signed on October 13, 2006. He focused on Chapter 4 of the Plan, Continuity of Care and Services, which includes the formation of Community Service Networks (CSNs). This is “the heart of how communities work together to meets the needs of people with mental illness,” he said.</p> <p>The entire program was accompanied by a comprehensive PowerPoint presentation. Handouts were distributed to everyone present.</p> <p>Ron explained the 4 major components, which he calls “The Four Cornerstones” of Chapter 4 of the Plan. They appear below as A, B, C, and D. He emphasized the overarching theme of recovery, and the pivotal importance of vocational services.</p>
A. Seven Community Service Networks.	<ul style="list-style-type: none"> • The state is divided into 7 CSNs (see chart on website). • Each CSN provides 8 core services: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services. • Functions of CSNs: <ul style="list-style-type: none"> › Assure delivery of services to all adult mental health consumers in the network area. › Maintain a “no reject” policy so that no consumer is refused needed service within the CSN area. Ron explained that the “no reject” expectation pertains to the network as a whole, not to individual providers. There may be exceptions, i.e. when needed services are only provided outside the network or even outside the State. The goal is to meet the needs as locally as possible. › Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. “Complex needs” means those that may be difficult to meet within normal services, i.e. co-occurring disorders, additional medical conditions, or physical disabilities. › Identify services necessary for consumers in the CSN who are at risk and provide those services. › Comply with all provisions of the Bates v. DHHS Consent Decree, especially where service coordination within the core service array is necessary. › Assess and identify resource gaps by geographical area and establish remedial measures and implementation timeframes. › Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care

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		<p>during a psychiatric crisis. Assure continuity of treatment during hospitalization and the full protection of a client's right to due process.</p> <ul style="list-style-type: none"> ▸ Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein. ▸ Plan based on data and consumer outcomes. Ron parenthetically explained the major differences between the CSNs and the former LSNs: 1) Planning will be done by consistent data gathered and disseminated by the State; 2) Leadership will be provided by OAMHS; 3) CSNs are explicit in the Court Order itself. ▸ Implement the Rapid Response protocols. Ron noted Rapid Response is in place in Aroostook County. ▸ Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Ron stated that this involves costs not covered by Medicaid and that are the burden of DHHS. Question: A member stated that in times past caseworkers participated in hospital care, but issues such as funding and hospitals blocking it changed things. Answer: These issues will be worked out in the context of CSN. At present BHN funds can pay for CSW worker to attend—if person is CSS client of the agency. Comment: There is a hole in the system--adults not yet enrolled cannot access BHN funds.
	<p>B. Performance Requirements/ Enforcement through contracts.</p>	<ul style="list-style-type: none"> • Contract Amendments were mailed out to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding for each CSN. Ron said that the Dept. may have a reputation for not enforcing its contracts, but the termination provisions outlined in the Plan for non-adherence must be carried out. Question: A hospital member requested more information and regarding the “no reject” policy in order to sign an MOU. Answer: OAMHS is drafting a letter clarifying the “no reject” policy which will be sent to all contracted providers and CSN participants, after the Attorney General’s office reviews it for adherence to the Consent Decree. Though community hospitals are not contracted with OAMHS, their MaineCare’s Provider Agreements will contain similar language (no reject). • Legislation is expected to define CSNs, assure momentum, and provide consistency with managed care in whatever final form managed care takes. • Quality Management Structure <ul style="list-style-type: none"> ▸ Replace monthly provider meetings with network meetings ▸ Provide data by agency and by network ▸ Problem-solve within network, with local consumer council • Realignment of Services <u>Community Support Services:</u> <ul style="list-style-type: none"> ▸ Each consumer will have CSW to coordinate ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. This is language from the Consent Decree Plan, Ron said. ▸ CSW’s employer is the lead agency for the client. ▸ Providers must assure 24/7 access to: ISP, Crisis Plan, health care advance directives, contact information for prescriber, and basic demographic and service information.

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	<p>Question: What service information does the last item refer to? Wouldn't that information be included in the ISP?</p> <p>Answer: Yes, most will be in the ISP.</p> <p>Question: Is this access in paper form or electronically?</p> <p>Answer: Either way, though electronically may be easier.</p> <p>Question: So, there's no proscription as to <i>how</i>, as long as it gets met?</p> <p>Answer: Yes. The CSN will determine the best way to achieve this.</p> <p><u>Crisis Services:</u></p> <ul style="list-style-type: none"> › Provided outside the Emergency Department, unless: consumer requests otherwise, medical condition need treatment, or person is in protective custody of the justice system. › Consumer's CSW is responsible during business hours. › During non-business hours, crisis service is responsible, unless consumer is enrolled in ACT. By definition, ACT is responsible 24/7, Ron stated. › In Emergency Department, crisis provider must: assess for less restrictive alternatives to hospitalization, locate and arrange for those services, and review crisis plan and advance directives. Ron explained that the purpose is to help get the person out of the ER to appropriate services in the community, if possible. "Of course, the physician in the ER makes the determination as to hospitalization." <p><u>Hospital Services</u></p> <ul style="list-style-type: none"> › Community hospitals are the first level of hospitalization response. MaineCare amendment will assure no-reject policy. <p>Question: A member asked what the forthcoming clarification will be on no reject policy.</p> <p>Answer: The central clarification is that the network as a whole is responsible to meet this policy, not individual providers or hospitals. The standards are reasonable, e.g. a provider can't violate capacity.</p> <p>Comment: A member summarized his understanding of the intent of the policy: The CSN is expected to meet needs to the fullest extent possible in the network. Each member is obligated/willing to configure themselves to meet the needs within the network. "Reasonable" may be a moveable standard, as gaps are identified and capacity grows and/or changes.</p> <p>Answer: Exactly right.</p> <ul style="list-style-type: none"> › Specialty hospitals, Acadia and Spring Harbor, are the next line of treatment. They will take admissions from community hospitals. › Public hospitals, Riverview and Dorothea Dix, will take referrals from Spring Harbor and Acadia, as well as forensic admissions. <p>The three levels are not locked in stone, Ron said. The Plan includes provisions for certain exceptions to this referral process, some of which may require OAMHS involvement.</p> <p>Question: To which degree with OAMHS be available after hours to join in to meet the needs?</p> <p>Answer: This is part of the Rapid Response system. OAMHS staff are on call to address such situations. If there is disagreement about someone "jumping over" a level, contact OAMHS.</p> <p>Question: That step is not in the Rapid Response Protocol. Will it be added as a piece of the design?</p> <p>Answer: Good thought—thank you.</p>

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	<p>C. Permanent Housing with Flexible Services</p>	<p>Ron explained that services will be unbundled from housing under the Plan, and will be provided as needed, when needed to consumers in homes of their own choice.</p> <p>The current link between services and housing will be broken. Only residential treatment will remain as a group home model or bundled service.</p> <p>PNMI is currently the major choice for residential treatment:</p> <ul style="list-style-type: none"> • This model requires the highest level of intervention for all residents, irrespective of need. • A needs assessment for this level of care will be undertaken to determine where and how many beds should be retained. <p>Ron informed that each CSN will determine how many beds to retain and where they should be located in the network.</p> <ul style="list-style-type: none"> • For those beds remaining, long-term stay is not the goal. • Successful treatment and re-entry into community life is the goal. <p>Ron said he is learning from some providers that there may be some flexibility with PNMI that could meet with the Plan's provisions. He expects some use of Section 17 or modified PNMI may be utilized. He acknowledged the need to explore how to achieve more independent living options and told the group that Don Chamberlain is convening a work group for this purpose.</p> <p>Housing options and Resources:</p> <ul style="list-style-type: none"> • Units developed with support of DHHS • BRAP • Shelter Care Plus vouchers • OAMHS will develop housing database
	<p>D. Consumer Councils and required peer services.</p>	<p>This cornerstone will be covered in the detail later in the program, Ron informed, but highlighted the fact that for the first time consumer participation is mandated and supported by the Legislature.</p> <ul style="list-style-type: none"> • Through 3rd supplemental budget of the 122nd Legislature, a mandate with \$323,000 was passed to establish consumer councils statewide. • A Transition Planning Group was formed with representation from virtually all segments of the consumer community. That work is underway and will be presented as part of this program. "They are well along in designing the system," Ron said. • This particular cornerstone will affect the strength and tenacity of all of the others. • It will undoubtedly have more impact in how the Maine mental health system delivers services than any other.
	<p>Vocational Services</p>	<p>Ron reiterated the vital importance of work in an individual's recovery process.</p> <ul style="list-style-type: none"> • Vocational services are absolutely pivotal to successful recovery. • 2 benefit specialists and 4 employment specialists will be out-posted across the state. • Each will produce work for a percentage of their caseload—15% is the expectation, Ron said.

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		<ul style="list-style-type: none"> • Training will be provided to over 525 CSWs across the state, as to the critical importance of work in the recovery process. • DHHS entered into an MOU with the Dept. of Labor and Bureau of Rehabilitation Services outlining the respective responsibilities of each. (Both Departments are named defendants in this litigation.) • Employment specialists, as is required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work. <p>Question: Is 4 the final number of employment specialists? Answer: I think it is a beginning—(since 15 is the recommended caseload for employment specialists). At this point, OAMHS has contracted with 4 now and will add 3 in July--to serve in all 7 CSNs. Question: How will OAMHS place the 4 current employment specialists? Answer: That will be based on VR waiting lists. Comment: A member stated her belief that VR waiting list data is not a true measure of what the need really is, since it measures only those assigned to caseloads. “How many people are actually <i>assigned to caseloads?</i>” she queried, and encouraged OAMHS to look at other data as well. Question: Does OAMHS expect CSWs to engage in vocational services? (That’s not covered in Section 17.) Answer: No, the training for CSWs will help them engage in conversations with clients about work—they will refer them appropriately for services. Question: Will people have to take time out from work for the CSW trainings? Answer: We anticipate development of an abbreviated training, perhaps 2 hours, which can be delivered to multiples sites via videoconference. This is a short-term approach—the long-term goal is to have this be part of the MHRT/C curriculum. Suggestion: Setting up a “bridge” for videoconference will allow many more sites to participate without having to travel to a central location in the area.</p> <p>Ron added that the current quarter-hour billing system for CSWs doesn’t make sense under this new system. “There is merit in considering a monthly rate in lieu of the quarter-hour,” he said, “and we’re going to explore that.”</p>
<p>III. Consumer Council and Consumer and Family Representation</p>	<p>Marya Faust presented this portion of the program, since Leticia Huttman, Director of the Office of Consumer Affairs, was unable to attend.</p> <p>Development of Statewide Consumer Council System</p> <p>Marya stated the importance of the consumer system developing outside of the OAMHS. To this end, the process is consumer led, with OAMHS providing support, only as requested. The development of the consumer council system began in April 2006 when the Transitional Planning Group (TPG) began to meet. The TPG is comprised of consumer leaders, meeting biweekly in a facilitated process. Their mission is to develop the basic elements and structure of the independent Statewide Consumer Council system.</p> <p>The TPG has developed a timeline, as follows:</p> <ul style="list-style-type: none"> • April 2006 – TPG begins meeting • March 2007 – 3 Regional Conferences • May 2007 – Form at least 3 temporary regional councils • June 2007 – Statewide Council seated and holds first meeting 	

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	<ul style="list-style-type: none"> • August 2007 – 7 Local Consumer Councils formed <p>The TPG has hired outreach workers, whose work will include getting people involved and excited, Marya said. They will be contacting providers and meeting with consumers/groups throughout the State.</p> <p>The draft design of the system consists of multiple tiers: Temporary and Periodic Regional Councils, Statewide Consumer Council, and Local Consumer Councils. The Temporary and Periodic Regional Councils will basically operate until the Statewide and Local Consumer Councils are formed, fading over time as this happens. Eventually, many Local Councils will be functioning throughout the State. They will be comprised of consumers from a wide variety of settings: Peer support programs, peer centers and social clubs, provider agencies, hospitals, at-large consumers, homeless shelters, club houses, and other places yet to be thought of. The meetings will be held in the form of town meetings, where all can contribute. The members or officers will be chosen based on an application process to be sure a diversity of experiences is represented. The Local Councils will elect representatives to send to the Statewide Consumer Council.</p> <p>Functions of Local Consumer Councils:</p> <ul style="list-style-type: none"> • Have a role in meaningful quality assessments Marya gave examples: Participate in licensing review process or in conducting agency consumer interviews. • Advocate/advise for local response to local issues • Report with representation to the full Statewide Consumer Council system • Receive and transmit information from wider world • Outreach for concerns beyond our members • Regional work to create and support local council efforts <p>Mission and Function of Statewide Consumer Council:</p> <ul style="list-style-type: none"> • Provide one-stop access for advice and planning on issues affecting lives of consumers. • Advice directed to and developed with DHHS and also to other departments and administrations. Marya said the Council will not just have a relationship with DHHS, but with other departments/entities as well, such as Department of Labor, Department of Education, and Community Action Programs. • Opportunity for consumers to learn from one another and to increase the impact of advice offered. The Council will provide a way to learn, grow, and to become more skillful and knowledgeable as consumers. • Support consumer-advising skills and develop interest in the Council system. • Develop/implement and oversee quality assessment of services and delivery systems in order to ensure quality services and participate in effective design. The Council will review Consent Decree quarterly reports, Marya said, and expects that vocational services will probably be high on their agenda for review. The Council will give ideas and suggestions for improvement. <p>Consumer and Family Participation in Community Service Networks</p> <p>Consumer representatives in the CSNs will come from two places: Each local council when formed (TPG representation in the interim) and from all peer centers/social clubs within contracted agencies or contracted independently with OAMHS.</p> <p>NAMI-ME is also providing a family member to each CSN to represent the concerns of families with adult family members who are living with mental illness.</p> <p>Question: What steps are being taken as the councils are formed for a broad base of participants, to ensure a variety of experiences and not just those who've had unfortunate experiences? Is there a way to provide true representation across the spectrum of</p>

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	<p>experiences within the MH system? Answer: The TPG has worked diligently in its deliberations about how to ensure local councils have broad representation. Their goal is to have wide range of experiences represented, to better enable CSNs to function without “getting stuck.”</p> <p>Marya added that Community Mediation Services may also play a role in helping people become “unstuck,” whether it’s a consumer or provider coming from a certain point of view.</p>
<p>IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols</p>	<p>Don Chamberlain presented the details of the CSN Implementation Plan, MOU, and Operational Protocols.</p> <p><u>CSN IMPLEMENTATION PLAN</u></p> <p>Development Timeframe</p> <ul style="list-style-type: none"> • Immediate deadlines are signing the contract amendments by November 19 and executing the MOUs and Operational Protocols by January 3. During November and December CSN participants will give input on roles, expectations, responsibilities, and develop MOU and Operational Protocols, signing both documents no later than January 3. • Over time with input from all parties: Statewide Policy Committee and monthly network meetings. By February 2007, CSN work plans will be created and CSNs will select participants for the State-Wide Policy Council (may push this date back to January, Don said). Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider, and vocational provider. <p>State-Wide Policy Council</p> <p>This council will be convened by OAMHS in February 2007 and will be directed by OAMHS senior management. Duties and timeframes as follows:</p> <ul style="list-style-type: none"> • Managing dynamics of network responsibilities. (February) • Assessing compliance with “no reject” policy. (March) • Assessing 24/7 CSW access. (March) • Review resource gaps and make recommendations. (March) • Develop and implement network-level planning tools. (May) • Identify all QA and QI performance measures that will become purview of CSNs to monitor and report on to OAMHS. (May-June) • This includes QA and QI processes and protocols that CSNs will use for review of data and recommendations to OAMHS. (May-June) • Develop CSN performance review process. (July) <p><u>MEMORANDUM OF UNDERSTANDING</u></p> <p>Don explained that OAMHS is gathering any and all suggestions for changes to the MOU through November. At the December meetings, CSNs will vote on any recommended changes for consideration by OAMHS. OAMHS then intends to craft one MOU. The MOU, as currently drafted, (and distributed in various mailings and in the Consent Decree Quarterly report), contains the following elements:</p> <p>Goals of CSN</p> <ul style="list-style-type: none"> • Provide integrated system of care • Core services available in area • Consumers’ changing needs met seamlessly

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	<ul style="list-style-type: none"> • Improve continuity of care, efficiency, outcomes, cost effectiveness <p>Guiding Principles</p> <ul style="list-style-type: none"> • Focus is adult mental health consumer • Quality of care depends on access and transitions without disconnection • Coordination makes effective, responsive system • Local planning, local problem solving, and a mutual understanding of the roles and expectations of each services provider should be effective ways to support continuity of care. This guiding principle is a statement of why CSNs really exist, Don said. • Based on current best practices and evidence based models, the mental health system must support consumers becoming knowledgeable about their condition, the availability of services, and self-directed regarding services. “The core of what we do is related to consumers,” Don added. • Providers and systems practice collaboration across disciplines, including peer disciplines, and health specialties. <p>Structure of CSN</p> <ul style="list-style-type: none"> • Meet at least monthly • Establish and oversee operational protocols • Establish outcome measures and assure quality • Establish sub and ad hoc committees, as necessary • Chaired by OAMHS <p>Agreement and Responsibilities Each member agrees to:</p> <ul style="list-style-type: none"> • Assure delivery of services to all adult mental health consumers in the network area. • Maintain a “no reject” policy so that no consumer is refused needed service within the CSN area. • Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. • Identify services necessary for consumers in the CSN who are at risk and provide those services. • Comply with all provisions of the Bates v. DHHS Consent Decree, especially where services coordination within the core service array is necessary. • Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis. Question: What if consumer does not want to involve other entities for support services? Is that the end of it? Answer: Yes, probably—however, the provider/CSW should be involved in educating and informing consumer about the advantages of the available resources. Question: One participant said he anticipates CSNs may struggle with issues of best level of care that client may or may not want to participate in. Answer: The Court Master and Plaintiffs are interested in knowing whether there was an honest and reasonable effort on the part of the provider, and the client refused; and whether it was documented. • Plan based on data and consumer outcomes. Planning should be focused on overall data, not just one case, Don said. • Implement the Rapid Response protocols. • Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Don said OAMHS is asking the Attorney General for clarification of confidentiality issues involved in this.

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	<p>The participant will:</p> <ul style="list-style-type: none"> • Appoint a representative who has the authority to make commitments on behalf of the participant and who will attend monthly meetings of the CSN. • Join in appropriate special projects and committees may be developed by the CSN. • Commit to the guiding principles, goals, and structure outlined above. <p><u>OPERATIONAL PROTOCOLS</u></p> <p>Purpose and Goals</p> <ul style="list-style-type: none"> • Same as listed under MOU “Goals of CSN” above. <p>Membership</p> <ul style="list-style-type: none"> • Each provider required to designate a representative. • Representative must be able to speak for organization. • Consistent representation is expected. • Not intended to be rotating designees. • Substitute designees may discuss, but not vote. <p><i>Eligibility:</i></p> <ul style="list-style-type: none"> • One representative from each provider with contracts with OAMHS who provide any of the core services. • One representative from each community hospital, with and without psychiatric units. • One representative from the psychiatric specialty hospital and from the state hospital. • One to three consumer representatives chosen by the consumer-run Transition Planning Group (eventually replaced by Consumer Council representatives). • One representative per social club or peer center, if part of a larger agency contracted to provide more than peer services. • One representative from NAMI-ME. • One representative from Community Mediation Services. <p><i>Service Array:</i></p> <ul style="list-style-type: none"> • Eight core services <p><i>Chairperson:</i></p> <ul style="list-style-type: none"> • Senior staff member of OAMHS. <p><i>Changes to Membership:</i></p> <ul style="list-style-type: none"> • May change depending on needs of CSN and changes in services/providers in CSN area. <p><i>Decision Making:</i></p> <ul style="list-style-type: none"> • Each member has one vote—vote shall be recommendation to OAMHS. <p>Meetings</p> <p><i>Regular:</i></p> <ul style="list-style-type: none"> • At least monthly, more often if necessary. • Scheduled by OAMHS. <p><i>Special:</i></p> <ul style="list-style-type: none"> • Called by OAMHS on its own or at the request of majority of membership. <p><i>Notice:</i></p>

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	<ul style="list-style-type: none"> • Notice given to each member not less than one week prior. <p><i>Quorum:</i></p> <ul style="list-style-type: none"> • Discussion and recommendations take place with those members present. <p><i>Voting:</i></p> <ul style="list-style-type: none"> • CSN decides on issues it shall vote upon. • Decided by simple majority of those present. • Advisory to OAMHS unless OAMHS states it will act on the vote. <p><i>Attendance:</i></p> <ul style="list-style-type: none"> • Absence from 3 or more consecutive meetings shall be reason for contract or provider agreement review <p><i>Agenda:</i></p> <ul style="list-style-type: none"> • Set by OAMHS with input from membership. • Include time set aside at each meeting for public comments. <p>Ad Hoc Committees</p> <ul style="list-style-type: none"> • CSN may designate ad hoc committees. • Chair will appoint committee chairs. • Committees will report to full CSN. <p>Don clarified that committees do not operate outside the CSN.</p> <p>Amendments</p> <ul style="list-style-type: none"> • CSN may amend the operational protocols from time to time. • Proposed amendments must receive majority vote of members present. • Proposed amendments must be approved by OAMHS before acceptance. <p>Question: Will there be any possibility to have a designated alternate that will be allowed to vote, in case of illness, etc.?</p> <p>Answer: Our purpose [in having one voting member] is to avoid this becoming a lower priority for members and sending substitutes in other than special circumstances.</p> <p>Question: Perhaps a statement could be included to the effect that the primary delegate attends regularly and only in instances of hardship a designated alternate may attend and vote?</p> <p>Answer: Darren Morgan voiced concern that the alternate might not be current on the issues and would slow down the process becoming informed at the meetings.</p> <p>Comment: A member stated that it would be the responsibility of the agency (member) to keep the alternate informed. Another said that it could be written in the protocols that the assumption is the alternate will be “ready to roll.”</p>
V. Consent Decree Standards: Indicators for Performance	<p>Marya Faust, Director of Policy, gave an overview and explanation of the Performance and Quality Improvement Standards that are part of the approved Consent Decree Plan.</p> <ul style="list-style-type: none"> • 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. They will not change. They are grouped under 10 categories, e.g. • OAMHS reports on these standards quarterly and all documents included in the reports are posted on OAMHS website. (The documents for the most recent quarterly report were included in the notebook provided to each attendee at this meeting.)

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	<ul style="list-style-type: none"> • Riverview Psychiatric Center has its own set of measures, also included in the quarterly reports. Dorothea Dix was not a party in the Settlement Agreement, so it is not part of this reporting process. • Some standards are measures of all people using the services and some are just for class members. Question: Do standards measure just the sub-population of class members or include the wider adult mental health population? Answer: Each standard specifies the group for which it applies. • Anyone who was a patient at AMHI on or after January 1, 1988, is a class member. This provision extends to Riverview, and each new admission becomes a part of the pool of class members. The number continues to grow. • The standards present a picture of how the mental health system is operating. Marya said that OAMHS will be consistently focusing on this picture “to see how we’re all doing.” <p>Meeting performance standards does not translate into “compliance,” Marya explained. Being in compliance involves a separate process, an additional step, which will be negotiated with the Court Master and Plaintiffs. She gave the following example of a current <i>performance standard</i> and an example of a possible <i>compliance standard</i>:</p> <p><i>Performance standard:</i> “Class members report in the class member survey that they are informed about their rights as MH consumer in a way they could understand.” (Currently the measure is 81.3% and the performance standard is 90%.)</p> <p><i>Possible compliance standard:</i> “For three full quarters, the standard is at 90% or better.”</p> <p>Marya reviewed the contents of the notebook provided to all attendees: It contains the full Consent Decree Plan approved October 13, 2006; and the November 1, 2006, Quarterly Report with all attachments. One of those attachments is the Performance and Quality Improvement Standards. Each Standard is listed, with data, and a graph depicting the baseline measurement, the performance standard required by the Consent Decree Plan, and the current measure. Marya discussed several of the standards, as follows:</p> <p>Standard 1: “Treated with respect for their individuality”</p> <p>The 2004 baseline shows 91.8%, the current measure is 92.3%, and the performance standard is 90%. “We’re all doing a good job on this standard,” Marya said.</p> <p>Standard 18: “Continuity of Treatment is maintained during hospitalization in community inpatient settings”</p> <p>The 2004 baseline shows 31.6%, current measure is 0%, and the performance standard is 90%. “Clearly, we must improve our performance here.”</p> <p>Marya pointed out that this information is collected from UR nurses, and the ISP must be included in the record to be counted. A telephone conversation about the client/ISP does not count in the performance calculations.</p> <p>She also said that some standards may not correspond with nationwide performance standards, some were set higher by the Court Master. Performance levels as specified are what is expected.</p> <p>Standards 26 & 27 – Vocational Employment Services</p> <p>Both standards show current measures well below expectations of the Court. The Consent Decree Plan places great emphasis on</p>

Agenda Item	Presentation, Discussion, Questions
	<p>vocational services and improvements must be made.</p> <p>Marya also discussed other items in the packet and notebook as follows:</p> <p>CSN Related Components Matrix</p> <ul style="list-style-type: none"> • Shows tasks and timelines related to the CSNs. • Excerpted from the overall Consent Decree Plan matrix attached to the November 2006 Quarterly Report. (Included in the notebook at Tab 2.) • Provides a quick reference to what needs to be done and when. <p>Contracted Services by Network Matrix</p> <ul style="list-style-type: none"> • Another attachment to the quarterly report, included in the notebook (Tab 7). • Starting point for identifying what services are provided by providers in each CSN area. • OAMHS will continue gathering information to update this matrix through RSVP forms each member received, as well as an electronic survey Muskie will develop and send out to all members to get more detailed geographic information and enable actual mapping of services. • This information is critical in identifying gaps and making remedial recommendations, as well as supporting budget requests to the Legislature. <p>OAMHS Website: Consent Decree</p> <ul style="list-style-type: none"> • All Consent Decree documents and quarterly reports are posted in electronic form. • Will add a Community Support Network section to post minutes and other documents.
<p>VI. Parking Lot Items</p>	<ul style="list-style-type: none"> • Non-enrolled clients and continuity of care issues • Hospital issues with CSW in hospital • Alternate delegate to CSN
<p>VII. Next Steps</p>	<ul style="list-style-type: none"> • Send suggested changes, information, requests regarding MOU, Operational Protocols, etc., to Muskie at eecker@usm.maine.edu. All correspondence will be passed on to OAMHS. <p>Question: Many members are not here. Will OAMHS contact them?</p> <p>Answer: Yes, absolutely.</p>
<p>VIII. Agenda for December Meeting</p>	<ul style="list-style-type: none"> • MOU • Operational Protocols • Vocational Services (standing item on each month's agenda) • Service Matrix – Mapping • Ongoing schedule of meetings – ITV connection?