

**Community Service Network 1 Meeting
Presque Isle Inn & Convention Center
December 13, 2006**

Approved Minutes

Members Present:

- Annette Adams, Acadia Hospital
- Greg Disy, AMHC
- Christopher Morse, Care & Comfort
- Lloyd Chase, Community Mediation Services
- Mary Louise McEwen, Dorothea Dix Psychiatric Center
- Peter Sirois, NMMC
- Tammy Carney, Transition Planning Group
- Ralph McPherson, TAMC

Members Absent:

- Allies, Inc.
- Aroostook Counseling & Evaluation
- Cary Medical Center
- Houlton Regional Hospital
- Life by Design
- New Day Counseling Services
- NFI North
- Northern Lighthouse

Others present:

- Patty Michaud, NMMC
- Mary White, AMHC

Staff Present: DHHS/OAMHS: Marya Faust, Don Chamberlain, Leticia Huttman, Darren Morgan. Muskie School: Elaine Ecker, Sherrie Winton.

Agenda Item	Presentation and Discussion
I. Welcome and Introductions	Darren Morgan welcomed everyone to the meeting and introductions were made around the table.
II. CSN Meeting Guidelines	Darren reviewed the "CSN Meeting Guidelines" and requested feedback. The group made no suggestions for changes.
III. Contract Amendments and Provider Agreements	Don Chamberlain informed the group that all contract amendments are in except for one Care and Comfort.
IV. Memorandum of Understanding	<p>This part of the discussion focused on proposed revisions to the draft Memorandum of Understanding (MOU) and Operational Protocols (OP). It was explained that the preferred process for the group to make recommendations for changes would be by making and seconding motions, discussing, and voting. It was also explained that after all 7 CSNs make their recommendations (through the last meeting of this "round" on December 18), OAMHS will finalize and send out MOU/OP to all CSN members for signature.</p> <p>The members voted to recommend the following two changes/additions to the MOU, with highlights from the discussion listed in bullet points below each item:</p> <p><u>Comments and Recommendations:</u></p> <ul style="list-style-type: none"> • The group recommended that each authorized representative have a designee that could attend in the rep's absence. Though the authorized rep would make every attempt to attend the CSN, when unable to do so the designee would be up to speed on what is going on so that he/she can represent the agency and vote on items. • There is a concern about lack of attendance. Some people are not here at this meeting and were not here last time.

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	<p>It was recommended that this CSN be advised as to what is happening with the people who aren't attending, ensuring that they are being held to a standard, and that the names of these absent agencies be included in the minutes. The names of absent agencies were read to the group. It was noted that some of these providers may be representing other networks</p> <ul style="list-style-type: none"> • Members of each CSN should be posted publicly for all CSNs to access. <p><u>Clarification:</u> Some members represent CSNs in more than one region. Representatives should be participating in the network that they are providing services in. OAMHS is following up with who is not attending.</p>
V. Operational Protocols	<p>The group voted that their recommendations for changes to the MOU also apply, as appropriate, to the Operational Protocols.</p>
VI. Provider Services Data Matrix, Maps, Service Gaps	<p>Marya Faust presented several data items, explaining the OAMHS is working to provide usable and accurate data from a variety of sources. She emphasized the importance of building accurate data for planning and resource purposes. She also requested that members share their own data, knowledge, and suggestions to improve the "picture" of services and unmet needs in their CSN.</p> <p><u>2006 Profile</u> Data collected from MaineCare and from mental health services funded by the General Fund shows:</p> <ul style="list-style-type: none"> • 33,874 people are receiving mental health services • 10,129 of those have serious mental illness (43.3%) • 38% of the 10,129 have co-occurring disorders of mental illness and substance abuse • National Medicaid data shows people with serious mental illness live 25 years less • 69% have one or more other health conditions; 46% have two or more; 28% have three or more • 1 in 5 have diabetes, compared to 1 in 10 for MaineCare members with no mental illness <p>Marya stated that these numbers can inform workforce development and training issues and has great implications for service planning given the number of people with mental illness in MaineCare struggling with complex medical issues. Ron added that these facts make obvious the reasons why hospitals are required to participate in the CSNs.</p> <p><u>Data Matrix and Maps</u> Marya explained that the data CSN members provided from the electronic data forms will be presented in two ways: (1) maps, for a visual picture of where services are delivered, (2) a data matrix, for comprehensive, in-depth written information. This effort is just beginning, she explained, and the data will continue to be gathered and refined. She showed PowerPoint slides representing the population density of Maine, and symbols (both town and county-wide) indicating where each core service is located/delivered (as reported in the data sheets through 12/4/06). The maps will continue to be developed to show more clearly where services are located/delivered and depict more about the depth and coverage areas.</p> <p>Members were asked to review the information in the matrix and provide any revisions or missing data to Elaine Ecker at the Muskie School: eecker@usm.maine.edu.</p> <p><u>Unmet Needs/CSN Summary</u></p>

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	<p>Marya distributed a report showing the number of specific unmet needs of clients in this region. The sheets show that in Aroostook county, 37 individuals have a total of 53 unmet needs. The client pool includes people receiving Community Integration, Intensive Community Integration, and Assertive Community Treatment services; mental health services through General Funds; and Consent Decree Class Members who request certain services through OAMHS directly.</p> <p>She explained this report will be generated every 90 days, and over time will provide valuable information about where needs continue to be unmet. She briefly explained the process of determining a need is “unmet,” i.e. that the particular service is not provided within a certain acceptable timeframe set by the Court. The information about needs comes from clients’ Individual Support Plans (updated every 90 days) as input by Community Support Workers, case managers, Consent Decree Coordinators, etc., into the RDS-EIS reporting system.</p> <p>Marya reiterated that all the data gathering efforts are works-in-progress. She explained that the more pieces we put together, the better the picture of unmet needs will be for the area.</p> <p><u>Clarification:</u> As we get better at collecting information, it may not be accurate to assume that the needs are getting worse, but rather, we’re getting better at providing an accurate picture of what has been going on.</p> <p><u>Comment:</u> It’s important to be clear on the population being measured, for instance people who are on blue cross are not included in this data.</p>
VII. Vocational Services	<p>Don Chamberlain reported on three items related to vocational services.</p> <p><u>DOL VR /DHHS OAMHS Memorandum of Understanding (MOU)</u> He referred people to copy of this MOU in the packet and discussed the following highlights from this agreement between DOL Vocational Rehabilitation Services (VR) and DHHS OAMHS:</p> <ul style="list-style-type: none"> • Goals: Strengthen partnership, ensure ethical best practices, maximize vocational funds, increase number of MH clients employed. • Joint Responsibilities: A workgroup is being convened to fulfill the activities listed in this section of the MOU. Jim Braddick of OAMHS and a representative (not yet named) from VR will co-chair the workgroup. Anyone interested in being on this workgroup should notify Elaine Ecker, eecker@usm.maine.edu. • Attachment A: Addresses issues with OAMHS’ new Employment Specialists (ES) and VR. It ensures that when a client moves into VR services (from the waiting list), any plan developed with the ES will be accepted by VR. The client has the choice of staying with the ES after becoming eligible for VR services and will have full access to the resources VR offers its clients. <p>OAMHS will place four ES during this fiscal year--in Portland, August, Lewiston, and Bangor. Three more ES will be placed by July 1. Each CSN will have one ES, housed in an agency that offers substantial community support services. The ES will be available for clients throughout the CSN, not just those served by the host agency. OAMHS expects 15% of the ES’ annual caseload to be employed at least 20 hours per week in competitive employment at minimum wage or better.</p> <p><u>Memorandum to ACT Teams</u> Don distributed a copy of a memorandum he sent out to all ACT teams, explaining the requirements of the Consent Decree Plan that Employment Specialists on ACT teams must spend 90% of their time on employment functions and that 15% of their annual caseload becomes employed.</p>

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	<p><u>Vocational Training for Community Support Workers (CSWs)</u> Training for CSWs is being finalized. Plans are for a short training that will use ITV to provide multiple sites and opportunities to attend. The goal of the training is to raise awareness of the importance of identifying vocational issues and goals in plans and ISPs. Comments: Some teams may not have known how to use the E.S. or pulled the E.S. in to address what seemed like more immediate issues.</p>
<p>VIII. Role of Consumers in Licensing</p>	<p>Leticia Huttman stated that OAMHS sees consumer involvement in licensing as an important component in developing a recovery-oriented system of care. She said consumers indicate less interest in being involved in the details of licensing and more interest in assessing whether the services delivered are recovery-oriented, consumer-driven, and person-centered. While this is difficult to evaluate, consumers have been looking at using standardized tools like the Elements of a Recovery Facilitated Systems (ERFS) to use in interviewing consumers and staff members.</p> <p>The hope is that this will provide an opportunity for consumers, providers, and OAMHS to work together to improve services—not to be viewed as threatening or faultfinding. Consumers would be trained and compensated, and would most likely go out in teams. Providers will be informed about what the assessment involves and what to expect before any visits occur.</p> <p><u>Clarification:</u> The training will be provided to consumers and there will be some preparation work that is completed system wide so that providers know what to expect before these visits occur. Training will focus on how to use tools as well as on the environment in which consumers will be working. In addition, training will focus on how to use the data in ways that move us forward.</p>
<p>IX. Housing and Support Services Workgroup Update</p>	<p>Don reported that this workgroup has met twice already and will continue meeting weekly through February. There are three consumers and a number of providers in the group working on identifying and categorizing the number and types of existing housing units in each community and clarifying the service delivery models that are in place. They are finding that some providers are being inventive in efforts to wrap services around the consumers.</p> <p>Minutes from this workgroup will be posted on OAMHS Consent Decree website on an ongoing basis.</p> <p><u>Clarification:</u></p> <ul style="list-style-type: none"> • The definitions that this housing group is working on will be sent to the CEOs and people at that level. • This work excludes shelters and substance abuse treatment programs. The focus is on PNMI, section 97, and agency owned “stand alone” units that have no service dollars attached to them.
<p>X. Contract Compliance Template</p>	<p>Marya handed out a draft “Agreement Review Checklist” noting OAMHS’ intent to improve consistency in working with providers on contract compliance. Marya noted that this checklist intentionally does not include things licensing attends to in its review process. This draft is open to revision, and feedback should be sent to Elaine Ecker, eecker@usm.maine.edu.</p> <p>Reviews for this region are set for February 1st and 2nd. Time slots are set, but providers may arrange between themselves to trade times, as long as they notify Darren Morgan of any changes to the original schedule.</p> <p><u>Comments/Recommendations:</u> Providers in this region may be able to participate by teleconference.</p>

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XI. Beds: Crisis Stabilization/Observation	<p>Don opened a discussion about crisis stabilization beds and observation beds: He asked some of these following questions: Are there enough crisis stabilization beds in the CSN? Is there a need for more Observation Beds? Is there the right number of beds in the right configuration? Are there alternatives to hospitalization that people in distress can access in addition to crisis beds?</p> <p><u>Comments:</u></p> <ul style="list-style-type: none"> • In this region the problem isn't necessarily the bed issue, but rather the capacity of the psychiatrist to see the person. • Acadia could use more observation beds due to the number of requests that they have. They have 14 beds now, and this is working well. There has been a 5.2 million drop in inpatient costs during first year after the observation beds were added. • One issue that has stood out is the number of people who have had medical complications. • AMHC asked if DHHS is interested in hospitals being the location for an observation bed; reimbursement requires that they be in hospitals. TAMC will do some research on this issue and bring information back to the next meeting. • It may also be helpful to think about less intensive levels that might be out of the person's home. For example, Sweetser has peer supervised crisis beds. <p>*A possible agenda item for January is having hospitals looking at their data and their use of crisis and observation beds.</p>
XII. Statewide Policy Council	<p>Don reviewed the tasks of the Statewide Policy Council, listed under Tab 5 in the reference binder. He explained that the process originally outlined to fill this council had grown to include more categories, producing an unworkable number of representatives (49, plus staff). He asked the group for their suggestions on how to achieve a more reasonable number, noting that all the CSNs will make suggestions for OAMHS consideration. He also stated that the timeline for convening the council has been pushed back to March.</p> <p><u>Group recommendation:</u> There should be two representatives for this council. If there is something on the agenda that involves a specialty topic, the CSN can look at methods of having other members participate or provide feedback. Meeting quarterly would be better than monthly. Having the option of sometimes participating by ITV would be helpful.</p> <p><u>Comments:</u> All members can't be providers. People from the Alliance for the mentally ill are missing here.</p> <p>Time will be allocated on the January agenda for the CSN members to choose their representatives.</p>
XIII. Ongoing Meeting Schedule	<p>Darren reported that the next meeting will be held on January 25, 2007 from 9:00-12:00at the Presque Isle Inn. We will try to offer ITV next time and this may result in a change of location. Members will be notified if there is a change in location. The group chose the fourth Thursday morning of the month from for an ongoing meeting schedule. An alternate would be the third Thursday morning of the month. The February meeting will be held on February 22nd from 9-12.</p> <p><u>Comment:</u> At some point the group would like to look at whether or not they need to meet for three hours.</p>
XIV. Agenda for January Meeting	<ul style="list-style-type: none"> • Procedure and Protocols for Inpatient Admissions • Rapid Response and Crisis Plans • Representation to Statewide Policy Council • Crisis Stabilization/Observation

