

**Community Service Network 2 Meeting – Hancock, Washington, Penobscot, Piscataquis Counties
Dorothea Dix Psychiatric Center, Bangor
November 14, 2006**

Minutes

Present: Robert Miller-Tinch, Together Place; John A. Edwards, WCPA; Kay Carter, CHCS; Joe Pickering, Patsy Murphy, Mary Haynes, Thomas Lynn, CHCS; Lydia Richard, AIN; Annette Adams, Acadia Hospital; Jeremy Ashfield, Families United; Robert Mathien, Maine Mental Health Connections; Sharon Greenleaf, Chuck Tingley, NOE; Betty Foley, Judith Provencher, MCD; Bambi Magaw, Community Mediation Services; Marjone Snyder, Mary Louise McEwen, Dorothea Dix; Richard Brown, Mary Dunn, Charlie Clemons, Patricia Kelleher, Charlotte White Center; Jean Gallant, ESM; David McClusky, Community Care; Cassandra Redwine, Phoenix Mental Health; Kathy Smith, OHI; Jennifer Weaver, Bangor Counseling Center; Leah Ruffin (for Jacqueline Dodge), Susan Buck, Fellowship Health Resources; Nancy Patterson, MDI Behavioral Health Care; Sharon Dean, Sunrise Opportunities. Presenters from OAMHS: Ron Welch, Leticia Huttman, Don Chamberlain, Marya Faust, Darren Morgan. Muskie School: Sherrie Winton, 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 most questions should be posed after 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). PowerPoint presentation (see website to view)</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>	
	<p>A. Seven Community Service Networks.</p>	<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.

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		<ul style="list-style-type: none"> ‣ 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. Assure continuity of treatment during hospitalization and the full protection of a client’s right to due process. ‣ 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. ‣ 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. <p>Ron stated that this involves costs not covered by Medicaid and that are the burden of DHHS.</p>
	<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. • 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 <p><u>Community Support Services:</u></p> <ul style="list-style-type: none"> ‣ Each consumer will have CSW to coordinate ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. Ron stated that this is language from the Consent Decree Plan. ‣ 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. <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. ‣ Ron stated that during non-business hours, crisis service is responsible, unless consumer is enrolled in ACT. By definition, ACT is responsible 24/7. ‣ In the 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.”

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		<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. › 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>Ron mentioned that the three levels are not locked in stone. The Plan includes provisions for certain exceptions to this referral process, some of which may require OAMHS involvement.</p>
	<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 mentioned that 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 explained, 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.

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		<ul style="list-style-type: none"> • 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.
	Vocational Services	<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. • 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.
III. Consumer Council and Consumer and Family Representation	<p>Leticia Huttman, Director of the Office of Consumer Affairs, presented this portion of the program.</p> <p>Development of Statewide Consumer Council System</p> <p>Leticia 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 • August 2007 – 7 Local Consumer Councils formed <p>The TPG has hired outreach workers, whose work will include getting people involved and excited. 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>	

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	<p>Functions of Local Consumer Councils:</p> <ul style="list-style-type: none"> • Have a role in meaningful quality assessments Leticia 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. 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 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 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>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.

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	<p>State-Wide Policy Council 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 • 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. • 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

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	<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. • Plan based on data and consumer outcomes. Planning should be focused on overall data, not just one case. • 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 mentioned that OAMHS is asking the Attorney General for clarification of confidentiality issues involved in this. <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>Question: Will the MOU be signed individually or as a general agreement? Answer: Each individual participant will sign. It will be one per organization, or one per consumer, or one per peer center. Each individual that signs is committing to the work of the CSN.</p> <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).

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	<ul style="list-style-type: none"> • 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> <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.

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<p>V. Consent Decree Standards: Indicators for Performance</p>	<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 12 categories. • 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.) • 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. • 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</p>

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	<p>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 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>Questions and Answers</p>	<p>Most of members' questions were asked at the conclusion of the entire presentation, as follows:</p> <p>Answer: Ron referenced a question that had been asked earlier about the flexibility of a referral process between different psych units. He identified page 27 in the notebook under unusual circumstances. He noted that there are clearly instances when people might go directly to a state hospital or a specialty hospital, but there has been an attempt to build flexibility in there. The language can't be changed but if it is discovered that something is not working, it needs to be documented through the Q and A system so that it can be brought back to the court master.</p> <p>Question: Is it your intent that all referrals to hospitals come through the specialty hospitals?</p> <p>Answer: Typically they would.</p> <p>Question: Don't they have to be screened through the specialty hospital?</p> <p>Answer: Yes.</p> <p>Question: I'm speaking of the situation that talks about how individuals go from the community hospital to Dorothea Dix, bypassing the specialty hospital. Is it covered if they can bypass the specialty hospital in certain circumstances?</p> <p>Answer: We're expecting some kind of review with specialty hospitals. I think that should be considered under point 2 (Specialty Hospitals, p. 26 in section 1 of the notebook). A consumer's documented history should be considered. If someone would not benefit from Acadia, then the next referral up would be Dorothea Dix. But the discussion still needs to go through Acadia.</p>

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	<p>Question: So if it appears that this person is appropriate for Dorothea Dix, you're adding an additional step that the crisis team needs to consult with specialty hospital.</p> <p>Answer: The Specialty hospital would say go to Dorothea Dix or if you disagree with this, you can call the office....</p> <p>Question: This adds additional steps and Acadia is going to be very busy. This adds an additional layer for the crisis team. I don't know how that enhances continuity of care.</p> <p>Answer: It might be appropriate that the CSN takes a look at this.</p> <p>Question: Under unusual circumstances, it states that an individual should be transferred to a hospital closest to consumer's community. What happens when all beds are filled?</p> <p>Answer: For instance, someone from E. Millinocket is not going to go down to Spring Harbor when there is an open bed here.</p> <p>Question: I'm not talking about state hospitals, but when Acadia has all beds filled what happens?</p> <p>Answer: At that point we need to consider Dorothea Dix as an option.</p> <p>Question: For appropriate patients, it's supposed to flow... we're struggling with how you assure there are beds in the right places at the right time.</p> <p>Answer: When you look at budgeting you see funding available for special populations like the backdoor population, such as a person with MH/MR and behavioral problems or physical health issues.</p> <p>Question: I want to put on the table the issue of confidentiality. There are a lot of implications. It brings in HIPAA, rights of recipients... when is it appropriate to share information?</p> <p>Answer: We've asked for clarification from the Attorney General's office. It could be an issue but we want to know where it needs to be fixed, if it does need to be fixed. We hear different perspectives about that very issue. We recognize we should have a system wide agreement.</p> <p>Question: There is legislation that has been proposed to identify....</p> <p>Answer: Section number 8 there is a draft.</p> <p>Question: Who is involved in putting that draft together? It hasn't been addressed in the past. Most often it is that we ask the attorney general an opinion, we go screaming in different directions and we wish legislation was brought forth for clarification. Thank you for providing this clarification. I understand how fraught with problems it is, but in order for us to do this, these issues have to be addressed. HIPAA makes it more complicated, but not dealing with it would make this whole plan impossible. Thank you. Also when proposing legislation, include licensing boards for the clinical staff and people who run programs. What we bring to legislation has to address licensing boards and those kinds of things.</p> <p>Answer: Good recommendation. The draft includes what current law is. It is natural to get input.</p> <p>Question: We don't want to be at odds with our clinical licensing boards</p> <p>Answer: It's a three phase process: 1) Making sure the consumer is informed about what is being requested and sharing benefits of continuity of care. 2) The legislation 3) Clarification of existing policy.</p> <p>Question/Comment: Not just state law, but HIPAA-- we need some consultation on that issue, as it is very complex.</p> <p>Question: Have we heard from the other hospitals?</p> <p>Answer: We'll be following up with who was here and who wasn't and contacting them. Hospitals will be asked by Medicaid to re-negotiate. Those that don't have psych units especially want the opportunity to interface with the community because they don't have resources and supports.</p> <p>Question: What about community hospitals. Can the consumer bypass it?</p> <p>Answer: Yes. The goal is keep people home. The thought process is: How do you provide services effectively in their communities, recognizing there are some exceptions? The thrust is about serving the population of who live in our geographic area the best possible way. We go to the next levels if critically necessary. For example, if someone was sexually assaulted in a hospital, that would be a reason not to make them go back there. It may mean looking at why place "A" can't take people and what do we do in our local system to ensure more availability.</p> <p>Question: Don said the CSW is the cornerstone. If the CSW is the cornerstone of the system, what needs to change is a fundamental</p>

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	<p>change by the state. We need to change reimbursement from unit by unit to a monthly rate. If we're talking about continuity of care and flexibility you can't achieve it by unit by unit. The CSW is also doing a lot of other stuff that isn't reimbursed and this needs to be looked at.</p> <p>Answer: The CSW is crucially important. This came up yesterday about the additional burdens on CSW and they are real. It's fair to say that we need to re-examine the billing process for CSWs. We talked about doing a functional analysis—looking at how much can we expect from a CSW, as well as look at salary and reasonable caseload.</p> <p>Question: I want to stress if you don't change unit by unit reimbursement, it won't work, it's going to be too fragmented.</p> <p>Question: What organizations...who is included in the CSN and who is not included, and why? State hospitals are in and is intensive case management in?</p> <p>Answer: Darren is always here and always chaired by OAMHS</p> <p>Question: So they're in?</p> <p>Answer: We're in.</p> <p>Question: The rules are the same for all? Are the QFCs out? If you're going to have continuity of care, you've got to have all of the programs in and intensive case management services.</p> <p>Answer: It's a program that is represented at the table. You might want to review the list.</p> <p>Question: Under public law 2005, everybody was in the first two years except the state operated hospitals.</p> <p>Question: How is this going to interface with managed care? Another question is: children who are 18 years old, 19, 20 years old-- how does that relate? The state is calling for a whole range of things, 24/7, no reject, and most of these are unfunded mandates. You need to take a look at how you're going to pay for this and the method that you pay or it won't work. My last comment, and this goes broader than HIPAA, there are all kinds of state laws and regulations that say you have to do the best you can for the organization, then there are licensing requirements, and this has to be considered for the CSN.</p> <p>Question: Does the CSN have legal standing? Who gets sued?</p> <p>Answer: Start at the bottom; Your vulnerability, as I see it, would come through violation of the contract. You're not a defendant, we are. But the rules are such in this plan that we can't contract with people who can't play by these rules. That's the reality of it. We don't think that this is a bad plan.</p> <p>Question: The most intelligent thing to do is to ask intelligent questions to improve.</p> <p>Answer: We're giving you a lot of information today asking you to move toward the examples that we gave mostly because of the timeframe. Then as you become more comfortable and see need for change, you can then get into the tweaking.</p> <p>Question: Since this is based on the AMHI consent decree, how vulnerable are they to the overall governing? Are we guilty of also violating the AMHI agreement because we are brought on?</p> <p>Answer: You are not defendants. We ended up with a plan that was negotiated with the court master and the plaintiffs. Participation in this network is a function of contract. It's what you agree to do by accepting money from the state. Now these conditions are part of the contract.</p> <p>Question: Given the timeframes, is there a way that we can talk via e-mail? Could we send suggestions to everyone? Each agency representative could have a vote if the regular rep is out of town. I would want my agency to represent me when I'm not there.</p> <p>Answer: Muskie could send back e-mails suggestions to each agency so that everyone gets that information.</p> <p>Question: You talked about revision of section 17. Is there a projection of that, where is that?</p> <p>Answer: There will be five providers, consumers, staff from offices and a representative from MaineCare. Our target date is to come forward with what needs to change by Feb 07. The providers are: Nancy Ives, Charlie Zeph, Ed Blanchard, Ingraham and Kennebec Valley. We want to keep the process moving, to make decisions, and move forward but we also want to let people comment and provide input on things. We're trying to set up a website for CSN where you can look at minutes and as we start to draft material, that might be the place we end up posting it.</p> <p>Question: While looking at feedback of the MOU and protocols, I heard flexibility there. It would be helpful if you or Muskie could send information of the draft MOU and protocol, and identify these things that are cast in stone and these things that are not. Or is it all open?</p> <p>Answer: My perspective is that what is cast in stone is one representative from each organization and one vote. We did not want to get</p>

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	<p>into a lengthy discussion about bi-laws. We wanted guidelines with guiding principles but most are open.</p> <p>Answer: If by a certain date there is not consensus on an item then the department imposes a model to get it rolling.</p> <p>Question: You just talked about Section 17...</p> <p>Answer: The barrier that I've run into when you're trying to provide wraparound without PNMI, it's different with how much community support you can get away with. We need to make some changes. We're opening up section 17, it has to change.</p> <p>Question: Probably you want more than just housing people on there. When you did it with section 65, a lot got pushed through without people knowing it until too late. I'd like to be on the committee too. You do stuff that people don't know about, then it's too late.</p> <p>Answer: I appreciate it (your participation on the committee)</p> <p>Answer: Everything is going to come back to you as a CSN, before it goes anywhere.</p> <p>Question: The more input you get early on...if Feb is a target date then there is a lot of work to be done quickly that you don't want to have to redo.</p> <p>Answer: Communicate with me (Don Chamberlain) with what needs to be done. E-mail me.</p> <p>Question: Would it make sense to have a member from each CSN there (on the committee)?</p> <p>Answer: I think that's reasonable. We'd have to be sure that each CSN is covered.</p> <p>Question: In that section you have a lot more to address than just housing.</p> <p>Question: My recommendation is that one representative from each CSN bring the information forward.</p> <p>Question: You're going to discuss the PNMI with housing and you'll have reps for this but section 17 is much broader. These other issues would need to be addressed.</p> <p>Question: If that's the case, we understood that it was about that small part of the consent decree of how housing is going to be delivered. All of us have had concerns about resources, how services are delivered. If this team is about section 17 and looking at issues that aren't fully explored, maybe we need a different team?</p> <p>Answer: Let's take that into consideration. Maybe there could be two teams...one is housing and how section 17 operates but in that process you may not be able to address other issues. Maybe broader issues could be addressed separately. We just don't want to lose the focus of housing.</p> <p>Question: In one presentation, there was a listing of the role of the CSW. What struck me is that it was such an incomplete list. We have to have a place to look at that dialogue. Section 17: skill teaching and problem solving support wasn't in there..what's actually happening in the field.</p> <p>Answer: I like Don's idea of—let's see how the housing goes with the clear understanding that we need to look at section 17 more broadly.</p> <p>Question: How it's funded and what we ask of the CSWs, I can't emphasize enough that we're constantly working with our CSWS and letting them know that we understand that there is a lot more being put on them and we have a workforce looking at this, and that we plan to address it proactively.</p> <p>Question: It's very important in terms of timing. That is such a critically important piece and section 17 is such a critical piece. The Department has to make a serious commitment to solving critical pieces.</p> <p>Comment: The timing of this discussion and the building of the CSNs is exciting. Having someone from the CSN, utilizing the process of using them to give feedback, what a great way to see how they work.</p> <p>Question: What is the communication process? There have been a lot of concerns expressed. What about communicating with us the follow up to the concerns so that we are kept in the loop?</p> <p>Answer: In the presentation we talked about a work plan for the CSN, we should have a similar product for other issues. So we are tracking progress, timeframes, issues that are being addressed.</p> <p>Question: It's nice to know that there is a tracking piece.</p> <p>Answer: We expect to capture them in the minutes to see if there is a response to that.</p> <p>Question: When will we get the minutes?</p> <p>Answer: Muskie is hoping before the Thanksgiving holiday</p>

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	<p>Question: Are we going to get everyone's e-mail address?</p> <p>Answer: Yes not the attendees, but the designees.</p> <p>Answer: There needs to be clarification from members who send suggestions to me (Elaine Ecker at Muskie). I need to know who the designee is.</p>
VI. Parking Lot Items	<ul style="list-style-type: none"> • Referral Process to Psychiatric Admission • Confidentiality Issues • Interface with Managed Care • Youth in Transition Issues • Section 17 Changes
VII. Next Steps	<ul style="list-style-type: none"> • OAMHS and Muskie is gathering material here from every discussion and will come together with all input. • In December: MOU and Operational Protocols will be explored. • For this particular CSN, it might be useful to add section 17 to the conversation.
VIII. Agenda for December Meeting	<ul style="list-style-type: none"> • MOU • Operational Protocols • Service Matrix – Mapping • Ongoing schedule of meetings