

**Community Service Network 2 Meeting
Dorothea Dix, Bangor, Maine
December 12, 2006**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Annette Adams, Acadia Hospital • Lydia Wright-Richard, AIN • Debra Henderlong, Allies Inc. • Dr. Alston Oliver, Bangor Counseling Center • Amy Dobson, Blue Hill Memorial Hospital • Tammy Smith, Care & Comfort • Joe Pound, Charlotte White • Charlie Clemons, Charlotte White | <ul style="list-style-type: none"> • David McCluskey, Community Care • Kay Carter, CHCS • Bambi Magaw, Community Mediation Services • Mary Louise McEwen, Dorothea Dix • Mary Wergyzn, Families United • Jacquelyn Dodge, Fellowship Health Resources • Robert Mathien, MMHC • Nancy Patterson, MDI Behavioral Health Care • Betty Foley, Medical Care Development | <ul style="list-style-type: none"> • Sharon Greenleaf, NOE • Charles Tingley, NOE • Penelope Kneeland, Penobscot Valley Hospital • Kathy Smith, OHI • Cassandra Redwine, Phoenix MH Services • Sharon Dean, Sunrise Opportunities • Donna Ruble, Sweetser/Protea • Dr. Robert Miller-Tinch, Together Place • John Edwards, WCPA |
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Members Absent:

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| <ul style="list-style-type: none"> • Amicus • CA Dean Memorial Hospital • Calais Regional Hospital • Down East Community Hospital • EMMC | <ul style="list-style-type: none"> • Kidspeace • Maine Coast Memorial Hospital • Maine Vocational Associates, Inc. • Mayo Regional Hospital | <ul style="list-style-type: none"> • Millinocket Regional Hospital • NFI North Inc. • Regional Medical Center at Lubec • St. Joseph Hospital |
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Others Present:

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| <ul style="list-style-type: none"> • Mary Dunn, Charlotte White • Joe Pickering, CHCS | <ul style="list-style-type: none"> • Tom Lynn, CHCS • Nichole Proulx-King, Families United | <ul style="list-style-type: none"> • Mary Haynes, CHCS • Pamela Easton, DHHS |
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Staff Present: DHHS/OAMHS: Ron Welch, Don Chamberlain, Marya Faust, Leticia Huttman, Darren Morgan. Muskie School: Elaine Ecker, Sherrie Winton.

Agenda Item	Presentation and Discussion
I. Welcome and Introductions	Darren 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. A few concerns were brought up, relating to members not being able to attend the CSN due to significant issues that may arise, as well as needing to turn cell phones off during meetings and as a result, missing important calls, etc. Darren explained that some of these issues are rules of the group and what their expectations are and that some of the attendance and alternate issues will fit into the discussion around the operational protocols and the MOU.
III. Contract Amendments and Provider Agreements	All contract amendments for OAMHS providers are in acceptance, none are outstanding for this region. There are provider amendments agreements for Maine Care hospitals. OAMHS will be tallying them to see if they gotten them from all of the hospitals.
IV. Memorandum of Understanding	Ron Welch led the discussion on proposed revisions to the draft Memorandum of Understanding (MOU) and Operational Protocols (OP). He explained that the preferred process for the group to make recommendations for changes would be by making and seconding motions, discussing, and voting. He 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.

Agenda Item	Presentation and Discussion
	<p>The following issues were clarified:</p> <ul style="list-style-type: none"> • The CSN would be focusing on those who are section 17 eligible, with the exception of crisis and peer services. • A three-page document (Attachment A to these minutes) of provider concerns was addressed and it led to the following summary of discussions: • When a concern was brought up about how the CSN could operate and reach goals without a legal system, the role of the CSN was clarified and differentiated from the LSNs in the way that the CSN is a creature of the court, it's staffed and chaired by state government, and the decision making and recommendations about the quality of resources and distribution of services is predicated on data. Additional clarification about the role of the CSN includes the fact that it is a collaborative group and its advisory role is necessary. Specifically, in order to move in decision-making the CSN must provide advice. <p>*It was recommended that an attorney general get involved so that the CSN can be made aware of legal issues.</p> <p>These additional issues were clarified/addressed:</p> <ul style="list-style-type: none"> • OAMHS is not moving away from the complaint and grievance process that is currently being used to support rights of recipients. Instead, they are hoping to raise awareness that this service is available and to clarify and build upon that process. • Managed care will link to this work but it is presently unclear as to exactly how this process will look. • Statutory clarification on confidentiality and what the CSN can and can't do was requested. OAMHS is checking into this. In addition, OAMHS envisions that CSNs will identify an approach of how to share information across boundaries always predicated on consumer approval. • A recommendation was made to distribute the agenda to members two weeks ahead of time and to put in writing that the CSN will not be asked to vote on something without seeing it a month in advance. • A suggestion was made that the minutes should be approved by the CSN. • Follow up Suggestion: Contact Dr. Douglass Jennings, Mill House Lawyer
V. Operational Protocols	<p>Representation: The group agreed that 3A (on the provider comments, Attachment A) accurately captured what they are looking for. Specifically, "that provision be made for a designated alternate, with voting privileges, for when the designated primary representative for an agency is not available."</p> <p>The group voted that the three pages of documented provider concerns be made for recommendation to be considered in the final both the MOU and 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

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	<ul style="list-style-type: none"> • 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 who are also struggling with complex medical issues. It was 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> Marya distributed a report showing the number in each CSN with unmet needs. The two sheets show that 741 clients have 1870 unmet needs in the Hancock/Washington/Penobscot/Piscataquis area. 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, and that the more pieces that are put together, the better the picture of unmet needs will be for the area.</p> <p><u>Comments/Concerns:</u></p> <ul style="list-style-type: none"> • It may be important to explore whether or not this area is considering unmet needs differently than other areas, whether or not individuals are getting their needs met somewhere else, and whether or not people are aware of resources and services in the area that can be accessed to meet unmet needs. • It was stressed that part of the CSN is to look at this in a more data-driven way and to look at where we need to break out of the box, where we need more resources, and how to use data to be more strategic about where we're going.
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></p>

Agenda Item	Presentation and Discussion
	<p>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> <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.</p> <p><u>Comment:</u></p> <ul style="list-style-type: none"> • This issue can be considered from an individual or systems perspective, and it needs to be looked at closely. For instance, it's important to look at the role of the individuals on ACT teams and what responsibilities they have been funded to perform.
VIII. Role of Consumers in Licensing	<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>

Agenda Item	Presentation and Discussion
	<p><u>Comments:</u></p> <ul style="list-style-type: none"> Peers should be part of the licensing team and not viewed as a separate entity. It's a learning process for the team, the agency, and the consumer. It may be helpful to blend the team and have 2-3 consumers so that there is a cross fertilization of ideas. It would be helpful for providers to be prepped beforehand on how the model is designed, so that they can learn what to expect and get some of their questions answered about how this will work.
IX. Housing and Support Services Workgroup Update	<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>
X. Contract Compliance Template	<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>Contract review meetings with providers in Region III are set for February 1 and 2. Time slots are set, but providers may arrange between themselves to trade times, as long as they identify Darren Morgan of any changes to the original schedule.</p>
XI. Beds: Crisis Stabilization/Observation	<p>Don opened a discussion about crisis stabilization beds and observation beds: 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 an access in addition to crisis beds?</p>
XII. Statewide Policy Council	<p>Ron 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>Recommendation:</u> One person could be the delegation lead and that person would be as consistent as possible. Other people from the CSN could participate based on interest in and the relevance of scheduled agenda item topics. The regular representative would be responsible for getting the right person there, based on upcoming pertinent discussions.</p>
XIII. Ongoing Meeting Schedule	<p>The next meeting will be held January 24th from 9-12. For a regular meeting date, the group chose the second Tuesday of the month in afternoon from 1-4 pm. This schedule will start in February: The back up date is the second Tuesday of the month in the morning.</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 Beds/Observation Beds

Attachment A

Community Service Network
MOU and Protocols
Comments from Providers

As DHHS OAMHS and the community work together to achieve the goals of the Consent Decree Plan and to form the Community Service Networks, some foundational issues need to be addressed. This paper is written to frame the areas of concern as written in the draft Memorandum of Understanding and the draft protocols. It is hoped that through a full exploration of these issues and a commitment of the resolutions to writing as part of the MOU and protocols, the CSNs in Region III will be established in a way which assures their success.

Issues to address:

1) **Institutionally, what is a Community Service Network? Is it a legal entity? What is the liability of members of the CSN?**

Deleted:

- a) The **authority and responsibility of the CSN appear to be mis-aligned**. Questions related to this include
 - i) **What is the Authority of the CSN to direct its member entities?** It appears that the CSN is only advisory to DHHS OAMHS and has no real authority to direct any member towards any end, service delivery, service design, expenditure of resources, etc.
 - ii) **What is the responsibility of the CSN and its member agencies to assure the provision of services to individuals within the geographic area?** This is related to the no-reject language in the MOU. In signing the MOU, as written, all provider organizations agree to a no-reject policy. This does not take into account issues such as resources needed to deliver the service (financial and staffing), provider competency, program availability and capacity, safety and liability issues, etc. We recognize that the Department has developed and distributed a letter of clarification about this issue (11/15/06 from Ronald Welch to Providers in the Community Service Networks). We suggest that there be two changes. First that issues which go to contract compliance be those based on the provider's demonstrated "unwillingness" versus the currently stated "inability" to provide contracted service, and second, that there be an exploration first to itemize the barriers to providing the service and the possible solutions which would make it possible for the services to be provided.
 - iii) **When taken together** – i.e. a CSN with no real authority or ability to carry out its responsibility, it appears that the full responsibility of achieving the goals of the CSN lie with the individual and separate providers. There is no structure with the ability to bring about the goals of the CSN. This raises questions of accountability for system outcomes. What is the Department's vision of how the CSN can/will handle accountability? How will this pertain when an individual is not enrolled in the system yet? What will prevent people from falling through the cracks? Does the Department imagine a case review function at the CSN level? If so, what is your vision of how it will operate?
 - iv) **Multiple dual roles exist among the membership of the CSN** – e.g. provider/overseers of services; contractor/contractee; advisor/authority; auditor/auditee, etc. What are the Department's thoughts about how these dual relationships will be handled within the CSN?

Section 17. These are two significantly different statements and need to be clarified within the MOU and protocols

- c) **How does the Department see the CSN and the proposed management of care system working together?**
- 2) **Confidentiality and release of information when authorization from the consumer is not available** – Efforts have been made and will continue to be made to assure that there are appropriate releases of information for the sharing of personal health information between providers. However there are some situations in which the Release will not be available. This issue must be fully resolved, with agreement from - and compliance with - HIPAA, professional licensing boards, rights of recipients, licensing, etc.
- 3) **Membership and attendance at the CSN** – Tying attendance at CSN meetings by a single specific person from an agency to contract compliance is unrealistic. The provider members strongly urge the following:
 - a) That provision be made for a designated alternate, with voting privileges, for when the designated primary representative for an agency is not available, and
 - b) That if a) above is incorporated that the tie between contract compliance and attendance at meetings be retained, but if a) is not incorporated than we suggest that non-participation in the CSN be considered more broadly and be defined in real terms and not limited to attendance only as now proposed or defined.
 - c) Any agenda item requiring action by the CSN needs to be distributed to CSN members, with appropriate background material, at least two weeks ahead of the meeting so that members can review at the appropriate level within their organization.
 - d) Who sets the agenda for the CSN? Can items be added to a CSN meeting agenda? By whom and how? Who ratifies the minutes of the CSN?
- 4) **Unfunded Mandates** – The MOU and protocols contain several unfunded new mandates which need to be addressed. These include:
 - a) **The cost of 24/7 record availability** – this cost varies by provider, depending on the provider’s current records system and on-call options.
 - b) **No Reject policy** – This has a significant fiscal component which needs to be addressed. How will services to un-insured or underinsured be covered, especially as it pertains to the provisions of the Consent Decree?
 - c) **Training time and cost for staff** – This is in terms of both staff salary and missed productivity.
 - d) **With increased administrative responsibility for the community support worker as well as other mental health professionals, the structure of MaineCare reimbursement needs to be reviewed and revised so that it is more in line with the requirements of the positions.**
 - e) **Participation in all aspects of the CSN, including among other things personnel time and data requirements, will be costly.** How will this be addressed?
- 5) In this time of change in the service delivery system, the **breach of contract** language needs to be modified in two ways:

- 7) The goals of the CSN include continuity of care for recipients of services, efficiency, effectiveness, and outcomes. For this to be achieved, all providers which impact the system need to be part of the process. This includes Community Health Centers, Federally Qualified Health Centers, private practice providers and non-contract providers, as well as all components of the state service delivery system.
- 8) Is the Department thinking that client complaints and grievances will be handled in any different manner than established under Rights of Recipients of Mental Health Services? If so, please explain. What is the role of the Mediation Service in the CSN?
- 9) Reference has been made to a Statewide Policy Committee. What is the role of this group? It's authority and responsibility? Selection and terms of office of the members? Expectation as to constituency representation from the local level?