

**Community Service Network 2 Meeting
Dorothea Dix, Bangor, Maine
March 13, 2007**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Annette Adams, Acadia Hospital • Melinda Davis, AIN • Theresa Oliver, Bangor Counseling Center • Tammy Smith, Care & Comfort • Richard Brown, Charlotte White • David McCluskey, Community Care • Kay Carter, CHCS • Bambi Magaw, Community Mediation Services | <ul style="list-style-type: none"> • Marjorie Snyder, Dorothea Dix • Jacquelyn Dodge, Fellowship Health Resources • Robert Mathien, MMHC • John Spieker, Mayo Regional Hospital • Betty Foley, Medical Care Development • Scott Dufour, NFI North • Charles Tingley, NOE | <ul style="list-style-type: none"> • Kathy Smith, OHI • Michael Corbin, Penobscot Valley Hospital • Cassandra Redwine, Phoenix MH Services • Sharon Dean, Sunrise Opportunities • Sharon Tomah, Sweetser/Wabanaki • Lydia Wright-Richard, TPG • Corey Schwinn, WCPA |
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Members Absent:

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| <ul style="list-style-type: none"> • Allies Inc. • Amicus • Behavioral Health Center • Blue Hill Memorial Hospital (excused) • CA Dean Memorial Hospital | <ul style="list-style-type: none"> • Calais Regional Hospital • Down East Community Hospital • Families United • Maine Coast Memorial Hospital • Maine Vocational Associates, Inc. | <ul style="list-style-type: none"> • MDI Behavioral Health Care (excused) • Joanne Marian, NAMI-ME Families • Regional Medical Center at Lubec • St. Joseph Hospital • Together Place |
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Alternates/Others Present:

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| <ul style="list-style-type: none"> • Melanie Sachs, Beacon Health Strategies • Victoria McCarty, Consumer Council System of Maine • Tom Lynn, CHCS • Joe Pickering, CHCS | <ul style="list-style-type: none"> • Sharon Sprague, DHHS • Annamaria Labutti, Fellowship Health Resources • Judy Provencher, Medical Care Development | <ul style="list-style-type: none"> • Sharon Greenleaf, NOE • Cindy Fagan, Sweetser • Trish Niedorowski, Wings |
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Staff Present: DHHS/OAMHS: Don Chamberlain, Darren Morgan. Muskie School: Elaine Ecker.

| Agenda Item | Presentation, Discussion |
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| I. Welcome and Introductions | Darren opened the meeting and participants introduced themselves. |
| II. Review and Approval of Minutes | <p>The minutes were approved after requesting the following changes:</p> <ul style="list-style-type: none"> • Add Richard Brown, Charlotte White, to members present. • In Section V: SUFU (<i>Speaking up for Us</i>). • Add under Peer Services: Wabanaki/Sweetser member requested consideration of developing more culturally responsive/appropriate peer services and social activities. • In Agenda Item VIII: Revise the bullet list to indicate which are formal recommendations/position statements and which are concerns/comments, as follows: <p style="margin-left: 20px;"><i>Concerns:</i></p> <ul style="list-style-type: none"> • <i>This plan seems to be realigning crisis services in very strategic ways and does not take into consideration other undertakings in the region or studies that have been completed—concerned that collective expertise is not utilized.</i> • <i>Strategic Focus #1: Significant concern about this process—example of excluding community-based crisis</i> |

| Agenda Item | Presentation, Discussion |
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| | <p><i>teams.</i></p> <ul style="list-style-type: none"> • <i>Should have been more collaborative process, including wide public input.</i> • <i>Need multiple meetings to cover concerns of all stakeholder groups and also need thorough presentation of what this really means.</i> <p><i>Formal CSN recommendations/position statements:</i></p> <ul style="list-style-type: none"> • <i>Forums not adequately publicized—also conflicted with other hearings.</i> • <i>Re: Statement of Guiding Philosophy (first page of draft report): Should be completed by CSNs rather than small group that worked on the Plan. “Shared vision of consumer recovery” needs discussion in a group process beyond minimal input available at public forums.</i> • <i>Strategic Focus #3: Recommend that CSNs 1 and 2 accomplish implementation and completion of needs assessment.</i> • <i>Stakeholder associations should have been part of process.</i> • <i>MR/DD Association needs to be involved—ramifications for them, too.</i> • <i>Missing: Providers not listed as stakeholders.</i> • <i>Want to see “recovery principles” spelled out. Consumers unclear on what admission criteria will be—concerned too narrow. Very concerned about lack of publicity.</i> |
| <p>III. Crisis Services/Crisis Stabilization Units</p> | <p>Crisis Stabilization Units Don reported that OAMHS is anxious to make progress on this service in Washington County, and mentioned In-Home Crisis Supports as a possible way to meet the needs in outlying areas. Sunrise Opportunities and WCPA are working together to develop a viable proposal to address to this challenging situation. OAMHS has approved the addition of 2 CSU beds in Washington/Hancock and would prefer getting something underway this year, if possible.</p> <p>Crisis Services</p> <p><u>WCPA</u></p> <ul style="list-style-type: none"> • 19 years operating hotline for all four counties, physically located in Washington County. • Land-line PHONE HELP calls originating in any of the four counties are routed to WCPA. • If face-to-face contact is needed, hotline contacts appropriate crisis team: CHCS--Penobscot, Piscataquis; WCPA—Washington, Hancock. • If crisis bed is needed, crisis team contacts the CHCS CSU. • Hotline staff have minimum of MHRT/C qualification. • Based in Machias and Ellsworth, evening/overnight respond from home. • Average response time: 45 min. <p><u>CHCS</u></p> <ul style="list-style-type: none"> • If cannot be resolved over the phone, face to face arranged: approximately 1/3 in ER, 1/3 in homes, and 1/3 in other places—crisis offices or other provider offices. • Supply 24/7psychiatric telephone consultation. • Offices in Lincoln, Bangor, Dover, Ellsworth, Machias. • Local warmline, one part-time paid staff, volunteers. • Staff work from Dover or Bangor offices, or their present location. |

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| | <p><u>NOE</u></p> <ul style="list-style-type: none"> • Operate their own 24/7 crisis line, in keeping with their “quick access policy.” • Resolve crisis over the phone, if possible. Psychiatric back-up available. • 70% of calls are not crisis, rather people asking for services. • Problem-solve over the phone, and arrange to see for service by the next day, if at all possible. • Goal is to keep clients out of ERs or inpatient. <p><u>Acadia Consult Service</u> (not State-funded)</p> <ul style="list-style-type: none"> • St. Joseph’s Hospital and EMMC contract for consultation services in their ERs and inpatient. • Do fair amount of crisis and disposition. • Inpatient consults mainly geriatric, dementia, brain injury. • Purely consultation role: give recommendations to physicians. • Facilitate/present clinical case for admission to hospital or CSU (agreement with CHCS CSU). <p>Members reviewed the Crisis Services Performance Indicator data for 2006 and discussed various aspects of crisis services:</p> <ul style="list-style-type: none"> • Comparing numbers across the state can be challenging unless structure of local crisis system is known (e.g. rerouted calls may be counted twice). • During the day, the preferred person to contact in crisis is the CSW, then secondarily crisis. • People with CSWs should have a crisis plan. OAMHS concern with low numbers with crisis plan compared to numbers with case managers. • There are a number of clients who decline to make a crisis plan. • The wide range of percentages statewide raises concern that the categories are not clearly understood/classified. • Crisis standards look at response time from call to face-to-face, not time to complete assessment. • Don stated that the standard to work toward is 30-minute average response time and asked the members to consider what is needed to accomplish it? Staff? Funds? • A hospital provider asked for clarification on determining time between call and assessment, when person in ER can’t be cleared medically sometimes for hours because of inebriation, for example, and can’t be assessed until sober. Don said the time begins when person is ready for assessment. • Is goal to keep all out of the ER? Most appear to need to be there. • Hospital member stated that if first time in crisis in rural area, ER is appropriate place for them. Careful how message is conveyed re: reducing ER visits. • Parts of the system encourage people to call 911, go to ER. • If consumers want to see Acadia’s people, they will go to EMMC ER. • Don said that OAMHS doesn’t have the position that no one should go to ER. • Member stated that crisis standards clearly say that ER visits need to decrease. Mobile crisis units have qualified clinicians with ability to assess whether person needs to go to the ER. • Don said from OAMHS perspective this CSN doesn’t need another crisis service. • Need to look at snapshot today and then look at what happens after all the changes in the budget—how impact of impending changes in community services will affect future crisis services. |

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| IV. Peer Services | <p>Melinda Davis of AIN suggested holding meetings/forums with consumers in each county to educate them about the possibilities and to ask what would serve them best. Don mentioned a similar effort in CSN 4 and asked about interest in forming a subcommittee to make plans to get input from area consumers. Bob Mathien, Lydia Richard, Melinda Davis, and Victoria McCarty volunteered.</p> <p>Members received a handout on “Peer Support 101,” a 3-hour class presented by the Office of Consumer Affairs and offered to anyone interested in learning more about peer support (also a requirement for participation in the Peer Support Specialists Certification). Several classes are scheduled for March and April (listed on handout). Providers may request a shortened 1-hour version as well.</p> |
| V. Confidentiality Statement | <p>Members requested time to comment on the draft Confidentiality Statement distributed at last month’s meeting. Comments will be given to AAG Kathy Greason for consideration in drafting the final version. Don reiterated that this document is the Department’s advisory to the best of AAG’s ability.</p> <p>Comments on Statement:</p> <ul style="list-style-type: none"> • Section on releasing to appropriate DHHS representative should say, “when acting under appropriate statutory authority.” • Verbal or written release, thinking of difficulty obtaining written release in the middle of the night. • Under release in dangerous situations, shouldn’t “can” call law enforcement be “must” call law enforcement? • Under mandatory reporting, add “neglect and exploitation” to abuse. • May be helpful to have references (statutes, etc.) listed in the paragraphs. • Under release to family caretakers, what are “procedural steps”? Spell out. • Can agencies use this document to support acting on its principles? Don: Yes, to large extent. <p>General discussion:</p> <ul style="list-style-type: none"> • Does crisis provider need release from consumer in order to request information from CSW? Yes, unless in very rare instances crisis determines person is not able to do so. • Some organizations won’t take release from other organizations even though approved by licensing and all elements are the same. Creates a barrier. • 24/7 Access: DHHS has chosen not to dictate how each agency will achieve this—“many individual solutions out there”—expect agencies to let crisis providers know who to obtain the information. • If consumer refuses to sign release, can stop process “dead in its tracks” in non-emergency situations. |
| VI. Review of Community Support Services (ACT, ICI, CI) | <p>Due to lack of time, this item will be discussed at next month’s meeting.</p> |
| VII. Budget Update | <p>No budget update at this time—in process.</p> <p>Members made a formal recommendation that OAMHS provide a “service by service” presentation on the ASO (Administrative Services Organization) RFP (Request for Proposal) at the CSN meeting following the release of the RFP. Release is expected by April 13, contract awarded by July 1, with implementation August or September, Don reported.</p> |
| VIII. Rate Standardization | <p>Members reviewed a 4-page handout containing various types of information around the rate-setting. A bar graph compared Maine’s highest and lowest Medicaid rate for various services and compared them to the average of New England states and other states. Other sheets listed various current rates, proposed rates, and differences, as well as the</p> |

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| | <p>calculation process by which rates may be determined.</p> <p>Don explained that rate standardization is driven by: 1) Maine's rates are higher than other states, and 2) desire for one rate per service, not variable by agency. Rates to-date have been driven by costs—another approach is to build budget/structure on what is expected for income.</p> <p>Comments:</p> <ul style="list-style-type: none"> • A math error affected one proposed rate by 12%. • When cuts are made and Court Master wants more, how will MOUs be renegotiated at this point? • How or will OAMHS prioritize core services if provider decides not to offer? • What is role of CSN if one of the core services “has to go by the wayside?” • Is State looking at agencies reaching fidelity when it comes to rates? For instance, if an agency isn't reaching fidelity for ACT, why are they paid for providing ACT? • No empirical analysis was done re: rates of other states. In some cases in other states, found that Medicaid rates were augmented by grants and supplemental budgets. • This is putting the whole system of service at risk. No agency at this table is “sitting on a fat black bottom line.” |
| IX. Service Gaps: Response to Court Master Concern | <p>Don reported:</p> <ul style="list-style-type: none"> • The Court Master appreciates the process and input of the CSNs, but will not allow for delay in remediation of service gaps on their account. • The Court Master is extremely interested in seeing that budget requests are based on identified needs, not on whether funds are available or approval is expected. |
| X. Other | A member gave strong caution about using acronyms—consumers can't fully participate. |
| XI. Public Comment | None. |
| XII. April Agenda Items. | <ul style="list-style-type: none"> • Community Support Services • Peer Services • Outpatient Services |