

**Community Service Network 2 Meeting  
Dorothea Dix, Bangor, Maine  
May 8, 2007**

**Approved Minutes**

**Members Present:**

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| <ul style="list-style-type: none"> <li>• Annette Adams, Acadia Hospital</li> <li>• Melinda Davis, AIN</li> <li>• Theresa Oliver, Bangor Counseling Center</li> <li>• William Donahue, Behavioral Health Center</li> <li>• Andrea McGill O'Rourke, Blue Hill Memorial Hospital</li> <li>• Tammy Smith, Care &amp; Comfort</li> <li>• Richard Brown, Charlotte White</li> <li>• David McCluskey, Community Care</li> <li>• Kay Carter, CHCS</li> </ul> | <ul style="list-style-type: none"> <li>• Bambi Magaw, Community Mediation Services</li> <li>• Mary Louise McEwen, Dorothea Dix</li> <li>• Jeremy Ashfield, Families United</li> <li>• Susan Buck, Fellowship Health Resources</li> <li>• Bob Mathien, Maine Mental Health Connections</li> <li>• John Spieker, Mayo Regional Hospital</li> <li>• Judy Provencher, Medical Care Development</li> <li>• Joanne Marian, NAMI-ME Families</li> <li>• Scott Dufour, NFI North</li> </ul> | <ul style="list-style-type: none"> <li>• Sharon Greenleaf, NOE</li> <li>• Bonnie-Jean Brooks, OHI</li> <li>• Sharon Dean, Sunrise Opportunities</li> <li>• Sharon Tomah, Sweetser/Wabanaki</li> <li>• Dr. Robert Miller-Tinch, Together Place</li> <li>• Vickie McCarty, TPG</li> <li>• Lydia Wright-Richard, TPG</li> <li>• Corey Schwinn, WCPA</li> </ul> |
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**Members Absent:**

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| <ul style="list-style-type: none"> <li>• Allies Inc.</li> <li>• Amicus</li> <li>• Care &amp; Comfort</li> <li>• CA Dean Memorial Hospital</li> <li>• Calais Regional Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• Down East Community Hospital</li> <li>• Maine Coast Memorial Hospital</li> <li>• Maine Vocational Associates, Inc.</li> <li>• MDI Behavioral Health Care</li> <li>• Phoenix MH Services (excused)</li> </ul> | <ul style="list-style-type: none"> <li>• Penobscot Valley Hospital (excused)</li> <li>• Regional Medical Center at Lubec</li> <li>• St. Joseph Hospital</li> <li>• Wings</li> </ul> |
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**Alternates/Others Present:**

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| <ul style="list-style-type: none"> <li>• Michelle St. Louis, Behavioral Health Center</li> <li>• Mary Dunn, Charlotte White</li> </ul> | <ul style="list-style-type: none"> <li>• Tom Lynn, CHCS</li> <li>• Dan Wathen, Court Master</li> </ul> | <ul style="list-style-type: none"> <li>• Jill Peters, Dirigo Counseling Clinic</li> <li>• Alan Algee, Dirigo Counseling Clinic</li> </ul> |
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**Staff Present:** DHHS/OAMHS: Don Chamberlain, Chris Robinson, Darren Morgan, Scott Kilcollins. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Darren opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	Minutes from the April 10 meeting were approved as written, with one revision: Record Bob Mathien as present, not absent.
III. Legislative Updates: Budget, Rate Standardization, Bills: Including LD 1745	<p><b>Legislative Updates/Bills</b> Don mentioned two bills up for hearing this week: LD 1855 and LD 1745. The public hearing for LD 1855, which he explained as "Involuntary Commitment (Blue Paper)" bill which came from the AG's Office (to clean up some of the language to reflect current practice) is scheduled for May 9<sup>th</sup> at 2 p.m., and the work session for May 16<sup>th</sup> at 1 p.m. The public hearing for LD 1745, "CSN Legislation," is scheduled for May 10<sup>th</sup> at 1 p.m., and the work session for May 17<sup>th</sup> at 1 p.m.</p> <p><b>Budget/Rate Standardization</b> Don explained that rate standardization is still in flux. However, both Democrats and Republicans do agree on the total amount that must be saved by rate standardization over the next biennium: \$20M. They differ on how to split the amount between the two years: Democrats: \$6M and \$14M for 2008 and 2009, respectively. Republicans: \$10M and \$10M.</p>

Agenda Item	Presentation, Discussion
	<p>The ASO (Administrative Services Organization) RFP (Request for Proposal) has gone out and projected savings has been built into budget proposals.</p> <p>Comments, questions, discussion:</p> <ul style="list-style-type: none"> <li>• Are we cutting off our noses to spite our face at a time when people are being moved into the community quicker [since most of the cuts will be in community support services]? Don explained that some providers believe that rate cuts equal service cuts. The Department assumes agencies can adjust or other providers will “come into the fold” to provide the services for the new rate, so potentially there will be no reduction in services.</li> <li>• Will grant dollars go away in PNMI’s? Don said that currently grant dollars are “solid”—the same as previously with minor adjustments here and there. PNMI’s are excluded from rate standardization.</li> </ul>
<p>IV. NAMI’s Peer to Peer Program</p>	<p>Joanne Marian (CSN 2 member) and Tammy Swasey-Ballou (CSN 4 member) presented information on NAMI’s Peer-to-Peer Program.</p> <ul style="list-style-type: none"> <li>• Trainers from NAMI-National came to Maine and trained 6 teams of 3 “consumer/mentors” to lead this 9-week course around the State.</li> <li>• Peer-to-Peer is free for participants. NAMI provides funding (through grant) for mentors and supplies.</li> <li>• Course held in Washington County (using a room at Sunrise Opportunities) is nearly completed (9 or 10 participants).</li> <li>• A 4-member mentor team, all consumers with jail experience, will be leading this course in the Penobscot County Jail starting later in May.</li> <li>• Very often the sessions evolve into lasting peer support groups.</li> </ul> <p>Members viewed a DVD of NAMI’s Peer-to-Peer Outreach Video, which features consumer experiences with Peer-to-Peer and explanation of its principles. The video can be viewed at NAMI’s website, link below:  <a href="http://www.nami.org/template.cfm?template=/contentManagement/contentDisplay.cfm&amp;contentID=11121">http://www.nami.org/template.cfm?template=/contentManagement/contentDisplay.cfm&amp;contentID=11121</a></p>
<p>V. Community Support Services</p>	<p>Don mentioned the key performance indicator for community support services (case manager assigned within 7 days of referral) and asked for issues around compliance with this standard. Payor mix? Staffing?</p> <p>Kay Carter of CHCS (the main provider of community support services in this CSN), said faulty data collection resulted in what appears to be a gap in case managers being assigned within 7 days. They’ve changed their data procedures and the numbers now reflects the reality that no such gap exists.</p> <p>ICI: Don reported that for most Beacon reviews showing inappropriate levels of care (re: community support), a higher level was needed, specifically ICI (Intensive Community Integration).</p> <ul style="list-style-type: none"> <li>• CHCS has 2 ICI teams in Penobscot County (one is “dual-recovery”), both of which are usually at caseload. They have a small team in Ellsworth, which could handle a few more clients. There are not enough consumers to support a team in Dover-Foxcroft area.</li> <li>• Lincoln area also does not have enough consumers for ICI team. CHCS has 4 CI (Community Integration) workers, psychiatrist, RNC, and one therapist serving the area. The caseload for CI supports this number of staff, with no wait list. A benefit of a rural office is that CI often operates like ICI re: case coordination.</li> <li>• Sunrise reported that though every so often “one comes up” (ICI client), they don’t have a psychiatrist or enough clients to support an ICI team.</li> </ul>

Agenda Item	Presentation, Discussion
	<p>A discussion followed around the difficulty in assessing the need for ICI, when many people and the entities from which they currently receive some care don't know about or understand community support services.</p> <ul style="list-style-type: none"> <li>• NAMI-ME family representative said there's always a long wait and long travel to obtain some services. "On the ground, what I see are people not being able to get in for 6 months." For all the people agencies serve, there is probably twice that many out there floundering.</li> <li>• Mayo Hospital rep said they only provide outpatient services, so they have no history or understanding of what community support services might be needed.</li> <li>• WCPA, crisis provider, said they see complicated cases and are impressed with how rural caseworkers provide services and respond to clients where they don't have ICI or ACT teams providing coordination.</li> <li>• Dan Wathen, Court Master, added that it's difficult to identify needs in rural areas, because "they make it work." "Are services missing? It's difficult to know, because <u>they adapt</u>. Can you really run a system adequately without these services (CI, ICI, ACT)?"</li> <li>• A member asked if the needs in the jail system are being captured, and gave a review of statistics recently learned about the high numbers of inmates in the Penobscot County Jail currently receiving psychotropic medications.</li> <li>• Why not have a blue-ribbon commission on mental health in the State of Maine?</li> <li>• It might be very valuable to have Sheriff Ross sit in on this discussion—law enforcement sees the people who are self-medicating or who won't enter the system due to stigma.</li> <li>• The four counties in this CSN comprise a "very complex geo-political climate." A person with mental health needs looks very different in Bangor than Washington County—very different cultures.</li> <li>• Rural people often show up at primary care (without a psychiatrist available) and their physician is caring for them the best they can.</li> <li>• For those who contact the system, we can get them served. For those that don't, it's difficult to know their unmet needs.</li> </ul>
<p>VI. Training Needs for the CSN Area: July 2007-June 2008</p>	<p>Chris Robinson, OAMHS Training &amp; Best Practices Coordinator, briefly explained their current training philosophy (fewer conferences, more skill-building) and the cooperative agreement with the USM Muskie School (which encompasses most of OAMHS trainings and mental health certification programs). She mentioned the pros and cons (less costly, greater access, though less interaction) of web-based trainings and asked members for feedback on the following questions:</p> <ol style="list-style-type: none"> <li>1) How is recruitment and retention of staff going?</li> <li>2) Specific needs and training topics for next year?</li> <li>3) Preferred delivery methods of trainings, e.g. web-based, face-to-face, combination?</li> </ol> <p>Comments on delivery methods:</p> <ul style="list-style-type: none"> <li>• Follow-up to trainings is absolutely critical.</li> <li>• ITV does provide opportunity for some interaction.</li> <li>• Staff doesn't like web-based or ITV—boring, get distracted, do other things.</li> <li>• People like to build relationships with others in training.</li> <li>• One member said they recently partnered with three other agencies to provide a recertification training—cut costs per person drastically.</li> <li>• Some trainings lend well to web-based delivery and some don't. For some things that are mandatory, very didactic, with high cost to providers would work very well: MANDT, Orientation, First Aid, Fire Safety, Video/Display Terminal, Sexual Harassment, etc.</li> </ul>

Agenda Item	Presentation, Discussion
	<p>Comments on recruitment/retention:</p> <ul style="list-style-type: none"> <li>• Recruitment is tough—huge demand, low pay, stressful, lots of paperwork.</li> <li>• One agency said they try to provide some benefits, but find people will leave for other agencies that pay a bit more, but have less benefits.</li> <li>• Cost of turnover is very high, particularly training costs.</li> </ul> <p>Comments on training topics:</p> <ul style="list-style-type: none"> <li>• Any discussion of merging MR and MH trainings (DSP and MHSS)? For agencies who serve both populations, very costly to for staff to do both. Chris said they have identified some overlap with a certain number of modules; however, the other modules are different enough to not be “an even exchange.” (Chris will follow up a particular situation with OHI.)</li> <li>• Strong team facilitation in wraparound meetings.</li> <li>• Skill in assessment of other health needs and referrals for those needs.</li> <li>• Diagnosis, symptoms, and some methods and styles of direct care.</li> <li>• Documentation training for community support staff, i.e. “writing for medical necessity” would be a great web-based training.</li> <li>• CSN consumer representatives met via conference call on April 11 and compiled the following list of training topics/ideas: <ul style="list-style-type: none"> <li>○ Consumer perspective on recovery</li> <li>○ Case managers need resources to give to consumers to get connected with peer services and community</li> <li>○ The medical community needs training on what is going on in the behavioral health community</li> <li>○ Trauma informed curriculum developed by consumers</li> <li>○ Training on wellness – how to get better</li> <li>○ Training for employment specialist in the career centers for mainstreaming in the employment field – people going back to work – accommodations</li> <li>○ Direct Service Providers – The importance of attitude and action in the messages that are conveyed are critical to hope for and belief in recovery</li> <li>○ What is “meaningful-useful work”</li> <li>○ Helping folks move into being able to disclose – boundary issues in agency (further explanation: some providers are also consumers—OK to disclose in some agencies, not in others—need ethical discussion on provider disclosure)</li> <li>○ How providers can be open to consumer input – their role in effective consumer participation</li> <li>○ Consumers self-esteem and personal empowerment</li> <li>○ Urge providers to attend HOPE Conference</li> <li>○ Providers need to attend Peer Support 101</li> <li>○ Information to consumers on email opportunities (free account information)</li> <li>○ Training for consumers on use of internet</li> </ul> </li> </ul> <p>Members also mentioned mandated trainings that “come down to us,” from the federal government—for example, trainings in fraud and abuse in connection with the Deficit Reduction Act in 2005. Don asked that members notify Chris Robinson when such trainings come up, since OAMHS may not be aware of them.</p> <p><b>ACTION:</b> Members may pass on any other ideas or comments to Chris Robinson at 287-4865 or <a href="mailto:christine.c.robinson@maine.gov">christine.c.robinson@maine.gov</a>.</p>

Agenda Item	Presentation, Discussion
VII. IMD Report	<p>Don reported that Ron Welch had determined who would assist with the rewrite of the IMD Report (Resolve, To Improve Quality and Access to Mental Health Care Through the Development of a Joint Strategic Plan): Dottie Hill, Dennis King, a provider recommended by MAMHS (Maine Association of Mental Health Services), and a consumer will meet with Ron on May 17 to take input received from various sources and re-craft the report for presentation to the Health &amp; Human Services Committee.</p> <p>A member asked Don if he'd met with Bill Hughes about this matter, as stated at the last CSN meeting.</p> <p><b>ACTION:</b> Don will have discussion with Bill Hughes of OACPD (Office of Adults with Cognitive and Physical Disabilities) before the rewrite of the IMD Report.</p>
VIII. Protocol Guidelines for Hospitalization	<p>Members received a draft of Protocol Guidelines for Psychiatric Hospitalization Process. Review of this document led to a varied discussion, which ultimately helped to clarify its impetus, purpose, and framing: How Emergency Room personnel ought to approach and provide care to people with mental health issues who appear in the Emergency Room.</p> <p>Discussion:</p> <p>Face-to-face Assessment:</p> <ul style="list-style-type: none"> <li>• Re: "evidence-based clinical assessments"—Is there a specific model?</li> </ul> <p>Holistic Understanding of Crisis:</p> <ul style="list-style-type: none"> <li>• If case manager or group home staff is not available is there any penalty? Answer: No, only in case of being routinely unavailable.</li> </ul> <p>Advance Directives and Crisis Plans:</p> <ul style="list-style-type: none"> <li>• Should say "Psychiatric" or "Mental Health Care" Advance Directives, differentiating these from other types of advance directives.</li> <li>• What's the policy for people under public guardianship? Answer: Haven't had that discussion yet.</li> <li>• Kay Carter pointed out a significant difference between crisis plans and advance directives. Crisis plans are clinical documents and advance directives are <u>legal</u> documents. "An Advance Directive done correctly is wonderful," she said, "and an Advance Directive done incorrectly is dangerous." She also expressed concern over what OAMHS and/or the Consent Decree Plan expects of case managers in the preparation of advance directives. Don said that case managers would <u>not</u> be helping write advance directives.</li> </ul> <p>Main reason behind development of guidelines:</p> <ul style="list-style-type: none"> <li>• A consumer member shared details of a very traumatic and negative experience with a local Emergency Room. She said every point in the document addressed an aspect of her experiences, and that she had strongly encouraged development of these guidelines for Emergency Room personnel.</li> </ul> <p><b>Recommendation:</b> Table this for further discussion at next meeting, with the suggestion that special effort be made to have hospital ER representatives present.</p>
IX. Consent Decree Quarterly Report	Not discussed—Don mentioned the report and asked members to review, particularly Standards 1,4,13,18,26,33.
X. Outpatient Services	No time to discuss—on next agenda.

Agenda Item	Presentation, Discussion
XI. Medication Management	No time to discuss—on next agenda.
XII. Policy Council Report	No time to discuss—on next agenda.
XIII. Other	Request to provide a list of acronyms. “Asked months and months ago for a list of acronyms, so all can participate.”
XIV. Public Comment	None.
XV. June Agenda Items	Protocol Guidelines for Hospitalization Outpatient Services Medication Management Policy Council Report Budget/Legislation