Community Service Network 2 Meeting
Dorothea Dix, Bangor, Maine
June 12, 2007

DRAFT Minutes

Members Present:

- Annette Adams, Acadia Hospital
- Melinda Davis, AIN
- Debra Henderlong, Allies Inc.
- Theresa Oliver, Bangor Counseling Center
- Tammy Smith, Care & Comfort
- Mary Dunn, Charlotte White
- David McCluskey, Community Care
- Kay Carter, CHCS
- Bambi Magaw, Community Mediation Services
- Mary Louise McEwen, Dorothea Dix
- Jeremy Ashfield, Families United
- Sherrie Colby, Fellowship Health Resources
- Bob Mathien, Maine Mental Health Connections
- John Spieker, Mayo Regional Hospital
- Judy Provencher, Medical Care Development
- Sharon Greenleaf, NOE
- Kathy Smith, OHI
- Sharon Dean, Sunrise Opportunities
- Sharon Tomah, Sweetser/Wabanaki
- Lydia Wright-Richard, Together Place
- John Edwards, WCPA

Members Absent:

- Amicus
- Behavioral Health Center
- Blue Hill Memorial Hospital
- CA Dean Memorial Hospital
- Calais Regional Hospital
- Down East Community Hospital
- Maine Coast Memorial Hospital
- Maine Vocational Associates, Inc.
- MDI Behavioral Health Care
- NAMI-ME Families
- NFI North (excused)
- Phoenix MH Services (excused)
- Penobscot Valley Hospital (excused)
- Regional Medical Center at Lubec
- St. Joseph Hospital
- Wings

Alternates/Others Present:

- Marjorie Snyder, Dorothea Dix
- Charlie Clemons, Charlotte White
- Tom Lynn, CHCS
- Betty Foley, Medical Care Development
- Bonnie-Jean Brooks, OHI
- Corey Schwinn, WCPA

Staff Present: DHHS/OAMHS: Ron Welch, Donald Chamberlain, Darren Morgan. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Darren opened the meeting and participants introduced themselves.
II. Minutes	Discussion on the minutes began with two participants strongly requesting that meeting minutes and, more importantly, agendas be sent out sooner—especially when those agendas request that providers bring data. It is “unacceptable to ask us to bring such data as late as we were,” stated Kay Carter of CHCS. The minutes from the May 14 meeting were approved with amendments, as follows: • Corey Schwinn attended for WCPA, not John Edwards. • Under Item V. Community Support Services, bullet 3: Sunrise Opportunities asked that “the overall number of clients to support it,” be changed to “enough clients to support an ICI team.”
III. Budget, Rate Standardization	**Legislation** **ACTION:** OAMHS will compile a complete listing this session’s bills related to mental health issues and provide to all CSN members. **Budget/Rate Information** Ron reported on the biennial budget passed by the legislature:

Agenda Item	Presentation, Discussion

	• A total of $6M must be saved in FY08, as follows:
	  ‣ $1M added to projected savings of Administrative Services Organization—for a total of $6.5M.
	  - $1M saved by changes in use of Skills Development services. OAMHS found that 20% of clients in this program receive 80% of the services (principally in Kennebec/Somerset counties). There is currently a wide interpretation of what's provided under these categories
	  ‣ $4M saved by package of changes in rate standardization.
	• $14M must be saved in FY09, $4M of which will carry over from FY08 rate standardization. The remaining $10M savings is not defined.
	• $11M in FY08 and $22M in FY09 were appropriated for Medicaid (MaineCare) seed funds for new clients/services.
	• Rate changes averaged across services results in a 6.6% overall reduction for FY08.
	• If providers decide to decrease or eliminate services, please notify OAMHS and the CSN to discuss possibilities to meet that service need.
	• The budget language also requires DHHS to set up three work groups, made up of providers, consumers, family members, and DHHS staff, to carry out specific tasks pertaining to: 1) Administrative burden reduction, 2) System redesign, and 3) Rate standardization. The work groups have tight timeframes—convening by July 1, 2007, and completing work before the new Legislative session begins in December. Dept. Commissioner Geoff Green will be making appointments to the work groups and coordinating their work.
	
	Members received handouts of the new rates, which the group reviewed, as well as a legislative document entitled "Part AAAA" detailing the work groups described above.
	
	Discussion:
	• Is there a mechanism for work groups to invite feedback from non-MAMHS members? Response: The provider representatives noted in the document to be "designated by the department" will be non-MAMHS members.
	• What is meant by "3 representatives of the interests of consumers of adult and children's mental health services identified by the department"? Will they be employees of the Office of Consumer Affairs? Response: No, they will be consumers from outside of the Dept.
	• Re: administrative burden: What about the 2006 APOC (Administrative Processes Oversight Committee) report? Response: This should be looked at as homework for the work group members.
	• Is there going to be any considerations for the amount of paperwork, data collection, elaborate contracting, etc.? Answer: Yes, work group #1 will address this. Also, OAMHS is working with IT (Information Technology) to improve data collection from agencies.
	• I worry about OAMHS enhancing capacity and then asking for <u>more</u> data.
	• There has to be a driving force that has the political will to change the system.
	• Allies Inc. representative said they have hired a full-time person just to make phone calls to MaineCare to solve/address billing and denial issues. Clients' MaineCare status changes month-to-month, and it requires a lot of work to keep up with this.
	
	Funding for In-Home Outpatient Services
	Members had a long discussion about grant dollars no longer being available to support in-home outpatient services for SMI "dual-eligibles" (MaineCare and Medicare) and Medicare-only clients.
	
	• Those will now be fee-for-service; and at the rates allowed by Medicare, there will be no way to provide geriatric in-home outpatient services.

Agenda Item	Presentation, Discussion
	• The OAMHS '08 contracts clearly lists it as fee for service, and there's no way that service can continue. The Dept has known that's the only way that service could have been provided. It is not a lot of money, but it is what makes that service available. • The question is (to OAMHS): Do you want geriatric in-home outpatient to survive? • Over the past five years, I have seen almost all geriatric services de-funded, which I assume is by design. • There are people now receiving this service that will not be available in 18 days—how many does this affect? • This change currently might affect 32 clients (CHCS 20 and WCPA 12). WCPA has no caseload presently, due to lack of staff. The staff person at CHCS left the position previously, and it has not been filled due to uncertainty about funding. • The service will be provided in some form—ER, crisis… • Assume person is homebound due to illness? • Many of these same people can make their other doctors' appointments—why not their outpatient therapy appointments? • WCPA: Quite frankly, it's the stigma. • Don reframed question/issue: We have a population that is not able to be served--it's Medicare that discriminates against mental health services compared to medical services. • Darren said that OAMHS is not trying to purposely target the elderly, but that in tight budget times, the costs are high in providing an in-home service that could be done in the office. • Isn't there information within the state system about in-home utilization and how many clients have met the qualifications for this service? • This population has very little ability to advocate for themselves. Maybe we should struggle within the CSN about our priorities. **ACTION:** Don will find out if this issue has already been addressed/solved, in the time since the contract letters went out. The discussion continued with the larger issue of a growing geriatric population and "in what direction are things going with treating the elder population?" It's a bigger problem that the grant dollars issue—discussion is still worthwhile whether the in-home outpatient service is grandfathered or not, one member stated. Sharon Tomah shared her thoughts—that it would be very helpful to get input and ideas from other partners serving elders, such as Eastern Area Agency on Aging, in-home visiting nurses, Federally-Qualified Health Centers, Maine Center on Aging, etc., to find out what they're seeing, what they're doing. The group agreed with Bonnie-Jean Brooks' subsequent suggestion that the CSN invite Noelle Merrill from the Eastern Area Agency on Aging and Lenard Kaye from the Maine Center on Aging to July's CSN meeting, giving that discussion 1 to 1½ hours of the meeting time. The suggestion was also made that a subcommittee would subsequently form to bring back follow-up ideas. **ACTION:** Bonnie agreed to take care of inviting Noelle Merrill and Lenard Kaye to July's meeting. A member also asked about the report from the JAC (Joint Advisory Committee on Select Services for Older Persons), "so we don't go over plowed ground." **ACTION:** Email JAC task force report to members.

Agenda Item	Presentation, Discussion
IV. 24/7 Access to Community Support Information	Don reminded the group that OAMHS is expecting to receive copies of the written protocols from crisis providers and community support providers by June 15, and implementation of the protocols begins July 1. He invited members to share any issues/comments, and the conversation revealed that WCPA is experiencing difficulty with the many details and logistics involved in having so many providers with so many people and varying ways of contact. The group decided to call a meeting of the crisis providers (WCPA/CHCS) and community support services providers to discuss that and other issues involved in the 24/7 access protocols. **ACTION:** Crisis and community support providers will meet on Friday, June 15, from 11 a.m. to 1 p.m., at the Region III Office, Conf. Room 2. Elaine will send an email reminder. Other comments/questions: • One member said they have "good linkage" with crisis program, but "our folks may show up anywhere." Response: First goal is to accomplish linkage in the local area—take on inter-area problems later. • One suggestion: Add information through EIS, with levels of restricted access. OSA (Office of Substance Abuse) is already running a system like that for narcotic prescriptions. • Is the data already resident electronically anywhere? Isn't it in EIS? Response: Some, not all—not crisis plans. Couldn't those be added? • One member expressed concern about outdated information, saying that on the "MR side," it was determined that outdated information could be more detrimental than no information, and the system did not have capabilities the make sure the most recent data was available. • Ron clarified that information that needs to be available for this protocol is the prescriber, not the meds, and that crisis plans are usually current. He also reminded that this pertains to people receiving community support services in the process of moving toward inpatient care, usually in ERs. "We're down the road on EMRs [electronic medical records]," he said, "probably 2-3 years."
V. Guidelines for the Psychiatric Hospitalization Process	Discuss next month.
VI. Medication Management	Discuss next month.
VII. Outpatient Services	Discuss next month.
VIII. Policy Council Report	Discuss next month.
IX. Other	**Report on Consumer Forums** Melinda Davis distributed a multi-page report that summarizes the results of the Peer Services Subcommittee's meetings with consumers in five consumer forums and recommends three specific proposals to help meet the peer support needs in the CSN area. 1. Establish a Native American peer support and recovery center at Wabanaki/Sweetser in Bangor. A written proposal is under development and the narrative section was attached to the report. Sharon Tomah gave a brief review and appeal for support of this proposal, saying a good number of consumers are ready, enthusiastic, and excited to begin. 2. Fund a full-time position at the Together Place Social Club to help expand and develop peer support and recovery programs and activities. 3. Create a Traveling Peer Support and Recovery Center with the intended outcome of the eventual development of permanent consumer-run peer support and recovery centers in Washington, Hancock, and Piscataquis Counties.

Agenda Item	Presentation, Discussion
	With the exception of Wabanaki/Sweetser (because of different culture), the subcommittee recommends that peer centers not be built under a provider agency, but rather be consumer-run efforts. The group will discuss the proposals recommended by the subcommittee at the next CSN meeting. Melinda also stated (included in the report) that the Advocacy Initiative Network recently visited two social clubs in Aroostook County as part of its contract with DHHS to provide technical assistance and organizational development to social clubs and peer centers across the state. Aroostook Mental Health Center (AMHC) runs both social clubs, and as a matter of policy, all consumers must be clients receiving services from AMHC to be members. This policy and lack of consumer direction/ management makes programs more like day programs than peer service programs. This not only inflates the actual funding provided for peer services, but also is a barrier to the development of any real peer service in that area.
X. Public Comment	None.
XI. July Agenda Items	Discussion with Noelle Merrill and Lenard Kaye on elder issues Guidelines for the Psychiatric Hospitalization Process Medication Management Outpatient Services Policy Council Report Peer Support Subcommittee Recommendations The group was given the option of not holding an August meeting, which they approved. **UPDATE:** OAMHS cancelled all July CSN meetings, so August meetings will be held as originally planned.