

**Community Service Network 2 Meeting
Acadia Hospital, Bangor, Maine
October 16, 2008**

DRAFT Minutes

Members Present:

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| <ul style="list-style-type: none"> • Brent Bailey, Allies Inc. • Michelle St. Louis, Behavioral Health Center • Mary Dunn, Charlotte White Center • Thomas Lynn, CHCS • Dale Hamilton, CHCS • David McCluskey, Community Care • Vickie McCarty, Consumer Council System of ME • Jill Peters, Dirigo Counseling Clinic | <ul style="list-style-type: none"> • Mary Louise McEwen, Dorothea Dix Psychiatric Center • Jeremy Ashfield, Families United • Susan Buck, Fellowship Health Resources • Robert Mathien, Maine Mental Health Connections • Sue Rouleau, MDI Behavioral Health Care • Betty Foley, Medical Care Development • Gayla Dwyer, MMC Vocational Employment Coordinator • Sheryl Bowen, MMC Vocational Employment Specialist | <ul style="list-style-type: none"> • Charles Tingley, NOE • Sharon Greenleaf, NOE • Bonnie-Jean Brooks, OHI • Michael Corbin, Penobscot Valley Hospital • Lydia Richard, Together Place • Sharon Tomah, Wabanaki-Sweetser • Corey Schwinn, WCPA • John Edwards, WCPA |
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Members Absent:

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| <ul style="list-style-type: none"> • Acadia Hospital • AIN • AMICUS • Bangor Counseling Center • Blue Hill Memorial Hospital • CA Dean Memorial Hospital • Calais Regional Hospital • Care & Comfort | <ul style="list-style-type: none"> • Down East Community Hospital • Eastern Maine Medical Center • Maine Coast Memorial Hospital • Mayo Regional Hospital • Millinocket Regional Hospital • NAMI-ME Families • NFI North | <ul style="list-style-type: none"> • Phoneix Mental Health Center (excused) • Regional Medical Center at Lubec • St. Joseph's Hospital • Sweetser • Together Place Housing Inc • Wings |
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Alternates/Others Present:

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| <ul style="list-style-type: none"> • Jennifer Anderson and Suz Norton, Schaller Anderson | <ul style="list-style-type: none"> • Katherine Carter, MAMHS | <ul style="list-style-type: none"> • Vicki Karlsson, LCPC (private practice) • Loretta Alley, Allies, Inc. |
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Staff Present: DHHS/OAMHS: Sue Lauritano, Mary Louise McEwen, Don Chamberlain, Dr. Steven Gressitt. Muskie School: Anne Conners.

Agenda Item	Discussion
I. Welcome and Introductions	Sue Lauritano welcomed participants; introductions followed.
II. Review and Approval of Minutes	<p>The minutes from the August meeting were approved with the following amendments:</p> <ul style="list-style-type: none"> • Change meeting location from Dorothea Dix to Acadia. • On page 3 of 6, Non-categorical coverage—Eligibility for Grant Funds/First Bullet/Last Sentence. Replace last sentence with the following: “Consider a number of alternatives to reduce the unmet needs of people who are outside of the cap of non-categorical waiting lists.” • On page 6 of 6, Public Comments on Budget, replace two sentences with: “In no way should this be seen as completing his (Ron Welch’s) obligation for input on the budget.” • On page 5 of 6 and 6 of 6, budget discussion: Lydia Richards asked that the minutes reflect her motion for more funding go to the areas where there are more than 100 unmet needs. She said the motion was seconded by Melinda Davis. Acadia voted against the motion; all others abstained; motion failed. • On page 2 of 6, Legislative Session January 2009-Suggested bills/Discussion/Bullet 3, replace “education” with “educate.”

Agenda Item	Discussion
<p>III. Feedback on OAMHS Communications</p>	<p>Sue asked members if they had any feedback on OAMHS communications over the past month.</p> <p>Bonnie-Jean Brooks expressed concern that critical issues addressing continuity of care for adults who receive public mental health services were not on the current agenda. “When I looked at all the things on this agenda, I don’t think there is anything on this agenda as important as CSN s having frank discussions regarding what we’ve been hearing about significant budget cuts that will affect every citizen in Maine.” She said she would like the following questions answered:</p> <ul style="list-style-type: none"> • What is the state budget deficit? • Has the Department been asked to make a 10 percent cut? If so, in what areas? • Will these cuts decimate the Department? • How will they affect the people we support? • How will rehab changes affect PNMIIs? <p>None of these items are on the agenda. “We may be fiddling as Rome is burning.” Dale Hamilton seconded these concerns.</p> <p>Tom Lynn said he would like to report on discussions that WCPA and CHCS have had regarding material sent out by the Crisis Work Group. He shared the following:</p> <p>WCPA and CHCS have a demonstrated history of providing crisis services in the two Districts. In reviewing the Work Group’s system and MOU requirements, WCPA and CHCS have identified the following as barriers to successful improvements in the system:</p> <ul style="list-style-type: none"> • Timeline: the material from the Work Group was promised at the beginning of September, but did not arrive until the end of the month (and then was incomplete) and yet the overall timeline has not changed. • Several requirements in the material are things that we currently have in our systems. There are, however, requirements that will add to rather than reduce costs of the delivery of services. • DHHS has not provided us with the grant dollar amounts that we have to work with to accomplish these changes. Moreover, the MaineCare rates that will fund the system won’t be known until January, after the final system design is due. When working within a capacity-based system, it is vital to know what resources we have to deploy. • The Work Group’s material requires crisis programs to organize systems of crisis care, but gives no authority to the crisis providers to carry out these mandates. Moreover, some of the minimum requirements have an assumption that crisis programs can dictate medical care requirements to hospitals. • It is our understanding that DHHS wants crisis providers to organize the systems without any direct help from DHHS. This appears to be counter to the legislation which calls upon DHHS to “negotiate the implementation of MOUS among providers.” • DHHS can’t get all the CSN providers to show up for meetings, how can it expect crisis providers to organize a system that imposes mandates on other providers? <p>ACTION</p> <p>Tom suggested that the Crisis Work Group meet with all crisis providers to clarify the scope of the material and the roles that DHHS and crisis providers can take together to improve the system of care.</p>

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	<p>Discussion: Corey Schwinn said that the MOU Minimum contains good ideas in process and structure; however, crisis providers would like assistance with certain things that they may not have the authority and leverage and ability to carry out. “Considering our initial workplan is due in mid-November, we’re feeling like we’re being pushed a bit to make that happen when we still don’t know what the dollars will look like.”</p> <p>Lydia asked if CHCS had filled out the form. Tom: yes.</p> <p>ACTION Tom will email form to Lydia.</p> <p>Dale suggested that the entire agenda be scrapped so that the CSN could focus on critical issues such as the budget and the crisis service minimums.</p> <p>Lydia said that September’s entire agenda was focused on the budget and that this information was provided in advance of the meeting yet the only people who came with budget information were consumers and their organizations. No providers came with budget input. For crisis services, the Legislature wanted to put crisis services out to RFP with one crisis provider per district. Crisis providers said they didn’t want to do this and instead wanted to work together. “Now crisis providers are saying they can’t do this because they don’t have the leverage/authority.” Lydia said that providers need to provide service and that 50 consumers from around the state wrote in regarding their experiences with crisis services. She said she was tired of hearing providers say they don’t have a chance to provide input.</p> <p>Recommendation: Don Chamberlain suggested that Schaller Anderson give its scheduled presentation and then the members would decide how to spend the rest of the meeting. After a discussion, members agreed to proceed in this manner.</p>
<p>IV. Schaller Anderson Presentation</p>	<p>Sue welcomed Jennifer Anderson and Suz Norton of Schaller Anderson to the meeting.</p> <p>Background: Schaller has been in Maine for two years; its original contract with DHHS’s Office of MaineCare Services (OMS) was to provide a care management pilot to a chronically ill segment of the MaineCare population. At that time, this encompassed 300 members. In 2007, Governor John Baldacci expanded the program and the MaineCare Care Management benefit went into effect. The Care Coordination benefit has six components: member identification; evidence-based practice; collaborative practice models that include physician and support-service providers; member self-care management education; process and outcomes measurement, evaluations and management; routine reporting/feedback loop (including communication with members, physicians, ancillary providers and provider profiling). Schaller’s contract now includes care coordination for the top 10 percent of the chronically ill adult population and the top 5 percent of the chronically ill pediatric population.</p> <p>Schaller does not provide prior authorization as APS does.</p> <p>Members are identified as candidates for the free Care Coordination benefit through a stratification process using predictive modeling. If a member is stratified and placed in a high-risk category, a case manager contacts the member and assesses health care needs or barriers to accessing health care services. Once identified, members eligible for the</p>

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	<p>benefit receive a letter from Schaller Anderson asking if they would like to enroll. Most common clinical conditions are: asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, depression.</p> <p>The MaineCare Care Management Benefit is open to the following MaineCare members:</p> <ul style="list-style-type: none"> • Patients with multiple chronic conditions/co-morbidities • Patients with poly-pharmacy • Patients in need of self-management education • Patients with special needs • Patients whose medical care is complicated by depression • Patients with multiple emergency room or inpatient admissions • Patient who need coordination of multiple services for their medical needs • Patients exhibiting non-adherence with plans of care <p>The following exclusions apply:</p> <ul style="list-style-type: none"> • Members who are dually eligible, i.e. have any other insurance in addition to MaineCare. Common example: Medicare/MaineCare. • Members with an HIV/AIDS diagnosis—OMS has a waiver program in place to address their specific needs. <p>Jennifer Anderson, Manager of Care Management at Schaller, said that Schaller would like to work with DHHS and agency case managers and community resources to get people as healthy as they can be given their illnesses. She asked for assistance in reaching the hard to reach such as the transient and homeless populations. Jennifer and Suz said that Schaller addresses Maslow's hierarchy of needs: Do clients need transportation, winterization, etc.? She said that Schaller has had a difficult time getting in touch with those with SMI and has backed into the process and wishes that contact had been established with CSN providers earlier.</p> <p>Discussion</p> <p>Don said that CSN members have been concerned with their clients' perception that they will lose their community integration worker because Schaller is doing the same thing. Jennifer said that Schaller does not want to compete with existing services and doesn't bill its services to the state in the same way as mental health agencies. Schaller focuses on the medical piece. For example for someone with a diagnosis of schizophrenia and diabetes, Schaller can help case managers address the clients' diabetes and can provide information about drug interactions. Suz said Schaller's mission statement is very similar to the CSNs in that both are seeking to provide seamless care.</p> <p>Dale asked if Schaller Anderson has a role in authorizing services such as APS does for psychiatric services. Jennifer said that Schaller has a care management department and a utilization review department but does not do prior authorization. Mike Corbin said that from the hospital perspective UR frequently results in loss of service. Jennifer: "I think you haven't heard from the care management department as much as you wish you had."</p> <p>Chuck Tingley asked a series of questions to which Jennifer provided the following information: Schaller is funded through a flat-rate contract and reports via a metric system. Schaller does not interface with APS. Schaller refers people to home health services such as CHCHs. Schaller operates in a managed care manner with a block payment per client provided. Schaller's contract mandates certain cost savings.</p>

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	<p>David McClusky asked if most of the people being helped by Schaller Anderson have a case manager in place. Suz: Many of them do, although she noted that she is surprised by the number that don't.</p> <p>Bonnie-Jean asked if Schaller serves people with intellectual disabilities who may not be funded under the waiver but may be funded under PNMI. Jennifer: "Yes, and they are hard to find." Jennifer said that Schaller has a difficult time finding "folks who are in PNMI, residential care, foster care." Staff at these institutions "don't know us so hesitant to talk to us." She said Schaller is acting as an agent of the state and would like to get that word out so the reaction is not "Schaller who?" Bonnie said that people with intellectual disabilities can be found through EIS. Jennifer said she didn't know if Schaller had access to EIS.</p> <p>Mike Corbin observed that there are difficulties surrounding releases of information for admitted patients on HIV, mental illness, and substance abuse. Because of this it is difficult to send all of the information that Schaller wants. History and Physical form is currently sent. He asked the mental health agencies present if they share information with Schaller Anderson in a collaborative way, would that open up the door for Schaller to provide utilization review?</p> <p>David McClusky noted that Schaller serves the top 10 percent of adult chronically ill and top 5 percent of children. How many people does this represent? Jennifer: 12,000 to 13,000. He also asked what mental health information Schaller currently gets. Suz: Schaller gets some mental health information, such as prescribing information for psychiatrists and/or in-patient hospitalization days; however, it does not receive information about mental health agencies/case managers.</p> <p>Dr. Steve Gressitt asked how Schaller links the mental health world with a primary care home. Jennifer: links psychiatrists and physicians frequently. Because of claims data, Schaller may be the only entity in the position of knowing all the medications and psychotropic medications being prescribed.</p> <p>Sue asked if Schaller is looking at high end users of the ER. Jennifer: yes, target population.</p> <p>Bonnie asked if Schaller has identified anyone who can provide IV sedation for dental care. Jennifer: no.</p> <p>Kay Carter: "Are you tracking those with non-categorical status who have disabilities?" Jennifer: "Not currently tracking that but it is something to consider. Thank you." Kay: "What is average caseload?" Suz: 450. Telephonic care management. Kay: "Does your data show you all services being provided?" Jennifer: No. Kay: "Could you make claims data show that a person is getting Community Inclusion services from the Charlotte White Center?" Jennifer: "No, would love to have that information. Discussion for you and the people who contract with you."</p> <p>Sharon Tomah asked if Schaller looks at race and ethnicity in order to identify health disparities for certain populations. Jennifer: No, examine claims data which does not list this.</p> <p>Dale commented that all psychiatric service authorizations go through APS and that all of this data exists. He said it is remarkable that two systems are coordinating care and nothing is in place that allows information sharing between the two and that services aren't coordinated with DHHS. Jennifer: "We have asked for that and the state is working hard on making that available to us." She said she doesn't think there is a lack of desire to have a collaborative relationship.</p> <p>Betty Foley asked what relationships exists between APS and Schaller. Jennifer: No formal arrangement currently; confidentiality issues exist; business agreement with DHHS would have to be worked out.</p>

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	<p>Don said that OAMHS has just become involved in this process in the last couple of months as Schaller's original focus was on physical health. Work being done needs to be integrated with APS and mental health agencies. Ongoing collaboration effort.</p> <p>Kay said that budget restrictions require that duplication of services be eliminated.</p> <p>Don: Is there a way to share information about how to reach Schaller staff? Jennifer: Yes.</p> <p>ACTION</p> <p>Jennifer will send contact information on Bangor staff to Don who will distribute to CSN members.</p>
V. Budget	<p>Following the break, Sue observed that Dr. Gressitt had to leave the meeting so his presentation on Unused Prescription Drugs would take place at the November meeting. She also noted that Dale had to leave. After a discussion on how to reorder the rest of the meeting, members agreed to discuss budgetary issues followed by committee reports.</p> <p>Don reported that OAMHS budget request has been submitted to the Commissioner who is in turn meeting with DAFS and the controller followed by the Governor to determine the request that goes to the Legislature. Don said that much of what has been proposed by OAMHS probably will not go forward because it involves budgetary increases. The Governor has directed all state agencies to cut 10 percent of its base budget for 2010/2011. This does not translate to a 10 percent cut per office but an overall 10 percent. OAMHS does not yet know the impact of this.</p> <p>Discussion</p> <p>Bonnie asked if Don had any word about curtailments for the 2009 budget. Don: OAMHS has not heard any news about curtailments yet; however "reading the papers as you do we are anticipating something." He noted that last year the Governor's curtailment order was issued in the November/December timeframe. With limited information, Don said it is difficult to respond with a concrete proposal and perhaps the group could consider where members would look for substantial cuts.</p> <p>Kay asked about how the budget picture fits with the issues the court monitor is supposed to address. Don said the court monitor was hired a month ago and the target date for her report is March. Members discussed the parameters of the consent decree in terms of who is served. Don said that OAMHS has met with the court master and the plaintiffs in an effort to define the parameters of the consent decree. DHHS attorneys have asked for more detail and clarification from the court master. He noted that the Department is under the consent decree and not the Legislature and/or the Governor. While OAMHS can advocate for resources it needs to come into compliance, these requests could fall on deaf ears. Betty asked who pays for the court monitor. Don: OAMHS.</p> <p>Bonnie said that OHI works to get food stamps for people they support who live in a licensed home. On the mental health side, case managers say this is double dipping and don't allow it. She said clarifying this so that mental health consumers will understand how to legitimately access food stamps could result in cost savings.</p> <p>After Don asked the group to envision what, if they were in a third world country, would be absolutely necessary for mental health services and what they would build upon to meet all needs. Bonnie said that the current system hasn't spent nearly enough time building communities or relationships or developing the notion of sustainability unlike the third world where there is an emphasis on natural supports and volunteers and community. In the third world, NGOs provide</p>

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	services and are not wrapped up in the requirements of a bureaucracy.
VI. PNMI's	Don reported that the PNMI Rehab option will go into effect in April 2009, and the Department is working on a plan to be in compliance with these rules should they hold. The rule changes have a significant impact upon PNMI's under all the MaineCare sections, but, in particular, Adult Mental Health PNMI's under Appendix E.
VII. Wraparound Funds	<p>Sue explained that the regional offices currently manage the Wraparound funds program and that the Department has decided to shift this function to the CSNs. CSN members throughout the state can develop proposals on how to administer said funds. She gave examples of one CSN where one agency administers the funds or another CSN where members have proposed allocating funds per agency based on a formula. Another CSN is establishing a committee to meet weekly and decide on applications.</p> <p>Discussion Bonnie-Jean asked if consumer satisfaction surveys were being done for recipients of Wraparound funds. Sue: No. David asked the amount of funding available. Don: Not sure. Sue: Could be approximately \$40,000. Kay: Department should outline expectations around costs of administering the program and of other program functions. Don: All should have the Wraparound fund policy statement and application. Kay: Managing the program is different. Tom: Could regional office provide volume of applications in past couple of years to give an idea of how much time the function would take.</p> <p>Brent Bailey said in his former role with the Regional Office he administered the program and had a five-day turnaround deadline for applications. 85 percent of the applications come in incomplete and information has to be tracked down. Majority of his workweek was working on this request. He observed that the policy needs to be cleaned up and that for agencies that cross CSN boundaries having each agency have a certain amount of funding would be a headache. Bonnie: also have to factor in appeals process. Don: this is the only CSN where Regional Office administers the entire program. Members discussed having a consumer-run organization administer the funds as the funds are allocated for consumer use. Vickie McCarty said this was an interesting proposition.</p> <p>Bonnie recommended that the CSN members form a Subcommittee to develop a proposal. The following members volunteered: Bonnie-Jean, Brent, Lydia, and Vickie.</p> <p>ACTION Subcommittee will meet, develop a proposal, circulate to CSN members, and present at November meeting.</p>
VIII. Report from the Employment Services Network (ESN)	<p>Sheryl Bowen reported that she has an open caseload of 24 clients from the Charlotte White Center. She has distributed 168 Need For Change Scales and received 158 back. Of that, 50 plus have identified a need for change in employment status. She has opened 24 cases. Of that number, some are in jail, some are homeless and some are impaired in their functioning by their mental illness.</p> <p>Discussion David McCluskey asked about the maximum ES caseload. Sheryl: 25 is the fidelity standard recommended maximum. Don asked when the Employment Services Network will be open to all in the room. Gayla Dwyer said the answer depends on the budget discussions. As the effective caseload for vocational managers is 25, she said she is not sure but hopes to know more by the first of the year. David: when does it become first come first served. Gayla: haven't gotten that far yet. Don: At some point, it's important to get everyone referring. Gayla: ESN has a standing offer to come to agencies, distribute NFC scale, gather the data and give it to the agency.</p>

Agenda Item	Discussion
	<p>Gayla said she had some good news given state budget dollars being at a premium. She has been part of a workgroup that applied for a federal section 121 Native American Rehabilitation Grant. The Houlton band received the grant.</p>
<p>IX. Report from Consumer Council of Maine</p>	<p>Vickie Reported that the Consumer Council System of Maine (CCSM) is happy to report that it has hired Elaine Ecker as its Executive Director. She noted the group is extremely happy to have Elaine and feels that she can help the organization move forward. Vickie also said that the Council is working on electing new people. She noted that the council has had quite a rough year but is working to educate people around public policy and how to advocate for themselves. The Portland Local Council has done a good job on articulating concerns around PNMI and providing data regarding the same. “We are finding our sea legs and finding that we are definitely a valuable asset to the Department and to those who serve consumers.”</p> <p>She also announced the following regional meetings:</p> <ul style="list-style-type: none"> • Portland (Region 1): Tuesday, Oct, 21st from 2-5 p.m. at the Dana Center Auditorium at Maine Medical Center, 22 Bramhall Street, Portland. • Augusta (Region 2): Monday, Oct. 27 from 1-4 p.m. at DHHS 442 Civic Center Drive, Augusta • Bangor (Region 3): Wednesday, Oct. 22nd, 1-4 p.m., Bangor Motor Inn, 701 Hogan Road, Bangor.
<p>X. Other</p>	<p>The next regularly scheduled CSN 2 meeting falls on Veteran’s Day, a holiday, so the meeting was rescheduled for Nov. 18th from 1-4 p.m.</p> <p>ACTION Sue will check on availability of room at Acadia.</p>
<p>XI. Public Comment</p>	<p>None.</p>
<p>XII. Meeting Recap and Agenda for Next Meeting</p>	<p>See ACTION items above.</p> <p><u>November Meeting Agenda:</u> OAMHS Communication Legislative—particularly budget, allow time in agenda for people to discuss concerns re same” Consumer Council Update Employment Specialist and ESN Updates Wraparound Funds Subcommittee Report Unused Prescription Drugs</p>