

**Community Service Network 2 Meeting
Dorothea Dix, Bangor, Maine
April 8, 2008**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Annette Adams, Acadia • Melinda Davis, AIN • Brent Bailey, Allies Inc. • Theresa Oliver, Bangor Counseling Center • Michelle St. Louis, Behavioral Health Center • Beth Brown, Care & Comfort • Richard Brown, Charlotte White Center • Kay Carter, CHCS | <ul style="list-style-type: none"> • David McCluskey, Community Care • Bambi McGaw, Community Mediation Services • Vickie McCarty, Consumer Council System of Me • Jill Peters, Dirigo Counseling • Jeremy Ashfield, Families United • Bob Mathien, Maine Mental Health Connections • John Spieker, Mayo Regional Hospital • Sue Rouleau, MDI Behavioral Health • | <ul style="list-style-type: none"> • Judy Provencher, Medical Care Development • Joanne Marian, NAMI-ME Families • Charles Tingley, NOE • Kathy Smith, OHI • Michael Corbin, Penobscot Valley Hospital • Lydia Richard, Together Place • Sharon Tomah, Wabanaki-Sweetser • Corey Schwinn, WCPA |
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Members Absent:

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| <ul style="list-style-type: none"> • Amicus • Blue Hill Memorial Hospital • CA Dean Memorial Hospital • Calais Regional Hospital • Down East Community Hospital | <ul style="list-style-type: none"> • Fellowship Health Resources (excused) • Maine Coast Memorial Hospital • Millinocket Regional Hospital • NFI North • Phoenix Mental Health (excused) | <ul style="list-style-type: none"> • Regional Medical Center at Lubec • St. Joseph's Hospital • Sunrise Opportunities • Wings |
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Alternates/Others Present:

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| <ul style="list-style-type: none"> • Tom Lynn, CHCS • Sharon Greenleaf, NOE | <ul style="list-style-type: none"> • Katharine Storer |
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Staff Present: DHHS/OAMHS: Sue Lauritano, Marjorie Snyder, Don Chamberlain, Leticia Huttman. Muskie School: Elaine Ecker, Cheryl LeBlond.

Agenda Item	Discussion
I. Welcome and Introductions	Sue Lauritano opened the meeting and participants introduced themselves to the group.
II. Review and Approval of Minutes	The minutes from the March meeting were approved. At this point a couple of agenda items were added: V. Consumer Council Update, HOPE Conference; and under X. Other: Kent DeMerchant, Disability Program Navigator for Washington and Aroostook Counties.
III. CSN Purpose and Mission Statements	<p>Don pointed out the new agenda format, noting it provides a more convenient way to keep track of follow-up tasks for both members and OAMHS staff. He further explained that Regional MH Team Leaders (Sue in CSN 2) will be recording follow-up tasks, reminding those responsible to complete them, and noting items that need to appear on the next meeting agenda.</p> <p>Members received handouts of draft CSN Purpose and Mission Statements. Don explained that OAMHS developed these in order to clarify the focus and function of the CSNs and to provide boundaries and guidance to future CSN work. The Purpose Statement highlights the focus on <i>adult public</i> mental health services. The Mission Statement expands the purpose and describes the makeup and work of the CSNs. (He also noted that other CSNs advised adding “family members” to the Mission Statement.)</p> <p><u>Comments:</u></p> <ul style="list-style-type: none"> • “Ensure” is like a guarantee—we don’t “ensure” anything, language too strong—“work to promote” would be better.

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	<ul style="list-style-type: none"> • Kay Carter informed that she recently read the State Health Plan, which addresses publicly funded mental health services and talks about integration of primary care and mental health—to which Dr. Elsie Freeman’s presentation at the CSN a few months ago also relates. She suggested that a presentation of the State Health Plan be on a future CSN agenda, so people can understand the broader plan and see CSNs’ work within that plan and its interface with the broader scope of health and mental health in Maine. • Dick Brown voiced his support of having the opportunity to have a comprehensive view, saying “There’s a whole other sector addressing mental health services, outside of what we do here.” • Don reminded of OAMHS’s target population and the multi-office, multi-organizational aspects of the work with the broader population. • If CSNs are going to have a vital role, we need to address the larger plan. On the other hand, we do need to work on continuity of care of this narrow group. • One member stated his understanding that the Statewide Policy Group, now disbanded, was meant to coordinate CSN efforts across the state re: continuity of care. How do the various CSNs interact with each other and what is that process? • Also, how powerful if all CSNs worked in concert on an issue... <p>Don said that OAMHS will gather feedback from all CSNs on the statements, make revisions, and bring final version(s) back next month.</p> <p>ACTION: Members may send any additional feedback to Elaine, eecker@usm.maine.edu.</p>
IV. CSN Recommendation Process	<p>Don asked members to review this handout, which puts in writing the CSN recommendation process.</p> <p>ACTION: Members may send any feedback to Elaine eecker@usm.maine.edu.</p>
V. Consumer Council Update, HOPE Conference	<p>Consumer Council System of Maine</p> <p>Vickie McCarty, CCSM Outreach for Region III, reported on current happenings with the Consumer Council System of Maine (CCSM) at the Statewide level, as well as the development of local councils in this CSN.</p> <ul style="list-style-type: none"> • The legislature passed LD 1967 making the CCSM an official independent entity. • The Statewide Consumer Council is currently recruiting an Executive Director. • The Greater Bangor Area Local Council meets on the 2nd Tuesday of the month, at the Peace & Justice Center, 120 Park Street, Bangor, from 5:30 – 7:00 p.m., including tonight (April 8). • Information and planning meeting happens on April 17, 3-5 p.m., and every 3rd Thursday, at the Charlotte White Center in Dover-Foxcroft. • Any interested parties may attend, not just consumers. CCSM is looking for allies—providers, community, and consumers—to work together to find solutions. <p>Don and Leticia joined members in congratulating the CCSM on these major accomplishments, particularly the passage of LD 1967.</p> <p>HOPE Conference</p> <p>Leticia reported on the upcoming HOPE Conference, happening on May 21st at the Augusta Civic Center entitled “Many Paths: Electing Your Future,” with keynote Matthew Mathai. She said the conference has scheduled great workshops presented by people throughout Maine, it’s also open to providers and community members, and it’s free. Also, she asked</p>

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	that any organizations with vans willing to help provide transportation to consumers contact her by phone or email.
VI. Budget	<p>Budget Outcome</p> <p><i>Please note that the minutes on this item were compiled from all April CSN meetings to account for some variation in levels of detail and for consistency, as some information became clearer throughout the month.</i></p> <p>OAMHS reported on the final legislative actions on relevant items proposed for reductions or change in the legislative budget to the best of OAMHS' knowledge, as follows: (LD 2173 and LD 2290)</p> <p><u>Bridging Rental Assistance Program (BRAP)</u></p> <ul style="list-style-type: none"> • Funding increased by \$180,000. • Passed: Proposal to move funding source from OAMHS general funds to the Maine State Housing Authority HOME Fund, for one year, to be revisited in next budget cycle (\$2.9M). The HOME Fund is supported through Maine Real Estate Transfer Tax receipts. • OAMHS will still administer the funds as before. <p><u>ACT (Assertive Community Treatment)</u></p> <ul style="list-style-type: none"> • Proposed 100% cut from general funds. FY 09 funding restored. FY 08 curtailment also restored. • ACT reimbursement: Less than 16 days in service, providers reimbursed for ½ a month; 16 or more days, full month. (Previously providers could bill for a full month regardless of number of days in service within that month.) • CMS (Centers for Medicaid and Medicare Services) is pushing for a daily rate for ACT. The rate standardization work group is currently working on daily rates, both with case management included and excluded in anticipation of CMS regulations around unbundling case management. The unbundling issue has not yet been resolved. <p><u>Community Integration (CI)</u></p> <ul style="list-style-type: none"> • Proposed 100% cut from general funds (\$1.8M). Restored \$1M. (\$500,000 from Legislature; \$250,000 each transferred from Dorothea Dix and Riverview.) • Defeated: Proposal for one CI provider per CSN. <p><u>PNMI Consumers</u></p> <ul style="list-style-type: none"> • Defeated: Proposal to make uniform the amount of income consumers retain in certain PNMI's (\$50 monthly), savings of \$150,000. • The amount clients keep is now variable, depending on provider. OAMHS would like to see this standardized and equitable throughout. <p><u>Specialized Direct Services (general funds)</u></p> <ul style="list-style-type: none"> • Restored for FY 09. FY 08 curtailment remains. • Typically covers home-based services for elders. <p><u>Intensive Community Integration (ICI)</u></p> <ul style="list-style-type: none"> • Service eliminated, both MaineCare and general funds. • OAMHS expected this level of care to go away soon due to CMS regulations regarding case management.

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	<ul style="list-style-type: none"> • Consumers may still receive CI and medication management as separate services. <p>Question: How many people received ICI services throughout the state? A: 900 on MaineCare side, approximately 1,000 overall.</p> <p><u>Outpatient</u></p> <ul style="list-style-type: none"> • Passed: Proposed 100% cut from OAMHS general funds. • Proposed \$1.4M savings in MaineCare “seed” by: 1) combining all MaineCare sections pertaining to outpatient services into one section (i.e. Sections 65, 58, 100, 111) covering mental health, certain child welfare, substance abuse, psychological services; 2) opening widely to private practitioners to enter into contracts to provide MaineCare reimbursable outpatient services; and 3) setting hourly rates as follows: \$84 licensed mental health agencies; \$88 for private practitioners PhD level; \$55 other licensed private practitioners. • HOWEVER, providers have until June 1 to propose an alternate and approvable plan to achieve the same savings. If that is not accomplished, the proposal above will go into effect for FY 09. DHHS Deputy Commissioner Geoff Green will convene meetings of provider organizations and private practitioners for this purpose, the first being held on April 29. <p><u>Crisis Consolidation</u></p> <ul style="list-style-type: none"> • The original proposal for crisis consolidation with savings of \$1M (one provider for both adults and children per DHHS District chosen through RFP process) was replaced with another proposal less disruptive to the system. • The new proposal requires crisis providers and hospitals to accomplish the same goals (one provider or one “lead provider” for both adults and children per DHHS District that achieve specified savings) through Memorandums of Understanding (MOUs). The DHHS Districts correspond to CSN boundaries, with the exception of this CSN (2), which is divided into DHHS Districts 6 and 7, Piscataquis/Penobscot and Washington/Hancock, respectively. • The implementation of the plan is postponed to March 1, 2009, and requires savings before the end of FY 09 of \$134,000 MaineCare seed each for children and adults and \$33,600 in General Funds each for children and adults. OAMHS will issue contracts to current providers for eight months, with instructions to come together to work out solutions and MOUs by the beginning of February 2009. • OAMHS will include consumer and family representatives in their planning discussion to determine requirements and parameters for service delivery. Providers will negotiate what needs to be done to bring that about and execute MOUs. Consumers and families will participate with OAMHS in going over the resulting MOUs. <p>Comments:</p> <ul style="list-style-type: none"> • Who’s coordinating the discussions? A: Haven’t gotten that far yet, ‘adult’ and ‘kids’ offices need to work together to fully assess current structures, funds, etc. Then someone at the state level will convene, enlist stakeholders, and discuss the best way to structure the crisis system and the best ways to make savings. <p><u>Other</u></p> <ul style="list-style-type: none"> • NAMI-ME: Restored 50%. (FY 08 \$34,000; FY 09 \$138,900) • Amistad: Restored 100%. (FY 08 \$11,000; FY 09 \$44,000) • Maine Center for Deafness: Restored 100%. (FY 09 \$42,600)

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	<p><u>OAMHS Positions Eliminated</u></p> <ul style="list-style-type: none"> • 14 positions eliminated: 13 ICMs (Intensive Case Managers) and one central office manager. • ICM positions: 3 Long-Term Support (LTS) coordinators (employment); 3 Housing Coordinators; 3 Youth in Transition Coordinators. • Employment and housing functions will be covered by other means. • ICMs now focus on homeless, jail, shelter populations. Not carrying caseloads, rather connecting people to community services. <p>Questions/Comments:</p> <ul style="list-style-type: none"> • What do we do now re: LTS approval? A: Until July 1, continue as usual. We're in discussions, though not finalized, with Maine Medical Center Vocational Dept to have the Employment Specialists take on this responsibility. Won't change any contracts with providers, just the approval process. • Any announcement about the Employment Specialists? A: We believe MMC Voc Dept is notifying people this week of where the positions will be embedded. Most are hired, though a couple of positions are not filled. • Wait lists for services in Washington County continue to increase, while people are being laid off in local agencies. These are more than statistics, they are families that live in chaos. A: The reality of the state budget presently does result in some people not being served. No one likes it, and no one wants it this way. • Thought the purpose of CSNs was to fix gaps, but nothing gets addressed. Why do we continue to meet if little input gets respected? A lot of work is done and then gets ignored. A: OAMHS is mandated by the Consent Decree to identify unmet needs and then obligated to request funding for unmet needs. It's then up to the Governor and the Legislature to make the funding decisions. <p>Status of Grant Funding</p> <ul style="list-style-type: none"> • Class member entitlements will be paid from grant/general funds, if the member is not a MaineCare recipient. • As of July 1, general funds for CI, ACT, and WRAP will not be distributed through the contract process as in the past. OAMHS will retain the funds and pay on a case-by-case basis through an application process. The goals are to achieve more equitable distribution among providers and to serve the most needy with the limited funding. • Guidelines for WRAP fund use have not changed. • OAMHS is working on establishing eligibility criteria for CI and ACT. (See next agenda item.)
VI. Eligibility Criteria	<p>Don asked for input from CSN members as to establishing eligibility criteria for CI and ACT grant funds for people not eligible to receive those services through MaineCare. Acuity? Financial criteria?</p> <p>Questions/Comments:</p> <ul style="list-style-type: none"> • How defined now? A: Prior to cuts, anyone meeting "Section 17" clinical criteria was eligible. • Members discussed the "GAF score under 50" criteria listed in MaineCare Section 17. A consumer member said that people are being dropped because their GAF is above 50. A: A rising GAF score is not criteria to drop a person <u>already in service</u>. Suggest appeal if that occurs. • Who determines if person will deteriorate without service, and on what is it based? A: Clinician, through case review and assessment. Clinician is taking responsibility? A: Yes, and for MaineCare services APS Healthcare also. <p>Criteria suggestions:</p> <ul style="list-style-type: none"> • Two populations to prioritize: 1) people coming out of Maine State Prison after long incarcerations, and 2) families

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	<p>with mental health issues who lost their children due to child protective (they lose MaineCare in those cases).</p> <ul style="list-style-type: none"> • Should be equal access based on clinical criteria. Financial status is a totally separate question. • Look at opening MaineCare non-categorical coverage to include Community Integration. • If populations “A,B,C” are prioritized, the populations “D,E,F” will never be heard from. We won’t have true unmet needs information. • Another idea—short-term case managers/benefit specialists to work with people to get on MaineCare. <p>ACTION: Don will follow-up on the idea of opening MaineCare non-categorical coverage to include Community Integration.</p> <p>ACTION: Members may forward any additional thoughts or ideas to Elaine, eecker@usm.maine.edu.</p>
VII. RDS/EIS Unmet	<p>Members received several data documents prepared by Helen Hemminger of the Muskie School depicting and explaining 14 categories of unmet needs data derived from the RDS/EIS system for the 2nd quarter FY08. The data is separated by CSN and comparisons made between statewide numbers and other CSNs. The intent is to look at the data over time and compare quarterly reports on an ongoing basis.</p> <p>Don explained that all clients receiving any level of community integration services, whether funded by MaineCare or general funds, should be enrolled and ISP information updated every 90 days by providers. The enrollment and open case numbers show that <u>many</u> clients are not enrolled, re-enrolled, or overdue for update.</p> <p>Comments:</p> <ul style="list-style-type: none"> • If consumers aren’t educated about what’s available, they won’t ask for it, and it therefore won’t appear on ISPs as unmet needs. • Is there a Quality Assurance process that takes place on this system? We’ve entered information and then received letters [from OAMHS] saying we haven’t entered it. Is the system capturing what we’re reporting? A: yes, QA on the system; don’t have QA on what provider staff enters. <p>Don asked that if a provider is finding information isn’t being posted, to identify cases examples and send to Don, and IT staff will work with the provider. His understanding from IT is that the problem is not seen as resting with the system—it has historically, but not now. If fields are entered correctly, it goes through, he said.</p>
VIII. Enrollments/RDS	<p>Don informed that the enrollments and updates must be brought within 15% completion by May 1 (since postponed to May 15th), and providers have received notice of contractual consequences for not meeting this requirement. Once the 15% completion target is met and data is clean enough for transfer, APS will take over this function. Providers will then only enroll clients once, rather than twice as required under the current system.</p>
IX. CI Consolidation Work Group	<p>“There is no substitute for victory.” Dick Brown stated that the turnaround on this issue started with this group and powerful consumer representation, along with Helen Bailey clarifying the Plaintiffs’ position—changing the whole tenor of the legislative discussion. “Thank you all.”</p>
X. Med Management (with ICI ending)	<p>Kay Carter said that CHCS is in the process of transitioning ICI to a combination of CI and Med Management. The challenging piece: In the past ICI provided onsite med management and helped people over time learn to manage their meds in a step-by-step process to independence. In some cases people started out receiving their medications at the agency daily, then progress to managing their own weekly supply, to eventually managing on their own. It’s a challenge to translate that to CI [case managers], due to both knowledge base and time.</p>

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	<p>The discussion branched out into broader scope of med management issues. Don raised that Dr. Stevan Gressitt, new OAMHS Medical Director, will be requiring all organizations involved in med management to have a medical director. OAMHS assumed most agencies had a medical director, per licensing, but turned out not to be the case. More information on this is forthcoming, Don said.</p> <ul style="list-style-type: none"> • WCPA has ¼ - ½ time medication management—will incur additional expense and liability if acts as medical director, too. • Could be a barrier for Allies, Inc., in implementing plan for med management. • Also looking at rate structures coming out of work group—seen preliminary drafts and done modeling, substantially changes programs. • New rate structure won't accommodate rural delivery of that service. Reimbursed now by the ¼ hour—proposed to be “event” reimbursement, i.e. one payment regardless of time spent. • Re: medical director requirement: It's important to break out the <u>functions</u> you're looking for—people's definitions might differ. A: Good point. • Washington County needs subsidies for med management. (See next agenda item.)
<p>XI. Work Plan Subcommittee Reports</p>	<p>Washington County Med Management</p> <p>Don provided OAMHS's response to the recommendations made by the subcommittee and CSN as a whole. OAMHS is “grappling with med management,” Don said, noting on one hand the focus on people with severe and persistent mental illness required by the Consent Decree, and on the other, the need to broaden perspective and include other “offices” in working on this common issue. Solutions will be multi-office, multi-dimensional, with all players at the table, including Health Centers. OAMHS is supportive of consultation model [psychiatrists providing consultation to prescribing primary care physicians].</p> <p>Vickie McCarty informed that Washington County residential or group home clients have to go to Hancock County for med management. She also voiced concern that primary care physicians (PCPs) don't have time to keep current in the field of psychiatric medications—it will require education. Also, PCPs sometimes change prescriptions to meds that don't work as well.</p> <p>Kay stressed the importance of exploring/working on the interface between FQHCs [Federally Qualified Health Centers] and community mental health services, i.e. behavioral health in both community mental health and in healthcare—how to interface funding, what it means for people without primary care physicians, etc. She revisited the idea of reviewing the State Health Plan to get the broader perspective. Discussion resulted in the following motion being made, seconded, and passed by majority vote:</p> <p>MOTION: That the CSN invite Trish Riley or her designee to come to the CSN and inform about portions of the State Health Plan pertaining to the integration of community mental health centers and behavioral health in FQHCs and the integration of behavioral health and health care as envisioned in the State Health Plan.</p> <p>Joanne Marian suggested contacting two people who were willing to share their perspectives and experiences on these issues: Dr. Sue Bailey, now at Johns Hopkins, provided psychiatric services in Washington County for several years (at some personal sacrifice) and Holly Gartmeyer, now at Katahdin Valley Health Center, was key in the collaborative effort that brought mental health services into the Harrington Family Health Center.</p>

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	<p>Hospital/ISP Standards 5, 18 The subcommittee reports it has been stymied in collecting the information/data necessary to address the issue of why ISPs are not included in files of involuntary class member admissions in high enough numbers/percentages to meet the Consent Decree standard.</p> <p>Don stated that OAMHS is showing no progress on this standard and really needs to do so. He said members from crisis, hospitals, and community integration in this CSN need to “get down to the nitty-gritty” of where the barriers are, where the problems are in the handoff or communication that needs to occur. He also said that while the standard only pertains to involuntary class member admissions, the broader picture re: ISPs to hospitals must be addressed and improved as well.</p> <p>After members discussed whether this is a real problem in this CSN, what information is collected, who collects it, where it is collected, etc., it became evident that Dorothea Dix is the only hospital in the CSN where UR nurses would collect this information.</p> <p>Marjorie Snyder stated she had no knowledge of UR nurses looking at Dorothea Dix files and wondered exactly what the process could be or if they knew where to look in what quickly become very large files. She offered to go back through patient files and collect data on both voluntary and involuntary admissions, and once she knows what exactly UR nurses collect, to reconstruct the data accurately and to continue collecting future data for a period of time.</p> <p>When the data is available, the subcommittee can address whatever issues surface in order to make any necessary improvements.</p> <p>ACTION: Sue Lauritano will get information to Marjorie on what UR nurses collect in their reviews.</p> <p>Peer Services Leticia distributed a report from the subcommittee that met to discuss peer support development work in this CSN, outside of the Bangor area. They discussed the possibilities of finding an intern from the academic community or a VISTA volunteer, and also contacting the ecumenical council in Dover as a possible “connection hub” for the peer developer. They discussed possibilities in Washington County as well where the discussion explored the start and growth of support groups. Leticia also confirmed that the Advocacy Initiative Network (AIN) will act as fiscal agent as recommended by the CSN.</p> <p>At their next meeting, the subcommittee will continue to discuss possible internship and also a feasible plan for expenditure of money during FY 08.</p> <p>Comment: You may want to include nursing programs in possible contacts.</p>
X. Other	Kent DeMerchant, Career Center Disability Program Navigator for Washington and Aroostook Counties, introduced himself, described his services, and encouraged people to contact him for assistance. He said he functions as a link between people with disabilities and what they need to become employed. He works with Work Incentive Coordinators and expects to be part of the Employment Service Networks currently under development.
XI. Public Comment	No public comment.
XII. Meeting Recap and Agenda for Next Meeting	<u>Meeting Recap</u> See ACTION items above.

Agenda Item	Discussion
	<p><u>Next Agenda</u> CSN Purpose and Mission Statements Consumer Council Update Update on Rehab Option Budget Impact on Agencies Abandonment of Care Issues Work Plan Subcommittee Reports ICM Role, ICM Changes State Health Plan Presentation? Enrollments/RDS Update</p>