

**Community Service Network 3 Meeting – Kennebec, Somerset Counties  
Maine Principals' Association  
November 9, 2006**

**Minutes**

**Present:** Lora Wilford-McManus, Youth & Family Services; Karen Fatz, Mt. St. Joseph; Richard Weiss, Motivational Services; Dick Willauer, Alternative Services; Ann Lang, NAMI-ME; Emilie van Eeghen, Health Reach Network/MaineGeneral; Cheryl Davis, Donna Kelley, Karen Mosher, KVMHC; Mark Tully, CCA; Harold Graham, Graham Behavioral Svcs; Heather Gallant, ESM; Linda Baker, LINC; Ric Hanley, Spring Harbor; Amy Wilmot, Community Mediation Services; Rick Karges, Crisis & Counseling; W C Martin, Common Connections; Mark Jackson, Harmony Support Center; Elizabeth Dostie, Maine Children's Home, Don Harden, Catholic Charities. Presenters from OAMHS: Ron Welch, Leticia Huttman, Don Chamberlain, Marya Faust, Sharon Arsenault. Muskie School: Nadine Edris, Janice Daley, Elaine Ecker.

Agenda Item	Presentation, Discussion, Questions
I. Welcome and Introductions	Sharon Arsenault, Region II Team Leader, welcomed everyone to the meeting and introductions were made around the table, including the members of OAMHS senior management team presenting the program.
II. Overview of the Mental Health Plan approved by the Court Master on October 13, 2006.	<p>Ron Welch, Director of DHHS Office of Adult Mental Health Services (OAMHS), explained that this is the first meeting of the first round of meetings planned by OAMHS senior management to introduce the Community Service Networks in all 7 areas. The second round is already scheduled for dates in December.</p> <p>Ron presented an overview of the Consent Decree Plan, signed on October 13, 2006. He focused on Chapter 4 of the Plan, Continuity of Care and Services, which includes the formation of Community Service Networks (CSNs). This is "the heart of how communities work together to meets the needs of people with mental illness," he said.</p> <p>The entire program was accompanied by a comprehensive PowerPoint presentation. Handouts were distributed to everyone present.</p> <p>Ron explained the 4 major components, which he calls "The Four Cornerstones" of Chapter 4 of the Plan. They appear below as A, B, C, and D. He emphasized the overarching theme of recovery, and the underpinning foundation of vocational services which needs significant strengthening.</p>
<b>A. Seven Community Service Networks.</b>	<ul style="list-style-type: none"> <li>• The state is divided into <b>7 CSNs</b> (see chart on website).</li> <li>• Each CSN provides <b>8 core services</b>: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services.</li> <li>• <b>Functions</b> of CSNs: <ul style="list-style-type: none"> <li>▸ Assure delivery of services to all adult mental health consumers in the network area.</li> <li>▸ Maintain a "no reject" policy so that no consumer is refused needed service within the CSN area. <b>Question:</b> A member stated that more information is needed on "no reject" policy for organization to be able to sign the Contract Amendment. "What exactly is the provider committing to?" <b>Answer:</b> This will be covered in more detail later in the presentation.</li> <li>▸ Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. "Complex needs" means those that may be difficult to meet within normal services, i.e. co-occurring disorders, additional medical conditions, or physical disabilities.</li> <li>▸ Identify services necessary for consumers in the CSN who are at risk and provide those services.</li> <li>▸ Comply with all provisions of the Bates v. DHHS Consent Decree, especially where service coordination within the core service array is necessary.</li> </ul> </li> </ul>

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		<ul style="list-style-type: none"> <li>› Assess and identify resource gaps by geographical area and establish remedial measures and implementation timeframes. Ron said the goal is to have these gaps identified by January. Remedial measures may require development of fiscal strategies.</li> <li>› Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis. Ron referred to this as the “I-Beam” of the network—very important.</li> <li>› Plan based on data and consumer outcomes. Feedback on this missing under prior system, Ron said.</li> <li>› Implement the Rapid Response protocols. Sharon Arsenault will be meeting with hospitals/providers to get this underway very soon.</li> <li>› Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Ron stated that this is the heart of continuity of care. <b>Question:</b> A member asked if OAMHS will address the reimbursement implications of this? <b>Answer:</b> Yes, we have to.</li> <li>› Assure continuity of treatment during hospitalization and the full protection of a client’s right to due process.</li> <li>› Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein. This is an important change, Ron explained, with very real authority vested to them through the Court order, which must be recognized. <b>Question:</b> To clarify, the authority to coordinate does not mean the authority to prescribe? <b>Answer:</b> That’s right. Prescribing is not within the duties of a CSW.</li> </ul>
	<p><b>B. Performance Requirements/ Enforcement through contracts.</b></p>	<ul style="list-style-type: none"> <li>• <b>Contract Amendments</b> were mailed out to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding for each CSN. Ron said Plan outlines termination provisions (“the stick”) for non-compliance; and though DHHS may have a reputation among providers for not enforcing contracts, this protocol will be enforced.</li> <li>• <b>Legislation</b> is expected to define CSNs, assure momentum, and provide consistency with managed care “irrespective of what it does.”</li> <li>• <b>Quality Management Structure</b> <ul style="list-style-type: none"> <li>› Replace monthly provider meetings with network meetings.</li> <li>› Provide data by agency and by network. Every month and every quarter OAMHS will provide data—“information for you to make decisions with,” Ron said.</li> <li>› Problem-solve within network, with local consumer council.</li> </ul> </li> <li>• <b>Realignment of Services</b> <u>Community Support Services:</u> <ul style="list-style-type: none"> <li>› Each consumer will have CSW to coordinate ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. Ron iterated this does not include prescribing.</li> <li>› CSW’s employer is the lead agency for the client.</li> <li>› Providers must assure 24/7 access to: ISP, Crisis Plan, health care advance directives, contact information for prescriber, and basic demographic and service information. Typically, this pertains to crisis people or ER, Ron explained.</li> </ul> </li> </ul>

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		<p><u>Crisis Services:</u></p> <ul style="list-style-type: none"> <li>▸ Provided outside the Emergency Department, unless: consumer requests otherwise, medical condition need treatment, or person is in protective custody of the justice system.</li> <li>▸ Consumer's CSW is responsible during business hours.</li> <li>▸ During non-business hours, crisis service is responsible, unless consumer is enrolled in ACT. By definition, ACT is responsible 24/7, Ron stated.</li> </ul> <p><b>Question:</b> Can you explain the pragmatics of the CSW doing this?</p> <p><b>Answer:</b> What this means is the CSW is the key person to work the system for the consumer. The consumer still calls crisis, and the agency is responsible to be first responder. The consumer's CSW may or may not be able/available to triage. It's the responsibility of the agency—not the CSW at all times.</p> <p><b>Question:</b> A member stated that some consumers don't have a case manager; and sometimes when they come to the ER, the hospital (questioned one in particular) assesses that they don't need services. "I wouldn't be there if I didn't need services. What do I do next? Where do I go if [hospital] doesn't think I need services?"</p> <p><b>Answer:</b> (from hospital representative/member) That would warrant and justify spending case review time to address the situation with the person as quickly as possible. The hospital representative/member offered to discuss this with the member after the meeting.</p> <ul style="list-style-type: none"> <li>▸ In Emergency Department, crisis provider must: assess for less restrictive alternatives to hospitalization, locate and arrange for those services, and review crisis plan and advance directives.</li> </ul> <p><u>Hospital Services</u></p> <ul style="list-style-type: none"> <li>▸ Community hospitals are the first level of hospitalization response. MaineCare amendment will assure no-reject policy. Ron further explained that this pertains to community hospitals with or without psychiatric units. The MaineCare amendment focuses on the hospital's participation in the CSN (i.e. signing MOU) and provides incentive to hospitals when someone with mental illness presents in their ER.</li> <li>▸ Specialty hospitals, Acadia and Spring Harbor, are the next line of treatment. They will take admissions from community hospitals.</li> <li>▸ Public hospitals, Riverview and Dorothea Dix, will take referrals from Spring Harbor and Acadia, as well as forensic admissions. There is a list of exemptions to these referral steps contained in the Plan, Ron said.</li> </ul> <p><b>Comment:</b> Perhaps a decision tree tool that we've talked about before would be helpful.</p> <p><b>Question:</b> Is Riverview included at this table?</p> <p><b>Answer:</b> Yes. I don't know what happened today [that they're absent].</p>
	<p><b>C. Permanent Housing with Flexible Services</b></p>	<p>Ron explained that treatment services will be unbundled from housing under the Plan, and will be provided as needed, when needed to consumers in homes of their own choice.</p> <p><b>The current link between services and housing will be broken. Only residential treatment will remain as a group home model or bundled service.</b></p> <p>PNMI is currently the major choice for residential treatment:</p> <ul style="list-style-type: none"> <li>• This model requires the highest level of intervention for all residents, irrespective of need.</li> <li>• A needs assessment for this level of care will be undertaken to determine where and how many beds should be retained. Ron informed that each CSN will determine this.</li> </ul>

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	<p><b>D. Consumer Councils and required peer services.</b></p>	<p>This cornerstone will be covered in the detail later in the program, Ron informed, but highlighted the fact that for the first time consumer participation takes a prominent place in the mental health system.</p> <ul style="list-style-type: none"> <li>• Through 3<sup>rd</sup> supplemental budget of the 122<sup>nd</sup> Legislature, a mandate with \$323,000 was passed to establish consumer councils statewide.</li> <li>• A Transition Planning Group was formed with representation from virtually all segments of the consumer community. That work is underway and will be presented as part of this program.</li> <li>• This particular cornerstone will affect the strength and tenacity of all of the others.</li> <li>• It will undoubtedly have more impact in how the Maine mental health system delivers services than any other.</li> </ul>
	<p><b>Vocational Services</b></p>	<p>Ron reiterated the vital importance of <b>work</b> in an individual's recovery process. "It's absolutely core," he said, "and it hasn't been how we looked at the world heretofore."</p> <ul style="list-style-type: none"> <li>• Vocational services are absolutely pivotal to successful recovery.</li> <li>• 2 benefit specialists and 4 employment specialists will be out-posted across the state.</li> <li>• Each will produce work for a percentage of their caseload—15% of their clientele end up with work by the end of the contract year, Ron said.</li> </ul> <p><b>Question:</b> The employment specialists will be doing job development and getting people employed?  <b>Answer:</b> Yes, real live people are included in the budget.</p> <ul style="list-style-type: none"> <li>• Training will be provided to over 525 CSWs across the state, as to the critical importance of work in the recovery process.</li> <li>• DHHS entered into an MOU with the Dept. of Labor and Bureau of Rehabilitation Services outlining the respective responsibilities of each. (Both Departments are named defendants in this litigation.)</li> </ul> <p><b>Question:</b> Could we get a copy of this?  <b>Answer:</b> Yes, we will get that out.</p> <ul style="list-style-type: none"> <li>• Employment specialists, as is required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work.</li> </ul>
<p>III. Consumer Council and Consumer and Family Representation</p>		<p>Leticia Huttman, Director of the Office of Consumer Affairs, presented this portion of the program.</p> <p><b>Development of Statewide Consumer Council System</b></p> <p>Leticia said that though past efforts have not really been successful to organize and develop consumer voice, this new effort is well underway and holds much promise. The development of the consumer council system began in April 2006 when the Transitional Planning Group (TPG) began to meet. The TPG is comprised of consumer leaders, meeting biweekly in a facilitated process. Their mission is to develop the basic elements and structure of the independent Statewide Consumer Council system. The TPG is responsible for its own mission and processes, independent of OAMHS.</p>

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	<p>The TPG has developed a timeline, as follows:</p> <ul style="list-style-type: none"> <li>• April 2006 – TPG begins meeting</li> <li>• March 2007 – 3 Regional Conferences</li> <li>• May 2007 – Form at least 3 temporary regional councils</li> <li>• June 2007 – Statewide Council seated and holds first meeting</li> <li>• August 2007 – 7 Local Consumer Councils formed</li> </ul> <p>The March conferences, Leticia explained, are to kick off the education process, help people understand what’s involved, and form the temporary regional councils. The TPG has hired outreach workers to help with pre-work for conferences, and they will be contacting providers.</p> <p>The draft design of the system consists of multiple tiers: Temporary and Periodic Regional Councils, Statewide Consumer Council, and Local Consumer Councils. The Temporary and Periodic Regional Councils will basically operate until the Statewide and Local Consumer Councils are formed, fading over time as this happens. Eventually, many Local Councils will be functioning throughout the State. They will be comprised of consumers from a wide variety of settings: Peer support programs, peer centers and social clubs, provider agencies, hospitals, at-large consumers, homeless shelters, and other places yet to be thought of.</p> <p><b>Suggestion:</b> Add clubhouses?  <b>Answer:</b> Yes—that why we have blank circles—we know there are other avenues and places from which to draw.</p> <p>The meetings will be held in the form of town meetings, where all can contribute. The members or officers will be chosen based on an application process to be sure a diversity of experiences is represented, e.g. experience with peer services, hospitalization, co-occurring disorders, vocational services, etc. “For the councils to be legitimate, they need to bring broad-based experiences,” Leticia said. The Local Councils will elect representatives to send to the Statewide Consumer Council.</p> <p>Functions of Local Consumer Councils:</p> <ul style="list-style-type: none"> <li>• Have a role in meaningful quality assessments.</li> <li>• Advocate/advise for local response to local issues.</li> <li>• Report with representation to the full Statewide Consumer Council system.</li> <li>• Receive and transmit information from wider world.</li> <li>• Outreach for concerns beyond our members. For instance, problems in the area with landlords, police, etc., could be addressed in the local council, Leticia mentioned.</li> <li>• Regional work to create and support local council efforts.</li> </ul> <p>Mission and Function of Statewide Consumer Council:</p> <ul style="list-style-type: none"> <li>• Provide one-stop access for advice and planning on issues affecting lives of consumers.</li> <li>• Advice directed to and developed with DHHS and also to other departments and administrations—such as Dept. of Labor, Corrections, town hall, etc.</li> <li>• Opportunity for consumers to learn from one another and to increase the impact of advice offered.</li> <li>• Support consumer-advising skills and develop interest in the Council system. The Council will provide an avenue to “hone skills” and become more knowledgeable and successful in interactions and participation, Leticia said.</li> <li>• Develop/implement and oversee quality assessment of services and delivery systems in order to ensure quality services and participate in effective design. Consumers will work hand-in-hand with CSN, participating in quality assurance activities.</li> </ul>

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	<p><b>Consumer and Family Participation in Community Service Networks</b>  Consumer representatives in the CSNs will come from two places: Each local council when formed (TPG representation in the interim) and from all peer centers/social clubs within contracted agencies or contracted independently with OAMHS. Training and consumer support for participation in the CSN is being developed to give people tools to engage in partnerships, Leticia said.</p> <p>NAMI-ME is also providing a family member to each CSN to represent the concerns of families with adult family members who are living with mental illness.</p> <p><b>Comment:</b> This new council system might be able to provide consumer input to other groups that struggle for consumer participation, like homeless councils...</p> <p><b>Answer:</b> That's true. We see a lot of potential for things like that.</p>
<p>IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols</p>	<p>Don Chamberlain presented the details of the CSN Implementation Plan, MOU, and Operational Protocols.</p> <p><b><u>CSN IMPLEMENTATION PLAN</u></b></p> <p><b>Development Timeframe</b></p> <ul style="list-style-type: none"> <li>• Immediate deadlines are signing the contract amendments by November 19 and executing the MOUs and Operational Protocols by January 3. During November and December CSN participants will give input on roles, expectations, responsibilities, and develop MOU and Operational Protocols, signing both documents no later than January 3.</li> <li>• Over time with input from all parties: Statewide Policy Committee and monthly network meetings. By February 2007, CSN work plans will be created and CSNs will select participants for the State-Wide Policy Council (may push this date back to January, Don said). Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider.</li> </ul> <p><b>State-Wide Policy Council</b>  This council will be convened by OAMHS in February 2007 and will be directed by OAMHS senior management. Duties and timeframes as follows:</p> <ul style="list-style-type: none"> <li>• Managing dynamics of network responsibilities. (February)</li> <li>• Assessing compliance with "no reject" policy. (March)</li> <li>• Assessing 24/7 CSW access. (March)</li> <li>• Review resource gaps and make recommendations. (March)</li> <li>• Develop and implement network-level planning tools. (May)</li> <li>• Identify all QA and QI performance measures that will become purview of CSNs to monitor and report on to OAMHS. (May-June)</li> <li>• This includes QA and QI processes and protocols that CSNs will use for review of data and recommendations to OAMHS. (May-June)</li> <li>• Develop CSN performance review process. (July)</li> </ul> <p><b><u>MEMORANDUM OF UNDERSTANDING</u></b></p> <p>Don explained that OAMHS is gathering feedback and potential changes to the MOU through November. At the December meetings, CSNs will vote on any recommended changes for consideration by OAMHS. OAMHS then intends to craft one MOU to be used by all</p>

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	<p>CSNs. The MOU, as currently drafted, (and distributed in various mailings and in the Consent Decree Quarterly report), contains the following elements:</p> <p><b>Goals of CSN</b></p> <ul style="list-style-type: none"> <li>• Provide integrated system of care</li> <li>• Core services available in area</li> <li>• Consumers' changing needs met seamlessly</li> <li>• Improve continuity of care, efficiency, outcomes, cost effectiveness</li> </ul> <p><b>Guiding Principles</b></p> <ul style="list-style-type: none"> <li>• Focus is adult mental health consumer—agencies have broader scope, but this applies only to adult mental health consumers.</li> <li>• Quality of care depends on access and transitions without disconnection.</li> <li>• Coordination makes effective, responsive system.</li> <li>• Local planning, local problem solving, and a mutual understanding of the roles and expectations of each services provider should be effective ways to support continuity of care. This is a central principle of Consent Decree Plan, Don stated.</li> <li>• Based on current best practices and evidence based models, the mental health system must support consumers becoming knowledgeable about their condition, the availability of services, and self-directed regarding services.</li> <li>• Providers and systems practice collaboration across disciplines, including peer disciplines, and health specialties. This recognizes the need for crosswalk of medical needs, Don added.</li> </ul> <p><b>Structure of CSN</b></p> <ul style="list-style-type: none"> <li>• Meet at least monthly</li> <li>• Establish and oversee operational protocols</li> <li>• Establish outcome measures and assure quality</li> <li>• Establish sub and ad hoc committees, as necessary</li> <li>• Chaired by OAMHS</li> </ul> <p><b>Agreement and Responsibilities</b></p> <p>Each member agrees to:</p> <ul style="list-style-type: none"> <li>• Assure delivery of services to all adult mental health consumers in the network area.</li> <li>• Maintain a “no reject” policy so that no consumer is refused needed service within the CSN area.</li> <li>• Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served.</li> <li>• Identify services necessary for consumers in the CSN who are at risk and provide those services.</li> <li>• Comply with all provisions of the Bates v. DHHS Consent Decree, especially where services coordination within the core service array is necessary.</li> <li>• Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis.</li> <li>• Plan based on data and consumer outcomes.</li> <li>• Implement the Rapid Response protocols. Don apologized that these were not yet in place and said Sharon would be meeting with all involved to get these protocols underway.</li> <li>• Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Don emphasized the importance of including the CSW at these meetings.</li> </ul>

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	<p><b>Comment:</b> “A lot of us don’t have case workers, are on a long wait list, or we don’t fit in categories--so we’re out of luck,” one member stated.</p> <p><b>Answer:</b> We have to address the wait lists and eligibility issues.</p> <p><b>Comment:</b> It’s hard on families, too. We’re looking for answers to these issues.</p> <ul style="list-style-type: none"> <li>• Assure continuity of treatment during hospitalization and the full protections of a client’s right to due process.</li> <li>• Recognize the authority of the community support staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein.</li> </ul> <p>The participant will:</p> <ul style="list-style-type: none"> <li>• Appoint a representative who has the authority to make commitments on behalf of the participant and who will attend monthly meetings of the CSN.</li> <li>• Join in appropriate special projects and committees may be developed by the CSN.</li> <li>• Commit to the guiding principles, goals, and structure outlined above.</li> </ul> <p>Don mentioned again that members can give feedback on potential changes to MOU.</p> <p><b><u>OPERATIONAL PROTOCOLS</u></b></p> <p><b>Purpose and Goals</b></p> <ul style="list-style-type: none"> <li>• Same as listed under MOU “Goals of CSN” above.</li> </ul> <p><b>Membership</b></p> <ul style="list-style-type: none"> <li>• Each provider required to designate a representative.</li> <li>• Representative must be able to speak for organization.</li> <li>• Consistent representation is expected.</li> <li>• Not intended to be rotating designees.</li> <li>• Substitute designees may discuss, but not vote.</li> </ul> <p><i>Eligibility:</i></p> <ul style="list-style-type: none"> <li>• One representative from each provider with contracts with OAMHS who provide any of the core services.</li> <li>• One representative from each community hospital, with and without psychiatric units.</li> <li>• One representative from the psychiatric specialty hospital and from the state hospital.</li> <li>• One to three consumer representatives chosen by the consumer-run Transition Planning Group (eventually replaced by Consumer Council representatives).</li> <li>• One representative per social club or peer center, if part of a larger agency contracted to provide more than peer services.</li> <li>• One representative from NAMI-ME.</li> <li>• One representative from Community Mediation Services.</li> </ul> <p><i>Service Array:</i></p> <ul style="list-style-type: none"> <li>• Eight core services</li> </ul> <p><i>Chairperson:</i></p> <ul style="list-style-type: none"> <li>• Senior staff member of OAMHS.</li> </ul> <p><i>Changes to Membership:</i></p> <ul style="list-style-type: none"> <li>• May change depending on needs of CSN and changes in services/providers in CSN area.</li> </ul>

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	<p><i>Decision Making:</i></p> <ul style="list-style-type: none"> <li>• Each member has one vote—vote shall be recommendation to OAMHS.</li> </ul> <p><b>Meetings</b></p> <p><i>Regular:</i></p> <ul style="list-style-type: none"> <li>• At least monthly, more often if necessary.</li> <li>• Scheduled by OAMHS.</li> </ul> <p><i>Special:</i></p> <ul style="list-style-type: none"> <li>• Called by OAMHS on its own or at the request of majority of membership.</li> </ul> <p><i>Notice:</i></p> <ul style="list-style-type: none"> <li>• Notice given to each member not less than one week prior.</li> </ul> <p><i>Quorum:</i></p> <ul style="list-style-type: none"> <li>• Discussion and recommendations take place with those members present.</li> </ul> <p><i>Voting:</i></p> <ul style="list-style-type: none"> <li>• CSN decides on issues it shall vote upon.</li> <li>• Decided by simple majority of those present.</li> <li>• Advisory to OAMHS unless OAMHS states it will act on the vote.</li> </ul> <p><i>Attendance:</i></p> <ul style="list-style-type: none"> <li>• Absence from 3 or more consecutive meetings shall be reason for contract or provider agreement review.</li> </ul> <p><b>Question:</b> Does sending a designee count as attending?  <b>Answer:</b> No, not currently. We may want to address this.</p> <p><i>Agenda:</i></p> <ul style="list-style-type: none"> <li>• Set by OAMHS with input from membership.</li> <li>• Include time set aside at each meeting for public comments.</li> </ul> <p><b>Ad Hoc Committees</b></p> <ul style="list-style-type: none"> <li>• CSN may designate ad hoc committees.</li> <li>• Chair will appoint committee chairs.</li> <li>• Committees will report to full CSN.</li> </ul> <p>Don clarified that committees will not “go off on their own—they are responsible to the whole CSN.”</p> <p><b>Amendments</b></p> <ul style="list-style-type: none"> <li>• CSN may amend the operational protocols from time to time.</li> <li>• Proposed amendments must receive majority vote of members present.</li> <li>• Proposed amendments must be approved by OAMHS before acceptance.</li> </ul>
<p>V. Consent Decree Standards: Indicators for Performance</p>	<p>Marya Faust, Director of Policy, gave an overview and explanation of the Performance and Quality Improvement Standards that are part of the approved Consent Decree Plan.</p> <ul style="list-style-type: none"> <li>• 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. “Some are aimed at how well OAMHS is doing, but most are aimed at how well we are doing together,” Marya said.</li> <li>• OAMHS reports on these standards quarterly and all documents included in the reports are posted on OAMHS website.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Riverview Psychiatric Center has its own set of measures, also included in the quarterly reports. Dorothea Dix was not a party in the Settlement Agreement, so it is not part of this reporting process.</li> <li>• Some standards are measures of all people using the services and some are just for class members.</li> <li>• Anyone who was a patient at AMHI on or after January 1, 1988, is a class member. This provision extends to Riverview, and each new admission becomes a part of the pool of class members. The number continues to grow.</li> <li>• The standards present a picture of how the mental health system is operating. Marya said that OAMHS will be consistently focusing on this picture “to see how we’re all doing.”</li> </ul> <p>Meeting performance standards does not necessarily mean “compliance,” Marya explained. Being in compliance adds another level of complexity—like how long the standard is maintained, for example—which will be negotiated with the Court Master and Plaintiffs. She gave the following example of a current <i>performance standard</i> and an example of a possible <i>compliance standard</i>:</p> <p><i>Performance standard:</i>  “Class members report in the class member survey that they are informed about their rights as MH consumer in a way they could understand.” (Currently the measure is 81.3% and the performance standard is 90%.)</p> <p><i>Possible compliance standard:</i>  “For three full quarters, the standard is at 90% or better.”</p> <p>Marya reviewed the contents of the notebook provided to all attendees: It contains the full Consent Decree Plan approved October 13, 2006; and the November 1, 2006, Quarterly Report with all attachments. One of those attachments is the Performance and Quality Improvement Standards. Each Standard is listed, with data, and a graph depicting the baseline measurement, the performance standard required by the Consent Decree Plan, and the current measure. Marya discussed several of the standards, as follows:</p> <p><b>Standard 1: “Treated with respect for their individuality”</b></p> <p>The 2004 baseline shows 91.8%, the current measure is 92.3%, and the performance standard is 90%. “We’re all doing a good job on this standard,” Marya said.</p> <p><b>Standard 18: “Continuity of Treatment is maintained during hospitalization in community inpatient settings”</b></p> <p>The 2004 baseline shows 31.6%, current measure is 0%, and the performance standard is 90%. “Clearly, we need to continue to look and see how to improve performance in this area,” Marya said.</p> <p><b>Question:</b> Will we have an opportunity to understand how performance was derived at—what the practice expectations might be? If someone is hospitalized, the ISP should be available—is that the standard?</p> <p><b>Answer:</b> Yes, this information must be available 24/7.</p> <p>The members engaged in some discussion about the availability of ISPs (electronically or otherwise) and whether the State maintains the data (it does not). “If the State is able to maintain that data, it might be a good solution,” one member commented.</p> <p><b>Question:</b> How were these standards determined?</p> <p><b>Answer:</b> By intense negotiation with the Court Master and Plaintiffs. The standards, performance measures, and data sources were all negotiated. Any changes would have to be made through the Court.</p>

Agenda Item	Presentation, Discussion, Questions
	<p><b>Standards 26 &amp; 27 – Vocational Employment Services</b></p> <p>Both standards show current measures well below expectations of the Court. The Consent Decree Plan places great emphasis on vocational services and improvements must be made.</p> <p><b>Question:</b> One member made a technical suggestion—to keep the graph colors consistent that depict the baseline, current performance, and performance measures on all the standards.</p> <p><b>Answer:</b> We appreciate your pointing this out—we’ll be sure to make changes to be consistent throughout the standards.</p> <p><b>Question:</b> Another member pointed out how transportation issues impact vocational services.</p> <p><b>Answer:</b> Yes—if we look at <b>Standard 28 on Transportation</b>, it shows we’re not close to meeting the performance standard. It should be at 10%, but we’re only at 1.7%.</p> <p><b>Question:</b> How were the performance standards percentages arrived at?</p> <p><b>Answer:</b> The Court Master, OAMHS, and plaintiffs discussed these at length through long, arduous negotiations. Some may seem high, some low, but these are the standards we all have to live by.</p> <p>Members discussed the difficulty around accurately assessing and meeting transportation needs, noting that by some measures transportation doesn’t show up as a major unmet need. One member commented that perhaps the transportation issue is “so huge we’ve given up.”</p> <p><b>Question:</b> Is it possible to get a copy of the client survey?</p> <p><b>Answer:</b> Yes.</p> <p>Marya also discussed other items in the packet and notebook as follows:</p> <p><b>CSN Related Components Matrix</b></p> <ul style="list-style-type: none"> <li>• Shows tasks and timelines related to the CSNs.</li> <li>• Excerpted from the overall Consent Decree Plan matrix attached to the November 2006 Quarterly Report. (Included in the notebook at Tab 2.)</li> <li>• Provides a quick reference to what needs to be done and when.</li> </ul> <p><b>Contracted Services by Network Matrix</b></p> <ul style="list-style-type: none"> <li>• Another attachment to the quarterly report, included in the notebook (Tab 7).</li> <li>• Starting point for identifying what services are provided by providers in each CSN area.</li> <li>• OAMHS will continue gathering information to update this matrix through RSVP forms each member received, as well as an electronic survey Muskie will develop and send out to all members to get more detailed geographic information and enable actual mapping of services.</li> <li>• This information is critical in identifying gaps and making remedial recommendations, as well as supporting budget requests to the Legislature.</li> </ul> <p><b>Question:</b> Maine General is not listed in the matrix...?</p> <p><b>Answer:</b> Hospitals have not been added yet. This list is a starting place, and only includes contracted providers.</p> <p><b>Question:</b> Is it possible to know the number of class members by region? It would be nice to see the numbers in this CSN.</p> <p><b>Answer:</b> Yes—as much as we can build data, we should.</p>

Agenda Item	Presentation, Discussion, Questions
	<p><b>OAMHS Website: Consent Decree</b></p> <ul style="list-style-type: none"> <li>• All Consent Decree documents and quarterly reports are posted in electronic form.</li> <li>• Will add a Community Support Network section to post minutes and other documents.</li> </ul>
<p>Parking Lot Items</p>	<p>The members had a lengthy discussion about the “No Reject” policy, highlights as follows:</p> <ul style="list-style-type: none"> <li>• The intent is to assure to the maximum extent possible that people are served in their local area.</li> <li>• To assure access to services they need—that CSN makes every effort to serve every client.</li> <li>• To inform where gaps exist in the system in capacity and resources.</li> <li>• Balance capacity against denial—if there are waiting lists, all in the CSN should have waiting lists—problem-solve within the CSN to meet the needs.</li> <li>• Signing the contract means working within the CSN to resolve issues.</li> </ul> <p><b>Question:</b> How does the Court Master interpret this?  <b>Answer:</b> The Court Master wants to know why, for example, when Riverview calls around for a PNMI bed, providers are saying no.</p> <p>Members asked for additional clarification about what is expected of individual providers, emphasizing the need for this to be put in writing in order to sign contract amendments or MOU. One said, “I understand the network perspective, but I need to know what I’m committing my agency to on a contractual basis,” and asked for a letter from OAMHS to point to when “some auditor asks about this,” noting the November 19 deadline to sign the contract amendment.</p> <p>Other parking lot issues recorded throughout meeting:</p> <ul style="list-style-type: none"> <li>• Pragmatics of CSW availability.</li> <li>• Reimbursement for CSW role as outlined in Plan.</li> <li>• Crisis provider responsibilities in ED.</li> <li>• MaineCare reimbursement amendment.</li> <li>• List of exemptions to admission process to public hospitals.</li> <li>• Consumers without caseworker, wait listed, on not considered eligible.</li> <li>• Sharing information within the CSN.</li> <li>• Availability of ISPs.</li> </ul>
<p>VIII. Agenda for December Meeting</p>	<ul style="list-style-type: none"> <li>• MOU</li> <li>• Operational Protocols</li> <li>• Service Matrix – Mapping</li> <li>• Ongoing schedule of meetings</li> </ul>