

**Community Service Network 3 Meeting  
Maine Principals' Association, Augusta  
December 7, 2006**

**Approved Minutes**

**Members Present:**

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| <ul style="list-style-type: none"> <li>• Dick Willauer, Alternative Services</li> <li>• Matthew Demming, Care &amp; Comfort</li> <li>• Don Harden, Catholic Charities</li> <li>• Mark Tully, Community Correctional Alternatives</li> <li>• Amy Wilmot, Community Mediation Services</li> <li>• Rick Karges, Crisis &amp; Counseling</li> <li>• Jean Gallant, ESM</li> </ul> | <ul style="list-style-type: none"> <li>• Harold Graham, Graham Behavioral Services</li> <li>• Emilie van Eeghen, MaineGeneral/HealthReach</li> <li>• Sharon Abrams, Maine Children's Home</li> <li>• Richard Weiss, Motivational Services</li> <li>• Karen Fatz, Mount St. Joseph</li> <li>• Ann Lang, NAMI Family Member</li> <li>• Carol Carothers, NAMI</li> </ul> | <ul style="list-style-type: none"> <li>• Lori Michaud, Redington-Fairview</li> <li>• Ric Hanley, Spring Harbor</li> <li>• Donna Ruble, Sweeter/Protea</li> <li>• Alan LeTourneau, Richardson Hollow</li> <li>• Lynn Duby, Youth &amp; Family Services</li> </ul> |
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**Members Absent:**

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| <ul style="list-style-type: none"> <li>• Allies Inc</li> <li>• Inland Hospital</li> <li>• Kennebec Valley Mental Health Center</li> </ul> | <ul style="list-style-type: none"> <li>• Langley Vocational Services</li> <li>• LINC</li> <li>• NFI North</li> </ul> | <ul style="list-style-type: none"> <li>• Sebecook Valley Hospital</li> <li>• Transition Planning Group</li> </ul> |
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**Others Present:**

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- Kim Lane, HealthReach Network

**Staff Present:** DHHS/OAMHS: Ron Welch, Marya Faust, Donald Chamberlain, Leticia Huttman, Sharon Arsenault. Muskie School: Elaine Ecker, Janice Daley, Jacinda Dionne.

<b>Agenda Item</b>	<b>Presentation, Discussion, Questions</b>
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. CSN Meeting Guidelines	Sharon referred everyone to the "CSN Meeting Guidelines" and asked for suggestions for changes or revisions. She mentioned that all members are expected to attend and to please RSVP to Elaine Ecker at 626-5297 if unable to attend. The group made no recommendations for changes.
III. Contract Amendments and Provider Agreements	<p>Don Chamberlain reported that about 82% of OAMHS contracted providers have returned their contract amendments. Most from CSN 3 have been returned, though he said there are two outstanding contract amendments in this CSN (one from Health Reach and one from Care &amp; Comfort). He requested that these two providers return the contract amendments as soon as possible. He thanked everyone for responding in such a timely manner.</p> <p>Don also stated that the Provider Agreements have been sent out by MaineCare and that, as of December 6, none have yet been returned. They are expecting these to be returned shortly.</p>
IV. Memorandum of Understanding	Ron Welch led discussion regarding suggestions and recommendations for changes to the Memorandum of Understanding (MOU). He stated there was a fair amount of input regarding MOUs at the November round of CSN meetings, and these ideas, along with those recommended at the December meetings will be taken into consideration as OAMHS crafts the final MOU document. The members were then given the opportunity to briefly review the MOU draft and make

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	<p>recommendations for changes to the draft.  The following recommendations were approved by a majority vote:</p> <ul style="list-style-type: none"> <li>• Page 2, Section E: Voted to address or consider changing the language in the first sentence to say “Stay current with and implement” evidence-based practices. There was also discussion about the terms “evidence-based” (defined population) vs. “evidence-informed” (evidence and applying clinical practice in a thoughtful manner) and how they are used in the field. The term “evidence-informed” might better describe the services provided.</li> <li>• Page 3, Section 5C: Voted to recommend allowing one previously specified alternate to attend the alternate as well as representative should have authority to vote and speak for the organization.</li> <li>• Page 3: Change language from “Implement <b>the</b> Rapid Response Protocol” to “Implement <b>a</b> Rapid Response Protocol.”</li> <li>• “5A” of MOU: Determine what authority is and where it comes from to be included in the MOU.</li> </ul> <p>The following are other concerns expressed among the group, but were not voted on as specific recommendations for changes to the MOU:</p> <ul style="list-style-type: none"> <li>• Concern regarding a lack of clarity regarding obligation of agencies who sign MOU – CSNs have responsibility to offer service. If service goes out of region, would the remaining providers be responsible to meet or cover the needs within present resources? Concern was noted.</li> <li>• Clarification regarding the authority of a CSW and the issue of confidentiality within CSNs.</li> <li>• Details and specific protocols need to be addressed and that the definition of consumer needs to be clarified.</li> <li>• Clarification regarding the CSN’s authority to allocate resources and to ensure membership keeps its agreements.</li> <li>• Question: What is the process for all regions? Is this discussion going to be standard across all CSNs?  Answer: All CSNs will have the same agenda. We will look at input and have a draft ready for the January meeting to be signed. The MOU needs to be signed by the 3<sup>rd</sup> or we’ll be out of compliance with the consent decree. It also lays out a blueprint for how to do business.</li> </ul>
V. Operational Protocols	<p>Ron Welch asked the group if there were any items in the Operational Protocol that need to be addressed. The following item was passed by a majority vote:</p> <ul style="list-style-type: none"> <li>• Transfer and incorporate corresponding recommendations from the MOU into the Operational Protocols.</li> </ul>
VI. Provider Services Data Matrix, Maps, Service Gaps	<p>Marya Faust gave an overview of the provider services data that has been collected. She pointed out that it is important to look at how and what we’re collecting as data. It helps put the pieces together and provides a better picture of the people we serve. The following were some of the major points of Marya’s presentation:</p> <ul style="list-style-type: none"> <li>• Kennebec and Somerset counties (1 county with dense population and the other not densely populated) – this is an example of how to consider using resources and whether certain resources are applicable in different parts of county; one solution does not fit all.</li> <li>• Also important piece of information to look at is the number of consent decree clients per CSN.</li> <li>• Approximately 30,000 unduplicated clients receiving services through MaineCare and MH services funded by the general fund. Approximately 10,000 of these individuals meet the criteria for serious mental illness. Marya noted that the federal definition of serious mental illness was used in this analysis. <ul style="list-style-type: none"> <li>➤ One member noticed that the data for adults began at age 21 and did not address the 18-21 age group. Marya acknowledged that this was an important category and will be added to the list. The 16-20 age group category is also important.</li> <li>➤ Another member noted that there is a drop of functionality in the 45+ age range. He suggested starting to look at designing services for these individuals as if they were actually 65+. Marya noted that this was an</li> </ul> </li> </ul>

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	<p>excellent point and a way to improve in targeting training needs.</p> <ul style="list-style-type: none"> <li>• Marya noted that there are improvements in the data system and that it's starting to look like national standards.</li> <li>• MaineCare data: People receiving services are living an average of 25 years less than those not receiving services. Heart disease is #1 cause of death for that population. One in five have diabetes. <ul style="list-style-type: none"> <li>➤ One member noted the dramatic difference (living 25 years less) between those receiving services and those not receiving services.</li> </ul> </li> <li>• Unmet Needs Report: 90-day time period. Data may not give us full picture – unmet needs may be greater than what is reflected here in report <ul style="list-style-type: none"> <li>➤ One member asked if these figures are duplicated. Marya stated that they are duplicated; individual may have more than one unmet need; class and non-class members.</li> <li>➤ Still a lot of work in making data accurate, but still an improvement over old system; Need your help in making our reports more useful; continue to build info. on what we have in CSNs; looking at what you do in your own agencies and what you have for systems helps in identifying service gaps.</li> <li>➤ Member Comment: It is more than looking at gaps; need to look at new service models (e.g., systems in other states.)</li> <li>➤ Response: It is important to look outside the box (e.g., health issues).</li> </ul> </li> <li>• One member stated that it would be valuable to assess the health of the CSN providers as well, i.e. financial status, human resources, recruitment, etc.</li> </ul>
VII. Vocational Services	<p>Don referred everyone to the MOU between the Department of Labor/BRS and OAMHS. He explained that a workgroup will be convened and co-chaired by Jim Braddick and a representative from Vocational Rehabilitation (VR) to work on issues specified in the “Joint Responsibilities” section of the MOU.</p> <p>He also reported that four employment specialists (ES) will be placed in this fiscal year and three more in next fiscal year, providing one ES for each CSN. Each ES will be embedded in a mental health agency that provides Community Support Services.</p> <p>Don distributed a memorandum he sent to ACT Team Providers defining the requirements specified in the Consent Decree Plan relating to Employment Specialists on ACT Teams, as follows:</p> <ul style="list-style-type: none"> <li>• The role of ES on ACT Teams is focused on employment functions, not case management. OAMHS expects 90% of ES work time to be devoted to vocational/employment support related tasks.</li> <li>• Performance target of 15% of caseload employed.</li> </ul> <p>The following questions and comments were raised:</p> <ul style="list-style-type: none"> <li>• # 6 p. 6 of MOU: Can individual work with another ES besides the one in the CSN if they choose?</li> <li>• One member asked if earned income was being tracked and noted that more service doesn't necessarily lead to better outcomes. Marya responded that they will check and see if that information is tracked.</li> <li>• We need to provide training for CSWs statewide.</li> <li>• Once an individual is employed, are they still eligible for ACT services?</li> <li>• Annual performance target for each ES for employment of 15% of their caseload and 90% of the work time on vocational/employment support related tasks. Would it be more efficient to establish a standard for caseload and allow for flexibility? Answer: This wouldn't meet the requirements of the consent decree.</li> <li>• Concern raised around ACT issue – People enter ACT as they have level of need, then may transition to ICI level, then back to ACT if need increases.</li> </ul>

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VIII. Role of Consumers in Licensing	<p>Leticia Huttman stated that OAMHS sees consumer involvement in licensing as an important component in developing a recovery-oriented system of care. She said consumers indicate less interest in being involved in the details of licensing and more interest in assessing whether the services delivered are recovery-oriented, consumer-driven, and person-centered. While this is difficult to evaluate, consumers have been looking at using standardized tools like the Elements of a Recovery Facilitated Systems (ERFS) to use in interviewing consumers and staff members. They plan to begin training in the spring and to begin piloting later in the spring.</p> <p>The goal is to provide an opportunity for consumers, providers, and OAMHS to work together to improve services—and not viewed as threatening or faultfinding. Consumers would be trained and compensated, and would most likely go out in teams. Providers will be informed about what the assessment involves and what to expect before any visits occur.</p> <p>The training will focus on how to use tools as well as on the environment in which consumers will be working. In addition, training will focus on how to use the data in ways that move us forward.</p>
IX. Housing and Support Services Workgroup Update	<p>Don Chamberlain reported that the Housing and Support Services Workgroup have met twice. They are meeting weekly on Mondays. They are at the point of trying to define what's going on in the system and categorization of all beds.</p>
X. Contract Compliance Template	<p>Marya distributed a blank draft Contract Compliance Template and asked the group to think about the items that should go into a contract review and send feedback to Elaine Ecker at <a href="mailto:eecker@usm.maine.edu">eecker@usm.maine.edu</a>. They will have a more fully developed template in for the January meeting.</p> <p>Don added that OAMHS will be scheduling meetings to look at contracts in January and February; they are looking to have a dialogue with organizations around contracts.</p>
XI. Beds: Crisis Stabilization/Observation	<p>Because the meeting was running behind schedule, Don suggested tabling this and adding it to the agenda for January's meeting. He realizes there will be a lot of free discussion and does not want to cut it short. He suggested thinking about what our limitations are, do we need more beds/less beds, observation beds. This conversation will take place at the next meeting in January.</p>
XII. Statewide Policy Council	<p>Ron reported that the committee needs to identify providers from several areas; workload is spelled out in plan and includes a number of important issues; there needs to be a consensus at the policy level. He asked if there was any discussion of how to select candidates for January's meeting.</p> <ul style="list-style-type: none"> <li>• Would be expeditious to send email with categories and ask people to reply with nominations</li> <li>• Have larger group elect representatives or divide by service</li> <li>• Names should be sent out so that people can vote before January meeting.</li> </ul>
XIII. Ongoing Meeting Schedule	<p>The group's first choice for an ongoing meeting schedule was the 1<sup>st</sup> Monday of the month, in the morning. Other workable choices: 2<sup>nd</sup> Monday, 4<sup>th</sup> Monday, 1<sup>st</sup> Friday.</p>
XIV. Agenda for January Meeting	<ul style="list-style-type: none"> <li>• Procedure and Protocols for Inpatient Admissions</li> <li>• Rapid Response and Crisis Plans</li> <li>• Crisis Beds</li> <li>• Statewide Policy Council</li> </ul>