

**Community Service Network 3 Meeting
Maine Principals' Association, Augusta
June 4, 2007**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Susan Seeley, AIN • Dick Willauer, Alternative Services Inc. • Joe Tinkham, Care & Comfort • Don Harden, Catholic Charities • Charlie Clemons, Charlotte White • Mark Tully, Community Correctional Alternatives • Amy Wilmot, Community Mediation Services • Terry Casey, Crisis & Counseling | <ul style="list-style-type: none"> • Jean Gallant, ESM • Jennifer Raymond, Graham Behavioral Services • Emilie van Eeghen, MaineGeneral/HealthReach • Jim Talbott, Merrymeeting Behavioral Health • Richard Weiss, Motivational Services • Karen Fatz, Mount St. Joseph • Ann Lang, NAMI Family Member • Carol Carothers, NAMI-ME | <ul style="list-style-type: none"> • Lori Michaud, Redington-Fairview Hospital • David Proffitt, Riverview Psychiatric Center • Sharon King, Sebecook Valley Hospital • Ric Hanley, Spring Harbor • Donna Ruble, Sweetser • Carla Beaulieu, Transition Planning Group • Lynn Duby, Youth & Family Services |
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Members Absent:

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| <ul style="list-style-type: none"> • Allies Inc • Inland Hospital | <ul style="list-style-type: none"> • KVMHC • LINC Club | <ul style="list-style-type: none"> • Maine Children's Home • Richardson Hollow |
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Alternates/Others Present:

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- Kerry Sirois, Mount St. Joseph

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

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Sharon opened the meeting and participants introduced themselves.
II. Minutes	The minutes were approved as written.
III. Budget/Rate Standardization	<p>Ron Welch reported on the latest budget and rate change information, saying the Appropriations Committee finished their work on the proposed biennial budget:</p> <ul style="list-style-type: none"> • A total of \$6M must be saved in FY08, as follows: <ul style="list-style-type: none"> ▸ \$1M added to projected savings of Administrative Services Organization—for a total of \$6.5M. ▸ \$1M saved by changes in use of Skills Development services ▸ \$4M saved by package of changes in rate standardization (includes both adult and children's services) • \$14M must be saved in FY09, though how that will be achieved is not well defined at this point. • \$11M additional MaineCare seed funds added to FY08 and \$22M added to FY09, to increase volume/units of service (all mental health services, not just core services or SMI population.) • Clarification will be going out from Deputy Commissioner Geoff Green's Office (Marie Hodgdon)—about how to proceed with contracts. Directions, instructions, guidelines will be coming from OAMHS, as well. • CSN members have reported uncertainty about sustaining same level of services with rate reductions. Discussion is needed at all CSNs to discover major barriers, etc. If changes will be made, how will that be communicated to OAMHS, consumers, and other CSN members? Would like commitment from providers to communicate with OAMHS before public announcements are made—particularly concerned that “we don't set off alarms for consumers.”

Agenda Item	Presentation, Discussion
	<ul style="list-style-type: none"> • Specific rates should be coming shortly. Looks like a reduction of 5.85%, if averaged across services subject to standardization. • MaineCare non-categorical cap will be reduced from \$22M to \$13M. <p>Discussion:</p> <ul style="list-style-type: none"> • Really prefer to get official rates from the Department before making any decisions on services and hesitant to sign contract without further clarification. • While contracts are being put together, will there be any holdup in reimbursement for agencies continuing to provide services? Contracts need to be in place, Don responded, even if they may need to be amended—because no payment can be made without a contract. • (Ron) If rates are kept at current levels for a transition period (30-60 days), that dollar value would have to be absorbed somewhere else in the fiscal year. • If an agency changes how they do business to accommodate rates, how will that be experienced by people receiving services? • Telemedicine should be used more—if would be helpful if OAMHS advocated for expanding Telemedicine with MaineCare—needs to be done soon to avoid breaking services, especially in rural areas. Currently, application must be made to MaineCare for use of Telemedicine for very specific things in very specific locations. We should look at the whole range of services that could be provided via Telemedicine. <p>ACTION: OAMHS will compile a “legislative packet” listing this session’s bills related to mental health issues and provide to all CSN members.</p>
<p>IV. 24/7 Access to Community Support Information</p>	<p>Don Chamberlain told members that OAMHS has received questions regarding the protocols for 24/7 access to community support information, as protocols start to come in. (All crisis and community support providers are to submit their 24/7 protocols to OAMHS by June 15.)</p> <p>Discussion highlights:</p> <ul style="list-style-type: none"> • Will OAMHS be distributing community support provider protocols to crisis providers? No, community support providers are expected to communicate protocols directly with crisis services in their area. • The policy requires that <i>prescriber</i> information, not medication information, is available 24/7. • In theory, most transactions will be in local area and communication mechanisms will be worked out ahead of time. Providers are not required to develop protocols for all possible contingencies, e.g. if a client travels and has interaction with a crisis provider outside the community support provider’s area. • Each crisis program should determine how they would receive the information. • The requirement that community support providers respond to requests within one hour is a challenge when not open 24/7. • Mark Tully of Community Correctional Alternatives said their solution is for the on-call person to have the agency’s book of crisis plans and ISPs and give information to crisis by phone. The written information is faxed the next morning.
<p>V. Medication Management & Capitol Clinic</p>	<p>Medication Management</p> <p>What are some of the issues particular to this CSN re: meeting the 10-day requirement?</p> <ul style="list-style-type: none"> • Shortage of psychiatrist services. • KVCAP transportation is a major issue, since arrangements need to be made 2 weeks in advance. If we have an opening in the next day or two, clients can’t get there.

Agenda Item	Presentation, Discussion
	<ul style="list-style-type: none"> • We experience a trend creeping forward with consumers referred to med management—agencies restrict services to people receiving other services from the same organization. They don't provide med management as a stand-alone service. • Richard Weiss said Motivational Services bundles medication management with other services “so we assure it's available for people we serve.” It is not offered as a stand-alone service. • Donna Ruble said Sweetser/Protea offers med management as a stand-alone service, but there's sometimes a misconception that people have to move their other services to Sweetser to receive med management. • If people do not have MaineCare or insurance, they're “dead in the water” for medication management. They may end up de-compensating until they're hospitalized, and then they get services. Earlier intervention with med management may well prevent this. • KVMHC is the only provider in this CSN that gets grant dollars for medication management [to help pay for services for uninsured people]. • Sweetser/Protea does take Medicare patients, but not many, since the co-pay is 50% and most often people can't afford to pay it. • Medications given in a hospital may not be available or authorized by MaineCare outside the hospital. Person may have to go back into hospital or be weaned off one medication to be put on another (in other words, put back into crisis...). Also, MaineCare requires that certain trials steps of medication be taken first to see what will work. Sometimes these steps must be repeated, even though in the past the meds haven't work or have caused adverse reactions. • MaineGeneral's med management service is meant to be a transition service [from inpatient to community], but has a full caseload since they have “nowhere to refer to.” Need more psychiatrists and funding for psychiatrists to work with primary care providers who would like psychiatric advisement on a regular basis. <p>Capital Clinic David Proffitt described Riverview Psychiatric Center's Capital Clinic:</p> <ul style="list-style-type: none"> • Provides med management to forensic population discharged from the hospital. • Goal is not to serve civil clients—other than as a safety net while transitioning to community services. Presently have 23 longer-term civil clients that “we're trying to move to community providers.” • If people sign up for this safety net service, they must agree to community support services, too. <p>Idea for Medication Management Would like to see a centralized, area-wide medication management resource for those served by public funds (not private). Theoretically:</p> <ul style="list-style-type: none"> • People could call anytime, even on weekends, and information would be available to whoever is staffing. • If a psychiatrist participates in public funding system, they would have to buy in to the centralized organization and take part in on-call rotation. • Would eliminate bundling, if freestanding. • Would provide a screen for those who may need to call crisis or go to the ER (addresses calls from those not already being served). • Would provide significant recruitment value in having more than one back-up. • Would work best if statewide system—“If you're going to practice in Maine...you have to participate.”

Agenda Item	Presentation, Discussion
VI. Other	<p>Collaboration on Complex/High-Risk Cases Every Friday, MaineGeneral and other providers meet to discuss individual complex cases (with consumer permission/releases). Suggest creating some similar kind of venue where high-risk cases—with consumer permission—could be discussed in order for provider(s) to have the benefit of feedback, consultation, and perhaps collaboration with other providers in particularly difficult situations where person poses a risk to self or others. Two ideas discussed: 1) A debriefing venue or after-the-fact discussion of cases, and 2) a “during the process” venue for everyone providing services for a particular individual.</p> <p>Region II PNMI Pilot Project Sharon mentioned two items related to the new PNMI Pilot Project: 1) She will be present at a meeting tomorrow to answer questions that have arisen; and 2) instructional sessions are being arranged for three locations, so agencies, hospitals, etc., can get more information and ask questions about the protocol.</p> <p>Outcomes/Measures Have outcomes and measures been established for the CSNs? Marya said the policy council is tasked with that at the upcoming meeting.</p> <p>Critical Incident Process Do we have a critical incident review process? Critical incidents are reported and reviewed, but currently no formal tallies or comparative analysis is being done. Elsie Freeman is in the process of revising the whole process to include such analysis, and a draft is expected soon. Ric Hanley said Licensing has recently disseminated the 2006 sentinel event list (de-identified).</p> <p>New Medical Director Can we know who’s chosen for OAMHS Medical Director position [replacing Elsie Freeman, who is moving to another position]?</p> <p>ASO Can we know who has submitted ASO RFPs? OAMHS will publish a list after the June 8 deadline for proposals.</p>
VII. Public Comment	None.
VIII. July Agenda Items.	Budget/Rates Legislative Updates Changes in Service Delivery Actions for Medication Management Models ER Protocols/Guidelines