

**Community Service Network 3 Meeting
Maine Principals' Association, Augusta
April 2, 2007**

Approved Minutes

Members Present:

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| • Susan Seeley, AIN | • Tom McAdam, KVMHC | • Lori Michaud, Redington-Fairview |
| • Dick Willauer, Alternative Services Inc. | • Emilie van Eeghen, MaineGeneral/HealthReach | • Alan LeTourneau, Richardson Hollow |
| • Charlie Clemons, Charlotte White Center | • Theresa Turgeon, Merrymeeting Behavioral Hlth | • David Proffitt, Riverview Psychiatric Center |
| • Mark Tully, Community Correctional Alternatives | • Richard Weiss, Motivational Services | • Ric Hanley, Spring Harbor |
| • Amy Wilmot, Community Mediation Services | • Karen Fatz, Mount St. Joseph | • Donna Ruble, Sweetser |
| • Terry Casey, Crisis & Counseling | • Ann Lang, NAMI Family Member | • Carla Beaulieu, Transition Planning Group |
| • Jean Gallant, ESM | • Carol Carothers, NAMI-ME | • Lynn Duby, Youth & Family Services |

Members Absent:

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| • Allies Inc | • Crisis & Counseling | • LINC Club |
| • Care & Comfort (excused) | • Inland Hospital | • Maine Children's Home |
| • Community Rehabilitation Services | • Langley Vocational Services | • Sebecook Valley Hospital |

Alternates/Others Present:

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| • Bob Colby, Catholic Charities | • Mark Rosenberg, Crisis & Counseling |
| • Scott Moore, Crisis & Counseling | • Jennifer Raymond, Graham Behavioral Services |

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 Arsenault opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the March 2 meeting were approved as written.
III. Crisis Services/Crisis Stabilization Units (CSU)	<p>Scott Moore of Crisis & Counseling reviewed their crisis services:</p> <ul style="list-style-type: none"> • Based in Augusta, Waterville, Skowhegan. • Response time: Under 2 hours, often less. • Available 24/7. • Controls all CSU beds in Kennebec and Somerset Counties. • Assesses to determine level of care needed. • Has clear communication protocols with all hospitals in catchment area (including Inland Hospital). • Meets monthly with staff from MaineGeneral's ER and psychiatric unit. • In complicated cases, provides 30-day follow-up for clients: help connect to providers, phone support, in-person support, if necessary. • Crisis workers transport clients to "wherever they need to go." • The majority of clients do not need medical clearance, only those with medical issues such as diabetes. <p>Don reviewed the Crisis Performance Indicator data handout for the first two quarters of FY07 and mentioned:</p> <ul style="list-style-type: none"> • Concerned with goal of 30-minute response time from telephone call to face-to-face—though that data is not

Agenda Item	Presentation, Discussion
	<p>collected at this time.</p> <ul style="list-style-type: none"> • Low number of contacts for which a previously developed wellness plan, crisis plan, or ISP, or advance directive plan was available and used compared to the number of contacts who had case managers: 63 out of 483. • Looking to refine what data is collected: what from present data is useful, what else should be collected, what is unnecessary. <p>The members engaged in a lengthy discussion about the purpose and usefulness of the data being collected:</p> <ul style="list-style-type: none"> • Need a discussion about what this data actually means. Should have explanatory narrative attached to the data, so we understand what/why data is collected and what it means. • Validity issues have to be addressed to begin with. • Have we identified the quality indicators for which to collect data--need to do that first, <u>then</u> collect the data. • Regarding the numbers of those with case managers vs. number where ISP/Advance Directive was used: Need to ask hospitals and crisis if that information is actually helpful. • When can we expect changes in the report to happen? Answer: July 1, probably. We're still looking for input between now and then. • It's important to focus on <u>key</u> elements, rather than what some might <u>like</u> to know. Should we narrow the amount of questions/data collected across all of the services? • SAMHSA has a quality crosswalk—would that be helpful to use as a standard? Answer: Consent Decree standards sometimes match and sometimes don't match. • In general, we need data that shows if in compliance with contracts and the Consent Decree. • People being served do not have limitless capacity to provide data—one more question, one more question... • Need definitions of data we're collecting. • Would be helpful to know why each piece is collected—put into the column label itself. • Licensing needs to be brought to the table on some issues. • What have we accomplished in this conversation? Seem stuck. <p>Don concluded by noting that CSN members had identified no specific data to collect or anything to address re: crisis services.</p>
IV. Peer Services	<p>Leticia Huttman began the discussion by noting similar questions arise about data collection for peer services. Presently, OAMHS collects “counts” data, but “what does it tell us about services?” OAMHS will soon be working with an evaluator from SUNY on outcomes and measurements, she said, but also asked the members to indicate what data they see as important to collect from their viewpoints as consumer, provider, family member, etc.</p> <p>A member asked what consumers identify as the most important thing they'd like to see re: peer services. Leticia answered that in general, they want peer services that create an environment to move forward in recovery—then need to break down further into wellness indicators.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Can't get meaningful data from surveys—get it from engaging in meaningful conversations. Support increase in establishing meaningful personal contact with consumers. Surveys don't often reflect <u>honest</u> data—not as meaningful as personal conversations. • What's the outcome people want to see? Maybe the outcome is to find out how many people, if so, then count. If something else is identified as an outcome, let's measure that.

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	<ul style="list-style-type: none"> • Historically, data collected was based on desire to measure <u>access</u>, now it's more important to know about the value of service toward recovery. • Peer services is about <u>fellowship</u>, I'd hate to see it medicalized—"steps to follow, evaluate..." • There seems to be an artificial separation of families. Families want to be a part. • Without doing two things, we will continue to have this same conversation on each service we look at: <ul style="list-style-type: none"> ○ 1) Establish a list of items that <u>have</u> to be collected, whether useful to us or not. List them, collect the data, and don't worry about it. ○ 2) Determine what outcomes we want for each service. Take a small group of people "on the ground" and identify the outcomes and then the data that needs to be collected. ○ Also to consider: The intent of national substance abuse data may inform the state as well. Data such as SAMHSA collects would provide what the CSN needs. We should start with a solid base and build upon that.
V. Report from Subcommittee on Peer Services	Carol Carothers said she put together an inventory of peer services in this CSN (regardless of funding source), sent it out to those who volunteered to participate, and one organization responded. The information has been submitted to OAMHS.
VI. Review of Community Support Services (ACT, ICI, CI)	<p>Don mentioned that the number of new admissions not assigned a case manager within 7 days of eligibility indicates a gap in some CSNs, but not in this CSN. "Is it the sense that we have enough Community Support Services (ACT, ICI, CI) in this CSN?"</p> <p>A brief discussion came up around establishing a monthly rate for community support workers, rather than the current quarter-hour rate, with one member remarking it would be a "much more manageable system." Ron Welch reported that the "Feds don't want it." There are legal issues to be investigated---OAMHS has talked with one state that currently uses a monthly rate.</p> <p>Other comments:</p> <ul style="list-style-type: none"> • Would be nice at some point in time to get to sophistication of determining recovery milestones with ACT and ICI. • Would be interesting to know if people would get out of the hospital sooner if more ACT services were available. • Don't have adequate re-entry services in any of the jails.
VII. Budget Update VIII. Rate Standardization	<p>Ron reported that the biggest outstanding issue for budget appropriation is rate standardization. He explained that the 4-page handout members received contains what DHHS originally proposed to meet the required \$10M to be saved in each biennium of the upcoming budget. Through subsequent negotiations and discussions with H&HS committee, representatives from MAMHS, and others, that \$20M has been reduced to \$10M, broken down to \$3M the first year (FY08) and \$7M the second year (FY09). They also propose that three workgroups be established to consider three main areas in which savings could be achieved: 1) administrative burdens, 2) design of service structure, and 3) rate standardization. "We don't know what the Governor and Appropriations will do with this," he said. This solution is more gradual that what would previously have had to happen by July 1.</p> <p>He also reported that the "Plaintiffs' attorneys" gave the following input re: the workgroups: 1) Consumers/peers are on all three workgroups, and 2) any plans or proposals are aired through review process at CSNs. Timeframes in budget language will allow for that, Ron said.</p> <p>Ron said that Appropriations will be addressing this as a work session, date and time yet unknown.</p>

Agenda Item	Presentation, Discussion
	<p>ACTION: OAMHS will let members know when the work session is scheduled.</p> <p>Members continued to discuss information contained in the 4-page handout, including the Medicaid rate comparison with Maine and other states and the sample rate calculation based on salary, benefits, and costs (direct & indirect), etc. Comments:</p> <ul style="list-style-type: none"> • All parties do not agree upon these numbers as fact. • These are just Medicaid rates—does not include other supplementary funds that may be received by providers in other states. • One proposed solution is to establish a formula that uses external databases. For example, for LCSW outpatient services, one can go to the national Department of Labor and get salary figures. Should look for most objective external data source to get a rate. That takes away focus from the Dept. staff and objectifies information, based on <u>actual, factual information</u>. • Have an impartial group manage this process.
IX. Service Gaps: Response to Court Master Concern	<p>Members received copies of two documents submitted to the Court Master on March 16, 2007: 1) Letter (addressing his concerns on the Quarterly Report), and 2) Summary Assessment of Resource Gaps by CSN. Marya explained:</p> <ul style="list-style-type: none"> • Deadlines required that OAMHS submit this baseline report to the Court Master, using the best information available, including: input from CSN meetings, self-reports from agencies, RDS unmet needs data, and MaineCare data. Ongoing review of the core services will continue at the CSN meetings, and input from the CSNs will be considered in subsequent reporting to the Court Master. • The Court Master appreciates the process of the CSNs, but will not allow for delay in remediation of service gaps on their account. <p>Members reviewed the service gaps/remedies identified in CSN 3:</p> <ul style="list-style-type: none"> • Peer Services: Peers in the emergency department at MaineGeneral. • Medication Management: Need to investigate why people wait more than 10 days for services. • Supported Housing: Unmet needs data indicates a gap. • Vocational Services • Though no gap was identified for Outpatient Services, a member made the comment that the 30-day standard for first appointment “is a lifetime,” noting that their network experiences a 50% drop-off of people making it to their first appointment even with the 7-12 days they currently achieve. • Inpatient: What is the standard? More an issue of appropriate use of beds—addressed in IMD Plan.
X. Training	<p>Marya asked that members be prepared at next month’s meeting to make recommendations or suggestions as to what training issues/needs the CSN wants to address to best utilize the Muskie contract. A member asked that the discussion address issues of costs, methods, etc., and how that impacts participation of provider staff.</p>
XI. Other	<p><u>LD 1745 “CSN Legislation”</u> Members received a copy of draft LD 1745, An Act to Improve Continuity of Care within Maine’s Community-based Mental Health Services. Ron reminded that this legislation cleans up language and changes “LSN” to CSN.</p> <p><u>Draft Confidentiality Statement</u> Don asked for feedback from members on this document to pass along to the AAG. One member gave detailed responses to several concerns. These concerns are documented as comments in bold type within the Statement itself (provided by</p>

Agenda Item	Presentation, Discussion
	member), a copy of which will be attached to these minutes. One other comment was added by another member: <ul style="list-style-type: none"> • Clarify “certain procedural steps are taken” under the section on release to family caretakers.
XII. Public Comment	A member asked about status of rewrite of grievance procedures. Ron explained that the earliest that could be addressed is after the legislative session, perhaps June 1 st .
XIII. April Agenda Items.	A member requested that legislative updates be an ongoing agenda item. Outpatient Services Peer Services Medication Management

3-16-07

Comments on DHHS draft memo

DRAFT.....DRAFT.....January 30, 2007

DHHS EXPECTATIONS ABOUT APPLICATION OF CONFIDENTIALITY LAWS
TO CONSUMERS OF MENTAL HEALTH SERVICES

The Bates v. DHHS Consent Decree Implementation Plan describes a state mental health system that is grounded in consumer-directed recovery and that offers and supports continuous care to consumers. Confidentiality laws sometimes mark the junction between consumer autonomy and system accountability. Inappropriate invocations of confidentiality by service providers inhibit continuous care for mental health system clients. Disregard of the confidentiality laws abrogates consumer rights.

Applying confidentiality laws in a way that protects consumer rights and encourages system accountability is a challenge. The purpose of this memo is to describe in general and practical terms what the Department expects of its mental health service contractors when they are asked to release consumer-specific information. Because it is not possible to summarize briefly and accurately how the laws might apply in all situations, this memo simply offers an overview related to situations that may arise fairly often for holders of confidential consumer information. The Department expects that if a contractor has a different understanding of how confidentiality laws govern a specific situation, the contractor will consult its own attorneys, and the Department as appropriate, in an effort to reach an appropriate resolution.

Comment: the confidentiality laws and rules covered by this memo are only those applicable to entities licensed or funded by DHHS to provide mental health services, principally 34-B M.R.S.A. § 1207, the *Rights of Recipients of Mental Health Services*, and the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164. Other confidentiality laws and rules apply in other settings.

RELEASE TO CONSUMERS

Consumers generally have the right to review their records at any reasonable time within three working days of the request to review the records, and the right to request copies of records, to be provided at the cost of reproduction.

Comment: the mental health laws and rules are silent on permissible copying charges for mental health records. The general statute on copying fees for health care records, 22 M.R.S.A. § 1711-A, states that the provider may charge "reasonable costs," not to exceed \$10 for the first page and \$0.35 for each additional page.

However, access to psychotherapy notes (**Comment:** although the HIPAA Privacy Rule permits restriction of access to "psychotherapy notes" in jurisdictions where that category is recognized, Maine law does not recognize the concept of "psychotherapy notes.") and to information compiled in anticipation of litigation can be restricted. Access to the record can also be restricted if allowing access would physically endanger someone or if allowing access might cause harm to a person named in the records. The consumer's access can also be restricted if information in the record was obtained from someone other than a health care provider under a promise of confidentiality, and allowing access would reveal the source of the information.

RELEASE TO OTHER PROVIDERS

Release of confidential consumer information to other providers generally requires a client authorization or court order.

Comment: while the above guideline may be generally appropriate, specific applications may vary. For example, from time to time in the past, DHHS has taken the position that sharing of otherwise confidential information may be permissible or even mandated under the statutory provisions relating to quality improvement councils, 34-B M.R.S.A. § 3607, and/or local service networks, 34-B M.R.S.A. § 3608. Further, the statutory definition of a "community agency" in 34-B M.R.S.A. § 1208 states that a "community agency means a . . . private nonprofit organization . . . which operates a human service program at the community level," but then defines a "nonprofit organization" to mean "any agency, institution or organization which is, or is owned or operated by, *one or more* corporations or associations . . ." Thus, a consortium of nonprofit organizations could satisfy the statutory definition of a single "community agency."

There are some exceptions to this general rule, including release of information in dangerous situations. (See below.)

Comment: the complete list of exceptions provided by 34-B M.R.S.A. § 1207 and the *Rights of Recipients of Mental Health Services* is as follows:

- as necessary to carry out statutory functions of DHHS;
- as necessary to carry out statutory hospitalization provisions;
- as necessary to obtain the services of an interpreter in cases in which the recipient does not speak English or is deaf;
- as necessary to allow investigation by the rights protection and advocacy agency (i.e., the Disability Rights Center);
- as necessary to allow investigation by the Office of Advocacy;
- as necessary to cooperate in a child protective investigation or other child protective activity;
- as necessary where Adult Protective Services is acting as guardian or conservator of the recipient;
- as ordered by a court of record;
- information relating to the physical condition or mental status of a recipient may be disclosed to the recipient's spouse or next of kin upon proper inquiry;
- necessary and appropriate biographical or medical information may be disclosed to commercial or governmental insurers, or any other corporation, association or agency from which the provider may receive reimbursement, as needed to support such reimbursement;
- de-identified information may be used in connection with an educational or training program established between a public hospital and any college, university, hospital, psychiatric counseling clinic or school of nursing;
- information may be disclosed may be made to persons involved in statistical compilation or research, provided that only coded or otherwise de-identified records may be removed from the facility and any reports must preserve the anonymity of the recipients;

- information may be provided to the Commissioner of DHHS for administration, planning, or research, provided that all client-identifying information is replaced by a code that is furnished only to the Commissioner and no other person;
- information regarding the status and medical care of a recipient may be released by a professional, upon inquiry by law enforcement officials or treatment personnel, if an emergency situation exists regarding the recipient's health or safety;
- confidentiality may be violated if there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the recipient on him or herself or upon another;
- information regarding diagnosis, admission to or discharge from a treatment facility, the name of any medication prescribed, side effects of that medication, the likely consequences of failure of the recipient to take the prescribed medication, treatment plans and goals, and behavioral strategies may be provided to family members or others in the recipient's household; and
- any person conducting an evaluation of a mental health client in a professional capacity, who has a clear and substantial reason to believe that the mental health client poses an imminent danger of inflicting serious physical harm on the evaluator or others, must provide information regarding such danger or harm to any other person to whom that client's care or custody is being transferred.

RELEASE TO LAW ENFORCEMENT

A client authorization or court order is generally required for release of information for law enforcement purposes. There are some exceptions to this general rule in dangerous situations. (See below.)

Comment: additionally, "information regarding the status and medical care of a recipient may be released by a professional, upon inquiry by law enforcement officials or treatment personnel, if an emergency situation exists regarding the recipient's health or safety."

A state hospital must release blue paper information under subpoena to a grand jury that is considering violations of gun control laws.

Comment: while debatable, this interpretation was recently upheld in a ruling by a magistrate judge of the U.S. District Court for the District of Maine. Therefore, it is currently the law at least for federal grand juries considering alleged federal violations.

MANDATORY REPORTING

Providers subject to mandatory reporting related to suspected abuse or suspected misconduct of certain professional licensees may release the information required by the reporting statutes, but may not disclose any otherwise confidential information beyond the minimum required by the reporting statutes.

RELEASE TO FAMILY CARETAKERS

Providers may release some information to family or live-in caretakers without a court order or consumer consent only if certain procedural steps are taken, and only if the disclosure of information is for treatment purposes.

RELEASE TO DISABILITY RIGHTS CENTER ADVOCATES

Providers can release records to advocates of the Disability Rights Center if the consumer or guardian gives permission. DRC advocates further have access if they are investigating a complaint concerning a consumer who is either his or her own guardian or a DHHS ward, and if there is probable cause to believe that abuse or neglect is occurring, and if they are unable to get permission from the consumer because of the consumer's mental or physical condition. DRC advocates also have access if they are investigating a complaint concerning a consumer's guardian, if there is probable cause to believe that the health or safety of the consumer is in serious and immediate jeopardy, and if the advocate's attempts to work with the guardian have failed.

RELEASE TO DHHS

Providers can release client information to appropriate Department representatives.

Comment: Although DHHS often interprets this provision to permit unfettered DHHS access to client information, in fact the statutory and regulatory authority is limited to disclosures that are "necessary to carry out statutory functions of the department." Providers should always confirm that DHHS representatives are seeking information for a proper statutory purpose. For example, the DHHS Critical Incident Report Form purports to gather client information for purposes of "quality improvement," a purpose that is not included in the statute.

RELEASE IN DANGEROUS SITUATIONS

If there is a clear and substantial reason to believe that a consumer poses an immediate danger of serious physical harm to a specified person, providers can notify law enforcement and the endangered person without client authorization or a court order.

If a person conducting a professional evaluation of a consumer has a clear and substantial reason to believe that the consumer poses an immediate danger of serious physical harm, the evaluator must provide this information to persons to whom the consumer's care or custody is being transferred.

These exceptions would not necessarily support release of substance abuse information.

Comment: substance abuse treatment program information is subject to an entirely different set of confidentiality rules, under 42 C.F.R. Part 2.

RELEASE OF SUBSTANCE ABUSE INFORMATION

Client authorization or a court order is required for release of substance abuse information.

Comment: substance abuse treatment program information is subject to an entirely different set of confidentiality rules, under 42 C.F.R. Part 2. Those rules do contain exceptions, but the exceptions have detailed requirements and the rules require strict compliance.

NOTE:

Consumer confidentiality is governed by many detailed laws and regulations. These include:

- HIPAA (regulations at 45 CFR Parts 160 and 164), and federal law related to privacy of health information;
- Federal substance abuse law (regulations at 42 CFR Part 2);
- State mental health confidentiality law (34-B M.R.S.A. § 1207);
- Federal protection and advocacy agency regulations (42 CFR Part 51); and
- State mental health confidentiality regulations (Rights of Recipients of Mental Health Services, Part A(IX)).

Comment: health care confidentiality laws of general applicability are found at 22 M.R.S.A. §§ 1711 – 1711-E. The health care confidentiality law governing minors is found at 22 M.R.S.A. § 1505. It should be noted that certain provisions of the DHHS *Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment* are in conflict with applicable Maine confidentiality laws relating to minors.

The information above is drawn from these laws and other sources, but does not represent legal advice or provide comprehensive answers to questions pertaining to consumer confidentiality.