

**Community Service Network 3 Meeting
Senator Inn, Augusta
May 7, 2007**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Susan Seeley, AIN • Joe Tinkham, Care & Comfort • Don Harden, Catholic Charities • Richard Brown, Charlotte White • Mark Tully, Community Correctional Alternatives • Amy Wilmot, Community Mediation Services • Rick Karges, Crisis & Counseling • Jean Gallant, ESM | <ul style="list-style-type: none"> • Jennifer Raymond, Graham Behavioral Services • Dee Nilsen, LINC Club • Emilie van Eeghen, MaineGeneral/HealthReach • Jim Talbott, Merrymeeting Behavioral Health • Richard Weiss, Motivational Services • Karen Fatz, Mount St. Joseph • Ann Lang, NAMI Family Member | <ul style="list-style-type: none"> • Carol Carothers, NAMI-ME • Tamara Cooper, Riverview Psychiatric Center • Sharon King, Sebecook Valley Hospital • Ric Hanley, Spring Harbor • Cindy Fagan, 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 • Alternative Services Inc. (excused) • Inland Hospital | <ul style="list-style-type: none"> • KVMHC • Langley Vocational Services • Maine Children's Home | <ul style="list-style-type: none"> • Redington-Fairview Hospital • Richardson Hollow |
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Alternates/Others Present:

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| <ul style="list-style-type: none"> • Mark Rosenberg, Crisis & Counseling | <ul style="list-style-type: none"> • Dan Wathen, Court Master |
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Staff Present: DHHS/OAMHS: Ron Welch, Marya Faust, Donald Chamberlain, Leticia Huttman, Chris Robinson, Sharon Arsenault. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Sharon opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the April 2 meeting were approved as written.
III. Legislative Updates: Budget, Rate Standardization, Bills: Including LD 1745	<p>Legislative Updates/Bills Ron mentioned two bills up for hearing this week: LD 1855 and LD 1745. The public hearing for LD 1855, which he explained as a "housekeeping bill relating to the blue paper commitment process," is scheduled for May 9th at 2 p.m., and the work session for May 16th at 1 p.m. The public hearing for LD 1745, which builds upon existing "LSN" language and puts actual language from the Consent Decree Plan around Community Support Networks (CSNs) into statute, is scheduled for May 10th at 1 p.m., and the work session for May 17th at 1 p.m. More information is available on the Legislature's web page.</p> <p>Budget/Rate Standardization Ron informed that the Appropriations Committee has voted on 80 percent of the state budget, but that the remaining 20 percent includes items of concern, including rate standardization. The last opportunity for public input was May 4, at a meeting to which Appropriations invited certain parties, including the Court Master. Both Democrats and Republicans agree on the total amount that must be saved by rate standardization over the next biennium: \$20M. They differ on how to split the amount between the two years: Democrats: \$6M and \$14M for 2008 and 2009, respectively. Republicans: \$10M and \$10M.</p>

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	<p>The ASO (Administrative Services Organization) is projected to save \$5-6M. The RFP (Request for Proposal) has gone out and more information is available on the DHHS website.</p> <p>Comments, questions, discussion:</p> <ul style="list-style-type: none"> • A member stated that though the term being used is “rate standardization,” it is actually “rate reduction,” the results of which could be very chaotic. • A member expressed concern about using “seed account” funds. Ron replied that the only other option would be to further erode the general/grant funds. • A member asked if MaineCare administrative funds are the funding source for the ASO. Ron said he is not actively engaged in that process—but will inquire and let CSN members know the answer. • A member reported that the DHSS Commissioner said the ASO will save \$6.5M in the first year and \$8.5M the second year.
<p>IV. Training Needs for the CSN Area: July 2007-June 2008</p>	<p>Chris Robinson, OAMHS Training & Best Practices Coordinator, briefly explained their current training philosophy (less conferences, more skill-building), the cooperative agreement with the USM Muskie School, and asked members for feedback on the following questions:</p> <ol style="list-style-type: none"> 1) How is recruitment and retention of staff going? 2) Specific needs and training topics for next year? 3) Preferred delivery methods of trainings, e.g. web-based, face-to-face, combination? <p>Comments on recruitment/retention:</p> <ul style="list-style-type: none"> • Two major factors putting drain on recruitment and retention: 1) ability to keep pace with health care, and 2) no cost-of-living increases. Flat funding has been the rule and makes increases impossible. • Seeing significant vacancy rate in mental health, in general. Jobs are really difficult—paperwork, technology, compliance, complexity, multi-tasking. Less longevity now—people end up doing less of what they took the job to do—direct work with clients. Budget restraints result in pressure to “squeeze more production out of people.” • Maybe there are some things state government could do the promote working in mental health. • A hospital member reported similar problems recruiting and retaining CNAs—due to health insurance and flat funding. “Becomes a revolving door.” • In many instances, medical insurance is more important to staff than increased wages. • Spring Harbor reported that their issues tend to be around nursing. Only one percent of nurses go into mental health, resulting in a very small pool. Also presents a real challenge to “back-fill staff when we pull them off the unit for training.” <p>Comments on training topics:</p> <ul style="list-style-type: none"> • Need to look at training specifically in the area of recovery—working with individuals. Would be nice to have consistent program to utilize around the communities. • CSN consumer representatives met via conference call on April 11 and compiled the following list of training topics/ideas: <ul style="list-style-type: none"> ○ Consumer perspective on recovery ○ Case managers need resources to give to consumers to get connected with peer services and community ○ The medical community needs training on what is going on in the behavioral health community

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	<ul style="list-style-type: none"> ○ Trauma informed curriculum developed by consumers ○ Training on wellness – how to get better ○ Training for employment specialist in the career centers for mainstreaming in the employment field – people going back to work – accommodations ○ Direct Service Providers – The importance of attitude and action in the messages that are conveyed are critical to hope for and belief in recovery ○ What is “meaningful-useful work” ○ Helping folks move into being able to disclose – boundary issues in agency (further explanation: some providers are also consumers—OK to disclose in some agencies, not in others—need ethical discussion on provider disclosure) ○ How providers can be open to consumer input – their role in effective consumer participation ○ Consumers self-esteem and personal empowerment ○ Urge providers to attend HOPE Conference ○ Providers need to attend Peer Support 101 ○ Information to consumers on email opportunities (free account information) ○ Training for consumers on use of internet <ul style="list-style-type: none"> ● Helping clients prepare advance directives. Chris responded that OAMHS is working with Helen Bailey of the Disability Rights Center in preparation for trainings on advance directives. <p>Comments on delivery methods:</p> <ul style="list-style-type: none"> ● Web-based training would be very positive, especially for Mental Health Support Specialist curriculum. This 40-hour program is expensive to provide and to have staff attend. ● Yes to web-based trainings. Also would like to see unified certification for MR (DD) and MH direct support staff. Staffing shortages cause a lot of crossover, and training time and costs are horrendous. Ron responded that OAMHS can and will look at that with the Office of Cognitive and Physical Disabilities to try to eliminate duplication, since there are a number of agencies that serve both DD and MH populations. ● ITV is very useful and workable. <p>ACTION: Members may pass on any other ideas or comments to Chris Robinson at 287-4865 or christine.c.robinson@maine.gov.</p>
V. Progressive Treatment Program	<p>Don Chamberlain briefly explained the Progressive Treatment Program, which currently operates in two locations in the State. Requirements:</p> <ul style="list-style-type: none"> ● Must come from involuntary commitments to either Riverview or Dorothea Dix. ● Must have history of poor outcomes in community and positive experience in the hospital. ● Goes through court process, similar to recommitment. Superintendent and medical directors petition the court. ● Must participate in ACT Team, so consumer agrees to live within 25-mile radius. <p>Riverview’s program began in November and currently has one person, with two more in the court process. Community Health and Counseling’s ACT Team has been amended to add five slots for Dorothea Dix’s program. Three documents related to the Progressive Treatment Program will be posted to OAMHS website soon.</p> <p>Questions/Comments:</p>

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	<ul style="list-style-type: none"> Are there family members/groups working with this program? NAMI-ME member responded that they are not involved now, but families are interested in that.
<p>VI. Consent Decree Quarterly Report</p>	<p>Members received copies of the Consent Decree Quarterly Report filed on May 1, 2007. Marya pointed out the added summary section of the Performance and Quality Improvement Standards and brought up a few of the standards for discussion. Highlights:</p> <p>Standard 4: Class members informed about their rights.</p> <ul style="list-style-type: none"> Provider members all indicated they have processes in place for all clients to be informed of their rights, most happening at admission. They acknowledged some clients may not be able or inclined at that time to process or remember this information, which could explain the survey results of 81.3%. If OAMHS coordinated this with licensing, would come up with 100%. Licensing is “on this.” Would like to see performance incentives. Need standard definitions (on all standards), so everyone is answering the same question. Until then, data is questionable. <p>Standard 18: Admissions for whom hospital obtained ISP. Group discussed possible ways the process may break down and possible solutions.</p> <ul style="list-style-type: none"> We may have a process, but not get signatures of client or guardian. Couldn’t we develop concrete transmittal arrangements? It’s a flow problem—community support workers don’t hospitalize. CSWs are contacted at some point subsequent to hospitalization if client grants permission. The new ASO will be required to have electronic ISPs, so that will take care of MaineCare population. <p>Standard 33: Recovery.</p> <ul style="list-style-type: none"> Don’t think we stress resiliency enough—still foster institutionalized treatment. Does system support recovery? It’s a conundrum to manage when focus is on medical necessity, etc., for MaineCare funds. Medical necessity implies illness...why promote recovery from “illness” and lose funds? System is not structured for family members and natural supports to be involved—so <u>many</u> constraints. Nowhere in Medicaid does it mention recovery, resiliency... <p>Court Master Dan Wathen shared his current thinking on developing exit criteria for compliance and said he is working/struggling to craft a mechanism that puts standards that are met “on the back burner.” He explained a bit about the goal being <i>reasonable</i> compliance rather than <i>substantial</i> compliance on some subjective data such as is gathered via survey (e.g. Standard 4). He said, “The secret [to meeting compliance] is to deal with more critical issues that tell more about how the system is working.”</p>
<p>VII. Protocol Guidelines for Hospitalization</p>	<p>Members received a draft of Protocol Guidelines for Psychiatric Hospitalization Process. Leticia asked for feedback and explained these are guidelines rather than protocols for ER personnel.</p> <p>Discussion:</p> <ul style="list-style-type: none"> The face-to-face assessment section does not mean the consumer must go through two assessments to determine whether they will be hospitalized (i.e. crisis and hospital staff). Consumer feedback indicates sometimes they have

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	<p>no (or late) face-to-face contact with hospital staff.</p> <ul style="list-style-type: none"> • Sweetser Crisis: Hospitalization happens based on recommendation of crisis staff. If assessments happen outside the ER, than they don't go to ER at all. • MaineGeneral: Crisis makes recommendation and discusses with doctor on call. If assessment is done in the community, then ER needs to do medical clearance before admission to inpatient. If person comes into ER and attending ER doctor and psychiatrist agree person needs hospitalization, then crisis is not called. • People who call 9-1-1 are told to go to the ER, not informed of crisis services. • Would be very pleased if ER staff would do 15-minute check-ins with people waiting to be seen in ER. • Add Guardianship, Medical Power of Attorney, and ISP. <p>ACTION: OAMHS will bring back revised document after receiving feedback from CSNs and others. Additional comments may be emailed to Elaine Ecker at eecker@usm.maine.edu.</p>
VIII. Community Support Services	<p>Don reviewed the central key performance indicator for community support services (case manager assigned within 7 days of referral). He said this CSN is doing a good job in this area.</p> <p>Don also reported that where Beacon reviews of community support services showed inappropriate levels of care, the needed level was higher rather than lower.</p>
IX. Policy Council Report	<p>Don Harden reported that the CSN Policy Council has been working on the following items:</p> <ul style="list-style-type: none"> • Refining the CSN Purpose Statement: What is CSN? How to achieve meaningful consumer participation? Continuity of care—how often to review? Efficiency of care? Council is working on list and timeline—not yet complete. • 24/7 access of community support records: Implementation document will be distributed to members soon—concern re: resources for rural and smaller agencies. • “No-reject” policy: Assuring access to services within the CSN—received initial narrative, continuing to work on this.
X. Outpatient Services	<p>The intended focus (assigned within 30 days) is the SMI population.</p> <p>Comments:</p> <ul style="list-style-type: none"> • SMI people often not accepted into outpatient services. • Often a function of payor source mix, i.e. restrict number of MaineCare, Medicare, and uninsured clients. <p>Specialty therapies available?</p> <ul style="list-style-type: none"> • DBT: KVMHC, Youth & Family Services, MaineGeneral. • Insufficient therapists: American Sign Language, dual-diagnosis (DD/MI), traumatic brain injury. • Rural areas, i.e. I-95 corridor, fewer services available now than five years ago. Expansion of “tele-health” would help extend services to rural MaineCare clients.
XI. Medication Management	<p>Due to lack of time, this item will be discussed in-depth next month, including:</p> <ul style="list-style-type: none"> • Payor mix issue. • Significant problems with wait/capacity issues. <p>Two provider members mentioned possible closings of some of their medication management services.</p>

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XII. Other	ACTION: Sharon will email everyone the Universal Referral Form and other documents related to the new Regional II PNMI Pilot Project.
XIII. Public Comment	Nothing additional.
XIV. June Agenda Items	Legislative/Budget Update Medication Management