

**Community Service Network 3 Meeting
Augusta Civic Center, Augusta
November 3rd, 2008**

DRAFT Minutes

Members Present:

- | | | |
|---|---|---|
| • Brent Bailey, Allies, Inc. | • Elaine Ecker, Consumer Council System | • Karen Fatz, Mount St. Joseph |
| • Dick Willauer, Alternative Services, Inc. | • Donna M. Ruble, Cornerstone Behavioral Care | • Ann Lang, NAMI-ME Families |
| • Annalee Polley, Assistance Plus | • Lynn Duby, Crisis & Counseling | • Lori Michaud, Redington-Fairview General Hospital |
| • Joe Tinkham, Care & Comfort | • Jen Raymond, Graham Behavioral Services | • Mary Louise McEwen, Riverview Psychiatric Center |
| • Cherri McDougal, CCA | • Tom McAdam, Kennebec Behavioral Health | • Sharon King, Seabasticook Valley Hospital |
| • Bob Colby, CCME | • Emilie van Eeghen, MaineGeneral/HealthReach | • Ric Hanley, Spring Harbor |
| • Charlie Clemons, Charlotte White | • Bonnie York, Merrymeeting Behavioral Health | • Bob Fowler, Sweetser |
| • David McCluskey, Community Care | • Richard Weiss, Motivational Services | • Lora Wilford-McManus, Youth & Family Services |
| • Bill Tanner, Community Correctional Alternatives Inc. | • Deborah Thibodeau, MMC Emp. Spec., CSN 3 | |

Members Absent:

- | | | |
|---------------------------------------|------------------------|--|
| • AIN | • ESM | • LINC Club |
| • Catholic Charities Maine | • HOPE Recovery Center | • Maine Children's Home for Little Wanderers |
| • Community Correctional Alternatives | • Inland Hospital | • Mount St. Joseph |

Alternates/Others Present:

- | | | |
|-------------------|--|-------------------------|
| • Eric Meyer, APS | • Helen Bailey, Disability Rights Center | • Pam Holland, DHHS/CDC |
|-------------------|--|-------------------------|

Staff Present: DHHS/OAMHS: Sharon Arsenault, Don Chamberlain, Marya Faust, Leticia Huttman, Wanita Page, Lisa Wallace, Ron Welch. Muskie School: Anne Conners, Julia Mason.

Agenda Item	Discussion
I. Welcome and Introductions	Sharon Arsenault welcomed participants; introductions followed.
II. Review and Approval of Minutes	The October minutes were approved as written.
III. Feedback on OAMHS Communications	No member feedback on this agenda item.
IV. APS Healthcare <ul style="list-style-type: none"> • <i>Review of Current Data</i> • <i>Discussion of issues including feedback on data entry</i> 	<p>In response to a discussion generated by the Schaller Anderson presentation at the October meeting, Marya Faust distributed a handout to explain the DHHS/OMS Primary Care/Care Management (PCCM) program and its Schaller Anderson Care Management program. She encouraged members to review the information sheet and distribute it to agency staff. In brief, the PCCM program matches MaineCare clients with a primary care medical home while Schaller Anderson providers care management for the top 10 percent of chronically ill adults and the top 5 percent of chronically ill children served by DHHS/OMS through the MaineCare Care Management Benefit.</p> <p><u>Eric Meyer, APS HealthCare Presentation</u> Eric disturbed four data sheets for member review: <i>Maine ASO Dashboard Report Adult Mental Health September 2008; Maine ASO Quality Improvement Program: Appendix C Fiscal Year 2009 Dashboard; Community Hospital Utilization Review Performance Standard 18-1,2,3 by Hospital: Class Members (4th Quarter, FY 2008); and Community Hospital Utilization Review Performance Standard 18-1,2,3 by Hospital: Class & Non Class Members (1st Quarter, FY 2009).</i></p>

Agenda Item	Discussion
	<p>Eric said that the sheets represent a distillation of 60 or so reports with multiple breakdowns that APS generates per month. Appendix C shows the cumulative total (new fiscal year started in July). Data is broken out by age, race, out-patient or in-patient setting, and diagnosis of smi. As APS scans people enrolled per month, the numbers increase because they represent everyone authorized since July. In addition to demographic and clinical information, the sheets represent a series of data points DHHS uses to measure APS's performance and APS uses to measure its work.</p> <p>He noted that the <i>Dashboard Report for Adult Mental Health</i> differs from the <i>Appendix C Dashboard</i> in that it is a snapshot of use at a particular point in time. He also said that some of the data tracking done throughout the course of the year has spiked and dropped according to changes in MaineCare Policy. He said he hopes that this will settle out in 2009 so more consistent information about services can be provided.</p> <p>Eric also said that the data sheets have been presented to the APS Provider Advisory Council. The Council's feedback was that the sheets were data rich and information poor. He said the key thing is developing actionable data to move the system in the direction it needs in terms of access to care and quality outcomes. In 2009, APS hopes to add actionable data as well as a month-by-month look at who is in service. The information will be posted on the DHHS and APS web sites. DHHS is currently analyzing the cost savings provided by APS by examining claims data. While Eric said he did not have access to the claims data, he added that information will come out in January when the Legislature begins its session.</p> <p><u>Discussion</u></p> <ul style="list-style-type: none"> • <u>Question:</u> What does demographic utilization and access measure? • <u>Answer:</u> How people were authorized. • <u>Question:</u> Can you explain why the total number of authorized in-patient psychiatric services and discharges are so different? Usually those numbers are the same. Also same question for the total number of people authorized for residential services. • <u>Answer:</u> It appears that discharges aren't consistently being submitted in APS CareConnection, when members are actually being discharged from the facilities. APS clinical team plans a follow up with providers to support the submission of discharges to ensure accurate data. • <u>Question:</u> Does in-patient psychiatric admissions include Riverview and Dorothea Dix? • <u>Answer:</u> No. • <u>Question:</u> Does in-patient include Acadia and Spring Harbor? • <u>Answer:</u> Some of the data includes Acadia and Spring Harbor. Coming out in public for the first time, will be tweaked and revised. • <u>Comment:</u> It would be helpful to know the hospitals covered here. • <u>Answer:</u> Hospitals that review with us are Acadia and general hospitals with dedicated psychiatric units. Admissions at hospitals that do not have a psychiatric unit, but it is a psychiatric admission, are not part of this. Riverview and Dorothea Dix are not part of this. • <u>Question:</u> What does the average length of stay for community integration reflect? • <u>Answer:</u> Registration since February—APS does not have start dates prior to that. <p><u>Summary Findings from Visits to Selected Mental Health Providers by Don Chamberlain, DHHS/OAMHS</u></p> <p>At the suggestion of Don Harden of Catholic Charities and the Chair of the Adult Committee of MAMHS, Don Chamberlain and a mental health team leader conducted site visits to get an on-the-ground view of the APS Healthcare process. Mr. Chamberlain asked Mr. Harden to set up site visits with a number of providers ranging from a low tech provider to a high tech provider. He also asked the Behavioral Health Collaborative for a couple of providers to meet with.</p>

Agenda Item	Discussion
	<p>Mr. Chamberlain and the mental health team leader from the appropriate region met with front line staff, supervisors, billing staff, and others from the organizations. The agencies are: Shalom, Catholic Charities, Common Ties, Kennebec Behavioral Health, CSI, and Community Counseling Center.</p> <p>*The findings:</p> <ul style="list-style-type: none"> • For continuing stay reviews, the additional time required is from 20 minutes to one hour per case. The low end is for therapists in outpatient settings. Other than one provider, all the rest have to take their treatment plan in their clinical record and translate it to Care Connections. This task seems to be easier for master’s level clinicians than MHRTCs. • Most providers have established systems that require the plan to be reviewed by either the supervisor or the Quality Department prior to submission. This adds time internally before the data can be entered into APS. • The increase of CI from six-month continuing stay reviews to every 90 days has substantially increased the administrative costs to CI providers. To do the RDS would take a much more limited time. Recommendation: Get the RDS information at the 90-day mark and do the full continuing stay at the six-month point. • The comment section of CareConnections is being used for additional goals and other ongoing information which can not be brought forward in continuing stay reviews, which results in additional work for each review. • A decrease in initial authorization visits for outpatient services results in more reviews than need to occur. The original authorization allowed the treatment of many consumers to be completed and therefore not require a review. The current initial authorized visits cause nearly every case to require a continuing stay review. Recommendation: Return to the earlier number of authorized visits. • One provider has an electronic interface which eliminates, for the most part, the need for clinicians or others to enter the information. However, every time there is an APS change, the provider must pay an IT cost. • While there was a reduction in the information required for outpatient for continuing stay reviews, one has to go through all the pages to get to the appropriate section, which causes confusion and time. • When a question arises, telephone tag on both sides requires more time. • Given the agency processes and the telephone tag, the five-day pre- and post-the date for review is difficult to meet. Recommendation: Increase from 5 to 7 days on either side. • For PNMI, the 30-day review is a bit short since the OAMHS has approved the placement in the first place. Getting the registration and discharge into APS in the 24-hour time frame is sometimes problematic. Recommendation: Increase the time frame for the continuing care review and allow an additional 24 hours to get registration and discharge data into APS. • Recommendation: Those with computerized records would like batch up loading to save time and expense on the provider side. • General concerns regarding the language and information that APS is asking is medically oriented based upon problems whereas the ISP is strength-based. Licensing may require something else. Recommendation: That these be aligned. • There is variability in agency capacity to easily track visits and time for approvals from one agency that has had to set up a spread sheet to an agency in which all is computerized and can send out reminders. • Everyone indicated that the reviewers and staff at APS were easy to work with and very professional. <p>Mr. Chamberlain noted that he has not had a chance to discuss this information with Eric yet.</p> <p>*(The findings listed above reflect a report issued by Mr. Chamberlain following this meeting and are not an exact transcription of discussion at the meeting).</p>

Agenda Item	Discussion
	<p>Eric thanked Mr. Chamberlain for the information and said that it was significant that he was attending the November CSN meetings as APS started in Maine one year ago this month. Eric encouraged members to fill out the <i>ASO Administrative Burden Issues and Solutions Form</i> he distributed at the meeting. In making direct suggestions, Eric encouraged members to consider the following:</p> <ul style="list-style-type: none"> • What would you rate as your top issues and concerns? • How can this review system be sustainable? • What services are related to that? • What is the number of staff involved and people served? <p>While APS is not making this a requirement, Eric said that if agencies have tracked the average hours per week that it takes staff to perform APS reporting requirements and which tasks are taking the most time, he would be interested in that data. Eric asked that the <i>Administrative Burdens</i> form be returned to APS by the end of November.</p> <p><u>Discussion</u> Members discussed that APS forms are more medically centered and less consumer and recovery focused. One member said that his agency was recently cited by auditing for not having ISPs that were consumer focused enough, even though the agency was using the state ISP format. Mr. Chamberlain said that the state is in the midst of revising the ISP manual. As far as APS is concerned, it is part of MaineCare and as such medical necessity has to exist to deliver services; hence the conundrum. Eric said that APS' challenge is to marry medical necessity with a strengths-based and recovery-focused treatment plan.</p> <p>Action: Members will return the <i>Administrative Burdens</i> form by the end of November.</p>
V. Budget Update	<p><u>Budget:</u> Ron Welch said that OAMHS submitted its budget request to the Governor's office based on the unmet needs identified through the RDS system. These funding requests were aired before each CSN and, in some cases, changes were made based on member feedback. Increases were requested for the Supplemental Budget as well as the Biennial Budget for FY 2010/2011. Increases ranged from \$8 million for the Supplemental Budget to \$10 million for the first year of the Biennial Budget and then \$11 million for the third year. The state then reported a \$200 million budget gap for the Supplemental Budget with \$100 million cut coming from DHHS. Shortly after that, state revenue forecast a shortfall of \$500 million for the Biennial. In addition, a curtailment order for the current year is expected from the Governor within the next two weeks. The last time a curtailment order was issued, mental health grant funds were cut; however, the Legislature restored most of those. This year, Ron said he is not optimistic that will happen because he does not know where the Legislature will find the money.</p> <p>Ron said it is time to look at new and innovative ways to manage available resources because after the current legislative session, the world as we know it won't exist any more. He said the mental health delivery system will need a radical redesign and that the state can not continue with the plethora of private agency management that it now has. One model to consider is the 1963 comprehensive community mental health legislation, which identified single lead agencies in CSN-type areas where one agency provided a comprehensive array of services. While the federal government originated this system, it then began pulling resources out and mental health services became MaineCare and state grant-funded. This model may be the only way to retain the services the state has provided.</p> <p><u>Consent Decree:</u></p>

Agenda Item	Discussion
	<p>Ron also informed the group that the Court Master recently issued an order, copies of which were provided to members, stating that unmet needs will be predicated on a broader definition of eligibility for services than used in the original consent decree. OAMHS is in discussions with the Court Master and the plaintiffs regarding the parameters of the eligibility definition.</p> <p><u>Discussion:</u> Members discussed whether the Department will request Medicaid waivers that allow restructuring on choice, on numbers of people served, on numbers of providers, on the development of a 1915 I waiver, which was done in Iowa and defines eligibility not by diagnosis but by functionality. A member asked if home and community-based care waivers are a possibility. Ron said these are all possibilities: waivers require cost neutrality and amendment does not.</p> <p>Elaine Ecker asked how much guidance the Department will provide once the final budget numbers are known, especially as Ron mentioned major cuts and radical changes. She noted that the consumer movement would like to be involved in setting the priorities. Ron said the Department has an obligation to do that. Previously agencies have merged or gone out of business. Minimum standards have already been put in place for the crisis system.</p>
<p>VI. Disaster Behavioral Health Team</p>	<p>Pam Holland, Director, Disaster Behavioral Health for the Maine CDC, gave a presentation on Disaster Behavioral Health: Part of Maine's Support System.</p> <p><u>Highlights from the presentation:</u></p> <ul style="list-style-type: none"> • The Congressional Disaster Relief Act of 1974 established parity of mental health with physical/medical risks associated with post disaster symptoms. Maine, as a state with more than 220,000 citizens with reported disabilities, falls within the requirements of the Act. • Maine's experience with disasters has been a major disaster every two years since 1998: ice storm, flooding in Southern & Northern Maine, the Ft. Fairfield ice jam, the Patriot's Day storm. • Maine has begun to focus on its resources and established a behavioral health position with in CDC/OPHEP. • Accomplishments to date: development of county resource guides, training curriculum, identify and train volunteers, establish a seat in county and state Emergency Operations Centers, utilize the Health Alert Network. • DBH Team Development: 40 people trained across the state; 8 completed two-day trainings; 10 county resources completed; background checks required; NIMS IS-100 and IS-700 for Incident Command System required. • Team responsibilities: provide psychological first aid, different from what crisis does when responding to individuals. Provided by non-clinical staff. Responsibility is to work in collaboration with CDC, MEMA, Red Cross and other emergency response agencies to provide individual assistance throughout the state. • Psychological first aid consists of: making contact, stabilize, gather information, develop a plan, and follow up. PFA is not counseling by licensed counselors nor does it take a clinical approach. • Throughout the state, 62 social workers and more than 65 government workers and community helpers have been trained. More people are being trained than are taking the test and background check to become a volunteer. • Response activated through MEMA, requested by county EMA, requested by DBH Director, collaborate with crisis agencies statewide. • DBH goals: distribute trained volunteers throughout the state, increase capacity for local response in counties, activate volunteers to respond promptly, collaborate with Regional Resource Centers and crisis agencies. • Use resources already in place; identify collaborative agencies and work through them to find special populations who would need additional support in a disaster situation.

Agenda Item	Discussion
	<ul style="list-style-type: none"> • Need to look at type of disaster, populations affected, how they are affected, and model response appropriately. • Other states models: New Jersey has a team of 8 people in the state who have a special certification for disaster mental health response and have trained more than 1,000 volunteers. One of the paths for Maine may be to form its own consortium; Pennsylvania did that and it worked quite well. • Maine needs MOUs with crisis agencies for collaboration. Need training in psychological first aide. • Designing an abbreviated curriculum so don't have to take crisis workers off the front line. Need curriculum training in three pilot counties: Aroostook, York, and Knox. Training was done there prior to adoption of curriculum. • PFA is being taught to medical reserve corps trainers; mental health coordinators have been overlooked. <p>Discussion</p> <ul style="list-style-type: none"> • Question: How do you publicize trainings and recruit volunteers? • Answer: Distribution lists through Ad Care, regional resource centers. "So far I am quite disappointed in the enrollments in Kennebec." • Question: How many are scheduled for training in November? • Answer: 10. • Question: Is it accurate that as long as you are trained you can go anywhere statewide? • Answer: Yes. • Question: Of the 17 people trained in Kennebec, do you have an idea of who they are? • Answer: Many of them were in train-the-trainer and are from DHHS. • Question: On-line training? • Answer: Psychological first aid is not part of the on-line training. Incident Command Training 100 and 700 is. Tested at end, get certificate. • Comment: \$50 registration fee is too much. • Question: If I can give you 10-15 people, but none of them can afford the training? • Answer: I'd say we should discuss it. • Question: In the past, the Red Cross was the gatekeeper for crisis intervention training. Does this training take the place of that? • Answer: Yes. <p>Action: Mr. Chamberlain said that the office is supportive of the effort and will work with the DBH Team to get more people trained and condense the incident command component so it doesn't take as much time.</p> <p>Upcoming Trainings: Pam distributed brochures with information on the following 2008 Regional Trainings: <i>DBH: A Critical Response/Building Maine's Capacity to Respond</i>: Nov 17-18, Lee Pellon Conference Center, Machias, Miame, and November 20-21, Maple Hill Farm, Hallowell, Maine. For more information, email AdCare at adcare@neias.org</p>
VII. Consumer Council Update	<p>Elaine Ecker reported that she started in her role as Executive Director on October 20th. She is in the process of setting up her home office.</p> <p>Overview of recent activities:</p> <ul style="list-style-type: none"> • First time the Consumer Council System of Maine has been fully staffed. • Outreach Coordinators have been hired for all three regions of the state. • 11 Local councils have been established and a 12th one is about to be underway in the Augusta area.

Agenda Item	Discussion
	<ul style="list-style-type: none"> • Regional meetings were held in October in Portland, Bangor, and Augusta. • Another regional meeting for Region 2 is scheduled for November 17 at the Pine Street Arboretum; one meeting from 3-5 p.m. and one from 6-8 p.m. The latter meeting is being held so consumers who work can attend. • In December, regional elections will be held and new members will be elected to the statewide council. • In this CSN, local meetings are being held in Augusta, Waterville, and Madison—soon in Augusta. • Criteria for local councils to become formally recognized: core membership of five to six people attending for six months; diversity in representation; have to take minutes and elect officers. Purpose of regional meetings is to talk about local issues and give feedback about services to the statewide council in addition to having consumers support one another and work locally. <p>Discussion:</p> <p>Question: Is it an expectation that area providers attend local meetings?</p> <p>Answer: Meetings are for consumers and allies in support; all are welcome to attend; not a mandate.</p> <p>Question: Can I be put on a mailing list regarding when and where the meetings are? People have voiced interest in participation, and I need to know how to direct them.</p> <p>Answer: Yes. One of the big things I will be tackling is getting information out.</p> <p>Comment: Attended meeting in August and was very graciously received. Was interesting to hear a different point of view of the needs and what is not being met.</p>
VIII. Wraparound Funds Proposal and Finalization	<p>Wanita Page presented a proposal developed by a Subcommittee for CSN 3 to Manage Wrap Around Funds. The following structure was proposed:</p> <ul style="list-style-type: none"> • Funds will be distributed to each agency based on a formula of number of consumers served and acuity. • For those consumers who don't receive services from any agency, there will be an agency or other entity to manage funds for them. • If a small agency feels that managing Wraparound funds would be too much, they also could have their amount of funds in the same account as the consumers without service or they may partner with another agency. • At the end of this fiscal year, there would be an evaluation to see how this system worked and if any changes were needed. <p>The proposal was developed based on feedback received at the October CSN meeting.</p> <p>Motion: Following a lengthy discussion about the value of centralized distribution of funds versus a dispersed administration of funds, Ric Hanley made the following motion: That WRAP funds be administered by MoCo for Southern Kennebec County and by Kennebec Valley Behavioral Health for northern Kennebec County and Somerset County.</p> <p>Discussion: Members discussed expanding the number of agencies involved in fund administration, concerns that the administrative burden of distributing the funds and making decision on same would further extend staff struggling with APS administrative burdens, and the statewide criteria on fund eligibility. Tom McAdem of KBH said that he wasn't comfortable taking on the task and suggested that the Consumer Council or NAMI Maine do so. Bill Tanner said that NAMI Maine has been asked to consider administering the funds but does not have the internal resources to manage them. Elaine Ecker said that the Counsumer Council would be interested in doing so but is not ready to take on the funds at this point. Following this discussion, Ric Hanley withdrew his motion.</p> <p>Motion: Dick Willhauer then motioned that the Department take over the responsibility for making the decisions about</p>

Agenda Item	Discussion
	<p>the disbursement of WRAP funds with the agencies administering the checks.</p> <p>Discussion: David McCluskey asked if the state's involvement could be limited to the first two months of 2009 so that the Consumer Council could then take over the role if it was ready to do so. Mr. Chamberlain said that under that scenario, the state should probably take it on for the balance of the state's fiscal year. Members agreed.</p> <p>Action: The Wrap Subcommittee will be disbanded. The state will take over administration of funds through June 30, 2009.</p>
<p>XI. Employment</p> <ul style="list-style-type: none"> • <i>Report on Employment Network Meeting</i> 	<p>Deborah Thibodeau gave the following update on ESN 3:</p> <ul style="list-style-type: none"> • Currently working as a team to develop a marketing tool, <i>Myths & Facts</i>, re the hiring of persons with mental disabilities. • Currently identifying employer names, company type, contact person, to partner with employers to develop a "Work Ready" program • Distributed 540 need for Change Scales: <ul style="list-style-type: none"> ○ 322 scales returned or 60 percent ○ 28 percent of people who completed the survey are on active caseload or are pending referrals ○ 23 percent of persons surveyed chose not to participate ○ 49 percent of persons surveyed are not sure of change or are satisfied with current status <p>Dick Willhauer said that the Department has a list of vocational providers who have already identified employers willing to participate in the program. "Instant resources." Ron Welch asked for the pie charts distributed to include number of clients along with percentages. Elaine Ecker encouraged collaboration on the part of providers and consumers as the process goes forward.</p>
<p>XII. Other</p>	<p>Consent Decree: Ron Welch further updated members on the Consent Decree. Heretofore the Consent Decree was clear regarding who constituted a class member. However, when the state elected to go to the Law Court to challenge the right of the Superior Court to appoint a receiver for the former AMHI, the state won on that point. The Law Court also expanded the definition of who constitutes a class member. Ron said the Department has had a "hard time getting to 'yes' on exactly who that population is." The plaintiffs have put forth ideas as have the Department. The formal dispute resolution provision in the consent decree is being called upon. Recommendations issued on October 29th in which court master clarifies class member definition. The Department still has some questions about this and needs to have further discussions about the impact of the ruling. In anticipation of a boarder definition of a class member, the Department made its budget request accordingly. Whether this broader definition holds up remains to be seen.</p>
<p>XIII. Public Comment</p>	<p>Helen Bailey said the Superior Court found the state in contempt of the provision that it provide equal services to people similarly situated. What is needed is a sustainable system where people are treated similarly.</p>
<p>XIV. Meeting Recap and Agenda for Next Meeting</p>	<p>Sharon offered the following meeting recap:</p> <p>APS Health Care APS will post its data reports on DHHS and APS web site. Providers please fill out APS Administrative Burden form by the end of November.</p> <p>Disaster Behavioral Health Trainings</p>

Agenda Item	Discussion
	<p>2008 Regional Trainings: DBH: A Critical Response/Building Maine's Capacity to Respond: Nov 17-18, Lee Pellon Conference Center, Machias, Maine, and November 20-21, Maple Hill Farm, Hallowell, Maine. For more information, email AdCare at adcare@neias.org</p> <p>Consumer Council Regional meeting for Region 2 is scheduled for November 17 at the Pine Street Arboretum; one meeting from 3-5 p.m. and one from 6-8 p.m.</p> <p>Consent Decree Full ruling of Court Master is on DHHS web site under Consent Decree. Also latest quarterly report.</p> <p>The CSNs will not meet in December.</p> <p>Agenda for next meeting:</p> <ul style="list-style-type: none"> • OAMHS Communication • Budget Update • Consumer Council • Employment