

**Community Service Network 4 Meeting – Knox, Lincoln, Sagadahoc, Waldo Counties
Rockland--DHHS
November 16, 2006**

Minutes

Present: Theresa Turgeon, James Talbot, Merrymeeting Behavioral; Tammy Swasey-Ballou, NAMI-ME; Steve Hoad, AIN; Karina Patton, ESM; Kelly Staples, Joan Manks, Sweetser; Paula Greenleaf, Transitional Planning Group; Dan Bennett, Waldo County General Hospital; Lisa Wallace, Leslie Mulhearn, MCMHC; Bob Fowler, Sweetser; David Proffitt, Riverview Psychiatric Center; Gail Wilkerson, Spring Harbor Hospital. Presenters from OAMHS: Ron Welch, Leticia Huttman, Don Chamberlain, Marya Faust, Sharon Arsenault. Muskie School: Sherrie Winton, Scott Bernier.

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I. Welcome and Introductions	Sharon Arsenault, Region II Team Leader, welcomed everyone to the meeting and introductions were made around the table. She briefly went over the meeting materials and explained the format of the meeting, i.e. that questions may be posed at any time during the presentations. Any questions requiring significant time to answer will be recorded in the “parking lot” and addressed during that part of the meeting.	
II. Overview of the Mental Health Plan approved by the Court Master on October 13, 2006.	<p>Ron Welch, Director of DHHS Office of Adult Mental Health Services (OAMHS), presented an overview of the Consent Decree Plan, signed on October 13, 2006. He focused on Chapter 4 of the Plan, Continuity of Care and Services, which includes the formation of Community Service Networks (CSNs). This is “the heart of how communities work together to meets the needs of people with mental illness,” he said.</p> <p>The entire program was accompanied by a comprehensive PowerPoint presentation. Handouts were distributed to everyone present.</p> <p>Ron explained, the 4 major components, which he calls “The Four Cornerstones” of Chapter 4 of the Plan. They appear below as A, B, C, and D.</p>	
	<p>A. Seven Community Service Networks.</p>	<ul style="list-style-type: none"> • The state is divided into 7 CSNs (see chart on website). • Each CSN provides 8 core services: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services. • Functions of CSNs: <ul style="list-style-type: none"> › Assure delivery of services to all adult mental health consumers in the network area. › Maintain a “no reject” policy so that no consumer is refused needed service within the CSN area. Ron explained that the “no reject” expectation pertains to the network as a whole, not to individual providers. There may be exceptions, i.e. when needed services are only provided outside the network or even outside the State. The goal is to meet the needs as locally as possible. › Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. “Complex needs” means those that may be difficult to meet within normal services, i.e. co-occurring disorders, additional medical conditions, or physical disabilities. › Identify services necessary for consumers in the CSN who are at risk and provide those services. › Comply with all provisions of the Bates v. DHHS Consent Decree, especially where service coordination within the core service array is necessary. › Assess and identify resource gaps by geographical area and establish remedial measures and implementation timeframes. › Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care

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		<p>during a psychiatric crisis. Assure continuity of treatment during hospitalization and the full protection of a client's right to due process.</p> <ul style="list-style-type: none"> › Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein. › Plan based on data and consumer outcomes. <p>Ron parenthetically explained the major differences between the CSNs and the former LSNs: 1) Planning will be done by consistent data gathered and disseminated by the State; 2) Leadership will be provided by OAMHS; 3) CSNs are explicit in the Court Order itself.</p> <ul style="list-style-type: none"> › Implement the Rapid Response protocols. › Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. <p>Ron stated that this involves costs not covered by Medicaid and that are the responsibility of DHHS.</p>
	<p>B. Performance Requirements/ Enforcement through contracts.</p>	<ul style="list-style-type: none"> • Contract Amendments were mailed out to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding for each CSN. Ron stated that the Dept. may have a reputation for not enforcing its contracts, but the termination provisions outlined in the Plan for non-adherence must be carried out. • Legislation is expected to define CSNs, assure momentum, and provide consistency with managed care in whatever final form managed care takes. • Quality Management Structure <ul style="list-style-type: none"> › Replace monthly provider meetings with network meetings › Provide data by agency and by network › Problem-solve within network, with local consumer council <p>Question: The mentor meeting and all of that goes away? Answer: There is the expectation that what you're hearing today goes back to respective staff and they know that this is the emerging world. There's flexibility in how you might utilize your staff with consumer involvement. Whom you select to put on that project is up to you.</p> • Realignment of Services <u>Community Support Services:</u> <ul style="list-style-type: none"> › Each consumer will have CSW to coordinate ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. This is language from the Consent Decree Plan. › CSW's employer is the lead agency for the client. › Providers must assure 24/7 access to: ISP, Crisis Plan, health care advance directives, contact information for prescriber, and basic demographic and service information. <p><u>Crisis Services:</u></p> <ul style="list-style-type: none"> › Provided outside the Emergency Department, unless: consumer requests otherwise, medical condition need treatment, or person is in protective custody of the justice system. › Consumer's CSW is responsible during business hours. › During non-business hours, crisis service is responsible, unless consumer is enrolled in ACT. By definition, ACT is responsible 24/7, Ron stated. › In Emergency Department, crisis provider must: assess for less restrictive alternatives to hospitalization, locate and arrange for those services, and review crisis plan and advance directives. Ron explained that the purpose

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		<p>is to help get the person out of the ER to appropriate services in the community, if possible. “Of course, the physician in the ER makes the determination as to hospitalization.”</p> <p><u>Hospital Services</u></p> <ul style="list-style-type: none"> › Community hospitals are the first level of hospitalization response. MaineCare amendment will assure no-reject policy. › Specialty hospitals, Acadia and Spring Harbor, are the next line of treatment. They will take admissions from community hospitals. › Public hospitals, Riverview and Dorothea Dix, will take referrals from Spring Harbor and Acadia, as well as forensic admissions. <p>The three levels are not locked in stone, Ron said. The Plan includes provisions for certain exceptions to this referral process, some of which may require OAMHS involvement.</p>
	<p>C. Permanent Housing with Flexible Services</p>	<p>Ron explained that services will be unbundled from housing under the Plan, and will be provided as needed, when needed to consumers in homes of their own choice.</p> <p>The current link between services and housing will be broken. Only residential treatment will remain as a group home model or bundled service.</p> <p>PNMI is currently the major choice for residential treatment:</p> <ul style="list-style-type: none"> • This model requires the highest level of intervention for all residents, irrespective of need. • A needs assessment for this level of care will be undertaken to determine where and how many beds should be retained. <p>Ron informed that each CSN will determine how many beds to retain and where they should be located in the network.</p> <ul style="list-style-type: none"> • For those beds remaining, long-term stay is not the goal. • Successful treatment and re-entry into community life is the goal. <p>Ron mentioned that he is learning from some providers that there may be some flexibility with PNMI that could meet with the Plan’s provisions. He expects some use of Section 17 or modified PNMI may be utilized. He acknowledged the need to explore how to achieve more independent living options and told the group that Don Chamberlain is convening a work group for this purpose.</p> <p>Housing options and Resources:</p> <ul style="list-style-type: none"> • Units developed with support of DHHS • BRAP • Shelter Care Plus vouchers • OAMHS will develop housing database
	<p>D. Consumer Councils and required peer services.</p>	<p>This cornerstone will be covered in the detail later in the program, but Ron highlighted the fact that for the first time consumer participation is mandated and supported by the Legislature.</p> <ul style="list-style-type: none"> • Through 3rd supplemental budget of the 122nd Legislature, a mandate with \$323,000 was passed to establish consumer councils statewide.

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		<ul style="list-style-type: none"> • A Transition Planning Group was formed with representation from virtually all segments of the consumer community. • That work is underway and will be presented as part of this program. “They are well along in designing the system.” • This particular cornerstone will affect the strength and tenacity of all of the others. • It will undoubtedly have more impact in how the Maine mental health system delivers services than any other.
	Vocational Services	<p>Ron reiterated the vital importance of work in an individual’s recovery process.</p> <ul style="list-style-type: none"> • Vocational services are absolutely pivotal to successful recovery. • 2 benefit specialists and 4 employment specialists will be out-posted across the state. • Each will produce work for a percentage of their caseload—15% is the expectation, Ron said. • Training will be provided to over 525 CSWs across the state, as to the critical importance of work in the recovery process. • DHHS entered into an MOU with the Dept. of Labor and Bureau of Rehabilitation Services outlining the respective responsibilities of each. (Both Departments are named defendants in this litigation.) • Employment specialists, as is required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work.
<p>III. Consumer Council and Consumer and Family Representation</p>	<p>Leticia Huttman, Director of the Office of Consumer Affairs, presented this portion of the program.</p> <p>Development of Statewide Consumer Council System</p> <p>The importance of the consumer system developing outside of the OAMHS was highlighted. To this end, the process is consumer led, with OAMHS providing support, only as requested. The development of the consumer council system began in April 2006 when the Transitional Planning Group (TPG) began to meet. The TPG is comprised of consumer leaders, meeting biweekly in a facilitated process. Their mission is to develop the basic elements and structure of the independent Statewide Consumer Council system.</p> <p>The TPG has developed a timeline, as follows:</p> <ul style="list-style-type: none"> • April 2006 – TPG begins meeting • March 2007 – 3 Regional Conferences • May 2007 – Form at least 3 temporary regional councils • June 2007 – Statewide Council seated and holds first meeting • August 2007 – 7 Local Consumer Councils formed <p>The TPG has hired outreach workers, whose work will include getting people involved and excited. They will be contacting providers and meeting with consumers/groups throughout the State.</p> <p>The draft design of the system consists of multiple tiers: Temporary and Periodic Regional Councils, Statewide Consumer Council, and Local Consumer Councils. The Temporary and Periodic Regional Councils will basically operate until the Statewide and Local Consumer Councils are formed, fading over time as this happens. Eventually, many Local Councils will be functioning throughout the State. They will be comprised of consumers from a wide variety of settings: Peer support programs, peer centers and social clubs, provider agencies, hospitals, at-large consumers, homeless shelters, club houses, and other places yet to be thought of. The meetings will be held in the form of town meetings, where all can contribute. The members or officers will be chosen based on an application process to be sure a</p>	

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	<p>diversity of experiences is represented. The Local Councils will elect representatives to send to the Statewide Consumer Council.</p> <p>Functions of Local Consumer Councils:</p> <ul style="list-style-type: none"> • Have a role in meaningful quality assessments Some of the following examples were given: Participate in licensing review process or in conducting agency consumer interviews. • Advocate/advise for local response to local issues • Report with representation to the full Statewide Consumer Council system • Receive and transmit information from wider world • Outreach for concerns beyond our members • Regional work to create and support local council efforts <p>Mission and Function of Statewide Consumer Council:</p> <ul style="list-style-type: none"> • Provide one-stop access for advice and planning on issues affecting lives of consumers • Advice directed to and developed with DHHS and also to other departments and administrations Leticia mentioned that the Council will not just have a relationship with DHHS, but with other departments/entities as well, such as Department of Labor, Department of Education, and Community Action Programs. • Opportunity for consumers to learn from one another and to increase the impact of advice offered The Council will provide a way to learn, grow, and to become more skillful and knowledgeable as consumers. • Support consumer-advising skills and develop interest in the Council system. • Develop/implement and oversee quality assessment of services and delivery systems in order to ensure quality services and participate in effective design. The Council will review Consent Decree quarterly reports, and it is expected that that vocational services will probably be high on their agenda for review. The Council will give ideas and suggestions for improvement. <p>Consumer and Family Participation in Community Service Networks</p> <p>Consumer representatives in the CSNs will come from two places: Each local council when formed (TPG representation in the interim) and from all peer centers/social clubs within contracted agencies or contracted independently with OAMHS.</p> <p>NAMI-ME is also providing a family member to each CSN to represent the concerns of families with adult family members who are living with mental illness.</p>
<p>IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols</p>	<p>Don Chamberlain presented the details of the CSN Implementation Plan, MOU, and Operational Protocols.</p> <p><u>CSN IMPLEMENTATION PLAN</u></p> <p>Development Timeframe</p> <ul style="list-style-type: none"> • Immediate deadlines are signing the contract amendments by November 19 and executing the MOUs and Operational Protocols by January 3. During November and December CSN participants will give input on roles, expectations, responsibilities, and develop MOU and Operational Protocols, signing both documents no later than January 3. • Over time with input from all parties: Statewide Policy Committee and monthly network meetings. By February 2007, CSN work plans will be created and CSNs will select participants for the State-Wide Policy Council. Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider, and vocational provider.

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	<p>State-Wide Policy Council This council will be convened by OAMHS in February 2007 and will be directed by OAMHS senior management. Duties and timeframes as follows:</p> <ul style="list-style-type: none"> • Managing dynamics of network responsibilities. (February) • Assessing compliance with “no reject” policy. (March) • Assessing 24/7 CSW access. (March) • Review resource gaps and make recommendations. (March) • Develop and implement network-level planning tools. (May) • Identify all QA and QI performance measures that will become purview of CSNs to monitor and report on to OAMHS. (May-June) • This includes QA and QI processes and protocols that CSNs will use for review of data and recommendations to OAMHS. (May-June) • Develop CSN performance review process. (July) <p><u>MEMORANDUM OF UNDERSTANDING</u></p> <p>Don explained that OAMHS is gathering any and all suggestions for changes to the MOU through November. At the December meetings, CSNs will vote on any recommended changes for consideration by OAMHS. OAMHS then intends to craft one MOU. The MOU, as currently drafted, (and distributed in various mailings and in the Consent Decree Quarterly report), contains the following elements:</p> <p>Goals of CSN</p> <ul style="list-style-type: none"> • Provide integrated system of care • Core services available in area • Consumers’ changing needs met seamlessly • Improve continuity of care, efficiency, outcomes, cost effectiveness <p>Guiding Principles</p> <ul style="list-style-type: none"> • Focus is adult mental health consumer • Quality of care depends on access and transitions without disconnection • Coordination makes effective, responsive system • Local planning, local problem solving, and a mutual understanding of the roles and expectations of each services provider should be effective ways to support continuity of care. This guiding principle is a statement of why CSNs really exist, Don said. • Based on current best practices and evidence based models, the mental health system must support consumers becoming knowledgeable about their condition, the availability of services, and self-directed regarding services. “The core of what we do is related to consumers,” Don added. • Providers and systems practice collaboration across disciplines, including peer disciplines, and health specialties. <p>Structure of CSN</p> <ul style="list-style-type: none"> • Meet at least monthly • Establish and oversee operational protocols • Establish outcome measures and assure quality • Establish sub and ad hoc committees, as necessary • Chaired by OAMHS

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	<p>Agreement and Responsibilities Each member agrees to:</p> <ul style="list-style-type: none"> • Assure delivery of services to all adult mental health consumers in the network area. • Maintain a “no reject” policy so that no consumer is refused needed service within the CSN area. • Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served. • Identify services necessary for consumers in the CSN who are at risk and provide those services. • Comply with all provisions of the Bates v. DHHS Consent Decree, especially where services coordination within the core service array is necessary. • Assure 24-hour access to a consumer’s community support services’ records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis. • Plan based on data and consumer outcomes. Planning should be focused on overall data, not just one case, Don said. • Implement the Rapid Response protocols. • Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings. Don said OAMHS is asking the Attorney General for clarification of confidentiality issues involved in this. <p>The participant will:</p> <ul style="list-style-type: none"> • Appoint a representative who has the authority to make commitments on behalf of the participant and who will attend monthly meetings of the CSN. • Join in appropriate special projects and committees may be developed by the CSN. • Commit to the guiding principles, goals, and structure outlined above. <p>Question: With that assurance that everybody has access, is the Department within it’s no reject policy still going to emphasize customer choice so that the CSN realizes that consumers may not use that network and move into other catchment areas because they choose a different service provider?</p> <p>Answer: Yes, it’s understood that this is consumer driven. Other exceptions are that a consumer might have had a bad experience with hospital A, so you may not go there, but let’s look at how we serve people locally.</p> <p>Question: Is there a line that reads, “while still accommodating consumer choice?”</p> <p>Answer: Yes. It will be consumer driven and based on their needs.</p> <p>Questions: You’re saying that “no reject” is going to be....instead of calling a provider and the provider says that they have no service available, there is going to be another step?</p> <p>Answer: It doesn’t mean that a provider has to make up a bed out of thin air if it doesn’t exist, but we need to address those system issues. If we don’t have the capacity, one thing for a CSN to do is some problem solving and to say, you might not have the capacity but how do you work together as a system, and you’ll talk about this problem and come up with a solution.</p> <p>Question: Will each provider be responsible for keeping data on refusals in a standardized way?</p> <p>Answer: Probably the CSN. There is a consent decree requirement for no reject, but if there are not beds, you’re excused. But now we’re adding this additional buffer to look at the community as a whole. We don’t have a magic bullet. We’ll require that it is documented so that it can come back to the discussion of the larger group. Information will always come back to you, as the CSN.</p> <p>Question: Is there anyplace or does there need to be a place for consumers in the local jails? Any transition from the jail to the community?</p> <p>Answer: It plays a part for sure. It is another transition place. Our consumers of adult mental health are all over the place in all kinds of systems and we need to work with those systems to assure continuity of care. We’ve excluded the jails so far, but we may want to get to that. We have consumers, hospitals, vocational providers, and so on, and we didn’t want to get too big but we</p>

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	<p>may add more later. We will be back to these issues in December so that every CSN can have the comments and recommendations of other CSNS.</p> <p>Question: I'm interested in this MOU containing some language that there be an element of the network that devotes itself to interfacing with other organizations so that people with dual diagnosis or multiple disabilities will be served appropriately with the local providers. Often, what I've seen is that there's little interface between mental health providers and some of the other services for people with multiple disabilities.</p> <p>Answer: Well taken. What we've indicated in the plan for CSNs is that over time they'll have greater involvement with Substance Abuse Treatment, hospital and crisis providers to get that interface. We will put that on the parking lot as well.</p> <p>Question: Will meeting minutes be available to other CSNs?</p> <p>Answer: Yes, you'll get that either by e-mail or hardcopy. Our plan over the next week is to get up a CSN category on our website and you can click on one of the seven CSNs and access the minutes and other activities going on with the CSN.</p> <p><u>OPERATIONAL PROTOCOLS</u></p> <p>Purpose and Goals</p> <ul style="list-style-type: none"> • Same as listed under MOU "Goals of CSN" above. <p>Membership</p> <ul style="list-style-type: none"> • Each provider required to designate a representative. • Representative must be able to speak for organization. • Consistent representation is expected. • Not intended to be rotating designees. • Substitute designees may discuss, but not vote. <p><i>Eligibility:</i></p> <ul style="list-style-type: none"> • One representative from each provider with contracts with OAMHS who provide any of the core services. • One representative from each community hospital, with and without psychiatric units. • One representative from the psychiatric specialty hospital and from the state hospital. • One to three consumer representatives chosen by the consumer-run Transition Planning Group (eventually replaced by Consumer Council representatives). • One representative per social club or peer center, if part of a larger agency contracted to provide more than peer services. • One representative from NAMI-ME. • One representative from Community Mediation Services. <p><i>Service Array:</i></p> <ul style="list-style-type: none"> • Eight core services <p><i>Chairperson:</i></p> <ul style="list-style-type: none"> • Senior staff member of OAMHS. <p><i>Changes to Membership:</i></p> <ul style="list-style-type: none"> • May change depending on needs of CSN and changes in services/providers in CSN area. <p><i>Decision Making:</i></p> <ul style="list-style-type: none"> • Each member has one vote—vote shall be recommendation to OAMHS. <p>Meetings</p> <p><i>Regular:</i></p>

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	<ul style="list-style-type: none"> • At least monthly, more often if necessary. • Scheduled by OAMHS. <p><i>Special:</i></p> <ul style="list-style-type: none"> • Called by OAMHS on its own or at the request of majority of membership. <p><i>Notice:</i></p> <ul style="list-style-type: none"> • Notice given to each member not less than one week prior. <p><i>Quorum:</i></p> <ul style="list-style-type: none"> • Discussion and recommendations take place with those members present. <p><i>Voting:</i></p> <ul style="list-style-type: none"> • CSN decides on issues it shall vote upon. • Decided by simple majority of those present. • Advisory to OAMHS unless OAMHS states it will act on the vote. <p><i>Attendance:</i></p> <ul style="list-style-type: none"> • Absence from 3 or more consecutive meetings shall be reason for contract or provider agreement review <p><i>Agenda:</i></p> <ul style="list-style-type: none"> • Set by OAMHS with input from membership. • Include time set aside at each meeting for public comments. <p>Ad Hoc Committees</p> <ul style="list-style-type: none"> • CSN may designate ad hoc committees. • Chair will appoint committee chairs. • Committees will report to full CSN. <p>Don clarified that committees do not operate outside the CSN.</p> <p>Amendments</p> <ul style="list-style-type: none"> • CSN may amend the operational protocols from time to time. • Proposed amendments must receive majority vote of members present. • Proposed amendments must be approved by OAMHS before acceptance. <p>Question: Is there a way to make those meetings be video-conferenced?</p> <p>Answer: We had some discussion about that in Aroostook, we are looking at that. We might talk about it as a CSN, recognizing that people are traveling long distances but at times people would need to be in the same room. People from Acadia sometimes have to up to Presque Isle. We agreed that they wouldn't have to drive up there for every meeting. This needs to be discussed.</p>
<p>V. Consent Decree Standards: Indicators for Performance</p>	<p>Marya Faust, Director of Policy, gave an overview and explanation of the Performance and Quality Improvement Standards that are part of the approved Consent Decree Plan.</p> <ul style="list-style-type: none"> • 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. They will not change. They are grouped under 12 categories. • OAMHS reports on these standards quarterly and all documents included in the reports are posted on OAMHS website. (The documents for the most recent quarterly report were included in the notebook provided to each attendee at this meeting.) • Riverview Psychiatric Center has its own set of measures, also included in the quarterly reports. Dorothea Dix was not a party in the Settlement Agreement, so it is not part of this reporting process. • Some standards are measures of all people using the services and some are just for class members.

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	<ul style="list-style-type: none"> • Anyone who was a patient at AMHI on or after January 1, 1988, is a class member. This provision extends to Riverview, and each new admission becomes a part of the pool of class members. The number continues to grow. • The standards present a picture of how the mental health system is operating. Marya mentioned that OAMHS will be consistently focusing on this picture “to see how we’re all doing.” <p>Meeting performance standards does not translate into “compliance,” Marya explained. Being in compliance involves a separate process, an additional step, which will be negotiated with the Court Master and Plaintiffs. She gave the following example of a current <i>performance standard</i> and an example of a possible <i>compliance standard</i>:</p> <p><i>Performance standard:</i> “Class members report in the class member survey that they are informed about their rights as MH consumer in a way they could understand.” (Currently the measure is 81.3% and the performance standard is 90%.)</p> <p><i>Possible compliance standard:</i> “For three full quarters, the standard is at 90% or better.”</p> <p>Marya reviewed the contents of the notebook provided to all attendees: It contains the full Consent Decree Plan approved October 13, 2006; and the November 1, 2006, Quarterly Report with all attachments. One of those attachments is the Performance and Quality Improvement Standards. Each Standard is listed, with data, and a graph depicting the baseline measurement, the performance standard required by the Consent Decree Plan, and the current measure. Marya discussed several of the standards, as follows:</p> <p>Standard 1: “Treated with respect for their individuality”</p> <p>The 2004 baseline shows 91.8%, the current measure is 92.3%, and the performance standard is 90%. “We’re all doing a good job on this standard,” Marya said.</p> <p>Standard 18: “Continuity of Treatment is maintained during hospitalization in community inpatient settings”</p> <p>The 2004 baseline shows 31.6%, current measure is 0%, and the performance standard is 90%. “Clearly, we must improve our performance here.”</p> <p>Question: What happens if the consumer doesn’t want the hospital to have the information? Answer: The CSW made the attempt and documented that the consumer didn’t want it to occur. The burden is on the hospital to have taken some action.</p> <p>Marya pointed out that this information is collected from UR nurses, and the ISP must be included in the record to be counted. A telephone conversation about the client/ISP does not count in the performance calculations.</p> <p>She also said that some standards may not correspond with nationwide performance standards, some were set higher by the Court Master. Performance levels as specified are what is expected.</p> <p>Standards 26 & 27 – Vocational Employment Services</p> <p>Both standards show current measures well below expectations of the Court. The Consent Decree Plan places great emphasis on vocational services and improvements must be made.</p>

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	<p>Question: A question was raised about the standards. Answer: These standards are what we negotiated. We'll be looking at performance whether collecting information with Rapid Response and other sources. Our intention is not to add more standards. Question: Will these be the standards that consumer advisory groups will be responsible for monitoring? Answer: Yes, as does the statewide council. It's a picture and not a complete picture and there are some data analysis problems. We also need to look at some other things... Question: Are these publicly available? Answer: You can download the standards piece and shows where we found national data and other data. The quarterly report will always be there for you and the website is available for you to download information. Question: As I understand this has been approved only by the court master Answer: It's been approved by the court master who had the authority from the court, and he did not do it without her approval. No additional signatures are needed. This plan forms the basis of how we move forward.</p> <p>Marya also discussed other items in the packet and notebook as follows:</p> <p>CSN Related Components Matrix</p> <ul style="list-style-type: none"> • Shows tasks and timelines related to the CSNs. • Excerpted from the overall Consent Decree Plan matrix attached to the November 2006 Quarterly Report. (Included in the notebook at Tab 2.) • Provides a quick reference to what needs to be done and when. <p>Contracted Services by Network Matrix</p> <ul style="list-style-type: none"> • Another attachment to the quarterly report, included in the notebook (Tab 7). • Starting point for identifying what services are provided by providers in each CSN area. • OAMHS will continue gathering information to update this matrix through RSVP forms each member received, as well as an electronic survey Muskie will develop and send out to all members to get more detailed geographic information and enable actual mapping of services. • This information is critical in identifying gaps and making remedial recommendations, as well as supporting budget requests to the Legislature. <p>OAMHS Website: Consent Decree</p> <ul style="list-style-type: none"> • All Consent Decree documents and quarterly reports are posted in electronic form. • Will add a Community Support Network section to post minutes and other documents.
Questions and Answers	<p>Additional Questions and Answers:</p> <p>Question: Is there an individual list of CSN services? Answer: This is the beginning. We hope to have who is in it and then a visual that displays locations and depth of services. Answer: The duties and responsibilities may feel like a lot, but rest assured that the office will be fully staffed permanently. Our role is to support you, bring products to you so that you can look at issues and make decisions. Question: So this means no more musical chairs? It's been hard to keep track of all of this. We should have a matrix of positions and</p>

Agenda Item	Presentation, Discussion, Questions
	<p>who's moved through them.</p> <p>Question: Has the Department thought about the gaps in services and what are you going to do about that? I know in the rapid response it impacts the CSN.</p> <p>Answer: What we have is in the back of tab 1, which is the budget for the next two years. They struck us as the most important: vocational services, BRAP money, peer services, and then all of the development that is going on this fiscal year is included. One of the reasons we desire the work regarding the matrix (binder, p. 81, tab 1) is that if we can get it ready before legislation adjourns, they can have a picture of what the needs are. The beauty of CSNs is that you're public and you can say what you've found in your area.</p> <p>Question: Does "medically compromised" include Huntington's disease?</p> <p>Answer: I assume any medical condition that needs medical oversight. We don't often have the beds and correct staffing to deal with a person with mental health and needs for nursing care, such as diabetes. It also includes other medical issues that clients have.</p> <p>Question: I asked about that disease because I know folks are going out of the state right now.</p> <p>Answer: We're very aware of that. The population with traumatic head injuries and mental health issues is another population that needs to be looked at. We are working with the office of cognitive disabilities.</p> <p>Answer: There's also something in this budget that speaks to geriatric issues. We have to keep that in mind as well, as we go through that matrix. This has medical ramifications as well. People are getting older and need mental health care. People are dying 25 years earlier sooner than they should be.</p> <p>Question: That was one of the things that we're trying to say...a person with mental health ages early and this issues needs to be addressed. I'm delighted to hear that this is being looked at</p> <p>Answer: At one point we might want to invite Elsie [Freeman] to a meeting because she has the data and makes a marvelous presentation of issues that we need to be looking at.</p>
VI. Parking Lot Items	<ul style="list-style-type: none"> • Need for Element of Network interfacing with others with different service needs • Discussion to include transition of people in jails • Mechanism for communication for CSNs (minutes, etc); Video Conferencing availability • Huntington's Disease/Head Injuries (\$ and services for mentally ill with medical complications).
VII. Next Steps	<ul style="list-style-type: none"> • Address Parking Lot Items • MOUs and Protocols in December Meeting
VIII. Agenda for December Meeting	<ul style="list-style-type: none"> • MOU • Operational Protocols • Service Matrix – Mapping • Ongoing schedule of meetings