

**Community Service Network 4 Meeting  
DHHS Offices, Rockland, Maine  
December 11, 2006**

**Approved Minutes**

**Members Present:**

- Lisa Levinson, Community Mediation Services
- Katrina Patton, ESM
- Theresa Turgeon, Merrymeeting Behavioral Services
- Leslie Mulhearn, MCMHC, PenBay
- Tammy Swasey-Ballou, NAMI-ME Family Member
- William Nelson, Riverview Psychiatric Center
- Gail Wilkerson, Spring Harbor
- Bob Fowler, Sweetser
- Charlotte Simpson, Sweetser Peer Center
- Paul Greenleaf, Transition Planning Group
- Dan Bennett, Waldo County General Hospital

**Members Absent:**

- AIN
- Allies Inc.
- Group Home Foundation, Inc.
- Miles Memorial Hospital
- St. Andrews Hospital & Healthcare Center

**Staff Present:** DHHS/OAMHS: Ron Welch, Marya Faust, Don Chamberlain, Leticia Huttman, Sharon Arsenault. Muskie School: Janice Daley, Scott Bernier.

Agenda Item	Presentation and Discussion
I. Welcome and Introductions	Sharon Arsenault welcomed everyone to the meeting and introductions were made around the table.
II. CSN Meeting Guidelines	Sharon reviewed the "CSN Meeting Guidelines" and requested feedback. The group made no suggestions for changes.
III. Contract Amendments and Provider Agreements	Don Chamberlain informed the group that all contract amendments for CSN 4 have been signed and returned to OAMHS. The overall statewide returns are just over 80 percent, he said.
IV. Memorandum of Understanding	<p>Ron Welch led the discussion on proposed revisions to the draft Memorandum of Understanding (MOU) and Operational Protocols (OP). He explained that the preferred process for the group to make recommendations for changes would be by making and seconding motions, discussing, and voting. He also explained that after all 7 CSNs make their recommendations (through the last meeting of this "round" on December 18), OAMHS will finalize and send out MOU/OP to all CSN members for signature.</p> <p>The members voted to recommend the following two changes/additions to the MOU, with highlights from the discussion listed in bullet points below each item:</p> <ol style="list-style-type: none"> <li>1. Authorized representatives may have an alternate who can attend and vote. <ul style="list-style-type: none"> <li>• One alternate is to be appointed.</li> <li>• The attendance of either the authorized representative or the alternate 'counts' in members fulfilling their attendance obligations.</li> <li>• It is the burden of the authorized representative to keep the alternate up-to-date.</li> </ul> </li> <li>2. The OAMHS memorandum clarifying the "no reject" policy is included as an addendum to the MOU. <ul style="list-style-type: none"> <li>• The Statewide Policy Council will be addressing this issue.</li> </ul> </li> </ol>

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	<p><u>Other Clarifications (issues raised by this and/or other CSNs):</u></p> <ul style="list-style-type: none"> <li>• A month’s advance notice will be given on any item requiring a vote, in order to provide adequate time for representatives to confer within their agencies before voting</li> <li>• It is the responsibility of the authorized representatives to keep their Boards of Directors informed and involved.</li> <li>• Individual CSNs will have the option of making amendments to their respective MOU and OP in the future, but for purposes of meeting the January 3<sup>rd</sup> deadline, the documents will be uniform across the CSNs.</li> <li>• OAMHS is working on language to address the responsibilities of CSN members if a member ceases to exist or to provide services.</li> <li>• The “one week notice for meetings” statement in the MOU applies to special/emergency meetings only. Attendance to special meetings is not included in the “three strikes rule.” (This refers to the directive that members missing three consecutive meetings will be subject to contract or provider agreement review.)</li> </ul> <p>The group also discussed the possibility of members attending by video or teleconference. After discussion, the group voted that members should try to attend in person first; but if necessary, they may attend by electronic means.</p>
V. Operational Protocols	<p>The group voted that all of their recommendations for changes to the MOU also apply, as appropriate, to the Operational Protocols.</p>
VI. Provider Services Data Matrix, Maps, Service Gaps	<p>Marya Faust presented several data items, explaining the OAMHS is working to provide usable and accurate data from a variety of sources. She emphasized the importance of building accurate data for planning and resource purposes. She also requested that members share their own data, knowledge, and suggestions to improve the “picture” of services and unmet needs in their CSN.</p> <p><u>2006 Profile</u>  Data collected from MaineCare and from mental health services funded by the General Fund shows:</p> <ul style="list-style-type: none"> <li>• 33,874 people are receiving mental health services</li> <li>• 10,129 of those have serious mental illness (43.3%)</li> <li>• 38% of the 10,129 have co-occurring disorders of mental illness and substance abuse</li> <li>• National Medicaid data shows people with serious mental illness live 25 years less</li> <li>• 69% have one or more other health conditions; 46% have two or more; 28% have three or more</li> <li>• 1 in 5 have diabetes, compared to 1 in 10 for MaineCare members with no mental illness</li> </ul> <p>Marya stated that these numbers can inform workforce development and training issues and has great implications for service planning given the number of people with mental illness in MaineCare struggling with complex medical issues. Ron added that these facts make obvious the reasons why hospitals are required to participate in the CSNs.</p> <p><u>Data Matrix and Maps</u>  Marya explained that the data CSN members provided from the electronic data forms will be presented in two ways: (1) maps, for a visual picture of where services are delivered, (2) a data matrix, for comprehensive, in-depth written information. This effort is just beginning, she explained, and the data will continue to be gathered and refined. She showed PowerPoint slides representing the population density of Maine, and symbols (both town and county-wide) indicating where each core service is located/delivered (as reported in the data sheets through 12/4/06). The maps will</p>

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	<p>continue to be developed to show more clearly where services are located/delivered and depict more about the depth and coverage areas.</p> <p>Members were asked to review the information in the matrix and provide any revisions or missing data to Elaine Ecker at the Muskie School: <a href="mailto:eecker@usm.maine.edu">eecker@usm.maine.edu</a>.</p> <p>Comment: The data sheet was more difficult to fill out than it appears, especially for a large agency. It was difficult to provide the information in the time allowed.</p> <p>Answer: We will try not to be so burdensome in the future. It is important to build a database for the CSN, and once it is in place, we will work on methods to allow agencies to keep their data updated within the database. Our apologies.</p> <p><u>Unmet Needs/CSN Summary</u></p> <p>Marya distributed a report showing the number of specific unmet needs of clients in CSN 4, as well as a sheet indicating the number of clients in each CSN with unmet needs. The two sheets show that 101 clients have 170 unmet needs in the CSN 4 area. The client pool includes people receiving Community Integration, Intensive Community Integration, and Assertive Community Treatment services; mental health services through General Funds; and Consent Decree Class Members who request certain services through OAMHS directly.</p> <p>She explained this report will be generated every 90 days, and over time will provide valuable information about where needs continue to be unmet. She briefly explained the process of determining a need is “unmet,” i.e. that the particular service is not provided within a certain acceptable timeframe set by the Court. The information about needs comes from clients’ Individual Support Plans (updated every 90 days) as input by Community Support Workers, case managers, Consent Decree Coordinators, etc., into the RDS-EIS reporting system.</p> <p>Ron emphasized that this data “has everything to do with resource allocation—It hasn’t in the past, but now it will.” He explained that the process is just beginning, but when the data is more fully developed, in a year or so, it will be released to the public and the legislature.</p> <p>Marya reiterated that all the data gathering efforts are works-in-progress. “The more pieces we put together, the better the picture of unmet needs will be for the area.”</p> <p><u>Member comments:</u></p> <ul style="list-style-type: none"> <li>• Be cautious about presenting incomplete data to the legislature.</li> <li>• It may be important to divide the data into the CSN’s four separate counties to more accurately show where certain unmet needs are, e.g. transportation may be an unmet need in one county, but not in the next.</li> </ul>
VII. Vocational Services	<p>Don Chamberlain reported on three items related to vocational services.</p> <p><u>DOL VR /DHHS OAMHS Memorandum of Understanding (MOU)</u></p> <p>He referred people to copy of this MOU in the packet and discussed the following highlights from this agreement between DOL Vocational Rehabilitation Services (VR) and DHHS OAMHS:</p> <ul style="list-style-type: none"> <li>• Goals: Strengthen partnership, ensure ethical best practices, maximize vocational funds, increase number of MH clients employed.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Joint Responsibilities: A workgroup is being convened to fulfill the activities listed in this section of the MOU. Jim Braddick of OAMHS and a representative (not yet named) from VR will co-chair the workgroup. Anyone interested in being on this workgroup should notify Elaine Ecker, <a href="mailto:eecker@usm.maine.edu">eecker@usm.maine.edu</a>.</li> <li>• Attachment A: Addresses issues with OAMHS' new Employment Specialists (ES) and VR. It ensures that when a client moves into VR services (from the waiting list), any plan developed with the ES will be accepted by VR. The client has the choice of staying with the ES after becoming eligible for VR services and will have full access to the resources VR offers its clients.</li> </ul> <p>OAMHS will place four ES during this fiscal year--in Portland, August, Lewiston, and Bangor. Three more ES will be placed by July 1. Each CSN will have one ES, housed in an agency that offers substantial community support services. The ES will be available for clients throughout the CSN, not just those served by the host agency. OAMHS expects 15% of the ES' annual caseload to be employed at least 20 hours per week in competitive employment at minimum wage or better.</p> <p><u>Memorandum to ACT Teams</u> Don distributed a copy of a memorandum he sent out to all ACT teams, explaining the requirements of the Consent Decree Plan that Employment Specialists on ACT teams must spend 90% of their time on employment functions and that 15% of their annual caseload becomes employed.</p> <p><u>Vocational Training for Community Support Workers (CSWs)</u> Training for CSWs is being finalized. Plans are for a short training that will use ITV to provide multiple sites and opportunities to attend. The goal of the training is to raise awareness of the importance of identifying vocational issues and goals in plans and ISPs.</p>
VIII. Role of Consumers in Licensing	<p>Leticia Huttman stated that OAMHS sees consumer involvement in licensing as an important component in developing a recovery-oriented system of care. She said consumers indicate less interest in being involved in the details of licensing and more interest in assessing whether the services delivered are recovery-oriented, consumer-driven, and person-centered. While this is difficult to evaluate, consumers have been looking at using standardized tools like the Elements of a Recovery Facilitated Systems (ERFS) to use in interviewing consumers and staff members.</p> <p>The hope is that this will provide an opportunity for consumers, providers, and OAMHS to work together to improve services—not to be viewed as threatening or faultfinding. Consumers would be trained and compensated, and would most likely go out in teams. Providers will be informed about what the assessment involves and what to expect before any visits occur.</p> <p>Question: What kind of training will be provided [to consumers]?</p> <p>Answer: They will be trained to use the standardized tool and how to understand and use the data they gather. They will also learn about the environments they'll be going into.</p> <p>Comment: What about family involvement? Research shows that those who have successful recovery have supportive family members. I hope there are plans to have family voices heard.</p>
IX. Housing and Support Services Workgroup Update	<p>Don reported that this workgroup has met twice already and will continue meeting weekly through February. There are three consumers and a number of providers in the group working on identifying and categorizing the number and types of existing housing units in each community and clarifying the service delivery models that are in place. They are finding that some providers are being inventive in efforts to wrap services around the consumers.</p>

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	Minutes from this workgroup will be posted on OAMHS Consent Decree website on an ongoing basis.
X. Contract Compliance Template	<p>Marya handed out a draft "Agreement Review Checklist" noting OAMHS' intent to improve consistency in working with providers on contract compliance. Marya noted that this checklist intentionally does not include things licensing attends to in its review process. This draft is open to revision, and feedback should be sent to Elaine Ecker, <a href="mailto:eecker@usm.maine.edu">eecker@usm.maine.edu</a>.</p> <p>Don added that contract review meetings with providers in Region II are scheduled for January 11 and 12. Time slots are set, but providers may arrange between themselves to trade times, as long as they notify Sharon Arsenault of any changes to the original schedule.</p>
XI. Beds: Crisis Stabilization/Observation	<p>Don opened a discussion about crisis stabilization beds and observation beds and posed a number of questions such as whether there are enough crisis stabilization beds in this CSN and whether there is a need for more observation beds. He also asked if there are alternatives to hospitalization that people in distress can access in addition to crisis beds.</p> <p>The group discussed various issues, including the need for definitions of each service, how many beds are available within or near the CSN area, other possible services that could be developed or utilized, admission processes of individual hospital providers and staffing configurations. Don asked members to think about describing their programs and the services they provide including who they can serve, how these decisions are made, the geographic area covered, and their program's capacity. Ron explained that the Department is obligated to map out options, and observation beds are a new alternative.</p>
XII. Statewide Policy Council	<p>Ron reviewed the tasks of the Statewide Policy Council, listed under Tab 5 in the reference binder. He explained that the process originally outlined to fill this council had grown to include more categories, producing an unworkable number of representatives (49, plus staff). He asked the group for their suggestions on how to achieve a more reasonable number, noting that all the CSNs will make suggestions for OAMHS consideration. He also stated that the timeline for convening the council has been pushed back to March.</p> <p>The discussion included the following:</p> <ul style="list-style-type: none"> <li>• Why is it important what category or group within the CSN the representative is from when they are supposed to represent the CSN as a whole?</li> <li>• What is the time commitment for the SPC? Does it meet monthly? Answer: Yes. The majority of the work would be done by July.</li> <li>• The CSNs are made up of providers and consumers, so should consumers be on this committee? Answer: Yes.</li> <li>• If there were three representatives [one suggestion] from each CSN, I don't see why we couldn't pick at least one consumer. Can't each CSN say who they want to send? Answer: Yes.</li> <li>• It is important to know what the time commitment is and whether it ends in June.</li> </ul> <p>Time will be allocated on the January agenda for the CSN members to choose their representatives.</p>
XIII. Ongoing Meeting Schedule	Sharon reported that the next meeting will be held on January 29, 2007, from 1-4 pm in Rooms A/B at DHHS in Rockland. The group chose the 2 <sup>nd</sup> and 3 <sup>rd</sup> Mondays of each month as best times for an ongoing meeting schedule. Preferences gathered from all the CSNs will be considered and OAMHS will determine the ongoing schedule and notify the CSNs.

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XIV. Agenda for January Meeting	<ul style="list-style-type: none"> <li>• Procedure and Protocols for Inpatient Admissions</li> <li>• Rapid Response and Crisis Plans</li> <li>• Representation to Statewide Policy Council</li> </ul> <p>Members requested more information on agenda items in advance of the meetings. Marya noted that many items will appear due to Consent Decree Plan timelines and said future agendas will include page numbers of the Plan for reference.</p> <p>Concern was voiced about community hospitals not attending the meeting. OAMHS is following up on those who are not participating in the CSN.</p>