

**Community Service Network 4 Meeting
DHHS Offices, Rockland, Maine
April 9, 2007**

Approved Minutes

Members Present:

- Steve Hoad, AIN
- Karina Patton, ESM
- James Talbott, Merrymeeting Behavioral
- Leslie Mulhearn, MCMHC/Pen Bay
- Tammy Swasey-Ballou, NAMI-ME Families
- William Nelson, Riverview Psychiatric Center
- Tammy Blackman, St. Andrew's Hospital
- Gail Wilkerson, Spring Harbor (via phone)
- Bob Fowler, Sweetser
- Charlotte Simpson, Sweetser Peer Center
- Laurie Arguin, Transition Planning Group
- Paula Greenleaf, Transition Planning Group
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Members Absent:

- Allies Inc
- Community Mediation Services
- Group Home Foundation, Inc.
- Miles Memorial Hospital
- St. Andrew's Hospital
- Waldo County General Hospital (excused)

Others present: Priscilla Seimer, Sweetser; Dana Bontatibus, Sweetser; Martha Marchut, MCMHC.

Staff Present: DHHS/OAMHS: Don Chamberlain, Leticia Huttman, Sharon Arsenault. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Sharon Arsenault opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the 3-13-07 meeting were approved as written.
III. Rate Standardization/Budget Update	Don reported that through negotiations and discussions (among the Legislature's H&HS committee, representatives from MAMHS, and others), the proposed reduced amount of \$10M to be saved by rate-setting for the biennial budget has been broken down to \$3M the first year (FY08) and \$7M the second year (FY09). They also proposed that three workgroups be established to consider three main areas in which savings could be achieved: 1) administrative burdens, 2) design of service structure, and 3) rate standardization. The Governor and Appropriations have yet to approve.
IV. LD 1745: CSN Legislation	<p>Members received a draft of LD 1745, "An Act to Improve Continuity of Care within Maine's Community-based Mental Health Services. Don noted that this document addresses two things: 1) putting the already existing Institute Councils into law, and 2) the Community Service Networks.</p> <p>A member pointed out that "consumers and family members" are not included §3608 where it states, "A network shall consist of..." Don said that had been pointed out at another CSN meeting and would definitely be addressed.</p> <p>In response to members' questions, he said that the AAG (Assistant Attorney General) working on the Confidentiality Statement would also look at Item F under Responsibilities to make sure everything is consistent with current understanding and practice, and is not in fact "looser," as it might appear at first read-through. Don said he would ask the AAG for some practical examples.</p>
V. Report to the Court Master	<p>Members received copies of two documents submitted to the Court Master on March 16, 2007: 1) Letter (response to his concerns on OAMHS Quarterly Report) and 2) Summary Assessment of Resource Gaps by CSN. Don explained:</p> <ul style="list-style-type: none"> • Deadlines required that OAMHS submit this baseline report to the Court Master, using the best information

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	<p>available. As services are reviewed month by month at CSN meetings, OAMHS will probably revise some things.</p> <p>Review of service gaps/remedies reported for CSN 2 and comments/questions:</p> <ul style="list-style-type: none"> • Peer Services: address later in meeting—make recommendation(s) at May meeting. • Crisis Stabilization Units: 2 beds added to MCMHC. • Community Support: wait times beyond 7 days may indicate gap in Community Integration services. • Outpatient: wait times beyond 30 days. • Medication Management: wait times greater than 10 days; also difficulty with low Medicare rates for dually-eligible populations (MaineCare/Medicare). • Residential: ratios suggest both MH beds and rental assistance vouchers are needed in this CSN. • Vocational: statewide need. Question: Any update on employment specialists? Answer: OAMHS is waiting on a “ruling” (unspecified) in order to move forward. <p>A member referenced the following sentence in the letter to the Court Master: “The Department recognizes that it must therefore make decisions with more limited CSN consultation at this early stage in order to satisfy the plan requirement to identify resource gaps and ways to close those gaps expeditiously.” He asked what “limited CSN consultation” really meant, i.e. did Department override the CSNs? Don answered that the CSN input was limited due only to the timeframe of reporting to the Court Master. The member also cautioned about being pushed too hard by timeframes, and said he hopes programmatic changes are pushed by <i>what’s needed</i> rather than by the Court.</p>
<p>VI. Crisis Services, Community Support Services</p>	<p><u>Crisis Services</u> Leslie of MCMHC updated members on the possible options in adding the 2 crisis stabilization beds: 1) acquire new building, or 2) build on to the less-than-ideal current facility (very tight situation, though cost effective). Also thinking about the possibility of putting at least crisis and CSU together, and perhaps also peer support.</p> <p>Discussion re: building on to current building:</p> <ul style="list-style-type: none"> • Handicapped accessible? Yes. • Office space (for mobile crisis team and CSU supervisor) would be eliminated and would present difficulties maneuvering with confidentiality. • Difficult for clients’ anxiety levels if rooms are too small. • Having seen it—would be very difficult to expand to 4 beds. • Consider also the hardship on staff having to move. <p>Leslie indicated people may contact her to visit the current facility, as long as confidentiality issues are addressed.</p> <p><u>Community Support Services</u> Members received a handout of Performance Indicator data for Community Integration (CI), Intensive Community Integration (ICI), Assertive Community Treatment (ACT) for the first 2 quarters of FY07. Members discussed issues around people being assigned a case manager within 7 days of eligibility.</p> <ul style="list-style-type: none"> • Very difficult to determine eligibility within 7 days. • Both MCMHC and Sweetser assign intake workers as “short-term case managers.” MCMHC counts those as being assigned a case manager; Sweetser does not, which accounts for some of the difference between MCMHC’s 100% and Sweetser’s much lower percentages. Sweetser reported only 4 actually on the waiting list—the rest

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	<ul style="list-style-type: none"> • have short-term case management. • Sweetser also indicated the data does not appear to be accurate, and they are investigating the glitch. • Sweetser currently has 2 unfilled case manager positions. <p>Members also discussed staffing challenges and difficulties:</p> <ul style="list-style-type: none"> • Part of the problem is that CSW (community support worker) staff are expected to do more—more paperwork and less client contact. They also experience recurring serious problems with the RDS system. • In very critical place now with staffing. • 24-hour access is also a recruiting nightmare. • Turnover: MCMHC experienced 80% turnover in last 3 years; ESM is attempting for the 4th time to fill one position; Sweetser indicated people tend to stay once hired, but “no one applies for open positions.” • Problem is salary and overburden of paperwork. <p>Non-cats and uninsured clients:</p> <ul style="list-style-type: none"> • Sweetser lost \$99,000 covering non-cats. (Non-cats “have MaineCare, but don’t have it as a result of disability or other ‘category’ and have very limited coverage.” Does not cover community integration services.) • Sometimes clients have temporary MaineCare that doesn’t continue—faced with dropping client.
VII. Draft Outcomes and Statistics	<p>Don said OAMHS had hoped to have drafts to distribute, but they are not ready. What outcomes do CSNs want to see for a service or services as a whole, and then, what data is needed to measure the outcomes? OAMHS is looking to reduce data collection to a minimum.</p> <p>Member question: In light of cuts, will anyone measure what happens with other services when community services are not as readily available?</p>
VIII. Peer Services	<p>Leticia reported on the focus groups recently held in Rockland, Belfast, and Damariscotta and distributed the minutes to the members. The meetings were sparsely attended, and the results were general in nature. The peer services subcommittee does not have a clear consensus at this time.</p> <p>Discussion that followed:</p> <ul style="list-style-type: none"> • Peer effort needs cultivation; build a nucleus, locally driven. Not an overnight project. • Peers would probably coalesce when consumers get to speak to the Department about the Department. Set of forums may be a real way to begin peers working with peers. These forums would differ from the recent consumer forums in that they would be more wide-ranging and more time would be allowed for planning and publicity. What about regular, predictable forums around the state, transportation provided? • Maybe the fear of being the only person to show-up inhibits people from attending. • A series of educational meetings on different illnesses, treatments, etc., where consumers are not required to share, might be an easier way to get started. Has worked re: other health issues in this area in the past. • This effort requires some paid oversight—a director of volunteers or something—give dollars to an agency(ies) to pay for position(s). <p>RECOMMENDATION: The CSN voted to formally recommend that the Department fund a full FTE to further efforts of peer support in this CSN, and that the position be linked with the Mid Coast Mental Health Center CSU.</p> <p>ACTION: OAMHS will report back on this recommendation at the May meeting.</p>

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	<p>Members a save-the-date notice for the HOPE Recovery & Wellness Conference on June 21 & 22 at the Augusta Civic Center. The theme is transformation and the keynote speakers are Renee Kopache and Daniel Fisher.</p>
IX. Outpatient	<p>Last year's data showed longer than 30-day wait for outpatient services (MCMHC). Sweetser has variations in different offices/locations—gathering that data to bring next time.</p> <p>Don said that the focus ought to be on people who are more seriously mentally ill. Also need to define what is an appropriate wait time. The Consent Decree requirement is 30 days—should it be different? Less, for instance when someone leaves the hospital? Is outpatient appropriate for urgent or emergent situations?</p> <p>Members discussed the availability of DBT (Dialectical Behavior Therapy) and other specialty treatments in this CSN, as well as eligibility issues around these treatments:</p> <ul style="list-style-type: none"> • Both Sweetser and MCMHC indicated demand is higher than they can meet for DBT, and other specialty treatments, i.e. eating disorders and sometimes trauma. • Unmet needs should be recorded on the ISP (Individual Service Plan), but CSW (community support worker) may not be able to identify. • Transportation is also an issue. • Non-cats are eligible for only 16 sessions of outpatient services—DBT requires individual therapy and weekly group sessions for a year. <p>ACTION: Don asked for members to bring the following information to May's meeting:</p> <ul style="list-style-type: none"> • Numbers waiting and wait time for DBT and other specialty treatments. • Identify what other specialties would help seriously mentally ill clients, if those treatments existed. • Identify the outpatient issues they would like the Department to address and whether each is an unmet need or gap. • For Sweetser: clarify if Protea is a resource, included in data, standards of care, and expectations.
X. Training	<p>Don told the members that OAMHS is looking for their input on training issues and needs for agencies, consumers, etc., to inform the Muskie contract for the upcoming year. Chris Robinson, OAMHS Best Practices Coordinator, will be present at the May meeting to discuss this.</p>
XI. Other	<p>Sharon informed the members of a forthcoming new pilot project for Region II for regarding PNMI referrals and placements. A universal intake form is being developed for agencies to complete, which will go to Beacon Health Strategies for their decision on whether PNMI is the appropriate level of care. (If not, they will make recommendations.) For those approved for PNMI level of care, a 4-member panel at OAMHS (including Sharon) will decide which residential opening best fits the need and approve that placement.</p> <p>Questions:</p> <ul style="list-style-type: none"> • How long will it take Beacon to assess the level of care? Answer: Expect 2-3 business days. • How will consumer be included in this process? Answer: Assume the consumer is involved in the referral process—then the chosen agency will meet with consumer to determine if the consumer wants to accept the placement. • Will there be training for community support workers on this? Answer: We're not at that point yet.

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	<p>Sharon explained that when the procedure is written and the universal form is drafted, OAMHS will meet with residential providers. She also said that Beacon has started reviewing current PNMI placements to determine if that level of care is appropriate.</p> <p>_____</p> <p>A member mentioned the need to explain acronyms. Steve Hoad offered to send the member a glossary list.</p> <p>_____</p> <p>A member stated that minutes are coming out too close to the meeting to be useful in providing reminders of actions, etc.</p>
XII. Public Comment	None.
XIII. May Agenda Items	<p>Outpatient OAMHS Response to Peer Support Recommendation Training Medication Management</p>