

**Community Service Network 4 Meeting
DHHS Offices, Rockland
June 11, 2007**

DRAFT Minutes

Members Present:

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| <ul style="list-style-type: none"> • Leslie Mulhearn, MCMHC/Pen Bay • James Talbott, Merrymeeting Behavioral • Tammy Swasey-Ballou, NAMI-ME Families | <ul style="list-style-type: none"> • Teresa Mayo, Riverview Psychiatric Center • Sandra Weissman, Spring Harbor • Bob Fowler, Sweetser | <ul style="list-style-type: none"> • Charlotte Simpson, Sweetser Peer Center • Dan Bennett, Waldo County General |
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Members Absent:

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| <ul style="list-style-type: none"> • AIN • Community Mediation Services | <ul style="list-style-type: none"> • ESM (excused) • Miles Memorial Hospital | <ul style="list-style-type: none"> • St. Andrew's Hospital • Transition Planning Group |
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Staff Present: DHHS/OAMHS: Ron Welch, Marya Faust, Leticia Huttman, Sharon Arsenault. Muskie School: Elaine Ecker.

| Agenda Item | Presentation, Discussion |
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| I. Welcome and Introductions | Sharon opened the meeting and participants introduced themselves. |
| II. Minutes | The May minutes were approved as written, with one change: Sweetser's <i>Bangor</i> office, not Waterville, has unused capacity re: medication management. |
| III. Budget/Rate Standardization | <p>Budget/Rates Ron Welch reported on the biennial budget passed by the legislature.</p> <ul style="list-style-type: none"> • A total of \$6M must be saved in FY08, as follows: <ul style="list-style-type: none"> - \$1M added to projected savings of Administrative Services Organization (ASO)--now \$6.5M in FY08 and \$8.5M in FY09. - \$1M saved by changes in use of Skills Development services. OAMHS found that 20% of clients in this program receive 80% of the services (principally in Kennebec/Somerset counties). - \$4M saved by package of rate changes, including both adult and children's services (approximately 60/40). • \$14M must be saved in FY09, \$4M of which will carry over from FY08 rate standardization. The remaining \$10M savings is not defined. • Rate changes resulted in reduction of 5.85%, if averaged across services. Specific rates, overall and agency-by-agency, will be coming out very soon. • Budget language also requires DHHS to set up three work groups, made up of providers, consumers, family members, and DHHS staff, to carry specific tasks pertaining to: 1) Administrative burden reduction, 2) System redesign, and 3) Rate standardization. The work groups have tight timeframes—convening by July 1, 2007, and completing work before the new Legislative session begins in December. <p>ASO Marya reported on status of ASO proposals, saying eight proposals were received by the June 8th deadline. The review process should be completed within 3 weeks, and OAMHS expects to have a contract in place by October or sooner, depending upon whether there are appeals, etc. OAMHS will soon publish an official list of companies that submitted proposals.</p> |

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| | <p>Question: Will ASO participate in the three work groups? Marya said that what the ASO requires of providers will be discussed, but the ASO will not be physically involved.</p> <p>Service Changes Ron asked if providers are thinking about any services discontinuing or changing. Responses:</p> <ul style="list-style-type: none"> • Sweetser will discontinue ICI (Intensive Community Integration) services as of June 30 (Brunswick). Other services are under discussion, but no decisions yet. • MCMHC is “considering everything.” There will definitely be changes, just don’t know yet—need to see the actual numbers. <p>Ron asked that providers notify OAMHS when such decisions are made, as well as discuss with the CSN.</p> <p>Communication Ron expressed concern about the degree to which consumers didn’t really get the “straight scoop with what was happening with the budget.” He said some consumers thought that social clubs and peer services would be affected—and those services were “never on the drawing board.” “How can we better help people we serve understand the budget process, so people don’t get so alarmed?” he asked.</p> <ul style="list-style-type: none"> • Leslie of MCMHC mentioned two contributing factors: 1) It is hard to get correct information unless at the table as a member of provider group, with close relationship to OAMHS; and 2) Sometimes important meetings conflict and can’t be at both—dates and meetings are not well coordinated. • Leticia also commented that because “it’s a <i>political</i> process, the information in newspapers or on TV may be alarming.” • Dan of Waldo County General posed the idea of OAMHS using their website to provide correct/current information, and people made several suggestions: <ul style="list-style-type: none"> - Ron could have a blog—and people could tell when it’s updated. - Along with the website, have a contact person who has access to the latest information. If there were someone to call to verify information before it goes out to large listserves, for example, it would save a lot of problems. - Perhaps it could be an interactive website where questions are raised and answered. • Consumer council organization will be a good point organization to disseminate information to peer centers and social clubs. • Ron added that every local consumer council [as formed] will be represented at their CSN. <p>Status of Consumer Council System Leticia reported that the development of the consumer council system is well underway. Three regional conferences were held in May, and regional council meetings start next week. In July, the regional councils will select representatives to the statewide council. The statewide council will provide support for local councils as they form. Leticia explained that the level of “local” will evolve and not necessarily be by towns—they want to make sure the local councils include diverse viewpoints, experiences, and perspectives and are “looking at creative ways to make diversity happen.” The regional councils will eventually dissolve as enough local councils become functional.</p> <p>Legislation ACTION: OAMHS will compile a complete listing this session’s bills related to mental health issues and provide to all CSN members.</p> |

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| IV. 24/7 Access to Community Support Information | <p>Marya asked if members needed clarification or had questions on this agenda item, and reminded everyone that OAMHS is expecting to receive copies of the written protocols from crisis providers and community support providers by June 15. Compliance requires that written protocols exist between the following, with a copy on file with OAMHS:</p> <ul style="list-style-type: none"> • Crisis providers and community support service providers within the CSN; • Crisis providers and any and all hospitals in the catchment area; • ACT Team providers and crisis providers in their CSN; • Crisis providers and Mental Health Team Leaders re: accessing ICM information. <p>Marya further explained that the assumption is that crisis providers have worked out protocols with hospitals, and that community support service providers have worked out protocols with crisis providers. Crisis providers are responsible to have or obtain information about community support services and provide to any hospital to which consumer is in admission process.</p> |
| V. Medication Management | <p>The Consent Decree standard--services within 10 days of identification of need. Members discussed their working interpretations of the standard, i.e. 10 days from client request, 10 days from day of referral, etc. Marya said OAMHS is working on clarifying the definition of the standard for the next fiscal year.</p> <p>Medication management providers in this CSN: MCMHC, Sweetser, and Mid Coast Hospital.</p> <p>MCMHC</p> <ul style="list-style-type: none"> • Meets 10-day standard for clients with urgent level of care, but not as a general rule for all. May need more than one standard, 1) urgent care, and 2) standard care. This expectation for mental health care is out of whack with the rest of health care. • Barriers to meeting standard: Lack of providers. Currently have 2 FTEs psychiatrist and 2.5 FTEs nurse practitioner. • For private psychiatrists, payor mix is huge problem—MaineCare and Medicare. Required paperwork involves huge amount of time-consuming work. • In response to a question about Telemedicine: Would increase access—but already have a “line at the door.” Not enough time available for Telemedicine. Looking for model that works financially, provides quality, and practitioner satisfaction—haven’t found it yet. • 20% no-show rate—tracked by practitioner. • Transportation is an issue, but not tracked. • Response to question about conducting medication groups: Major problem is that only 10 people can be invited to a group. With those who fall away, the group ends up with five members, perhaps, which is not financially viable. It would help if the group could start with more than 10 to have enough lasting members to sustain it. <p>Sweetser</p> <ul style="list-style-type: none"> • Starts counting at day of referral. • Barrier: recruitment. Currently has 1 FTE psychiatrist and estimates 4 FTEs nurse practitioners. Working on restructuring so psychiatrist supervises nurse practitioners, though they haven’t been able to recruit the nurse practitioners. • No-shows are a problem—anecdotally, a lot of appointments get missed. Transportation and co-morbid conditions also factor in no-shows. |

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| | <p>Other comments:</p> <ul style="list-style-type: none"> • Where does a person get a prescription when they leave ED under crisis services assessment with only 10 days of medication...? • See problems getting med provider with 30-days of medication after leaving the hospital. • Often people end up seeing a primary care physician for meds—primary care physicians’ comfort with managing many of the prescriptions would increase if they had more communication and consultation with psychiatrists. |
| VI. Policy Council Report | <p>Since this CSN’s policy council member was not present, Marya and Ron gave a brief review of the policy council’s tasks, including defining the purpose of the CSNs both globally and specifically, looking at outcomes to measure, and eventually to develop a format for taking unmet needs data all the way through to legislative funding proposals.</p> |
| VII. Other | <p>Service Changes on Agenda Sharon suggested that perhaps provider service changes should be a routine part of the agenda. Comments:</p> <ul style="list-style-type: none"> • It depends on what we can do with/about the information. • We can discuss what else can we do to meet the need—think outside the box—who and how. • It’s a way to communicate with other providers and consumers that services are changing in the area. <p>Serving Difficult Clients Tammy, NAMI-Maine representative, informed the group of two serious situations with involving consumers and a crisis provider: One person who has repeatedly called crisis has been banned from calling again under threat of charges being pressed. Charges have been pressed against the other individual for repeated and offensive calls, even after a meeting with the crisis provider’s attorney resulted in consumer’s agreement not to call again. Both consumers are not well and may indeed find themselves in a serious crisis—and not able to call for crisis services.</p> <p>ACTION: Sharon will discuss the details with Tammy after the meeting and take information to Don Chamberlain to address at the CLASS Initiative meeting in that area, as appropriate.</p> <p>Leslie said MCMHC has had similar challenging consumers, and used a “community meeting” for one person. She said often they find out the consumer needs a different level of care or has a critical problem such as housing that needs to be addressed. When that critical need is addressed, the crisis problem abates.</p> <p>Discussion from question, “Can an agency refuse service to a client?”</p> <ul style="list-style-type: none"> • MCMHC has had huge challenges with difficult and assaultive clients, trying to find a way to continue to serve them in a safe way. In one case they had a restraining order that the person could come for an appointment, but not hang out. • Issues like these seem to be increasing over the past few months. • It’s a slippery slope to try to address—and not addressing is also a slippery slope. • Human Resource issue is crucial, too, if staff don’t feel safe. <p>Region II PNMI Pilot Project Sharon said the final documents related to this project are ready and will be distributed soon.</p> <p>Future Agenda Item Ron said Elsie Freeman of OAMHS wants to attend CSN meetings to discuss integrated care and psychiatric workforce development.</p> |

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| | <p>August Meeting? Ron asked if members would like a hiatus from meeting during the month of August. Members voted not to meet in August.</p> <p>UPDATE: CSN meetings were cancelled in July, so August meetings will go forward as scheduled.</p> |
| VIII. Public Comment | None. |
| IX. July Agenda Items | Provider Service Changes |