

**Community Service Network 4 Meeting
DHHS Rockland Office, Rockland
June 9, 2008**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • Paula Greenleaf, AIN • Eileen McGuire, Community Mediation Services • Alan Letourneau, ESM | <ul style="list-style-type: none"> • Tammy Swasey-Ballou, NAMI-ME Families • Patti Isnardi, PenBay Healthcare (MCMHC) • Stephanie Field, St. Andrews Hospital | <ul style="list-style-type: none"> • Priscilla Seimer, Sweetser • Alex Veguilla, Sweetser Peer Center • Andrea Walker, Waldo County General |
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Members Absent:

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| <ul style="list-style-type: none"> • Allies, Inc. • Consumer Council System | <ul style="list-style-type: none"> • Group Home Foundation • Merrymeeting Behavioral (excused) | <ul style="list-style-type: none"> • Miles Memorial Hospital • Spring Harbor |
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Others Present: None

Staff Present: DHHS/OAMHS: Sharon Arsenault, Leticia Huttman, Lisa Wallace, Brion Gallagher, Teresa Mayo, Naya Blue. Muskie School: Elaine Ecker, Helen Hemminger.

Agenda Item	Discussion
I. Welcome and Introductions	Sharon opened the meeting and participants introduced themselves.
II. Review and approval of minutes	The April minutes were approved as written.
III. Enrollments/RDS Update	<p>Leticia reported that overdue information on enrollments and RDS (Resource Data Summary) updates improved from 58% to approximately 30% by the May 15th deadline, but the 15% mark must still be met. Some providers have received "Level II" contract notices from OAMHS, meaning that they must have a compliance plan in place to meet the 15% level. OAMHS is working with two agencies in this CSN for compliance.</p> <p>Lisa informed that as of August 1, OAMHS plans for APS Healthcare to take over the enrollment and RDS process and download to the state's EIS/RDS system. This will eliminate the need for providers to enter data into both systems. At that point, the many missing enrollments must be entered into their system in order for providers to receive payment for services. This and the required continuing stay reviews should result in current and accurate information. Lisa emphasized the importance of this data, since it drives unmet needs reports and complies with the Consent Decree as a basis for budget requests.</p>
IV. Review of Crisis Data	<p>Members received copies of Adult Mental Health Crisis Reports for the 3rd Quarter of State Fiscal Year 2008, including: 1) the statewide summary for all providers of adult crisis services, 2) individual data "face sheets" for each provider in the state, and 3) data packet(s) for the crisis provider(s) in their CSN (MCMHC and Sweetser in CSN 4). Lisa said that submitted data will be sent to crisis providers monthly to inform and check for accuracy. CSNs will continue to receive quarterly reports. Crisis providers are meeting on June 18, Lisa said, to address discrepancies in definitions and how data is reported/counted.</p> <p>Lisa and Leticia reviewed the data with the group and pointed out:</p> <ul style="list-style-type: none"> • Numbers re: face-to-face contacts whose community support worker was notified: 89% statewide, 60% Sweetser, 80% MCMHC. • OAMHS would like to see lower numbers seen in Emergency Departments, more in the community. • Numbers are lower than expected re: those who have a community support worker whose wellness plan, crisis

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	<p>plan, ISP, or advanced directive plan was used in face-to-face contacts with crisis. (24 of 60, Sweetser; 29 of 94, MCMHC) With such a wide variety of avenues for crisis planning, these numbers indicate an area that needs improvement.</p> <p>Discussion:</p> <p><u>Crisis planning:</u></p> <ul style="list-style-type: none"> • A member wondered if everyone thinks these various documents are the same... I've never heard a clear definitions or descriptions of each. And who is responsible for them? • The definition of a crisis plan is pretty clearly defined for crisis providers in the crisis standards. • Not so with community support providers. Crisis agencies are dependent on the community support provider to get the crisis plan. • Consent Decree Coordinators go to community support agencies to look for plans and collect information—are community support workers helping clients develop plans and getting them to crisis? • Some crisis plans don't go beyond "call crisis services." • Some consumers may feel, "If I do a crisis plan and no one pays attention to it, why do it?" • A provider member pointed out, "There are times clients don't want to do one more piece of paper." The lack of a plan might be the client's choice. Also, over the last six months, more staff are burning out than I've ever seen before. Need to be sensitive—staff may not have time and clients are not always interested. <p><u>30-minute measure:</u></p> <ul style="list-style-type: none"> • Is "seen within 30 minutes" from the time of the call? A: It's from when the person is available and ready to be seen. • The reason for the disparity between MCMHC and Sweetser re: the 30 minutes: MCMHC sees so many walk-ins in both their Rockland and Belfast offices that it skews the data. If separated out the walk-ins, would find very different numbers. Also, Sweetser covers many coastal areas that require considerable travel time to reach. <p><u>WRAP</u></p> <ul style="list-style-type: none"> • Paula of AIN suggested that more WRAP (Wellness Recovery Action Plan) programs, offered outside of providers, would help consumers 1) realize that recovery is possible, 2) recognize what they look like when well or not so well, and 3) determine for themselves what will help them avoid a crisis. She shared that in her own life, WRAP came across as something different--giving a real sense of ownership in the plan. "I put this in place for me." • Lisa pointed out that the OAMHS website contains information on WRAP and other resources. <p><u>24/7 Availability</u></p> <ul style="list-style-type: none"> • When CSNs started, wasn't there talk about having a centralized system for accessing crisis plans? A: Not a statewide system, but community support agencies are responsible to set up a system with the crisis program in their area. Agencies do it in different ways, but the crisis programs know how to access agencies in their coverage areas. If client reports having a case worker or agency, then the crisis worker will contact them for required information. • The information that must be available 24/7: name of community support worker, medication prescriber, any type of crisis plan, and goals on the ISP (Individual Service Plan).

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	<p><u>Communication with Primary Care Physicians (PCPs)</u></p> <ul style="list-style-type: none"> • It's not part of the data, but are PCPs notified when person has a crisis? MCMHC/Pen Bay: Impetus is to contact medical doctor as soon as possible—making a huge effort in-house to get information to PCP and try to get it reciprocally. How's that (reciprocity) going? Not so well... • AIN is hearing from consumers that PCPs are saying they don't want to hear about mental health. • Patti and Stephanie described a couple of initiatives or pilots that are integrating mental health consultation and/or provision of mental health services in primary care practices. • Leticia said integration of mental and physical health is an area OAMHS is looking at more and more.
<p>V. Hospital and Crisis Communication</p>	<p>Leticia asked if there are any meetings already happening in CSN 4 that address rapid response, crisis issues, i.e. people stuck in ED, etc.? Sharon explained that Regions I and III hold regular crisis/hospital (CLASS-type) meetings, but none are currently held in Region II.</p> <ul style="list-style-type: none"> • Sweetser meets quarterly with Mid Coast Hospital. • MCMHC/Pen Bay holds internal meetings re: crisis and ED, more focused on system than individuals. • MCMHC meets as needed with Waldo County General. <p>The group discussed whether CSN 4 would like to convene a meeting to address crisis issues, who should be included, whether a currently held meeting could be expanded, etc. The group made no decision, but noted the following:</p> <ul style="list-style-type: none"> • Meet only if there is a very clear focus and purpose. • Should include all hospitals, not just those with psychiatric units. • Should include Spring Harbor Hospital, since their parent organization, Maine Health, now oversees the majority of mental health service organizations in the area. <p>ACTION: Sharon will get more specific information from Regions I and III on their meetings and bring back to CSN 4 for further discussion on this issue.</p> <p><u>Other Comments:</u></p> <ul style="list-style-type: none"> • Why isn't Miles Memorial at the CSN table? At the beginning, there was emphasis on sanctions for those not participating... • Shouldn't the Department be meeting with Spring Harbor? A lot of decisions will be financially driven—how does pressure get put on the power players re: service integration? Do "locals" have enough power and clout to change anything if there's not buy-in at the higher levels?
<p>VI. Unmet Needs Reports</p>	<p>Participants received a multi-page report on the EIS/RDS enrollment and unmet needs data for the 3rd Quarter of FY 2008 (Jan-Mar) prepared by Helen Hemminger of the Muskie School in conjunction with OAMHS.</p> <p>Lisa emphasized the importance of this unmet needs data in budget planning and Consent Decree compliance, and the essentiality of it being up-to-date and complete. She also explained that the system is programmed to determine if a need is <i>unmet</i> according to specific time parameters for each service category. OAMHS would appreciate help from agencies in reducing entries in the "other" subcategories, preferring that case managers use named categories if possible.</p>

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	<p>The group reviewed each table in the materials, and noted that most of the changes between Qtr 2 and Qtr 3 probably reflect data cleaning and better reporting.</p> <p>The group discussed the process of how clients' needs are included on their ISPs, noting:</p> <ul style="list-style-type: none"> • It's really about the case manager and consumer discussing what the consumer wants to work on together. • People may need to be educated about services or even that recovery is possible. • Substance abuse unmet needs may be so low because clients don't see it as a problem or need. <p>Other:</p> <ul style="list-style-type: none"> • Members also pointed out the high level of unmet housing needs and noted the high cost of housing on the coast. • CSN 4 has the highest <u>rate</u> of unmet needs, well above the state median rate. • Where are people on wait lists? A: Included in the data if they have a case manager—if they don't, then it is not included. • If they're waiting for a case manager, it's not recorded? A: APS Healthcare is recording who is waiting for community integration services. APS process also resolves the issue of people being on several agency wait lists at the same time. • The overall number of people with unmet needs of any kind would be an important piece of information.
VII. Consumer Council Update	<p>Paula reported on Consumer Council System of Maine (CCSM) updates:</p> <ul style="list-style-type: none"> • The Statewide Consumer Council (SCC) is the process of hiring an Executive Director. • The Law making the CCSM a public instrumentality goes into effect on June 28. • Eventually each local council will have a representative at the CSN. • Local councils will bring community issues and concerns to the SCC and the SCC will decide what to report on behalf of the CCSM. • The second local council meeting in Brunswick will be held on June 25th. • Paula and Melissa Wallace-Moore, Outreach Coordinator for Region II, will soon begin work on organizing a meeting in Rockland. <p>ACTION: Paula will send the flyer on the Brunswick Local Council meeting to Elaine to forward to all CSN 4 members.</p>
VIII. Legislative Session January 2009	<p><u>Involuntary Medication – 2007 Legislation</u></p> <p>Paula relayed that consumers have voiced concerns and questions around the make-up of the Review Panels that decide on involuntary medication for those already admitted to inpatient psychiatric hospitals. Who can be present? Does the law allow for peer participation or just doctors?</p> <p>Teresa Mayo of Riverview said they have developed a policy which does include a peer representative being present.</p> <p>ACTION: Paula and Teresa will meet to review Riverview's policy and the provisions of the pertinent law.</p> <p>Work on the next budget will begin at the August CSN meetings. Members are also encouraged to raise issues for which they would like to see legislation submitted by OAMHS.</p>

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	<p>ACTION: Any ideas for legislation can be submitted to Elaine, eecker@usm.maine.edu.</p>
<p>IX. Community Integration, ACT, and Daily Living Skills Funding</p>	<p>Lisa explained the process for accessing general funds for Community Integration (CI) and ACT services, beginning Aug. 1: <i>(Please note: For clarity and consistency, the notes below include some information given at other CSN meetings).</i></p> <ul style="list-style-type: none"> • OAMHS chose not to assign dollars to agencies as in the past, but to pool the funds and disburse on a case-by-case basis. • All CI providers will have access to the funds. CI provider contracts will contain a “not to exceed” dollar amount—a technical fiduciary requirement in order to disburse funds for those services. The amount may be amended, if necessary. • The process is to apply through APS Healthcare and register for prior authorization (PA) in the same way it is done for MaineCare services. APS will give the PA and do reviews for continued services. The difference is the payor—providers will bill OAMHS and OAMHS will match the authorization with the invoice and process payment. • OAMHS is working to finalize the eligibility criteria list--so far it includes: <ul style="list-style-type: none"> ○ People coming out of hospitals ○ People coming out of jails ○ People coming out of CSUs (crisis stabilization units) ○ People on spend-down with income under 150% of poverty level ○ People on SSI/SSDI under 150% of poverty level • APS will screen for eligibility using the final criteria list. • Dollars will be distributed by CSN, by the number of people with SMI (severe mental illness). This number will be calculated using the population of adults and the percentage of the population that is expected to have SMI, as determined by the National Institutes of Health. • Small amount for Daily Living Skills is included in this funding pool. <p>IMPORTANT: People already receiving grant-funded CI services will continue to do so in the usual manner through the end of July.</p>
<p>X. Peer Support & Recovery Subcommittee</p>	<p>Leticia reminded that the OAMHS Sweetser contract will be the avenue for the Peer Community Organizer position for CSN 4. The next step is for the subcommittee to reconvene to plan, etc. Previous members and anyone else interested in participating should notify Elaine.</p> <p>ACTION: Members should notify Elaine if they wish to participate in the Peer Support & Recovery Subcommittee.</p>
<p>X. Other</p>	<p>What happened with the CSN Mission and Purpose Statements? A: Nothing has moved forward yet.</p> <p>ACTION: Lisa will check into status of CSN Mission and Purpose Statements.</p>
<p>XI. Public Comment</p>	<p>There was no public comment.</p>
<p>XII. Meeting Recap and Agenda for Next Meeting</p>	<p><u>Meeting Recap</u> See ACTION items above.</p>

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	<p data-bbox="562 167 722 191"><u>Next Meeting</u></p> <p data-bbox="562 196 1446 220">Members voted to cancel the July meeting. The next meeting is August 11.</p> <p data-bbox="562 258 747 282"><u>August Agenda</u></p> <p data-bbox="562 287 961 311">Legislative Session January 2009</p> <p data-bbox="562 316 972 341">Consumer Council System Update</p> <p data-bbox="562 345 888 370">Hospital and Crisis Meeting</p> <p data-bbox="562 375 1041 399">Peer Support & Recovery Subcommittee</p>