

Community Service Network 5 Meeting – Androscoggin, Franklin, Oxford Counties
DHHS Lewiston Office
November 13, 2006

Minutes

Present: Chris Copeland, TCMHS; Julie Shackley, AHCH; Tracy Quadro, Community Mediation Services; Craig Phillips, Common Ties; Phillip Schneider, 100 Pine Street; Ryan Gallant, ESM; Ira Shapiro, SMRMC/SOCHS; Stephanie Crystal Wolfstone-Francis, Transition Planning Group; Christine Vincent, LSS; Dick Willauer, Susan Bundy, ASI; Al Monier, Rumford Group Homes; Tom Vurgason, St. Mary’s; April Guagenti, Richard Batt, Evergreen Behavioral Services; Joan Churchill, Community Concepts; Mark Rush, Richardson Hollow MHS; Jamie Morrill, Riverview Psychiatric Center; Darlene K. Hayden, OCMHS; Dexter L. Billings, Beacon House; Eric Rutberg, CCA. Presenters from OAMHS: Ron Welch, Leticia Huttman, Don Chamberlain, Marya Faust, Sharon Arsenault. Muskie School: Janice Daley, Elaine Ecker.

Agenda Item	Presentation, Discussion, Questions
I. Welcome and Introductions	Sharon Arsenault, Region II Team Leader, welcomed everyone to the meeting and introductions were made around the table. She briefly reviewed 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) and mentioned that this plan was approved with very tight timelines.</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. He emphasized that vocational services are the keystone to the overarching theme of recovery.</p>
A. Seven Community Service Networks.	<ul style="list-style-type: none"> • The state is divided into 7 CSNs (see chart on website). Ron mentioned that these areas are similar to the catchment areas of the community mental health centers. • Each CSN provides 8 core services: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services. He explained that all services must be provided in the CSN; however, they may not be offered in all parts of the network area. • 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. ▸ 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.

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		<ul style="list-style-type: none"> › Assess and identify resource gaps by geographical area and establish remedial measures and implementation timeframes. Ron emphasized that this task needs to be completed by January and he will introduce tools that will lead to budget requests to the legislature. › 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. Ron parenthetically explained the major differences between the CSNs and the former LSNs: 1) the State takes the lead; 2) everything is data driven; and 3) this effort is driven by a court-approved plan. › 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. › Assure continuity of treatment during hospitalization and the full protection of a client's right to due process. › Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein. Ron emphasized that the community support staff have definitive responsibilities in this plan that must be recognized by the team. <p>Question: What does coordination mean (regarding the responsibility of the community support staff who must act as coordinators of the ISP and the services)?</p> <p>Answer: This will be more of a team-building role.</p>
	<p>B. Performance Requirements/ Enforcement through contracts.</p>	<ul style="list-style-type: none"> • Contract Amendments were mailed to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding finalized and approved for each CSN by January 3rd. Termination provisions for non-adherence are outlined in the Plan. Ron emphasized that the contract amendments outline steps that need to be taken to terminate a contract; however, he is optimistic that they will not need to do this. • Legislation is expected to define CSNs, assure momentum (vis a vis timeframes in the Plan), and provide consistency with managed care. • 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 Ron mentioned that the OAMHS will provide this data to the network and will be able examine this for planning purposes. The topic of data points and what is important was added to the parking lot. • Realignment of Services <u>Community Support Services:</u> <ul style="list-style-type: none"> › Each consumer will have CSW to coordinate their ISP and crisis plan; locate, obtain, facilitate, coordinate, monitor services. This is language from the Consent Decree Plan, Ron said. › CSW's employer is the lead agency for the client. <p>Question: How will it be determined who lead agency will be for a client who works with a number of agencies?</p>

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		<p>Answer: The lead agency is always employer of CSW.</p> <p>Question: I would like the consumer to pick the lead agency. For example, if the person has an agency but is not comfortable with them, why can't the consumer choose the lead?</p> <p>Answer: The point is well taken. We're picking up a lot of points from these network meetings and anticipate that there will be some changes and flexibility; however, we may need to go back to the Court Master for some.</p> <p>Question: Who is client? Class members?</p> <p>Answer: The clients are people with severe and persistent mental illness, everyone who is eligible for services under Section 17 of MaineCare. They are not just class members.</p> <ul style="list-style-type: none"> › 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 data on all of this will be collected so there will be a picture as to how well services are working in the network. <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. Ron informed the group that the no-reject policy raised a fair amount of discussion at the last CSN meeting. He explained that they're talking about making every reasonable attempt to accommodate everyone, and that this is a burden for the Network. The OAMHS is consulting with the Attorney General's Office and will clarify this in writing as soon as possible. › 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>Ron explained that as a provider of two State Hospitals, he recognizes a need to recognize specialty hospitals that are able to take people for a long time. There is a need to understand that there are exceptions to all of these rules. The Plan talks about how to do direct admissions as well.</p> <p>Question: Are they going to increase the number of forensic beds?</p> <p>Answer: No, we have 44 as part of the way Riverview was built.</p> <p>Question: Are you turning away people because beds are full?</p> <p>Answer: We got rid of stage 3 and the Court wants us to look at them. Most are for safety reasons. There has not been an increase in pressure on the forensic side as the prisons and jails have their own beds.</p>
	<p>C. Permanent Housing with</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>

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	<p>Flexible Services</p>	<p>Ron explained that they want to break the link between housing and services now linked in PNMI that are defined by the highest level of need. There is a need to restructure Section 17 and PNMI. Don Chamberlain is convening a work group to look at the amount of flexibility in PNMI so as to provide people with what they need, when they need it.</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. • For those beds remaining, long-term stay is not the goal. • Successful treatment and re-entry into community life is the goal. <p>Question: Is Cornerstone C the desired philosophy of the system? Answer: As far back as the 1990s Plaintiffs Attorneys said the State wasn't using a design that allowed people to have a permanent home if they want it. The current model is suspect and one is needed that meets people's needs.</p> <p>Question: Where will money come from for new housing? Answer: BRAP and Shelter Plus Care will be used, and seed money from PNMI will enhance Section 17 services. I talked with a huge provider of PNMI services on Saturday, and he thinks that flexibility can be provided within PNMI.</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, Ron informed, but 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. • 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 • 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.

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	<p>Vocational Services</p>	<p>Ron explained that this is the biggest issue for the Court Master.</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 required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work. <p>Discussion from CSN members cited literature that demonstrated that it is supported employment and not routine vocational services that are seen as effective. Another individual stated that most people who are older don't choose a supported employment model, but one called ABEL, and traditionally people with mental health disabilities are given menial jobs that they don't want to do as part of vocational rehabilitation.</p> <p>Ron explained that they there are also approximately 525 Community Support Workers whose top issue is not employment. Marya Faust explain that the first step in their strategy is to show that CSWs have learned the skills and language to engage clients in these discussions about work and change the CSW culture.</p> <p>One provider commented that he wondered about the existing and future workforce and was concerned that we don't wear them out in trying to meet court-ordered mandates. Ron stated that he was thinking of a concrete way to address this and saw a need to do a functional job analysis that would get at how much a person does and how much change a person can make.</p>
<p>III. Consumer Council and Consumer and Family Representation</p>	<p>Leticia Huttman, Director of the Office of Consumer Affairs, presented this part of the program.</p> <p>Development of Statewide Consumer Council System</p> <p>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. Leticia stated that the group of consumers was chosen from various stakeholder groups, and their mission is to be independent.</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>	

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	<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 Local Consumer Councils are designed to be inclusive and will include people with a wide variety of experiences. 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 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 • 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>Leticia reported that the TPGs sent out applications for consumers to be in CSNs now, so that consumers can be represented while the CSNs are being developed.</p> <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 • 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. <p>Question: Are Councils restricted to consumers? Answer: Voting membership will be consumers and the TPG is working out details. They want the ability to partner with the larger Community and to make sure meetings are accessible. This is an opportunity for peer support and peer mentoring. TPG has hired a coordinator and three outreach workers to help with this initiative.</p> <p>Consumer and Family Participation in Community Service Networks 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>Comment: There is a Peer/Consumer program and Human Rights Committee at Riverview and you may be able to draw from that.</p>

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IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols	<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 in January. Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider, and vocational provider. <p>State-Wide Policy Council</p> <p>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

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	<p>Don explained that it is not discharge planning, but transition planning.</p> <p>Question: Is it under rules that you have to use medication management?</p> <p>Answer: It is as defined in Section 17 (of MaineCare).</p> <p>Question: People find alternative ways of doing things- will system change?</p> <p>Answer: I hope yes, but it will not include kids or people who don't meet Section 17 criteria.</p> <ul style="list-style-type: none"> • 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 is key to the notion of community service networks, 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 consumer takes front stage," 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 <p>Agreement and Responsibilities</p> <p>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. Don stated that they are not saying that everyone has to go internally (within their CSN), but most will. An example of a person who may not use a service in their CSN is someone who lives nearer to a hospital in another CSN than in their own. • 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. Question: Who's giving permission to access consumer records? I am concerned about this. Answer: We're talking about getting releases and having CSWs develop crisis plans and Advance Directives. Question: Do you have a back up plan if consumers don't give permission? Answer: This is what we're driving for, it won't happen tomorrow. • 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. Don stated that he takes responsibility for not developing Rapid Response Protocols and will get it done. • 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.

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	<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>Don reiterated that they are looking for those people who can make decisions, someone in the position of authority. He asked members to look at the MOU as this will be discussed at the next meeting.</p> <p>Question: How will the MOU be executed? Will there be a vote and does it need to be unanimous? Answer: It is a recommendation to the OAMHS and we think it will apply to all CSNs; however, it may be idiosyncratic, particular to one CSN. The Court has the draft MOU now and they will need signatures.</p> <p>Question: We had an Assistant Manager at my club who left. We don't pay enough and now can't stay open. Answer: (Don) We don't have an answer but will need to answer collectively. Ron added, "We will go through the process of identifying needs."</p> <p>Question: I'm still concerned about the contracts and the no reject policy. Answer: We are talking about the system, not just individual agencies. The flipside is trying to assure access and the CSN ought not to exclude people. In that sense this becomes a resource development tool.</p> <p>Question: An immediate issue- Don made the assumption that at some point the state determines one to be eligible for MaineCare, Chapter 17, and that one needs to be disabled. My question: who is falling through the cracks with this no reject policy? Answer: We need your help in defining that problem so we can do something.</p> <p>Question: Richardson Hollow has chosen one person to act as CSN representative. Should we rethink? Answer: Yes, you may want to rethink this, but if you're in multiple CSNs you can opt out. The question is how much of a presence you have as to whether you want to participate.</p> <p>Don explained to members that they will receive a communication from the Department that clarifies the no reject policy, and that the state hospital is also part of the no reject. Marya clarified that the no reject focuses more on whether a service exists, not so much on eligibility.</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.

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	<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>Question/Comment: From a consumer perspective, I'm glad you're all participating. I have a problem with those who do not participate (in the CSNs) since they will not be on same page.</p> <p><i>Chairperson:</i></p> <ul style="list-style-type: none"> • Senior staff member of OAMHS. Don explained that they don't know who the OAMHS Chairperson will be. Right now it is the OAMHS Management Team. At some future juncture it would be one person, perhaps the Team Leader. <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> <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. Don explained that these absences would result in a discussion with the provider. <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. Don explained that this will be done at every meeting.

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	<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>Question: How will the CLASS committee relate to the CSNs? There is one statewide committee and two regional committees, one in Cumberland/York and one in Region 3.</p> <p>Answer: These need to be part of the CSNs.</p> <p>Question: I'm requesting flexibility since I can't be at every meeting and there are often other staff involved.</p> <p>Answer: Maybe the other staff could join you at a meeting? We will discuss this more in December. You could bring someone who can discuss, but if they cannot make a decision on behalf of your organization, this would be a problem.</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>Don asked members to bring any issues regarding the MOU and operational protocols to the next meeting.</p> <p>Question: Give an example of what we might vote on.</p> <p>Answer: Examples may include names of people for ad hoc committees or a need to vote on a crisis program.</p> <p>Question: I want my own Board not to be passive participants as this has many implications. However we do this, Boards need to be involved.</p> <p>Answer: Perhaps we can make a commitment to not ask people to vote on an item unless it is on the agenda. There would be a problem if whoever attends cannot vote. Ron commented that it is good to bring this information to Boards. He also recommended that members send changes regarding the MOU to them by writing to Elaine Ecker (ecker@usm.maine.edu).</p> <p>Question/Comment: From a consumer perspective, I am impressed with how this is being initiated. I hope it will be implemented in the same spirit, and that this is an initiative that brings people together and moves things forward.</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. She referenced materials pertaining to the standards in the packets and notebooks. Marya explained that some standards cover all class members. Since anyone admitted to Riverview after January 1, 1988, is automatically a member of the class and part of the Consent Decree, then this pool keeps growing.</p> <ul style="list-style-type: none"> • 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. They will not change. • 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. <p>Question: Do standards measure just the sub-population of class members or include the wider adult mental health population?</p> <p>Answer: Each standard specifies the group for which it applies.</p> <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

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	<p>each new admission becomes a part of the pool of class members. The number continues to grow.</p> <ul style="list-style-type: none"> The standards present a picture of how the mental health system is operating. Marya said 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>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> <p>Question: What are the sources of data? Answer: These are described in the appendix at the end of Section 11 of the notebook. Ron stated that shortly they will have data available to the CSNs, so each network can look at its own performance by mid December to mid January. It is important to be come familiar with the standards as this is what has been negotiated and stamped with the Court’s</p>

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	<p>approval.</p> <p>Question: Will the Department supply tools to collect data?</p> <p>Answer: It's the Department's responsibility to continue to work with providers to make improvements.</p> <p>Question: How are you going to capture if everyone says everything is wonderful?</p> <p>Answer: Data is not just from surveys or from one piece. It is important to de-identify the data so reporters are safe and anonymous. We can also get data from other sources such as unmet needs.</p> <p>Marya then referenced the CSN work plan in the packet which is just CSN related tasks and summary. She also referenced Section #2 in the notebook which contains the Consent Decree Plan and .</p> <p>The last section she referenced was the Service Matrix in Section #7 of the notebook. She explained that the OAMHS is collecting this information from the RSVPs and they will be reporting on these results to the CSNs.</p> <p>She also discussed the OAMHS website which has a section on the Consent Decree that members may download. The packets contain a copy of the home page. This section of the website contains the October 13th Consent Decree plan and the quarterly report, and the OAMHS will continue to post updates to this.</p> <p>Marya reminded members to send comments related to the operational protocols and MOU to Elaine Ecker at the Muskie School, eecker@usm.maine.edu.</p> <p>Ron concluded the meeting by stating that he heard that one of the biggest issues is the no reject policy, and he hopes to send a response within a week. He said that this response would reflect changes with an emphasis on the system. He stated that he needs to think about funding and the fact that there are new people in the system every day. The parking lot will be used to reflect topics that were not covered at this meeting and may be addressed at future meetings.</p>
<p>VI. Parking Lot Items</p>	<ul style="list-style-type: none"> • Discussion about peer services re: hospitalization • How will disagreements be worked out re: coordination of services? • Who is the "lead agency" if there is no CSW? • Criteria for ACT – should there be more available ACTs because this would prevent a consumer from having to go from one program (CSW who they know) to crisis? • Advanced directives • PNMI's re-examining Fed Medicaid • Barriers for housing for sex offenders • Understanding of CSWs roles/responsibilities and how to support <u>them</u>, i.e. pace of change/functional job analysis of CSWs. • Reimbursement for CSWs • PNMI (Oxford & Franklin County) • How do we make sure this happens in all geographic areas? Discussion of outreach workers. • 1-800 line (Consumer Councils) • Concerns that consumers have to take meds to be eligible. * Section 17 Eligibility Criteria • Permission to access records (this is with appropriate releases). • Financial support for agencies to attend hospital discharge meetings • Resource development to be able to provide services to consumers with multiple issues, non-categorical MaineCare but eligible. • Gap between disabled enough for services but not disabled enough for MaineCare. • How do we improve the response rate? • Is there a better process other than surveys to get the info? (Make it safe for consumers to be honest)

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VII. Next Steps	<ul style="list-style-type: none"> • Send suggested changes, information, requests regarding MOU, Operational Protocols, etc., to Muskie at eecker@usm.maine.edu. All correspondence will be passed on to OAMHS.
VIII. Agenda for December Meeting	<ul style="list-style-type: none"> • MOU • Operational Protocols • Service Matrix – Mapping • Ongoing schedule of meetings