

**Community Service Network 5 Meeting  
DHHS Offices, Lewiston  
December 18, 2006**

**Approved Minutes**

**Members Present:**

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| • Julie Shackley, AHCH                            | • Michael Cyr, Creative Work Systems             | • Lauret Crommet, Riverview Psychiatric Center    |
| • Dick Willauer, Alternative Services             | • Ryan Gallant, ESM                              | • Ric Hanley, Spring Harbor Hospital              |
| • Dexter Billings, Beacon House                   | • April Guagenti, Evergreen Behavioral Services  | • Ira Shapiro, St. Mary's Regional Medical Center |
| • Craig Phillips, Common Ties MH                  | • Christine Vincent, Lutheran Community Services | • Donna Ruble, Sweetser/Protea                    |
| • Joan Churchill, Community Concepts              | • Darlene Hayden, OCMHS                          | • Stephanie Crystal Wolfstone-Francis, TPG        |
| • Mark Tully, Community Correctional Alternatives | • Mark Rush, Richardson Hollow                   | • Chris Copeland, TCMHS                           |
| • Tracy Quadro, Community Mediation Services      |  |   |

**Members Absent:**

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| • 100 Pine Street (RSVP'd unable to attend) | • Friends Together                  | • Rumford Group Homes              |
| • Bridgton Hospital                         | • Maine Vocational Associates       | • Rumford Hospital                 |
| • Central Maine Medical Center              | • Pathways Inc.                     | • Sisters of Charity Health System |
| • Christopher Aaron Counseling Center       | • Possibilities Counseling Services | • Stephens Memorial Hospital       |
| • Community Rehabilitation Services         | • Pottle Hill Inc.                  | • Supportive Housing Associates    |
| • Franklin Memorial Hospital                | • RM-Transition Inc.                | • Transitions Counseling Inc.      |

**Others Present:**

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| • Sue Bundy, Alternative Service | • Rebecca Chandler, Evergreen Behavioral |
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**Staff Present:** DHHS/OAMHS: Ron Welch, Marya Faust, Donald Chamberlain, Leticia Huttman, Sharon Arsenault. Muskie School: Elaine Ecker, Anne Conners.

Agenda Item	Presentation, Discussion, Questions
I. Welcome and Introductions	Sharon Arsenault welcomed participants to the meeting and introductions were made.
II. CSN Meeting Guidelines	Sharon reviewed the guidelines with meeting participants. A member requested that pagers be turned off as well as cell phones. Agreed to by CSN members.
III. Contract Amendments and Provider Agreements	Don Chamberlain gave an update on OAMHS contract amendments and MaineCare provider agreements, reporting that two employment support providers have not returned their contract amendments. MaineCare provider agreements have gone out to all hospitals across the state.
IV. Memorandum of Understanding	Ron Welch gave the group an update on the MOUs, which have not yet been revised to incorporate changes suggested at the CSN meetings in November. Since the question of alternate designees has come up at all seven CSN meetings, Ron reported that OAMHS has decided that each voting entity should be allowed an alternate designee who would have voting rights. Also, the legal predicate for CSNs has been raised at several meetings. Ron said that OAMHS is committed to clarifying that and has requested an analysis from the Attorney General's office regarding confidentiality in the context of CSNs. Once these clarifications are made, they will be distributed to the CSN. The revised MOU must be signed by the agency's corporate head by January 3 <sup>rd</sup> .

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	<p>The group voted to recommend the following revisions/additions to the MOU/OP:</p> <ul style="list-style-type: none"> <li>• Reasonable accommodations will be made for all members to fully participate.</li> <li>• Merge the MOU and Operational Protocols into one document.</li> <li>• Clarify language on page 2 of the MOU, Section IV, point 8, regarding the role of community hospitals.</li> <li>• Address concerns about having the resources to implement all services covered in the MOU, using the following language suggested by a member: <i>To assure that the CSN possesses the adequate and necessary capacity and resources to be successful and effective in the achievement of the CSN goals, principles, structures, service delivery, training functions, and obligations.</i></li> </ul> <p><u>Other Discussion</u></p> <ul style="list-style-type: none"> <li>• Ron addressed what would happen if an existing provider pulled out of the network: He said that the resources would stay within the CSN and be redistributed via an RFP or a sole source.</li> <li>• Question: Will MOUs be the same throughout the state? Answer: Yes, at the early stages of the CSNs. Later, the MOUs may be modified to reflect regional needs/differences.</li> <li>• The member said that he was more concerned about resources to cover new activities to meet the standards of the CSNs. Ron said this could be addressed in part through collecting data on unmet needs. The member said he was concerned about the requirement that records be accessible 24/7. Ron said that the Statewide Policy Council would be charged with finding a reasonable way to implement this requirement.</li> <li>• Regarding meeting protocols, Don said that after the MOU process is completed, the attendance list would be added to the minutes and posted on the web sites. At future meetings, members will approve the minutes at the start of the meeting.</li> </ul>
V. Operational Protocols	No further discussion.
VI. Provider Services Data Matrix, Maps, Service Gaps	<p>Marya Faust 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 continue to be developed to show more clearly where services are located/delivered and depict more about the depth and coverage areas.</p> <p>Question: Can version of data maps be posted on the web? Answer: Yes</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>Marya distributed a handout (2006 Profile) of data collected from MaineCare and from mental health services funded by the General Fund showing:</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> </ul>

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	<ul style="list-style-type: none"> <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 said that this data has great implications for service planning, given the number of people with mental illness in MaineCare struggling with complex medical issues. She also said that this information provides OAMHS with strategies for service and training for staff.</p> <p>Marya distributed a report showing the number of specific unmet needs of clients in CSN 5, as well as a sheet indicating the number of clients in each CSN with unmet needs. The two sheets show that 157 clients have 318 unmet needs in CSN 5, Androscoggin, Franklin, and Oxford counties. 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>Comment: Data sheet lists 30 people with unmet vocational services needs, which does not take into account those on the VR waiting list.</p> <p>Ron said that participants in the Portland meeting also discussed the need for outreach for those not receiving services and reiterated that the data just presents a beginning picture. Also illustrates a training issue to make sure those filling out the forms do so correctly. Marya encouraged agency directors to work with staff to collect unmet needs data which can be used to further develop budget requests.</p> <p><u>Discussion:</u></p> <ul style="list-style-type: none"> <li>• A member commented that the data doesn’t capture a lot of people who are using ISPs, i.e, Franklin County does not have a lot of CSWs. Those with CSWs tend to have many of their needs met already, the member said, and the data does not reflect those who have no needs met at all.</li> <li>• Question: Hancock/Washington/Penobscot/Piscataquis report 741 unmet needs; far higher than Androscoggin/Franklin/ Oxford’s 157. Is this a reporting/data collection difference? Answer: Yes, that could be the reason. Also, whatever the reporting differences, the data tends to cluster around the same needs, i.e., vocational services, transportation, housing.</li> <li>• Ron said that the concern about having enough resources to provide services is predicated on documenting unmet needs so OAMHS can provide this data to the Legislature. The unmet needs data needs “to see the bright light of day.”</li> <li>• One member commented that it would be interesting to see a distribution of the 10,000 geographically: where are the service needs and where is the money going?</li> <li>• A member commented that the 10,000 figure is extremely low and that many people out there are not receiving services. Another said that people with Medicaid and a diagnosis of serious mental illness may be a patient but may not have a community support worker.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Suggestion: Convene a brainstorming session so creative ideas could be developed on capturing additional information through the back door, i.e., social clubs, DRC, Protection and Advocacy for Individuals with Mental Illness.</li> <li>• Question: Will anything be done with this unmet needs data in the current legislative session? Answer: Most likely that data will be presented in the 2<sup>nd</sup> Regular Session of the Legislature. Since the current budget being considered started a year ago. The CSN needs to be confident that the data is accurate and that budget needs match.</li> <li>• Question: Can OAMHS compare how many ISPs are open statewide and compare to the 10,000 figure? Also provide a breakdown per CSN? Answer: Will try to do so.</li> </ul>
VIII. Role of Consumers in Licensing	<p>Leticia Huttman gave an overview of the Role of Consumers in Licensing initiative underway at the Department. The OCA in OAMHS sees this as a valuable component of a consumer-driven, recovery-oriented system of care. This requirement is also one that is included in the consent decree. Consumers have given feedback that they do not want to be involved in the nuts and bolts of licensing but rather are interested in assessing: Are the services delivered recovery-oriented? Are they person-centered? Do they help people live full and satisfying lives in the community? This effort is seen as part of an overall Quality Improvement process.</p> <p>Specific protocols have not yet been developed; consumers have looked at tools like Elements of a Recovery-Facilitated System (ERFS) or the Recovery-Oriented Systems Inventory.</p> <p><u>Comments/Questions:</u></p> <ul style="list-style-type: none"> <li>• Question: Why pick licensing and not some other Utilization Review/Quality Improvement process? Licensing has a specific role in saying Provider A is allowed to provide these services and can be a fairly scary process. Answer: The Courtmaster wanted to see consumer review as part of the licensing process. OCA/OAMHS is also looking at how licensing can move into Quality Improvement and how all these pieces could be married to build a quality management system.</li> <li>• Question: Would patients be part of a licensing survey team? Do patients who have appendectomy go into the hospital and review its licensing requirements? Answer: Elements of a Recovery Facilitated System is a different process. It's an opportunity to take a look at what happens in licensing but from a different angle: trying to assess: are services recovery-oriented?</li> <li>• A member commented that the basic philosophic underpinnings of the effort need to be questioned, as a thorough literature search reveals no data for an evidence-based recovery model. The model is an advocacy model and "having a mental illness doesn't give you an expertise as to whether hospitals are following their license, but does give you an expertise in a Consumer Satisfaction Survey." The member concluded that he felt this effort was a "major mistake."</li> <li>• Question: From a community provider perspective, what is the timeframe for implementation? Answer: Training of consumer teams will begin in the spring; still hasn't been decided whether consumers will go out with the licensing team or on a separate visit. Some consumers have said that they would prefer a separate visit.</li> <li>• A representative from Riverview Psychiatric Center said that the recovery model is a wonderful one and said that RPC gets valuable information through its Peer Program. This may be a better process than licensing.</li> <li>• Another member discussed the tracer system used in the hospital licensing process and said that through the Co-Occurring Initiative grant, a consumer visit/survey has been developed that is working well.</li> </ul>

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	<ul style="list-style-type: none"> <li>Ron Welsh commented that recovery is an emerging best practice and that eventually the data will be available to show it is an EBP.</li> </ul>
IX. Housing and Support Services Workgroup Update	<p>Don reported that the Housing and Support Work Group has met three times. The group has agreed to meet weekly until February. It is taking a look at the definition that the Department has in contracts and elsewhere and try to recast in light of where Department is trying to go. Examples: Group Homes that operated 24/7 and serve unique individualized populations, specific subsets of clients or four or five clients in a complex that operates like a group home but is categorized as something else. The group is working to define categories of housing services more clearly and to determine which bucket the range of residential services belong in.</p> <p>By next week, information on the workgroup should be posted on the DHHS web site with minutes and meeting schedule/</p> <p><u>Discussion:</u></p> <ul style="list-style-type: none"> <li>Question: Is work group addressing housing for sex offenders or others with felony charges who can not access federal housing supports? Answer: No.</li> <li>Sharon said that CSNs may want to form a subgroup on this issue at some point.</li> <li>Question: Have changes been made to Chapter 17 and 97? Answer: Hasn't been addressed yet.</li> </ul>
X. Contract Compliance Template	<p>Marya distributed an Agreement Review Checklist/template. She said that the template seeks to address two issues: assure that OAMHS has good stewardship of taxpayer's money and reviews contracts and have some way to assure that contract reports are submitted in a timely fashion. OAMHS and Purchased Services will meet with the provider at least annually to discuss compliance with the agreement as well as areas of non-compliance. The document will continue to be modified to improve its usefulness. Licensing review and corrected action plan would be captured here. Concentrate on what is needed in contract. Submit comments/thoughts to Elaine Ecker at the Muskie School, <a href="mailto:eecker@usm.maine.edu">eecker@usm.maine.edu</a>.</p> <p>Question: How will checklist be used? Answer: Basis for discussion at annual review. Will try not to duplicate things that occur elsewhere.</p> <p>In Region II, these meetings will take place on January 11 and 12. Initial meetings will focus on those with larger services; lower priority on those with MaineCare seed only/or contract outpatient providers. They may not be reached in this first round. Don said that eventually he would like to conduct such reviews twice a year.</p>
XI. Beds: Crisis Stabilization/Observation	<p>Don said that OAMHS would also like to have this discussion/conversation in January. He directed participants attention to the "Persons Experiencing Psychiatric Crises: Specific Actions" section of the Consent Decree Plan, pages 37-38, Tab 1 of the reference binder. He asked participants to think about what needs to be done regarding crisis stabilization units, outpatient observation beds, acuity and whether resources are located in the right areas, recognizing that everyone's efforts are to avoid hospitalization/crisis beds if possible. It would be helpful, he said, if those with crisis bed services bring information on their occupancy to the January meeting.</p> <p>He reported that there have been conversations in Franklin County regarding establishing observation beds there but is not sure whether reimbursement levels are sufficient to do that. Another concept being considered is establishing "Living Rooms" which is a type of drop-in arrangement with peers available.</p>

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	<p><u>Discussion:</u></p> <ul style="list-style-type: none"> <li>• One member commented that Spring Harbor does not designate any beds specifically as observation beds but rather uses any of its 48 adult beds as observation beds as need. On any given day, 3-4 patients are in observation status.</li> <li>• Comment: Observation beds are not the issue; the issue is getting aggressive treatment in the Emergency Department. If this happens, decreases likelihood of hospitalization.</li> </ul>
XII. Statewide Policy Council	<p>Ron reviewed the tasks of the Statewide Policy Council (SPC), 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. The SPC would run until June, meeting once a month.</p> <p>Ron suggested two ideas discussed at other CSNs: 1) electing three people at large to represent the CSNs, or 2) have a core person who attends each month and brings other members, as necessary, with expertise related to particular agenda items under discussion.</p>
XIII. Ongoing Meeting Schedule	<p>The group agreed on the following possible meeting schedule: 2nd Monday of each month, p.m.; 3<sup>rd</sup> Monday of each month, p.m. There were no requests for ITV.</p>
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>• Voting for Statewide Policy Council</li> <li>• Crisis/Observation Beds Discussion</li> </ul>