

**Community Service Network 5 Meeting  
DHHS Offices, Lewiston  
November 17, 2008**

**DRAFT Minutes**

**Members Present:**

<ul style="list-style-type: none"> <li>• Kim Lane, Alternative Services</li> <li>• Dale (Grace) MacDonald, Common Ties 100 Pine St.</li> <li>• Craig Phillips, Common Ties Mental Health*</li> <li>• Joan Churchill, Community Concepts.</li> <li>• Bill Tanner, Community Correctional Alternatives</li> </ul>	<ul style="list-style-type: none"> <li>• April Guaguenti, Evergreen/Franklin Memorial</li> <li>• Dalene Sinskie, Evergreen Behavioral Services</li> <li>• June Watson, Friends Together</li> <li>• Scott Morrison, Lutheran Community Services</li> <li>• Angela Desrochers, MMC Emp Spec, CSN 5</li> <li>• Ron McHugh, Oxford County Mental Health</li> </ul>	<ul style="list-style-type: none"> <li>• Lauret Crommett, Riverview Psych. Center</li> <li>• Lyn Suggs, Spring Harbor Hospital</li> <li>• Roger Wentworth, Sweetser</li> <li>• Stephanie Crystal Wolfstone-Francis, Transition Planning Group</li> <li>• Chris Copeland, Tri-County Mental Health</li> </ul>
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**Members Absent:**

<ul style="list-style-type: none"> <li>• AHCH</li> <li>• AIN (vacant)</li> <li>• ESM (vacant)</li> <li>• Merrymeeting Behavioral Services</li> </ul>	<ul style="list-style-type: none"> <li>• Possibilities Counseling</li> <li>• Rumford Hospital</li> <li>• Rumford Group Homes</li> <li>• Sisters of Charity Health System</li> </ul>	<ul style="list-style-type: none"> <li>• Stephens Memorial Hospital</li> <li>• Transitions Counseling, Inc.</li> </ul>
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**Others/Alternates Present:**

<ul style="list-style-type: none"> <li>• Eric Meyer, APS Healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Kelly Bickmore, APS Healthcare</li> </ul>	
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**Staff Present:** DHHS/OAMHS: Sharon Arsenault, Don Chamberlain, and Cindy McPherson. Muskie School: Phyllis VonHerrlich

<b>Agenda Item</b>	<b>Discussion</b>
I. Welcome and Introductions	Sharon welcomed participants; introductions followed.
II. Review and Approval of Minutes	Minutes from the October meeting were approved as written.
III. Feedback on OAMHS Communications	No issues discussed around communications, although communication issues were noted in discussion of agenda items.
IV. APS Healthcare <ul style="list-style-type: none"> <li>• <i>Review of current data</i></li> <li>• <i>Discussion of issues , including feedback on data entry</i></li> </ul>	<p>Don Chamberlain introduced the discussion with APS Healthcare by giving a summary on his findings about the APS process that was gathered from visits to MH providers. In most instances, the Regional MH Team Leader worked on these site visits with Don. Don Harden of Catholic Charities and Chair of the Adult Committee of MAMHS suggested this approach and set up the first interviews. Chamberlain then asked the Behavioral Health Collaborative to identify and set up additional meetings. In all, six providers were interviewed: Shalom, Catholic Charities, Common Ties, Kennebec Behavioral Health, CSI, and Community Counseling Center. Information was gathered from a range of staff including frontline staff, supervisors, billing staff, and others. Recommendations for changes have come out of this process. Information gathered, briefly summarized, included the following:</p> <ul style="list-style-type: none"> <li>• With the APS system, continuing stay reviews require additional time to process, with increases ranging from 20 minutes on the low end to 1 hour on the high end. Therapists in out-patient settings are on the low end for time increase, while practitioners who have to translate treatment plans in clinical records to the CareConnections format tend to need the longer time. Master's level clinicians seem to find it easier than MHRTCs.</li> <li>• A supervisor or Quality Department review before data can be entered into APS adds time; most</li> </ul>

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	<p>providers have such reviews.</p> <ul style="list-style-type: none"> <li>• The increase of CI from 6 month continuing stay reviews to every 90 day reviews has substantially increased administrative costs to CI providers. To do RDS would take much less time. <b>Recommendation: get RDS information at the 90-day point, then do the full continuing stay review at the 6-month point.</b></li> <li>• The comment section of CareConnections is being used for additional goals and other ongoing information that cannot be brought forward in continuing stay reviews, resulting in additional work for each review.</li> <li>• Initial authorization visit decrease for Outpatient results in a need for more reviews. The original authorization allowed the treatment of many consumers to be completed and therefore not require a review. The current initial authorized visits cause nearly every case to require a continuing stay review. <b>Recommendation: return to the earlier number of authorized visits.</b></li> <li>• One provider interviewed has an electronic interface that eliminates, for the most part, the need for clinicians or others from having to enter information manually into APS. However, every time there is an APS change, there is an IT cost for the provider to make that adjustment in their system.</li> <li>• While there was a reduction for information required for Outpatient for continuing stay reviews, one has to go through all the pages to get to the appropriate section. This causes confusion and time.</li> <li>• Telephone tag (on both sides) when there are questions results in more time spent.</li> <li>• Given the agency processes and the telephone tag, the 5-day pre and post the date for the review is difficult to meet. <b>Recommendation: increase from 5 to 7 days on either side.</b></li> <li>• For PNMI the 30-day review is a bit short since the OAMHS has approved the placement in the first place. Getting the registration and discharge into APS in the 24 hour time frame is sometimes problematic. <b>Recommendation: Increase the timeframe for the continuing care review and allow an additional 24 hours to get registration and discharge data into APS.</b></li> <li>• <b>Recommendation: Those with computerized records would like batch up-loading to save time and expense on the provider side.</b></li> <li>• General concerns regarding the language and information that APS is asking – it is medially oriented based upon problems, whereas the ISP is strength-based, and Licensing may yet require something else. <b>Recommendation: That all these (language and information) be aligned.</b></li> <li>• There is variability in agency capacity to easily track visits and time for approvals. The range is from one agency that has had to set up a spread sheet to an agency where all is computerized and can sent out reminders.</li> <li>• Everyone indicated that the reviewers and staff at APS were easy to work with and very professional.</li> </ul> <p>Eric Meyer and Kelly Bickmore of APS were present to discuss and answer questions. <u>Points of information included:</u></p> <ul style="list-style-type: none"> <li>• December 1 marks the one-year point for APS in Maine. The first year has been one of adaptation and adjustment, with numerous changes, but they see the upcoming year, given the changes that have been made in the past year, as the sustainability part of the service system, although they are always open to suggestions and feedback. APS has asked for direct feedback from users and that, in combination with Don's data, will be analyzed and further adjustments will be made based on that analysis. These additional changes are coming in January, or shortly thereafter. Changes reflect what is happening at the Department as well as improvements in the system for APS. Training will also be forthcoming so that all users have maximum skills and ease for use.</li> </ul>

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	<p data-bbox="598 134 1696 164"><b>Action:</b> APS asked for direct feedback. A form for this was included in the meeting materials.</p> <ul data-bbox="743 199 1990 383" style="list-style-type: none"> <li data-bbox="743 199 1751 228">• CSN member Comment: Appreciation to APS for willingness to receive feedback.</li> <li data-bbox="743 232 1864 261">• Question: Is the work associated with the APS process considered an Administrative Cost?</li> <li data-bbox="743 264 1990 383">• DHHS Answer: Don noted that this issue is being discussed. There are instances in some DHHS services where paperwork / data processes are considered Admin Costs (therefore billable costs), but the Department is still exploring this for APS. No answer is available on this at this time, but Mr. Chamberlain noted that it likely would not be.</li> </ul> <p data-bbox="598 415 1556 444"><b>Action:</b> DHHS will provide this information with agencies as soon as it is clarified.</p> <ul data-bbox="743 480 2024 1528" style="list-style-type: none"> <li data-bbox="743 480 1646 509">• CSN Member Question: Is there a difference in error rate for data entry?</li> <li data-bbox="743 513 2024 751">• APS Answer: It appears that those who have had more clinical experience find it easier to do than those who have not had much clinical experience, but the error rate is a complex factor based on what category of service, whether or not the staff is entering the data directly or handing it off to someone else, and the amount of training in the APS system the staff member has had. A further factor is that of APS support – how easily the staff can connect with APS staff to get their questions answered. Training and support are clear factors in the error rate, the category of service is less of a factor. It is clear that more training needs to be done when the next changes are made to the system and that changes need to be made for the availability of APS support.</li> <li data-bbox="743 755 2003 846">• DHHS Comment: DHHS staff do positive, strengths-based assessment; the APS system is based on a medical model. MaineCare will pay for a service if there is a medical need; with the strength-based approach there is sometimes the possibility of obscuring that need.</li> <li data-bbox="743 849 1990 940">• APS Comment: Adjustments may be needed for reporting periods, but accuracy in entering data and review of data would cut down on error rate (some providers do have a system in place for review). Inaccurate data can cause an entry to be placed on hold, and therefore interfere with the billing cycles.</li> <li data-bbox="743 943 2024 1034">• CSN Member Questions: [summarized] What is the difference between APS System and how case managers have been trained– is it just a matter of terms? Has the training been broad enough? What is driving increase in administrative costs?</li> <li data-bbox="743 1037 2003 1187">• APS Response: One is clinically based and one is strength-based The cases on hold are a very small percentage of the overall cases. Case Managers do good service. In the past, they had help with the clinical data, whereas today they have to enter it themselves. There also is a difference between a treatment plan and a utilization treatment plan (which is what is required for APS). It takes time to learn this and become proficient.</li> <li data-bbox="743 1190 2003 1281">• DHHS Comment: everyone has to do plans on a regular basis, but now the plans have to be translated into the format require for APS. There are issues of presenting the data in the new format and there are issues of being able to maneuver through the pages of the program.</li> <li data-bbox="743 1284 2024 1403">• The ideal situation would be if there could be one format for the treatment plan, but complicating factors – requirements for insurances, some providers have purchased specific plan software, etc. – preclude that. Better planning and a more accurate acknowledgement of the time to do data entry were needed up front, but adjustments are being made and the next year will be smoother for operation.</li> <li data-bbox="743 1406 1976 1468">• CSN member comment: Standardized forms for services associated with state funding would also be helpful. There was an attempt at this at one point, but they have not been developed as of yet.</li> <li data-bbox="743 1471 2003 1528">• CSN member comment: One member thought there had not been adequate forward knowledge of the switch to APS and also asked if agencies might need cross-training in medical language. The member</li> </ul>

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	<p>also urged standardized forms; others felt providers and consumers had been kept informed.</p> <ul style="list-style-type: none"> <li>• APS Response: A better job had been done with consumers that have clearly identifiable groups; more work needs to be done to make sure all are informed – asked for ideas on how to do that. APS offered to put the member on the APS email distribution list so they would get information in a timely manner.</li> </ul> <p><b>Action:</b> APS asked for ideas on how to keep consumers better informed. Consumer representatives to CSN will be placed to be on their email distribution list</p> <ul style="list-style-type: none"> <li>• CSN member comment: There needs to be a feedback loop to the service providers. Has there been any cost savings with the new system? Service providers need to know that.</li> <li>• APS response: APS was not asked by the state to track cost reduction.</li> <li>• A cost analysis is being done (by the Muskie School) and this information will be available in January – the information will be public.</li> <li>• Eric Meyer provided samples of reports and reviewed the types of reports that APS runs for the state; there are 60 in all. He invited those present to give feedback on what might be areas of inaccurate information or to suggest ways in which the information could be made clearer.</li> </ul> <p><b>Action:</b> APS asked for feedback on data reports and suggestions for changes.</p> <ul style="list-style-type: none"> <li>• The first step in analysis for the system is to have a baseline, and the data from July – September 2008 will be that baseline. 2009 will give the data for comparison and analysis. Reports will be run quarterly. There were a number of questions about what the data is telling us, but Eric noted that the numbers will have value only after a year once the baseline is established and the measures set. A specific question about whether or not “repeats” (those clients who appear a number of times in the data) could be identified (for the purpose of seeing the value of the service, or to point to other needed services). The answer is “yes.” Concern about whether or not those who go off services could get back on easily if needed. Suggested a category for “voluntary hold from services” while someone tests their wings, but being able to get back on services quickly if need be. APS Staff assured that their clinicians are trained in this area and the goal is for clients to have connections to all needed services. There were also concerns about waiting lists and the length of time it takes for folks to have access to the services they need.</li> <li>• Future changes will be done on a more orderly basis – done at specific points – to make it more manageable for the users. Changes tied to cost savings may be coming. MaineCare eligibility numbers need to be checked – how often – and how much – do these numbers change? Question about the value of the data to OAMHS and whether or not new directions were indicated. OAMHS – data has not been used in this way yet, although a closer look will be made as more data is generated.</li> <li>• CNS Comments: Data to date shows that providers have responded well to this new system – have been able to learn quickly and use accurately. Data to date show providers are not over-referring.</li> </ul> <p><b>Contact Information for APS:</b>  <a href="mailto:emeyer@apshealthcare.com">emeyer@apshealthcare.com</a>  866-521-0027 – phone  866-325-4752 – fax  Web site: <a href="http://www.qualitycareforme.com">www.qualitycareforme.com</a></p>

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V. Budget / Legislative Issues	<p>Mr. Chamberlain reported:</p> <ul style="list-style-type: none"> <li>• There is a major financial crisis in the state because of the national economy. Curtailments are coming, but what the specifics are is not known yet. There is essentially a 10% cut for DHHS, but this will not be “across-the-board” by service. Cuts will be directed to targeted services, but it is not known at this point what this means for Adult Mental Health Services.</li> <li>• A CSN member referenced a targeted tax (increase) that had been used in earlier times, but there seems to be little support at this time for any tax increase in the state for any purpose. A tax-limiting movement in the state appears to be coming back.</li> <li>• There were concerns about the Consent Decree and whether any funding for AMHS could be cut because of this.</li> <li>• There is some lack of clarity about the 10% administrative cap – whether this means that the administrative costs have to be held to 10% of the overall budget (for agencies) or whether this means there must be a 10% reduction in current administrative costs (of the agencies).</li> </ul> <p><b>Issue: 10% Administration reduction needs to be clarified.</b></p> <ul style="list-style-type: none"> <li>• The Department must reduce its budget, as well as looking for costs savings in contracts with the agencies.</li> <li>• The message coming from the Governor’s office is cut administrative costs, not services.</li> <li>• As for the formula for distribution of funds, it will remain the same unless changes are proposed that the Department can agree with. Some providers are happy with the current formula; some are not. It was noted that the Collaborative wants to stay with the current formula.</li> <li>• As for the rates, there is some discussion about this, but any change is not yet known.</li> <li>• As for the recent change in leadership at the Federal level, what impact this may have on funding is not yet known.</li> <li>• There are changes coming (in January 2009) in the Americans With Disabilities Act which actually broadens the definition of what it means to be considered disabled (it has been expanded), but employers are no longer required to “reasonably accommodate” someone who is “regarded as” disabled. The implications are not yet known, but could be far reaching and result in more charges filed with EEOC and more litigation. Don noted that he needed to look at these upcoming changes.</li> <li>• Question: A consumer representative had a question about a recent local television show that Chris and Craig appeared on (with Representative Margaret M. Craven). They explained that a request had come their way as local providers of MH services to appear on the program. The program focuses on what is happening in the state capital and offers viewers information and insight about this. Their intent in appearing on the program, they explained, was to make a case to the audience (and to Representative Craven) that there should be no cuts to MH services. There was sentiment expressed by the consumer representatives that consumers themselves need a voice in such conversations. It was acknowledged that such programs taking place is helpful.</li> <li>• Don noted that the curtailments in this year’s budget do not necessarily get rolled into next year, but the full impact of the economic downturn and federal cutbacks is not yet known, nor is it possible to predict what impact any further federal economic stimulus packages might have.</li> <li>• CSN member noted that the distribution of funds is being done by district and these do not follow CSN lines. He was curious if re-distribution of funds would be warranted based on consumers served (e.g. a provider program is based just outside the district, but draws many clients from within the district). Don said programs should feel free to pursue this at the district/CSN level, but encouraged them to have a rationale and guidelines for the request.</li> </ul>
VI. Consent Decree Quarterly report online Included budget requests	<ul style="list-style-type: none"> <li>• Don noted that the Court Master has come out with a ruling recently (October 29, 2008) that has implications for service. (Paul Bates, et al, v. Commissioner, [Maine] Department of Health and Human Services).</li> <li>• The ruling is that non-class members need to be treated the same as class members – i.e., there cannot be</li> </ul>

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	<p>different sets of rules.</p> <ul style="list-style-type: none"> <li>• CSN 3 (Kennebec) and CSN 6 (Portland) closed down admissions last week. Information about a referral still needs to go to APS, but they do not need to serve the customers until there is an opening in their admissions. Sometimes these changes come about quite quickly. Referrals will either get services or be tracked as an unmet need. There will be a backlog for admissions, but cases where there is extreme need will be addressed.</li> <li>• Changes in criteria for non-class are coming shortly. Don noted there are some issues that still need to be clarified.</li> <li>• Details of the ruling were in printed material made available at the meeting. Don noted that the population needing to be served has increased and that additional funds have been requested, but it is not known yet if they will be forthcoming.</li> </ul>
VII. Consumer Council Updates	<p>Stephanie Crystal Wolfstone-Francis reported:</p> <ul style="list-style-type: none"> <li>• The Council met in October and identified three primary issues of concern: 1) transportation, 2) housing, and 3) budget cuts. There have been some discussions at city and county levels regarding transportation systems.</li> <li>• The Council also discussed the need for a 'call place' for people who are not connected with an agency.</li> <li>• There was a question about 'bed-hold days,' the change in this policy, and where the Council could get clarifying information about this.</li> <li>• Don referred her to the DHHS Adult Mental Health Website. It was noted that better communication is needed because some do not have or always have computer access.</li> </ul> <p><b>Issue:</b> better communication is needed because some do not have or always have computer access.</p>
VIII. WRAP Funds Proposal	<ul style="list-style-type: none"> <li>• A contact agency to be the keeper of the WRAP funds not dedicated to specific agencies needs to be identified before January 1, 2009. In that there is no December CSN meeting, someone needs to come forward now. After a discussion of the possible ways the funds could be housed (an agency or a committee or a CSN),</li> </ul> <p><b>Action:</b> Tri-County agreed to house the WRAP funds initially, with the understanding that a change could be made later if needed.</p>
IX. Report from Employment Specialist and Employment Service Network (ESN)	<p>Angela Desrochers reported and provided a written report.</p> <ul style="list-style-type: none"> <li>• Over 63% of all jobs obtained are through networking (Angela asked those present to note any jobs they are aware of on an index card she distributed to each).</li> <li>• 36 job seekers are currently in the program, with two more intakes scheduled for next week. Some are involved in multiple activities, but the breakdown is thus: 8 are employed, 6 are volunteering, 3 are in school, 9 are involved in an active job search, 3 are engaged in career exploration, 2 are in Peer Support Specialist Program, and 12 are involved in outreach and other activities.</li> <li>• ESN will present to the Androscoggin County Chamber of Commerce in the next few months – to explain who they are and how they can be useful to business in the community.</li> <li>• Looking for a resource person to the Career Center in Franklin County.</li> <li>• Teleconferencing / Poly-Conferencing are being used to conduct meetings.</li> <li>• Need more employment specialists (ways to expand have been discussed, although no change yet).</li> <li>• "Need for Change" self-rating scale (related to a felt need for change in employment status) is a useful tool for agencies to use in determining referrals to employment / training resources (some do currently use this).</li> <li>• Consumer point: better transportation is needed – to coincide with class schedules at schools, particularly to CMCC -</li> </ul>

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X. Other	<p>Issues:</p> <ul style="list-style-type: none"> <li>• There is a need for standardized MOUs and Standards for these – could CSN discuss and arrive at a common decision? Answer: This is appropriate for discussions in other settings.</li> <li>• GLBT Meeting – there is good interest in this group. A “thank you” to providers who let their consumers know about the group. There is need for more knowledge on the part of providers re: GLBT and Peer-to-Peer support.</li> </ul>
XI. Public Comment	There were no public comments.
XII. Meeting Recap and Agenda for Next Meeting	<p>Email or send Eric any suggestions  Admin burden needs to be clarified – keep posted on Web site  Next Consumer Council meets before Thanksgiving  WRAP funds – continue to work on administration for  Add Crisis Services and Peer supports in CS  Next meeting scheduled for third Monday in January</p>