

**Community Service Network 5 Meeting
DHHS Offices, Lewiston
September 15, 2008**

DRAFT Minutes

Members Present:

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| <ul style="list-style-type: none"> • Kim Lane, Alternative Services • Annalee Polley, Assistance Plus • Dale MacDonald, Common Ties 100 Pine St. • Craig Phillips, Common Ties Mental Health • Joan Churchill, Community Concepts • Bill Tanner, Community Correctional Alternatives • April Guaguenti, Evergreen/Franklin Memorial | <ul style="list-style-type: none"> • Scott Morrison, Lutheran Community Services • Angela Desrochers, MMC Emp Spec, CSN 5 • Deborah Rouleau, MMC Vocational Services • Tanya Williams, Merrymeeting Behavioral Health • Samantha Stancil, Merrymeeting Behavioral Health | <ul style="list-style-type: none"> • Bob Pontbriand, Oxford County Mental Health • Lyn Suggs, Spring Harbor Hospital • Roger Wentworth, Sweetser • Stephanie Crystal Wolfstone-Francis, Transition Planning Group • Chris Copeland, TCMHS |
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Members Absent:

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| <ul style="list-style-type: none"> • AHCH • AIN (vacant) • ESM | <ul style="list-style-type: none"> • Friends Together • Rumford Hospital • Rumford Group Homes | <ul style="list-style-type: none"> • St. Mary's/Sisters of Charity • Stephens Memorial Hospital • Transitions Counseling, Inc. |
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Others/Alternates Present:

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| <ul style="list-style-type: none"> • Dot Treadwell, Common Ties 100 Pine St. | <ul style="list-style-type: none"> • Koriene Low, Community Concepts |
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Staff Present: DHHS/OAMHS: Sharon Arsenault, Don Chamberlain, Ron Welch, Lauret Crommett, Cindy McPherson. Muskie School: Scott Bernier

Agenda Item	Discussion
I. Welcome and Introductions	Sharon opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the August meeting were approved as written.
III. Feedback on OAMHS Communications	<p>Sharon reminded members present that communications from OAHMHS are also posted to the CSN website: http://maine.gov/dhhs/mh/csn/index.html</p> <p>Communications from OAMHS now go through the CSN groups to be disseminated within the agencies.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Did you email this change? A. No. • If I'm out, word will not get filtered down as quickly within my agency. Response: Information is also posted on the website. • More information is better. Please merge your email lists. • Are there any more details on the Crisis Memorandum? A. It is being reviewed. Hopefully, it will be out later this week. It will contain a series of items: <ul style="list-style-type: none"> ○ The minimum requirements for crisis systems ○ A list of who within the local CSN is providing crisis services ○ The funds available for crisis services ○ A cover memo suggesting that mobile crisis providers set-up the first meeting in regards to crisis services within their CSN with the understanding that they will report back to OAMHS with recommendations by November. ○ At the minimum, we would like to have the hospitals and crisis providers within the CSN present at that

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	<p>meeting.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • So you're pulling the meeting together, but you're not determining how services will be provided? A. We're leaving how services are provided up to the providers within the CSN. • When will this change take effect? A. March, 2009 • Will contract requirements change? A. Yes and no. It will depend on what is decided by providers at the crisis meeting. • Are you looking for any consumer support into this? A. We already have consumers involved. We do not discourage involvement. This is a major step for CSN to design a mechanism for the delivery of services. • Is allocation of funds less? A. Overall, yes. • I have a question on the formula used. Did you take into account the modified population for CSN 5? The Bridgton Region had been left out previously and counted as part of CSN 6. A. The legislation refers to districts rather than CSNs. Districts are slightly different in their borders. There are 8 districts in comparison to 7 CSNs. We did take the population data provided into account in our calculations. • How much are the reductions? A. \$300,000 for the last 4 months. We are still trying to determine how much of this is grant funds. • Is the expectation of reduction based on peer services, warm lines, and other similar services which are helping to keep people out of crisis? A. No. It is based on an elimination of duplication of services.
<p>IV. Legislative Session January 2009</p>	<p>Ron presented an overview of the bills/requests that DHHS-OAMHS is proposing to the legislature:</p> <ol style="list-style-type: none"> 1. <u>Prior authorization for PNMI beds</u>: MaineCare does not allow for prior authorization for PNMI beds, and legislative authority is required to change the MaineCare rule. 2. <u>Add forensic patients to the bill authorizing clinical review panels to mandate involuntary medications</u>: At this time, only those civilly committed come under the provisions of this bill. OAMHS would like legislation to include people on the forensic side as well. Also, the "lay advisor" terminology in the bill needs to be clearly defined. 3. <u>Expansion of CNA Registry to include other direct care workers</u>: Presently, there is no registry for people working in the mental health field with MHRT certifications and therefore no way to track or record the performance of those working in the field. OAMHS would like to expand the current CNA registry to include direct support mental health professionals (MHRT/C, MHRT I, MHSS) as a way of assuring knowledge and quality of practitioners. This would also provide a mechanism for decertification, which presently none exists. 4. <u>Exempt critical incident reporting from discovery and expand and clarify the mandate for reporting.</u> 5. <u>Reduction and disposal of unused medications (two concepts, for safety and less waste)</u>: <ol style="list-style-type: none"> a. Shorten new medication prescriptions to 14 days, with no co-pays: Finding the most effective medications often requires trials and can result in waste and disposal issues if abandoned prescriptions have been written for the usual 60-90 day period. Under this concept, any new prescription would be written for a shorter period and consumers would not be liable for co-pay on any of them, even if it involves several trials. b. Establish authority of Department of Public Safety (DPS) re: disposal of unused drugs, rather than the Department of Environmental Protection (DEP). DHHS and DPS want to remove disposal of unused drugs from DEP regulations and establish new regulations. DHHS and DPS see drugs as different from other hazardous materials, and DPS would be better able to manage proper control, storage, etc. <p>Discussion:</p> <ul style="list-style-type: none"> • In regards to the registry, will it be for only for adult services, or will it include children's services? A: At this

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	<p>point, only adult services. However, we can look at including children services.</p> <ul style="list-style-type: none"> • Add a criminal background check. A: We can look at that. • In regards to unused drugs, it is a shame we can't redistribute medications as prescriptions change. • In regards to reducing the term of prescription drugs, there aren't many psychiatrists in the state, so it may be difficult to implement this and get a short-term prescription as many times, there is a month or more wait for an appointment with a psychiatrist. • In the past, when the state has done its planning for services, mental health services has not been considered a core required service. A: You are speaking of MaineCare-federal funds. Most of our services are considered optional under MaineCare. Mainecare required services are along the lines of medical/nursing care. We could move to a waiver program, but then growth within the program would be limited. For example, Iowa has moved to a waiver system. They have set-up individual accounts for people. The person then determines what services they receive. So far, people have been conservative with their funds and Iowa has saved a little money over their previous system. • Under Medicaid/MaineCare, we can't have transportation as a service. We should change that. <p>MOTION: Expand the MaineCare Transportation Benefit to include transportation services to meet the needs of the ISP and/or Recovery Plan.</p> <p>Discussion: What this might mean is that recovery plans and ISP's may be more clearly written.</p> <p>Vote: The motion passed.</p> <ul style="list-style-type: none"> • Can we come back next month with more ideas? A: We need ideas before the end of this month from all CSNs. Please email any additional ideas to Elaine Ecker (eecker@usm.maine.edu). OAMHS' deadline is shorter. We need to submit our input to the commissioner by October 1st. We'll know what gets in by December 1st. <p>MOTION: Require all group homes to have a designated medical director to handle medications.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Why add this when a doctor is already prescribing medications? • Our clients have doctors. • Aren't there licensing requirements already in place for psychiatrists to follow through on? • Yes, there are. • On the mental health side, all our homes are licensed. This may not be the case on the developmental disabilities side. <p>Vote: The Motion failed.</p> <ul style="list-style-type: none"> • Revisiting the medication piece, it is a serious concern. Medications that are being thrown away are a huge cost. Response from Ron: I can invite Dr. Stevan Gressitt to attend a future meeting to discuss his involvement with the unused medication issue. This can take place in October or November depending on his schedule. • Do we need to agree to the six proposals you have proposed? A: No, these are ideas, which may go nowhere. <p>MOTION: Review reimbursement to providers to reflect the increasing cost of service delivery and offset cuts in recent legislative sessions.</p> <p>Vote: The Motion passed.</p>

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V. Budget	<p>Ron informed that work is underway on the Supplement Budget for 2009 and the Biennial Budget for FY 2010/2011. We've started to formulate budget requests with the understanding that a second round of requests will come from the CSNs.</p> <p>He pointed out the memo and budget template OAMHS sent out in August for members' use, which included two main categories for budget requests: 1) client-specific needs, backed up with data; and 2) systems needs. Most present indicated that they did not receive the template. Only those who are also members of other CSNs received the worksheet. Some who have received them (by being members of other CSNs) have sent in their worksheets online.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Substance abuse unmet needs appears to be low. • Changes in medication management billing are such that you can't be paid for both a doctor and a nurse visit on the same day. Billing codes are now the same for both. We shouldn't have to bring someone in on two different days to receive their services. Response: It is an issue statewide. We're working on a solution. Perhaps we'll keep the single code, but increase the time allowed so you can combine the billing. • On unmet needs, for CSN 5, where does the data come from? It seems a bit high. A: The data is generated from case managers doing RDS. The increase in unmet needs between the third and fourth quarters is a result of more data being gathered. • The issue I'm raising is how accurate is this data? There is a belief that the RDS is being filled out by just the community integration (CI) worker rather than the CI worker and consumer together. • Our case managers are reliable. Data submitted should not be automatically suspect. • Is demographic information being used to project any of the budget criteria? A: We've done a projection based on population. We've been focusing on CSNs. If data doesn't look right or something is missing, please provide us with the data to correct this. • Fuel assistance is a concern for us. The current federal assistance will only cover two weeks of oil. I hope that the state recognizes that there will be a huge need this winter. The Maine Community Action Program can provide you with the data in regards to the need for fuel assistance. • We are concerned with the changes in the rules for PNMI bed-hold days that have been eliminated. Here we are promoting recovery, but people can't leave their PNMI for a day without losing their bed. Response: On adult mental health side, at the end of the day/year, the agency will be reimbursed up to their approved cost. No agency should be put at risk beyond the 1.5% cost reduction cap. CMS said there are no bed hold days. Medicare will not pay for services that are not delivered. <p>ACTION: Members should complete budget forms and submit them to Elaine before Sept. 26. Please see the CSN website for the form. www.maine.gov/dhhs/mh/csn.</p>
VI. Public Comment on Budget	None.
VII. Consumer Council Update	Stephanie reported that the local council cancelled their previous meeting and will next meet in October. The statewide council is in the process of hiring an executive director. Interviews for the director's position are taking place this week. The statewide council is planning to have a meeting in October.
VIII. Transportation Subcommittee Report Out	Tabled until next month.

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<p>IX. Report from Employment Service Network (ESN)</p>	<p>Angela provided two handouts to those present a research article on Consumer perspectives on work and her report to the group (transcribed below).</p> <p>I. Article on “The Work Project Survey: Consumer perspectives on work”</p> <ul style="list-style-type: none"> • I chose this article to share because it is similar to the CSN project in the way the data was collected (directly from the consumers), but also because the consumer comments in the discussion are similar to what I am finding when talking with clients. Certainly, there has been an expressed need for greater education and training. There has also been a lot of concern around losing benefits and working. Additionally, I find that when I talk with people they want to work, but more importantly they want a career that will change their life. • People with MI are significantly underrepresented in American workforce. Only 15% are competitively employed. • Research indicates that people with a psychiatric disability rate lack of employment resources as one of the greatest barriers to successful community integration. • Primary goal of the study was to assess the desire to work among people with sever mental illness. Also, to get a better understanding of work incentives and disincentives by soliciting information directly from the consumers. • Although it may be important and useful to understand the perceived barriers to employment, it may be equally important to help instill in consumers a realization of the benefits of work for increasing self-regard and control over one’s own life. (p. 66) <p>II. What types of things I am working on with people...</p> <ol style="list-style-type: none"> a) My caseload is now up to 25 people and I have two intakes scheduled. b) Two are employed. Two are enrolled in school. One is in the process of signing up for an oil burner technician course that begins in November. Another person has filled out an application to volunteer at CMMC and a couple of others are investigating the Senior Community Service Employment Program. <p>III. ESN</p> <ol style="list-style-type: none"> a) Region 5 ESN has been meeting monthly. Last month, we looked at the economy of the Lewiston/Auburn area; including top industries, occupations and employers. In Lewiston/Auburn, the top 5 employers are: <ol style="list-style-type: none"> 1. St. Mary’s Regional Medical Center 2. Central Maine Medical Center 3. TD Banknorth 4. Bates College 5. LL Bean Call center b) There was a case presentation done by the ACT Team Employment Services c) Discussed barriers to obtaining employment: transportation, clothing, and education d) We also spent time talking about top occupations, of which health care was at the top of the list and since the two largest employers in L/A are St. Mary’s and CMMC, we decided that it would be important to outreach these employers in upcoming months. We decided to look at what positions, with potential for growth, are available in the healthcare field and how we can assist people in obtaining those positions. However, we also recognized that many of those positions require training or education. Therefore, we wanted to explore ways that we could assist an individual in both attaining her longer term career goals yet still help her in the short term. As a result, there will be a representative from Manpower, at the September ESN. She will be discussing what they are looking in workers, available positions and ways they have accommodated workers with disabilities in the past. <p>The ESN meetings are held the third Wednesday of the month at the Lewiston CareerCenter from 1 to 3 pm, which provides access to teleconferencing equipment, enabling people in Franklin and Oxford Counties to join in without having</p>

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	to travel to Lewiston. We hope to invite other employers to future meetings.
X. Impact of Energy Costs	<p>Item covered earlier during the budget discussion.</p> <ul style="list-style-type: none"> • Are you considering increases in contracts for energy increases? A. We think the governor will take that into account.
XI. Wraparound Funds	<p>Don and Sharon covered this topic. Wraparound funds are flexible funds to help pay for services such as a security deposit. It is paid directly to the vendor. Until recently, these funds were embedded in some agencies, and OAMHS also handled some of them. We are now asking the CSNs how they want the funds managed within that CSN. Contracts were written for these funds with the agencies that currently handle them through the end of this year. We are seeking input on what to do going forward after that. OAMHS wants to cease handling these funds directly.</p> <p>Volunteers were asked to participate in the process. Cindy McPherson took down those who volunteered and will schedule the meeting.</p> <p>Can we recommend things be left as they are? A. No. OAMHS wants to get out of handling these funds.</p>
XII. Other	None.
XIII. Public Comment	There was no public comment.
XIV. Meeting Recap and Agenda for Next Meeting	<p>See action items above.</p> <p><u>October Meeting Agenda:</u> OAMHS Communication Budget/Legislative Update Consumer Council Update ESN Update Transportation Subcommittee (Tabled from this month) Wraparound Funds</p>