

**Community Service Network 6 Meeting – Cumberland County
Double Tree Hotel, Portland
November 17, 2006**

Minutes

Present: Simonne Maline, Amistad/Maine Warm Line; Peter Driscoll, Amistad; Richard Balsler, SMMC; Karen A. Evans, Transition Planning Group; Kitty Purington, MAMHS; Don Harden, Catholic Charities Maine; Sue Boisvert, Parkview AMC; Laura Gottfried, Leslie Brancato, Community Counseling Center; Joe Brannigan, Shalom House, Lois Skillings, Mid Coast Hospital; David S. Proffitt, Riverview Psychiatric Center; Marion Killian, Community Mediation Services; Mary Jane Krebs, Spring Harbor Hospital; Roger Wentworth, Sweetser; Burma Wilkins, Mercy Hospital; Lori Tully, Goodwill Industries NNE; Nancy Ives, VOA; Susan Percy, Creative Works Systems; Bonita Gouzie, Gouzie Assoc. Inc.; Phoebe Prosky, Freeport Counseling; Andrea Paul, Youth Alternatives; Catherine Snow, Portland Help Center; Kelli Star Fox, Transitions Counseling; Sherry L. Sabo, Counseling Services, Inc.; Kristen Fortier, Marie Gray, Mary Tagney, DHHS. Presenters from OAMHS: Ron Welch, Don Chamberlain, Leticia Huttman, Marya Faust, Carlton Lewis. Muskie School: Sherrie Winton, Janice Daley, George Newell.

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I. Welcome and Introductions	Carlton Lewis, Region I Team Leader, welcomed everyone to the meeting and introductions were made around the table. He briefly went over the 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).</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 the overarching theme of recovery, and the pivotal importance of vocational services.</p>
A. Seven Community Service Networks.	<ul style="list-style-type: none"> • The state is divided into 7 CSNs (see chart on website). • Each CSN provides 8 core services: Peer Services, Crisis Services, Community Support Services, Outpatient Services, Medication Management, Residential Services, Vocational Services, Inpatient Services. • 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. “Complex needs” means those that may be difficult to meet within normal services, i.e. co-occurring disorders, additional medical conditions, or physical disabilities. › 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. › Assess and identify resource gaps by geographical area and establish remedial measures and implementation

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		<p>timeframes.</p> <ul style="list-style-type: none"> › 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. 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. › Plan based on data and consumer outcomes. › 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. <p>Ron stated that this involves costs not covered by Medicaid and that are the burden of DHHS.</p> <p>Question: In two of the pieces here about the authority of the CSW and the full communication between community support and the hospital, why are some residential services that are 24/7 left out of the list? They are the ones who know immediately the med changes and crisis.</p> <p>Answer: We will try to cover that in a discussion of the 3rd cornerstone.</p>
	<p>B. Performance Requirements/ Enforcement through contracts.</p>	<ul style="list-style-type: none"> • Contract Amendments were mailed out to all providers with OAMHS contracts. The amendment must be executed by November 19, and requires operational protocols and a Memorandum of Understanding for each CSN. Ron explained that the Dept. may have a reputation for not enforcing its contracts, but the termination provisions outlined in the Plan for non-adherence must be carried out. • Legislation is expected to define CSNs, assure momentum, and provide consistency with managed care in whatever final form managed care takes. • 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 • Realignment of Services <p><u>Community Support Services:</u></p> <ul style="list-style-type: none"> › Each consumer will have a CSW to coordinate 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. › 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.

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		<ul style="list-style-type: none"> › 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 that the purpose is to help get the person out of the ER to appropriate services in the community, if possible. “Of course, the physician in the ER makes the determination as to hospitalization.” <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. › 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 mentioned that the Plan includes provisions for certain exceptions to this referral process, some of which may require OAMHS involvement.</p> <p>Question: If a community hospital does not have psych beds, must they be admitted to a medical bed? Answer: Not admitted, but go through the process.</p>
	<p>C. Permanent Housing with Flexible Services</p>	<p>Ron explained that services will be unbundled from housing under the Plan, and will be provided as needed, when needed to consumers in homes of their own choice.</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> <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. <p>Ron informed that each CSN will determine how many beds to retain and where they should be located in the network.</p> <ul style="list-style-type: none"> • For those beds remaining, long-term stay is not the goal. • Successful treatment and re-entry into community life is the goal. <p>Ron mentioned that he is learning from some providers that there may be some flexibility with PNMI that could meet with the Plan’s provisions. He expects some use of Section 17 or modified PNMI may be utilized. He acknowledged the need to explore how to achieve more independent living options and told the group that Don Chamberlain is convening a work group for this purpose.</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.

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	<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. “They are well along in designing the system.” • 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.
	<p>Vocational Services</p>	<p>Ron reiterated the vital importance of work in an individual’s recovery process.</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 is required under the fidelity standards of ACT, will be required to show evidence that, in fact, their entire focus is dedicated to work. <p>Question: Will there be discussion about obligations of agencies who do not have a CSW? Answer: Yes. Question: For the 4 Employment Specialists will they be state workers? Answer: No. Question: What will the focus be? Answer: They’re going to get embedded in community agencies. The focus will be on areas where we have the greatest caseload and waiting list with VR. There will be a focus on mental health agencies.</p>
<p>III. Consumer Council and Consumer and Family Representation</p>	<p>Leticia Huttman, Director of the Office of Consumer Affairs:</p> <p>Development of Statewide Consumer Council System</p> <p>Leticia discussed the importance of the consumer system developing outside of the OAMHS. To this end, the process is consumer led, with OAMHS providing support, only as requested. 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.</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 	

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	<ul style="list-style-type: none"> • 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> <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 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 Some examples are as follows: Participate in licensing review process or in conducting agency consumer interviews. • 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>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 Leticia mentioned that the Council will not just have a relationship with DHHS, but with other departments/entities as well, such as Department of Labor, Department of Education, and Community Action Programs. • 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. The Council will review Consent Decree quarterly reports, it is expected that vocational services will probably be high on their agenda for review. The Council will give ideas and suggestions for improvement. <p>Consumer and Family Participation in Community Service Networks</p> <p>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>

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	<p>Question: Reps from peer centers, we have them in our contract. Should we have them represented? Answer: The way that it was represented--social clubs and peer centers. There've been additional suggestions like clubhouses. Answer: One of the things that will be happening, I think these CSNs will be an evolving process and we will be learning more and more about who are the players and who is missing.</p>
<p>IV. Community Service Networks: Implementation Plan, Memorandum of Understanding, and Operational Protocols</p>	<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 (may push this date back to January, Don said). Participants from each CSN: consumer, community support services provider, crisis services provider, hospital provider, and vocational provider. <p>State-Wide Policy Council 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>Question: How will assessing compliance with no rejects be done? Answer: We're looking for that in the CSN. Question: Will that be the only mechanism to assess? Answer: We're looking at issues like what happens in the rapid response, what are the issues where people get stuck. We're looking at issues area by area. For example, there was a bed, there wasn't a bed, and what else is going on in the CSN. The data comes from the local CSN. Question: What kind of data will the Department be assessing for compliance with the no reject policy? Answer: People getting served in their local area, how much activity is going on and why or why not. It might be helpful to reframe “no reject” to access to service. When someone is not being served, what is happening to cause this? What issues surround this? If a person is having difficulty in getting served in hospitals and it's a bed issue, CSN will look at this issue. Some people were in beds in Fort Fairfield from everywhere outside of that region. Question: So the data could be people in beds outside of regions?</p>

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	<p>Answer: Another example might be not having a CSW.</p> <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 • 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 guiding principle is a statement of why CSNs really exist, 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 core of what we do is related to consumers," Don added. • Providers and systems practice collaboration across disciplines, including peer disciplines, and health specialties. <p>Question: We have an integrated system of care and you're focusing on mental health, what about substance abuse services? Answer: Our focus is on the mental health consumer. That doesn't mean in the future that we can't make the tent broader. But we're not focused on substance abuse without a mental health issue and who doesn't meet the chapter 17 requirements Answer: The commissioner has an interest in looking at this as well. This could be something that we address and look at in the future. Question: And child mental health? Answer: Children are outside the sphere of our focus. It may be that those things will be layered in. Question: But we are including co-occurring disorders? We should address issues that they face. Answer: Yes.</p> <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

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	<p>Question: It would be the ISP that would define the need? Answer: Yes. We recognize the difficulties of our EIS system, but it is the place to grab the unmet need and document it.</p> <p>Agreement and Responsibilities 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. • 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. • 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. • 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. Don said OAMHS is asking the Attorney General for clarification of confidentiality issues involved in this. <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><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. <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.

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	<ul style="list-style-type: none"> • 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><i>Chairperson:</i></p> <ul style="list-style-type: none"> • Senior staff member of OAMHS. <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 <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. <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>Don clarified that committees do not operate outside the CSN.</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>Question: Could you say more about the 24-hour access to records?</p>

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	<p>Answer: We are looking for the ability of the crisis program to have access to the records by calling the CSW's organization to get those records. It could be electronic, paper copy, and so on. Any way we can get the information to the folks is appropriate. We don't oppose any universal situations and recognize that some agencies are there already, and some are not.</p> <p>Answer: We're looking at the ISP, crisis plan, prescriber's name and address, the principle items.</p> <p>Question: We already make information available to the crisis provider during regular business office so I'm not sure why language says we need to have 24-hour access when we're already providing it.</p> <p>Answer: If they already have it, then that's fine. But if there is a crisis at midnight, they have to have access to it.</p> <p>Question: If there is access to the ISP and crisis plan would that make up for a person not being available?</p> <p>Answer: In most cases. It may not always be a CSW either.</p> <p>Question: Anyone would have to be compensated. I'm trying to think if you're paying someone for additional 8 hour days year round... will that money come from the ordinary budget to support clients?</p> <p>Answer: This is the issue that got raised with the plaintiff and the court master, it doesn't happen enough. The information isn't available for the crisis worker during off business hours so it's part of the plan. The idea isn't that the CSW has to take care of the entire crisis but they need to be at the front end of the conversation. The crisis program can have enough information to intervene adequately with sufficient information.</p> <p>Question: Some of the things that you raised around no reject come with...especially if you have consumers who may not be on Medicaid, it's hard to agree to something when there are costs associated and no guarantee of reimbursement.</p> <p>Answer: The no reject is more of a planning process of the fact that there isn't this service available so we need to develop problem solving that feeds into the budget request then working toward a solution</p> <p>Question: If individual providers sign this and they don't have the service available, they won't be seen as non-compliant?</p> <p>Answer: As long as it all makes sense, yes. We're taking about it as what is appropriate and what makes sense. It's not so much about whether to accept the person or not, but what additional service is needed to serve this person.</p> <p>Answer: We know some agencies can do it and are doing it now, some are not. Our goal is to get closer.</p> <p>Answer: Marya will provide you with a doable process for collecting data.</p> <p>Question: I'm wondering how would the consumer be made aware and informed that they would have access to this form of problem solving? Particularly in the event of non-compliance. Maybe mediation should be considered?</p> <p>Answer: I think you're being here helps us move toward awareness of your availability to get CSW familiar with what your services are and how best to access it.</p> <p>Question: A representative to speak for the organization, what does that mean? You want people to make legal commitments. Some of the questions that CSN get at will be resource allocations and so on. Some of the people who represent organizations aren't here today. Looking ahead, what does it mean to speak for the organization?</p> <p>Answer: Maybe we need to strengthen it more. At no time we'll be asking a CSN to make a decision or recommendation that they haven't had prior notice. So they might talk about it today and vote on it the next meeting. On the other hand, you wouldn't want to agree to things for another person and then have it overturned later.</p> <p>Question: A question was raised about attendance.</p> <p>Question: So if you're on vacation or in the hospital it doesn't matter?</p> <p>Answer: The dilemma is making sure people are here; but if you're deathly ill, one could understand that. We have to be looking at how that impacts attendance.</p> <p>Question: What about situations where services are being offered across county lines? Like crisis services for York county? In section 7, it talks about contracted services by network</p> <p>Answer: We will come back to that. We need some help on elaborating on that. We had some discussions about Brunswick. The network needs to talk about the access and flow of clients across the mental health system, for the most part you have those providers in the room and you ought to be in the CSN that makes the most sense in that regard. If Brunswick is one of those cases that we thought would be in the mid-coast, and we're rethinking that as to what makes sense. It's where your service</p>

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	<p>providers are--compared with others. We also talked about Bridgton. That one we've put in CSN 5.</p> <p>Question: On the rep piece, I'm hoping that something can be revisited in terms of designees. I think that this is important if you need the person to make a commitment on behalf of the agency, there is a legal piece and an authority to make those commitments. I have other meetings that are required unless you're dead. This is a really an important undertaking and an important population. It's also narrow. We're talking about adults that receive chapter 17 services. At the CEO there are many things that we have to be at, having a commitment and having a voice and having a designee would help keep it moving forward in a positive way and I hope that will be revisited</p> <p>Answer: That will be up in the parking lot. If there is something more concrete you'd like to include in the operational protocol, you can document that and also send specific suggestions in language to Muskie. Our intent is that it's the high enough level for the person to commit to the organization, and for them to not be committing to things that I couldn't support as the CEO</p> <p>Question: On notice on meetings, part of having consistent representation is to have a consistent regular time.</p> <p>Answer: A set date each month would be helpful</p> <p>Question: CSN decides on issues to be voted on, isn't it possible that something could come from the statewide group to weigh in on? I get the impression that you might tell us we're going to vote on something?</p> <p>Answer: You could make a decision on the consensus of the group</p> <p>Question: You may ask a small group of people who are not members to sit in on the committee?</p> <p>Answer: Absolutely.</p> <p>Question: If you have a desired rep depending on the topic, would we bring in other sources?</p> <p>Answer: I don't see why not. Lets add to the parking lot. This is the beginning of meeting the requirement but we can make amendments and adjustments as we go on.</p> <p>Question: If there was a change could it be just for one area or if Cumberland county wants to change an operational protocol could they do this if isn't seen as the same need in Aroostook County?</p> <p>Answer: We're open to some CSNs being locally driven, but we don't want to end up with everyone operating differently. We'd like to have the opportunity to have them be the same across the board.</p> <p>Answer: You haven't had the benefit of hearing what other CSNs have talked about but you will be able to see this information. I would advocate for our dates right now, if we could agree to one statewide, then go back over time as you see fit and modify your protocols.</p> <p>Question: Time for public comments, is it a public open meeting where anyone could show up?</p> <p>Answer: That was the intent but we didn't think of having one big open meeting. But there may be a need for a non-member to bring an issue and they should have that opportunity. The only people we're planning to invite are the people here.</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.</p> <ul style="list-style-type: none"> • 34 standards were negotiated with the Court, the Plaintiffs, and OAMHS. They will not change. They are grouped under 10 categories. • 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. • Anyone who was a patient at AMHI on or after January 1, 1988, is a class member. This provision extends to Riverview, and each new admission becomes a part of the pool of class members. The number continues to grow.

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	<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>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: A question was raised about class members. Answer: We tried to answer some parts of that. The settlement agreement originally talked about class members than we talked to the court and the law court said your system is just not based on class members but also the whole array of people needing services. There are instances, however, in which the court let us look at class members to measure how the mental health system is doing. We can do some more explanation of that, but with the data we tried to be clear if we were talking about a class member or the broader population. Question: How was the data collected Answer: Our utilization nurses do a chart review Question: Utilization reviews... do they look at the hospital and the CSW?</p>

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	<p>Answer: Just the hospital. Question: So how would you look at this data and include DOL? Answer: We have an MOU with DOL that we'll be sharing with the group. Part of the agreement is that if someone is starting in the system on one side, they don't need to repeat something on the other side. Question: Going back to the standards I didn't see any for peer support. Answer: Interestingly, when we signed the settlement agreement recovery wasn't even a concept. We did include some on recovery, not on peer services, but clearly included expectations and commitments related to peer services. Answer: We talked earlier about things like "no reject", what other things do you think are important that we should be including? There are some things that we want to measure and collect that wouldn't burden us or you-- that we might like to add. We should think about what those things are.</p> <p>Marya also discussed other items in the packet and notebook as follows:</p> <p>CSN Related Components Matrix</p> <ul style="list-style-type: none"> • Shows tasks and timelines related to the CSNs. • Excerpted from the overall Consent Decree Plan matrix attached to the November 2006 Quarterly Report. (Included in the notebook at Tab 2.) • Provides a quick reference to what needs to be done and when. <p>Contracted Services by Network Matrix</p> <ul style="list-style-type: none"> • Another attachment to the quarterly report, included in the notebook (Tab 7). • Starting point for identifying what services are provided by providers in each CSN area. • OAMHS will continue gathering information to update this matrix through RSVP forms each member received, as well as an electronic survey Muskie will develop and send out to all members to get more detailed geographic information and enable actual mapping of services. • This information is critical in identifying gaps and making remedial recommendations, as well as supporting budget requests to the Legislature. <p>OAMHS Website: Consent Decree</p> <ul style="list-style-type: none"> • All Consent Decree documents and quarterly reports are posted in electronic form. • Will add a Community Support Network section to post minutes and other documents.
Questions and Answers	<p>Other general Questions/Answers:</p> <p>Question: I'm from a community hospital so mental health is less than a tenth of what we do. I'm not familiar with everyone at the table and where they fit in the organizational chart. Could we have an organizational chart of the OAMHS and some of the people associated with CSNs like someone from the consumer council system? Answer: We can do that for you. Question: There are some threshold questions. How do we communicate in a CSN around people we serve and the whole confidentiality thing. When these things should happen, I'm not clear on? Answer: Those kinds of issues need to receive the priority of this network Question: Coordination between crisis, residential and ICM is another big one. Question: We should discuss who is a member of the CSN. If we're trying to look at continuity of care, it should include more than just those contracting for services</p>

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	<p>Question: It's a fairly complicated task to figure out what's local and what overshadows other groups.</p> <p>Question: I think that's important to get going. 24 access—are you going to change the crisis plan? I need to talk to the crisis program to see how that will work and not sure how much of that is CSN talk.</p> <p>Answer: Once you give us your six people to the council, then we'll form the group.</p>
VI. Parking Lot Items	<ul style="list-style-type: none"> • Absence of 24/7 residential staff at discharge/treatment planning meetings? • Discussion regarding consumers who do not have a CSW and how this will effect them. • Why are family representatives only being sent from NAMI? • How will peers be included from and within agencies for representation on CSN? • If a provider serves consumers from a different CSN and their actual agency is in another area, could they be represented at the CSN area where the consumers are coming? • Why are the statewide committee members not made up of the same 8 service areas under the seven community service networks (pg 3 of hand-out)? • How will assessing compliance with “no reject” policy be done? • What kind of data will DHHS be assessing to determine compliance? • If integrated system of care, how about including substance abuse services? • What are we looking for when needing 24 access to records? • If a person is on call 8 hours a day, year round, how would that cost be included in the budget? • If there is a cost attached to a service that is not included in the budget, how would an agency be compensated for the additional service? • How are “non-categoricals” and other non-reimbursable insurances being dealt with by CSN for those who meet eligibility for section 17? • How can representatives under membership who are not the CEO for the organizations make a final decision? • How is representation accomplished where services cross CSN areas? How can we do this effectively? • Will there be a set date each month when CSN meetings will take place versus notifying people one week in advance? • Will other meetings fold into the CSN? • Can members of ad hoc committees be members who are not participants of the CSN? Who can these be? • Public comment? What does this mean? Who can bring comment to the meeting? • There still seems to be some confusion regarding “class members” and the mental health community as a whole. How should we look at this? • How does OAMHS and DOL talk to each other to resolve vocational issues? • No standards for Peer Supports?
VII. Next Steps	<ul style="list-style-type: none"> • The drafts and protocols will be reviewed at the next meeting. • Next Meeting: December 15, 2006 at 9:00 AM
VIII. Agenda for December Meeting	<ul style="list-style-type: none"> • MOU • Operational Protocols • Service Matrix – Mapping • Ongoing schedule of meetings