

**Community Service Network 6 Meeting
DHHS Office, 161 Marginal Way, Portland, Maine
January 22, 2007**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • David Bouthilette, AIN • Peter Driscoll, Amistad • Carolyn Holbrook, Casco Bay Mental Health • Don Harden, Catholic Charities • Laura Gottfried, Community Counseling Center • Susan Percy, Creative Work Systems • Michael Pescatello, First Atlantic/Hawthorne House • Glenn Shelton, Goodwill Industries • Michelle Belhumeur, Gorham House • Sally Cloutier, Ingraham | <ul style="list-style-type: none"> • Burma Wilkins, Mercy Hospital • Lois Skillings, Mid Coast Hospital • Richard Balser, MMC Voc Services • Jennifer Tingley Prince, NOE • Susan Boisvert, Parkview Adventist Medical Center • Dana Manel, Possibilities Counseling • Michael Faust, PSL-Services • John Bradley, Preble Street • Jamie Morrill, Riverview Psychiatric Center • Joe Brannigan, Shalom House Inc. | <ul style="list-style-type: none"> • Mary Jane Krebs, Spring Harbor • Catherine Snow, Spurwink/Portland Help Center • Roger Wentworth, Sweetser • Charlotte Simpson, Sweetser Peer Center • Christine Holler, Transition Planning Group • Karen Evans, Transition Planning Group • Nancy Ives, VOA • Andrea Paul, Youth Alternatives • Holly Hathaway, Smart Child & Family Service |
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Members Absent:

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| <ul style="list-style-type: none"> • Sherry Sabo, CSI • Phoebe Prosky, Freeport Counseling (excused) • Food Addiction Chemical Dependency Consultants | <ul style="list-style-type: none"> • Healthy Perspectives • Gouzie Associates • New England Rehab Hospital of Portland | <ul style="list-style-type: none"> • Kelli Star Fox, Transitions Counseling (excused) • Regional Transportation Program, Inc. • Work Opportunities Unlimited |
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Others present:

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| <ul style="list-style-type: none"> • Kirk Little, Ingraham • Tom Dunne, Ingraham • Christine McKenzie, MMC Voc Services | <ul style="list-style-type: none"> • Chuck Tingley, NOE • Stephen Habeeb, PSL-Services | <ul style="list-style-type: none"> • David Proffitt, Riverview Psychiatric Center • Cindy Fagan, Sweetser |
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Staff present: DHHS/OAMHS: Ron Welch, Marya Faust, Don Chamberlain, Leticia Huttman, Carlton Lewis. Muskie School: Elaine Ecker, Janice Daley, Jacinda Dionne.

Agenda Item	Presentation, Discussion, Questions
I. Welcome and Introductions	Carlton Lewis welcomed everyone to the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes were approved as written.
III. Meeting Schedule	Carlton noted that ongoing meetings will be held on the 3 rd Friday of the month, beginning February 16.
IV. CSN Participation	Don Chamberlain reported that most members have returned signed contract amendments and CSN MOU, but many hospital provider agreements have not been returned. Documents have not yet been returned by First Atlantic (Hawthorne House).
V. Budget and Legislative Update	<p>Ron Welch reported on some budget and legislative updates.</p> <p>Supplemental Budget Because managed care did not happen and the \$10.4M anticipated savings will not be realized, that amount has been submitted in the Governor's supplemental budget, pending passage by the legislature.</p>

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	<p>Biennial Budget (07-08, 08-09) Issues</p> <ul style="list-style-type: none"> • <u>Administrative Services Organization (ASO)</u>: An ASO will perform (if approved by the Legislature) the following administrative services: 1) enrollment, 2) prior authorization for some services, and 3) utilization review for some services. The ASO would contract with the Department, not providers, to receive payment for these administrative services with no risk assumed by the ASO. First-year Department-wide savings to be \$5M, second year \$6.5M. These savings come from Maine Care seed funds, resulting in a \$2 Federal match loss for every \$1 MaineCare saves (does not spend). The total biennial budget impact, therefore, is \$15M for the first year and \$19.5 for the second year. The Request for Proposal (RFP) is currently being drafted. • <u>Rate standardization--community support services</u>: Meetings are underway (with DHHS and members of the Maine Association of Mental Health Services) to determine standardized rates for certain community support services. (Historically, providers have individually negotiated rates with DHHS, which accounts for the current variety of rates.) The rate standardization must result in a savings of \$10M in each year of the biennial budget (\$4M from adult, \$4M from children's, \$2M from "MAP" private practitioners). The savings will come back to the Department for reinvestment in community programs, and CSNs will have opportunities to discuss and make recommendations on the reinvestments. The savings are MaineCare seed funds, so the Federal match loss (described above) applies. • <u>Reassignment of ICM positions</u>: If the legislature passes the proposed budget, 30 positions now held by OAMHS Intensive Case Managers (ICMs), will be transferred through attrition (retirement, job changes, etc.) to the Office of Integration Access and Support (OIAS). The OIAS, which handles Temporary Assistance to Needy Families (TANF), food stamps, etc., is seriously understaffed and under Federal scrutiny for delays. As ICM vacancies do occur, OAMHS may relocate remaining positions to best cover service needs. <ul style="list-style-type: none"> ○ A member noted that the ICMs are "providers of choice" for those not covered by MaineCare, so that type of service will be lost from the system. <p>Legislation/Statutes</p> <ul style="list-style-type: none"> • Statute clarifying CSNs. (Draft version provided at "Tab 8" in Members' Reference Materials binder.) • "Clean up" of language on Involuntary Commitment statute. <p>ACTION: OAMHS to send out legislation to CSN members when available.</p>
<p>VI. Review Data on Contract Performance and Consent Decree Requirements</p>	<p>Don Chamberlain provided an overview of the contract reviews conducted in Region II (CSNs 3, 4, and 5). The Region I (CSNs 6 & 7) reviews are currently scheduled for February 26th and 27th</p> <p>Contract reviews conducted so far revealed the following themes:</p> <ul style="list-style-type: none"> • Notifying consumers and families of NAMI-ME services: Though most agencies report they do inform consumers of these services, most do not have actual written policies and procedures in place. • 24/7 access to records: Some providers already do it, some in the process, and some not at all. • Community support workers at treatment and discharge meetings: Agencies report that they attend when they know, but note difficulties/breakdown in communication regarding hospitalizations. OAMHS will be working with crisis providers, community support agencies, and hospitals to improve communication for better continuity of care. • Mechanism needed for consistent reporting on compliance with requirement that community support service providers meet with consumers within 4 days of discharge from inpatient care. • More information needed regarding how we deal with the "non-categorical populations."
<p>VII. Policy Directive from OAMHS regarding information sharing</p>	<p>Ron Welch explained that this is still under review in the Attorney General's Office. A member voiced concern that this may need a broader consumer voice than the select groups already involved.</p>

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	<ul style="list-style-type: none"> • Nurse comes to unit five times/week • Treatment provided depends on what needs are (i.e. stabilization, connecting with community resources, providers, etc.) • Connection with Peer Support and Recovery Center • Average length of stay for FY2006 was 4.5 days • Admission criteria is 18 years or older • Average daily census: 74% • 200 individuals per year • Discharge locations: 200 admissions FY2005-2006; 73% discharged home; 4% went to psychiatric hospital • Hospital stepdowns: work with Spring Harbor and Mid-Coast Hospital • Occupancy has remained at about 75% over three years • Wide range of diagnoses of individuals coming to crisis unit <p>Sweetser Peer Center</p> <p>Charlotte Simpson provided the following information regarding Sweetser's Peer Center:</p> <ul style="list-style-type: none"> • 3 peer beds • Staffed by peers, volunteers, 1 full-time employee; volunteers and staff have training for peer support model • 52% occupancy • Average length of stay is 4.2 days • Primarily home discharge • Source of referrals: word-of-mouth, referrals, emergency dept. • Individuals must have crisis plan in place for respite bed • Does not operate on medical model like crisis unit. Some individuals go to peer center rather than crisis unit because they feel safer, less stigmatized, and do not favor the medical model of treatment <p>Ingraham Broadway Crossings</p> <ul style="list-style-type: none"> • 8 beds • 11 staff (9 of these are full-time); most are MHRT I certified; 2 are master's-level • 385 clients served/year • Average length of stay is 3-5 days • Model of treatment is a blend of the medical and recovery models • All individuals that come to the center have had a crisis assessment; step-downs arranged through crisis services. • Full range of diagnoses (2/3 have mood disorders, some psychotic disorders, co-occurring Axis II disorders) • Occupancy rate: mid 70s, can vary <p>Other Comments/Observations:</p> <ul style="list-style-type: none"> • Average length of stay is similar across CSUs. • Need consistent data set, need to identify gaps. • Need data regarding number of people who go from crisis bed to observation bed. • Utilization rates are similar across state. What are the choices (increasing beds in CSUs, more observation beds, etc.)? • What is the outcome of these services? This is an important question – need these data before determining what changes to make. • What are the reasons people are not accepted to CSU? This is important question to answer to identify gaps.

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	<p>ACTION: Members will make recommendations around crisis stabilization services in CSN 6 at the February meeting.</p> <p>ACTION: In response to the many additional data requests made at this and other CSN meetings in January, OAMHS will compile these requests and send out to all CSU providers and report on the results at the February meetings, where possible.</p>																				
<p>X. Statewide Policy Council</p>	<p>Ron Welch reported that OAMHS has taken into consideration all ideas and input from the last CSN round and has decided to create a council of 14 members. He referred everyone to the memo in their packet that lists the service categories of representation. One CSN member recommended that a representative for homeless providers also be included. It was agreed that a homeless provider would be added as a representative, bringing the total number of council members to 15. Ron asked everyone to please nominate themselves or someone else to fill one of these categories and send those nominations to Elaine Ecker at the Muskie School by Feb. 1 (later extended to Feb. 9), eecker@usm.maine.edu.</p> <p>ACTION: OAMHS will select representatives to the Council, notify all CSN members, and convene meetings in March.</p>																				
<p>XI. Adequate geographical coverage and resource gaps</p>	<p>Marya Faust distributed a chart showing Maine’s population and the numbers of people with Serious Mental Illness (SMI), broken down by counties and CSN. The numbers are based on the 2000 US Census and the 5.4% rate the federal government uses to establish the number of adults (18 years and over) with an SMI. Using these calculations:</p> <ul style="list-style-type: none"> • 52,579 adults in Maine with SMI. • 10,997 in CSN 6 (Cumberland). <p>Marya Faust stated that as part of the Consent Decree, OAMHS is assessing resources and services in each CSN to determine whether they provide adequate geographical coverage. A planned, on-going review of eight types of services (Peer, Crisis, Community Support, Outpatient, Medication Management, Residential, Vocational, and Inpatient) will be conducted and input and discussion from the CSNs is needed to determine how to plan resources, identify gaps, and make decisions regarding new resources in each of these eight service areas. Marya emphasized that examining resources and service gaps cannot be a “one-shot deal,” but rather a continual, on-going process.</p> <p>OAMHS will present and distribute data regarding services, funding, utilization, and other information at monthly CSN meetings and will ask for recommendations and material at the following meeting, according to the following schedule:</p> <table border="1" data-bbox="422 1057 1759 1203"> <thead> <tr> <th>Month</th> <th>Service</th> <th>Month</th> <th>Service</th> </tr> </thead> <tbody> <tr> <td>January</td> <td>Crisis Stabilization, Peer Services</td> <td>May</td> <td>Residential Services</td> </tr> <tr> <td>February</td> <td>Other Crisis Services</td> <td>June</td> <td>Vocational Services</td> </tr> <tr> <td>March</td> <td>Community Support Services (ACT, ICI, CI)</td> <td>July</td> <td>Inpatient Services</td> </tr> <tr> <td>April</td> <td>Outpatient, Medication Management</td> <td></td> <td></td> </tr> </tbody> </table> <p>A few members of the group expressed concern regarding the intended outcome of these reviews and how the information gathered will be utilized. The primary outcome is to improve continuity of care. Marya noted that it is not a “perfect process” and that some of it will “develop as we go.”</p> <p>Review of Peer Services</p> <p>Leticia Huttman provided a brief overview of the geographic distribution of funding for peer support programs from OAMHS. Peer support programming refers to a variety of programs from social clubs and peer centers to warm lines to networking organizations. She distributed a handout, highlighting total peer support funding for each CSN, funding for statewide peer support programs, and funding for</p>	Month	Service	Month	Service	January	Crisis Stabilization, Peer Services	May	Residential Services	February	Other Crisis Services	June	Vocational Services	March	Community Support Services (ACT, ICI, CI)	July	Inpatient Services	April	Outpatient, Medication Management		
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	<p>peer centers and social clubs for each CSN.</p> <ul style="list-style-type: none"> • Peer Support funding by CSN totals \$1,314,832—of which \$555,118 covers CSN 6 for peer center/social clubs, peer support in the Emergency Department, and other peer services. • Using the federal rate of 5.4% of population having SMI (10,997 in CSN 6), total per person peer support funding is \$50, representing the highest among the seven CSNs. • The funding level for peer centers/social clubs in CSN 6 is \$37 per person, again the highest among the CSNs. <p>Leticia stated that there will be more discussion of peer support funding at next month's meeting and questions to answer include what kind of data missing and what does the CSN see as useful data to add? Also, do we have an appropriate array of resources and how do we, as a group, continue to build the best system?</p> <p>ACTION: Members will make recommendations around peer services in CSN 6 at the February meeting.</p>
<p>XII. Procedures and Protocols for Inpatient Admissions</p>	<p>David Proffitt led a discussion on the protocols for inpatient admissions and on how Riverview, Dorothea Dix, Spring Harbor, Acadia and the community hospitals are implementing the admissions process.</p> <ul style="list-style-type: none"> • Dorothea Dix and Acadia developed primary screen/referral. • Spring Harbor will be primary referral source for Riverview. • Does not anticipate any dramatic changes in patients seen in either hospital. • Addresses those seeking to bypass other levels of care. • Spring Harbor is gatekeeper to Riverview and Acadia is gatekeeper to Dorothea Dix. <p>Question: Doesn't Crisis decide where someone should go? Answer: Crisis decides that they need hospitalization, not where. Further discussion was tabled until next month's meeting.</p>
<p>XIII. Update on vocational initiatives</p>	<p>Due to time constraints, this item was tabled for the next meeting.</p>
<p>XIV. Public Comment</p>	<p>None.</p>
<p>XV. Plan for February meetings</p>	<p>The next meeting is scheduled for Friday Feb. 16th.</p>
<p>XVI. Agenda Items</p>	<ul style="list-style-type: none"> • Peer Services, Part II • Crisis Stabilization Units, Part II • Crisis Services Review • PL 192 Draft Report