

**Community Service Network 6 Meeting
DoubleTree Hotel, Portland, Maine
March 16, 2007**

DRAFT Minutes

Members Present:

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| <ul style="list-style-type: none"> • David Bouthilette, AIN • Peter Driscoll, Amistad • Don Harden, Catholic Charities • Kitty Purington, Community Counseling Center • Lois Jones, CSI • Dan Jackson, First Atlantic/Hawthorne House • Phoebe Prosky, Freeport Counseling • Glenn Shelton, Goodwill Industries • Michelle Belhumeur, Gorham House • Joe Everett, Ingraham | <ul style="list-style-type: none"> • Burma Wilkins, Mercy Hospital • Pam Dyer, Mid Coast Hospital • Richard Balsler, MMC Voc Services • Tracie Morgan, NAMI-ME Families • Dana Manel, Possibilities Counseling • Michael Faust, PSL-Services • Donna Yellen, Preble Street • Jennifer Tingley Prince, NOE • David Proffitt, Riverview Psychiatric Center | <ul style="list-style-type: none"> • Joe Brannigan, Shalom House Inc. • Holly Hathaway, Smart Child & Family Service • Mary Jane Krebs, Spring Harbor/MMC • Roger Wentworth, Sweetser • Christine Holler, Transition Planning Group • Karen Evans, Transition Planning Group • Kelli Star Fox, Transitions Counseling • Wayne Barter, VOA • Julia Riley, Youth Alternatives |
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Members Absent:

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| <ul style="list-style-type: none"> • Casco Bay Mental Health • Creative Work Systems • Food Addiction/Chem Dependency Consultants • Gouzie Associates | <ul style="list-style-type: none"> • Healthy Perspectives • New England Rehab Hospital of Portland • Parkview Adventist Medical Center • Regional Transportation Program, Inc. | <ul style="list-style-type: none"> • Spurwink/Portland Help Center • Sweetser Peer Center (excused) • Work Opportunities Unlimited • Youth Alternatives |
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Alternates/Others present:

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| <ul style="list-style-type: none"> • Susan Seeley, AIN • Jane Caron, Goodwill • Kirk Little, Ingraham | <ul style="list-style-type: none"> • Christine McKenzie, MMC Voc Services • Sharon Greenleaf, NOE | <ul style="list-style-type: none"> • Cindy Fagan, Sweetser • Thomas Lusth, Sweetser |
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Staff present: DHHS/OAMHS: Don Chamberlain, Carlton Lewis. Muskie School: Elaine Ecker, Melissa Padgett.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the February 16 meeting were approved as written.
III. Crisis Services/Crisis Stabilization Units	<p>Sweetser Crisis Stabilization Units (CSU) Roger Wentworth reviewed Sweetser's CSU data:</p> <ul style="list-style-type: none"> • 71% occupancy rate (July 05 – June 06) • 42 out of 91 days at 100% occupancy (April, May, June 2006). Haven't historically tracked how many days full or number turned away. Tracking both going forward. • 202 admissions; 72 unduplicated. (July 1, 2005 to June 30, 2006) • Average length of stay: 4.5 days • 42% admissions from CSN 6; 50% from CSN 4. • 24% assessed in home; 30% in ED; 40% in crisis office. • 8 of 202 admissions went to inpatient psych unit; 96% did not need to go on to higher level of care.

Agenda Item	Presentation, Discussion
	<ul style="list-style-type: none"> • Staffing: 2 MHRT-1 (or above) on 24/7; MHRT/C Clinical supervisor; psychiatrist and nurse come in 5 days a week, and available for consultation. • Working to broaden admission criteria to be able to take some not accepted in the past. • Very interested in adding the “living room.” Have space available in the Peer Center. • Close relationship with Mid-Coast Hospital: often do step-downs; meet monthly. <p>Ingraham Broadway Crossings CSU Joe Everett reviewed Ingraham’s CSU data:</p> <ul style="list-style-type: none"> • 34 out of 91 days at 100% occupancy (April, May, June 2006). • 419 admissions; 300 unduplicated. (July 1, 2005 to June 30, 2006) • Average length of stay: 5 days • 412 admissions from Cumberland County. • 38 of 419 admissions went to inpatient psych unit. • Staffing: 2 residential technicians on each shift; psychiatrist does rounds M-F, weekend coverage. <p>Looking at ways to make admissions easier (more “user-friendly”) and increase step-downs.Crisis Services</p> <p>Crisis Services <u>Sweetser Crisis - Brunswick</u></p> <ul style="list-style-type: none"> • Serves northern Cumberland County (CSN 6) and Lincoln/Sagadahoc Counties (CSN 4). • Connected with Mid-Coast, Parkview, Miles, and St. Andrew’s hospitals. Have appropriate credentials for ER. • Endeavor not to use hospitals, and be as community-based as possible. • Developed a crisis assessment suite in Bath, with comfortable waiting room for families and children. • Focus on getting out to clients’ homes—numbers increasing slowly and steadily. ER number decreasing slowly and steadily. • Crisis team is staffed with goal to respond within 30 minutes of call. <p><u>Ingraham Crisis</u></p> <ul style="list-style-type: none"> • 31,000+ calls in 2006 • Have electronic record availability • Calls can lead to mobile assessment, then can lead to CSU. • Have some walk-ins since located in downtown Portland. <p><u>NOE</u></p> <ul style="list-style-type: none"> • Operates their own 24/7 crisis line, in keeping with their “quick access policy.” • Resolve crisis over the phone, if possible. Psychiatric back-up available. • Most calls are not crisis, rather people asking for services. • 80% resolved over the phone. <p>Member question:</p> <ul style="list-style-type: none"> • How can a state-contracted agency [NOE] not be a part of the state crisis program? <p>Several crisis and hospital providers described their current procedures and working relationships:</p> <ul style="list-style-type: none"> • MMC ER: First cleared medically, then psychiatrist, assess for level of care. If need inpatient, Spring Harbor; if need CSU, Ingraham.

Agenda Item	Presentation, Discussion
	<ul style="list-style-type: none"> • Mid-Coast Hospital: calls Sweetser Crisis; also have their own psychiatrist doing consults and may start meds. • Mercy Hospital: No psych unit or psychiatrist on staff. Have contracted with private social worker(s) and psychiatrist (on call). Social worker helps make assessment: if safe to go, discharge plan is made; if not safe to go, inpatient bed sought. If ED physician is comfortable with psychiatrist's recommendation, then start meds in the ED. Mercy does not contact crisis provider, since they discontinued working with Ingraham over 10 years ago. (Ingraham not "credentialed" at Mercy since 1997.) Mercy recently had someone in ED for 30 hours, attempting to find an available inpatient bed. <p>Mercy's procedures and policies and recent situation prompted discussion at several points in the meeting, including:</p> <ul style="list-style-type: none"> • Why didn't Mercy send person immediately to MMC? "EMTALA" (law) prevents transfer to another ED—patient appearing in ED must be treated unless those services are unavailable. • Who decides level of care?—that's what crisis is for. • Seems like having crisis program involvement would solve most of this situation. • Other places have solved the credentialing problems—Mercy should have solved this in 10 years. • Ingraham would like open feedback if there's any concern about their services. A meeting with Mercy would need two things to work: 1) facilitator, and 2) goal of having more streamlined, less costly process. • It seems evident from the conversation that work needs to be done in this CSN to better align who's doing what with the goals of continuity of care and appropriate levels of care. <p>Don suggested making this matter a focus for discussion at the Region I CLASS/Hospital Initiative meeting and reporting back to CSN.</p>
IV. Peer Services	<p>The group decided to explore adding the "living room" to the crisis/peer services in this CSN and formed a subcommittee, chaired by Peter Driscoll of Amistad. Members will meet and report back at the next CSN meeting.</p> <p>Members received a handout on "Peer Support 101," a 3-hour class presented by the Office of Consumer Affairs and offered to anyone interested in learning more about peer support (also a requirement for participation in the Peer Support Specialists Certification). Several classes are scheduled for March and April (listed on handout). Providers may request a shortened 1-hour version as well.</p> <p>Karen Evans announced new support/education groups sponsored by OAMHS and Maine Medical Center Vocational Department, meeting weekly on Sundays (1-2:30 pm) and Wednesdays (5:30-7 pm) at 39 Forest Avenue. Members received flyers and cards to post/distribute.</p>
VI. Review of Community Support Services (ACT, ICI, CI)	<p>Members received handouts of Performance Indicators Data from 2006 for the three levels of Community Support Services: Assertive Community Treatment (ACT), Intensive Community Integration (ICI), and Community Integration (CI).</p> <p>Don pointed out that for some providers in this CSN the number of new admissions assigned a CI case manager within 7 days of eligibility determination was not in compliance with Consent Decree. Will discuss possible reasons why at next month's meeting.</p> <p>Member Christine Holler pointed out that there should be more than just one option/agency (Goodwill) available for CI services for hearing-impaired consumers.</p> <p>More discussion next month on ACT Teams in this CSN, including Spring Harbor's new Intensive Action Team.</p>

Agenda Item	Presentation, Discussion
VII. Budget Update	No update – in process.
VIII. Rate Standardization	<p>Members reviewed a 4-page handout containing various types of information around the rate-setting. A bar graph compared Maine's highest and lowest Medicaid rate for various services and compared them to the average of New England states and other states. Other sheets listed various current rates, proposed rates, and differences, as well as the calculation process by which rates may be determined.</p> <p>Don explained that rate standardization is driven by: 1) Maine's rates are higher than other states, and 2) desire for one rate per service, not variable by agency. Rates to-date have been driven by costs—another approach is to build budget/structure on what is expected for income.</p> <p>Comments:</p> <ul style="list-style-type: none"> • This is a one-sided analysis. • Rates as shown for other states are all debated. • Present proposal cuts rates an average of 30% effective July 1. What does this create to have nearly all providers experience this size cut on July 1? • Court Master said in work session that it doesn't make sense to reduce rates at this time. • Court Master is asking providers to step up to the plate and do more. • Will that mean that consumers will lose services? • A consumer member said that her caseworker has already pressured her to cut back her services in anticipation of managed care. • A homeless provider said it is scary to imagine that the system will get harder to access—they already see more people with mental health issues than ever before.
IX. Service Gaps: Response to Court Master Concern	<p>Don reported:</p> <ul style="list-style-type: none"> • The Court Master appreciates the process and input of the CSNs, but will not allow for delay in remediation of service gaps on their account. • The Court Master is extremely interested in seeing that budget requests are based on identified needs, not on whether funds are available or approval is expected. • OAMHS reported gaps and remedial measures for all the CSNs to the Court Master, using the best information available. Will bring back to the CSNs next month.
X. Other	<p>Members made the following comments on the draft Confidentiality Statement distributed at last month's meeting. Comments will be given to AAG Kathy Greason for consideration in drafting the final version.</p> <ul style="list-style-type: none"> • Under release in dangerous situations, "can" notify law enforcement should be "should" or "will." • Clarify "appropriate Department representatives." • Will be sticky point: What is "imminent risk?" • Need to clarify specifically in Confidentiality Statement: If client has not released community service records, then they would not be available under the 24/7 provision.
XI. Public Comment	None.

Agenda Item	Presentation, Discussion
XII. April Agenda Items.	Community Support Services Peer Services Outpatient Services Report to the Court Master