

**Community Service Network 6 Meeting
DHHS Offices, Portland, Maine
June 15, 2007**

Approved Minutes

Members Present:

- | | | |
|--|---|---|
| • David Bouthilette, AIN | • Kirk Little, Ingraham | • Amy Thomas, Smart Child & Family |
| • Peter Driscoll, Amistad | • Burma Wilkins, Mercy Hospital | • Mary Jane Krebs, Spring Harbor/MMC |
| • Don Harden, Catholic Charities | • Lois Skillings, Mid Coast Hospital | • Cathleen Snow, Spurwink/Portland Help Ctr |
| • Art DiMauro, Casco Bay Mental Health | • Jennifer Tingley Prince, NOE | • Roger Wentworth, Sweetser |
| • Kitty Purington, Community Counseling Center | • Susan Boisvert, Parkview Adventist Med Ctr | • Donna Weaver, Sweetser Peer Center |
| • Tracy Quadro, Community Mediation Services | • Michael Faust, PSL-Services | • Kelli Star Fox, Transitions Counseling |
| • Lois Jones, Counseling Services Inc. | • Jamie Morrill, Riverview Psychiatric Center | • Karen Evan, Transition Planning Group |
| • Phoebe Prosky, Freeport Counseling | • Ed Blanchard, Shalom House Inc | • Christine Holler, Transition Planning Group |
| • Michelle Belhumeur, Gorham House | | • Wayne Barter, VOA |

Members Absent:

- | | | |
|-----------------------------------|--|---|
| • Creative Work Systems (excused) | • MMC Voc Services | • Preble Street (excused) |
| • Goodwill Industries | • NAMI-ME Families (excused) | • Regional Transportation Program, Inc. |
| • Hawthorne House | • New England Rehab Hospital of Portland | • Work Opportunities Unlimited |
| • Healthy Perspectives | • Possibilities Counseling | • Youth Alternatives |

Others present:

- | | | |
|-------------------------|---------------------|-----------------------|
| • Joe Everett, Ingraham | • Mary Tagney, DHHS | • Kelly Staples, DHHS |
| • Kristen Fortier, DHHS | | |

Staff present: DHHS/OAMHS: Marya Faust, Don Chamberlain, Leticia Huttman, Carlton Lewis. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Minutes	The minutes from the May meeting were approved as written, with one change: Add CSI as present.
III. Budget, Rate Changes	<p>Budget Don reported on the biennial budget passed by the legislature: (Includes both children and adult mental health services.)</p> <ul style="list-style-type: none"> • A total of \$6M must be saved in FY08, as follows: <ul style="list-style-type: none"> › \$1M added to projected savings of Administrative Services Organization—for a total of \$6.5M. › \$1M saved by changes in use of Skills Development Services.* › \$4M saved by package of changes in rate standardization. • \$14M must be saved in FY09, \$4M of which will carry over from FY08 rate standardization. The remaining \$10M savings is not yet defined. • The budget language also requires DHHS to set up three work groups, made up of providers, consumers, family members, and DHHS staff, to carry out specific tasks pertaining to: 1) Administrative burden reduction, 2) System redesign, and 3) Rate standardization. The work groups have tight timeframes—convening by July 1, 2007, and completing work before the new Legislative session begins in December. Dep. Commissioner Geoff Green will be making appointments to the work groups and coordinating their work. Members received a legislative document

Agenda Item	Presentation, Discussion
	<p>entitled “Part AAAA” detailing the membership and tasks of the work groups.</p> <p>Rate Changes Members received handouts of the new rates, which the group reviewed in some detail. Don pointed out that the rates for some services still reflect a range, though the floor is higher and the ceiling is lower. Other services have a set rate for all providers. The overall rate reduction, averaged across services, is 6.571%.</p> <p>A member asked about the rates for children’s services, and OAMHS will provide these to members when available.</p> <p>ACTION: Elaine will email rate sheets for children’s services to all members when received from OAMHS.</p> <p><u>Skills Development (SD)- \$1M Reduction*</u> Don explained that costs need to be cut by \$1M in addition to “x” amount of dollars saved by the new rate, which means the units of service need to be reduced. He said that 2006 data shows that 20% of clients in this program receive 80% of the services from a very small number of providers in Region II. (151 clients) These services are used very differently in different parts of the state—some use many hours a day, some a few hours a week.</p> <p>Questions/Discussion:</p> <ul style="list-style-type: none"> • How might this affect people being able to move out of PNMI—which may require increasing SD and in-home supports? Limiting these services might increase stays in PNMI or other group homes. • Have the 151 clients been asked about what they’re receiving? If not, why not? Don responded that OAMHS hasn’t gotten to that step yet. • Don explained that the goal of the Consent Decree as it relates to housing is that the system have a few residential treatment facilities, but the majority of consumers live in their own homes with services wrapped around them so people don’t have to move to receive different levels of treatment. • Will need wraparound infrastructure to be well-developed and flexible. • And MaineCare rules will have to be revised. • Is Dept. looking at resurrecting day treatment or partnering with social clubs or something for provision of intensive daylong services? Response: Not yet—can be part of discussion. <p>Providers Report on Service Changes</p> <p><u>Catholic Charities</u></p> <ul style="list-style-type: none"> • First, caveats: Rates changes were 5.85%, now 6.571%; also, ASO kicks in later. • ACT, ICI, CI: Not intending to close any components. • If we don’t do anything different, we’ll be out \$250,000. • Have to shift business practice—increase productivity to adjust to lower rate. What causes lower productivity? Travel and no show rates. We’ll be asking ourselves, will we travel to as many homes for CI? Will we travel to a home if person often isn’t there? • For ACT, it means more people on the caseload. • We’re not closing any services, but things will feel a little different. Over the next few months, we will monitor for losses and may have to make further adjustments. <p><u>Casco Bay Mental Health</u></p> <ul style="list-style-type: none"> • We’ll all work harder for a little less money—pro bono efforts may shift.

Agenda Item	Presentation, Discussion
	<p><u>Ingraham</u></p> <ul style="list-style-type: none"> • We're looking hard at Daily Living Support (DLS)... If we decide to discontinue DLS, we would like to discuss the transition process. (Don indicated the group would make time later in the meeting to discuss this further.)** • Very high productivity is expected—we have a vacant position, but have chosen not to fill it. • We have clients where DLS keeps them out of higher-cost levels of care. If the direction is to least restrictive levels in places where clients are comfortable, it's foolish to reduce rates for these services. <p><u>Transitions Counseling</u></p> <ul style="list-style-type: none"> • Pretty nervous...not making changes at this time. <p><u>Freeport Counseling</u></p> <ul style="list-style-type: none"> • "Planning to eat less..." <p><u>Smart Child & Family</u></p> <ul style="list-style-type: none"> • Just seeing the rates today—not ready to comment. <p><u>Counseling Services Inc.</u></p> <ul style="list-style-type: none"> • Rates changes are significant—expect \$3M impact. • Have not settled on what we're going to do—we're struggling—looking at adjusting business practices. • Travel is a big issue—don't know strategies yet. <p><u>NOE</u></p> <ul style="list-style-type: none"> • Newest branch of NOE, have Outpatient and Community Integration services. Discussion is happening, no comments at this time. <p><u>Sweetser</u></p> <ul style="list-style-type: none"> • Many places will be impacted—adjust business practices, look at how things are working, not sure what changes we'll make or how those may impact the bottom line. • ICI Team in Brunswick will be ending. <p><u>Community Counseling Center</u></p> <ul style="list-style-type: none"> • Basically losing in every program. Most of us are non-profit, mission-driven—preserve services first, jobs second. • We are community-based and person-centered and don't want that to change. <p><u>Amistad</u></p> <ul style="list-style-type: none"> • We'll have dramatic cuts in number of people and hours of operation for the warmline, starting in September. Will keep current level through the summer. • This is a real loss—warmline has been enormously successful. This is a bad direction. <p><u>Shalom</u></p> <ul style="list-style-type: none"> • First, the consequences of the ASO is a wild card—can't know yet. • Shalom does a lot of PNMI residential—those rates haven't changed for years and we're already absorbing losses. So these new reductions must be taken into consideration in the whole picture. • We're ending DLS services on July 1—we've lost money for two years. Expectation of 36 hours out of 40 direct services—can't do that level. Gave notice already to our clients for a 30-day transition. It affects 20-25 clients, 3-4 hours a week. We regret that we had to make that decision, but a 19% reduction in rate to a service already losing money makes it necessary. • Community Integration will continue: productivity increase, savings in costs. • Skills Development: Keeping—increasing numbers of clients, and growing the program in the Saco area. <p><u>Portland Help Center</u></p> <ul style="list-style-type: none"> • Could reiterate some of what others have already said. • ICI Team will take on more clients. Concerns: With ASO, will those clients meet criteria? Also, the case managers will have to move more quickly—may miss something and hospitalizations could increase.

Agenda Item	Presentation, Discussion
	<ul style="list-style-type: none"> • Costs increase every year: rent, insurance... Staff haven't had raises for years now, not a good way to operate. <p><u>Consumer Concern</u></p> <ul style="list-style-type: none"> • I don't feel like the Governor is listening to our needs. He hired Brenda Harvey—if she's the liaison for children and families, there's miscommunication. The Governor isn't following the Consent Decree—the quality of life is decreasing. He needs to ask the consumers if their needs are being met. I'm fearful—what if Community Counseling's deaf program closes? What can you do to alleviate these concerns? What will you do with the information you're hearing today? • Don responded, that the question is, what will <u>we</u> do about it? Is there something CSN members can do to minimize the impact? The more consumers raise their voices... • Consumer: The Governor isn't listening! <p><u>Spring Harbor/MMC</u></p> <ul style="list-style-type: none"> • Outpatient: Starting looking 4-5 years ago, nationally re: managed care—in better place today than 5 years ago. • ACT: Committed to continuing and following fidelity measures—volume will increase. Biggest concern is Children's ACT Team—begun process of applying for grant funding. <p><u>Consumer Concern</u></p> <ul style="list-style-type: none"> • My concern is for the consumers. I'm glad Shalom gave 30-day notice. If services discontinue, give fair advance notice and try to problem-solve with consumers. <p>Don mentioned the idea of pooling certain “back room” functions, such as purchasing, billing, HR, finance, etc. Is there a role for CSNs to discuss this? Mary Jane said Maine Health Systems has saved funds and increased efficiencies this way. She emphasized the CSN's obligation to meet needs of consumers within the CSN and to look at things in a fiscally responsible way.</p> <p>Additional discussion about DLS service reductions:**</p> <ul style="list-style-type: none"> • What will we about DLS being cut? Does OAMHS want this service to go away? We need to be thoughtful about the way this happens. Response: OAMHS has no intent to do away with this service. • The 36 hours billable is <u>untenable</u>. • A consumer emphasized that she wouldn't want to see services that work well in <u>this</u> area be affected by misuse or mismanagement in <u>other</u> areas of the state. • Shalom explained that some their clients receiving DLS services are also on ICI teams and/or in supported housing, so they decided to build some DLS into those services for them. • Describe skills in DLS? Maintain apartment (difficulty managing environment), help to get to appointments, food planning and shopping... • How different from homemaker services? Response: Cleaning, for example, is done <u>with</u> them, not <u>for</u> them. • Ingraham: What could be built into other services? How can we manage this well? What's going to be best for the clients? If we decide to wind down this service and then 2 months later another agency starts the service, that would defeat the purpose of the CSN. This is a very vulnerable population—they make strong bonds with DLS workers and may find it very difficult to phase out, even in 30 days. We wouldn't want another agency to take this on only find they need to cut it, too. • Do we want to wind up this service in this area? • Need to ask the consumers...consumers will want it to continue. • Model here can't be done at the current rate structure. • This is not a service that can afford to stand alone. We need to look at all the services we're providing and how we can build this into programs we already have.

Agenda Item	Presentation, Discussion
	<p>The discussion ended with plans for ongoing inquiry into:</p> <ul style="list-style-type: none"> • Community services and resources, e.g. Clutterers Anonymous, transportation programs, etc. • Region II model—what are they doing, what are they going to do? • How homemaker staff might be “trained up” to cover some DLS services. (Don Harden)
<p>IV. Intentional Peer Support Specialist Program</p>	<p>Leticia Huttman gave a brief overview of the development of the Certified Intentional Peer Support Specialist program, starting with the initial consumer committee, the CMS grant, and through to the implementation of the curriculum developed by Chery Mead.</p> <p>The first step toward certification is completion of Peer Support 101, a 3-hour foundation course that OAMHS makes widely available to consumers, providers, and others who wish to attend. The next step is to complete the curriculum, which involves a web-based introductory section, 7 full days and 3 half days of classes over an 8-week period, and a final test. To continue in the certification process, people 1) participate in quarterly co-supervision, 2) complete two continuing education classes per year, and 3) do peer support for at least 75 hours during the year.</p> <p>Intentional Peer Support Specialist Certification is currently required for people who work on the Maine Warm Line and in Emergency Departments. In the future, ACT Teams may be required to have 1 FTE of peer support and those people will be required to be certified.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Will there be clarification of the role of peer supporter on ACT Teams? I felt like a babysitter and a doorman. Response: Yes. • Peter of Amistad voiced concerns: OAMHS has created an enormously complicated and costly system, Intentional Peer Support, which is not nationally recognized and not agreed on by the committee. We asked for trainings that are web-based, competency-based, local, and not a burden on providers. None of those things happened with this. (Leticia: This training is more like MHSS or MHRT/C and not well-suited to be web-based.) Peter emphasized the burden this 90-hour training puts on staff who also have additional training for the warm line, Riverview program, or Emergency Departments. • Another member said that he would not want to see this go in the direction of MaineCare reimbursement, and become “professionalized” and “rule-ized.” • Mid Coast Hospital said the training has been <u>very</u> helpful for peers working in their Emergency Department. • A consumer who is participating the current session said, “It’s not the only peer support model, but I’ve gotten a lot from the training.” • Don Chamberlain said that the rate for ACT will be adjusted when Certified Peer Specialists are required.
<p>V. Medication Management</p>	<p>No time for discussion.</p>
<p>VI. Consent Decree Quarterly Report</p>	<p>No time for discussion.</p>
<p>VII. Services for Returning Veterans</p>	<p>No time for discussion.</p>
<p>VIII. Policy Council Report</p>	<p>No time for discussion.</p>

Agenda Item	Presentation, Discussion
IX. Other	None.
X. Public Comment	None.
XI. July Agenda Items	Budget/Rates/ASO Medication Management Services for Returning Veterans Policy Council Report