

**Community Service Network 6 Meeting
DHHS Office, 161 Marginal Way, Portland
October 17, 2008**

DRAFT Minutes

Members Present:

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| • Jan Burns, AIN | • Glenn Shelton, Goodwill Industries | • Maria Tripp, Preble Street |
| • Peter Driscoll, Amistad | • Burma Wilkins, Mercy Hospital | • Jamie Morrill, Riverview Psychiatric Center |
| • Sally Temm, Catholic Charities Maine | • Tom Kivler, Mid Coast Hospital | • Joe Brannigan, Shalom House |
| • Kitty Purington, Community Counseling Center | • Sara Therrian, MMC Vocatioal Employment Specialist | • Amy Thomas, Smart Child & Family Services |
| • Karen Evans, Consumer Council System | • Christine McKenzie, MMC/Spring Harbor/Voc Services | • Leslie Mulhearn, Sweetser |
| • Georgana Prudhomme, Crossroads for Women | • Jennifer Tingley Prince, NOE | • Kelli Star Fox, Transitions Counseling, Inc. |
| • Phoebe Prosky, Feeport Counseling Center | | • Pat McKenzie, Youth Alternatives/Ingraham |

Members Absent:

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| • Counseling Services, Inc. | • Gorham House | • PSL-Services |
| • Creative Work Systems | • NAMI-ME Families | • Spurwink-Portland Help Center |
| • First Atlantic/Hawthorn House | • Parkview Adventist Medical Center | • Volunteers of America |

Alternates/Others present:

- None

Staff Present:

- DHHS: Carlton Lewis, Dr. Elsie Freeman, and Ron Welch
- Muskie: Anne Connors and Scott Bernier

Agenda Item	Discussion
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes were accepted as written.
III. Feedback on OAMHS Communications	Leslie Mulhearn asked about the absence of communications around crisis grant funds. Ron Welch said he may have information on this later today.
IV. "Dying 25 Years Too Soon"	<p>Dr. Elsie Freeman gave a presentation on "Dying 25 Years Too Soon" explaining how those with mental illness tend to have other chronic health problems that lead to them living 25 fewer years on average than the rest of the population. She noted that those with serious mental illness have been dying sooner than those without since the 1850s; however, in the past the gap was not as great with a difference of about 10 years in life expectancy.</p> <p>Highlights of the presentation included:</p> <ul style="list-style-type: none"> • Looking at serious mental illness (SMI) in Vermont, surveying why someone left services, they found that 20% didn't leave, they died. • Deaths from most major chronic health issues such as heart disease, pneumonia, influenza, liver disease, diabetes, cancer, even dental disorders are greater among SMI population than the general population. • For persons with SMI, chronic health conditions are an expectation rather than an exception. In Maine, almost 30 percent of the SMI population has three or more medical conditions. • Department survey: those who reported 14 or more days of poor physical health were also less satisfied with their

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	<p>mental health services and social supports.</p> <ul style="list-style-type: none"> • Research shows that metabolic changes are related to mental illness. For example, those who are depressed have sticker platelets, leading to more blood clots in those individuals. Also, those who are depressed and suffer a heart attack are more likely to not survive the heart attack. • Those with mental illness tend to have other risk factors such as obesity/overweight, smoking or substance abuse Smoking rate in SMI population is about 40 percent as compared to 20 percent in the general population. • The interactions between physical and mental health are a factor in the population as a whole. Behavioral Risk Factor Surveillance System (BRFSS) data for Maine shows that if individuals answer positively to any of the mental health questions, they are more likely to be obese, a heavy drinker, a smoker, and not exercise. “This is something that affects every Mainer. The lifetime prevalence of depression in the state is 1 in 5 or 20 percent of the population.” Important to know this because when go to health care providers can say this isn’t just a special population but applies to everyone. • 1 in 4 of SMI population has diabetes; prevalence rate of 17 percent; Maine general population rate is 7 percent Those with mental illness are also less likely to get good healthcare/pre-screening for chronic conditions resulting in unnecessary hospitalizations and use of the Emergency Room. • Despite the demonstrated links between physical and mental health, the systems of care are separate. “In our system of care, the head has been completely cut off from the body and the teeth aren’t in there very well either.” • What is out there? Health issues being incorporated into MHRTC recertification; SAMHSA sponsoring the 10 by 10 initiative. By the end of the next 10 years, reduce the mortality deficit for SMI by 10 years. NASMHPD White Papers on importance of primary care, obesity, smoking cessation. About to come out with a white paper on health screening in mental health systems. • Enormous push in the state for bringing mental health into primary care and adopting the medical home model which emphasizes a team approach, including behavioral health, and 24/7 services. Care management practice. Multi-year pilot launched this year to bring medical homes statewide. Pay for performance for quality medical care. Certain care management practices get extra reimbursement. • Complex medical conditions for this population. Can’t produce the medical care in our mental health system. “Our only real hope is how do we do it virtually, how do we link? How do we get free flow of information?” • Consumers: “What do we as a mental health system do for our consumers to help them make effective use of the medical system? Just referring to primary care is probably not going to work.” • Should track medical risk factors as part of diagnosis, should be part of the care plan. If history of diabetes in the family, don’t start treating with high weight gain anti-psychotics. • Self-management education: not very different from how we think about recovery. Partnership. One has to as a consumer know enough about what the options are and make choices. Health literacy: know about your disease, know how to advocate for, know how to get the most out of the system. • Creative uses of what already exists. For example, MaineCare pays for diabetes education classes. May not be very welcoming for this population. How can they be adapted? We need to figure out how to do it. <p>Dr. Freeman wrapped up by asking the CSN how they might move forward within the CSN. For example, CSNs could start health care workgroups.</p> <p><u>Feedback/Discussion:</u></p> <ul style="list-style-type: none"> • Karen Evans: Amistad has a Peer Patient Navigator who works with 23 people and goes with them to doctor’s appointments and meets with them re their medical needs. Dr. Freeman: Yes, how can we think creatively on the

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	<p>notion of peer programs, adapt lay health educator model? How do we integrate medical care management with mental health case management? Environmental policies can make a difference: example: Riverview Psychiatric Center only serves sugar-free pies because of high prevalence of diabetes of population. Some PNMI's nearly 100 percent of residents have diabetes. How obtain nutrition education assistance?</p> <ul style="list-style-type: none"> • Kitty Purington: It would be interesting to have healthcare providers at this meeting to get their perspective on treating mental illness. Response: It would be difficult to get them to do so. It would be easier to try and go to them. Kitty: microcosm of issue, mental health system is also being burdened with care productivity and fiscal pressures. • Karen: The Consumer Council has received a grant to educate the public. Its drama group is creating a skit to be performed in the community to educate the public about the fact that the mentally ill are dying 25 years too soon. • Pat McKenzie: Youth Alternatives/Ingraham has hired a nurse educator, though it has been difficult, financially, to do so. It has been incredibly useful and initiated a huge change for the agency. YAI is trying to integrate it into service plans so that clients can work wellness into their goals. With resources like this, perhaps YAI could share them with others, such as trainings on diabetes, smoke cessation programs, etc. Dr. Freeman: That's a good point-you need a champion. • Burma Wilkins: Major funding grant is needed. At Mercy Hospital, a primary care practice had a case manager for mental health for two years. Had to stop because of reimbursement issues. The caseload became overwhelmingly Medicare or free care. Had a higher no show rate. Difficulty accessing medications if free care therefore difficulty treating illnesses. If services were capitated, could show over time that mental health integration was cost effective. In short term, not possible to show that outcome. Dr. Freeman: Not only does it cost more on MaineCare health side, also costs more on the MaineCare psychiatric side. Collecting data and continuing to present data does help. We've been able to hold forums in Androscoggin and Kennebec Counties with healthcare providers in attendance. It is agreed that it will be very difficult to move forward due to no dollars, but we must start somewhere. • Burma: Licensing is also a major issue. Licensing for substance abuse services differs from licensing for mental health services which differs from licensing for primary care services. Have to complete two accreditations, two state licensing surveys. DHHS OSA regs prohibit diagnoses of PTSD because licensing will say substance abuse provider is not a mental health agency. Dr. Freeman: I absolutely agree. How do we go ahead and make the case? • Joe Brannigan: Day living skills are not a core service according to the state. Shalom House is going to push for it as a core service through the court master. Staff is not high paid, but they do know the people we serve. • Christine McKenzie: Thank you for the presentation. At the last CSN meeting, health care was one of the top two if not the number 1 unmet need. Since already prioritized by consumers and practitioners, could we look at data as a CSN and say: what would be the best strategies to respond to unmet needs? CSN representatives could volunteer to go to primary care associations and medical associations and educate providers. • Jan Burns said that she has been diagnosed with diabetes. My doctor's nurse gave me a long list of what I could not eat. I went to a diabetic clinic and was told what I could eat and in what quantities. It was positive compared to the negative of the doctor's visit. Doctors don't always give the best advice. <p>Dr. Freeman wrapped up by informing the group that OAMHS has applied for a grant to address this issue and that she should hear whether it has been awarded on October 20th.</p> <p>ACTION: Ron recommended that given the level of interest, this topic will be placed on the November CSN agenda.</p>
V. Legislative & Budget Updates	Ron reported that DHHS has gathered the input from CSNs, the Consumer Council System of Maine, the Quality Improvement Councils, along with unmet needs data and used this information to develop the \$90 million budget submitted

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	<p>for 2010-11. OAMHS request and those of other departments are being reviewed. The state needs to cut \$200 million from its budget and half of that is to come from DHHS. We're electing to keep on the table what we've documented. We will be looking at changes to the mental health system. The commissioner will review it next week. We're trying to minimize the impact on the community system. We're looking at impact changes that could eliminate certain state functions. This fiscal year, there will be curtailments, but we don't know where we can go with it. There are only some grant funds that could be cut, but we won't offer to do so unless we have to. We're holding our own compared to other states. For example, California has dropped state worker salaries to minimum wage.</p> <p><u>Questions/comments:</u></p> <ul style="list-style-type: none"> • Karen: Elizabeth Jones attended the last Consumer Council meeting and she informed us that the court master is thinking of a lawsuit based on the Americans with Disabilities Act (ADA). Can Ron clarify this? Is this correct information? <ul style="list-style-type: none"> ○ Ron: When Ms. Jones was appointed as a receiver for AMHI (RPC), the state appealed the Superior Court's authority to do so to Maine's Supreme Court. In terms of the authority of the Superior Court to do this, the state prevailed. The court added that the ADA requires that class is defined as anyone who at any time in their life spent time at AMHI or anyone of comparable clinical circumstances. What this definition means is up for discussion and is what Ms. Jones was referring to. OAMHS' budget request is based on the broader definition, in case it prevails. If it doesn't, money for that wider audience may be withdrawn. It will all depend on the final decision on who is eligible for services. A court-appointed receiver can't override the Legislature. If we have a broader definition and the budget goes forth, we've done what we must do whether or not the Legislature passes it. "Given the \$200 million deficit in the budget, it's an ominous sky we are looking at." • Pat: How will the DHHS Commissioner find \$100 million in savings? Similar to finding savings in crisis services. I appreciate your stance that you can't cut anymore. It bewilders me how you could find that much. It looks like more limitations on services and billing. <ul style="list-style-type: none"> ○ Ron: In the crisis system, it wasn't a large amount, and the Legislature only cut funds for this year. What's really at stake on the community side are the grant dollars. MaineCare is an entitlement while grant dollars are our flex money. For crisis, the Legislature only cut for 2009 and not for the biennium. Crisis providers need to be aware of this. • Sally Temm: How long is the contract with APS? Can it be cut? <ul style="list-style-type: none"> ○ Ron: Two-year contract of about \$8 million. Clause would allow the state to terminate it early, but there would be a cost. ○ Sally: I truly believe we're not seeing a benefit to APS. We'd be better to cut that than services. • Kitty: Do you know what the curtailments will look like? <ul style="list-style-type: none"> ○ Ron: Don't know if there will be a curtailment yet; Revenue Forecasting Committee met yesterday. • Joe: You must have received some directive so far for the budget. <ul style="list-style-type: none"> ○ Ron: The directive is to self fund the supplemental through the rest of this year and on top of that start thinking about curtailment. Have to self-fund 2-4 percent increases for state employees. • Pat: Agencies and the Department are coming to a better understanding of the process and I appreciate it. If this can help us find solutions, I'm all for it. <ul style="list-style-type: none"> ○ Ron: Maybe it's good we have no option, but to work together. • Kelli Star Fox: Our agency has been around 13 years and still many don't know who we are. Working through the CSN has been helpful. Other newer agencies are able to get what they want because of political power. <ul style="list-style-type: none"> ○ Ron: When we first designed this system, we envisioned these CSNs spinning off and incorporating. They

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	<p>would then oversee funds for that CSN and obtain political clout within Augusta. We're still hoping that will eventually happen. This process will take time.</p> <p>Ron wrapped-up by indicating that the budget for unmet needs will be sent to CSN members within the coming week. Has already been sent to Consumer Council and the two provider organizations.</p>
VI. Unused Prescription Drugs	<p>Ron reported that Dr. Gressitt could not attend due to a scheduling conflict. Presentation will be rescheduled for the November meeting.</p>
VII. Wraparound Funds	<p>Carlton said that the Department is seeking—statewide—to turn WRAP funds and the administration of the same over to the CSNs. Wraparound funds are discretionary funds to meet urgent needs of adult mental health consumers that can not be met through the needs of the regular system. Agencies administer; regional office can be a source of funds if the needs are extreme. In CSN 6, three agencies--Shalom House, Catholic Charities Maine (CCM) and Youth Alternatives/Ingraham(YAI)--receive wraparound funds. Because CCM is managing the bulk of the funds, OAMHS has asked the agency if it would be willing to manage all the funds. Tentative agreement to this idea from Shalom House and YAI.</p> <p><u>Discussion:</u></p> <ul style="list-style-type: none"> • CCM is looking at it in the following approach: Other agencies would authorize the use of the funds for their clients and we would cut the check. Are you comfortable with this? • Joe asked for clarification as what Carlton stated sounds like everyone could access the funds. <ul style="list-style-type: none"> ○ Response: Yes. There would be one fund for all to tap into. • Joe continued pointing out that the group must also remember that this is treated as a quasi-loan. It is well controlled. It will take some work for us to make it work from a single source. You might have to eliminate the loans. • Sally responded that it does take time to manage the loans, but without them the funds would be used up quickly. She's not sure if CCM could manage this for the entire CSN. • Karen is in favor of having loans that need to be paid back. Part of recovery is to take responsibility for oneself. • Sally stated that without loans the current funds would be gone by November. But it is high maintenance. For example, on a \$700 security deposit, it might get paid back \$5 at a time and we don't get reimbursed for the labor. Or we can have the landlord agree to reimburse us directly when the client moves. Each situation is treated individually as it arises. • Peter added that it appears that the status quo appears to be working in this CSN. Why can't we stick to that? <ul style="list-style-type: none"> ○ Carlton: As long as DHHS gets out of wraparound funds, that's fine. • So, if we keep the status quo, how do others access these funds? Why not distribute funds that DHHS still has to other agencies? <ul style="list-style-type: none"> ○ Carlton: The problem with multiple agencies handling wraparound funds is that some consumers will go services "shopping." If they are denied at one agency, they'll go another and another until they get the funds. • So funds have universal access? <ul style="list-style-type: none"> ○ Response from another member: Yes, but it's not the practice in this CSN. It's easier to provide funds to those you know/are serving than to a stranger coming in the door. • It would be good to have a neutral party to handle these funds that DHHS currently has. But who would do it? • Carlton pointed out that a single agency handles the funds in CSN 1.

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	<ul style="list-style-type: none"> • Pat stated that there are very few agencies in CSN 6 that provide community inclusion (CI) services. What's the criterion for wraparound funds? Must they be eligible for Section 17? • Carton clarified that the policy does not stipulate Section 17 eligibility. • Karen advocated that funds be kept open to consumers outside of services. Why can't the state continue to do it? • Ron thought there was going to be a panel of people who would review requests. • Pat stated that the problem with a panel is that you can't have a rapid response to requests and sometimes you need a rapid response such as the example given last month about the client who had a flat tire and needed to get his vehicle fixed so he could get to work. • Joe asked who has CI services in CSN 6: NOE, Shalom House, YAI, CCM, Sweetser (with CSN 4). Anyone else? • Ron pointed out that if the wraparound funds are not allocated before the next quarter it could disappear. The HELMS contract statewide is for \$450,000. Carlton added that this CSN received \$40,000 for wrapfunds for the six months that ends in December. • Pat stated that it sounds like this group needs to come-up with an interim plan. Would CCM be willing to hold the funds for now? • Leslie added that when someone comes in cold, it's hard to determine if they're eligible. It's part of the reluctance to accept funds. • Ron stated that he'll get numbers to CCM/YAI/Shalom House. He hopes that if a panel is formed that there will be a consumer on it. • Carlton reminded the group that these are last ditch funds to be used when all other resources have been exhausted. • Peter thought it would be fabulous to have a peer review team that could meet weekly to review these requests. Sally responded that at CCM, they already review requests twice a week and on the fly for urgent cases. • Pat believes that some requests could be approved by panel via email if the request is deidentified. <p>ACTION: CCM, YAI and Shalom House will meet to develop proposals re the wraparound funds prior to the next meeting. Should they come to consensus before then, they will email the Department, who will forward that email out to the rest of the CSN.</p>
VIII. Consumer Council Update	<p>Karen gave the report. Elaine Ecker is the new executive director of the Consumer Council of Maine. She starts on October 20th. The local council is the first recognized local council in the state. At the last local meeting, Elizabeth Jones was present. The Council also had a discussion around budget issues with consumers. Pat McKenzie of YAI was also present. At the regional level, the next meeting will be on October 21, 2-5 p.m. at the Dana Center. Statewide system-we didn't have a conflict of interest statement. We've worked with a lawyer and have one now. We have discussed our election process and will vote in officers at the next meeting. We held a meeting this past weekend about CSN meetings and how to support each other at them. Some members are still finding it intimidating to attend with all the providers represented. Local councils were also discussed and the work needed to get them going. We've produced problem statements on issues that need to be addressed such as funding for Warm Lines, PNMI bed rules, etc.</p> <p>Ron reminded Karen that the local council can elect others to represent them at the CSN. Karen indicated she knew this and that the council can have up to 3 representatives at the CSN.</p>

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IX. Report from Employment Service Network (ESN)	<p>Sara reported that:</p> <ul style="list-style-type: none"> • She has sent out 300 out of 800 Need for Change scales. She has received back 12%. 63% of those who responded have a strong need for employment. • She is starting to meet with clients. • The ESN met last Tuesday and at their next meeting they will have an employer HR person come in to talk. We will also work on recruiting techniques and finding employment champions. • She asked for contact information from CSN members present for people they know who have businesses within Cumberland County. • She has started employment meetings at CCM for consumers to help them develop their own employment resources. Meetings are held twice a month. Attendees would like to see it happen weekly. If we can obtain approval, we may move to a weekly meeting. <p>Christine reported that with the exception of CSN 2, data that has been coming back indicates that more consumers are reporting a need to work in comparison to those that don't. It is 40% or higher in all CSN's (except CSN 2). If you include those who answered "unsure", it goes up to 60 to 70%.</p> <p>ACTION: This agenda item will be moved to the top of the agenda at future meetings.</p>
X. Impact of Energy Costs	<p>Ron reported that Department energy needs will be sent to CSN members. He suspects that any response from the governor will cover non-profits statewide.</p>
XI. Other	<p>Karen reported that consumers are reporting that dental clinics are refusing services to those without case management. Ron responded that he will send out a letter.</p> <p>PNMI: The PNMI Rehab option is proposed to go into effect in April 2009, and the Department is working on a plan to be in compliance with these rules should they hold. The rule changes have a significant impact upon PNMI's under all the MaineCare sections but in particular Adult Mental Health PNMI's under Appendix E. Joe reported that a Senator from Minnesota has put in a bill to allow bundled services to continue. If there is a change of administration, perhaps the rule change will not go into effect.</p>
XII. Public Comment	
XIII. Meeting Recap and Agenda for Next Meeting	<p><u>Meeting Recap</u> See ACTION items above.</p> <p><u>Next Month (list Month) Agenda</u> Health Care Followup ESN Update OAMHS Communication Consumer Council Update Wraparound Funds Unused Prescription Drugs Impact of Energy Costs</p>

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	Report back re Dental Clinic