

**Community Service Network 6 Meeting
DHHS Office, 161 Marginal Way, Portland
November 21, 2008**

DRAFT Minutes

Members Present:

<ul style="list-style-type: none"> • Donald Harden, Catholic Charities Maine • Sally Temm, Catholic Charities Maine • Kitty Purington, Community Counseling Center • Karen Evans, Consumer Council System of ME • Christine Holler, Consumer Council System of ME • Lois Jones, Counseling Services Inc. 	<ul style="list-style-type: none"> • Larry Davis, First Atlantic/Hawthorne House • Phoebe Prosky, Freeport Counseling Center • Craig Anderson, Goodwill Industries • Burma Wilkins, Mercy Hospital • Tom Kivler, Mid Coast Hospital • Sara Therrian, MMC Vocational Employment Specialist • Christine McKenzie, MMC/Spring Harbor/Voc Services • Jennifer Tingley Prince, NOE 	<ul style="list-style-type: none"> • Jon Bradley, Preble Street • Michael Faust, PSL-Services • Joe Brannigan, Shalom House • Catherine Lorello-Snow, Spurwink-Portland Help Center • Kelli Star Fox, Transitions Counseling, Inc. • Vicki MacWhinnie, Volunteers of America • Michael Tarpinian, Youth Alternatives/Ingraham • Pat McKenzie, Youth Alternatives/Ingraham
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Members Absent:

<ul style="list-style-type: none"> • AIN (Excused Absence) • Amistadx • Crossroads for Women 	<ul style="list-style-type: none"> • Gorham House • NAMI-ME Families • Parkview Adventist Medical Center 	<ul style="list-style-type: none"> • Riverview Psychiatric Center • Smart Child & Family Services • Spring Harbor Hospital
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Alternates/Others present:

<ul style="list-style-type: none"> • James Corbett, Mercy Hospital 	Jennifer Anderson, Schaller Anderson Laurie Long, Schaller Anderson	Eric Meyer, APS
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Staff Present:

<ul style="list-style-type: none"> • DHHS: Carlton Lewis, Stevan Gressitt, M.D., Lisa Wallace • Muskie: Anne Conners, Linda Kinney
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Agenda Item	Discussion
I. Welcome and Introductions	Carlton opened the meeting; introductions followed.
II. Review and Approval of Minutes	The minutes were accepted as written.
III. Feedback on OAMHS Communications	Two members said that OAMHS informed APS Healthcare to stop accepting grant-funded clients on November 12; however, providers were not notified of this until later. Members agreed it would be preferable if the communications aligned.
IV. Schaller Anderson	Jennifer Anderson gave an overview of Schaller Anderson. The company started 20 years ago in Phoenix as a small entrepreneurial company to provide managed care services to the Medicaid population. The company is now nationwide and was awarded an RFP in Maine two years ago. The initial RFP was for a 300-person pilot program where MaineCare members were offered care management services, educated about available community resources, and linked to those services. Pilot results showed that ER use went down and hospitalization rates decreased. Last year, Schaller Anderson's contract was expanded to include the top 10 percent of adults and top 5 percent of children who are at high risk for utilization. The MaineCare Care Management benefit identifies people with chronic disease, high ER use and high hospitalization rates and attempts to treat their medical needs for improved health outcomes. Schaller has discovered that a large part of the population it is trying to enroll in the MaineCare Care Management Benefit program has both mental health

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	<p>and physical health needs. Many are already receiving services from behavioral health agencies; however, Schaller initially did not have access to that data. However, it now does. Jennifer said that she has been working with OAMHS to get the word about Schaller's services out. She said Schaller wants to partner with mental health agencies and not replace case management services – a service Schaller cannot bill for. Schaller can do outreach to primary care practices to enroll people in the practice; and can identify people who may need help by looking at claims data.</p> <p><u>Discussion</u></p> <ul style="list-style-type: none"> • <u>Question:</u> How do you interface with APS? • <u>Answer:</u> We do the care management piece. We don't authorize services for mental health. We outreach to the members. We also do utilization review and concurrent review. • <u>Comment:</u> Our agency knew of your services early on and did refer consumers. Their feedback was that the program was okay, but wasn't really that useful because consumers were looking for a relationship that usually occurs in case management. • <u>Answer:</u> Once we enroll members in care management, most never want to leave. Our job is to empower people not enable them. Most work done through phone outreach. • <u>Question:</u> Do you conduct in-service programs for agencies if there were a group of clients in the same place at one time? • <u>Answer:</u> That would be ideal. • <u>Question:</u> Can you assist people in getting a primary care physician? • <u>Answer:</u> Yes, those are the people we are trying to reach the most. • <u>Question:</u> Are your services home-based? • <u>Answer:</u> All over the phone. We have RNs, LCPCs, medical assistants, exercise physiologist, nutritionist. We offer a variety of services to folks. • <u>Question:</u> What steps are taken to prevent frequent use of ER? • <u>Answer:</u> From claims data, we can see who the high users of ER are. Once we get in touch with them, we do a health risk assessment: gives us a jumping off point: What are the medical issues? What are the behavioral issues? • <u>Question:</u> Do you have any peers on your staff? • <u>Answer:</u> No, but very good idea to consider. • <u>Comment:</u> Utilizing peers to talk to other peers could be useful. • <u>Question:</u> How do you get paid? • <u>Answer:</u> Contract with the state. • <u>Question:</u> You don't get paid per person? • <u>Answer:</u> No. • <u>Question:</u> Can you give support and recovery services information on our clients that you want to connect with? • <u>Answer:</u> Yes. • <u>Question:</u> Are you working with the Primary Care Care Management Program offered by DHHS/OMS? • <u>Answer:</u> Serve on Steering Committee for PCCM program. • <u>Question:</u> Is Schaller involved in approving out-of-state placements/services? • <u>Answer:</u> The state has asked us to look at MaineCare folks receiving services out of state to see if they still need to be out of state or can we bring them home. • <u>Question:</u> Many folks with head trauma are in very expensive facilities out of state. Will you come up with

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	<p>recommendations on what we need in the state to support clients and families?</p> <ul style="list-style-type: none"> • Answer: Yes. We've been asked to make recommendations. • Question: Is the Schaller contract through OMS? • Answer: Yes. • Question: Do you only work with MaineCare clients? • Answer: Yes. • Question: Do you work dual eligibles (Medicare/Medicaid). • Answer: No. • Question: Do you cover eye care/pharmacy? • Answer: For pharmacy, state has an agreement with I Care Pharmacy in Fort Fairfield. Offers MaineCare participants no co-pays on generic medications with most medications filled for 90 days and mailed directly to client's home. Doesn't provide eye care coverage but can try and help clients find service that does. • Question: Does program cover hearing aids? • Answer: No, but has helped people find them as well as dentures. • Comment: A number of the pole we see are Medicare only. They have needs: chronic disease, mental health, family disintegration. When are we going to understand as a community and as a state, that these folks deserve some entitlements? • Answer: I hear you, but we are bound by the terms of our contract. • Comment: This is more directed to the state; Schaller and APS are duplicating services. We can't afford that in these fiscal times. <p>Jennifer said she is more than willing to meeting with provider agencies or give presentations to staff. She can be reached at 207-464-0342, Jennifer.anderson@schalleranderson.com</p>
<p>V. APS HealthCare</p> <ul style="list-style-type: none"> • <i>Review of current data</i> • <i>Discussion of issues including feedback on data entry</i> 	<p>Lisa Wallace presented the following findings on behalf of Don Chamberlain</p> <p><u>Summary Findings from Visits to Selected Mental Health Providers by Don Chamberlain, DHHS/OAMHS</u></p> <p>At the suggestion of Don Harden of Catholic Charities and the Chair of the Adult Committee of MAMHS, Don Chamberlain and a mental health team leader conducted site visits to get an on-the-ground view of the APS Healthcare process. Mr. Chamberlain asked Mr. Harden to set up site visits with a number of providers ranging from a low tech provider to a high tech provider. He also asked the Behavioral Health Collaborative for a couple of providers to meet with. Mr. Chamberlain and the mental health team leader from the appropriate region met with front line staff, supervisors, billing staff, and others from the organizations. The agencies are: Shalom, Catholic Charities, Common Ties, Kennebec Behavioral Health, CSI, and Community Counseling Center.</p> <p><u>The findings:</u></p> <ul style="list-style-type: none"> • For continuing stay reviews, the additional time required is from 20 minutes to one hour per case. The low end is for therapists in outpatient settings. Other than one provider, all the rest have to take their treatment plan in their clinical record and translate it to Care Connections. This task seems to be easier for master's level clinicians than MHRTCs. • Most providers have established systems that require the plan to be reviewed by either the supervisor or the Quality Department prior to submission. This adds time internally before the data can be entered into APS. • The increase of CI from six-month continuing stay reviews to every 90 days has substantially increased the

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	<p>administrative costs to CI providers. To do the RDS would take a much more limited time. Recommendation: Get the RDS information at the 90-day mark and do the full continuing stay at the six-month point.</p> <ul style="list-style-type: none"> • The comment section of Care Connections is being used for additional goals and other ongoing information which can not be brought forward in continuing stay reviews, which results in additional work for each review. • A decrease in initial authorization visits for outpatient services results in more reviews than need to occur. The original authorization allowed the treatment of many consumers to be completed and therefore not require a review. The current initial authorized visits cause nearly every case to require a continuing stay review. Recommendation: Return to the earlier number of authorized visits. • One provider has an electronic interface which eliminates, for the most part, the need for clinicians or others to enter the information. However, every time there is an APS change, the provider must pay an IT cost. • While there was a reduction in the information required for outpatient for continuing stay reviews, one has to go through all the pages to get to the appropriate section, which causes confusion and time. • When a question arises, telephone tag on both sides requires more time. • Given the agency processes and the telephone tag, the five-day pre- and post-the date for review is difficult to meet. Recommendation: Increase from 5 to 7 days on either side. • For PNMI, the 30-day review is a bit short since the OAMHS has approved the placement in the first place. Getting the registration and discharge into APS in the 24-hour time frame is sometimes problematic. Recommendation: Increase the time frame for the continuing care review and allow an additional 24 hours to get registration and discharge data into APS. • Recommendation: Those with computerized records would like batch up loading to save time and expense on the provider side. • General concerns regarding the language and information that APS is asking is medically oriented-based upon problems whereas the ISP is strength-based. Licensing may require something else. Recommendation: That these be aligned. • There is variability in agency capacity to easily track visits and time for approvals from one agency that has had to set up a spread sheet to an agency in which all is computerized and can send out reminders. • Everyone indicated that the reviewers and staff at APS were easy to work with and very professional. <p>Eric Meyer disturbed four data sheets for member review: <i>Maine ASO Dashboard Report Adult Mental Health September 2008; Maine ASO Quality Improvement Program: Appendix C Fiscal Year 2009 Dashboard; Community Hospital Utilization Review Performance Standard 18-1,2,3 by Hospital: Class Members (4th Quarter, FY 2008); and Community Hospital Utilization Review Performance Standard 18-1,2,3 by Hospital: Class & Non Class Members (1st Quarter, FY 2009.</i> He also distributed an <i>ASO Administrative Burden Issues and Solutions</i> form and encouraged members to fill out the form and return it by the end of November.</p> <p>Eric said he appreciated the efforts of Don and many providers to carefully describe, identify and map out the administrative burdens. He said he wanted to attend all the CSNs across the state and extend the invitation to share with APS directly. He encouraged people to make recommendations on how to ensure that the utilization review process is one they can live with over time. An action plan will be developed from recommendations received as part of an ongoing quality improvement process.</p> <p>Discussion</p> <ul style="list-style-type: none"> • Question: The interface with MaineCare is not working properly. Providers know that someone has been

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	<p>reinstated to MaineCare before APS does. If we are going to use these systems, they need to work for us.</p> <ul style="list-style-type: none"> • <u>Answer:</u> APS is aware of problem. Temporary fix is to manually create authorizations by bypassing Care Connections. Not permanent solution. • <u>Question:</u> For daily downloads, you'll see the same numbers appear for several days with no change. We do the downloads and have to scan who we dealt with the day before. Could that be cleaned up? • <u>Answer:</u> Will look into it. • <u>Comment:</u> Would be more reasonable to increase number of days for continuing stay review to 5-10 versus 5-7. All of us are operating on less staff capacity to do these things. Didn't get any more staff or money from the state to do this added work. • <u>Answer:</u> Level of commitment and effort by providers is clear. • <u>Comment:</u> Level of review of cases by clinical staff varies. Hope that you are working toward consistency. • <u>Answer:</u> Really important to us that there be consistency. • <u>Comment:</u> Also encourage consistency in language: could abbreviate more. • <u>Answer:</u> Choice of language is a tough issue because we are doing this statewide and different regions use different terms. • <u>Comment:</u> Faxing continued stay reviews has been a problem. • <u>Answer:</u> will ask Carla to follow up with you. • <u>Comment:</u> We've been using the ISP developed by the state and have put considerable time and training into getting our staff to write consumer-focused ISPS. We think it's critical that the clinical information you are requesting on APS match that format. Already seeing conflicts: what you are asking for is much more medical. If asking us to change treatment and recovery focus, we need time to do that. My preference is that you change what you are asking for in APS service plan. • <u>Answer:</u> We've gotten that feedback from a lot of quarters and it's a very good point. We are not interested in people changing from a strengths-based and recovery focus in work. We share that view of community mental health services. We need to revisit how we are doing this. The complication is that MaineCare is a medically based insurance program so there is an element of medical necessity that needs to be established. • <u>Question:</u> Is there an overlap between your services and Schaller Anderson? • <u>Answer:</u> Schaller Anderson works with the consumer and MaineCare. APS works with providers. APS is contracted for prior authorization and utilization review for MaineCare mental health services. Schaller's focus is to ensure that health outcomes for individual MaineCare members improve so that their use of the health care system decreases. We've done a lot of cross training and meeting regularly with their Executive Director. There's been a push within the Department, Schaller, and APS to integrate – we're crossing lots of boundaries of service areas that traditionally have not been crossed. We'll take that as a hopeful sign for the future. • <u>Question:</u> What is the role of consumer advocate within APS? <u>Answer:</u> Title is member liaison; one role is outreach to community; other is speaking to consumers who contact APS. <p>Don Harden encouraged members to fill out the APS Administrative Burdens form. He said that MAMHS has been surveying its members about the costs of complying with APS and lost service capacity to consumers as a result of same. So far, six agencies have identified a \$1.9 million cost to meet the APS burden.</p> <p>Action: Members should fill out the Administrative Burdens form and return to by the end of November.</p>

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<p>VI. Report from Employment Specialist and Employment Service Network (ESN)</p>	<p>Sara Therrian gave the following update:</p> <p><u>Re the ESN:</u></p> <ul style="list-style-type: none"> • Another consumer joined • Recruited a business champion, human resources director from Alternative Solutions in Westbrook <p><u>Re the Employment Support Group</u></p> <ul style="list-style-type: none"> • Meetings first and third Thursday of the month • Will meet weekly in December due to demand for group • Will feature consumer telling story of how they became employed, what worked and didn't work for them <p><u>Re NFC Scales</u></p> <ul style="list-style-type: none"> • Still receiving a steady stream of NFC scales back. Been getting many referrals from case managers. Have a wait list. More than half of the NFC scales show a strong or urgent need to work. Almost half state that they are not in school and have a strong or urgent need to get back in school. <p><u>Re Job Development contacts</u></p> <ul style="list-style-type: none"> • Received three new contacts at the CSN meeting last month • Can be everything from a large business to a nonprofit to a mom and pop operation <p><u>Discussion</u></p> <p>A consumer commented that she has been looking for work for seven months and would prefer that her job developer accompany her to businesses which has not happened. Sara said that she provides services to consumers who are clients of Catholic Charities, but can offer advice and community resources that may be helpful. Christine McKenzie also offered to discuss this following the meeting and the consumer agreed.</p> <p>Karen Evans said she was shocked that the employment specialist was only working with the clients of one agency and said she thought the person was supposed to work with all agencies. Christine said that the goal is to get services for people who receive Section 17 throughout the state. "We'll get there." Don Harden said this is an evolving initiative. MMC recently looked at people who reported in a NFC scale that they had a strong or urgent need to work to see how long it had been since they worked. The average time was 13 years. The major predictors for successful reentry into employment are the desire to return and the second is how recently you've been employed. For this population statewide, the average is 13 years.</p>
<p>VII. Unused Prescription Drugs</p>	<p>Stevan Gressitt presented on the Safe Medicine Disposal for ME initiative, which has a goal of removing unneeded prescription drugs from circulation by providing an environmentally safe way to dispose of medications. Studies are revealing negative environmental impacts on water quality and aquatic life form. Some poisonings have been reported to poison control centers from the accidental ingestion of medications that have been left unsupervised and within the reach of children. Teens can abuse prescription drugs and home burglaries related to prescription drug abuse are on the rise.</p> <p>Dr. Gressitt said that the amount of unused prescription medication is costly and unsafe. 50 percent of medications prescribed at the 90-day level is not finished. Dr. Gressitt distributed envelopes which can be used to mail in unwanted or expired medicine. The federal DEA has just announced that it would like to use the Maine program as a nationwide model.</p>

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	<p>Discussion: Question: Have you done outreach to hospitals and primary care practices? Answer: No, the grant is consumer-based. Hospitals can engage in a commercial contract for drug disposal as can clinics. Little dicer in long-term care facility. Question: Can we give the envelopes to primary care providers to give to patients? Answer: Yes. Question: Is this different from bringing unused or expired drugs to a drop off place? Answer: Yes, different effort. Question: Why aren't we requiring drug companies to pay for this? Answer: Walk a fine line on that one. You buy your own walkman or phone but nobody buys their own drugs: you have insurance companies as intermediaries. Comment: Someone will have to take care of the cost because the state of Maine will not. Comment: Most industries have to pay an environmental cost to the federal government. Pharmaceutical companies may need to think about the environmental costs of their product.</p> <p>For more information, contact Jen Crittendon at UM, 207-262-7923.</p>
VIII. Budget Update	<p>Carlton announced that the Governor's curtailment order is out and can be found on the Governor's web site: http://www.maine.gov/governor/baldacci/policy/Curtailing.html</p>
IX. Consent Decree	<p>Carlton said that the Quarterly Report submitted to the Court Master is now on-line: http://www.maine.gov/dhhs/mh/consent_decree/November-2008/index.html</p> <p>Carlton also announced that the Court Master recently issued a ruling, a copy of which was provided to members, that finds that withholding services for clinically eligible non-class members would violate the parity provisions of the Settlement Agreement as construed by the Law Court as well as the Department's own comprehensive plan. The Court Master recommended that the Department reinstate service eligibility for these individuals and resume funding, seeking any necessary appropriations to provide mental health services included in the State's Medicaid Plan (i.e. community integration, ACT, daily living supports, skill development, out patient services, medication management, and residential treatment) for all persons who are clinically eligible, even though they may be financially ineligible for MaineCare.</p> <p>Members discussed that the ruling essentially eliminates the history in the state in terms of thinking in terms of class and non-class members with class members always having the priority. Grant funds previously restricted to class members will now be used for both class and non-class, according to the ruling. The class member designation still holds, but now has less to do with service delivery. The Department was trying to narrow the definition in terms of public service eligibility to those on MaineCare. The Court Master's ruling says that the Department can't do this.</p> <p>Discussion: Members discussed that it is good news that a legal framework exists that people deserve these services; however, the Department and providers are unclear how services will be paid for. If the state is obligated to pay for all of the services, then there is no incentive for private insurance companies to pay.</p> <p>Question: Can we require people to pay if they have the ability to do so? Answer: We don't know yet.</p>

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X. Consumer Council System of ME Update	<p>Karen Evans gave the following update:</p> <p><u>Local and regional activities</u></p> <ul style="list-style-type: none"> • Regional meeting at the Dana Center today from 3-5 p.m. and from 6-8 p.m. • Local Meeting: elected chair and secretary; Anne Pringle presented; local council recommended three people for Maine Med/Spring Harbor Advisory Committee. • Local Council will elect CSN representative at next meeting and will have APS presentation as well. <p><u>Statewide Council:</u></p> <ul style="list-style-type: none"> • Still working on conflict of interest statement. • Helen Bailey presented on involuntary treatment legislation and clinical review panel. • Leticia Huttman presented on the budget; members discussed using the rainy day fund. • Elections for officers for the statewide council will happen soon; did not happen at the last meeting due to time.
XI. WRAP Funds Proposal	<p>Ingraham and Shalom will continue to disperse the funds as they have been and will invoice Catholic Charities of Maine. Catholic Charities will cut the checks.</p> <p>Action: Members agreed to this proposal.</p>
XII. Other	<p>Members discussed issues with ISPs and coordination of care. CS workers are showing up at hospitals and participating in treatment and discharge planning, but somehow, individual ISPs are not coming with them. If hospitals have concerns, they should contact their local crisis provider.</p> <p>Action: Put ISP on agenda for future discussion</p>
XIII. Meeting Recap and Agenda for Next Meeting	<p><u>Meeting Recap</u> See ACTION items above.</p> <p>CSNs will not meet in December.</p> <p><u>January Agenda Items:</u> ISP Follow Up ESN Update OAMHS Communication Budget Update Consent Decree Consumer Council Update</p>