

**Community Service Network 6 Meeting
DHHS Offices, 161 Marginal Way, Portland
June 20, 2008**

Approved Minutes

Members Present:

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| • Jan Burns, AIN | • Phoebe Prosky, Freeport Counseling | • Ed Blanchard, Shalom House Inc |
| • Peter Driscoll, Amistad | • Glenn Shelton, Goodwill Industries | • Joyce Cotton, Spring Harbor Hospital |
| • Kitty Purington, Community Counseling Ctr | • Larry Davis, Hawthorne House | • Catherine Snow, Spurwink/Portland Help Ctr |
| • Karen Evans, Consumer Council of Maine | • Burma Wilkins, Mercy Hospital | • Leslie Mulhearn, Sweetser |
| • Christine Holler, Consumer Council of Maine | • Eric Haram, Mid Coast Hospital | • Kelli Star Fox, Transitions Counseling |
| • Lois Jones, Counseling Services Inc. | • Dick Balser, MMC/Vocational Services | • Sarah Rawlings, Volunteers of America |
| • Sue Percy, Creative Work Systems | • Michael Faust, PSL Services | |
| • Georgana Prudhomme, Crossroads for Women | | |

Members Absent:

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| • Catholic Charities | • NAMI ME Families (excused) | • Smart Child & Family (excused) |
| • Community Mediation Services (excused) | • NOE (excused) | • Sweetser Peer Center |
| • Gorham House | • Parkview Adventist Medical Center | • Work Opportunities Unlimited |
| • Mercy Hospital | • Preble Street (excused) | • Youth Alternatives/Ingraham |

Alternates/Others present:

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| • Helen Bailey, DRC | • Christine McKenzie, MMC/Vocational Services | • Don Burns, AIN (CSN 7) |
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Staff present: DHHS/OAMHS: Don Chamberlain, Jamie Morrill, Carlton Lewis. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Carl opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	<p>The minutes from the April meeting were approved as written.</p> <p>At this point, Karen Evans again asked Don about the issue of consumer notification re: their information being given to APS Healthcare.</p> <p>Don asked provider members to speak to this. One provider said their clients sign the usual HIPAA document required for proper reimbursement; however, she also expressed concern about the large quantity of information shared with APS—much broader than needed for billing. APS asks for much more detail than she has ever seen with other insurance prior authorizations. Don agreed that it is a lot of information that goes to APS.</p> <p>Karen said she has heard that many consumers don't even know about APS—as noted by discussion at the recent HOPE Conference. Consumers are being left out of the loop, she said. She also said that APS has indicated it is the responsibility of providers to inform their clients—so as things stand, no group is taking responsibility for informing consumers. APS does have some staff that provide member education.</p> <p>Helen Bailey added that APS sent out handbooks earlier in the process using information from MECMS (MaineCare) and many were returned due to bad addresses. Perhaps APS should resend with contact information taken directly from enrollment? Karen requested that OAMHS ask APS to resend the handbooks to all members.</p>

Agenda Item	Presentation, Discussion
	<p>ACTION: Don will ask APS to resend member handbooks.</p>
<p>III. Enrollments/RDS</p>	<p>Don reported on the progress of data entry for enrollments and RDS (Resource Data Summary) information. Overdue entries improved from 58% to approximately 30% by the May 15th deadline, but 15% mark must still be met. Some providers have received “Level II” contract notices from OAMHS, meaning that they must have a compliance plan in place to meet the 15% level in order to receive a contract for FY 2009. Don further explained this covers only cases already in the system, not the substantial number that have never been enrolled.</p> <p>As of August 1, APS Healthcare will take over the enrollment and RDS process and download to the state’s EIS/RDS system--thus eliminating the need for providers to enter data into both systems. Beginning at that point, the many missing enrollments must be entered into APS in order for providers to receive payment for services. This and the continuing stay reviews should result in current and accurate information. Don emphasized the importance of this data, since it drives unmet needs reports and complies with the Consent Decree as a basis for budget requests.</p> <p>Don said OAMHS is working on aligning the 90-day RDS update and the 180-day continuing stay review requirements.</p>
<p>IV. Consumer Council Update</p>	<p>Christine Holler and Karen Evans gave the following updates on the Consumer Council System of Maine:</p> <ul style="list-style-type: none"> • The Statewide Consumer Council (SCC) held a retreat last week to work on various policy matters. • A particular concern is that materials generated by the State are often written on a college level—materials should be written on a more understandable level. • SCC members, Christine Holler and Lydia Richard, each have accepted assignments to an OAMHS committee: Quality Assurance and Crisis Services, respectively. • The SCC is seeking a no-cost extension for FY 2008 funds. • The SCC is in the process of hiring an executive director, which is a priority goal. The position was offered to an ideal candidate who had similar experience in another state, but the person had accepted another job and thus declined.
<p>V. Unmet Needs Reports</p>	<p>Participants received a multi-page report on the EIS/RDS enrollment and unmet needs data for the 3rd Quarter of FY 2008 (Jan-Mar) prepared by Helen Hemminger of the Muskie School in conjunction with OAMHS.</p> <p>Don re-emphasized the importance of this unmet needs data in budget planning and Consent Decree compliance, and the essentiality of it being up-to-date and complete. The system is programmed to determine if a need is <i>unmet</i> according to specific time parameters for each service category. OAMHS expects to see greater unmet needs data as reporting improves.</p> <p>The group reviewed each table in the materials, and noted that most of the changes between Qtr 2 and Qtr 3 probably reflect data cleaning and better reporting. Also noted:</p> <ul style="list-style-type: none"> • CSN 6 had 61% of its enrollments current compared with 69% statewide. • In all categories, CSN 6 was at or below statewide rate in unmet needs reported per 1,000 open cases. <p>Comments/questions:</p> <ul style="list-style-type: none"> • MaineCare should be covering dental care, eye care, etc.—I don’t know what we’re waiting for—what’s being done

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	<p>about it? A: Such changes are not solely OAMHS issues—DHHS as a whole, Governor, and legislature would make those decisions.</p> <ul style="list-style-type: none"> • Outreach is not represented in any way—this data ignores folks that are not part of the system. There are no attempts to gather or acknowledge their needs. This is a snapshot of only those people who are in this system already. A: That’s correct. • Consumers might not ask for what they know is not available, i.e. Living Skills. Are providers letting people know that (though farfetched) if they ask for a service, it might be reinstated? OAMHS would like to see community support workers discuss needs even if the service doesn’t exist—the needs should show up on the RDS. • Need consistent understanding of what each subcategory actually means. Is there sufficient and timely training for community support workers, especially in light of frequent staff turnovers? A: Community support workers are trained—though additional training may be needed. Consent Decree Coordinators (CDCs) and agencies do the trainings. Also, if components or subcategories are missing, the CSN can advocate for changes. • Healthcare shows up with consistently high numbers of unmet needs, and data shows that people with serious mental illness die 25 years sooner than the general population. We should be focusing our efforts on that. • What are we going to do in regards to these reports? Look at them and then what? A: Look to see what you want to focus on and work on as a CSN.
<p>VI. Brief Review of Subcommittees</p>	<p>Don directed people to the back of the agenda for a list of the subcommittees begun last year and now ready to reconvene:</p> <ul style="list-style-type: none"> • Housing—Standard 12(1) • Vocational—Standard 26 • Recovery—Standard 33 • Hospital Readmissions (not sure of continuing status) <p>All members were requested to choose a subcommittee to join. Since healthcare is closely linked with recovery, the Recovery Subcommittee will discuss adding healthcare to its list of issues.</p>
<p>VII. Subcommittee Work Sessions and Report Out</p>	<p>Each subcommittee met for approximately an hour and reported out items discussed as follows:</p> <p><u>Housing</u></p> <ul style="list-style-type: none"> • Needs are greatly underreported. Discussed possible reasons. • Increasing numbers on Section 8 wait lists. • BRAP: Will those who lose Section 17 eligibility (through APS process) lose eligibility for BRAP? Should revisit eligibility criteria for BRAP. • Too many evictions happening. More people could benefit from individualized, flexible supports—could provide an early warning system when difficulty with landlord starts. Perhaps go to a per diem model, like much else in the system. <p><u>Vocational</u></p> <ul style="list-style-type: none"> • MMC’s statewide initiative—Employment Specialist (ES) in each CSN. CSN 6’s ES is hosted by Catholic Charities in Portland. • What data would be helpful to gather? • Distributed packet of information (to all CSN members), which includes the “Need for Change” survey tool being used for clients to self-rate their need to change employment or education status.

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	<ul style="list-style-type: none"> • In response to a member’s suggestion, Don agreed that the best vehicle to address employment issues in the CSN would be the Employment Service Network (ESN), under construction in each CSN per the contract with MMC. Anyone interested should join the ESN and report to the CSN. <p><u>Recovery</u></p> <ul style="list-style-type: none"> • Members agreed that the issue of healthcare warrants its own subcommittee. Recommendation: Convene a healthcare subcommittee that will work closely with the Recovery Subcommittee due to clear overlap. • Invite Dr. Elsie Freeman to a CSN meeting to give a presentation on the “25 Years Too Soon” data and initiative. • The Recovery Subcommittee will begin by using the National Consensus Statement on Mental Health Recovery, “The 10 Fundamental Components of Recovery,” as a jumping off point. (link: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/) <p><u>Hospital Readmissions</u></p> <ul style="list-style-type: none"> • Data for readmission to different hospitals would be difficult to get—couldn’t do it statewide. Maybe APS could do—would have access to information? Don Chamberlain will follow up with APS. • Dual diagnosis (MR/MH)—how to serve when mental health needs are acute. • Jail Diversion; obtain current information on Co-Occurring Court in Augusta. • ISPs (Individual Service Plans) at admission. • Will continue as a subcommittee. Add medical issues and healthcare? <p><u>Question:</u> Why is it so hard for hospitals to get the ISPs? Is the 24/7 availability requirement not working? Files contain other supporting documents from community support providers, why not the ISP? Don asked to defer this discussion to the Region 1 Hospital/CLASS meeting for practical work by the providers involved.</p> <p>ACTION: Carlton will bring this issue to the Region 1 Hospital/CLASS meeting.</p>
VIII. Review of Crisis Data	<p>Members received copies of Adult Mental Health Crisis Reports for the 3rd Quarter of State Fiscal Year 2008, including: 1) the statewide summary for all providers of adult crisis services, 2) individual data “face sheets” for each provider in the state, and 3) data packet(s) for the crisis provider(s) in their CSN (Youth Alternatives/Ingraham in CSN 6). Don noted that the next round of reports will include percentages on the face sheets and pie charts will be better labeled.</p> <p>Don also reported that crisis providers met recently and went through data categories to clarify consistent definitions and counting practices. Data will be continue to be published quarterly for CSNs, but will have some shift in information in future editions.</p> <p>Don reviewed the Ingraham’s crisis report with the group, and pointed out:</p> <ul style="list-style-type: none"> • Because MMC handles its own psychiatric cases in its Emergency Department (ED) and because Mercy Hospital does not have an agreement with Ingraham, the numbers reported seen by crisis in the ED appear lower. Without the numbers seen in MMC’s and Mercy’s EDs, the overall picture of how many are seen in EDs is unknown and presents a concern in this CSN area. OAMHS is looking to reduce the numbers seen in EDs, where sometimes crises worsen, and to increase numbers seen in the community.

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	<ul style="list-style-type: none"> • Lower than expected numbers re: those who have a community support worker whose wellness plan, crisis plan, ISP, or advanced directive plan was used in face-to-face contacts with crisis. (82 of 186 – CSN 6) Don explained that the number using plans includes plans created by crisis or by outpatient providers, and this inclusive approach will continue. • NOE should be excluded from the data, since they no longer have a crisis contract with OAMHS. <p>Questions/Discussion:</p> <ul style="list-style-type: none"> • Peter of Amistad asked how warmline data should be reported. Don said it would be useful to report on it quarterly in all CSNs. He and Peter will discuss details after the meeting. • Are there people falling through the cracks? There are such high numbers of calls compared to face-to-face contacts. A: Can't answer—the provider is not present to discuss. • Would Amistad's Peers in the ED program at MMC have numbers of contacts seen? That information would be helpful. • The number of telephone contacts referred to the police would be very telling data. How often do people call crisis and end up with the police at their door? Don said he will see what he can do about getting that data. <p>ACTION: Don and Peter will discuss and plan for warmline reporting.</p> <p>ACTION: Don will follow up re: data on number of crisis calls that result in law enforcement contact.</p>
IX. Legislative Session January 2009	<p>Don briefly explained that initial budget work for FY 2010 begins in August and also encouraged members to raise issues for which they would like to see legislation submitted by OAMHS. Further discussion on both budget and bills will be on the August and following agendas.</p>
X. Community Integration and ACT Funding	<p>Don explained the process for accessing general funds for Community Integration (CI) and ACT services, beginning Aug. 1: <i>(Please note: People currently receiving grant-funded CI and ACT services will continue to do so for the month of July.)</i></p> <ul style="list-style-type: none"> • OAMHS chose not to assign dollars to agencies as in the past, but to pool the funds and disburse on a case-by-case basis. • All CI providers will have access to the funds. CI provider contracts will contain a “not to exceed” dollar amount—a technical fiduciary requirement in order to disburse funds for those services. The amount may be amended, if necessary. • The process is to apply through APS Healthcare and register for prior authorization (PA) in the same way it is done for MaineCare services. APS will give the PA and do reviews for continued services. The difference is the payor—providers will bill OAMHS and OAMHS will match the authorization with the invoice and process payment. • OAMHS is working to finalize the eligibility criteria list--so far it includes: <ul style="list-style-type: none"> ○ People coming out of hospitals ○ People coming out of jails ○ People coming out of CSUs (crisis stabilization units) ○ People on spend-down with income under 150% of poverty level ○ People on SSI/SSDI under 150% of poverty level • APS will screen for eligibility using the final criteria list. • Dollars will be distributed by CSN, by the number of people with SMI (severe mental illness). This number will be calculated using the population of adults and the percentage of the population that is expected to have SMI, as determined by the National Institutes of Health.

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	<ul style="list-style-type: none"> • IMPORTANT: People already receiving grant-funded CI services will continue to do so in the usual manner through the end of July. <p>OAMHS will be sending out more information on the above process soon.</p>
IX. Other	<p><u>Warmline Staffing</u> Karen Evans asked why DHHS pays for two people to staff the 211 referral service, but only one for Amistad's statewide warmline. She said the warmline has only one staff for overnight (from 1 a.m. to 8 a.m.), which she believes creates "a dangerous situation for consumers." Don responded that the warmline is funded with a fixed figure, and the provider then manages the service within that context. He said he doesn't know how the 211referral service is funded.</p>
X. Public Comment	None.
XI. Meeting Recap and Agenda for Next Meeting	<p>See ACTION items above.</p> <p>Members voted to meet in both July and August. (Some CSNs opted not to meet in July.)</p> <p><u>July Agenda Items:</u> Subcommittee Work and Reports Consumer Council Update</p>