

**Community Service Network 6 Meeting
DHHS Offices, 161 Marginal Way, Portland
September 19, 2008**

Draft Minutes

Members Present:

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| <ul style="list-style-type: none"> • Jan Burns, AIN • Mary Loalker, Amistad • Sally Temm, Catholic Charities • Kitty Purington, Community Counseling Center • Karen Evans, Consumer Council of Maine • Susan Percy, Creative Work Systems • Georgana Prudhomme, Crossroads for Women • Glen Shelton, Goodwill | <ul style="list-style-type: none"> • Burma Wilkins, Mercy Hospital • Tom Kivler, Mid Coast Hospital • Sara Therrien, MMC Vocational Employment Specialist • Deborah Rousseau, MMC/Vocational Employment Coordinator • Joe Brannigan, Shalom House • Holly Hathaway, Smart Child & Family | <ul style="list-style-type: none"> • Joyce Cotton, Spring Harbor Hospital • Catherine Lorello-Snow, Spurwink/Portland Help • Leslie Mulhearn, Sweetser • Kelli Star Fox, Transitions Counseling, Inc. • Wayne Barter, VOA • Pat McKenzie, Youth Alternatives/Ingraham |
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Members Absent:

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| <ul style="list-style-type: none"> • Counseling Services, Inc. (excused) • Freeport Counseling (excused) • Gorham House | <ul style="list-style-type: none"> • NAMI ME Families (excused) • NOE • Parkview Adventist Medical Center | <ul style="list-style-type: none"> • Preble Street (excused) • PSL Services • Riverview Psychiatric Center |
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Alternates/Others present:

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Staff present: DHHS/OAMHS: Carlton Lewis, Marya Faust, Ron Welch, Leticia Huttman, Jereal Holley, and Dr. Stevan Gerrits. Muskie School: Elaine Ecker, Scott Bernier.

Agenda Item	Discussion
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	<p>The minutes from the August were amended as follows:</p> <p>Page 4, third line: "...client by identifying all unmet needs at once." Please change to: "...client by identifying all goals at once."</p> <p>Minutes were approved as amended.</p>
III. Feedback on OAMHS Communications	A member asked for an update on the status of the Crisis MOU. A. The minimum requirements for crisis services will be out within two weeks.
IV. Legislative Session January 2009 – Suggested Bills	<p>Ron and Marya explained that during September, OAMHS files topics for legislation. At this point in the process, OAMHS has put forward several concepts without specific language for the DHHS Commissioner and Governor to consider:</p> <ol style="list-style-type: none"> 1. <u>Prior authorization for PNMI beds</u>: MaineCare does not allow for prior authorization for PNMI beds, and legislative authority is required to change the MaineCare rule. 2. <u>Add forensic patients to the bill authorizing clinical review panels to mandate involuntary medications</u>: At this time, only those civilly committed come under the provisions of this bill. OAMHS would like legislation to include people on the forensic side as well. Also, the "lay advisor" terminology in the bill needs to be clearly defined. 3. <u>Expansion of CNA Registry to include other direct care workers</u>: Presently, there is no registry for people

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	<p>working in the mental health field with MHRT certifications and therefore no way to track or record the performance of those working in the field. OAMHS would like to expand the current CNA registry to include direct support mental health professionals (MHRT/C, MHRT I, MHSS) as a way of assuring knowledge and quality of practitioners. This would also provide a mechanism for decertification, which presently none exists.</p> <ol style="list-style-type: none"> 4. <u>Exempt critical incident reporting from discovery and expand and clarify the mandate for reporting.</u> 5. <u>Reduction and disposal of unused medications (two concepts, for safety and less waste):</u> <ol style="list-style-type: none"> a. Shorten new medication prescriptions to 14 days, with no co-pays: Finding the most effective medications often requires trials and can result in waste and disposal issues if abandoned prescriptions have been written for the usual 60-90 day period. Under this concept, any new prescription would be written for a shorter period and consumers would not be liable for co-pay on any of them, even if it involves several trials. b. Establish authority of Department of Public Safety (DPS) re: disposal of unused drugs, rather than the Department of Environmental Protection (DEP). DHHS and DPS want to remove disposal of unused drugs from DEP regulations and establish new regulations. DHHS and DPS see drugs as different from other hazardous materials, and DPS would be better able to manage proper control, storage, etc. <p>Discussion:</p> <ul style="list-style-type: none"> • The registry would be a way for an agency to report on ethical behavior violations? A. Yes. • As part of this registry will it include a requirement for annual training? A. We're looking at that. • I urge the establishment of this registry...perhaps it could be established in a way that provides some relief for agencies in licensing reviews? • In York County, the police are already managing unwanted medications, and it has been a real help. Marya responded that law enforcement is obligated to take unused medications, keep them safe, and safely dispose of them. Another member noted that some pharmacies offer take back days for unwanted medications which are then turned over to law enforcement. • A member reiterated her concern about lay advisors (in No. 2 above). A. Currently language for lay advisors is unclear and is one of the areas being looked at. Response from member: I'm concerned that one lay advisor without training will have to go up against a hospital. Will they stand up against 2 or 3 psychiatrists?
V. Budget	<p>Ron informed that work is underway on the Supplement Budget for 2009 and the Biennial Budget for FY 2010/2011. He said that this is the first year OAMHS had the benefit of reliable unmet needs data providers submitted through the RDS. The data isn't perfect yet, he said, but adequate for preparation of budget requests in the initial steps of the process. Though OAMHS has submitted their initial budget requests, the Commissioner is well aware OAMHS is gathering additional input from the CSNs, the Consumer Council System of Maine, and QIC to see if additional needs are not yet addressed. OAMHS has requested increases resources for housing, outpatient services, and medication management.</p> <p>Ron pointed out the memo and budget template OAMHS sent out in August for members' use, which included two main categories for budget requests: 1) client-specific needs, backed up with data; and 2) systems needs. Several members indicated they had not seen the form. Copies were made and passed around. Members may submit their requests via email to Elaine Ecker before September 26.</p> <p>ACTION: Members should complete budget forms and submit them to Elaine before Sept. 26. Please see the CSN website for the form. www.maine.gov/dhhs/mh/csn.</p>

Agenda Item	Discussion
	<p>Budget/Unmet Needs Discussion:</p> <p><u>In-Home Support for Elders</u></p> <ul style="list-style-type: none"> We're struggling with in-home support for elders who are not consent decree members. Mental health and medical needs are critical. We can submit data from our agency in regards to the need. Are there others seeing this? Response from others: Yes. It is a struggle to meet needs of our elder population. We don't have appropriate services for them. It is hard for them to reach out for help. Home help agencies are turning to us for help. <p><u>Health Care</u></p> <ul style="list-style-type: none"> I'm concerned by the Elsie Freeman report on how the mentally ill die 25 years sooner than others. We need to do something about it. What is being done to address the reduced life expectancy of the mentally ill? A. That is an excellent point. The Department is considering what priority issues to work on in the next year, and one of them is to set up a system so everyone we serve has a medical home. People with MaineCare are eligible for health care—it's a linkage issue. If community mental health providers had some nursing capacity, they could screen regularly for health issues. <p><u>Housing</u></p> <ul style="list-style-type: none"> Make sure people also have a physical home before a medical home. A. OAMHS has requested a dramatic expansion in BRAP funding—more than double where we are now. <p><u>Adult DD/MH Population</u></p> <ul style="list-style-type: none"> Caring for DD/MH (Developmentally Disabled/Mental Health) populations has become a challenge. DD consumers are frequently cycling through the emergency department (ED). Hospitals do not have the specialty to handle them. A. This has been brought up by other CSNs. This population is best served by PNMI residential treatment. Response from the member: The needs go beyond the community care level and need intensive placement. We don't have that. A. Carlton: In my experience with DD rapid response, they are better served in their PNMI setting. They will "up staff" rather than go to the Emergency Department. Response: We have tried that and there are times when it's not enough. They keep going back to ED. It produces a safety issue in the group homes and sometimes law enforcement has to be called in. It's not the best for the individual, but the group home needs that level of safety. Ron's response: There are few people with psychological and developmental disabilities issues who have been residing at Dorothea Dix Psychiatric Center (DDPC) way too long. We're working with OACPD to create a very discrete tu[e of residential facility for them. Our goal is to move five or six of them out of DDPC and to serve as a model for what we can do in the rest of the state. Traditional MH CSU's can't be used for MR--it isn't appropriate. Would need to be retooled, which would have costs, but might be able to meet some of the need. There are little things that can be done to help them with healthcare issues such as screening blood pressure. <p><u>Transportation</u></p> <ul style="list-style-type: none"> Transportation is always a kicker. It is a challenge to get people to care/appointments with making it a crisis every time.

Agenda Item	Discussion
	<p><u>Medication Management</u></p> <ul style="list-style-type: none"> Ron explained that under the new “Super 65” (MaineCare Section 65), the single code for Medication Management that allows for only a half-hour billed on any one day doesn’t cover what agencies need to do to provide that service. OAMHS has been working to address this issue, and the matter is “on the Commissioner’s desk now.” <p><u>Corrections</u></p> <ul style="list-style-type: none"> We’re seeing higher acuity and more aggressive behavior with our clients, and we’re ill equipped to handle it. Additional training is needed so we can manage these clients, especially those coming out of jails. Is there anything in the budget on corrections/diversion issues? A. Not in what we have proposed. We are keeping the ICMs that are focused on this population, continuing the ACT Team for the Co-Occurring Court, and if we get the additional BRAP funds, will work to make provision for waiving the preclusion of people from correctional systems. Member response—then you have to find landlords that will take them. <p><u>Peer Support</u></p> <ul style="list-style-type: none"> Peer support is an unmet need, even though it is not rated highly on the unmet needs report—there are many reasons why that may be—people in many areas of the state don’t even know what it is. <p><u>Data and APS Healthcare Administrative Burden</u></p> <ul style="list-style-type: none"> Catholic Charities is experiencing a severe impact in working with APS. The time involved to give them data is taking away from needed time with clients. If something is not changed, we will cease to exist in 18 months. A. We are aware of this. Don Chamberlain is meeting with all agencies to get a comprehensive survey and will send a written review to everyone. Another member: It’s taking too long. We’re cutting positions now. The administrative burden just gets worse and worse and worse. A. Don should be done in a week or so, and we will be meeting with APS to look for solutions. We can tell staff there is hope? A. We’re all frustrated, and we’re hoping something comes out of this. It’s time to look at how we can simplify the process. We’re waiting seven days to get prior authorization for services. What is APS going to do with 17,000 stay reviews in a 3 to 4 week period later this fall? A. We’re making a note of it. We also need to stop collecting redundant/duplicate data. We can’t afford it. Could we have a universal assessment like they did in Ohio? Why do we have such an inefficient system? Caution is needed re: where the “data arm” of state government is taking us. <p><u>Data/Consent Decree</u></p> <ul style="list-style-type: none"> Ron: Most of the data collection is Consent Decree driven. We’re obligated to turn in reports quarterly. It’s one way to make sure services are in place and things are moving. Ron also gave a brief history of the Consent Decree, noting it originated in 1991 against AMHI and does not even contain the word “recovery.” One member voiced support for the Consent Decree, saying at the time, the lawsuit was very necessary, but did take on a life of its own “once the lawyers got a hold of it.”

Agenda Item	Discussion
	<ul style="list-style-type: none"> • Ron agreed, saying as acting commissioner at that time, he had supported the lawsuit going forward. The Department wrote in many things on the “community side.” There have been unintended consequences that could be troublesome to everyone, he said. • A member suggested Elizabeth Jones (the recently appointed Court Monitor) be invited to attend a CSN meeting to hear what members are saying. Another member voiced agreement as long as that doesn’t take the place of Ms. Jones meeting with them or their boards individually. The members made and passed the following recommendation: <p>RECOMMENDATION: That Elizabeth Jones is invited the next CSN 6 meeting she can make it to.</p> <p><u>Moving to Next Level of Care/Reimbursement</u> Members engaged in a discussion about the difficulties of moving people to the next appropriate level of care, whether higher or lower. Beds are not always readily available and sometimes providers may be hesitant to take person lest they also end up unable to move the person as needed.</p> <p>Ron encouraged providers on the local level to work together for solutions for these “continuity of care” situations, noting the solution is not “in Augusta.” Members agreed, emphasizing that they do this all of the time, but providers are stretched. Joyce of Spring Harbor reported that lengths of stay are “skyrocketing,” and due to particular needs/acuity/gender/history/behavior of some inpatients, they cannot fill all of their beds all of the time. “Right now we have 4 people on a unit where usually we have 14,” she stated.</p> <p>Members concluded that in the face of great collaboration, teaming, and problem-solving there continues to be a dilemma. Providers are afraid of the day when they aren’t going to be paid for the time a person is waiting to be placed in the next level of care, despite their best efforts. “If we show we don’t have capacity, will the Department be behind us?” Providers need to be sure there’s funding if a person can’t move for a period to the appropriate level of care.</p>
VI. Public Comment on Budget	Those present agreed that public comment was covered during the budget discussion above.
VII. Wraparound Funds	<p>Discussion</p> <ul style="list-style-type: none"> • I like having the funds with the agency. It makes the process go faster for the consumer. • I just wrote a check for tires this week so that a consumer could continue to drive to work. • The group was in agreement to keep the wraparound process as is in this CSN. <p>Wraparound Funds will be raised one more time at the October meeting. If you have any thoughts before then, please email them to Elaine Ecker at eecker@usm.maine.edu.</p>
VIII. PNMI Discussion	<p>PNMI Bed Hold Days</p> <p>Karen reported that the Shalom Consumer Advisory Council voted to work with the Local Consumer Council to draft a problem statement about loss of bed hold days in PNMI facilities. She noted that Chapter 115 states an agency can bill for 30 bed hold days, yet providers say it is only 24 hours. This conflicting information is creating confusion among consumers. Where is the truth? Ron responded that OAMHS had proposed 30 days in legislation during the last session. However, CMS (Centers for Medicare & Medicaid Services) stepped in and ruled there can be no bed hold</p>

Agenda Item	Discussion
	<p>days—the federal government will not pay for services that are not provided. A person can be absent for under 24 hours only in order for providers to bill for that day. OAMHS readjusted funding/rates to cover some bed hold days so PNMI can recover costs up to a cap.</p> <ul style="list-style-type: none"> • Is this amount enough? A: PNMI's 'settle up' (cost settlement process) at the end of the year. Response: It can take 2-3 years to receive those settlement funds. We can no longer afford to wait that long. • There was an increase in funding, but a reduction in the cap. The loss of bed hold days and the reduction in the cap results in Shalom losing \$55,000 this year, Joe Brannigan said. • Susan Percy of Creative Work Systems reporting they anticipate losing \$85,000 this year, and may not be able to continue as a PNMI provider. • Ron: The CMS Ruling was a curve ball to us, too—flies in the face of recovery—it's seriously problematic. Don Chamberlain is at a PNMI meeting this morning with other DHHS Offices that are dealing with this issue trying to find solutions. • Consumers will be hit as hard as providers—re: recovery and integration into the community. <p>Members engaged in a discussion about how consumers might end up being denied away days, and if so, how would this be tracked? Also at issue is how consumers will be notified of this change and what appeals process they would use for being denied away days. Carlton informed of some safeguards in that OAMHS must be notified when a person leaves a bed. (It was unclear to this note taker if that refers to permanent or temporary leaving of a bed.)</p> <p>Karen stated that consumers do need to be notified of this change and of the appeals process to use should they be denied away days.</p> <p>Ron added that this highlights the pitfalls of funding this service through MaineCare. In the longer term, the movement is toward funding more with BRAP or other housing subsidies and providing wraparound services. OAMHS has proposed at least 20 beds funded by BRAP in the 2011 budget.</p>
IX. Consumer Council Update	<p>Karen reported on the Consumer Council System of Maine:</p> <ul style="list-style-type: none"> • The Statewide Consumer Council (SCC) did not meet in September and plans to hold an annual meeting on October 8 and 9. They did meet with the state about unmet needs. • The local council (LC) in Portland held elections for the chair and secretary positions. The LC also drafted a letter in regards to the PNMI situation. • MMC's Employment Program has approached the LC with a request for consumer representation on the ESN. • The LC's next meeting is Oct. 7, 4-6 pm at the Dana Center. Pat McKenzie of Youth Alternatives/Ingraham will talk about crisis services at the meeting.
X. Report from Employment Service Network	<p>Sara Therrien has been hired as the ESN for this CSN. She introduced herself, handed out business cards to those present, and gave an update:</p> <ul style="list-style-type: none"> • She is learning about educational opportunities within this CSN area. • She is meeting with teams at Catholic Charities, her host agency. • She has had six referrals already. • She has attended one ESN meeting where they reviewed a case study and discussed it. They also discussed approaches for job development.

Agenda Item	Discussion
	<ul style="list-style-type: none"> • She is also taking inventory of training/job opportunities within the CSN and will report this back to the CSN.
XI. Impact of Energy Cost	<p>Ron initiated this agenda topic. Please refer to the third page of the worksheet that was sent out on system needs. We made some initial projections around this. We're asking for all members to fill-out the third page and submit it back to us. Please do same for your mileage costs. The governor may decide to put all requests together from all non-profits. We will also seek a bond issue to seek assistance to do energy audits of your buildings.</p> <p>Discussion:</p> <ul style="list-style-type: none"> • Youth Alternatives/Ingraham is doing some work around this now. I could email this CSN on our results. It's an intensive five-day training and we might be able to make some slots available for other agencies.
XII. Other	<p>Karen thanked Don Harden for providing the requested information about rep payee fees. She also stated that she doesn't think people with substance abuse should be charged more for this service as apparently the regulations allow.</p>
XIII. Public Comment	<p>There was no public comment.</p>
XIV. Meeting Recap and Agenda for Next Meeting	<p>See ACTION items above.</p> <p><u>November Meeting Agenda:</u> OAMHS Communication Consumer Council Update ESN Update Wraparound Funds Elsie Freeman "25 Years Too Soon" Presentation Elizabeth Jones?</p>