

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

January 16, 2009

Approved Minutes

Members Present:

<ul style="list-style-type: none"> Amistad – Peter Driscoll Catholic Charities Maine – Sally Temm Community Counseling Center – Kitty Purington, Consumer Council – System of ME - Karen Evans (left at 11 AM) Creative Work Systems – Susan Percy Freeport Counseling Center – Phoebe Prosky Mid Coast Hospital – Tom Kivler 	<ul style="list-style-type: none"> MMC/Spring Harbor/Voc Services – Christine McKenzie, Richard Balser, Mary Jean Mork NAMI-ME Families – Alice Woodall Preble Street – Jon Bradley Riverview Psychiatric Center – William Nelson Shalom House – Ed Blanchard, Mary Haynes-Rodgers Smart Child & Family Services – Amy Thomas Spring Harbor Hospital – Joyce Cotton, Ric Hanley 	<ul style="list-style-type: none"> Spurwink-Portland Help Center – Catherine Lorello-Snow Support and Recovery – Robert Sheehan Sweetser – Leslie Mulhern Transitions Counseling, Inc. – Kelli Star Fox (left 11 AM) Volunteers of America – Vicki MacWhinnie Youth Alternatives/Ingraham – Pat McKenzie, Steve Addarrio
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Members Absent:

<ul style="list-style-type: none"> AIN (Excused Absence) Counseling Services Inc. Crossroads for Women (Excused absence) First Atlantic/Hawthorne House 	<ul style="list-style-type: none"> Goodwill Industries Gorham House MMC Vocational Employment Specialist 	<ul style="list-style-type: none"> Mercy Hospital NOE Parkview Adventist Medical Center PSL-Services
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Alternates/Others present:

<ul style="list-style-type: none"> Dennis King- presenter 	Barbara Shaw – USM Muskie School - presenter	
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Staff Present:

<ul style="list-style-type: none"> DHHS: Carlton Lewis, Leticia Huttman, William Nelson, Ron Welch Muskie: Phyllis vonHerrlich, Linda Kinney
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Agenda Item	Discussion
I. Welcome and Introductions	Mr. Lewis opened the meeting; introductions followed.
II. Review and Approval of Minutes	The minutes for November 21, 2008, were accepted as written. The representative from the Consumer Council System of Maine (CCSM) asked to have the minutes sent to her by U.S. mail. ACTION: Minutes will routinely be mailed to the CCSM representative.
III. Feedback on OAMHS Communications	<u>Comment:</u> There is a lack of information about the January changes for APS coming from the Department. <u>Response:</u> DHHS has received a recent report from APS. This will be sent out to the CSNs. ACTION: APS report will be by DHHS to CSNs.
IV. Employment Report from Support and Recovery on employment	Sally Temm reported: Catholic Charities is the host agency in CSN 6 for this initiative. The <i>Need for Change</i> survey was sent to 350, and roughly 30% responded (96). Half indicated a strong desire to be employed, with roughly 10% reporting they were “not sure.” The

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initiative	<p>Specialist will work focus on those with the “strong/urgent” need for employment. The caseload will be 27, consistent with recommendations for a good program and consistent with employment initiatives in other CSNs. A strong desire for schooling is evident. Use of “Need for Change” scale was urged for all service providers as they work with clients seeking support in gaining employment. Data can be used to advocate for resources to support programs for employment. Catholic Charities uses the scale at intake—it is easy to use. Ms. Temm offered to show anyone how to use the form, and noted it can be obtained from Maine Medical Center.</p> <p>ACTION: Anyone wanting assistance with “Need for Change” tool can contact Sally Temm at Catholic Charities.</p>
V. Maine Mental Health Partners Initiative	<p>Ron Welch introduced Dennis King of Spring Harbor Hospital (SHH) to report on the Maine Mental Health Partners Initiative (MMHP), noting this is a proposal to manage (administrative/business aspects) behavioral health services for a wide section of Maine. Mr. Welch noted that DHHS is not taking a stand on MMHP, but does need to provide a venue for service providers to hear about and discuss this initiative and what it offers. Mr. King is meeting with each CSN to present this information and has met with four so far.</p> <p>Mr. King explained the origin of MMHP at Spring Harbor Hospital and explained that it is a nonprofit integrated delivery network affiliated with MaineHealth. MMHP provides networking and services to mental health treatment providers in the area that MaineHealth encompasses (Cumberland, York, Knox, Lincoln, Sagadahoc, Waldo, Oxford, Androscoggin, Franklin, Kennebec, Somerset counties) which corresponds to CSNs 3–7 and for which SHH is the designated “safety net” psychiatric hospital. The way in which physical health and mental health services (and vice-versa) are integrated is of primary concern , as is cooperating in ways to help keep people from hospitalization. Eastern and Northern Maine are not included in this coverage area, but hopefully something similar will evolve there. The first trustees’ meeting was held late in 2008, and there are no member organizations as of yet. Providers can be associated with MMHP in three ways: 1) by contract, 2) by affiliation, or by 3) membership in the network. Services and costs vary for each, with membership offering the most services and benefits at the best value. Partnerships are the most efficient way to do certain kinds of administrative and financial business – economies of scale give better prices for purchasing (materials, equipment, insurances, etc.).</p> <ul style="list-style-type: none"> ➤ <u>Mission:</u> MMHP “supports the mission of MaineHealth by promoting and maintaining a high-quality, integrated system of mental health treatment providers whose care is continually enhanced by professional training and clinical research” (from handout provided by Mr. King). ➤ <u>Overview:</u> 1) integrated delivery system for MaineHealth region; 2) coordinated regional care continuum with services close to home, provided without regard for ability to pay, and access to SHH “safety net,” collaboration and continuum of services that are appropriate, timely, and affordable (but not hospital based); 3) quality and cost benefits, including clinical integration (quality standards, education and research to inform evidence-based care delivery); access to specialized services (SHH / MMC psychiatry / tele-psychiatry); shared services organization for economies of scale (purchasing, insurances, etc.). ➤ <u>Vision:</u> 1) promote individuals’ successful functioning in the community; 2) easily accessible, safe, high-quality care; 3) continuum of care specific to region (design, develop, and support); 4) advocacy; 5) create model systems for leadership, clinical excellence, innovation, and expertise; 6) be the network of choice for high-quality of care, education, research, and careers. [Mr. King noted that this area needs to be promoted as a good career choice; Maine’s changing demographics will make it harder to find workers for this career.)

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	<ul style="list-style-type: none"> ➤ Measures of Success: 1) ease of finding appropriate services; 2) consumers’ satisfaction & involvement; 3) use and dissemination of evidence-based guidelines and practice (developed by members and affiliates); 4) decrease in time individuals spend at highest, most expensive care levels; 5) high-quality outcomes at lowest possible costs. ➤ Partnering philosophy: 1) recognition of interdependence of stakeholders; 2) mutually developed quality standards; 3) honesty, transparency, & collaboration; 4) joint planning for shared economic benefits and risks. ➤ Membership benefits: participation in oversight, control and management of MMHP; access to benefits (group health, purchasing, energy, development, payor contract negotiations, legal & audit services, and financial services); being part of a system serving psychiatric care needs of MaineHealth’s inpatient units and emergency departments, part of a system that relies on step-down services for 150+ youth & adult psychiatric hospital beds; and access to MMHP’s specialty services. <p>Discussion points/questions:</p> <p>Question: When does it start?</p> <p>Answer: The first board of trustees’ meeting was October 2008. Staffing is part time and they are pulling from MaineHealth.</p> <p>Question: What role do families and consumers have?</p> <p>Answer: With the governance structure of the hospital, consumers and family members are on Spring Harbor’s governance board. This is an expectation for the MMHP board.</p> <p>Question: Will the Consumer Council System have a role (statewide group)?</p> <p>Answer: We see it more as a regional initiative.</p> <p>Comment/Question: There are providers working collaboratively/cooperatively currently – collaborators include law enforcement, crisis services, inpatient service, housing supports (housing is always an issue; status of housing has impact on outcome in cases), and others in integrated case management. The ACT model (Assertive Community Treatment –team approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to those with PMI) is best practice, based on research and evaluation, and has been proven clinically and cost effective. Essentially, how would or how could MMHP enhance this?</p> <p>Answer: Service of that quality we support and welcome. MMHP goals are to: 1) allay fears of clients (who generally experience system as chaotic), 2) get every provider to high levels of quality standards and safety, 3) bring about a quicker movement through the process for clients.</p> <p>Comment/Question: Concerning consumer involvement, how many agencies have more than one consumer on Board of Trustees, rather than just have them work on committees? [Show of hands.] Few - only two had more than one. The Consumer Council System representative stressed the need to have consumers on Boards (including on MMHP).</p> <p>Response: For MMHP we need certain skills on our Board, but we always look at consumer and family representation.</p> <p>Comment: CCSM representative stressed that more work needs to be done in this area – true consumer representation needs to be on provider agency boards. This sentiment was seconded by the NAMI-</p> <p>Response: Having consumers on MMHP Board is a complex job – we have to accommodate the family to be able to participate. Board and staff need to be clearer as system evolves – can we work together to develop skills consumers need to serve on Boards?</p> <p>Comment: CCSM representative suggested that Mr. King could make a presentation to the Consumer Council.</p> <p>Testimony: Consumers have a great deal to offer – recovery is hard—maybe harder than job of a CEO.</p>

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	<p>Comment: There is a screening process in place for folks who would serve on a board as a participant from Consumer Council. We want our representatives to be successful.</p> <p>Comment: The issue of merging under MMHP – economically it could be good, but no particular single corporation owns the system of care—it is owned by the people. These are financially challenging times, but it is a worry that the individuality of various providers would be lost. MMHP could offer help, but be careful of “single point” in care—there is the risk abandoning the system of care we have worked so hard to develop. Fear MMHP will “gobble” everyone else up, particularly the smaller agencies.</p> <p>Response: Those involved with MMHP think about that, also. It is not the direction we are going. We need a system of competition to make it work. MMHP is not set up to be—and it does not want to be—the “big cheese.” Spring Harbor began looking at this issue 2 years ago and our mission is to try to coordinate and maintain standards of quality. We do not want a “flat” single point system that is all the same. Emphasis has to be on local service and choice for consumer.</p> <p>Comment: There is also the issue of who gets the services – do those who are clients of providers who participate in MMHP get access to services first? There is fear that clients of agencies that can’t join will be left out.</p> <p>Response: On the other side, there was a concern about how to access services on the outside for those clients leaving the hospital setting. Not sure how to address the fear, but it should be noted that MMC kicks in about \$1 M into the system for uncovered folks. The intent is equality in access to care.</p> <p>Comment: Family members could care less about how you are organized. They just want to know where to go to get help—a “one gate” system to get all the services they need is the ideal.</p> <p>Comment: MMHP is looking at new ways of how the system needs to be structured – as others have done. The organization in Somerset and Kennebec counties have been addressing this issue for many years—and their system works well. They are submitting legislation to address their situation/organization by state statute. The economy is very challenging; we desire to do a better job. The CSN is an opportunity to define and coordinate a system of care.</p> <p>Comment (DHHS): WRAP is an example of how hard it is to work in a collaborative system-but also an example of how it can be done.</p>
VI. Budget Update	<p>Ron Welch reported:</p> <p>There was a work session on the supplemental budget this week, the status is as follows:</p> <ul style="list-style-type: none"> ➤ Of the \$795,850 curtailment some of the major cuts were are as follows: \$350,000 from WRAP and Community-Integration Daily Living Supports (CIDLS) funds, which means no one will lose coverage, but no one will be added on; approximately \$182,524 from Dorothea Dix (staffing cuts – 3 unfilled positions and the rest from dietary staff overstaffing); \$100,000 from Special Revenue accounts at hospitals; approximately \$62,000 from 3 contracts (among these cuts, \$10,000 less to NAMI and \$2,000 cut for Center on Deafness, and MMC Voc. Program, approximately \$50,000). ➤ None of the cuts continue in the 2010/2011 budget. ➤ Waits lists are being used for those waiting for services – July will see a turn in the budget year and will try to serve those on the lists. ➤ If you have clients seeking Community Integration Services, fill out the form that goes to APS – and this is the wait list. A chronologic sequence will be used when pulling back into service. <p>We are also moving to a different tool to determine need under Section 17, from GAF to LOCUS.</p> <p>Discussion:</p>

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	<p>Question: Is it certain that funds will be restored?</p> <p>Response (DHHS): The budget process is not over, but the funds cut in the supplemental have been request to be put back in for the 2010/11 budget</p> <p>Comment: False hope is a concern.</p> <p>Response (DHHS): Keep track of your needs – having the data is important.</p> <p>Question: There are issues of time and engagement (related to keeping wait lists). Some calls are easy (i.e., staff can just take down the information), but other calls can take a good deal of time. We are not reimbursed for this time nor for the time it takes to do the APS entry.</p> <p>Response (DHHS): We will try to abbreviate APS process for the wait list – the essentials are Name, SS#, service request date. The State will address this.</p> <p>Question: Why can't the State track this?</p> <p>Response (DHHS): This question will go back to DHHS and we will report back to the CSN.</p> <p>ACTION: The question about an alternative method to create wait lists will go back to DHHS and a report back to CSNs will be forthcoming.</p> <p>Comment: We have 80+ caseloads and we are picking up lots who are not eligible for care. We can help identify some who do not qualify, but there are hosts of people who do not qualify. We need an alternative method for identifying folks in the community who need services.</p> <p>Budget update continued: The 2010/2011 budget came out last Friday. The printed budget is hard to understand. It is available online at the Governor's page. There are accounting changes because of the DHHS/BDS merger that we still see in it. The way in which eligibility for Section 17 CSS is being changed from GAF to the LOCUS scale. A score of 16 or less is not eligible for CI, but do get other services. Trying to create targeted case management system for those with scores of 16 or less.</p> <p>Comment: Consumers panic about when they get out of service; they fear they cannot get back into service when they need to.</p> <p>Response (DHHS): We are looking to fund a temporary service that consumers can move in and out of with relative ease as they need. This would be available through service providers. This service would be a bridge to stability. Leticia Huttman is taking the lead on this. Flexibility is what we need.</p> <p>Comment: Addressing the fear will help those making the transition – like the concept.</p> <p>Question: The shift from GAF to LOCUS – where is the data to support this?</p> <p>Response (DHHS): This is only for new people coming into service. Current level 1 + 2 consumers will retain service.</p> <p>Comment: A LOCUS trainer [to whom the speaker had spoken] questioned using LOCUS for determining care.</p> <p>Response (DHHS): 1st level of care is diagnostic, then the more refined levels of care will be determined by using LOCUS. CI will use this process for now, but will try to use for ACT later.</p> <p>Question: Where is the data on the tools - GAF / LOCUS?</p> <p>Response (DHHS): We will get back to you on this. This change has to be negotiated with the plaintiff's attorneys. We are looking to have highly trained LOCUS administrators for the tool. We will send a clarification about this [use of LOCUS in determining CI benefits] before it is implemented. There will be more opportunity for comment. The change may have to go into effect by Emergency Rule in that we have agreed that there will be no rule changes as we transition to the new fiscal agent (for all fiscal & all claims the new fiscal agent will be in place by September).</p>

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	<p>Comment: There could be real administrative problems with APS in defining the score – the criteria for the decision is the key. Need to look at whole picture – not just the numbers.</p> <p>Comment (DHHS): We did well in keeping the budget in place – not sure where we will be at the end of the Legislative Session. There is hope for federal dollars coming to Maine, but this funding may not come – we will know soon.</p> <p>Question: B.R.A.P. (Bridges Rental Assistance Program) – there is no additional funding, correct?</p> <p>Response (DHHS): We made a request for additional funds for unmet needs, but B.R.A.P. is flat funded. This was not included in the Governor’s budget, even though it was recommended. Individuals could still advocate for this if they wish – essentially, anyone can voice support for any of the unmet needs.</p>
VII. Consumer Council System Update	<p>[This item was moved up in order from the agenda because the CCSM representative needed to leave early.] Karen Evans reported.</p> <p>The Consumer Council System of Maine is growing. Five new members have been identified to attend regional meetings. CCSM is working with DHHS on Customer Service Standards and they are very interested in the Crisis Services planning. New officers have been elected at the statewide level (Karen is the new vice chair). Their Web site, where extensive information can be found, is http://www.maineccsm.org/welcome.html.</p>
Break	There was a brief 10-minute break from 10:50 to 11:00 AM.
VIII. Crisis Planning Update	<p>Pat McKenzie introduced Steve Addario, who was to give the report, and thanked Leslie Mulhern, M.J. Moore, and Steve who worked on this plan with her. There was also input from others. She noted it was great example of collaboration and gave credit to all for this move toward a more integrated system. The new policy reflects the guidelines set by DHHS and show great movement toward doing crisis services better.</p> <p>Steve Addario reported as follows:</p> <p style="padding-left: 40px;">DHHS determined that all districts must create Memorandums of Understanding (MOUs) "to consolidate the adult and child crisis programs and develop integrated services" in each district. They issued guidelines with minimum standards regarding service provision within each district. DHHS also established timelines where each district would provide a report to the Department by November 14, 2008 and a final product outlined on January 9, 2009. Youth Alternatives Ingraham (YI [adult crisis services]) and Sweetser (child crisis services) (collectively known as Cumberland County Crisis Response - CCCR) joined with Maine Medical Center (MMC) and Mercy Hospital to create the MOU. This MOU was also informed through multiple discussions with the Region I Crisis and Hospital group members who meet monthly. Participants include the aforementioned parties and representatives from Amistad and Spring Harbor Hospital. There was also feedback received from other local providers.</p> <p>The MOUs are in several sections: MOU for DHHS District 2 between CCCR, MMC and Mercy Hospital. In addition to spelling out the agreements made by these entities as a whole, this also lists the main guiding principles adopted:</p> <ol style="list-style-type: none"> A. Increasing consumer and family centered care, B. Encouraging cost effective use of resources, C. Streamlining processes for timely delivery of services, D. Reducing barriers to services and increasing community responsiveness in order to improve access to appropriate levels of care,

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	<p>E. Committing to continuous quality improvement and improving quality of care through the use of performance measures,</p> <p>F. Including the consumer voice,</p> <p>G. Promoting health,</p> <p>H. Providing services to people in the communities in which they reside.</p> <p>Attachments to the MOU spell out appropriate agreements between the 2 crisis service providers (CCCR) as well as between CCCR and each of the area hospitals (MMC and Mercy Hospital). The final addendum indicates outcome data that will be gathered and reviewed through continuing participation in the monthly Region 1 Crisis and Hospital meeting. These attachments are working documents that will be reviewed regularly and improved as appropriate. The full MOU is currently being reviewed by DHHS. The parties included in the agreement are reviewing each section of the MOU.</p> <p>There are both outcome data and protocol for procedures – both will be reviewed and analyzed. Crisis services in the Region have been meeting for many years and the new MOUs are a starting point for improving on the system. We are seeking feedback from consumers. Changes that consumers would like to see are clear, although it these would take time. It is clear there is better collaboration overall and this is a major benefit.</p> <p>Question: How are you keeping other providers informed?</p> <p>Answer: There is an educational piece re: the MOUs, but you might check with the crisis provider in your area to be sure you have the most recent information (which will serve as a reminder to them that all providers in their area need to know). We do need to improve communications. There is also a Portland Crisis Team that functions outside of this and we communicate with them. We are working to make the whole system better. Please send your comments to us.</p> <p>Comment/testimony: This is an improvement. They are doing good work – and do give them feedback.</p> <p>Question: How is law enforcement involved in this?</p> <p>Answer: They are involved in training and Crisis Services has a liaison to them. We could, however, improve in this area.</p> <p>Comment: One of the hard aspects vis-à-vis law enforcement is to make sure that each officer has adequate training, but we are building the relationship between crisis and law enforcement.</p> <p>Comment: There is variability as you move outside of Portland.</p> <p>Response: Yes, but the county sheriff’s office is involved. The MOU process addresses the law enforcement issue.</p> <p>Question: What is the best way to have input?</p> <p>Answer: Those interested are welcome to attend meetings, or direct phone contact to those working on this would be welcome.</p> <p>Comment: A group for Outpatient Providers had been meeting, but are not now. This needs to be picked up again.</p>
IX. Psychiatric Advance Directives	<p>Barbara Shaw provided a written document on this topic and reported as follows:</p> <p>The Muskie School of Public Service of the University of Southern Maine has been working with the Office of Adult Mental Health Services to increase consumer and provider understanding of advance directives for both medical and mental health treatments. Advance directives are legally enforceable documents that provide a way for consumers to state a</p>

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	<p>preference about important health care decisions, such as preferences for mental health and physical health treatment, in the event they may no longer have decision-making capacity during a mental health or medical crisis. Advance directives also allow one to name a healthcare agent, who can make healthcare decisions if that individual ever lacks capacity to make healthcare decisions.</p> <p>Our project seeks to increase awareness of advance directives among mental health consumers and their providers. We are interested in answering your questions and listening to your concerns about advance planning for mental health consumers. Through this project we hope to improve the accessibility, usefulness, and availability of advance directives that may provide critical information during a medical or mental health crisis.</p> <p>We are working with a collaborative of consumers and mental health providers to:</p> <ol style="list-style-type: none"> 1. Identify barriers to access and use of medical and mental health advance directives 2. Increase understanding of the benefits and limitations of these documents and compare them with other planning tools for mental health consumers, such as WRAP and Crisis Plans 3. Identify best ways- to educate and communicate with consumer, families and providers about advance planning 4. Improve and support enhanced integration of advance planning for both medical and mental health services 5. Provide feedback about recently revised advance planning forms 6. Help create programs to assist consumers in completing forms <p>The Muskie School of Public Service is conducting focus groups with key stakeholders from both the consumer and clinical communities in the coming year. Several focus groups will be held. We would like to engage the CSN and the Consumer Council System of Maine in this process. We will use the results of those groups and interviews to develop plans for consumer and provider education that address your issues and concerns.</p> <p>The project is funded through a MeHAF grant and others are collaborating on this (Spring Harbor and NAMI). To get involved or to gain more information one should contact Barbara Shaw at USM Muskie School, barbaras@usm.maine.edu or (207) 780-4015. They are seeking feedback on the recently revised form.</p> <p>Discussion:</p> <p>Comment: The form itself is often a barrier.</p> <p>Response: Yes. That is an issue we are trying to address, therefore the grant and the collaborative work with providers, advocates, and others. The new form has been reviewed and approved by an Assistant Attorney General, so it is being moved forward (although lawyers may disagree). Comments from consumers and providers are being sought. At the core of the issue is that consumers should have the help they need.</p> <p>Comment: Training is also an issue – not only for those need to have an advance directive, but for those who work with them, and those who would be providing services in a crisis situation.</p> <p>Response. The intent is for that to come into the process – issues of liability, ethics, and response to the directives.</p> <p>Comment: What about the issue of the false promise – having a directive creates an expectation and what if that directive cannot – for whatever reason – be met?</p> <p>Response: There need to be candid discussions about the benefits and limitations of advance directives. Cumberland County is a focus for the demonstration project – what happens there will have implications statewide.</p>

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	<p>Clarification: The MeHAF grant includes a pilot project through the ACCESS program at Spring Harbor. Informational workshops will be offered at Spring Harbor and the Maine Med Family Med. Clinic is also to be included. “Regular” advance directives and M. H. advance directives are connected. Having an advance directive increases the odds that the consumer’s wishes will be followed. The program promoters want to meet with Boards and consumer groups to build awareness to bring about change to make system more responsive to consumers.</p>
<p>X. WRAP Process</p>	<p>Sally Temm reported as follows: Catholic Charities Support and Recovery Services (SRS) is serving as the fiscal agency for WRAP funds in CSN6. Sally passed out a draft document on the process. She asked that any feedback be sent to her. The points of the report included the following:</p> <p>Wrap-Around Funds are available on a limited basis for clients who meet the clinical criteria for Section 17 services, are either eligible for enrollment, or are currently enrolled in the DHHS system, and who also reside in the CSN #6 region. The primary purpose of Wrap Funds is to assist clients in obtaining services or necessities that they are otherwise unable to obtain. Two other agencies in Cumberland County (Shalom Inc. and Ingraham/Youth Alternatives) have agreed to participate with SRS in the approval and oversight of these available dollars for clients with mental illness. SRS will manage the account, keep records of payments, and draw up the checks following approval. Generally, eligible clients will have significant and persistent major mental illness and a GAP score of 50 or less. The following procedures outline and explain the process for accessing Wrap-Around funding.</p> <ul style="list-style-type: none"> ➤ The case manager working with the client in need of Wrap dollars will have first exhausted all other possibilities for funding before applying. Please refer to the “Wrap- Around Fund criteria” which outlines alternative funding sources before resorting to requesting Wrap Funds. Case managers will be required to demonstrate, on behalf of their client, that they have attempted all other resources and have been unsuccessful. ➤ Wrap Funds can only be utilized if they support the attainment of one or more goals on the client’s current ISP/Case Plan. A copy of the plan goal must be noted on the Wrap Request Form. ➤ Non-emergency requests must be in by Monday, before noontime, in order to get payment processed by Thursday. ➤ Emergency requests (i.e., heat in winter, emergency housing, medications that have run out) can be made anytime Mon-Fri 8:30 am-4:00 pm. ➤ Funding requests from case managers of the participating programs are emailed to the identified Wrap Fund Program Committee member at their program (SRS, Shalom, or Ingraham/YA). These individuals will review the request and note their recommendation on the form and then forward to the other Committee Members for their review. ➤ Each committee member will have one workday (Monday through Friday) to respond to the email; if available and accessible resources have not been utilized, a recommendation to deny funding will occur.

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	<ul style="list-style-type: none"> ➤ These committee members will identify another program staff member to function in their capacity during vacations. Two of the three participating agencies must agree on funding the request before a check is written. ➤ In the event that the email inquiry is not responded to in one work day, the Wrap Fund Program Administrator at SRS will make the final decision to fund or not fund the request. ➤ Any client receiving Wrap Funding will sign a “Wrap Around Loan Agreement” form which indicates how much money is being requested, for what purpose, and the plans for repayment of the loan. The case manager is responsible for completing this with the client. ➤ Any funds that are repaid go towards the administrative costs of managing the program. ➤ If a client has accessed Wrap Funds in the past, and failed to repay them, they are not eligible for additional funding until a payment plan has been negotiated for the new request. ➤ The cap on Wrap Funds per year is \$500.00. However, there are circumstances (primarily housing related) under which an individual can access more than \$500.00. Those situations will be reviewed individually. ➤ Once approved, the check (or other form of payment) will be processed. In special circumstances arrangements may be made for the check to be picked up. ➤ The Wrap Fund Program Administrator will provide information regarding current balance and loan repayments to Shalom and/or Ingraham/Youth Alternatives as requested. <p>Question: Why this new way to manage WRAP funds? It slows the process down, it is administratively obtuse, and the decision now has to be a joint decision, which adds time.</p> <p>Comment from the presenter: If the process continues as now, SRS does a report, sends it to the Catholic Charities office, then they get reimbursement from the State. This is an administrative burden. If the point is to get funds out quickly, there could be a more expedient process.</p> <p>Response (DHHS): At the core of the whole process is that we want the WRAP process to be responsive to needs of the local CSN area, which is happening; but even with that, we have to use the guidelines for accountability that are set by the State Office of Purchasing. They set the accountability standards, and we have to meet them.</p> <p>Response: The local agency responsible <u>will</u> make it work within the guidelines.</p> <p>Comment: Not all consumers have had access to WRAP in CSN 6 – trying to make it more equal. The new process gives access to all agencies. Forms for the new process will be sent out via Mr. Lewis at Regional DHHS office.</p> <p>ACTION: New WRAP forms will be sent out via DHHS Regional office.</p> <p>Note: WRAP funds from last year are still available until end of February.</p>
XI. Psychiatric Consultation	<p>Mr. Welch reported:</p> <ul style="list-style-type: none"> ➤ This project, developed by the Maine Association of Psychiatric Physicians (MAPP) in collaboration with the Maine Academy of Family Physicians (MAFP), links volunteer psychiatrists with providers in rural primary care

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	<p>practices.</p> <ul style="list-style-type: none"> ➤ An ongoing consultative relationship is developed and the primary care practitioner can call on the psychiatrist as needed for advice and guidance. These are “informal consultations” rather than treatment or supervision and happen via telephone or email contact. The relationship is ongoing, which allows for the development of a shared body of experience and the opportunity to consult on a case over time. ➤ The project began in 2004, in response to a lack of psychiatric service resources in rural areas. There are 20 psychiatrist volunteers and 40 primary care practices currently involved. The project has been nominated twice for the American Psychiatric Association’s District Branch Best Practice Award. ➤ The project is funded by grants from American Psychiatric Association and OAMHS of Maine DHHS. Further information can be obtained from Cindy Paradis at cindy_fox_paradis@yahoo.com or David Moltz MD at dmoltz2@gmail.com. ➤ Prescribing psychiatric drugs is one of the important areas of consultation and the program is an effort to connect the expertise of the psychiatrist with that of the rural primary care physician. Dr. Stephan Gressitt, OAMHS Medical Director supports and promotes this program. ➤ Psychiatry is a specialty area of medicine and needs to be used as such – such relationships between areas of medical expertise is the heart of integrated care. <p>Question: Does this for both adults and children? Response: We will clarify that and back to you. Question: Is it possible to have a list of providers participating in this> Response: This will be provided. ACTION: DHHS will provide a list of providers participating in the Psychiatric Consultation project and ACTION: DHHS will clarify if the service is available for both children and adults.</p>
XI. Other	<p>Other issues identified for discussion:</p> <ul style="list-style-type: none"> ➤ Feedback from APS on process-where does this stand? Response: APS has solicited information and compiled a report based on the initial months of service. State staff will get this sent out to the CSNs before the next meeting. ➤ Elizabeth Jones Analysis (an analysis of the funding for MH services ordered by Consent Decree)-where does this stand? Response: DHHS met with the Court Master on 1/15/09. A draft report will be forthcoming to DHHS in early February and available to the public by the end of the month. ➤ Deloitte Rate Setting Report – what is the status? Response: The report does not deal with any rate change through the biennium. It is not to happen until 2010/11. Needs to be reviewed carefully and the best approach may be to hold regional sessions to discuss with DHHS.
XII. Public Comment	There were no public comments.
XIII. Meeting Recap/Agenda items for next meeting	<p>ACTIONS from the meeting:</p> <ul style="list-style-type: none"> ➤ Minutes will routinely be mailed to Consumer Council System of Maine representative. ➤ APS report will be sent by the state to CSNs.

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	<ul style="list-style-type: none"> ➤ Anyone wanting assistance with “Need for Change” tool can contact Sally Temm at Catholic Charities. ➤ The question about an alternative method to create wait lists will go back to DHHS and a report back to CSNs will be forthcoming. ➤ New WRAP forms will be sent out via DHHS Regional office. ➤ DHHS will provide a list of providers participating in the Psychiatric Consultation project ➤ DHHS clarify if the service is available for both children and adults. ➤ State staff will get this sent out to the CSNs before the next meeting. ➤ DHHS will follow up about the Elizabeth Jones Report with CSNs at the end of February. ➤ DHHS will follow up with the CSNs re: the Deloitte Report.