

**Department of Health and Human Services
Office of Adult Mental Health Services
COMMUNITY SERVICE NETWORK
MEMORANDUM OF UNDERSTANDING (“MOU”)
December 21, 2006**

I. INTRODUCTION

The purpose of the Community Service Network (CSN) is to coordinate services among network providers so that consumers with serious mental illness can receive all needed mental health services in their home network area. The seven community service networks are:

1. Aroostook
2. Hancock, Washington, Penobscot, Piscataquis
3. Kennebec, Somerset
4. Knox, Lincoln, Sagadahoc, Waldo
5. Androscoggin, Franklin, Oxford
6. Cumberland
7. York

Participants in the CSN are the providers of core services in the network area, designated consumer representatives, community hospitals, and the Office of Adult Mental Health Services (“OAMHS”). Dorothea Dix Psychiatric Center and Acadia Hospital are part of CSN 1 Aroostook County and CSN 2 Hancock, Washington, Penobscot, and Piscataquis Counties. Riverview Psychiatric Center and Spring Harbor are part of the remaining CSNs 3 through 7.

II. GOALS OF THE COMMUNITY SERVICE NETWORK

- A. To provide an integrated system of care in the CSN.
- B. To ensure to the maximum extent possible that residents of the CSN geographic area are able to receive core services within the area.
- C. To ensure that consumers can receive seamless, integrated care to meet their changing needs.
- D. To improve:
 - Continuity of care for recipients of service within and across service provider systems.
 - Efficiency of care for service providers and recipients of service alike.
 - Outcome effectiveness of service for recipients of service.
 - Cost effectiveness for recipients of service and for the community as a whole.

III. GUIDING PRINCIPLES

- A. The focus of the CSN is the adult mental health consumer with serious mental illness.
- B. Quality of care for consumers depends in large part upon how easily they can access services and make transitions among services without being disconnected.
- C. Coordination among service providers, with appropriate sharing of information, and a primary focus by the providers on their contributions to the whole mental health system, is what makes an effective and responsive system.
- D. Local planning, local problem solving, and a mutual understanding of the roles and expectations of each service provider should be effective ways to support continuity of care.

- E. Based upon the current best practice and evidence based models, the mental health care system in the CSN must support the recipient of service and members of his or her personal support system both in becoming knowledgeable about the consumer's mental health condition and the available services and in participating actively in making decisions about choosing services.
- F. Providers and service systems should practice collaboratively in an integrated manner across professional disciplines (inclusive of peer disciplines and supports) and health specialty areas.

IV. STRUCTURE OF COMMUNITY SERVICE NETWORK

- A. The CSN will include the following state-funded core service providers from the area, designated consumer representatives, and the community, state, and specialty hospitals as noted in the Introduction:
 - 1. Crisis Services, including Crisis Stabilization Units
 - 2. Peer Services
 - 3. Community Support Services (Community Integration, Intensive Community Integration, and Assertive Community Treatment Services; Daily Living Support, Skills Development, and Day Support Services)
 - 4. Outpatient Services
 - 5. Medication Management
 - 6. Residential Services
 - 7. Vocational Services
 - 8. Inpatient Services (including hospitals that do and hospitals that do not provide inpatient psychiatric services)
- B. The CSN will meet no less than monthly.
- C. The CSN will establish and oversee operational protocols, which may include by-laws, that the CSN deems necessary to achieve the goals of the CSN. The initial operational protocols and any subsequent must be approved by OAMHS. Attachment A is the Operational Protocol and it is included as a part of the MOU.
- D. The CSN will establish outcome measures and assure the quality of continuity and integration of services in the CSN.
- E. The CSN may establish subcommittees or ad hoc committees as needed
- F. The Chair of the CSN will be a senior staff member of OAMHS.

V. AGREEMENT AND RESPONSIBILITIES OF ORGANIZATIONS

- A. The participant recognizes that the CSN is responsible for the care of those persons who reside in the CSN area, and agrees to ensure that consumers in the CSN area can be served in the CSN area, except as approved by OAMHS.
- B. As a member of the CSN, the participant agrees to:
 - Assure delivery of services to all mental health consumers in the network area (see Attachment B for clarification);
 - Maintain a "no reject" policy so that no consumer is refused needed service within the CSN area (see Attachment C for clarification);
 - Engage in problem solving in the CSN to ensure that clients with complex needs are appropriately served;

- Identify services necessary for consumers in the CSN who are at risk and provide those services;
 - Comply with all provisions of the Bates v. DHHS Consent Decree, especially where service coordination within the core service array is necessary;
 - Assure 24-hour access to a consumer's community support services' records for Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT) for better continuity of care during a psychiatric crisis;
 - Plan based on data and consumer outcomes;
 - Implement the Rapid Response protocol;
 - Provide coordination among the community support program, the crisis program and hospitals to ensure the appropriate sharing of information, including the ISP and community support worker attendance at hospital treatment and discharge planning meetings;
 - Assure continuity of treatment during a psychiatric hospitalization and the full protection of a client's right to due process;
 - Recognize the authority of the community support services staff (CI, ICI, ACT) as coordinators of the ISP and the services contained therein.
- C. The participant will appoint a representative who has the authority to make commitments on behalf of the participant and who will attend monthly meetings of the CSN. The participant may also appoint a designated alternate who may attend when the representative is unavailable.
- D. The participant will join in appropriate special projects and committees as may be developed by the CSN.
- E. The participant commits to the guiding principles, goals, and structure outlined above.

Authorized organization signature _____
Date

For _____
Name of organization

Below are the names of the representatives and alternate delegates for the CSNs in which we are participating: *(Please Print)*

	Appointed Representative	Alternate Delegate
CSN 1		
CSN 2		
CSN 3		
CSN 4		
CSN 5		
CSN 6		
CSN 7		

OPERATIONAL PROTOCOL FOR COMMUNITY SERVICE NETWORKS (CSNs)

COMMUNITY SERVICE NETWORKS

The seven Community Service Networks are:

1. Aroostook
2. Hancock, Washington, Penobscot, Piscataquis
3. Kennebec, Somerset
4. Knox, Lincoln, Sagadahoc, Waldo
5. Androscoggin, Franklin, Oxford
6. Cumberland
7. York

PURPOSE

Community Service Networks were established in the Bates v. DHHS Consent Decree Plan approved by the Court Master on October 13, 2006. The CSNs are based on the premise that local planning, problem solving, and a mutual understanding of the roles and expectations of each service provider are effective ways to support continuity of care. The Office of Adult Mental Health Services (OAMHS), consumers, service providers, hospitals, and the community at large all have a part to play in ensuring a comprehensive, effective mental health system.

The goals of the community service network are as follows:

- A. To provide an integrated system of care in the CSN;
- B. To ensure to the maximum extent possible that residents of the CSN geographic area are able to receive core services within the area;
- C. To ensure that consumers can receive seamless, integrated care to meet their changing needs;
- D. To improve:
 - Continuity of care for recipients of service within and across service provider systems;
 - Efficiency of care for service providers and recipients of service alike;
 - Outcome effectiveness of service for recipients of service;
 - Cost effectiveness for recipients of service and for the community as a whole.

MEMBERSHIP

Each provider must designate a representative to the CSN, and that representative must be able to speak for the organization. Consistent representation is expected to ensure continuity in the work of the CSN. The representative slots are not intended to be rotating designees. The provider may designate an alternate delegate to the CSN, and that alternate must be named in the MOU. The alternate will provide agency representation when the appointed representative is unable to attend.

Membership of the CSN will include the following:

- One representative from each provider with contracts with the DHHS/Office of Adult Mental Health Services who provide any of the services listed below within this CSN;

- One representative from each community hospital with and without inpatient psychiatric units who are located within this CSN;
- One representative from the psychiatric specialty hospital and from the state hospital that provide coverage to this CSN;
- One to three interim consumer representatives chosen by the consumer-run Transition Planning Group; these representatives will be replaced by representatives of the Consumer Councils once they are in operation;
- One consumer representative per social club or peer center, if that club or center is part of a larger agency that provides more than peer services by contract with OAMHS;
- One representative from NAMI-ME;
- One representative from Community Mediation Services.

OAMHS may change the membership of the CSN depending on the needs of the CSN and changes to services and/or providers in the CSN area.

SERVICE ARRAY

The following services for adults form the base array of services for the CSN:

1. Peer Services;
2. Crisis Services, including Crisis Stabilization Units;
3. Community Support Services (which currently include Community Integration, Intensive Community Integration, Assertive Community Treatment, Daily Living Skills, Skills Development, and Day Support Services);
4. Outpatient Services;
5. Medication Management;
6. Residential Services;
7. Vocational Services;
8. Inpatient Services (including hospitals that do and hospitals that do not provide inpatient psychiatric services).

MEETINGS

Chairperson

A senior staff member of OAMHS will chair the CSN and will run the meetings.

Regular Meetings

The CSN will meet as often as necessary and at least monthly. OAMHS shall schedule these meetings and shall establish a predetermined schedule with each CSN.

Special Meetings

Special Meetings may be called by OAMHS on its own or at the request of a majority of the membership.

Notice of Meetings

OAMHS will provide notice of each meeting to each member not less than one week prior to the meeting.

Quorum

Members present will constitute a quorum.

Voting

Each member present (either the appointed representative or, in his or her absence, the alternate delegate) will have one vote.

The CSN will determine which issues it will vote on. All issues voted on will be decided by a simple majority of those present at the meeting. Voting is advisory to the OAMHS, unless OAMHS specifically states that it will act on the vote of the membership.

Attendance

Absence from three or more consecutive meetings shall be reason for contract or provider agreement review.

Agenda

OAMHS will set the meeting agenda, with input from CSN membership. The agenda will include time set aside at each meeting for comments from the public.

Minutes

OAMHS will be responsible for keeping minutes, and will present the minutes at the next regular CSN meeting for review and approval by the membership.

AD HOC COMMITTEES

The CSN may designate ad hoc committees, and the CSN Chair will appoint committee chairs. Membership on the ad hoc committees may be individuals other than CSN representatives or alternates. Committees will report to the full CSN.

AMENDMENTS

The CSN may amend the operational protocols from time to time. The proposed amendments must receive a majority vote of the members present and then must be approved by OAMHS before acceptance.



John Elias Baldacci
Governor

Maine Department of Health and Human Services

Office of Adult Mental Health Services
32 Blossom Lane
11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

Ronald S. Welch
Mental Health Director

Attachment B

MEMORANDUM

TO: Providers in the Community Service Networks
FROM: Ronald S. Welch, Director, Office of Adult Mental Health Services
DATE: December 20, 2006
RE: Clarification of CSN Participant Responsibilities

Contracted service providers and hospitals have requested a clarification of the following statements that are part of the Community Service Network (CSN) Memorandum of Understanding (MOU):

V. AGREEMENT AND RESPONSIBILITIES OF ORGANIZATIONS

- A. The participant recognizes that the CSN is responsible for the care of those persons who reside in the CSN area, and agrees to ensure that consumers in the CSN area can be served in the CSN area, except as approved by OAMHS.
- B. As a member of the CSN, the participant agrees to:
 - o Assure delivery of services to all mental health consumers in the network area;
 - o Identify services necessary for consumers in the CSN who are at risk and provide those services;

This statement is intended as a commitment by the provider and the CSN as a whole to work together to assure the recognition, development, and provision of needed services, in collaboration with OAMHS. OAMHS is not requiring individual providers or the CSN to assume the overall financial risk or legal responsibility for developing and providing needed services that are not currently being provided within the CSN. OAMHS is requiring all providers and the CSN to participate in problem solving to determine what needed services cannot currently be delivered within the network, and to make recommendations about how best to address those unmet needs.

OAMHS requires good faith participation in the identification of unmet needs, and collaboration in developing new or augmented services to address those needs, but OAMHS does not intend the language quoted above from the MOU to be read as transferring the Department's overall responsibility for Consent Decree compliance to providers or the CSN. It is, however, the shared obligation of OAMHS, the provider, and the CSN to meet the intent of the Consent Decree.

I hope this memo clarifies the intentions of this language. I encourage continued discussions about how the CSN will meet the goals expressed by this language in the MOU, and expect that the MOU will be amended as the CSN develops.

Our vision is Maine people living safe, healthy and productive lives.



John Elias Baldacci
Governor

Maine Department of Health and Human Services

Office of Adult Mental Health Services
32 Blossom Lane
11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

Ronald S. Welch
Mental Health Director

Attachment C

MEMORANDUM

TO: Providers in the Community Service Networks
FROM: Ronald S. Welch, Dir, OAMHS
DATE: November 15, 2006
SUBJECT: Clarification of the "No Reject" Policy

Contracted service providers and hospitals have requested a clarification of the following statement that is part of the Community Service Network (CSN) contract amendment, the Office of MaineCare amendments to the provider agreements, and the memorandum of agreement:

Maintain a "no reject" policy so that no consumer is refused needed service within the CSN area;

The intent of this statement is as a commitment of the provider and of the CSN as a whole to work together to assure access to services for consumers within the CSN. It is based on the principal that services should be provided as close to the consumer's home as possible. OAMHS is requiring a transparent process so that all providers work together to locate services within the network, to collect data on when this is not possible, to participate in problem solving to create needed resources within the network, and to make recommendations about how best to achieve this policy.

It is not the intent of the OAMHS to penalize agencies or the CSN as a whole if it is not possible for individual consumers to receive services within the geographic area. OAMHS will, however, track data about services that are not provided within the network and will determine what corrective actions, including resource development, may be necessary. It would become an issue for contract performance if individual providers demonstrated an inability to provide service to consumers and/or if the provider did not actively engage in problem solving to improve access to service within the CSN geographic area. OAMHS recognizes that there are times when services cannot be provided within the network, particularly for specialized services which would not be efficient to maintain.

The Consent Decree has an obligation for individual providers to assure access, so this is not a new provision. The addition of the CSN and the concept of applying the resources of the CSN in fact add some protection for individual providers. There should be less need to invoke the individual agency "no reject" obligation if the network as a whole has done a good job wrapping services around the individual.

I hope this memo clarifies the intentions of this language. These issues will continue to be a part of the work of the CSN, and I encourage continued discussion about how the CSN will monitor itself in regard to this policy.

cc: Kathy Greason, AAG
Phyllis Gardiner, AAG

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