

**Meeting Minutes for
C.L.A.S.S.
(Community Linkage Assessment and Stabilization Services)
March 3, 2006**

**Sebago Room
Riverview Psychiatric Center
Augusta, Maine**

Present: Annette Adams, Acadia; Steve Addario, Sweetser; Diane L. Belanger, Turner Crisis/Rumford Group Homes; Lorraine Chamberlian, AMHC; Anne Conners, Muskie; Dr. Andy Cook, OCFS-DHHS; Wes Davidson, AMHC; Peter Driscoll, Amistad; John Edwards, WPCA; Dr. James Fine, DHHS, Region II; Darlene K. Hayden, Oxford County Mental Health Service; Debra Henderlong, DHHS, Region III; Jennifer Goodwin, CS; Elizabeth Jones, DHHS Consultant; Cheryl LeBlond, Mid Coast Mental Health; Carlton Lewis, Acting MH Team Leader DHHS, Region I; Thomas Lynn, CHCS Crisis Services; Simone M. Maline, Amistad/Warm Line; Mary Louise McEwen, Dorothea Dix; Scott Moore, Crisis and Counseling; Mary Jean Mork, Spring Harbor/MMC; Doug Patrick, OCFS-DHHS; Larry Plant, Director, Behavioral Services, SMMC; Lee Rice, DHHS QI; Margaret Rode, MH Team Leader, DHHS Region II; Corey Schwinn, WCPA; Sharon Sprague, DHHS/AMHS; Rita Soulard, SMMC; Richard Weiss, MoCo; Roger Wentworth, Sweetser; Bill Wypyski, Acadia Hospital.

Check In

Cheryl LeBlond reported that Mid Coast Mental Health is integrating with NorthEast Health (Penobscot Bay Hospital) and that Jeff Hermon will start on March 20th as vice president of behavioral health. This VP position will replace the former Executive Director position. Leslie Mulhearn will be the interim Executive Director.

Hospital Observation Beds –

Tom Lynn offered the following observations on hospital observation beds:

- 42-72 hour observation period is very useful in some instances as it gives people an opportunity to stabilize.
- It would be helpful to have more medical support available for observation beds.
- Crisis stabilization beds are similar in length of stays: crisis stabilization beds and observation beds should be viewed on a spectrum.
- Observation beds and crisis stabilization beds serve different populations.
- A clearer definition needs to be created for both crisis stabilization beds and observation beds.

- Communication between the observation bed staff and providers is absolutely crucial as patients can go in and come out before the providers know they've been anywhere.

Following Mr. Lynn's observations, Scott Moore asked if the Department was changing its priority from expansion of crisis beds to observation beds. Sharon Sprague said that she has met with Acting Commissioner Brenda Harvey and that while Ms. Harvey wants to take a closer look at observation beds, there are no plans to change the funding of crisis beds. Ms. Sprague also said that this is an issue that Ms. Jones will be examining. Mr. Moore said that although observation beds are useful, if the system goes too much in that direction, people will be taken out of their communities because observation beds aren't always located in the client's community.

Mary Jean Mork said that people don't go to observation beds unless they need hospital level of care and that their status can change from observation status to in-patient status. Definitions of the two bed categories would be very useful, she said.

Wes Davidson said he is concerned that the mental health system does not incentivize collaboration and communication, which are integral to continuity of care. Dr. James Fine said that observation beds are decisively medical, are attached to large hospitals, and extend what goes on in the emergency room. In 12 hours, he said, people either get better or worse and the idea of having them there for an acute period is a good one. Active treatment in the Emergency Room, he said, would move things along more than anything else.

Mr. Davidson said that communication between providers and hospitals is sometimes lacking and said that, for example, Ingraham is not allowed in the Emergency Department at Maine Medical Center and that Crisis and Counseling is not allowed in the Emergency Department at Acadia Hospital.

Ms. Mork responded that Maine Med does hold coordinating meetings but that it doesn't duplicate evaluation/assessment efforts. Regarding collaboration and communication, Lorraine Chamberlain said that gaps in data exist; for example, Acadia Hospital does not report out on Children's Services. Ms. Mork said that hospitals don't have contracts with the state to provide these services.

Mr. Davidson said that the mental health system creates parallel systems, which don't work well together. "We can't afford to do this anymore," he said.

Elizabeth Jones said that certain myths grow up around the mental health system and its rules, which may not necessarily be true. Ms. Jones also said that the tasks she has been given include looking at the crisis service system, observation beds, and the use of hospital Emergency Departments. These larger tasks, she said, need to be broken down to:

- What should the definition of crisis stabilization and observation beds be?

- What are the regional differences that exist in the state that need to be protected?
- What do services look like in different areas?
- What does the funding look like?

Ms. Jones said that her recommendations are due in July and that the larger purpose among these tasks is to have the system work as one.

**Dr. Fine RE: Protocol: *Acute Psychiatric Patient Medical Clearance*
Draft 9 16 05**

Dr. Fine said that the goal of the protocol is to get people out of the Emergency Department without doing anything for them and that most people with mental illness in the Emergency Room can be treated by a family practice doctor. The problem, he said, is that there is usually no treatment. The question, he said, should be: “What can I do for this person to get them care or get them home—this prevents that from happening.” This wouldn’t happen to any other population but the mentally ill, Dr. Fine said, and plays into creating “a second class treatment for the people we serve.”

Dr. Andy Cook said that the protocol was not developed by the Initiative Group and originated from Eastern Maine Medical Center. Dr. Cook said in summary of Dr. Fine’s presentation, “Treat not triage. We need to work on a system of care policy so we aren’t just putting people in placements without treating them.”

Dr. Fine also announced that he is leaving as Region II medical director and will assume a position at the Capitol Clinic.

Managed Care Organization

Dr. Cook reported that the first of several stakeholder meetings will be held on Monday, March 6. Peter Driscoll asked when the regional forums will be held; Ms. Sprague responded that they have not been scheduled yet but will be.

Parking Lot Issues

Crisis Curriculum

Dr. Cook said that he met with Rick Karges of Crisis and Counseling Centers; John Edwards of Washington County Psychotherapy Associates; and Janice Daley of the Muskie School to discuss the implementation of the Maine Crisis Network’s Crisis Training Curriculum. The curriculum will have to meet MHRT-C requirements and will be rolled out in May or June.

One Referral Process

Ms. Chamberlain said providers are very interested in having one referral process for hospital admission. Ms. Mork said that while the general content area can be the same,

the process might vary at different hospitals. Dr. Cook said some C.L.A.S.S. members might want to meet with the Maine Hospital Association on this issue. Ms. Jones said the Association has a meeting scheduled for March 17th and it may be possible to get this topic on the agenda. Ms. Sprague said she would email David Winslow on this matter.

Next Meeting

WEDNESDAY, MARCH 29, 2006 - 11:00 am to Noon
Conference Room #1
Marquardt
Augusta, Maine

Agenda Items:

Misdirected Calls Update
Delay in Hospital Admission Data