

**Community Service Network 2 Meeting  
CHCS, Bangor, Maine  
January 13, 2009**

**Approved Minutes**

**Members Present:**

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| <ul style="list-style-type: none"> <li>• ACADIA HOSPITAL - Annette Adams, David Proffitt, Jamie Morrell</li> <li>• AIN - Melinda Davis</li> <li>• ALLIES, INC. - Brent Bailey</li> <li>• BANGOR COUNSELING CENTER - Theresa Oliver</li> <li>• CHARLOTTE WHITE CENTER - Richard Brown</li> <li>• CHCS - Thomas Lynn and Dale Hamilton</li> <li>• CHOICES - Lonnie Plante</li> <li>• COMMUNITY CARE -David McCluskey</li> <li>• CONSUMER COUNCIL OF MAINE - Elaine Ecker, Vickie McCarty</li> </ul> | <ul style="list-style-type: none"> <li>• DIRIGO COUNSELING CLINIC -Jull Peters</li> <li>• DOROTHEA DIX PSYCH. CTR - Mary Louise McEwen</li> <li>• FAMILIES UNITED – Jeremy Ashfield</li> <li>• MAINE MENTAL HEALTH CONNECTIONS - Robert Mathien</li> <li>• MDI BEHAVIORAL HEALTH CARE - Sue Rouleau</li> <li>• MEDICAL CARE DEVELOPMENT – Betty Foley, Judy Provencher</li> <li>• MMC VOC. EMP. COORDINATOR – Gayla Dwyer</li> <li>• MMC VOC. EMP. SPECIALIST – Leah Barteaux</li> </ul> | <ul style="list-style-type: none"> <li>• NFI NORTH – Scott Dufour, Linda Catterson</li> <li>• NOE – Charles Tingley</li> <li>• OHI – G. Kathy Smith</li> <li>• PENOBSCOT VALLEY HOSP. – Michael Corbin</li> <li>• PHOENIX M.H. SERVICES – Barbara Kerrigan</li> <li>• SUNRISE OPPORTUNITIES – Sharon Dean</li> <li>• TOGETHER PLACE – Lydia Richard</li> <li>• WABANAKI-SWEETSER – Sharon Tomah</li> <li>• WCPA – Corey Schwinn, John Edwards</li> <li>• WELLSRING – Pat Kimball</li> </ul> |
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**Members Absent:**

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| <ul style="list-style-type: none"> <li>• AMICUS</li> <li>• Behavioral Health Center</li> <li>• Blue Hill Memorial Hospital</li> <li>• CA Dean Memorial Hospital</li> <li>• Calais Regional Hospital</li> <li>• Care &amp; Comfort (Excused Absence)</li> </ul> | <ul style="list-style-type: none"> <li>• Down East Community Hospital</li> <li>• Eastern Maine Medical Center</li> <li>• Fellowship Health Resources</li> <li>• Maine Coast Memorial Hospital</li> <li>• MAMHS</li> <li>• Mayo Regional Hospital</li> <li>• Millinocket Regional Hospital</li> </ul> | <ul style="list-style-type: none"> <li>• NAMI-ME</li> <li>• Regional Medical Center at Lubec</li> <li>• St. Joseph's Hospital</li> <li>• Sweetser</li> <li>• Together Place Housing Inc</li> <li>• Wings, Inc.</li> </ul> |
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**Alternates/Others Present:**

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| <ul style="list-style-type: none"> <li>• FAMILY MEMBER – Joe Pickering</li> </ul> | <ul style="list-style-type: none"> <li>• SHALLER ANDERSON - Tammy Smith</li> </ul> |
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**Staff Present:** DHHS/OAMHS: Don Chamberlain, Marya Faust, Leticia Huttman, Scott Kilcollins, Sue Lauritano; Muskie School: Phyllis vonHerrlich

Agenda Items	Discussion
I. Welcome and Introductions & reminder to sign in	Sue Lauritano welcomed participants and reminded people to sign in if they had not done so already; introductions followed.
II. Minutes – Review and Approval of November minutes	A correction to the spelling of a name was made and the minutes for November 18, 2008, were accepted as corrected.  <b>ACTION:</b> Minutes from November 18, 2008, were accepted as corrected.
III. Feedback on OAMHS Communications	<ul style="list-style-type: none"> <li>• Clarification was requested about the January 1, 2009, change in requirements for MHRTC certification.</li> </ul> <b>ACTION:</b> Marya Faust will clarify the change in requirements for MHRTC certification.
IV. Employment – Report from Charlotte White Center on	Richard Brown, CEO of Charlotte White Center, reported. Mr. Brown gave the background to the development of this employment program. He noted that in this culture employment is central to one's feelings of self-worth

<p>Employment Initiative</p>	<p>– that jobs give people a sense of hope and connectedness to society. Maine Medical Center was awarded the contract for this demonstration project to establish 7 sites (one in each CSN) to provide services to those seeking employment and/or developing skills for employment. CSN regional partners were sought, and Charlotte White Center was selected as the partner agency for this area. Leah Barteaux, who has an extensive background in this work, has recently been hired. She will be based at CWC, and for the first phase will have a work caseload of 25 clients, all of whom receive services through CWC. As the program develops, this will be expanded so that those who receive services from other agencies will be able to participate.</p> <p><b>Question:</b> What is the funding source?  <b>Answer:</b> State grant funded and only for those eligible for Section 17 services. CWC used the “Need for Change” survey, to which they received 150 responses, then selected the first 25 to participate.</p> <p><b>Question:</b> Other agencies have employment specialists – how does this program interface with other programs?  <b>Answer:</b> This one was developed specifically based on the Consent Decree, is for Section 17 only, and at this point is only for those receiving services through the partner agency (CWC). The caseload is 25 and currently there is a waiting list. This program does collaborate with others. M.H. Long Term Support was noted as another resource.</p> <p><b>Comment:</b> Don clarified that the pilot will be expanded and those outside the partner agency will have access to this service in the future. He also noted that there are avenues in addition to referral by the Employment Specialist to M.H. Long Term support, although an agency needs a L.T. Support contract to be able to draw on these funds.</p> <p><b>Comment:</b> A caseload of 25 is the ideal based on the current best practice in this field. All the CSNs have developing projects, although the position in CSN 4 has not been filled yet.</p> <p><b>Comment/Concern:</b> The Consumer Council of Maine executive director noted a concern about the way this program had been rolled out. It was not clear initially that the program would be limited to serving only those connected to the partner agency. She noted that there are some who have been on waiting lists for employment assistance for some time (prior to the establishment of this program) and she had thought these folks would be eligible for this program. She asked for a timeline on how the program would be rolled out or, alternatively, clarification from the Department on exactly what will be happening with the program.</p> <p><b>Question:</b> How are those exiting the correctional system being served by this program, since they do have major challenges to employment?  <b>Answer:</b> There is no special service other than a form of insurance available for Bonding that can be obtained (they can get \$5,000 federal insurance) if they need this, and there are some instances when requests can be made to expunge a record or a pardon can be requested.</p> <p><b>Comment:</b> The final comment was an expression of hope that the program can expand.</p> <p><b>ACTION:</b> Requested: a timeline on how the employment program would be rolled out or, alternatively, clarification from the Department on exactly what will be happening with the program.</p>
<p>V. Crisis Planning Update</p>	<p>Tom Lynn and Corey Schwinn reported on planning on the part of CSN2 crisis providers in light of the March system changes.</p>

	<p>Tom Lynn reported for District 6 (Penobscot and Piscataquis Counties):</p> <ul style="list-style-type: none"> <li>➤ An umbrella organization has been set up where all 13 providers have agreed to join and operate under a common MOU.</li> <li>➤ They will work on efficiencies and offer effective high quality services that meet standards set out by DHHS.</li> <li>➤ The umbrella system has set meetings, goals, and objectives and will develop plans to address concern as they arise.</li> <li>➤ Each service provider has a separate MOU to govern procedures and protocols. Noted: a number of the providers have been working together for many years.</li> <li>➤ The MOUs that currently exist will be updated with the specifications set by DHHS. Verbal commitment to participate in the crisis group has been expressed by all 13 providers and the formal agreements are being developed or current ones being amended.</li> <li>➤ It is anticipated that the first meeting will be in February.</li> </ul> <p>Corey Schwinn reported for District 7, which serves Hancock and Washington counties. Their work includes:</p> <ul style="list-style-type: none"> <li>➤ An umbrella organization for the District, to operate under a District MOU.</li> <li>➤ The minimum standards for the District and the Minimum MOU standards have been reviewed.</li> <li>➤ Long-standing MOUs will be brought inline with the new standards.</li> <li>➤ District 7 hospitals met and discussed: 1) District 7 plan, 2) each facility’s level of involvement, and 3) draft MOUs for each.</li> <li>➤ Consumers/Family member representatives will be included in the District 7 system.</li> <li>➤ Law enforcement also involved in the District 7 Crisis Service discussions.</li> </ul> <p><b>Question:</b> Do you want consumer membership on your overarching group?</p> <p><b>Answer</b> (Corey): Yes. We have had talks with some families who are consumers. Law enforcement offices and first responders will be included also.</p> <p><b>Answer</b> (Tom): Family members (consumers), law enforcement and others will be brought into the discussion of the Crisis Response System – they will be included but not part of the overarching group.</p>
<p>VI. Psychiatric Consultation Project</p>	<p>Don Chamberlain reported:</p> <ul style="list-style-type: none"> <li>➤ This project was developed by the Maine Association of Psychiatric Physicians (MAPP) in collaboration with the Maine Academy of Family Physicians (MAFP). It links volunteer psychiatrists with providers in rural primary care practices.</li> <li>➤ An ongoing consultative relationship is developed and the primary care practitioner can call on the psychiatrist as needed for advice and guidance. Specific or general issues can be covered and the purpose is to allow the general practitioner to have access to specialists so they feel comfortable handling medication management and in caring for patients with psychiatric conditions.</li> <li>➤ 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. Consultation for both adult and child</li> </ul>

	<p>patients is provided.</p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ The project is funded by grants from American Psychiatric Association and OAMHS of Maine DHHS. The program is managed by a part time staff person at MAPP. Further information can be obtained from Cindy Paradis at <a href="mailto:cindy_fox_paradis@yahoo.com">cindy_fox_paradis@yahoo.com</a> or David Moltz MD at <a href="mailto:dmoltz2@gmail.com">dmoltz2@gmail.com</a>.</li> </ul> <p><b>Question:</b> Is this on a case-by-case basis?  <b>Answer:</b> It depends upon how the consultation session is set up, but it tends to be case-by-case.</p> <p><b>Question:</b> How will primary care physicians know about this – there is a great need.  <b>Answer:</b> There is promotional material out there – the program has been publicized.</p> <p><b>Question:</b> Is it mostly medication consultation? Are you leaving out psychologists and others who are not pharmacological?  <b>Answer:</b> It is primarily pharmacological now, but we would be open to psychologists and others, but at this point MAPP is the organization that has turned to their members to volunteer and they are promoting it. It is a small (\$7,000) contract that DHHS provides to MAPP to support the program. DHHS is trying to address some of the other issues mentioned.</p> <p><b>Question:</b> Will DHHS share with the CSNs any reports they receive about this project?  <b>Answer:</b> Yes. Reports would not necessarily by geographic region, so it might not be readily apparent how this is happening in any particular region.</p> <p><b>ACTION:</b> DHHS will share reports on the PCP project as they are available.</p>
<p>VII. Subcommittee Reports- Peer Services</p>	<p>Leticia Huttman reported on an initiative to provide opportunities for peer services for those in outlying areas of CSNs where such services are not readily available. The program is called “Peer Support Without Walls.” AIN has a central role in the initiative and has a small budget of \$21,500. For the fall, staffing for the program through AmeriCorps is being considered. A challenge will be raising awareness of the availability of the service. Ms. Huttman noted that any suggestions for creative marketing can be sent to her.</p> <p><b>ACTION:</b> Send suggestions for creative marketing for “Peer Support Without Walls” to Ms. Huttman at <a href="mailto:leticia.huttman@maine.gov">leticia.huttman@maine.gov</a>.</p>
<p>VIII. Preliminary report compiled by the Review and Transformation of State System Committee</p>	<p>Chuck Tingley reported for the committee (Mr. Tingley, Sharon Greenleaf and public members Joe Pickering and Kay Carter), which was established in 2007.</p> <p>Brief summary of report:  Purpose of committee: to review positions in the 2008-09 DHHS budget and identify those that are duplications of role and function of positions in Community Mental Health Centers. The intent was to identify cost savings for the state budget by proposing DHHS staff cuts, transferring positions or resources to CMHCs,</p>

and/or eliminating unnecessary positions and duplicated efforts. Guiding principle: *prevention* is the core guiding principle – prevention of a situation or need from escalating from manageable situations (with appropriate supports) into crisis situation (whether it is housing or a specific direct service).

Areas identified as opportunities for Cost Savings and System redesign:

1. Case Management Positions

The committee identified over 1000 state caseworker and caseworker supervisor positions that appear to be redundant to CMHC roles and functions. The state positions are much more expensive because of disparity in salary and benefits. Suggestion: identify duplication of services; transfer positions/functions to CMHCs; eliminate unnecessary positions. Savings: unknown (but substantial).

2. Role Clarification within State Policy

A. Role of State in management and operation of mental health system: Serving both roles of the deliverer of services and the entity with oversight is ineffective and costly. Recommendation: re-design DHHS to focus on key areas of mental health services (planning, monitoring, funding, evaluation) and remove state from delivery of services.

Role of State Hospitals and State delivered community services: how these fit in the larger continuum of care is unclear. “Same or similar” provided services are redundant to the community system, which results in duplication of services, blurring of lines, inefficient use of funds. State services have limited or no oversight from managed care (APS review and authorization process) and no externalized gatekeeper functions (as required of the community-based system). State services are more expensive because of salary/benefit and administrative cost disparities. Suggestion: move the following to community-based programs: outpatient treatment, day treatment, medication management, vocational services, community support, case management, crisis services, ACT services. Savings: unknown (but substantial). Suggestion: study Riverview and Dorothea Dix Psychiatric Center to identify and eliminate services that community mental health services are providing (as noted above). Savings: Substantial.

B. Community Mental Health System as gatekeeper: to reduce the cost of the mental health system utilization of the following must be reduced: emergency rooms, private hospitals, and public hospitals. One way to do this is to transfer responsibility for management of these “gates” to community mental health centers.

Suggestions: eliminate APS managed care – or make more streamlined; and establish CMHCs as the gatekeepers of private and public inpatient settings and emergency rooms for those seeking MH services to eliminate redundant hospital services or unnecessary emergency room/hospital stays. Savings: significant. Of note: administrative costs for APS managed care are very high for small CMHCs is very high ( N= 3 FTEs ), which is a burden and has not been proven to be effective at this time. Savings: Substantial.

C. Targeted Case Management: DHHS rates for TCM are high when compared to that of CMHCs (69% higher). Medicaid rates differ (\$21.52 vs. \$33.56 for CMHCs and State DHHS respectively). Suggestion: Transfer all TCMs to CMHCs. Savings: \$2 million

D. MaineCare Eligibility is shrinking: reasons for shrinkage include capping non-categorical MaineCare, tightening eligibility, centralizing and restricting grant monies, MaineCare/Medicare dual eligibility (where Medicare rates are significantly lower), and the acceptability of wait lists. ADA and AMHI Consent Decree findings argue against the two-tiered system. The 2007-2008 budget reflects substantial grant funds, but detail on use/application is hard to discern. Grant dollars pay for needed services to non-MaineCare eligibility individuals. Suggestions: review all MaineCare eligibility categories; review and streamline process for eligibility; place all grant money “on the table” for discussion/disclosure; identify any grant-funded positions that are actually “shadow” state positions (operate within the state system, but are employed outside state system). Savings: unknown, but substantial (based on an estimated \$100,000,000 in grant funds).

E. Community Mental Health Center Caseloads: CMHC caseloads are higher than DHHS caseloads per capita. Suggestion: eliminate state direct service and afford consumers quick access to existing CMHCs. (Lost positions would migrate to CMHC programs which have lower pay and benefits.) Savings: Substantial

F. Community Service Networks: required by AMHI Consent Decree, but the structure is largely unproductive and impose costly administrative burden on participants. Adequate time needs to be allotted for CSN member input, and relevant background information must be provided. Suggestion: empower CSNs or introduce legislation to eliminate them.

G. Crisis System: for Crisis Services, the committee felt the process used by DHHS for consolidating the mental health crisis system was not sufficiently objective and did not conform to legislative requirements. They felt it destabilized many crisis programs and distributed funds disproportionately. (No suggestions were included.)

Rate Parity: rates paid to Federally Qualified Health Centers for physical and mental health services are higher than those for CMHCs for similar services. Suggestions: establish parity rates; through legislation establish a work group of CSN and legislators to identify inequities in MaineCare reimbursement and programs across all sectors (FQHC, private PCP, CMHC; Child Day Treatment-who can provide; comparison of rates for DHHS delivered services vs. CMHC rates for same services).

Summary (quoted from the report): “In the face of the above discussion [referring to the full report] and the looming State of Maine budget deficit, it is clear that many roles and functions of the State DHHS can be absorbed by the community system at less cost. This will result in a more coordinated, responsive system of care with the State Department of Health and Human Services fulfilling it appropriate role of planning, managing, funding, an devaluating the system of services. Let’s move in that direction. This Review and Transformation Committee of CSN II will begin to identify more specifics in this regard and report back to the CSN. We have begun to do this in this report.

Discussion points:

- It was noted that the community mental health system and oversight were the major focus of the report. There is too much oversight, they want equality with other institutions, and they want same rates (particularly in the Targeted Case Management services). Eligibility is shrinking, dual eligibility is creating challenges to some for services. When the community system is compared to the state system, it is more efficient. With the upcoming budget, they will be looking to see what new positions there are, and will look at the use of the Muskie School, also. The community mental health centers have lost a great deal in the past few years.
- Clarification: Concerning a point on page 5 of the report (F. Community Service Networks-see summary above) that read “. . . at the CSN Meeting there was but a few minutes of disjointed discussion about the needs . . .” it was noted that an entire CSN meeting was spent talking about unmet needs and that proposals and suggestions were received from consumers. The words “a few minutes” do not represent the time spent on this topic. It was acknowledged that the entire full discussion is yet to occur.
- Clarification: It was noted that APS does affect the private hospitals.
- Comment: For the cost of APS – the burden goes to the agency and hospital. Administrative burden is not factored into cost of APS. The money spent on administration [for APS process] is not available for services.
- The subcommittee was congratulated on the report: great job – good report. Good issues were brought to light.
- Question: CSN III has a standing agenda item around APS – could not CSN II do that, also?  
Answer: A discussion of APS will be a standing item on the agenda.
- Question: APS has said denial rate is negligible – what are they saving in terms of cost?  
Answer/Clarification: APS has solicited information and compiled a report based on the initial months of service. State staff will get this sent out to the CSN before the next meeting.
- Question: Does APS report savings or less use? Can we get the baseline data – what are we using?  
Answer: APS reports numbers and Jay Yoe’s office does the analysis.
- Question: Kelly [Bickford] was here last time – we gave recommendations – what happened?  
Answer from State: There is a report. We need to get it out.
- Comment: There needs to be a forum on APS and the issue of the minimal unit [of approved service] possible.  
Response from State: Ask for what you need. If you get turned down, tell DHHS.
- Comment: APS says they want more accurate representation of service needs.  
Response from State: You can project need – APS is not trying to reduce units.
- Comment/Question (summarized): This is an undue process on community organizations – it is a “nightmare” to change forms. There is a heavy financial/administrative expense, which the providers are absorbing. There is an impact on service load and services delivered. The Department needs to know this. Is there a forum where we can talk with the Department? A Department sponsored forum – without APS?  
Response from State: APS is not a requirement only of OAMHS – it is a system that DHHS

	<p>overall is using. This would have to be done for all of the State and for all providers.</p> <ul style="list-style-type: none"> <li>➤ <u>Comment</u>: There is frustration with the APS process – the premise is that it is to save money; there is no proof of this. Look at all the expenses.</li> <li>➤ <u>Clarification requested by State</u>: Are both children and adults included in the \$100,000,000 figure included on page 4 of the report – MaineCare eligibility shrinkage (2 D, above). <u>Response</u>: Yes, services for both are represented in this amount.</li> </ul> <p><b>ACTION</b>: Discussion re: cost of APS to providers will be placed on the agenda for the next meeting. <b>ACTION</b>: State will send APS report to CSN members</p>
IX. Consumer Council Update	<p>Elaine Ecker reported:</p> <ul style="list-style-type: none"> <li>➤ Focus now is to hold regional council meetings and recruit and identify representatives to the Regional meetings.</li> <li>➤ CCM has 19 members at the Statewide Council and they meet tomorrow with Muskie.</li> <li>➤ OIAS is working on customer service standards – will meet with them – the focus is to provide better customer service and updating Web site.</li> <li>➤ CCM will be electing officers and working on organizational details.</li> <li>➤ A mission statement is coming.</li> <li>➤ Focus of work is to develop statewide council and develop local councils in the communities; the local councils will send representatives to statewide council (reps from regions now).</li> <li>➤ CCM has three outreach workers – one for each region.</li> <li>➤ Have a new toll-free number – it is on the Web site.</li> <li>➤ By the next meeting, a packet of reference information will be available.</li> <li>➤ CCM is developing and support from CMHCs is appreciated.</li> </ul> <p>Vickie McCarty reported on the local council:</p> <ul style="list-style-type: none"> <li>➤ The local council will meet January 26 at the Peace and Justice Center, 5:30 – 7 PM.</li> <li>➤ The local council has been distributing flyers and inviting folks.</li> </ul> <p><u>Comment</u>: CCOM is about collaboration; we don't want to be adversarial – we want to collaborate.</p>
X. State Review of IMDs: Spring Harbor, Riverview, Acadia, Dorothea Dix	<p>Annette Adams reported.</p> <p>Points made during the discussion:</p> <ul style="list-style-type: none"> <li>➤ The four MH hospitals in the state have specialized levels of care.</li> <li>➤ Reductions in service need to be presented at the CSN meetings.</li> <li>➤ Dorothea Dix had a reduction from 60 down to 54. <u>Response from State</u>: There was a loss of between 6–12 long-term care beds at DD in mid-November 2008 because there was no psychiatrist available. The hiring freeze prevents filling this position, but the position will be filled when the hiring freeze is lifted and these will be available again. The interim director reported one unit had been closed and the department plans to reopen this unit when key positions are hired.</li> </ul>

- What is the impact of this [DD reduction]? Recent incidents include: a 24-hour stay in emergency, which was experienced by four people and a “rapid” response for one person, which in reality took over 24 hours.  
Response from State: this was an issue of a person who was 18, but still being served in Children’s Services, but came as rapid response to an adult team. Situations of this sort need to be addressed by the State.
- It has been said that there are increasing forensic patients on the civil bed side at Riverview.  
Response from State: There has been some cross-over, but there are always beds available. There has never been a civil bed waiting list.
- What is the correct size for beds at Dorothea Dix?  
Response from State: It is a complex issue - that of accessibility of acute care.
- Mental Health care providers need to hear about reduction of services prior to experiencing them – to be able to anticipate problem areas.
- There is a reduction of services across the board – need to look at services – need to look at it in a systemic way – all services.
- What is the interpretation of the unmet needs data from the state’s data?  
Response: It shows only those already in system.
- There is an increase in unmet needs every quarter. How does the department use that as a predictor?  
Response from State: There have been some data problems – sometimes there is double counting. State staff do not see an increase in unmet needs, although we continue to have unmet needs in MH, housing, and health care.
- Does the State have an assessment and a position on the impact of the budget cuts on hospital outpatient services?  
Response from State: This is fair to ask, but OAMHS can’t answer that question; it needs to be directed to the Commissioner. **ACTION:** OAMHS will ask for clarification of the impact from the Commissioner’s Office.
- How is unmet need determined?  
Response from State: One has to come into the system to be identified as having a need that is not being met. It is not a global assessment. DHHS/OAMHS did make request in the supplemental budget and the 2010-2011 budget, but it is not clear yet what will be forthcoming – possibly additional funds for housing and community integration. Additional funding for WRAP was also requested, as was funding for Out Patient, Medication Management, Daily Living, Community Integration, and ACT.
- Do you have a plan to respond to budget proposals?  
Response from State: The budget came out on Friday (1/9/09) and we are still analyzing it. Once we have done the analysis, we will get the summary out to CSN members before the February meeting. **ACTION:** Summary analysis of supplemental budget will be sent out by OAMHS.
- Request: If a provider is having a change in service, report this to the CSN. Crisis programs, in particular, need to know of changes – it has a huge impact.

	<ul style="list-style-type: none"> <li>➤ How is the budget change impacting service delivery in the CSN – this needs to be clear and we need to discuss it at the network level. Reduction of funding will result in MH hospitals and other services curtailing services. This will drive up unmet needs. We also need to be able to discuss this around the CSN table. <ul style="list-style-type: none"> <li><u>Response from State:</u> There are reductions in reimbursement for services that we do not control, for example the hospital reimbursement rates for physician services.</li> </ul> </li> <li>➤ Reduction of reimbursement for hospital-based physicians has a great impact on that institution. While those in private practice can limit the numbers of MaineCare patients they see, this is not the case for hospitals. Added financial burden for hospitals has far reaching impacts and consequences on the care provided. <ul style="list-style-type: none"> <li><u>Response from State:</u> The Legislature is still trying to figure this out. It is clear that there are changes in eligibility under Section 17; otherwise, no. The efforts of MH consumer groups voicing their concerns to the legislature was an important effort.</li> </ul> </li> <li>➤ The real concern is for the consumers. Consumers need to know what changes are coming and what impact these will on services. Give consumers specific information – particularly if you want them to lobby the Legislature.</li> </ul>
<p>XI. WRAP Process</p>	<p>Susan Lauritano reported.</p> <ul style="list-style-type: none"> <li>➤ As of January 1, the Charlotte White Center will serve as the agency for finances and review of applications for WRAP funds for this CSN.</li> <li>➤ Representation from one other provider agency is being sought to serve on the review board. It is important to have a transparent process.</li> <li>➤ Denials (of applications) will go to the Regional Office for appeal review.</li> <li>➤ The policy for WRAP funds has been revised. The policy is being changed and the changes include: 1) security deposit or rent- 1 time per year (and the cap for this is \$500 in one year; the only exception is if rent or security is over this cap); heat at 100 gal./year; emergency hotel housing - 1 time per year; lights – 1 time per year; meds – two week supply 1 time per year; \$150 for other emergency needs. WRAP funds have to be the last step in seeking assistance before they will be awarded. These will be sent out. <b>ACTION:</b> policy for WRAP funds will be sent out.</li> <li>➤ As for who can have access to WRAP funds, Section 17 criteria must be met, but the applicant does not have to be a client with a specific service provider. The specific application will need to be completed and the turn around time is approximately 48 hours.</li> <li>➤ The review board will meet weekly and appeals will be forwarded weekly.</li> <li>➤ <u>Comment:</u> With the WRAP funds, there was an increase in the total going to agencies, but an overall reduction in WRAP identified funds. These funds were actually allocated to specific services</li> <li>➤ <u>Question:</u> Do you take feedback [about the WRAP process] – are you looking toward a streamlined process with more consistency? <ul style="list-style-type: none"> <li><u>Response:</u> Charlotte White will be reporting back to the Regional office – there is feedback.</li> </ul> </li> </ul>

XII. Drug Disposal Discussion	<p>This item will be discussed at a subsequent CSN 2 meeting.</p> <p><b>ACTION:</b> The Discussion of the Drug Disposal initiative will be scheduled for a later date.</p>
XIII. Other	<p>Request for grant funding for services:</p> <ul style="list-style-type: none"> <li>-Don Chamberlain clarified: in regard to the closing of CSNs for new cases for services, providers are to use service notification to APS if someone comes to their door for services. It is necessary to report only the name and service requested. This is the way the demand for services (unmet needs) will be tracked.</li> <li>-APS is difficult to use in this way. No way to distinguish class from non-class recipients.</li> <li>-Waivers are available to those who were already in care who have lost MaineCare; a waiver is something the provider would request (just for Section 17).</li> <li>-There are questions, concerns, and lack of clarity about who is going to lose Community Integration services.</li> </ul> <ul style="list-style-type: none"> <li>➤ Transportation Tool Kit: It was reported that this is available on the DOT Web site. <a href="http://choices.muskie.usm.maine.edu/newsletter/TransportationToolkitNov2008.pdf">http://choices.muskie.usm.maine.edu/newsletter/TransportationToolkitNov2008.pdf</a></li> <li>➤ <b>ACTION:</b> Request for a PNMI update for the next meeting.</li> <li>➤ Allies, Inc. can serve individual, ages 17 – 25, for job employment needs.</li> <li>➤ Budget Clarification: request for clarification about changes in budgeting for the supplemental budget and for the 2010/2011 budget. <u>Response from State:</u> We should know this week what is or is not included in the budget.</li> </ul>
XIV. Meeting Recap/Agenda for Next Meeting	<p>Issues for action:</p> <ul style="list-style-type: none"> <li>➤ Change in MHRTC certification will be clarified.</li> <li>➤ Request for a time line for roll out of employment program/or a clarification from the Department.</li> <li>➤ Send suggestions for on how to promote “Peer support Without Walls” to Leticia Huttman.</li> <li>➤ State will send APS report to CSN members.</li> <li>➤ Place APS discussion on next agenda.</li> <li>➤ Request to DHHS Commission for the department’s position on assessment/impact of budget cuts on unmet needs.</li> <li>➤ DHHS will share reports on PCP initiative as available.</li> <li>➤ Request for a PNMI update for the next meeting.</li> <li>➤ New policy for WRAP funds will be sent out.</li> </ul> <p>Issues identified for the next meeting:</p> <ul style="list-style-type: none"> <li>➤ Clarify MHRT certification requirements.</li> <li>➤ Clarification on how the employment initiative will be rolled out.</li> <li>➤ Report on information re: Psychiatric Consultation Program.</li> <li>➤ Discussion of costs of APS to providers.</li> </ul>

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|  | <ul style="list-style-type: none"><li>➤ PNMI update.</li><li>➤ Discussion of the Drug Disposal initiative.</li></ul> |
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