

DHHS / OCFS/ CBHS Provider Meeting Minutes

Districts 3, 4, 5

October 21, 2010

Meeting place conflict resolved with move from Riverview to Augusta City Hall Learning Center. Thank you all for your patience and cooperation.

Kathy Alley – CGHS Team Leader/ Updates

Central Enrollment for Home & Community Treatment (HCT) with CBHS ended October 1. All referrals for this service will now be made directly to the agencies that provide HCT services. Provider Lists are found on our web site at: <http://www.maine.gov/dhhs/ocfs/cbhs/index.shtml>. CBHS, Districts 3, 4, 5 still has about 25 children on a waitlist for this service. All children on the CBHS waitlist will be assigned before APS will allow any new assignments for this service.

The application process for Intensive Temporary Residential Treatment (ITRT) has changed slightly. An in-house team of Mental Health Coordinators and others was meeting weekly on Thursdays to review applications. All pieces of an application had to be submitted by Tuesday of each week for the review. In some cases, because applications were incomplete when submitted, it was felt that attention to the applications was held up longer than necessary. At this time applications that are not complete will continue to be turned back and not reviewed until all elements of the application are in the hands of the Mental Health Coordinators for review. When the Mental Health Coordinators receive a completed packet the MH Coordinators will review and notify as soon as possible. Case Managers might consider contacting and involving our MH Coordinators early on in the process when ITRT may be a consideration. They will gladly walk providers through the process and in some cases are able to attend team meetings. Mental Health Coordinators are assigned by the geographic area in which the family lives. Please call into our CBHS office 1-800-866-1814 or 624-5261 or check our website for a list of the MH Coordinator staff names if you are unfamiliar with the staff covering your area.

Training will be offered for an on-line version of the CAFAS. A provider was wondering if it will be mandated in the future that the CAFAS evaluation will have to be submitted in the paperless form. At this time it will still need to be optional but in the future that may change. CAFAS evaluations are still needed for Case Management but for HCT the YOQ or the CAFAS is used.

Marjorie Withers, Director of the Community Caring Collaborative (CCC)

The Community Caring Collaborative (CCC) is a collection of 30 entities in Washington County. Washington County has a population of 32,000, 10% of whom are Native Americans. Washington County has very low employment. The largest town in this county has only 3,000 people, and is 3 hours away from anything. They have 1 ½ pediatricians and are 90 miles away from most services. Washington County is a revolving door for physicians. There is a lack of continuity for health care services as a result. Generally physicians serve in rural areas for limited periods of time in order to meet their school loan obligations. 1 out of 3 children are born to parents with substance abuse problems. There is no cell phone reception for ½ of the population. In general the population becomes very hopeless.

Marjorie initially began the collaborative group with 15 to 20 interested parties gathered to begin grant writing. They were finally given private funding from the C. F. Adams Foundation (funding projects in Massachusetts, Maryland and Washington County) and a \$60,000 grant. Now CCC works with a \$5 million dollar budget.

Tory Harrison began training staff with initial grant money to work with teen mothers. They accomplished 50 trainings in the 1st year with all having to do with early intervention. They continue their work around the next generation working with children 0 to 8 with families, communities, tribes, provider agencies and state agencies.

A curriculum has evolved of 60 to 65 hours. It is now integrated into University of Machias course work and Eastern Maine Medical Association training. It includes Substance Abuse Information, Trauma issues and Poverty issues. They conduct a summer institute each year that is well attended.

There has been no money put into space, so staff now uses computers and cell phones in order to spend funds in an efficient manner. They have been trained to do assessments for needs and mobilize somewhat differently for those in rural areas. They have data systems to measure effectiveness of programs.

The Bridging Program has worked hard to identify addicted mothers so that more services can be given a baby in drug withdrawal at the time of birth. Mark Brown an MD at Eastern Maine is now working more effectively with fragile parents and babies at the time they are in the hospital by encouraging drug testing and evaluations at admission and by getting services in place before leaving the hospital and in some cases by have the child spend more time in the hospital in treatment before leaving. Withdrawal systems for babies sometimes take 24 to 48 hours after birth to show up. They are now able to gather information whereas Early Intervention leads to fewer services needed later on. In the case of treating babies for longer times in the hospital, they have been able to reduce the rate of further hospitalizations for these children.

Agencies are now grouping together to write grants. They now have specific sites in 6 different areas. They are presently serving 145 families and continue to build. They will continue to work on the possibility for re-imbursment rates to be at a higher rate for rural participants.

New curriculum should be available in a few days. They do provide consultation services outside of Washington County usually for a fee. The Summer Institute is open to all.

Marjorie's closing words were "Early Intervention is truly a miracle time".

Bill Hughes – DHHS/Office of Adults with Cognitive and Physical Disabilities

The office has been in transition for some time. The latest transition was changing their billing system from monthly to weekly billing as of September 1.

Case Management is now the only entitlement offered.

There are currently 28,000 people on a Home & Community Based Waiver (Sec. 21) receiving services. This program was closed for 28 months and has recently just opened up very modestly. The average age of people receiving this service is 50. Currently they are able to bring about 6 or 7 people a month into the system (partly as people pass away in the program). They must look at those who are most in need. There are currently 400 on a waitlist for the service. 160 are considered category 1. Those with the highest needs are prioritized (health and safety issues, those living with elderly parents) to receive service first. Application forms and information can be found on the WEB.

Case Management is distributed on a first come, first serve basis. Received funding for 65 persons. They have brought on 30 clients this year and are serving another 10. Parents need to understand that there are people on a waitlist for the program and that more is done as funding is available. It costs approximately \$100,000 to place an individual on the waiver program. They are looking at more shared living arrangements and more employment to help bring the costs down. The department no longer supports sheltered workshops but they do have 90% supported employment and wish to have parents support work for their adult children with disabilities. (70% are not employed).

Information on Guardianship and other information can be found on their WEB.

Scott Hayward – Providence Service/ Virtual Residential Program (VRP)

This is a proven clinical model started in Colorado ten years ago. It is considered a step up (designed to keep children out of residential placement) or a step down program from residential placements.

The Step 1 of the program is scheduling all time in the home 20 to 50 hours a week; identifying “hot spots” -- times of conflict and establishing training with parents. Need to move from times of attack to training parent about behaviors that help. Stage 2 (acceptance stage) must get parent buy-in and work through problems with resistant parents. Schedules include ½ hour of chores or tasks with ½ hour of earned “free” time. Communication logs are used and progress notes are kept in duplicate so parent has all information. Contextualized Feedback Information System (CFIT) scores consisting of twenty questions is used to evaluate progress and team meetings are held weekly to refocus tasks that are set for the week. Behavior management techniques are described in the log.

Referrals are made directly to the agency. There is a 1 page application and then a prescreening process for this program. 79% of children in this program in other states have remained in their homes. At this time there is a 2 month wait for service and they are able to provide service in Bingham, Hallowell, Brunswick, Auburn, Bangor and Portland. Waldo and Knox Counties can be covered. This is an HCT service funded as a “medical necessity”. Some referrals that didn’t work out were because parents were not at home enough. The goals are to stabilize without injury, re-program parents and work into the last phase which is the Working Stage of the program. Parents are then in charge. They work with videos to check body language and fidelity to scripts and consistency with behaviors. Meetings continue with parents to check progress and review videos.

Providence Maine has only been working with the program since April. They have taken on very difficult cases and have remained excited about the program. They have worked with 2 foster families. The Program that has been working out of state for 10 years reports on progress every 2 years.

Next meeting will be Friday January 21 at Riverview.

