

Provider Meeting
CBHS-Region 1
December 13, 2010

Present:

Bob Barton (CBHS)
Jim Allen (CBHS)
Jennifer Dondero (CBHS)
Erica Whiting (Port Resources)
Rhonda Juneau (Growing Opportunities)
Kelly Parnell (APS Healthcare)
Emilee Taplin-Lacy (Affinity)
Katie Demanche (Affinity)
Kathy Kosnow (PROP)
Ellen Martzial (Woodfords)
Michelle Armstrong (CBHS)
Holly Hathaway (SMART)
Laura Harvey (Independence)
Ellen Tims (CBHS)
John Regan (CAFÉ)
Melissa Maurais (CAFÉ)
Wayne Chasse (Progressions)
Kane Loukas (YAI)
Marcia Hard (Merrymeeting Behavioral Health)
Tracy Haller (Casa)
Jim Pease (Casa)
Durinda Chace (Spurwink)
Meg Hall (Spurwink)
Rob Ridlon (Spurwink)
Amy Mihill (MVRA)
Clarice Dunn (CBHS)
Sally Hunt (CBHS)
Lisa Salger (CBHS)
Kinsey Tinelli (Bridges)
Corinne Whitling (Providence)
Rebecca Ryan (Living Innovations)
Tara Moulton (Back to Basics)
Nancy Givren (Community Counseling)
Kristine Belanger (Milestone)
Rachel Posner (CBHS)
Brenda Gagnon (CBHS)
Mike Parker (CBHS)
Tom Riddle (Sweetser)

Vineland and ABAS: This is particularly related to children receiving services under Section 28. CBHS needs a Vineland, an ABAS, a Battell or a Bayley, done within the past year. Score needs to be ---(**Bob—fill in here). For case managers, the important point is that those scores need to be within the past year, for initial referral; and score needs to be current within the past 2 years, for continued stay review. We're counting on case managers to help families get those evaluations done. These instruments are pretty short, they're not time intensive. Encourage agencies to keep track of when Vinelands are going to run out.

Diagnosis codes: A lot of times CBHS receives diagnoses, without a diagnostic code. Diagnostic codes are needed in order to enter the information for authorization. Also, if a case manager is making a referral to an evaluator, please make sure the diagnosis is done in compliance with the current version of the DSM. Case management supervisors: please make sure to fill in the section of the referral form that asks for the reason for the referral. Please don't just say "refer to evaluation". The reason for referral is used by CBHS staff when making a match for the service.

Y-OQ and Electronic CAFAS: The administration of the CAFAS is moving from a paper to an electronic tool. The electronic CAFAS allows for scoring and different functions that cannot be done on paper. Spurwink, pilot site, reports no issues thus far and expressed that available graphs detailing such things as outcomes are much more helpful and visually pleasing. There is a glitch in terms of electronically changing from one case manager to another. Spurwink also reports that overall the electronic CAFAS seems very user friendly.

All of southern Maine ACT and HCT clinicians are currently being trained with the developers of the YOQ which will take the place of the CAFAS for those service areas. The tool is very different than the CAFAS. It is a big systems change. The reason for the change is to get more family input and child input for scoring. There is a long and short version that can be administered, 64 questions vs. 30. The Y-OQ can be administered initially and can be done every week to two weeks so progress can better be measured. Kennebec Behavioral Health has been using it for four years and finds it helpful and says it opens dialogue much more between clinicians and family as well as better tracking of outcomes. The youth and parent speak with their own voice, and this instrument can accurately capture their voice. The clinician can also easily identify when safety and therapies aren't going well. There are also opportunities for the clinician to see inconsistencies between child and parent report. Supervisors will also have the ability to obtain aggregate information, and use it as part of their supervision when working with individual clinicians using information such as patterns across cases, etc. The parent version of the Y-OQ is for children/youth ages 4-17; the youth self-report version is for ages 12-18. CBHS is working with HCT and ACT agencies around a monetary incentive for obtaining laptops or netbooks in order to administer the Y-OQ, particularly for use by with clients in more rural areas who may not have access to a computer. The role out is mid January and the assumption is that it will happen once the training is completed.

The Y-OQ, unlike the CAFAS, is not meant for cross-agency comparisons. There was brief discussion about information available on the APS Healthcare website. Helpful and informative data can be found on the APS website, including information about HCT services, as well as hospital recidivism.

Trauma Survey- The recent webinar was unsuccessful but agencies reported that they used the time in other ways. Doug Patrick reports that the webinar will be posted on the THRIVE website in the next 3 weeks. Agencies will have until March or April to have staff watch it. A readministration of the survey is scheduled for this spring, for agencies that were not able to get complete data the first time. In a year there will be a follow up administration of the survey for all agencies. There was concern that if agencies have questions and/or feedback that the opportunity will not be available. Also there was question around how many people from each agency should take the webinar. Rachel suggested that if agencies have questions around their specific agencies to email her and Doug Patrick. There are a unique set of issues/problems with each of the different populations. We all want to be trauma informed and agencies should ask themselves how they can 'raise the bar' looking at it in various short and long term steps. Agencies seem to be waiting until after the New Year to begin this. Rachel suggested that agencies begin thinking seriously about it.

Referrals for Outpatient & Medication Management: these handouts come from some training that our Medical Director did for Child Welfare caseworkers. They may be helpful for providers, to help families in making sure that therapy and medication management are effective.

*The 2 handouts are at the end of these minutes

This information is intended to help families, case managers and others be well informed consumers of the service. This sheet is designed to help the family and case manager ask good questions. Therapists, like medical practitioners, need to do full informed consent with the client.

Case managers and parents are encouraged to be well informed consumers, regarding whether the treatment is likely to be effective; how the therapist will measure progress; and how the family will know that the child/family are ready for discharge.

In discussion, it was mentioned that families struggle when things aren't going well, in terms of how to ask questions, and how to decide whether it's time to move on (from this therapist). There are also times when "family work" is really just a check-in for 5 minutes at the end of the session, rather than real family therapy.

Regarding the handout on psychotropic medication, Jim Allen highlighted some items:

- What are the risks and benefits of using this medication?
- What are the risks and benefits of using no medication?

- Common side effects—there is particular concern about weight gain, which could lead to obesity, and possibly diabetes down the road. Need to take into consideration the long-term risks and benefits. These need to be explained to the parents.
- If there is weight gain, how will this be monitored? For example, getting blood drawn regularly can be difficult for some families for various reasons.
- How long will the child stay on this medication?
- Why are you choosing this medication, in conjunction with other medical conditions the child may have?

Please encourage parents to make sure they are involved in the decision making. This can be an issue for children in residential treatment, where the family may not be involved by the residential program in the medication management.

Managed Care: Information is regularly posted on the DHHS website about the Medicaid Managed Care initiative, including membership of workgroups, minutes from committee meetings, etc.

http://www.maine.gov/dhhs/oms/mgd_care/mgd_care_index.html

Last Friday there was a meeting for potential vendors of managed care. Brenda provided some information from that session.

Over 4 years, MaineCare enrollment has increased while costs are decreasing.

The most recent information we have about the timelines for the managed care initiative are as follows:

- June 2010 Managed Care Initiative Launched
- May 2011 RFP Issued
- April 2012 Year 1 Enrollment Begins: Mandatory & Voluntary Populations
- Feb. 2013 MCO Readiness Reviews of Year 3 populations
- April 2013 Year 2 Enrollment Begins: Waiver to mandate voluntary populations; specialized services are phased in
- April 2014 Year 3 enrollment begins: Dual eligibles, waivers

The key objectives of the initiative are:

- Measure and reward quality outcomes
- Align incentives of the State, MCO, providers and members
- Offer a mandatory program with at least 2 options
- Prescribe predictable costs/risk transfer
- Facilitate constructive member and provider engagement
- Encourage a health focus for the population

There are 6 core workgroups:

- Special Services
- Quality work
- Regulatory/policy
- Operations

- Finance
- Procurement

The RFP will be announced in the Kennebec Journal.

Detailed information is available on the DHHS managed care website about the ways in which various populations of MaineCare recipients will be phased into managed care over 3 years.

By December 22, questions & answers from potential vendors will be on the website.

Some basics about managed care were described. The RFP will be for an MCO (Managed Care Organization). Currently, APS Healthcare operates as an ASO (Administrative Services Organization). Difference between an ASO and an MCO (*****insert definitions here).

Waiver: Mike Parker indicated that about a month ago, the final draft of the children's waiver was sent to CMS in Boston. DHHS is waiting for word back from CMS. The current waiver (the adult waiver) that is currently in operation is for age 18 and above. Children don't qualify for the waiver that is currently administered by OACPD (Adult Developmental Services). It might be spring or early summer before CBHS can start working with children's providers on starting the services under the new children's waiver.

Flex funds: Michelle Armstrong reminded the group that there are new forms for flex funds. And please include the ISP with the form. The form also asks for family contribution. If the family can't make a contribution, please include a letter saying that the question was discussed with the family, and they aren't able to help financially. Please contact CBHS if you have questions.

CBHS Website: Mike Parker indicated that a CBHS Provider Information Form will be the new way for providers to update their information on the CBHS website. This should be used for any change in the agency. This should be used for address changes, change in who the contact is at the agency, change in phone numbers, etc. The form will be used statewide. Mike will be talking to 3 agencies about piloting the use of this form.

Ensuring Effective Psychotherapy for Children

Effective Therapy helps children to have fewer problematic behaviors, and to be more successful with caregivers, families and friends. Effective therapy results in better outcomes for children and families.

How to Select the Right Therapist for a Child:

1. **Describe the child's behaviors that are of concern in a specific and measurable way** (e.g., "Billy is hitting the children in the foster home 3 times/day.")
2. **What experience does the clinician have** in working with children exhibiting these behaviors?
3. **What model of therapy does the clinician use** to help a child with these problems? Is there evidence supporting the model? How does the therapist make sure that he/she is following the model? A clinician should be able to give an outline of how they would approach the case.
4. **What measurable goals and objectives would the clinician include in a treatment plan** for a child with these problems?
5. **How will the clinician measure progress?**
6. **How long** does the therapist think it will take to achieve the treatment goals?
7. **How will parents/guardians be included** in the therapy? How often does the clinician expect to see the adults?
8. Does the provider have a **back-up plan in case of emergency?**
9. What are the **costs of treatment** likely to be?

Make Sure that Therapy is Effective:

After therapy has started, it is important to speak to the therapist to see what progress the child has made. On a regular schedule (at least every 90 days) it is important to ask the following questions:

1. **What goals have been achieved?** If goals have been achieved, what new goals have been established? How long does the therapist think it will take to achieve these new goals?
2. **If goals have not been met, what are the barriers to progress?** How does the therapist plan to address these barriers?
3. Expect a written report every 90 days.
4. **Expect progress at each 90-day review.**

PSYCHOTROPIC MEDICATION QUESTIONS FOR CW WORKERS

The two most important overall questions are:

- 1) What are the risks and benefits of using this medication?
- 2) What are the risks and benefits of using no medications?

Some specific questions that will often be helpful:

- 1) What is the diagnosis?
- 2) What is the prognosis untreated? In other words, what is likely to happen if no medication is prescribed?
- 3) Is there evidence to support the use of medication in this situation?
- 4) Which medications have been found to be effective? What are the risks and benefits of each of them?
- 5) What are the target symptoms for the medication trial?
- 6) What are the chances the medication will reduce the target symptoms?
- 7) How large of a change in the target symptoms are we likely to see?
- 8) What are the most common side effects?
- 9) What are the most serious side effects?
- 10) For which side effects should the parent/guardian contact the physician immediately?
- 11) How will you monitor for side effects?
- 12) For medications that cause weight gain:
 - a. How will you monitor the child's weight
 - b. How will you monitor the child's blood sugar and cholesterol?
- 13) How will response to the medication be assessed? How will information from parents/caregivers and from the school be included in the assessment of response?
- 14) If the medication is helpful: how long should the child stay on the medication?
- 15) If the medication is not helpful:
 - a. Is the diagnosis correct?
 - b. Does the dose need adjustment?
 - c. Are there other medications that would be more helpful?