

Report from Workgroup on Clinical Transition of Community Support Services

Community Support is a service designed to accomplish four goals in the array of the current service system:

1. enhance skills necessary to address complex mental health and/or substance abuse symptoms of children and adults who have significant functional deficits, and to promote symptom reduction and improve functioning in their daily environments;
2. assist the child/adolescent and family in acquiring the necessary skills for reaching recovery , and for self-management of symptoms and for addressing vocational, housing, and educational needs;
3. link recipients to, and coordinate, necessary services to promote clinical stability;
4. monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

The mission of the Clinical Transition Workgroup was to describe the consumers currently receiving CSS in our system, determine a level of risk for those consumers, identify services currently available in our system to address ongoing needs, and to note gaps in services that may exist as a result of the loss of CSS.

The initial **data** gathering identified 33,000 consumers of CSS, both Medicaid (approximately 30,000) and State funded (approximately 3750) services, in our system. Using paid claims data, the identified consumers were sorted into groups of those receiving CSS and an additional service (clinical home service, non-clinical home service, and basic service; approximately 11,000 consumers) and those receiving only CSS. The assumption was made that if a CSS consumer had another service identified, the provider for that service would be responsible for the consumer and the PCP. The remaining consumers (22,000+) were identified as having CSS only (no other service paid). Using the VO risk scale and data system, the top 20% of consumers most at risk were identified (6800). Those receiving only CSS services (61%/4155) were identified as a priority population within the high risk grouping.

On Tuesday, September 29, 2009, LMEs were given access to this information and sent a letter describing the information, the plan to contact providers, and the need to assess the service needs for our priority population. The entire data set for consumers within the LME catchment was provided to each of the LMEs. This data is to be shared with the providers to evaluate their consumer population for services. The primary task is to triage individuals for transition to alternate services as medically necessary (MN). Along with that, as the LME should identify gaps in medically necessary services that may exist.

The **discharge documents** noted in IU#60 were reviewed and edited to provide more accurate elements. The amended documents will become available through the next IU and will be implemented at a soon to be announced future date. Edits included clarifying the language, and adding a space for consumer and/or guardian signature.

This document is to be completed at the time of the next authorization request or admission to CSS. This is an effort to begin the conversation of the need for alternative services, as CSS is no longer allowed. The time for entrance into community support was extended until 1/1/2010 from the initial announced date of 10/12/2009.

The **full service array** available to serve consumers currently in CSS identified includes basic benefits (outpatient and medication management), clinical home services (IIH, MST, ACTT, CST, etc), non-clinical home services (PSR, day treatment, etc), and natural community supports. Based on the evaluation of our consumers currently served in community support, many may be eligible for one of the above services as medically necessary. The purpose of the DC plan noted above is to clinically review those consumers and determine if there is a medically necessary service in the current service array that can appropriately serve the consumer

1. **Basic benefit** (Outpatient/medication management) - It is noted that as CSS is no longer an available service, the basic benefits will assume an important role in our service array. Outpatient treatment as a model of care was not emphasized in early reform as the array of services was developed. It is critical now to actively support the new model of outpatient treatment that includes active engagement models of care, best practice models of outpatient treatment, and curriculum based models of care. Many of these models are described National Registry of Evidenced-based Practices and Programs (see www.nrepp.samhsa.gov) and should become the cornerstone of outpatient treatment in North Carolina. Many of our current CSS consumers can successfully transition to these programs of care.
2. **Clinical Home Services**- Some CSS consumers may need an enhanced level of support during this transition period. The clinical assessments by providers of those consumers identified by providers and LMEs may indicate the medical necessity of these enhanced services.
3. **Non-clinical home services**- Some consumers are currently served in programs that are not identified as clinical homes, and are not formally responsible for the completion of the PCP. Some consumers are in residential settings (group homes, ACH, TFC, etc) where CSS may be provided at the same time. An evaluation for the medical necessity of continued support will be done to determine if CM (see below) may be necessary or appropriate; this will be determined in another workgroup.
4. **Natural/Community Supports**- One major portion of our recovery model undermined by excess CSS was the development of natural and community supports in our system. The ability of communities to assist in providing services for our consumers must be developed and supported. Each provider as a condition of national accreditation must demonstrate active community involvement. The LMEs must assure that this component of accreditation is strengthened and indeed the engagement of faith based programs, YMCA,

Boys and Girls clubs, volunteer organizations etc is strongly supported in our system. The development of community supports for our consumers will support their independence, autonomy, and their sense of participation and value to their communities.

Issues to address that may support gaps in service:

1. **Peer Supports**- The development of a definition for Peer Supports as a formal service under Medicaid would be beneficial. This is a service that could provide additional support to our consumers who are using CSS as a support to function in the community setting, to gain experience with daily tasks, and help navigate the system.
2. **Case Management**- A service in CSS that needs evaluation is the function of case management within the current CSS definition. It is understood that an additional workgroup is addressing this specific issue, but the need for a CM component, especially for our most at risk SPMI population, of our service system is supported by this workgroup.
3. **CPT code addition 98960**- The consideration for the inclusion of this code for education and training to support self-management of illness by our consumers is supported. There was active discussion as to how extensive this code should be, as there are specific descriptions of the functions of the scope of the code, but these may be extended to include more curriculum based models of care. This decision on the extent of the scope needs to be made, but the inclusion of the code is supported by the workgroup.