

**Community Support Steering Committee Sub-Group  
Comprehensive Provider  
September 16, 2009  
9:00-12:00  
Dix Campus, Anderson Building, Room 139**

**Attendees:**

Dick Oliver	Dan Zorn	Tom Savidge
Spencer Clark	Melvin Nowling	Tim Hall
Dave Peterson	Tad Clodfelter	Victoria Whitt
Karen Mcloud	Mark Grimaldi	Beverly Stolarick
Peggy Balak	Lisa Jackson	Bill Painter
Jeanne Duncan	Khalil Nassar	John Tote
Bob Hedrick	Robert Robinson	Richard Anderson
Starleen Scott-Robbins	Dexter Mitchell	Dr. Lauren Durant
Cindy Ehlers	Christina Carter	Yvonne French
Mike Rhodes	Charles Schoenheit	

**Welcome & Introductions:** Dick Oliver, DMH/DD/SAS, LME Systems Performance Team Leader welcomed everyone. Committee members and those joining by phone introduced themselves.

**Task of Sub-Group:** Define Comprehensive Provider by determining the array of services and related infrastructure characteristics that would be required to be eligible for that designation.

- **Three year accreditation:** If a provider didn't have a three year accreditation they would have one year to receive a three year accreditation from an accrediting body recognized and accepted by DHHS. An issue was raised that CARF gives a one year accreditation which is the standard for many substance abuse providers.
- **Provides a continuum of three or more Community Intervention services (CIS) for each age/disability group:** Comprehensive Provider may choose to deliver services in Adult Mental Health, Child Mental Health, or Substance Abuse Service array. They don't have to provide services for all age and disability groups. Discussion started about endorsement and the group was reminded that this is not endorsement. This is to change how providers enter into the system.

Meeting the requirements will lead to signing a contract. The LME will be responsible for enforcing the contract.

- Group discussion involved questions and comments regarding liability issues (need a way to measure the outcomes). Going beyond check-sheets for endorsement. Quality vrs standards. The standards set forth will be an attempt to get people to the beginning stages of becoming a Comprehensive Provider. Should Community Intervention Services (CIS) include more than the enhanced services? Would children's services such as Therapeutic Foster Homes, PRTF qualify as a Comprehensive Provider or will they be exempt as a stand alone service? In the absence of a waiver can this be done? Can we make the requirement of one Medicaid service be contingent upon another Medicaid service? Rural areas may be able to sustain comprehensive providers and continuity of care. Adding clinical interview as a component of endorsement. Statewide verification of the three services in every LME. What would an affiliate look like? An affiliation would only work if we can come up with an affiliation that works and doesn't repeat problems in the past.
- **Providers must have three services in each LME region that they choose to provide services in:** If someone provides 2 mental health services and one developmental disability service they would not be considered comprehensive. The services may be different for each region as the needs vary for each (LME specific). Do we need a standard form of corporate verification that indicates there is the clinical administrative infrastructure in place to deliver an array of services? A comprehensive provider will be successful if they have the infrastructure to serve a large number of consumers with a varying array of services that has levels of care. The services and varying levels of care should enable consumers to move up and down levels as clinically appropriate. There would need to be continuity of moving consumers across service types based on the consumers changing needs. In addition, they would need the financial stability to sustain in a volatile market. Performance Bonds and rate cuts. How will the transition look? Corporate verification may include interviews.
- **Service to Medicaid and State funded consumers:** The group agreed that this was an appropriate practice and expectation.

- **Meets staffing requirements appropriate to supervise/support service array:** Recommendation was that the comprehensive service provider have 1 full time employed (FTE) Psychiatrist. Clinical Director licensed or in the case of DD masters level training and 5 years of experience in the field. Training Coordinator – 1 FTE. Quality Improvement manager – 1 FTE. Group discussion involved difficulty in carrying a FTE Psychiatrist. It also involved consistency and standardization of training and affiliates. A lack of training has resulted in problems in the past. If there is to be affiliates, they should be held to the same standards and meet the same quality criteria.
- **Primary Care:** The comprehensive provider should assure that everyone of its consumers have some contact with primary care.

### **Final Thoughts:**

- Test corporate verification (pass to get to LMEs). Separate process – requiring FTEs will require provision of multiple services; 1 service couldn't sustain these FTEs.
- Free clinics doing enhanced services.
- Look at how many providers are accredited for 1 year.
- State funded services (issue of CASP) will there need to be exemptions?
- What services need to be exempt?
- Basic benefits should be included. Basic benefits and 2 CIS services (may help address substance abuse services).
- Clinical Requirements (Psychiatrists). Employment vrs contracting.
- What about the scale issues?
- Psychiatrist/Med. Director

Comments due to Dick Oliver at [Dick.Oliver@dhhs.nc.gov](mailto:Dick.Oliver@dhhs.nc.gov) by close of business on Monday 9/21/09. After reviewing the comments, we will provide the group members with a document. We will also provide a list of services that will qualify and the basic combinations. The document will be reviewed on October 1, 2009 during the next Community Support Steering Committee meeting in the Clark Building conference room on Dix campus.