

Community Support Steering Committee Minutes

August 12, 2009, 3:00-5:00pm

Dix Campus, Clark Building, Conference Room

Attendees:

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| Christina Carter | Bernadette Williams | Tara Larson |
| Leza Wainwright | Carl Noyes | Lisa Jackson |
| Brianne Smith | Jesse Chavis | Starleen Scott-Robbins |
| Jim Jarrard | Laura Beaver | Kelly Crosbie |
| Tad Clodfelter | Barry Graham | Carolyn Floyd-Robinson |
| Richard Anderson | Maria Fernandez | Will Woodell |
| Peggy Balak | Mark Grimaldi | Tim Hall |
| Gordon J. Simmons | Bill Bullington | Mark O'Donnell |
| Dan Zorn | Michael Watson | Kelly Crowley |
| Debra Dihoff | Roy Wilson | |

Welcome & Introductions: Leza Wainwright, DMH/DD/SAS, Division Director, Christina Carter, DMH/DD/SAS, Implementation Manager and Tara Larson, DMA, Chief Clinical Operating Officer, welcomed everyone. Committee members and guests in attendance and those joining by phone introduced themselves. Minutes were briefly discussed from the last meeting and accepted.

Goals & Outcomes: The *Goals & Outcomes* handout from the last meeting was reviewed within the context of comments/suggestions that had been submitted as an assignment from that meeting. Following are the links to these specific contributions:

- 1) Bill Painter's [handout](#) relating to Goals & Outcomes
- 2) Deby Dihoff's [additions](#) to Goals & Outcomes
- 2) Deby Dihoff's handout of the [draft Peer Support Service definition](#)

General group discussion revolved around how to track transition of consumers and the progress being made as this transition takes place (e.g., How can we know that the transition process is working?). There was concern from the stake holders concerning the numbers of consumers that would need to transition. DMHDDSAS and DMA must implement a transitional process that keeps individuals whole and unharmed and enables providers to function. DMA and DMH/DD/SAS will have internal dialogue regarding the actual timeframes for the transition and share with the group at the next meeting

Case Management Update:

There was an update regarding DMA's Case Management Steering Committee meeting. A draft document was distributed from the Case Management Steering Committee that reflects the definition of Case Management and Care Management. The following is the link to the draft document:

1) Case Management and Care Management

There was discussion around two people needing to be assigned to the current Case Management Steering Committee from this Community Support Steering Committee in order to facilitate sharing of ideas. Many issues remain to be discussed about case management and care management and will be covered in DMA's Case Management Steering Committee meetings.

Lessons Learned: Gordon Simmons reviewed the document that Bob Hedrick and himself had created entitled, Lessons Learned:

The Committee felt that this document serves as a good starting point as it looks at redesigning the service system. Considering "lessons learned" during the implementation of Community Support may result in avoiding other mistakes, especially as the system develops service definitions. While this document focused more on "lessons learned" from the provider perspective, a suggestion was made that a "lessons learned" from a consumer and LME point of view may be helpful as well.

Collaboration and partnering efforts between the State, LMEs, providers, consumers, families, and other stake holders needs to take place to ensure a smooth transition.

Following are the key points which the Committee emphasized regarding transition:

- a) There will be **no** cross walk in this process;
- b) Time lines need to be determined;
- c) The comprehensive service provider concept encouraged;
- d) Edits and audits will not be turned off in the payment system;
- e) The system should be streamlined to remove redundancies and non productive tasks;
- f) There should be specific training requirements, methods and designated training agencies;
- g) Qualified competent supervisors must be in place;
- h) Adequate cash flow must be available (from an operational standpoint, billing can't happen on the Medicaid side until provider qualifications are met);

There must be honest dialogue around what the services delivered can actually accomplish. How do we get the best treatment outcomes? Some people confuse treatment modality with the funding source. It was noted that efficiencies and economies of scale will not support many stand alone providers who deliver single services.

Some Committee members have been tracking legislation and the special provisions in an attempt to understand how our enhanced service system's foundation would change without Community Support and have created a schematic to illustrate this. The schematic may include out patient therapy, care by medical doctors, psychiatric evaluations, clinical assessment, case management, care management, administrative support, maintenance services: rehab recovery skills training (e.g., Boston Recovery Model), peer support specialists, etc. System needs to view this as chronic disease

management; individuals would have their own Wellness Plan. It was suggested that The State would assume a leadership role in this process.

Peer Support: Debra Dihoff reviewed the [Peer Support Services](#) handout. This document is recovery focused as well as the language used in creating it.

Draft Letters (pertaining to guidance for the transition process):

Dan Zorn discussed the [provider letter](#) which he had created

Leza Wainwright brought the draft of the LME letter but due to time constraints, the letter was not discussed. The Committee did briefly consider whether there should be 2 separate letters or one systems letter to cover both provider and LME guidance. The group did not come to a final resolution on this issue.

Transition Gaps within Services: Determining transition gaps within the service system will involve looking more closely at the data. From a clinical perspective, providers will review caseloads and determine individual needs to identify gaps. One suggestion was to invest more funding into recruiting therapists into the State. Respite Care is another service for children that was discussed today as a viable means to ease some of the transition burden; DMA does support moving forward with this on a fee-for-service basis. Other transition gaps impacting the system include rate reductions. Even though rate reductions will go into effect 10/01/09, the enhanced services of Multi-Systemic Therapy, Intensive In-Home, and Mobile Crisis Management Teams will not experience reductions.

Community Support Data:

- 1) *Proportion of recipients by diagnosis, [child](#)*
- 2) *Proportion of recipients by diagnosis, [adult](#)*
- 3) *[Respite Services for CAP recipients](#) DOS SFY 2009*
- 4) *[Summary Report of Enhanced Services Providers IPRS, child](#)*
- 5) *[Summary Report of Enhanced Services Providers IPRS, adult](#)*
- 6) *[Summary Report of Enhanced Service Providers Medicaid, adult](#)*
- 7) *[Summary Report of Enhanced Service providers Medicaid, child](#)*

Next Steps:

The Committee was asked to complete these assignments for the next meeting:

- ▶ review Dan Zorn's provider letter
- ▶ study the data documents given out at today's meeting

Agenda items for the next meeting:

- Comprehensive Service Provider Concept
- Documents distributed today from DMA pertaining to *Proportion of recipients by diagnosis* and *Respite Services for CAP Recipients*
- Documents distributed from DMH pertaining to *Summary Reports of Enhanced Service Providers* for adults and children (both Medicaid and IPRS)
- Adult Care Home Data

- Community Support data by EIN's from the Accountability
- Peer Support Specialist service definition
- Consumers within CS served by diagnosis data (pd claims)

Future Agenda items:

- Lessons learned from consumer and LME perspectives

Next meeting: August 18, 1-4pm, Dix Campus, Anderson Bldg., conf. room 139