

Community Support Steering Committee Minutes
September 1, 2009 1:00-4:00
Dix Campus, Clark Building Conference Room

Attendees:

Leza Wainwright	Tara Larson	Jim Jarrard
Flo Stein	Dr. Michael Lancaster	Dick Oliver
Laura Beaver	Dr. Craigan Gray	Carolyn Floyd-Robinson
Stephanie Beck	Richard Anderson	Tracie Hanson
Kathy Smith	Yvonne Copeland	Sharita Lawson
Peggy Balak	Brianne Smith	Foster Wilkins
Gordon Simmons	Bill Painter	Kenny Burrow
Debra Dihoff	Cindy Ehlers	Mabel McGlothlen
Dan Zorn	Mark Grimaldi	Barry Graham
Tad Clodfelter	Starleen Scott–Robbins	Dexter Mitchell
Tim Hall	Lisa Jackson	Karen Kincaid
Bart Grimes	Debbie Webster	Mary Slade
Bob Hedrick	Kelly Crosbie	Dana Jackson -Barnes
Jesse Chavis	Sara Leonard	Stacy Smith
Tasha Gaskins	Susie Deter	Kent Earnhardt
Manay Gunter	Steve Owen	Mike Schwartz
Donna Duggins	John Tote	Michael Watson
Roy Wilson	Bill Bullington	Jamie Bourquin
Carl Noyes	Will Wordell	

Welcome & Introductions: Leza Wainwright, DMH/DD/SAS, Division Director, and Tara Larson, DMA, Chief Clinical Operating Officer welcomed everyone. Committee members and guests in attendance and those joining by phone introduced themselves.

Minutes: Minutes were approved by acclamation.

Draft Peer Support Specialist: Group discussion generated questions and comments. The Peer Support Specialist (PSS) definition will be submitted to the Centers for Medicare & Medicaid Services (CMS) for approval as a Medicaid covered service.

Comments included:

<http://www.dhhs.state.nc.us/dma/csupport/CsupportPeerServDef.pdf>

- the request to provide examples/scenarios of situations in which a PSS would be involved
- the concern that certification for PSS is handled through university affiliation with UNC-Chapel Hill
- the need to consider how LMEs would endorse this service (with sensitivity to consumer needs who are filling roles of PSS)

- the suggestion that the party responsible for developing the Person-Centered Plan needs to have training and a strong understanding of the service array since PSS will not be designated as a “clinical home”
- the recommendation to create a “Centers of Excellence” for PSS as training is critical and should be delivered consistently

Additional comments on Peer Support are to be sent to Debbie Webster at Debbie.Webster@ncmail.net by Thursday September 3, 2009.

Comments and input are welcome but the responsibility for submission of the final service definition product(s) to CMS for approval ultimately rests with the Division of Medical Assistance.

Draft Comprehensive Provider:

<http://www.dhhs.state.nc.us/dma/csupport/CSupportEndorse.pdf>

Originally, the Community Support Comprehensive Service Provider Corporate Endorsement Standards document had been developed approximately 18 months ago for use as a self assessment tool. The purpose of the tool was to determine if the provider agency exhibited indicators of a stable comprehensive agency in these areas: governance, fiscal management, training, quality assurance/improvement, and service provision. Dick Oliver gave a brief background of this document. Discussion stemmed today around using this document, with editing, for corporate verification of any comprehensive provider.

Comments were made that the Comprehensive Provider document needs to be clearly defined, so that LMEs will know when providers have attained Comprehensive Provider status. They will need to have the ability to do evidenced-based practices. Management staff needs to be appropriately credentialed. Other comments included the need for standardization, taking responsibility to maintain integrity, and avoiding duplicative processes in comparison of the Comprehensive Provider document and national accreditation.

Input was given from the members of the North Carolina Council of Community Programs; they do support the concept of Comprehensive Providers and acknowledged that accreditation is a large component of any discussion involving Comprehensive Providers. Inter-Rater Reliability will be necessary in determining Comprehensive Provider status (with inter-rater reliability, raters agree with the "official" rating of a performance; they agree with each other and they agree about which performance is better and which is worse). Following are some of the Council’s suggestions and input pertaining to the original Comprehensive Provider document (disseminated at the 8/18/09 meeting):

- it was not specific enough
- it lacks the allowance of stand-alone services
- it supports the concept of Comprehensive Service Providers to increase consumer access to appropriate levels of care based on clinical needs

There was also discussion today regarding a regionalized version of Comprehensive Providers; a regional group of LMEs, with state participation, would determine who meets Comprehensive Provider status and there will need to be some type of transition period as these changes occur. Committee members discussed the idea of an affiliation model, but if one party in an affiliation has problems and cannot sustain operations, this could jeopardize the remaining party or parties in this arrangement. Other Committee members supported the idea of a comprehensive array of services in a waiver environment with a strong Memorandum of Agreement (MOA) for affiliates. A need to consider in this discussion of Comprehensive Providers is how to interact with primary health care providers (including pediatrics) and create referral processes between the players in this system (LMEs, providers of mh/dd/sa services and primary health care providers). Implementation Update #39 contains helpful information regarding Comprehensive Providers (can be found on the DMH website).

Peggy Balak, Gordon Simmons, Bob Hedrick and others had edited the document given out at the 8/18/09 meeting and that document was given out at today's meeting and is posted on the websites: <http://www.dhhs.state.nc.us/dma/csupport/CSupportEndorse.pdf> Peggy explained how the standards for a Comprehensive Provider will be developed after the role and responsibility are determined. Basic foundation services would be in the array and then other services would be added. LMEs would still endorse services within the Comprehensive Provider system.

The long term vision is that the system is moving to a capitated, risk-based system (limited networks, negotiated contracts) for mh/dd/sa services.

Additional comments on Comprehensive Service Provider are to be sent to Dick Oliver at Dick.Oliver@dhhs.nc.gov by Tuesday September 8, 2009 by 12:00 noon.

Community Support Data: Review of Data and Maps.

<http://www.dhhs.state.nc.us/dma/csupport/CSupportAdultByCounty.pdf>

<http://www.dhhs.state.nc.us/dma/csupport/CSupportChildByCounty.pdf>

<http://www.dhhs.state.nc.us/dma/csupport/CSupportProviders.pdf>

The data sheet containing numbers of consumers (child and adult) being served by 98 providers in the State who only deliver Community Support services was reviewed. Out of the 33,000 individuals being served by Community Support statewide, approximately 3600 are being served by these 98 providers. Maps detailing services (and gaps in services) for both children and adults were also reviewed and briefly discussed.

Community Support Clinical Discussion: Clinical directors were asked to be present for today's meeting to explore how they were preparing for the consumers served by their organization to be transitioned and to discuss their service array and what services their consumers would be getting in the future after Community Support ends.

One provider indicated that in looking at his demographics, he found that 38% of the people his organization served were over the age of 50; one-half of these individuals have

depression. Community Support is not an appropriate way to treat depression. There do need to be more evidence based practices for people with mental health needs over 50. This provider also learned that of the children his agency served who had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), many of them were diagnosed incorrectly by adult psychiatrists and were referred by the school system. Dr. Michael Lancaster, Chief of Clinical Policy for the DMH/DD/SA Services, said that he had found a significant number of children diagnosed with ADHD in the State who did not have medications prescribed for them. Also, in regards to service delivery for children, Intensive In-Home and Day Treatment are appropriate for children with more intense needs. Other providers commented that they are trying to identify viable intensive interventions and transition steps (especially in the area of Substance Abuse services). Substance Abuse providers do integrative work already with consumers, dealing with multiple needs (e.g., pregnant women dealing with Substance Abuse issues). Another provider indicated that he is doing strategic planning in looking at his service array and feels that comprehensive providers can help do research and development around working differently—more efficiently and trying out new methodologies. This requires infrastructure, capital, and auditing measures to be in place.

Following are the Committee’s comments regarding needs/gaps:

- the need for more child psychiatrists
- the need for more providers who deliver medication management
- the need for more providers who deliver outpatient therapy
- the need for some level of service beyond a psychiatrist and outpatient therapy for consumers who won’t meet the need for enhanced services
- the need for case management to support people in other areas of their lives: housing (fear of homelessness can be a psychosocial stressor within itself) , accessing services in general or accessing services to other systems (e.g., Division of Social Services, etc.)
- skill building needs to be integrated into case management
- gap in collaboration/referral processes between primary care providers and behavioral health providers and LMEs (people with mental health needs are having serious medical health needs going unmet)
- the need for more evidence based practices (the DMH/DD/SAS has a Practice Improvement Collaborative [PIC] which meets regularly and reviews evidenced based practices, best practices and emerging practices; this group is composed of academicians, clinicians, consumers, family members and other key stakeholders from each of the three disability groups)
- can Psychosocial Rehabilitation (PSR) be delivered outside of a clubhouse (e.g., “PSR without walls” or a more flexible PSR definition)
- rural areas have gaps and lack of accessibility to services
- parent education
- geographical landscape and sparsely populated areas make service delivery of some services cost prohibitive
- need a call center to perform check-in services for consumers
- need to get one prescribing physician in each county
- need for case managers to have a good understanding of all services

- need for respite services
- need to focus on Natural Supports – family and faith based
- need for Mobile Crisis to respond more in homes and schools and not in the emergency departments
- need to develop the clinical support as a platform from which to deliver evidence-based toolkits (e.g., Integrated Dual Disorder Treatment can only be supported in Assertive Community Treatment Teams and Illness Self-Management or Wellness Self-Management can be supported in Community Support Team)
- need for transportation
- need for the PCP to include a crisis plan (beyond calling 911) and a description of how natural supports will be used (in addition to paid supports)

Other comments from the group: people are service dependent or have been under-treated. What services are lacking? What needs to be built into the system? Under what services would people meet “medical necessity?”

There are 2 groups of individuals that we need to consider:

1. Who are the people at risk--but due to workforce issues--can't get the help they need (e.g., children who need treatment from a child psychiatrist)
2. Who are the people who will not have a service to go to once Community Support ends?

In Summary: Following are the key points from today's discussion:

- Need for some continued form of case management for individuals who need to have regular follow up regarding such areas as housing, medications, etc.
- Support for Comprehensive Service Provider concept
- Flexible PSR as a possible solution
- Better linkage with primary care
- Need for school based interventions
- Need for Family Psycho-education
- Gap in treatment for pregnant women in residential care
- Need more services for people over 50

Next Steps:

- ▶ Peer Support Comments are due by Thursday September 3, 2009 to Debbie Webster.
- ▶ Comprehensive Provider comments due by 12:00 noon on Tuesday September 8, 2009 to Dick Oliver.
- ▶ Adult Care Home discussion will be an agenda item for the next meeting (Carolyn Floyd Robinson, Michael Watson, and Yvonne Copeland/NC Council).

The meeting was adjourned.

Next Meeting: September 9, 2009 9-12:00, Council Building, Conference Room,
Dix Campus.