

## Community Support Steering Committee Minutes

September 9, 2009 9:00-12:00

Dix Campus, Council Building Room 201

### Attendees:

Leza Wainwright	Mark Grimaldi	Tad Clodfelter
Christina Carter	Gail Cormier	Richard Anderson
Jim Jarrard	Connie Ray	Bob Hedrick
Bill Painter	Rep. Earline W. Parmon	Deby Dihoff
Brianne Smith	Rep. Beverly Earle	Dr. Craigan Gray
Gordon Simmons	Dexter Mitchell	Roy Wilson
Laura Beaver	Melvin Nowling	Bill Bullington
Will Woodell	Mary Powell	Jamie Bourquin
Cindy Ehlers	Tim Hall	Lisa Jackson
Dan Zorn	Susie Deter	Yvonne Copeland
Kent Earnhardt	Tracie Hanson	Dick Oliver
Antonio McMillian	Kelly Crosbie	Michael Watson
Carolyn Floyd-Robinson	Kenny Burrow	Flo Stein
Jane Harris		

**Welcome & Introductions:** Leza Wainwright, DMH/DD/SAS, Division Director and Christina Carter, DMH/DD/SAS Implementation Manager welcomed everyone. Committee members and guests in attendance and those joining by phone introduced themselves.

**Minutes:** There were areas of correction/clarification from the **September 1, 2009 minutes.**

- Expansion of Peer Support Specialist Certification Resources. On page 1, the second bulleted item included the comment from one member who requested that this item be expanded to read: *the concern that certification for Peer Support Specialist is handled through university affiliation with UNC-Chapel Hill rather than any one of the five consumer technical assistance centers funded by the Centers for Medicare and Medicaid Services (CMS).*
- Inclusion of Developmental Disabilities with Comprehensive Service Providers. On page 3 (middle of the page) minutes indicated *“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.”* The question was raised today as to whether the comprehensive service provider concept would be limited to mental health/substance abuse services or would it ultimately apply to providers delivering Developmental Disability services and thus, be equally applicable to CAP. Leza Wainwright clarified by stating that it would

cover mental health/substance abuse providers immediately but could ultimately apply to Developmental Disability service providers as well. A group discussion ensued and some questioned how Developmental Disabilities could be separated or left out of a large comprehensive provider system and others commented that to remain in the world of delivering Developmental Disability services, providers may need to become comprehensive. The CMS section of the rehab option would not include Developmental Disabilities.

- Terminology Concerning Skill Building. On page 4, the sixth bulleted item reads “*skill building being integrated into case management.*” Discussion resulted in changing this item to read, “*skill building and case management are integral.*” A committee member stated that skill building can be provided by individual therapists and through group therapy by qualified clinicians. Others in the group indicated that consumers would still fall through the cracks as they don’t often keep their outpatient therapy appointments and this is due, in many situations, to transportation issues. Peer Support for adults and Intensive In-Home (IIH) for children were mentioned as alternatives for skill building with the loss of skill building that had been such a part of Community Support. While the draft Peer Support Specialist definition does restrict group activity, Peer Support Specialists work in Assertive Community Treatment Teams (ACTT), Community Support Teams (CST), and Psycho-Social Rehabilitation (PSR) sites. Other comments: skill building can be handled through the current service array and that most clinicians have the skill to do case management. Another Committee member offered the opinion that outpatient therapy doesn’t have to be delivered only in office settings. Recovery is a long process and people need on-going support. One challenge for providers is to find licensed professionals willing to go into the homes and do the field work required (many new licensed clinicians expect to become very successful just by “hanging a shingle” and working out of their office); this gets into changing the way licensed clinicians are trained. Providers cannot easily afford to pay a licensed professional to go to a consumer’s home and have the consumer not be there or fail to answer the door. Embedding case management in current services is efficacious versus making case management a “stand-alone” definition.

Planning for the timely transition of persons losing Community Support is made more difficult by the unanswered questions regarding case management. If case management services were still available, it would make these transition challenges seem much more doable. Committee focus was re-emphasized: to establish which services into which consumers can transition and to establish how providers can deliver services to meet the needs of consumers who experience gaps in service. Models of transition were discussed and how they may help people these situations.

Leza reported that the draft Implementation Update to discuss changes regarding Community Support, case management, and residential care is still on hold due to the

Office of State Budget and Management needing to approve the rate reductions that the Division of Medical Assistance (DMA) recommended. The General Assembly mandated this rate reduction. The earlier assumption was that the rate reduction was to take place by 09/01/09. The longer it takes for the rate reductions to be approved, the greater the financial impact on the budget in terms of more cuts needed to get a balanced budget. At this point in time, DMA has agreed not to reduce some service rates: ACTT, Mobile Crisis Teams (MCT), IIH, and Multi-Systemic Therapy (MST), but as a result, other services may take a bigger hit than was expected.

How can the system maintain quality service delivery and cause the least disruption to consumers and families as efforts are made to meet this budget mandate? One means of addressing this is that the next authorization request from a provider to ValueOptions must have a discharge plan on any consumer transitioning from Community Support. Parents of children not in the Division of Social Services custody will also need to plan for their children's transition. ValueOptions representatives have seen within a specific timeframe between one quarter and one third of requests for authorizations of CST services not getting approved due to lack of medical necessity documentation (typically, denial rates are somewhere in the 3-5% range). Several Committee members were concerned with lower level providers learning how to game the system and "throwing" as many requests for authorizations as they can to ValueOptions and hoping some "stick". The appeals process may have helped create this problem. Data is available regarding the high users/utilizers of services. Representative samples of the data should be used to inform this process.

**Provider Practices and Endorsement Discussion** (editorial note: this was not a specific agenda item from the last meeting, but was such a thorough discussion today that it merits its own heading in today's minutes): The Committee is concerned with the high number of providers who are "racing" to become endorsed for other services so they can transition all or most of their consumers into that service. LMEs are getting bombarded with new applications for transition to CST, PSR and IIH. There is a need for more IIH and Day Treatment providers; however, these providers must be qualified and the standards are being raised. LME timelines for completing endorsements will be doubled to better allow LMEs time to deal with this onslaught of provider endorsement requests. The standards for providers need to be raised before they become qualified to deliver services. There will be no conditional endorsement as there was with Community Support. Defining qualifications from both the clinical and the business perspective would help in knowing whether providers meet the standards. The need for more provider and clinical education/training was brought up. At some point, it would be helpful to have a sub-group or work group focus on training and developing a sustainable training resource. On a related note, the need for family education was discussed too; consumers and families lack the education to know what to expect from the services they receive. The system should be more outcome-driven and should help families understand what outcomes can be expected.

As the group discussed the difficulty with holding providers to a higher standard, pulling endorsement and how that often times leads to legal battles, other alternatives that

circumvent this problem were discussed. Post payment reviews are very effective in locating fraudulent and clinically inappropriate activities and service delivery. By increasing post payment reviews and monitoring, LMEs can determine which providers may need to be monitored more often and they can utilize DMA's Program Integrity when fraudulent acts are suspected. With post payment reviews, it is easier to determine whether the consumers receiving that particular service actually needed it.

**Draft Peer Support Specialist (PSS) definition:** Comments submitted on the draft PSS definition are still being compiled. Once this work is completed, the revised draft will be sent out to the Committee electronically. Several members were concerned that DSS and the academic arena are not represented in these meetings. While having DSS representation may be more easily achievable in the near future, involvement with the academic community may be a longer term goal.

**Comprehensive Provider:** The summary of comprehensive service provider comments document was handed out with the minutes and other items of discussion for this meeting. Additional comments came in and will be sent out electronically. Dick Oliver led this discussion, indicating that many of the comments echoed recurring themes: uncertainty as to the number of services in a comprehensive provider service array (e.g., should there be three (3) or five (5) services?), concerns around affiliations, duplication of accreditation, and questions regarding financial information. Mr. Oliver stated that the document was designed and proposed for providers who were new to the service arena and have not been nationally accredited for three (3) years. They would have to demonstrate that they could be accredited for three (3) years and would have a year to get this accreditation in place. This initial Comprehensive Provider document referred to as the Corporate Verification Standards document would be contained within the Comprehensive Provider Contract. Services placed together in a comprehensive array must be clinically relevant. They must have "step up" and "step down" services for when consumer needs change and they require a higher or lower level of care. These services are actually systems of care for diagnostic care as people recover or relapse. Leza Wainwright asked the group to think about services that an array may not include: what about CAP services or residential services? Would there be affiliates? The group had concerns with the criteria of a Comprehensive Service Provider (CSP) needing to have a psychiatrist and how that would limit most providers from being able to become CSPs. Crisis services (Mobile Crisis and Walk-in) should be a part of the CSP. One comment was made that a "no eject/no reject" policy needs to be observed. The system needs to work with consumers and providers and ensure that there isn't discrimination based on the needs of consumers and the costs of their care. Other comments were made about telepsychiatry and how it is being expanded.

**Adult Care Home Data:** Michael Watson discussed the Adult Care Home (ACH) document that included informal comments by members of the North Carolina Council of Community Programs. As a result of today's meeting, 3 sub-groups will be created. More information concerning these three sub-groups can be found on the following pages. One of these three sub-groups will deal with consumer protocol transitions and developing clinical guidance to give the field in the transition of consumers from Community

Support to other alternative services. This clinical sub-group chaired by Dr. Mike Lancaster, Chief of Clinical Policy for DMH/DD/SAS, will need to look at this issue of ACHs and how best to meet the needs of persons with mental illness who reside in them. Carolyn Floyd-Robinson discussed ACH information that she had gleaned from her research. Robeson County has 209 ACH beds. The numbers of ACHs can be identified by county and following is the link to the DHHS website for this information:

<http://www.ncdhhs.gov/dhsr/data/ahlist.pdf>

Carolyn found that there is not a lot of data available in terms of persons with substance abuse issues being served in ACHs.

**Sub-Group Development:** Leza asked for interest in a sub-group to look at endorsement criteria and service definitions and give feedback regarding weaknesses in the processes.

### **Endorsement Criteria and Service Definitions Sub-Group**

This first sub-group will consider the four definitions of: Day Treatment, Intensive In-Home, Psycho-Social Rehabilitation, and Community Support Team. This sub-group was instructed to take these new draft definitions (which have been posted for public comment) and the “old (current)” endorsement checksheets and redo the checksheets so they match the new draft definitions and create the most proscriptive instructions for endorsement.

**Chair:** Cindy Ehlers, Assistant Area Director for Clinical Operations from the East Carolina Behavioral Health LME

Cindy’s email address is: [cehlers@ecbhlme.org](mailto:cehlers@ecbhlme.org)

**Provider Co-Chair:** Carolyn Floyd-Robinson, New Life Services

Carolyn’s email address is: [CLR004C@aol.com](mailto:CLR004C@aol.com)

This group’s first meeting will be: **September 17<sup>th</sup> from 9 am to 3 pm, Royster Bldg., room 210, Dix Campus.**

Call in number: **919- 233-3810**

### **Comprehensive Provider Sub-Group**

A second sub-group was tasked with developing a definition for Comprehensive Provider, complete with Corporate Verification Standards.

**Chair:** Dick Oliver, Team Leader, LME Systems Performance Team Leader, DMH/DDSAS

Dick’s email address is: [Dick.oliver@dhhs.nc.gov](mailto:Dick.oliver@dhhs.nc.gov)

This group’s first meeting will be: **September 16<sup>th</sup> from 9 am to 12 noon, Anderson Bldg., room 139, Dix Campus**

Call in number: **919-733-2508**

### **Clinical Guidance Sub-Group**

A third sub-group will be tasked with developing consumer transition protocols. This group will create the clinical guidance to provide the field in transitioning consumers from Community Support to other alternative services. This group will need LME involvement/representation. Leza Wainwright also gave the Committee the email address

for Tammie Bradshaw ([Tammie@bradshaw.ncmail.net](mailto:Tammie@bradshaw.ncmail.net)), Executive Assistant to Dr. Lancaster, so that persons interested in participating in his sub-group could email her directly.

**Chair:** Dr. Mike Lancaster, Chief of Clinical Policy, DMH/DD/SAS

Dr. Lancaster's email address: [michael.lancaster.ncmail.net](mailto:michael.lancaster.ncmail.net)

This group's first meeting will be: **September 16<sup>th</sup> from 1 pm to 4 pm, Anderson Bldg., room 139, Dix Campus**

Call in number: **919- 233-3810**

**Please note: There will not be another full Steering Committee meeting until October 1<sup>st</sup>, 1-4 pm, Clark Bldg., conference room, Dix Campus,** so as to allow these three sub-groups time to meet and prepare their deliverables for review at the October 1<sup>st</sup> meeting.

**Deliverables from these groups will be due to Christina Carter ([Christina.Carter@dhhs.nc.gov](mailto:Christina.Carter@dhhs.nc.gov)) by COB on Tuesday, September 29<sup>th</sup>,** so that she can send them out to the Committee at large on Wednesday, September 30<sup>th</sup>, for discussion on October 1st.

The meeting was adjourned.