

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

**Attendees:**

Leza Wainwright	Dr. Michael Lancaster	Lisa Jackson
Flo Stein	Dr. Craigan Gray	Mark Grimaldi
Christina Carter	Michael Watson	Debbie Webster
Jim Jarrard	Will Woodell	Peggy Balak
Dick Oliver	Starleen Scott –Robbins	Richard Anderson
Gordon Simmons	Bob Hedrick	Tad Clodfelter
Dan Zorn	Khalil Nassar	Tim Hall
Dennis Mitchell	Craig Bass	Kristen Girardi
Taliak Stewart	Tosheba Chambers	Gail Cormier
John Deir	Dr. Lauren Durant	Tracie Hanson
Spencer Clark	Julie Sinclair	Tabitha Haynes
Trina Satterwhite	Susie Deter	Brian Hairston
Sharita Lawson	Stephanie Beck	Ann Oshel
Laura Beaver	Carolyn Floyd-Robinson	Ranota Hall
Karen Kincaid	Melvin Nowling	Dexter Mitchell
Cindy Ehlers	John Tote	Bill Painter
Alberto Blanco	Charles Davis	Dave Graham
Dan Harris	Debra Dihoff	Bill Bullington
Charles Schoenheit	Kenny Burrow	Tara Larson

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

**Minutes:** Minutes were approved by acclamation.

**Background:** Leza discussed the history of the Steering Committee and how the three sub-groups came into being. The focus needs to be on goals and outcomes that are consumer-driven. Both DMH and DMA appreciate the feedback and recognized the need to look at issues, but the primary focus should be on the system issues which include the clinical services. These are clinical interventions. Plans are being made to move forward with a 1915B Waiver (a type of managed care approach).

**Sub-Groups:** Each sub-group had its own charge. **Comprehensive Provider** sub-group was to come up with definitions of a Comprehensive Provider. **Endorsement Criteria and Service Definitions** sub-group was to develop recommendations for the revisions to the endorsement check sheets and instructions for four definitions (Community Support Team, Psychosocial Rehabilitation, Intensive In-Home, and Child and Adolescent Day Treatment [MH/SA]). The **Clinical Transition Guidance** sub-group was to create the clinical guidance to provide the field in transitioning consumers from Community Support to other alternative services based on clinical appropriateness. The three groups focused on how the system would move forward.

Deliverables being considered for submission to the Centers for Medicare and Medicaid Services, upon recommendations from DMH and/or DMA, will be submitted first to the Secretary for his approval. The main goal all along was to have a system of mental health care that can be sustained with quality, clinical services.

**Comprehensive Provider:** Dick Oliver, DMH/DD/SAS' LME Systems Performance Team Leader (sub-group Chair) presented the draft document and the focus and details of the Comprehensive Provider sub-group.

- **Service array:** *Service array* was one of two criteria (with the other being *staffing requirements*) which generated a great deal of discussion. Dialogue continues as to which (and how many) services should be included in the core services list and which (and how many) should be included in the additional services list and whether delivery of the services should be required in all areas.
- **Staffing requirements:** *Staffing requirements* was the other major issue which created a great deal of discussion and controversy. Some saw the staffing requirements as they were originally written as an extra and unnecessary expense.

Staffing expectations were changed for the position of the Medical Director based on comments received (One proposed solution is for the Comprehensive Provider to have one single named Medical Director [licensed physician or psychiatrist] for 20 hours and an additional 20 hours of medical/psychiatric oversight may occur through affiliations.).

One of the items not changed or compromised is that the Clinical Director must be a fully licensed clinician. Two providers who are unable to meet staffing requirements may affiliate to share a single clinical director as one full time equivalent (FTE).

Requiring a full time training director produced several comments from the group. The group explored whether it would be more appropriate to combine positions such as the Training Director and Quality Improvement Director. Another comment was that corporate compliance language and financial language needs to be included. Proposed solutions were for two or more providers who are unable to meet staffing requirements for other positions like the Quality Improvement Director and Training Director to affiliate. This would be most appropriate in agencies where licensed clinical staff actually provided the services. There were

also comments about 32 hours being considered full time. A statement was made about requiring a primary care physician being linked to the mental healthcare provider via a Memorandum of Understanding (MOU). It wouldn't be likely that they would want to be linked to a contract. The suggestion was to have them linked via a letter explaining their working relationship and its significance.

- State and Medicaid funds: Everyone agreed that this was an acceptable expectation. There were not many comments on this.
- Standard Contract: Everyone agreed to this expectation.
- Performance Bond: Details are still being worked out around the Performance Bond. One proposal has been made that both parties to an affiliation purchase a Performance Bond.
- Affiliations: If the provider was not able to deliver all of the services, the provider could enter into an affiliation relationship with another provider who was comprehensive. At least one provider of this relationship had to be comprehensive.

**Discussion topics:** Some group members provided examples of how small providers are utilized and what they bring to the service arena. There was discussion around the difficulty of providing a multitude of services in the rural areas of the state. Some group members mentioned services such as Psychosocial Rehab that they felt should not need to be affiliated and should be separate from the comprehensive provider expectations. Others stated that without affiliates, some providers may decide to just provide stand alone services and then the system would lose the array of services that consumers need to transition as their needs change.

There was discussion on how separating various services would hinder the relationships between providers making it more difficult for consumers to move to appropriate services. Besides quality, another goal of the Comprehensive Provider requirement was to enable consumers to have a continuum of services (which without affiliations and these relationships between providers, it will be difficult for consumers to have). In lessons learned, Community Support consumers became trapped in that one service. Providers are increasing for Community Support Team (CST) and Intensive In-home (IIH) services. It is imperative that the providers understand the service, definition and application. The primary issue is that people are not meeting medical necessity. Some providers within the group stated that there were consumers who didn't want to change services or agencies. There was discussion as to how this is slowly moving in the direction of waivers. A provider who would currently be considered comprehensive stated that it places them at a disadvantage (including incurring additional costs) when they are required to have certain positions that non-comprehensive providers aren't required to have. There was concern from the group as to whether being comprehensive was going to solve the quality issues. A statement was made about how endorsement and accreditation didn't set high enough standards and control to ensure quality services from all providers. There was a general consensus that providers need to be held accountable for providing quality services.

A question was raised about whether it should be left to providers to choose the services that they would deliver. There should be more choice for the consumers so it is a sensible continuum. The need for more consistent training was discussed and Centers of Excellence should be part of the system's new vision in this respect. A statement was made regarding the need for a training coordinator and that providers need to "get it right" this time. The "no eject /no reject" concept for consumers who are high risk/high cost doesn't seem to be working.

A question was asked about restricting the network. Tara Larson indicated that with a fee for service, there cannot be a restriction as long as the provider meets the requirements to deliver a service. However, enrollment does not guarantee clientele. There needs to be a marketing plan to determine whether there are enough consumers that need a particular service. Accreditation has not ruled out weak providers.

The group had concerns about LME staff not being qualified to perform some of their managerial tasks regarding reviews and monitoring (e.g., sending bachelor level Qualified Professionals [QPs] out to do clinical and high cost reviews). The group asked for accountability and roles being defined within the LME, as well as between the providers and LMEs. There should be unduplicated accountability and responsibility. A statement was made regarding evidenced based practices. Service needs to be connected to a clinical model with evidenced based practices. Outcomes should be measured to improve the service. There was a question as to whether waivers will be standardized or whether each LME will develop their own.

Michael Watson, Assistant Secretary for Mental Health/Developmental Disabilities/Substance Abuse Services, stated that problem solving needs to be based on lessons learned. Everyone has lived with unintended consequences from one time or another. The system is moving towards waivers. If there are five providers in an area delivering the same two services and other needed services are not being provided, then the system will be in the same situation. There's a greater emphasis on accountability so there are no surprises. One proposal is that Case Management will be tied to a Comprehensive Provider. CMS will need a clear definition of what constitutes a Comprehensive Provider.

**Endorsement Criteria & Service Definitions:** Cindy Ehlers, ECBH Assistant Director, (sub-group Chair) presented the documents and focus of the group. The draft service definitions which had gone out for public comment were used as the focus of this group (Community Support Team, Intensive In-Home, Psychosocial Rehabilitation, and Child and Adolescent Day Treatment). The check-sheets and instructions came directly from the revised service definitions.

- One way to strengthen endorsement was by "tightening" the check-sheets or making them more proscriptive. Not everyone wanted them tightened.
- Redefine what is meant by "site" in the current endorsement policy.
- Consideration of a Clinical Interview as a component of the endorsement process to better ensure quality treatment for consumers.

- Consideration of the use of Cost and Market Analysis as a component of endorsement.
- Consider applying the same Access to Care time frame requirements for Urgent, Emergent, and Routine that are in the LME Performance Contract to the endorsement process.
- Include in the check sheets the requirements for the provider to integrate primary health care and behavioral health care and demonstration of such at the consumer level on 60 day follow-up.
- Lack of enforcement of requirements for payer mixes other than Medicaid contract for many providers resulting in financially unstable provider communities.
- Biggest issue: Lack of consistency and endorsement process from LME to LME. A suggestion was that LMEs be required to have training and certification. A rebuttal to that was National Accreditation.
- Ensure quality treatment for consumers with clinical and medical directors and licensed professionals.
- No plan of corrections. Either providers meet the criteria or they don't.

**Discussion topics:** Providers should be required to do a market analysis. Some providers don't understand the business they are in. There is a lack of enforcement requirements. The strategy is to tighten the system. LMEs are getting flooded with applications and need a tool to make the criteria more restrictive. Endorsement specialists should be certified so there is consistency. There should be peer reviews. Are people doing endorsement inconsistently as a result of different interpretations? Ideas were proposed that offer a different structure to reduce inconsistencies. What about expanding payer resources--grants, public resources, Veterans Administration, Duke endowment, etc.? Providers are looking at other system dollars to try to expand resources to do more good in the community. Example of a payer mix: a Vocational Rehabilitation Supported Employment provider delivering employment services in a Psychosocial Rehabilitation site.

**Clinical Transition Guidance:** Dr. Michael Lancaster, DMH/DD/SAS' Chief of Clinical Policy (sub-group Chair) presented his group's document and details of their discussion:

- Endorsement. Explored where the gaps were and what could be done.
- The system does not need ineffective Community Support providers delivering ineffective Community Support Team services.
- The group looked at level of risk and identified services that are currently in the system.
- They looked at data and tracked those consumers getting Community Support and another service. This group would have a service to fall back on and wouldn't be left without a service.
- Of the 33,000 consumers receiving Community Support, 22,000 were only receiving Community Support.

- They looked at the high risk rating and identified the highest risk categories.
- 6800 consumers were found to be in the top 20% of the highest risk group.
- 61% of the 6800 (4155) highest risk consumers were only receiving Community Support. This confirmed that it wasn't clinically appropriate for these consumers to be receiving only Community Support.
- The information was sent to the LMEs and the LMEs were asked to develop a discharge plan.
- LMEs were instructed to meet with their providers and go over the data so they could develop the discharge plans.
- Substance abuse data could not be sent to the LMEs because they were not the provider. A letter was sent asking them to be sure to look at those receiving substance abuse services.
- The sub-group felt that the documentation will not likely reflect the presentation of the consumers who are listed in the top 20%. Those that do have symptom presentations at this level should have been in a higher level of care/service.
- Alternative services. Outpatient treatment (cognitive behavioral therapy), and evidenced based practices that are designed to look at outcomes should be utilized.
- Many of the higher risk consumers getting only Community Support should have been in a higher level of service such as Intensive In-Home and ACTT services.
- Natural and community supports. We need to utilize these supports, such as after school programs, boys and girls clubs, YMCA and Church programs.

The full service array available to serve consumers currently in Community Support identified includes basic benefits (outpatient and medication management), clinical home services (Intensive In-Home, Multi-Systemic Therapy, Assertive Community Treatment Team, Community Support Team, etc.), non-clinical home services (Psychosocial Rehabilitation, 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 discharge plan 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.

**Issues identified to help with gaps:**

- 1) Peer Supports. What would peer support look like? Substance abuse has been providing it freely for years. This service could provide additional support to consumers who currently use Community Support to function in the community, gain experience with daily tasks and help navigate the system.
- 2) Case Management. Case Management can be a significant component to helping high risk consumers remain stable.
- 3) CPT code 98960. This could be valuable but would need to be limited. It could help with self management of illness issues. It should not be a stand alone code. For example, if a consumer has schizophrenia, it can be used to help with medication management and possibly education training.

**Discussion topics:** Services identified to help with the gaps and to transition consumers into clinically appropriate services were met with concern from several members of the steering committee. The concern was that many of the services required licensed clinicians and that there were not enough licensed clinicians in the state. Discussion centered around the difficulty with getting the provisionally licensed clinicians to become licensed. Providing clinical supervision can resolve this issue. The suggestion was made to develop internships.

New Community Support admissions will stop in January 2010. When consumers are being admitted to the service, there must be a discharge plan. Consideration needs to be made that this service is going away and determine whether it would be more appropriate to link the consumer to another clinically appropriate service. Concern was raised about consumers not getting a choice as to whether they would want to stay in Community Support for several more months or whether they wanted to transition now. Members of the group stated that this was because providers have informed them that they are no longer providing Community Support and are discharging consumers.

Issues regarding timelines for the Person Centered Plans to be complete for authorization were raised. Not all of the plans come due at the same time. Staggering the completion will help to resolve this issue.

There was nothing specific about the deaf because of the effort to streamline target categories. The deaf should qualify on their symptoms and diagnosis and not on their being deaf.

Members of the group that requested the risk rating scale and a summary were asked to send the request via email to Dr. Michael Lancaster.

**Next Steps:** Another meeting will be scheduled in approximately two weeks. The LMEs are receiving their Community Support data. Peer Support will be placed back on the table. There will be no cross walk. The group was encouraged to submit comments regarding Community Support transitions needed to achieve the desired outcomes.