NC State Consumer and Family Advisory Committee

Gaps and Barriers/Veterans Subcommittee

2019 Report and Recommendations

NC Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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Foreword

This report is respectfully submitted by the Gaps and Barriers/Veterans Subcommittee to the North Carolina State Consumer and Family Advisory Committee, in order to appropriately request Legislative action from General Assembly and the North Carolinas Secretary of the Department of Health and Human Services. The findings and research conducted, as well as the voices of the consumers of MH/IDD in North Carolina has impacted these recommendations. It is with great confidence that these recommendations will support the LME/MCO's and communities with the identified gaps in service delivery.

Ronald Rau
Chairperson

Lori Richardson
Chairperson

Brandon Wilson

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Special thanks to Ms. Megan Brewer UNCA work intern with Veterans Services of the Carolinas for her contributions of research and insight for this report.

Table of Contents

State Consumer and Family Member Advisory Committee
Service Gaps & Needs/Veterans Subcommittee Charter

Purpose

The purpose of the Services Gaps & Needs/Veterans Subcommittee of the State Consumer and Family Members Advisory Committee (SCFAC) is to assist in assuring adequate services for North Carolina citizens, including veterans, who require Mental Health (MH), Intellectual Developmental Disabilities (IDD), and Substance Abuse (SA) Services by means of recommendations regarding any gaps and needs according to North Carolina General Statute §122C-171.

Authority

The authority for the specific responsibilities of the Services Gaps & Needs/Veterans Subcommittee is found in NC General Statute § 122C-171 (2014) as follows:

1. Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
2. Identify service gaps and underserved populations.
3. Make recommendations regarding the service array and monitor the development of additional services.
4. Review and comment on the State Budget for mental health (MH), intellectual developmental disabilities (IDD), and substance abuse (SA) services.
5. Participate in all quality improvement measures and performance indicators.
6. Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
7. Provide technical assistance to local CFACs in implementing their duties

Meetings

Meetings of the subcommittee will be conducted in the following manner:

- The chair will set up meetings monthly or as appropriate
- The chair is responsible for setting the agenda.
- The chair will assign a subcommittee member the responsibility to take minutes.
- The chair or designee will report out and make recommendations to the full SCFAC.
- Communication needs (letters written, research, follow-up information, etc.) will be conveyed to SCFAC for assistance and resolution.

Specific Activities of the Service Gaps & Needs Subcommittee

Subcommittee member will review gaps and needs analyses:

- Collect gaps and needs from NC Department of Health and Human Services and/or LME/MCO's
- Collect gaps and needs information from NC Department of Military & Veterans Affairs
- Look for state-wide trends for consumers and veterans
- Communicate state-wide gaps and needs to other subcommittees as appropriate

Subcommittee members will participate in the development of the State Plan:

- Participate in SCFAC conference calls and any agency meetings or conference calls regarding the State Plan
- Make recommendations regarding the substance and implementation of the State Plan using info from gaps and needs work including veterans
- Stay abreast of agency regulations and legislation regarding the substance or implementation of the State Plan
- Coordinate subcommittee activity with the SCFAC and make recommendations through communications with appropriate individuals and committees

Subcommittee members will receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, intellectual developmental disabilities, and substance abuse services

- Participate in the State-to-Local CFAC conference calls and any agency meetings or conference calls regarding service gaps and needs within the local service areas
- Coordinate subcommittee activity with the SCFAC and make recommendations through communications with appropriate individuals and committees
- Participate with the local CFAC's regarding the annual DHHS report to CMS on service gaps & needs

Social Determinants of Health

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH).We know that poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health. This also can impact children during their youth, and we know this from the Adverse Childhood Experiences Study (ACES). We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. Social determinants carry a lot more influence on a person's health than we know. With the movement to transform Medicaid, social determinants are necessary to consider because of the major effects they have on one's health. Recent studies will show that toxic stress has detrimental effects on one's neuro chemistry resulting in poor overall health. Housing, employment, transportation, education, clothing, adequate food are all social needs that lead to challenges in demographics, economic stability, education which are known as social determinants that cause some level of stress. A lot of social determinants can manifest to eventually cause toxic stress. If social determinants have a negative correlation with overall health then medical professionals need to be looking at patients holistically. As a society we need to first examine the quality of life and the stresses one patient may be under before trying to examine their health. Resources that enhance the quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, educational opportunities, adequate transportation, and public safety, availability of healthy foods, local emergency/health services and environments free of life-threatening toxins.

If we can focus on the social determinants and try to relieve some of the stresses then it is possible that a person's overall health will improve. This is why social determinants are at the fore front of discussion during both Medicaid expansion and reform and are now driving decisions at all levels of communities.

Background

Both the NC Medicaid and the DMH/DD/SAS contract require the LME/MCO to conduct and maintain a minimum of three (3) performance improvement projects. These performance improvement projects shall be based on the following criteria, indicated by the Quality Improvement Office from DHHS.

- Topics for performance improvement projects shall be identified through consumer, family, provider, and stakeholder surveys, performance measures, quality improvement studies, and continuous data collection and analysis.

- The LME/MCO shall give priority to projects that address initiatives of the NC General Assembly and DHHS.

- Any projects developed and implemented in accordance with this Contract may also be used to meet the requirements of LME/MCO's accreditation body and NC Medicaid.

- Reports on all performance improvement projects shall be submitted to DMH/DD/SAS and NC Medicaid no later than August 31 of each year.

DMH/DD/SAS and NC Medicaid monitor the LME/MCO performance improvement projects on a quarterly basis as a part of the Interdepartmental Monitoring team reviews. Quarterly review monitoring includes: Updated measurement results and trend data (baseline, trend and current)

1. Progress made
2. Barriers
3. Interventions
4. Next steps

Gaps and Analysis Report

Gaps and Barriers: Reliable Transportation, Housi	Transportation	Housing	Employment
Alliance Behavioral Healthcare (Members)	N/A	N/A	N/A
Vaya Health (Members)	11% (29 members)	18.6% (40 members)	17.2% (37members)
Cardinals (Members)	30.76%	26.66%	36.76%
Partners (Members)	14.6% (24 members)	14.0% (23 members)	17.7% (29 members)
Sandhills (Members)	15.9% (66 members)	13.97% (58 members)	N/A
Eastpointe (Members)	33.59% (86 members)	N/A	N/A
Trillium (Members	11.35%	6.03%	10.56%
	Average = 19.5%	Average= 14.7%	Average= 20.5%
Gaps and Barriers: Reliable Transportation, Housi	**Transportation**	**Housing**	**Employment**
Alliance Behavioral Healthcare (stakeholders)	N/A	N/A	N/A
Vaya Health (stakeholders)	49.5% (283 members)	19% (109 members)	16.6% (95 members)
Cardinals (stakeholders)	69.09%	54.10%	45.43%
Partners (stakeholders)	73.5% (25 members)	67.6% (23 members)	55.9% (19 members)
Sandhills (stakeholders)	16.3% (259 members)	22.69% (395 members)	
Eastpointe (stakeholders)	N/A	N/A	N/A
Trillium (stakeholders)	8.21%	N/A	N/A
	Average= 43.3%	Average= 40.8%	Average= 39.3%
Gaps and Barriers: Reliable Transportation, Housi	**Transportation**	**Housing**	**Employment**
NCServes	2% (215 members)	25% (2249 members)	19% (1747 members)
Gaps and Barriers: Reliable Transportation, Housi	**Transportation**	**Housing**	**Employment**
Averages for both members and stakeholders	31.40%	27.75%	29.90%

Vaya Health also had supported employment long term follow up stats showing that 35 members had gaps/barriers making that a 16.2% gap/barrier.

Vaya also had supported living stats showing 37 members reported gaps/barriers making it 17.2%

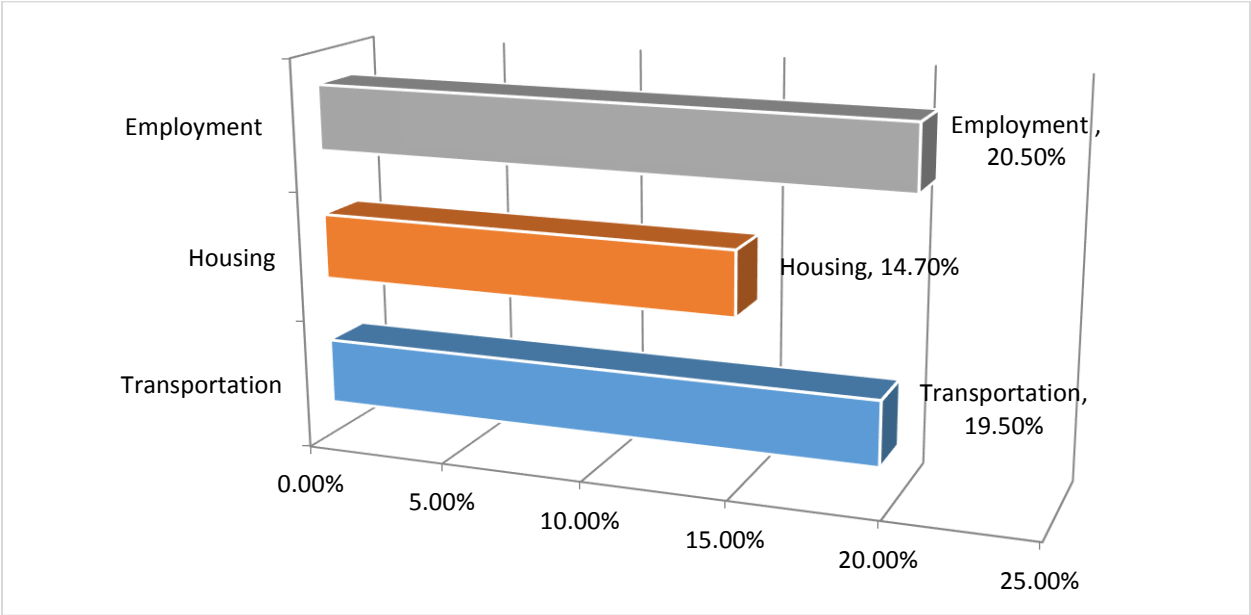
Vaya Health also had supported employment long term follow up stats showing that 94 stakeholders reported gaps/barriers making a 16.4%

Vaya also had supported living stats showing 109 stakeholders reported gaps/barriers making it 19%.

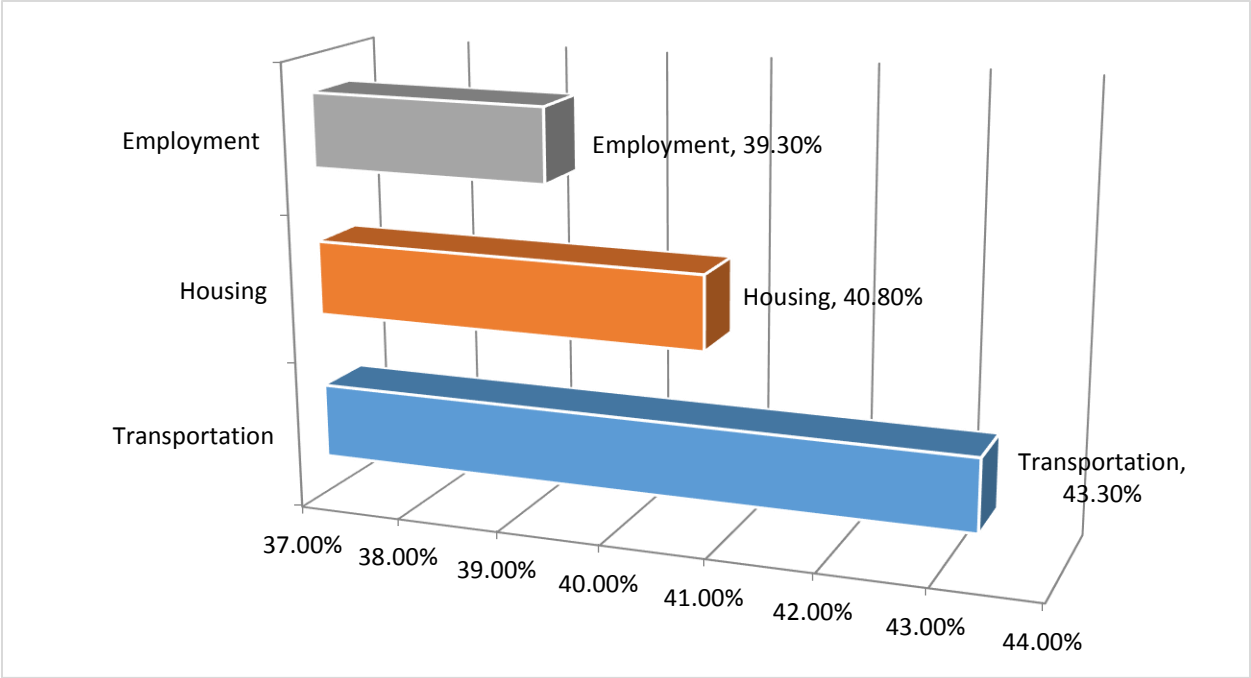
Sandhills has data for lack of transportation and housing gaps/barriers; For members, 66 responded having transportation gaps/barriers for a 15.9% total. 259 stakeholders responded having transportation gaps/barriers for a 16.3% total. 58 members responded having housing/homelessness gaps/barriers for a 13.97% total (5.78% are completely homeless). 395 stakeholders responded for housing/homelessness gaps/barriers for a 22.69% total (10.74% completely homeless).

Alliance BH on pages 19 and 22 (parts 2 and 4) list both transportation and housing as barriers for consumers, family members, and stakeholders, however, there was no data presented in adequacy report.

Average Gaps/Barriers for Consumers:

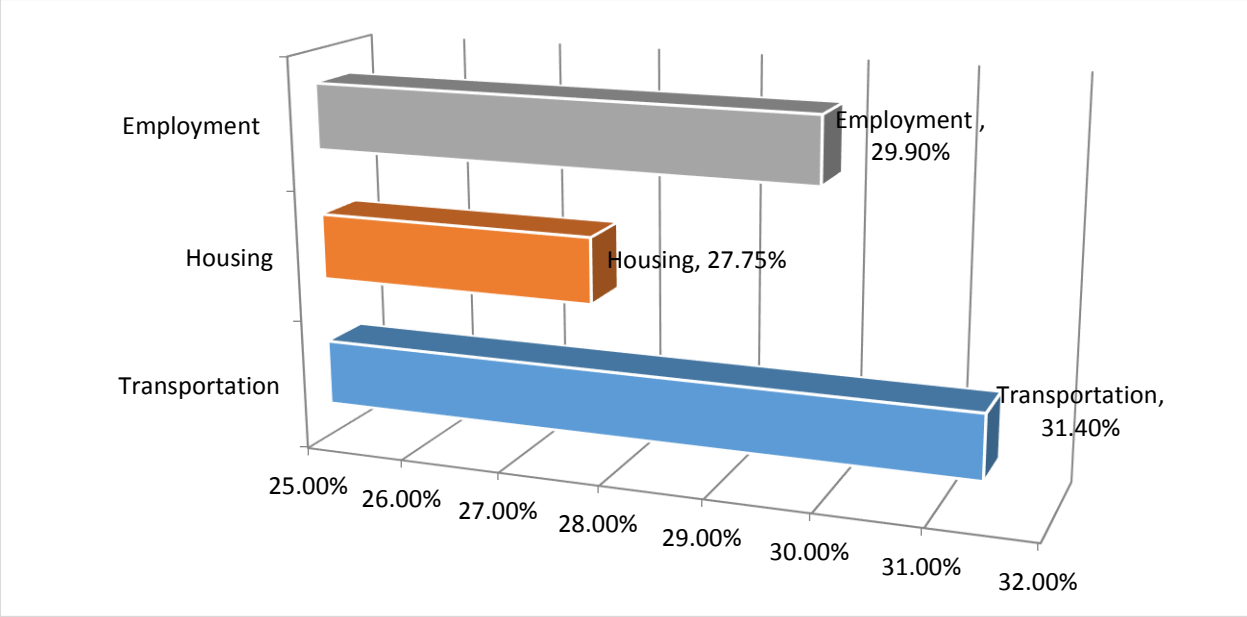


Average Gaps/Barriers for Stakeholders:



*The following graph's data was calculated from the preceding two graphs (consumers and stakeholders. It is an average of the consumers and stakeholders surveys for employment, housing, and transportation.

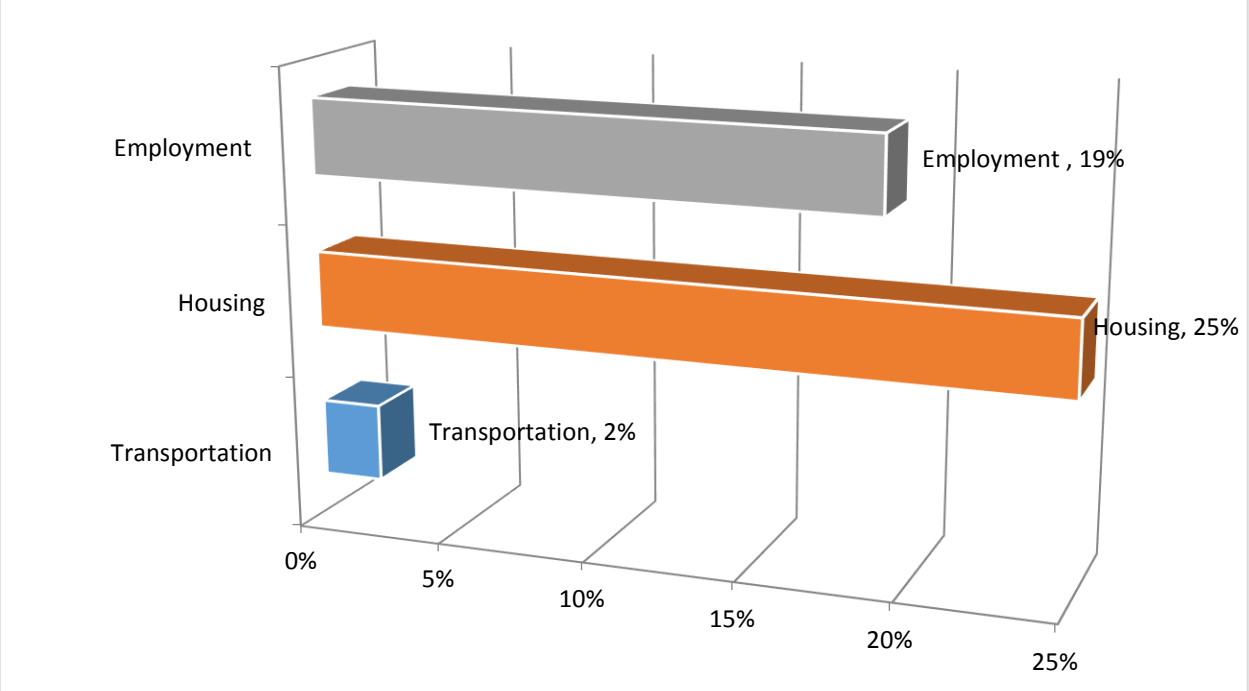
Average Gaps/Barriers for Consumers & Stakeholders:



NCServes Gaps and Analysis Report on Veterans

NCServes is the state's first coordinated network of public, private and non-profit organizations serving Veterans, Service Members and their families. NCServes uses a web based platform (Unite Us) to guide and collaborate with local, state, and national partners in order to both enhance service delivery and track outcomes of the services. NCServes operates four networks across North Carolina and currently provides services in 64 counties. NCServes Western (Buncombe) NCServes Metrolina (Mecklenburg), NCServes Central (Wake) and NCServes Coastal (Jacksonville), although each network operates independently, they often work together and are able to collaborate through inter-network referrals.
Unlike the Network Adequacy Reports, which are solely based on participation in surveys from both members and stakeholders, the following graph is derived on actual outcomes based on service needs being requested by our Veterans, Service Members and their families. The outcomes measured are calculated in aggregate by both resolved and unresolved.

Average Gaps/Barriers for NCServes in Comparison to Needs:



Network Adequacy Reports

The Subcommittees reviewed all LME/MCO Network Adequacy reports (formerly known as Gaps/Analysis Report). The Subcommittee is highlighting both the top 3 needs indicated by both the stakeholder and consumer surveys. The committee however is focusing on three pertinent needs also indicated by the surveys and local CFAC feedback. These needs are housing, transportation, and employment. All of which can be considered social needs categorized in the Social Determinants of Health.

Top 3 Gaps and Barriers from LME/MCO Network Adequacy 2018

The following data was retrieved from adequacy reports from the 2018 year. There was no standard report among the providers making it difficult to retrieve the correct data. According to the following data, transportation and the inability to pay for services were the two most common gaps/barriers to care. Other gaps/barriers include housing, employment, lack of insurance, location of providers, and lack of adequate food.

Unfortunately, there were a couple of providers that failed to present all the data in their adequacy report. This makes it harder to compare and contrast; ultimately affecting the efficiency of compiling the necessary data. In order to ensure a more concise data collection, providers should follow a standardized format that has common language and data. If there was common formatting it would make it easier and faster to be able to find the appropriate data. This will be a recommendation for DHHS moving forward.

Citations: The adequacy reports data was retrieved from the following pages from each respected LME/MCO individual report. Due to the complexity of these reports and the unique reporting from each region, some of this data's interpretation may have discrepancies.

Alliance- found pgs. 19 & 22 (parts 2&4); Cardinal- found on pgs. 8 & 103; Eastpointe- found on pg. 16; Partners- found on pgs. 89 & 122; Sandhills- found on pgs. 29-30; Trillium- found on pgs. 33-34; Vaya Health- found on pgs. 24-25;

Network Adequacy Reports

Alliance BEHAVIORAL HEALTHCARE

*There were no specific numbers/data on report, however, Alliance stated that both housing and transportation were barriers for consumers. They also reported that housing was a barrier reported by stakeholders.

Cardinal Innovations HEALTHCARE SOLUTIONS

Members*

1. Employment- 36.76%
2. Transportation- 30.76%
3. Medical issues- 29.03%

Stakeholders*

1. Transportation- 69.09%
2. Cannot pay for services/medications- 62.30%
3. No insurance- 55.50%

EASTPOINTE

1. Transportation- 33.59%
2. Service not available close to my home-17.58%
3. There are no providers available in my community- 14.06%

PARTNERS Improving Lives. Strengthening Communities.

Members*

1. Medical/health issues- 26.2%
2. Cannot pay for services- 23.2%
3. Mental health/substance use- 18.3%

Stakeholders*

1. Transportation- 73.5%
2. Cannot pay for services- 70.6%
3. Homeless/housing issues- 67.6%

Members*

1. Transportation- 15.90%
2. Housing- 8.19%
3. Lack of adequate food- 6.02%

Stakeholders*

1. Transportation- 16.30%
2. Cannot pay for services- 13.47%
3. Lack of adequate food- 9.06%

Members*

1. Transportation- 26.38%
2. Wait too long for appointments- 17.32%
3. Cost of medication- 13.32%

Stakeholders*

Are concerned that Trillium does not provide services that are available for all their members' cultural and ethnic needs, why?

1. Gaps or limited services- 18.33%
2. Establish or improve partnership with Trillium- 15.56%
3. Mental health services/support – 15.00%

Members*

1. Availability of qualified staff- 63 members
2. Quality of service provider- 55 members
3. Availability of specialized services- 53 members

Stakeholders*

1. Transportation- 283 stakeholders
2. Availability of service providers who accept insurance- 223 stakeholders
3. Availability of psychiatric services- 236 stakeholders

LME/MCO Performance Improvement Projects

(Performance improvement projects were last submitted to the state on August 31, 2018.)

The following was reported by the DHHS Quality Improvement Team during the monthly State CFAC meeting on January 9, 2019. All LME/MCO's are required to report the priorities being addressed in each respected Performance Improvement Projects. The highlighted areas indicate an area on improvement being addressed from the top three identified areas of improvement of Housing, Employment, and Transportation.
**Note that only Housing is being addressed by an existing program which was expanded; TCLI (Transitions to Community Living).*

Alliance
BEHAVIORAL HEALTHCARE

Access to Care: To improve the number of Emergent callers who show for care within the 2:15 hour timeframe, as calculated by Alliance

Access to Care: Increase in consumers needing urgent care who show for care within 2 calendar days

Access to Care: Increase in consumers needing routine care who show for care within 14 calendar days

First Responder: Increase providers with a test call rated as Satisfactory (Live Answer by Staff or Answering Service, or Message Returned Within 1 Hour)

TCLI: Increase members housed during the measurement period within 90 days of housing slot assignment

UM Expedite Care: Decrease average authorization decision turn-around time for youth discharging from local emergency departments to 3 days or less

UM Innovations Requests Turnaround Times: Decrease average authorization decision turn-around time for Innovations service requests to 8 days or less

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Cardinal Innovations
HEALTHCARE SOLUTIONS

Show how providers benefit from technical assistance and education through PCM resolutions with the goal of improving quality of care

Increase follow up with outpatient provider 7 and 30 days after hospitalization and FBC admission for mental health concern

Increase follow up with outpatient provider 7 and 30 days after hospitalization and FBC admission for substance use concern

Increase the percentage of members (age 6 and up with a principle diagnosis of mental illness who had a follow-up visit for mental health at 7 and 30 days following an emergency department visit

Increase the percentage of members (age 6 and up with a principle diagnosis of substance use disorder who had a follow-up visit for mental health at 7 and 30 days following an emergency department visit

Quality of grievance resolution (decreasing the types of grievances which occur most often)

IDD adherence to monitoring requirements

Timely submission of Quality of Life surveys

Decrease the number of members who experience three or more crisis services in a 12-month period

Improved Recovery Assessment Scores consequent of Peer Support provision

Increase the percentage of members in an ACH or at risk of ACH admission who have a claim for Supported Employment provided by a fidelity provider

Increase percentage of children 1-17 with two or more prescriptions for antipsychotics who receive metabolic monitoring

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EASTPOINTE

Increase percentage of members who received a face to face service within 48 hours.

Decrease state psychiatric hospital 30-day readmissions for high risk members.

Decrease Emergency Department(ED) admissions for Active Members

Increase Percent of members discharged who were admitted for mental health treatment that received a follow-up visit within 7 days after discharge from inpatient treatment facility

Increase Total dollar amount of Approved Encounter Claims

Increase the percent of individuals who receive a 2nd service within ≤ 14 days.

Increase percentage of individuals served in the Priority Population by a Fidelity Provider to fifty percent (50%) monthly.

PARTNERS
Improving Lives. Strengthening Communities.

Increase Physical Health/Primary Care Physician (PCP) referrals to Behavioral Health

Increase the Percentage of Consumers Completing an Episode of Treatment via NC-TOPPS

Increase Initial NC-TOPPS Interviews

Increase Utilization Rate of B3 Supported Employment Services by the IDD Population of Consumers

Promoting follow -up within seven (7) days of discharge from a Community Hospital, State Psychiatric

Hospital, and Facility Based Crisis Service for Mental Health Treatment.

Promoting follow -up within seven (7) days of discharge from Community Hospital, State Psychiatric

Hospital, State ADACTs and Detox/Facility Based Crisis Services for SUD Treatment.

Transition to Community Living Initiative (TCLI) -Individuals Transitioned within 90 days of House Slot Issue Date

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Sandhills Behavioral Center, Inc.

Ensure that members have access to routine behavioral health assessments in a timely and appropriate manner

Shaping the Network to improve provider choice and ensure members access to quality services

Increase the Evidenced Based Best Practices employed by our provider network, and increase the documentation supporting the use of those practices.

Maximize the benefit of Child Mental Health Level III

Decrease the number of days from when a housing slot is issued to the actual transition date

Improving access to behavioral health information and services for Hispanic members by improving content available to members of this population seeking such services

Increase the number of members authorized for Psychosocial Rehabilitation Services with correct diagnosis or sufficient clinical information

Increase timely completion and submission of Quality of Life Surveys

Increase number and percentage of members with routine appointments who keep their appointment within 14 calendar days of contacting with the Call Center

Increase and maintain a minimum number of ten (10) participants in the Project SEARCH program so it can be self-sustaining

Assure consistent connection to community services following Facility Based Crisis Services

Improve member's access to care by ensuring follow through with routine and urgent scheduled appointments

Enhance Network Provider Directory; improve the accuracy of provider information in the Network Provider Directory

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Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)

DMA and DMH Mental Health 7 Day Follow-Up

DMA and DMH Substance Use Disorder 7 Day Follow-Up

Improving the percentage of timely contacts with members in In-reach status

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Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion

Inpatient Rapid Readmission

Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants

Follow-Up After Discharge from Inpatient Mental Health Treatment

Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment

Increase housing placements through the Transitions to Community Living Initiative

Transportation

Limited access to reliable transportation causes millions of Americans to forgo important medical care every year. Transportation barriers are most prominent among the poor, elderly, and chronically ill—populations for whom routine access to ambulatory and preventive care is most important. As identified in **all** Network Adequacy Reports transportation continues to be a large barrier for consumers across North Carolina. Some MCO's are working to address this barrier in small pilot projects. An example of such a project is with Vaya Health in their Complex Case Management Program. They are in partnership with RHA and Mission Hospital; and provide Bus Passes to people leaving the hospital with MH and SU issues, so that they can access community services and make follow-up appointments. It is important to keep in mind that a large majority of consumers in NC live in rural areas where mass transit options are nonexistent. However, supporting and funding these types of initiatives will lead to a success's with consumers.

Some states have taken steps to address transportation barriers by providing non-emergency medical transportation (NEMT) benefits to select beneficiaries. A majority of Medicare Advantage (MA) plans and state Medicaid programs currently provide NEMT benefits, North Carolina being one of these states. Currently in North Carolina the Division of Social Services arranges NEMT, however under the new tailored plan design our MCO's will arrange NEMT in the future.

An approach that has attracted considerable attention is the use of transportation network companies (TNCs)—such as Uber or Lyft—to provide NEMT services. Recently both Lyft and Uber have been authorized transport consumers and receive payment from Medicaid sources. Both companies are working to train drivers to work with people who use wheelchairs, walkers and scooters. Both Lyft and Uber are contracting directly with health plans and delivery organizations to provide NEMT services.

In Texas and Florida there are bills that would allow Medicaid Managed Care Companies to use Uber, Lyft and others transportation networks to transport patients to appointments. Through our recommendations, it is our hope that DHHS and the LME/MCO's will work with communities to create projects that will enhance this SDOH. We understand that each community is different and that a vast array of creative ideas must be approached and implemented to assure we are addressing this need across North Carolina.

Recommendations

1.) That the Department of Health and Human Services specifically fund the LME/MCO's for Transportation needs for consumers receiving services from each LME/MCO. Funding to be $250,000 for transportation projects for each LME/MCO. (this would be a $1.75 million dollar investment)

2.) NCDHHS to give authorization for LME/MCO's to utilize transportation funds in any innovative means to support access to care. This includes formal partnerships with transportation networks such as Uber and Lyft.

3.) That NCDHHS mandate that top tiered needs identified in Network Adequacy reports be addressed in each Performance Improvement Project from LME/MCO's.

4.) SCFAC would like to have a comprehensive report from NC Quality Improvement Team on all Network Adequacy Reports each year; in order to best gauge both gaps and barriers and the performance improvement projects being submitted.

5.) That NCDHHS mandate the correct question for LME/MCO's on initial assessments and follow ups for Veterans. ***'Have you or an immediate family member ever served in the active Military, Guard or Reserve?'***

6.) That DHHS and General Assembly allocate funding for the NCServes networks to enhance service delivery and track outcomes for Veterans and families across North Carolina; and that these networks work with the NCCares 360 project in unison.