2009-2010

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, & SUBSTANCE ABUSE SERVICES

MINUTES

AGENDA

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

January 14, 2009, 10:00 A.M.; Room 643, Legislative Office Building

Representative Verla Insko, Co-Chair, Presiding

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1. **Greetings and Opening Comments** — **10:00**
   Senator Martin Nesbitt, Co-Chair
   Representative Verla Insko, Co-Chair

2. **Remarks from Newly-Appointed DHHS Secretary** — **10:00 – 10:10**
   Lanier Cansler, Secretary, Department of Health and Human Services

3. **Final Report of the Taskforce on Substance Abuse Services** — **10:10 – 11:30**
   Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

4. **Reporting Deaths in State Facilities; Rulemaking Process** — **11:30 – 12:00**
   John R. Corne, Chairman, Commission on MHDDSA

5. **Outcomes for Previously Hospitalized Consumers** — **12:00 – 12:30**
   Carol Ripple, Ph.D., Program Evaluation Division

LUNCH — **12:30 – 1:30**

6. **Local Management Entities** — **1:30 – 2:30**
   a. **Pathways**
      Rhett Melton, Area Director
   b. **Orange Person Chatham**
      Judy Truitt, Area Director
   c. **The Beacon Center**
      Karen Salacki, Area Director

7. **Expenditure of Service Dollars** — **2:30 – 2:45**
   Leza Wainwright, Director, Division of MH/DD/SAS, DHHS

8. **State Psychiatric Hospital Update** — **2:45 – 3:00**
   Dr. Jim Osberg, Chief, State Operated Services
   Division of MH/DD/SAS, DHHS

9. **Update on DHHS Involuntary Commitment Workgroup** — **3:00– 3:15**
   Flo Stein, Chief, Community Policy Management

ADJOURN — **3:30**

Next meeting date is yet to be determined.

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

January 14, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, January 14, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, James Forrester, Vernon Malone, and William Purcell and Representatives Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw and Representatives Van Braxton and William Brisson were also present.

Denise Harb, Ben Popkin, Shawn Parker, Susan Barham, Joyce Jones, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the December 18, 2008 meeting. The motion was made by Senator Purcell and the minutes were approved.

Representative Insko asked Leza Wainwright, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to come forward and provide an update on the Albemarle LME. Ms. Wainwright said that in October, Albemarle had requested a $4.5 million increase in its State funding. (In comparison, Albemarle's total allocation of State service dollars and systems management dollars is $15 million.) She indicated that Albemarle's allocation had not been reduced from last year, and that therefore the Department could not understand how there could be such a shortage so early in the fiscal year. She said a review team of DHHS staff found significant problems in four key local management functions – finances, provider relations, customer services, and the utilization management of state funds. Providers have not received payment for services provided after September 2008. The LME issued reductions in workforce notices to 80 employees with layoffs effective January 15th. Ms. Wainwright said that Albemarle's board had decided to terminate the director effective February 1, and has appointed an interim director. She said the board may ask the State to take a more proactive role in finding solutions to Albemarle's problems. She said that there was still $8 million in the State budget to help.

Representative Insko introduced the new Secretary of Health and Human Services, Lanier Cansler. Secretary Cansler said he looked forward to working with the Committee to try

to solve some of the issues facing the system. He said he would work to have an enhanced focus on developing community capacity and to take pressure off of the State facilities. He said he would continue to work with local hospitals to serve people in their local community. Secretary Cansler also expressed concern over the care of patients in the State facilities. He stated there would be a clear policy stating a zero tolerance for neglect or abuse of patients. He said that Governor Perdue wants openness, transparency, and accountability.

Pam Silberman, President of the North Carolina Institute of Medicine (NCIOM), gave the final report of the Taskforce on Substance Abuse Services. (See Attachment No. 2a) She explained that in 2007, the General Assembly asked the NCIOM to study the substance abuse system for the State with an interim report due in 2008, and a final report in 2009. Important issues addressed during her presentation included:

- Over 700,000 people abuse alcohol or drugs in North Carolina
- 90% of those entering prison have a substance abuse problem
- Substance abuse costs NC more than $12 billion a year
- Only 10% with addiction problems are being served
- System not accessible to those seeking treatment
- Addiction is a chronic illness that affects the brain
- Addiction must be addressed on 4 levels – prevention, early intervention, specialized services, and recovery support
- One fourth of active and retired military have addiction problems or suffer from post traumatic stress and/or depression
- Severe shortage of licensed or credentialed substance abuse professionals
- Suggested recommendations of the Taskforce, which focus on filling in gaps to create a comprehensive substance abuse services system ranging from prevention to recovery support (See Attachment No. 2c)

Dr. Silberman was asked to provide data characterizing the prevalence of drugs in children ages 12 to 15. Representative Insko said that the LOC would consider the recommendations in developing its report to the General Assembly.

Next, John Corne, Chairman of the Commission on MH/DD/SAS, reported on deaths in State facilities. (See Report - Attachment No. 3) He said the Commission was charged with studying the death reporting statutes, and any additional reporting requirements or modifications to existing rules or procedures. Mr. Corne addressed the issues discussed by the Commission on the Death Report.

- Commission suggests that all deaths in facilities be reported to the Department and to the Disability Rights organizations to capture any questionable deaths that might have gone unreported
- Current reporting requirements are unduly complex with different requirements
- There should be uniformity in the reporting of the different deaths – 7 days vs. 3 days

Again, Representative Insko said the recommendations would be considered for the committee's report to the General Assembly.

Dr. Carol Ripple from the General Assembly's Program Evaluation Division reported on the results of the evaluation of services delivered by the Division of MH/DD/SAS. (See Attachments No. 4a and 4b; the full report is available from the Program Evaluation Division) The report provides independent analysis of data on services received by a specific group of individuals hospitalized at least once for mental health or substance abuse problems. Points made by Dr. Ripple included:

- The report focused on one subgroup of consumers due to the large scale of consumers receiving services from the Division
- The report looked at- the types of facilities; hospitalizations during calendar year 2007; rates of re-hospitalization, and services in the community of those with MH or SA disorders
- Hospitalization findings: 21% of consumers were rehospitalized in 2007; those with multiple hospitalizations were likely to be rehospitalized; 42% stayed short term in State facilities; only half discharged from hospital received follow-up services
- Community Based Services findings: Consumers receiving outpatient services were more likely to be rehospitalized; 48% stayed short term in community psychiatric wards; low-intensity services were offered more frequently to high-risk consumers; 54% saw a psychiatrist following discharge; LMEs struggling to serve community based services to high-need consumers
- Recommend that the Division of MHDDSAS develop individualized information systems to track services – move towards electronic health records
- Recommend that Division continue efforts to strengthen community-based services – more access to crisis services, more community hospital beds, better follow-up

After lunch, Rhett Melton, Area Director of Pathways LME, highlighted Pathways' accomplishments, gave an overview of challenges, and offered suggestions to improve the system. (See Attachment No. 5) Items included were:

Accomplishments:

- A very robust continuum of care of crisis services
- Strong consumer feedback and collaboration
- Single stream funding
- Reduced demand and utilization of hospital bed days by 4,000 from 2007-2008 by developing crisis continuum

Challenges:

- Constant change in system, hard on everyone, stressful to consumers
- Increase demand on system and simultaneous budget cuts
- Challenge to care for consumers as providers go out of business

Suggestions:

- Case management by LME would provide better knowledge of the quality of care within the network
- Comprehensive assessments need to be done by LME; no vested interest
- Better collaboration between State and LME
- Pay providers based on successes with consumers

- Advocate for waiver to grow throughout the State

Next, Judy Truitt, Area Director for Orange-Person-Chatham Area Program (OPC), spoke to the Committee. (See Attachment No. 6) She provided a staff profile of OPC, addressed how county funds were distributed, and briefly gave an update on housing. She also reviewed initiatives that OPC was involved in which included:

- OPC identified as one of six sites to implement a model to improve how we are using the funds available through MAJORS and increasing the opportunities of adolescents in the system
- Developing comprehensive trauma training for provider network
- Developing staff liaison position to work between OPC, the Department of Social Services, and the Department of Juvenile Justice
- Working to design a training program for providers and staff to increase skills in meeting the needs of consumers
- Two training projects being implemented for substance abuse professionals

Karen Salacki, Area Director of the Beacon Center, provided an analysis of hospital admissions and bed day utilization. (See Attachment No. 7) Items emphasized in her presentation included:

- When trying to decrease admissions and bed days, community collaboration is necessary
- Developed strategies in pre-admission, acute admission, long term admission, and post discharge, resulted in fewer admissions and bed day utilization
    - 10,000 bed day reduction from 2006-2007 and 2007-2008
    - 373 admissions dropped between 2006-2007 and 2007-2008; could further drop 253 admissions in 2008-2009
- Hospital contract dollars needed
- Data and tracking information does not "share" well between State institutions
- Need to look at policy issues regarding undocumented consumers
- Impact of provider failure – increase in bed days and increase in admissions

Leza Wainwright, Director of the Division of MH/DD/SAS, provided an update on the expenditure of service dollars. She said a special provision in the Appropriations Bill last year directed DHHS to work with providers and LMEs to determine why service dollars are not being fully spent and to make recommendations.

- The group identified four challenges to the efficient expenditure of State funds:
    - Timing of when dollars are available, and the fact that appropriations revert at the end of the year
    - The capacity of LMEs to effectively screen/monitor providers, authorize services and manage the resources
    - Providers are challenged to operate efficiently and effectively
    - The design of the State IPRS system

- Proposed solutions by the group were:
    - Allow 2 years for the expenditure of any expansion funds
    - LMEs should enter into multi-year contracts rather than year-by-year

- New initiatives contracts should be program based rather than fee for service
- Standardize business practices across the LMEs
- All billing transactions should be on the U.S. national standard HIPPA compliance transaction sets
- Simplify the authorization process across LMES of how State funds are authorized
- LMEs should change some of authorization processes – concentrating on high-cost, high-end services and grant broader authorization for the lower-cost, low-end services
- Payment incentives for providers who engage in State funded services including longer authorization periods, creative financing and payment mechanisms
- Providers should be required to bill within 60 days in order to receive payment
- Unexpended funds at end of year should go to the Mental Health Trust Fund

Ms. Wainwright said some of the suggestions would require action by the General Assembly. She was asked to let the committee know how much money was currently in the MHTF.

Next, Dr. Jim Osberg, Chief, State Operated Services for DHHS, provided an update on State psychiatric hospitals as follows:

- Broughton Hospital has been recertified by CMS, and the hospital is getting ready to reapply for Joint Commission accreditation in February. The design process has begun for the new hospital at Broughton. Construction should begin in June, 2010 with a completion date of September, 2012.
- Central Regional Hospital (CRH) has a new director, Mike Hennike. CRH is certified with CMS and a follow-up visit from the survey agency will occur in February to confirm the plan of correction put in place from the December survey. CRH is Joint Commission accredited for both campuses (Butner and Raleigh). Once all patients are merged at CRH, accreditation will be recognized as one.
- Cherry Hospital is operating under the direction of Carl Fitch of the Compass Group until a permanent director is found. Cherry Hospital is not CMS certified. Compass is working on improvements in order to reapply this spring. Cherry is Joint Commission accredited. Construction at Cherry will begin in June with a completion date of September, 2011.
- A 2 day conference was held in December on the procedures to reduce the use of seclusion and restraints in order to develop more effective and appropriate therapeutic communication skills and conflict resolution skills.

Representative Insko explained that a draft of the LOC report to the General Assembly would be sent out to committee members before the next meeting in February. She suggested that members contact staff with specific items to include in the report. Senator

Nesbitt added that if money was needed for the system, the committee had the responsibility to tell the General Assembly even in bad economic times.

A special thanks was rendered to Secretary Dempsey Benton for the leadership he provided to the Department of Health and Human Services. Under his leadership there are more hospital beds at the local level and more coming; there is a movement to put Utilization Management back with the LMEs; mobile crisis units are across the State, cost of community supports is down substantially; and tiered rates have been approved in community supports.

There being no further business, the meeting adjourned at 3:27 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Will Woodell	Value Options
Bob Fitzgerald	Retired
[illegible]	R. Lloyd & Assoc.
Mary Short	Taylorsville, NC MR/DD Family
Katie Short	Taylorsville, NC CAP-MR/DD RECIPIENT
M Terry Fuller	Raleigh NC MR/DD Family member
Janell Albany	Raleigh NC CAP MR/DD Recipient
Gail Boswell	MH Consumer, Wilson, NC
Hope Turlington	MH "New Day Hospital on the Hill" Advocate + 2 high rise DMHS office Bldgs.
Louise G. Fisher	Volunteer Advocate for Mentally Ill.
David Chapman	Caramore Community Chapel Hill.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dale Willetts	NCTASC Training Institute Coastal Horizons Center 613 Shipyard Blvd, Suite 100 Wilmington NC 28412
Wes Stewart	Coastal Horizons Center Region I TASC 2805A Front Rd. Nowborn, N.C. 28562
Kim Chapple	Coastal Horizons 613 Shipyard Wilmington NC 28412
Margaret Weller-Stargell	Coastal Horizons Center, Inc. 615 Shipyard Blvd. Wilmington, N.C. 284
TAD CUDDECTER	SOUTHLIGHT INC, RALEIGH, NC SA FEDERATION
DAVID R. TURPIN	SUBSTANCE ABUSE FEDERATION / CLINICAL SERVICES N.C
Leah S. Atwell	NASW-NC 400 Morson St/Raleigh, NC
Kay PARSON	BSW Intern, NASW-NC 400 Morson st/ Raleigh, NC
Pam Andrews	New River Behavioral Healthcare
Leslie Arnold	SOG-Daily Bulletin
WREN RIVENBARK	Addiction Professionals of NC / SA FEDERATION

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Virginia N Price	NC Department of Correction MSC 4211 Raleigh NC 27699-4211
Angie Barthe	SA Federation
Tony Beatty	Mecklenburg County Provided Services Organization 3430 Wheatley Avenue Charlotte, NC 28205
Christopher White	LifeSpan 200 Clanton Rd. Charlotte N.C. 28217
Sandra Farmer	Brain Injury Association of NC P.O. Box 9012 Raleigh, N.C. 27605
JOSEPH A. MARTINEZ	FIRST AT BLUE RIDGE / SUBSTANCE ABUSE FEDERATION MEMBER PO BOX 40, 32 KNOX ROAD RIDGECREST, NC 28770
John McHugh	Gov Office
Bill Scott	DHHS-MH
TOM SAVIDGE	PORT Human Services 4300-100 Sapphire Court Greenville, NC 27834
GLENN BUCK	PORT Human Services/ Federation
ERIC DAVIS	PROGRAM RESOURCE INSTITUTE/ NC SUBSTANCE ABUSE FEDERATION

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	Ken Melton & Assoc.
[signature]	Bone & Asso.
[signature]	WCSR
Tracy Kimbrell	Parker Poe
Joanne Stevens	(Nursing) Stevens + Assoc
[signature]	NCAHTCF
[signature]	NCPA
David Barnes	Poyner Spruill
Patrick Buffkin	NMRS
Jamal Jones	NCHA
Mike Vicario	NCHA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hawthorne	DHHR; NCALA; NCOTA
Robin Huffman	NC Psychiatric Assoc
Janet Schwarzenbach	Indigo Consulting
Bob Hedrick	NC Providers Council
Gene Rodgers	Universal MH/DD / NCPC
Dora Price	DVRS
Mary Ann Neff	NAMI NC
Anne Dorfman	Education / ADCNC
John Tate	MHA-NC
John Allen	NMRS
TY DEXTER	TROSA / NC SA. FEDERATION

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Yvonne Copeland	NC Council of Comm Progs.
Martha W Lowrance	Youth Advocacy & Involvement Office/ DOA
JAMES L. FORTE	OSA
Roy Wilson	ECBH
Dale Richard	The Arc
David Swann	Crossroads BHC
ARTHUR CARDER	Western Highland Network
Betty Taylor	CenterPoint Human Services
Billie Pierce	Guilford Centers

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 14, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Judy Truitt	OPC
Cim Brailer	OPC
Rhett Melton	Pathways
Hank Debnam	CCMHC
Phil Mooring	NC Parent Resource Center
Jacquelyn Betts	NC EAPA
Donna M. Cotter	Recovery NC
Erin McLaughlin	MHANC
Annalicse Dolph	Disability Rights NC
Sally Cameron	NC Psychological Assoc
MEGAN CARROLL	GOVERNOR'S INSTITUTE.

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alisha Nash	Governor's Institute on Alcohol & Substance Abuse
Larry Woodard	Governor's Institute on Alc + SA
Pamela Shipman	PBH, Concord NC
Mary Powell	NC Substance Abuse Federation Governor's Institute on Alc + SA
Sara McEwen, MD	Exec Director Governor's Institute
DAN Jones	Onslow Carteret BHS Jacksonville, NC
Karen Salacki	Beacon Center Rocky Mount, NC

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maureen Morrell	Autism Society of NC
Kathleen Thomas	Shepe Center, UNC

North Carolina Institute of Medicine Task Force on Substance Abuse Services

Presentation to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services
January 14, 2009
Pam Silberman, JD, DrPH
President & CEO

NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

NC Institute of Medicine

- An independent, quasi-state agency chartered by the NC General Assembly in 1983
- Provides balanced, nonpartisan information on important health issues facing the state
- Convenes task forces of knowledgeable and interested individuals to study complex health issues facing the state in order to develop workable solutions
- Studies health issues at the request of the NCGA, state agencies, foundations, health professional organizations, and others

NCIOM 2

Legislative Charge

- The NCGA asked the NCIOM to convene a task force to study substance abuse services in NC
  - Section 10.53A of Session Law 2007-323
- Requested to make interim report and recommendations to the 2008 session and a final report to the 2009 session
- Task Force chaired by Rep. Verla Insko, Sen. Martin Nesbitt, and Dr. Dwayne Book
  - Includes 52 other members

Substance Abuse Problems in North Carolina

- According to the National Survey on Drug Use and Health:
  - 642,000 people 12 years and older (7.7% of people 12 years or older) in North Carolina reported illicit drug use in the past month
  - 1.63 million people in North Carolina (19.5% of people 12 years or older) reported alcohol binge drinking
  - ***Approximately 709,000 people reported either alcohol or drug abuse or dependence in North Carolina***
    - Most do not receive treatment

Source: 2005-2006 NSDUH data, using 2008 NC population estimates.

Substance Abuse Has Large Costs to Society

- North Carolina spent $138 million in 2006 to fund the public substance abuse services system
- In addition to direct treatment costs, there are significant indirect costs:
  - 5% of traffic accidents are alcohol related (27% of traffic related deaths)
  - In NC, 90% of all those entering the prison system need substance abuse services
  - ~40% of juvenile offenders in the court system have underlying substance abuse problems

NCIOM 5

Substance Abuse Has Large Costs to Society

- Substance abuse is one of the leading contributors to:
  - Child abuse and neglect
  - Loss of child custody
- ***Alcohol and drug abuse estimated to cost the North Carolina economy over $12.4 billion in direct and indirect costs in 2004***

NCIOM 6

Prevention, Diagnosis and Treatment is Difficult

- A large percentage of individuals with substance abuse problems do not recognize they have a problem
- Many who know they have a problem do not seek treatment
  - Stigma attached to the condition
  - The substance abuse service system is not always accessible, or may not offer services the clients want or need
  - Substance abuse services are not readily available in a primary care setting
  - As a result, only about 10% of the people in North Carolina with addiction problems obtain treatment services

Addiction is a Chronic Illness

- Historically, society has viewed addition as an acute illness
  - We expect people to go into treatment and be "cured"
  - If a person relapses, we consider this relapse a moral failure
- However, addiction is really a chronic illness that affects the brain
  - Addiction has adherence and relapse rates similar to other chronic illnesses
- ***We need to change the current treatment paradigm from an acute-care "curative" model to a long-term management of chronic illness model***

Addiction is a Chronic Illness

Chronic Disease	Substance Abuse	Asthma	Diabetes	Hyperten-sion
Adherence	~60%	60%	<40%	<40%
Relapse/Recurrence	40%-60%	50%-70%	30%-50%	50%-70%
Genetic Inheritability	.34-.61	.36-.70	.30-.55	.25-.50
Cure?	No	No	No	No
Research-based Treatment Guidelines and Protocols?	Yes	Yes	Yes	Yes
Parity With Other Medical Conditions?	No/Yes	Yes	Yes	Yes

Sources: McLellan 2000 JAMA, except SA adherence: Gilmore, Lash, Foster, Blosser. Adherence to Substance Abuse Treatment: Clinical Utility of Two MMPI-2 Scales. Journal Of Personality Assessment, 77(3), 524-540. Bottom seven rows from "Comparisons Among Alcohol-Related Problems, Including Alcoholism, and Other Chronic Diseases." Ensuring Solutions to Alcohol Problems, George Washington University Medical Center. Available on line at: http://www.ensuringsolutions.org/usr_doc/Chronic_Disease_Comparison_Chart.pdf

NCIOM

9

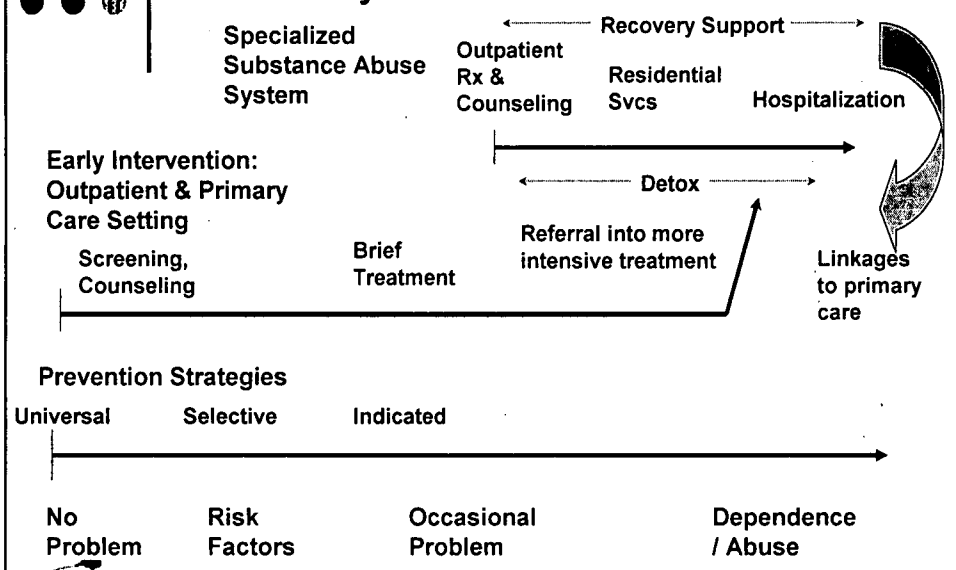
Comprehensive System of Substance Abuse Services

- To effectively address this problem, North Carolina needs to create a comprehensive substance abuse service system
  - *Prevention*—start with prevention to delay initiation or prevent people from using alcohol, drugs, or tobacco
  - *Early intervention*—screen, counsel and refer people when they first start using/abusing alcohol, drugs, or tobacco
  - *Specialized services*—provide more intensive services for people with addiction or dependence problems
  - *Recovery support*—provide long-term recovery supports to help support people in recovery

NCIOM

10

Comprehensive Substance Abuse Services System



NCIOM

11

Prevention

- Addiction is a disease that begins in childhood or adolescence
  - 38% of high school students had at least one drink in last 30 days
  - 36% have used marijuana
  - 19% currently smoke cigarettes

NCIOM

12

Adolescents are Particularly Vulnerable to Effects of Alcohol and Drugs

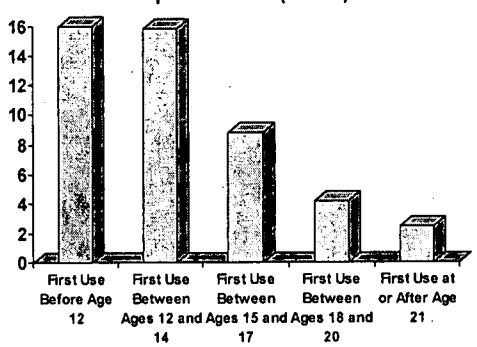
- Pre-frontal cortex controls decision making that involves longer-term trade-offs
  - But pre-frontal cortex is not fully developed until approximately age 25
  - As a consequence, adolescents are less focused on longer-term consequences of drug use
- Substance use or abuse can alter the normal maturation of the brain

NCIOM 13

Prevention (cont'd)

- Prevention activities should be targeted to youth
  - People who start using alcohol, tobacco, or other drugs when they are young have a higher risk of later abuse or neglect

Early Initial Use of Alcohol Associated with Higher Risk of Abuse or Dependence (2007)



NCIOM SAMHSA. The NSDUH Report: Alcohol Dependence or Abuse and Age at First Use. 2007. 14

Prevention (cont'd)

- Prevention activities need to target alcohol, tobacco, and other drugs
  - Tobacco is often one of the first substances that children use
  - Alcohol is the most commonly used drug among youth
    - Use of alcohol is associated with death from injury, risky sexual behavior, and increased risk of sexual and physical assault
- Need to offer universal, selective, and indicated prevention interventions
  - US Substance Abuse and Mental Health Services Administration (SAMHSA) has a registry of evidence-based prevention programs and practices: www.nrepp.samhsa.gov

Prevention Recommendations

- **Rec. 4.1. (PRIORITY)** The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) should develop comprehensive state and local substance abuse prevention plans.
  - The NCGA should appropriate $1,945,000 in SFY 2010 and $3,722,000 in SFY 2011 to DMHDDSAS to support this effort.
    - $1,770,000/$3,547,000 would be used to fund six comprehensive prevention pilot projects at local level
    - Pilots should be evaluated and, if successful, expanded to other parts of the state

Prevention Recommendations

- **Rec. 4.2.** The NCGA should direct State Board of Education, and the University and Community College system to review existing prevention plans and report to NCGA.
- **Rec. 4.3.** DMHDDSAS, Division of Public Health (DPH), Division of Alcohol Law Enforcement, and Department of Public Instruction (DPI) should develop a plan to further reduce tobacco and alcohol sales to minors.

Prevention Recommendations

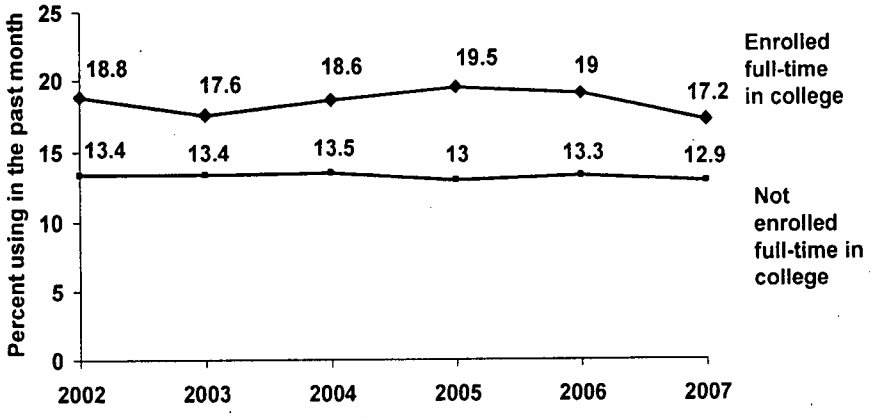
- **Rec. 4.4. (PRIORITY)** The NCGA should increase tobacco tax to the national average. Funds should be used to support effective prevention and treatment efforts.
- Rec. 4.5. The NCGA should appropriate $1.5 million to support the Quitline.
- **Rec. 4.6. (PRIORITY)** The NCGA should ban smoking in all public buildings, including but not limited to restaurants, bars and worksites

Use of Alcohol and Drugs Highest Among Adolescents and Young Adults

- Use of alcohol highest among young adults (ages 21-29)
- Use of drugs highest among older teens and young adults (ages 17-25)
- Young adults 18-22 in college are more likely to drink than those who are not enrolled in college full-time

NCIOM

Heavy Alcohol Use Among Adults Ages 18 to 22, by College Enrollment: 2002-2007



NCIOM

Additional Prevention Recommendations (After Interim Report)

- Nationally, 130 college presidents and chancellors signed a statement to encourage a broader discussion of the minimum legal drinking age ("Amethyst Initiative")
- National data show that motor vehicle fatalities increased by 10% when drinking age lowered to 18, and decreased by 16% when the drinking age increased to 21

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Prevention Recommendations

- **Rec. 4.7. (PRIORITY)** The NCGA should increase the excise tax on malt beverages (including beer), and index taxes on malt beverages and wine to the consumer price index. Funds should be used to support effective prevention and treatment efforts.
- Rec. 4.8. The NCGA should not lower the drinking age to less than 21.
- **Rec. 4.9. (PRIORITY)** College campuses should reduce high-risk drinking on college campuses.
  - The NCGA should appropriate $610,000 in recurring funds to DMHDDSAS support these efforts.

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Prevention Recommendations

- **Rec. 4.10.** DMHDDSAS, DPH, DSS, and other providers should develop prevention plan to prevent alcohol spectrum disorders and report plan to LOC no later than July 1, 2009.
- **Rec. 4.11.** DMHDDSAS should work with the Attorney General's Office, Controlled Substances Reporting System (CSRS), and health professional groups to explore options to exchange information from the CSRS to other practitioners.

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Early Intervention

- Goal of prevention efforts is to reduce the number of people who use, abuse, or become dependent on alcohol, tobacco, or other drugs.
- There are people who will use drugs despite prevention activities.
  - Important to intervene before the person is already addicted
  - Primary care providers ideally situated to screen individuals to identify people who currently use alcohol, tobacco, and other drugs

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Early Intervention

- SAMHSA has developed evidence-based screening and brief intervention program for individuals who are at risk for substance abuse problems
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been tested in primary care provider offices, emergency departments, hospitals, and other outpatient settings
  - Helps individuals who are at risk, but not yet addicted, to reduce the use of these substance
  - Helps link those with more serious addiction problems into treatment

SBIRT Effective

- Research has shown that people are more likely to quit smoking if advised by physician, particularly if combined with other treatment and intervention
- Counseling also important as part of intervention for alcohol or drug use
  - Has been shown to be successful in reducing consumption of illegal drugs or binge drinking

Early Intervention Recommendations

- Rec. 4.12. NC health professional schools, AHEC, residency programs, and health professional associations should expand training on SBIRT
- **Rec. 4.13. (PRIORITY)** DMHDDSAS should work with the Office of Rural Health (ORHCC), Governor's Institute, and the Area Health Education Centers (AHEC) program to expand use of SBIRT in primary care and outpatient settings--targeted to CCNC practices.
  - The NCGA should appropriate $1.5 million to DMHDDSAS to support this effort.

Early Intervention Recommendations

- Rec. 4.14. The NCGA should direct NC Health Choice to pay for annual wellness visit for children and adolescents.
- Rec. 4.15. The ORHCC should facilitate the co-location of substance abuse professionals in primary care practices
  - The NCGA should appropriate $750,000 in recurring funds to ORHCC to support this effort.
- **Rec. 4.16. (PRIORITY)** The NCGA should mandate that insurers offer same coverage for treatment of addiction diseases as other physical illnesses, and should provide reimbursement for substance abuse brief counseling

Specialized Substance Abuse Services

- Individuals who have addiction problems need more intensive services
  - The specialized substance abuse services are offered primarily through the DMHDDSAS, Local Management Entities (LMEs), and contracted providers
- People with substance abuse problems need a range of services to match their needs and choices
  - Comprehensive system should offer screening, assessment, brief intervention, outpatient services, medication management, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium-intensity residential treatment, inpatient services, crisis services, detoxification
  - Also need access to recovery support to help people live without alcohol, tobacco, and other drugs

LMEs Are the Gateway for Specialized Services

- Local Management Entities (LMEs) serve as the gateway for most people who seek specialized substance abuse services
- However, LMEs not serving most in need:
  - LMEs serve between 4% and 11% of estimated need for children
  - LMEs serve between 5% and 11% of estimated need for adults

Many LMEs Do Not Engage Consumers Actively in Treatment (4th Qtr, SFY 2008)

Active Participation Standard (DMHDDSAS Performance Targets)	# LMEs Meeting Targets	% of Consumers Who Receive Care Acc'g to Standards
Individuals receive 2 visits within 14 days (71%)	3	36%-82%
Individuals receive 4 visits within 45 days (50%)	6	27%-63%
Individuals receive community based services within 7 days of discharge (36%)	5	0-53%

Specialized SA Services Recommendations

- **Rec. 4.17. (PRIORITY)** DMHDDSAS should develop plan for recovery oriented system of care for adults and adolescents and ensure that services are available and accessible across the state
  - Should develop performance-based contracts to ensure timely engagement, active participation in treatment, retention, program completion, and participation in recovery supports
  - Identify barriers and strategies to increase quality and quantity of substance abuse providers in the state
  - Immediately begin expanding capacity of adolescent treatment services
  - Report back to the Legislative Oversight Commission on Mental Health, Developmental Disabilities and Substance Abuse Services on progress in achieving goals

Specialized SA Services Recommendations

- Rec. 4.18. DMHDDSAS should develop 6 pilot programs to implement county or multi-county recovery oriented systems of care. The pilots should be evaluated and if successful, implemented statewide.
  - The NCGA should appropriate $17.2 million SFY 2010 and $34.4 million SFY 2011 to DMHDDSAS to support this effort.
- **Rec. 4.19. (PRIORITY)** Additional state funding is needed to increase state staff to support these recommendations.

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Specialized Systems for Subpopulations

- In addition to the LME system offered to general population, other services targeted to specific subpopulations, including:
  - Juveniles in juvenile justice system
  - Adults in the workplace
  - Adults involved in Work First or Child Protective Services system
  - Adults in criminal justice system
  - Active or retired military personnel

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Juvenile Justice System

- Department of Juvenile Justice and Delinquency Prevention (DJJDP) charged with providing treatment and intervention services to reduce delinquency
  - 43% of juveniles in the DJJDP system are in need of further assessment or treatment for substance abuse
  - DJJDP and DMHDDSAS provide services to juveniles in need of substance abuse services
    - MAJORS provides screening and assessments, therapy, life skills training, and ongoing monitoring
    - Improvements needed to coordinate care between DJJDP system, substance abuse providers, and juvenile courts

Juvenile Justice Recommendations

- Rec. 5.1. DMHDDSAS and DJJDP should develop and pilot models to better coordinate services across agencies.
  - The NCGA should appropriate $500,000 to DMHDDSAS to support this effort.

Employee Assistance Programs (EAP)

- Employees with addiction disorders often create problems on the job
  - Can affect employee job performance or work environment for other employees
  - Nationally, loss of productivity from depression, alcohol and drug addiction estimated to cost businesses $287 billion/year.
- Some businesses offer EAP program to help resolve employee productivity problems, including substance abuse
- However, there is a problem with availability and quality of EAP providers.

Employee Assistance Program (EAP) Recommendations

- Rec. 5.2. LMEs should assess the availability and need for EAP services in their catchment areas. If there are insufficient numbers of providers, LMEs should work with local business representatives to develop a strategy to expand EAP services.
- Rec. 5.3. By 2014, the NCGA should ensure that all individuals holding themselves out as EAP providers are licensed or working under a licensed EAP provider. All organizations that promote themselves as offering EAP services should be required to provide statutorily defined core services.

Adults Involved in Work First or Child Protective Services

- Work First is intended to move families with dependent children from welfare to self-sufficiency
  - Substance abuse problems of parents is a major barrier to achieving self-sufficiency
- Nationally estimated that substance abuse is one of the underlying problems of 75% of the children entering the foster care system (Child Protective Services)

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Adults Involved in Work First or Child Protective Services

- LMEs outstation substance abuse professionals in DSS offices to coordinate substance abuse services for adults who have addiction disorders
  - However, there are insufficient numbers of substance abuse professionals to meet the needs
- Rec. 5.4. DMHDDSAS should hire additional substance abuse professionals to work with parents in the Work First or Child Protective Services System.
  - The NCGA should appropriate $475,000 to DMHDDSAS to support this effort.

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Criminal Justice System

- Many of the people arrested for criminal activities have underlying addiction disorders
  - More than one-fourth of all fatal motor vehicle crashes
  - 90% of criminals who enter prison system
- Specialized systems available to people
  - Some offenders go through drug courts
  - DWI system
  - Community corrections for people on probation or community sentencing
  - Prison system for those with more serious offenses

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Criminal Justice System

- DMHDDSAS provides care management to people with addiction disorders who are on probation or in community corrections through Treatment Accountability for Safer Communities (TASC)
  - Services available through the Criminal Justice Partnership Program (CJPP), funded through the Division of Community Corrections (DCC)
  - NC Sentencing and Policy Advisory Commission found that adult offenders who received TASC and completed treatment were less likely to be rearrested over the next two years.
  - TASC funding only sufficient to serve approximately 25,000 or the 75,000 who need services.

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Criminal Justice System

- Rec. 5.5. DMHDDSAS should expand availability of TASC services.
  - The NCGA should appropriate $2.8 million in SFY 2010 and $2.8 million in SFY 2011 in recurring funds to DMHDDSAS to support this effort.
- Rec. 5.6. DCC should expand the availability of CJPP-funded substance abuse services.
  - The NCGA should appropriate $500,000 in recurring funds to DCC to support this effort.

Criminal Justice System

- Drug courts have been shown to be effective in engaging people with addiction disorders into active treatment.
  - NC operates family drug courts, juvenile drug courts, and adult drug courts.
  - Typically these courts begin with federal grant funds, but need ongoing state funds to sustain.
- **Rec. 5.7 (PRIORITY).** Administrative Office of the Courts (AOC) should expand adult drug treatment courts, treatment services, and probation officers to support drug treatment courts.
  - The NCGA should appropriate $500,000 in SFY 2010 and $500,000 in SFY 2011 to AOC (to expand adult drug treatment courts), and another $570,000 each year (for treatment services through DMHDDSAS and probation officers through DCC to support drug treatment courts).

Criminal Justice System

- 90% of offenders have been found to need substance abuse services when they enter the prison system.
  - 63% have severe addiction disorders needing residential treatment.
  - Availability of treatment beds has not kept pace with needs:
    - Between SFY 2001-2007, prison population grew by 20%, but treatment beds declined by 21%
    - Only about one-third of inmates who need treatment receive it

Criminal Justice System

- Rec. 5.8. The Department of Correction (DOC) should expand the availability of treatment services to adults in the prison system, as well as residential services for those on probation or parole.
  - The NCGA should appropriate $4.5 million in recurring funds to DOC to support this effort.

Active and Retired Military

- There are 107,000 active duty personnel based at one of the NC military bases or deployed overseas, and another 11,500 who serve in the National Guard or reserves
- There are 773,630 veterans living in NC
- Approximately one-fourth of active and retired military personnel report alcohol or drug problems, many others suffer from post traumatic stress disorder (PTSD) and/or depression

Active and Retired Military

- Many returning veterans receive their health care services from civilian health professionals
  - But not all civilian health professionals may recognize or screen for PTSD, depression, or substance abuse
  - Veterans Administration offers some training for civilian health professionals, but more is needed
  - Other services are available through the Veterans Administration but not fully accessed, such as housing for homeless veterans

Active and Retired Military

- Rec. 5.9. The Veterans Administration should continue to work with appropriate partners to provide training for mental health and substance abuse professionals, LMEs, primary care providers, school personnel, and others about the medical and behavioral health needs of veterans and their families.
  - The NCGA should also appropriate $200,000 in SFY 2010 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem program for transitional housing for homeless veterans with substance abuse or mental health disorders.

Substance Abuse Workforce

- North Carolina needs qualified substance abuse professionals in order to ensure that people with addiction disorders receive prevention, early intervention, treatment, and recovery supports.
- However, there is a severe shortage of licensed or credentialed substance abuse professionals.
  - Eight counties with no professionals.
  - Range in other counties—from 1 provider for every 48 people with a substance abuse disorder (Polk) to 1 provider for every 3,092 (Pasquotank)

Substance Abuse Professionals

- **Rec. 6.1. (PRIORITY)** North Carolina should develop a scholarship program to increase the number of qualified substance abuse professionals.
  - Funding should be available for people who pursue appropriate degrees in community colleges or universities including associate, undergraduate or and masters degrees.
  - People who receive scholarships would be required to work in a public or private non-profit substance abuse agency for one year for every $4,000 received in scholarships.
  - The NCGA should appropriate $750,000 in recurring funds in SFY 2010 increasing to $2.0 million in SFY 2013.

Substance Abuse Professionals

- More work is also needed to better train existing health professionals in substance abuse.
- Rec. 6.2. AHEC should develop and support new residency training rotations for psychiatrists, family physicians, emergency medicine, or other physicians likely to enter the addiction field.
  - The NCGA should appropriate $200,000 to AHEC to support this effort.
- Rec. 6.3. The NC State Personnel Commission should reevaluate and increase pay grades for substance abuse professionals with appropriate credentials recognized by the NC Substance Abuse Professional Practice Board.

Data Needs

- Policy makers need good data to make informed policy choices.
- We know that many North Carolinians have addiction problems, but few people are receiving treatment for these problems.
  - LMEs have been unable to spend all of their substance abuse funds, despite the large number of people who need, but are not receiving services.
- We need better data to profile populations most at risk; the types of services needed; availability and accessibility of services; service use, intensity and completion rates; and recidivism rates.

Data Recommendations

- Rec. 5.1. DMHDDSAS should enhance and expand current data system, including the development of an electronic health record and additional analytic capacity to understand barriers that prevent LMEs and other providers from engaging consumers in treatment.
  - The NCGA should appropriate $1.2 million to DMHDDSAS to support this effort.
- Rec. 5.2. DMHDDSAS should work with other agencies, including DJJDP, DOC, and other DHHS agencies to collect comprehensive data on substance abuse prevention and treatment services and people served.
  - The NCGA should adopt an equalization formula to ensure that LMEs receive comparable funding to achieve equity in access to care and services.

Return on Investment

- Investing in substance abuse prevention and treatment works.
- SAMHSA estimates communities can save $5 for each $1 invested in prevention.
- Other studies suggest investments in substance abuse treatment can exceed costs by a ratio of 12 to 1.

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North Carolina Cannot Afford to Wait

- Investing in prevention, early intervention, and treatment services costs money.
- However, the cost of not providing these services is much greater over the long term in increased health care costs, lost worker productivity, broken families, increased costs of incarceration, and lost lives.

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For More Information

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North Carolina Institute of Medicine Task Force on Substance Abuse

EXECUTIVE SUMMARY

Dependence on alcohol, tobacco, and other drugs is a complex and costly *chronic illness*. Drug addiction is a brain disorder.{{837 Friedman, D.; }} Although this disorder is triggered by the use of substances, there are predisposing genetic and environmental factors that can make some people more susceptible to addiction.

Addiction disorders are remarkably similar to other chronic diseases, although there is a widespread perception that substance abuse and addiction represent a failure of an individual's morals. People with addiction disorders have similar adherence and relapse rates as do people who have asthma, type 2 diabetes, or hypertension. Chronic diseases, including substance abuse disorders, are generally lifelong conditions. They are not "cured" in the acute care sense. Instead, the goal of treatment is to *manage* them so that the burden on the individual—and to the healthcare system, the workplace, and society in general—is minimized as much as possible.

In North Carolina, there are more than 250,000 people aged 12 years or older who report illicit drug dependence, and more than twice as many (550,000) who report alcohol dependence or abuse.{{821 Substance Abuse and Mental Health Services Administration, Office of Applied Studies; }} Yet fewer than 10% of those with dependence on illicit drugs and fewer than 5% of those with alcohol dependence or abuse received treatment in North Carolina (SFY 2007) from providers funded through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the lead agency charged with coordinating prevention, treatment, and recovery supports. Many individuals with substance abuse problems either do not recognize they have a problem or do not seek treatment. Even those who do seek treatment are not always able to get the services they need when they need them or with the intensity needed to successfully address their problem. Further, people with substance abuse problems need ongoing recovery supports to help prevent relapse.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has primary responsibility for the coordination of substance abuse services throughout the state. Most of the direct provision of publicly-funded substance abuse services is managed by Local Management Entities (LMEs). Services are also offered through, or in collaboration with, many other agencies throughout the state. Overall, North Carolina spent $138 million in 2006 to fund the public substance abuse service system in the state, a sum that left North Carolina substance abuse services underfunded in relation to other states.{{827 North Carolina Department of Health and Human Services. Division of Mental Health, Developmental Disabilities, and Substance Abuse 2006; }} A report presented to the North Carolina General Assembly in 2007 estimated it would take an additional $35 million in appropriations to achieve parity with national per capita funding for substance abuse services.{{526 Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services 2007; }}

Substance abuse carries both direct and indirect costs to society. In addition to the direct costs of prevention, treatment, and recovery supports, there are indirect costs associated with motor vehicle accidents, premature death, comorbid health conditions, disability, lost productivity, crime, unemployment, poverty, homelessness, and a host of other social problems. Alcohol and drug abuse cost the North Carolina economy over $12.4 billion in direct and indirect costs in 2004.{{823 Alcohol/Drug Council of North Carolina; }} Nationally, alcohol or drug abuse is a contributing factor in more than 75% of the cases when children are removed from the home and placed in foster care. {{1471 Robert Wood Johnson Foundation and Schneider Institute for Health Policy 2001}} Substance abuse is also an underlying problem for many youth involved in the juvenile justice system. In North Carolina, 43% of North Carolina juveniles involved in the juvenile justice system were determined to need further assessment or treatment for substance use.

Substance use is also one of the major causes of motor vehicle deaths in the state. In 2005, more than 5% of all traffic accidents in the state were alcohol-related, and these accidents accounted for 26.8% of all crash-related fatalities.{{822 University of North Carolina Highway Safety Research Center; }} Alcohol and drug-related crimes also consume a large amount of criminal justice resources. Almost 90% of the people entering the North Carolina prison system needed substance abuse treatment, with 63% of new prisoners needing residential treatment.{{1118 North Carolina Department of Corrections, Division of Alcoholism and Chemical Dependency Programs}}

The North Carolina General Assembly asked the North Carolina Institute of Medicine (NC IOM) to convene a task force to study substance abuse services in the state (SL-2007-323 §10.53A) and to present an interim report with recommendations to the 2008 General Assembly and the final report and recommendations to the 2009 General Assembly. The Task Force is cochaired by: Dwayne Book, MD, Medical Director, Fellowship Hall; Representative Verla Insko, Representative District 56, North Carolina House of Representatives; and Senator Martin L. Nesbitt Jr., JD, Senator District 49, North Carolina Senate. It includes 63 other members including other legislators, state and local agency officials, substance abuse providers, other health professionals; consumers, educators, and other knowledgeable and interested individuals. In addition, the work of the Task Force is guided by a 12-member steering committee. The Task Force met 14 times between October 2007 and December 2008 working to develop the final report to the North Carolina General Assembly.

Prevention: Most of the Task Force's work focused on developing a comprehensive system of care to provide evidence-based interventions based on a person's need. This comprehensive system begins with a strong prevention effort, targeted at adolescents and young adults. Targeting youth and young adults will help reduce the number of people who later become addicted, as evidence shows that people who initiate substance use in childhood or adolescence are more likely to later become addicted. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), communities can save 4 to 5 dollars for every 1 dollar they spend on substance abuse prevention.{{831 SAMHSA; }} The following is a summary of the Task Force's prevention

recommendations. The full recommendations are included in the report in Chapter 4. Priority recommendations are noted in bold.

- **Recommendation 4.1**
  (PRIORITY RECOMMENDATION)
  North Carolina General Assembly (NCGA) should appropriate $1,945,000 in SFY 2010, $3,722,000 in SFY 2011 to develop comprehensive state and local substance abuse prevention plans. Of these funds, $1,770,000/$3,547,000 would be used to fund six comprehensive prevention pilot projects at local level. Eligible LMEs must develop a comprehensive plan that includes a mix of evidence-based strategies, and should include a wide array of community partners. The General Assembly should appropriate $250,000 to evaluate these pilots and, if successful, to recommend roll-out to other parts of the state.

- Recommendation 4.2
  The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, NC Community College system, and University of North Carolina system to review existing substance abuse prevention, early intervention, treatment and referral programs, plans and policies and report on these plans to the General Assembly.

- Recommendation 4.3
  The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Alcohol Law Enforcement; and Department of Public Instruction should develop a plan to further reduce tobacco and alcohol sales to minors.

- **Recommendation 4.4**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should further increase the tobacco tax to the national average, with the increased revenues used to support effective prevention and treatment efforts.

- Recommendation 4.5
  The North Carolina General Assembly should appropriate $1.5 million to support Quitline NC.

- **Recommendation 4.6**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should enact a law which prohibits smoking in all public buildings including, but not limited to, restaurants, bars, and worksites.

- **Recommendation 4.7**

(PRIORITY RECOMMENDATION)
In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). In addition, the excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. Funds raised should be used to support effective prevention and treatment efforts.

- Recommendation 4.8
  The North Carolina General Assembly should not lower the drinking age to less than 21.

- **Recommendation 4.9**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should appropriate $610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

- Recommendation 4.10
  The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Social Services; and other providers should develop a prevention plan to prevent alcohol spectrum disorders and report the plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009.

- Recommendation 4.11
  The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the Controlled Substances Reporting System, Attorney General's Office, and other appropriate health professional organizations to explore options to allow the exchange of prescription information obtained through the CSRS between health care practitioners.

Early Screening and Intervention: Early screening and intervention strategies are needed for people who start to engage in risky behaviors but who have not yet become addicted. Without early intervention services, these individuals are likely to progress to worse stages of abuse and/or dependence. The Substance Abuse and Mental Health Services Administration has developed an evidence-based screening, brief intervention, and referral into treatment (SBIRT) program for individuals who are at risk for substance abuse problems. Although SBIRT has been shown to be effective in helping at-risk individuals reduce their use of alcohol, tobacco, or other drugs, providers do not routinely use these strategies.{{870 Babor,T.F. 2001; }} The Task Force's recommendations focus on educating primary care and other providers about the SBIRT model or other strategies to encourage providers to identify and treat people with substance abuse disorders. A summary of the Task Force's recommendations in this area are as follows:

- Recommendation 4.12
  North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the NC Area Health Education Centers program, residency programs, health professional associations, and other appropriate organizations should expand training for primary care providers and other health professionals in academic and clinical settings, residency programs, or other continuing education programs on screening, brief treatment, and referral for people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.

- **Recommendation 4.13**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should appropriate $1.5 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to work with the Office of Rural Health and Community Care, Governors Institute on Alcohol and Substance Abuse, and Area Health Education Centers program to expand use of SBIRT in Community Care of North Carolina (CCNC) networks and other primary care and outpatient settings.

- Recommendation 4.14
  The North Carolina General Assembly should direct NC Health Choice to pay for annual wellness visits for children and adolescents and to pay for annual screenings for tobacco, alcohol, and drug use beginning at age 11.

- Recommendation 4.15
  The North Carolina General Assembly should appropriate $750,000 in recurring funds to the Office of Rural Health and Community Care. Funding can be used to help support co-location of licensed substance abuse professionals in primary care practices, or to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to provide substance abuse services to Medicaid and uninsured patients. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs.

- **Recommendation 4.16**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should mandate that insurers offer the same coverage for treatment of addiction diseases as for other physical illnesses. Insurers should reimburse for substance abuse screening, intervention, and treatment services whether offered through primary care providers or specialized substance abuse providers. Insurers should also reimburse for telephone consultations by

psychiatrists, as well as for mental and behavioral health services provided on the same day as medical services are provided.

Specialized Substance Abuse Services and Recovery Supports: Individuals with more severe problems need different levels of treatment offered through the specialized substance abuse system. Substance abuse services are generally provided through private providers under contract with Local Management Entities (LMEs). Local Management Entities screen people to determine eligibility and need for services and then help these individuals access appropriate services. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has established performance standards to ensure that people with substance abuse problems can obtain timely services with the frequency needed to address their problems.

Local Management Entities do not currently serve the majority of people who have substance abuse disorders. In fact, the LMEs that are serving the highest percentage of people who need services are only reaching 11% of the estimated number of children or adults who need services; the LMEs reaching the lowest percentage of people in need are only serving 4% of the estimated number of children and 5% of the adults who need services. Local Management Entities also vary in their ability to meet the state's performance standards for timely initiation of treatment and ongoing engagement in the substance abuse system. Further, even when services are offered, they may not be provided with the level of intensity needed to help a person achieve sobriety.

The Task Force recognizes that individuals with substance abuse problems should have access to a full continuum of services including screening and assessment, brief intervention, outpatient services, medication management, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium-intensity residential treatment, inpatient services, and crisis services including detoxification. In addition, individuals also need access to recovery supports in order to help them live without use of alcohol, tobacco, and other drugs. To achieve this goal, the Task Force recommends:

- **Recommendation 4.17**
  (PRIORITY RECOMMENDATION)
  The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop a plan for a recovery oriented system of care for adults and adolescents, ensure that services are available and accessible across the state, and are coordinated among different providers. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop plans for performance based incentive contracts to ensure that services are provided to a significant portion of those in need, that the services are provided in a timely fashion, that people are provided the intensity of services appropriate to their needs and engaged for appropriate lengths of time, and that people are provided appropriate recovery supports. In addition, DMHDDSAS should identify barriers and strategies to increase

the quality and quantity of substance abuse providers in the state including, but not limited to, electronic health records, reduced paperwork, streamlined administrative processes, expanded service definitions, and adequacy of reimbursement rates. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should also immediately begin expanding the capacity of adolescent treatment services across the state.

- Recommendation 4.18
  The North Carolina General Assembly should appropriate $17.2 million in SFY 2010 and $34.4 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should make funding available on a competitive basis to Local Management Entities (LMEs) to support 6 pilot programs to implement county or multi-county comprehensive recovery oriented system of care. The North Carolina General Assembly should appropriate $750,000 to independently evaluate these projects and, if successful, build a plan to expand systems across the state.

- **Recommendation 4.19**
  (PRIORITY RECOMMENDATION)
  The General Assembly should appropriate funding for additional staff in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Office of Rural Health and Community Care, Division of Medical Assistance, and Department of Public Instruction to provide substance abuse services in support of the task force recommendations.

In addition to prevention, early intervention, and treatment services provided to the general population with substance abuse problems, there are other services available for specific subpopulations. Many of these services are tailored to specific groups of individuals involved with the juvenile justice or criminal justice system. Other services are available to employees in the workplace, families involved in Work First and/or Child Protective Services, or active and retired military personnel. A summary of the Task Force's recommendations for these subpopulations is listed below. The full text is included in Chapter 5.

Juvenile Justice: The Department of Juvenile Justice and Delinquency Prevention (DJJDP) is responsible for providing prevention and intervention services to reduce delinquency as well as treatment services and sanctions for juvenile offenders. By necessity, DJJDP helps link juveniles to available substance abuse services, as 43% of juveniles in the juvenile justice system need further assessment or treatment for substance abuse.{{1002 North Carolina Department of Juvenile Justice and Delinquency Prevention; }} Most of the substance abuse services for youth involved in the juvenile justice system are provided through the MAJORs program. MAJORS is funded through DMHDDSAS and administered by DMHDDSAS in collaboration with DJJDP.

MAJORS provides substance abuse screening and assessment, therapy, life skills training, and ongoing monitoring, but additional work is needed to coordinate care between the juvenile, substance abuse provides, and juvenile courts. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and DJJDP are piloting a Cross Area Service program to provide better coordination and to enhance the quality of services offered through MAJORS. However, this pilot needs to be tested in additional sites before expanding statewide. To achieve this goal, the Task Force recommended:

- Recommendation 5.1
  The North Carolina General Assembly should appropriate $500,000 in recurring funds to expand the Cross Area Service Program model in two additional DJJDP regions. If successful, the program should be rolled out statewide.

Employees: Employees with substance abuse problems often have performance and/or conduct problems that adversely affect their job performance. Loss of productivity, depression, and alcohol and drug addiction cost businesses $287 billion each year.{{1305 Anonymous 2003}} Many companies turn to employee assistance programs (EAPs) to help them identify and resolve employee productivity problems, including employees' substance abuse problems. However, finding affordable worksite model EAPs can be difficult, particularly for small firms. In addition, employers need to ensure that providers offering EAP services have the necessary training and skills to address workplace problems. To address these concerns, the Task Force recommends:

- Recommendation 5.2
  Local Management Entities (LMEs) should assess the availability and need for EAP services in their catchment area. If there are insufficient providers to address this need, the LMEs should work with the local Chambers of Commerce or other business organizations to develop a strategy to expand the availability of EAP services.

- Recommendation 5.3
  The North Carolina General Assembly should ensure that all individuals advertising and promoting themselves as providing EAP services must be licensed or have EAP specific training and work under the supervision of licensed EAP professionals, no later than 2014. All organizations that promote themselves as providing EAP services should be able to offer all the statutorily defined core services.

Families Involved in Work First or the Child Protective Services System: The goal of the Work First program is to move families with dependent children into employment and self-sufficiency. However, substance abuse and mental health issues are significant barriers to self-sufficiency. In addition, substance abuse is one of the major contributors to child abuse and neglect. Nationally, the Child Welfare League of America estimates that alcohol and/or drug abuse was an underlying factor in at least 75% of children

entering foster care. {{1471 Robert Wood Johnson Foundation and Schneider Institute for Health Policy 2001}} The North Carolina Division of Social Services and DMHDDSAS have developed a number of programs to serve these adults. One of these initiatives involves outstationing substance abuse professionals in local departments of social services to help parents with substance abuse problems engage in appropriate treatment. However, there are insufficient numbers of outstationed substance abuse professionals to work with all of the parents in need of services.

- Recommendation 5.4
  The North Carolina General Assembly should appropriate $475,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuser Services to hire seven additional Licensed Clinical Addition Specialists to work with parents involved with the Work First or Child Protective Services System.

Adults Involved in the Criminal Justice System: Many of the people arrested for criminal activities have underlying addiction disorders. Driving while impaired is a criminal offense; more than one-quarter of motor vehicle fatalities involved the use of alcohol. Approximately 90% of the criminals who enter the prison system have a substance abuse problem requiring treatment. {{1118 North Carolina Department of Corrections, Division of Alcoholism and Chemical Dependency Programs}} In response to these problems, North Carolina agencies have developed special substance abuse assessment, treatment, and monitoring programs for people convicted of driving while impaired, for those who have been convicted and are serving their sentences or probation in the community (community services) as well as for those serving active prison sentences (institutional services). However, there are severe shortages in the availability of services—both for people who are on probation or community corrections and for people who are currently incarcerated. For example, DMHDDSAS provides care management to people with substance abuse disorders who are on probation or in community corrections through the TASC (Treatment Accountability for Safer Communities) program. Treatment Accountability for Safer Communities' counselors link individuals with substance abuse disorders to services provided through the Criminal Justice Partnership Program (CJPP). A NC Sentencing and Policy Advisory Commission recidivism study found that adult offenders who received TASC services and completed their treatment were less likely to be rearrested over the next 2 years.{{1123 North Carolina Sentencing and Policy Advisory Commission; }} Despite its strong track record, only a fraction of people who need TASC services receive it. In SFY 2008, the Division of Community Corrections supervised 24,773 offenders convicted of non-trafficking drug offenses, however more than 75,000 people may need these services.

Drug courts have also been shown to be successful in engaging people with substance abuse disorders into active treatment. North Carolina currently operates three specialized courts that involve people with substance abuse disorders: family drug treatment courts (for adults who are having their children removed), juvenile drug treatment courts, and adult drug treatment courts. Typically, these courts begin with a federal grant, but

ongoing state funding is needed to sustain the work and treatment resources after the initial federal funding is exhausted.

Treatment services are also needed for people who enter the prison system. Of the 23,111 offenders screened in FY 2007, 63% needed residential substance abuse treatment, and another 23% needed some other substance abuse intervention.{{1118. North Carolina Department of Corrections, Division of Alcoholism and Chemical Dependency Programs}} The Division of Alcoholism and Chemical Dependency (DACDP) provides different levels of substance abuse services, depending on the needs of the prisoners. However, the availability of treatment resources has not kept pace with the need. Between SFY 2001-2007, the prison population grew by 20% (from 31,899 to 38,423), but the treatment beds declined by 21% (from 1,898 to 1,490).{{1122 Price, Virginia; }} Because of limited resources, only about one-third of the prisoners who need services receive them.

To address these outstanding needs for substance abuse screening, care management and treatment services, the Task Force recommends:

- Recommendation 5.5
  The North Carolina General Assembly should appropriate $2.8 million in recurring funds in SFY 2010 and an additional $2.8 million in SFY 2011 to expand the availability of TASC services.

- Recommendation 5.6
  The North Carolina General Assembly should appropriate $500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of CJPP-funded substance abuse services.

- **Recommendation 5.7**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should appropriate $500,000 in recurring funds in SFY 2010 to the Administrative Office of the Courts to support four new adult treatment courts, and $500,000 in recurring funds in SFY 2011 for an additional four adult treatment courts. In addition, the General Assembly should increase appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by $570,000 in recurring funds in SFY 2010 and $570,000 in recurring funds in SFY 2011 to support treatment services for people involved in the drug treatment courts. The General Assembly should also appropriate $269,940 in recurring funds in SFY 2010 and an additional $269,940 in SFY 2011 to fund probation officers to support the drug treatment courts.

- Recommendation 5.8
  The North Carolina General Assembly should appropriate $4.5 million in recurring funds to expand the availability of substance abuse services to adults

within the prison system, as well as residential services for those on probation or parole.

Military Personnel: There are currently 107,000 active duty personnel based at one of North Carolina's seven military bases or deployed overseas, {{1273 Williams,J.W.,Jr 2008}} and another 11,500 soldiers, marines, and airmen who live in North Carolina and serve in the National Guard or reserves. In addition to these men and women actively serving in our armed forces, we have another 773,630 veterans who live in North Carolina. Alcohol and other drug use is a serious problem for many in the military. Almost one-fourth (24%) of active duty military personnel and returning National Guard have reported alcohol dependence problems.{{1256 RTI International; }} {{1469 Wheeler,E. 2007}} Further, many of the returning veterans report post-traumatic stress disorder, depression, and substance abuse disorders. A study of more than 88,000 soldiers who returned from active duty in Iraq showed that 20.3% of active duty soldiers, and 42.4% of the National Guard and reserve component were identified as needing mental health or substance abuse treatment post deployment.{{1402 Milliken,C.S. 2007}} While some veterans services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans. Many returning veterans receive their health care services through civilian health professionals, rather than from health professionals who serve in the military or the Veterans Administration (VA) system. Civilian health professionals may not recognize or may fail to screen returning veterans for common problems, including post traumatic stress disorder, depression or substance abuse disorders. The (VA) has offered trainings, in conjunction with the Area Health Education Centers (AHEC) program and other organizations, to increase the skills and awareness of community mental health, substance abuse, and medical practitioners on the medical and behavioral health needs of returning veterans and their families.[1]{{1258 Stein, F.; }} However, more work is needed to disseminate this information. In addition, returning veterans and their families need help with other non-related health services. To address these problems, the Task Force recommends:

- Recommendation 5.9
  The Veterans Administration should continue to work with appropriate partners to provide training for mental health and substance abuse professionals, DMHDDSAS and LME agency staff, primary care providers, psychiatrists, school personnel, and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families. In addition, the North Carolina General Assembly should appropriate $200,000 in SFY 2010 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

The Task Force recognized that the state will be unable to address any of these issues without an adequate supply of qualified substance abuse professionals. North Carolina

[1] AHEC provides 6-hour trainings for different health professionals, and one-hour webinars are available to primary care providers through I-CARE.

has begun to build a cadre of qualified substance abuse professionals, but more people are needed to expand the supply of licensed and certified substance abuse providers as well as physicians and other health care professionals and counselors with addiction training. The North Carolina Substance Abuse Professional Practice Board (NCSAPPB) offers seven different types of substance abuse credentials.[2] The number of qualified substance abuse professionals varies considerably across the state. Although all LMEs have some substance abuse clinicians who can provide services directly to people with addiction disorders, the availability of these professionals varies considerably across the state. In September 2008, there were eight counties that had no qualified substance abuse clinicians and another 33 counties with five or fewer clinicians. Other health professionals—such as physicians, nurse practitioners, physician assistants, licensed clinical social workers, psychologists (PhD), licensed marriage or family therapists, or licensed professional counselors—are authorized under their licensure laws to provide substance abuse services. These professionals can provide substance abuse services directly under their own licensure laws. However, available data suggests that there are few health professionals who are providing substance abuse services. There are no health professionals with addiction specialties in the eight counties that lack licensed, credentialed, or certified substance abuse professionals. Further, there continues to be a large discrepancy in the availability of all substance abuse clinicians even when including licensed health professionals. Polk County has the highest proportion of licensed, credentialed, or certified substance abuse clinicians (including both substance abuse and health professionals) to estimated population in need of substance abuse services, with one clinician to every 48 people with a substance abuse disorder.[3] Aside from the eight counties with no clinicians, Pasquotank has the fewest clinicians, with one clinician for every 3,092 people estimated to be in need of substance abuse services. State and local agencies have particular problems attracting qualified substance abuse professionals because of the low state pay grades assigned to people with these credentials.

Although data are not available about the total number of licensed health and counseling professionals who provide substance abuse services, anecdotal information presented to the Task Force from organizations that hire qualified substance abuse professionals to provide counseling and other substance abuse services all point to the serious workforce shortage.{{1405 Holliman, Ellen;1408 Pharr, Martin; 1406 Stein, Flo; }} The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services commissioned a workforce study to examine the adequacy of the behavioral health workforce and found significant behavioral health workforce shortage in the state.{{1396 North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services; }} North Carolina has several other scholarship or loan forgiveness

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[2] Licensed Clinical Addiction Specialists (LCAS), LCAS-Provisional (LCAS-Provisional), Certified Clinical Supervisor (CCS), Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Prevention Consultant (CSAPC), Certified Substance Abuse Residential Facility Director (CSARFD), and Certified Criminal Justice Addictions Professional Credential (CCJP).

[3] This ratio examines the number of substance abuse or health professionals to population estimated to be in need of substance abuse services. The population figure includes all people who are estimated to have substance abuse disorders, not just those expected to seek services through the public substance abuse system. The clinicians include CSAC, LCAS-P, LCAS, Certified Substance Abuse Peer Specialists, physicians, PAs, NP, RNs, and LPNs.

programs targeted to produce certain types of professionals who are in short-supply in the state. The Task Force recommended that North Carolina adopt a similar approach to encourage more individuals to be trained as substance abuse providers. A summary of the Task Force's recommendations are listed here. The full text is included in Chapter 6.

- **Recommendation 6.1**
  (PRIORITY RECOMMENDATION)
  The North Carolina General Assembly should appropriate $750,000 in recurring funds in SFY 2010, $1.5 million in recurring funds in SFY 2011, increasing to $2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, masters degrees, or those who are seeking to pay for their hours of supervised training needed for their license. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every $4,000 in scholarship funds. In addition, the General Assembly should appropriate $200,000 in recurring funds to the Area Health Education Centers program to establish clinical training sites for people seeking their substance abuse professional credentials.

- Recommendation 6.2
  The North Carolina General Assembly should appropriate $200,000 in recurring funds to the Area Health Education Centers program to develop and support new residency training rotations for psychiatrists, family physicians, emergency medicine, or other physicians likely to enter the addiction field.

- Recommendation 6.3
  The North Carolina State Personnel Commission should reevaluate and increase the pay grades for substance abuse professionals with appropriate credentials recognized by the North Carolina Substance Abuse Professional Practice Board.

The Task Force also examined the data needs of the state. North Carolina needs good data to make informed policy choices. Not only does the state need to enhance its data collection capacity, it also needs to enhance its analytic capability to better identify needed changes in the existing substance abuse service system. A summary of the Task Force's recommendations regarding data is listed below. The full text of these recommendations is found in Chapter 7 of the report.

- Recommendation 7.1
  The North Carolina General Assembly should appropriate $1.2 million in recurring funds to DMHDDSAS to enhance and expand the current data system. Funding should be used to develop an information technology plan, including

adoption of electronic health records, and to develop additional analytic capacity and undertake studies to understand systemic patterns and barriers to identification, referral, and engagement of consumers in treatment.

- Recommendation 7.2
  The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with other agencies, including the Departments of Juvenile Justice and Delinquency Prevention, Corrections, and other Health and Human Services agencies to collect comprehensive data on substance abuse prevention and treatment services and people served with public funds. Further, the North Carolina General Assembly should adopt an equalization formula to ensure that Local Management Entities receive comparable funding to achieve equity in access to care and services.

The importance of a comprehensive substance abuse delivery system cannot be overstated. Our failure to adequately prevent, treat, and provide recovery supports to people with addiction problems has huge implications to our state. We can no longer afford to stigmatize and ignore people with addiction problems. Rather, we need to work together to ensure that appropriate evidence-based education, prevention, treatment, and recovery resources are available and accessible throughout the state. This will take the involvement of many different agencies, providers, and treatment professionals. This report provides a roadmap that can be used to ensure that comprehensive publicly-funded substance abuse services are available throughout the state. However, more work is needed to examine substance abuse workforce issues, financing options (including performance-based contracts to reward positive outcomes), and the availability and adequacy of services offered through other public and private organizations.

APPENDIX F
RECOMMENDATIONS OF THE TASK FORCE ON SUBSTANCE ABUSE SERVICES

CHAPTER 4: SUBSTANCE ABUSE COMPREHENSIVE SYSTEM OF CARE

Prevention

Recommendation 4.1 (PRIORITY RECOMMENDATION)

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.**
   1) **DMHDDSAS should work with appropriate stakeholders to develop, implement, and monitor the prevention plan at the state and local level. Stakeholders should include, but not be limited to, other public agencies that are part of the Cooperative Agreement Advisory Board, consumer groups, provider groups, and Local Management Entities (LMEs).**
   2) **DMHDDSAS should direct LMEs to involve similar stakeholders to develop local prevention plans that are consistent with the statewide comprehensive substance abuse prevention plan.**

b) **North Carolina General Assembly should appropriate $1,945,000 in SFY 2010 and $3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to develop this comprehensive substance abuse prevention.**

c) **Of the recurring funds appropriated by the North Carolina General Assembly, $1,770,000 in SFY 2010 and $3,547,000 in SFY 2011 should be used to fund six pilot projects to implement county or multi-county comprehensive prevention plans consistent with the statewide comprehensive substance abuse prevention plan. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three MHDDSAS regions across the state. Technical assistance should be provided to the selected communities by the regional Centers for Prevention Resources. LMEs should serve as fiscal and management agencies for these pilots. The six pilot projects should:**
   1) **Involve community agencies, including but not limited to the following: Local Management Entities, local substance abuse providers, primary care providers, health departments, social services departments, local education agencies, local universities and community colleges, Healthy Carolinians, local tobacco prevention and anti-drug/alcohol coalitions, juvenile justice**

organizations, and representatives from criminal justice, consumer, and family advisory committees.

2) **Be comprehensive, culturally appropriate, and based on evidence-based programs, policies, and practices.**
3) **Be based on a needs assessment of the local community that prioritizes the substance abuse prevention goals.**
4) **Include a mix of strategies designed for universal, selective, and indicated populations.**
5) **Include multiple points of contact to the target population (ie, prevention efforts should reach children, adolescents, and young adults in schools, community colleges and universities, and community settings).**
6) **Be continually evaluated for effectiveness and undergo continuous quality improvement.**
7) **Be consistent with the systems of care principles.**
8) **Be integrated into the continuum of care.**

d) **The North Carolina General Assembly should appropriate $250,000 of the Mental Health Trust Fund or from general funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to arrange for an independent evaluation of these pilot projects and for implementation of the state plan. The evaluation should include, but not be limited to, quantifying the costs of the projects; identifying the populations reached by the prevention efforts; and assessing whether the community prevention efforts have been successful in delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents, and young adults. The evaluation should also include other community indicators that could determine whether the culture of acceptance of underage drinking or other inappropriate or illegal substance use has changed, including but not limited to arrests for driving under the influence, underage drinking, or use of illegal substances; alcohol and drug related traffic crashes; reduction in other problem indicators such as school failure; and incidence of juvenile crime and delinquency.**

e) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should use the findings from the independent evaluation of prevention services to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.**

Recommendation 4.2

a) The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, North Carolina Community College System, and University of North Carolina System to review their existing substance abuse prevention plans, programs and/or policies, and availability of substance abuse screening and treatment services, in order to ensure that these educational institutions offer comprehensive substance abuse prevention, early intervention and treatment services to students enrolled in their schools. These institutions should submit a description of their prevention plans,

programs and/or policies, procedures for early identification of students with substance abuse problems, and information on screening, treatment, and referral services to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Appropriations Subcommittee on Education, and Education Committees no later than the convening of the 2010 session. The description should include the following:

1) Information about what evidence-based or promising prevention programs, policies, and practices have been or will be implemented to prevent or delay children, adolescents, and young adults from initiating the use of tobacco, alcohol, or other drugs, or reducing the use among those who have used these substances in public schools, community colleges, and the public universities.[1]
2) Information from the State Board of Education on how local education agencies have implemented the substance abuse component of the Healthful Living Curriculum, including the educational curriculum or other services provided as part of the Safe and Drug Free Schools Act.
3) A plan from the Office of Non-Public Education to incorporate similar prevention strategies into home school and private school settings.
4) Information from the State Board of Education, North Carolina Community College System and the University of North Carolina System on the schools treatment referral plans, including linkages to the Local Management Entities and other substance abuse providers, the criteria used to determine when students need to be referred, and whether follow-up services and recovery supports are available on campus or in the community.

b) The Department of Public Instruction, North Carolina Community College System, and University of North Carolina system should coordinate their prevention efforts with the other prevention activities led by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to ensure the development of consistent messages and optimization of prevention efforts. Prevention efforts should be based on evidence-based programs that focus on intervening early and at each stage of development with age appropriate strategies to reduce risk factors and strengthen protective factors before problems develop.

Recommendation 4.3

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the North Carolina Division of Alcohol Law Enforcement; the Division of Public Health; and the Department of Public Instruction should develop a strategic plan to further reduce tobacco and alcohol sales to minors.

Recommendation 4.4 (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should increase the tax on a pack of cigarettes to meet the current national average. The cigarette tax should be

[1] The Task Force was unable to identify any evidence-based strategies that had been tested to prevent, delay, or reduce the use of alcohol or drugs on a community-college setting, as the students are commuters and generally older than on college campuses. Therefore, the Task Force recommended that the North Carolina Community College System identify best practices for use in a community college system.

regularly indexed to the national average whenever there is a difference of at least 10% between the national average cost of a pack of cigarettes (both product and taxes) and the North Carolina average cost of a pack of cigarettes.

b) **The North Carolina General Assembly should increase the tax on all other tobacco products to be comparable to the current national cigarette tax average, which would be 50% of the product wholesale price.**

c) **The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco and other drugs.**

Recommendation 4.5

The North Carolina General Assembly should appropriate $1.5 million in recurring funds to the Division of Public Health to support Quitline NC. The Division of Public Health should use some of this funding to educate providers and the public about the availability of this service.

Recommendation 4.6 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should enact a law which prohibits smoking in all public buildings including, but not limited to, restaurants, bars, and worksites.

Recommendation 4.7 (PRIORITY RECOMMENDATION)

a) **In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). Malt beverages are the alcoholic beverages of choice among youth, and youth are sensitive to price increases.**

b) **The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. The excise tax for beer was last increased in 1969, and wine was last increased in 1979. The increased fees should be used to support prevention and treatment efforts for alcohol, tobacco, and other drugs.**

c) **The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco and other drugs.**

d) **The General Assembly should appropriate $2.0 million in recurring funds in SFY 2010 to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation, reduce underage alcohol consumption, reduce alcohol abuse or dependence, and support recovery among adolescents and adults.**

Recommendation 4.8

The North Carolina General Assembly should not lower the drinking age to less than age 21.

Recommendation 4.9 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate $610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

a) **$500,000 per year should be used to be used to replicate the Study to Prevent Alcohol Related Consequences (SPARC) intervention at six additional North Carolina public universities by establishing campus/community coalitions that use a community organizing approach to implement evidence-based, environmental strategies.**
b) **$110,000 per year should be allocated to provide coordination, monitoring and oversight, training and technical assistance, and evaluation of these campus initiatives.**

Recommendation 4.10

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Public Health; the Division of Social Services; and appropriate provider associations should develop a prevention plan to prevent fetal alcohol spectrum disorders and report this plan to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009. The plan should include baseline data and evidence-based strategies that have been shown to be effective in reducing use of alcohol in pregnant women and adolescents as well as strategies for early screening and identification, intervention, and treatment for children who are born with fetal alcohol spectrum disorders. The plan should:
    1) Focus on women and adolescents at most risk of giving birth to children with fetal alcohol spectrum disorders.
    2) Identify a standardized substance abuse screening tool that local health departments, primary care and obstetrical providers can use for early identification and appropriate referral for services for pregnant women.
    3) Include strategies to educate, train, and support caregivers of children born with fetal alcohol spectrum disorders.
    4) Identify strategies to educate primary care providers about early identification of infants and young children born with fetal alcohol syndrome disorder, available treatment, and community resources for the affected children and their families.

Recommendation 4.11

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should work with the NC Medical Society, NC Academy of Family Physicians, NC Psychiatric Association, NC Chapter of the American Society of Addiction Medicine, Governor's Institute on Alcohol & Substance Abuse, physician representation from the CSRS Advisory Committee and NC Office of the Attorney General to explore options to allow for the exchange of information obtained from the CSRS between health care practitioners.

Early Intervention Services

Recommendation 4.12

a) North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers (AHEC) program, residency programs, health professional associations, and other appropriate organizations

should expand SBIRT training for primary care providers and other health professionals in academic and clinical settings, residency programs or other continuing education programs with the goal of expanding the health professional workforce that has demonstrated competencies in SBIRT. The curriculum should include information and skills building training on:

1) Evidence-based screening tools to identify people who have or are at risk of tobacco, alcohol or substance abuse or dependency.
2) Motivational interviewing.
3) Brief interventions including counseling and brief treatment
4) Assessments to identify people with co-occurring mental illness.
5) Information about appropriate medication therapies for people with different types of addiction disorders.
6) Successful strategies to address commonly cited disincentives to care for patients in a primary care.
7) Strategies to successfully engage people with more severe substance abuse disorders and refer them to specialty addiction providers for treatment services.
8) The importance of developing and maintaining linkages between primary care providers and trained addiction specialists to ensure bi-directional flow of information and continuity of care.

Recommendation 4.13 (PRIORITY RECOMMENDATION)

a) **The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should work collaboratively with the North Carolina Office of Rural Health and Community Care (ORHCC), the Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate professional associations to educate and encourage healthcare professionals to use evidence-based screening tools and offer motivational counseling, brief intervention, medication assisted therapies, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the SBIRT model.**

b) **The North Carolina General Assembly should appropriate $1.5 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to work with the aforementioned groups to develop a plan to implement SBIRT within primary care and ambulatory care settings. The plan should include:**

   1) **Mental health and substance abuse system specialists to work with the 14 Community Care of North Carolina (CCNC) networks and other provider groups. These staff will work directly with the CCNC practices to implement and sustain evidenced-based practices and coordination of care between primary care and specialty services. This would include but not be limited to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model allowing for primary care providers to work toward a medical home model that has full integration of physical health, mental health, and substance abuse services. In keeping with the SBIRT model, the mental health and**

substance abuse system specialists would work within communities to develop systems that facilitate smooth bidirectional transition of care between primary care and specialty substance abuse care.

2) **Efficient methods to increase collaboration between providers on the shared management of complex patients with multiple chronic conditions that is inclusive of mental health, developmental disabilities, and substance abuse. An effective system would smooth transitions, reduce duplications, improve communication, and facilitate joint management while improving the quality of care.**
3) **A system for online and office-based training and access to regional quality improvement specialists and/or a center of excellence that would help all healthcare professionals identify and address implementation barriers in a variety of practice settings such as OB/GYN, emergency room, and urgent care.**
4) **Integrated systems for screening, brief intervention, and referral into treatment in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.**

Recommendation 4.14

The North Carolina General Assembly should expand the services covered under the NC Health Choice program to provide coverage for annual wellness visits for children and adolescents. The wellness visit should include but not be limited to:

a) An annual psychosocial behavioral assessment.
b) An annual screening for tobacco, alcohol, and drug use, beginning at age 11.
c) Brief intervention and/or anticipatory guidance at the time of screening.

Recommendation 4.15

a) The North Carolina Office of Rural Health and Community Care should work in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Governors Institute on Alcohol and Substance Abuse; the ICARE partnership; and other professional associations to support and expand co-location in primary care practices of licensed health professionals trained in providing substance abuse services.
b) The General Assembly should provide $750,000 in recurring funds to the North Carolina Office of Rural Health and Community Care to support this effort. Primary care practices eligible for state funding include private practices, federally qualified health centers, local health departments, and rural health clinics that participate in CCNC. Funding can be used to help support the start-up costs of co-location of licensed substance abuse professionals in primary care practices for services provided to Medicaid and uninsured patients. Alternatively, funding may be used to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to be qualified to provide substance abuse services to Medicaid and uninsured patients with substance use disorders. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the

use of or dependency on tobacco, alcohol, and other drugs. Funding priority should be given to practices that meet one or more of the following criteria:

1) Primary care practices with a co-located mental health professional.
2) Primary care practices with a significant population of dually diagnosed patients with mental health and substance abuse problems who have prior experience in screening and intervention for mental health and/or substance abuse problems.
3) Primary care practices actively involved in other chronic disease management programs.

Recommendation 4.16 (PRIORITY RECOMMENDATION)

a) **The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.**
b) **The North Carolina General Assembly should direct the Division of Medical Assistance, NC Health Choice program, State Health Plan, and other insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to screen for tobacco, alcohol, and drugs, provide brief intervention and counseling, and refer necessary patients for specialty services.**
    1) **Specifically, the plans should provide reimbursement for:**
        i) **Screening and brief intervention in different health settings including, but not limited to, primary care practices (including OB/GYN, federally qualified health centers, rural health clinics, and hospital-owned outpatient settings), emergency departments, Ryan White Title III medical programs, and school-based health clinics.**
        ii) **CPT codes for health and behavior assessment (96150-96155), health risk assessment (99420), substance abuse screening and intervention (99408, 99409), and tobacco screening and intervention (99406, 99407) and should not be subject to therapy code preauthorization limits.**
        iii) **Therapy codes (90801-90845) for primary care providers who integrate qualified mental health professionals into their practices.**
        iv) **Appropriate telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists. Specifically, payers should explore the appropriateness of reimbursing for CPT codes for consultation by a psychiatrist (99245).**
    2) **Reimbursement for these codes should be allowed on the same day as a medical visit's evaluation and management (E&M) code when provided by licensed mental health and substance abuse staff.**
    3) **Fees paid for substance abuse billing codes should be commensurate with the reimbursement provided to treat other chronic diseases.**
    4) **Insurers should allow psychiatrists to bill using E&M codes available to other medical disciplines.**
    5) **Providers eligible to bill should include licensed healthcare professionals including, but not limited to, primary care providers, mental health and substance abuse providers, emergency room professionals, and other**

healthcare professionals trained in providing evidence-based substance abuse and mental health screening and brief intervention.

c) The Division of Medical Assistance should work with the Office of Rural Health and Community Care (ORHCC) to develop an enhanced Carolina Access (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.

d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings.

<u>Comprehensive System of Specialized Substance Abuse Services</u>

Recommendation 4.17 (PRIORITY RECOMMENDATION)

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan organized around a recovery-oriented system of care to ensure that an appropriate mix of substance abuse services and recovery supports for both children and adults is available and accessible throughout the state. The plan should utilize the American Society of Addiction Medicine (ASAM) levels of care. In developing this plan, DMHDDSAS should:
    1) Develop a complete continuum of locally and regionally accessible substance abuse crisis services and treatment and recovery supports.
    2) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, emergency departments, or recovery supports.
    3) Develop a minimum geographic-based access standard for each service. In developing its plan, DMHDDSAS should identify strategies for building an infrastructure in rural and underserved areas.
    4) Include evidence-based guidelines for the number of patients to be served, array of services, and intensity and frequency of the services.

b) DMHDDSAS should work with LMEs and providers to develop a more comprehensive performance based accountability plan that includes incentives and contract requirements between the Division, LMEs and providers.
    1) The plan should include meaningful substance abuse performance measures for LMEs and providers to ensure that: substance abuse services are successfully extended to a significant portion of those persons in need, substance abuse services are provided to individuals in a timely fashion, people are provided the

intensity of services appropriate to their needs, people are engaged in treatment for appropriate lengths of time, individuals successfully complete treatment episodes, and that these individuals are provided appropriate recovery supports.

2) This plan may include, but not be limited to: financial incentive payments, regulatory and/or monitoring relief, advantages in the competitive bidding process, independent peer review recognition, and broader infrastructure support.
3) The plan should strengthen the Division's current performance benchmarking system for LMEs, including the establishment of more rigorous performance standards and targets for LMEs.
4) The plan should develop a similar performance benchmarking system for LMEs to use with providers. The benchmarking system for providers should include, but not be limited to measures of: active engagement, consumer outcomes, fidelity with evidence based or best practices, client perception of care, and program productivity.
5) In developing the plan, DMHDDSAS, LMEs and providers should consider other incentive strategies developed by the National Institute on Drug Abuse Blending Initiative.
6) The plan should include data requirements to ensure that program performance is measured consistently by LMEs and providers across the state.

c) DMHDDSAS should develop a plan to implement electronic health records for providers that use public funds.
d) DMHDDSAS should develop consistent requirements across the state that will reduce paperwork and administrative barriers including but not limited to:
    1) Uniform forms for admissions, screening, assessments, treatment plans, and discharge summaries that are to be used across the state.
    2) Standard contract requirements and a system that does not duplicate paper work for agencies that serve residents of multiple Local Management Entities (LMEs).
    3) Methods to ensure consistency in procedures and services across LMEs along with methods to enforce minimum standards across the LMEs. Enforcement methods should include, but not be limited to, remediation efforts to help ensure consistent standards.
    4) Standardized outcome measures.
e) DMHDDSAS should develop a system for timely conflict resolutions between LME and contract agencies.
f) DMHDDSAS should work with its Provider Action Agenda Committee to identify barriers and strategies to increase the quality and quantity of substance abuse services and providers in the state. These issues include, but are not limited to, administrative barriers, service definitions, and reimbursement issues.
g) DMHDDSAS, in collaboration with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, should immediately begin expanding the capacity of needed adolescent treatment services across the state including new capacity in the clinically intensive residential programs, consistent and effective screening, assessment, and referral to

appropriate treatment and recovery supports for identified youth. In addition, the plan should systematically strengthen early intervention services for youth and adolescents in mainstream settings such as schools, primary care, and juvenile justice venues.

h) DMHDDSAS should report the plans specified in Recommendation 4.17.a-b, report on the progress in developing the plan for electronic health records in Recommendation 4.17.c, and report on progress made in implementing Recommendations 4.16.d-g to the NC IOM Task Force on Substance Abuse Services and Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than September 2008.

Recommendation 4.18

a) The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services should select six county or multi-county regions to develop and implement a recovery-oriented system of care.

b) The North Carolina General Assembly should appropriate $17.2 million in SFY 2010 and $34.4 million in SFY 2011 to DMHDDSAS in recurring funding to support these six pilot programs. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three MHDDSAS regions across the state. Funding should include planning, evaluation, and technical assistance. The pilot programs should:
    1) Identify those in need of treatment.
    2) Ensure or provide a comprehensive continuum of services for adolescents and adults. Services should include screening, counseling, brief treatment, and the full spectrum of ASAM services for both adolescents and adults.
    3) Provide recovery supports for those who return to their communities after receiving substance abuse specialty care, including Oxford Houses or other appropriate recovery supports. The goal of the project is to reduce the length and duration of relapses that require additional specialty SA care. Programs should work closely with existing recovery services, programs, and individuals and build on the foundations that exist in their local communities.
    4) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, hospitals, or recovery supports.

c) The North Carolina General Assembly should appropriate $750,000 of the Mental Health Trust Fund or general appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to arrange for an independent evaluation of these pilot programs. The evaluation should examine whether the comprehensive pilot programs lead to increased number of patients served, timely engagement, active participation with appropriate intensity of services, and program completion.

d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should use the findings from the independent evaluation of the pilot programs implementing county or multicounty recovery-oriented systems of care to develop a plan to implement the successful strategies statewide. The plan should be presented to the

Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

Recommendation 4.19 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate:

a) **$650,000 in recurring funds to DMHDDSAS to hire 13 FTE staff to assist in developing and implementing a statewide comprehensive prevention plan, a recovery-oriented system of care, a plan for performance-based incentive contracts, and consistent standards across the state to reduce paperwork and administrative barriers; oversee and provide technical assistance to the pilot programs; and otherwise help implement the Recommendations 4.1-4.3, 4.9-4.10, 4.13, 4.15-4.18 and Recommendation 5.1, supra.**

b) **$100,000 in recurring funds to the Department of Public Instruction to hire staff to implement Recommendations 4.1-4.3, and 4.17 above.**

c) **$130,000 in recurring funds to ORHCC to hire a statewide coordinator and administrative support to work directly with the regional CCNC quality improvement specialists funded in recommendation 4.13 and to assist in implementing recommendation 4.15.**

CHAPTER 5: SUBSTANCE ABUSE PREVENTION AND TREATMENT PROGRAMS TARGETED TO SPECIFIC SUBPOPULATIONS

Children, Youth, and Young Adults

Recommendation 5.1

a) The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should continue to work with the Department of Juvenile Justice and Delinquency Prevention to expand the pilot test of the DMHDDSAS-DJJDP Cross Area Service Program model in two additional DJJDP regions.

b) The North Carolina General Assembly should appropriate $500,000 in recurring funds to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to support this pilot.

c) If successful, the DMHDDSAS-DJJDP Cross Area Service Program model should be rolled out statewide.

Adults

Recommendation 5.2:

a) As part of the annual community assessment, LMEs should explore and report on the need for EAP services by employers in their catchment area and the availability of organizations providing EAP services to meet this need.

b) If the LME determines that there are insufficient EAP providers to address the needs of employers, then the LMEs should work with the local Chambers of Commerce, other

business organizations and others to develop a strategy to promote the availability of EAP services in the community.

Recommendation 5.3:
The North Carolina General Assembly should ensure that by 2014:

a) All individuals advertising and promoting themselves as providing EAP services in NC must be licensed or have EAP specific training and work under the supervision of professionals licensed to provide EAP services by the North Carolina Board of Employee Assistance Professionals.
b) All programs or organizations located in North Carolina that advertise, or promote themselves, as providers of EAP services should be able to document that they have the capability of providing the core services as defined in statute and that the services are provided under the supervision of NC licensed EAP staff.

Recommendation 5.4
The North Carolina General Assembly should appropriate $475,000 in recurring funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, for seven full-time Licensed Clinical Addiction Specialists to be distributed to the LMEs with the highest number of referrals for the Work First, Class H or I Controlled Substance felons and CPS populations compared to existing Qualified Professionals in Substance Abuse.

Recommendation 5.5
The North Carolina General Assembly should appropriate $2.8 million in recurring funds in SFY 2010 and an additional $2.8 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to expand the availability of TASC services.

Recommendation 5.6
The North Carolina General Assembly should appropriate $500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of CJPP-funded substance abuse services.

Recommendation 5.7 (PRIORITY RECOMMENDATION)

a) **The North Carolina General Assembly should increase the annual appropriations to the Administrative Office of the Courts to fund eight new adult drug treatment courts. The amount of the increased appropriations should be as follows:**
    1) **$500,000 in recurring funds in SFY 2010 for four new adult drug treatment court coordinators**
    2) **$500,000 in recurring funds in SFY 2011 for four new adult drug treatment court coordinators**
b) **The North Carolina General Assembly should increase the appropriations to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services by $570,000 in recurring funds in SFY 2010 and an additional $570,000 in**

recurring funds in SFY 2011 to support treatment services for adult drug treatment court participants.

c) **The North Carolina General Assembly should increase the annual appropriations to the Department of Correction, Division of Community Corrections by $269,940 in recurring funds in SFY 2010 to fund four new probation officers and an additional $269,940 in recurring funds in SFY 2011 to fund an additional four probation officers to support the new drug treatment courts.**

Recommendation 5.8:
The North Carolina General Assembly should:

a) Appropriate $1,500,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs to expand the availability of state substance abuse services to adults within the prison system.
b) Appropriate $2,000,000 in recurring funds in FY 2010 to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs to build one additional residential treatment facility for female adult offenders with substance abuse and addiction problems who are on probation or parole.
c) Appropriate $1,000,000 in recurring funds in FY 2010 to the NC Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the existing residential treatment facility at DART Cherry in Goldsboro for adult male offenders with substance abuse and addiction problems who are on probation and parole.
d) Appropriate $12,500 in non-recurring funds to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to study the feasibility of establishing a single mission drug treatment and re-entry prison for offenders with substance abuse and addiction problems.

Military Personnel

Recommendation 5.9

a) The Veterans Administration should:
   1) Continue to work with appropriate partners to provide training for mental health and substance abuse professionals, DMHDDSAS and LME agency staff, primary care providers, psychiatrists, school personnel and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families.
   2) Provide consultation services for veterans being treated by community-based primary care providers, mental health or substance abuse professionals.
   3) Work with the North Carolina Division of Social Services, Department of Housing and Urban Development, and other community agencies to ensure that veterans learn of other support services, such as housing vouchers, employment opportunities, and family services.
b) The North Carolina General Assembly should appropriate $200,000 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

CHAPTER 6: SUBSTANCE ABUSE WORKFORCE

Recommendation 6.1 (PRIORITY RECOMMENDATION)

a) **The North Carolina General Assembly should appropriate $750,000 in recurring funds in SFY 2010, $1.5 million in recurring funds in SFY 2011, increasing to $2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be used to:**
   1) **Pay up to $3,000 per year for up to two years of community college training for 50 students enrolled in a human services program with the intention to enter the substance abuse field**
   2) **Pay up to $5,000 per year for up to four years of undergraduate training for 50 qualified undergraduates who have declared a major in a human services occupation that would meet the requirements for LCAS, CSAC, CSAPC, CSARFD, or CCJP**
   3) **Pay up to $5,000 per year for up to two years of graduate level substance abuse training to 50 eligible individuals with a bachelors degree who has been accepted into one of North Carolina's master's level substance abuse programs.**
   4) **Pay up to $2,000 per year for up to two years to purchase training or supervision hours for 50 qualified individuals with a bachelors or masters degree in an appropriate field who are working towards CSAC, LCAS or CCS licensure**
   5) **Students who receive scholarship funds would be required to work for one year in a public or private not-for-profit substance abuse treatment program for every $4,000 received in scholarship funds and would be required to pursue substance abuse licensure or certification.**
   6) **Students who do not complete their substance abuse training or licensure, or who fail to meet the work requirements would be required to pay back the scholarship funds with 10% interest with appropriate time standards.**

b) **The North Carolina General Assembly should appropriate $200,000 in recurring funds in FY 2010 to the Area Health Education Centers program to create and incentivize five programs to serve as substance abuse clinical training sites for people seeking CSAC, LCAS, CCS, CCJP, CSARFD or CSAPC credential.**

Recommendation 6.2

a) The Area Health Education Centers Program should work with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Psychiatric Association, and other relevant organizations to develop residency rotations for psychiatrists and other physicians in addiction medicine. The goal is to develop new residency training opportunities in ADATCs and other appropriate settings to improve the substance abuse training of psychiatrists, family physicians, emergency medicine or other physicians likely to enter into the addiction field for adolescents or children in both inpatient and outpatient settings.

b) The North Carolina General Assembly should appropriate $200,000 in recurring funds SFY 2010 to the Area Health Education Centers program to develop and support new residency training rotations in substance abuse.

Recommendation 6.3
The NC State Personnel Commission should:

a) Reevaluate and increase the pay grades for substance abuse professionals with a LCAS, CCS, CSAC, CCJP and CSAPC credentials.
b) Allow for a trainee progression for LCAS and CCS.

CHAPTER 7: DATA

Recommendation 7.1

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop a long term consumer-centered Information Technology (IT) vision and plan to meet the state's data needs through enhanced integration of current systems, including the statewide adoption of an Electronic Health Record among community providers and LMEs.
b) The North Carolina General Assembly should appropriate $1.2 million in recurring funds to DMHDDSAS to enhance and expand current data collection systems and develop new data systems as needed to provide epidemiological information on people with substance abuse issues across the lifespan.
c) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop capacity to utilize data to identify patterns and trends in the prevalence, prevention, and treatment of substance abuse so as to provide an evidence-based process for the development and evaluation of prevention and treatment interventions, as well as provide a data-driven platform for the funding of prevention and treatment programs across the state.
d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should review national research on patterns of consumer participation and client referral within the substance abuse prevention and treatment systems. Special studies should be undertaken as needed to determine if there are systemic patterns and barriers to identification, referral, and engagement of substance abuse consumers into treatment in North Carolina.
e) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should enhance their collection and analysis of data on substance abuse services to include information on:
    1) Active identification and timely screening, triage, and referral into care for substance abuse consumers separately from other disability groups.
    2) Timely and effective coordination of care between screening, triage, and referral (STR) and engagement in treatment.
    3) Length of time in treatment.
    4) Responsiveness of community systems, including utilization of inpatient programs, as is currently done for detox and outpatient programs.
    5) Admission and readmission into ADATCs, as is currently done for state hospitals.
    6) Continuity of care after discharge from detox and inpatient programs, as is currently done for ADATCs, and state hospitals.
    7) Provision of recovery-oriented treatment and support within communities.

Recommendation 7.2

a) The Department of Juvenile Justice (Juvenile Crime Prevention Council), Department of Corrections (Criminal Justice Partnership program), Division of Public Instruction, Division of Social Services, Division of Public Health, and county commissioners should provide data to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services quarterly on public funds used to support substance abuse prevention and treatment services, number of people served, and types of services provided in each county.

b) The North Carolina General Assembly should choose and implement an equalization formula to ensure that Local Management Entities (LMEs) receive comparable funding to achieve equity in access to care and services while recognizing the inherent challenges of delivering services in low-wealth rural counties. This equalization formula should be used to distribute any new state funds provided to support substance abuse prevention and treatment activities, with low-funded LMEs obtaining a higher proportion of the funding.

Attachment 3

Report

to the

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

On

Recommendations on the Death Reporting Requirements under North Carolina General Statute 122C-26(5)c

Session Law 2008-131
Senate Bill 1770
Section 3

December 2, 2008

North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services: Report on Death Reporting Requirements

December 2, 2008

Pursuant to Session Law 2008-131, Senate Bill 1770, the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (Commission) is charged with studying the current death reporting requirements under N.C. Gen. Stat. 122C-26(5)c and assessing the need for any additional reporting requirements or modifications to existing rules or procedures.

The Commission, per the request from the North Carolina General Assembly, reviewed the process of death reporting from state-operated facilities and other mental health, developmental disabilities and substance abuse services facilities and heard several presentations from the North Carolina Department of Health and Human Services Divisions of Health Services Regulation and Mental Health, Developmental Disabilities and Substance Abuse Services. The Commission found the current reporting requirements for State-operated, licensed and unlicensed facilities to be unduly complex, with different timelines and reporting requirements depending on the type of death and whether the facility is State-operated, licensed or unlicensed (see attached reporting grids).

N.C. Gen. Stat. 122C-31 states that, *"A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide."* However, *by policy* State-operated facilities (and not other facilities) must report *all deaths* regardless of cause. In addition, more recent legislation amended N.C. Gen. Stat. 122C-31 to require reporting in a licensed facility to the local Medical Examiner. See N.C. Gen. Stat. 122C-31(g).

The Commission's recommendations regarding all facilities are as follows:

- The Commission recognizes that the current reporting system has been developed and modified over time by statute, rule and policy.
- Wherever possible, these reporting requirements should be consistent and set forth in the North Carolina General Statutes.
- Statutes should also better reflect the diversity of the current facilities and programs serving mh/dd/sas clients.
- In addition, in smaller programs and services true independent internal review of deaths is not feasible at present. Independent review should be implemented.

The Commission's recommendations regarding State-operated facilities are listed below:

- For patients who die shortly after discharge, deaths may not be reported back to the facility, creating barriers to compliance. Ways to improve this linkage and reporting should be studied.
- For deaths occurring in State-operated facilities, any lapses in mandated death reporting should be regarded as a management problem for which the Directors of the facilities and their designees should be held strictly accountable.

Finally, the Commission recommends that the North Carolina General Assembly further study death reporting requirements and to the extent that is feasible:

- assure maximal consistency of reporting and review requirements across all types of facilities;
- assure independent review of deaths; and
- assure all State and LME reporting and reviewing responsibilities are clearly delineated and coordinated.

	State Operated[1]	Licensed	Unlicensed
Statutes	1. **NCGS 122C-31** – Any death in a State operated facility must be reported by the facility to the Medical Examiner in the county where the death occurs [cross reference 130A-383(a)] Additionally, a facility must notify the Secretary immediately upon death of any client of the facility that occurs within 7 days of physical restraint or seclusion, and within 3 days following death from violence, accident, suicide or homicide. (*Also applies to inpatient psychiatric hospitals licensed under NCGS 131E)	1. **NCGS 122C-31** - A facility must notify the Secretary immediately upon death of any client of the facility that occurs within 7 days of physical restraint or seclusion, and within 3 days following death from violence, accident, suicide or homicide. (*Also applies to inpatient psychiatric hospitals licensed under NCGS 131E)[2]	
Rules	1. **10A NCAC 26C .0300 - .0303**[3] – Report deaths to DHSR which occur following restraint and seclusion, or from violence, accident, suicide or homicide.	1. **10 NCAC 26C .0300-.0303** - Report deaths to DHSR which occur following restraint and seclusion, or from violence, accident, suicide or homicide. 2. **10 NCAC 27G .0604** – Must send copy of incident report for Level III incident (all deaths except natural deaths) to the LME and DMH within 72 hours of becoming aware of the incident. All Level II incidents (including natural deaths) must be reported to the LME directly, and the LME sends a report to DMH quarterly.	1. **10 NCAC 26C .301(b)** – Report deaths to DMH/DD/SAS 2. **10 NCAC 27G .0604** – Must send copy of incident report for Level III incident to Home and Host LME(s) and DMH within 72 hours of becoming aware of the incident.
Policies	1. **APSR 4092**- Approved March 26, 2008 – Facilities must report deaths of patients which occur at State operated facilities to the ME in the county in which the body of the deceased is located, to Division of Health Services Regulation, and the State Operated Services of the Division of MH/DD/SAS. If the death resulted while or within 24 hours of the patient being secluded or restrained, facility must report by the close of the next business day. All other deaths in facilities must be reported within 3 business days.		1. **September 20, 2007 Memo** - Effective Oct. 1, 2007, all consumer deaths from Unknown Causes are to be considered and processed as Level III incidents and reported to the home and host LME(s) and the Divisions Quality Management Team.

Created for exclusive use of The North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services. The sole intended use of this document is to assist the Commission in studying death reporting requirements pursuant to N.C. Gen. Stat. 122C-26(5)(c) and Session Law 2008-131. It is not intended as an exhaustive review of all death reporting statutes.

[1] State Operated Facilities are operated under Secretary Rules, pursuant to NCGS 122C-112.1(b)(10)

[2] Facilities, such as adult care homes and facilities for the care of minors are governed by statutory requirements, found in NCGS 131D-34.1 and 131D-10.6, respectively.

[3] .0301 states that licensed facilities shall report client deaths to the Division of Health Service Regulations and unlicensed facilities shall report client deaths to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This death report is restricted in .0303(b) and (c) to deaths following restraint and seclusion, or from violence, accident, suicide or homicide.

	Type of Facility	State Operated Facilities[4]	Licensed Facilities (not state operated)	Unlicensed Facilities (Not State Operated)
	Agency in charge of monitoring/ triaging death reports	DHSR, DMH/DD/SAS and State Operated Services	DHSR, LME, and DMH/DD/SAS (Quality Management Team and Customer Service)	Local Management Entities (Host) and DMH/DD/SAS
TYPE OF DEATH	Restraint and Seclusion (report all deaths occurring within 7 days of restraint and seclusion)	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.* Policy: APSR 4092 Procedure[5]: DHSR triages and immediately initiates investigation of deaths upon receipt of death report; sends report to Disability Rights of NC. Reviewed by the Medical Examiner.	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.*;10A NCAC 27G .0604 Procedure: DHSR triages and immediately initiates investigation of deaths upon receipt of death report; sends report to Disability Rights of NC. If the consumer receives publicly funded mh/dd/sas, providers report to DHSR. Level III deaths reports are submitted to LMEs and DMH/DD/SAS. LME reviews to ensure that death was reported to DHSR.	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Violence, accident, homicide, suicide (report within 3 days)	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.* Policy: APSR 4092 (details reporting procedures to CMS, DHSR, State Operated Services, and the Medical Examiner.) Procedure: DHSR triages and investigates deaths as needed; sends report to Disability Rights of NC. Reviewed by the Medical Examiner.	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.*; 10A NCAC 27G .0604 Procedure: DHSR triages and investigates deaths as needed; sends report to Disability Rights of NC. If the consumer receives publicly funded mh/dd/sas, providers report to DHSR. Level III deaths reports are submitted to LMEs and DMH/DD/SAS. LME reviews to ensure that death was reported to DHSR.	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Unknown	Policy: ASPR 4092 Procedure: Investigation as determined by DHSR and Medical Examiner.	Rule: 10A NCAC 27G .0604 Policy: Sept. 20, 2007 Memo Procedure: LME must report the death to Quality Management of DMH of DMH/DD/SAS. LME will review, triage, and provide monitoring; DMH provides additional follow up as needed.	Rule: 10A NCAC 27G .0604 Policy: Sept. 20, 2007 Memo (all deaths from unknown causes are processed as Level III incidents) Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Natural Causes	Policy: APSR 4092 Procedure: Investigation as determined by DHSR and Medical Examiner.	Rule: 10 NCAC 27G .0604 (Level II incidents are reported the LME, which must report to DMH all Level II incidents quarterly) Procedure: LME will triage, and provide monitoring as needed.	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.

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[4] State Operated Facilities are operated under Secretary Rules, pursuant to NCGS 122C-112.1(b)(10).
[5] These procedures refer to the process various agencies follow after receiving a report of a death.

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

Caring For Previously Hospitalized Consumers: Progress and Challenges in Mental Health System Reform

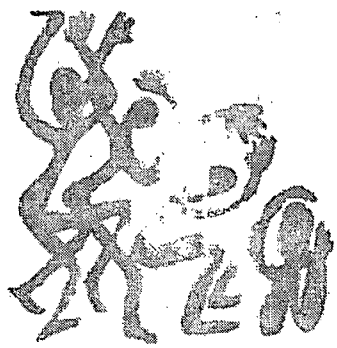
A presentation to the
Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

January 14, 2009

Carol H. Ripple, Ph.D., Principal Program Evaluator

Mental Health Services: Evaluation Purpose

- Examine mental health system services delivered since March 2006
- Provide an independent analysis of data
- Focus on previously hospitalized individuals
- Test the ability of reform to maintain individuals in the community



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Mental Health Services: Evaluation Overview

- Tenets of reform are on target, but improvements are still needed
- The Division of Mental Health, Developmental Disabilities and Substance Abuse should:
  - Develop individualized information systems to track services
  - Continue efforts to strengthen community-based services

Mental Health Services: Scope and Background

Evaluation Scope

- Examine services received since March 2006
  - Previously hospitalized individuals
  - More severely ill, high-risk consumers are likely more costly to serve
  - Important role of community-based services after discharge
- Address research questions
  - What outpatient and hospitalization services were received by previously hospitalized consumers?
  - What factors affected services received?

Report p 2

Background: Care for Individuals with Mental Illness

Intensity of Illness

Community-Based Services

Community Hospital Psych Unit

State Psychiatric Hospital

Report p 3

Background: Care for Individuals with Mental Illness

Intensity of Illness

Community-Based Services

Community Hospital Psych Unit

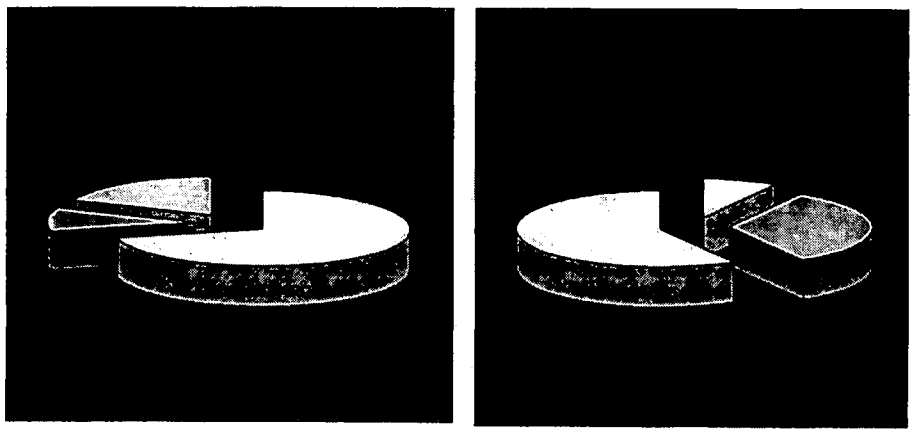
State Psychiatric Hospital

Report p 3

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

Federal Funds Cover a Large Proportion of Community-Based Services

Evaluation Sample: Claims Paid in Calendar Year 2007



Note: Medicaid costs based on assumption of 36% state share in Calendar Year 2007

Background: Assumptions Based on Goals of System Reform

Hospitalization rates should reflect...

1. **Low rehospitalization overall.**
2. **Relatively longer stays (of more than a week) in state hospitals.**

Report pp 1, 5

Background: Assumptions Based on Goals of System Reform

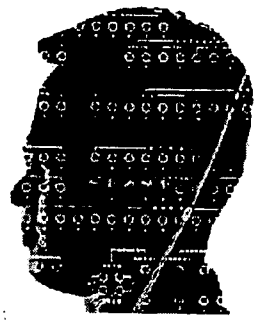
Community-based services should...

1. Be more accessible after discharge from community hospitals.
2. Be linked to less rehospitalization.
3. Include high-intensity care.
4. Be available in each Local Management Entity's catchment area.

Report pp 1, 5

Evaluation Method: Data Sources

1. Medicaid and state electronic claims data
2. Survey of Local Management Entities administrators (N = 24)



Evaluation Method: Sample

Calendar Year 2006

Sampling Criterion:
1 or more hospitalizations

Four facility types

- **State psychiatric hospitals**
- **State Alcohol & Drug Addiction Treatment Centers (ADATCs)**
- **Private psychiatric hospitals**
- **Community hospital psychiatric units**

Evaluation Method: Sample

Calendar Year 2006

Sampling Criterion:
1 or more hospitalizations

Calendar Year 2007

Outcomes:
Services received

Four facility types

- **State psychiatric hospitals**
- **State Alcohol & Drug Addiction Treatment Centers (ADATCs)**
- **Private psychiatric hospitals**
- **Community hospital psychiatric units**

Outcomes

- **Rehospitalization**
- **Community-Based Outpatient Services**

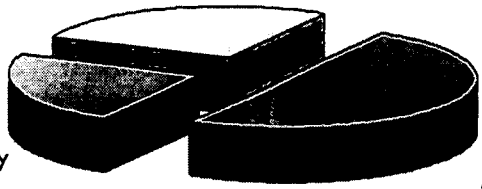
Evaluation Method: Sample

22,516 previously hospitalized consumers with mental health and/or substance abuse disorders

- **7% of total served in 2006**
- **22% children under 21 years of age**
- **60% White, 35% Black**
- **Similar to total served except fewer children**

Report p 6

Evaluation Sample: Diagnoses



n = 22,516

Report p 7

Mental Health Services: Findings

Findings: Hospitalization

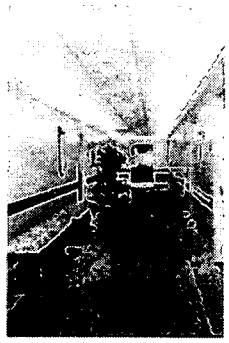
Assumption: Reduced rates of rehospitalization

- 21% were rehospitalized in 2007
- Consumers who had multiple 2006 hospitalizations were more likely to be rehospitalized in 2007

Report pp 9-10

Findings: Hospitalization

Assumption: State psychiatric hospitals reserved for consumers who need longer stays



- Short stays of a week or less were common in state hospitals
- In this sample, 42% of rehospitalizations of a week or less were state hospitals

Report pp 9-10

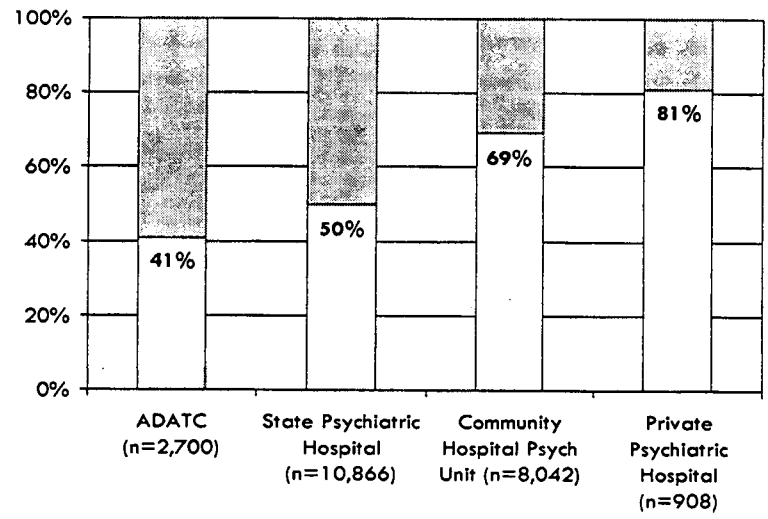
Findings: Community-Based Services

Assumption: Community-based services should be more accessible after discharge from community hospitals

- There was better follow-up after discharge from community hospitals (69%)
- However, only half of those discharged from state hospitals got follow-up

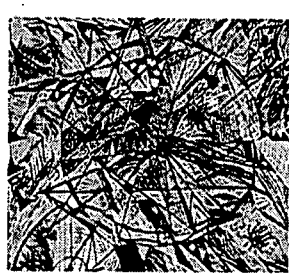
Report pp 11-14

Findings: Community-Based Services



Findings: Community-Based Services

Assumption: Community-based services linked to reduced hospitalization



- **Those who got outpatient services were <u>more</u> likely to be rehospitalized**
- **However, only half of consumers with a history of one hospitalization received follow-up services**

Report pp 11-14

Findings: Community-Based Services

Assumption: High-intensity services for high-risk consumers

- Most services received were low intensity
- Low-intensity services were far more frequent than high-intensity
- Just over one-half (54%) saw a psychiatrist

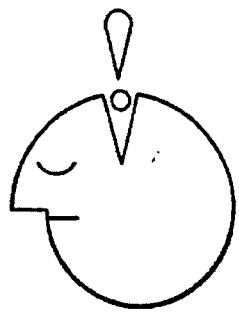
Report pp 14-16, 17-21

Findings: Community-Based Services

Assumption: Services should be available in each Local Management Entity

- LMEs still struggled to serve high-need consumers
  - Insufficient crisis services
  - Shortage of substance abuse treatment
  - Only five LME administrators reported sufficient access to psychiatric services

Mental Health Services: Recommendations



Recommendation 1. Pursue electronic health records to track individuals across facilities and service providers

- Electronic Health Records
  - Better tracking of individual-level care
  - More complete system data

Report pp 21-22

Recommendation 2. Continue to focus on increasing capacity and quality of community-based services

- More access to high-intensity services, especially crisis
- More beds in community hospitals
- Need better follow-up
  - ➢ Discharges from state facilities
  - ➢ Consumers who may be relatively less severely ill (history of one vs. multiple hospitalizations)

Report pp 22-23

Mental Health Services: Summary

- The tenets of reform appear on track
- The Division concurs with recommendations
- There is still a need for:
  - ➢ Individualized data
  - ➢ Wider access to services, especially crisis
  - ➢ More attention to follow-up:
    - Discharges from state facilities
    - For *all* consumers

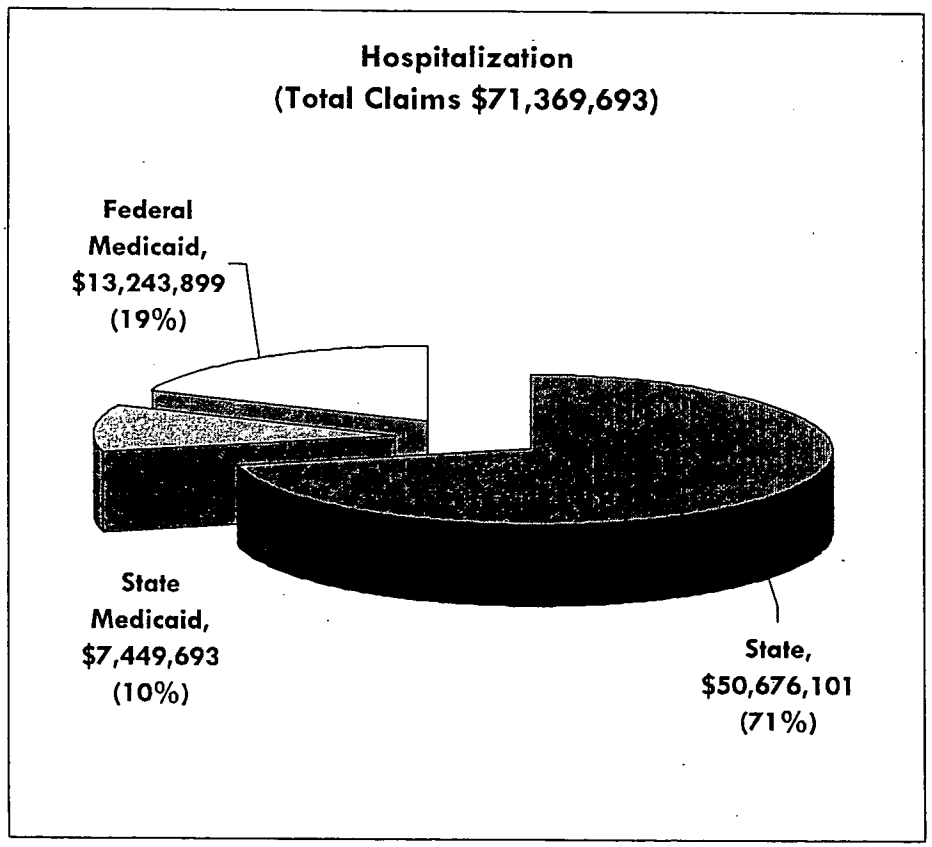
Caring For Previously Hospitalized Consumers: Progress and Challenges in Mental Health System Reform

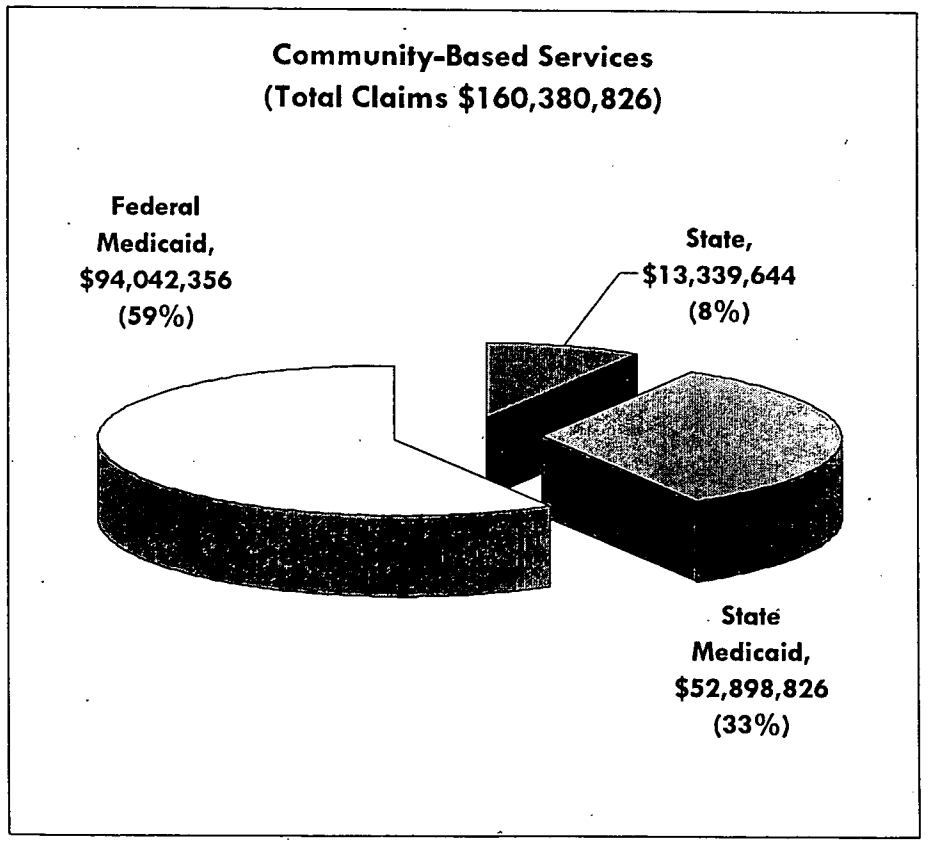
Full Report & Presentation available at
http://www.ncleg.net/PED/Reports/Topics/Health.html

Carol H. Ripple
carolr@ncleg.net

Federal Funds Cover a Large Proportion of Community-Based Services

Evaluation Sample: Claims Paid in Calendar Year 2007





Note: Medicaid costs based on assumption of 36% state share in Calendar Year 2007

Report p 14

Pathways
Local Management Entity

Report to the Legislative Oversight Committee
January 14, 2009

Rhett Melton
Area Director

Items To Be Discussed

- Overview of Pathways LME
- Highlights of local accomplishments during reform
- Overview of a few significant challenges Pathways faces
- Suggestions on improvements to the system

Pathways LME

- Covers Gaston, Lincoln and Cleveland Counties
- 2008 population = 374,208; 9th largest LME in the state
- Gaston-Lincoln Mental Health was established on July 1, 1965 and Cleveland County merged in 1999 to form Pathways.
- Prior to mental health reform, employed approximately 750 staff and directly provided care to approximately 70% of the consumers served
- Now have 60 LME funded staff and contracts/M.O.A.'s with 129 enhanced benefit providers

Pathways' Community Data

- 124 Medicaid providers and 54 IPRS providers
- Last year 12,760 consumers served by the local system
- Penetration rate among the highest in the state in all age and disabilities, exceeding the state average in all categories.
- Unemployment in the area @ 10.0% compared to the statewide average of 7.9%
- Pathways is guardian to 169 wards

5 Successes Experienced During Reform

- Development of a comprehensive crisis continuum
- Consumer voice within the system
- Single stream funding
- High penetration rate
- Reduction in state hospital bed day utilization

5 Challenges/Frustrations

- Constant change
- Increased utilization with decreased funding
- Continuity of care challenges when providers cease operations
- Quality of care concerns where LME's have limited authority to impact
- Lack of coordination between the state and local system

5 Suggestions for Improvement

- Case management should be done by the LME
- Initial, comprehensive assessments should be done by the LME
- Figure out a way to have better collaboration between the state and LME's
- Rate setting based on outcomes
- Waiver

Thank you

OPC
Area Program

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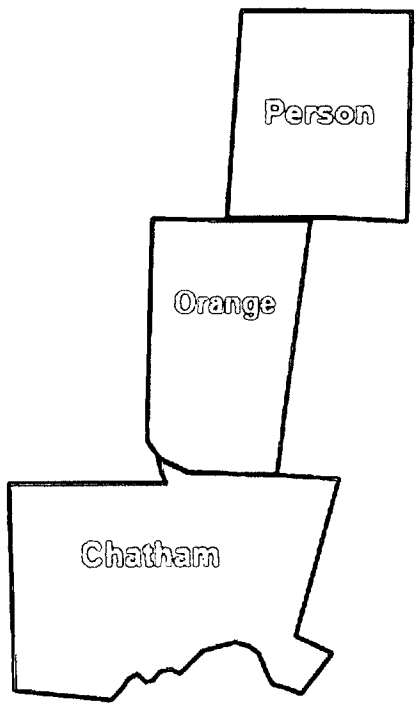
Suite 490
Chapel Hill, North Carolina
27517

opcareaprogram.com



Total Population: 225,285

County Funds Allocations - SFY2009

	Percent*
I. Traditional Services	
CFAC	1.3%
Crisis Services	1.6%
Property Management	2.7%
UNC Hospital	33.4%
Consumer Support	1.0%
Housing	4.4%
Psychiatry	19.4%
Provider Specific Support	17.9%
II. New Initiatives	
Pro Bono Therapy Project	1.3%
Medicare Incentives	1.3%
Psychiatric Consultation for Jails	0.6%
Transportation Project	2.7%
III. Dedicated / Restricted Funds	
Chatham Rent Subsidy	1.3%
Chatham SA IOP	2.9%
IV. Other LME Initiatives	
JCPC Liaison	3.3%
Guardian Coordinator	0.8%
Miscellaneous	4.1%
	100.0%

* % of funds encumbered

OPC Staff Profiles

Total number of staff = 66

Youngest staff member = 25

Oldest staff member = 66

Average age = 44

# of licensed & credentialed clinical staff
27 or 41% of the LME workforce

8 other staff hold master's degrees in various fields

Most senior member of OPC staff has 27 years & 4 months of service

Average seniority = 14.4

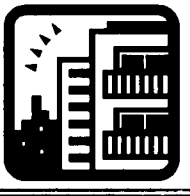
Workforce Turn-over rate for SFY08 = 4.7%

Number of bi-lingual staff = 4

OPC
Area Program

OPC Initiatives

- Reclaiming Futures- Orange and Chatham counties are one of six NC sites involved in this national initiative from Robert Woods Johnson Foundation to connect youths involved with juvenile justice to evidenced-based substance abuse treatment and meaningful community involvement.
- Trauma-Informed System of Care- Three Community Collaboratives and OPC have begun developing a more trauma-informed system of care, including exploring multiple funding streams to bring several evidenced-based trauma treatment models to the community.
- Juvenile Justice/Social Services/LME Liaison- OPC has a unique partnership with Orange-Chatham Juvenile Crime Prevention Council and the Orange Department of Social Services to fund a care coordinator position to connect youths involved with juvenile court and social services with mental health providers.
- OPC is collaborating with Wake AHEC, Durham Technical Community College, and the new UNC Center for Excellence in Community Mental Health to pilot a comprehensive introductory course for mental health and substance abuse workers who are new to the field. The aim is to provide inexperienced workers in OPC's catchment area with high-quality training in the MH/SA service definitions, along with an overview of mental health and substance abuse fundamentals. Curriculum development has begun, and guest lecturers from the Psychiatry Department at UNC Hospitals are being identified to speak on such subjects as clinical boundaries, direct practice skills, and the major mental illnesses.
- OPC and the provider community have identified concerns over the shortage of qualified Addictions Professionals in OPC's catchment area. To address this shortage and help interested professionals in achieving the necessary credentials in the addiction field, OPC started a training series in the addiction field. A four-part training (20 hours) on 12 Core Functions started in September 2008 and will conclude in January 2009. The second series, a five-part training (15 Hours) on Clinical Supervision and Best Practices in Addiction Treatment, will run from February to June 2009. We hope to continue to offer various training options in the future to help address work force shortage and develop a strong provider community in the addiction field.



OPC Housing Update

- OPC has six Shelter Plus Care grants that serve approximately 29 individuals.
- OPC was awarded a Shelter Plus Care grants to serve chronically homeless individuals. We now serve nine chronically homeless individuals. In 2008, an additional housing subsidy was added to serve a chronically homeless person. OPC is a member of the Executive Team for the Orange County Ten Year Plan to End Homelessness; this plan targets the chronically homeless population and is directly aligned with federal initiatives that prioritize funding for this population.
- Housing for New Hope, OPC's Projects for Assistance in Transition from Homelessness (PATH) provider, was awarded $90,000 in Mental Health Trust Fund dollars to provide housing subsidies to assist up to six homeless and chronically homeless individuals as they move toward securing permanent supportive housing. OPC also allocated funds to Housing for New Hope to create a Housing Support position and expand their existing Community Support Team from Durham.
- Orange County recently had two new developments approved for 2008 Tax Credits. OPC will serve as the Local Lead Agency (LLA) for the 14 targeted units that will be set aside for persons with disabilities from these two projects. These units are affordable such that tenants pay no more than 30% of their income toward rent. LLAs facilitate access to an array of supportive services for tenants in targeted units and act as the liaison between the property manager and service provider, ensuring that supportive services are intact.
- OPC participated as a lead planning partner in the 2007 and 2008 Orange County Project Homeless Connect. In 2007 more than 130 individuals received services at the event; in 2008 the number grew to more than 202. In both 2007 and 2008 OPC had at least six staff members participating in the event to aid persons in accessing these much-needed services.

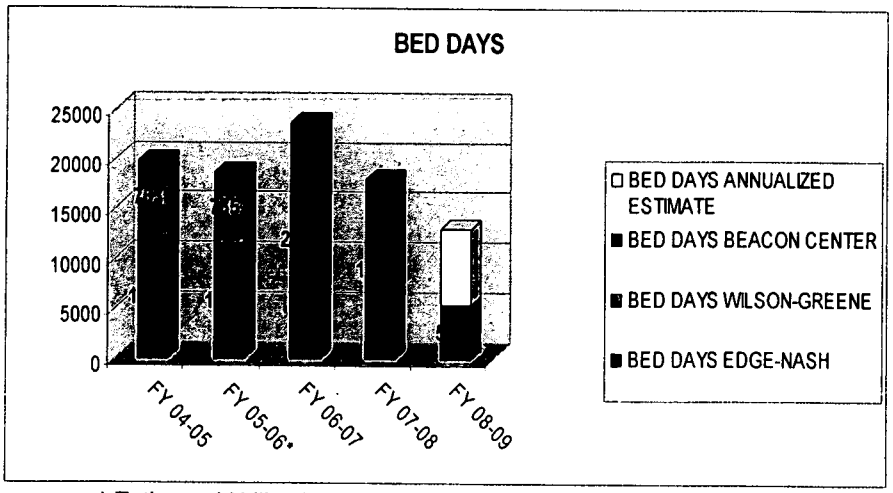
Analysis of Hospital Admissions and Bed Day Utilization

The Beacon Center

Review of data and trends revealed:

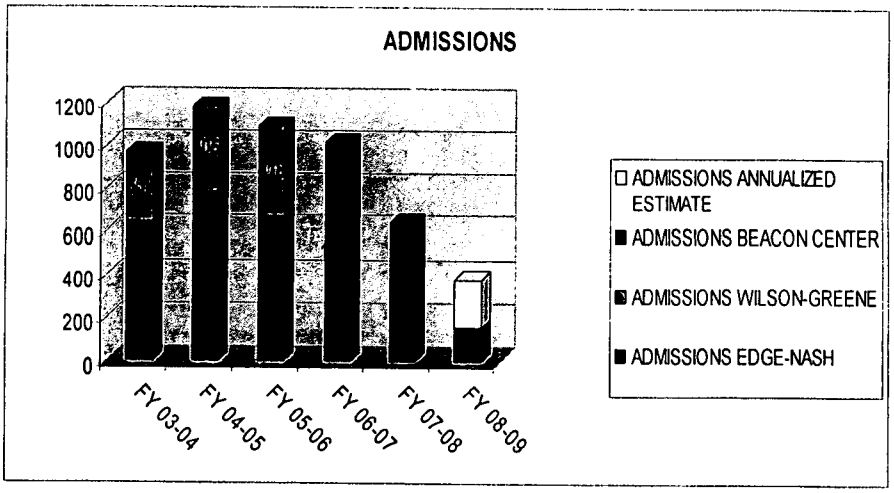
- There appears to be a correlation between divestiture and merger activities an and increase in admissions and utilization.
- Strategies can be used to positively impact both admissions and bed day usage.
- Successful reduction can only occur when the LME, local hospitals, providers, State hospital staff and consumers work together.

Bed Day Utilization



* Estimated Utilization

Admission Data



How did execute this change?

- Pre-Admission Strategies
- Acute Admission Strategies
- Long Term Admission Strategies
- Post Discharge Strategies

Pre-admission strategies

- Mystery Shopper program
- Marketing and branding The Beacon Center name
- Educating the community, consumers and stakeholders that service access is not a "place".
- CIT

Acute Admission Strategies

- Use of local hospital resources through contracting
- Cherry admissions AM report
- Increased linkage with the Providers in the community to the hospital to track consumers and their follow up.
- Hospital Liaison efforts

Long Term Admission Strategies

- Focused efforts of the LME staff
- A target effort of all LME staff, i.e., fiscal, provider relations to make transition a success.
- Use of telecommunication equipment
- Ensuring that you have the right provider and community supports in place before discharge occurs.
- Reimbursement for providers who are working on discharge of a consumer.

Post Discharge Strategies

- LME staff follow up to ensure transition plan is executed as developed.
- Educating other partners of "at risk" or "relapse" behavior.
- Development of post discharge tracking and data system.

Much has been done but much is left to do

- Hospital contract dollars needed
- Data sharing, tracking and coordination efforts
- Policy decisions regarding undocumented status consumers
- Impact of major provider failure

AGENDA

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

February 17, 2009, 15 minutes after the last chamber adjourns;
Room 643, Legislative Office Building
Senator Martin Nesbitt, Co-Chair, Presiding

---

1. **Greetings and Opening Comments**
   Senator Martin Nesbitt, Co-Chair
   Representative Verla Insko, Co-Chair

2. **State Consumer and Family Advisory Committee**
   Carl Noyes, MS, CPSS, SCFAC Representative

3. **Update on DHHS Involuntary Commitment Workgroup**
   Flo Stein, Chief, Community Policy Management

4. **LOC 2008 report to the 2009 General Assembly**
   LOC staff

ADJOURN

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 17, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Tuesday, February 17, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, James Forrester, and William Purcell and Representatives Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justus, and Fred Steen. Advisory member Representative William Brisson was also present. Also in attendance were Representatives Pat Hurley, Wil Neumann, Hugh Blackwell, Pearl Burris-Floyd, and Kelly Alexander.

Denise Harb, Ben Popkin, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. He asked for a motion to approve the minutes from the January 14, 2009 meeting. The motion was made by Representative Justus and the minutes were approved. Representative Insko introduced Allen Feezer, the new Deputy Director for the Department of Health and Human Services.

The committee first heard from Carl Noyes from the N.C. State Consumer and Family Advisory Committee (SCFAC), who reported on the role of the organization and its accomplishments. (See Attachment No. 2) Mr. Noyes said that SCFAC is charged with advising the Division of MHDDSAS and the General Assembly. He emphasized that they could provide immediate feedback from the consumers perspective, and requested that the LOC consider allowing SCFAC report to the LOC on a quarterly basis.

Mr. Noyes reviewed the responsibilities of the various Task Teams which include:

- The Planning Team, which monitors the State Plan
- The Services Team, which identifies service gaps and underserved populations, and makes recommendations;
- The Budget Team, which reviews, comments and advises on the State budget for MHDDSAS;
- The Interface Team which reviews findings and recommendations from the local CFACs; and
- The Response Team, which responds quickly to issues and concerns.

He explained that SCFAC members provide advice and recommendations on key issues of interest. Finally, he mentioned that Crisis Intervention Team (CIT) training was provided to law enforcement in Wayne and Duplin Counties.

Next, Flo Stein, Chief of Community Policy Management for the Division on MHDDSAS, gave an update on the study on outpatient involuntary commitment statutes in North Carolina. (See Attachment No. 3) She said the members of the workgroup reviewed a number of reports and studies from other states including studies by Dr. Marvin Swartz, a leading expert on involuntary outpatient commitment. She said that North Carolina has one of the oldest outpatient commitment laws in the nation, and the workgroup tried to determine if the law was effective and what the public could expect from the statute. Ms. Stein said that research showed that service intensity was critical and outpatient service for less than 180 days was not effective. She said the current outpatient commitment statute is not generally being used in the courts. The only place individuals are receiving outpatient commitment orders are in the State hospitals. By statute, the clerk of court is only responsible for keeping a list of people on commitment. She said that some courts send the list to LMEs, others do not.

According to Ms. Stein, one of the workgroup's proposals is to establish a pilot project to look at individuals being released from hospitals. She outlined the roles of the LMEs, the courts, the State hospitals, and the providers under the proposed pilot. She indicated that there were several other questions that still needed to be answered, and a checklist of items that still needed to be done such as training and materials that are consumer friendly.

Next, Shawn Parker from the Research Division and Denise Harb from the Fiscal Research Division reviewed the LOC draft report to the General Assembly along with two bill drafts. (See Attachment No. 4) Also attached for review, was a crosswalk which showed the amount of money appropriated within the recommendations and where the topics could be found within the report. (See Attachment No. 5) Mr. Parker and Ms. Harb summarized the 3 areas of findings (System Administration, State-Operated and Licensed Facilities, and Community-Based Services) and reviewed the recommendations corresponding with each of the findings. The changes reflected below were all approved by committee members.

Under Finding One, System Administration, Committee changes to the recommendations included:

- Item 4. Appropriate up to $500,000 to the Department to fund the Mental Health Leadership Academy. Also, direct the Department, in consultation with the Mental Health Leadership Academy, to provide for training and information sharing opportunities on innovative and effective practices among LMEs.

- Item 10. Increase the tax on cigarettes to a level that reflects the national average. The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco and other drugs. (Borrowing language from the

Substance Abuse Task Force Study, staff was instructed by the committee to adjust the language of the bill to reflect the Task Force recommendation.)

Under Finding Two, State-Operated and State-Licensed Facilities, Committee changes to the recommendations included:

- Item 3. Under the State Medicaid program, individuals seeking to qualify for Medicaid must provide certain documentation as evidence of residency of North Carolina. Likewise, to address significant increases in county expenditures for State-County Special Assistance, the General Assembly should change the residency requirement for eligibility for special assistance from 90 days to 180 days to decrease the likelihood of persons moving to North Carolina from border states solely for the purpose of qualifying for State County Special Assistance. Also, the Department should study the issue of consumers with mental illness residing in adult care homes and report recommendations to the LOC.

- Item 6. The Department of Health and Human Services should identify a screening tool to assess level and intensity of need of all individuals with developmental disabilities receiving publicly-funded services.

Under Finding Three, Community-Based Services, Committee changes to the recommendations included:

- Item 2. Direct the Department to submit to the LOC a report about the tiered CAP-MR/DD waiver program. Specifically, the report must include:
    - The service array and intensity of CAP-MR/DD services for the two existing and two planned tiers;
    - How the relative intensity of need for each consumer will be determined and how this determination will be used to assign individuals into the tiers;
    - The criteria DHHS will use to select a valid assessment instrument and how the instrument will be administered;
    - Mechanisms to ensure operational accountability;
    - How the implementation of the tiers will lead to cost savings, how much cost savings are projected, and an estimate of how many additional consumers can be served within the current budget.

  The report should be submitted within six months after this reporting requirement is adopted by the General Assembly.

- Item 6. Direct the Department to continue allocating $8 million of its substance abuse funds for regionally-purchased, locally-hosted substance abuse programs. The Department should allocate an additional $2 million towards these types of programs if it has additional funds available.

- Item 9. Appropriate $8,227,932 to the Department to fully fund local crisis programs that were partially funded in the 2008 appropriations act. Also appropriate to the Department $16,096,500 for an additional 150 local inpatient psychiatric beds. (This recommendation was added to the findings.)

It was suggested the primary bill be divided into two pieces of legislation: one including all items needing appropriation and one including items without appropriation, which are: Section 1.(a). Merger or Consolidation of LMEs, 1.(d).Medicaid Waivers, 1.(e). State/County Special Assistance Residency Requirements, and 2.(d). Death reporting in Facilities Providing MH/DD/SA Services.

Senator Nesbitt requested a motion to approve the report with recommended changes and to authorize staff to make technical corrections, including updates to cost estimates and appropriation amounts. Representative Insko made the motion and the committee approved the report.

There being no further business, the meeting adjourned at 5:55 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 17, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chip Baggett	NCMS
John Bourdeau	AstraZeneca
Samuel R. Bone	Bone + Associates
Ted Bone	Bone + Asso
Lou Wilson	NCALTCF
Lin Ann Peyton	NCPA
Zeb Alley	Nelson Mullins
Andrew Cagle	DLC and NCLOC.
Evelyn Hawthorne	EHGR; NCAP
John McMillan	NFIS
Olivia Ford	Ford Home
Cherrie Rager	Ford Home

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 17, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner Spruill
Joel Maynard	GPM & Assoc.
Conor Brockett	NCSBA
Annaliese Dolph	DRNC
Fred Walker	Eastern Seals UCP
Matt Harrell	TPG
Karen McLeod	CFSA-NC
Dave Sproat	BBMS
Cam Cavey	BPMHL
David Boaz	MWC
Debra Bowman	NAMI NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 17, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

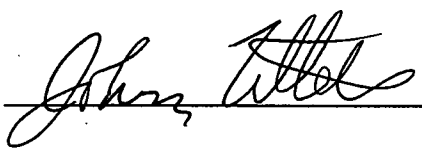
NAME	FIRM OR AGENCY AND ADDRESS
Will Woodell	Value Options
Louise Fisher	Volunteer Advocate for the Mentally Ill
Barbara Barrett	Parker Poe, Raleigh
Karen Chapple	Central Regional Center
Kim Schmidt	NC MHCO - Raleigh
Gail Boswell	NC MHCO MH Consumer/Family Mem
Vicky Young	NDOT
Kathleen Thomas	Shaps, UNC
Julia Leggett	The Arc of NC
Mary Short	Alexander County
Christy Agner	Governor's office

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 17, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	MVC

North Carolina State Consumer & Family Advisory Committee

Presented By: Carl Noyes, MS, CPSS

Purpose

- The State Consumer and Family Advisory Committee (SCFAC) is a 21 member self-governing and self-directed advisory organization, composed entirely of consumers and family members of consumers of mental health, developmental disabilities, and substance abuse services.

Mission

- The mission is to advise the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

Membership

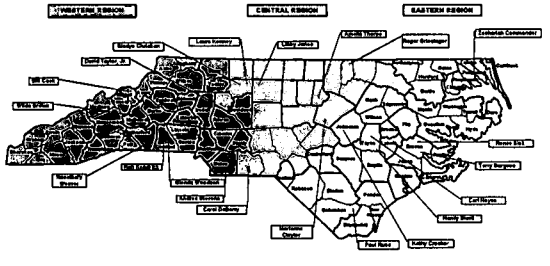
The State CFAC is composed of 21 members. The terms of members are three years, and no member may serve more than two consecutive terms. Vacancies shall be filled by the appointing authority. The members are appointed as follows:

- Nine by the Secretary. The Secretary's appointments shall reflect each of the disability groups. The terms shall be staggered so that terms of three of the appointees expire each year.

Membership

- Three by the General Assembly upon the recommendations of the President Pro Tempore of the Senate
- Three by the General Assembly upon the recommendations of the Speaker of the House of Representatives
- Three by the Council of Community Programs
- Three by the NC Association of County Commissioners

State CFAC Representation as of February 16, 2009



Our Role

The State CFAC is responsible for the following:

- Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services
- Identify service gaps and underserved populations.
- Make recommendations regarding the service array and monitor the development of additional services.

Our Role

- Review and comment on the State budget for mental health, developmental disabilities, and substance abuse services.
- Participate in all quality improvement measures and performance indicators.
- Receive the findings and recommendations by local CFACS regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services.
- Provide technical assistance to local CFACS in implementing their duties.

SCFAC Task Teams

Plans Task Team:

- Roger Griesinger-Chair

- Project Focus: Review, comment & advise, and monitor the implementation of the State Strategic Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services

SCFAC Task Teams

Services Task Team:

- Andrea Stevens-Chair
- Identify service gaps and underserved populations, make recommendations regarding the service array and monitor the development of additional services, and participate in all quality improvement measures and performance indicators

SCFAC Task Teams

Budget Task Team:

- Carl Noyes-Chair
- Review, comment and advise on the State budget for mental health, developmental disabilities, and substance abuse services

SCFAC Task Teams

SCFAC/LCFAC Interface Task Team

- Kathy Crocker-Chair
- Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services and provide technical assistance to local CFACs in implementing their duties

SCFAC Task Teams

SCFAC Response Team

- Ron Kendrick-Chair
- The focus of this team is to address issues and concerns that SCFAC receives

Our Accomplishments

- Appointed members to assist with a variety of work groups within the Division of MH/DD/SAS and DHHS:
  - External Advisory Committee
  - Staff Qualifications workgroup
  - Program Management Database workgroup
  - Executive Leadership Team
  - Hospital Management and Operations workgroup
  - Crisis Services workgroup
- Produced a Guardianship Report addressing concerns regarding guardianship issues

Accomplishments

- Assisted with the development of the CFAC Leadership Training Conference in Winston-Salem, NC
- Supported the CFAC Chairs Leadership Training event in Winston-Salem, NC
- Participated in the Substance Abuse Symposium in January 2007
- Local CFAC to SCFAC Survey and Data report

How We Make A Difference

SCFAC Members have provided advice and recommendations on the following key issues:

- Person centered planning
- Access to services
- Consumer focused outcomes
- Quality management systems and protocols
- Early intervention and prevention
- Workforce development
- Staff competency requirements
- "No Wrong Door" policy

How We Make A Difference

SCFAC Members have provided advice and recommendations on the following key issues:

- Statewide CIT training with law enforcement
- State Strategic Plan 2007-2010
- Consumer-friendly version of the State Strategic Plan 2007-2010
- Eliminating tobacco use in mental health facilities
- Over-utilization of community support services
- The Secretary's proposal for voluntary LME regionalization
- Long range plan and funding allocation report

What We have to Offer the LOC

We can offer Immediate feedback from a consumers perspective about:

- Proposed rules
- Service arrays and systems

This feedback may be informal by way of email or telephone call thru a designated liaison or in person by a representative of SCFAC.

In conclusion and for your consideration

- We ask that you utilize the resource that you have established by asking for position statements or assigning task that are within our capabilities to execute.
- We ask that you hold us accountable for deliverables as chartered. We might suggest quarterly ten minutes updates from one of our Task Teams to be included on your agenda.

Study Outpatient Involuntary Commitment—Appropriate Supervision G.S. 122C-236

Flo Stein, Community Policy

Other Studies

- First Commitment Pilot—expediting the evaluation process by qualified licensed professionals
- Use of telemedicine for commitment evaluations 122c-263 (c)

WORKGROUP MEMBERS

- Melissa Makowski, Wake CFAC
- Marvin Swartz, MD, Duke
- Lisa Corbett and Richard Slipsky, Office of the Attorney General
- Lena Klumper and Mark O'Donnell, DMHDDSAS
- Ed Burnett, Five County LME
- Mark Hazelrigg and Sally Cameron, NC Psychological Association

Work Group Members (continued)

- Arthur Carder, Director, Western Highlands LME
- Eddie Caldwell, NC Sheriff's Association
- Margie Sved, MD, Durham LME
- Michael Lancaster, MD, DMHDDSAS
- Gregg Stahl, Administrative Office of the Courts
- Deby Dihoff, NAMI NC
- Rebecca Carina, DMHDDSAS Facilitator
- Martha Brock, Observer, DRNC

Reviewed

- Western Highlands Outpatient Commitment Policy and Procedures.
- NC Outpatient Commitment Statutes 1973-present.
- Outpatient Commitment Statutes in several states.
- Involuntary Outpatient Commitment: A View Post Virginia Tech, Services Effectiveness Research Program , Duke University Medical Center, Marvin S. Swartz, MD.
- Seung Hui Cho case.

States need effective strategies to improve treatment adherence

- Treatment nonadherence is a vicious cycle for patients and mental health, criminal justice and social welfare systems.
- Uncontrolled state expenditures result from nonadherence.
- States are badly in need of strategies to improve treatment adherence.
- Marvin Swartz, MD

Controversies about OPC

- Availability of appropriate services with aggressive outreach might obviate the need
- Should not be used as a substitute for inadequacies in the service system
- Applying coercion to patient blames the victim for services deficiencies
- System of care should be held accountable for gaps in care

Summary

- Other findings:
  -OPC can reduce violence, victimization, family strain, arrests, and improve medication adherence and quality of life.
- However:
  -To be effective it must be delivered for an extended period of time AND in combination with regular mental health services.

New York : Assisted Outpatient Treatment

- Death of Kendra Webdale led to the passage of a pilot statute to establish AOT, court procedures and enforcement.
- $32 million was appropriated to support statewide implementation program of OPC and $125 million to support community services.
- Early evaluation shows increased participation in services and medication adherence.

New OPC Legislation

- New York--Kendra's Law (1999)
- California—Laura's Law (2003)
- Michigan—Kevin's Law (2005)
- Florida—Reform of Baker Act (2004)
- Virginia—Mandatory Outpatient Treatment Process (2007)

Duke Mental Health Study

- Included CRH (JUH), Durham Center, OPC and Five County (VGFW)
- Outpatient Commitment can reduce recidivism however:
  - -OPC must be applied for an extended period of time
  - -It is most effective for people with psychotic disorders
  - -It is only effective when delivered in combination with frequent mental health services

- Swartz,1999

Is OPC a Method to Prevent an Act of Severe Violence—like Virginia Tech?

- Data available indicate OPC can reduce minor acts of violence.
- Acts of serious violence are far too infrequent to study accurately.
- Might infer that improving treatment adherence may reduce serious violence—but there is no evidence.
- OPC law should be considered on the merits of improving treatment adherence and reducing relapse not preventing violence prevention per se.

What makes a difference

- Intensity of services
- Consistent length of stay
- Diagnostic criteria to determine eligibility
- Strengthened services system, especially ACTT
- Including Advance Directives in crisis plans

Work Group Proposal

- Request special provision to allow for a pilot to test new process for commitment with a sunset provision.
- Begin with individuals in state hospitals where treatment history is already known.
- At first hearing set time for inpatient commitment and also set time for outpatient commitment for not less than 180 days.

Role of the LME in the Pilot

- LME is the point of accountability-tracking and overseeing the patient at all times.
- Must arrange for an accepting provider.
- Incentives, including performance bonuses may be paid to providers for accepting difficult cases. Western Highlands pays $1600 per case.
- Designation of hospital liaisons to assist with discharge planning.

Courts Role in the Pilot

- Treatment is court ordered and mandatory.
- Extend the commitment period to no less than 180 days.
- Make necessary changes in forms to designate the LME and the receiving provider.
- Supplemental orders will be needed for transfers.
- Clerk would enter the data and notify LME. The AOC will work to develop an automated data tracking system should the pilot go forward.

Courts (continued)

- Attorney from the AGs office is assigned to each state hospital. Clerk will send the outpatient order to the designated LME. The AG's Office will monitor the process.
- Judge review the discharge plan.
- Re-hearings will be required to extend period of commitment.

Role of the State Hospital in the Pilot

- Agree to utilize the eligibility criteria for determining which patients can benefit from OPC.
- Work with LME hospital liaison to present a treatment plan to the Judge prior to discharge. Plan should address housing and transportation.
- Ensure that an Advocate works with the consumer to review rights and information about the process.

Provider Role in the Pilot

- Join the LME provider community as a provider willing to accept and individual on a court ordered Outpatient Commitment.
- Provide intensive services with adequate frequency based on the court approved plan.
- Notify LME of any change in consumer status.
- Appear before the court to provide evidence of compliance.

Questions that need to be answered prior to statutory changes

- Will eligibility criteria, increased intensity of supports result in improved adherence?
- Can infrastructure for enforcement and accountability be developed?
- Strengthened service system?
- Role of the new crisis system, security?

Remaining to be done

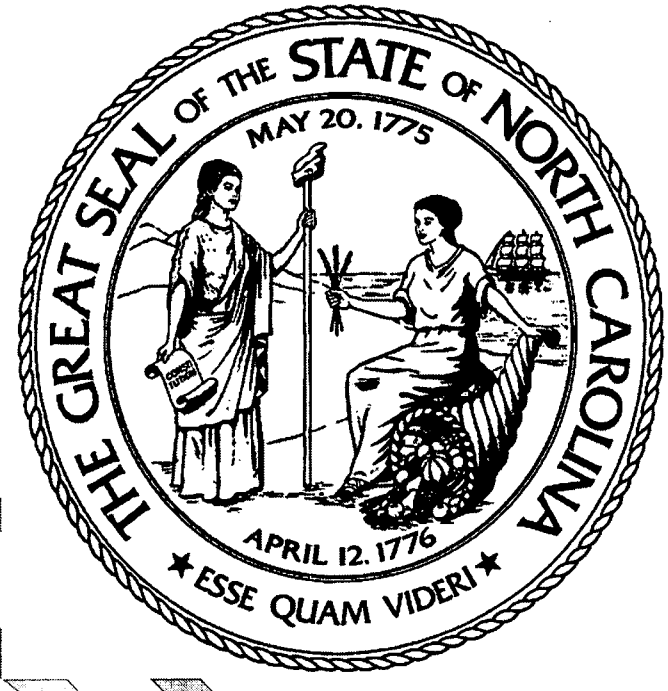
- Training for consumers, clerks, LMEs, law enforcement Including Crisis Intervention Training (CIT) and providers. Clerks do not know the LMEs.
- Materials written by and for consumers.
- Review with state and local CFAC and other consumer groups.
- Develop procedures for LME management.
- Finalize eligibility criteria.

Data for 06-07

- The number of court orders for OPCs from all four state hospitals for the period July 1, 2006 to June 30, 2007 was 2857 (this is not individual people).

- All of these people would not meet the criteria. If ½ did at the incentive rate of $1600 the cost would be $2,286,400.

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES



REPORT TO THE 2009 REGULAR SESSION OF THE 2009 GENERAL ASSEMBLY

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27603

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

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March 1, 2009

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, Co-Chair

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The Committee consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the Committee. The Co-Chairs for 2008-2009 are Senator Martin Nesbitt and Representative Verla Insko.

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COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met seven times during the 2008-2009 interim. Following is a summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

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August 26, 2008

The LOC convened its first meeting of the interim on August 26, 2008 at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed returning members, new members, and guests.

Staff members Andrea Poole, Fiscal Research Division, and Shawn Parker, Research Division, presented a review of 2008 legislative actions.

Gann Watson, Bill Drafting Division, and Denise Harb, Fiscal Research Division, discussed community support services. Ms. Harb summarized legislative actions taken to improve and strengthen fiscal oversight for community services. Ms. Watson discussed changes to the current Medicaid appeals process.

Dr. William Lawrence, Acting Director, Division of Medical Assistance (DMA), Department of Health and Human Services (DHHS), reported on the Division's actions and recent spending on Community Support Services.

Andrea Poole, Fiscal Research Division, discussed the State's psychiatric hospitals. Ms. Poole summarized expansions and reductions in the budget and reviewed legislative and statutory changes.

Dr. Mike Lancaster, Co-Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS), DHHS, gave an update on the State's psychiatric hospitals including Broughton Hospital, Cherry Hospital, and Central Regional Hospital.

Shawn Parker, Research Division, reported on LME administration and reviewed changes from the 2008 legislative session.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS, discussed LME performance and reviewed the guidelines LMEs must meet to qualify for single stream funding.

Denise Harb, Fiscal Research Division, summarized legislative actions relating to crisis services.

Next, Ms. Wainwright reported on crisis services on behalf of the Division. Ms. Wainwright said that the goal of the crisis system is to provide a prompt response to emergency situations and that to be effective, all the components of

the system must work together. She then reviewed new components, including mobile crisis teams, respite beds, and walk in crisis clinics.

Denise Harb, Fiscal Research Division, discussed CAP-MR/DD Tiered Waivers. Ms. Harb reviewed legislation including: a) a directive for DHHS to implement the tiered CAP waiver program; b) the creation of four tiers; c) a requirement for DHHS to review, on a case by case basis, tier funding exceeding $100,000; and d) a directive for DHHS to implement a plan to increase Piedmont Behavioral Health slots to the statewide average.

Ms. Wainwright gave an update on DHHS actions regarding CAP-MR/DD Tiered Waivers and reported that two new waiver applications were submitted to CMS on August 1, 2008. Common elements of Tiered Waivers include person centered planning, quarterly waiver slots, deadlines for providers, and risk assessment. Priority is given to individuals leaving State developmental centers, people leaving Piedmont Behavioral Healthcare catchment areas who were participating in Innovations, and individuals served through the Money Follows the Person grant. Ms. Wainwright then reviewed the supports waiver and the comprehensive waiver.

Finally, Ms. Harb reported on MH/DD/SA System Indicators.

September 25, 2008

The LOC convened its second meeting of the interim on September 25, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Daniel Hahn, Executive Director of the Alamance-Caswell-Rockingham LME, discussed the challenges facing the MH/DD/SA system from a local perspective.

Next, David Swann, representing Crossroads Behavioral Healthcare LME (Iredell, Surry, and Yadkin counties), gave an overview of mental health services in rural North Carolina. Mr. Swann mentioned several challenges for LMEs in rural areas: the recruitment and retention of professional staff; fewer providers due to a lack of volume; the additional costs of providing services to rural areas; and limited public transportation.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including certification and reimbursement status for each facility.

Dr. William Lawrence, Acting Director of the Division of Medical Assistance (DMA), DHHS, discussed the suspension of Medicaid benefits and Medicaid enrollment for recipients in institutions for mental disease or those incarcerated.

Dr. Lawrence also reviewed a chart on community support expenditures. Dr. Lawrence explained that DMA has submitted an amendment to the State Plan

and is waiting on approval from the Centers for Medicaid and Medicare Services (CMS) before updating the State Plan with legislative changes including: tiered rates for community support and requiring every community support provider organization employ a licensed clinician.

Senator Nesbitt, Co-Chair, then reviewed the MH/DD/SA System Indicators chart. He noted that the placement of people in local beds result in a reduction in the 1-7 day admissions in the State psychiatric hospitals.

Leza Wainwright, Co-Director for the Division of MH/DD/SAS, discussed Traumatic Brain Injury (TBI) Services. Ms. Wainwright explained the difference between traumatic and non-traumatic brain injury. Ms. Wainwright also reviewed the types of services available in North Carolina under Medicaid and State funded services.

Flo Stein, Chief of Community Policy Management, Division of MH/DD/SAS, DHHS, gave an overview of the funding provided to expand the regional substance abuse initiative: Cross-Area Service Programs (CASP).

Next, Trish Hussey, Executive Director of Freedom House Recovery Center, described the Center; the 5 district outpatient clinic sites in Orange, Person and Chatham counties; and the long-term residential homes in operation in Durham County.

Senator Nesbitt, Co-Chair, then called on members of the audience to come forward for the public comment period of the agenda.

October 16, 2008

The LOC convened its third meeting of the interim on October 16, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Dr. Hunter Thompson, Medical/Clinical Director of Albemarle Mental Health Center (AMHC) addressed the LOC and expressed his concern over the reform efforts by the State. Dr. Thompson explained that AMHC developed a partnership with the local hospital in Elizabeth City, establishing a dedicated crisis unit with a Telemedicine service that allows doctors to perform assessments to all regions of the catchment area. Next, Charlene Allen, Finance Officer for AMHC, discussed budgetary issues for AMHC.

Dr. Janis Nutt, Area Director, Johnston LME, addressed the successes and challenges in Johnston County during mental health reform. Dr. Nutt gave a brief history, reviewed the 5 basic services provided, and explained how strong community collaborations and partnerships contributed to the strength of the LME.

Next, Dr. Shealy Thompson, Quality Management Team Leader, Division of MH/DD/SAS, DHHS, provided a matrix summarizing LME performance measures that are tracked and reported quarterly in the Community Systems Progress Report.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State ADATC facilities and on the State psychiatric hospitals including certification and reimbursement status for each hospital.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS gave an overview of the changes in Community Supports for Medicaid and State funded services including the number of people receiving services and the types of services received.

Tara Larson, Acting Director of the Division of Medical Assistance (DMA), DHHS, presented information on the appeals process for Community Supports. Ms. Larson also informed the LOC that expenditures for Community Supports for the first quarter this year were down to $139 million compared to the first quarter last year of $262 million, a difference of 47%.

Valerie Bradley, President of Human Services Research Institute, presented a review and recommendations from a stakeholders group in the developmental disabilities field concerned about the direction of the system. She discussed the challenges facing North Carolina and other states including: the aging population, the growing waiting lists for home and community based services, and the need to strengthen case management.

Next, Leza Wainwright addressed the issue of family members providing CAP-MR/DD services. Ms. Wainwright explained that the topic of family caregivers as paid providers of the CAP-MR/DD waiver has been a topic of interest since October 2006.

Cynthia Vester from the NC Consumer, Advocacy, Networking and Support Organization (NC-CANSO), reported that NC-CANSO was created as a result of legislation (H.B. 1888) that established an independent statewide organization formulated to facilitate communication and support among people with MH/DD/SA issues. Ms. Vester reviewed NC-CANSO's accomplishments during the past year and respectfully requested additional funding for the next session.

November 20, 2008

The LOC convened its fourth meeting of the interim on November 20, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Dr. Shealy Thompson, Quality Management Team Leader for the Division of MH/DD/SAS, reviewed the LME performance measures matrix presentation. Dr. Thompson explained that the matrix provides a summary of State and LME performance on 21 different measures published quarterly.

Al Huntoon, owner of Catalyst Consulting Services, management consultant for Kenan Flagler Business School, and managing director of the Mental Health Leadership Academy (MHLA), addressed the LOC. With Mr.

Huntoon was James Johnson, Faculty Director. Mr. Huntoon discussed the Business School's statewide initiative to train senior LME staff, Division staff, and community partners. The initiative provides resources and expertise to the LMEs to help manage money, people, information, and partnerships. Mr. Huntoon provided an overview of the last year at the Leadership Academy which included: program design, goals, evaluation methodology, and findings.

Three LMEs discussed the benefits of working with MHLA:

- Mike Watson, Sandhills Center LME (Sandhills), summarized Sandhills' Capstone project. According to Mr. Watson, the MHLA provided an opportunity to look at particular issues in the community and tailor projects effectively. Mr. Watson gave a brief description of the Sandhills hospital transition program, explained the goals of the program, and discussed the program's financial model.
- Don Scott, Five County Mental Health Authority LME (FCMHA), summarized FCMHA's Capstone project. The FCMHA project came from a local business plan that recognizes and consistently accesses high-performing providers through published performance criteria and outcomes.
- Anna North, Quality Improvement Director, Eastpointe LME (Eastpointe), discussed Eastpoint's Capstone project, Walk-In Crisis Centers. Ms. North explained the goals for the project were to reduce bed day utilization, reduce the number of State hospital admissions, increase the use of respite, increase the use of private hospitals, and increase the use of walk-in crisis facilities.

Mr. Hank Debnam, Area Director, Cumberland County LME, provided statistical information about Cumberland County as well as information on the successes, challenges, and needs of the county. Mr. Debnam mentioned several successes including: the establishment of a Crisis Intervention Team (CIT) program for local law enforcement personnel; the implementation of a system of care for children; and the expansion of housing resources for persons with disabilities. Several of the needs mentioned by Mr. Debnam included: stable funding, transportation resources for rural areas, and resources for relocating military families.

Mr. John Hardy, Area Director, Mental Health Partners (MHP) serving Catawba and Burke counties, discussed the importance of stability in the system and the importance of community relationships. Mr. Hardy stressed the need for a standardized electronic medical record and a standard IT system. He also suggested that there needed to be more current regulations regarding guardianship.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, DHHS, reported on the status of the special provisions funded in the 2008.

Dr. James Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including the regulatory status of the hospitals.

December 18, 2008

The LOC convened its fifth meeting of the interim on December 18, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests.

Dan Jones, Area Director from Onslow-Carteret Behavioral Healthcare (OCBHS), provided statistical information about Onslow and Carteret counties. Mr. Jones stated that to provide stability within the community, both counties have Walk-In Clinics with providers housed in Carteret County. Mr. Jones stated that OCBHS has been working closely with local hospitals to obtain crisis beds.

Dr. Dana Hagele and Dr. Lisa Amaya-Jackson, Co-Directors of the North Carolina Child Treatment program, discussed a mental health pilot in the northeastern part of the State for children and adolescents exposed to extreme trauma. According to Dr. Hagele, the program is based on a public health approach and has had excellent outcomes. In most cases treatment lasts no longer than 4 months. She explained that the pilot project covered 28 counties and was initially funded $1.8 million for 3 years, ending in June 2009. Dr. Hagele stated that an annual recurring legislative appropriation of $2 million dollars was needed to continue the program.

Senator Nesbitt reviewed several items on the MH/DD/SA System Indicators sheet for November that is prepared monthly by staff.

Next, Leza Wainwright, Co-Director of the Division of MH/DD/SAS, gave an overview of residential options for persons with developmental disabilities. Ms. Wainwright discussed the number of people with developmental disabilities currently served in the public sector. Ms. Wainwright then reviewed a chart showing the types of residential facilities available and the number of beds in those facilities.

Next, Carol Donin from DHHS State Operated Services presented an overview of the three State-operated developmental centers: Murdoch, Caswell, and Riddle. Ms. Donin provided general data about the residents and explained the special programs offered at the centers including the PATH program, BART, the STARS program, and the MR/MI program.

After lunch, Ms. Wainwright gave a presentation on community ICF/MR facilities, DD Group Homes, and Adult Care Homes serving consumers with developmental disabilities, that provided general data on each type of facility.

Rose Burnette, Tiered Waiver Project Manager, Division of MH/DD/SAS, presented a brief summary of the CAP-MR/DD Supports Waiver and the Comprehensive Waiver. According to Ms. Burnette, each waiver has an annual per-consumer service dollar cap ($17,500 for the Supports Waiver and $100,000 for

the Comprehensive Waiver); however, a consumer is not automatically entitled to the maximum service level. Ms. Burnette explained that the services and supports for both waivers are based on the needs of the individual outlined in their Person Centered Plan.

Ms. Burnette then reviewed a new service, Home Supports. She explained that the Home Supports, only available with the Comprehensive Waiver, provides habilitation and personal care services.

Dr. Michael Lancaster, Co-Director, Division of MH/DD/SAS, provided a brief update on the State psychiatric hospitals.

January 14, 2009

The LOC convened its sixth meeting of the interim on January 14, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building. Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests.

Leza Wainwright, Director, Division of MH/DD/SAS, provided an update on Albemarle LME. According to Ms. Wainwright, a review team of DHHS staff found significant problems in 4 key local management functions: finances, provider relations, customer services, and the utilization management of state funds. Ms. Wainwright stated that the LME board has decided to terminate the director effective February 1, 2009 and has appointed an interim director.

Representative Insko introduced the new Secretary of Health and Human Services, Lanier Cansler. Secretary Cansler spoke briefly about issues facing the system and the development of community capacity to reduce pressure on State facilities. Secretary Cansler also expressed concern over the care of patients in the State facilities and stated there would be a clear policy of zero tolerance for the neglect or abuse of patients.

Pam Silberman, President, North Carolina Institute of Medicine (NCIOM), presented the final report of the Taskforce on Substance Abuse Services. She explained that in 2007 the General Assembly asked the NCIOM to study the substance abuse system for the State with an interim report due in 2008, and a final report due in 2009. Suggested recommendations of the Taskforce focused on filling in gaps to create a comprehensive substance abuse services system ranging from prevention to recovery support.

John Corne, Chairman, Commission on MH/DD/SAS, reported on deaths in State facilities. The Commission was charged with studying the death reporting statutes and any additional reporting requirements or modifications to existing rules or procedures.

Dr. Carol Ripple, Program Evaluation Division, reported on the results of an evaluation of services delivered by the Division of MH/DD/SAS. Dr. Ripple explained that the report provided an independent analysis of the outcomes experienced by consumers who were hospitalized at least once for mental health or substance abuse problems.

Rhett Melton, Area Director, Pathways LME, presented an overview of the LME including: highlights of local accomplishments during reform, significant challenges, and suggestions for improvements to the mental health system.

Judy Truitt, Area Director, Orange Person Chatham LME (OPC), reviewed data on county funds allocation, staff profiles, initiatives, and housing.

Karen Salacki, Area Director, the Beacon Center, discussed hospital admissions and bed day utilization wit in the LME's catchment area. Ms. Salacki reviewed pre-admission, acute admission, long term admission, and post-discharge strategies utilized by the LME to reduce hospital admissions and bed day utilization in the State psychiatric hospitals.

Leza Wainwright, Director, Division of MH/DD/SAS, DHHS, gave an update on the expenditure of service dollars.

Dr. Jim Osberg, Chief of State Operated Services, Division of MH/DD/SAS, DHHS, gave an update on the State psychiatric hospitals including certification and reimbursement status for each facility.

February 17, 2009

The LOC convened its seventh meeting of the interim on February 17, 2009, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Mr. Carl Noyes provided an update from the State Consumer and Family Advisory Committee.

Flo Stein, Chief of Community Policy Management, Division of MH/DD/SAS, DHHS, gave a progress report on the Outpatient Involuntary Commitment Workgroup. The Workgroup...

LOC staff presented a review of the draft report, the Committee adopted the report as amended.

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INTRODUCTION

The basic tenant of Mental Health Reform, enacted in S.L. 2001-437, is that consumers are best and most effectively served when the services they need are delivered in a community setting. Moreover, the system must be:

- participant-driven
- prevention-focused
- recovery-oriented
- State directed and locally managed
- cost-effective
- based on recognized best practice treatments, and self-determination of outcomes.

Every year since 2001, the General Assembly has enacted legislation to support the reform and restructuring of the State's system for delivering MH/DD/SAS services. These reform efforts have aimed to increase local management of the system, decrease reliance on State institutions, encourage the use of community-based best practice treatments, increase consumer involvement in the system, allow access to a range of qualified providers, and hold system providers and managers accountable to both State and local government. Through provisions it has enacted, the General Assembly has directed the Secretary of the Department of Health and Human Services and the Division of MH/DD/SAS to administer the system's reform. Oversight of reform efforts has been provided by the General Assembly and its Joint Legislative Oversight Committee on MH/DD/SAS (LOC).

To continue to work toward system reform, the LOC recommended and the 2008 session of the General Assembly approved significant increases in funding and numerous modifications to existing MH/DD/SAS statutes. This report builds on ideas proposed last year and emphasizes the need to fully fund current programs while also supporting new initiatives vital to successful system reform.

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COMMITTEE FINDINGS AND RECOMMENDATIONS

FINDING ONE: SYSTEM ADMINISTRATION

The Economic Crisis is straining our already-fragile provider network.
The economic crisis our country and State is experiencing has imposed serious financial difficulties at every level of our State's economy. One level is the resulting credit-crunch, significantly reducing the extension of new credit, and increasing the number of lenders requiring immediate repayment of loans. This impact is creating severe cash-flow problems for local governments, including local management entities, and for providers. Cash-flow problems have a negative impact on the availability of services.

It is the State's responsibility to support the LMEs in order to maintain and improve the system's functioning.
Local Management Entities (LMEs) are responsible for managing and overseeing the public system of Mental Health, Developmental Disabilities, and Substance Abuse Services at the community level. The State through the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department) is responsible for LME oversight, to build and support state-wide system uniformity, to ensure LME administration is adequate and to enforce the law. The ability of the LME to function effectively is vital to reform's success.

LMEs must develop and share creative solutions; The Department can encourage innovation by pursuing statewide Medicaid waivers.
During the 2008-2009 interim, the LOC continued its practice of hearing presentations from LMEs. Including presentations heard in recent interims, the LOC has now received advice and recommendations from all twenty-four LMEs. Based partially on these presentations, the LOC realizes that LMEs need a forum for learning from each other. Individual LMEs develop creative solutions to difficult, commonly-faced problems, and can be a good source of lessons, ideas and innovations for other LMEs. Additionally, as a second method to improve innovation and flexibility, the Department of Health and Human Services may pursue statewide Medicaid waivers, including 1915(b)(c) waivers.

The State and the LMEs must cooperate to foster the development and success of the provider network.
Providers maintain that different LMEs use different forms for the same purpose, which makes work difficult and unnecessarily time-consuming for providers who serve consumers in multiple LMEs. In addition, many LMEs have or are in the process of developing varying electronic systems that cannot necessarily communicate with one another; this can compromise or delay the continuity of care for consumers who move from one area of the State to another.

Over-expansion of LME catchment areas diminishes local oversight and control.
Consumers are best served in the community, and the oversight for those services should be in the community as well. Mergers that expand an LME's catchment area by hundreds of square miles or by additional, far-reaching counties take away from local oversight and control. Legislation in 2008 limited mergers, with some exception, until January 2010. The LOC recommends extending the prohibition until June 1, 2010, while allowing for mergers of LMEs that are contiguous and that are approved by each Board of County Commissioners for all member counties.

Utilization Management should be returned to LMEs.
LME's core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor. The 2008 General Assembly directed the Department to return utilization management to LMEs representing at least 30% of the State's population. As a next step, the Department should return utilization management to LMEs representing at least 60% of the State's population by January 1, 2011. To achieve this greater proportion, LMEs must be allowed to contract with one another to perform this function, notwithstanding prohibitions on LME mergers. Also the Department should be permitted to extend its contract with an outside vendor until September 30, 2010.

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State dollars appropriated to LMEs for direct services must be fully spent
Despite continuing demand for State-funded services, the 2008 LOC report noted that State dollars appropriated for direct services were under-spent. To help LMEs use these dollars for services to consumers in need, the 2008 General Assembly took multiple actions, including requiring the Department to provide non-single-stream-funded LMEs with some funds at the very beginning of the fiscal year and directing the Department to simplify the State Integrated Payment and Reporting System. Additionally, the General Assembly directed the Department to consult with LMEs and to report to the LOC about barriers to spending State service dollars. The Department recommended several strategies to increase expenditures, including that services be charged against the month in which they are provided, so that State funds used to pay for services rendered in May and June would be reconciled to the correct fiscal year; that providers should be required to submit bills within a certain number of days, and that the Department should reallocate unspent service dollars at mid-year towards those LMEs who appear most likely to be able to spend them.

Tobacco is a gateway drug to future substance abuse.
Data collected by the Surgeon General, the CDC, and other research organizations has long demonstrated that cigarette smoking and the use of other tobacco products, as well as exposure to second-hand smoke, is harmful to virtually all of the body's vital organs. In addition to the physical conditions and illnesses caused by smoking, taxpayers bear a substantially higher cost in health care premiums and treatment to provide health care for tobacco-related illnesses. It has also been documented that nicotine is a gateway drug to the addiction of other drugs. Many states have implemented no-smoking laws to protect the health of children and adults by prohibiting the use of tobacco products in public places. In the 2007-2008 legislative session, the North Carolina General Assembly enacted laws prohibiting smoking in government buildings and vehicles and permitting local governments to do the same. This policy has encouraged the introduction in the 2009-2010 regular session of at least one bill extending the smoking prohibition to places of employment and all but a few public places, as well as authorizing local governments enact ordinances that are more restrictive than State law.

RECOMMENDATIONS: SYSTEM ADMINISTRATION

1. Direct the Department to continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs by increasing the number of LMEs performing these functions to encompass at least sixty percent (60%) of the State's population by January 1, 2011. The Department shall designate by July 1, 2010, which LMEs are authorized to perform these functions. Also, prohibit the Department from contracting with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligating the State for these functions beyond September 30, 2010.

2. Clarify that contracts between LMEs for service authorization, utilization review, and utilization management functions do not constitute a merger or consolidation.

3. Prohibit the Secretary to take any action that would force or otherwise result in the merger or consolidation of LMEs, prior to June 1, 2010. Allow contiguous LMEs on their own initiative, to merge or consolidate under the following circumstances: (i) an LME does not meet the catchment area requirement of G.S. 122C-115, or (ii) the LMEs have received approval from each board of county commissioners within the affected multi-county areas.

4. Appropriate funds to the Department to fund the Mental Health Leadership Academy. Also, direct the Department, in consultation with the Mental Health Leadership Academy, to provide for training and information sharing opportunities on innovative and effective practices among LMEs.

5. Authorize the Department to apply for 1915(b) and (c) waivers to provide LME flexibility in management functions.

6. Direct the Department to create an "Incurred but Not Reported" category of funds such that services are paid based on the actual date of service rather than the date when the invoice is received. Categories created by the Department should be subject to approval by the Office of State Budget and Management

7. Permit the Department to require providers to bill LMEs for state-funded services within 60 days of the occurrence of the service.

8. Permit the Department to create a formal mid-year process by which to reallocate State service dollars among LMEs.

9. Remain mindful of the impact on services to people most in need of them, our vulnerable populations, in requesting additional funds from the federal government and in considering budget cuts at the State level.

10. Increase the tax on cigarettes to a level that reflects the national average and direct the resulting revenue towards prevention programs and reducing health care expenditures to treat lung disease, cancer, addiction disorders and other serious illnesses and conditions brought on by long-term tobacco use and exposure to second-hand smoke.

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FINDING TWO: STATE-OPERATED AND STATE-LICENSED FACILITIES

Consumers served in residential settings are entitled the assurance that treatment they receive is in a safe environment free of neglect and abuse.
In cases of abuse or neglect resulting in a resident's death, the issue must be resolved expeditiously and the aggrieving party must be held accountable. To encourage transparency, the LOC recommended and the General Assembly enacted a requirement that all deaths occurring in State institutions listed in Part 5 of Article 4 in Chapter 122C of the General Statutes be reported to the State Medical Examiner to determine if further investigation into the cause of death and circumstances surrounding the death is necessary. Despite this measure, there are questions regarding compliance with this requirement. Moreover there are hundreds of residential facilities licensed under Chapter 122C that remain outside the scope of the new law.

The Department must maintain a database that contains records of any death that occurs in a facility either operated or licensed under the provisions of Chapter 122C.
The database should be recorded and maintained in a database which would include the facility name, the time and date of the death, and circumstances surrounding the death. While it is important for full public disclosure to improve oversight and accountability, access to these records is intended to provide relevant details about the death but not compromise the patient's right to privacy. In order to improve compliance, all direct care and administrative employees must be aware of the procedures and legal requirements to be followed when a death occurs within their facility.

The General Assembly should strengthen the residency requirements to qualify for State-County Special Assistance.
The LOC in cooperation with the North Carolina Study Commission on Aging has studied the issue of consumers with mental illness residing in adult care homes. An influx of these consumers can strain the ability of the homes to provide adequate care, and also strain the limited resources of LMEs, who are responsible for coordinating care for individuals that reside within their catchment. The LOC supports increasing the residency requirements to qualify for special assistance.

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An Outpatient Commitment from State Psychiatric Hospitals should be for a period of not less than 180 days.

On multiple occasions this interim, the Committee heard concerns regarding methods of tracking and following up care for patients discharged from the State psychiatric hospitals. The State psychiatric hospitals, where appropriate, utilize the involuntary outpatient commitment process as part of its discharge planning and have found that applying the current statutory provisions has not had the desired results. Specifically, the hospitals have experienced difficulties with the ability to track post-patient care resulting in increased recidivism rates. As reported to the Committee, studies show outpatient commitment of less than 180 days actually increased hospital use and outpatient commitments are most effective when combined with regular mental health services. Treatment non-adherence detrimentally impacts patients and burdens the mental health, criminal justice, and social welfare systems. Effective and appropriate outpatient involuntary commitments can reduce violence, victimization, family strain, arrests, and improve medication adherence and quality of life.

The General Assembly should appropriate funds for a Residential Step Down Unit for consumers at the Murdoch Center's BART Unit.

The Murdoch Center – one of the State's three residential centers for developmental disabilities – offers a 12-bed residential program called the Behaviorally Advanced Residential Treatment (BART), for young men between the ages of 16 and 25 who have mild mental retardation, other developmental disorders, or extremely challenging behavior. Many of the residents have autism without severe to profound intellectual disability. The Murdoch Center has successfully treated many of these consumers in the BART unit, but needs a residential step-down unit to help consumers transition out of the Murdoch Center and into the community. Currently, the BART unit receives more referrals than it can accept, while some consumers at the BART unit could live in the community if they received appropriate and adequate transition supports including a step-down unit. The LOC supports funding for a step-down unit for these consumers.

The Department should oversee consumer access to privately-operated ICFs-MR.

Oversight by the Department is essential in order to ensure that consumers are served at the appropriate level of care. A screening tool implemented by LMEs would provide this oversight, would separate screening from service delivery, and would encourage LMEs to be involved in actively managing the consumers in the LME's catchment area who are in ICFs-MR.

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RECOMMENDATIONS: STATE-OPERATED AND STATE-LICENSED FACILITIES

1. Direct the Department to create and maintain a database of all deaths that occur in facilities governed by Chapter 122C of the North Carolina General Statutes. The database shall include the name and location of the facility, the time and date of the death, and relevant details relating to the death.

2. Direct the Department to provide training on the statutory and rule provisions relating to death reporting to all administrative and direct care employees who work in State Operated facilities.

3. Under the State Medicaid program, individuals seeking to qualify for Medicaid must provide certain documentation as evidence of residency of North Carolina. Likewise, to address significant increases in county expenditures for State-County Special Assistance, the General Assembly should change the residency requirement for eligibility for special assistance from 90 days to 180 days to decrease the likelihood of persons moving to North Carolina from border states solely for the purpose of qualifying for State County Special Assistance.

4. The Department of Health and Human Services should work with the Administrative Office of the Courts to implement a pilot program that would authorize judges to order outpatient commitment for a minimum of 180 days for qualifying individuals. The purpose of the pilot program would be to determine whether extended outpatient commitment would result in reduced recidivism and greater tracking and services for the outpatient committees. The General Assembly should appropriate the funds necessary to support the pilot program for the 2009-2011 fiscal - biennium.

5. Appropriate $300,000 in recurring funding and $1,500,000 in non-recurring funding to create a step-down unit for consumers served in the Murdoch Center's BART unit.

6. The Department of Health and Human Services shall identify a screening tool that will be used by LMEs to determine how consumers currently access services provided by ICFs-MR. This will help ensure that the services are provided to consumers at the appropriate level of care.

7. The General Assembly should continue funding the Housing Initiative (formerly the "Housing 400 Initiative") by appropriating $10 million to the Housing Trust Fund and $2.5 million to the Department for recurring

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operating support for approximately 500 units. By providing stabilizing services and supports to prevent crises from occurring, appropriate housing will reduce the need for State Psychiatric hospitals in the long-term.

8. The General Assembly should appropriate funds to DHHS to increase salary ranges for the Division, including State psychiatric hospital personnel, to help with recruiting and retaining qualified staff.

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FINDING THREE: COMMUNITY-BASED SERVICES

The Department should apply for waivers for Traumatic Brain Injury services
North Carolina's FY 2008-09 budget includes $2.7 million in dedicated State TBI funding, of which $1 million was newly-appropriated in the 2008 legislative session. However, there is concern that State dollars are insufficient to serve the TBI population. According to the Department, national statistics from the federal Centers for Disease Control and Prevention suggest that approximately 0.2% of the population is living with TBI (or approximately 18,500 North Carolinians). However, according to Department estimates, the State in 2008 served only 302 people with TBI in the community with state funds and 13 people with TBI in state facilities.

As of 2007, twenty-three states operated a special Home and Community Based Services Medicaid waiver for individuals with TBI. Typically, a TBI waiver is used to allow consumers to waive an institutional level of care (e.g., nursing home care) and to allow the State to establish asset and income levels for eligibility that differ from the State's standard Medicaid program.

Local inpatient psychiatric capacity must be fully funded and expanded.
Although the benefits of community-based care are many, State hospital usage – the most expensive type of care for the State – remains high, tying up resources that could be used to serve more consumers in less-expensive settings. Because Medicaid will not pay for inpatient care at a stand-alone psychiatric hospital for consumers aged 18-64, research by the North Carolina General Assembly's Program Evaluation Division indicates that the State pays 81% of the cost of care for adults in State hospitals, but only 41% of the cost of community-based care.

It is the State's policy that beds in the three State-run psychiatric hospitals are intended for long-term admissions for consumers who cannot be adequately or safely treated in the community, including in community general hospitals with psychiatric beds. However, as of December 2008, just under 45% of State hospital admissions, on average, were for seven days or less. These consumers should be served in their communities, not at State hospitals. The FY 2008-09 budget included partial-year funding to increase community capacity to achieve this goal.

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Regionally-Purchased Locally-Hosted Substance Abuse Services are an effective use of State dollars.

In the 2007 legislative session, the General Assembly directed the Department to spend $6 million of substance abuse dollars on regionally-purchased, locally-hosted substance abuse services (often called Cross Area Service Programs, or CASP); the General Assembly in 2008 increased that directive to $8 million. The Department reported to the LOC that it used these funds to increase community capacity for adult substance users and pregnant women and to increase the capacity of residential programs with a vocational component. The LOC finds that CASP is an appropriate and effective use of substance abuse dollars.

Fully fund the CAP-MR/DD Waiver's Tier 1 slots; Plan for future Tiers.

The purpose of tiered CAP-MR/DD waivers are to assure that individuals receive the services they need (no more and no less) and to manage the system's operation so that services are allocated equitably, with the highest-cost services and/or those delivered at the highest level of intensity going to those with the most significant needs. The 2008 General Assembly directed the Department to develop and implement four CAP-MR/DD tiers. To date, the Department has developed and implemented Tier 1 and Tier 4, and intends to carve Tiers 2 and 3 out of Tier 4.

Before the Department moves forward with the development, submission of proposal to CMS and implementation of a four-tiered waiver, the LOC needs to understand the Department's plan to assure that the four tiered waiver meets the purposes listed above. The LOC needs to see what services are assigned to each of the four tiers, at what intensity level and at what range of costs. The LOC is interested in having the CAP-MR/DD Waivers designed to assure that individuals receive the services they need with services and costs consistent with the intensity of their needs. This also has as a requirement that the development of a formula, based on a reliable, valid, statewide assessment of intensity of need, be administered to all persons eligible for DD services that assigns individuals to tiers based on measured intensity of need. In addition to waivers the General Assembly should appropriate sufficient funds to fully fund implementation of Tier 1 of the CAP-MR/DD program.

The Department must support and facilitate workforce development in the field of Developmental Disabilities

The North Carolina Council on Developmental Disabilities convened a workgroup ("Looking Forward: a Summit on the Developmental Disabilities System in North Carolina") to develop recommendations concerning services and supports for consumers with intellectual and developmental disabilities, and their families. The Summit noted areas for improvement within the current system, including the need for a viable workforce. The LOC has reviewed the recommendations of the Summit and believes that the Department should establish statewide competency and values-based portable training and certification requirements for direct support workers, front-line supervisors and case managers. To do this, the Department needs a staff member with expertise in assessing workforce issues, who can serve as the project manager for implementing the Division's workforce development initiatives, particularly the recommendations identified in the *MH/DD/SAS Workforce Plan.*

The General Assembly should provide funds for the Department to continue participating in the "Money Follows the Person" demonstration grant

The Money Follows the Person Demonstration Project is a federally-supported initiative to help transition consumers out of nursing facilities, state psychiatric hospitals, and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). The federal Centers for Medicare and Medicaid Services (CMS) provides a higher federal match for services for transitioned consumers. However, the enhanced federal match is not available for administration services, or for the first year (planning) of the Demonstration. For the remaining four years of the Project, the enhanced match is available for qualified home- and community-based services provided to each individual transitioned and is available for 12 months following transition. During the 2008 legislative session, the General Assembly appropriated funds for two FTE positions within the Division of Medical Assistance to implement the grant. The LOC supports providing the Department with the additional funding it needs to continue participating in the grant program.

The General Assembly should appropriate funds to scale up the Evidence-Based Mental Health Treatment for Children Pilot

The North Carolina Child Treatment Program is a pilot program serving children and adolescents who have been exposed to serious trauma, and their families. The program operates as a partnership between Duke and UNC and has been funded with $1.8 million in State and private funding. The pilot currently serves northeastern North Carolina by training licensed clinicians, linking traumatized

children and adolescents with trained clinicians, providing effective mental health treatment, paying for the treatment if needed, and providing ongoing clinical support to the clinicians. The LOC supports appropriating State funds to scale-up the pilot to provide statewide services.

The General Assembly should appropriate funds to advance recommendations of the NC IOM Substance Abuse Taskforce.

The 2007 General Assembly directed the North Carolina Institute of Medicine (NC IOM) to convene a taskforce to identify the continuum of services needed to treat substance abuse, including prevention, outpatient services, residential treatment, and recovery supports. The NC IOM found that addiction is a chronic disease that requires a recovery-oriented system of care throughout life and that therefore, it is necessary also to emphasize prevention and early intervention. The Taskforce provided the LOC with recommendations to improve substance abuse services in North Carolina; the LOC finds that funding is needed to advance several of the Taskforce's priority recommendations.

The NC IOM should study the availability of MH/DD/SA Services for military personnel

The LOC recognizes that as a State with a large military presence, North Carolina has many returning service personnel who have suffered a traumatic brain injury and/or who may have significant mental health and substance abuse needs. At the LOC's recommendation, the General Assembly in 2008 directed the Department to included veterans and their families as a target population for MH/DD/SA services; also, the Department has established the "Returning Support for Veterans Program" as a one-stop service where veterans and their families can receive all the information they need about available services. However, to assure that the available services are adequate, it is important to know how many service personnel are receiving services provided by the state, the nature of those services and the prevalence of unmet needs.

RECOMMENDATIONS: COMMUNITY-BASED SERVICES

1. Appropriate the necessary funds to the Department to establish a Workforce Development Specialist position within the Division of MH/DD/SAS.

2. Direct the Department to submit to the LOC by September 2009 a report about the tiered CAP-MR/DD waiver program. Specifically, the report must include:

   - The service array and intensity of CAP-MR/DD services for the two existing and two planned tiers;
   - How the relative intensity of need for each consumer will be determined and how this determination will be used to assign individuals into the tiers;
   - The criteria DHHS will use to select a valid assessment instrument and how the instrument will be administered;
   - Mechanisms to ensure operational accountability;
   - How the implementation of the tiers will lead to cost savings, how much cost savings are projected, and an estimate of how many additional consumers can be served within the current budget.

3. Appropriate funds for the 2009-2011 fiscal biennium to fully fund the implementation of Tier 1 of the CAP/MR-DD program.

4. Appropriate $10 million to the Department to implement one or more of the Substance Abuse Taskforce's priority recommendations, which included developing a comprehensive substance abuse prevention plan for use at the state and local levels; funding six pilot projects to implement county or multi-county comprehensive prevention plans; supporting efforts to reduce high-risk drinking on college campuses; and educating and encouraging healthcare professionals to use the SBIRT (screening, brief intervention, and referral to treatment) model promoted by the federal government.

5. Appropriate $2 million to the Department for the NC Child Treatment Program.

6. Direct the Department to allocate $10 million of its substance abuse funds to establish additional regionally-purchased, locally-hosted substance abuse programs.

7. Appropriate the necessary funds for the Department to continue to participate in the Money Follows the Person Demonstration Grant.

8. Direct the North Carolina Institute of Medicine (NCIOM) to conduct a study of State- and Medicaid-funded mental health, developmental disability and

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substance abuse services currently available to active, reserve and veteran members of the military and National Guard and the need for increased State services to these individuals. The NCIOM shall submit a report of its findings and any recommended legislation to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services prior to the convening of the 2010 Regular Session of the 2009 General Assembly.

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APPENDIX

Copies of the proposed legislation begin on the following page.

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U D

BILL DRAFT 2009-MCx-33 [v.2] (1/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2009 3:26:34 PM

Short Title:	Increase Cigarette Tax.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO INCREASE TO THE NATIONAL AVERAGE THE RATE OF TAX ON CIGARETTES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-113.5 reads as rewritten:

"**§ 105-113.5. Tax on cigarettes.**

A tax is levied on the sale or possession for sale in this State, by a distributor, of all cigarettes at the rate of ~~one and three fourths cents (1.75¢)~~five and ninety-five hundredths (5.95¢) per individual cigarette."

SECTION 2. This act becomes effective July 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H D

BILL DRAFT 2009-MGz-26* [v.31] (2/2)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
2/13/2009 8:30:23 AM

Short Title:	Recommendations of MH/DD/SA Oversight Comm.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ENACT VARIOUS LAWS TO IMPROVE THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a). Merger or Consolidation of LME's. –

(1) The Secretary of the Department of Health and Human Services shall not take any action prior to June 1, 2010, that would result in the merger or consolidation of local management entities (LMEs), or that would establish consortia or regional arrangements for the same purpose.

(2) Notwithstanding the provisions of subdivision (1) of this section, contiguous LMEs may implement a merger or consolidation if at least one of the following criteria is satisfied:

a. At least one of the LMEs does not meet the catchment area requirements of G.S. 122C-115 and the merger or consolidation is to overcome noncompliance with G.S. 122C-115; or

b. Each board of county commissioners within the multicounty area comprising each of the LMEs involved in the proposed merger or consolidation has approved the merger or consolidation.

(3) Contracts between LMEs for service authorization, utilization review, and utilization management functions do not constitute a merger or consolidation as addressed in this section.

SECTION 1.(b). Leadership Academy Funds. – There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ___ ($) for the 2009-2010 fiscal year and the sum of ___ ($) for the 2010-2011 fiscal year. These funds shall be allocated to LMEs for LME staff participation in the Mental Health Leadership Academy at the University of North Carolina Kenan-Flagler Business School.

SECTION 1.(c). LME Peer Training. – Beginning July 1, 2009, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with the Mental Health Leadership Academy, shall

hold at least one meeting each calendar quarter to facilitate peer training and peer sharing among LMEs with respect to best practices and innovations in management and coordination of mental health, developmental disabilities, and substance abuse services.

SECTION 1.(d). Medicaid Waivers. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services may develop and apply to the Centers for Medicare and Medicaid Services for additional 1915(b), and 1915(c) Medicaid waivers in order to increase the flexibility of LMEs with respect to management and coordination of mental health, developmental disabilities, and substance abuse services. If approved, the Department shall not implement any waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of any waiver developed or applied for pursuant to this subdivision to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than March 1, 2010.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall apply to the Centers for Medicare and Medicaid Services (CMS) for a 1915(c) waiver to permit individuals who sustain traumatic brain injury after age 22 to access home and community-based Medicaid services. If approved, the Department shall not implement the waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of the waiver to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than March 1, 2010.

(3) Not later than September 30, 2009, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit a written report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services summarizing its implementation of Tiers 1 and 4 of the CAP-MR/DD program and future plans for implementation of Tiers 2 and 3 of the CAP-MR/DD program. The summary shall include an explanation of (i) the planned array and intensity level of services to be made available under each of the four tiers, (ii) the range of costs for the planned array and intensity level of services to be made available under each of the four tiers, (iii) how the relative intensity of need for each CAP eligible individual will be reliably determined, and (iv) how the determination will be used to assign individuals appropriately into one of the four tiers. The Department shall not develop or submit an application to the Centers for Medicare and Medicaid Services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program until it has submitted the report required by this subdivision.

SECTION 1.(e). State/County Special Assistance Residency Requirements. – G.S. 108A-41(b) reads as rewritten:

"(b) Assistance shall be granted to any person who:

(1) Is 65 years of age and older, or is between the ages of 18 and 65 and is permanently and totally disabled; and

(2) Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission; and

(3) Is one of the following:

a. A resident of North Carolina for at least ~~90~~180 days immediately prior to receiving this assistance;

b. A person coming to North Carolina to join a close relative who has resided in North Carolina for at least 180 consecutive days immediately prior to the person's application. The close relative shall furnish verification of his or her residency to the local department of social services at the time the applicant applies for special assistance. As used in this sub-subdivision, a close relative is the person's parent, grandparent, brother, sister, spouse, or child; or

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181."

SECTION 1.(f). – Child Treatment Program Funds. – There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two million dollars ($2,000,000) for the 2009-2010 fiscal year and the sum of two million dollars ($2,000,000) in recurring funds for the 2010-2011 fiscal year for the North Carolina Child Treatment Program. These funds shall be used to provide (i) training and ongoing support to clinicians who provide treatment under the program and (ii) evidence-based mental health treatment to children and adolescents residing in this State who have experienced serious psychological trauma and their families.

SECTION 1.(g). – Fully fund implementation of Tier 1 of CAP/MR-DD Program. – There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of $ for the 2009-2010 fiscal year and the 2010-2011 fiscal year. These funds shall be used to fully fund implementation of Tier 1 of the CAP/MR-DD Program.

SECTION 1.(h). – Housing Initiative Funds to reduce long-term need for State psychiatric hospitals. – There is appropriated from the General Fund to the Housing Trust Fund the sum of ten million dollars ($10,000,000) for the 2009-2010 fiscal year for the Housing Initiative in order to reduce the need for State psychiatric hospitals in the long-term.

SECTION 1.(i). – DMH/DD/SA Funds for Housing Initiative Units. – There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two million five hundred thousand dollars ($2,500,000) for the 2009-2010 fiscal year and the sum of two million five hundred thousand dollars ($2,500,000) for the 2010-2011 fiscal year to continue operating support for an estimated 500 units of the Housing Initiative in order to reduce the need for State psychiatric hospitals in the long-term.

SECTION 2.(a). Billing Changes. –

(1) The Department of Health and Human Services (DHHS) shall create an "incurred but not reported" category of funds such that mental health, developmental disabilities, and substance abuse services provided in May and June of each fiscal year could be billed using normal protocols, thereby allowing State funds used to pay for these services to be reconciled to the correct fiscal year. The Department shall submit proposed new categories to the Office of State Budget and Management for its review and approval.

(2) The Department of Health and Human Services may require that providers of mental health, developmental disability and substance abuse services submit bills to the LME for State-funded services within sixty days of the date the services were provided.

SECTION 2.(b). Service Dollar Re-allocations. – The Department of Health and Human Services may create a mid-year process by which it can reallocate State service dollars away from LMEs that do not appear to be on track to spend the LME's full appropriation and towards LMEs that appear able to spend the additional funds

SECTION 2.(c). Screening tool for ICF/MR placement. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall identify a screening tool that will determine how consumers currently access services from Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and that will ensure that consumers of these services are served at the appropriate level of care. The screening tool identified by the Department shall be administered by the LME to ensure that the screening is provided independent of the service provider and that LMEs are involved in actively managing the care of consumers in the LME's catchment area who are residents in ICFs/MR.

(2) Not later than March 1, 2010, the Department of Health and Human Services shall report on the identification and implementation of the screening tool to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 2.(d). Death reporting in facilities providing MH/DD/SA services. –

(1) The Department of Health and Human Services shall establish and maintain a database of all deaths occurring in facilities subject to regulation under Chapter 122C of the General Statutes. The database shall include the name and location of the facility, the time and date of death, and the cause of death as well as all details surrounding the death. All facilities regulated under Chapter 122C of the General Statutes, and all facilities required by law to report death occurring in the facility to the State Medical Examiner, shall report the information to the database within ten days of the date of the death.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall provide training on death reporting to administrative and direct care employees that are employed in State facilities subject to regulation under G.S. 122C-181.

SECTION 2.(e). Funds for Regionally-Hosted Substance Abuse Services. – Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the 2009-2010 fiscal year for substance abuse services, the Department shall allocate ten million dollars ($10,000,000) for the 2009-2010 fiscal year to support regionally-hosted substance abuse services. These funds shall be allocated to continue or expand Cross Area Service Programs (CASP) and other substance abuse treatment and prevention initiatives.

SECTION 2.(f). Money-Follows-the-Person Demonstration Grant. – There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of forty thousand dollars for the 2009-2010 fiscal year. These funds shall be used to supplement a

federally-supported grant for the transition of consumers out of nursing facilities, State psychiatric hospitals, and Intermediate Care Facilities for the Mentally Retarded (ICFsMR) to more appropriate levels of care.

SECTION 2.(g). NCIOM Substance Abuse Task Force Recommendations. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars ($10,000,000) for the 2009-2010 fiscal year. These funds shall be used to implement one or more of the NCIOM Substance Abuse Task Force priority recommendations. Priority recommendations of the NCIOM Task Force include:

(1) Development of a comprehensive substance abuse prevention plan for use at the State and local levels.

(2) Providing funding for the establishment of six pilot projects to implement county or multi-county comprehensive prevention plans.

(3) Supporting efforts to reduce high-risk drinking on college campuses.

(4) Development of a pilot program to provide chronic disease management services to substance abuse clients and former clients. The purpose of the pilot is to decrease the number of short-term hospital admissions and to provide discharge planning and follow-up to reduce substance abuse client recidivism.

(5) Educating and encouraging healthcare professionals to use the screening, brief intervention, and referral to treatment (SBIRT) model promoted by the federal government.

SECTION 2.(h). Service Authorization, Utilization Review, and Utilization Management.

(1) The Department of Health and Human Services shall continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs for all clients. Not later than January 1, 2011, the Department shall return utilization review, utilization management, and service authorization for publicly funded mental health, developmental disabilities, and substance abuse services to LMEs representing in total at least sixty percent (60%) of the State's population. An LME must be accredited for national accreditation under behavioral health care standards by a national accrediting entity approved by the Secretary and must demonstrate readiness to meet all requirements of the existing vendor contract with the Department for such services in order to provide service authorization, utilization review, and utilization management to Medicaid recipients in the LME catchment area. Not later than July 1, 2010, the Department shall designate those LMEs that will be performing utilization review, utilization management, and service authorization on and after January 1, 2011, in accordance with this section.

(2) The Department shall not contract with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligate the State for these functions beyond September 30, 2010. The Department shall require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments, as well as person-centered plans and random or triggered audits of services and assessments.

SECTION 2.(i). Outpatient Commitment. – The Department of Health and Human Services and the Administrative Office of the Courts shall develop a pilot program to test a new process for tracking and providing services to persons in State psychiatric hospitals for whom an outpatient commitment order has been issued. The pilot should initially focus on

individuals in State hospitals where the individual's treatment history is known, and should provide for extended outpatient commitment for not less than 180 days. The pilot shall include arrangements with LMEs as the point of accountability-tracking and overseeing the individual's services and treatment at all times. The pilot shall identify a provider willing to accept outpatient commitments that have a history of difficulty in maintaining tracking and treatment of the client. The pilot shall also arrange for the designation of hospital liaison personnel to assist with discharge planning. Except for the 180 extended outpatient commitment time, if a conflict arises between this subsection and Part 7 of Article 5 of Chapter 122C of the General Statutes pertaining to outpatient commitments, Part 7 of Article 5 prevails.

SECTION 2.(j). Workforce Development Funds. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of $ for the 2009-2010 fiscal year, and the sum of $ for the 2010-2011 fiscal year. These funds shall be used to establish a workforce development specialist position in the Division.

SECTION 2.(k). Psychiatric Hospital Bed Funding. There is appropriated in the to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of thirty-two million nine hundred seventy-two thousand one hundred sixty dollars ($32,972,160) for the 2009-2010 fiscal year. These funds shall be allocated as follows:

(1) $16,985,660 to fully fund psychiatric hospital bed days funded in part for the 2008-2009 fiscal year, and

(2) $16,096,500 to purchase one hundred fifty additional local inpatient psychiatric beds or bed days.

The one hundred fifty additional beds or bed days funded under subdivision (2) of this subsection shall be distributed across the State according to need as determined by the Department. The Department shall enter into contracts with the LMEs and community hospitals for the management of beds or bed days funded under this subsection. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 10 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient services under contract with community hospitals, including beds or bed days being purchased through Hospital Pilot funds appropriated in S.L. 2007-323. Not later than March 1, 2010, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or bed days purchased (i) with local funds, (ii) from

existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection.

SECTION 2.(l). BART Step-down Unit Funds. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one million eight hundred thousand dollars ($1,800,000) for the 2009-2010 fiscal year. These funds shall be used to develop a behaviorally advanced residential treatment (BART) step-down unit that would be operated by the Murdoch Center. These funds include private provider training and technical assistance to facilitate replication through the State.

SECTION 2.(m). Funds to increase staffing and salary ranges at DHHS and the State psychiatric hospitals.

There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of $ for the 2009-2010 fiscal year, and the sum of $ for the 2010-2011 fiscal year. These funds shall be used to increase staff and raise salary ranges for Division and State psychiatric hospital personnel.

SECTION 2.(n) The North Carolina Institute of Medicine (NCIOM) is requested to conduct a study of mental health, developmental disability and substance abuse services that are funded with Medicaid funds and with State funds. The purpose of the study is to determine what services are currently available to active, reserve, and veteran members of the military and National Guard and the need for increased State services to these individuals. The NCIOM shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before the convening of the 2010 Regular Session of the 2009 General Assembly.

SECTION 3. Section 1.(a) is effective when this act becomes law. The remainder of this act becomes effective July 1, 2009.

LOC 2009 Report to the 2009 Regular Session
Bll Draft Recommendation Crosswalk
[Based on 2.13.09 Report Draft]

Finding / Recommendation	Topic	Bill Draft Provision	Provision Cost
Finding 1, Rec. 1	LMEs Service Auth and UM	Sec. 2(h)	-
Finding 1, Rec. 2	LMEs Service Authorization	Sec. 1(a) sub 3	-
Finding 1, Rec. 3	LME Mergers	Sec. 1(a)	-
Finding 1, Rec. 4	Mental Health Ldsp Academy	Sec 1(b) and 1(c)	Undetermined
Finding 1, Rec. 5	1915(b)(c) waivers	Sec. 1(d)	-
Finding 1, Rec. 6	IBNR billing for LMEs	Sec. 2(a)(1)	-
Finding 1, Rec. 7	Providers bill w/in 60 days	Sec. 2(a)(2)	-
Finding 1, Rec. 8	DHHS reallocate $ mid-yr	Sec. 2(b)	-
Finding 1, Rec. 9	Economic Crisis	None	-
Finding 1, Rec. 10	Tobacco tax	2009-MCx-33	-
Finding 2, Rec. 1	Database	Sec. 2(d)	-
Finding 2, Rec. 2	Training on death reporting	Sec. 2(d)	-
Finding 2, Rec. 3	SA residency requirement	Sec. 1(e)	-
Finding 2, Rec. 4	Outpatient commitment	Sec. 2(i)	-
Finding 2, Rec. 5	BART step-down	Sec. 2(l)	1,800,000
Finding 2, Rec. 6	ICF-MR Screening tool	Sec. 2(c)	-
Finding 2, Rec. 7	Housing 400 Initiative	Sec. 1(h) and 1(i)	12,500,000
Finding 2, Rec. 8	Increase DHHS salary ranges	Sec. 2(m)	Undetermined
Finding 3, Rec. 1	DHHS workforce specialist	Sec. 2(j)	Undetermined
Finding 3, Rec. 2	CAP-MR/DD report	Sec. 1(d)(3)	-
Finding 3, Rec. 3	Fully fund CAP-MR/DD Tier 1	Sec. 1(g)	3,333,333
Finding 3, Rec. 4	NC IOM SA Taskforce	Sec. 2(g)	10,000,000
Finding 3, Rec. 5	NC Child Treatment Teams	Sec. 1(f)	2,000,000
Finding 3, Rec. 6	CASP for SA	None	-
Finding 3, Rec. 7	Money follows Person	Sec. 2(f)	40,000
Finding 3, Rec. 8	NCIOM veterans study	None	-
Finding 3, [To be added]	Local Inpatient capacity	Sec. 2(k)	33,082,160
		Total	**$ 62,755,493**

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	9/23/09	10/14/09	11/10/09	12/9/09	1/13/10	2/10/10	3/10/10	4/14/10	5/6/10	9/8/10	10/13/10	11/9/10	12/8/10	1/12/11			
Senator Martin Nesbitt, Co-Chair	√	√	√	√	√	√	√	√	X	X	X	X	√	√			
Senator Austin Allran	√	√	√	X	√	√	X	X	X	√	√	X	√	√			
Senator Bob Atwater	√	√	√	√	√	X	√	X	X	√	√	√	√	√			
Senator Doug Berger	√	√	√	√	√	√	√	√	X	X	X	X	√	X			
Senator Charlie Dannelly	X	√	√	√	√	√	√	√	X	√	√	√	√	√			
Senator Jim Forrester	√	√	√	X	√	X	X	√	√	√	√	X	√	X			
Senator Ellie Kinnaird	√	√	√	√	√	√	√	X	√	√	√	√	X	√			
Senator William Purcell	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
Representative Verla Insko – Co-Chair	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
Representative Martha Alexander	√	√	X	√	√	X	X	√	√	√	√	X	X	√			
Representative Jeffrey Barnhart	√	√	√	√	√	√	√	√	X	√	√	√	√	√			
Representative Beverly Earle	√	√	√	√	√	√	√	√	X	√	X	√	√	√			
Representative Bob England	√	√	√	√	√	√	√	√	√	√	X	X	√	X			
Rep. Jean Farmer-Butterfield	X	√	√	X	√	√	√	√	√	√	√	√	√	√			
Representative Carolyn Justus	√	√	X	√	X	X	√	√	√	√	X	X	X	X			
Representative Fred Steen	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
STAFF																	
Rennie Hobby	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
Joyce Jones	√	√	√	√	√	√	X	√	√	√	√	√	√	√			
Shawn Parker	√	√	√	√	√	√	√	√	√		√	√	√	√			
Susan Barham	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
Ben Popkin	√	√	√	√	√	√	√	√	√	√	√						
Lisa Hollowell	√	√	√	√	√	√	√	√	√	√	√	√	√	√			
Gann Watson	√	√	√	√	√	√	X	X									
Janice Paul											√	√	√	√			
ADVISORY MEMBERS																	
Senator Larry Shaw	X	√	√	X	X	X	√	√	√	√	√	√	X	X			
Representative Van Braxton	√	√	√	√	√	√	√	X	X	√	√	X	X	X			
Representative William Brisson	√	√	√	√	X	√	√	√	√	√	X	√	X	√			

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

AGENDA

September 23, 2009, 10:00 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair Presiding

I. Greetings, Opening Comments and Introduction of Members 10:00-10:15
Representative Verla Insko, Co-Chair
Senator Martin Nesbitt, Co-Chair

II. Overview of 2009 Legislative Actions 10:15-11:00
Lisa Hollowell and Shawn Parker, LOC staff

III. DHHS Response to Budget Cuts and Enacted Legislation 11:00-12:30
Lanier Cansler, Secretary, DHHS

Lunch 12:30-1:30

IV. Community Support Services 1:30-2:30

- Status of Community Support Services
  Dr. Craigan Gray, MD, Director, DMA
- Overview for Transition
  Leza Wainwright, Director, Div. of MH/DD/SAS

V. CAP-MR/DD Supports Waiver 2:30-3:00
Leza Wainwright, Director, Div. of MH/DD/SAS

VI. DHHS- Divisions and Offices Organizational Structure 3:00-3:15

- Division of Medical Assistance
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- Division of State Operated Healthcare Facilities

VII. Closing Comments and Adjourn 3:15-3:30
Representative Verla Insko, Co-Chair
Senator Martin Nesbitt, Co-Chair

Next Meeting:
Wednesday October 14th

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES	9/23/09																
MEMBERSHIP																	
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	X																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	X																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

September 23, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, September 23, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justus, and Fred Steen. Advisory members Representative Van Braxton and Representative William Brisson were also present. Representative Pat Hurley and Senator A.B. Swindell were also in attendance.

Lisa Hollowell, Joyce Jones, Gann Watson, Ben Popkin, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She introduced new members to the Committee, Senators Doug Berger and Ellie Kinnaird. Representative Insko also introduced Mike Watson who joins the Department of Health and Human Services as the new Assistant Secretary for Mental Health Services Development. She also said that Dr. Patricia Porter would be continuing as a consultant to the LOC. Leza Wainwright, Director of the Division of MH/DD/SAS, was recognized to introduce Stuart Berde, Acting chief of Advocacy and Customer Services and Luckey Welsh, Director of the Division of State Operated Healthcare Facilities. Representative Insko asked for a motion to approve the minutes from the last LOC meeting on February 17, 2009. The motion was made by Senator Purcell and the minutes were approved.

Shawn Parker from the Research Division provided a summary of the ratified legislation from the 2009 Session. (See Attachment No. 2) He addressed relative legislation that was enacted under four general categories – LMEs, Facilities, Involuntary Commitments, and Medicaid appeals.

Next, Lisa Hollowell from the Fiscal Division reviewed major budget actions from the Joint Conference Committee Report on Continuation, Expansion and Capital Budgets. (See Attachment No. 3)

- Total appropriation from General Fund for Division was $660M, down from over $800M in the Continuation Budget.
- Positions eliminated – do not have to meet the 350 positions targeted but must meet the money reduction; report will follow later on how this was achieved.

- Items No. 3, 4, and 5 all relate to amount of fund reductions going to LMEs, $75M for 09/10 which includes an additional $15M mandated by the Governor of 5% for agencies.
- Consolidation of Case Management - $41 M in 09/10 and $72.9M – recurring reductions; impacts mental health and public health; Department to report on comprehensive plan for consolidation.
- LME System Management Funds – Administrative dollars, reduction in State funds $3M 09/19 and $3.6M 10/11

Ms. Hollowell then reviewed the summary of the Special Provisions. (See Attachment No. 4) She said that the summary included Special Provisions that had not been addressed or were related to a money item pertaining to the Division on MH/DD/SAS.

Mr. Lanier Cansler, Secretary, Department of Health and Human Services stated that he hoped to address the LOC each month to report on the issues facing DHHS in order to receive input and move forward in a team approach. Secretary Cansler provided a handout "Project Excel" (See Attachments No. 5) and explained the Department is looking at technology, looking at preparedness, analyzing needs and weaknesses, looking at how to strengthen these items, and how to apply more measures to outcomes that are desired. The Secretary provided a second major initiative handout "State Operated Healthcare Facilities: System of Care" (See Attachment No. 6) and explained how State facilities would now operate as a system instead of acting independently; developing consistency across all facilities; maintain consistent high standards; revisit process of allocating funds to LMEs, and well trained employees with ongoing training offered.

The Secretary then addressed the Committee in response to recent legislative directions, some of the items the Secretary spoke to in this presentation include:

- Budget cuts - $350-$400M impact to the mental health system.
- Involving perspectives from all stakeholders regarding budget reductions.
- Target dates for cuts for Medicaid items will be missed due to delays in CMS approval and implementation; for every month there is a delay, there is a $54M increase that must be recognized the remainder of the year.
- $75M reduction to LMEs including the Governor's cut – reduction to LME was based on formula that took into account the special provision that directed the cut.
- October date to stop new clients into Community Support has been extended to January 1 to allow providers ample time to transition.
- Consolidation of case management difficult but necessary to create system of care that is coordinated.
- New website available in 60 days called "DHHS Open Window" – view of each division's programmatic activities and services, see related budgets showing State and federal dollars, program measures currently in place, contracts associated with those programs, and all the information regarding what the program is and what it does.
- Hope to have restraining order lifted to begin moving patients out of Dix Hospital into Central Regional. Adequate space is not available in new facility for forensic patients or children. Dix will probably maintain 120 patients for a period of time.

- Some responsibilities of the new Secretary of Mental Health Development will be to build capacity; consistency in endorsement process; and coordinate efforts between those providing services, Medicaid, public health, Community Care Network in Rural Health.
- Not closing all of the Level III and IV group homes, mostly those over 16 beds; Department is tracking all children; concerned for those children coming into the system due to limited capacity.
- Case management is not being taken out of public health; there will be less money to work with; public health at the local level will have complete freedom to design a case management program to meet the mutually agreed upon objectives.

After lunch, Representative Insko asked Dr. Craigan Gray, Director of the Division of Medical Assistance, to address the status of Community Support Services (CS). (See Attachment No. 7) Dr. Gray said there were those within the State that felt that CS was one of the biggest entitlement programs ever seen for the vendor, and others have said the service was one of the fundamental mental health supporting mechanisms in the State that needs to continue. He reviewed the cost associated with CS since 2007 and stated that many recipients had been "parked" in CS for a long period of time. Important issues addressed during his presentation included:

- Review of the many lessons learned as DMA refines and redesigns the CS program moving forward in other services.
- Strong collaboration of stakeholders during the CS transition process.
- All 33,000 in CS program will have a discharge plan.
- Improve the quality of the providers by eliminating paraprofessionals in CS.
- Moved date of no new CS admissions from January 1, 2010 to coincide with the implementation of the State Plan Amendment. Objective is to keep a system of mental health support in communities. Also in the State Plan Amendment will be a new refined case management definition. A new peer support definition will be submitted under a different State Plan Amendment.
- Transition date of June 2010 should have the current enrollment of 33,000 down to 2,300 children (EPSDT) and 0 adults.
- The basic philosophy changing the financial target has to do with the value added community based mental health services, not volume added community health services.
- Other programs have overlap in level of services with elements of community support in these programs. (Programs have entry date and exit date thus avoiding the "parking" of patients.)
- Transition allows promotion of quality services and monitor growth – measuring outcomes and refining service definitions.
- Important to break down communication barriers between providers and case managers.
- New Excel Program, a basic management tool which allows DMA to accomplish objectives. Decisions that can be based on real-time data tracking the financial progress and financial scope of all programs comparing month-to-month, year-to-date and benchmark goals of the future. Program will enable all to monitor program.

Dr. Gray was asked why there was so little money shown on the Department's slide for CS funding for FY2009-10. Tara Larson, Chief Clinical Operations Officer, DMA, answered that the remaining funds from CS (after the $65M reduction) would be spent in other Medicaid categories that offer similar services as CS did. She added there will be new Medicaid service definitions for the Enhanced Community Support and the other lower level services previously provided under CS, will continue to be provided within other existing Medicaid categories. Dr. Gray said he would send a list of all the LMEs and a list of all enhanced services offered in those LMEs. The Department will present specific information on these services at the next LOC meeting showing the breakdown of expenditures within DMA and what those funds will be paying for once CS is gone. Senator Berger requested that the staff detail how much money is available for community based programs once CS is closed. The Committee also requested descriptions of Intensive In Home Services and Multisystemic Therapy. In response, Secretary Cansler suggested that the Department would provide a chart depicting the services that were offered under Community Supports, what the arrays of services are, and how they fit together. Along with that information, Senator Berger said that $65M was cut in FY 2009-10 and $95.5M in FY 10-11. Based on information the Department gave the General Assembly the program had $640M but the projection in the power point was $449M, allowing for a $200M difference. He requested reconciliation in the difference.

The Committee as a whole expressed great concern over the availability of alternative services statewide, the lack of a service definition for low needs children, whether there was sufficient time to restructure the transition from CS to other services.

Next, Leza Wainwright, Director of the Division of MHDDSAS, gave an overview of the Community Support transition. (See Attachment No. 8) Ms. Wainwright noted points included in the Special Provision passed as part of the budget.

- Admissions to CS originally planned to stop this October has been changed to January 2010.
- A broad-based steering committee has been convened to help through the transition process.
- Data figures include individuals receiving CS paid for by State funds; fewer children than Medicaid and more adults but a total of less people receiving State funded CS.
- Variability by LME reflects Medicaid eligibility patterns and provider growth patterns.
- East Carolina Behavioral Health and Cherry Hospital have a pilot project with Peer Support group working with consumers transitioning them back into the community.
- Three work groups in steering committee are looking at Comprehensive Service Provider, Endorsement for Replacement Services, Clinical transitions, will complete work by September 30, with full group meeting on October 1.

Secretary Cansler spoke briefly on the Divisions and offices organizational structure. He welcomed and provided brief background information on Mike Watson, Assistant Secretary of Mental Health Services Development who begins work on September 30; Dr. Craigan Gray, Director of DMA; and Luckey Welsh, Director of State Operated Healthcare Facilities.

There being no further business, the meeting adjourned at 3:30 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Whited	NC Med Society 222 Person
Chy Burgess	NCMS
Gill Hinton	
Peggy Dalton	Sayano Grp
Ken McLeod	CFSA-NC
Fred Wadsworth	Easter Seals UCP-NC
Rebecca Troutman	NCACC
DAWN BARNES	Poyner Spruill
Maureen Morrell	Autism Society of NC
Annalise Dolph	DRNC
Janet Boyce	NDmdgt

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gail Boswell	Wilson, NC / NCMHCO gsboswell@aol.com
Kim Schmidt	NC MHCO Raleigh, NC
Marc Jacques	NC MHCO – Executive Director Raleigh, NC
NANCY BLACK.	SCFAC. MARKETLINK2002 @ YAHOO.COM.
MARTHA LOWRANCE	VA DMHDDA
MICHAEL COTTINGHAM	CENTERPOINT HUMAN SERVICES
	MHM Services
	TPG
	RHA
	Pride In NC
	MHM Services Inc.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
William Stanley	NAMI-WAKE
Rev. Dr. Floyd McKissick Johnson	NC-Council / Board Member Cumberland County
Hank Debnam	Cumberland County LME, Fayetteville, N.C.
Satana Deberry	TROSA
ALEXANDER DUDA	NCCPPR
Donald Bramer	CMS
Julia Leggett	The Arc of NC
Anna K. MacDonald Dobbs	The Arc of NC
Angela Jones	Native Angels Homecare Agency, Inc.
Bobbie Jacobs-Glatfelter	Native Angels Homecare Agency, Inc.
John Carbone MD	NC Dept of Correction (Mental Health)

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Hoffman	OSBM
John Dervin	Gov's Office
Cim Brailer	OPC LME
Peyton Magnum	
Jamal Jones	NCHA
Leslie Bracken Conn	Capstrat
Lu-Ann C Penny	NCPA
Tracy Kimbrell	Parker Poe
Tom Gilmer	KidsPeace

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roy Wilson	~~East~~ Carolina Behavioral Health
Yvonne Copeland	NC Council of Community Programs
Ken Jones	Eastpointe
Rhett Melton	Pathways LME
Sharon Prevatte	Southeastern Regional LME
Kathy S. Baker	Southeastern Regional LME
Will Woodell	Value Options
Karen Salacki	The Beacon Center
Mary Shannon Thomas	STEP CMHC/UNC SSW
Bebe Smith	STEP/UNC Department of Psychiatry

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Bert Fisher	Community Partnerships, Inc.
Laurie Stickney	Community Partnerships, Inc
Charles Hinn	Charles Hinn & Son, Inc
Tom Wilson	OE Enterprises, Inc. 717 N. Park Ave Arlington, NC 27217
Sandra Farmer	Brain Injury Association of NC
Dennis Beardshaw	Residential Services Inc.
John Lautarbach	Caring for Children PO Box 19113 Asheville, NC 28815
Rudolph G. Clark	R. Clark & Assoc.
Chris Fitzsimon	NC Policy Watch
Kim Genardo	NBC 17 News
James Romoser	

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 23, 2009

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Alecia Anderson	North Carolina State University Dept of Sociology and Anthropology
Tom Taaffe	Self
Don Cochran	DBH
Al Adt	self
Mary Shott	Self/dtr.
Kathy Griffin	Orbit Billing
Misty Martin	Lighthouse Counseling Center, LLC Self 2800 Breezewood Ave, Suite
Mike Mauk	Fayetteville, NC 28303
Bain Jones	OAH
Wayne Williams	OSBM

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Name of Committee _____ Date _____

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NAME	FIRM OR AGENCY AND ADDRESS
Daniel Hahn	AL Lmt
Pat Potter	Gen Assembly - Research
TODD CLODFELTER	SOUTHLIGHT, INC / SA FEDERATION
Ron Rau	Alcohol & Drug Servs 119 Chestnut Dr, High Point, NC
Tom Thomas	New River Behavioral Health Care 895 State Farm Rd, Boone, NC
Pam Andrews	"
Dorothy Attman	parent of CAP recipient 517 N. East St. Raleigh 27604
Louise B Fisher	Volunteer Advocate for mentally ill
Vicki Smith	DRNC

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Richards	Nami - Pres. Hickory Affiliate
Margaret Malone	NCHFA

Summary of Substantial Ratified Legislation 2009 Session to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

LMEs:

SL 2009-189 (H576)- Authorizes an LME *to remove a provider's endorsement* when a provider *fails to allow access* to the facility in accordance with rules established under G.S. 143B-139.1 (include rules governing monitoring) and in the event of an emergency or in response to a complaint related to the health or safety of a client.

SL 2009-186 (H673)- Directs *LME's to develop a waiting list* of persons with intellectual or *developmental disabilities* that are waiting for specific services. The Secretary is directed to establish criteria and rules relating how the date should be collected. The data is to include numbers of persons who are: (1) Waiting for residential services; (2) Potentially eligible for CAP-MRDD; (3) In need of other State funded services and supports.

SL 2009-191 (H672)- Requires *single stream LMEs to report on the allocation of service dollars* biannually and allow public comment on the allocation at a regularly scheduled LME board of directors meeting. The act requires any LME prior to proposing reducing State funding to HUD group homes and HUD apartments to have Departmental approval and hold a public hearing prior to reducing HUD funding. The act directs the Department to *analyze the effectiveness* of single-stream funding.

SL 2009-190 (H1087)- Extends the requirement to establish human rights committees to provider entities and renames these committees "*client rights and human rights committees*".

Facilities:

SL 2009-299 (S799)- Expands the *death reporting requirement* to include patients *recently discharged* (14 days) and requires the facility to report the death to the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 106-402) as well as the Secretary. The act provides the following information related to the death is *public information*:

- The name, sex, age, and date of birth of the deceased.
- The name of the facility providing the report.
- The date, time, and location of the death.
- A brief description of the circumstances of death
- A list of all entities to whom the event was reported

Only applies to State Operated Facilities

SL 2009-361 (H1309)-Directs Secretary to adopt additional rules for residential facilities that treat individuals with TBI and makes changes to the NC Traumatic Brain Injury Advisory Council including renaming the council to the NC Brain Injury Advisory Council.

SL 2009-184 (H1088)- amends the State purchase and contract laws to exempt group purchases made by developmental centers, neuromedical treatment centers, and alcohol and drug abuse treatment centers through a competitive bidding purchasing program.

SL 2009- 490 (H884) directs the Department to establish a pilot program to study the *use of electronic supervision devices* as an alternative means of supervision *during sleep hours* at facilities for children and adolescents who have a primary diagnosis of mental illness and/or emotional disturbance. The act further directs the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to adopt rules establishing standards for electronic monitoring and alternate staffing requirements at such facilities.

Prepared by LOC Staff
09/22/2009

Involuntary Commitment:

SL 2009-340 (H243) Provide if inpatient treatment is warranted, and a 24 hour facility is not immediately available or appropriate, the respondent *may be detained at the site of the first examination* and the custody order remains in effect *for up to 7 days* and provides a process for required release after that period of time. The Act *expands the Involuntary Commitment Pilot program* to *15 LMEs* (allows a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals)

SL 2009-315 (H1189)- Requires a physician or eligible psychologist to contact the LME when a respondent has been scheduled for an appointment with an outpatient treatment center. The act also allows first examinations for involuntary commitment for mental illness to be conducted by telemedicine.

SL 2009-574 (H945) Mental Health Commitment Statutes (H.B. 718 – Brisson, Justus) – The Legislative Research Commission may study the *involuntary commitment statutes* in Chapter 122C of the General Statutes, in particular G.S. 122C-263(a), to determine *if an individual* lawfully ordered to undergo an examination by a physician or eligible psychologist is being *appropriately supervised* to protect the health and safety of the individual and others during the period of the individual's examination.

Certain Medicaid Appeals:

SL 2009-550 (H274) Section 1.1-1.3 and SL 2009-526 (H191) Section 2-

Section 1.1(a) & (b) modifies the appeals process for *recipients* by reducing the minimum days prior to the effective date of an adverse action that the Department shall provide proper notice and codifies that during the appeal an appellant has a right to services at the level or manner prior to the appeal.

Subsection (b) makes the following changes:

- Directs OAH to hear cases with 55 days of appeal (was 45 days)
- Provides hearings shall be conducted telephonically or by video conference, unless the appellant requests an in-person hearing. In-person hearings are to be in Wake County, but can be moved to the appellant's county of residence upon good cause shown.
- Stipulates continuances shall only be granted in accordance with NCAC rules (currently NCAC03.0118 would govern), continuances are not to be granted on the day of the hearing, and failure to appear (after proper notification) will result in an immediate dismissal.
- Authorizes petitioner to submit evidence obtained prior to and subsequent to the Department's action
- Provides that in each adverse action the hearing shall determine if the Department substantially prejudiced the rights of the appellant by exceeding its authority; acting erroneously; failing to use proper procedure; acting arbitrarily or capriciously; or failing to act as required by law.

Section 1.1(c) modifies the appeal process for *community support providers* as follows:

- Authorizes a hearing officer to take testimony and receive evidence by telephone or electronic means
- Removes a hearing officer's authority to subpoena the attendance of a witness
- Modifies what the Department must provide as a record of the hearing if the provider petitions for judicial review
- Requires a final decision to be rendered with 180 days (was 90 days) from the date of filing of the petition.

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Major Budget Actions - Joint Conference Committee Report on Continuation, Expansion and Capital Budgets

FY2009-10 and FY2010-11, *Session Law 2009-451, Senate Bill 202*

Attachment 3

1. Adjustments to Continuation Budget ($74.4M) 09/10 ($91.6M) 10/11

Major Items included:

- Salary Related Items (Holiday and Premium Pay, Workers Comp, Longevity, Temp Salaries, Overtime Pay)
- Medical Supplies
- Utilities increases and Lab Equipment
- Annualizing partially funded programs

2. Position Eliminations ($12.9M) recurring

Approximately 350 positions to be eliminated

Special Provision 10.35A provides the Secretary flexibility in meeting the reduction; he does not have to cut exactly 350 positions, it may be a lesser number of eliminations but the money reduction must be met.

3. State Funded Services ($40M) 09/10 ($40M) 10/11 (Nonrecurring Reductions)

Special Provision 10.19A and House Bill 836 states that the Secretary has flexibility in meeting this budget reduction by "giving consideration to the LME's unrestricted fund balance and the LME's ability to supplement funding of services without impairing its financial stability". Requires additional accounting of LME's accumulation of fund balances and requires LME's to report quarterly to DHHS.

4. CAP MR/DD Reductions ($16M) Recurring

Reduction of Community Service Funds used to fund services for CAP-MR-DD recipients. Special Provision 10.21B prohibits LME's community service funds from being spent on services for CAP MR/DD recipients except for services that are not funded within the CAP MR/DD waiver program. Those include: guardianship, room and board, and time-limited supplemental staffing to stabilize residential placements. Former Thomas S. recipients living in community placements may continue to receive state-funded services.

5. Non-Core Community Services Reduction ($4M) Recurring

Reduces funding for services that not core to the mission of DMHDDSAS.

6. Reduce Community Support Services ($65M) in FY2009/10 and ($97.5M) in FY2010/11

Special Provision 10.68A directs DHHS to submit a new service definition for the case management and peer support components of Community Support and transition these services to other defined services by June 30, 2010. It also:

- Prohibits new service authorizations for community support group or individuals unless DHHS determines that more appropriate services are unavailable;
- Clarifies that no community support services shall be provided with other enhanced services, but that community support case management services may be provided for Level III and IV group home discharge planning;
- Extends the current moratorium on community support provider endorsements, and eliminates the paraprofessional level of service 60 days from the enactment of this act;
- Within 30 days of enactment, requires any concurrent request for service be accompanied with a discharge plan for the recipient, and failure to do so will result in denial of payment;
- Clarifies that a provider whose endorsement or Medicaid participation has been terminated is not entitled to payment while appeals are pending, but will be paid in full if the final agency decision is in favor of the provider;
- Requires that community support providers who go out of business must provide 30 days advance written notification to the LME, recipients, and the prior authorization vendor, must maintain medical and financial records, and failure to comply will result in suspension of further payment and denial of enrollment in Medicaid or other State-funded service.

7. Consolidate Case Management ($41M) in FY2009/10 and ($72.9M) in FY2010/11 – Recurring Reductions

Impacts case management services provided throughout DHHS. Section 10.68A (a) (10) directs DHHS to develop comprehensive plan for the consolidation of case management services by December 1, 2009.

8. Reduce Group Homes ($15.8M) in FY2009/10 and ($22.5M) in FY2010/11 – Recurring Reductions

Section (a) (7) restructures child Medicaid residential group home services and lays out required transition plans for recipients into more appropriate care. Specifically, the provision directs DHHS to submit a revised service definition to CMS, reexamine entrance and continued stay criteria for all residential services, promoting the least restrictive services in the home prior to residential placement, and requiring community activities and parental or legal guardian participation in treatment, and require all existing providers or agencies to be nationally accredited within one year, giving preference for accredited providers for new placements, and requiring any newly enrolled providers to be subject to national accreditation standards.

Before a child is admitted to a Level III or Level IV group home:

- Placement must be a step down from a higher level placement,
- Multisystemic therapy or intensive in-home therapy has been unsuccessful,
- Alternatives for placement have been reviewed by the Child and Family team,
- Transition or discharge plan is submitted with the initial request;
- Limits length of stay to no more than 120 days, with exceptions;
- Requires submission of a discharge plan for all recipients;
- Requires providers to group home providers who go out of business must provide 30 days advance written notification to the LME, recipients, and the prior authorization vendor, must maintain medical and financial records, and failure to comply will result in suspension of further payment and denial of enrollment in Medicaid or other State-funded service;

DHHS must report on the plan for transitioning children out of Level III and IV group homes to the LOC by October 1, 2009.

9. Freeze CAP-MRDD slots ($6.6M) in FY2009/10 and ($7.2M) in FY2010/11 Recurring Reductions

Directs DHHS to submit an implementation plan for Tiers 1 through 4 of the CAP-MR/DD Program by April 1, 2010. The plan shall describe the implementation of Tiers 1 and 4 and the proposed implementation of Tiers 2 and 3, including the array and intensity level of services, the range of costs for each tier, and how the need for each level will be determined and assigned.

10. Non-Core State Operated Services Reduction ($4.5M) Recurring

Special Provision 10.21C addresses the First Family Infant and Preschool Program (FIPP) operated within the Iverson Riddle Developmental Center. The FIPP program is directed to seek additional third party receipts, establish a sliding fee scale, and accept child care subsidies to offset general fund appropriations. Additionally, the Department shall take steps to incorporate the FIPP program with the Children's Developmental Services Agency for the age appropriate program within FIPP.

11. LME System Management Funds ($3M) 09/10 ($3.6M) 10/11

12. Crisis Services $12M expansion

Special Provision 10.12 Provides a total of $20.1 recurring funds for the purchase of community beds within local hospitals for psychiatric inpatient services.

13. Dorothea Dix Operations $6M One-time Funds

14. **Annualize Mobile Crisis Teams $1M** S.P. 10.12 appropriates $5.7M for support of 30 mobile crisis teams.

15. Annualize START $579,084 Recurring

Special Provisions Summary
Joint Legislative Oversight Committee on Mental Health,
Developmental Disabilities, and Substance Abuse Services
Session Law 2009-451, Senate Bill 202

10.12 –

- The Secretary may not force mergers of LME's prior to January 1, 2010, except those LME's that do meet the catchment area requirements of GS 122C-115. LME's may voluntarily consolidate.

- The Division may reallocate state service funds midyear, and direct funds away from LME's not on track to spend all of its funds and allocate additional funds to those LME's who need more funding.

- The Division shall continue implementation of the Supports Intensity Scale assessment tool pilot project if the pilot has demonstrated effectiveness and validity. The Department shall report on the progress by May 1, 2010.

10.12A – Of funds appropriated to Department of Health and Human Services, the Division shall use funds to continue developing a health care information system for State institutions.

10.13 – Continues the direction for School-Based Child and Family Team Initiative

10.15 – LME's may use 1% of its Substance Abuse Service Funds to provide nominal incentives for consumers. Continues the direction for the Treatment Accountability for Safer Communities (TASC) program and directs that up to $300,000 be used for the program. Allows for an LME to contract with a single treatment provider for non-Medicaid eligible participants.

10.16 – Directs the Secretary to implement Total Quality Management in the state facilities.

10.18B – Directs the Division to review and streamline all data collection and reporting requirements by the Division and LME's.

10.20 – Directs the Division to work with LME's to enhance administrative capabilities to assume utilization management responsibilities for the provision of community-based services.

10.21 – Directs any committed Mental Health Trust Fund dollars to be spent on the specific approved projects and those funds not revert to the General Fund.

10.21A – Requires the Department to decentralize the maintenance operations at Western Regional Maintenance and Butner Facilities. A report is required on October 1, 2009.

10.21D – Continues the Joint Study Committee on Autism Spectrum Disorder and Public Safety. The Committee shall terminate on December 31, 2010.

10.21E – Directs the Secretary to transfer the patients from Central Regional Hospital – Raleigh Campus to Central Regional Hospital – Butner Campus in a safe and timely manner after the restraining order is lifted resulting from the Disability Rights North Carolina, et. Al. v. North Carolina Department of Health and Human Services case.

MAJOR INITIATIVES

Attachment 5

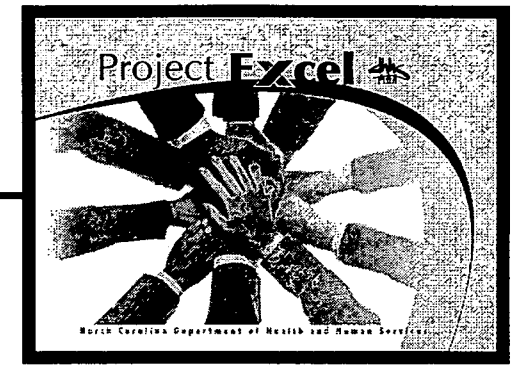
State Healthcare Facilities: A True System of Care

- Goals of the Healthcare Facilities Strategic Plan
  - **Ensure High Standards** - Heighten standards and uniformity in the State's facilities to stabilize and improve direct care staffing and enhance opportunities for staff training and skill development, with the goal of achieving increased safety and quality of care for patients/clients and eliminating instances of abuse and neglect.
  - **Develop A True System of Care** – True to the motto of "*Touching Lives Enriching Futures*, transform the State's facilities from 15 independently operated and managed facilities into a true system of care capable of ensuring public confidence in our ability to successfully serve and meet the needs of our citizens with mental illness, developmental disabilities, and suffering from substance abuse who are entrusted to our care.
  - **Implement Best Practices** - Develop and implement consistent and uniform policies based upon best practices and methods proven effective, both clinically and operationally, that ensure each of our facilities are providing the highest standards of care while operating in the most cost efficient manner.
  - **Financial Accountability** - Develop and implement an enhanced system of financial accountability across all facilities that document the best and most appropriate use of available funding in all departments, and guarantees that every dollar of appropriate revenue is identified and collected.
  - **Well Trained Workforce** - Strengthen our workforce by developing and implementing a system of training that provides all staff members with the knowledge and tools to consistently provide the highest level of care and safety for our patients/clients.

North Carolina Department of Health and Human Services

Attachment 6

MAJOR INITIATIVES
Project *EXCEL*



- Goals of Project ***EXCEL***
  - Well prepared, positioned, and capable management team
  - Management structure providing both a broad and deep knowledge base that eliminates dependence on the individual in favor of the team and lessens issues of succession
  - Transform the segregated/siloed management approach in favor of better coordinated departmental management that is proactive rather than reactive
  - Implement technology that expands reach of management, provides tools for management, and delivers complete and accurate data for solid management decisions
  - Ensure solid internal controls maximizing confidence in operations
  - Ensure ability to provide required and appropriate oversight and monitoring of programmatic activities and financial resources
  - Gain ability to measure performance by development of specific programmatic and operational goals and measuring outcomes
  - Structured ability to provide continuing management education as necessary to enhance and update knowledge and maintain skills
  - Earn and maintain reputation of DHHS being the best managed agency in NC state government

North Carolina Department of Health and Human Services
Division of Medical Assistance

Community Support Services

September 23, 2009

1

Community Support (CS): Today

Session Law 2009-451 Section 1068.A

- Community Support no longer under the NC Medicaid State Plan as of June 30, 2010
- Reduce Community Support
  - FY 09-10 $65,000,000
  - FY 10-11 $97,500,000

****Opportunity to make <u>significant</u> changes****

2

Community Support (CS): History

Community Support Cost

FY 2007	**$ 808,000,000**
FY 2008	**$ 824,000,000**
FY 2009	**$ 449,000,000**

FY 2008- 2009

- **22,000 children (per/mo)**
- **11,000 adults (per/mo)**
  - **consistent**
  - **80%-90% of adults/children receive CS ONLY**

3

Community Support: Overview

A. **Service components**: case management & skill bldg

B. **Eligibility**: Children & adults with identified mental health/substance abuse needs + functional needs

C. **Providers:** Endorsed by LMEs, oversight by Licensed Professional (as of 1/09)
   - Qualified Professionals (Lic./master/bachelor + exp)
   - Associate Professionals (master/bachelor + exp)
   - Paraprofessionals (Diploma/GED + exp)

Community Support (CS): Lessons Learned

- Any "willing & *qualified* provider"
- Lack of accurate budget/utilization forecasting
- Lack of expected clinical outcomes
- Lack of qualified workforce/providers
- No **recovery** focus
- ~100 providers of CS-ONLY (current)
- Most consumers remained in CS

Community Support (CS): Lessons Learned

OBJECTIVES

(ALL services going forward)

- Clinical treatment managed by a Licensed Professional
- Comprehensive treatment environment that facilitates transition through and out of services
- Well-documented quality and outcome standards
- Focus on recovery & self-management

Community Support (CS): Transition

Goals

- Manage transition thoughtfully
- Use transition to make positive steps forward—improve clinical quality & outcomes

Transition Process

- DMA & DMH/DD/SAS collaboration w/community stakeholders
  - Recognition of consumer impact & unintended consequences
- DMA policy changes

Community Support (CS): Transition

Stakeholder Workgroup

- Lessons Learned
- Needs of current CS recipients
  - 1/3 more intensive services
  - 1/3 less intensive/OTPT/natural supports/primary care
  - 1/3 **high priority in transition**
- Unintended Consequences/Jobs

Agreement: Right Person, Right Care, Right Time

Transition: CS Policy Changes

- **October 12, 2009**
  - Elimination of paraprofessional in CS*
- January 1, 2010
  - No new CS admissions*

*EPSDT

Transition: CS Policy Changes

- September 28, 2009
  - All (prior authorization) requests:
    - May not exceed **90 days**
    - Must include a **Discharge/Transition Plan**
      - Indicates how individual will transition out of CS

Transition: CS Enrollment Forecast**

- Late Fall 2009
  - 22,000 children (mo)
  - 11, 000 adults (mo)
- Early 2010
  - 12,500 children
  - 5,500 adults
- Early Spring 2010
  - 7,400 children
  - 2,700 adults
- Late Spring (June 2010)
  - 2300 children (EPSDT)
  - 0 adults

****Results of policy changes**

Community Supports - Adults

	FFY 10	FFY 11
Expenditures with no change	$131,174,727	$131,174,727
Projected service expenditures **with** phase out of Community Supports	$47,672,955	$0
Increases in existing enhanced services due to phase out of Community Supports	$8,674,801	$19,944,802
Total Cost Avoidance	**($74,826,971)**	**($111,229,925)**
Federal Share	**($48,734,806)**	**($72,922,339)**
State Share	**($26,092,165)**	**($38,307,586)**

Community Supports - Child

	~~FFY 10~~	~~FFY 11~~
Expenditures with no change	$318,271,090	$318,271,090
Projected service expenditures **with** phase out of Community Supports	$123,090,652	$0
Increases in existing enhanced services due to phase out of Community Supports	$2,439,660	$4,503,988
Total Cost Avoidance	**($192,740,778)**	**($313,767,102)**
Federal Share	**($125,532,069)**	**($205,705,712)**
State Share	**($67,208,709)**	**($108,061,390)**

Transition: DMA Policy Changes

Current/Projected Growth

- Intensive In Home Services (IIH)
- Community Support Team (CST)
- Multisystemic Therapy (MST)
- Assertive Community Treatment Team (ACTT)
- Psychosocial Rehabilitation (PSR)

Transition: DMA Policy Changes

Promote Quality Services & Monitor Growth

- Add metrics to measure outcomes
  - Clinical & financial dashboards
- Refining service definitions
  - Increasing provider qualifications
  - Requiring Licensed clinical oversight & delivery of services
  - Requiring family-based treatment for children
  - Defining clinical outcomes

Transition: DMA Policy Changes

Peer Support Services

- Early development w/stakeholders

Case Management

- Consolidation of medical/behavioral health
- Reduce duplication

DMA Vision

Community Support Transition

Legislative Oversight Committee
on MH/DD/SAS

September 23, 2009

DMH | DD | SAS

Transition Points Required by Special Provision

- Service to be eliminated June 30, 2010
- No new admissions allowed unless other services not available – plan for 10/12/09
- Paraprofessional component eliminated w/in 60 days of enactment – 10/12/09
- Requests for authorization require a discharge plan

DMH | DD | SAS

Transition Process

- Convened broad-based stakeholder group
  - 30+ representing provider agencies
  - LME representatives
  - Consumers and Consumer/Family Associations
  - ValueOptions
  - DHHS Staff
- Began meeting August 6; have held 5 meetings to date

DMH | DD | SAS

Review of Data

- Service utilization – Medicaid and state funds
  - 14,107 adults, 23,523 children
  - 4,083 living in Adult Care Homes
  - Variability by LME
    - Child: Johnston, MH Partners, Onslow-Carteret lowest; Albemarle, ECBH, Southeastern Regional highest
    - Adult: Johnston, Wake, Guilford lowest; Pathways, WHN, Southeastern Regional highest
- Utilization of other services
- Diagnostic trends
- Provider information
  - 797 providers
  - 98 offer CS only

DMH | DD | SAS

New Service

- Peer Support
  - Service for adults (18 and over)
  - Medicaid and state funds
  - Provider must be comprehensive agency – not stand-alone service
  - Licensed clinician oversight
  - Peers must be certified in accordance with DHHS requirements – minimum 60 hours of training (UNC certifies training curricula and trainers)
  - Aid consumer in transitions (hospital, jail, home, etc.)
  - Assist consumer to learn how to manage their symptoms and illness
  - Help develop natural supports and self-advocacy skills

DMH | DD | SAS

Work Groups

- Comprehensive Service Provider
  - Goal is to develop provider organizations that can deliver array of services to provide continuity of care for consumers.
  - Services to be included and excluded
  - Provider requirements – staffing, etc.
- Endorsement for Replacement Services
  - Ensure quality, aid provider transition
- Clinical transitions
  - Estimate alternative services not obvious for 1/3 of current caseload
  - Clinical staff reviewing alternatives

DMH | DD | SAS

Current Activities

- Providers have primary responsibility for transition of consumers currently being served
  - Effective 9/28/09 all requests must be accompanied by a discharge plan
- LMEs
  - meeting with providers to advise of changes and make sure they are aware of alternatives available for consumers
  - paying special attention to providers serving large numbers and serving high-need consumers
  - recruiting providers for alternative services

DMH | DD | SAS

Impact on Other Providers

- LMEs working to recruit alternative service providers
- Until case management alternative is implemented, some providers who previously did not have responsibility for development of person centered plans will be asked to take on that task:
  - Child and Adolescent Day Treatment,
  - Psychosocial Rehabilitation,
  - Opioid Treatment,
  - SA Medically-Monitored Community Residential Treatment,
  - SA Non-Medical Community Residential Treatment, and
  - Partial Hospitalization

DMH | DD | SAS

Future Plans

- Next meeting of full group is October 1.
- Peer Support and case management service definitions submitted to CMS for review
- All material available on the web:

http://www.dhhs.state.nc.us/mhddsas/comm_support/index.htm

DMH | DD | SAS

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

AGENDA

October 14, 2009, 10:00 A.M.; Room 643, Legislative Office Building
Senator Nesbitt, Co-Chair Presiding

I. Welcome and Chair's Opening Comments **10:00**

- Senator Martin Nesbitt, Co-Chair
- Representative Verla Insko, Co-Chair

II. Secretary's Remarks **10:00-10:30**

- Lanier Cansler, Secretary, Department of Health and Human Services

III. Reduction in Level III and IV Residential Facilities **10:30-11:30**

- Christina Carter, LCSW, Implementation Manager, Division of MH/DD/SAS
- Grace Crocket, Director, Mecklenburg Area Mental Health

IV. Status of CAP-MR/DD Supports Waiver **11:30-12:00**

- Leza Wainwright, Director, Division of MH/DD/SAS

V. Report on Community Supports – **12:00-12:30**

- Follow-up from September Meeting
- Leza Wainwright, Director, Division of MH/DD/SAS

Lunch **12:30-1:30**

VI. Child Mental Health Project – **1:30-2:00**

- Dr. Melissa R. Johnson, Ph.D, Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative

VII. Funding for Former Thomas S. Class Members **2:00-2:30**

- Leza Wainwright, Director, Division of MH/DD/SAS

VIII. Case Management for Persons with Mental Illness, Developmental Disability or Substance Abuse Disease **2:30-3:30**

- Tara Larson, Chief Clinical Operating Officer, DMA

IX. Final Remarks and Adjournment **3:30-4:00**

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	10/14/09																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

October 14, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, October 14, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representative Van Braxton and Representative William Brisson were also present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. Senator Nesbitt acknowledged and endorsed the advocates' efforts in seeking additional funds in the mental health system as recently recognized in the press. Representative Insko added that it was important for people to be involved from all concerned parties. She said that plans were underway preparing for the cut of stimulus dollars next year and that it was important to work together and look for efficiencies and a way to pull back. She also said she was appreciative of the Department efforts and the partnership that has been developed.

Secretary Lanier Cansler from the Department of Health and Human Services (DHHS) provided an update on the $1.5 B coming out of the healthcare system to try to accomplish the budget reductions required by the Legislature. He added that attempting to keep the system together while adjusting for the budget reductions is a difficult task. He explained the Department is moving away from independent "silos of care" towards a more coordinated system of care with better communication, making the system stronger, more streamlined and more efficient in order to improve the overall care of those receiving services. It is important to not duplicate services or provide services that are not clinically sound. Furthermore publically funded mental health services must have a clinical basis. The Secretary noted that all providers will be impacted and some services will have to change through imposing the reductions. To sustain itself the system will move towards the use of comprehensive providers or critical access behavioral health agencies that offer an array of services that are clinically founded led by properly trained clinicians, and some services will be provided only through a comprehensive provider, or

in affiliation with a comprehensive provider; other services will be available through an independent provider.

Shawn Parker, Legislative Analyst, explained that as directed in the money report, funding for high risk intervention Level III and IV group homes is to be reduced by $15.8M in FY 2009-2010 and $22.5M in FY 2010-2011. Based on budget estimates, the current program costs about $180M with the State share costing about $60M. The budget directed the establishment of a team inclusive of providers, LMEs, and other stakeholders to assure effective transition of recipients to appropriate treatment options.
The restructuring shall address all of the following:

- Submission of the therapeutic family service definition to CMS.
- Reexamination of entrance and continued stay criteria for all residential services.
- Require all existing residential providers or agencies to be nationally accredited within one year of enactment of this act.
- Length of stay is limited to no more than 120 days.

Specifically for Level III and IV group homes, before a child can be admitted for placement one or more of the following must apply:

- Placement is from a higher level placement such as psychiatric residential facility or inpatient
- Multi-systemic therapy or intensive in-home therapy has been unsuccessful
- The Child and Family Team has reviewed all other alternatives and recommends Level III or IV placement due to maintaining health and safety
- A transition or discharge plan is submitted as part of the request.
-

Christina Carter, Implementation Manager with the Division of MHDDSAS reported on how the transition of the Level III and Level IV group homes is taking place across the State. (See Attachment No. 2) Ms. Carter's presentation focused on:

- The intricate role of the LME in transitioning children – triage, seeing that Best Practice is provided; Child and Family Team evaluate and insure System of Care principles are implemented; and complete evaluation of services in each catchment area within each LME.
- How Community Supports Qualified Professionals coordinate appropriate supports.
- A review of discharge plan criteria under Implementation No. 60 and No. 62.
- Ms. Carter indicated that most of 8 residential providers with 16 plus beds have decided to reduce or convert to PRTF; all 16 plus beds must be eliminated. She offered data which included the number of recipients in Level III and IV group homes; discharge percentages; types of referrals from Child Family Teams; and services that need to be expanded across the State and indicated that the outcomes were being tracked in a variety of ways to insure positive results.

Requests from committee members included a chart depicting the services offered verses those needed per county; request for the number of children that have returned home from a group home; information on PRTF – how many children per unit, what type of building and where they are located.

Committee members shared a great concern over downsizing and emphasized the need to follow up to see that children are taken care of and not going into the Department of Corrections. There was also concern over accountability and having the system of care coordinator track children as they move through the service array.

Ms. Carter was asked how North Carolina has such a disproportionate number of children (¼ of the national population) in Level III and Level IV facilities. She responded that she thought it was a historical problem – legislation, rules, policies, procedures, the way we think about care, moving people out of institutions, the models we have, the practices put in place, and financial incentives or disincentives in the system. Leza Wainwright, Director of the Division of MH/DD/SAS said that there had been the desire to find an alternative to the institutional level of care so the group homes were designed to be less intensive. The problem occurred when the rules and requirements were not that significant and the rates were attractive and more providers offered this level of care than was anticipated. As a result, alternative services that would have maintained children at home could not grow because the Level III providers had saturated the market.

Grace Crockett, Director of Mecklenburg Area Mental Health provided a presentation on how Local Management Entities were being impacted by the transition of child Level III and IV residential services. (See Attachment No. 3) She said that Mecklenburg County began 3 to 4 years ago moving children out of Level III homes and into therapeutic foster care or other services. The LME approached the transition with providers not as a financial issue but rather one of Best Practice. Mecklenburg currently has no Level IV homes and Level III beds have gone from a high of 579 to 166 beds and will likely continue to decline.

Lisa Hollowell from Fiscal Research told members that the upcoming report on Community Support was a follow-up to questions asked at the last meeting. She said there was a $65M reduction in the budget in the first year for Community Support and a greater amount in the second year. When the budget was put together members were told that the entire budget for Community Support was $640M. There were some inconsistencies with that information and what was presented last month. Ms. Hollowell said the Department would reconcile that information and address other concerns in their presentation today.

Leza Wainwright, Director of the Division of MH/DD/SAS, said she would respond to the programmatic concerns and Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, would respond to budgetary aspects as they are in DMA. Ms. Wainwright addressed what Community Support service does now, what the alternatives are, and how many alternative services are available in each catchment area. (See Attachment No. 4) Her presentation included:

- Review of case management functions and other services currently offered by Community Support for children and adults.
- Review of alternative services available based upon consumer's medical needs.
- Availability of alternative services chart based on providers who are billing for services.
- Piedmont operates under Medicaid waiver and directly enrolls their own providers; not necessarily enrolled in larger Medicaid program resulting in incomplete data.
- Case Management and Peer Support amendments are in final steps of preparation and will be sent to CMS shortly; effective date of Case Management anticipated to be January 1, 2010; Peer Support – July 1, 2010.

Tara Larson addressed the expenditures of Community Support as well as other mental health services within the Medicaid budget. (See Attachment No. 5) Her presentation provided:

- Review of historical expenditures from 2007 – 2010 YTD.
- Community Support is a Medicaid program and service must be provided so money may need to be moved from one part of Medicaid to another. A Medicaid service cannot be denied based on the lack of availability of funds.
- Transitioning can take place even with all the competing factors; clinically the array is in place to meet the needs of the consumer.
- $210M difference in budgeted funds from 2008 to 2009 and $166M difference from 2009 to 2010.
- More recipients served under Community Support in 2009 than in 2008. Number of providers stayed the same in some areas or decreased overall statewide as a result of not meeting some of the accreditation requirements.
- Recipient appeals – 1,800 – 2,000 people in the appeals process; being processed in the 90 day time frame. Most cases resolved in mediation process at OAH.

After lunch, Dr. Melissa Johnson representing Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative, (an interdisciplinary group supporting mental health efforts in children from birth to age five), addressed the Committee to request that the Committee consider recommending funding an Institute of Medicine study to determine needs statewide and suggest effective strategies for serving this age group. (See Attachment No. 6) An NC IOM study could focus on:

- Expanding the capacity of existing services to include professionals skilled in addressing needs of birth to five age group.
- Expanding existing services to include skilled professionals to work with this population.
- Reviewing types of children effected and needing services; data supporting needs of this population; kinds of services offered.

Members expressed interest in recommending that the IOM do a study. With the endorsement of the Committee, IOM could begin a study in June 2011. The Committee decided that the recommendation would be included in the next LOC report to the General Assembly.

Senator Nesbitt asked for a motion to approve the minutes from the last LOC meeting on September 23, 2009. The motion was made by Senator Purcell and the minutes were approved.

Leza Wainwright reported on the status of the CAP MR/DD Supports Waiver. (See Attachment No. 7) She provided a brief description of the Supports Waiver and said that the waiver was expected to serve nearly 1,000 people this year. Ms. Wainwright explained how Supports and Comprehensive Waivers are alike and how they are different. The current average annual benefit for the Comprehensive Waiver is $48,000. About 10,000 people are being served between the two waivers with 187 on the Tier 1 waiver and the remaining on the Comprehensive Waiver. A key service on the

Comprehensive Waiver but not offered under the Supports Waiver is residential support. MS. Wainwright explained that when the Comprehensive Waiver is broken up into 3 waivers, Tier 2 will offer self-directed services. She noted that the Department is writing an RFP for a financial management service agency to help participants with self-direction and community resource consultant, to advocate, guide, and assist participants will be selected through a RFP.

The Committee was interested in knowing how much the cost would be beyond the Supports Waiver at $17,500, for financial management services, for a community resource consultant and for case management. Ms. Wainwright was also asked to explain how the population currently being served would be distributed across Tiers 1-4. She replied that she would get the information for the members.

As an introduction to the Case Management presentation, Joyce Jones from the Bill Drafting Division said that the budget included a significant, recurring reduction in funds for Medicaid Case Management services in the amount of $41M in FY2009/2010 and $72.9M in FY2010/2011. She said there was not much discussion about this reduction in the Appropriations Subcommittee because this option was not provided by the Fiscal Research Division. The Department presented this option late in the budget process. The special provision on Case Management directs the Department to absorb this cut by developing a comprehensive plan for consolidating all case management services throughout the Medicaid program (other than HIV case management) by December 1, 2009. Ms. Jones said the Department was asked to address many specific issues related to implementation of a new consolidated Case Management system, including:

- Whether there are any additional purposes for Case Management consolidation, other than the originally stated purposes of eliminating duplication and reducing costs;
- The current status of Case Management duplication;
- Total Case Management Budget at this time, broken down by state and federal dollars;
- Projected rate changes;
- And very importantly, CCNC's role in this process.

Tara Larson reported on what has happened thus far regarding the consolidation of Case Management as directed by the General Assembly. (See Attachment No. 8) A Public forum has been held and a work group has been established to develop a plan of consolidation, including impact on other non-Medicaid reimbursable services. The work group has drafted proposals which have been distributed and posted to a website for feedback. Some major issues covered in the presentation include:

- An elimination of some of the administrative duties.
- Clear definitions for Case Management and Care Management to eliminate confusion.
- Review of expenditures of Case Management for SFY 2009.
- ICF-MR cannot bill for Case Management since it is part of the per diem.

- Results to changes in Case Management should create better outcomes in other health care and Medicaid services.
- Projected savings - $14 to $17 million – elimination from line items in Case Management.

Ms. Larson was asked to provide statistics on other states successes and failures regarding case management, the cost projections, and implications.

There being no further business, the meeting adjourned at 4:25 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Thompson	Covenant w/ NC's Children
Tom McLeod	CFSA - NC
Bill Rowe	NC Justice Center
ERIC GARCIA	RHA
Peggy Baum	The Square Grp.
Amy Whited	NC Medical Society
Kim Chapple	Coastal Horizons Ctr
Janet Shamyn Woods	Indep
Tom Culver	KidsPeace
Larry Swabe	NCCDD
Sarah Tucke	NCCDD

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	MHANC / Coalition
John Tote	MHA/NC
Britton Allen	Allen Law Offices, PLLC
Iris Green	Disability Rights NC
Leslie Bacagan Cowan	Capstrat
Chris Adams	Capstrat
Annaliese Bulloch	DRNC
Bob Fitzgerald	Wake Med
Chip Baggett	NCMS
Peggy Mayo	
Brad Adcock	NC Providers Council

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lou Kilian	NCAHTCF
Lee-Ann Poynor	NC Psychiatric Assoc.
[illegible]	MHM Services, Inc.
Brad Bannister	DJSDP
Martin Thorn	DJJDP
Jaquelle Bore	Bore & Associates, LLC
MARTHA THOMPSON	~~HRT~~ LIBERTY CORNER ENT. COM
Jenny Reggi	Liberty Corner Ent
Mike Lancaster	DMH/DD/SAS
Prudencia B Carter	DMH/DD/SAS
Steven Wade	DMH/DD/SAS

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dexter Mitchell	Structured Family Interventions, LLC 1530 N. Gregson St, Suite 3A, Durham, NC 27701
Denise Ramseur	Ramseur Homes, Inc. 223 East Chatham St, Cary, NC 27511
Kerri Massey	Holy Angels Inc. 6600 Wilkinson Blvd. Belmont, NC 28012
Aaron Bernard Ransom	Arc of North Carolina - Charlotte (Consumer)
Glenda Ransom	Parent of Consumer 13623 Michael Lynn Rd. Charlotte 28278
Montee O. Brown, II	Provider 905 Dunn St. Durham, NC 27701
James R. Brown	Parent of Recipient. 905 Dunn St, Durham, N.C. 27701
Roger Brooks	ARC of N.C.
Karen Kinsick Dunn	Club Nova 103 D West Main St. Carrboro, NC 27510
Linda Guzman	The Arc of NC 343 E Six Forks Rd ste 320 Raleigh NC 27609
Steve Strom	The Arc of Wake County 1300 Saint Marys St, Ste. 502 Ral 27605

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sean Kenny	Eastern Carolina Case Management
Bain	OAH
Martha W. Lawrence	VA ID/DDA
Janet Presson RN, M.Ed.	Parent and President of Small Miracle, Inc. Goldsboro, NC
Evelyn S Dawson	Executive Director BriteSmilz Family + Community Connections
Meta Rawls	BriteSmilz - Roanoke Rapids, NC.
TERESA Lee	ReStart Inc 2602 Cartier Drive Greenville, NC 27834
Regina Moody	Holy Angels, Inc 6600 Wilkinson Blvd, Belmont, NC 28012
KAREN PRICE	AfterGATEWAY, INC 501 S. Mendenhall, Greensboro Public Relations Chairperson Bd of Directors
Cynthia Billups	Community-Based Developmental Services, Inc 3274 Rosehill Rd, Suite 2 Fayetteville, NC 28301
Kathy Griffin	14120 Hwy 210 Orbit Billing Solutions Spring Lake NC 28390

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
LISA R. MOON	DIV. STATE OPERATED HEALTHCARE FACILITIES
Carol Donin	Division of State Operated Healthcare Fac 3006 MSC, Raleigh
Renee McCoy	DAHS Public Affairs 101 Blair Dr. Rue.
Wayne Williams	OSBM
Jennifer Hoffmann	OSBM
John Dervin	Governor's Offi
Annette Newkirk	Governor's Office
Kent Earnhardt	MHPC / NAMI-NC
Amy Anderson	Community Innovations Inc 801 Weston St., Wilkesboro, NC
Emily Wilbourne	RHA
James R. Hinnant	705 South Taylor St Goldsboro, N.C 27530

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	Wayne Opportunity Center
Charles G. Nail	113 Hounds Run Dr. Goldsboro, NC 27530
June Fields	Hope program w/ Wayne Opportunity Center 804C Corporate Dr Goldsboro, NC 27530
Flo Stein	DMH/DD/SAS
Kelly Crosbie	DMA
Catharine Goldsmith	DMA
C. Gray MD	DMA
[illegible]	DMA
[illegible]	DSOAP
Jim Farrar	DMH/DD/SAS
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Name of Committee **Date**

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Doug Harrison	ReNu Life 501 Forest Hill Dr. Goldsboro NC 27534
Ann Nuwanae	A Small Miracle, Inc 1890 Tommy Rd Goldsboro 27534
Manay Gunter	Club Horizon, Inc. 101-B Forest Drive Knightdale, NC 27545
Julia Leggett	The Arc of NC
Ellen Russell	The Arc of NC
Jodi Maynard	
Portia Maynard	
Carolyn Newsome	ETC, K
Tracy Kimbrell	Parker Poe

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Betty Taylor	CenterPoint Human Services
Joyce Cockett	Mecklenburg Area Mental Health
Dennis Mitchell	ReStart Inc. Greenville NC
Donnie L. Phillips II	Community Intervention Center, Inc Greenville, NC 27858
Heather St. Clair	Community Intervention Center, Inc Greenville, NC 27858
Donnie L. Phillips SR	Community Intervention Center, Inc P.O. Box 30196 Greenville NC 27833-018
Judy Klimchuck	South Light. org 301 Sunset Dr Fuquay Varina NC 27526
Mary Freeman	Tammy Lynn Center for Dev. Dis 739 Chapel Dr Raleigh 27606 Also NC ICFMR Assoc
Roger Giles	Carobell, INC. 198 Cinnamon Dr Hubert, NC 28539 r.giles@carobell.com
Tara Alley	The Mental Health Association in NC 1331 Sandoll Drive Raleigh NC 27609.
Ivan Evans	Structured Family Interventions 1530 N. Gregson St. Suite 3A Durham, NC 27701

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Joint Legislative Oversight Committee on MH/DD/SAS October 14, 2009

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LANIER CANSLER	DHHS
Allen Feezor	DHHS
Shemeiah Wilson	DHHS
	DHHS
Jim Southern	CNC/Access
Lia McNeilly	parent of spec. needs child
Maureen Morrell	Autism Society of NC
Sherri Green	UNC at Chapel Hill, NC
Kim Schmidt	NC MHCO Raleigh, NC
Pam Shipman	PBH (LME)
Lesley Dover	Eastern Carolina Case Mngt.

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Richard Anderson, Executive Director	Footprints Carolina, LLC 2020 Remount Rd. Gastonia, NC 28054
Valerie Hennike Area Director	Five County Mental Health Authority 1345 Garnett Str. Henderson, NC 27541
James Cuellar Executive Director	C & B Support Services, Inc. PO Box 15393 Asheville, NC 28813
Kelly Nesbitt Gale Bruce	NAMI North Carolina
Allen Sutton	NAMI NC
Maria Lewis Administrator	The Right Track Inc. 883 US Hwy 70 W. Garner, NC 27529
Dorian Locklear Director	Structured Family Interventions, LLC 1530 N. Gregson St. Ste. 5A Durham, N.C. 27701
William Kriss Executive Director	Central State of the Carolinas 122 N. Elm Ste 810 Greensboro, NC 27401
Rita Quinn Case Management Intern	Central State of the Carolinas 122 N Elm St. Ste 810 Greensboro NC 27410
Kathy Bargan Case manager	central state of the carolinas 122 N Elm St Suite 810 Greensboro NC 27401
Mark Bulot Case Manager	CSC 1528 S. Mebane St Apt. # 1405 Burlington, NC 27215

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Crystal Summermatter	Omni Visions Inc 910 C. Street N. Wilkesboro NC 28659
Trera Johnson	Omni Visions Inc 910 C Street Suite 8 N. Wilkesboro 28659
Leslie Kellenberger	Child & Family Services, Assoc. 610 S. Boylan Ave. Raleigh 27603
Deanna Janus	Pride In North Carolina
Janine Britt	Southeastern Regional MH-LME 450 Country Club Rd Lumberton NC 28360
Jeanette Jordan-Huffam	Southeastern Regional MH/DD/SAS LME 450 Country Club Lumberton, NC 28360
ERIC DAVIS	PORT HUMAN SERVICES 206 PINE ST. ABERDEEN, N.C. 28315 GREENVILLE
Tim Hall	Robeson Health Care Corp 60 Commerce Drive, Pembroke, N.C. 28372
Thomas Maynor II	Robeson Health Care Corp 60 Commerce Drive Pembroke NC 28372 910-521-2900
Randall Hall MD	ValueOptions

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Jesse Galindo	Le'Chns Health Systems, Inc.
Billy West	DAYMARK Recovery Services Concord NC
BRIAN INGRAHAM	SMOKY MTN CNTR SYLVA
Douglas Finley	Aym Technologies LLC
Donald Grantham	Omega Independent Living Services
Shandra Ross	Omega Independent Living Services, Inc.
Trixy Baldwin	Omega, Independent Living Services
Delwin Clark	Omega Independent Living Services
Joe Murphy	MurSys, LLC
Steve Blakeman	Integrity Support Services, Inc
Dennis Bradshaw	Residential Services Inc

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Karen Krueger	Plans For Life, LLC P.O. Box 1767 Brevard, NC 28712
ALISANDER DUDA	NC CENTER FOR PUBLIC POLICY RESEARCH PO BOX 430 RALEIGH, NC 27602
HANK DEBNAM	CUMBERLAND LME 711 Executive Pl - Fayetteville, NC 28305

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Angela Scott	Plans For Life 19 Twin Springs Rd, Hendersonville, NC 28792
Sarah Schwarz + Linda-Weeks McDonald	LeChris Health Systems 1405 S. Glenburnie New Bern, NC 28560
Rebecca Trank	NCACC
[illegible]	[illegible]
Betty Forman	Smoky Mtn. Center
Melvin Nowling	Integrated Family Solutions, LLC 5300 Six Forks Rd
Zan Bunn	NC Taxpayer + Voter
Gale Wilkins	NC Taxpayer & Voter
Kimberly Stone	SouthLight, 3125 Poplarwood Court, Ste 20 Raleigh, NC 27604
Margy Pettit	The Arc of NC
Wendy Russell	The Arc of Moore Co.

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JOHN LASTERBAUS	Caring for Children PO Box 1913 Asheville, NC 28802
Jill Krahwinkel	Caring Family Network 6050 Six Forks Rd Raleigh, NC 27609
Debra C Farrington	OPC Area Program 100 Europa Dr. Suite 490 Chapel Hill, NC 27516
Mary A Hooper	NC Council of Community Programs 585 Oberlin Rd Raleigh NC 27605
Victoria White	Sandhills Center LME West End NC 27376
Rob Robinson	Durham Center 501 Willard St Durham, NC 27701
Gina Tipton	TIPTON THERAPEUTIC Foster Care Homes 1027 EAST MAIN ST SPINDALE, NC 28160
Penny Jenkins	"
Roy Wilson	ECBH - New Bern

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MENTAL Health — 10-14-09

Name of Committee — Date

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Will Woodell	Value Options
Jim Shaheen	Strategic Behavioral Health
Steve Church	NAMI-Wake County
Rachel Dupree	NCGA
Dawn Bryant	Carolina Dispute Settlement Services 2300 Lakewoods Dr, Suite 120, Raleigh, NC 27607
Diann Seigle	" "
Kathy Crocker	SCFAC. State Consumer & Family Advisory Committee
Amy Thorne	Le'Chris
Mike Vicario	NCHA
Joseph A. Martinez	First at Blue Ridge P.O Box 40 Ridgecrest NC 28770
Ann Doolen	ADENC - Durham, NC

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MENTAL HEALTH — 10-14-09

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Jimmie Bunham	CHEA Consulting Serv. Lillington, NC 1617 E 14th
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Bennie Kidd	Ralph Scott Lifeservices Burlington, NC 27217
Laura Coker	NC-CANSO (NC Consumer Advocacy Network and Support Org.) Winston-Salem
Kathy Holland	NC-CANSO NC consumer Advocacy Network ing Organization
CASE VAN DER KNIJF JOANNE VAN DER KNIJF	CSS INC 4024 OLEANDER DRIVE, STE A-3 WILMINGTON, NC 28449
Melissa Morris	ACI Support Specialists, Inc 3220-1 Burnt Mill Dr. Wilm. NC 28403
Rita Barnes	ACI Support Specialist Inc 1007 Hwy 70 West Suite 109 Garner NC 27529
Mary & Katie Short	Taylorsville, NC Consumer/Parent
Terry Rutter	Raleigh NC Parent
Janell Albany	Janell is my daughter

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Dre Rachel	The Arc
Steve Mitchell	Astellas
Darryl Peebles	Redirection Youth Center
Simeon Hutchinson	Redirection youth Center
Dr Mike Martin	Lighthouse Counseling Center
Annalliese blyn	DRNC
Jennifer Hancock	A Caring Heart Case Mgmt. Inc
Carol Choate	A Caring Heart Case Mgmt. Inc.

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MENTAL HEALTH 10-14-09

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Ellen Hollimon	Durham LME
Kaye Hinson	DHHS / Budget & Analysis
Carol L. Wright	Monarch
Aleshia Holland	Monarch
Alisia Diggs	Monarch
William Hancock	Family of consumer
Wayne Hancock	consumer D/D services

Residential Level Transitions: Levels III and IV

Christina Carter, Implementation Mgr
DMHDDSAS

1

System of Care Response

Mutual Agreement with:

- DHHS
- Department of Juvenile Justice and Delinquency Prevention
- Department of Public Instruction
- Administrative Office of the Courts

Committed to System of Care (SOC).

2

LME Role: Triage

- LME System of Care Coordinators + LME care coordination staff have triaged most of the list of currently placed youth based on severity of need and authorization timelines.
- LME's are coordinating with Community Support providers in order to ensure compliance timelines of transition plans.
- Clinical information used for triage:

Most recent ITR	Current Person Centered Plan
Risk Questionnaire	Other Clinical & Medical Info

3

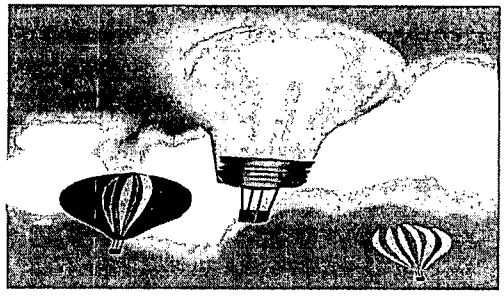
LME Role: Best Practice

- LME System of Care Coordinators and/or other LME care coordination staff are **expected to attend all Child and Family Team meetings** for youth in their catchment areas.
- LME System of Care Coordinators will ensure that the Child and Family Team process that occurs for each child/youth follows the best practice principles of the System of Care model.

4

LME Role: Ongoing Learning

- Results from the LME Triage process plus the Child and Family Team (CFT) meetings will be coordinated to determine community needs and service gaps.



5

Community Support Provider Tasks

Community Support QP identifies appropriate supports for the child/youth through transition.

- **If the appropriate service is Psychiatric Residential Treatment Facility (PRTF)**

  the CS QP works with the individual and her/his parent and/or legally responsible person to select a provider agency which meets the needs of the individual.

- **If the appropriate setting is Home:**

  1. Appropriate supports

  2. Appropriate training for family members

  3.Appropriate services Intensive In-Home (IIH) or Multi-Systemic Therapy (MST)

****The Community Support QP continues to monitor the progress of the individual**

6

Level III or Level IV Residential Provider and the Child & Family Team Process

1.The Level III & Level IV Provider with the Child & Family Team:

- ✓ Meets with the Child Family Team
- ✓ Assures the Person Centered Plan is current
- ✓ Crisis plan is current
- ✓ Must develop a discharge plan on the approved DMH/DD/SAS and DMA Discharge Plan (IU #62)
- ✓ Works with the individual to support the discharge plan and to minimize disruption
- ✓ Shall fully inform the youth and family of all service options.

7

Eligibility Criteria for Level III & IV Implementation Update 60:

- In addition to the current eligibility criteria documented in DMA Clinical Coverage Policy 8D-2, before a child can be admitted to Level III or Level IV placement the following shall apply:

- 1. Placement may be a transition from a Psychiatric Residential Treatment Facility (PRTF) or inpatient setting

OR

- 2. Multisystemic Therapy (MST) or Intensive In-Home (IIH) services did not meet the youth's treatment needs within the last six months and severe functional impairments persist;

AND

- 3. The Child Family Team has reviewed all other alternatives and recommendations and recommends Level III or IV residential placement due to maintaining the health and safety of the child.

8

Discharge Plan Criteria: Implementation Update # 60 & #62

- **Must be processed within a Child And Family Team Meeting (s)**
- Includes a new comprehensive clinical assessment:
  - Addresses co-occurring disorders as appropriate
  - Conducted by a psychiatrist (independent of the residential provider and its provider organization)
  - Must include clinical justification for continued stay at this level of care.
- Must used Standardized DMHDDSAS & DMA Discharge Form
- Demonstrate that family and/or caregivers are actively engaged in treatment goals and objectives
- Promote least restrictive environment
- Expected discharge dates
- Engagement of natural and community supports
- Signatures of the recipient and/or responsible person
- Must be submitted with any authorization
- Failure to submit assessment and discharge plan will be returned as " Failure to Process"

9

Residential Providers with 16 + Beds

- Current Status:
  - Met with 8 Providers on August 24, 200
  - Required Providers to submit Plan for reduction with reduced numbers of beds & effective date of correction
  - Providers are located in the following LME's:

Guildford (1)	Smoky (1)
Wake (1)	Johnson (1)
Centerpoint (1)	Mecklenburg (2)
Cumberland (1)	

  - Most have decided to reduce or convert to PRTF

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Residential III and IV Results:

Recipients In Level III and Level IV Residential Services

8/1/09 **Recipients in Level III residential services.** **2138**	8/1/09 **Recipients in Level IV residential services.** **116**	10/5/09 **Recipients in Level III residential services** **1287** **Difference of 851**	10/5/09 **Recipients in Level IV residential services** **74** **Difference of 42**

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Residential III and IV Results:

Recipients who have been Paper Triaged	Recipients who have had an initial Child and Family Team (CFT)	Recipients who have had a follow-up Child and Family Team (CFT) meeting	Recipients who have been discharged from Level III residential services	Recipients who have been discharged from Level IV residential services
1927 **Discharge Percentage 85%**	**1791** **Discharge Percentage 79%**	**893** **Discharge Percentage 39%**	**816** **Discharge Percentage** 38%	**48** **Discharge Percentage 41%**

12

Average Length of Stay in Level III & IV

- Level III
  - Previously: 310 Days per year
  - Anticipated: 120 Days**
- Level IV
  - Previously: 192 Days per year
  - Anticipated: 120 Days**

**Exceptions must follow EPSDT (Early Periodic Screening, Diagnosis and Treatment) procedures and requirements

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Residential III and IV Results:

- **Where Child Family Teams are referring children** (in order of need):
  - Medication Management **(300 + Referrals)**
  - Outpatient Individual Therapy
  - Outpatient Family Therapy
  - Intensive In Home
  - Natural Supports
  - Therapeutic Foster Care **(660+ Referrals)**
  - PRTF **(100+ Referrals)**
  - Day Tx
  - Residential Level II **(147+ Referrals)**
  - MST **(21+ Referral)**
  - Residential Level III
  - Residential Level IV
  - SAIOP
  - Outpatient Group
  - Respite **(39+ Referrals)**

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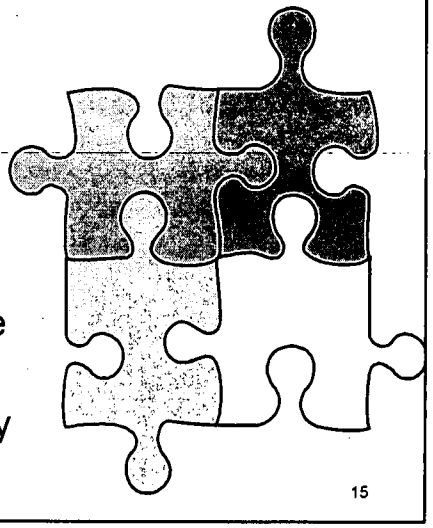
Residential III and IV Results:

- Services in which some catchment areas require expansion:
  - Respite
  - Intensive In Home
  - Multisystemic Therapy
  - SAIOP
  - Day Treatment
  - Therapeutic Foster Care
  - Psychiatric Residential Treatment Facility



15

Residential III and IV Results:

Level III Beds as of August 1, 2009	10/5/09 Level III Beds in your catchment area as of the date of this report	Level IV Beds as of August 1, 2009	10/5/09 Level IV Beds as of the date of this report
2276	2170	156	120
	Percentage Remaining: 95%		Percentage Remaining: 76%

16

For More Information on the
Residential III and IV Transition Process

http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm

Thank you

17

MECKLENBURG COUNTY
Area Mental Health, Developmental Disabilities and Substance Abuse Services

429 Billingsley Rd., 2nd Floor
Charlotte, NC 28211-1098

Transition of Child Level III and IV Residential Services

Current Residential Placement Status:

- 71 currently placed in Level III (originally 139) – 51% decrease
- 4 currently placed in level IV (originally 8) – 50% decrease
- 36 involved with DJJ
- 17 involved with DSS
- 100 internal risk assessments/paper triages completed
- 95 have first transition planning CFT scheduled/completed
- 74 have second transition planning CFT scheduled/completed
- 68 consumers discharged from level III
- 4 consumers discharged from level IV

Provider Relations/Capacity Report:

- No identified service gaps
- Challenges/Opportunities for growth:

1. Endorsed providers reluctant to accept highly acute consumers coming from Level III and IV placements.
2. Training of foster parents to be equipped to handle more acute consumers
3. Training on how to implement EPSDT requirements so that consumers can get the required services in TFC homes or in their own home settings.

Transition Plans:

Process

- The overall process for the level III and IV transition to assure coordination with other agencies (e.g. juvenile justice, Value Options) has been successful. Plans are to proceed with ongoing collaboration via the following key strategies already implemented:

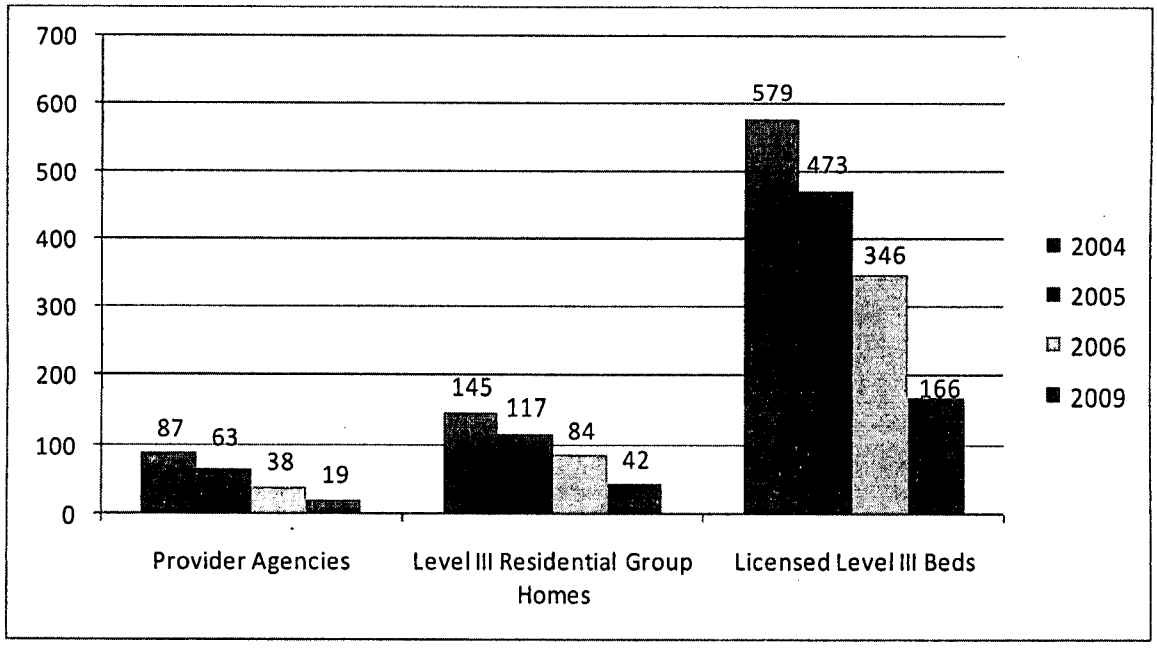
1. The level III/IV consumer's are followed by the Intensive Care Management (ICM) staff and SOC Coordinator until each consumer is transitioned to either a higher or lower level of care.
2. Specialized case staffing is coordinated by the ICM Supervisor who also serves as the DJJDP liaison for Utilization Management.

3. The SOC Coordinator will jointly convene a Child and Family Team meeting with the Qualified Professional for all new admissions to level III/Level IV placements to ensure the appropriateness of authorization request and foster fidelity to SOC philosophy and Wraparound practice.
4. Discharge plans required for residential service re-authorizations will be reviewed and signed off by the SOC Coordinator or designee through the Care Review Team process.
5. SOC Coaches are available and assigned to MeckCARES consumers placed in Level III/IV homes as needed and requested.
6. Interagency Group Case Consultation is encouraged and available for MeckCARES enrolled consumers placed in Level III/IV homes on a monthly basis.
7. Ongoing dissemination information/updates via Hot Sheet announcements and at InfoShare and other community venues.

Projected Deadline:

- A deadline for the completion of this process is fluid due to the State still allowing concurrent and new authorizations for level III/IV placements.
- A consumer's acuity level and medical necessity dictates new or continued involvement in residential placements which prohibits the ability to project a definitive deadline. For highly acute consumers, cases are staffed with the medical director to recommend a higher placement such as PRTF, or an extended discharge plan date (typically 60 additional days) in which an increase in case monitoring occurs as a result.

Mecklenburg Level III Residential Facilities



Attachment 4

Community Support Follow-Up

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

October 14, 2009

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Alternatives to CS for Children

Services Currently Available in Community Support Service Definition	Alternative Services Available Based upon Consumer's Medical Needs:					
	Intensive In-Home, MST, SAIOP	Day Tx., Partial Hospital.	Case Management	Evidence-based Outpatient Services	Mobile Crisis, Facility Based Crisis	Education and Training CPT Code
Case Management Functions:						
1) Assessing needs of the individual	X		X	X		
2) Linking/referral to appropriate services	X		X	X		
3) Facilitating Person Centered Planning	X		X			
4) Monitoring effectiveness of services	X		X			
Therapeutic interventions per goals of PCP	X	X		X		
Psycho-education re: self-management of medications and symptoms	X	X		X		X
24/7/365 First Responder responsibilities	X				X	
Psycho-education for families and caregivers re: consumers illness, symptoms, etc.	X			X		
Coordination of natural and community supports	X	X	X	X		
Skill building to foster recovery and independence	X	X		X		X
Skill building in specific areas depending upon consumer's illness: behavioral skills and anger management, relapse prevention, etc.	X	X		X		X
Rehabilitation of skills related to daily and community living	X	X		X		X

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Alternatives to CS for Adults

Services Currently Available in Community Support Service Definition	Alternative Services Available Based upon Consumer's Medical Needs:						
	Community Support Team, ACTT, SAIOP, SACOT	PSR, Partial Hospital., SA Medically Monitored and Non-Medically Monitored Residential	Case Management	Evidence-based Outpatient Services	Mobile Crisis, Facility Based Crisis	Peer Support	Education and Training CPT Code
Case Management Functions:							
1) Assessing needs of the individual	X		X	X			
2) Linking/referral to appropriate services	X		X	X			
3) Facilitating Person Centered Planning	X		X				
4) Monitoring effectiveness of services	X		X				
Therapeutic interventions per goals of PCP	X	X		X			
Psycho-education re: self-management of	X	X		X		X	X
24/7/365 First Responder responsibilities	X				X		
Psycho-education for families and caregivers re: consumers illness, symptoms, etc.	X			X			
Coordination of natural and community supports	X	X	X	X			
Skill building to foster recovery and independence	X	X		X		X	X
Skill building in specific areas depending upon consumer's illness: behavioral skills and anger	X	X		X			X
Rehabilitation of skills related to daily and community	X	X		X		X	X

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Availability of Alternative Services

	Adults			Children		Either	
	Assertive Community Treatment Team (ACTT)	Community Support Team (CST)	Psycho-Social Rehabilitation (PSR)	Intensive In-Home	Multi-Systemic Therapy (MST)	Licensed Outpatient Clinicians	Mobile Crisis
Alamance-Caswell	4	4	3	14	0	78	1
Albemarle	0	9	3	24	1	53	2
Beacon Center	2	12	3	21	1	63	1
Centerpoint	3	14	4	13	0	142	1
Crossroads	3	5	4	6	0	93	2
Cumberland	3	7	1	26	0	153	1
Durham	2	33	1	31	1	210	1
Eastpointe	5	17	6	25	0	120	3
ECBH	2	16	5	35	3	247	6
Five County	2	19	2	16	0	87	1
Guilford	4	21	3	28	1	231	1
Johnston	0	1	2	3	0	41	
Mecklenburg	1	22	2	46	5	317	1
Mental Health Partners	2	4	4	4	1	139	1
Onslow-Carteret	0	7	3	4	1	82	1
Orange-Person-Chatham	2	6	2	3	1	151	1
Pathways	1	11	3	15	1	145	1
Piedmont*	0	0	0	4	1	105	0
Sandhills	3	15	10	33	1	163	2
Smoky Mountain	8	10	9	22	1	352	7
Southeastern	3	13	2	17	2	270	1
Southeastern Regional	3	16	8	34	5	78	1
Wake	4	22	5	24	3	561	1
Western Highlands	8	14	3	14	1	353	3
Total	**65**	**298**	**88**	**462**	**30**	**4234**	**40**

* Data comes from paid claims and, due to waiver, incomplete data available from PBH

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Timing

- Case Management and Peer Support service definitions require a Medicaid State Plan Amendment (SPA).
  - Anticipate January 1, 2010 effective date for CM
  - Anticipate July 1, 2010 effective date for PS
- All other alternative services already available or can be added without State Plan changes (educational CPT code.)
- Training should not be a problem
  - Lots of providers currently perform CM functions within other service definitions and are very familiar with those requirements.
  - Currently have in place a process for training and certifying Peer Support Specialists and are currently reimbursing for their services within ACTT and CST and with state funds.

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Attachment 5

COMMUNITY SUPPORT EXPENDITURE ANALYSIS

Historical Expenditures

	Community Support	*Enhanced Mental Heatlh*	*Independently Enrolled MH*	*Total Mental Health*	*Specialized Therapies*	*Total Nonphy Practitioners*
2007	$ 808,098,625	$ 82,845,550	$ 53,051,705	$ 943,995,879	$ 56,065,150	$ 1,000,061,030
2008	$ 823,907,297	$ 124,440,897	$ 68,000,692	$ 1,016,348,886	$ 67,000,402	$ 1,083,349,288
2009	$ 449,156,823	$ 258,837,514	$ 84,838,789	$ 792,833,123	$ 79,518,246	$ 872,351,370
2010 YTD	$ 95,689,274	$ 104,845,845	$ 23,682,425	$ 224,217,544	$ 21,856,604	$ 246,074,148

Budgeted Expenditures

	Community Support	*Enhanced Mental Heatlh*	*Independently Enrolled MH*	*Total Mental Health*	*Specialized Therapies*	*Total Nonphy Practitioners*
2009 Authorized	$ 724,955,262	$ 83,038,952	$ 53,175,553	$ 861,169,767	$ 56,196,033	$ 917,365,800

2009 Community Support Target set at 70% of Nonphysician Practitioners $ 642,156,060

	Community Support	*Enhanced Mental Heatlh*	*Independently Enrolled MH*	*Total Mental Health*	*Specialized Therapies*	*Total Nonphy Practitioners*
2010 Base Budget	$ 445,767,020	$ 338,755,249	$ 94,944,077	$ 879,466,346	$ 88,989,795	$ 968,456,141
Continuation	(53,499,811)	(30,830,564)	(10,105,288)	(94,435,663)	(9,471,550)	(103,907,212)
Growth	28,956,451	16,686,857	5,469,426	51,112,735	5,126,419	56,239,154
Rate	(14,173,844)	(8,168,021)	(2,677,220)	(25,019,085)	(2,509,322)	(27,528,407)
Program	(186,406,653)	-	-	(186,406,653)	-	(186,406,653)
2010 Budget	$ 220,643,164	$ 316,443,521	$ 87,630,995	$ 624,717,680	$ 82,135,343	$ 706,853,023
2010 State Portion	$ 77,225,107	$ 110,755,232	$ 30,670,848	$ 218,651,188	$ 28,747,370	$ 247,398,558
2009 State Portion	$ 157,204,888	$ 90,593,130	$ 29,693,576	$ 277,491,593	$ 27,831,386	$ 305,322,979
Change	$ (79,979,781)	$ 20,162,102	$ 977,272	$ (58,840,405)	$ 915,984	$ (57,924,421)

Who are we and why are we here?

Volunteer group of interdisciplinary professionals from Wake and Mecklenburg counties concerned about mental health issues of children from birth to five throughout our state

Our goals for this meeting

- Demonstrate the need for strengthening mental health services for children birth to 5
- Request an Institute of Medicine study to determine statewide needs and suggest effective strategies
- Suggest expanding the capacity of existing services to include professionals skilled in addressing mental health issues in infants, toddlers, preschoolers and their families

What is young child mental health?

Positive social-emotional development

Developing the ability to:

- Form secure relationships
- Handle emotions
- Manage one's own behavior
- Feel safe, secure, and loved
- Explore and learn

Why is this need so urgent?

- Now is the perfect time to include birth-5 issues while the mental health system is being re-examined and improved.
- Healthy social/emotional development in young children builds the foundation for a well-functioning, economically vibrant community
- Effective support of birth-5 mental health will reduce future costs to the mental health, substance abuse, education, foster care, and juvenile justice systems, and create healthier, happier, and smarter citizens.

- Up to 20% of teens and adults have mental health problems
- In the first five years, we can OFTEN identify the children likely to have problems later AND intervene effectively
- The earlier the intervention, the more cost-effective; the costs of remediation increase with age

- Cognitive development is dependent on positive social-emotional development
- Mental health support from birth-5 can actually enhance the development of the growing brain
- Conversely, "toxic" environments without such support can damage developing brain structure and function

What children are we talking about? A few examples...

- Toddlers moved from foster home to foster home due to uncontrollable tantrums
- Preschoolers expelled from multiple day care centers, causing parents to lose jobs
- Children arriving at kindergarten unable to get along with other children despite normal intelligence
- Child witnesses or victims of violence
- Babies whose growth is stunted due to lack of nurturing care.

A few numbers...

- NC is 5th highest in pre-K expulsions among the 40 states with data; rate is 1 in 77 pre-K children expelled!
  - (Gilliam et al., 2005))
- Between 9.5 and 14.2 % of children 0-5 have social-emotional problems
  - (NCCP, 2009)
- Behavior problems in preschoolers: 10-20% at home or day care; for children in poverty, 20-50%
  - (Williford & Shelton, 2008)
- FPG study: screening resulted in 18.8% of pre-K children being referred for MH services
  - (Barbarin, 2007)

What do services entail?

- Helping families function more effectively
- Helping parents understand and support their child's emotional needs by enhancing their interactions with their child.

  Intervening in child care settings AND the home to help children in distress
- Helping children develop competence in social and emotional tasks such as forming relationships, developing self-control, tolerating frustration, sharing, communicating needs appropriately

Isn't NC addressing this already? YES AND NO

Agency	Mission	Mental Health Services for 0-5
Smart Start	High quality comprehensive system of care and education for every child	Local Smart Start partnerships provide family support and health-related programs
Child Development Services Agency (CDSA)	Helping children with development delay	Many infants and toddlers with mental health issues do not meet CDSA eligibility requirements; CDSA lacks access to full array of mental health services
Preschool Services	Meeting educational needs to prepare for school success	Not the focus; intensive family work not possible

Agency	Mission	Mental Health Services for 0-5
Child Protective Services	Keeping children safe	Mental health issues in 0-5 are part of a complex balance of family problems, domestic violence, employment, housing, substance abuse...
Health Care System	Mental, as well as physical, health of 0-5 often evaluated here first	Very limited access to mental health resources
Mental Health System	Currently designed for older children and for severe, persistent mental illness in children and adults	Limited family-based interventions available or funded. Limited access to research on effective methods. Few clinicians trained in the unique skills and strategies that work for 0-5 age group.

How can we move forward?

- Integrate, collaborate, and support the resources of each system to address the mental health needs of children from birth to five
- Obtain more information for our entire state, not only Wake and Mecklenburg.

An Institute of Medicine study could...

- Examine the needs, gaps, strengths and resources of service systems throughout the state as they affect 0-5 mental health
- Evaluate recent treatment research for its potential to work with our children
- Recommend ways to move forward, using our limited resources to best effect
- Spearhead policy shifts that will make a difference across North Carolina

Incorporating Birth to Five into current system

- If we consider the unique needs of this group in all our current efforts, we will be most effective in serving North Carolinians throughout life.

REFERENCES: READILY AVAILABLE RESOURCES ON EARLY CHILDHOOD MENTAL HEALTH

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Gilliam, W.S. (2005). Prekindergartners left behind: Expulsion rates in state prekindergarten systems. New Haven, CT: Yale University Child Study Center.
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Williford, A.P. & Shelton, T. L. (2008). Using mental health consultation to decrease disruptive behaviors in preschoolers: adapting an empirically-supported intervention. The Journal of Child Psychology and Psychiatry, 49:2, 191-200.

http://gucchd.georgetown.edu/78358.html What Works? A Study of Effective Childhood Mental Health Consultation Programs

www.developingchild.net Center on the Developing Child, Harvard University

http://www.nccp.org/publications/pub_882.html Social-emotional Development in Early Childhood: What Every Policymaker Should Know

www.zerotothree.org Website for Zero to Three National Center for Infants, Toddlers and Families; click on Public Policy link

www.challengingbehavior.org Technical Assistance Center on Social Emotional Intervention for Young Children

http://www.youtube.com/watch?v=tLiP4b-TPCA
"The Science of Early Child Development"

http://www.youtube.com/watch?v=GbSp88PBe9E
"Change the First 5 Years and You Change Everything"

The Wake County Young Child Mental Health Collaborative,
Sarah Sabornie, Coordinator, ssabornie@gmail.com

ZFive Infant Mental Health Working Group of Mecklenburg County
Libby Cable, Coordinator, lcable@tlwf.org

Status of Implementation of the Supports Waiver for CAP-MR/DD

Legislative Oversight Committee
on MH/DD/SAS
September 23, 2009

DMH | DD | SAS
division of mental health | developmental disabilities | substance abuse services

What is the Supports Waiver?

- The Supports Waiver, also known as the Tier 1 waiver, offers services and supports to people with developmental disabilities whose needs can be met with services costing no more than $17,500 per year.
- Implemented in November, 2008, the Supports Waiver served 187 people in SFY 2009.
- Expect to serve nearly 1,000 this year.

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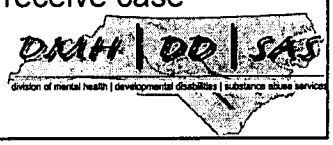
How are the Supports and Comprehensive Waivers Alike?

- Eligibility criteria are the same
  - Must meet ICF/MR Level of Care criteria
  - Federal definition of developmental disabilties
  - Same financial eligibility criteria
    - Asset and income standards
    - Waive parental and/or spousal assets and income
- Not entitlements – can limit participation based upon CMS approval and fund availability
- When services are covered in both waivers the services are the same: service definitions, requirements, provider qualifications, etc.
- Neither waiver includes case management within the waiver but both require participants to receive case management services



How are they different?

- Supports
  - Max annual benefit = $17,500
  - Serves people living in their own home or with family
  - Offers opportunity to self-direct services
- Comprehensive
  - Max annual benefit = $135,000
  - Serves people living in their own home, with family, or in group settings
  - Does not offer self-direction option

Services in the Supports Waiver

The only services in the Comprehensive Waiver that are not available in the Supports Waiver are Home Supports (family as provider) and Residential Supports (paid living settings.) For all of the rest, the difference is amount and intensity to stay within the $17,500 maximum.

- Personal Care
- Respite Services
- Transportation
- Participant/Natural Support Training and Education Services
- Home and Community Support Services
- Individual Goods and Services
- Augmentative Communication
- Home Modifications
- Supportive Employment
- Specialized Equipment and Supplies
- Personal Emergency Response System
- Vehicle Adaptations
- Adult Day Health
- Day Supports
- Long Term Vocational Support
- Specialized Consultative Services
- Crisis Services
- Behavioral Consultation

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Self-Direction

- Self-Direction is a national movement in the DD community. It is about helping people live up to their full potential and includes the following principles:
  - Freedom of choice of services/supports to receive and the staff who deliver them
  - Authority over how services/supports are delivered
  - Support for organizing services/supports in a way that may be unique to the individual
  - Responsibility to manage public funds appropriately

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Self-Direction in the Supports Waiver

- Effective November 1, the Supports Waiver will include the option for recipients to self-direct the following services:
  - Personal Care
  - Respite
  - Training and Education
  - Home and Community Supports
  - Individual Goods and Services
  - Respite
- Recipients who self-direct will have access to the other services in the waiver through the agency-directed model

Self-Direction Requirements

- Individuals wishing to participate in self-direction will be assessed to determine risks and their individual supports needs
- The budget will be based upon the prior year's Cost Summary, if the person was previously on the waiver, or the Person Centered Plan if they are new to the waiver.
- Individuals self-directing will be required to use the services of a financial management agency and a Community Resource Consultant.

Participant's Responsibilities

- May be assisted by a non-paid representative
- Determines which services in plan will be self-directed and which will be agency-directed
- Recruits, interviews, selects staff – terminates staff when necessary
- Negotiates salary rates and benefits
- Determines staff duties and evaluates performance
- Verifies time worked
- Manages budget

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Financial Management Service (FMS) Agency

- FMS will be selected through a Request for Proposal process. All participants who self-direct will be required to use the state vendor.
- RFP has not yet been released.
- This is an administrative function; the cost is not included in the maximum benefit available through the waiver.
- FMS Duties:
  - Serves as employer of record for participant's staff
  - Conducts all required employment verification checks – criminal records, citizenship status, credentials.
  - Performs all payroll functions, including tax withholding, W2s, etc.
  - Advises the participant on the availability and cost of insurance and other employee fringe benefits.
  - Processes any payroll deductions and payments for fring benefits.
  - Maintains separate accounting for each participants budget and expenditures
  - Provides participant, LMEs and state with status reports on participants' budgets and expenditures.
  - Bills Medicaid for services provided (average of 25 hours per participant per year).

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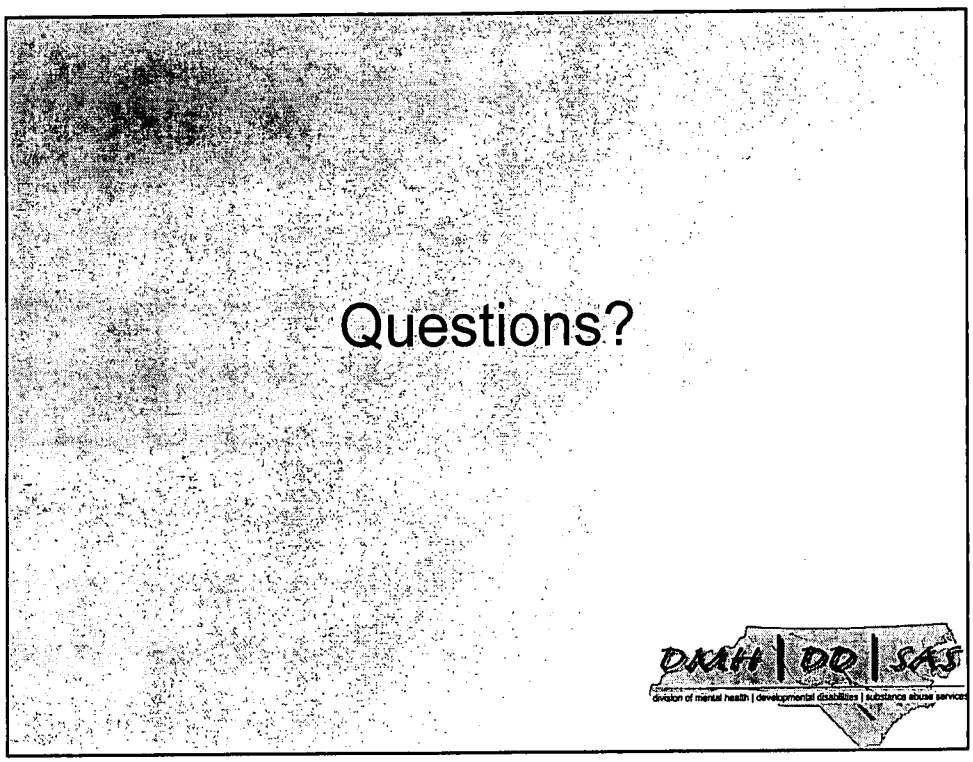
Community Resource Consultant

- CRC will be selected through a Request for Application process. All participants who self-direct will be required to use a state vendor.
- RFA has not yet been released.
- This is an administrative function; the cost is not included in the maximum benefit available through the waiver.
- CRC Duties:
  - Assist and train the recipient on how to recruit, train, hire, evaluate staff performance, etc.
  - Assist participant to develop staff job descriptions and scheduling plans
  - Provide on-going information to the participant to understand their responsibilities under self-direction
  - Assist the participation to objectively evaluate their experience with self-direction

Future Plans

- General Assembly has directed DHHS to implement 4 Tiers of the CAP-MR/DD Waiver.
- Current Comprehensive Waiver will be amended when Tiers 2 and 3 are developed.
- Plan to include self-direction as an option in Tier 2 (maximum annual benefit of $45,000


Questions?
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Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Case Management for Persons with MH/DD/SA

October 14, 2009

Legislation

- **Section 10.68A (a) (10) states that:** *The Department of Health and Human Services shall develop a plan for the consolidation of case management services. The plan shall address the timeline and process for implementation, the vendors involved, the identification of savings, and the Medicaid recipients affected by the consolidation. Consolidation under this subdivision does not apply to HIV case management. By December 1, 2009, the Department shall report on the plan to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.*

The Process

- A public forum was held – over 300 people attended.
- A work group was formed consisting of providers, family/recipients, other DHHS divisions, local Health Depts., local DSSs, LMEs and other interested parties.
- Agendas and call-in number was posted on the DMA website. Minutes and handouts were posted to the website.
- The group examined definitions, functions, administrative rules, documentation, qualifications of staff and providers, rates and impact on indigent care and other service delivery
- The draft proposals were distributed and posted. Final meeting is scheduled to discuss feedback received and next steps

Goals and Outcomes

Recipient Goals/Outcomes

- The recipient must be the center of our care instead of having case management done on a program specific basis.
- The recipient will have timely and uncomplicated access to care via "no wrong door" policy.

Goals and Outcomes cont'd

Case Manager Goals/Outcomes

- Increase quality and continuity of care of recipients through effective and efficient case management including simplifying and eliminating ineffective administrative processes where allowed by regulations.
- Implement client specific outcomes which address all identified needs.
- Decrease 'silo' case management
- Maintain disability/need specific expertise of the case manager.
- Case managers shall receive training to promote the highest quality possible and to insure the prevention of substandard service delivery.
- Develop professional standards for case managers.

Goals and Outcomes cont'd

System Goals/Outcomes

- Simplify the maze of the various types of case management services and systems for families and recipients.
- Eliminate duplication of functions and increase coordination/integration across case management functions to eliminate unnecessary use of Medicaid and other publicly funded services.
- Reduce costs or potential cost increases in the various covered benefit categories of Medicaid
- Support the development of interoperable medical record systems that support collaboration across the continuum of care.
- Reduce costs or potential cost increases in the various covered benefit categories of Medicaid
- Support the development of interoperable medical record systems that support collaboration across the continuum of care. Reduce costs or potential cost increases in the various covered benefit categories of Medicaid
- Support the development of interoperable medical record systems that support collaboration across the continuum of care.

Purpose for Consolidating CM

- Increase quality and continuity of care
- Person centered
- Eliminate duplication
- Decrease 'silo' case management
- Reduce costs as a result of better coordination and quality care

Case Management

- Services that assist individuals in gaining access to needed medical, social, educational, and other services.
- Consists of 4 federally defined functions:
  - assessment,
  - development of care plan,
  - referral, and
  - monitoring and follow-up
- Optional Medicaid service
- CAP waivers require case management services

Care Management

- Addresses programmatic and preventive services needs of population
- Outcome-focused
- Uses data to monitor population and service delivery
- Uses systems, incentives, and information to improve care and manage medical/social/ behavioral health conditions more effectively

Expenditures in SFY 2009 (CM in Enhanced MH/SA and Community Support are estimates)

Summary of Case Management and Related Services, Dates of Service in SFY 2009

Program	SFY 2009 Distinct Recipients	Distinct Recipients in CCNC[4]	CCNC Percent	Paid	Units	Estimated Total Cost of CM	Amount Paid for Case Management Federal 64.46%	State & Local 35.54%
CAP/C CM (per 15 min)	765	438	57.3%	$ 1,418,611	95,223		$ 914,437	$ 504,174
CAP/C CM (per month)	230	76	33.0%	$ 657,000	1,752		$ 423,502	$ 233,498
CAP/DA Case Mgmt	13,278	2,764	20.8%	$ 24,705,273	1,691,109		$ 15,925,019	$ 8,780,254
CAP/Choice Care Adv	63	27	42.9%	$ 129,649	8,503		$ 83,572	$ 46,077
CAP/MRDD Waiver TCM	10,137	5,580	55.0%	$ 38,686,410	1,875,280		$ 24,937,260	$ 13,749,150
DD Targeted CM	8,960	4,881	54.5%	$ 24,401,164	1,188,048		$ 15,728,990	$ 8,672,174
At Risk Case Mgmt[1]	5,008	2,099	41.9%	$ 3,445,246	357,006		$ 3,445,246	
HIV Case Mgmt	2,485	1,429	57.5%	$ 5,449,188	396,244		$ 3,512,547	$ 1,936,641
Child Svcs Coord	18,633	16,292	87.4%	$ 9,560,371	440,057		$ 6,162,615	$ 3,397,756
Maternal Care Coord	28,690	10,538	36.7%	$ 13,171,818	450,770		$ 8,490,554	$ 4,681,264
MaternalOutreachWrkr	2,662	1,779	66.8%	$ 1,157,236	70,498		$ 745,954	$ 411,282
Early Intervention	14,852	11,886	80.0%	$ 13,693,170	468,221		$ 8,826,617	$ 4,866,553
Health Check Coord	933,208	816,307	87.5%	$ 2,871,750	8,274,961		$ 1,851,130	$ 1,020,620
Total				**$ 139,346,886**	**15,317,672**		**$ 91,047,443**	**$ 48,299,443**
				Bundled Service Programs				
SubAbuseIntervOutpat	1,190	798	67.1%	$ 2,591,956	17,999	$ 994,985	$ 641,367	$ 353,618
Assertive Comm Tx Tm	2,762	1,137	41.2%	$ 30,422,785	94,074	$ 1,616,024	$ 1,041,689	$ 574,335
Comm Support Team	5,564	3,053	54.9%	$ 100,282,481	5,862,194	$ 3,209,897	$ 2,069,099	$ 1,140,797
Intensive InHome Svcs	4,152	3,349	80.7%	$ 46,226,294	179,522	$ 2,338,225	$ 1,507,220	$ 831,005
Multi-Systemic Therapy	508	406	79.9%	$ 4,956,193	132,850	$ 312,113	$ 201,188	$ 110,925
SA CompOutpat Tx	504	370	73.4%	$ 3,409,031	69,224	$ 1,530,543	$ 986,588	$ 543,955
Total				**$ 187,888,740**	**6,355,863**	**$ 10,001,786**	**$ 6,447,151**	**$ 3,554,635**
				Community Support Programs				
CommSupp-Child	43,248	34,576	79.9%	$ 294,624,481	21,151,258	$ 24,930,145	$ 16,069,971	$ 8,860,174
CommSupp-Adult	22,099	12,174	55.1%	$ 121,578,635	8,725,657	$ 12,699,174	$ 8,185,888	$ 4,513,286
CommSupp-Gp	582	431	74.1%	$ 246,244	56,368	$ 7,882	$ 5,081	$ 2,801
Total				**$ 416,449,360**	**29,933,283**	**$ 37,637,201**	**$ 24,260,940**	**$ 13,376,261**

DRIVE data were queried October 12, 2009 for Dates of Service July 1, 2008 to June 30, 2009 (SFY 2009)
Query criteria for each program/service are given in Table 2.
CCNA counts were run on 07/21/2009 using criteria specified by CCNC

Providers

- CAP-MRDD – Private agencies endorsed by LME
- CAP-DA – case management provided by lead agency. Can be DSS, hospital, home health or senior program
- CAP-C – case management provided by local county agencies such as DSS, hospital, home health, or case management agency
- Case Management agencies providing case management to people with DD
- Local public health depts. and other agencies who provide other types of case management such as Maternal Care, Child Service Coordination, EI, etc.

- ICF-MR facilities are not effected because case management is part of the per diem. It is part of the social worker function and may not be billed separately.

General vs Specialized CM

- The definition of case management is the same across program types
  - As the program silos are eliminated and administrative functions reduced, staff qualifications can be "general"
  - Acuity of the recipient may require "specialized" CM or more highly trained
  - Qualifications will be based upon the required expertise of recipient acuity, not based upon disability, condition or provider type
  - Differentiate rate based upon the qualifications not on provider type
- Access will be based upon the clinical policy criteria

Short Term Plan

- Limit Number of Units and clarify the entrance, continued stay and discharge criteria
- Increase Administrative Efficiencies: Examples:
  - *Allow direct billing for CAP DME waiver supplies*
  - *Consolidate and reduce forms*
  - *Align CAP waiver policies*
- Modify rate structure
  - *Standardize rates among programs*
  - Move to a case rate structure instead of current method of billing in 15 minute units

Short Term Plan

- Eliminate duplication
  - *Place audit in system to not allow billing by more than one CM provider in the same month*
  - *Examples: CAP-MR/DD with Community Support, HIV CM with Community Support, MST with Community Support, Maternal Care with Community Support*
- Develop linkages to CCNC networks and Primary Care Physician
- Reduce or eliminate prior authorization on targeted case management, when appropriate
- Coordinate with CS workgroup and make changes as needed
- ***Residual effect of consolidating case management will be a reduction of other health care/Medicaid services through better coordination***

Projected Savings

Recommended Change	Projected State Savings 2010
Establish Unit Limits or modifying criteria (effective 11/1/09) *finalizing limits*	$10 -13,000,000
Eliminate Duplication (effective 11/1/09)	$ 2,500,000
Eliminate Prior Approval on CAP-MRDD	$ 1,400,000
Consolidate Health Check into CCNC (effective 11/1/09)	$ 280,000
TOTAL	$14 -17,180,000

DRAFT

CASE MANAGEMENT SERVICES

DMA
- Finance
- Clinical Oversight
- Rate Setting
- Clinical Policy

MEDICAL HOME
PCP & OBGYN
Every Medicaid recipient will have a medical home.
FFS

NC CCN Inc.
- Practice Coordination
- Clinical Policy
- Quality Assurance
- Outcomes Metrics

PMPM

PMPM

CCNC pays PMPM

CCNC Pays PMPM

Managed Care Capitated Rate

LMEs
- STR
- Endorsements
- Care Coordination
- Monitoring
- Quality Assurance
- Outcome Metrics
- Program Integrity

Local CCNC Networks
- Health Check
- Case Management
- Care Management
- Data Transfer & Mgmt
- Quality Assurance
- Outcome Metrics
- 1st Level Program Integrity

Local PH Depts.
- High Risk OB
- Quality Assurance
- Outcome Metrics
- CSHN
- EI

FFS

CAP MRDD
Including CM

Comprehensive MH Providers
Includes CM

DD CM

No DMA $$

At Risk CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

FFS

FFS

FFS

HIV CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

CAP/DA CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

CAP/C CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

DRAFT

DRAFT

CCNC's Role

- Identify high risk factors with TCM agencies and ensure clinical coordination
- Develop patient risk profiles for entities such as LMEs who are charged with care management activities for an assigned population
- Expand key medical information to be provided for all Medicaid patients at point of care to prevent service duplication and optimize coordination of care
- Expand role of privacy officers and deploy network staff facilitate appropriate data transfer and clinical coordination with private case management agencies on a patient by patient basis
- Care Management functions to Health Check enrollees
- Per Member/Per Month will be increased for CCNC to provide for infrastructure enhancements

Future Plans

- Develop Service Definition
- Revise and submit State Plan Amendments (SPAs) to CMS
- Define outcome metrics for each area of CM
- Define risk factors that indicate CM (general and specific) needed for each area
- Submit CAP waiver revisions to make program policies more consistent

Future Plans cont'd

- Modify business processes and roles as a result of changes
- Develop data sharing processes and agreements
- Revise payment structure
- Determine implementation strategy and plan
- Develop Time Line for implementation
- Develop transition plan for current recipients and providers
- Develop Training plan

Coordination with Community Support Work Group

- Case Management definition is being submitted to CMS
- Comprehensive MH providers will be responsible for providing case management as a part of their services.
- DD Case Management will remain as stand alone agency and not be a comprehensive provider.

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

AGENDA

November 10, 2009; 10:00 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair Presiding

I. Welcome and Chair's Opening Comments • Representative Verla Insko, Co-Chair • Senator Martin Nesbitt, Co-Chair	10:00
II. Secretary's Remarks • Lanier Cansler, Secretary, Department of Health and Human Services	10:00-10:30
III. Local Management Entities: Update on Service Funds Reductions • DHHS Perspective: Michael Watson, Assistant Secretary for MH/DD/SAS Development • LME Perspective: W. Rhett Melton, Director of Pathways LME (Serving Gaston, Cleveland, and Lincoln)	10:30-11:00
IV. Funding for Former Thomas S. Class Members • Leza Wainwright, Director, Division of MH/DD/SAS	11:00-11:30
V. Changes in Funding for CAP-MR/DD Recipients • Leza Wainwright, Director, Division of MH/DD/SAS	11:30-12:00
LUNCH	12:00-1:00
VI. Community Support Services • Curtis Venable, Pisgah Legal Services	1:00-1:15
VII. Report on Consumer and Family Advisory Committees • Kathy Crocker, State Consumer and Family Advisory Committee	1:15-1:45
VIII. Update on State Psychiatric Hospitals • Luckey Welsh, Director, Division of State Operated Healthcare Facilities	1:45-2:15
IX. Report on Local Inpatient Psychiatric Community Hospital Contracts • Michael Watson, Assistant Secretary for MH/DD/SAS Development	2:15-2:45
X. Case Management Follow-up • Tara Larson, Chief Clinical Operating Officer, DMA	2:45-3:30
XI. Final Remarks & Adjournment	3:30-3:45

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	11/10/09																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	X																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

November 10, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Tuesday, November 10, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory members Representative Van Braxton and Representative William Brisson were also present. Also in attendance was Representative Hugh Blackwell.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. The Visitor Registration Sheet is attached and is included as a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the October 14, 2009 meeting. The motion was made and the minutes were approved.

Representative Insko asked Lisa Hollowell from Fiscal Research to provide background information on service funds reductions to the LMEs. Ms. Hollowell reminded members that the total reduction made by the General Assembly for the services managed through the LMEs was $60M for FY 2009-2010 and FY 2010-2011. She said that there was a $40M reduction for the non-disability specific general service fund; a $16M reduction of services supplementing the CAP-MR/DD waiver package; and a $4M reduction of services identified as "non-core" to the mission of the Division of MH/DD/SAS. There was an additional 5% reduction ($15M) of the services administered through the LMEs but that money was reinstated by the Governor. The remaining budget totals over $490M for the LME services and administration.

Michael Watson, Assistant Secretary for MH/DD/SAS Development provided the DHHS perspective on the LME funding reductions. Mr. Watson reviewed last year's LME budget reductions, including how funds were allocated to LMEs, how LMEs reduced their budgets, the effect of the reductions on fund balances, and the impact on services. (See Attachment No. 2) His presentation addressed the following items of interest:

- $8M of the $16M State funds supplementing CAP-MR/DD consumers was transferred to DMA but will come back into the system as a match for additional CAP slots.

- Assumption that LMEs will be making fund balance allocations to offset budget cuts from this year and next year.
- DHHS requested fund balance of $21.9M; received $24.9M - 114% went into system to offset budget cuts, 3 LMEs gave more than requested, 2 gave less. DHHS will review final audit of those 2 that gave less.
- Consequence to cuts is impact on providers serving a number of LMEs particularly Substance Abuse programs.
- Great concern over impact affecting jails and ER's; meetings with Sheriff's Association and the Hospital Association showed concern over waiting time and mental health and substance abuse patients in the ER's.
- Accumulative effect of cuts on system – decisions made on community level regarding State dollars will intersect changes in Medicaid rates and changes in the Medicaid service array.

Rhett Melton, Director of Pathways LME, discussed budget reductions at the community level. He addressed specific dollar amounts at Pathways, the strategies used in developing a reduction plan, and some of the current challenges. (See Attachment No. 3) Items of interest in his presentation included:

- Pathways experienced a net loss of $4.6M, which is equal to a 26% reduction of State funds for the LME.
- Responses to cuts include an internal group tracking IPRS earnings; benefits grid outlines array of services for eligible consumers by age and disability groups.
- Expressed concern over gaps that already exist and the impact of the elimination of additional services.
- There is currently a very strong provider network – protecting consumers and stepping up by exploring other opportunities to meet the needs of the consumer.
- No way to continue same level of care as in the past with 26% less funding; ramifications will continue to unfold.
- $3M was used to pay providers for services from fund balance, fund balance cannot be replenished and will create problems if cash flow from State continues.

Mr. Watson was asked to check into Mobile Crisis Services. Representative Brisson expressed concern that his district had no service after 5:00 in the afternoon but they were being funded for 24 hour service. Mr. Watson said he would be back in touch with him.

Members agreed that the $40M cut to the LMEs has been devastating and that the funding issue must be addressed when the General Assembly resumes in May.

Secretary Lanier Cansler, from the Department of Health and Human Services (DHHS), said that DHHS was examining Critical Access Behavioral Health Agencies to ensure flexibility exists for providers and that the services provided are based on clinical need while still controlling costs. He said DHHS was working with the Department of Commerce and the Employment Security Commission to try to minimize the impact of the reductions coming out of health care while maintaining access to services. Secretary Cansler was asked to provide the dollar amount on the impact from the H1N1 virus.

Regarding Community Supports, he said DHHS was trying to see that services provided in the bundled services would be available separately.

Leza Wainwright, Director of the Division of MH/DD/SAS, provided a review of funding for former Thomas S. class members. (See Attachment No. 4) She discussed outcomes from the Thomas S lawsuit and explained that the State continues to offer services to those who would have qualified for services as Thomas S. consumers. Points of interest included:

- Services received by former Thomas S. consumers are no different from the services that most individuals with intellectual or developmental disabilities and a co-occurring behavioral health issue receive.
- Thomas S. lawsuit entitled consumers to priority funding for services. Former members of Thomas S. continue to receive a broader array of State funded services than non-Thomas S. consumers on the CAP MR/DD waiver.
- Medicaid provides psychiatric services for a significant number of former Thomas S. class members.

Secretary Cansler was asked in light of the Fort Hood incident, how our State psychiatrists and other care providers are evaluated. He responded that he would try to get the information.

Continuing, Ms. Wainwright addressed the changes in State funding for CAP-MR/DD recipients previously receiving some State funded services in addition to CAP waiver services. (See Attachment No. 5) She reminded members that the General Assembly reduced the budget of the Division of MH/DD/SAS by $16M with $8M of that being turned into slots for the CAP-MR/DD waiver. $4M went to Tier 1 slots for the Supports Waiver and the rest went to a soft freeze on the Comprehensive Waiver. Items of interest mentioned included:

- 11,000 people served on PHB Innovations Waiver and the Comprehensive Waiver.
- $5.5M was funded for services that could have been covered through the waiver.
- Almost $53,000 was funded through the waiver that could have been funded through the Medicaid State Plan.
- $26M was for services that could partially be covered through the waiver and some portion of the cost could not.

Next, Tara Larson, Chief Clinical Operating Officer with the Division of Medical Assistance (DMA) reviewed a handout with the medical expenditures for the last FY 2009 as well as the year-to-date. (See Attachment No. 6) Ms. Larson was asked to provide the number of people receiving Community Support Team and Assertive Community Treatment Team services.

After lunch, Curtis Venable from Pisgah Legal Services explained that he worked with those receiving services, providers, and those paying for services which gave him a unique perspective on the system. His comments focused on specific problems with possible solutions. (See Attachment No. 7) Points of interest included:

- Services must be reduced in a way to allow communities and providers time to plan; currently there is a lack of clarity resulting in people losing jobs.
- No timetable depicting when the new array of services will be available; no firm information regarding how much people will be paid for delivering services and confusion over who is going to deliver what services.
- DHHS has not indicated exactly what set of services are meant to replace Community Support.
- Assuming that Community Support services will end January 1, 2010, providers are terminating professional staff now.

Representative Insko requested that DHHS respond to the presentation at a later date. Members of the committee voiced great concern over the pending January 1 date to end Community Support without an appropriate alternative in place. DHHS is scheduled to address the LOC next month to explain what the system would look like.

Secretary Cansler said that within two weeks there should be a plan that would outline how to proceed. He said that DHHS was waiting to hear from CMS but approval by CMS might take months. He indicated that the vast majority of services in Community Support would be available. Secretary Cansler said DHHS was trying to make decisions that do not damage the system but also accomplish the budget cuts that are required. He told members that if necessary the January 1 date would be extended again but that hopefully the transition pieces would be in place allowing providers the ability to plan.

Kathy Crocker, representing the State Consumer and Family Advisory Committee (SCFAC), reported on the response from their survey. (See Attachment No. 8) She explained that electronic surveys were sent to Local Consumer and Family Advisory Committees (LCFAC). SCFAC provided the recommendations to the Division of MHDDSAS and the Secretary. Points in her presentation included:

- Survey indicates service arrays offered in the community are not enough to meet the needs of the individual.
- People served need skill building supports; without Case Management people will lose services and quality of life.
- Who is held accountable when services are not working or families are not getting what is needed?

Next, Shawn Parker, from the Research Division briefed the committee on the charge of the Division of State Operated Healthcare Facilities. He said the oversight and management of the State institutions has been assigned to the new Division which works in partnership with the Division of MH/DD/SAS, LMEs, regional advocacy groups, and private providers.

The Committee requested that Mr. Luckey Welsh, Director, discuss the organizational structure of the new Division and specifically the State Psychiatric Hospitals. Mr. Welsh stated that over 12,000 employees care for individuals in our State facilities. Over 3,000 patients reside in the facilities. He said that one of the challenges facing him was to regain the trust of the citizens in the healthcare facilities. He reviewed information that

showed how the Division was accomplishing their goals. (See Attachment No. 9) Items in his presentation included:

- Last year occupancy at State hospitals was over 100% which puts too many patients in a facility without enough staff to care for them.
- Admissions to State facilities are decreasing as admissions to facilities in the community increase.
- Total budget reductions at facilities were over $24M this year.
- 100 patients will be transferred to Central Regional Hospital the first quarter of next year; staff positions have not been cut, they have been relocated.
- Admission delays have been fueled by the economy and an increase in population has increased the demand of psychiatric care.

Senator Purcell suggested and members agreed favorably that the LOC should tour some of the State facilities. The Co-Chairs asked for a proposal from DHHS with a suggested itinerary for the Committee.

Joyce Jones from the Bill Drafting Division provided a brief introduction to Mike Watson's presentation on *Local Inpatient Psychiatric Community Hospital Contracts.* She stated that, according to a recent article in the News & Observer, there are an increasing number of patients with mental illness showing up in emergency rooms and waiting days for an open bed in one of the State psychiatric hospitals or in a local community hospital capable of providing adequate psychiatric care. Last year's budget allocated $8.1M for the purchase of additional inpatient psychiatric beds or bed days in local community hospitals across the State, to increase local bed capacity and divert admissions from the State psychiatric hospitals. This year's budget increased the allocation to $20.1M annually. DHHS is charged with entering into three-way contracts with LMEs and community hospitals for the effective management of these additional beds or bed days. DHHS has entered into some of these three-way contracts, but the perception is that the contracts are coming on line slowly. Ms. Jones reviewed several items of interest that would be a part of Mr. Watson's presentation.

Mr. Watson commended the N.C. Hospital Association on the work that had been done in working with DHHS in encouraging the development of community inpatient psychiatric beds and in encouraging their members to become involved in the initiative. (See Attachment No. 10 to review Mr. Watson's comments.) Items of interest included:

- To expand community bed capacity, some inpatient psychiatric units are taking involuntary commitments.
- Contract with community hospitals states that if a patient becomes too difficult that person is placed on a priority list to be transferred to a State facility.
- Total of 191 new beds under this initiative; 77 beds started last year, 44 beds contracted in Wake County, 14 beds in Johnston County, and 19 beds at Smokey.
- With the available funding of $20M, the start of 114 new beds, the capacity is there to serve almost 5,000 new admissions in the community.
- Additional funding allows hospitals to be brought in that have underutilized capacity.

Tara Larson addressed follow-up questions on Case Management from the October LOC meeting. (See Attachment No. 11)

- Access to Case Management – transportation is not a billable service under Case Management.
- Case Managers must constantly update and evaluate the system and their clients.
- Communication, regardless of the number of agencies, is paramount; all must know what is going on with a client.
- The provider of Case Management for developmental disabilities cannot also be the provider of direct service.
- Once CMS approves an old State Plan Amendment (SPA), another SPA will be submitted to CMS for approval that changes the 15 minute billing unit to a case rate.
- Work group working on a definition of Case Management for SPA; also looking at knowledge, skills, and ability of Case Managers since quality of Case Management is not the same among the providers or across the stand alone Case Management Agencies.
- Report to be submitted to General Assembly on the rate and billing structure with Community Support.

There being no further business, the meeting adjourned at 3:40 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Ken Richardson	County Commissioner
Fred Bone	Bone & Asso.
DAVID BARNES	Pozner Spruill
Fred Wedell	Eastern Seals UCP NC/VA
Leslie Swagan Cona	Cops Direct
Annie Smith	Youth Villages, Inc
Christi Seals	Youth Villages, Inc.
[illegible]	CFST-NC
[illegible]	NHA-NC
Julia Leggett	The Arc of NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ray Ulrison	ECBH - New Bern NC.
Yvonne Copeland	NC Cancil of Comm Prog.
Kim Chapple	Coastal Horizons Center
Julie Ewing	Advocate
JIM PARRIS	RALPH SCOTT LIFESERVICES INC.
Jennifer Holden	RSL, Inc.
Bennie Kidd	Ralph Scott Lifeservices
Amy Whited	NC Medical Society
Don Richard	Telfa
Jay Kortemeyer	Brynn Marr Hospital
Amy Bryson	NC Assn. Long Term Care Facilities

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Satana Deberry	TROSA
Hank Debnam	CCLME
Tyrone McRae	Omega ILS
Delwin Clark	Omega ILS
Daphne Lyon	OERI
Angie Barther	SA Federation
Gina Peace	NC DURS
Joanne Stevens	NCNA / nursing
John Bowdich	AstraZeneca
Bob Oldrid	NCPE

VISITOR REGISTRATION SHEET

Mental Health/DD/SAS — November 10, 2009

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Martin	Lighthouse Counseling Center 2800 Breezewood Ave, Fay, NC 28303
Misty Martin	Same as above
Pam Shipman	PBH LME
Mari Jacques	North Carolina Mental Health Consumers Org
Kim Schmidt	" "
Martha W Lowrance	VA IOI DVA
[illegible]	MHM Services, Inc
Deanna Jarvis	Pride Inc
Debby N Deno	Pride Inc
Emily Willbourne	RHA
Peg Thompson	DDFA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kaye Holden	DHHS/Budget & Analysis
	me
	anfo
	AnFo Child and Adult
Deborah Morgan	Pathways for Success
Anita Byrd	Pathways for Success
Douglas Finley	Aym Technologies LLC
Beka Smith	UNC Dept. of Psychiatry
Phil Freeman	Consumer Solutions LLC
Dave Lloyd	Smith Myers Soules
Dwaylon Whitley	A-1 Community Support LLC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Treva Johnson	omni visions 910 c Street suite 8 N. Wilkesboro NC 28659
Crystal Nonnemaker	Omni Visions 910 c Street Suite 8 N. Wilkesboro NC 28659
Louise G. Fisher	Volunteer Advocate for Mentally Ill
Martha C Brode	Advocate, Raleigh NC
AISANDER DUDA	NC CENTER FOR PUBLIC POLICY RESEARCH
Annaliese Dolph	DRNC
Dan Zorn	Families Together
Anthony Brown	Consumer Solutions LLC
Mary Powell	NC Substance Abuse Federation
Laura Keeney	State Consumer and Family Advisory Committee
Robin D. Henderson-Wiley	Southlight, Inc.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Will Woodell	will.woodell@valueoptions.com
Robin Huffman	NC Psychiatric Assoc.
Maureen Murrell	ASNC
Jennifer Mahan	MHANC / Coalition
Rebecca Trent	NCACC
Justin Norman	Southeastern Center, Wilmington NC
Cindy Brailer	OPC Area Program
Judy Truitt	OPC Area Program
Kathy Baker	Southeastern Regional MH/DD/SAS
Sharon Prevatte	SE Reg LME
Beth Garriss Hardy	Family Member / Advocate

VISITOR REGISTRATION SHEET

Jt. Leg Oversight Comm on MH/DD/SAS — Nov 10, 2009

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hal Jones	TRIUMPH, LLC RALEIGH
Curtis Venable	Pisgah Legal Asheville
John Dervin	Governor's Office
Renee McG	DHHS
Rhett Melton	Pathways LME
Bill Scott	DHHS
Jamal Jones	NCHA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 10, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Hunter	OERI
Tom Calver	Kidsplace
Michael Slack	Kidsplace
Andrew Stockland	DRNC
Vicki Smith	DRNC

FY 09-10
LME FUNDING REDUCTIONS: METHODOLOGY, COMMUNITY DECISIONS & IMPACTS

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and
Substance Abuse Services
November 10, 2009

1

LME STATE FUNDING REDUCTIONS

Total Reductions: $60,017,219

- General Services Reduction: $40,000,000
- State Funds supplementing CAP-MR/DD Consumers: $16,000,000

2

LME STATE FUNDING REDUCTIONS

- "Non-Core" Community (Comprehensive Treatment & Service Program): $4,017,219
- Reduction = 16% of total recurring State/Federal service dollars

Note: $15,000,000 - 5% Reserve reallocated to community services

3

$15,000,000 RESERVE REALLOCATED TO LMEs

LMEs	Original Pro Rata Reduction	Revised Pro Rata Reduction	Additional Funding Available for SFY 2009-2010
Alamance-Caswell	787,422	390,039	367,383
Albemarle	998,354	466,277	441,077
Beacon Center	751,444	386,960	364,484
Centerpoint	1,773,404	913,224	860,180
Crossroads	972,686	500,890	471,796
Cumberland	874,381	450,268	424,113
Durham	875,054	450,614	424,440
Eastpointe	1,007,312	518,721	488,591
ECBH	1,741,704	896,900	844,804
Five County	1,180,456	592,435	558,023
Guilford	1,393,235	717,454	675,781
Johnston	388,991	200,313	188,678
Mecklenburg	1,959,193	1,008,897	950,296
Mental Health Partners	952,891	490,696	462,195
Onslow-Carteret	426,740	219,752	206,988
Orange-Person-Chatham	993,858	511,792	482,066
Pathways	1,670,495	860,231	810,264
Piedmont	1,813,210	933,722	879,488
Sandhills	2,027,563	1,044,156	983,407
Smoky Mountain	2,234,284	1,150,697	1,083,727
Southeastern	896,954	461,737	434,917
Southeastern Regional	1,028,554	529,130	497,454
Wake	2,009,005	1,033,903	973,902
Western Highlands	2,322,978	1,196,232	1,126,746
GRAND TOTAL	30,928,000	15,928,000	15,000,000

4

LME FUNDING REDUCTION METHODOLOGY

- CTSP reductions ($4,017,219) were allocated to LMEs in proportion to their total allocation of these dollars
- State funds/CAP-MR/DD reductions ($16,000,000) were based on actual data by LME (e.g. total State dollars spent supporting CAP-MR/DD consumers)

5

LME FUNDING REDUCTION METHODOLOGY

- General service reduction ($40.0 million) allocated to LMEs as follows:

*$2,200,000 in reductions (10.3%) to Cross Area Service Programs (CASP)

*$21,875,000 (LME fund balance appropriations)

*$15,925,000 (based on each LME's total non-CASP State/Federal funding allocation)

6

LME REDUCTION PLAN INSTRUCTIONS

- Protect Crisis Services (e.g. Mobile Crisis Teams, Walk-In Crisis Clinics, DD START Teams)
- Reductions taken in State dollars only
- Demonstrate consumer, family, provider and LME Board involvement

7

LME REDUCTION PLAN INSTRUCTIONS

- Appropriate identified fund balance amount—If not—Why?
- Identify funding reductions by age/disability group & seek to define consumer impacts
- Describe changes in the LME's State Funded Benefit Plan

Note: All LME Reduction Plans have been reviewed and approved by DMH/DD/SAS

8

LME FUND BALANCE APPROPRIATIONS

Methodology:

› Multi-County LMEs

- Exclude approved reserved amounts (all or a portions)
- Excluded 8% of unreserved amount
- Assumed that 90% of remaining funds were available for appropriation during FY 09-10 & FY 10-11 (50% per year)

9

LME FUND BALANCE APPROPRIATIONS

- Single County Programs
  - Reviewed appropriated vs. actual expenditures for the last two years
  - Assumed any difference represented a contribution to county fund balance

10

LME FUND BALANCE APPROPRIATIONS

- Single County Programs Continued
  - Excluded 8% of the amount and assumed that 90% of the remainder was available for appropriation during FY 09-10 & FY 10-11 (50% per year)

Note: 16 of 24 LMEs were requested to appropriate fund balance to offset the impacts of funding reductions

11

FUND BALANCE UTILIZATION

- Requested LME Fund Balance Appropriation = $21,875,000
- Actual Fund Balance Appropriation = $24,944,906 (114%)
- Track LME service expenditures and fund balance utilization during FY 09-10

12

LME FUNDING REDUCTION STRATEGIES

- No good choices—need to reconcile very limited funding with increasing demand
- Protect core services
- No reductions in Crisis Services
- Protect hospital transition services
- Protect Walk-In Crisis & psychiatric access

13

LME FUNDING REDUCTION STRATEGIES

- Protect residential services
- Across the board reductions for service contracts

14

LME FUNDING REDUCTION STRATEGIES

- Adjustments in LME Consumer Benefit Plans
  - *Reductions in level of service authorization for both initial and continuing authorizations
  - *Increased frequency of review for intensive/high cost services
  - *Closure of services to new admissions (e.g. Developmental Therapy, Personnel Assistance, Community Support Team, ACTT, etc.)
  - *Setting "caps" on service availability (e.g. limiting the number of State funded consumers who get ACTT at any one time)
- Manage reductions fairly among age/disability groups

15

GENERAL CONCERNS

- Loss of new initiatives as the system cuts back to protect "Core Services"
- Impact on providers who serve more than one LME as cuts build up

16

GENERAL CONCERNS

- Impacts across the system (e.g. jails, ERs, State Hospitals)
- Increased impacts on consumers & providers as State funding reductions intersect changes in Medicaid rates and service array

17

Pathways LME
Response to 2009-2010 Funding Reductions

Rhett Melton
Area Director

1

Items to Review

- Summary of the financial impact at the local level
- Overview of strategies utilized in the development of the local reduction plan
- Current status of changes

2

Local Financial Impact

Cross Area Service Program (CASP) Reduction	<$149,137>
Non Core Community Services Reduction	<$73,327>
State $$ Supporting CAP MR/DD Consumers Reduction	<$2,534,839>
General IPRS Service Fund Reduction	<$2,670,495>
October restoration of funds	$810,264
Net Loss of Service Funding	<$4,617,534>
Percentage of beginning recurring state allocation	26%

Development of Local Plan to Respond to Loss of Service Funds

- Preparation began in late Spring for anticipated reductions
- Met frequently with local interested parties including providers, consumers/family members and community stakeholders
- Internal workgroup already in place to process changes
- Board of Directors active in the analysis and planning of system changes

Considerations Critical in the Plan Development

- Ensure that community safety net and crisis services remained available and viable
- Ensure compliance with legislative requirements re: CAP MR/DD consumers
- Spread the burden across age and disability groups
- Do the least harm to the fewest consumers
- Be fair to providers
- Be mindful of identified gaps in the existing service system

Funding Reduction Plan Specifics

- Began by reducing funding as directed in two areas: CAP MR/DD and CASP
- Worked from reduced contract amounts which resulted from prior year funding changes
- Pathways' Board allocated $1 million to reduce the impact from the state's reductions
- The remaining reductions resulted in changes to all age and disability groups

Current Situation

- Overall, local providers responding to decreased funding while attempting to safeguard current consumers
- There has been, and will continue to be, significant ramifications to current consumers
- Demand increasing dramatically at a time when funds are dropping significantly
- Other identified needs will not be able to be addressed

Current Situation (cont'd)

- Pathways has expended 37% of our allocation through October 31st
- Decreasing fund balance may compromise our ability to protect the cash flow of our providers
- The system must work together, locally and statewide, to recover from this situation

Funding for Former *Thomas S.* Class Members

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
October 14, 2009

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division of mental health | developmental disabilities | substance abuse services

History of the *Thomas S.* Lawsuit

- Lawsuit filed July 7, 1982.
  - Suit alleged that state was not providing adequate services to individuals with mental retardation in state psychiatric hospitals. Originally only 1 plaintiff – Thomas S.
- In 1984 the Court declared the case inactive pending the State's provision of adequate services.
  - Plaintiff attorneys continue to pursue, identify four other plaintiffs, files as class action.
- November 21, 1988. Court rules for the Plaintiffs
  - State appeals. US Supreme Court refuses to hear appeal.
- January, 1991. Court appoints Special Master and Independent Evaluator
- January 24, 1998. Court finds State has met requirements. Injunction and Special Master removed, lawsuit over.

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Requirements of the State

- Continue to assure that class members and other consumers in similar circumstances are:
  - Protected from harm and treated in safe conditions
  - Have freedom from undue restraint
  - Receive habilitation services designed to reduce aggression, self-abuse, or prolonged isolation from home and community
  - Receive any treatment necessary to address injuries caused by prior inappropriate treatment

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Criteria for Class Membership

- In order to be considered a *Thomas S.* class member, an individual had to be
  - Over age 18
  - Have been confined to a state psychiatric hospital at any time since March 22, 1984
  - Be mentally retarded – or have been treated as if he/she was mentally retarded

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#of Thomas S Class Members

- When the lawsuit ended, there were 1,349 confirmed *Thomas S* class members
- In 2003 the State discontinued labeling *Thomas S* consumers. At that time there were 1,139 individuals in the following categories:
  - 838 remaining confirmed class members
  - 182 who met class criteria & were receiving TS funding, but had not been confirmed prior to the end of the lawsuit
  - 119 who appeared to meet the criteria, had not been confirmed and were not funded

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Location of Individuals

- The 1,139 people identified in 2003 currently live in every county of the state except three:
  - Stokes, Tyrell, and Washington Counties
- Over 25% live in 6 counties:
  - Wake - 61
  - Guilford - 51
  - Mecklenburg - 49
  - Burke - 47
  - Durham – 45
  - Alamance - 38

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Type of Residence

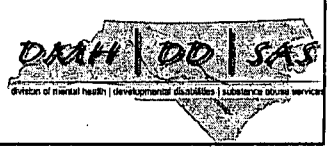
- 657 people live in a MH/DD/SA licensed, non-ICF/MR community residential placement – group home, apartment with roommate(s), etc.
- 233 live in their own home or with family
- 160 live in adult care homes
- 49 live in a state developmental center
- 37 live in a community ICR/MR
- 3 live in a state Neuro-Medical Treatment Center

Funding Sources

- 1,047 of the 1,139 individuals received non-ICF/MR community funding in SFY 2009:
  - 173 received CAP-MR/DD funded services only: Total $8,928,261, average = $51,608/person
  - 418 received state-funded services only: Total $13,499,759, average = $32,296/person
  - 456 individuals received a combination of state-funded and CAP-MR/DD funded services: Total = $38,467,854, average = $84,359/person. $23,451,809 CAP-MR/DD, $15,016,045 state

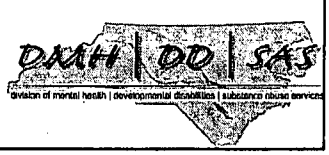
Types of Serviced Received

- The services that former *Thomas S.* class members receive are the same services received by the rest of the DD population:
  - residential supports,
  - guardianship,
  - employment support,
  - day activities,
  - habilitation,
  - personal care,
  - supplies



State-Funded Services with CAP-MR/DD

- The state-funded services received by former TS class members who were also on the CAP-MR/DD waiver in 2009 were also the same as those received by the rest of the dually-funded DD population:
  - guardianship,
  - personal care,
  - employment support,
  - residential support



Changes in State Funding for CAP-MR/DD Recipients

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
November 10, 2009

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Background

- Both the CAP-MR/DD Comprehensive Waiver operating in 95 counties and the PBH Innovations Waiver operating in the 5 counties of the Piedmont Behavioral Health LME offer a fairly robust benefit.
  - Average cost in SFY 2009 = $45,759
  - Maximum benefit of $135,000/year in the Comprehensive Waiver
- Historically, some CAP-MR/DD recipients have also received state-funded services. In SFY 2009, 1,549 waiver recipients also received state funded services, totaling $31,883,865. Many of those services could have been covered through the waivers.

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Legislative Action

- In SB 202, General Assembly reduced state funds for DD services by $16 million, transferring $8 million to DMA for new CAP-MR/DD slots.
- Section 10.21B states: "Except as otherwise provided in this section for former Thomas S. recipients, CAP-MR/DD recipients are not eligible for any State-funded services except for those services for which there is not a comparable service in the CAP-MR/DD waiver. The excepted services are limited to guardianship, room and board, and time-limited supplemental staffing to stabilize residential placement. Former Thomas S. recipients currently living in community placements may continue to receive State-funded services."

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State-Funded Services SFY 2009: Could be covered thru the Waivers

	Dollars	Persons
Developmental Therapy - Individual	$ 107,426	59
Developmental Therapy - Group	$ 1,025	1
Long Term Vocational Support	$ 86,640	71
Respite	$ 61,692	40
Personal Assistance	$ 2,509,218	158
Developmental Day	$ 268,216	35
Adult Day Vocational Program (ADVP)	$ 1,595,158	362
Supported Employment	$ 82,204	14
Day Activity	$ 705,931	64
Residential Supports	$ 73,400	2
	$ 5,490,910	806

Note: Persons will be duplicated across these categories, since a single person might receive more than one service.

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State-Funded Services SFY 2009: Could be covered thru the State Plan

	Dollars	Persons
Community Support - Child	$ 2,590	1
Mobile Crisis	$ 1,330	2
Personal Care	$ 1,233	4
Case Management	$ 44,539	123
Forensic Evaluation	$ 400	2
Medication Management	$ 2,617	19
	$ 52,709	151

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State-Funded Services SFY 2009: Could be Partially Covered thru the Waiver (no room and board)

	Dollars	Persons
Independent Living	$ 118,558	12
Family Living	$ 413,959	24
Supervised Living	$ 17,565,794	478
Group Living	$ 7,986,314	423
	$ 26,084,626	937

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State-Funded Services SFY 2009: Not covered by Medicaid

	Dollars	Persons
Guardianship	$ 335,089	129

Process

- LMEs reviewed all CAP-MR/DD recipients receiving state-funded services to determine appropriate alternatives
- Allowed sufficient time to alter CAP-MR/DD Plans prior to terminating state-funded services
- Some former *Thomas S.* consumers still receiving residential services with additional staffing.

Results

- Through claims paid in September, 2009:
  - Number of CAP-MR/DD recipients receiving state funded services dropped 57%, to 662
  - Similar number of persons receiving guardianship services
  - 337 individuals receiving room and board assistance, down 64%; based upon 1st quarter expenditures, project total cost to decrease to approximately $9 million/year; down from $26 million

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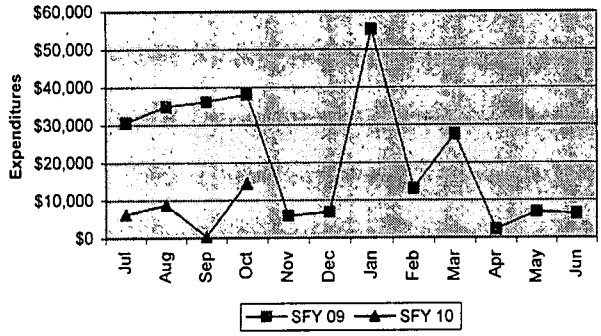
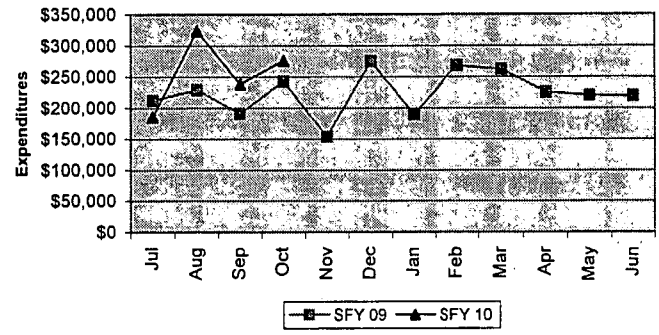
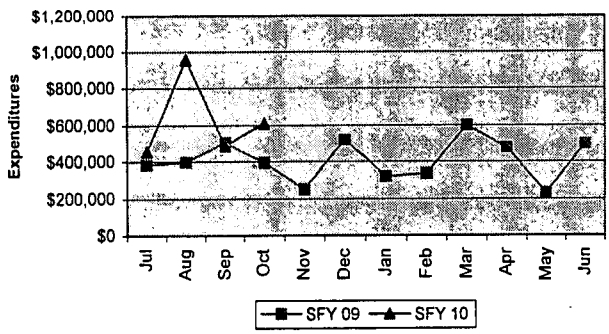
Non-Hospital Medical Detox
H0010



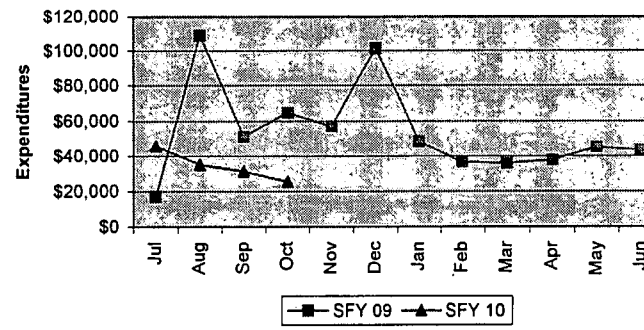
Substance Abuse Intensive Outpt Program
H0015



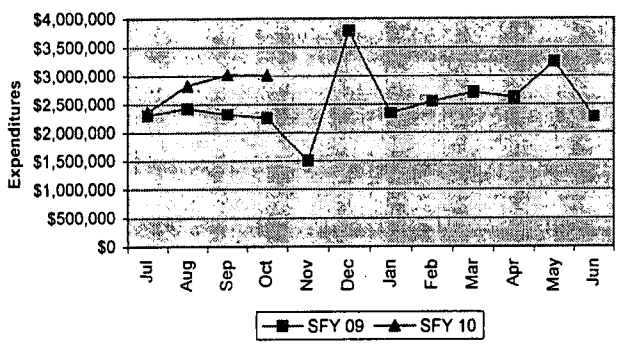
Opioid Treatment
H0020



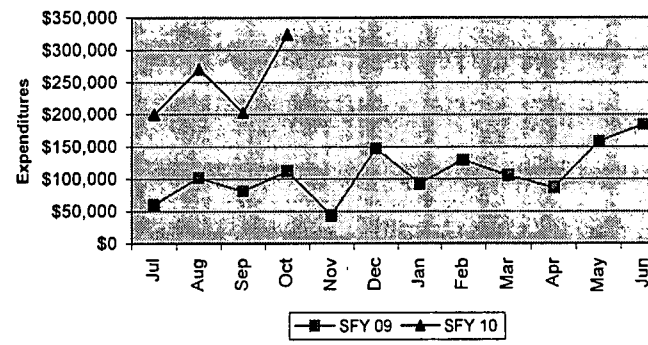
Partial Hospitalization
H0035



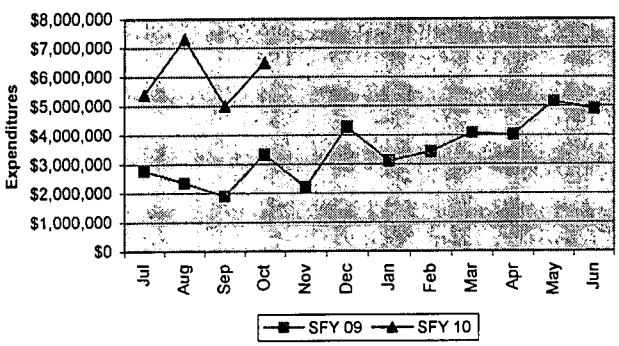
Assertive Community Treatment Team
H0040



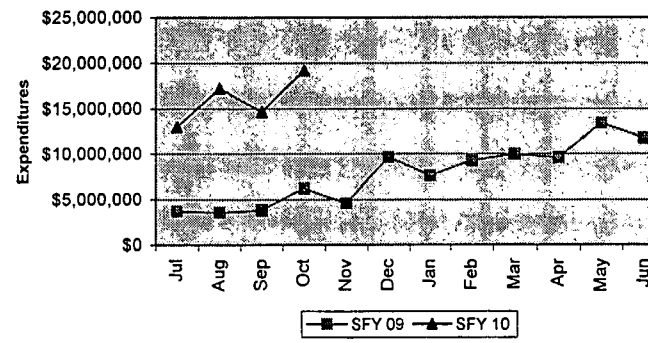
Mobile Crisis Management
H2011



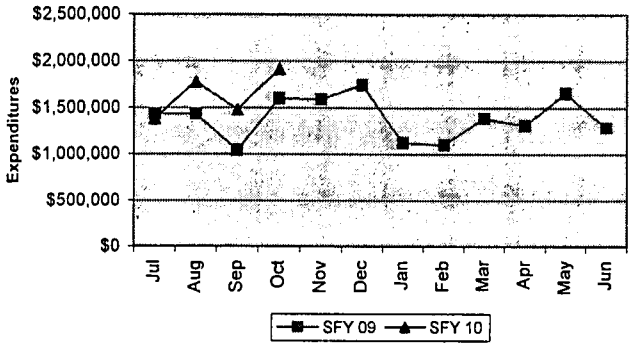
Child and Adolescent Day Treatment
H2012



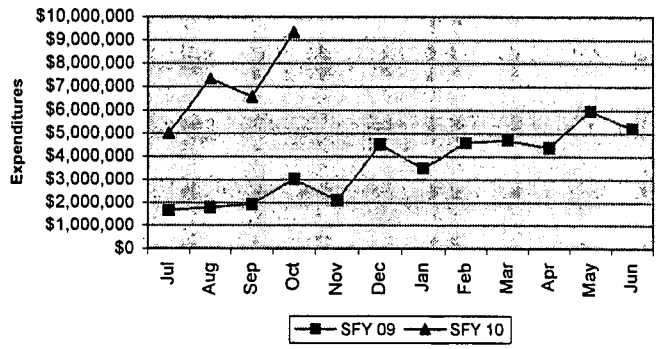
Community Support Team
H2015



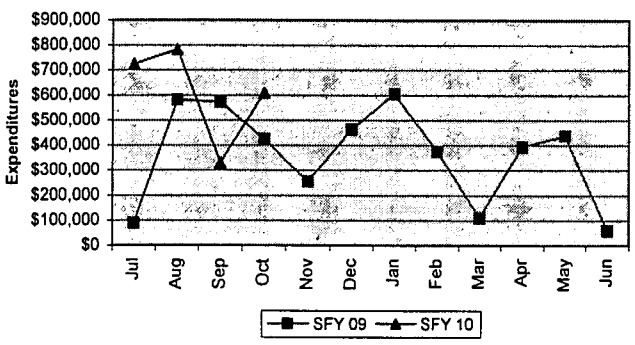
Psychosocial Rehab
H2017



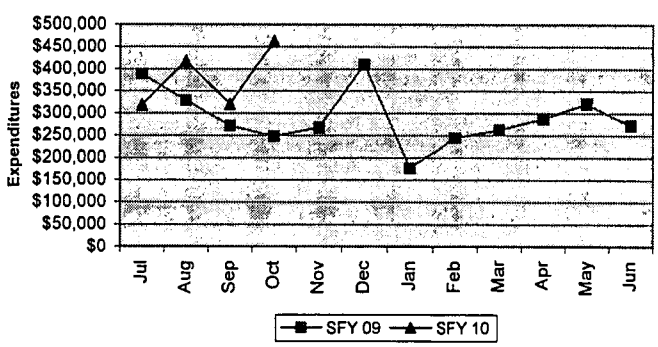
Intensive In-Home
H2022



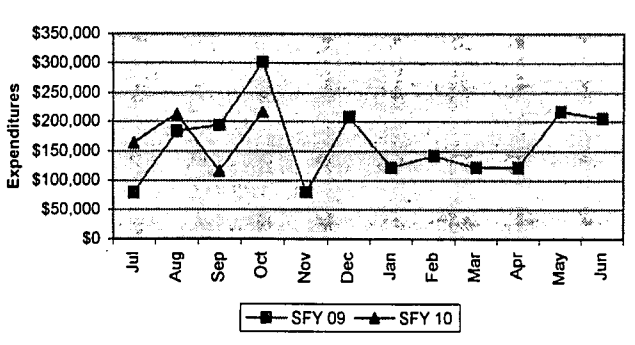
Multisystemic Therapy
H2033



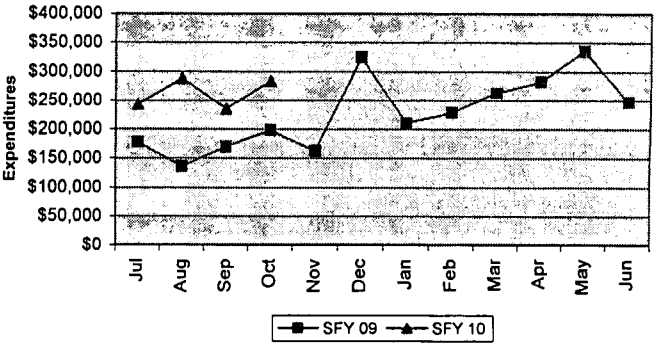
Substance Abuse Comprehensive Outpt Tx
H2035



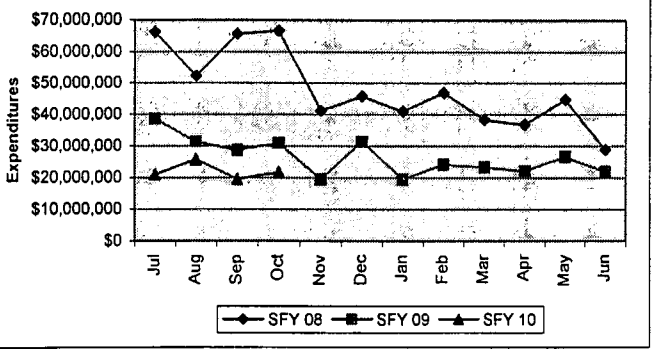
Professional Tx Svc in Facility Based Crisis Pgms
S9484



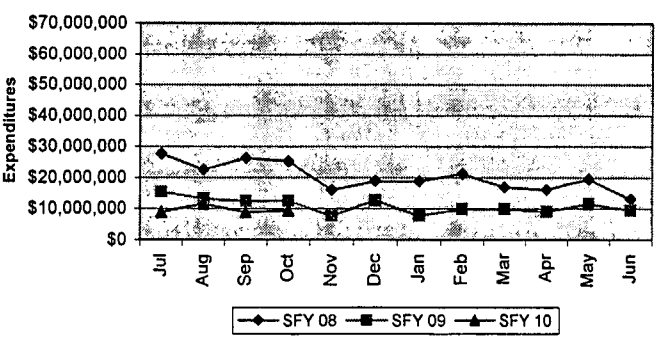
Diagnostic Assessment
T1023

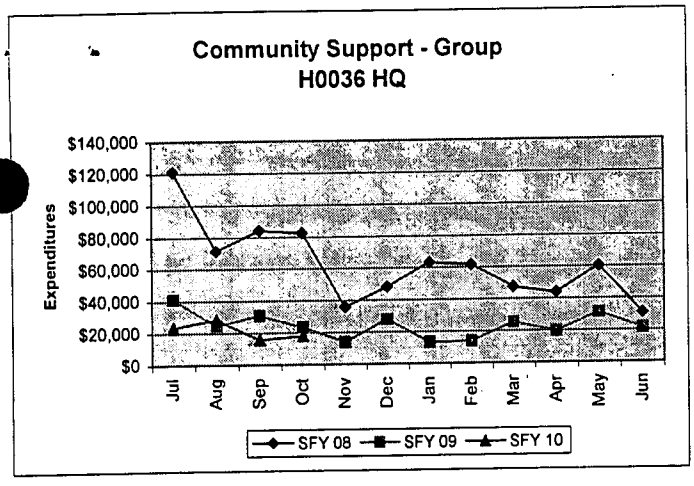


Community Support - Individual Child
H0036 HA



Community Support - Individual Adult
H0036 HB




Community Support - Group
H0036 HQ
Expenditures
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
SFY 08
SFY 09
SFY 10

PISGAH LEGAL SERVICES

Pisgah Legal Services

Post Office Box 2276
Asheville, North Carolina 28802-2276
Phone: (828)253-0406 • Fax: (828)252-8927

Memo

To: Sen. Martin Nesbitt

Date: 11/09/2009

Re: Mental Health Services

Continued deterioration of access to services: as the Department has yet to implement successor services for Community Support, larger, better run behavioral health providers continue the downsizing of their entities. Several hundred professional level staff have been terminated as these providers operate upon the assumption that services will end by 1/1/2010 with no defined replacements upon which they can sustain their business models.

Recommendations:

- Obtain tacit, though unofficial, approval from CMS for the new services/codes.
- Move forward with new services/codes without CMS approval.
- Retract the termination date for CS. Leave it open until 60 days post CMS approval of new services/codes.

Difficulty in starting/expanding enhanced mental services: present Department policy requires providers to have staff on salary prior to receiving endorsement for services. As endorsement is the beginning of the process, it is normally 4 to 6 months later before the provider can begin billing for the service. This "hiring before endorsement" policy results in significant capital costs. A new CST will require a capital outlay of $25 to $30,000; Day Treatment, $50 to $75,000; ACTT, $90 to $100,000. Present capital markets allow little ability to create or expand these enhanced services.

Recommendation:

- Change to a "hire before delivery" policy. This would result in providers carrying unbillable staff costs for only a couple of weeks versus the present situation of months. Accredited staff would need to be in place before the actual delivery of any services.

Lack of validation of billing codes by CMS: one key components of the Department's plan to replace CS skill building is the use of patient education CPT billing codes. The specific definitions of these billing codes requires education and training for patient self-management by a qualified, non-physician professional using a standardized curriculum, face-to-face with the patient. The problem with this solution: the codes are intended for the education of asthmatics and diabetics—not ongoing skill building for the mentally ill. Presently, no state is known to use these codes in this manner. Intelligent, cautious providers will not use the billing codes due to the risk of CMS disapproval.

Recommendation:

- Confirm CMS approval for use or some type of provider "Hold Harmless."

Questionable case management quality: the Department has not defined limits to the number of consumers that any one case manager can assist. Provider finances will benefit from high case loads. But consumers benefit from low case load ratios.

Recommendation:

- Mandate maximum caseloads for mental health case managers.

Questionable mental health case management rate: the Department's plan to cover the higher cost of its Comprehensive Mental Health Provider requirements by assigning these higher costs to the rate paid for case management carries significant risks for providers. Assigning provider-wide costs to a single service is contrary to the standard practice of spreading in-direct costs (such as various administrative costs) across the multiple services delivered by a provider. If CMS should later disallow the this rate structure, providers will be saddled with the high costs of comprehensive provider status but without a means of recovering the costs.

Recommendation:

- Confirm CMS approval of the exclusive allocation of comprehensive provider costs to the single case management rate.
- Allocate comprehensive provider costs across agency services

SCFAC
State Consumer and Family Advisory Committee

2009 LCFAC to SCFAC Survey Response Report

SCFAC to LCFAC Interface Task Team

Kathy Crocker, Chair

Rosemary Weaver	Terry Burgess
David Taylor, Jr.	Gladys Christian

§ 122C-171. State Consumer and Family Advisory Committee (SCFAC)

The State CFAC shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse services system.

SCFAC RESPONSIBILITIES

- Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.
- *Identify service gaps and underserved populations.*
- *Make recommendations regarding the service array and monitor the development of additional services.*
- Review and comment on the State budget for MH/DD/SA services.
- Participate in all quality improvement measures and performance indicators.
- *Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of MH/DD/SA services.*
- *Provide technical assistance to local CFAC's in implementing their duties.*

TECHNICAL ASSISTANCE

DEFINITION:

"Information, support, referrals, resources and training provided to Local CFAC's by the State CFAC in a variety of ways as determined by the SCFAC based on information received from the State and Division of MH/DD/SA Services or from communications from the Local CFAC's."

LCFAC to SCFAC Survey

In May 2009, the SCFAC distributed an online questionnaire utilizing a program called "Survey Monkey". There are currently 24 LCFAC's across the state of NC. The SCFAC received 22 completed surveys from LCFAC's.

The following responses were taken directly from the 2009 LCFAC to SCFAC Survey and were edited for grammar, punctuation, length not affecting original content.

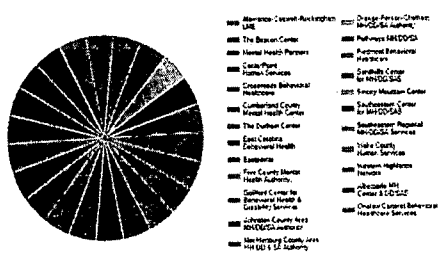
LCFAC's Represented:

- Alamance-Caswell-Rockingham LME
- The Beacon Center Mental Health Partners
- Center Point Human Services
- Crossroads Behavioral Healthcare
- Cumberland County Mental Health Center
- The Durham Center
- East Carolina Behavioral Health
- Eastpointe
- Five County Mental Health Authority
- Guilford Center for Behavioral Health & Disability Services
- Johnston County Area MH/DD/SA Authority
- Mecklenburg County Area MH DD&SA Authority
- Orange-Person-Chatham MH/DD/SA Authority
- Pathways MH/DD/SA
- Piedmont Behavioral Healthcare
- Sandhills Center for MH/DD/SAS
- Smoky Mountain Center
- Southeastern Center for MH/DD/SAS
- Southeastern Regional MH/DD/SA Services
- Wake County Human Services
- Western Highlands Network
- Mental Health Partners

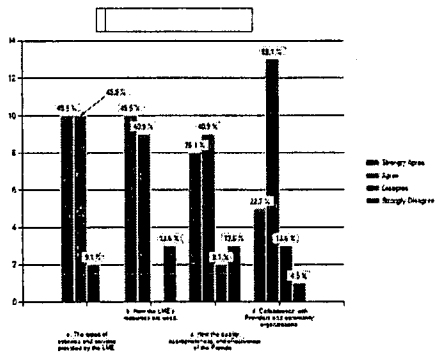
LCFAC's Not Represented:

- Albemarle MH Center & DD/SAS
- Onslow Carteret Behavioral Healthcare Services

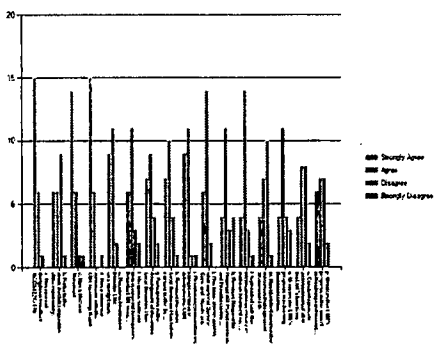
LCFAC's



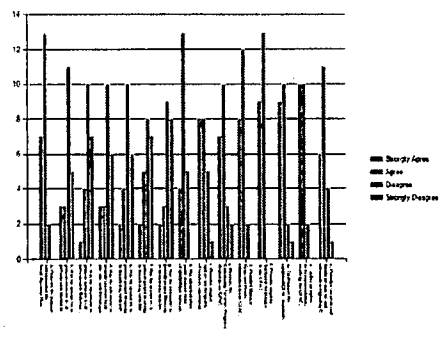
CFAC Members Give Input On:



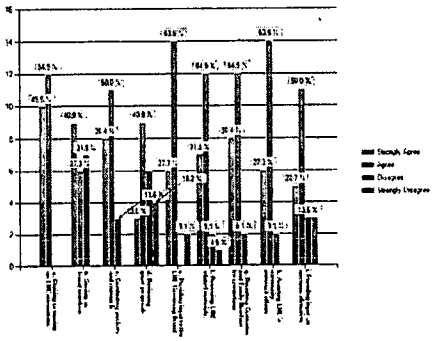
Our CFAC:



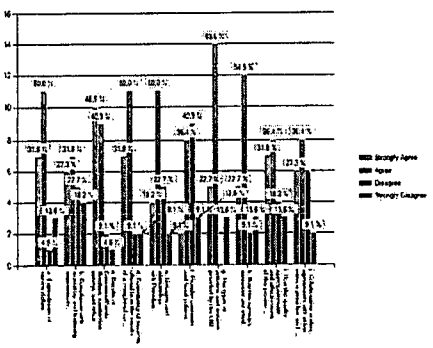
Our LME's:



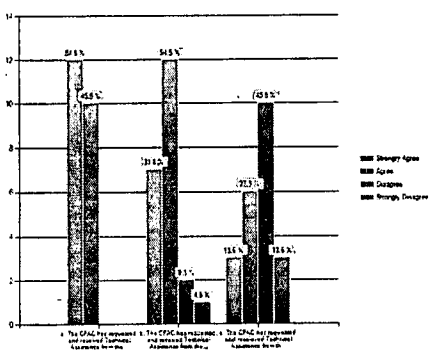
Consumers / Family Members are involved in leadership roles in the LME



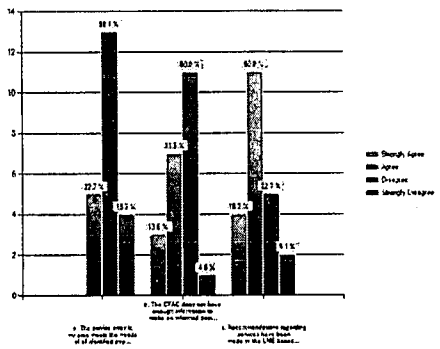
Our CFAC annually reviews and gives input on:



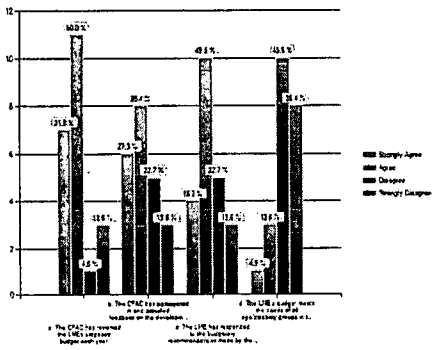
Technical Assistance to Local CFAC's:



Service Array, Monitoring, and Development of New Services



Budget for Mental Health, Developmental Disabilities and Substance Abuse Services



TOP 5 RECOMMENDATIONS

- SERVICES
- GAPS
- HOUSING
- PROVIDER
- TRANSPORTATION

TOP 5 RECOMMENDATIONS

#1 – SERVICES

•Service array does not meet the needs of all identified population groups.

•Improve the availability and quality of outpatient mental health and substance abuse services.

•Increase quality programs and slots for all populations to facilitate and maintain independence based on individual needs.

•Quality and timeliness of services is vital and needs to be a priority when establishing LME goals as it enables inclusion for people with disabilities into the fabric of everyday life, creating a more vibrant, inclusive, and interdependent community as a whole.

•Improve Service Quality through workforce development projects and provide SCFAC / LCFAC's with written reports quarterly on progress.

•Equal, consistent MH/DD/SA services.

•Keep Community Support Services in NC.

TOP 5 RECOMMENDATIONS

#1 – SERVICES (cont'd)

- Assign specific accountability within the Division for each of the 2007 Strategic Objectives and require quarterly reporting to SCFAC and local CFAC's on actions and status.
- Improve collaboration between Division and Lme's.
- When appropriate-quality case management.
- Cap waiting list.
- Keep Wright School & Level III & IV Group Homes.
- More concern from state govt. for local issues.
- Privatized Services have not been the answer to improved services for the populations we are supposed to serve. The "REFORM" process has added another layer of overhead. We have one layer with the LMEs and another with the 100's of Service Providers.

TOP 5 RECOMMENDATIONS

#2 – GAPS

- Identify minorities and youth.
- Dual diagnosis services.
- Increased transition services from school to work and / or life for all populations.
- Assistance with affordable medications.
- Develop and provide funding for Peer Support Services.
- Increased peer support use.

TOP 5 RECOMMENDATIONS

#2 – GAPS (cont'd)

- Adolescent services-acute and into adulthood.
- Increased availability of clinical services to Hispanic / Latino consumers.
- Expansion of Jail Diversion Services.
- Recreation and leisure opportunities for people with disabilities which is imperative to good mental health. Overall well-being is undervalued and under funded in our communities.

TOP 5 RECOMMENDATIONS

#4 – PROVIDERS

- Quality of Providers.
- Increase availability of psychiatrists and therapists in rural areas.
- Need more psychiatrists in the state.
- Mandate accuracy of provider reporting.
- Insufficient number of providers with sign language proficiency.
- Ongoing, affordable training for providers

TOP 5 RECOMMENDATIONS

#5 – TRANSPORTATION

- Increased affordable and reliable transportation options: 24/7 transportation that would be available to help transport individuals to appointments, shopping, work integration (some jobs are after 5 p.m.) particularly needed in rural areas.
- Transportation for people with disabilities is inconsistent, ranging from some service to no service, and is important to the basic needs of Consumers.

SCFAC to LCFAC Interface Task Team

Next Steps:

- Send 2009 LCFAC to SCFAC Survey Response Report to LCFAC's and LME's, General Assembly, LOC, and Secretary Cansler.
- Identify LCFAC's with "Disagree / Strongly Disagree".
- Refer concern to LME, Consumer Empowerment Team, SCFAC accordingly.
- Address concerns as determined by SCFAC's "technical assistance" definition.
- Recommend LCFAC's take recommendations to LME to fulfill statutory responsibilities.
- Make recommendations to General Assembly / LOC and Division of MH/DD/SA Services based on survey findings to fulfill statutory responsibilities.

Attachment 9

Division of State Operated Healthcare Facilities

Legislative Oversight Committee
Presentation

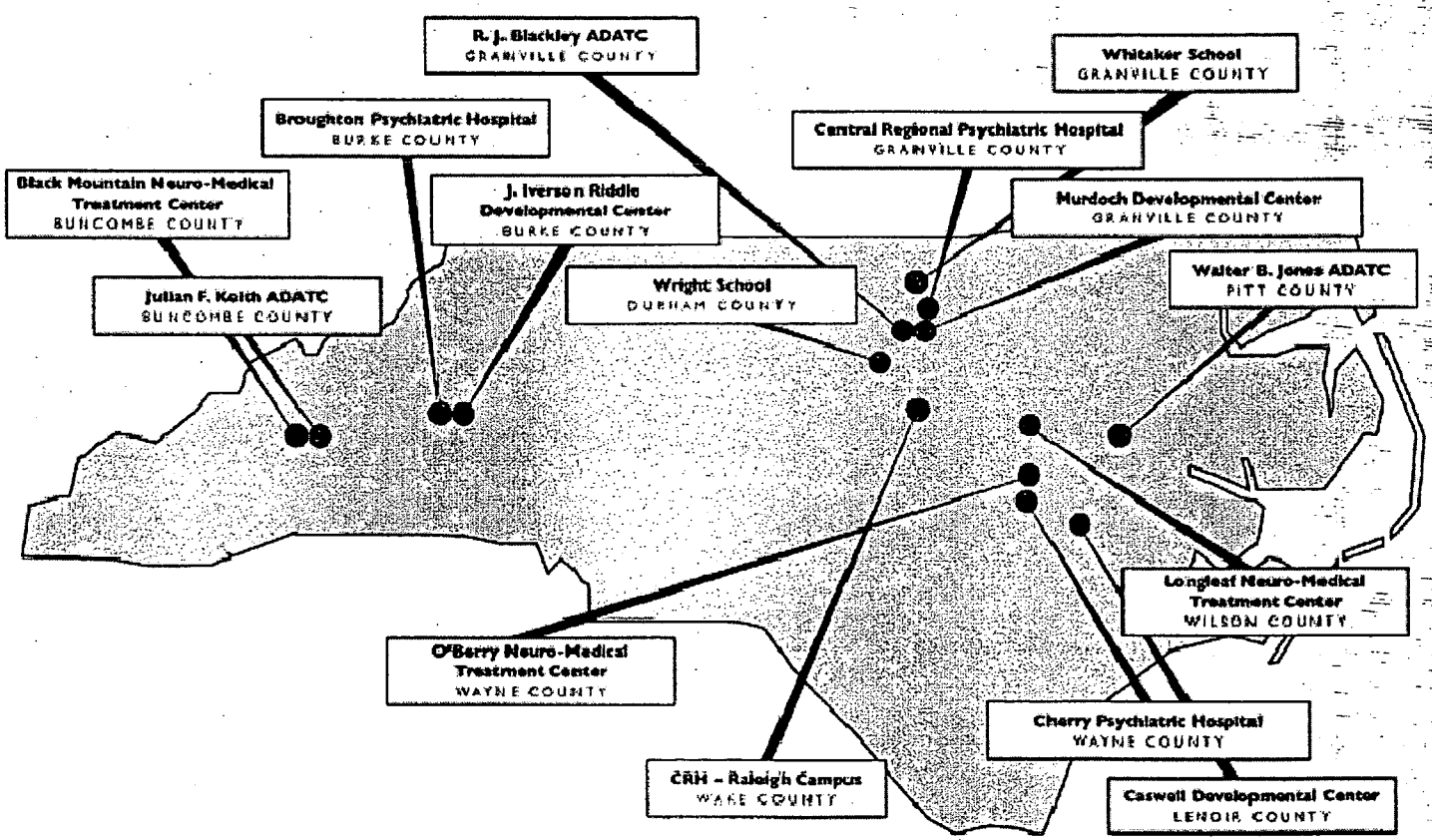
November 10, 2009

Division Mission Statement

We are a
system of healthcare facilities
that
respects the dignity of individuals
and
provides
individualized,
compassionate,
efficient,
quality care
to the citizens of North Carolina
with
developmental disabilities,
substance use disorders and
psychiatric illnesses
and
whose needs exceed
the level of care
available in the community.

Touching Lives. Enriching Futures.

The Facilities



Touching Lives. Enriching Futures.

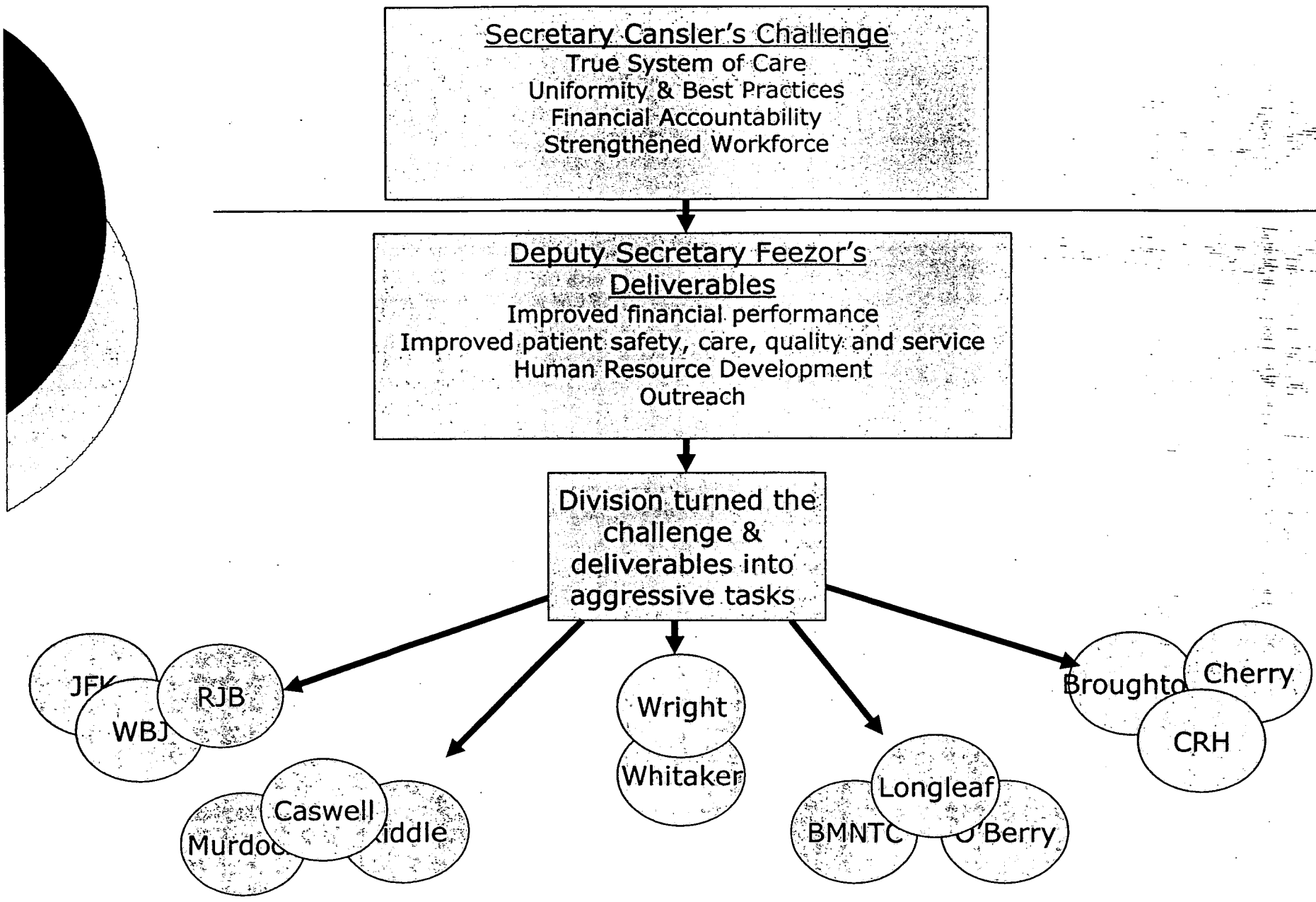
Partnerships

- Division of MH/DD/SAS
- Local Management Entities
- Provider Agencies
- Community Hospitals
- Advocacy Groups
- Office of Educational Services
- Division of Health Service Regulation
- Division of Public Health
- Universities and Colleges

Facility Adoption

We have implemented performance measures at each facility in the areas of:

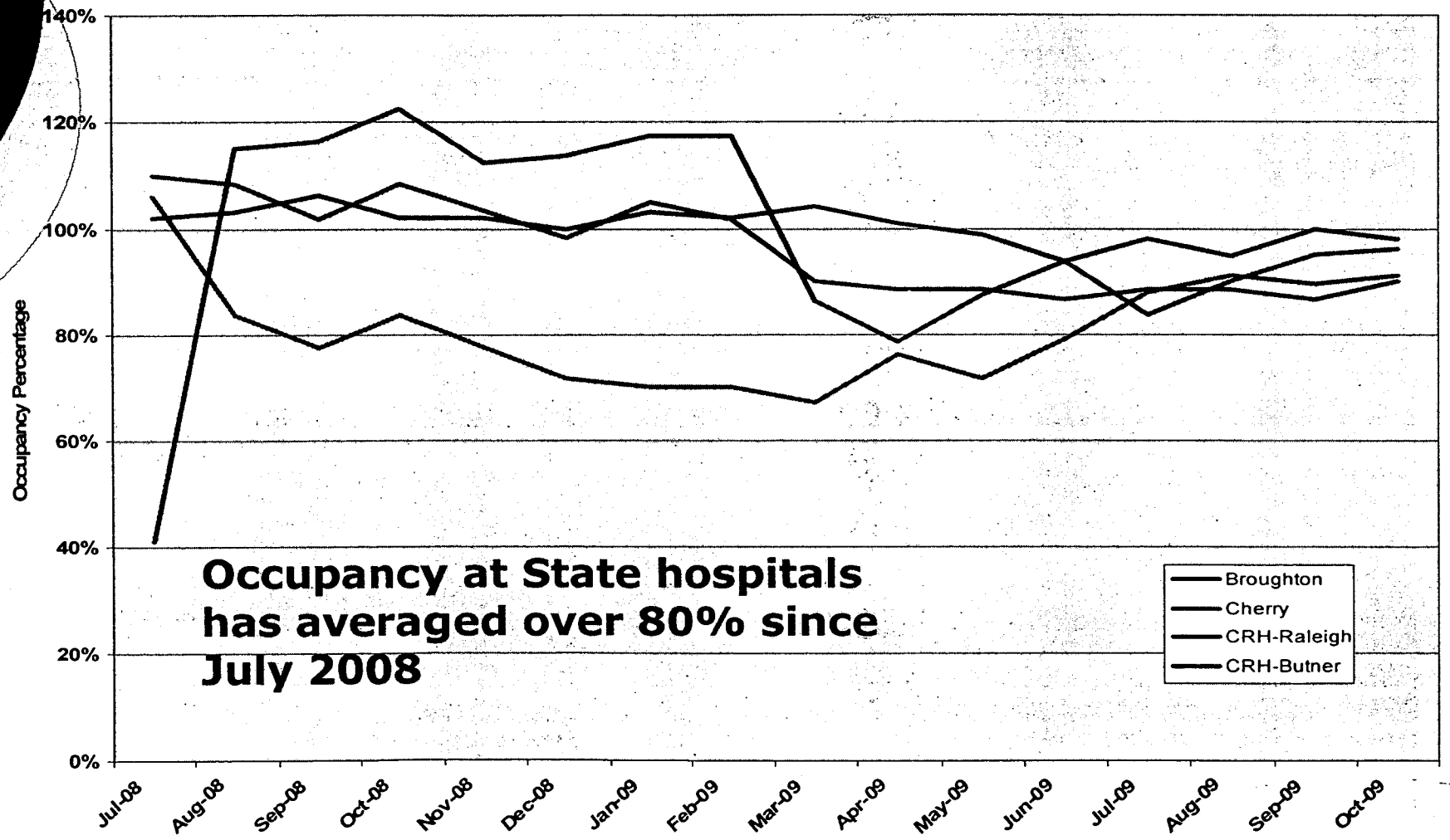
- Patient/Resident Safety and Clinical Care
- Financial
- Human Resources and
- Customer Service


Secretary Cansler's Challenge
True System of Care
Uniformity & Best Practices
Financial Accountability
Strengthened Workforce
Deputy Secretary Feezor's Deliverables
Improved financial performance
Improved patient safety, care, quality and service
Human Resource Development
Outreach
Division turned the challenge & deliverables into aggressive tasks
JFK
WBJ
RJB
Caswell
Murdoc
iddle
Wright
Whitaker
Longleaf
BMNTC
O'Berry
Broughto
Cherry
CRH

Accreditation & Compliance

- All State psychiatric hospitals are currently certified by CMS
- Cherry & CRH Butner/Raleigh are accredited by Joint Commission; Broughton is preparing to reapply for Joint Commission accreditation

Adult Admissions Units
Occupancy vs Capacity

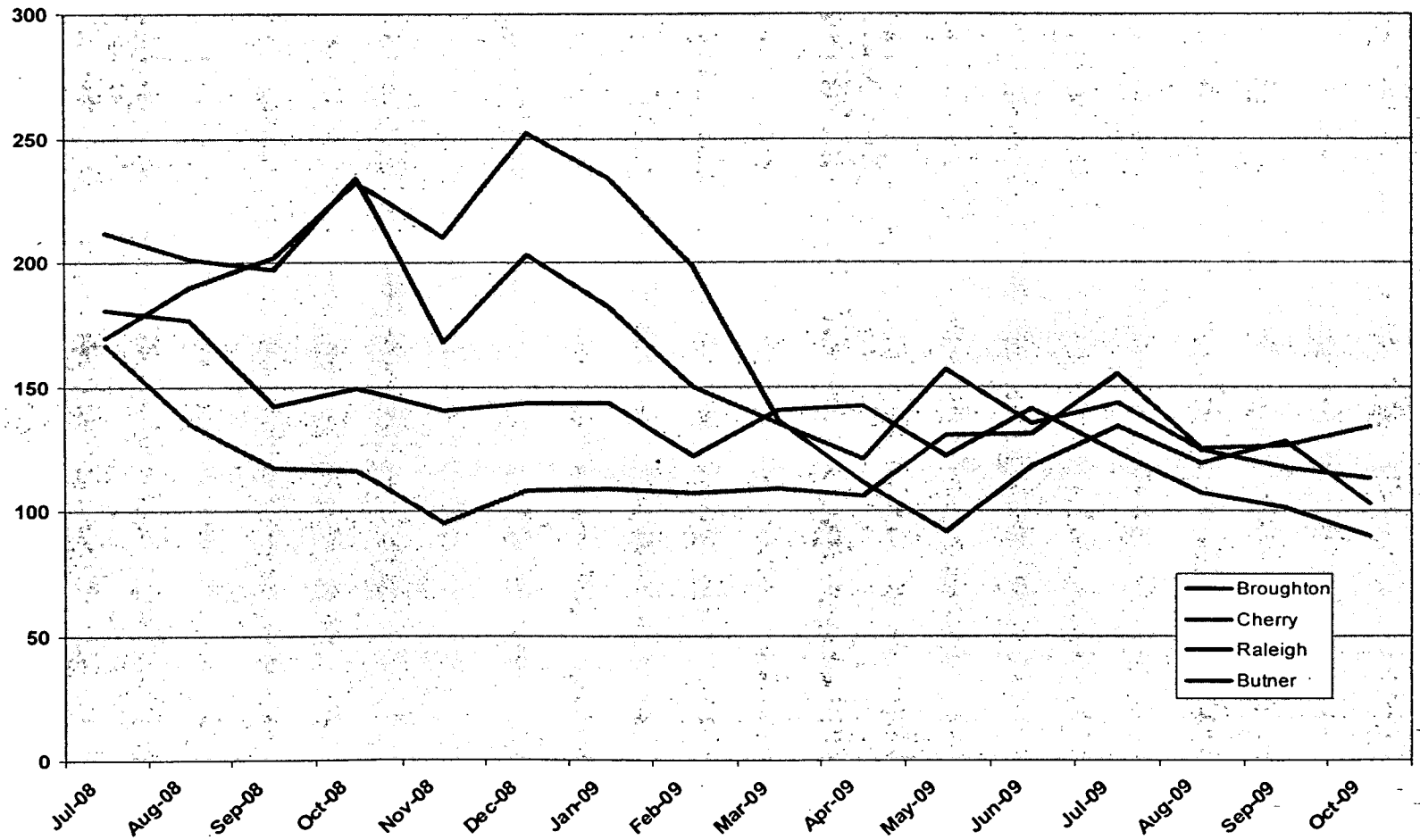


Occupancy Rate for Community Hospitals

75.2% Occupancy:

Criteria used by the North Carolina State Facilities Medical Plan when determining the need for additional beds for hospitals of 200+ beds

Adult Admissions Units
Monthly Admissions



Decrease in Admissions

- Reduction in capacity of adult in-patient beds at the State psychiatric hospitals; in 2007 there were 419 and currently have 302, a reduction of 117 beds (28%)
  - Broughton – 95
  - Cherry – 67
  - CRH Butner – 80
  - DDH - 60

- Average length of stay has increased
  - Higher acuity of patients; community hospitals serving lower acuity patients
  - Ability to delay allows for longer course of treatment before discharge; resulting in decreased recidivism rate

2009 – 2010 Plan

- Bed allocation plan was originally developed to assist LMEs in identifying community service needs

- Current bed allocations for each LME are based upon their per capita share of available beds, not historical use
  - Adult Admissions
  - Adult Long Term
  - Geriatric Admissions
  - Adolescent Admissions

2009 – 2010 Plan (Cont)

- Utilization of all other beds is tracked, but not allocated
- Allocation changes for 2009-2010 plan reflect post-budgetary capacity changes and regional realignment of LMEs
- There is no charge for over-utilization

Recurring Position Eliminations $12.8m & Non-core Service Reductions $4.5m

- The General Assembly granted DHHS the flexibility to meet the target budget reductions with a combination of positions and operating costs
- Reduced a total of 402.2 (314 vacant; 87.5 filled; 265 clinical) positions
- Limits adult admission capacity at CRH to 80
- Limits staffed capacity to 28 beds at BH adolescent unit (current average daily census is 19)

Cherry & Broughton Reductions

- The Cherry Hospital budget was reduced by $3,027,471, including 49 FTEs* leading to a reduction in operating capacity of 25 adult admission and adult long term beds

- The Broughton Hospital budget was reduced by $3,000,000 including 55 FTEs* leading to a reduction in operating capacity of 25 adult admission beds

* included in total FTE reduction on previous slide.

Total budgetary reductions made at the facilities this year equals

$24,219,098.00*

(does not include the $55,000,000 of unfunded overtime pay, shift differential or workers' compensation)

Touching Lives. Enriching Futures.

Federal Payback

- Successful appeal of CMS decertification at Broughton Hospital will result in recoupment of billing during "decertification" period

- Projected recoupment is approximately $8,329,268 and currently have received approximately $5,921,283

Transition Plan from Dix to CRH

- Approximately 100 patients will be transferred to CRH
  - **Adolescent – November 16 - 25, 2009**
  - **Geriatric – November 16 - 25, 2009**
  - **Adult Long Term – First Quarter 2010**
  - **Forensic Maximum and Medium – First Quarter 2010**
- 300+ positions will be transferred to CRH
- Positions at DDH will be filled based on seniority; employees are indicating facility & shift preference
- Employees not placed in a position at DDH will be offered a position at CRH

Dorothea Dix Hospital
Short-term Plan

- DHHS is currently in the process of requesting from CMS separate provider numbers for CRH and Dorothea Dix Hospital
- Pending CMS approval, targeted date for separation is January 1, 2010
- The future plans for DDH includes 121 beds, with the following services:
  - Adult admissions – 60 beds
  - Forensic Minimum – 25 beds
  - Psychiatric Residential Treatment Facility for adolescents – 24 beds
  - Clinical Research Unit – 12 beds

Challenges Associated with the Separation

- $6,000,000 of the funding for DDH is non-recurring
- Re-establishing management positions at DDH
- Joint Commission accreditation & CMS certification
- Retraining of staff associated with the move

New Hospital Construction

- Cherry Hospital
  - Construction drawings have been submitted for review
  - Anticipated ground-breaking: April 2010
  - Anticipated completion date: Oct 2012
- Broughton Hospital
  - Schematic design drawings have been submitted for agency review
  - Anticipated ground-breaking: Nov 2010
  - Anticipated completion date: May 2013

Admission Delays at the Psychiatric Hospitals

- There is State-wide crisis of capacity for in-patient psychiatric beds
- Over the last two years the State has funded the opening of additional beds in the community that you will hear about in the next presentation
- During the same period we have reduced a substantial (117) number of State psychiatric beds in order to improve safety and clinical care
- There is an increased demand for psychiatric admissions
- Average delays are 36 - 48 hours, but can be several days

Strategies Related to Delays

- DMH/DD/SAS has visited EDs that have experienced significant delays in order to elicit information
- Facility directors have held meeting with LMEs and law enforcement in each region to improve the admission process
- Increased efforts to improve customer service in State hospital Screening and Admission Offices

Questions

?

Attachment 10

DHHS REPORT ON LOCAL INPATIENT COMMUNITY HOSPITAL CONTRACTS (3 WAY CONTRACTS)

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
November 10, 2009

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

3 Way Contracts
Basic Information

- Contract between a Community Hospital, DHHS and an LME to purchase expanded Inpatient Psychiatric Care
- Expanded Beds =
  - Opening New Beds
  - Staffing Up Unused Capacity
  - Opening Existing Capacity to Involuntary Commitments

3 Way Contracts
Basic Information

- Payment Rate = $750 per day (Hospital Daily Rate + Psychiatric Care + Discharge Medications)

- Contract gives participating Hospitals priority in transfers to State Hospitals—Encourage taking difficult patients

3 Way Contracts
Basic Information

- Contract requires aggressive discharge efforts
- Available Funding = $20,121,644
  (FY 08-09 $8,121,644 + FY 09-10 $12,000,000)

3 Way Contract Goals

- Increase Community Psychiatric Inpatient Capacity
- Treat Consumers Closer to Home—Improve Hospital Transitions
- Reduce Short-term Admissions (7 days or less) to State Hospitals
- Decrease Emergency Room Wait Times & Impact on Law Enforcement

FY 08-09 Contract Utilization

- Contracts were initiated with 11 Community Hospitals
- Contracts were Phased In throughout the year as increased Capacity Came on Line
- Increased Capacity = 67 Beds
- Participating Hospitals Served an additional 1,453 patients over FY 07-08 Actual Admissions

Projected FY 09-10 Utilization

- Annualized Cost of Current Contracts ($13,755,938) will support 3,317 admission during FY 09-10
- New Funded Contracts (November 1st Start Up @ Cost of $6,424,313) = 47 New Beds that Can Serve an additional 1,508 Admissions

Projected FY 09-10 Utilization

- Maximum Projected Total Admissions = 4,825 (Note: Assumes 5.5 day average length of stay)
- 3 Way Contracts Open in 16 of 24 LMEs

SFY 2009 and SFY 2010
3 Way Hospital Contracts

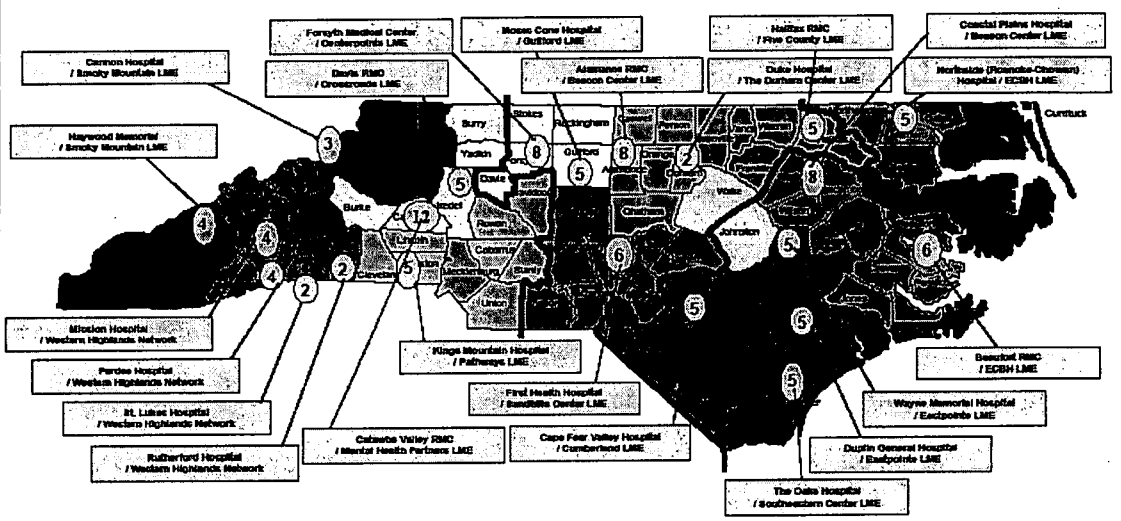
SFY 2009 and SFY 2010 Three-Way Hospital Contracts

	SFY 2008-2009				Renewed 2008-2009			New 2009-2010			
LME	Total 2008 Admissions of Less than 8 Days	2008 < 8 Day Lengths of Stay per 100,000 population	Community IVC Beds Prior to Contract	Beds Added SFY 2008 through Various Funding Initiatives	Community Hospitals in 3-way Contract	# of Beds	Contract Amount	Community Hospitals in 3-way Contract (Assumes November 1 Start Date)	# of Beds	Proposed Contract Amount	Total Community IVC Beds
Wake	1481	58.03	0	44							44
CenterPoint	2481	48.57	81		Forsyth Memorial	8	1,643,800				89
Alamance-Caswell	240	140.89	36		Alamance Regional	6	1,642,800				42
Durham	236	89.08	33		Duke	3	410,624				36
Guilford	226	47.60	104					Moses Cone	5	683,438	109
				12	Haywood Regional	4	631,350				16
				7	Charles Gannon, Avery County	3	615,938				10
Smoky Mountain	189	32.33	0		1st Health Moore	5	1,231,875				40
Gaston/Lincoln	166	36.59	34		The Oaks, New Hanover Memorial	5	1,025,625				39
Southeastern	161	44.57	30		Coastal Plains, Nash General	9	1,643,100				45
Beacon	180	65.02	31					Duplin General	5	683,438	31
Piedmont	153	27.72	20					Wayne Memorial	5	683,438	6
Five County	135	37.65	20					Hartley Regional	5	683,438	25
Western Highlands Network	126	26.56	129					Any combo of WHN hospitals	12	1,640,250	140
OPC	102	44.32	73								73
Cumberland	100	31.65	24					Cape Fear Valley	5	683,438	31
Johnston	94	50.64	6	14							20
Pitt	81	11.03	24								24
East Carolina Behavioral Health	77	26.23	95		Beaufort Memorial	4	1,231,875	Northside, Roanoke-Chowan	5	683,438	107
Cleveland	75	37.60	0					Davis Regional	5	683,438	5
Mecklenburg	55	7.51	120								120
Onslow-Carteret	53	24.40	0								0
Southeastern Regional	45	19.20	33								33
Mid Partners	43	17.80	103		Catawba Valley	12	2,463,750				115
Albemarle	41	21.68	0								0
Pathways	13	3.43	45		Kings Mountain	5	1,026,563				50
Total	8,774	69.62	1,097	77		87	19,766,888		47	8,425,813	1,825

Total New Beds = 191

Total 3-Way Contract Community Hospital Beds

(As of 11-6-09)



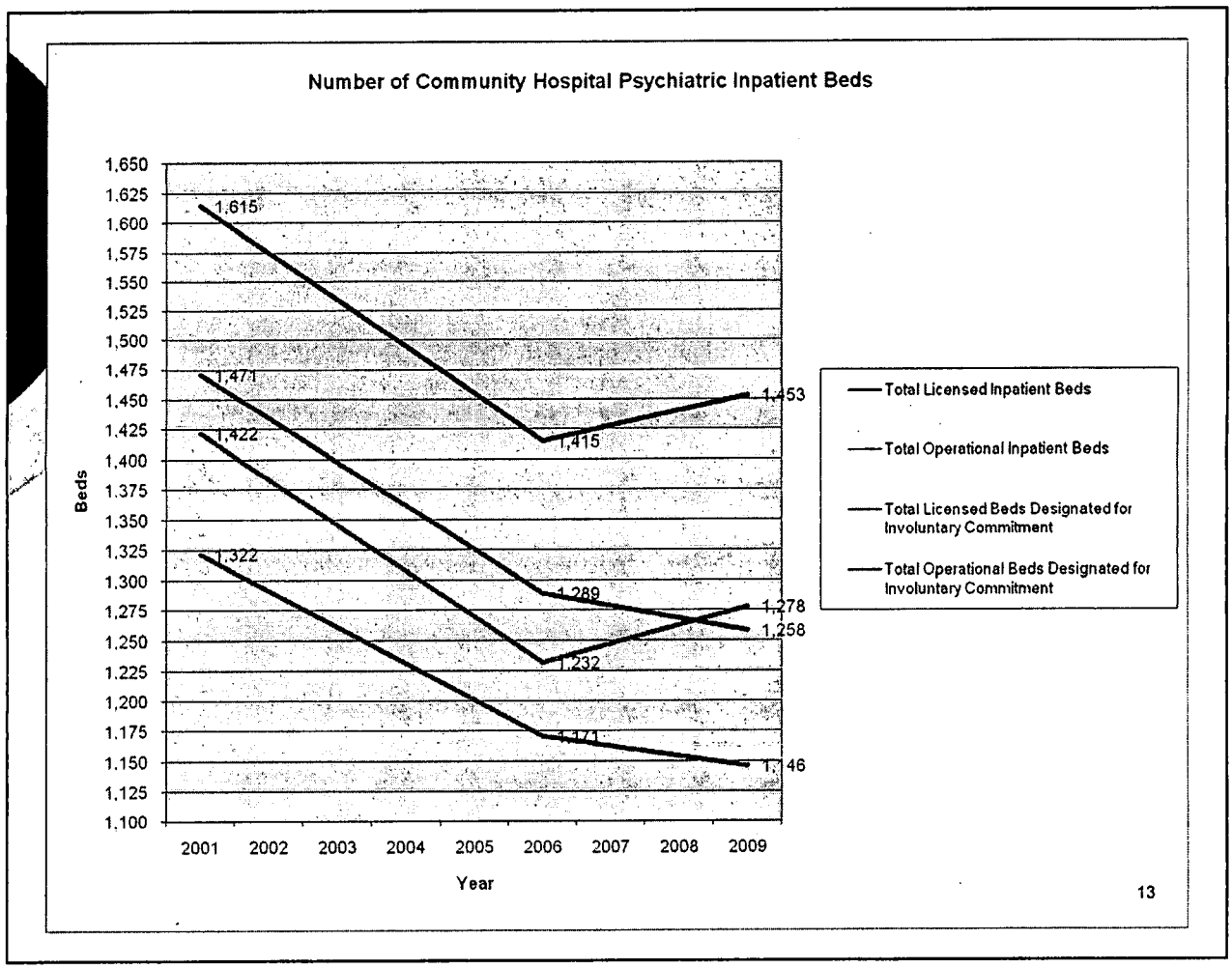
22 Three Way Contracts in 2009 and 2010 with 114 designated beds

LME Contract Responsibilities

- Authorization of Admissions
- Collecting Patient Data
- Facilitating Discharge Planning (Follow Up Appointment with in 7 days)
- Coordinating Discharge Planning with Other LMEs
- Submit Hospital Claims to DMH/DD/SAS
- Pay Hospitals Within 10 working Day of Receipt of State Payment

Contract Tracking Requirements

- Separate State Billing Code
- Admissions
- Hospital Denials
- Bed Utilization
- Transfers to State Hospitals
- Billing/ Expenditure Data


Number of Community Hospital Psychiatric Inpatient Beds
Beds
Year
1,650
1,625
1,600
1,575
1,550
1,525
1,500
1,475
1,450
1,425
1,400
1,375
1,350
1,325
1,300
1,275
1,250
1,225
1,200
1,175
1,150
1,125
1,100
2001
2002
2003
2004
2005
2006
2007
2008
2009
1,615
1,471
1,422
1,322
1,415
1,289
1,232
1,171
1,453
1,278
1,258
1,46
Total Licensed Inpatient Beds
Total Operational Inpatient Beds
Total Licensed Beds Designated for Involuntary Commitment
Total Operational Beds Designated for Involuntary Commitment
13

Future Funding Issues

- Annualized Cost For FY 09-10 Contract Start-up ($3.3 Million)
- Expansion Funding for Additional Beds
- Issue: Funding Support for Existing Community Capacity

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Case Management for Persons with MH/DD/SA

November 10, 2009

1

MH/SA/IDD Case Management Providers

- Mental Health/Substance Abuse (MH/SA) case management will be provided by Critical Access Behavioral Health Agencies (CABHA)
- Case management for people with Intellectual or Developmental Disabilities (IDD), both waiver and non waiver, will continue to be provided by Targeted Case Management Agencies.
- Both agency types will be required to interface with primary care.

2

Critical Access Behavioral Health Agencies (CABHA) for MH/SA

Services Provided

- Medication management, outpatient therapy, and comprehensive clinical assessment
- 2 additional enhanced services (continuum)
- Can provide Case Management and Peer Support Services (optional)

**Outlined in Implementation Update #63

3

Case Management

- Services that assist individuals in gaining access to needed medical, social, educational, and other services.
- Consists of 4 federally defined functions:
  - **Assessment**,
  - Development of **Care Plan**,
  - **Referral**, and
  - **Monitoring** and Follow-Up
- Should not be viewed as "forever" service. Goal is to teach person how to navigate the system- to promote independence, not to teach dependence.
  - Should promote recovery focused
  - Chronic diseases promote self-management

4

Access to Case Management

- LME through screening, triage, and referral (STR)
- Community Care of North Carolina (CCNC) refers to LME (or CABHA) as defined by acuity
- No 'wrong door' for access
- Other services that include CM
- Work group is working on acuity tool or target population in order to determine need for specialty case management
  - Administration
  - Frequency of authorization

5

Case Management Example 1

Situation: 50 year old man

- Schizophrenia
- Hypertension, Diabetes
- 2 ER visits in the last 6 months
- History of non compliance with his medication & personal care
- social isolation, limited social supports

6

Case Management Example 1 cont'd

- LME evaluates through Screening Triage and Referral (STR)
- LME refers to Case Management Agency
- **Assessment:** Case Manager refers for assessments, compiles assessment (medical, behavioral) & reviews
- **Care Planning**: CM meets with recipient & paid/unpaid supports to develop care plan w/outcome measures and crisis plan. Include agencies, supports who are involved or could be involved with the person. Plan addresses all aspects of the person's life such as housing, medical care, disease management – specifically addressing his diabetes and high blood pressure. Examination of ER use.
- **Referral**: Peer Support, primary care physician, community social groups, and transportation.
- **Monitoring:** CM reviews progress toward outcomes & goals in care plan; makes additional referrals, and makes modifications in plan as needed. Interacts with resources, such as his primary care physician to inform of issues that impact overall care. Incentives to be compliant with medications and interventions.

7

Case Management Example 2

Situation: 10 year old boy

- Moderate mental retardation
- Cerebral Palsy
- Requires total assistance with all basic skill needs
- Attends school program 6 hours per day 5 days per week

8

Case Management Example 2 cont'd

- LME evaluates through STR
- LME refers to Case Management (independent of services provision) Agency
- **Assessment:** Case Manager (CM) schedules meeting with recipient and family. Gains knowledge of family, assessments completed, IEP gathers assessments already completed and determines if additional assessments are needed.
- **Care Plan:** CM, recipient, family and any other natural supports develop Care Plan w/goals.
- **Referral** could include: Personal care, Respite, medical doctor, therapy, DME, assistive technology, arranges for natural supports. Works with needs of family in order to maintain healthy family.
- **Monitoring:** CM follows up with recipient/family & monitors provider for progress on goals. There should be heavy linkage and monitoring of services and interactions with school and medical community. Communication should be sending and receiving status reports. Attendance at IEP meetings and interfacing of IEP and care plan are important.

9

Case Management for People with DD or other Intellectual Disabilities

- Will continue to be provided by independent case management agencies
- Due to reduction in administrative functions and other identified efficiencies, units may be reduced for some recipients
- NC is waiting for approval for an old DD CM SPA. Once the SPA is approved, another SPA will be submitted that changes the 15 minute billing unit to a case rate
- Provider and staff qualifications will be examined prior to submission of next SPA
  - Outcomes established

10

Community Support

- Case Management is currently "bundled" in Community Support
  - A state plan amendment is prepared for a stand alone CM definition
    - Definition change, provider qualification change, and
    - entrance/exit criteria that prioritizes target populations and higher acuity recipients
    - Rate moving forward will be a case rate, not the current 15 minute billing unit
  - Once CMS approves the stand alone definition, only CABHA agency may provide CM to MH/SA
  - In the interim, the existing CS agencies continue to provide CM
    - Currently working with CMS regarding options if CM SPA is not approved effective January 1.

11

Other Case Management in MH/DD/SA services

- Case management is "bundled" in Intensive In-home, ACT, MST, Community Support Team, Substance Abuse Intensive Outpatient, and Substance Abuse Comprehensive Outpatient Treatment
  - Current plans do not include "de-bundling" CM
  - Evidence based practice of ACT and MST include CM as part of the definition. Changing the model, challenges the fidelity of the definition
  - Case management will continue to be provided by CS Team agencies.
    - Rate and/or billing structure will change for CS Team
  - No other changes to bundled rate structure anticipated
  - Changes are anticipated
    - Endorsement of providers
    - Establishing provider outcomes/benchmarks – including linkage to primary care, including disease self management
    - Entrance and continued stay criteria

12

Summary of Current Status

- Developing any specific requirements of the definition, including provider qualifications, individual staff skills, agency outcomes/benchmarks
  - Stakeholder workgroups
- Determining Case rates
  - Differential rates based upon acuity?
  - Differential rates based upon performance or meeting established outcomes
- Revising State Plan Amendments (SPAs) for CMS for DD and for MH/SA
- Developing CAP waiver technical amendments to CMS
- Developing time line for implementation
- Developing training plan

13

LINCOLN TIMES-NEWS
"AN INDEPENDENT NEWSPAPER"
Jerry G. Leedy
PUBLISHER
Frank Taylor
MANAGING EDITOR

GUEST VIEW

Reform for mental health system still lacking in NC

Since the failed 2001 mental health reform effort, North Carolina has done precious little to improve the accountability, cost or efficiency of that system. In fact, the budget approved this year threatens to make the situation worse, by stripping away needed funding at so critical a time.

Mental health advocates have asked Gov. Beverly Perdue to convene a special legislative session focused on the problem in the hopes that lawmakers can engineer a successful and funded reform. While Perdue has resisted that request, fixing that broken system stands at the forefront of the state's most pressing public concerns.

The mental health reform effort undertaken early in the first term of Gov. Mike Easley represented an ambitious attempt to remake a group of disparate entities into a more cohesive system of care. Lawmakers attempted to streamline the number of agencies responsible, shut down mental health hospitals and use contractors to provide some services. They expected lower costs and better care as a result.

Citizens now know that effort had the opposite effect. A haphazard system of accounting caused the state to lose more than $400 million, thanks to overcharging service providers and poor practices. Dozens of patients died in mental health care facilities, according to a series of investigative reports by the News & Observer. And instead of thoughtful reform, the state was left with officials trading blame and poorer care for the more than 340,000 who rely on services.

Lawmakers faced this full accounting in 2008. Mental health reform was a key issue leading to the 2008 elections. Promises were made, and assurances given.

Yet, with an economy on the slide, lawmakers slashed $1.7 billion from the N.C. Department of Health and Human Services this year, including between $65 million and $75 million from the community services budget which serves those affected by mental illness, developmental disability or addiction. Though Perdue announced the restoration of $15 million on Tuesday, that hardly represents the type of reform needed to improve service.

North Carolina cannot afford to leave those in need without the professional and affordable care they deserve. That has prompted advocates to call for a special session of the Legislature, which seems unlikely given the governor's deflection of the subject recently.

However, lawmakers cannot ignore this problem or wish it away. Avoiding the hard work needed to reform this system risks lives, and North Carolina should act with haste to help.

— from *The Daily Reflector* of Greenville, N.C.

SENATOR JIM FORRESTER
NORTH CAROLINA SENATE
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2009-2010

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, & SUBSTANCE ABUSE SERVICES

MINUTES

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA

December 9, 2009 10:00 A.M.; Room 643, Legislative Office Building
Senator Martin Nesbitt Co-Chair Presiding

Welcome and Opening Comments • Senator Martin Nesbitt, Co-Chair • Representative Verla Insko, Co-Chair	10:00-10:15
I. Expenditures and Utilization Tracking Update • Tara Larson, Chief Clinical Operating Officer, DMA	10:15-10:30
II. Critical Access Behavioral Health Agencies • Michael Watson, Assistant Secretary for MH/DD/SAS Development	10:30-11:30
III. Committee Discussion - Direction for NC DHHS's presentation on System Vision for MH/DD/SAS in January	11:30-12:00
Lunch	12:00-1:00
IV. Community Support Services with Other Enhanced Services • Leza Wainwright, Director, Division of MH/DD/SAS	1:00-1:30
V. Developmental Disability Targeted Case Management • Tara Larson, Chief Clinical Operating Officer, DMA	1:30-2:00
VI. Residential Level III and IV Group Homes Update Private Residential Treatment Facility Requirements • Christina Carter, LCSW, Implementation Manager, Division of MH/DD/SAS	2:00-2:30
VII. Cross Area Substance Abuse Programs • Flo Stein, Chief, Community Policy Management, Division of MH/DD/SAS	2:30-3:00
Final Comments and Adjourn	3:00-3:15

Next meeting Wednesday January 13th, 2010, 643 LOB

Central Regional Hospital Raleigh/Butner Campuses site visits Thursday January 14h

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	12/9/09																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	X																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	X																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	X																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

December 9, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, December 9, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Bob Atwater, Doug Berger, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justus, and Fred Steen. Advisory members Representative Van Braxton and Representative William Brisson were also present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. The Visitor Registration Sheet is attached and is included as a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the November 10, 2009 meeting. The motion was made by Representative Bob England and the minutes were approved. She announced that handouts received in advance of our meetings will be posted to the LOC website prior to the start of our meetings in order to provide access to our listening audience. Representative Insko also told members that a list of acronyms was now included in their folders.

Presiding Chair, Senator Martin Nesbitt, called on Tara Larson, Chief Clinical Operating Officer for the Division of Medical Assistance (DMA), to explain the graph provided detailing data on service expenditures, number of recipients per service, and units per recipient. (See Attachment No. 2) Her presentation addressed the following points of interest:

- The expenditures graph represents funds spent based on check writes for the designated time period.
- The recipients graph shows how many people are being served based on paid claims.
- The unit per recipient graph indicates how many 15 minute units a person is receiving per month or per week.
- The graphs indicate that Community Support Team and Intensive In-Home services continue to increase. The Division is monitoring this increase to ensure that clients are receiving appropriate services. Utilization of Community Support

is decreasing, but clients who previously received Community Support services are likely being shifted to other services.

Ms. Larson indicated Community Support (group and individual) will end June 30, 2010. The General Assembly will receive a report explaining the methodology used to plan for the changes in Community Support.

Ms. Larson also reported that fraud and abuse which occurred under Community Support continues to be tracked. Every recoupment must have a notice of recoupment, and an appeal right. The appeals process is lengthy. Funds have been received from providers. Once the State recognizes that there is a problem, it is up to the State to pay the Federal share back within 60 days regardless of whether the funds are ever recovered from a provider.

Ms. Larson was asked to provide the total amount the State has paid back to the Federal government. She was also asked to provide information indicating what other services were being provided to consumers that previously had received Community Support; the number of behavioral healthcare providers there are in the system, and how many have gone out of business in the last 6 months.

Michael Watson, Assistant Secretary for MH/DD/SAS Development, addressed the Critical Access Behavioral Health Agency (CABHA) and the changes to provider qualifications. (See Attachment No. 3) He explained that the CABHA model derives from the need to return quality, accountability and oversight to our community service system. In addition, Mr. Watson pointed out the significance of the budget reductions and the financial challenges as well as the need to bring case management back into the system upon the termination of Community Support services on June 30, 2010. His presentation addressed the following items:

- Subject to approval by CMS, the State Plan Amendment for Case Management will specify that, effective July 1, 2010, medically necessary case management must be delivered within the CABHA framework.
- Concern over results of recent audit by the Division of Mental Health which indicate that consumers are receiving services (such as Community Support Team, Day Treatment and Intensive In-Home services) that are not medically necessary, not properly documented, and not delivered by qualified providers.
- To some extent, the provider network is characterized by a large number of providers who focus on relatively few services forcing consumers to accept a limited array of services.
- 20 applications for CABHA certification have been received since the inception of the certification process on December 1, 2009.
- Clubhouses would no longer be able to bill for Community Support Team.
- Providers not in CABHA would be able to provide DD Services, Residential Care, Substance Abuse Intensive Out-Patient, and ACTT.
- The goal is the development of a clinical platform based on a limited number of critical services that have been subject to abuse in the past.

- Hope is that smaller providers will come together to create larger more efficient organizations developing resources necessary to do CABHA.

Members expressed concern about how consumers in rural areas will access services under the CABHA model if there are no CABHAs physically located within these rural communities. Members were especially concerned that all services needed to be addressed and not just the few under CABHA. Members stressed that quality services must be provided and that funds must be spent wisely. They were also concerned that the limited number of providers across the State will limit consumer access and choice. It was also noted that State government should not keep changing the rules on providers forcing them to close.

Members requested that Mr. Watson provide information showing how many clients a CABHA would need in order to be financially viable as well as a breakdown of the number of for-profit and not-for profit agencies applying for CABHA certification. He was also asked to provide the number of qualified professionals who are currently providing services to consumers and the number of consumers these qualified professionals are serving.

Senator Nesbitt asked that 3 members of the audience address the Committee regarding their thoughts on CABHA. Items of concern included:

- Unreasonable for agency with only 150 consumers to be required to have a 50% FTE Medical Director; how is it economically feasible?
- State should put effort into developing the infrastructure which would allow various sized agencies to coexist as long as they meet certain reasonable standards.
- CABHA is a deliberate act by the State to run people out of business.
- Why are rules changing; agencies not asking for special consideration but rather equal consideration.
- Bigger is not always better and definitely not more cost effective.
- Concern that consumer may be "trapped" within a CABHA agency and not referred out.
- Massive change within the system in such a short time frame on the heels of budget cuts will potentially continue to defragment and destabilize the system.
- Potentially 1,500 agencies will go out of business with approximately 36,000 people losing their jobs.
- Ask that State find a reasonable resolution so that the vast majority of small providers who provide quality care can continue to meet the needs of the consumers they serve.
- People should back the State in their efforts because funds may not be there in the new budget year.

After lunch, the discussion on CABHA continued. It was suggested that a psychiatrist should address the Committee. Mr. Watson continued with his address to the Committee and noted that DMA is in the process of doing a cost model on the CABHA designed to

include administrative costs into the case management rate or the rates of other services associated with the CABHA.

Mr. Watson was asked to provide information on whether the 20 agencies applying for CABHA were for-profit or not-for-profit and if they are publicly held. Members wondered if 1 Medical Director could oversee 20 satellite centers, could not 1 Medical Director oversee 5 small providers. The Committee suggested that more time might be needed to see that services are done correctly and that consumers needed to be more involved in making decisions.

Leza Wainwright, Director of the Division of MH/DD/SAS, provided a report on Community Support services with other enhanced services. (See Attachment No. 4) Highlights of the presentation include:

- Far more children are receiving Community Support under Medicaid than are adults.
- The numbers on the graph reflect the decline of persons being served under Community Support as consumers are transitioned out of the service. Note that November numbers may be understated due to the fewer number of check writes.
- Skill building will be provided under enhanced services.
- The modified PCP will be available the beginning of January. The new form will reflect the quality of the planning process.

Next, Tara Larson, from DMA, responded to questions from the last LOC meeting regarding Case Management for people with Developmental Disabilities. (See Attachment No. 5) Points of emphasis include:

- Once the State Plan Amendment has been approved by CMS, Case Management providers will bill directly with Medicaid so that the money will not flow through the LME.
- DD Targeted Case Management consists of 4 federal definition functions: assessment, development of care plan, referral and monitoring, and follow-up.
- Providers will have to be endorsed when the new Case Management definition is approved by CMS.

Christina Carter, Implementation Manager from the Division of MH/DD/SAS, provided an update on Residential Level III and Level IV Group Homes and Private Psychiatric Residential Treatment Facilities, (PRTF). (See Attachment No. 6) Her presentation included the weekly survey system of care coordinator which provides current data on the number of recipients in Level III and Level IV Group Homes and the Department's commitment to personal follow up through the System of Care Coordinator at the LME level. As part of the presentation on the residential treatment facilities, Ms. Carter explained that the number of PRTF beds does not include the 25 beds at Dix Hospital and the majority of beds are community based. To explain the increase in beds from '08 to '09 Ms. Carter indicated that it was due to the number of providers who have rolled over to Level IV beds and have requested a licensure to become a PRTF.

Ms. Carter was requested to provide additional data showing the types of placements children are being moved into. She added that assessments were taking place according to the child's needs. If the service is available and a proper match for the child, the child will go through a transitional period, and then move to that service.

Flo Stein, Chief, Community Policy Management of the Division of MH/DD/SAS, gave an update on substance abuse treatment and recovery – Cross Area Service Program (CASP). (See Attachment No. 7) Ms. Stein explained that the General Assembly gave the Division permission to draw in funds not being utilized in the community due to the newness of divestment and mental health reform to purchase substance abuse services on a more regional basis. The three-way partnership between the Division, LMEs, and selected provider organizations, allows for collaboration to design programs, decide how the money is to be spent, and to set the standards for expected outcomes. The program piloted in North Carolina has been identified as a national model in versions of health reform regarding how to provide addiction services.

There being no further business, the meeting adjourned at 2:57 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peggy Balash	The Sagamore Grp
Richards Anderson	Footprints Carolina
Kizzy Cole	Alternative Behavioral Solutions, Jr.
Tara Smith	Alternative Behavioral Solutions
Vicki Smith	Disability Rights NC
Camilla Ungaro	Psych Support Inc. 211 E Six Forks Rd suite 108 Raleigh, NC
Linda Tucker	Psych Support Inc. 211 E. Six Forks Rd. Ste. 108 Raleigh, NC 27609
Dolan Willias	Psych Support Inc. 211 E. Six Forks Rd Ste 108 Raleigh NC. 27609
Tara Fields	Children & Family Services Assn.
[illegible]	CFSA
Fred Wadale	Eastern Seals UCP NC/VA

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Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

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NAME	FIRM OR AGENCY AND ADDRESS
Pam Shipman	PBH, Concord NC
Billy West	Daymark Recovery, Concord NC
Bert Ward	Partnership for a Drug-Free NC
Corinne Baker	Carolina Center for Counseling, Gastonia NC
Anna MacDonald Tabbs	The Arc of NC Raleigh, NC
Scott Hammontree	Carolina Center for Counseling, Gastonia
Gail Boswell / Wilson Co.	NC MH Consumers' Organization NC-CANSO
Joann Clark	Community Network Greensboro NC
Terri Harris	Sunrise Clinical Durham NC 27703
Tarshia Graham	Community Network Greensboro NC
Pamela Bradford	H.O.P.E Foundations 3712 Benson Drive Raleigh NC 27609
James Harris	Emmanuel Residential Facility 208 Countryclub Dr Greenville NC 27834

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Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

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NAME	FIRM OR AGENCY AND ADDRESS
Chip Baggett	NCMS
Andrew Cagle	DLC + Assoc.
Bob Fitzgerald	Wake Med
Mike Vicario	NCHA
Jewell Cox	A Better Child
Aaron Wilkins	Positive Connection Community Services Plymouth NC 27962
Sarah Bowden	Alternative Home Care, ~~Charlotte~~ Greensboro, NC
Helen Gaylord	Alternative Behavioral Greensboro NC
Stephanie Genwright	FFC Institute For Change
F Clark	FFC Institute for Change Whiteville NC
P Florence	FFC 333 Jefferson St Whiteville, NC 28472
Janet Stephens	FFC Institute for Change
Larry Bland	↓
Ronnie Parker	↓

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Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

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NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	MHANC / The Coalition
Annaliese Dolph	DRNC
Julia Leggett	The Arc of NC
Theresa DeBerry	Foundations Strong, LLC P.O Box 17805 Greensboro N.C 27417
Crystal Pressley	Crystal Home / Greensboro
Patrina Mosley	VIP Care Services, Inc. 7830 North Point Blvd Ste 203 Winston-Salem, NC 27106
Marc Mosley	VIP Care Services, Inc. " "
Amelia Thorpe	Durham LME, Safe CFAS
Evelyn S. Dawson	Brite Smitz Family + Community Connections P.O. Box 86 Roanoke Rapids, N.C. 27870

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Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

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NAME	FIRM OR AGENCY AND ADDRESS
Martha W Lowrance	YAIO / Dept. of Administration
Charles Graham	STARS Youth Academy - Lumberton, NC
Donna Revels	Stars Youth Academy, Lumberton NC P.O. Box 753
Judy W. St Amour	Stars youth Academy, Lumberton 28359
ADC JACQUES	North Carolina Mental Health Consumers Organizatio
Kim Schmidt	NC MHCO - Raleigh, NC
Maureen Morrell	Autism Society NC
Sally Cameron	NC Psychological Assoc, Raleigh
Angie Barther	SA Federation
Dan Ruhl	NC Arc
John Rote	MHA

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NAME	FIRM OR AGENCY AND ADDRESS
Anthony Barnett	Bridging The Gap. LLC. 205 Plaza Drive Greenville, NC 27858
Emmanuel Barnett	Bridging The Gap. LLC 205 Plaza Drive Greenville NC 27858
Jenna Lackard	Ivy House: Center for Self Sufficiency 502 E. 15th Street Winston Salem, NC 27105
Essie Gregg	United Youth Care Services 2104 4th street Greensboro nc 27405
Antonina Griffin	A Greater Divine Place Inc 3606 Bremen Garden Dr. Lexington 27295
Darin Griffin	A Greater Divine Place Inc. 3606 Bremen Garden Dr. Lexington 27295
Holly Riddle	NC Council on Developmental Disabilities
Brandi Taylor	TR Consulting Sanford, NC
Alexis Wright	Classic Care family services 1118 Grecade St, Greensboro NC 27408
Regina Ratliff	Classic Care family Services 1118 Arcade St. Greensboro, N.C 27408
Larry Ratliff	Classic Care family Services 1118 Grecade St Gso.

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NAME	FIRM OR AGENCY AND ADDRESS
Roy Wilson	ECBH - New Bern
David Swann	Crossroads Beh. Healthcare
Rhett Melton	Pathways LME
Josephine Okek	Mercy Home Services Inc.
Hoochuta	Group home Services
Kara Pace	Plans For Life, LLC
Pearl Griffin / B. Jackson	New Outlook Second Chance, Inc.
Pam Andrews	New River BHC
Tom Thomas	New River BHC
Ranota Hall MD	Value Options
Bob Hope III	424 Cameron Woods Dr Apex, NC 27523

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Name of Committee _____ Date _____

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NAME	FIRM OR AGENCY AND ADDRESS
Tanisha Adams Barbara Brunson	Upward Change Health Services, LLC 807 E Main St. Suite 4-100 Durham, NC 27702
Beatrice Marrow	Upward Change Health Services, LLC 807 E Main St. Suite 4-100 Durham, NC 27702
Judy Truitt	OPC 100 Europa Dr Suite 490 Chapel Hill, NC
Cim Brailer	OPC LME 100 Europa Dr Suite 490 Chapel Hill, NC 27517
Kathy S. Baker	Southeastern Regional LME 450 Country Club Road Lumberton, NC 28360
Betty Taylor	CenterPoint Human Services 4045 University Pkwy. Winston-Salem, NC
Deanna Jones	Pride In North Carolina, Inc.
Dan Zorn	Families Together, Inc. 708 Grove St., Asheville, NC 28801
HAL JONES	TRIUMPH, LLC RALEIGH, NC
Amy Whited	NC Med Society
Janet Schanzenbach	Indigo Consulting

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Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Jane Vernette	Institute for Family Centered Servs
Ragan Pate	Safe-Haven House LLC
Linda Clemons	Better Connections, Inc.
DONALD McMILLAN	LIFE OPPORTUNITIES INC
Jumeka Little-Singletary	Family Legacy Mental Health Services, Inc. 6012 Six Forks Road, Ste 204 Raleigh, NC 27615
John Williams	Better Connections Inc.
Frances B. Gladden	Evans Family Care Homes LLC, 46 Cricket, Greensboro NC 27405
Murad Timmons	Genesis Residential Care Ctr, LLC.
Melvin Nowling	Integrated Family Solutions, LLC 5300 Six Forks Rd Suite 213 Raleigh, NC. 27609
Almeanor Hines	Restored Hope 41 Imperial Court Asheville, N.C. 28803
Walter Young	A Positive Life Inc. 3108 Dyke st. Fayetteville N.C 28306

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NAME	FIRM OR AGENCY AND ADDRESS
Amy McKissick	H.O.P.E. Foundations 3712 Benson Dr. Raleigh NC
Jeffrey Wand	Duke Gardner Integrative Services P.O. Box 2934 Greenville NC 27836
Jeff Jones	WTB New Vision, Inc. 102 W. 3rd Street Suite 502 Winston-Salem, NC 27101
Anna Gawn	Capstat 1201 Edwards Mill Rd Raleigh NC
Darryl Brown	Fidelity First Health Care Services Wilmington, NC 28401
Ms. Maria Lewis	The Right Trax, Inc. Garner, NC 27529
Dexter Mitchell	Structured Family Interventions, LLC 1530 N. Gregson St. Ste. 3A, Durham, NC 27701
Donald Grantham	Omega Independent Living Services 3029 Stonybrook Dr. Suite 105 Raleigh NC 27604
James Hardy	Cambridge Behavioral Health Services 622 S. Memorial Dr. Greenville, NC 27834
Teresa Johnson	Omni Visions Inc 910 C Street Suite 8 North Wilkesboro NC 28659
John Cauterbach	Caring for Children PO Box 19113 Asheville, NC 28815

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Joint Legislative Oversight Committee on MH/DD/SAS December 9, 2009

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NAME	FIRM OR AGENCY AND ADDRESS
Mike + Misty Martin	Lighthouse Comm. Center - Fayetteville, NC
Ann Newman	Candidate HR103
Yvonne Copeland	NC Council of Comm Prog
Takisha Cranford	ABS, Inc. Greensboro NC
LuWanda S. Daniels	ABS, Inc Greensboro NC
Illya Daniels	ABS Inc " "
Artisha Elliott	ABS, INC " "
Ruthann Thomas	Day By Day Family Services, LLC
KENYATO LEWIS	ABS, INC " " "
Will Woodell	Value Options
Tracy Kimbrell	Partner POC

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NAME	FIRM OR AGENCY AND ADDRESS
April Stuckes	Sunrise Clinical Services Durham, NC
Miguel Idoll	Forever Young Group Care
Sandy White	Safe-Haven House, LLC - PO Box 323 Julian NC 27283
Mikki Robertson	S & L Home Care Agency Greensboro NC 27401
Fleta Starnes	S & L Home Care Agency Greensboor NC 27401
Michael Scales	Halikierra Community Services 200 W. 4th St Ste 101 Goldsboro, NC 27530
Monica V Stimpson	Care Link Solutions Inc PO Box 3137 Asheboro, NC 27204
Richmond Okoro	Carelink Solutions Inc Box 3137 Asheboro NC 27204
Danny Freeman	North Carolina Quality Care Provider Assoc.

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NAME	FIRM OR AGENCY AND ADDRESS
Heather Settle MSW, LCSW Joyce Allison MA, QP	Faith In Families Inc. 232 Gilmer St. Suite 206 Reidsville, NC 27320
ALSANDER DUDA	NCAPPR
ERIC DAVIS	PORT HUMAN SERVICES
Steve Blakeman	Integrity Support Services
Nate Peterkin	PRI Counseling Services 108 N. orange Ave, Dunn, NC
Eric Page	NCQCPA
Steve England	NCQCPA
Pam Phillips	NC QCPA
Gloria Sexton	NC QCPA
Jan Williams	NCQCPA
Lola Bracy-Conn	Corpstrat

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NAME	FIRM OR AGENCY AND ADDRESS
Collin Lee, Mary Ellen Slade, Jackie Pattisall	Club Nova 103-D W Main St Carrboro NC 27510
Ethel Benjamin, Jerome Faulkenberry	
Jimmie Smith, Nancy Clark, Elena Fowler	
Matthew Cox, Heather Nash, Karen Dunn	
Kristle Brown	The Bridges Project, LLC Britton and Crump, Inc.
Mary Shannon Thomas	STEP Clinic, UNC-CH
Jennifer Russell	HUHFY, Inc.
Beth Call	
Erica Locklear	Sunrise Clinical; Durham NC

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NAME	FIRM OR AGENCY AND ADDRESS
Tyrone Peterson	4031 Cavalier Drive
LaTasha Thorgrove	3650 Cornell Blvd WS NC 27107
Arencatha Phifer	4031 Cavalier Dr WS NC 27104
Scottie J. Vanhook	SRS, Inc. P.O. Box 655, Lillington NC 27546
Patricia Dillard	A-1 Community Support 560 Dabney Dr., Henderson, NC
Dixylon Whitley	A-1 Community Support 560 Dabney Dr., Henderson, N.C.
David Buchanan	Adolescent Alternatives PO Box 16162 Greensboro NC 27416
Shirena Smith	Adolescent Alternatives po Box 16162 Greensboro NC 27416
Lorenzo Hanley	Adolescent Alternatives P.O. BOX 16162 Greensboro NC 27416
Tyrone McRae	Omega ILS 3029 Stonybrook Dr ste 105 Raleigh NC 27604
Delwin Clark	Omega ILS 3029 Stonybrook Dr. Ste. 105 Raleigh, NC 27604

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NAME	FIRM OR AGENCY AND ADDRESS
Barbara Reddick	307 Liberty Street Compassionate Care Family Net Work Williamston, N.C. 27892
Stephanie Alexander	DHSR, 805 Biggs Dr., Raleigh, NC
Ilena S. Ramsey	Hope Trust, LLC PO Box 1503 Roanoke Rapids, NC 27870
Mita Rawls	Brite Smiles - PO Box 86, Roanoke Rapids, NC. 27870
Charlotte Drummond	P.O. Box 100 Walkertown, NC 27051
Sandra Davis	P.O Box 1681 WSNC 27102
Jeffrey Cunningham	4421 Bisbee Dr. Greensboro, NC 27407

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NAME	FIRM OR AGENCY AND ADDRESS
Mary Powell	NC Substance Abuse Federation
Venus Malloy	Governor's Institute on Alcohol & Substance Abuse
Jere Carter	NuDay Case Management

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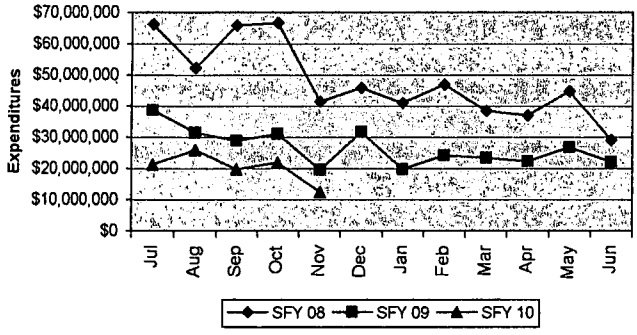
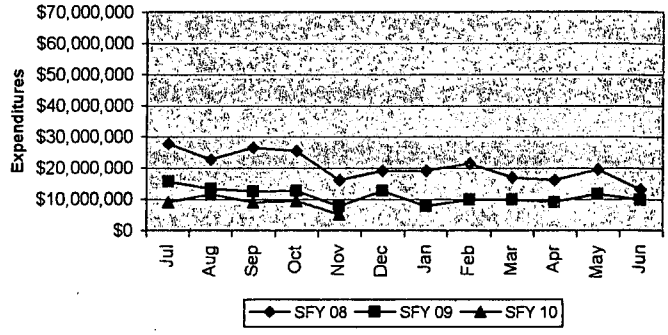
NAME	FIRM OR AGENCY AND ADDRESS
Rhonda Trask	NCACC
Peyton Maynard	DOT
Lou B. Walker	NCALTCF
Lu-Ann C Penny	NCPA

Community Support - Individual - Child
H0036 HA



Community Support - Individual - Adult
H0036 HB



Community Support - Group
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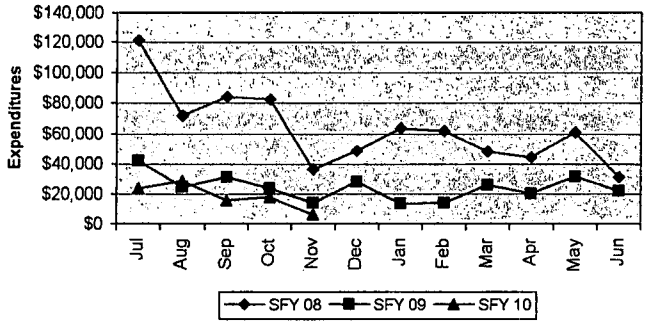
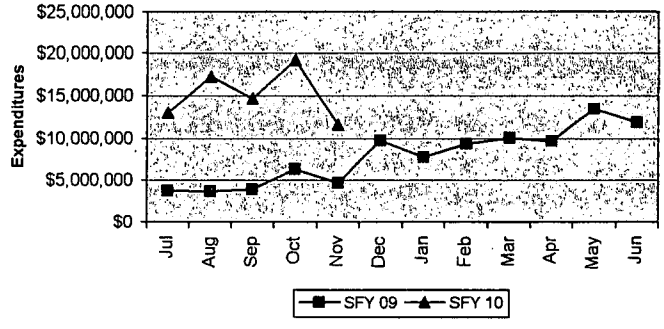
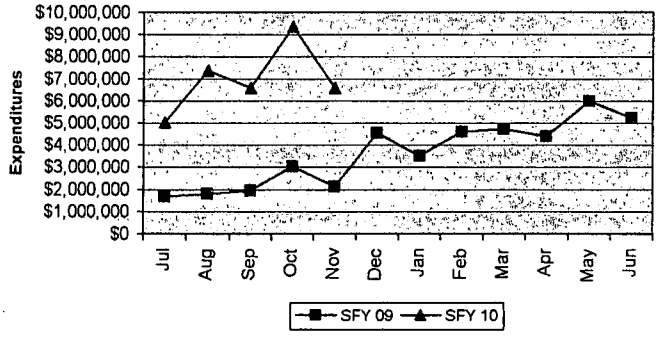


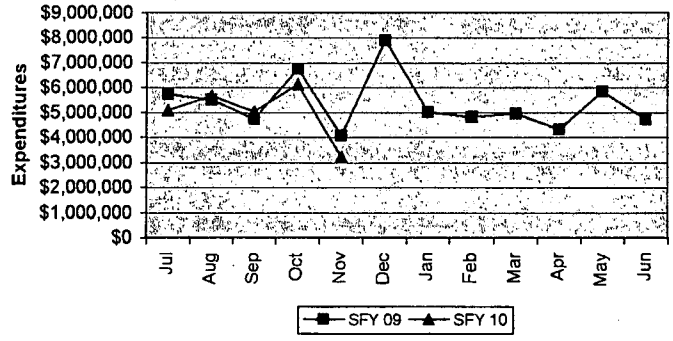
Community Support Team
H2015



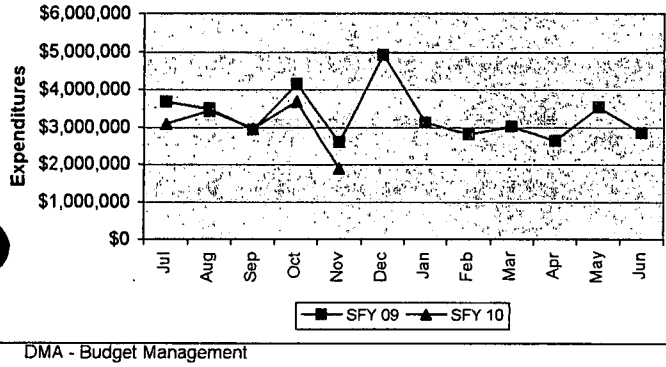
Intensive In-Home
H2022



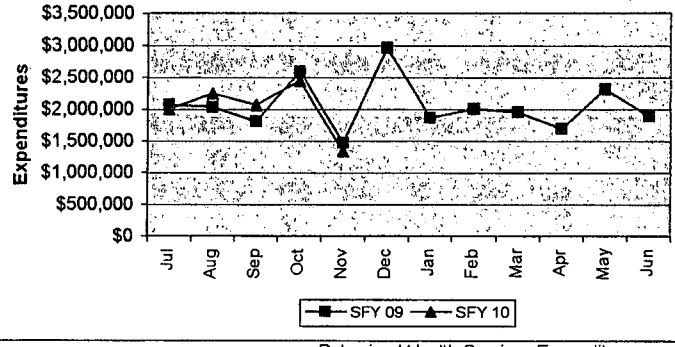
Targeted Case Management-DD ALL
T1017 HI



Targeted Case Management-DD CAP Only
T1017 HI



Targeted Case Management-DD NON CAP only
T1017 HI



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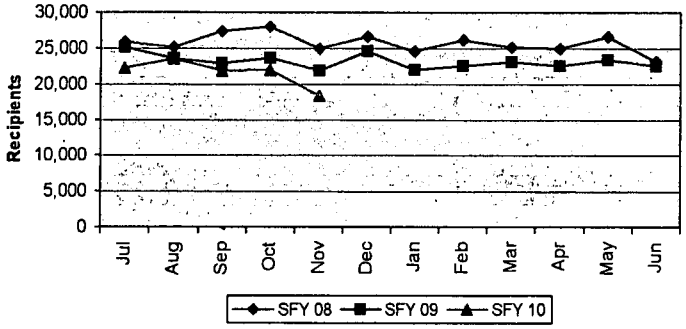

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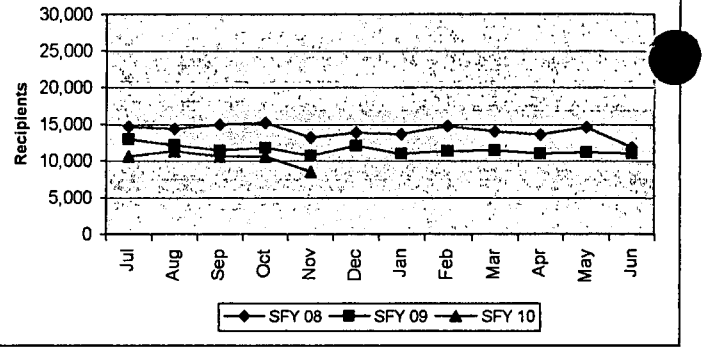
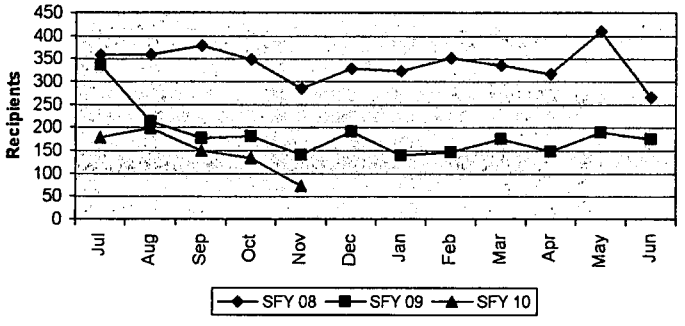
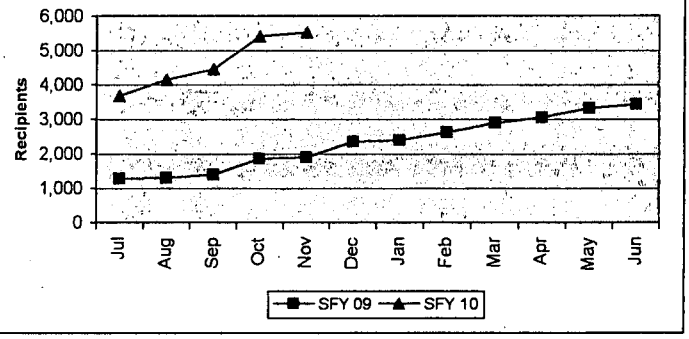


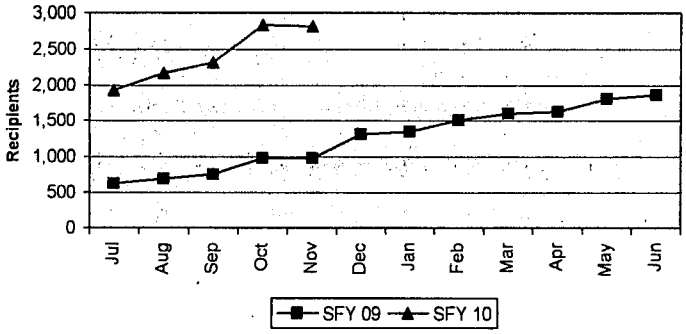
Community Support - Group
H0036 HQ



Community Support Team
H2015



Intensive In-Home
H2022



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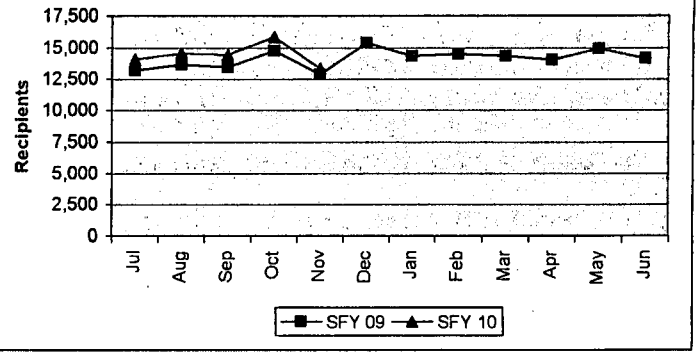

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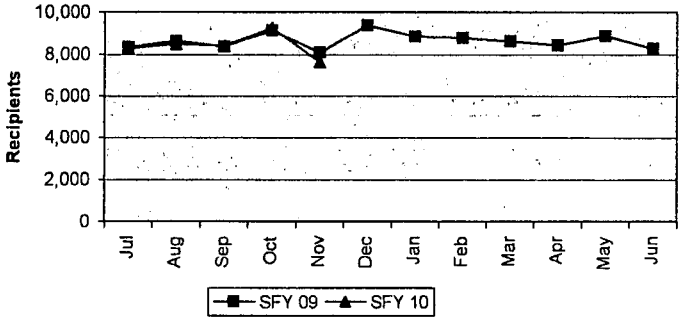

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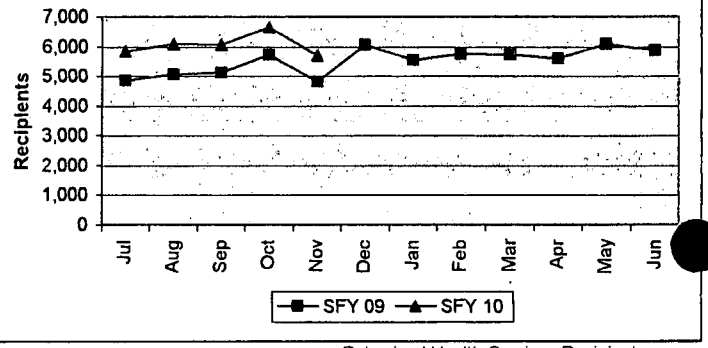

Community Support - Individual - Child
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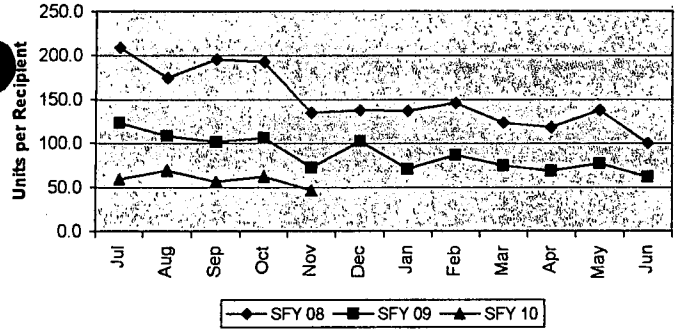

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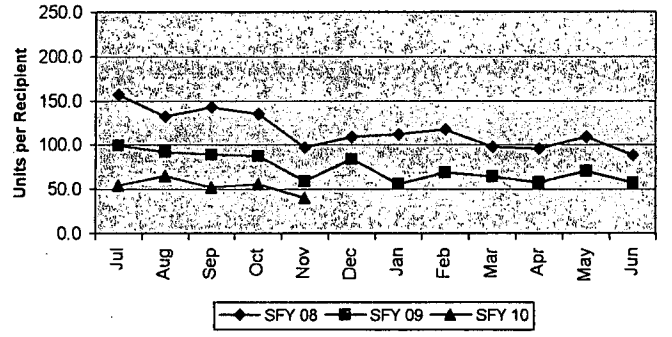

Community Support - Group
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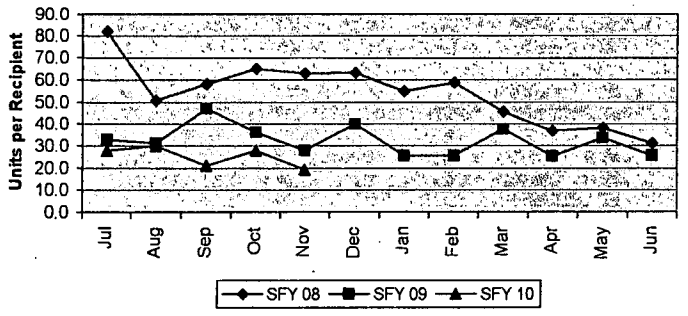
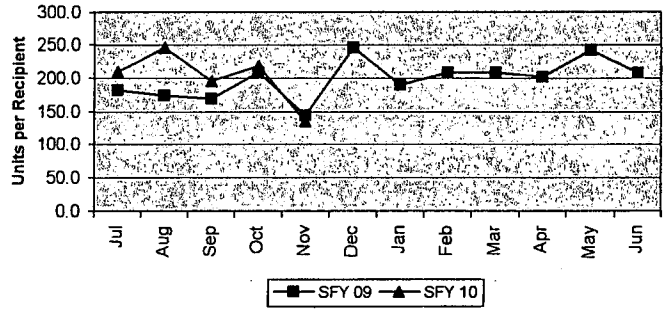


Community Support Team
H2015



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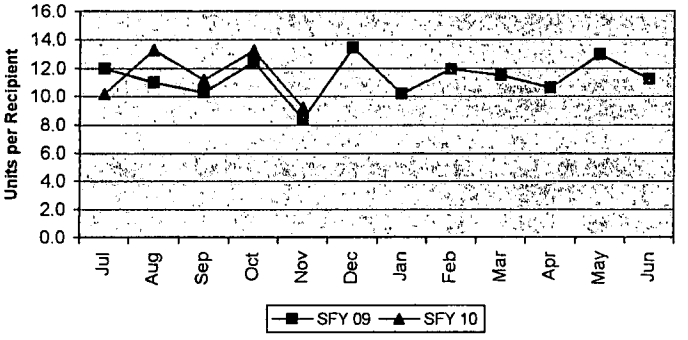

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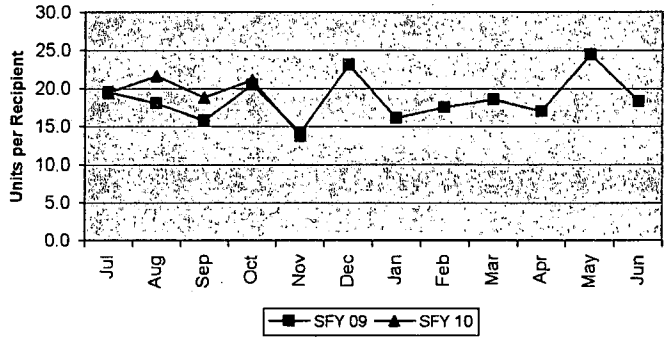

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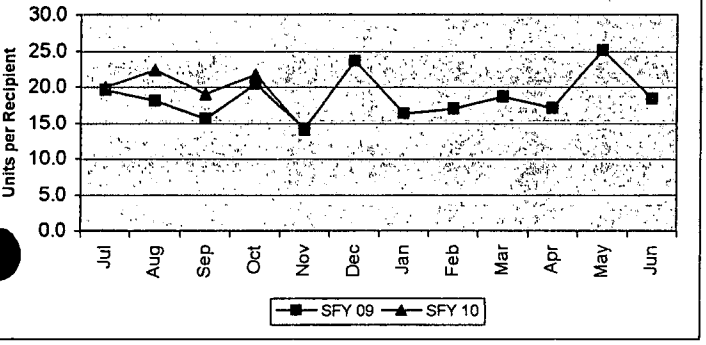

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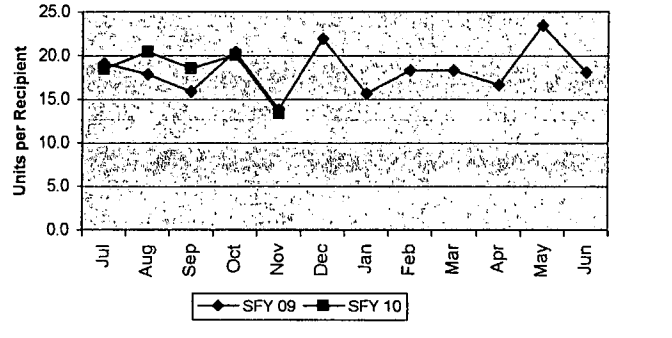

Critical Access Behavioral Health Agency (CABHA)

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

December 9, 2009

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

1

GOALS:
CABHA IMPLEMENTATION

- To ensure that mental health and substance abuse services are delivered within a clinically sound provider organization with appropriate medical oversight.
- Move the system over time to a more comprehensive and coherent service delivery model
- Increase economies of scale and efficiencies in the service system
- Increase consumer/family/stakeholder confidence in our provider network

2

GOALS: CABHA IMPLEMENTATION CONT'D

- Reduce clinical fragmentation—Reduction of "Stand Alone" service delivery
- Increase provider "1st Responder" capacity
- Embed case management in comprehensive clinical provider
- Insure that consumers have access to an array of appropriate clinical services
- Increase accountability within the MH/SA service system—monitor service and referral patterns
- Provide a competent clinical platform on which to implement best practice service models

3

Basic CABHA Service Requirements

- **Services that must be delivered within the CABHA structure:**
  - Community Support Team (CST), Intensive In-Home (IIH), Day Treatment (Effective July 1, 2010)
  - New Services: Case Management/Peer Support subject to CMS approval to be approved by CMS

4

To Be or Not to Be CABHA

- **Not all agencies will need to pursue CABHA certification:**
  - Agency does not provide CST, IIH, or Day Treatment services or does not want to provide case management or peer support
  - Agency provides a specialized service (e.g. MST, ACTT, SAIOP, PSR-Clubhouse, residential services) and does not need to provide Case Management or Peer Support
  - Services for Developmentally Disabled consumers not included under CABHA certification requirement

5

CABHA Certification Process

- Provider Attestation Letter w/documentation
- Desk reviews conducted by DMH/SA and DMA staff
- Site reviews conducted by
  - DMH/SA staff
  - DMA staff
  - Licensed clinicians from LMEs (including a Medical Director)

****NOTE: Certification Process began December 1, 2009**

6

CABHA Certification Requirements

- Must provide the **core** services of:
  - Comprehensive Clinical Assessment
  - Medication Management
  - Outpatient Therapy

- Must deliver at least two enhanced services
- in the same location where it provides the three core services to create a continuum of care

7

CABHA Certification Requirements

- **Active National Accreditation of at least 3 years**
- **Medical Director**
  - 100% FTE for providers serving more than 750 consumers
  - 50% FTE for providers serving less than 750
- **Clinical Director 100% FTE**
- **Quality Management/Staff Training Director 100% FTE**

NOTE: **The clinical oversight and management functions represented by these positions must be actively in place at least two months prior to the provider receiving an onsite review for CABHA certification.**

8

Medical Director Qualifications

- Education and experience with the populations served.
- If the Medical Director is a Psychiatrist or ASAM certified physician the Medical Director & Clinical Director functions may be performed by the same individual.
- Medical Director may be employee or contract function.

9

Medical Director Specifications

- May provide direct services up to 60% of budgeted time.
- **CABHAs serving more than 750 MH/SA consumers at any site other than the CABHA certification site must designate a Lead Physician for that site.**
  - Lead Physician functions under supervision and direction of the CABHA Medical Director.
- **CABHAs required to have 100% FTE Medical Director**
  - No more than two different physicians

10

Medical Director Specifications

- **CABHAs required to have 50% FTE Medical Director**
  - **No more than one physician**

NOTE #1: **Data indicate that 16 providers are currently serving 750 or more MH/SA consumers and that 48 providers are serving between 300 and 750 MH/SA consumers. Provider consolidations may significantly impact these numbers.**

NOTE #2: **50% Medical Director requirement designed to accommodate needs of smaller providers.**

11

Clinical Director Specifications

- **Clinical Director 100% FTE**
  - May be shared by no more than two individuals on site
  - Education & experience sufficient to provide clinical direction to the staff employed by the provider agency

12

Clinical Director Specifications

- **Accepted licenses:**
  - PA (with experience with population served)
  - Licensed Clinical Social Worker
  - Licensed Psychologist (Doctorate Level)
  - Licensed Psychological Associate
  - Licensed Professional Counselor
  - Licensed Marriage and Family Therapist
  - Mastered Degree Nurse – advanced practice only (NP, PNPs, etc.)
  - Licensed Clinical Addiction Specialist
  - Certified Clinical Supervisor

13

QM/Training Director Specifications

- **Quality Management/Staff Training Director**
  - **One 100% FTE required to provide evidence of quality improvement activities**
  - **Bachelors Degree and three years experience or a Masters Degree and one year of experience utilizing data to support the development of a quality management program**

14

BASIC CABHA REQUIREMENTS

- Medical Oversight
- Clinical Director
- Quality Management
- Staff Training
- National Accreditation

****NOTE: Based on a single site certification, CABHAs (subject to local LME endorsement) may deliver services on a statewide basis.**

15

If Not A CABHA: How To Become One?

- Agencies can merge to become a CABHA but:
  - ➢ Current endorsed services do not transfer to new entities.
  - ➢ Any change in ownership requires re-endorsement/re-enrollment with Medicaid

16

CABHA Endorsement/Contract Issues

- CABHAs are still required to meet site specific LME endorsement standards for all enhanced services including Case Management and Peer Support
- Sign an MOA with all LMEs in which they have a service specific site endorsement
- Contract with LMEs for State funded services where appropriate

17

CABHA & Primary Healthcare

- **To ensure that the consumers behavioral health and physical health care needs are met, CABHAs will be expected to maintain close collaboration with:**
  - Primary Care Physicians
  - Public Health Departments
  - Federally Qualified Health Clinics
  - Community Care of NC

18

CABHA Appeals/Withdrawal of Certification

- **If denied CABHA certification**
  - Right to appeal the decision to the Office of Administrative Hearing (OAH) within 60 days from receipt of the Review Results letter.
  - The procedure to file an appeal and the required forms may be obtained from **www.oah.state.nc.us**
- **If CABHA Certification withdrawn**
  - Lose statewide ability to provide Case Management, Peer Support, CST, IIH and Day Treatment Services

19

CONCLUSION

- **CABHAs represent a critical step toward returning quality and accountability to our community service system**
- **CABHAs establish a strong clinical foundation on which to build community service capacity**
- **Need to monitor CABHA service utilization patterns and statewide consumer access/choice issues**

20

Community Support Update

Legislative Oversight Committee on MH/DD/SAS

December 9, 2009

Leza Wainwright, Director, DMH/DD/SAS

DMH | DD | SAS
division of mental health | developmental disabilities | substance abuse services

Status of Transition Plan

- Work groups have completed their work
- Evaluation of the need for additional services to be added to the service array has been completed
- State Plan Amendments (SPAs) drafted for replacement services

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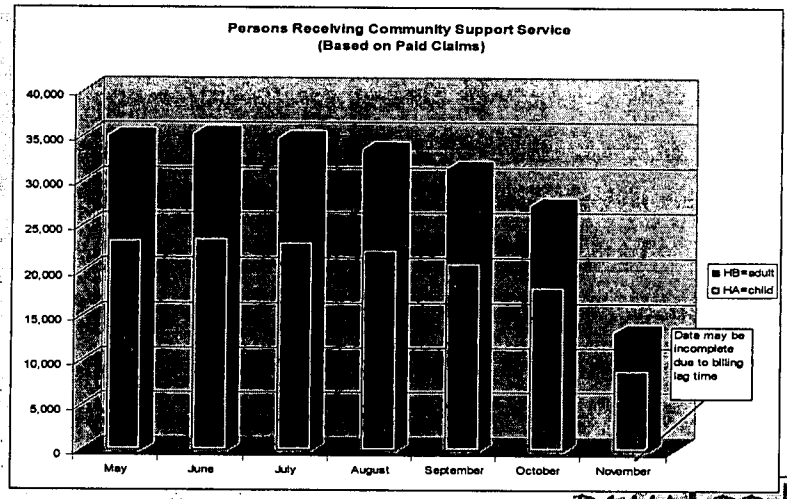
Trend in Persons Served



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Community Support with Other Enhanced Services

- As of the end of November, 2009
  - 7% of children authorized to receive CS and another enhanced service
  - 5.3% of adults
- Discontinued authorizing CS with other enhanced services effective October 12, 2009
  - EPSDT for children
  - Current authorizations for children and adults allowed to continue until end of authorization period.

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Services to Replace CS Currently Available

- Other enhanced services
  - All LMEs have Community Support Team, Intensive In-Home and Psycho-Social Rehabilitation
    - 2 LMEs do not have Assertive Community Treatment Team
    - 6 LMEs do not have Multi-Systemic Therapy
  - LMEs working to recruit providers to deliver missing services, until then, substitute Intensive In-Home or Community Support Team
- Outpatient Therapists
  - At least 40, and up to several hundred, available in each LME

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Replacement Services Requiring CMS Approval

- Case Management
  - Draft definition submitted to CMS for preliminary review; awaiting approval of previous CM SPA and finalizing rate setting process prior to submission of formal SPA
  - Permission to continue "case management component" of CS (Licensed Professional or QP only) during the interim
- Peer Support
  - Submitted to CMS; no feedback yet

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Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Case Management for Persons with Developmental Disabilities

December 09, 2009

Tara Larson, Chief Clinical Operating Officer, DMA

1

Eligible Population

- Children birth to 3 who are at risk for, or have been diagnosed with developmental disability (Early Intervention, CAP-MR/DD or DD),
- Children birth to 5 who have a diagnosed developmental delay (Child Service Coordination or DD or CAP-MR/DD),
- Adults and children 5 years of age and older who have (DD or CAP-MR/DD):
  - A diagnosed developmental disability manifested prior to the age of 22; OR
  - Diagnosed with mental retardation; OR
  - A mental or physical impairments similar to developmental disabilities as the result of a traumatic brain injury.

2

Number of Recipients

- CHILDREN (ages 0-20):
  - CAP-MR/DD Waiver - 4,409
  - Non-waiver – 4,136
  - Total 8,545
- ADULTS (ages 21+)
  - CAP-MR/DD Waiver – 6,017
  - Non-waiver - 5,226
  - Total 11,243

3

LMEs

- In the past, LMEs did provide DD case management services. The case management was a combination of administrative and direct services.
- Today, LMEs have all divested themselves and no longer provide case management. Direct service Case Management is contracted to private providers. DP1
- There are no plans to limit the number of providers of TCM for persons with DD.

4

Provider Qualifications

- Since the LMEs are all divested, the only providers are private providers who were subcontracted through the LME. Provider agencies will direct enroll with Medicaid once the SPA is approved.
- By 7/1/2010, private providers must be endorsed by the LME (this is the old SPA).
  - Each provider must ensure that each case manager has 20 hours of training relating to case management functions within the first 90 days of hire.
  - In addition, case management agencies will need to meet the endorsement criteria which includes core rules and service specific requirements.

5

Provider Restriction

- Providers cannot provide other services and TCM to the same recipient.

6

Number of Agencies

- Since the providers are subcontracting with the LMEs, the LME is billing for them.
- Therefore, there is no automated way to accurately identify the number of private providers.
- Approximately – there are 355 DP2

7

Service Definition

- A new service definition has NOT been submitted to CMS yet. CMS has instructed the State that a new definition will not be processed until the earlier SPA is approved DP3
- A CM workgroup has been created to work on developing the revised definition. The definition will be the federal definition. The State will provide details about limitations, provider qualifications for both the agency and staff, outcomes to be accomplished and other state specific details.
- This work is not complete.
- The plan is for everyone to have a medical home, through CCNC. The process for communication and roles/responsibilities continue to be worked.

8

Unit Limits

- As part of the short term goals of the CM Steering Committee, there are plans to reduce the unit limits.
- This reduction would include DD.
- Before this takes effect, recipients will receive a 30 day notice and providers will be notified via the Medicaid bulletin and the Implementation Updates. Any current authorization will be allowed to "run through the authorization period" before changes occur.
- As part of the long term goals of the CM Steering Committee, there are plans to establish a case rate. However this must have CMS approval.

9

Rate Reductions

- Effective 1/1/09, the rate for TCM was reduced from $22.00/15 minute unit to $18.75 per 15 minute unit.
  - This was made to adjust a rate that was originally established in 2005 and based on LME provider costs. DMA worked with providers to obtain actual cost of providing this service. Following a complete review of costs and collaboration with providers, the new rate was agreed to reflect the average cost of providing TCM services. No responsibilities were reduced. This change was made to match the rate with the cost of providing the service.
- Effective 10/1/09, rates were reduced to $17.67 consistent with the legislatively approved budget.

10

TCM Provider Fees

- The only additional fees are the enrollment fees included in the legislatively approved budget.
- These fees apply to all NEW providers enrolling in Medicaid or at the next renewal.
- All providers currently being re-credentialed are exempted from the fee for this one time.

11

Residential
Level III and Level IV
Update

Legislative Oversight Committee on
MHDDSAS

December 9, 2009

Christina Carter, Implementation Mgr

1

Residential III and IV Results:

Recipients In Level III and Level IV Residential Services

9/28/09 Recipients in Level III residential services. 2390*	12/7/09 Recipients in Level III residential services 1157 Difference of 1233	9/28/09 Recipients in Level IV residential services. 134*	12/07/09 Recipients in Level IV residential services 58 Difference of 76

2

Residential III and IV Results:

Recipients who have been Paper Triaged	Recipients who have had an initial Child and Family Team (CFT)	Recipients who have had a follow-up Child and Family Team (CFT) meeting	Recipients who have been discharged from Level III residential services	Recipients who have been discharged from Level IV residential services
2317 (at October LOC= **1982)**	**2162** (at October LOC= **1828)**	**1811** (at October LOC= **852)**	**1180** (at October LOC= **856)**	**87** (at October LOC= **46)**
Discharge Percentage .091	**Discharge Percentage 0.85**	**Discharge Percentage 0.71**	**Discharge Percentage 0.49**	**Discharge Percentage 0.64**

3

Residential III and IV Results:

- **Where Child & Family Teams are referring children**

400-1000 Plus referrals	100-150 referrals	0-150 referrals
▪Medication Management	Psychiatric Residential Treatment Facility	▪Residential Level III
▪Outpatient Individual Therapy	▪Day Treatment	▪Residential Level IV
▪Outpatient Family Therapy	▪Residential Level II	▪Substance Abuse Individual Outpatient
▪Intensive In Home	▪Multisystemic Therapy	▪Outpatient Group
▪Therapeutic Foster Care	▪Natural and Community Supports	▪Respite

4

Residential III and IV Results:

- Services in which some LME's areas require expansion:
  - Respite (4 LMEs)
  - Therapeutic Foster Care (6 LMEs)
  - Multisystem Therapy (5 LMEs)
  - Day Treatment (6 LMEs)
  - Psychiatric Residential Treatment Facility (6 LMEs)
  - Residential Level II-Group (6 LMEs)
  - Intensive In Home (3 LMEs)
  - Substance Abuse Individual Outpatient (1 LME)

5

Residential III and IV Results:

Level III beds as of September 1, 2009	Level III beds in as of December 7, 2009	Level IV beds as of September 1, 2009	Level IV beds as of December 7, 2009
2407	1875 Percentage of Level III beds Remaining: 77%	346	108 Percentage of Level IV beds Remaining: 31%

6

Psychiatric Residential Treatment Facility (PRFT)

- Service available to recipients under the age of 21
- Non- acute impatient facility care for Mental Health and/or Substance Abuse
- Each PRTF unit serves no more than 12 children or adolescents
- Highly structured 24-hour therapeutic setting (life skills, problem solving & medication mgmt)
- History of multiple hospitalizations with poor adherence to other interventions
- Educational services are provided through a facility based school

7

Psychiatric Residential Treatment Facility (PRFT)

- Program is directed by a board-eligible or certified child psychiatrist or general psychiatrist with experience in treating children
- Must be nationally accredited
- Must be licensed by Division of Health Service Regulation
- May be subject to institutional building codes
- Highly medically monitored and supervised
- Facilities require 2 staff for every 6 recipients
- Authorization for 14 days with option for up to 30 days (not intended for long stays)

8

Current Status of PRFT's

- Proposed amendment to current rule presented in August to the MHDDSAS Commission
- Proposed amendment to the current rule would allow PRTF's to serve up to 18 children or adolescents per unit
- Allows for expanded component of the treatment continuum
- Service has expanded from 298 Beds (2008) to 405 Beds (2009)

**Commission approved proposed amendment-currently pending for fiscal note and then public comment period

9

Attachment 7

Real Partnerships for Substance Abuse Treatment and Recovery

Cross Area Service Program (CASP) Initiative: SFY 09-10

Substance Abuse Services Regionally Funded and Locally Hosted

Presented by: Flo Stein, Chief, Community Policy Management Section, DMH/DD/SAS

H.B. 1473, S.L. 2007-323

Increase Availability of Substance Abuse Treatment: (Section 10.49)

"...funds appropriated in this act to the DHHS, DMH/DD/SAS for regionally funded, locally hosted substance abuse services shall be allocated for the purpose of developing and enhancing the American Society of Addiction Medicine (ASAM) continuum of care at the community level."...

New Cross Area Service Programs (CASPs)

1. Increase adult SA comprehensive community treatment capacity and supportive housing services
2. Increase adolescent SA comprehensive community treatment capacity and residential program services
3. Increase community capacity for SA Prevention Coalitions
4. Increase community capacity for SA services specific to pregnant women or women with children utilizing gender-specific treatment
5. Develop expanded residential SA programs with a vocational component treatment capacity

Cross Area Service Program

- A Cross Area Service Program (CASP) is a program that has been designated by the Division to receive specially earmarked funding to provide comprehensive regional or statewide services across multiple Local Management Entities (LMEs).
- LME Services are directed through a designated LME to a provider entity to serve the needs of an identified client population.
- Services are targeted to eligible clients and their families in an identified region or regions, but are available to all eligible clients and their families statewide as program capacity allows.

Three-Way Partnerships

- NC has created three-way partnerships of the Division, designated LMEs, and selected Provider Organizations to provide comprehensive regional treatment and recovery programs.
- Funds provided by the NC General Assembly on recommendation of the Legislative Oversight Committee on Mental Health (LOC).

Model Programs

- Model reviewed by the North Carolina Institute of Medicine (IOM) and discussed in the Institute's report on substance abuse.
- Partnerships include DMH/DD/SAS, the Treatment Research Institute (TRI), formerly led by Thomas McClellan, selected LMEs and providers.
- The Division has provided training and consultation.

Model Description

- Focus on comprehensive clinical assessment, treatment, and recovery services and supports.
- Emphasis on continuous, seamless transitional services from one ASAM level to next in continuous step-down process
- Target population of clients referred from state and private hospitals, ADATCs, detox programs, TASC, and prisons.

Recovery-Oriented Systems of Care

- Comprehensive
- Person-Centered
- Self-Directed
- Strength-Based
- Flexible and Readily Adjustable
- Evidence-Based
- Coordination with Multiple Systems
- Outcomes-Driven

Recovery-Oriented Services and Supports

- Linkages to primary care for medical and dental
- Medication-assisted therapies
- Housing supports
- Transportation
- Employment supports
- Faith-based supports
- Peer supports
- Case Management
- Recovery clinical checkups
- Telephone recovery support calls
- Continuous measurement, monitoring, and use of outcomes to improve care (NC-TOPPS)

Adult Regional CASPs for Substance Abuse

Provider	Location	LME
October Road N=140	Asheville	Western Highlands
Partnership for Drug-Free North Carolina N=140	Winston-Salem	CenterPoint
Freedom House (includes Oxford House) N=240	Chapel Hill	O-P-C
Coastal Horizons N=140	Wilmington	Southeastern Center

Adult Regional CASPs for Substance Abuse (continued)

Provider	Location	LME
Southeastern Recovery Alternatives N=140	Lumberton	Southeastern Regional
Tri-County Community Health Council N=140	Newton Grove	Eastpointe

Adolescent CASPs for Substance Abuse

Provider	Location	LME
Vision Quest N=20	Durham	Durham
PORT Human Services N=40	Pender County	Southeastern Center

Women's CASPs for Substance Abuse

Provider	Location	LME
UNC-Horizons N=16	Chapel Hill	Orange-Person-Chatham
Community Choices N=16	Durham	Durham
Robeson Health Care Corporation (Expansion) N=6	Greenville	East Carolina Behavioral Health
Community Choices (Expansion) N=6	Charlotte	Mecklenburg

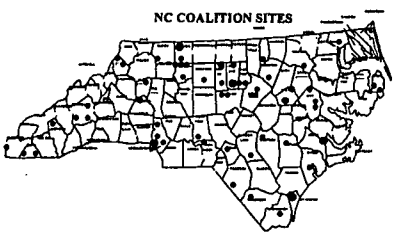
Residential SA Treatment with a Vocational Component

Provider	Location	LME
First Step Farm N=100	Candler (Asheville)	Western Highlands
TROSA N=100	Durham	Durham

Prevention Coalitions for Substance Abuse

Contractor	LME
Wake Forest University	CenterPoint

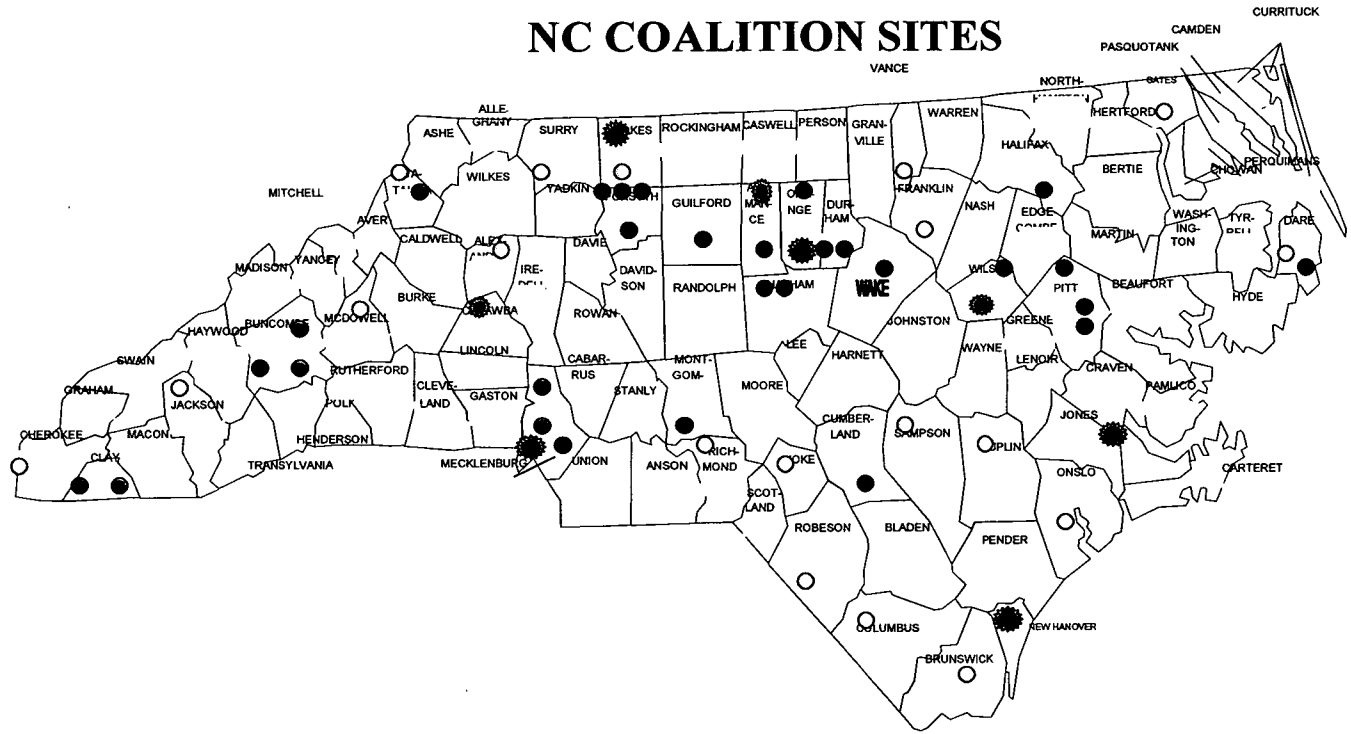
North Carolina Coalition Sites



Adult SA CASPs Highlighted at December 2, 2009 NC Council of Community Programs Conference

- Outstanding recovery-oriented systems and practices
  - Freedom House (OPC) – Community linkages and natural and peer supports for recovery
  - Coastal Horizons (SEC) – Sober housing options and medication-assisted therapies
  - Partnership for Drug-Free NC (CenterPoint) – Client outreach, engagement, and seamless transitions between inpatient and intensive outpatients levels of care and medication assisted therapies

North Carolina Coalition Sites



Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services

AGENDA

January 13, 2010 10:00 A.M.; Room 643, Legislative Office Building
Rep. Verla Insko Co-Chair Presiding

Opening Comments – Chairs ***10:00-10:10***	
Overview of Revenues **10:10-10:20**	Barry Boardman, Fiscal Research Division
Medicaid Budget Shortfall **10:20-10:30**	Lee Dixon, Fiscal Research Division
Comments on CABHAs (as requested by LOC) **10:30-10:50**	April Harris-Britt, Ph.D. John Gilmore, M.D.
System Vision for MH/DD/SAS **10:50-12:00**	Michael Watson, Assistant Secretary for MH/DD/SAA Development
CABHAs (Follow-up) **12:00-12:30**	Michael Watson, DHHS
Lunch **12:30-1:30**	
First Commitment Pilot **1:30-2:00**	Mark O'Donnell, LME Liaison and Project Director for the 1st Evaluation Pilot Project
Telemedicine SL 2009-315 (H1189) Update on HB 243 **2:00-2:20**	Michael Lancaster, Chief of Clinical Policy for DMH/DD/SAS
Mobile Crisis Services **2:20-2:40**	Michael Lancaster, DHHS
START Teams **2:40-3:00**	Christina Carter, LCSW, Implementation Manager, Division of MH/DD/SAS
General Public Comments and Concerns re: State Institutions **3:00-3:30**	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	1/13/10																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	√																
Representative William Brisson	X																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

January 13, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, January 13, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory member Representative Van Braxton was also present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. Representative Insko informed attendees that the tours to Dix Hospital and Central Regional were cancelled due to logistical problems, but encouraged members to tour the facilities on their own. She advised that public comments would be heard on the two facilities during the meeting. She asked for a motion to approve the minutes from the December 9, 2009 meeting. The motion was made by Senator William Purcell and the minutes were approved.

Dr. Barry Boardman from the Fiscal Research Division provided an overview of revenue projections. He noted that collections were behind expectations for the month of November - $110M short of the budget target. The shortfall through December was eliminated due to a one-time collection of $422M ($272M more than budgeted) through the Department of Revenue working with corporate taxpayers. Problems with revenue now are economy based – sales tax collection, and wage withholding, caused by a weak economy. He said withholding represents 40% of the General Fund and that is 4% below last year. Sales tax represents 25% - 28% of the General Fund collection and that is running 12% below last year. Absent the $272M, the shortfall should be about 2.6%. Dr. Boardman projected the remainder of the fiscal year looked bleak primarily due to the unemployment situation.

Dr. Boardman was asked how much money North Carolina owed the federal government to pay back funds borrowed for unemployment and if interest was accruing. He responded that he would get that information. Senator Nesbitt clarified that it was a federal program that actually owed a trust fund debt, and not a debt of the State. He was

also asked to address the new "baseline" for the continuation budget after the Governor's 5% hold-back. Lisa Hollowell from Fiscal Research responded that the 5% withholding by the Governor was a one-time/non-recurring fix, anticipating a revenue or budget shortfall. These reductions are not recurring and when the budget is put together for next year the General Assembly will have the option of making some of these reductions permanent. Much like this year's budget, the General Assembly also took some of the Governor's reductions she made in last year's budget.

Lee Dixon from Fiscal Research provided an update on the Medicaid budget shortfall. He said that Medicaid enrollment was contributing to the shortfall. He said projections indicated that there would be an additional 18,000 enrollees by the end of this fiscal year. The increase is the cause of $85M of the shortfall. Utilization is also contributing to the shortfall. Mr. Dixon said the Medicaid budget in 2009 was based on a utilization of .25%. Utilization was up 4% across the board through November. This increase contributes an additional $90M towards the shortfall. There were also some planned budget reductions made be the General Assembly which required DHHS to submit State Plan Amendments to the Centers for Medicaid and Medicare Services (CMS). DHHS cannot implement the budget cuts until CMS approves the amendments. Community Care of North Carolina (CCNC) manages the utilization of services across the Medicaid population. In the last 14 months CCNC has undertaken managing services for the aged and disabled. Because the proper infrastructure is not in place, CCNC is not able to realize the $70M savings called for the budget. Mr. Dixon said that since September DHHS had been working to develop better management tools to determine what is happening across the Medicaid budget.

Representative Insko reminded members that at the last LOC meeting, members requested to hear comments from psychiatrists and psychologists concerning -CABHAs. First, Dr. April Harris-Britt, a licensed psychologist, presented her concerns on the potential impact of the CABHA model on mental health services. (See Attachment No. 2) Points of interest in her presentation included:

- Most controversial aspect of the CABHA model is the mandate of a medical director and the cost of this position. Fiscal feasibility of this requirement is questionable and it is uncertain whether it will achieve the desired clinical oversight.
- Current model anticipates having only 40-60 CABHA agencies statewide which would severely limit client and consumer choice.
- Goal should be to improve rather than eliminate existing services.
- In the end, the anticipated savings by these changes will eventually be channeled to support other issues and outcomes typically associated with untreated mental health problems.

Dr. John Gilmore, from the Department of Psychiatry at UNC, provided his opinion on the CABHA model from the perspective of a psychiatrist. His presentation included the following points of interest:

- North Carolina Psychiatric Association and those at the Department of Psychiatry at UNC strongly support the intent of CABHA to restore clinical integrity to the public mental health system.

- Current system is fragmented, wasteful, and often fails to provide the treatments proven to work.
- The cornerstones of effective treatment are a good diagnostic assessment, and evidence-based treatment provided by an integrated team of professionals; CABHAs are a definite step in that direction.
- There needs to be a transparent business model which ensures that good small providers are not put out of business.
- Fragmentation of the system has driven many professionals away; the CABHAs model will create a strong and stable provider network to correct that deficiency.

Members questioned DHHS about how new professionals could enter the system and provide the array of services offered within the CABHA model if CABHA certification requires three years of accreditation. Michael Watson, Assistant Secretary for DMH/DD/SAS Development, responded that people would enter the system and become accredited with non-CABHA services and then have an opportunity to become nationally accredited in order to move into CABHA services. Mr. Watson advised that the Department has received 250 applications from providers seeking CABHA certification. Members requested specific information on the number of small providers represented in the 250 applicants. Members expressed concern for small providers and the clients depending upon these services, and questioned whether the CABHA model should be a pilot.

Michael Watson addressed the initiatives from DHHS regarding MH/DD/SAS over the next one to two years. (See Attachment No. 3) He said the Department has a set of significant initiatives to reshape and define the service system at the community level, many of which are driven by instructions from the General Assembly. Points of interest included:

- Audit of the quality of services showed that 35% to 40% of services were (i) not medically necessary, (ii) poorly documented making it difficult to determine if and how the services were delivered or how they were delivered, (iii) delivered to people who did not need the services, or (iv) in some cases, false information was sent to Value Options as part of the authorization process.
- Services delivered by CABHAs include: Day Treatment, Intensive In-Home Therapy, Community Support Team, Case Management, and Peer Support.
- A technical amendment has been submitted to CMS that takes the Piedmont 1915(b) waiver and makes it a North Carolina waiver allowing DHHS to add 1-2 LMEs to the waiver in January 2011. CABHA initiative restructures the provider network to mirror what is required under a waiver environment.
- Mental Health Initiatives –Providers need to have capacity to deal with their own consumers in the community before going to an emergency room. DHHS is meeting with the Sheriff's Association and the Hospital Association regularly regarding capacity issues – how people are processed, how beds are found, and how assessments are made.
- Community Support Teams is close to becoming a $250M a year service; it has grown over the last 18 months from 1,000 people to 6,000 people receiving service.

Mr. Watson was questioned about the effect CABHA would have on clubhouses. He responded that clubhouse services do not require the provider to be a part of a CABHA. However, he added that clubhouses would be impacted if they were providing Community Support since they would not be able to deliver Case Management services. Mr. Watson said DHHS was looking at the workload of the clubhouses and considering a shorter Person Centered Plan. He added that they were also considering changing from daily notes to weekly notes in order to reduce paperwork for providers.

When questioned about how smaller providers could become CABHAs, Mr. Watson said many would either be acquired by larger providers or merge. The Department agreed to answers questions and offer guidance regarding mergers and corporate structure. Mr. Watson responded to members' questions regarding how CABHAs would be monitored by explaining that the LMEs would go on-site investigating complaints, reviewing records, and the LMEs and DHHS would have access to paid claims data for State funded services and Medicaid.

Representative Insko explained that, in anticipation of the site visits to the State institutions, the LOC had requested comments from interested parties. She recognized Larson Taylor with UE local 150, NC Public Service Workers Union. (See Attachment No. 4) Ms. Taylor's concerns addressed the Zero Tolerance policy implemented by DHHS in January, 2009. She expressed the frustration of all concerned that there is not a voice for the frontline workers. Rebecca Hart commented that the policy enabled patients to act as they wished and that staff was afraid of losing their jobs if patients were not handled exactly as the strict guidelines require.

After lunch, Michael Watson provided an update and answered questions from the December meeting and other questions from staff and the Committee on CABHA. (See Attachment No. 5) Points of interest included:

- The purpose of the CABHA is to ensure that mental health and substance abuse is delivered within a clinically sound framework, with economy of scale and efficiency.
- CABHAs seek to address clinical fragmentation by reducing stand alone service providers by having services delivered as part of a more comprehensive provider organization.
- With approval from CMS, CABHA will be funded by Case Management Case Rate which would pay providers per month for Case Management services.
- Two thirds of the 230 providers indicating interest in becoming a CABHA have met the requirements or will be able to meet the requirements.

Shawn Parker from the Research Division provided an introduction for the First Commitment Pilot item on the agenda. Mr. Parker provided the details for the process for inpatient involuntary commitment and provided a narrative of the legislation enacting the pilot program in 2003. The Appropriations Act of 2006 extended the pilot by 1 year. In the fall of 2006, DHHS presented a report to the LOC on the pilot in which the committee recommended that the pilot be made permanent and extended statewide. The LOC made

the recommendation and the General Assembly enacted in SL 2007-504 a three year extension and authorized up to five more LMEs to become pilots. This session the Secretary was authorized in SL 2009-340 to expand the program to 15 LMEs but absent further legislative action the program will sunset October 1, 2010.

Mr. Mark O'Donnell, LME Liaison and Project Director for the 1st Evaluation Pilot Project, DMH, together with Dr. Nidu Menon, Director of Evaluation of the Health Wellness Trust Fund, provided an update on the program. (See Attachment No. 6) Points of interest during their presentation included:

- In 2007, 32 counties across the State did not have registered psychiatrists; 26 counties did not have a psychologist. Numbers were also low for licensed clinical social workers and licensed clinical addictions specialists.
- Evaluation results showed a very high degree of correlation in decisions made between 3 groups of reviewers.
- Recommendation that waiver be continued and expanded statewide, since the pilot project indicates that licensed clinical social workers and licensed clinical addictions specialists who are properly trained, tested and certified, would make decisions similar to those made by psychologists, physicians, and psychiatrists.

Representative Insko stated that the recommendation would appear in the LOC report for consideration by the Committee to the General Assembly.

Representative Insko then recognized members of the audience, who had signed up previously, to come forward for the public comment period. Concerns expressed by the audience included:

- Professional Association Council - Support for DHHS in efforts to restore clinical integrity to the public mental health system to the philosophy outlined in the CABHA, recommendation to implement: clinical supervision, strengthen service definitions, confidence based system, valuing outpatient care, adequate rates and compensation, and workforce development.
- Support for NC Clubhouse Coalition – Model of best practice used and recognized in over 27 countries; 8 clubhouses average 20 years of service to N.C.; 90% success rate in avoiding rehospitalization; CABHAs will drive out small providers; ICCD Clubhouse program needs to build case management and continue Community Support Team without CABHA requirements; need a sustainable way for Clubhouse PSR programming; need simplified Person Centered Plan and return to monthly notes.
- Club Nova – N.C General Assembly needs to create and fund a model law that upholds the Umstead decision, the ADA and the basic civil rights of our citizens living with mental illness.
- The Coalition – Would like to be on LOC agenda to share information regarding cuts to services; ask that LOC work with other General Assembly members to make MHDDSAS a priority in the budget and in funding.
- N.C. Quality Care Provider Association – Need to slow down, system cannot handle the implementation of CABHA; infrastructure is not in place; rural areas struggling, difficult to find psychiatrists to work with adults and children;

mandated that if physician is serving as medical director they must be ASAM certified which further reduces the pool of available talent; create a phase in approach – work on coordination, share information, move to collaboration, then integration of services continuum of care.

- N.C. Psychiatric Association – Psychiatrists have concern regarding the Involuntary Commitment Pilot project and evaluation - safety of undiagnosed medical illnesses that present with psychiatric symptoms. When unrecognized and not treated promptly and appropriately, results can be catastrophic.

There being no further business, the meeting adjourned at 3:10 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Fitzgerald	WakeMed 3000 New Bern Ave Raleigh
Anne MacDonald Dobbs	The Arc of NC 2434 E. Six Forks Rd. Raleigh
John Horton	Youth Villages, 2815 Coliseum Ctr. Dr., CLT
Annie Smith	Youth Villages [illegible] Hartford NC
[illegible]	[illegible]
David Swann	Crossroads [illegible]
Roy Wilson	ECBH - New Bern
Janet Stromsbach	[illegible]
Genny Pugh	Turning Point Services Inc.
Rebecca Tuttle	Eastpointe, Goldsboro, NC
Kevin Thompson	Dept of Correction

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dan Hall	AL LME
Jandy Andrews	Alamance - Caswell LME Burlington, NC
Jodi Hackman	AC LME, Burlington, NC
mary cook	Club Nova
Erin Spence	Club Nova
Elena Fowler	Club Nova
William Owen	Club Nova Community, Inc. 103D W. Main St, Carrboro, NC 27510
Collin Lee · Karen Dunn Kathy Peck · Jimmie Smith · Ethel Benjamin	Club Nova
Ron M. Huber	Sandhills Center CFAC
Susie Deter	Threshold 609 Gray St. Durham NC 27703

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Yvonne Copeland	NC Council of Community Programs Raleigh, NC
Floyd W. Johnson, Jr.	NC Council of Community Programs Member/Area County LMHB Board
HANK Debnam	Cumberland LME, Fayetteville, N.C.
Joseph Hodge	Jesus peace Ministries Fay, NC
Marshella McGrady	Multi-cultural Resource Center Fay. NC
Misty Martin	Lighthouse Counseling Center Fay., NC
Richard S. [illegible]	R. [illegible] Associates
Maureen Pierce	Autism Society of NC
Vicki Smith	DRNC
Joe Donovan	self
Billy West	DAYMARK Recovery Services Concord

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Martin	Lighthouse Counseling Center 2800 Breezewood Ave. Fay. NC 28303
Fred Bore	Bore : Asso
Mike Vicario	NCNA
Bob Hedrick	NCPC
Karen Salacki	The Beacon Center Inc
Linda Hawley	The Beacon Center Inc
Lesley Dover	Eastern Carolina Case Mngt.
Sean Kenny	Eastern Carolina Case Management
Julie Ewing	Parent Advocate
Crystal Nunnemaker	Omni Visions Inc
Cynthia Chapman	Omni Visions 3717 National Dr. Raleigh 27612

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Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shelly Foreman	Smoky Mountain Center
Brian Ingraham	Smoky Mountain Center
Dave Sprout	BMS
Billy Warden	Communications & Imagination Group
Peggy Balentine	The Sageman Grp.
[illegible]	MHM Services, Inc
Shaunda Grainous	Inspirations Group Home
Amy Whited	NC Medical Society
[illegible]	NCPA
John Gilmore	UNC & NCPA
Robin Huffman	NC Psychiatric Assoc

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Treva Johnson	Omni Visions inc 910 C Street Suite 8 NW
Marty Wiems	e-dapativity 31 Portus Glen A. Durham
James Hardy	Cambridge Behavioral Health Services 622 S. Memorial Dr. Greenville, 27834
Donald Grantham	Omega Independent Living Services. INC.
TAO CLODFELTER	SOUTHLIGHT / SAFederation
Valerie Hemrick	Five County Mental Health Authority
Jean Harrison	Alliance Rehabilitation Care, Inc
Lee Creighton	CWBH Consultants, Raleigh
Marilyn Brothers	CWBH Consultants, Raleigh

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Kincaid Dunn	Club Nova
Bebe Smith	UNC Psychiatry CB7160 Chapel Hill NC 27599
Kathryn Melissa Peck	Member - Club Nova, Singer, CH
BETTY CRAVEN	WARNER FOUNDATION
MICHAEL WARNER	MENTAL HLTH ASSO. IN ORANGE COUNTY
Ran Coble	NC Center for Public Policy Research
Miguel Hall	Forever Young Group Care 4761 Redford Rd. Fay. NC
A.B.	Clubhouse Sponsor for Senate Positions
Shannon Clay	Threshold Clubhouse 609 Gary St. Durham N.C. 27703
Vonda Burton	Piedmont Pioneer House, Inc. 910 Roberts Drive Gastonia NC 28054
David J. Barnett	Threshold clubhouse 609 Gary St Durham N.C. 27703

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
~~Nancy Clark~~	
Mary Bode	AARP-NC
Martha Lowrance	YAIO/DDA
Kelly Kemp	Nat'l Alliance on Mental Illness NC
Julia Leggett	The Arc of NC
Sally Cameron	NC Psychological Assoc.
Kathleen Herr	Student, NCCU School of Law
MARC JACQUES	North Carolina Mental Health Consumers' Organization
Kim Schmidt	NC MHCO Raleigh
Kathy Griffin	Oxford Building Solutions
Mary Boswell	NC SA Federation

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gail Boswell	NCCANSO Wilson, NC NC MHCO
Cynthia Billops	Community-Based Developmental Services, Inc. Fayetteville, N.C.
Yumekco Little-Singletary	Family Legacy Mental Health Services, Inc. 204 N. Person Street Raleigh, NC 27604
[signature]	MHA/NC Ral, NC
[signature]	MHANC / The Coalition
ALEXANDER DUDA	NCC PPR
Robert Hufham	Arrowhead Dr.
Becky Fields	FACT Specialized Services Jacksonville
TARA FIELDS	CFSA-NC
Tyrone McRae	Omega ILS
Delwin Clark	Omega Independent Living Services

VISITOR REGISTRATION SHEET

Mental Health — 1/13/2010

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Shutman	UNC
Lowell L. Siler	Durham County
Ellen Hallman	Durham Center, Durham, NC
Andy Anderson	Community Innovations, Inc
Victor Armstrong	Center Point Human Services
Laron Johnson	Rockingham Co. Human Services Director
Craig Cardwell	Reidsville Area Foundation
Emily Welborne	RHA
Catherine Goldsmith	DMA
Tara Larsen	DMA
Steve Owen	DMA

VISITOR REGISTRATION SHEET

Mental Health — 1.13.2010

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Will Woodell	Value Options
John Dern	Governor's Office
Brad Bannister	DJJDP
Deanna Gantt	Pride In NC
Ken Melvin	CASA
Betsy Brannon	DMH
CARL NOYES	PAI
John Bourdeau	Burke's County
Rebecca Troxler	NCACC
Lee Hilton	NCALTCF

VISITOR REGISTRATION SHEET

Mental Health — 1.13.2010

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
C. Covay	DMA
Michael Lancaster	DMH/DD/SAS
Flo Stein	DMH/DD/SAS
Jim Jarrard	DMH/DD/SAS
Lucky Walsh	DSOX
Tonya Wennings	DMH/DD/SAS
M. Watson	"
A Feezor	DHHS
Christina B Carter	DMH/DD/SAS
Renee McCoy	DHHS - OPA
Erica Nelson	Rep. Insko Intern

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kristie Brown	Britton + Crump, Inc / Bridges Project, LLC
Sandy Davidson	Davis Group Home
Louise Jordan	NAM. WAKE Board
Kalterne Wilson	North Carolina Quality Care Providers Association
Pamela Phillips	North Carolina Quality Care Providers Association
Danny Freeman	North Carolina Quality Care Provider Association
Jeff Carrington	Foot Genesis Group Home
Anne Hendricks, MD	Best Life Inc & Elites Consulting, LLC
Katayoun Tabrizi, MD	Psychiatrist
Barbara Moeykens	NC. Health & Wellness Trust Fund
Larsene Taylor	UE Local 150 DHHS-Div Council

VISITOR REGISTRATION SHEET

Mental Health

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tommy Gunn	Adventure House Shelby, NC
Fred Mead	Adventure House, Shelby, NC
Sheila Herring	Horizons Group Homes Inc Wadesboro, N.C.
Dy Vang	Horizons Group Homes, Inc. Wadesboro, NC
Charles Vang	Horizons Group Homes Inc Wadesboro, NC
Ethelyn Bengtson	Act Team, Carrboro, NC 27510
WENDELL D. WELLS	Horizons Group Homes, WADESBORO, N.C.
Kathy Baker	SRMH/DD/SAS LME
J. Smith	Club Manor Carrboro NC 27510
Karen Prewett	SRMH/DD/SAS-LME
Judy Truitt	OPC-MHC Chapel Hill, NC

VISITOR REGISTRATION SHEET

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cim Brailer	OPC LME 100 Europa Dr. Suite 490 Chapel Hill 27517
Rob Robinson	Durham Center LME 501 Willard St, Durham, NC 27701
Donna Revels	Companion Home Care 4820 Fayetteville Rd Lumberton NC 28358
C. Graham	Companion Home Care / STARS Youth Academy 4820 Fayetteville Rd. Lumberton, NC 28358
Judy St. Amour	companion home care / stars youth academy 4820 Fayetteville Rd Lumberton, NC 28358
Colleen Kochanek	NCCEP
Angie Bantker	SA Federation
Rob Thompson	Covenant with NC's Children
Mike VICARIO	NCHA - 240 WESTON PKWY, CARY NC
Jim SOUTHERN	CNC/ACCESS 803 TYVOLIA RD CHARLOTTE NC
Mary Shannon Thomas	STEP Comm. MH Clinic UNC-CH Chapel Hill

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

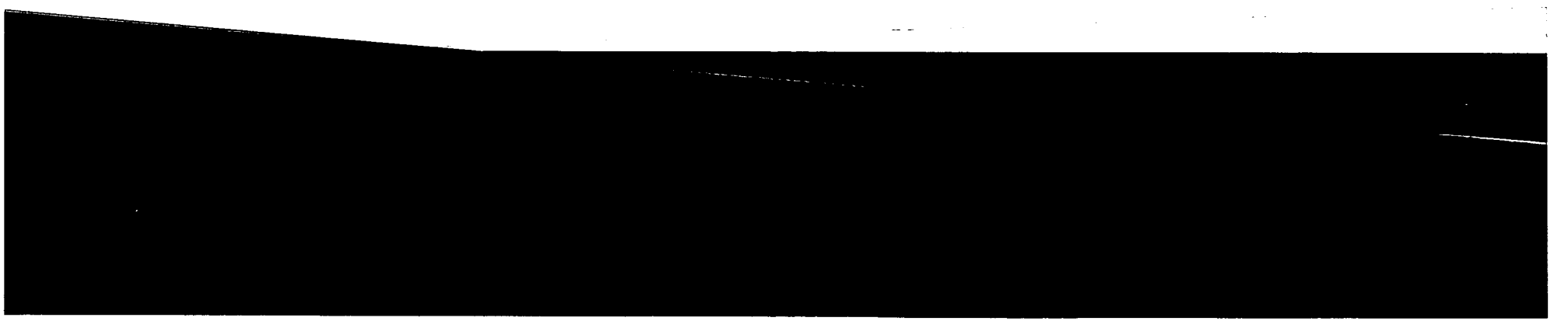
VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charles Perry	USISO DHHS. ~~DHHS~~
Richard Topping	PBH
Pam Shipman	PBH
Dan Coughlin	PBH
Erin McLaughlin	MAPNC
Jill Rushing	NCCDD
Rose Hoban	NC Public Radio, WUNC
Geoffrey Zeger	Social Worker

Attachment 2

Concerns about the CABHA Model

April Harris-Britt, PhD
Licensed Psychologist, HSP-P



Parts of the Old System that Contributed to the Problem

Unclear Service Definitions that allowed:

- Un- or undertrained individuals to provide mental health services.
- Lack of distinction between Community Support as a preventative model versus an intervention model, resulting in services that were recreational.
- Services without clinical oversight or linkage to Outpatient Therapy (OPT).

Changes that Have Already Improved the Quality of Services

- Increasing educational and training requirements for those providing enhanced services (no more PP's or AP's).

- Requiring a Licensed Clinician/Clinical Director within every agency.

Concerns about the CABHA Model....

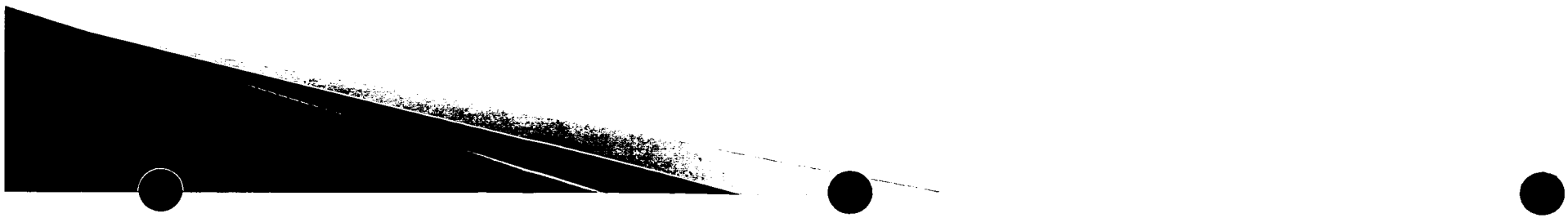
- Fraher, Swartz, & Gaul (2006) report revealed that the overall supply of psychiatrists in NC is severely limited.
- Within the last five years nearly two-thirds of North Carolina's counties have experienced a decline in Psychiatrists and approximately 17 counties had no psychiatrists as of 2004.
- So where will we find Medical Directors?

Concerns about the CABHA Model....

- If there are not enough Psychiatrists to serve as Medical Directors or as Lead Physicians for the hundreds of satellite sites that will have to be created to provide services in every county, what will happen to the clients and consumers in those areas?
- They will not receive services.

Concerns about the CABHA Model....

- Is having a Medical Director the *only* way to achieve competent clinical coordination of services?
- We should recognize that other trained, competent, licensed professionals can provide quality clinical oversight. Having them do so, may in fact be necessary in order to ensure that there are services for all those in need.

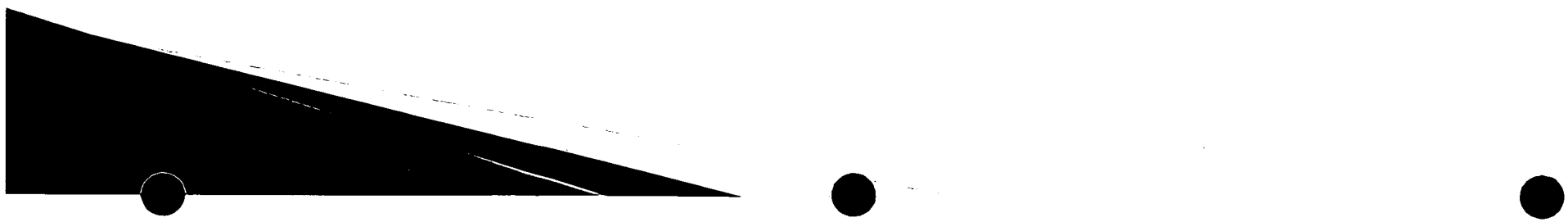


Concerns about the CABHA Model....

- What about consumer choice? What options will individuals have if they are dissatisfied with services of their local CABHA?
- An agency must already have a 3-year accreditation before applying as a CABHA. How can new agencies ever be opened?
- Mandating a required "menu" of services will result in agencies taking on services that they may not be comfortable or competent to provide.

Concerns about the CABHA Model....

- With so few Psychiatrists, so few CABHA's, the number of different services being required, and the anticipated consumer caseload of each large agency, case-by-case clinical oversight will be nearly impossible. So how will clinical quality be improved?
- Why not allow smaller agencies to exist?



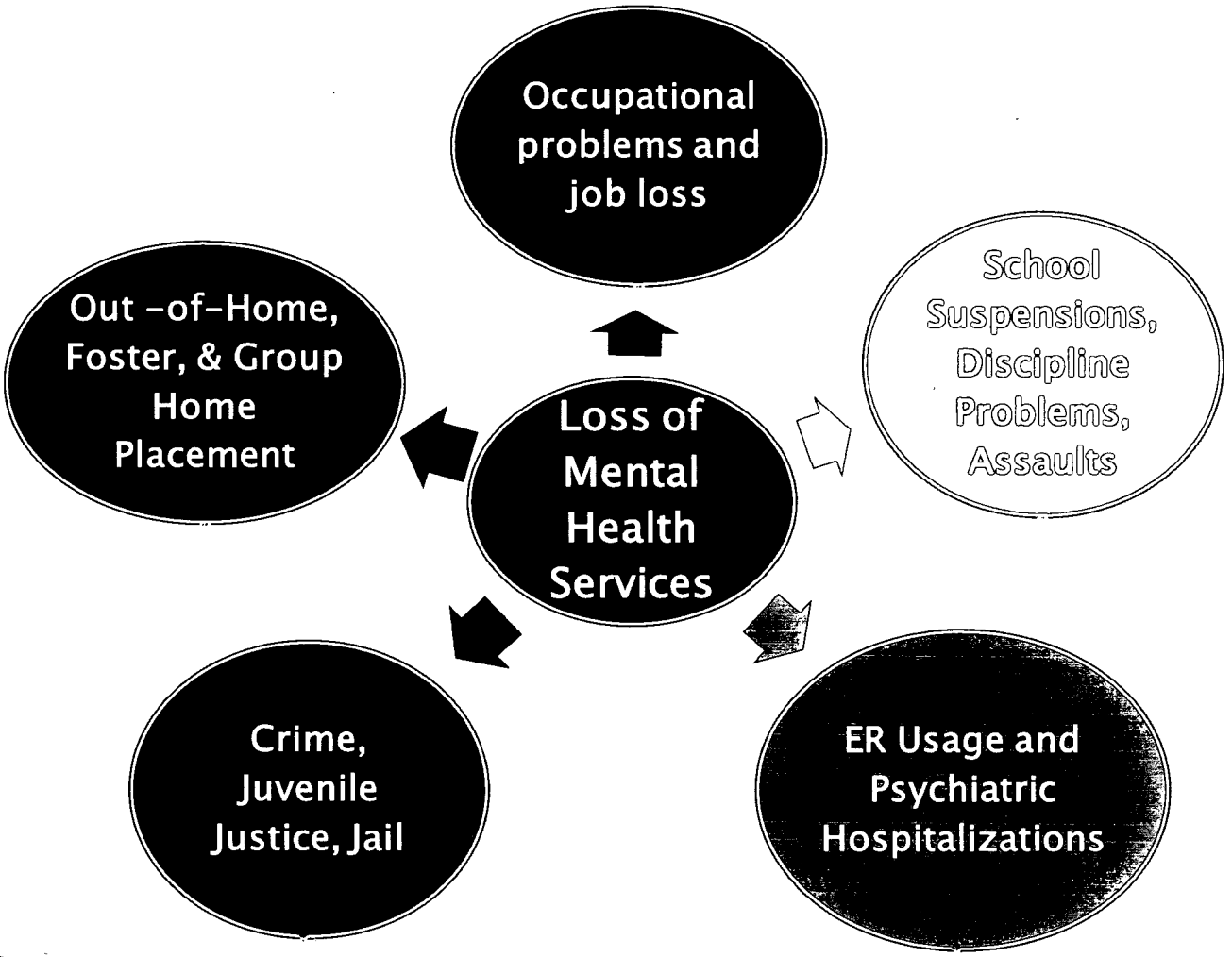
Improve but Do Not Eliminate Existing Agencies

- The untested CABHA model will not "fix" our mental health system.
- Why not implement a pilot of the CABHA model in several different areas of the state (rural and urban)?
- Obtain outcome data that assesses the feasibility and quality of the services, before mandating this model state-wide.

Improve but Do Not Eliminate Existing Agencies

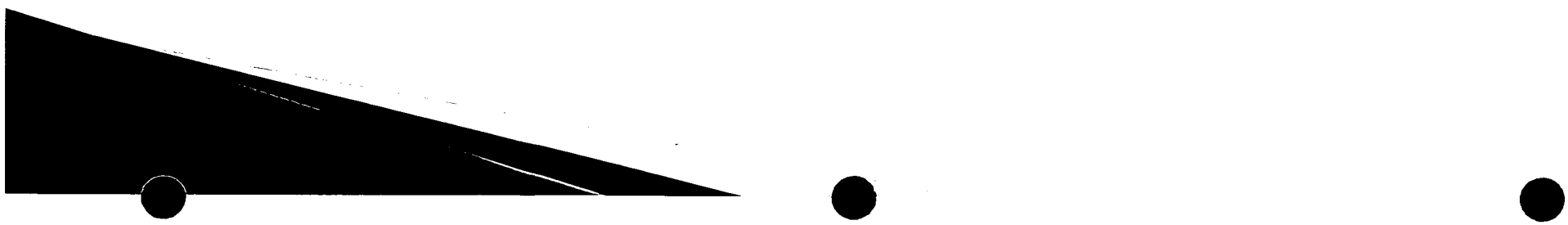
- Improve the quality of clinical services in existing agencies, large and small.
  - Comprehensive and/or standardized assessments.
  - Training and supervision in culturally sensitive, evidence-based models.
  - Services should be time-limited, during crises, to support previous or ongoing therapeutic interventions

Effects of Loss of Services



There are already so few resources for individuals with mental health needs in this state.

PLEASE do not make what services are available, less available to our children, adults, and families.



- Contact Information:
  Harris_Britt@msn.com

- Reference: *The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform.*
  http://www.shepscenter.unc.edu/hp/publications/Psychiatrist_Brief.pdf

DHHS: MH/DD/SAS STRATEGIC INITIATIVES

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
January 13, 2010

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

1

PRESENTATION FORMAT

- Structure & Goals
- Current Realities in Community System
- Cross Disabilities Initiatives
- Mental Health Initiatives
- Substance Abuse Initiatives
- Developmental Disabilities Initiatives
- System Management: Local Management Entities (LMEs) & DMH/DD/SAS

2

STRUCTURE & GOALS

- Ambitious agenda – Given Limited Resources
- Focus on Practical/Concrete Issues (1 – 2 year statement of Strategic Initiatives)
- Focus on Quality Concerns in Community System
- Provides opportunity for consumer, family and provider input into system change

3

STRUCTURE & GOALS CONT'D

- Driven by Realities/Values
- Initiatives reflects close coordination between DMA & DMH/DD/SAS
- Address the "New Realities" of our post-reform world

4

STRUCTURE & GOALS CONT'D

- Provides framework inside which to understand current budget/program/management initiatives
- Reflects a number of initiatives associated with Legislative requirements
- Set of initiatives connected by common themes

5

CURRENT REALITIES

- Strategic Initiatives must recognize the following realities with regard to our current community system:
  - Need to create a more Stable System
  - Significant concerns with Service Quality – Critical Focus
  - Need/Demand exceeds existing resources
  - Limited resources require that we focus on clear coherent objectives

6

CURRENT REALITIES CONT'D

- Need to set clear policy direction for Providers/LMEs
- Create financial incentives/payment mechanisms that support quality consumer outcomes
- Address legislative mandates/timeframes/special provisions regarding system management

CURRENT REALITIES CONT'D

- Support the development of a quality provider network
- Protect critical Core/Crisis Services
- Provide the tools essential to the management of our "Free Market" service environment
- Increase Accountability, Credibility, Efficiency & Consistency within the System

CURRENT REALITIES CONT'D

- Expand community inpatient psychiatric capacity
- Require the utilization of best practice service models
- Support consistent local system management – clear roles/accountability/economies of scale
- More anticipatory/less reactive management strategies
- Create system on which we can build as funding returns
- Need for constant monitoring & feedback on system changes

CROSS DISABILITY INITIATIVES

- Review critical Medicaid/State Funded Service Definitions
  - Require Evidence Based Practice Models
  - Strengthen Clinical Supervision Requirements
  - Strengthen Provider Qualifications (CABHA)

10

CROSS DISABILITY INITIATIVES CONT'D

- Expansion of Medicaid Waivers 1915 (b) (c)
  - Supports capitated, at risk Medicaid Services for MH/DD/SAS consumers
  - December 17, 2009: Technical Amendment (TA) submitted to CMS
  - TA turns modified version of Piedmont Wavier into NC Waiver for Statewide implementation
  - Plan: 1 – 2 new LMEs to join waiver during FY 10-11

11

CROSS DISABILITY INITIATIVES CONT'D

- Selection of 1 – 2 LMEs in June 2010 (RFP Process)
- January 2011 Start up – Expanded waiver sites
- Waivers generate predictable Medicaid costs & best practice financial incentives
- Impact on number and size of LMEs (economies of scale/risk management)
- Returns Medicaid Utilization Management (UM) to the community
- Combines Medicaid/State funded UM activities at the community level

12

CROSS DISABILITY INITIATIVES CONT'D

- CABHA Implementation (How does it fit in?)
  - Support Quality Services
  - Increased Medical/Clinical oversight
  - Improved 1st Responder/Crisis Capacity for CABHA consumers
  - Increased System Accountability
  - Supports movement into a Medicaid Waiver Environment by creating more comprehensive service providers
  - Planned Implementation Date: July 1, 2010

13

CROSS DISABILITY INITIATIVES CONT'D

- Support Provider Training and Development
- Performance Improvement Collaborative (PIC) continue to identify new and promising practices
- Strengthen Provider Endorsement Process
  - Include Clinical Interviews in process
  - Monitor LME consistency/look behind reviews

14

CROSS DISABILITY INITIATIVES CONT'D

- Workforce Issues
  - Working with Academic Centers to identify additional training/internship opportunities designed to encourage students to enter public sector service
  - Continue to expand the use of telemedicine
  - Support permanent approval to train and employ additional categories of licensed clinicians to perform 1st Evaluation for Involuntary Commitment - expand statewide

15

CROSS DISABILITY INITIATIVES CONT'D

- Increase Consumer and Family Ownership
  - Implementing opportunities for self-direction in Supports waiver (also included in Medicaid waiver expansion)
  - Implementation of Peer Support services as a Medicaid-covered activity for MH/SA
  - Working with State and Local CFACs and statewide consumer and family self-advocacy groups to develop avenues for increased consumer and family input
  - Implementing revised Person Centered Plan with additional training designed to focus on intent of understanding the consumer's strengths and goals, rather than focusing on the form itself

16

CROSS DISABILITY INITIATIVES CONT'D

- Primary Health Care Integration
  - Foster CCNC/LME Care Management Coordination around high cost/high risk consumers
  - Develop Care Management Protocols between LMEs & CCNCs
  - Integrate CABHA Medical Directors in the Primary Care Integration efforts
  - Increase psychiatric training/support capacity within the CCNC Network

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MENTAL HEALTH INITIATIVES

- Increase Community Psychiatric Inpatient Capacity
  - Implement/Monitor new and existing 3-Way Hospital Contracts
  - Transfer funds among contracts to insure full utilization
  - FY 10-11 Funding Request (Annualize existing contracts/expansion opportunities)
  - Reduce short term admissions to State Hospitals
- Support the Development/Refinement of Community Crisis Services (e.g. Mobile Crisis Teams, Walk-in Crisis Services, Provider 1st Responder Capacity)

18

MENTAL HEALTH INITIATIVES CONT'D

- Improved Outcomes for Consumer Discharged from State/Community Hospitals
- Address Community Issues Regarding Emergency Room Waiting Times for MH/SA Consumers
- Support the Development of Recovery Oriented Services
  - Development Alternative Payment Vehicles
  - Address data collection/outcome issues

19

MENTAL HEALTH INITIATIVES CONT'D

- Phase out Community Support Services (June 30, 2010)
- Introduce Peer Support and Case Management as new services in the Medicaid/State funded Service Array – July 1, 2010
- Develop Alternative Payment Mechanisms for Community Support Teams (CST)
- Continue Refinement of Community Child MH System – reduce dependency on Level III – IV Group Homes/Identify Service Gaps
- Introduce Therapeutic Family Services (TFS) as new Child MH Residential Service

20

SUBSTANCE ABUSE INITIATIVES

- Increase the recovery-orientation of the system through increased provider clinical competence (CABHAs) and the use of evidence-based practices.
- Use the Waiver and other avenues to develop more flexible ways to purchase SA services, recognizing the negative demand curve for those services.
- Monitor CABHA SA referrals & treatment patterns

21

SUBSTANCE ABUSE INITIATIVES CONT'D

- Offer technical assistance to SA providers to help them become financially successful in a fee-for-service environment, recognizing that far fewer SA consumers are Medicaid eligible but federal parity legislation (and, potentially, health care reform) will begin to mean more SA consumers have insurance benefits.
- Continue to refine and expand the Cross Area Service Program concept to make more SA services available on a regional basis.

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DEVELOPMENTAL DISABILITIES INITIATIVES

- Expand Implement of 1915 (c) Waiver (Developmental Disabilities) to 1 – 2 additional LMEs by January 2011
- Prepare a new Traumatic Brain Injury (TBI) Waiver for funding consideration
- Review use of State DD funds—Can they be better leveraged as Medicaid Match?

23

DEVELOPMENTAL DISABILITIES INITIATIVES CONT'D

- Monitor/refine implementation of DD Start Teams (Specialized Crisis Service) and increase collaboration with Mobile Crisis
- Develop Improved Resource Allocation Methodology for DD funds — Supports Intensity Scale (SIS)
- Develop standardized authorization guidelines for LME funded DD Services
- Monitor utilization of new Tier I CAP MR/DD Slots

24

DEVELOPMENTAL DISABILITIES INITIATIVES CONT'D

- Develop Waiting List Methodology for DD Consumers at the Community Level

25

SYSTEM MANAGEMENT (STATE & LOCAL)

- Local Management Entities (LMEs):
  - Expand Medicaid Waiver Program
    - Add 1 - 2 New LMEs by January 2011
    - Impact size/number of LMEs
    - Must be able to assume risk (Organizational Models)
    - Local Management vs. Efficiency & Economies of Scale
  - Work to expand Community Psychiatric Inpatient—reduce ER waiting times
  - Improved Consistency in provider endorsement and monitoring—add Clinical Interviewing to the endorsement process

26

SYSTEM MANAGEMENT (STATE & LOCAL) CONT'D

- Transfer of Medicaid Utilization Management function to two LMEs (Durham & Eastpointe) by July 1, 2010.
- Support CABHA development and implementation
- Continued IT Improvements
- Implement standardized protocols for the coordination of primary care/behavioral health care integration

27

SYSTEM MANAGEMENT (STATE & LOCAL) CONT'D

- DMH/DD/SAS:
  - Review Staff Capacity vs Emerging System Demands (workload + skill sets)
  - IT/Information Upgrades/Management Reporting
  - Increased Data Sharing (Hospitals/LMEs/Primary Care)
  - Paperwork Reduction-LMEs/Providers
  - Joint DMA & DMH/DD/SAS monitoring of Medicaid Service Array changes

28

SYSTEM MANAGEMENT (STATE & LOCAL) CONT'D

- Monitoring LME Reserve Fund Utilization
- Implement new State Funded Service Definitions
- Monitor Utilization of State funds by CAP recipients
- Review/Update DHHS/LME Annual Contract

29

CONCLUSION

- Strategic Initiatives Designed to:
  - Focus Limited Resources on the Delivery of Quality Services
  - Foster Efficiency, Accountability, Consistency and Credibility
  - Provide Direction for Future System Development

30

CONCLUSION CONT'D

- Successfully Transition Increased System Management Responsibilities to the Community Level (Medicaid Wavier)
- Encourage the Implementation of Best Practice Service Models
- Reflect the Financial Realities That Confront our System
- Create a More Stable & Clinically Sound Service Environment

31

13 January 2010

Meeting of the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

Presented by:
UE local 150, NC Public Service Workers Union

Representing workers at Cherry Hospital, Central Regional Hospital, Dorothea Dix Hospital, Broughton Hospital, Murdoch Center, Caswell Center, Longleaf Neuro-medical Center, O'berry Center, and Eastern NC School for the Deaf

Overview:

Since its implementation in January 2009, the Zero Tolerance policy in Department of Health and Human Services (DHHS) has resulted in dozens of seasoned, skilled workers losing their jobs over minor incidents and hundreds of workers and patients getting badly injured. Many experienced staff including Health Care Technicians, Registered Nurses, Licensed Practical Nurses, Social Workers and Psychiatrists have quit their jobs in fear of losing their professional licenses or of getting permanently injured at work. This worsened the quality of care for the patients that are already struggling to get adequate services.

Currently, workers are not allowed to put their hands on patients to protect themselves or the patients. With Zero Tolerance in place when incidents do occur, actual abuse and neglect is not distinguished from oversight. In addition, workers should not be disciplined harshly when understaffing, lack of training, equipment or other managerial issues are the cause of the problem.

Urgent:

We call for an end to the Zero Tolerance Policy.

January 13, 2010 - Meeting of the LOC for MHDDSAS

Presented by: UE local 150, NC Public Service Workers Union

Case studies since beginning of Zero Tolerance Policy (see attached fliers):

These are just a very few of the overall incidents resulting from Zero Tolerance primarily focusing on CRH and Dix, given the LOC's upcoming site visit.

Firings:

1. Greg Williams - Longleaf Center - March 2009 - fired for clipping nails of patient too short.

2. Candace Perkins - Dorothea Dix - July 2009 - fired for talking too loudly to patient.

3. Weldon Thomas, Cedric Lewis, Kenneth Gaddy, Charles Bennett - Central Regional Hospital - June 2009 - fired for failing to do 15 minute observation rounds while working 3rd shift.

4. James Crawford - Central Regional Hospital - December 2009 - fired for taking eye off patient for 2-3 minutes while on observation.

* All workers mentioned above had either 1 or zero write-ups in their personnel file prior to incident.

Injuries:

1. Donnell Cooley - CRH - Punched 4-5 times in the face which resulted in broken orbital bone (eye socket), and many other facial bones such as upper jaw and nose were fractured or injured and nerves in eye/face injured. His glasses were also broken and his sight was impaired. The other workers present at the time were not able to respond in a timely manner to intervene because of the overwhelming fear of doing an improper hold or restraint, like those that had resulted in the loss of many workers jobs recently.

2. Amos Smith - November 2009 - Beaten badly by patient and damaged bones in right elbow.

3. Bobby Turner - October 2009 - Patient bit her arm through the flesh, kicked her several times, bruised upper and lower arm, bruised stomach. Same patient head-butted another staff.

4. Sandra Moss - CRH - January 2010 - Twisted her wrist badly while working with a large, heavy patient that had just injured 3 other workers. Sandra was then forced to stay overtime with the injury to work the next shift to cover an understaffed ward. In December, another worker, Mary Outlaw was injured by patient and left work, Sandra was forced to stay to monitor 8 patients by herself.

Institution	Workers Injuries 6 Months Before Zero Tolerance	Worker Injuries 6 Months After Zero Tolerance	Percent Increase
JUH/CRH	254	295	16%
Cherry	137	196	43%
Dorothea Dix	293	153	-48%*
Broughton	291	295	2%

* Patient levels at DDH significantly decreased and staffing levels improved.

Note: Injuries post-Zero Tolerance are not only more common but according to workers reports to UE150, they have also increased in severity.

Mental Health Worker Abused Broken Bones in Face Zero Tolerance for Unsafe Conditions!

On Mon. August 3, Healthcare Tech Donnell Cooley was assaulted by a patient while working at Central Regional Hospital. He was punched 4-5 times in the face which resulted in **broken orbital bone** (eye socket), and many other facial bones such as **upper jaw and nose were fractured or injured and nerves in eye/face injured**. His glasses were also broken and his sight was impaired.

Donnell Cooley day after attack, Aug 4.

The other workers present at the time were not able to respond in a timely manner to intervene because of the overwhelming fear of doing an inproper hold or restraint, like those that have resulted in the loss of many workers jobs recently.

This fear is especially great with a Zero Tolerance policy and in a period of heightened unemployment, budget cuts and lay-offs. Cameras were also above head recording the situation. Several workers were fired unjustly in early June due to camera "evidence" and Zero Tolerance policy.

The **Zero Tolerance policy**, which scapegoats workers for the problems of the DHHS as a whole, along with an **inadequate grievance procedure that denies due process and representation in grievance hearings,** must be changed before **MORE WORKERS AND PATIENTS ARE INJURED**. This will only happen through our collective action and through building a strong union!

Donnell Cooley Speaks Out!

"Our lives are constantly at risk, he could have killed me. Workers really don't have any rights and if we do something wrong, then we ain't got a job. I seen many people lose their jobs since I have been over there. I have been there 20 years and never abused a patient and we shouldn't abuse patients. However, we cannot even put our hands on the patients. There should be Zero Tolerance for unsafe work conditions! With the major cuts in mental health funding this is a urgent matter of public concern." - Cooley, August 10, 2009

Help Defeat Senate Bill 800 and Defend our Rights!

Senate Bill 800 titled "Unpaid Investigatory Suspensions/DHHS" would further scapegoat workers for the problems of inadequate work conditions and assume workers are guilty until innocent.

Call Rep. Sutton at 919-715-0875 and Sen. Rand at 919-733-9892 and tell them to VOTE NO to SB800 and have Zero Tolerance for Unsafe Work Conditions in DHHS!

UE 150 – N.C. PUBLIC SERVICE WORKERS UNION

STAFFING FOR SAFETY

FAIRNESS NOT FIRINGS

DANGER ZERO TOLERANCE INJURES PATIENTS AND WORKERS

TIRED OF:

Unjust Firings?

Daily Injuries?

Bad Training?

Unfair Grievance Procedure?

Understaffing?

On Jan 5, 2010, CRH worker Sandra Moss twisted her wrist badly while working with a patient that had just injured 3 other workers. Sandra was then forced to stay overtime with the injury to work the next shift to cover an understaffed ward.

DEMAND:

END Zero Tolerance Policy—Allow hands on to protect patients, workers; separate actual abuse from oversights; don't discipline workers when conditions cause the problem

SAFE Staffing—Safe worker to patient ratio; no forced overtime; full time permanent staff

Training for SAFETY—More effective, regular trainings with more hours

FAIR Grievance Process—Due process: grievance assistants, access to all documents

FIGHT BACK! Zero Tolerance for Unsafe and Unfair Conditions

In coming days and weeks, we call on ALL workers to

1. File Formal Grievances
2. Call OSHA about Unsafe Conditions - **Call OSHA at (800) 625-2267**
2. Call DHHS Secretary Cansler to end the "zero tolerance" policy

Speak-Out to State Legislators!

Wed, Jan 13th 12noon - 2pm
Legislative Office Building, Room 643
300 N. Salisbury Street, Raleigh, NC

March in HKonJ

Join thousands in the 4th annual march for collective bargaining rights, living wages, end to wars, better schools and an entire People's Agenda!

SATURDAY FEB 13TH, RALEIGH

INTERNATIONAL WORKER JUSTICE CAMPAIGN "Building the Movement for Collective Bargaining Rights"

UE150 Mental Health Workers Bill of Rights Campaign • (888) 448-3150 • workerjustice@gmail.com

Mental Health Workers Bill of Rights

Mental healthcare workers provide care for people with special needs. In order to provide quality care, there must be basic rights and standards that every mental healthcare worker has a right to expect.

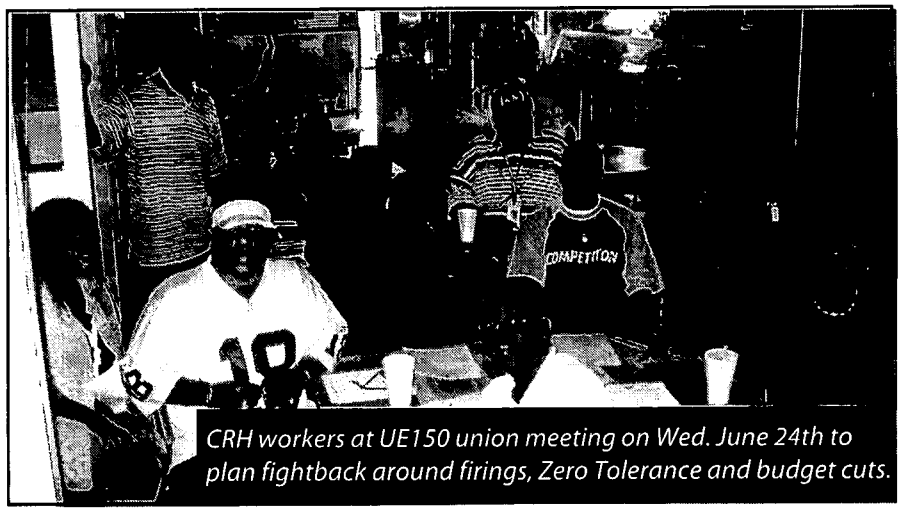
Core elements of a Mental Health Workers Bill of Rights include:

1. The right to a safe workplace, including the right to protect oneself from harm with consideration for the safety of the patients, and the right to refuse work that poses a danger to one's health and safety.
2. The right to adequate staffing levels.
3. The right to adequate and updated equipment and techniques to ensure safer working conditions and quality care for patients.
4. The right to family-supporting wages so that mental healthcare workers can devote their time to the care of their patients and not have to take on second jobs.
5. The right to refuse excessive overtime.
6. The right to a timely briefing about the behaviors of patients that workers are assigned to care for.
7. The right to be treated with respect and dignity regardless of job classification.
8. The right to fair and equal treatment and opportunities regardless of race, gender, age, national origin, immigration, sexual orientation, physical abilities, or religion.
9. The right to a grievance procedure, which includes the right to grieve all matters that can impact safety, evaluations, raises, transfers and promotions with representation of ones choice at all levels.
10. The right to have input in decisions impacting working conditions in the facilities where one works and at the Division and Legislative levels.
11. The right of workers to evaluate the performance of their supervisor as one of the criteria for their raises and ongoing duties.
12. The right to engage in collective bargaining over terms and conditions of work.

UE 150 – N.C. PUBLIC SERVICE WORKERS UNION

Re-Instate Fired CRH Workers - End Zero Tolerance Don't Balance Budget on our Backs! - Stop Racism!

With the looming $4.6 billion state budget deficit, the legislators and Governor Perdue are exerting lots of pressure on DHHS to make cuts that will have long-term effects to our jobs and communities. Gov. Perdue and DHHS Sec. Cansler continue to scapegoat workers for problems such as understaffing, lack of adequate training and input to decision making and continue on Zero Tolerance witch hunt, completely by-passing due process, and targetting primarily Black workers.



CRH workers at UE150 union meeting on Wed. June 24th to plan fightback around firings, Zero Tolerance and budget cuts.

Sign the Petition!

UE150 is circulating a petition calling for the reinstatement of Weldon Thomas, Cedric Lewis, Charles Bennett, Kenneth Gaddy, Keith Green, Elton Garner, Albert Hatcher, Beatrice Parker, Bobby Woody, and Lynwood Strickland as they have either been fired or suspended as a result of the unfair conditions. In addition, all fired workers are African American while we have noticed several cases where white workers were not given equally harsh discipline for similar actions. We say the racism of CRH administration must end now!

Linda Grimaldi, Vicki Williams and others in management should face disciplinary action up to dismissal for their on-going harassment of workers, racism and unjust actions.

Take Action!

- **Attend weekly Prayer Vigils for Justice Starting Wed, July 1, 7:45am CRH Parking lot**
- **Wear Red on Wednesdays to show unity and resistance.**
- **Attend Union Meetings, Monday, June 29th, 7:30am, 2:15pm and 3:30pm at Sam's Grill.**
- **Come to Raleigh to speak to Legislators Wed, July 1, leave CRH parking lot 9am**
- **Attend Worker Speak-out, let the community hear our story Time, location TBA soon! In local church**
- **File grievances about understaffing, harassment, racism or other work conditions.**

JOIN AND BUILD UE LOCAL 150, NC PUBLIC SERVICE WORKERS UNION
OFFICE TOLL FREE # 1-888-44-UE150

UE 150 – N.C. PUBLIC SERVICE WORKERS UNION

STAFFING FOR SAFETY

FAIRNESS NOT FIRINGS!

DANGER **ZERO TOLERANCE INJURES PATIENTS AND WORKERS**

TIRED OF:

Unjust Firings?

Daily Injuries?

Bad Training?

Unfair Grievance Procedure?

Understaffing?

Just two of the DHHS workers casualties of "Zero Tolerance" policy, understaffing, poor training, and unjust grievance procedure: HCT Donnell Cooley (left) almost lost an eye; RN Bobby Turner (right) was bitten through her skin.

DEMAND:

FAIR Zero Tolerance Policy—Allow hands on to protect patients, workers; separate actual abuse from oversights; don't discipline workers when conditions cause the problem

SAFE Staffing—Safe worker to patient ratio; no forced overtime; full time permanent staff

Training for SAFETY—More effective, regular trainings with more hours

FAIR Grievance Process—Due process: grievance assistants, access to all documents

FIGHT BACK! *Zero Tolerance for Unsafe and Unfair Conditions*

In coming days and weeks, we call on ALL workers to

1. File Formal Grievances and call OSHA about Unsafe Conditions - **Call OSHA at (800) 625-2267**
2. Call DHHS Secretary Cansler to change the "zero tolerance" policy
3. Call on faith, community, student allies to oppose "Zero Tolerance policy"
4. Join the UE150, the NC Public Service Workers Union - more info (888) 448-3150

Campaign Press Conference Kick-Off

Monday, November 16th
Butner
Place & time: to be announced

INTERNATIONAL WORKER JUSTICE CAMPAIGN "Building the Movement for Collective Bargaining Rights"

UE150 Mental Health Workers Bill of Rights Campaign • (888) 448-3150 • workerjustice@gmail.com

UE LOCAL 150 – NORTH CAROLINA PUBLIC SERVICE WORKERS UNION 26 FEB 2009

BILL OF RIGHTS

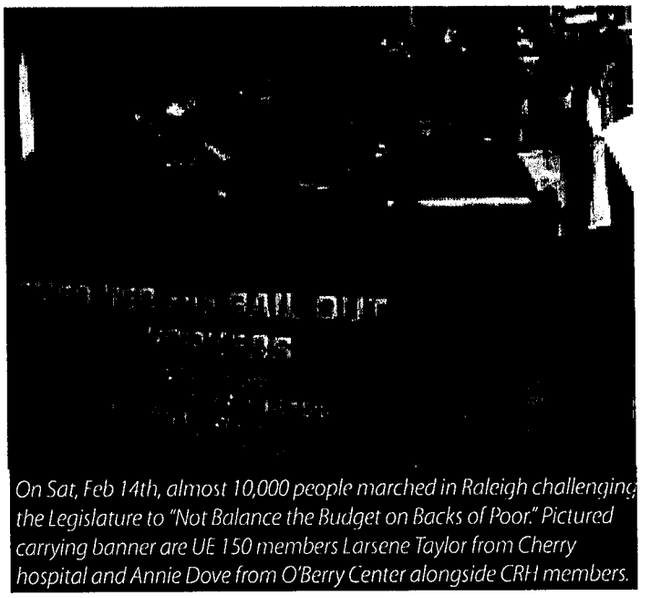
NC Abuses Workers w/ Understaffing, Much Overtime

AAU Fights 3 Weekends per Month

Due to understaffed wards, workers on AAU were forced to work an extra weekend in February, taking valuable time from our families. Over 70 workers signed a petition circulated by union members to collectively express their outrage.

Unit Nurse Manager, Linda Grimaldi, responded by organizing a meeting and promised workers that the hospital would hire more staff so that 3 weekends would only be needed for the month of February. Now management is saying it will extend into March too!

We will continue to organize and collectively challenge this so that it will not continue or spread to other units around the hospital.



On Sat, Feb 14th, almost 10,000 people marched in Raleigh challenging the Legislature to "Not Balance the Budget on Backs of Poor." Pictured carrying banner are UE 150 members Larsene Taylor from Cherry hospital and Annie Dove from O'Berry Center alongside CRH members.

Rehab Mandates Excessive Overtime

Management on Rehab has mandated excessive overtime hours. Many are working as much as 100 hours of overtime per month! This makes us tired, stressed and difficult to provide quality care to our patients.

This overtime has caused wear and tear on our bodies that has contributed to staff injuries - such as pulled muscles and hurt backs.

Workers Continue to be Blamed for Problems of the System

Since Gov. Perdue and DHHS Sec. Cansler rightfully stated they would accept "zero tolerance" for patient abuse, good workers continue to be inappropriately placed on leave, fired and brought up for criminal charges. Workers deserve fairness!

CRH 5 fired workers from AAU still need your support!

They still have not yet heard a decision from their hearing, we need to keep the pressure on!

Call DHHS Sec. Cansler 919-733-4534 to demand:

- N.C. Stop Blaming Front-line workers for the problems that are a result of understaffing, lack of training, mandatory overtime and stress.
- Rehire the CRH 5 - Pat Swan, Fred Gooch, Tim Strong, John Long Jr and Ben Hicks.

Two Actions This Week: Speak Out for Justice!

Make Voice Heard at Legislature

Tuesday, March 3rd, 10am - 2pm

1. Mental Health Workers Bill of Rights 2. NC: Stop Abusing Mental Health Patients and Workers 3. Full staffing 4. Collective Bargaining 5. Stop Merger of Dix and CRH, 6. Cost of living increase and raise, 7. Medical insurance - no premium or co-pay increase

Meet in CRH Parking lot to carpool to Raleigh, contact Bernell Terry, AAU 2nd shift union steward at 252-425-1162

Prayer Vigil, NC Stop Abusing Patients and Workers

Thursday, March 5th 7:30am, 2pm and 3:30pm

Smoke area by picnic tables in front parking lot of CRH

UNION MEETINGS: (Changed) MONDAYS 7:30am, 1:30 & 3:30pm at Sam's Grill

Join and build the UE150, NC Public Service Workers Union! For more info call 919-539-2051

UE LOCAL 150 – NORTH CAROLINA PUBLIC SERVICE WORKERS UNION 11 MARCH 2009

WORKERS BILL OF RIGHTS CAMPAIGN

DHHS Workers Speak Out

Against "Zero Tolerance" Unfair Firings

Since February, when Gov. Perdue and DHHS Sec. Cansler stated they would accept "zero tolerance" for patient abuse, over 30 workers have been inappropriately placed on leave, fired or brought up for criminal charges. We too believe patients should be free from harm, but this new policy does not address systemic problems instead it scapegoats us, the front-line workers.

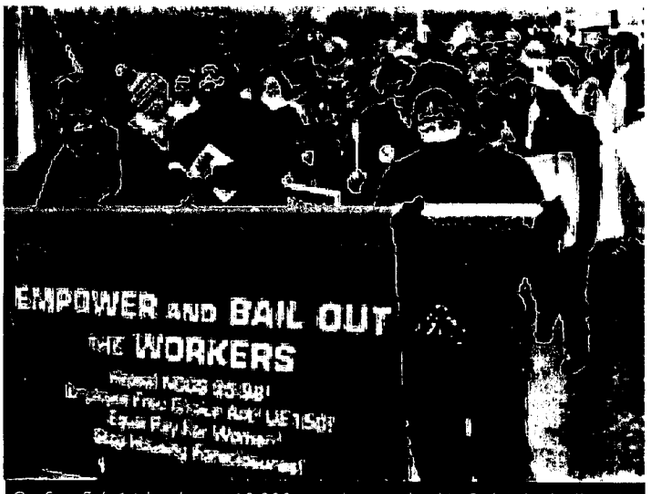
Bert Reddick, CRH, Out of Work on Criminal Charges, Speaks to Press

Bert Reddick, who was nominated as Employee of the Year, at Central Regional Hospital last year for his excellent work with children patients, is now being brought up on criminal charges for an abuse he says is insubstantiated. The state has done two investigations, both finding Bert innocent.

Bert knew that he could not sit by silent and let this happen, so he called the News and Observer and they wrote an article about his case where they quoted him saying, "It just sort of goes along with the territory,...Everyone that works there for any length of time will be accused at some point." We must speak out too so it won't happen to you next.

Greg Williams, Longleaf Center, Fired, Fights Back

UE 150 union member, Greg Williams, a HCT at Longleaf Center in Wilson, is another example of the way the state is scapegoating workers for the problems of the system. He, along with two other workers, were fired last week for an incident where a patients nails got clipped too short. He has been speaking out but needs your support or you will be next. He told the N&O, "They said we violated the patient's rights... All we were trying to do was keep her from harming others [with her long nails]." Stayed tuned on Greg's grievance.



On Sat, Feb 14th, almost 10,000 people marched in Raleigh challenging the Legislature to "Not Balance the Budget on Backs of Poor." Pictured carrying banner are UE 150 members Larsene Taylor from Cherry hospital and Annie Dove from O'Berry Center alongside CRH members.

Sign Petition for "Worker Policy Review Committee"

DHHS policies were forced upon workers without our input. Instead of building confidence among front line workers to provide quality care, we are fearful of taking initiatives and confused about the lines of communications and accountability in carrying out our assignments.

Many of us are being fired from careers that we love and have dedicated our lives too, including have our hard earned credentials tainted.

Many workers around the state are circulating a petition calling for the establishment of a permanent "Workers Policy Review Committee" at each DHHS institution that consists of HCT's, BT's, LPNs and RN's that will be given the power to review and draft updates in policies as needed.

Longleaf UE150 Union Meeting

Tues, March 17th, 3:30pm

2nd Floor, Activity Room

Discuss: 1) "Zero Tolerance" for abuse policy and how it impacts workers.
2) Political Action at Legislature
3) other issues important to you!

Join and build the UE150, NC Public Service Workers Union! For more info call 919-539-2051

Critical Access Behavioral Health Agency (CABHA) UPDATE

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

January 13, 2010

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

1

CABHA QUESTIONS & UPDATES

FROM THE DECEMBER 2009 MEETING

2

CABHA FUNDING

- Proposed Case Management (CM) Case Rate = $324.83 per consumer per month
- 27% of Rate ($89.30 per Case Management consumer per month) = CABHA Costs

3

CABHA FUNDING CONT'D

- CM Case Rate Covers:
  - Medical Director
  - Clinical Director
  - Quality Management/Staff Training
  - Associated Medical/Admin/Clinical Overhead

4

Clinical Director Specifications

- **Accepted licenses:**
  - Licensed Psychologist (Doctorate Level)
  - Licensed Psychological Associate
  - Licensed Professional Counselor
  - Licensed Marriage and Family Therapist
  - Mastered Degree Nurse – advanced practice only (NP, PNPs, etc.)
  - Licensed Clinical Addiction Specialist
  - Certified Clinical Supervisor
  - PA (with experience with population served)
  - Licensed Clinical Social Worker

5

CABHA FUNDING CONT'D

- CM Rate = 3.33 Hours of Case Management per consumer per month (Average)
- CABHA Specific Revenues (Average CM Case load):
  - 100 CM Consumers = $107,160
  - 150 CM Consumers = $160,740
  - 200 CM Consumers = $214,320
  - 400 CM Consumers = $428,640
  - **NOTE #1: CABHA break even point = 150-200 CM Consumers (50% MD) and 350-400+ CM Consumers (100% MD)**
  - **NOTE #2: Not all CABHA costs must be covered by CM. Clinical Director role is included in the cost of other service definitions and the Quality Improvement/Training functions are required by national accreditation and included in the rates for other services**

6

CABHA PROFITABILITY

- Service Mix
- Volume of Service
- Efficiency of Operations
- Economies of Scale
- **CABHA funding should not subsidize inefficient operations**

7

CABHA CERTIFICATION PROCESS

- Letters of Intent (Initial Stage)
  - Letter of Intent Received from 230 Providers
  - 26 Indicate they meet all criteria
  - Additional 35 indicate they will meet all criteria by April, 2010 (Staff hiring)
  - 133 out of 230 indicate that they do not currently meet the two Service Continuum requirement (most of these indicate that they are in the Endorsement process to add an additional needed service

8

CABHA CERTIFICATION PROCESS CONT'D

- 153 out of the 230 indicated that they did not meet the Medical Director Requirement. 115 of the 153 indicated they would have a Medical Director by April, 2010.
- 70 Providers lacked both a Medical Director and the two enhanced services

9

CABHA CERTIFICATION PROCESS CONT'D

- Letters of Attestation (2nd Stage)
  - Provider asserts that they meet all requirements
  - 20 Providers have submitted Letters of Attestation
  - 3 non-profit - 1 governmental - 16 for profit
  - **NOTE #1: Next Stage for these providers = desk review of documentation and check with DMA for compliance issues**
  - **NOTE #2: Consumer access and choice issues are significantly reduced as the number of certified CABHAs increase**

10

OTHER CABHA CERTIFICATION ISSUES

- DMH/DD/SAS setting up CABHA Certification Training for LME staff who will participate in the process
- DMH/DD/SAS preparing guidance on provider questions re: corporate structure, provider enrollment & provider endorsement

11

ADDITIONAL QUESTIONS

- Role of non-CABHA Providers:
  - Non-CABHA Providers may deliver all MH/DD/SA services with exception of Case Management, Peer Support, Day Treatment, Intensive In-Home Therapy & Community Support Team
- Who does Assessments?
  - Assessments may be done by all licensed clinicians regardless of CABHA affiliation
  - Impossible to determine the number of licensed clinicians who will/will not be associated with a CABHA
  - CABHA monitoring and oversight functions will be carried out by DMH/DD/SAS, DMA & the LMEs

12

First Commitment Waiver: Evaluation and Recommendations

DMH/DD/SAS
Nidu Menon, Ph.D.
Mark O'Donnell, M.P.H.
January 13, 2010

1

General Assembly Request

- General Assembly Request (**SESSION LAW 2007-504, HOUSE BILL 627**):
  - Can comparable competency be developed in Master's level professionals to evaluate an individual for first level commitment through training using a prescribed curriculum?
  - Will the immediate recommendation made by two professional groups be the same given the same set of information on an individual?

2

Why Expand First Commitment Capacity?

- A review of mental health and substance abuse professionals across the state of North Carolina show that:
  - In 2007, there were 32 counties across the state where there were no registered Psychiatrists; 26 counties that did not have a Psychologist.
  - In 2009, all but four counties in the state had one or more Licensed Clinical Social Workers (LCSWs); there were **1184 Licensed Clinical Addiction Specialists**; there were only **34 Master's level Psychiatric Nurses** in the state.
  - There were only **1,107 registered and active Psychiatrists** in the state of North Carolina and **1,801 PhD level Psychologists** in the State.

3

Why Expand First Commitment Capacity?

- Evident need to develop and supplement the workforce in order to meet the needs of individuals with mental health and substance abuse challenges who were in periodic need of first commitment evaluations across the state.

4

The First Commitment Process

- The process of involuntary commitment of an individual to a psychiatric hospital involves a "first level" examination by a Physician or an eligible Psychologist in a community setting.
- A Psychiatrist at the state psychiatric hospital then conducts a "second level" examination to confirm the need for involuntary commitment.

5

First Commitment Process

- First level commitment evaluations are typically done by Physicians/Psychiatrists or eligible Psychologists or, more typically, by emergency room physicians who are often aided by on-site Master's level licensed clinicians (Licensed Clinical Social Workers or Licensed Clinical Addiction Specialists, depending on the presenting individual's need and the scope of practice of the evaluating clinician).

6

First Commitment Waiver History

- In June 2003, the North Carolina legislature passed Session law 2003-178 (House Bill 883)
  - Secretary of the Department of Health and Human Services to develop a pilot program initially allowing up to five Local Management Entities (LMEs) to waive the current general statutes.
    - This waiver was instigated to evaluate whether licensed Master's level professionals could perform the initial examination for involuntary commitment as competently as Physicians/Psychiatrists and eligible Psychologists.

7

Phase I Pilot Study

- The first five LMEs that were selected by the Secretary to participate in the waiver were:
  - CenterPoint Human Services
  - Crossroads Behavioral Healthcare
  - Pathways MH/DD/SAS
  - Smoky Mountain Center
  - Piedmont Behavioral Healthcare

8

Phase I Pilot Study

- Data contributed by three of the five waivered sites, majority of the data coming from a single site.
- Master's level professionals are as accurate in referring a person to the second level evaluation as are Physicians/Psychiatrists or eligible Psychologists.
- No evidence that Master's level professionals released people when they should have been committed.
  - 162 individuals from the five pilot sites were evaluated by both Masters and Doctoral level examiners.
  - There was 97.5% agreement between Masters and Doctoral Level staff in their recommendations from First Level Examinations.

9

Phase I Pilot and Evaluation

- Recommendation from this study was that the pilot be expanded statewide to allow licensed Clinical Social Workers, Psychiatric Nurses, and Licensed Clinical Addiction Specialists to perform first level commitment examinations.
  - But the results were questioned and evaluation expanded in 2006
    - majority of samples coming from a single site,
    - lack of generalizability,
    - lingering questions about medical risk to individuals who were released.

10

Phase II Pilot and Evaluation

- In October 2007, the General Assembly extended the legislative waiver to five additional Local Management Entities and requested that the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) redesign the evaluation in an effort to obtain more conclusive results. (Session Law 2007-504, House Bill 627)

11

Phase II Pilot and Evaluation

- LMES were selected for the Phase II Pilot through a RFA process managed by DMH and approved by the Secretary.
  - Alamance-Caswell-Rockingham
  - Durham
  - East Carolina Behavioral Health
  - Eastpointe
  - Mecklenburg

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Phase II Pilot and Evaluation

- In January 2008, the Division of MH/DD/SAS reconvened the Stakeholders Advisory Committee (initially established during the first phase study) which included:
  - North Carolina Psychological Association
  - North Carolina Psychiatric Association
  - North Carolina Substance Abuse Board
  - National Association of Social Workers
  - North Carolina Council of Community Programs
  - North Carolina Medical Society
  - North Carolina Nurses Association
  - Representatives from the five Phase I sites (LMEs)

13

Phase II Pilot and Evaluation

- In designing this second evaluation, the Advisory group recognized the need to:
  - Balance the goals of expanding the work force in the state and ensuring the most desirable outcome for the individual being evaluated;
  - Address the perceived deficiencies identified by the Stakeholders Advisory Committee in the previous evaluation

14

Evaluation Plan

- The following evaluation plan was formulated after individual as well as group discussions were held with members of the Stakeholders Advisory Committee.
- The Committee agreed upon a plan that met all necessary conditions to produce a reliable and viable set of outcomes for evaluation purposes.

15

Evaluation

- The plan was to assess the level of agreement the trained, tested and certified Masters level professionals (LCASs and LCSWs) had in the recommendation they made on any given consumer with that of the Psychiatrists and Psychologists who are allowed to conduct First Commitment evaluation under the current statute.

16

The Process

- Consumer is brought in for First Commitment evaluation-
  - A masters level trained professional assesses the consumer;
    - Gathers information on the consumer on the prescribed assessment forms; and makes a recommendation on the consumer.
  - The standardized forms on which information was gathered is then given to three groups of professionals, [*Psychiatrists, Psychologists and a mix of Masters Qualified Social Workers and Substance Abuse*] who all ***independently*** review the assessment forms and make a recommendation on the desired immediate outcome.
  - All reviewers blinded on who did first assessment and recommendation made
  - The level of congruence was then determined between the four groups of reviewers.

17

The Reviewers

- Three groups of reviewers were identified
  - Representatives of the NCPA (Psychiatrists)
  - Representatives of NCPA (Ph.D. Psychologists)
  - Representatives of NCSAPPB/Local Management Entities (*all having received the First Commitment Evaluation training and all having been tested and certified as competent FC evaluators*)
  - The NCSAPPB/LME sites chosen were:
    - Durham Center
    - East Carolina Behavioral Health LME
    - Smoky Mountain-North LME

18

Preparation for First Commitment Evaluation: (Training/Testing/Certification)

- Each of the LCSW and LCAS reviewers and on-site FC evaluators were required to:
  - Participate in the three day structured class room training
  - Pass a standard test administered by the DMH/DD/SAS
  - Conduct 6 independent FC evaluations
  - Get sign off from a qualified eligible Psychologist or Psychiatrist on each of the recommendations made on the 6 consumers
  - Submit a letter from the supervisor stating that this phase has been successfully completed and the person is considered to be competent to conduct this evaluation

19

Who was included in the sample group?

- Any and all adult (>17 yrs of age) consumers being brought in for a First Commitment Evaluation
  - Any consumer with an Involuntary Commitment (IVC) petition filed

20

Sample Size

- By responding to the RFA the sites agreed to:
  - Provide the number of evaluations necessary to assess whether a statistically significant difference exists between the groups of professionals in their recommendation.

21

The Assessment Forms

- 3 data collection forms were identified
  - Mental Health Status Exam Form (developed locally)
  - The *Galatean Risk Screening Tool Version 3* (GRIST) Form (tested and validated form)
  - The Recommendation Form
    - All three forms combined into a module; Administered through Survey Monkey for ease of access and completeness.
    - Lengthy, but ***thorough.***

22

Mental Health Status Exam Form

- Two page document developed by professionals in North Carolina
- Gathers information on the physical characteristics/attributes of the consumer
  - Appearance
  - Dress
  - Mood
  - Verbal behavior
  - Motor activity

23

The GRIST Form

- Validated instrument developed at University of Aston, UK
- This form documents risk judgments associated with consumer's mental health
  - Demographic information
    - Age; gender, marital status; race; ethnicity
  - Two page *Rapid Screening Questions*
  - Followed by detailed questions on each of the domains of interest
    - Suicide; Self-harm; Harm to others or property; Self-neglect; Vulnerability to harm; questions relevant to more than one risk
  - Information on follow up modules collected only if determined to be an area of concern during Rapid Screening

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The Recommendation Form

- The last page of the module
  - Asks for the recommendation and the rationale for the recommendation
  - Recommendation choices
    - Outpatient commitment
    - Inpatient commitment
    - Release
    - Cannot make recommendation
  - This page was removed from the packet provided to the reviewers.
  - The reviewers were blinded to the recommendation of the first line reviewers who did the initial review

25

Evaluation Results

- Durham- 77; ECBH-57; Smoky Mountain-55,
  - Total sample size 189 cases
- Levels of concurrence calculated for each pair of reviewers

Site reviewers Vs Paper reviewers

'face to face' Site Level Reviewers X Masters Level Reviewers = 93.8%(.79)

'face to face' Site Level Reviewers X Psychiatrists= 85.6%(0.63)

'face to face' Site Level Reviewers X Psychologists= 88.6% (0.64)

26

Evaluation Results

- Concurrence between three groups of reviewers;
  - **It should be noted that all three groups of reviewers had the same information collected through the forms by the site level reviewers.** If there is any bias introduced through the data collection process the bias is uniform
- Masters level paper reviewers X Psychologists = 90.2%(0.72)
- Masters level paper reviewers X Psychiatrists = 91.0%(0.74)
- Further results and analysis available in the report

27

Medical Clearance

- Addressing stakeholder concerns of harm to physical health
  - All sites were required to set in place processes where by a consumer would have a physical health clearance prior to being evaluated for mental health competency
    - Durham: 98.7%
    - ECBH: 93.0%
    - Smoky Mountain North: 98.2%

28

First Commitment Expansion-Phase III

- In the most recent session of the General Assembly, a further extension of the waiver was passed to allow up to another five to participate in the waiver process via SESSION LAW 2009-340, H.B. 243. No evaluation component adhered to this most recent extension.

- The LMEs responding and accepted as Phase III sites include:
  - Western Highlands LME
  - Sandhills LME
  - Orange-Person-Chatham LME
  - Five Count LME
  - Southeastern LME

29

Recommendation

- Results of the evaluation showed a high level of consensus between the three group of independent reviewers and high level of concurrence.

  - It is the recommendation of the Division of MH/DD/SAS based on the results of two phases of evaluation that the waiver be expanded across the state.
  - The Division also recommends that there be continued consistent training and certification of masters level providers prior to them being able to conduct First commitment evaluation.
  - The Division also recommends annual refresher trainings for all certified providers

30

- Questions?
- For a copy of the report please contact Mark O'Donnell at mark.odonnell@dhhs.nc.gov

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Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA

February 10, 2010 10:00 A.M.; Room 643, Legislative Office Building
Senator Martin Nesbitt, Co-Chair, Presiding

I.	**Welcome and Opening Comments** Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair	10:00
II.	**Secretary's Remarks** Lanier Cansler, Secretary, DHHS	10:00-10:30
III.	**Expenditures and Utilization Tracking Update** Tara Larson, Chief Clinical Operating Officer, DMA	10:30-10:45
IV.	**Plans for Development & Implementation of the Tiered CAP-MR/DD Waiver** Rose Burnette, DD Project Manager, DMH/DD/SAS	10:45-11:45
V.	**Status of the Establishment of the DD Waiting List** Leza Wainwright, Director, DMH/DD/SAS	11:45-12:15
VI.	**CABHAs** Dr. Craigan Gray, State Medicaid Director	12:15-12:30
LUNCH		12:30-1:30
VII.	**Telemedicine SL 2009-315, H1189** **Update on SL 2009-340, H243** Michael Lancaster, Chief of Clinical Policy, DMH/DD/SAS	1:30-1:50
VIII.	**Mobile Crisis Services** Michael Lancaster, Chief of Clinical Policy, DMH/DD/SAS	1:50-2:10
IX.	**START Teams** Christina Carter, LCSW, Implementation Manager, DMH/DD/SAS	2:10-2:30
X.	**Update on Alcohol & Drug Abuse Treatment Centers** Luckey Welsh, Director of State Operated Healthcare Facilities	2:30-3:00
XI.	**Final Comments & Adjournment**	3:00-3:15

Next meeting Wednesday March 10th, 2010, 643 LOB

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES	2/10/10																
MEMBERSHIP																	
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	X																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	X																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	X																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 10, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, February 10, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Doug Berger, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory members Representative Van Braxton and Representative William Brisson were present. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She announced that for those listening over the internet, that handouts from the meeting were available on the LOC website. Representative Insko asked for a motion to approve the minutes from the January 13, 2010 meeting. The motion was made by Representative Braxton and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS) provided a brief update. Items of interest included:

- DHHS is examining ways to obtain greater input, ideas, and information from consumers. An example was to better utilize and strengthen the State Consumer Family Advocacy Council (SCFAC) which would provide better communication across the State.
- DHHS is finalizing the process of separating the accreditation and certification of Central Regional Hospital (CRH) and Dix Hospital. They were originally recognized as one hospital on two separate campuses. This change which will prevent future liability issues in one facility from affecting the other facility. Lack of adequate funding has created staffing difficulties at both hospitals. Recurring money is needed to hire permanent staff. The transfer of patients from Dix Hospital to CRH will hopefully take place within the next few months. The operation of all the facilities is costing approximately $30M a year more than budgeted. Actions are being taken to address the deficit at the State facilities.
- Murdoch Center is converting 6 beds into a short-term unit for emergencies for children until a better long-term solution can be provided.

- Personal Care Service – new system tracking services should be in place by March 1. It was determined that some consumers should not be receiving PCS services or were receiving too many of these services. Once letters go to consumers eliminating or reducing services, consumers can appeal the decision. Services will continue until a final decision is made on an appeal.

Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, gave an update on utilization of, and expenditures for: CS services, Targeted Case Management, CS Team, and Intensive In-Home Services. (See Attachment No. 2) She explained that the graphs on the left showed updates of expenditures of selected services requested by Committee members. On the left side, the graph indicates the actual number of people served. Ms. Larson was asked to group the child services and adult services together in the future.

Rose Burnette, Developmental Disabilities Project Manager for DMH/DD/SAS, addressed plans for development and implementation of the CAP-MR/DD Tiered waivers. (See Attachments No. 3A and 3B) Ms. Burnette explained the minor revisions to the Supports Waiver, the division of the Comprehensive Waiver into two separate Bands, and the new waiver – the Community Intensive Waiver. Her presentation included the following points of interest:

- The current Tier 1 waiver has 130 slots. The General Assembly appropriated $4M for Tier 1 slots allocating an additional 1,000 slots. DHHS created a standardized methodology to equalize the allocation of those slots. Using that formula gives each LME slots for their catchment area.
- Funding for the new Tier 3 waiver will come from funds in the current allocation.
- The goal is to more clearly define each waiver specific to the individual's needs; tailoring the services to meet those needs, thus creating more cost effectiveness and enabling more individuals to be served.

Leza Wainwright, Director for DMH/DD/SAS, addressed the status of the establishment of the DD Waiting list. (See Attachment No. 4) Ms. Wainwright reviewed the criteria established in legislation and information and statistics from other states with waiting lists. She explained that a standardized prioritization tool has been developed and is being used within the 2 tiers of the CAP MR/DD waiver. The tool takes into consideration the severity of need and the time an individual has been waiting for services. Ms. Wainwright reviewed the responsibilities of a stakeholders workgroup charged with designing a short term and long term solution to the mandate. The outcome of the short term solution will be in place within 30 days.

Dr. Craigan Gray, Director, Division of Medical Assistance, focused on questions from Committee members over the last few meetings regarding the demographics of recipients and providers participating in the Medicaid program. He noted:

- Since July, 2009, over 2.5 million people have been served by the Medicaid program. There is frequent transition in and out of the program. Average daily census is about 1.6 million.

- 39.7% of the Medicaid population is white, non Hispanic; 37.4% is African-American, non Hispanic; 9.1% is Hispanic; and; 13.6%, all others.
- Medicaid providers number 63,244 which only includes those processed through the Medicaid program. Of that number, 27,236 are physicians, 25,976 are ancillary providers, and 10,032 are non-licensed providers. The ethnic diversity of providers is not tracked.

After lunch, Dr. Michael Lancaster, Chief of Clinical Policy, DMH/DD/SAS, reported on the new legislative measures enacted in the last Legislative session (H.B. 1189 and H.B. 243) and on progress made in Mobile Crisis Services. (See Attachment No. 5) Items of interest included:

- H.B. 1189 - Outpatient commitment process information generated in the emergency department (ED) must be communicated to the LME prior to the consumer's discharge.
- Grant funding will allow the East Carolina University Department of Psychiatry to employ 3 psychiatrists to work through telepsychiatry with EDs throughout the east to provide psychiatry to underserved EDs.
- North Carolina is viewed as a leader in telepsychiatry with more billings and providing more services than other states in the country.
- DHHS wants ED's to establish a single number in their area to call for telepsychiatry services, perhaps through the LME Screening and Triage Referral line.
- H.B. 243 - Amends the law governing the affidavit and petition process for involuntary commitment where the affiant is a physician to provide that if inpatient commitment is recommended, but no 24-hour facility is available, the respondent may be detained temporarily at the site of first examination under appropriate supervision for up to seven days. If after seven days a 24-hour facility is still unavailable, then that fact is to be reported to the clerk of superior court and the commitment proceedings terminated. New commitment proceedings may be initiated, but the affidavits used in support of the earlier proceedings many not be used. New affidavits must be filed and, if the affiant is a physician, a new examination conducted.
- The act also amends the Session Laws creating the First Commitment Pilot Program and expands the pilot from 10 LMEs to up to 15 LMEs.

Regarding the Mobile Crisis Teams, (See Attachment No. 6), Dr. Lancaster reported that the General Assembly has funded 30 Teams across the State. Four years ago, this crisis service began as a pilot project with 10 Mobile Crisis Teams, 9 of which are still operational today. Several points of interest included:

- Some LMEs have more than 1 Mobile Crisis Team but virtually every county in the State is covered by a Mobile Crisis Team.
- Mobile Crisis Teams are available 24/7/365 and have expertise in MH/DD/SA. People should consider calling Mobile Crisis before going to an emergency room and the police should consider calling Mobile Crisis before taking someone to jail or an emergency room.
- 40-45% of services are in the ED setting.

- Mobile Crisis intervention early in crisis can prevent consumers from moving into a higher level of care.
- With the absence of a behavioral healthcare professional in the ED, the ED doctor is more likely to be more conservative in an assessment and admit the patient.

Christina Carter, Implementation Manager, DMH/DD/SAS, addressed the N.C. Systemic, Therapeutic, Assessment, Respite and Treatment Program (NC-START). (See Attachment No. 7) Points of interest included:

- North Carolina is the only state in the country to take the START model statewide.
- Part of collaboration is an automatic referral when someone is discharged from a developmental center to the NC-START Team.
- Data in graph covers information gathered from April, 2009 – September, 2009.

Luckey Welsh, Director of State Operated Healthcare Facilities, provided an update on the Alcohol and Drug Abuse Treatment Centers (ADATC). (See Attachment No. 8) He said that ADATCs provide the highest level of treatment for adults with substance abuse addictions and co-occurring mental health disorders that are so severe they cannot be served in the community. His presentation included the following points of interest:

- Overall admission to the ADATCs decreased in 2009 due to a number of beds closed at the Julian F. Keith center in preparation for other centers opening. The 2010 projection indicates that admissions will climb.
- Involuntary commitment admissions are rising in the Acute Crisis Units. Prior to the availability of ADATC Acute Care Units, these individuals would have been referred to the State psychiatric hospitals.
- Staffing difficulties exist due to budgetary restrictions and changes in the complexity of the population served at the ADATCs.
- ADATCs have contact with treatment facilities in the community since there is chance of a relapse. Sobriety may not be attained until after 6 or 7 treatments.

Mr. Welsh was asked to provide the number of community facilities there are across the State and their location.

There being no further business, the meeting adjourned at 2:25 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Fitzsimon	NC Policy Watch
Mitch Kokai	John Locke Foundation
Erin McLaughlin	NHPRC
Judy W. St. Amour	Companion PO Box 573 Lumberton
Donna Rouse	Companion Home Care P.O. Box 953 Lumberton
Pam Shipman	PBH
Dan Coughlin	PBH
[illegible]	NHA
John McMillan	NFOS
Will Woodell	Value Options
Clarissa Goodlett	Governors Institute

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brian Powell	Student Visitor, Camelot Academy
Mary Powell	NC SA Federation
Louise G. Fisher	Volunteer Advocate for M.I.
Kathy S. Baker	Southeastern Regional LME
Elizabeth Taylor	Kocharek Law Group
Anna Liesa Dolph	DRNC
Jennifer Mahan	MHANC / The Coalition
Sally Cameron	NC Psychological / The Coalition
Gail Boswell	MH Consumer / Wilson
Marc Jacques	NCMHCO / Wake
Tommy Suter	NOVARTIS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hedrick	NCPC
Janet Shamblaw	Indian Counseling
ERIC GABRIEL	RHA
Fred Wadak	Eastern Seals UCP
Ann Melvin	CFSA-NC
Amy Whited	NC Medical Society
Billy West	Provider - Concord
Dennis Smith	Youth Villages
Cynthia Chapman	Omni Visions
Sarah Tulluck	NCCDD
Larry Swabe	NCCDD

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trey Adams	PQA, Inc.
James Hardy	Cambridge Behavioral Health Services 622 S. Memorial Dr. Greenville, NC
Anna MacDonald Dorris	The Arc of NC 343 E. Six Forks Rd. Raleigh, NC
TAD CLODFELTER	SA FEDERATION / SOUTHLIGHT
Bernice Lee	Roanoke Valley Spec Svcs, Garysburg, NC
Evelyn Dawson	Brite Smilz family & Community Ctrs.
Sue Creighton	CenBH Consultants, Raleigh
Jeanne Harrison	Alliance Rehab'l Intensive Care, Inc
Yvonne Copeland	NC Council of Community Programs
Martha Lawrence	NAMI NC
Anna Francis	Capstrat

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Missy O'Neal	IBM
Sean Kenny	Eastern Carolina Case Management 154 Suite I, Beacon Dr, Winterville 28590
Valerie Hennike	Five Co. Mental Health Authority Henderson
Emily Wilbanks	TPG
Fred Bone	Bone & Assoc.
Douglas Finley	Aym Technologies, LLC
Kim Schmidt	NC MHCO Raleigh, NC
Mary S Thomas	Intern, STEP CMHC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS February 10, 2010

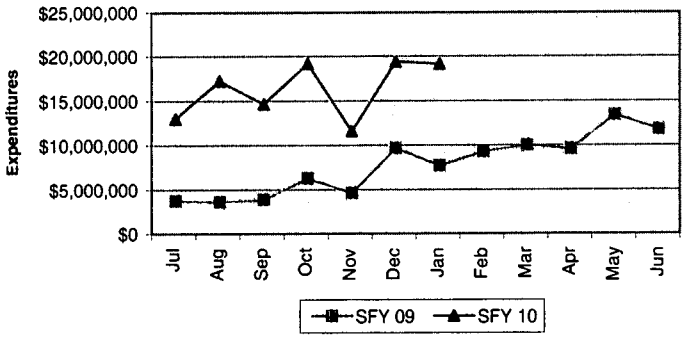
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

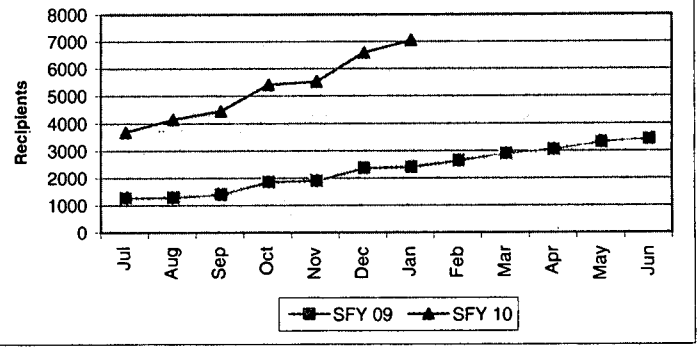
NAME	FIRM OR AGENCY AND ADDRESS
Judy Truitt	OPC Mental Health Chapel Hill
Myra Wellons	Lilly USA
Delwin Clark	Omega Independent Living Services Inc
[illegible]	[illegible]
[illegible]	[illegible]

Attachment 2

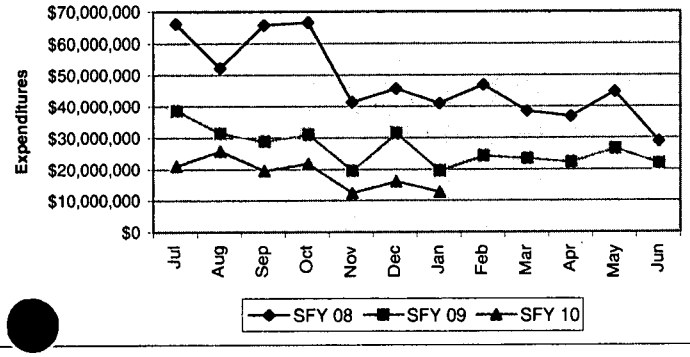
Community Support Team Expenditures



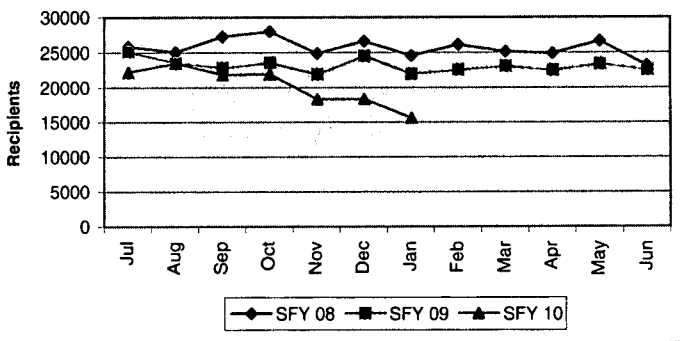
Community Support Team Recipients



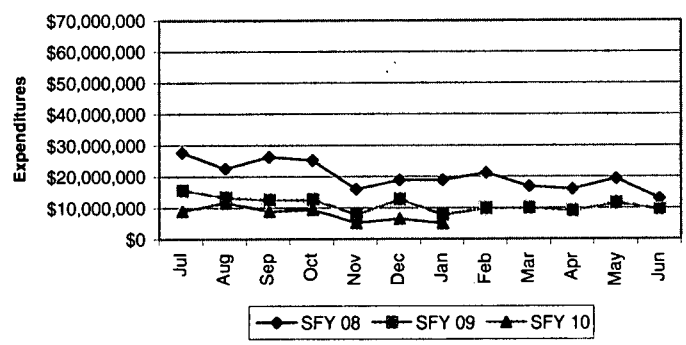
Community Support - Individual Child Expenditures



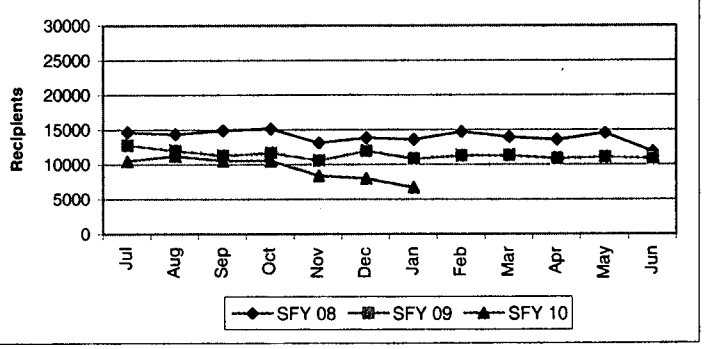
Community Support - Individual Child Recipients



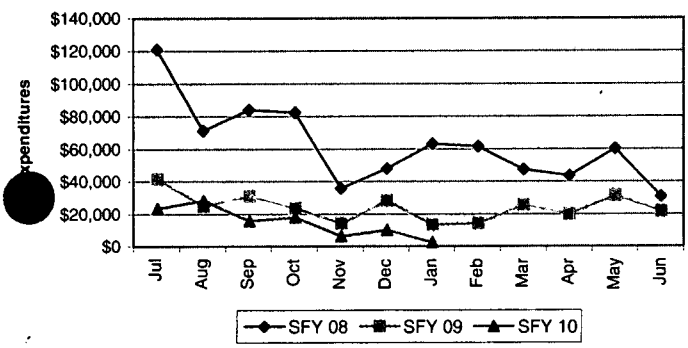
Community Support - Individual Adult Expenditures



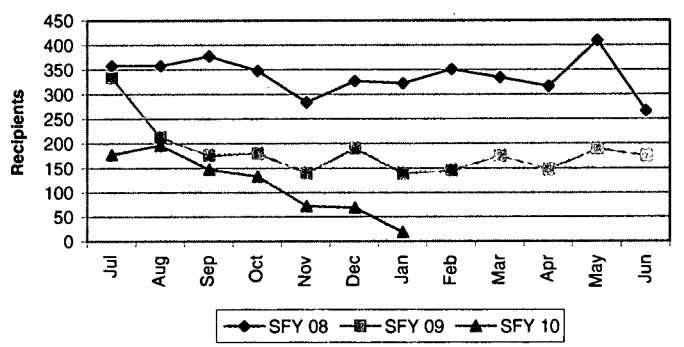
Community Support - Individual Adult Recipients



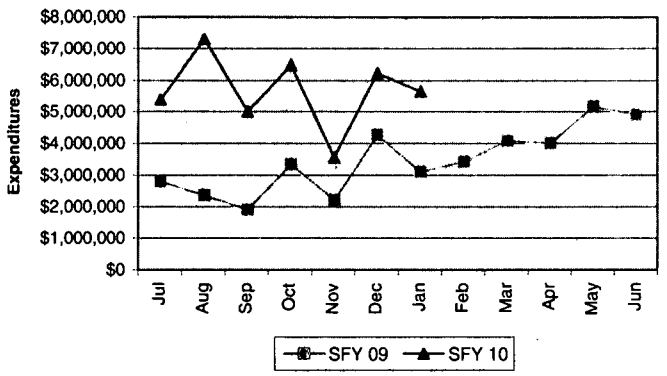
Community Support - Group Expenditures



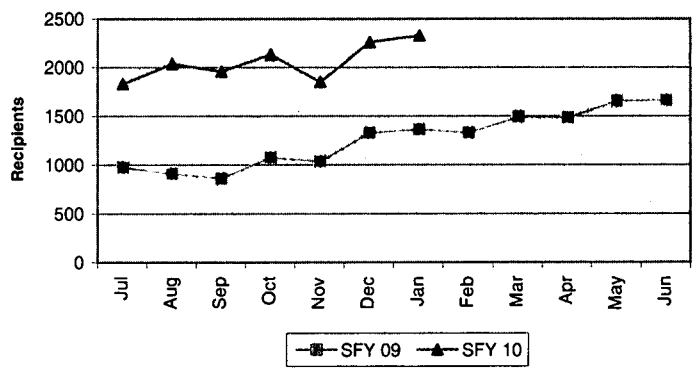
Community Support - Group Recipients



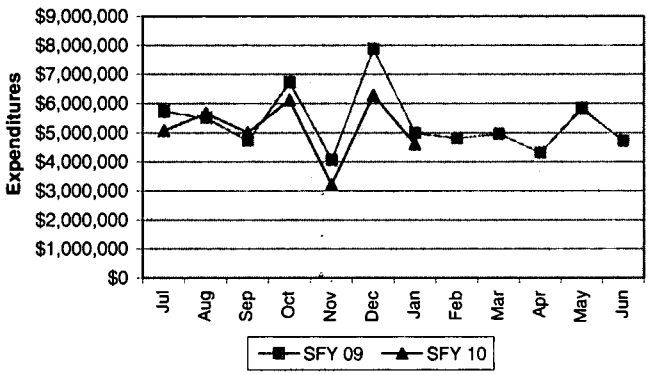
Child and Adolescent Day Treatment Expenditures



Child and Adolescent Day Treatment Recipients



Targeted Case Management-DD ALL Expenditures



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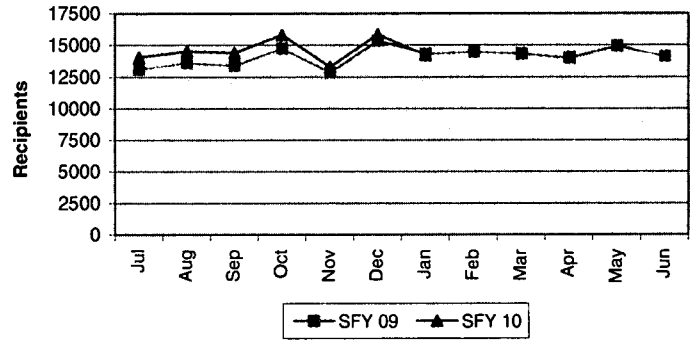
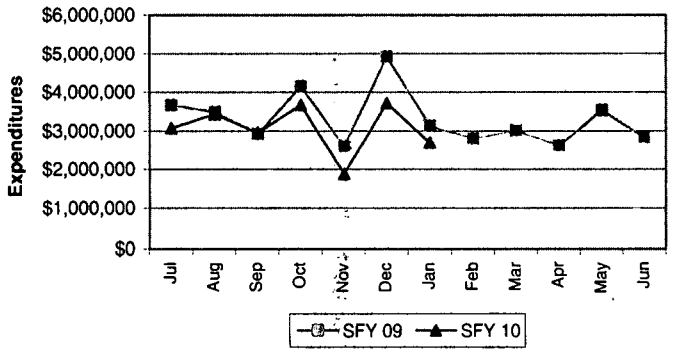


Targeted Case Management-DD CAP Only Expenditures



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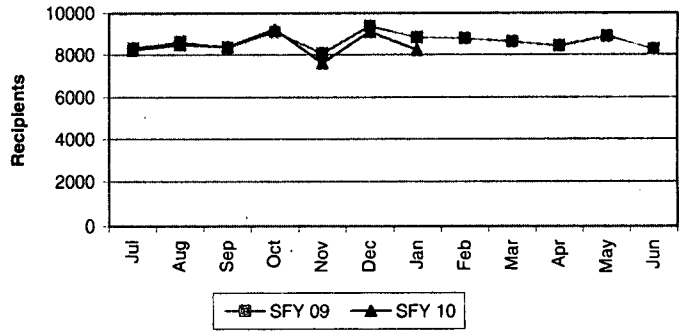

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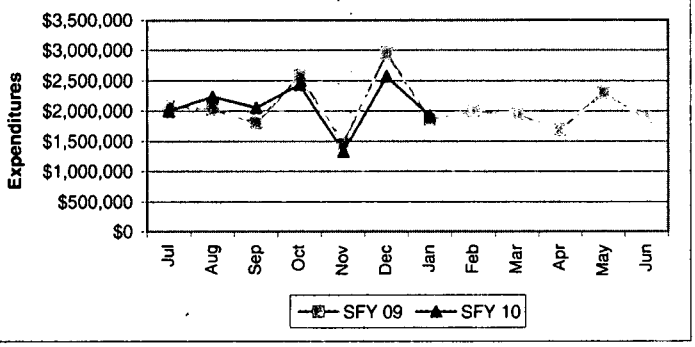
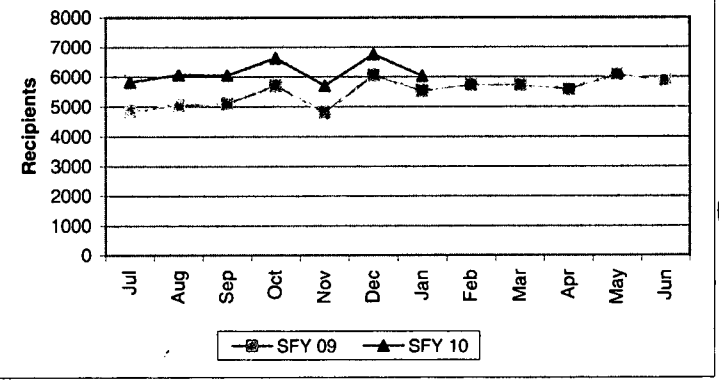
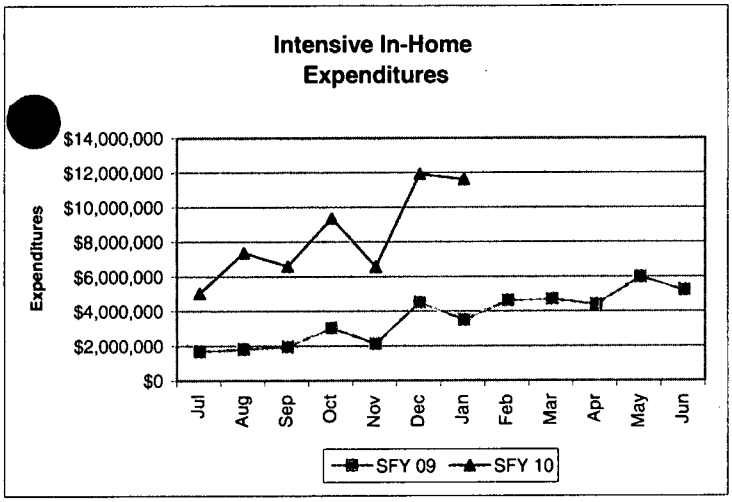


Targeted Case Management-DD NON CAP only Recipients

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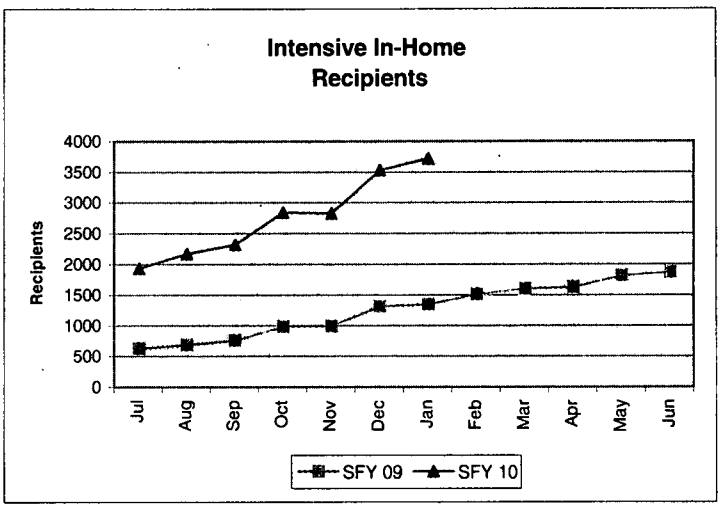
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SFY 10

Plans for Development & Implementation of the Tiered CAP-MR/DD Waivers

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

Rose Burnette
DMH-DD-SAS
2-10-10

1

CAP-MR/DD Waivers Summary of Planned Tiers

The Overall Goal of the Tiered waivers:

To improve efficiency in the expenditure of available funds and effectively identify and meet the needs of individuals who are eligible for CAP-MR/DD funding.

2

CAP-MR/DD Waivers Summary of Planned Tiers

Learning from the current waivers, feedback from stakeholders and from review and discussion with other states and national consultants.

3

CAP-MR/DD Waivers
Summary of Planned Tiers

Per federal regulations, each waiver must "stand alone" with its own quality assurance plan, eligibility criteria, financial tracking and reporting, etc. Each waiver requires effort by the State, LMEs and providers.

Can accomplish goal and minimize administrative burden by implementing three tiered waivers, rather than four.

4

CAP-MR/DD Waivers
Summary of Planned Tiers

Each waiver provides for the specifically defined needs of intended participants based on intensity of need, financial limits, and services/supports.

The development of the Tiered waivers system is intended to; 1) assure that individuals receive the services/supports they need; and 2) Services are authorized equitably based on the individual's intensity of need.

5

Three Targeted Waivers

- ☐ Supports Waiver
- ☐ Comprehensive Waiver-
  - ■ Band A
  - ■ Band B
- ☐ Community Intensive Waiver

6

Supports Waiver

The Supports Waiver is Designed for Individuals Who:

- Have natural/community/non-paid supports and/or low intensity of service/support need to enable them to live successfully in the community.
- Are at risk of out-of-home placement or loss of their current living situation due to the family/caregiver's inability to continue to provide support.

7

Supports Waiver

The Supports Waiver is Designed for Individuals Who:

- Needs are successfully met through the services offered in the Supports Waiver and/or with the addition of natural/community/non-paid supports.
- Need periodic and intermittent paid services/supports to maintain Habilitative skills and reduce risk or jeopardy of health and safety.

8

Supports Waiver

- Financial Maximum-$17,500 per year
- Includes the Self-Directed option
- The service array includes all services *except for*;
  - Home Supports,
  - Residential Supports,
  - Enhanced Personal Care,
  - Enhanced Respite,
  - Adult Day Health

9

Comprehensive Waiver

Divided Into 2 Bands:

- Based on the intensity of the individual's need
- Each contain a specific service array
- Financial limit per Band

10

Comprehensive Waiver-Band A

The Comprehensive Waiver-Band A is Designed for Individuals Who:

- Require a higher level of paid support/services than those available within the Supports Waiver **and/or** they require a service/or intensity of the service not available in the Supports Waiver.
- Are at high risk of out-of-home placement or loss of their current living situation due to the family/caregiver's inability to continue to provide support.

11

Comprehensive Waiver-Band A

The Comprehensive Waiver-Band A is Designed for Individuals Who:

- Require assistance and structured support to maintain current living arrangement, to develop and maintain life skills and to minimize the potential for victimization/exploitation.
- Support needs are routine, planned and structured to increase Habilitative skills and reduce risk or jeopardy of health and safety.

12

Comprehensive Waiver-Band A

- Financial Range-$17,501-$45,000 per year
- Includes the Self-Directed option

13

Comprehensive Waiver-Band A

The service array includes all Support Waiver services with the addition of the following:

- Residential Supports-*Levels I & II*
- Home Supports-*Levels I & II*
- Adult Day Health

14

Comprehensive Waiver-Band A

The service array includes:

- Services in the *Additional Supports Category;*
  - Home Modifications,
  - Vehicle Adaptations,
  - Augmentative Communications Devices
  - With a **limitation of $15,000** per the life of the waiver *for any combination* of these services.

15

Comprehensive Waiver-Band B

The Comprehensive Waiver-Band B is Designed for Individuals Who;

- Have greater intensity of support needs/are assessed at severe risk of loss of current living arrangement due to ongoing challenging behavior and/or chronic medical needs.
- Needs involve extensive supervision and support due to their related skill development, behavioral and/or medical needs.

16

Comprehensive Waiver-Band B

The Comprehensive Waiver-Band B is Designed for Individuals Who;

- Paid supervision and support needs are extensive meaning, frequency, duration and intensity are greater than for individuals served within Band A.
- Require *enhanced* medical monitoring/support (G-Tube feeding, suctioning, positioning).
- Require ongoing behavioral supports

17

Comprehensive Waiver-Band B

- Financial Range-$45,001-$75,000 per year
- Self-Direction is NOT an option

18

Comprehensive Waiver-Band B

The service array includes all Support Waiver services with the addition of the following:

- Residential Supports-*Levels III*
- Home Supports-*Levels III*
- *Enhanced* Personal Care
- *Enhanced* Respite

19

Comprehensive Waiver-Band B

The service array includes:

- ☐ Services in the *Additional Supports Category;*
  - Home Modifications,
  - Vehicle Adaptations,
  - Augmentative Communications Devices
  - with a **limitation of $20,000** per the life of the waiver *for any combination* of these services.

20

Community Intensive Waiver

The Community Intensive Waiver is Designed for Individuals Who:

- ☐ Support needs can not be adequately met in the Comprehensive waivers.
- ☐ Are at immediate risk of loss of their current living situation, and/or have health and welfare needs that require 24 hours per day supervision.
- ☐ Require specially trained staff to provide continuous, non-stop monitoring/supervision 24 hours a day to ensure the health, and safety.

21

Community Intensive Waiver

The Community Intensive Waiver is Designed for Individuals Who:

- Have chronic, pervasive, and extensive medical conditions that require specialized services and supports, **AND/OR;**
- Exhibit frequent intensive behavioral episodes that may include: sexual offending, self-injurious behaviors, aggression, property destruction, etc.
- Require on-going specialized therapeutic services by a qualified Behavioral Health Professional, **AND/OR** qualified medical professionals.

22

Community Intensive Waiver

- Financial Range-$75,001-$135,000 per year
- Self-Direction is NOT an option

23

Community Intensive Waiver

All services offered in the Supports and Comprehensive waivers are available in addition to these enhanced services;

- Residential Supports *Level IV*
- Home Supports *Level V*
- *Nursing* Respite

24

Community Intensive Waiver

The service array includes:

- Services in the *Additional Supports Category;*
  - Home Modifications,
  - Vehicle Adaptations,
  - Augmentative Communications Devices
  - with a **limitation of $25,000** per the life of the waiver *for any combination* of these services.

25

Determination of Intensity of Need

Determination of intensity of need will be made by using information gathered through the use of the:

- NC-SNAP
- Supports Intensity Scale
- Other assessments
- Person Centered Planning process

26

Supports Intensity Scale (SIS)

- The data accumulated from among the state's seven Pilot sites/LME(s) appear to be a representation of the entire state population.
- The total of adolescent and adult **SIS assessments completed as of January 31, 2010 is 488**, and this sample size appears to be average in making such a determination based on the use of the SIS in other states.

27

SIS Examiners

- SIS examiners are Licensed independent practitioners enrolled with Medicaid.
- The majority of SIS examiners are in private practice and therefore are independent of provider agencies delivering services.
- However, SIS examiners that provide services to provider agencies are not permitted to conduct SIS assessments for individuals served by that provider agency.

28

Transition Into the New Waivers

Individuals in the Supports and Comprehensive waivers will transition into the revised and new waivers based on information gathered from the NC-SNAP, SIS and other assessment and support needs information contained in each Person Centered Plan.

29

Projected Timeline for Implementation of the Tiered Waivers

- Development of the waivers with submission to CMS will occur by Spring 2011 allowing adequate time for CMS approval and transition to the new waivers when the current waivers expire on November 1, 2011.
- Current Supports Waiver will also have to be renewed on November 1, 2011.

30

Stakeholder Involvement

- The Division will solicit stakeholder input during the development process.
- Training opportunities for stakeholders regarding the details of the Tiered Waivers will occur prior to implementation of the new waivers.
- Training will involve both face to face regional meetings and web based options, in addition to information sharing through the LME(s) and web postings.

31

CAP-MR/DD Waivers Summary of Planned Tiers

- Questions???

32

Attachment 3B

NC CAP-MR/DD Waivers: Summary of Planned Tiers (3 waivers)

Home and Community Based (HCBS) Waivers

Three (3) targeted waivers – *Supports, Comprehensive, Community Intensive*: each waiver provides for the specifically defined needs of intended participants based on intensity of need, financial limits, and services/supports. The primary purpose of the Tiered waivers is to develop a system that; 1) assures that individuals receive the services/supports they need; 2) Services are authorized equitably based on the individual's intensity of need.
These waivers require individuals to participate in Habilitative services and are not intended to provide individuals 24 hour direct services/support.

TIER	FINANCIAL RANGE	LEVEL AND INTENSITY OF NEED	SERVICE ARRAY
Tier 1 **Supports Waiver**	Up to $17, 500	• Individuals have natural/community/non-paid supports and/or low intensity of service/support need to enable them to live successfully in the community. • The individual is at risk of out-of-home placement or loss of their current living situation due to the family/caregiver's inability to continue to provide support. • The individuals' needs are successfully met through the services offered in the Supports Waiver and/or with the addition of natural/community/non-paid supports. • Individuals need periodic and intermittent paid services/supports to maintain habilitative skills and reduce risk or jeopardy of health and safety.	**Self-Direction is an option** **Available Services/Supports** **Where People Live** • Home and Community Supports • Personal Care Services **Where People Work/Habilitative Activities** • Day Supports • Supported Employment • Long Term Vocational Services **Support to Caregivers** • Individual Caregiver Training and Education • Specialized Consultative Services • Respite **Crisis Management** • Behavioral Consultant • Crisis Services • Crisis Respite **Additional Supports** • Augmentative Communication Devices Maximum of $ 5,000 for the life of the waiver) • Specialized Equipment and Supplies (Maximum of

			$3,000 per plan year) • Vehicle Adaptations (Maximum of $15,000 for life of the waiver) • Personal Emergency Response System • Transportation (Maximum of $2,000 per plan year) • Home Modifications (Maximum of $15,000 for life of waiver) **Self-Direction** • Individual Goods and Services-**Self-Direction ONLY** (Maximum of $3,000 per the plan year) **Any combination of these services may not exceed the $17,500 maximum annual benefit of the waiver.**
TIER	**FINANCIAL RANGE**	**LEVEL AND INTENSITY OF NEED**	**SERVICE ARRAY**
Tier 2 **Comprehensive waiver** Difference in bands – **BAND A:** Can access any combination up to $45k adhering to individual category limits.	**Band A:** $17, 501 to $45,000	**Band A**: • The individual requires a higher level of paid support/services than those available within the Supports Waiver **and/or** they require a service/or intensity of the service not available in the Supports Waiver • The individual is at <u>high</u> risk of out-of-home placement or loss of their current living situation due to the family/caregiver's inability to continue to provide support • The individual requires assistance /support to maintain current living arrangement and to minimize the potential for victimization/exploitation. • The individual requires support to develop and maintain life skills (paying utility bills/rent on time to prevent disconnection, maintenance of home environment to prevent eviction, etc.). • The individual's support needs are routine,	**Self-Direction is an option** **BAND A** **Available Services/Supports** **Where People Live** • Home and Community Supports • Personal Care Services • **Residential Supports(Levels I and II)** • **Home Supports(Level I, II)** **Where People Work/Habilitative Activities** • Day Supports • Supported Employment • Long Term Vocational Services • **Adult Day Health** **Support to Caregivers** • Individual Caregiver Training and Education • Specialized Consultative Services • Respite **Crisis Management**

		• The individual's paid supervision and support needs are extensive; frequency, duration and intensity are greater than for individuals served within **Band A**. • The individual requires enhanced medical monitoring/support (G-Tube feeding, suctioning, positioning) • The individual requires ongoing behavioral supports.	• Day Supports • Supported Employment • Long Term Vocational Services • Adult Day Health **Support to Caregivers** • Individual Caregiver Training and Education • Specialized Consultative Services • Respite • **Respite-Enhanced** • **Respite-Institutional** **Crisis Management** • Behavioral Consultant • Crisis Services • Crisis Respite **Additional Supports ($20,000 per the life of the waiver on any combination of these services)** • Augmentative Communication Devices (Maximum of $ 5,000 for the life of the waiver) • Specialized Equipment and Supplies (Maximum of $3,000 per plan year) • Vehicle Adaptations (Maximum of $15,000 for life of the waiver) • Personal Emergency Response System • Transportation (Maximum of $2,000 per plan year) • Home Modifications (Maximum of $15,000 for life of waiver) **Any combination of these services may not exceed the $75,500 maximum annual benefit of Band B.**
TIER	**FINANCIAL RANGE**	**LEVEL AND INTENSITY OF NEED**	**SERVICE ARRAY**
Tier 3 **Community Intensive**	$75,001 to $135,000	• The individual's support needs can not be adequately met in either the Supports or Comprehensive waivers.	**Self-Direction is NOT an option** **All services offered in the Supports and Comprehensive waivers are available in addition to these enhanced**

		• The individual is at <u>immediate</u> risk of loss of their current living situation, and/or have an identified health and welfare needs that requires 24 hours per day supervision. • The individual requires specially trained staff to provide continuous, non-stop monitoring/supervision 24 hours a day to ensure the individual's health, safety and wellbeing. • The individual has chronic, pervasive, and extensive medical conditions that require specialized services and supports, **AND/OR;** • The individual exhibits frequent intensive behavioral episodes that may include; sexual offending, self-injurious behaviors, aggression, property destruction, etc. • The individual requires on-going specialized therapeutic services by a qualified Behavioral Health Professional, **AND/OR** qualified medical professionals.	**services.** **Available Services/Supports** **Where People Live** • Home and Community Supports • Personal Care Services • **Personal Care Services-Enhanced** • **Residential Supports(Levels IV)** • **Home Supports (Level V)** **Where People Work/Habilitative Activities** • Day Supports • Supported Employment • Long Term Vocational Services • Adult Day Health **Support to Caregivers** • Individual Caregiver Training and Education • Specialized Consultative Services • Respite • Respite-Enhanced • Respite-Institutional • **Respite- Nursing** **Crisis Management** • Behavioral Consultant • Crisis Services • Crisis Respite **Additional Supports ($25,000 per the life of the waiver on any combination of these services)** • Augmentative Communication Devices (Maximum of $ 5,000 for the life of the waiver) • Specialized Equipment and Supplies (Maximum of $3,000 per plan year) • Vehicle Adaptations (Maximum of $15,000 for life of the waiver) • Personal Emergency Response System • Transportation (Maximum of $2,000 per plan year) • Home Modifications (Maximum of $15,000 for life of waiver)

			Any combination of these services may not exceed the $135,000 maximum annual benefit.

Status of the Establishment of a DD Waiting List

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and Substance Abuse Services
February 10, 2010

Leza Wainwright
DMH/DD/SAS

DMH | DD | SAS
division of mental health | developmental disabilities | substance abuse services

HB 673, SL 2009-186

- Each LME shall maintain a waiting list for:
  - Residential services
  - CAP-MR/DD Waiver services
  - Other
- Secretary to develop rules regarding waiting list data
- LMEs to report waiting list information annually to DHHS

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Research on Waiting Lists

- National Association of State Directors of Developmental Disabilities Services (NASDDS)
- Consultation with Celia Feinstein, Temple University
- Survey of states

Waiting Lists in Other States

- Response from 31 states
  - 26 have statewide waiting lists
  - 5 do not
- In 26 states with waiting lists
  - 15 are based on "urgency of need" or prioritization for services method
  - 11 are based on "First Come, First Served"
- Many states' waiting lists collect data on individuals waiting for Home and Community Based Waiver services only

Other States

- Most states use or are developing a web-based tool
- Several states contract for maintenance of waiting list
- Most states require an annual "refresh" of waiting list data

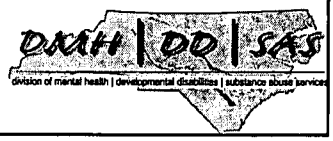
Progress To-Date

- All LMEs, except PBH, have been using a standardized prioritization tool
  - Tool takes into consideration both urgency of need and time waiting for services.
- Currently only applies to individuals waiting for waiver services

Convene Stakeholder Group

- LME staff
- Providers of I/DD services
- Consumers and family members

- Charge: design short term and long term solution

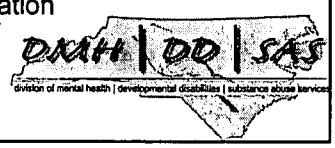


Short Term Solution

- Design a spreadsheet to collect aggregate data from LMEs:
  - # of individuals waiting for services, by type:
    - Potentially eligible for CAP-MR/DD
      - Currently receiving state-funded services
      - Not currently receiving services
    - Residential services
    - Vocational/Day supports
    - Other state funded services
  - Age of individuals
    - Children
    - Adults

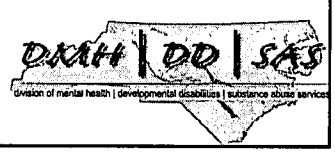
Implementation

- Train LMEs on use of the spreadsheet
  - Definitions of categories
  - Timeframes to be used
- Aggregate data in access database
- Analyze and report
- Benefits:
  - Can be done relatively quickly and inexpensively
  - Will give good "snap shot" of current situation
- Shortcomings:
  - Will be aggregate data only; no way to identify individuals who may be reported by more than one LME
  - No way to verify data against other state databases, such as Medicaid enrollment or paid claims information



Long Term Solution

- Analyze effectiveness of spreadsheet effort
  - Adequacy of categories
  - Quality of information received
- Evaluate feasibility of web-based solution
  - Cost
  - Timeframes for development and implementation



Conclusion

- Workgroup will make recommendation to DHHS on long term solution strategy
- Upon final decision by DHHS, workgroup will develop rules for implementation of the long term solution
- Timeframes:
  - Workgroup convened by end of February, 2010
  - Short term solution will begin implementation w/in 30 days
  - Deliberations regarding long term solution will begin after data collected and analyzed from spreadsheet effort
  - If final recommendation involves IT project, final timeframe will be dependent upon funding and IT workload

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Questions?

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New Legislative Measures

HB 1189
&
HB 243

Dr. Michael Lancaster, Chief of Clinical Policy
NC DHHS DMH/DD/SAS
January 13, 2010

1

HB1189

- Outpatient Commitment Process
  - Communication
- Use of Telepsychiatry for IVC Process
  - Increase access to psychiatry and psychology for IVC
  - Improve quality of the evaluation
  - Decrease wait times in the ED

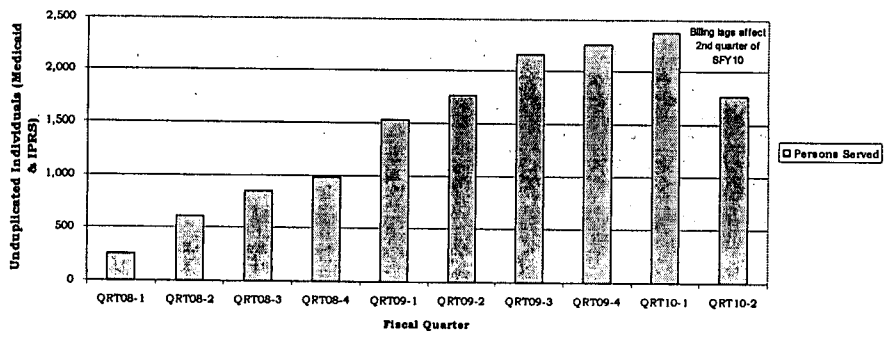
2

Example

- ECU Department of Psychiatry will employ three psychiatrists to specifically work through telepsychiatry with emergency departments throughout the east to provide psychiatry to underserved emergency departments.

3

Telepsychiatry: Persons Served SFY08 - SFY10 YTD
Medicaid and IPRS Claims Data



4

HB 243

- Release from IVC after first evaluation
- Outpatient commitment
- Continued IVC

5

Training for New Legislative Measures (HB 1189 and 243) Related to Emergency Departments

http://www.ncdhhs.gov/mhddsas/whatsnew.htm

6

MOBILE CRISIS TEAMS

Dr. Michael Lancaster, Chief of Clinical Policy
NC DHHS DMH/DD/SAS
January 13, 2010

MOBILE CRISIS TEAMS

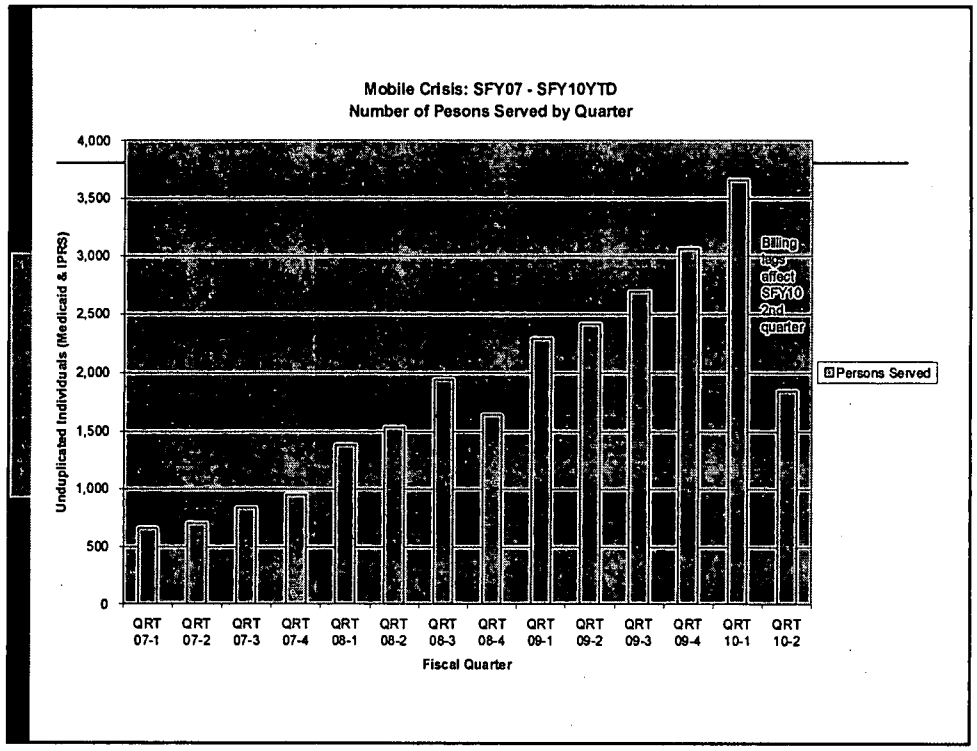
- Expertise in MH/SA/DD required
  - START available for DD consultation
  - Access to psychiatrist
- Available 24/7/365
- As of 11/09, 42 Mobile Crisis teams endorsed and providing services in NC

MOBILE CRISIS TEAMS

- Original pilots indicated at least 2 years in service provision prior to reaching maturity
- Establish relationships with law enforcement, magistrates, EDs, and providers
- 50-70% of consumers seen in Mobile Crisis are not admitted to inpatient settings

MOBILE CRISIS TEAMS

- Common locations for service provision
  - ED, Community Based (homes, provider offices), Schools
  - Work closely with law enforcement
- Mobile Crisis teams can work in ED settings in 18/23 LME catchment areas
  - Credentialing issues
  - Alternative services available provided by ED


Mobile Crisis: SFY07 - SFY10YTD
Number of Pesons Served by Quarter
Unduplicated Individuals (Medicaid & IPPS)
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Billing ... affect SFY10 2nd quarter
Persons Served
QRT 07-1
QRT 07-2
QRT 07-3
QRT 07-4
QRT 08-1
QRT 08-2
QRT 08-3
QRT 08-4
QRT 09-1
QRT 09-2
QRT 09-3
QRT 09-4
QRT 10-1
QRT 10-2
Fiscal Quarter

NC-START

North Carolina-Systemic, Therapeutic, Assessment, Respite and Treatment

Christina Carter
Implementation Manager

Division of Mental Health/Developmental Disabilities/Substance Abuse Services
January 13, 2010

1

NC START-Description

- In 2006, the Developmental Disabilities-Practice Improvement Collaborative recommended that NC adopt the START model
- An evidenced based model of community based crisis prevention and intervention services for people with Intellectual/Developmental Disabilities (I/DD)
- Individuals are 18 years or older and experience crises due to mental health and/or complex behavioral health issues.
- The model was co-authored by Dr. Joan Beasley, and Dr. Robert Sovner, in 1988 in Lynn, Mass.
- The priority is to enable individuals to remain in their home or community residential setting.

2

*NC is the only state to implement the model statewide.

NC START-Description

Services available within the model include:

Crisis support:

- Psychiatric Services
- Psychological Services
- Behavioral Support
- Crisis Intervention
- Crisis consultation to:
  - the family
  - treatment team
  - primary service providers.

3

NC START-Description

- Services available within the model include (continued):

Clinical Support:

- Functional behavioral assessment
- Prevention and intervention planning
- Crisis meetings with:
  - Families
  - Service providers
  - Treatment teams
  - Mobile Crisis teams

4

NC START-Description

- Services available within the model include (continued):

Planned short term respite provided in respite home:

- Planned respite for NC START consumers who live with their family and are unable to access traditional respite.
- Planned respite service elements include:
  -opportunities for NC START consumers to go to the respite home for a day or for a meal,
  -structured day activities,
  -education to families regarding behaviors.

5

NC START-Description

- Services available within the model include (continued):

Crisis respite provided in the respite home:

- Emergency respite for stabilization and diversion for individuals who live with their family and are unable to access traditional respite
- For individuals who live in group settings in order to maintain their current residential setting.

6

NC START-Description

- Services available within the model include (continued):

Collaboration:

- linkage of families and providers to community services & supports,
- working with case managers on planning for future needs,
- crisis planning in collaboration with community and institutional partners such as community psychiatrists, case managers, provider staff, and developmental center staff,
- developing & maintaining relationships with community partners through affiliation agreements with community hospitals, LMEs, etc.
- developmental center transition support

7

NC START-Development

- State appropriated funds were distributed to three host Local Management Entities (LME) to support:
  - -six crisis/clinical teams
  - -two teams per region
  - -twelve respite beds (four per region)
- **Host LMEs:**
  - -Western Highlands Network
  - -The Durham Center
  - -East Carolina Behavioral Health
- Host LMEs contract with selected providers for NC START services.
- **Selected providers are**:
  - RHA for the West and East regions
  - Easter Seals/UCP in the Central region

8

NC START-Development

Clinical Teams:

Each region has:

-A director who provides administrative oversight

-A part-time PhD psychologist (.5FTE) who serves as clinical director

-A part-time psychiatrist (.10FTE) who serves as the medical director

-Four qualified professionals, two per team.

9

NC START

- **Regional Respite Homes:**

*Composed of:

-two **crisis respite** beds (up to 30 days per admission)

-two **planned respite** beds (up to 72 hours per admission)

*Each respite home has one respite director and 13 respite staff.

*Respite service elements include:

- symptom and behavior monitoring,

-structured day activities,

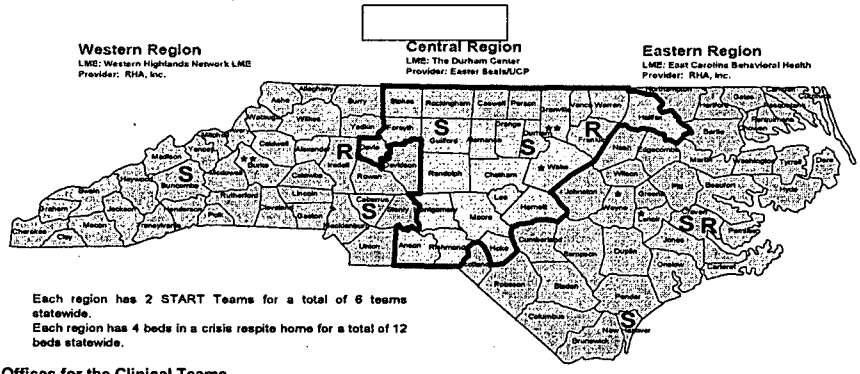
-collaboration with the family, providers, LMEs, etc.

-support/education to families, providers, and other community partners

10

NC START

START and Crisis Respite Teams Locations and Coverage Areas In North Carolina



Each region has 2 START Teams for a total of 6 teams statewide.
Each region has 4 beds in a crisis respite home for a total of 12 beds statewide.

Offices for the Clinical Teams
WEST: Concord and Asheville
CENTRAL: Durham and Greensboro
EAST: Wilmington and New Bern

Respite Homes: Statesville, Franklinton, and New Bern.

● State Psychiatric Hospital
● State Developmental Center

S START TEAM
R CRISIS RESPITE TEAM

11

NC START-Reporting

Individuals Served:

Total number of individuals served: **439**

Level of Intellectual Disability:
- Mild: **48%**
- Moderate: **33%**
- Severe to profound: **13%**

12

NC START-Reporting

Funding Source:

CAP-MR/DD Waiver: **36%**

Medicaid (non-CAP): **58%**

State funds only: **5%**

Prior Psychiatric Hospitalizations:

In past year: **44%**

Psychiatric Diagnosis:

Many individuals present with one or more psychiatric diagnosis

Medical Diagnosis:

Many individuals also present with multiple medical diagnosis

13

NC START-Reporting

Referral and Crisis Intervention Services Provided (cont):

Disposition of Cases:

Intervention in **350 crisis events** resulted in the following:

- Maintained in current setting: **227**
- Crisis respite provided: **55**
- Community psychiatric unit: **29**
- State psychiatric hospital admission: **14 FY09-quarter 4; 9 FY10-quarter 1**
- Referral/linkage to other services: **16**

*only for those who were not appropriate for NC START; i.e. no I/DD

It is critical to note that although the goal is to maintain individuals in their residence there are times when a psychiatric hospital admission may be determined to be necessary.

14

NC START-Reporting

Respite Home Utilization:

Total admissions: **130**
Planned: **61**
Crisis: **69**

Residential Setting Prior to Admission:
Most individuals were admitted from their family home or a group home setting.

15

NC START-Update

- National Institute of Mental Health (NIMH) Grant Proposal:

-Dr. Joan Beasley, in collaboration with The Heller School for Social Policy and Management, Brandeis University, has submitted a grant proposal to NIMH.

-The purpose of the proposal is to examine the START model in North Carolina to measure:

*the statewide implementation of START essential elements,

*establishment of START linkages for each region

*services received and associated outcomes for individuals served

16

Division of State Operated Healthcare Facilities

Overview of Alcohol and Drug Abuse Treatment Centers (ADATC)

Presentation to LOC for MH/DD/SAS
February 10, 2009

J. Luckey Welsh, Jr., FACHE
Director

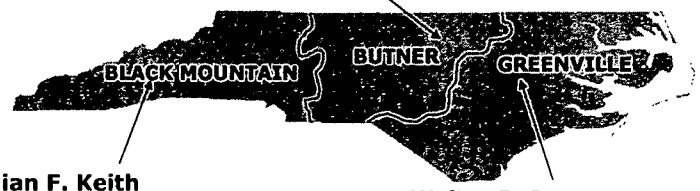
Division of State Operated Healthcare Facilities (DSOHF)

We are a system of healthcare facilities that respects the dignity of individuals and provides individualized, compassionate, efficient, quality care to the citizens of North Carolina with developmental disabilities, substance use disorders and psychiatric illnesses and whose needs exceed the level of care available in the community.

Touching Lives. Enriching Futures

Regions

R.J. Blackley
Opened 1950
Serves 25 central counties
Opioid Treatment Program



Julian F. Keith
Opened 1969
Serves 38 western counties

Walter B. Jones
Opened 1968
Serves 37 eastern counties
Statewide perinatal program for pregnant & post-partum women (babies under 12 months)

Touching Lives. Enriching Futures

Capacity

Facility	Acute Crisis Beds	Acute Rehab Beds	Average wait time *
Julian F. Keith	30	50	24 days
R.J. Blackley	21	44	8 days
Walter B. Jones	24	56	14 days

* Acute Rehab wait time July 1, 2009 – December 31, 2009
** No wait time for Acute Crisis Beds
*** R.J. Blackley will increase to 30 ACU and 50 ARS beds in August 2010 after the move to their new space.

Touching Lives. Enriching Futures

The ADATCs

- The three state operated Alcohol and Drug Abuse Treatment Centers (ADATCs) serve adults with addictions and/or co-occurring mental health disorders that are so severe they cannot be served in the community.
- ADATCs are certified by CMS as inpatient psychiatric hospitals.

Touching Lives. Enriching Futures

Changes at the ADATCs

- Originally, the programs in each of the 3 facilities were "rehab" programs offering only detox, education, recreation, VR, group therapy, and AA groups.
- The ADATCs now provide inpatient treatment services including:
  - Medically Monitored Detox
  - Psychiatric Services
  - 24/7 Nursing Care
  - Psychological Services
  - Evidence-Based Substance Abuse Treatment
  - Evidence-Based Mental Health Treatment
  - Family Therapy and Parenting
  - Licensed Recreational Services
  - Individual and Group Therapy
  - 12-Step and Dual Recovery Support Services

Touching Lives. Enriching Futures

Changes at the ADATCs (con't)

- Many of the ADATC programmatic changes were initiated by the move to acute crisis treatment.
- In 2001, the initial vision of the Acute Crisis Units (ACUs) was presented to the legislature. The ACUs were initially designed to treat individuals with complicated detox needs.
- This vision for the ACU beds changed to include serving individuals who may be under Involuntary Commitment and who would in the past have been referred to the State Psychiatric Hospitals.
- In 2004, the ADATC mission statement changed to reflect a co-occurring treatment focus and the move to a more acute crisis treatment approach.

ADATC Mission Statement

To provide medically monitored detoxification/crisis stabilization and short-term treatment preparing adults with substance use and co-occurring disorders for ongoing community based recovery services.

Total ADATC Admissions

SFY 2007	SFY 2008	SFY 2009
3530	**4327**	**4204**

Touching Lives. Enriching Futures

ACU/ARS Admissions

	SFY					
	2007		2008		2009	
	ACU	ARS	ACU	ARS	ACU	ARS
Julian F. Keith, ADATC	430	983	536	1079	676	644
Walter B Jones, ADATC	n/a *	974	1087	657	1319	542
RJ Blackey, ADATC	n/a **	1143	266	702	658	365
TOTALS		3100	**1889**	2438	**2653**	1551

*** WBJ ACU opened July 2007**
**** RJB data not separated from JUH FY 2007**

Touching Lives. Enriching Futures

Acute Crisis Unit Admissions

- The ADATCs now serve individuals under Involuntary Commitment (IVC).
- In SFY 09, 63% of all individuals referred to an ADATC came through the Acute Crisis Units (ACUs) from Emergency Rooms. The number and percentage of individuals served in the ACUs will increase now that the JFK ADATC ACU beds are fully operational.
- If the ADATC ACUs were unavailable, these individuals would have been referred to the State Psychiatric Hospitals.

IVCs

Facility	ACU*
Julian F. Keith	55%
R.J. Blackley	42%
Walter B. Jones	48%

*Percentage of ACU IVC admissions

SA Only Admissions to State Psychiatric Hospitals

	07/01/2006 - 06/30/2007	07/01/2007 - 06/30/2008	07/01/2008 - 06/30/2009	07/01/2009 - 12/31/2009
Total SA only Admissions to State Psychiatric Hospital	1549	813	800	176

Population Change: Acute Rehab Service

- In SFY 2009, 41% of patients served in the Acute Crisis Units stepped down to continue receiving Acute Rehab Services.
- The ADATCs continue to admit individuals directly in to Acute Rehab Service who have been unable to achieve sobriety and recovery in community but also meet inpatient admission criteria.

Population Change: Co-Occurring

- The change to a more acute care model also changed the population served both in Acute Crisis Units and Acute Rehab Service.
- In First Quarter SFY 2010, 66% of individuals served at the ADATCs had a co-occurring mental health diagnoses.

Touching Lives. Enriching Futures

Diagnostic Categories

Admissions 7/1/09 – 9/30/09	
Major Depression	27%
Bipolar Disorder	18%
Anxiety Disorder	17%
Post-Traumatic Stress Disorder	11%
Schizophrenia	5%
Personality Disorder	3%

Source: ADATC NC-TOPPS

Touching Lives. Enriching Futures

Program Redesign/Implementation

- In response to the changing population's needs, the ADATCs developed a new treatment model for individuals with substance use and co-occurring disorders.
- The ADATCs began implementation of the newly developed treatment model in 2006.
- This is an innovative evidence-based model that has been implemented at all ADATCs and presented nationally.

Challenges

- Resources:
  - Budgetary
  - Staffing
  - Ongoing training needs of employees
  - Equipment
  - Information Technology

Accomplishments

- Increased acute care capacity for individuals with substance use disorders
- Decreased "Substance Abuse Only" admissions to the State Psychiatric Hospitals
- Introduced an evidence-based treatment model to better meet the needs of the people we serve
- Maintained low recidivism rate of 3%
- Provide treatment for high-risk pregnant women and help the next generation of North Carolinians
- We are the safety net for North Carolinians with the most severe substance use and co-occurring disorders

Questions

?

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
March 10, 2010 10:00 A.M.; Room 643, Legislative Office Building

I. Welcome Opening Comments 10:00
Representative Verla Insko, Co-Chair, Presiding
Senator Martin Nesbitt , Co-Chair

II. Secretary's Remarks 10:00 – 10:30
-Department Updates
-Program Integrity
Lanier Cansler, Secretary, DHHS

III. 1915(b)/(c) Waiver Expansion for MH/DD/SAS 10:30 – 11:00
Michael Watson, Assistant Secretary for MH/DD/SAS Development

IV. PBH Demonstration 11:00 – 11:30
Dan Coughlin, Area Director/ CEO
Pam Shipman, Chief Operations Officer

V. CCNC and LME Integrated Care 11:30-12:15
Arthur Carder, CEO, Western Highlands Network
Jennifer Wehe, Executive Director, Access II Care of WNC
Dr. Richard Hudspeth, Medical Director, Access II Care of WNC

VI. NC Mental Health Policy and Practice Hub 12:15 -12:30
Al Huntoon, former Director NC Leadership Academy
Rob Lamme, Consultant, former Director Govt. Relations NCDHHS

Lunch 12:30 – 1:30

VII. Clubhouse Model 1:30 – 2:15
Joel Corcoran, Director, International Center for Clubhouse Development
Sue Estroff, PhD, Dept. of Social Medicine, School of Medicine, UNC
Charlene Lee, Club Nova Member

VIII. Report on Case Mgt. Consolidation 2:15 - 2:45
Tara Larson, Chief Clinical Operating Officer, DMA

IX. Comments from the Community 2:45 – 3:00
- State Consumer Family and Advisory Committee
Carl Noyes
-North Carolina Mental Hope
David Cornwell

Adjourn

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	3/10/10																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	X																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	X																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	X																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	X																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	X																
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

March 10, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, March 10, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Bob Atwater, Doug Berger, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representative Van Braxton and Representative William Brisson were present. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the February 10, 2010 meeting. The motion was made by Representative Earle and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS), provided a brief update on current issues relating to funding programs within DHHS. Limitations on the availability of funds continue to create problems. Most recently, DHHS had to find $7M to cover a shortage of funds in the Aids Drug Assistance Program. According to the Secretary, there is enough money to cover expenses through this fiscal year but additional funds will have to be appropriated to meet the need next year. Also, Medicaid continues to be over budget. Medicaid is a federal/State program and any changes to the program must be approved by the federal government. Finally, the Secretary noted that the Governor is making Program Integrity a top priority. Before services are cut or reduced there will be an effort to see that services are appropriate and that services are not being abused or fraudulently accessed in the system.

Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, provided details on expanding the 1915 (b)(c) Waiver to other local management entities. (See Attachment No. 2) Interesting points included:

- Waivers are requests to CMS that exempt operators of the waiver from certain requirements of the Social Security Act, this could include such requirements as

State wideness or the "any willing and qualified" provider provisions. Services must be managed in a cost neutral manner.

- The 1915 (b) waivers or "freedom of choice" waivers deal with managed care, 1915 (c) waivers are for Home and Community Based Services in lieu of institutional care. An example of this is our current CAP-MR/DD waiver.
- PBH formerly Piedmont Behavioral Health began operating under two waivers as a pilot project in 2005 for Medicaid funded services for MH/DD/SA on a capitated basis in the LME's catchment.
- Based on the performance of PBH and with guidance from the LOC and the General Assembly, DHHS has elected to expand the pilot beyond PBH.
- In 2009, DHHS submitted a waiver amendment to CMS designed to expand the pilot project through a modification of the existing PBH waivers. The Waiver Amendment has been approved.
- Interested LMEs that meet qualification criteria can apply for consideration by April 14, 2010 with a planned start up date of January 1, 2011.
- Operating under the 1915 (b)(c) Waiver allows a LME the opportunity to combine the utilization of State and Medicaid dollars at the community level.
- There are 6 LMEs that currently meet the criteria for 70,000 covered lives for the Waiver – Smoky Mountain, Western Highlands, Mecklenburg, Sandhills, CenterPoint, and Piedmont.

Several members expressed concern that the small to medium size LMEs would not be able to meet the criteria for the 70,000 population and that they could be put out of business due to the changes. Mr. Watson assured members that different options were available and that DHHS was trying to operate with as much flexibility in the process as possible in order to build on a firm foundation.

During questions about the waiver expansion, the issue of CABHAs and how consumers would be transitioned came up. Secretary Cansler stated that the process of how to transition consumers would begin on April 1. LMEs would work with providers that have not applied to become a CABHA. If an agency wishes to be certified as a CABHA July 1, they must apply before April 1. If an agency has not submitted a letter for attestation and they deliver one of the three services (Intensive Home, Day Treatment or Community Support Team) required to be classified as a CABHA, the transition of consumers would need to take place in order to see that services are not interrupted. He said the idea is to have a more clinically founded system. DHHS is in communication with CMS to see if there is some flexibility in the transition process. Representative Insko requested that members forward emails with concerns regarding the system to DMH in order for them to respond during the meeting on April 14th.

Dan Coughlin, Area Director and CEO of PBH and Pam Shipman, Chief Operations Officer, provided a detailed presentation of a Medicaid Waiver and a Managed Behavioral operating model. (See Attachment No. 3) They addressed how PBH is structured, how it operates, the effect on the community, the budgetary concerns and the quality of care for consumers. Additional points highlighted in the presentation included:

- The goal of Managed Care is to manage cost, manage limited resources, develop parity and match needs to services.
- Detailed data provides a connection between need, services, and cost enabling PBH to coordinate a managed system.
- Grievances are tracked and resolved within 30 days.
- Skill mapping software allows PBH to look at locations of consumers and providers. CMS requires that services be available within 30 miles/30 minutes. Important tool used in operating and enrolling providers in the PBH network.

Arthur Carder, CEO of Western Highlands Network (WHN), Jennifer Wehe, Executive Director of Access II Care of Western North Carolina, and Dr. Richard Hudspeth, Medical Director of Access II Care, provided a presentation on Community Care of North Carolina (CCNC) and LME integrated care. Mr. Carder pointed out that the National data shows that consumers with severe mental illness die 25 years sooner than the general public. He also said that partnerships have been formed between LMEs and CCNC to save the lives of consumers, to improve their quality of life, and to facilitate the use of limited resources – staffing and funding.

Ms. Wehe stated the following facts during her presentation:

- CCNC is a volunteer network of physicians, hospitals, health departments, local counties Department of Social Services and LMEs. Statewide there are 14 networks which include 4,000 physicians in all 100 counties and 990,000 Medicaid enrollees. Access II Care manages care for over 50,000 Medicaid enrollees.
- A Mercer analysis in FY 2007 indicated that CCNC saved tax payers of North Carolina between one hundred and thirty five million ($135M) and one hundred and forty nine million dollars ($149M).
- CMS recently awarded North Carolina a 646 Federal Demonstration Waiver allowing Community Care to expand strategies in the Medical Home model to the dually eligible and Medicare patients. As a precursor to the 646 Waiver, the network has expanded the focus to include Care Management programs for the complex chronically ill, aged, blind and disabled population. This population equals 20% of the Access II Care enrollees and 80% of the total Medicaid dollars spent.
- 47% of the total Medicaid cost for Access II Care is attributed to MHDDSA services.

Dr. Hudspeth also made the following points:

- Every system is perfectly designed to get the results it achieves. The current system is designed to fit within our cultural model and the results are products of that model. There is a mind/body silo with physical care in one place and mental care in another. The people in the silos do not communicate very well. An internal chart audit of primary care providers indicated that only 2% of the time showed there was information in the chart regarding the mental care provider.
- An example of one case provided an illustration of the short comings of the system and the potential for heightened collaboration between the LMEs and the

Community Care network. In the end, the inpatient utilization was reduced by 64%, MH/SA hospitalization by 25%, and ED utilization by 55%. The difference was the right care - all the members of the care team including the patient getting the right resources to the patient; right communication – relationship building between all team members, sharing information and data; and using the dollars to reduce cost and achieve better outcomes.

Secretary Cansler requested a road map for this project, to create a timeline for further implementation with the needs and further develop the cost saving analysis.

Joel Corcoran, Director of the International Center for Clubhouse Development (ICCD), explained what a Clubhouse is and how the ICCD organization operates to improve the life circumstances of people living with serious mental illness. (See Attachment No. 5) He said there were 334 member Clubhouses and 25 new start-up working groups in more than 30 countries. His presentation included the following points of interest:

- A Clubhouse is more than a program or a service or a contract with DHHS. It is a community of people intentionally designed to help people come together and to support each other while living with and overcoming the circumstance of mental illness.
- A Clubhouse is a membership organization and members have ownership and responsibilities for what goes on there.
- Clubhouses are organized around 36 internationally recognized and established Best Practices.
- Clubhouses are open to those 18 years and older with a diagnosis of a serious mental illness. The operation of the Clubhouse during the day include clerical duties, reception, food service, transportation, program management, outreach, managing the employment education program, managing the financial services, advocating for services with mental illness and more.
- Members and staff do all the work together in the Clubhouse side-by-side.
- Clubhouses are different than other PSR programs. Key differences – 60 years in refining and practicing the model; Evidence Based Practice; structured standards training and network of peer support for Clubhouses; and Clubhouse certification accreditation.

Next, Charlene Lee, a member of Club Nova, an ICCD Certified Clubhouse Model, provided the Committee with a testimony of her life and told of the profound effect Club Nova has had on her life. (See Attachment No. 6) Ms. Lee described how Club Nova helped her secure a job, find an apartment, enroll in Medicaid to help pay for medications and how she was approved for full disability with the help of staff. She concluded her speech by asking for support of the existing Clubhouses saying they were cost effective and a wise investment of public funds.

Dr. Sue Estroff with the School of Medicine, UNC, explained why there needs to be a Clubhouse specific service definition. (See Attachment No. 7) Her presentation included the following points of interest:

- Universities and community colleges benefit from teaching, training, and skills of Clubhouses. Social work students, nursing students, business students, and others train at Clubhouses.
- Clubhouses are already providing community support services as defined in administrative rules.
- Last year, Threshold provided over $137,000 in uncompensated care to members who lost county based funding and did not qualify for Medicaid. Overall, the Clubhouses in North Carolina gave $766,000 in uncompensated care because of the way the rates are established and because of the way the service definitions are written. Clubhouses are not able to continue with these expenditures without help.
- Between 1998 and 2009 the rates paid under the service definition increased $2.95. Clubhouses provide community support service and would like to be paid for what they are providing.
- Implementation of CABHA will result in the demise of Clubhouses in North Carolina.

Jackie Combs, a Clubhouse director and executive director of a non-profit mental health agency in Henderson County, read the 4 recommendations requested by the Clubhouse Coalition. (See Attachment No. 8)

Secretary Cansler said that because of the financial stability concern for the Clubhouses, he had recently requested Mike Watson and Leza Wainwright to recommend a way to adjust the rates to make the Clubhouses financially sustainable. He added that the Clubhouses are an important part of the continuum of care and DHHS is trying to identify funds to help. Secretary Cansler said he would follow up on the issue of a new service definition.

Rob Lamme, Consultant and former Director of Government Relations with DHHS, presented a proposal designed to help communication between the university system and the mental health system (See Attachment No. 9). Mr. Lamme described the Policy Hub as a place in the Keenan Flagler School of Business where those in the MHDDSA system, the University system and stakeholders in MHDDSA within the University system can collaborate. Formerly the Mental Health Leadership Academy (MHLA) was a program funded by the General Assembly that operated to provide leadership and management training for the LME system, but was disbanded last year largely due to the budget crisis. Despite the current economic picture, Mr. Lamme believes there is still a need for collaboration to apply for federal and private grants that cross agencies that could provide critical services and pilot programs for the system. The Hub could utilize the University's ability to find and obtain grants not only for the University system but also for the MHDDSA system. The Hub could help graduate and undergraduate students obtain experience in the MHDDSA system that is currently difficult to access. The Hub would be the portal into the University system to access resources. Mr. Lamme requested that the Committee consider recommending funding for the Hub to the General Assembly.

Tara Larson, Chief Clinical Operating Officer, DMA, reported on case management consolidation. (See Attachment No. 10) Points of interest included:

- Diagram illustrates what case management would look like in the future. Services are building off the CABHA as well as the 1915 (b)(c) waiver, and the integrated approach through CCNC.
- Workgroups are meeting in order to strategize on case management services consolidation.
- DMA requires linkages between primary care and behavioral health on all of the waiver implementation and the RFA. Through linkages and the workgroups, major triggers have been identified to establish better communication and coordination of care.
- Workgroup for forms standardization is looking at how computer systems can provide the same information rather than a particular block on a form.
- Short term goal - looking at ways to address costs associated with case management since that is a condition with consolidation.
- Unit limit has been established and went into effect March 1 requiring a reduction of 3 hours per month with an additional 6 hours that can be used for crisis.
- Prior authorization of CAP MR/DD case management has been eliminated which went into effect March 1. This will reduce some of the administrative burden on providers.
- Effective April 1, an edit has been placed in the system reducing the number of case managers in order to have single case managers dealing with families and consumers in order to eliminate confusion in the care of a recipient.

Andrea Stevens from the Services Task Team of the State Consumer Family and Advisory Committee (SCFAC), said that their efforts focused on service gaps and underserved populations; making recommendations regarding the service array; monitoring the development of additional services; and to participate in all quality improvement measures and performances. An outline of the Team's suggestions is attached. (See Attachment No. 11) Representative Insko noted that it was important to have more consumer input. Ms. Stevens commented that the timeliness of that input was important. She said it was imperative to be in the process from the beginning.

Carl Noyes, an eastern North Carolina representative of the SCFAC said there was concern among consumers that CABHAs will not build in areas where there is not enough population to support them and where CABHAs do build they will eliminate the small providers. There is also concern that the small provider may collapse under the tremendous growth that they will experience. He said that SCFAC would like to urge DHHS to slow down the process to allow providers the opportunity to determine how to manage the growth and have the proper infrastructure in place to support that growth. (See Attachment No. 12)

David Cornwell, Executive Director of North Carolina Mental Hope, a consumer-driven advocacy organization, addressed the problem of inclusion regarding collaboration between consumer-driven organizations and DMH. (See Attachment No. 13) He indicated that it was implied that stakeholder inclusion was synonymous with consumer

inclusion but that is not the case since consumers are not stakeholders. He said the State had the opportunity to recognize the equality of all citizens, the opportunity to work together for a better system.

There being no further business, the meeting adjourned at 3:15 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS March 10, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dave Richard	The Arc
KATHLEEN HERR	LAW STUDENT - NCCU SCHOOL OF LAW
Ron Rau	Alcohol & Drug Services 119 Chestnut Dr. High Point, NC 27262
Vic Nussbaum	GUILFORD CARES 1105 D EAST WENDOVER AVE GREENSBORO NC 27405
Debra C Farrington	OPC Area Program Chapel Hill, NC
Cim Brailey	OPC Area Program Chapel Hill, NC
Judy Taylor	MOM KIDS / RANE
David Taylor Jr.	People First
James Hardy	Cambridge Behavioral Health Services 622 S. Memorial Dr. Greenville, NC 27834
Seretra Wallace	Club Horizon (Clubhouse program) 101B Forest Dr. Knightdale, NC. 27545
Treva Johnson	omni visions 910 C Street Suite 8 NW NC 28659

VISITOR REGISTRATION SHEET

Name of Committee

Date

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NAME	FIRM OR AGENCY AND ADDRESS
Joe Donovan	Self
Yvonne Copeland	NC Council of Comm Progs
Bob Hedrick	NC Providers Council
Ellen Russell	The Arc of NC
Maureen Morrell	Autism Society, BNC
Fred Wadell	Easter Seals UCP NC & VA.
Lesley Dover	Eastern Carolina Case Management
Jaime Marcum	"
Sean Kenny	"
Amy Whited	NC Medical Society
Leigh Shingleton	Advocacy in Action

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS March 10, 2010

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NAME	FIRM OR AGENCY AND ADDRESS
HAL JONES	SAGUARO MGT. - RALEIGH
Brad Bannister	DJJDP
Jerry Mills	M H M. Services Inc
Misty Martin	Lighthouse Counseling Center - Fayetteville
Mark Sullivan	MHA Orange County
MARTHA THOMPSON	Liberty Corner Enterprises, Inc.
MARTHA LOWRANCE	YAIDDDA
AISANDER DUDA	NCCPPR
NANCY LANE	PDA
MIKE VICARIO	NCHA

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NAME	FIRM OR AGENCY AND ADDRESS
Ellen Perry	Advocacy in Action
Fred Bone	Bone & Assoc.
Joel Maynard	CFM & Assoc.
Will Woodell	Value Options
Yumekeo Little-Singletary	Family Legacy Mental Health Services, Inc. 204 N. Person St.; Raleigh, NC
Mike Gibson	MH/DD Services Inc.
Emily Welborne	TPLT
Peggy Magnus	SA
Lisa Jones	SAMHSA
Rob Lawrence	Citizen
[illegible]	Catalyst Consulting

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Joint Legislative Oversight Committee on MH/DD/SAS March 10, 2010

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NAME	FIRM OR AGENCY AND ADDRESS
Victoria Uhatt	Standhills Center LME United N.C.
Billy West	DAYMARK Recovery Services- Concord NC
Tammy Smith	NC AOC / Raleigh NC
BOB WERSTLEIL	DAYMARK RECOVERY SERVICES CONCORD NC
JILL PUSHING	NC COUNCIL ON DD
TARA HEASLEY	NC Council on DD
Vicki Smith	Disability Rights NC
Tony Hawkins	NC Food Bank
Janet Schanzenbach	Indigo Consulting

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Joint Legislative Oversight Committee on MH/DD/SAS March 10, 2010

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NAME	FIRM OR AGENCY AND ADDRESS
Matthew Cox	Club Nova 103 W. Main Carrboro, NC 27510
Erin Spence	Club Nova
Shira Belovicz	Club Nova
Jackie Pattisall	Club Nova
Mary Slade	Club Nova
Claire Salisbury	Club Nova
Katie O'Toole	Club Nova
Jeff Weiler	Club Nova
Kathryn M. Peck	Club Nova Community, Inc.
Ethelon Benjamin	Club Nova
Will Owen, Elena Fowler, Collin Lee, Karen Dunn	Club Nova

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Name of Committee _____ Date _____

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NAME	FIRM OR AGENCY AND ADDRESS
Gail Boswell	MH/Consumer/Advocate P.O. Box 7416 Wilson, NC 27895
Kathy Baker	Southeastern Regional LME 450 Country Club Road Lumberton, NC 28360
Tom Culver	KidsPeace
Kaye Holder	DHHS / Budget Analysis
Bernard	Threshold
Marcenia Aldridge	Threshold
Erica Weaver	Threshold Inc. 609 Gary St Durham NC 27703
Shannon Clay	Threshold Inc. 609 Gary St. Durham NC 27703
Mary Rica Todd	N.C. Housing Finance Agency
LARRY LEE GRANT SR	Threshold 609 Gary St. Durham, N.C. 27702
Annie Jones	Threshold 609 Gary St. Durham, N.C. 27704

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Joint Legislative Oversight Committee on MH/DD/SAS March 10, 2010

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NAME	FIRM OR AGENCY AND ADDRESS
Tommy Gunn	Adventure House, Shelby NC
Fred Mead	Adventure House, Shelby, N.C.
Patricia Wiggs	Adventure House shelby N.C. member
Jill Snyder	6th avenue West Clubhouse Hendersonville. NC
Gail Roberts	6th Avenue West Clubhouse Hendersonville, NC
Rena J Robinson	746th Avenue West Clubhouse Hendersonville NC
Jacqueline S. Combs	SIXTH AVENUE PSYCHIATRIC REHAB PARTNERS, INC HENDERSONVILLE, NC 28739
Susie Detr	Threshold Clubhouse
Ali Swiller	Threshold Clubhouse
Brenda McCaffery	theshold clubhouse
DON KAADE	THRESHOLD CLUBHOUSE, DURHAM

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NAME	FIRM OR AGENCY AND ADDRESS
Clarissa Goodlett	Governor's Institute on Alcohol & Substance Abuse
Karen Kincaid Dunn	103 D West Main St. Carrboro, NC 27510 Club Nova Community, Inc.
Jodi Lorenzo-Schibley	518 N. Elm St. Greensboro, NC 27401 Sanctuary House Clubhouse
Jennifer Stetler	Sanctuary House Clubhouse 650, NC 27401
Jennifer Anderson	Sanctuary House Clubhouse 518 N. Elm St. Greensboro, NC 27401
Clifford Lash II	Sanctuary House clubhouse 518 N. Elm St. Greensboro, NC 27401
Cary Davis	Sanctuary House Clubhouse 518 N. Elm St. Greensboro, NC, 27401
William Louis Pegues	sanctuary House Club house 518 N Elm st Greensboro N C 27401
Paul Wingfield	Sanctuary House Clubhouse 518 N Elm St Greensboro. NC 27401
Sherida Shaw	Sanctuary House Clubhouse 518 N Elm St. Greensboro NC 27401
Gloria Andrews	Sanctuary House 518 Elm St Greensboro, NC, 27401

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Joe Mamsey	UNC-CH
Marco Tomat	Youth Villages
Andrew Meehan	CapStat
Louise Fischer	Volunteer Advocate for M.A.
Tee Tolliver	Mental Behavioral Health Assn
Pam Andrews	New River Behavioral Healthcare
Susan King Cope	NAMI NC
Jeffrey Walton	GA10-DOA

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NAME	FIRM OR AGENCY AND ADDRESS
Robin Baker	The Arc of Orange Co.
Julia Leggett	The Arc of NC
Mary Gunter	Club Horizon, Inc.
Jennifer Mahan	MHANC
Sally Cameron	NC Psychological Assoc
Martha Brock	Advocate: NC Mental Hygiene
William Moore COO	Healing Interventions, Inc
Kenneth R Morris	Healing Interventions Inc

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NAME	FIRM OR AGENCY AND ADDRESS
Larry Thompson	Blue Ridge Area Foundation Inc
Jeanne Harrison	S.A. Alliance Rehabilitative Care, Inc.
Angie Bantha	SA Federation - NCSAPPB
Roy Wilson	East Carolina Behavioral Health
Tom Chapple	Coastal Horizons Center SA Federation
Jack Chatfield	SA federation / SouthLight, Inc.
William Robinson	Corrections
Sarah Parham	Connections Clubhouse - Newton, NC

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NAME	FIRM OR AGENCY AND ADDRESS
Crystal Nunnemaker	OmniVisions 910 C Street N. Wilkesboro NC 28659
Arthur CANOER	Western Highlands Network
Jennifer Wiche	Access II Care of WNC (CCNC)
Kimberly Norton	Access II Care of WNC (CCNC)
Michelle Bookas	Caramore community inc., Chapel Hill NC
Daniel Brown	Monarch, Albemarle, NC
Gene Rhodes	Universal - Raleigh

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NAME	FIRM OR AGENCY AND ADDRESS
Laurie Stickney	Community Partnerships, Inc. 3522 Haworth Dr. Raleigh, NC 27609
Rob Robinson	Durham Center LME 501 Willard St Durham, NC
M. Bullard	Durham Center Board Rel AB.

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NAME	FIRM OR AGENCY AND ADDRESS
Deanna Janus	Pride In NC
Ken Mason	DMHDDSAS - LME Team

DHHS 1915 b/c WAIVER ENTITY PROJECT

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
March 10, 2010

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

1

N.C. 1915 b/c WAIVER: WHAT IS IT?

- Waiver - Request to CMS that provisions of the Social Security Act (SSA) be "waived"
  - State wideness
  - Fee-for-Service payment requirements
  - "Any willing and qualified provider"
- 1915(b) waivers are commonly known as a "freedom of choice" or managed care waiver
- 1915(c) waivers are Home and Community Based Services waivers in lieu of institutional care, such as our CAP-MR/DD waivers
- b/c Waiver combines services for all Medicaid funded MH/DD/SA consumers into a single capitated funding model
- Waiver Allows: The operations of a capitated manage care system as vehicle for service provision to Medicaid recipients

2

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Waiver Goal - Implementing improvements in the Medicaid Program designed to increase cost-effectiveness, efficiency, consumer access, choice and provider quality. Providing uniform management approach to Medicaid and state funded services.
- 1915 (b) - B-3 Services allows for additional consumer services to be funded from "savings" in the Waiver
- 1915 (c) - Focuses on services to I/DD consumers and allows the management of State/Community ICF-MR services in addition to current CAP-MR/DD Waiver services and other Medicaid funded I/DD consumer services

3

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- 1915 b/c - Waivers have different authorization lengths and renewal periods (2 - 5 years)
- Provides opportunity to create fiscal incentives that can generate improved consumer outcomes
- Waiver eliminates "any willing and qualified provider" provision - LME MUST ADDRESS ACCESS AND CHOICE CONCERNS - can limit provider network

4

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Waiver LME can negotiate rates - generally follow current Medicaid rates
- Waiver management entity (LME) assumes risk in managing the delivery of MH/DD/SA Services within the financial framework of the Medicaid capitation rate
- Services must be managed in a cost/neutral manner (Actual waiver costs must be less than or comparable to actual fee-for-services (FFS) program costs

5

N.C. 1915 b/c WAIVER: WHAT IS IT CONT'D?

- Combines authorization management of Medicaid/State Funds at the community level
- Provides for **Stable** and **Predictable** Medicaid Expenditures for MH/DD/SA Services

6

1915 b/c WAIVER POLICY TOOLS

- **Capitation-** provides local flexibility and control of Medicaid/State funding
- **Claims Payment-** ensures that funds are spent in keeping with service authorizations
- **Rate Setting Authority-** allows waiver entity to adjust service rates to meet local needs

7

1915 b/c WAIVER POLICY TOOLS CONT'D

- **Closed Network-** allow competition/choice with right sizing the provider network/provider stability
- **Utilization Management-** provides a tool to ensure that consumers receive the right service at the right level
- **Care Management-** provides direct support to high cost/high risk consumers

8

WAIVER GOALS

- Improved Access to Services
- Improved Quality of Care
- Increased Cost Benefit
- Predictable Medicaid Costs
- Combine the management of State/Medicaid Service Funds at the Community Level

9

WAIVER GOALS CONT'D

- Support the purchase and delivery of best practice services
- Ensure that services are managed and delivered within a quality management framework
- Empower consumers and families to set their own priorities, take reasonable risks, participate in system management to shape the system through their choices of services and providers

10

WAIVER GOALS CONT'D

- Empower the LME to build partnerships with consumers, providers and community stakeholders with the goal of creating a more responsive system of community care.
- Increased consistency and economies of scale in the management of community services
- Create financial incentives for LMEs and providers to achieve state goals that improve consumer outcomes

11

1915 b/c WAIVER HISTORY IN NORTH CAROLINA

- April 2005: DHHS began operating under two new waivers in the PBH (formerly know as Piedmont Behavioral Healthcare) LME Area. These Waivers included:
  - The Piedmont Cardinal Health Plan—a pilot 1915 (b) Freedom of Choice Waiver Project, and
  - The Innovations Home and Community Based Services (HCBS) 1915 (c) Waiver

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1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- Waivers managed by PBH LME
- Pilot Project: Medicaid funded services for MH/DD/SA on a capitated basis in the five county (Cabarrus, Davidson, Rowan, Stanley & Union) area.

13

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- The capitated funding is paid to PBH in a per member per month (pmpm) payment that is based on the historical service costs associated with six different Medicaid eligibility groups
- PBH Waiver has received annual outside reviews and significant monitoring on the part of DMH/DD/SAS and DMA

14

1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- PBH is nationally accredited under NCQA and has developed an aggressive internal quality management and provider monitoring program.
- Based on the performance of PBH Waiver and the guidance from the LOC and the NC General Assembly, DHHS has elected to expand this pilot project beyond the PBH area.
- Expansion will initially be limited (1 - 2 LMEs) with the eventual goal of statewide implementation

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1915 b/c WAIVER HISTORY IN NORTH CAROLINA CONT'D

- December 2009: DHHS submitted waiver amendment to CMS designed to expand the pilot project through a modification of the existing PBH Waivers.

Note: This Waiver Amendment has since been approved by CMS.

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1915 b/c WAIVER EXPANSION SCHEDULE

- February 18, 2010: Posting of Request for Applications (RFA)
- March 4, 2010: Bidder's Conference
- April 14, 2010: RFA Application Due Date
- July, 2010: Selection of LME(s)
- January, 2011: Planned Expansion Waiver Start-Up Date

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1915 b/c WAIVER EXPANSION SCHEDULE CONT'D

- **Note #1**: 1-2 LMEs to be selected as expansion Waiver sites
- **Note #2**: Consumer participation in the RFA selection process
- **Note #3**: Requires Technical Amendment to current Waivers to add new LMEs

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WAIVER LME SCOPE OF WORK

- Recruiting & Credentialing providers
- Developing and overseeing a comprehensive MH/DD/SAS Provider Network

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WAIVER LME SCOPE OF WORK CONT'D

- Authorizing Payment for Service
- Processing and Paying Claims
- Conducting Care Management, Utilization Management and Quality Management Functions
- Compliance with DMA and DMH/DD/SAS Contract requirements

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WAIVER LME SCOPE OF WORK CONT'D

NOTE: These critical functions are required of all LMEs in their management of State funded services. However, successful operation in a capitated environment requires very sophisticated management, technical and IT capacity

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WAIVER EXPANSION SELECTION CRITERIA

Organizational Arrangements for Application:

- Single LME
- A merger of two or more LMEs (Per G.S. 122C-115.3(a) a full merger can only become effective at the start of a new State fiscal year)
- Various subcontracting arrangements among two or more LMEs
- A management agreement among two or more LMEs

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

- Note #1: DHHS may contract with a single LME, a merged LME or a lead LME—DHHS will contract with and make all State/Medicaid capitated funding payments to a single LME.
- Note #2: LMEs may propose to contract out one or more of the functions required under the DMA or DMH/DD/SAS contracts. LME responsible for all contractor performance.

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

Minimum Requirements:

- Medicaid eligible population (3 years or older) = 70,000+ (6 LMEs currently meet this standard)
- Fully divested of all State funded or Medicaid reimbursable services
- Fully accredited for a minimum of three (3) years Note: If not accredited by URAC or NCQA must become so by 3rd year of waiver operations

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

- Meet all Single Stream funding requirements
- Financial Status and Viability--Sufficient financial resources and strong financial management
- Letter of support from full LME Board assuming financial responsibility in submitting application
- Can not serve as legal guardian for a recipient of Medicaid funded MH/DD/SA Services

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

- No LME Staff or Board Member conflict of interest
- Strong IT Capacity
- Letter of Support from the LME Consumer and Family Advisory Committee (CFAC)
- Letter of Support from full LME Board

NOTE: MINIMUM REQUIREMENTS ARE REVIEWED ON A PASS/FAIL BASIS

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

Additional Requirements:

- Clinical Operations (35% of Score)
  - Customer Services
  - Care Management/Utilization Management
  - Quality Assurance and Quality Management
  - Consumer grievances and Appeals
  - Provider Network Management

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

- **Administrative Operations (35% of Score)**
  - Administrative Staff Qualifications
  - Health Information System
  - Records Management
  - Encounter Data and Claims
  - Financial Reporting Requirements
  - Clinical Reporting Requirements
  - Fraud and Abuse
  - Subcontracts
  - Timeliness of Provider Payments
  - Financial Management/Monitoring
  - Review of Proposed Organizational Structures

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WAIVER EXPANSION SELECTION CRITERIA CONT'D

- Implementation Plan (30% of Score)
  - Tasks
  - Timelines
  - Expected Results
  - Transition of implementation of subcontracted functions

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BASIC APPLICATION EVALUATION CRITERIA

- Track Record of Success as LME
- Demonstrated Capacity to Operate a Managed Care Program
- Strong Care Management/Utilization Management Function
- High Quality Provider Network Management Program
- Solvent and Financially Viable Organization

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BASIC APPLICATION EVALUATION CRITERIA CONT'D

- Automated Management Information System
- Demonstrated Capacity to Manage Systems of Care
- Ability to Facilitate the Development and Utilization of Natural Supports

Note: Applicant scoring based on Site and Desk Reviews

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WAIVER ISSUES/CONCERNS

- Capitation Rates:
  - Paid PMPM
  - Payment in Full for services
  - PMPM based on historical utilization + program changes
  - Total dollars increase/decrease with number of eligibles
  - Independent actuarial support

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WAIVER ISSUES/CONCERNS CONT'D

- Rate set for six (6) Medicaid eligibility groups (e.g. TANF-adult/child 3+, Foster Children 3+, Blind/Disabled 3-20, Blind/Aged/Disabled 21+, DD HCBS Innovations Waiver All Ages)
- Fair Rate = Fair Risk
- What services are in/out? (e.g. ER costs, pharmacy)

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RISK MANAGEMENT

- Waiver Model: Transfers Risk to LMEs
- Need Risk Reserve - Mercer recommends 16%
- DHHS will add 2% per year to capitation to develop restricted risk reserve

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RISK MANAGEMENT CONT'D

- Contract requires LMEs to "refresh" Risk Reserve if it falls below required level
- "Savings" can be placed in Risk Reserve
- Purchase of Stop Loss Insurance
- G.S. 122C-115.3.(g) place counties at risk for financial failure of LME

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PERFORMANCE MONITORING

- Consumer Satisfaction
- Consumer Involvement
- Consumer Access/Choice
- Complaints/Appeals
- Service Utilization Rates
- Cost Performance (Waiver vs. FFS)
- Prompt Pay – Providers
- Integration with primary care
- DHHS Monthly Monitoring

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ADMINISTRATIVE COSTS

- LMEs participating on the waiver will no longer receive a separate LME Systems Management Cost payment
- Will be negotiated as a percentage of overall funding
- PBH currently at 9.5% for both State & Medicaid funds

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IMPACT ON LME MANAGEMENT SYSTEM

- Waiver Model will reshape community management structure
- Increased consistency & economies of scale
- Reduce # of LMEs as a result of minimum covered lives requirement
- Economies of Scale vs. Local Management
- Generate Mergers & Alliances
- Demand technical competence
- Risk Management Concerns

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PROVIDER CONCERNS

- Limited Provider Network
- LME rate negotiation capacity (Note: higher rates can be paid to address access concerns)
- Expanded service authorization function
- Loss of direct enrollment in State Medicaid Program (contract with LME)
- Loss of State level cost reporting/cost finding
- Inclusion in larger system of care (e.g. community ICF-MR facilities)

Note: Some concerns can be addressed in DHHS/LME contracts

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STATE FUNDING MANAGEMENT ISSUES

- Waiver LME controls bed day funding at: State Hospitals, ADATCs & Developmental Centers
- Must purchase all bed day use
- Creates financial incentive to fund alternative community services

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STATE FUNDING MANAGEMENT ISSUES CONT'D

- Funding can follow the consumer if beds reduced
- Support Olmstead Goals
- Need to monitor impact on State Facility budgets (e.g. facility cost reductions may not equal lost LME receipts)

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CONCLUSION

- Waiver expansion provides long-term vision for our community system
- Serves to create financial incentives that generate effective outcomes for our consumers
- Create economies of scale in LME management system
- Provides consistency in management and generates economies of scale in both management and service delivery

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CONCLUSION CONT'D

- Provides predictable annual Medicaid costs
- Requires careful implementation and monitoring
- Expansion of one LME - 12-15% of N.C. Medicaid Eligible

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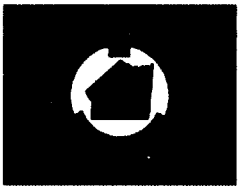
pbH

Piedmont Behavioral Healthcare

Creating solutions, One person at a time



Public Policy Considerations for North Carolina

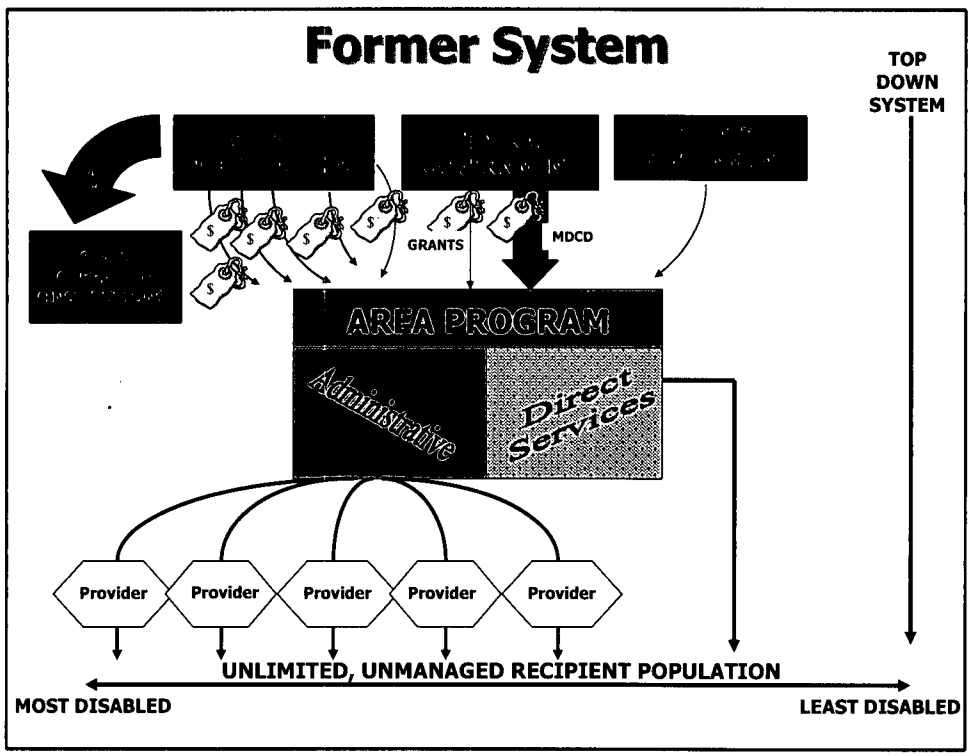
Management structure for public systems:

- **Statewide: too large, challenges in making adjustments for local needs.**
- **Regional: more efficient than local, but still able to make adjustments specific to the needs counties within the region. Electronic communications and electronic management software are one reason that a regional system of management with local presence is now possible.**
- **Local: very customized to local conditions but most counties are too small to provide the financial support needed to pay for the type of sophisticated infrastructure that is needed (IT, Quality, Management).**

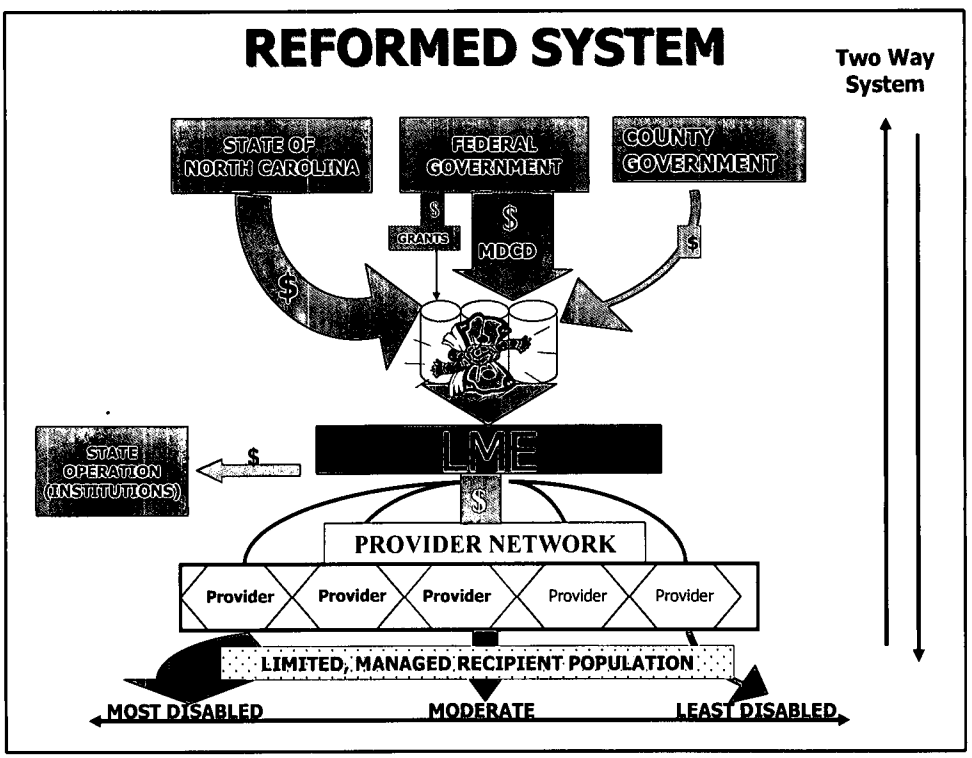
Policy: Resource Management? yes or no

If yes, then the 1915 b/c waiver model demonstrated by PBH is the best model.

PBH is a public entity, there is no profit motive, and there are stringent requirements on how funding is managed and reported.



REFORMED SYSTEM



Managed Care in a Public System

- The goal of managed care is <u>not to save money</u>.
- The goal is to <u>manage cost</u>, and control the rate of Medicaid growth.

- The goal is to manage care so that consumers are <u>efficiently</u> directed to <u>appropriate</u> services. This results in less average cost than in an unmanaged system (typical fee for service).

As a waiver manager our Goal is to make sure consumers receive appropriate care, that no one is over-served, and more importantly that no one is underserved. We must provide these assurances to the State.

PBH Medicaid costs (capitation payments) are significantly below Medicaid fee for service costs for the rest of the state.

Comparison of historical State Fee For Service costs to PBH Capitation Payments						
	2006-2007		2007-2008		2008-2009	
	State FFS	PBH	State FFS	PBH	State FFS	PBH
B waiver costs only.	140.66	93.60	157.34	92.95	123.72	100.24
B and C waiver costs.	174.46	132.69	194.93	129.72	163.69	137.36

Comparison of historical State Fee For Service costs to PBH Capitation Payments			
	2006-2007	2007-2008	2008-2009
PBH Medicaid Capitation payments are less than state fee for service Medicaid costs by the percentages shown below for three consecutive fiscal years:			
Not including 1915 C waiver.	50.3%	69.3%	23.4%
Includes1915 C state fee for service costs compared to PBH capitation payments for the Innovations waiver.	31.5%	50.3%	19.2%

The Savings illustrated here are a by-product of our effort to do the right thing for consumers, and demonstrate the impact of appropriate management against unmanaged services.

PBH has a low denial rate for Service Requests:

Treatment Authorization Requests (TAR):

Completion Rate:	Oct'09	Nov'09	Dec'09	Jan'10
Total Number of TARs Submitted	4,095	3,968	4,148	4,193
Number Reviewed within 14 Days	3,879	3,783	3,954	4,025
Compliance Rate	94.7%	95.3%	95.3%	96.0%
Average # of Days to Review TAR	4	4	4	3
Total TARs Approved	3,327	3,174	3,363	3,411
Total TARs Pended	768	794	785	782
Total TARs Denied	11	25	34	25
% Denied	0.3%	0.6%	0.8%	0.6%

A managed system coordinates

- »People
- »Resources
- »Benefits
- »Outcomes

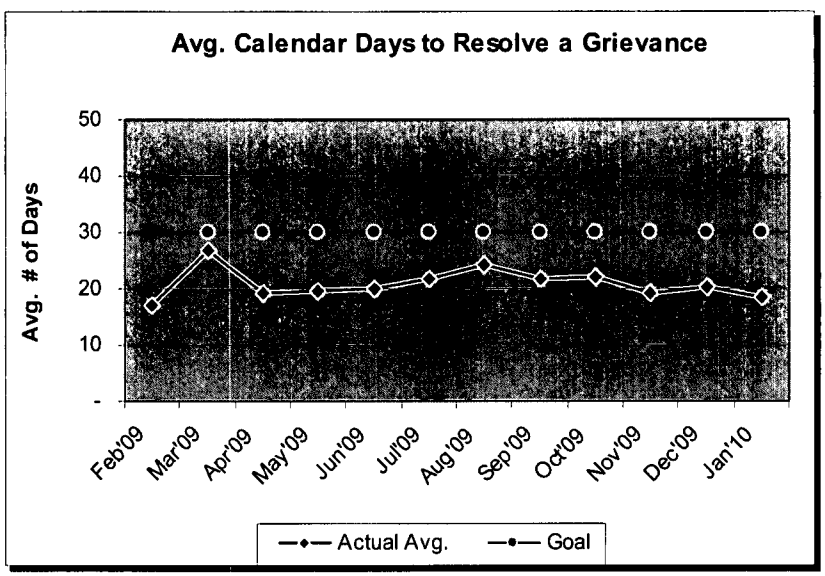
And reaches out to consumers with special needs to ensure they receive the care that they need.

Managed Care Tools:

- ***Capitation*** provides local flexibility and control of resources
- ***Payor of claims*** ensures that funds are spent in accordance with authorizations
- **Rate setting authority** allows us to adjust rates according to local conditions
- ***Closed Network*** allows for competition and choice while rightsizing the marketplace; ensures health of providers
- ***Utilization Management*** gives us the tools to ensure consumers receive both the appropriate service and amount of treatment to meet their needs.
- ***Care Coordination*** is an important activity that directly intervenes to ensure consumers that have high needs receive appropriate care. Care Coordinators work with consumers, providers and other healthcare systems.

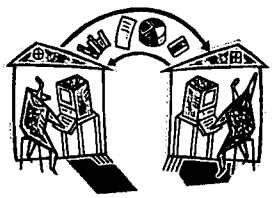
Balance in the System

Managed Care Roles and Responsibilities	Consumer Alternatives and safeguards required for Medicaid Managed Care Waivers
Easy Access	A consumer may enter the system through or the PBH 1-800 number. PBH has over 200 enrolled providers.
Authorization of the type and amount of services	• Local Reconsideration • Formal Appeal Option through Office of Administrative Hearings • Providers may advocate for consumers
Quality Services and Quality of PBH Management	• Grievance Tracking and Response System with goal of resolving grievances within 30 days. This is closely monitored by the Division of Medical Assistance. • Consumer may call the Division of Medical Assistance
Health and safety assurances	• Waiver manager investigations • DHSR investigations (for licensed facilities) • Incident Reporting and submission to DMA and DMH/DD/SA



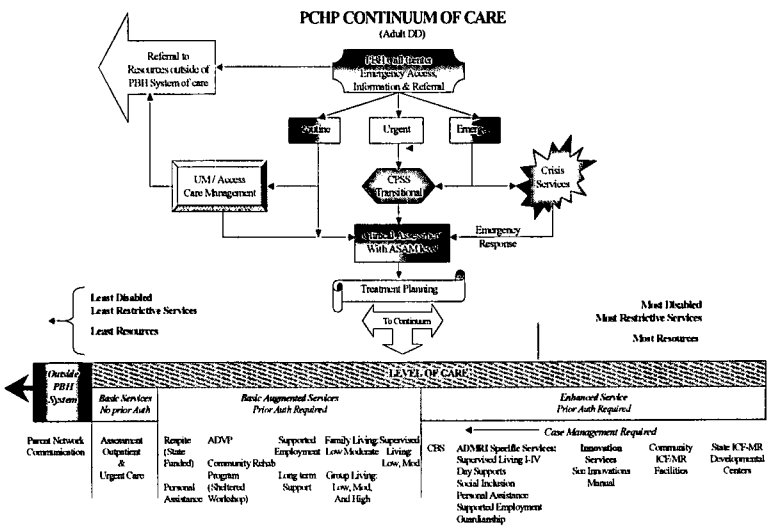
The Managed Care Service Continuum

- The key to a successful financial model in Managed Care, is that all financial resources, from the lowest level of care, to the highest level of care are included in the waiver.
- This allows the managing entity to balance costs across a system of care.
- Having both high cost intensive services and low cost least restrictive services in the same financial plan provides motivation to serve consumers at the least restrictive, but appropriate level of care.
- Consumers that do not receive adequate care and thus present problems to the community, present in the Emergency Department, or require high levels of intervention such as psychiatric hospitalization are identified through population monitoring strategies called Care Management. Care Coordinators provide hands on intervention to ensure high need or at risk consumers receive the care they need. Many such consumers need assistance in order to access care.

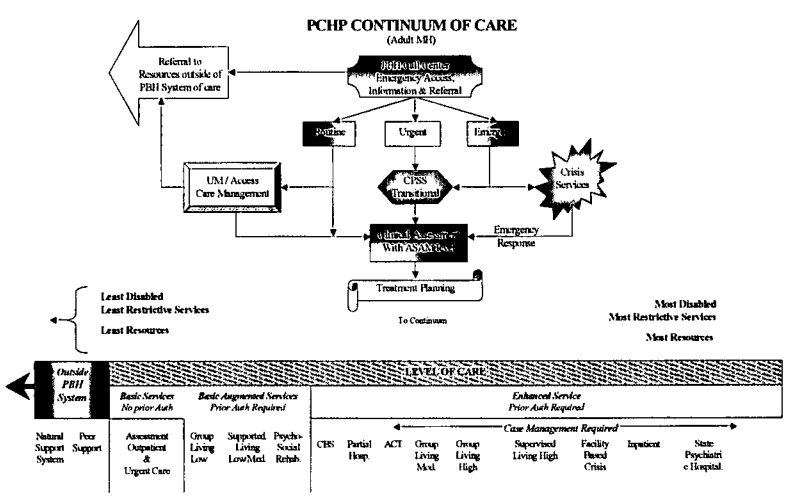


- Consumers that are a level of care that is higher than is needed, are also identified by regular review of functional status, risk, and length of time of services at a high level of care.
- Having the entire continuum under a single Manager, provides motivation and ensures accountability that people are directed to the most appropriate service (or level of care) to meet their needs. And, that when the person improves, they are transitioned to less intense services.
- This is why it is important to have Psychiatric Hospitalization and Medical Detoxification in the MH/SA Continuum of care and Intermediate Care Facilities (ICF-MR) in the DD Continuum of care.

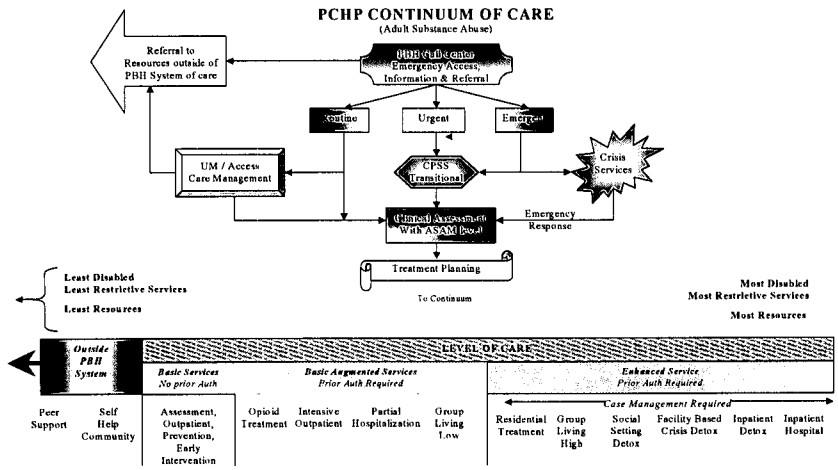
ADULT DD CONTINUUM



ADULT MH CONTINUUM



ADULT SA CONTINUUM



Policy: System Accountability

- If a <u>rationale, accountable system of care</u> is the goal, then a system that associates level of need with a specific amount of services is the answer.
- <u>Managed Care</u>, works differently in public systems than in commercial insurance systems, because the goals are different.
- There is a <u>relationship between</u> the person's level of need/risk and the amount and scope of the services provided.
- The goal is that the relationship between level of need/risk and amount of services is <u>*consistent across the system*</u> for consumers experiencing the same diagnosis, or degree of need or risk.

Challenges in Managing Care

- **In general, consumers with similar conditions and needs should receive similar amounts and types of services.**

- **There should be consistency across a system of care.**
- **There should be a <u>fair process for evaluating requests for services</u>, with <u>clear criteria</u> for decisions.**

The process for assessing and evaluating need is very different for consumers with MH/SA conditions vs. consumers with DD conditions

<u>Mental Health and Substance Abuse System</u>:

This is a <u>diagnosis driven system</u>. The diagnosis is critical in determining the course of treatment, and is guided by Clinical Practice Guidelines.

This is why a <u>good clinical assessment</u> is so important.

Service utilization is also largely predictable based on the diagnosed condition, functioning level of the individual, and level of risk.

Sometimes this is called a Medical Model.

This model is well understood by Mental Health and Substance Abuse practitioners.

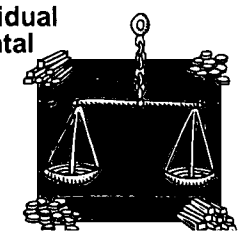
Therefore PBH and MH/SA providers approach treatment from a similar perspective.

Managing Care for People with Developmental Disabilities

- **In DD systems, the diagnosis is only important in establishing eligibility for services.**
- **The level of need is the most important factor in determining the amount of services a person requires.**
- **Need is a combination of the person's functional skills, risk behaviors, medical condition, living situation, and amount of natural supports.**

Measuring Need in Developmental Disabilities Systems of Care

- PBH uses Psychological Evaluations and Adaptive Behavior Assessments to determine whether a person is eligible for services.
- We use the Supports Intensity Scale to measure the level of need. This assessment is not focused a person's disabilities, it is focused on how much support a person needs.
- The Supports Intensity Scale is a proven individual evaluation system for people with developmental disabilities and is used in many states for the purpose of measuring need.



Authorizing Care in Developmental Disability Systems—we are still learning:

- Last year, as part of an extensive evaluation process, PBH discovered that there was no consistency in the amount of services approved among consumers with developmental disabilities when the person's level of need and amount of services were correlated.
- Based on this information, our goal is to develop a system to ensure that we are fair and consistent in authorizing services and supports for people participating in the Innovations waiver.
- Although the approach to achieving this goal for the Innovations Waiver will be very different from the process we use for consumers with Mental Health and Substance Abuse conditions, it is equally important to establish a clear model that is well understood by every one involved: consumers, families, providers and PBH staff.

Closed Provider Network

- The primary purpose of a closed network in public Managed Care, is to ensure that participating providers have enough market share to make necessary investments in infrastructure such as quality and information management.
- This also results in a high level of cooperation among provider agencies because their primary focus is not on obtaining more market share.
- Cooperation among PBH providers includes strong support for:
  - a Provider Council that has operated for nearly six years
  - a Global CQI Council that focuses on quality initiatives across the PBH Network
  - Cultural Competency initiative that has informed the training process, provided provider to provider assistance in developing Cultural Competency Plans, and collaborated with PBH on development of a Cultural Competency Monitoring Tool.
- There is enough competition to influence quality, but not so much that providers must continually focus on their survival.
- There are sufficient providers to offer choice to consumers.
- PBH has a closed network with 232 enrolled providers.

A Stable Business Environment

A closed network also helps to achieve a stable and predictable business environment.

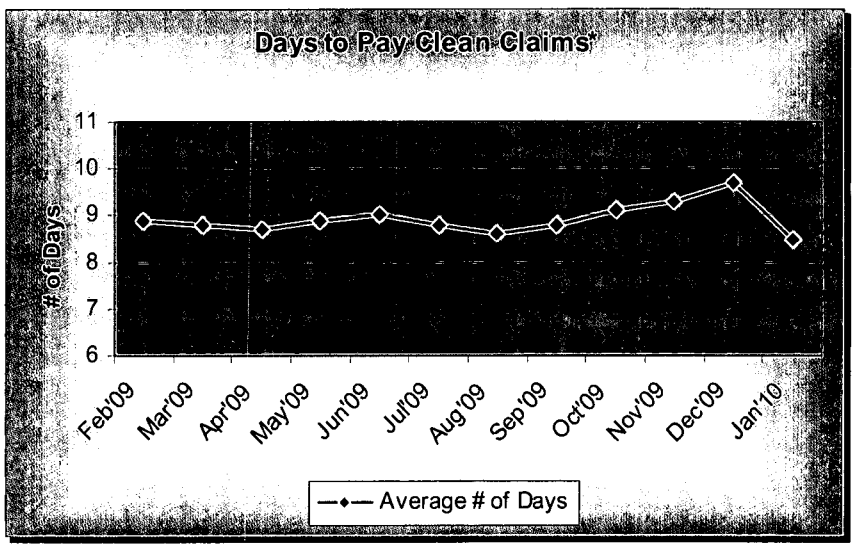
Evergreen contracts provide continuity for providers. Evergreen contracts do not need to be renewed annually. These contracts are active unless a provider voluntarily withdraws from the network or is terminated for poor quality services or performance problems such as compliance with Medicaid regulations.

The PBH Provider Network Is made of 232 Contracted providers. These providers include Comprehensive Care Providers (CCP), Agencies (single and multi-service), Group Practices, Individual Practices, Hospital Inpatient Services, and Hospital based outpatient services. There are currently 103 DD providers. The following chart shows the number of providers by provider type in the Network.

Type of Contract Provider	# of Providers
Agency	118
CCP	4
Group	25
Hospital Inpatient	7
Hospital Outpatient	3
Individual	73
pbh	2
Special	2
Total Providers	**234**
Total Contracted Providers	**232**

PBH Business Support for Providers

- **Valid and clean claims are paid within 10 days of submission.**
- **PBH accepts standard electronic claims.**
- **PBH offers a web based billing tool that supports small providers that do not use electronic billing software.**
- **PBH provides hands on assistance for providers---we want providers to submit claims successfully. This is more cost effective for <u>both</u> PBH and Providers.**



Accessibility Study

Calendar Year 2008 Data:

Availability of Providers by Type of Providers and Geographic Distribution

There are approximately 167,168 enrollees who are eligible for services under the Piedmont Cardinal and Innovations plans. 159,214 of these enrollees live inside the PBH Catchment Area (Cabarrus, Davidson, Rowan, Stanly, and Union Counties). On average, between 15% (25,000) and 17% (29,000) of eligible enrollees actively receive services from the PBH Provider Network annually.

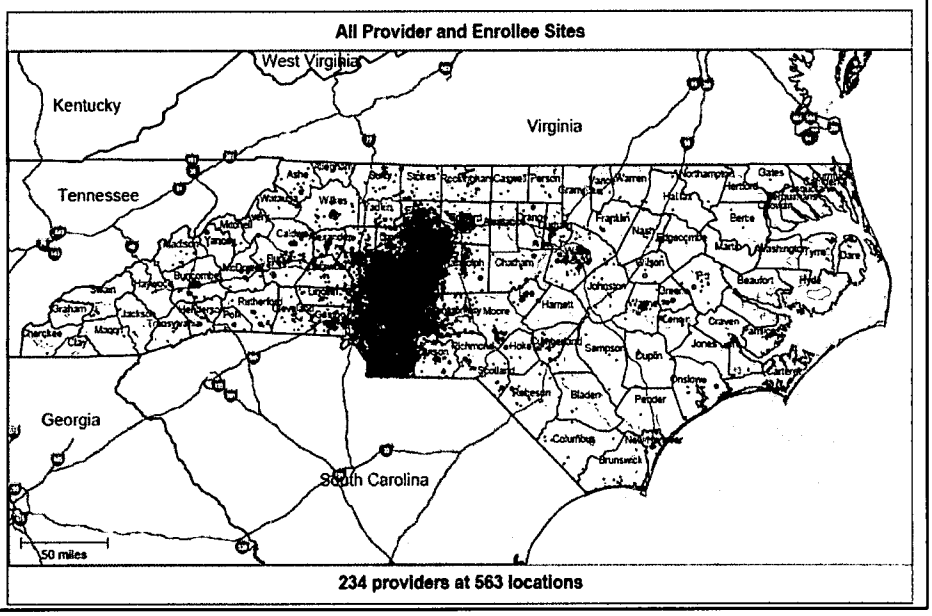
Accessibility Study

Calendar Year 2008 Data:

Based on 2008 data estimates from the United States Census Bureau all counties in PBH's catchment area are classified as rural. Access standards for the PBH Network are as follows:

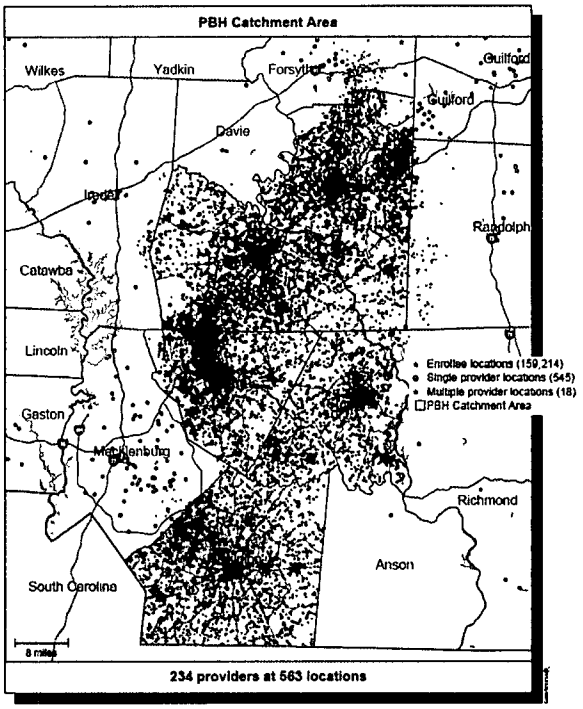
•Percent of open Psychiatrists	•60% open
•Psychiatrist/member ratio	•1 Psychiatrists/1000 enrollees actively receiving services
•Licensed Independent Practitioners (LIP) not including psychiatrist/member ratio	•4 LIPs/500 enrollees actively receiving services
•Geographic distribution of Psychiatrist and LIPs to each member	•1 open Psychiatrist and 1 other type of LIP within 45 miles/ 45 minutes (rural)
•Geographic distribution of Psychiatrist and LIPs to each member	•1 open Psychiatrist and 1 other type of LIP within 30 miles/ 30 minutes (urban)
•Geographic distribution of CCPs to each member	•(1) CCP within 20 miles/20 minutes
•Geographic distribution of residential facilities	•1 facility within 100 miles/100 minutes
•Behavioral health facility (inpatient psychiatric, crisis unit, detoxification unit, or substance abuse residential care).	•1 within 75 miles/75 minutes

Accessibility Study: 2008 Statewide

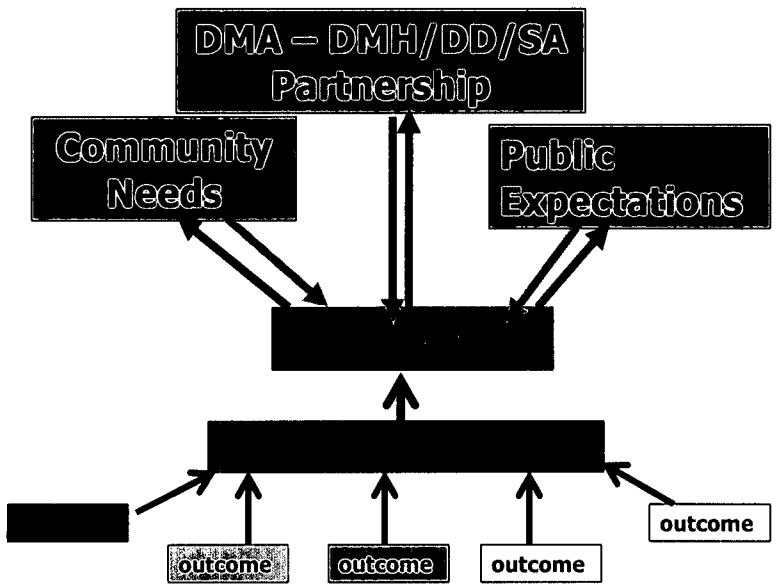


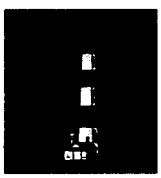
Accessibility Study: 2008

PBH Counties



Accountability

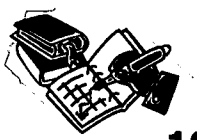




State Oversight

- As managed care entity, PBH shares with the state responsibility for calculating and reporting on performance indicators
- Quarterly, annual and semi-annual reporting

- PBH has also achieved full accreditation by NCQA, the highest level of accreditation for a managed care entity.

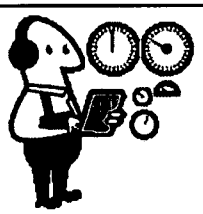


Additional State Oversight Requirements

- 1915(c) waiver subject to 1915(b) waiver requirements and managed care regulations

Extensive Reporting to the State that includes:

- Performance and utilization measures (PMs)
- Performance improvement projects (PIPs)
- Consumer & provider surveys
- Grievance & appeals reporting



Accountability

PBH has over 60 individual performance measures that are reported to DMA and DMH monthly or quarterly.

These measures relate to quality of care, how services are used, and how we manage funding.

Additional State (DMA) Oversight Requirements

- External quality review activities occur annually for:
  - Contract compliance review
  - Validation of Performance Improvement Projects

- Independent assessment:
  - Quality of care
  - Access to care
  - Cost effectiveness

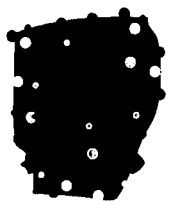
- Annual on-site review by state

"PBH has successfully completed the transition from a provider of care to a capitated managed care organization. There is clear evidence that PBH has impacted access, quality, and the cost of services for members. Other demonstrated areas of success related to managed care operations are noted below:

- Utilization Review.....
- Quality Management.....
- Credentialed Provider Network.....
- Use of data for managing eligibility, claims, clinical activities and administrative operations....."

Mercer Consulting on behalf of the NC DHHS Intradepartmental PBH Monitoring Team: Second Annual Review, October, 2007

PBH is a successful demonstration model of public management of a system of care that has oversight for <u>all public resources</u> in a given geographic area.



We have specialized in management functions:

- **System efficiencies**
- **Consumer outcomes**
- **Satisfaction**
- **Quality**

Management of operations in order to:

Assure partnerships with a competent provider network

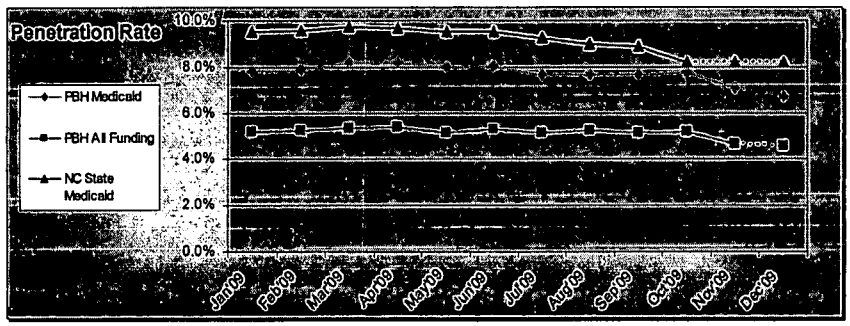
Establish a predictable business environment that will keep provider partners strong.

As a direct result of the PBH success story, Secretary Cansler has decided to expand the PBH model and waivers to other LMEs!

PBH Demonstration Outcomes April 2005-January 2010

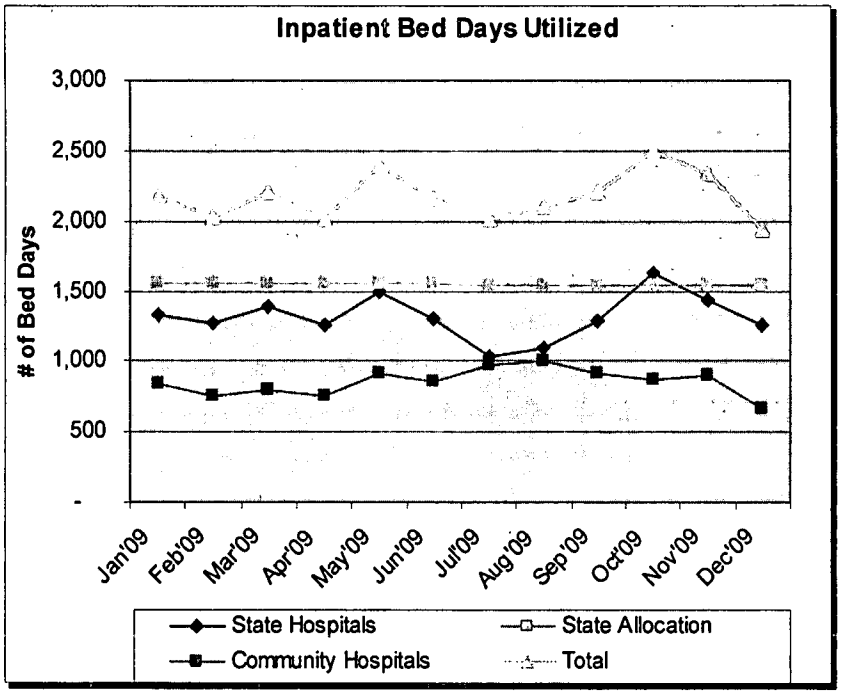
Sector	Outcomes	Tools
1. System stability and access to care	**Penetration rate increased.**	PBH Call Center infrastructure and quality control monitoring. Easy Access: consumers may enroll through any network provider. Advanced Access: walk-in capacity in each county; 8am – 8pm Mon-Fri. PBH Call Center links consumers directly to providers via warm transfer of calls. **Historical Notes:** Instability of system operations occurred in 2003-2004, resulting in a lower rate of reported services, due to divestment of services and merger with Davidson County. System instability occurred again during 2005-2006 due to implementation of new service definitions and divestment of MH-SA Case Management.
	Call Center Performance for 2007-2008: over 24,000 calls with an average speed of answer of 11 seconds. **Type of calls** **Emergent: 10,003** **Urgent: 737** **Routine: 7,083**	PBH operates a sophisticated information system that allows for monitoring of calls to our 1-800 number, time to respond and disposition of call.
	Advanced Access: over 10,000 consumers entered or re-entered the PBH system through our Advanced Access or walk in clinic operated by a Comprehensive Community Provider	Model is operated for PBH by DAYMARK Recovery Services. Comprehensive Community Provider Model makes this possible.
2. Psychiatric Hospital Utilization	**PBH is the third lowest user of State Psychiatric Hospital beds with a utilization rate of 48 per 100,000 population compared to the state average utilization of 103 per 100,000 population.** **Hospital Readmission within 30 days of Discharge:** • **PBH 7%** • **North Carolina 12%** • **National Average 8%**	Allocation of state psychiatric hospital dollars directly to PBH, allowing PBH flexibility in developing alternatives to state hospital placement. PBH direct control of utilization management and authorization. Crisis continuum established by PBH to intercede and divert to community services when appropriate. PBH has two 16 bed locked crisis-detox facilities that accept involuntary admissions; these facilities serves as a diversion for inpatient services for people that do not need hospital level of care.

Year	PBH Number Served	Davidson Number Served
99-00	7,563	4,774
00-01	6,600	5,027
01-02	10,490	5,167
02-03	8,247	4,445
PBH and Davidson Co Divestment occurs in 03-04. Number of people served drops.		
03-04	14,041	PBH + Davidson
Waiver begins 4-1-05. Below includes Davidson Co.		
04-05	18,514	
05-06	20,568	
06-07	20,637	
07-08	21,931	
08-09	20,413	

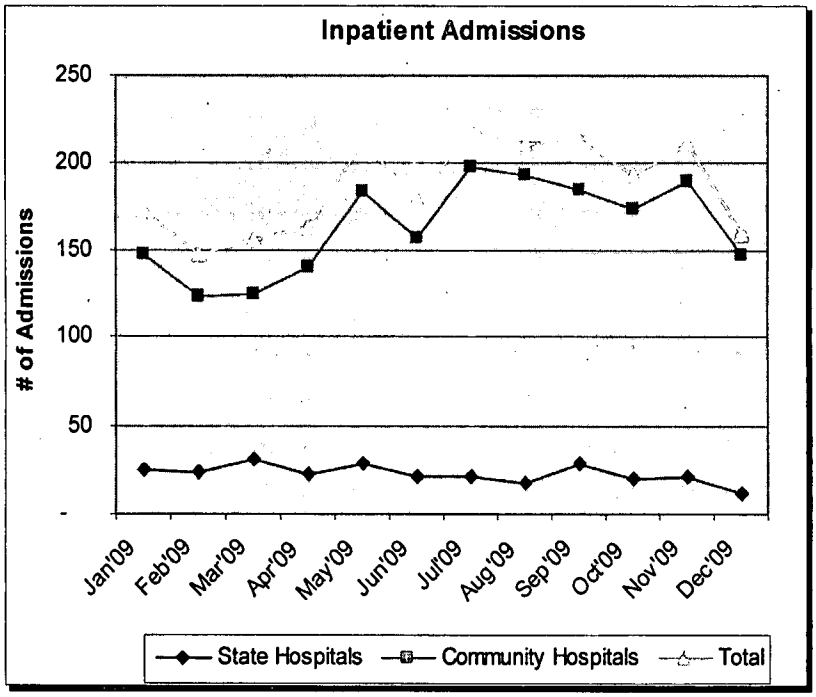


(Claims Data is incomplete for November and December 09)

PBH Demonstration Outcomes April 2005-January 2010		
Sector	**Outcomes**	**Tools**



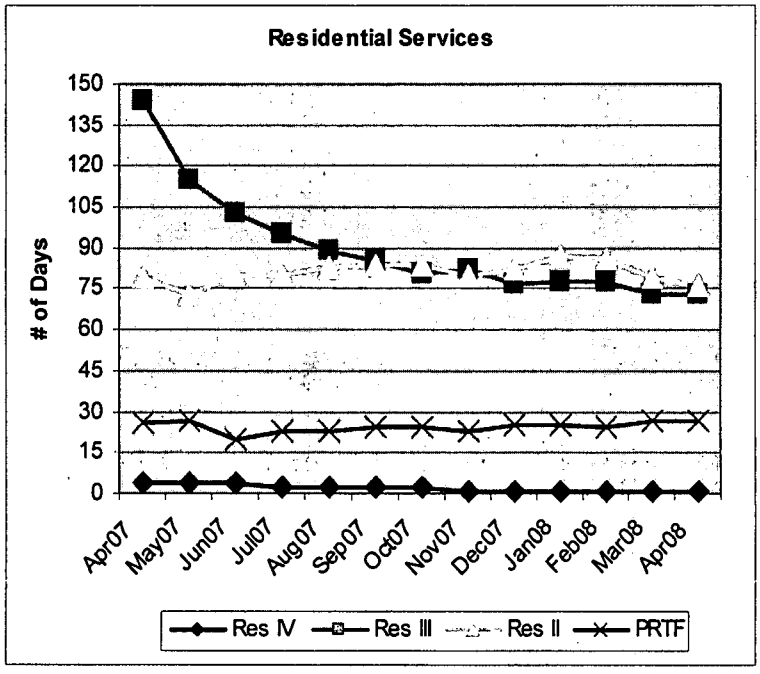
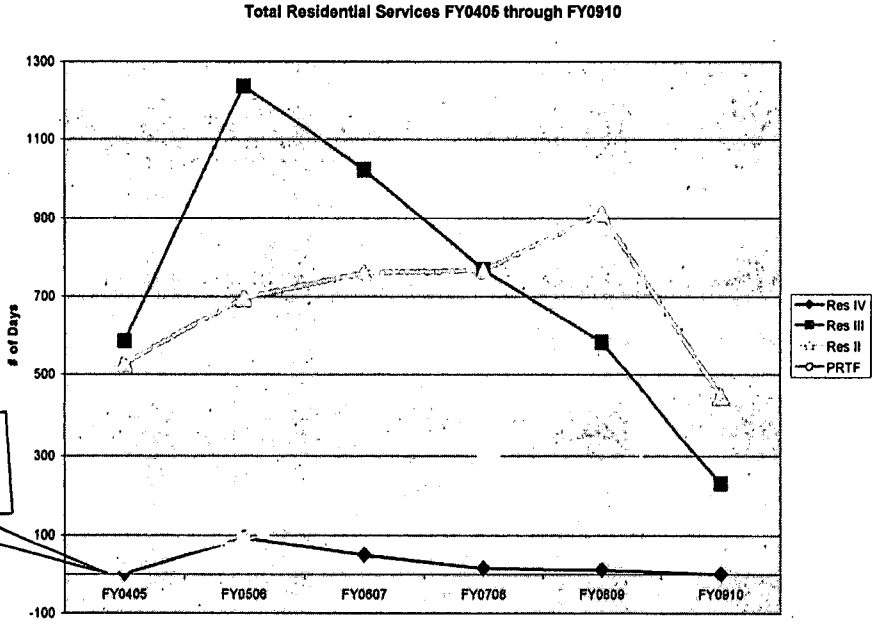
<u>Community hospital capacity</u> using Medicaid and state dollars is funded through contracts with two in-catchment hospitals and 2 adjacent county hospitals, making <u>74 local adult acute beds</u> available to PBH consumers. A contract in an adjacent county makes <u>30 child psychiatric beds</u> available. (see utilization comparison between state and community hospitals below)



PBH Demonstration Outcomes April 2005-January 2010

Sector	Outcomes	Tools
3. Effective Management of High Cost Medicaid Services.	**PBH has a low rate of denials for requested services:** **Treatment Authorization Requests (TAR):**	In order to ensure that the PBH system is transparent to consumers and providers the PBH Clinical Design Plan specifies how services are organized, (from basic to enhanced) and the requirements for accessing care. A **TAR** is a Treatment Authorization Request. (request for services)
4. Community Partnerships	**As of January 2010, and in partnership with local NAMI organizations, PBH has trained 236 law enforcement officers from 11 different law enforcement agencies in Crisis Intervention Training (CIT), a crisis intervention program for law enforcement officers.** **PBH has begun Crisis Intervention Training (CIT) for 911 Operators. So, far 31 operators have been trained.** **Geriatric Specialty staff provided 321 trainings to 3,321 Geriatric Professionals in area nursing facilities.** **During CY 2009 there were 20 '*Lunch and Learns*' with a total of 7 from the general public.** **Educational Presentations and Health Fairs: during CY 2009, there were 70 presentations with 2,804 attending from the general public** **Cultural Competency Conference was attended by over 350 consumers and professionals** **Child and Family Team Meetings: 95 people trained in 2009**	Community outreach. County level advisory councils. Focused communication with law enforcement.
5. Medicaid utilization: Child Residential Facility Utilization	**<u>April 07 - April 08 reduction in numbers of children placed in Level III Residential:</u>**	PBH management of utilization; control of provider network to limit number of residential providers. Care Managers facilitate discharge and access to community based services.

Completion Rate:	Sep'09	Oct'09	Nov'09	Dec'09
Total Number of TARs Submitted	4,094	4,095	3,968	4,148
Number Reviewed within 14 Days - Benchmark	3,909	3,879	3,783	3,954
Compliance Rate	**95.5%**	**94.7%**	**95.3%**	**95.3%**
Average # of Days to Review TAR	4	4	4	4
Total TARs Approved	3,330	3,327	3,174	3,363
Total TARs Pended	764	768	794	785
Total TARs Denied	18	11	25	34
%Denied	0.4%	0.3%	0.6%	0.8%

PBH Demonstration Outcomes April 2005-January 2010		
Sector	**Outcomes**	**Tools**
		
		
	The PBH Waivers began on April 1, 2005	
6. Excellence in Financial Management of limited public resources	**PBH had Medicaid Savings for two consecutive years. Since April, 2005, $11.5 in Medicaid dollars have been saved. These funds were reinvested in new services called b-3 services, in accordance with CMS waiver requirements. The balance of the savings was deposited into the Risk Reserve when CMS changed the requirements for payment of b-3 services (now we receive a capitation payment for b-3 services).**	PBH direct control over authorization and utilization review. Having a limited number of providers has direct impact on demand for services (controls provider driven utilization)

<table>
<tr><th colspan="3">PBH Demonstration Outcomes April 2005-January 2010</th></tr>
<tr><th>Sector</th><th>Outcomes</th><th>Tools</th></tr>
<tr><td></td><td>

PBH Medicaid costs (capitation payments) are significantly below Medicaid fee for service costs for the rest of the state.

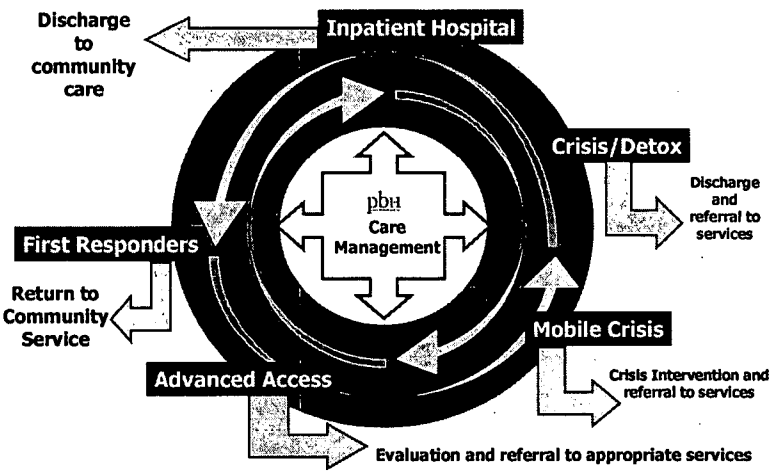
<table>
<tr><th colspan="7">Comparison of historical State Fee For Service costs to PBH Capitation Payments</th></tr>
<tr><th></th><th colspan="2">2006-2007</th><th colspan="2">2007-2008</th><th colspan="2">2008-2009</th></tr>
<tr><th></th><th>State FFS</th><th>PBH</th><th>State FFS</th><th>PBH</th><th>State FFS</th><th>PBH</th></tr>
<tr><td>B waiver costs only.</td><td>140.66</td><td>93.60</td><td>157.34</td><td>92.95</td><td>123.72</td><td>100.24</td></tr>
<tr><td>B and C waiver costs.</td><td>174.46</td><td>132.69</td><td>194.93</td><td>129.72</td><td>163.69</td><td>137.36</td></tr>
</table>

<table>
<tr><th colspan="4">Comparison of historical State Fee For Service costs to PBH Capitation Payments</th></tr>
<tr><th></th><th>2006-2007</th><th>2007-2008</th><th>2008-2009</th></tr>
<tr><td colspan="4">PBH Medicaid Capitation payments are less than state fee for service Medicaid costs by the percentages shown below for three consecutive fiscal years:</td></tr>
<tr><td>Not including 1915 C waiver.</td><td>50.3%</td><td>69.3%</td><td>23.4%</td></tr>
<tr><td>Includes1915 C state fee for service costs compared to PBH capitation payments for the Innovations waiver.</td><td>31.5%</td><td>50.3%</td><td>19.2%</td></tr>
</table>

</td><td></td></tr>
<tr><td>7. Crisis Services</td><td>

December 2007 NC Council Award for the development of a Comprehensive Crisis Continuum of Care:

No more revolving doors....people receive emergency intervention based on individual needs and are assisted in re-entering the service system



</td><td>

LME infrastructure commitment to collaborate with community stakeholders, especially local hospitals and law enforcement.

Funding flexibility obtained through the Medicaid waiver and single stream funding.

PBH Outreach team.

Training of providers in First Responder skills and responsibilities; including DD Providers.

Single provider for after hours on-call and emergency response.

Advanced Access: walk in crisis and urgent care 8 am – 8 pm Monday through Friday.

PBH contracts for two detox/crisis centers. These are 16 bed locked facilities that accept involuntary commitments. These facilities are an alternative to inpatient psychiatric care when the person's medical status does not require inpatient care.

</td></tr>
<tr><td>8. Psychiatric services</td><td>

Maintenance of psychiatric capacity.

12/31/03: 9 Psychiatrists employed by PBH

</td><td>PBH ability to support the community mental health center 501c-3 "spin off" agency through Medicaid waiver</td></tr>
</table>

PBH Demonstration Outcomes April 2005-January 2010		
Sector	**Outcomes**	**Tools**
	12/31/06: 9 Psychiatrists employed by DAYMARK for PBH counties (PBH spin off) **12/31/07: 9 Psychiatrists employed by DAYMARK** **12/31/08: 10 Psychiatrist employed by DAYMARK working in the PBH counties** **New psychiatric providers: Northeast Psychiatric Associates, RHA, Monarch and Family Services of Davidson are now options for psychiatric services** **Use of telemedicine across seven individual psychiatric practice locations across the five counties.**	and single stream state funding. Ability to set rates for services. ***PBH increased psychiatric rates in October 2007 in order to better fund this essential service and maintain psychiatric capacity through retention of physicians.*** PBH support of Telemedicine.
9. Housing	**Commitment to housing for people with disabilities.** **Partnership with housing agencies and interest groups across the PBH counties to form the PRCoC (Piedmont Regional Housing Continuum of Care). The following are awards that were made directly to PBH:** **2005 Competition:** • **PBH Shelter Plus Care Program #1 $160,860** • **PBH Samaritan S+C Program $110,340** **2006 Competition:** **Davidson Shelter Plus Care Renewal $73,176** **2007 Competition:** • **PBH Shelter Plus Care Program #2 $368,940** • **Davidson Shelter Plus Care Renewal $75,516** **2008 Competition:** • **Renewal $77,436** **2009 Competition:** • **Renewal $84,744** • **Other award announcements are pending**	PBH sponsored a regional housing continuum of care that has been responsible for HUD grants for the past five years.
10. Consumer empowerment	**Consumer collaboration in system management.** **Strong and supportive Consumer/Family Advisory Committee.** **Self direction-DD:** • **9 consumers/families self directing now** • **3 consumers/families in planning stages** **PCP Conferences:** **CFAC designed and sponsored** **Free to any consumer or family member** **2007: 326 attended** **2008: 354 attended** **Consumer Empowerment Training: Skills and Pizza** **2008-2009: 275 attended** **7/09-1/10: 240 attended** **Peer Support Specialists Training/Certification:** **As of January 2010, 68 consumers have been trained to support other consumers in Recovery. This is an extensive 40 hour training course.**	PBH CFAC (Consumer Family Advisory Committee) is highly integrated into PBH planning and management. PBH HCBS (1915 C) waiver design. PBH Office of Consumer Affairs
11. Provider Partnerships	**Real collaboration with providers through:** • **Provider Network Council. The PBH Provider Council has operated since its inception in 2004** • **Regular Provider Meetings; planned and chaired by Provider Council officers, not PBH** • **Provider focused Global Quality Improvement Committee**	Provider Relations Department has assigned "personal brokers" to each provider. PBH quick response to provider suggestions, problems and concerns.

<table>
<tr><th colspan="3">PBH Demonstration Outcomes April 2005-January 2010</th></tr>
<tr><th>Sector</th><th>Outcomes</th><th>Tools</th></tr>
<tr><td></td><td>

- **Providers participation in PBH operational forums:**
  - **Clinical Advisory Committee**
  - **Cultural Competency Committee**
  - **Housing Continuum of Care**
  - **System of Care Committee**

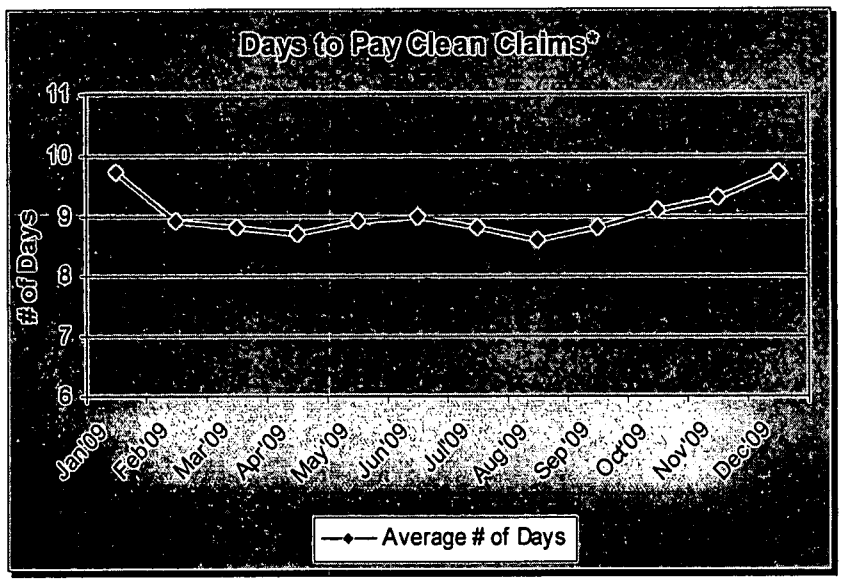
Stable, healthy provider network that is responsive to the needs of consumers.

<table>
<tr><td>Overall Provider Satisfaction</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Please rate your overall satisfaction in regard to your interactions with PBH</td><td>43.4%</td><td>56.3%</td><td>77%</td><td>83%</td></tr>
</table>

</td><td>PBH robust educational support of providers across all operational areas: claims, encounter reporting, enrollment, authorization requests, service definition implementation, crisis response, clinical documentation, etc.</td></tr>
<tr><td>12. PBH Information System</td><td>

Efficient and data informed operations:

- **Access to care: call center, referrals, admissions**
- **PBH processes over 50,000 claim lines per month**
- **PBH has a high claims volume: PBH pays $11 million dollars <u>per month</u> in claims**
- **PBH pays clean claims in less than 10 days**



</td><td>Information System capacity. PBH has designed and engineered an in-house managed care information system that has the capacity to support operations across a wide continuum of essential functions that require automation.

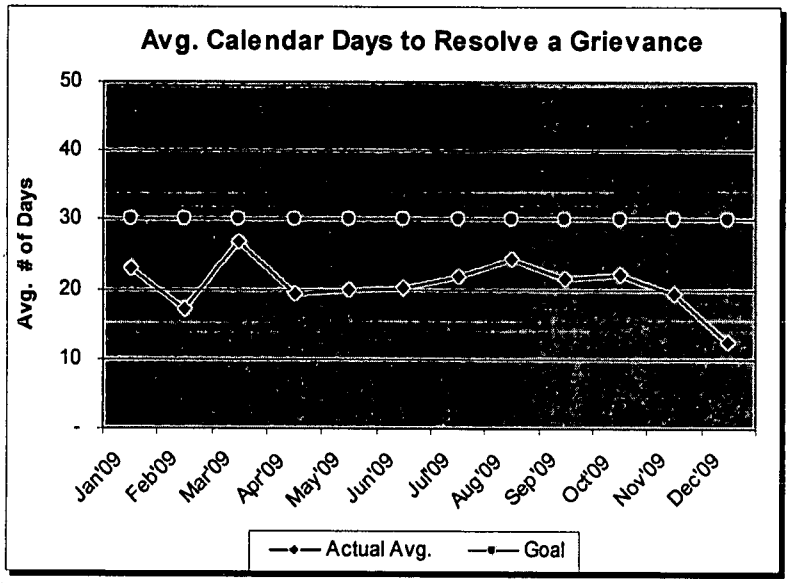
Provider collaboration in Network Management and Quality Improvement Activities.

• Electronic connectivity with providers through HIPAA transactions or through a web based system (for smaller providers). This connectivity supports provider business by providing:
o Eligibility and enrollment information
o Paid claims status and remittance advices
o Billing and re-billing</td></tr>
<tr><td>13. Quality of Care</td><td>

- **Quality Management activities include tracking and analysis of key indicators such as incidents, restrictive interventions and rights violations.**
- **Quality Management staff conduct on-site investigations of complaints and to respond to reports of abuse, neglect, exploitation and rights violations.**
- **PBH on site provider audits ensure provider accountability, provide education to providers and promote provider responsibility.**
- **Provider training is provided in order to support quality performance of providers**

</td><td><u>Data availability</u> supports informed decision making, appropriate care for consumers, and connectivity with providers.

<u>Investigative</u> team is available to quickly respond to complaints and threats to consumer health and safety.</td></tr>
<tr><td>14. Satisfaction</td><td>Consumer responses from the 2009 PBH Consumer Satisfaction survey (highest</td><td>PBH is committed to responding to</td></tr>
</table>

Sector	Outcomes	Tools
	rated questions): **89%: overall satisfied with services from PBH providers** **91%: service plan meets their needs** **96%: services meet needs of consumers' racial/ethnic background** **97%: privacy is respected** **94%: receive services within 1 hour of appointment** **90%: services provided assisted in achieving independence** **92%: translation services were available** **PBH takes complaints seriously and is quick to respond.**  	consumer needs. PBH tracks all consumer complaints and feedback and uses this information for quality improvement initiatives.

Attachment 4

Western Highlands Network
A LOCAL MANAGEMENT ENTITY

Lanier M. Cansler, Secretary
2001 Mail Service Center
Raleigh, NC 28699-2001

Wednesday, February 10, 2010

Dear Secretary Cansler:

We look forward to seeing you, Mike Watson and Luckey Welsh Friday morning, March 5th. We will be meeting at Access II Care's offices in Asheville and will include staff from Western Highlands and Access II Care. Our aim is to discuss some of the unique challenges in serving individuals with significant mental illness and substance use disorders who also suffer from chronic medical conditions (known as the Quadrant 4 population in a commonly used schematic for describing integrated care approaches). We would like to discuss how this high risk, high cost population can be served effectively with limited modifications in the service delivery management system. Through the establishment of standardized protocols and processes, we can first, increase primary care providers' confidence in treating the Aged Blind and Disabled population with co-morbid mental health and substance use conditions; and second, help behavioral health providers improve their identification of chronic medical conditions and their coordination with medical care. In addition to providing better care and improved outcomes, we believe we can achieve substantial cost savings, especially in ED and inpatient utilization and in pharmacy costs. Finally, we believe this model is replicable and can become a new standard for how the Q4 population is to be served by CCNC, the LMEs, primary care providers, the CABHAs and other specialized providers.

Western Highlands Network and Access II Care have been collaborating for a number of years. Care managers at Access II Care work closely with care coordinators at Western Highlands; both of our medical directors have been involved in jointly developing standards of care and reviewing complex cases. Based on our preliminary findings as well as more formal research conducted in other settings, we are confident that the success CCNC has demonstrated in the treatment and management of diabetes, asthma and other chronic conditions can also occur with this population.

In order to illustrate what can be accomplished, consider the following case example:

Middle aged female with history of Type I Diabetes, Seizure Disorder, Hepatitis C, Substance Abuse and Bipolar Disorder residing in a Family Care Home:

- *In the year prior to care management services she had 11 medical hospitalizations, four MH/SA hospitalizations, 11 ER visits and three arrests.*
- *Her case was assessed and care management services were initiated.*

- *Access II Care CM coordinated treatment team meetings and the sharing of patient information. Treatment team meetings were held at least monthly. The treatment team consisted of:*
    - *Patient*
    - *Representative from WHN responsible for care coordination and utilization review*
    - *Representative from WNC Ray of Hope (private provider)*
    - *Primary Care Provider from WNCCHS (Asheville-based FQHC)*
    - *Substance Abuse Counselor from WNCCHS*
    - *RN Case Manager for Mission Hospital*
    - *Access II Care CM*

- *In mid November the team developed and implemented a diversion plan between WNC Ray of Hope and Mission Hospital related to ER visits where cocaine abuse was determined to be a factor.*

- *Additional Access II Care interventions included but were not limited to visits to the patient at the family care home to provide diabetes education and support, assistance with obtaining a new primary care home, facilitation of involuntary commitment related to substance abuse, participation in discharge planning meetings at Copestone psychiatric inpatient unit, patient support and coordination of care related to ADATC commitment and completion of a voluntary 28 day stay.*

- *Patient now living at Family Care Home and attending Pathways of Change intensive outpatient program five days a week and attending AA/NA meetings daily on the weekend.*

- *During the 10 months of Access II Care CM intervention, inpatient medical utilization was reduced by 64%, MH/SA hospitalizations by 25% and ED utilization by 55%; and the patient had no further arrests.*

- *Total Medicaid Inpatient and ED Cost for one year prior to intervention: $46,630.*

- *Total Medicaid Inpatient and ED Cost during intervention year: $23,500.*

We have been able to produce comparable dramatic outcomes with many other individuals. In the future, we hope to increase the population we serve by:

1. Improving the mechanisms to **identify** current and future high risk, high cost consumers in both the behavioral health and medical practices.

2. Continuing to develop a comprehensive system between WHN and CCNC for referring consumers for **integrated care coordination** for Medicaid and State funded consumers meeting Quadrant IV criteria.

3. Developing a system wide **treatment network** that promotes appropriate standards of care and formalizes medical/behavioral health protocols for the identification and treatment for target individuals.

Identification and Referral:

In order to improve the quality of care and reduce the need for high cost emergency and crisis services we must begin by developing formal mechanisms for identifying consumers that are currently, or at risk of, becoming part of the Q4 population. We propose to do this by:

1. Jointly redesigning the Access Screening Triage and Referral Form (STR) to more fully assess medical conditions of consumers entering the behavioral health system; as a consequence, more Q4 consumers will be identified and appropriately referred.

2. Collaborating with the WHN behavioral health provider network to develop a comprehensive clinical assessment which includes a uniform medical screening tool to identify current and emerging medical conditions, as well as referral and follow-up protocols.
3. Establishing standardized protocols for physicians in the CCNC network to refer consumers who have chronic medical and behavioral conditions and are unstable.
4. Identifying Q4 consumers through the WHN/CCNC retrospective review processes, including:
    a. Quarterly review of CCNC's real time hospital and paid claims data
    b. CCNC medication reconciliation requests from pharmacists
    c. Ongoing service authorization reviews by WHN utilization management staff
    d. Ongoing provider monitoring of behavioral health providers' screening and follow-up regarding chronic medical conditions through the WHN Monitoring Unit.

Integrated Care Coordination (ICC):

After consumers are identified as Q4 consumers, they will be referred for care coordination. WHN and CCNC staff will work as an integrated team to access and coordinate services for referred Q4 consumers. The team will strive to assure quality care while reducing the need for higher cost crisis and inpatient services (see Attachment A).

Team activities will include:

- Implementing protocols for exchange of information between behavioral health and primary care, including the use of electronic technologies.
- Establishing appropriate care plans and ensuring a comprehensive crisis plan for newly referred Q4 consumers; review of care and crisis plans for established consumers with Q4 providers, including CABHAs and primary care.
- Referring Q4 consumers to medical/behavioral providers that have been designated by WHN and CCNC as Q4 provider sites.
- Referral for medication reconciliation. It is anticipated that this activity could yield significant savings to the Medicaid system through the reduction of unnecessary Medicaid reimbursed prescription drugs.
- Review of consumer outcomes to document improved clinical care and cost savings through reduced need for crisis and inpatient services.
- Assuring that no matter where the Q4 consumer shows up in the system, the provider is immediately engaged to provide transitional care back to the consumer's previous level of care or demonstrate to all Q4 Team staff why consumer must be moved to a higher level of care, including projected length of stay with accompanying utilization management of that higher level of care.

Integrated Behavioral/Medical Provider Network:

After a Q4 consumer is identified and referred for care coordination, the ICC team will establish a medical/behavioral health home with one of the designated Q4 providers. All Q4 providers

provide basic MH/SA services, including medication management. Consumers needing specialized services will continue to be referred to appropriate providers, including CABHAs with a commitment to integrated care. At present, WHN has established relationships with the following integrated care sites:

- Western North Carolina Community Health Services (WNCCHS)- Serves Buncombe County and is established as a Federally Qualified Health Clinic (FQHC)
- Blue Ridge Community Health- Serves Henderson County and some Transylvania County consumers and is established as a FQHC.
- Polk Wellness Center- Serving Polk County
- Bakersville Clinic- Serving Mitchell County

Other potential partners include:

- Rutherford Free Clinic- Serving Rutherford County
- Hot Springs Health Clinic- Serving Madison County
- Transylvania Health Clinic- Serving Transylvania County

In areas where no Q4 provider has been established, WHN will work with CCNC to establish a formal relationship between a designated Critical Access Behavioral Health Agency (CABHA) and an existing medical provider.

In addition, in order to facilitate appropriate communication and resources to our most rural counties, WHN will employ the use of its telemedicine/telepsychiatry network; most network sites provide both behavioral health and medical services.

Benefits and Outcomes:

Based on our experience to date, we are confident this model:

1. Improves access to medical and behavioral health care for Q4 consumers.
2. Improves quality of life for consumers. Improved coordination between medical and behavioral health practitioners.
3. Improves access to psychiatric consultation for medical practitioners.
4. Decreases use of high cost crisis, Emergency Department and inpatient services.
5. Decreases costs of prescription drugs.
6. Encourages more providers to offer integrated care to Q4 consumers.

Challenges to Implementation:

We have identified some specific areas where DHHS support would improve the effectiveness of the model.

1. We would like DMH to recognize the need for additional time for the screening, triage and referral of Q4 consumers.
2. We would like DMH to require that CABHAs identify and refer Q4 consumers for LME-CCNC care coordination.
3. We would like to increase WHN's care coordination resources, possibly through a PMPM for the Q4 population.

4. We advocate for rapid approval and implementation of the following two components of the CCNC Accelerated Plan:
    a. Employment of a network psychiatrist.
    b. Additional care coordination.
5. Consider implementation of a PM/PM for integrated PCPs.
6. We would like to have more leverage with "Medicaid only" providers within the WHN provider network.
7. We would like DHHS to establish specific standards for providers wishing to serve Q4 consumers.

From discussions in other settings, we know that providing cost-effective services to this population is a priority for the Department. We also know that the Department faces extraordinary budgetary pressure both this year and next. However, we believe that an investment in fully integrated care coordination will both improve health outcomes and save State and Medicaid resources. We are eager to discuss our current experience with this model and our ideas regarding the benefits which would accrue from its possible expansion.

Please let us know if there is additional information we can provide you before our meeting or have available on site during your visit.

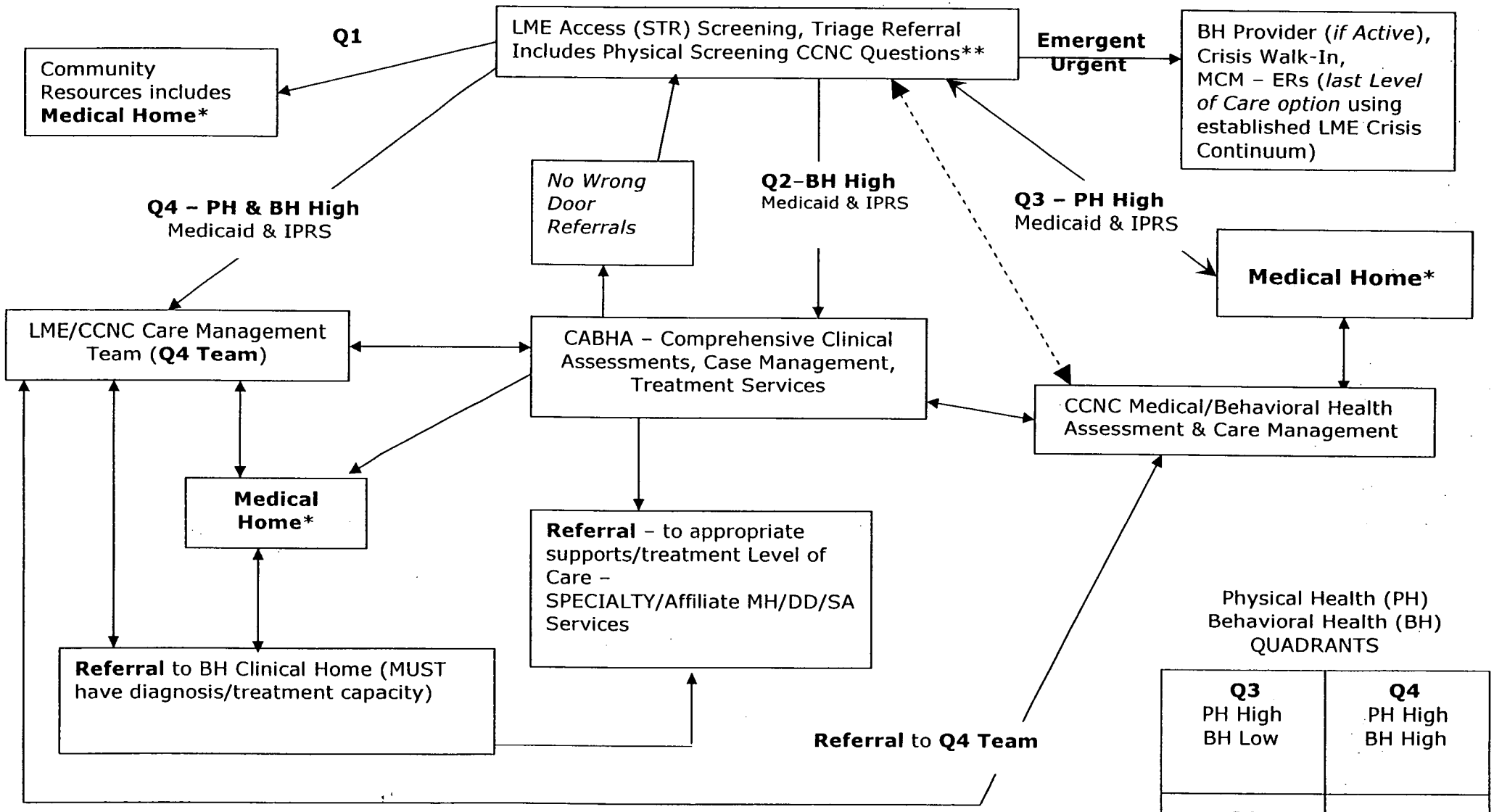
Sincerely,

Arthur Carder, CEO
Western Highlands Network

Jennifer Wehe, Executive Director
Access to Care of WNC

cc: Mike Watson
Luckey Welsh
Senator Martin Nesbitt

Integrated Screening, Referral & Coordination for ALL Physical Health (PH)/Behavioral Health (BH) Quadrants



Physical Health (PH)
Behavioral Health (BH)
QUADRANTS

Q3 PH High BH Low	**Q4** PH High BH High
Q1 PH Low BH Low	**Q2** PH Low BH High

***ALL Medical Homes** have referral capacity to community/medical specialties.
** No matter what Quadrant, LME Access may refer to **Medical Home**

◄- - - - ● - - - - ► = Consultation

2/25/10 WHN Version 5.0

Community Care of NC Networks	Main #	Executive Director / Network Coordinator
Access II Care of Western North Carolina BUNCOMBE, HENDERSON, MADISON, MCDOWELL, MITCHELL, POLK, TRANSYLVANIA, YANCEY	828-259-3858	Jennifer Wehe 828-259-3858 ext 305 jwehe@accessiicare-wnc
Access III of Lower Cape Fear BLADEN, BRUNSWICK, COLUMBUS, NEW HANOVER, ONSLOW, PENDER	910-763-0200	Lydia Newman 910-763-0200 lydia.newman@alcfnc.org
AccessCare ALEXANDER, ALLEGHANY, ASHE, AVERY, BURKE, CALDWELL, CATAWBA, CHEROKEE, CLAY, DAVIDSON, GRAHAM, HAYWOOD, IREDELL, JACKSON, MACON, ROBESON, SAMPSON, SWAIN, WATAUGA, WAYNE ALAMANCE, CASWELL, CHATHAM, ORANGE	919-380-9962 919-966-4123	Marci Miles 919-380-9962 mmiles@ncaccesscare.org
Carolina Collaborative Community Care CUMBERLAND	910-485-1057	Brenda Sparkes 910-485-1057 bsparks@carolinaccc.com
Carolina Community Health Partnership CLEVELAND, RUTHERFORD	704-484-5216	Debbie Clapper 704-484-5216 debbie.clapper@clevelandcounty.com
Community Care Plan of Eastern Carolina CARTERET, CRAVEN, DUPLIN, JONES, PAMLICO EDGECOMBE, GREENE, LENOIR, PITT HALIFAX, HERTFORD, NASH, NORTHHAMPTON, WILSON BEAUFORT, BERTIE, CAMDEN, CHOWAN, CURRITUCK, DARE, GATES, HYDE, MARTIN, PASUOTANK, PERQUIMANS, TYRRELL, WASHINGTON	 252-636-4962 252-847-7476 252-847-0067 252-847-0069	Jim Baluss / Laurie Nelson 252-847-6696 / 252-847-7476 jbaluss@pcmh.com / lnelson@pcmh.com
Community Care of Wake and Johnston JOHNSTON, WAKE	919-872-5197	Paul Harrison / Susan Davis 919-783-0404 ext.23 / (919)792-3626 pharrison@wakedocs.org / sdavis@wakedocs.edu
Community Care Partners of Greater Mecklenburg ANSON, MECKLENBURG, UNION	704-512-5555	Dana Baker 704-512-2282 dana.baker@carolinashealthcare.org

Community Health Partners GASTON, LINCOLN	 704-853-5069	Robert Spencer / Charlotte Lynch 704-853-5261 / 704-853-5069 rspencer@gfhs.info / clynch@gfhs.info
Northern Piedmont Community Care DURHAM FRANKLIN, GRANVILLE, PERSON, VANCE, WARREN	 919-620-8034 252-436-1053	Fred Johnson/Jessica Simo 919-681-4220/919-613-6512 johns427@mc.duke.edu simo0001@mc.duke.edu
Northwest Community Care DAVIE, FORSYTH, STOKES, SURRY,WILKES, YADKIN	 336-716-2698	Jim Graham 336-716-5654 hgraham@wfubmc.edu
Partnership for Health Management GUILFORD, RANDOLPH, ROCKINGHAM	 336-235-0930	Claudette Johnson 336-235-0930 ext 303 cjohnson@p4hm.org
Sandhills Community Care Network HARNETT, HOKE, LEE, MONTGOMARY, MOORE, RICHMOND, SCOTLAND	 910-246-9806	Tammie McLean 910-295-7250 tammiemclean@sccna3.org
Southern Piedmont Community Care Plan CABARRUS, ROWAN, STANLY	 704-783-4191	Cindy Oakes 704-783-1516 coakes@northeastmedical.org

International Center for Clubhouse Development

Joel D. Corcoran

Special Presentation For:

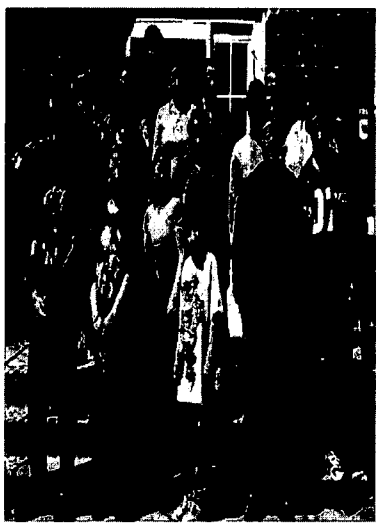
North Carolina Mental Health
Legislative Oversight Committee

March 10, 2010

What is a Clubhouse?

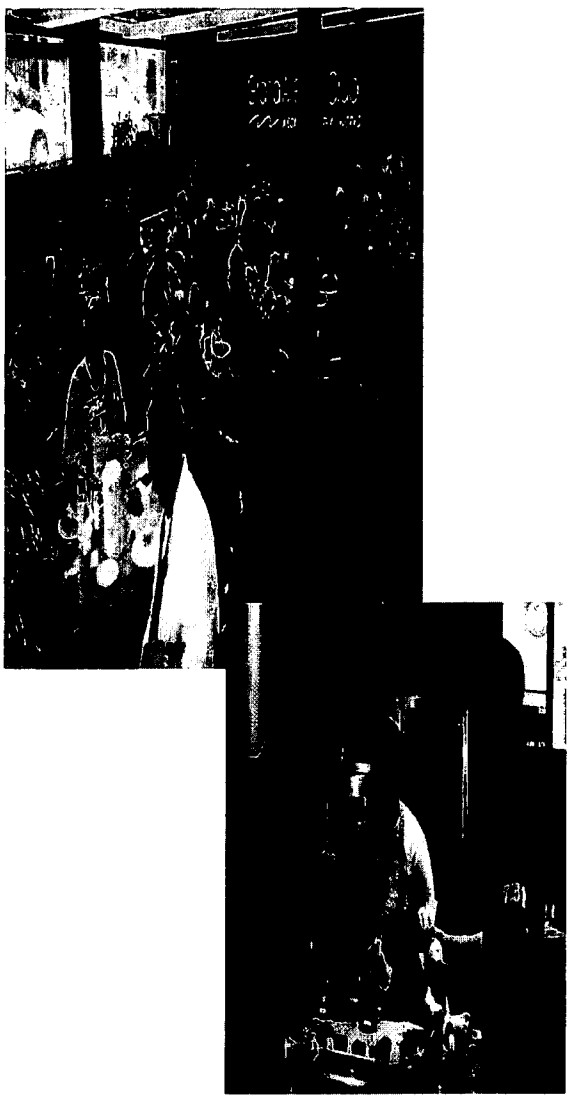
ICCD Clubhouses are more than just a program, they are:

- A community of people committed to each other's success.
- People working together
- A place where there are repeated opportunities to volunteer
- Opportunities to join or re-join the worlds of friendships,
  family, important work, employment, education and access to effective services and supports



What is a Clubhouse?

Clubhouse

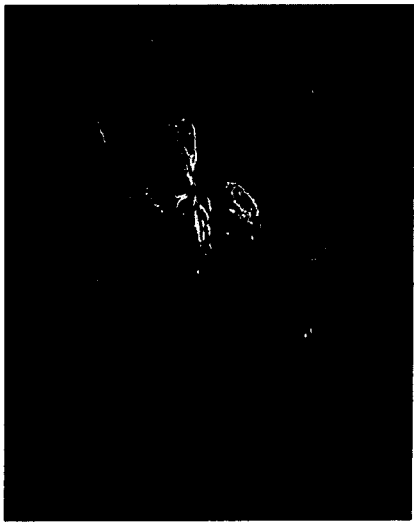


- First Clubhouse was started in New York City in 1948.
- It was started by a group of men who had been discharged from the state psychiatric hospital.
- The group met together as a "kind of club" and organized themselves to be a support system for people living with mental illness.
- Communities around the world have modeled themselves after Fountain House in New York and have embraced the term Clubhouse because it so clearly communicates the messages of membership and belonging.

About ICCD Clubhouses

ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*

- What is an ICCD Clubhouse?
  - A place where people with serious mental illness[1] ***participate in their own recovery process*** by working and socializing together in a ***safe and welcoming environment.***
  - An organization that operates on ***proven standards*** developed by the International Center for Clubhouse Development (ICCD) over 6 decades and ***effective in over 300 Clubhouses worldwide.***
  - A community-based approach that ***complements available psychiatric treatment.***



[1]Clubhouse participants are known as "members".

About ICCD Clubhouses

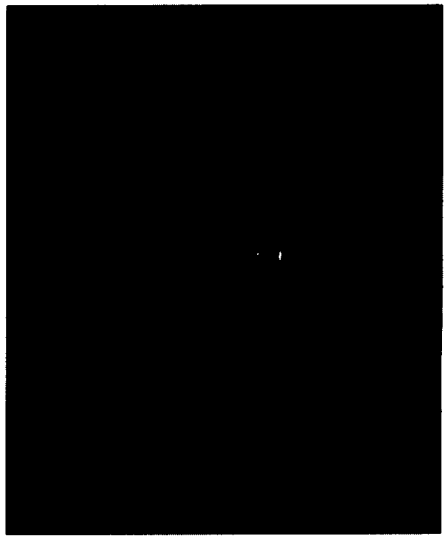
<u>ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*</u> They are:

- ***Holistic*** – offering participants (members) opportunities for friendship, employment and education, and access to quality housing, medical and psychiatric services through a single caring and safe environment.
- ***Inclusive*** – allowing members to meet and follow the example of others who are achieving their personal aspirations and goals.
- ***Sustaining*** – helping members become productive members of society over the course of their lives.
- ***Responsive*** – dedicated to continuous improvement based on direct feedback from members.
- ***Cost-Effective*** – providing members, families and communities significantly more value for money than other approaches.

About ICCD Clubhouses

ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*

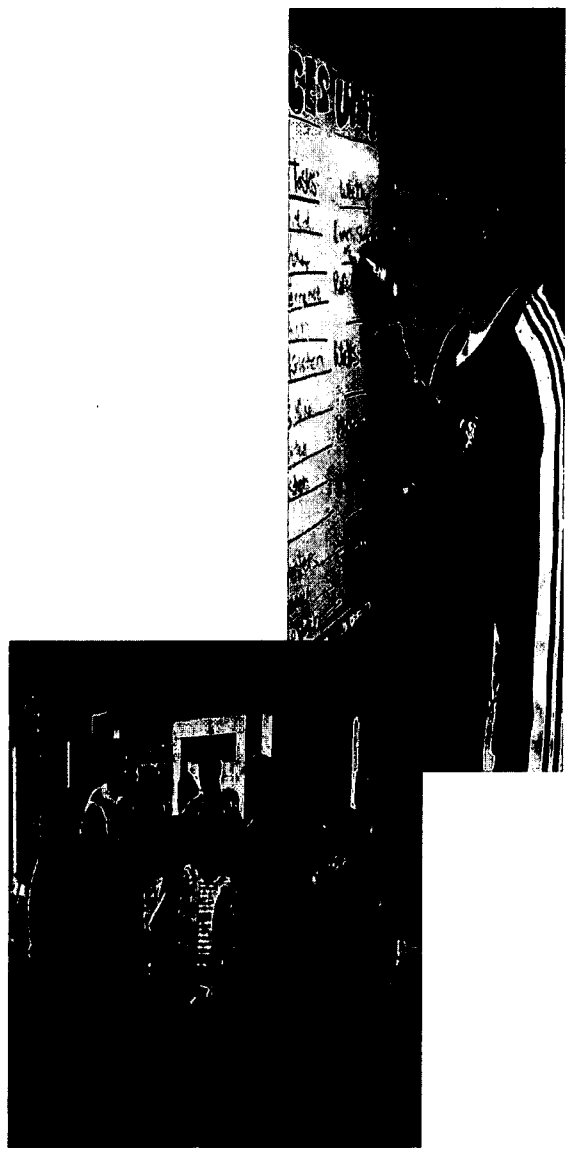
- What are the characteristics of an ICCD Clubhouse?
  - ***Membership is voluntary*** and ***long-term***.
  - ***Members have a key role*** in organizing Clubhouse activities. Staff and members work together as colleagues.
  - ***Work and social activities*** in the Clubhouse are ***meaningful*** and help members regain ***self-worth, confidence and purpose***.
  - Clubhouses provide ***paid employment opportunities in local community businesses*** for members who want work; they ***help members become successful employees.***



About ICCD Clubhouses

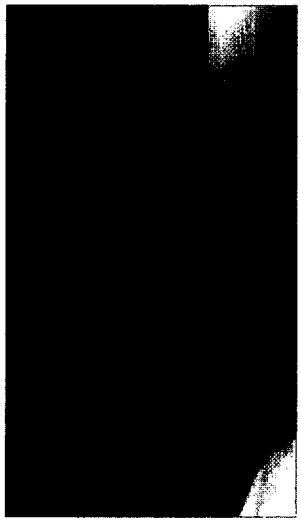
Values

- The belief that every member can recover from the effects of mental illness and have a personally satisfying life.
- All members, even those struggling with the most severe issues with mental illness can make a contribution to the work of the Clubhouse.
- Shared work is restorative and forms a foundation for growth and achievement.
- Socializing and having fun is an important part of recovery.



About ICCD Clubhouses

Meaningful Relationships: The Core ingredient

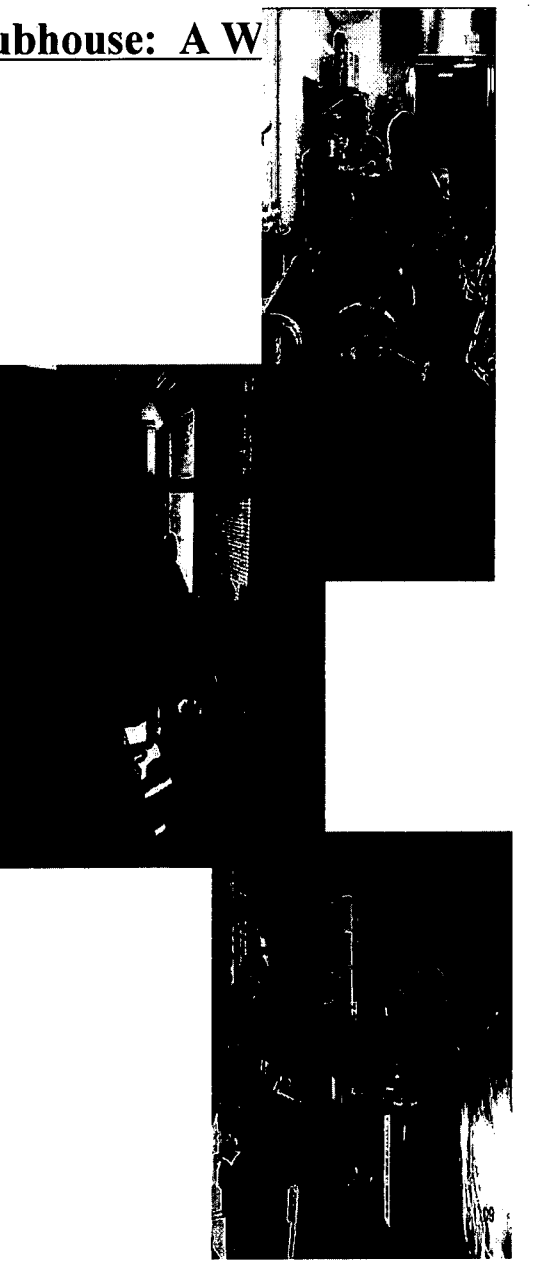


- People working together side-by-side is the preferred method.
- Staffing levels are intentionally kept low so that members participation is need each day.
- The relationships that develop between members and staff and members and members is the key to the Clubhouse rehabilitation system.
- Staff are not there to "teach" or "train" members but rather to work with members as colleagues and create real mutually dependent relationships.

About ICCD Clubhouses

The basic components of Clubhouse: A W

- Daily activities are organized around a structured schedule known as the Work-Ordered Day.
- The Work-Ordered Day in a Clubhouse parallels typical business hours. Usually 8 hours.
- Members and staff work side-by-side to do the work.
- There are no clinical therapies and treatment programs in a Clubhouse.
- Members volunteer to do as much or as little work as they feel ready to do.



About ICCD Clubhouses

The basic components of Clubhouse: The Employment Programs

- Returning to paid employment is a right of membership and a priority at the Clubhouse .
- Three types of employment programs:
  -Transitional
  -Supported
  -Independent
- All Clubhouse employment is at the employer's place of business and pays the prevailing wage for the required work.

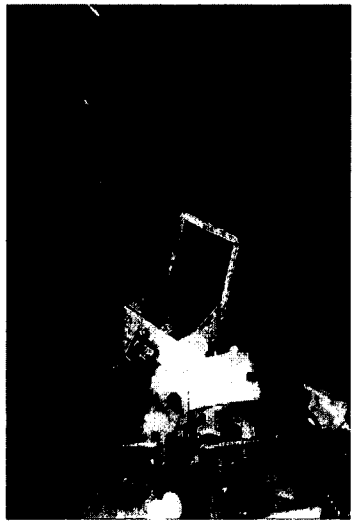
About ICCD Clubhouses

The basic components of Clubhouse: The Evening, Weekend and Holiday Programs

- In addition to work activities Clubhouses provide social and recreation programming.
- Members and staff together organize structured and unstructured "fun" activities.
- Always outside of the Work-Ordered Day hours.
- Holidays are always celebrated on the actual day on which they fall.

About ICCD Clubhouses

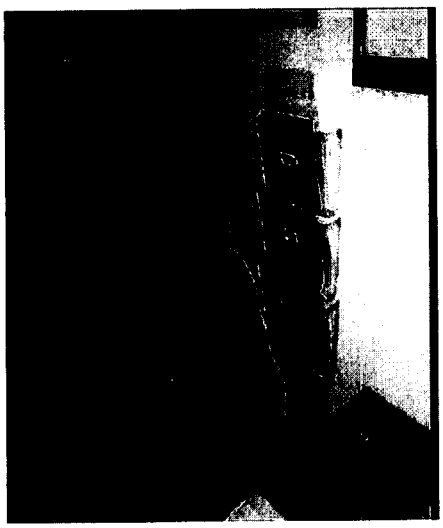
The basic components of Clubhouse: Community Support



- Members are given help accessing the social and healthcare services they require.
- Members get help with acquiring and keeping affordable and dignified homes.
- Members get help with government disability and pension benefits.
- Community support services are coordinated and provided by members and staff of the Clubhouse.

About ICCD Clubhouses

The basic components of Clubhouse: Reach-Out



- Part of the daily Clubhouse work is keeping track of all the active members.
- Members who are unusually absent are given "reachout" phone calls or visits to check in and be encouraging.
- Members in the hospital receive visits from their colleagues.
- In reachout work each member is reminded that he or she is missed and welcomed and needed at the Clubhouse.

About ICCD Clubhouses

The basic components of Clubhouse: Education

- Many members have had their education interrupted by their illness.

- The Clubhouse provides opportunities and assistance helping members complete or start their certificate or degree programs at colleges and universities.

- The Clubhouse uses the talents and skills of its members and staff to provide tutoring and assistance with school.

About ICCD Clubhouses

ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*

- What are the outcomes for people who participate in the ICCD Clubhouse experience?
  - ***Employment***, with longer on-the-job tenure for members engaging in transitional employment
  - ***Cost effective***, compared to other mental healthcare approaches
  - ***Reduced hospital stays***
  - ***Reduced incarcerations***
  - ***Improved well being:*** more likely to have close friendships and people to rely on
  - ***Better physical and mental health*** through reduced disconnectedness.

About ICCD Clubhouses

ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*

- What evidence is available to substantiate the positive outcomes for members?
  - Better Transitional Employment Results: longer on-the-job tenure found to be ***highly correlated*** with Clubhouse attendance.[1]
  - Cost-Effective: the cost of Clubhouses estimated to be ***one-third*** of the cost of the IPS Supported Employment model; about ***half*** the annual costs of Community Mental Health Centers; and ***substantially less*** than the ACT model.[2]
  - Reduced Hospital Stays: membership in a Clubhouse program resulted in a ***significant decrease*** in the number of hospitalizations.[3]

[1]Source: Macias, Kinney and Rodican (1995).

[2]Source: McKay, Yates, and Johnsen (2005); IPS model reported by Clark et al (1998); ACT model reported by Macias et al (2001).

[3]Source: De Masso, Avi-Itzak and Obler (2001).

About ICCD Clubhouses

ICCD Clubhouses offer people who have mental illness *hope and opportunities* to achieve their *full human potential.*

- What evidence is available to substantiate the positive outcomes for members? (cont.)
  - Reduced Incarcerations: criminal justice system involvement ***substantially diminished*** during and after Clubhouse psychosocial program membership.[1]
  - Improved Well-Being:
    - Compared with individuals receiving services as usual, Clubhouse members were significantly more likely to report that they had ***close friendships*** and ***someone they could rely on*** when they needed help.[2]
    - A recent study suggests that service systems should prioritize services that offer ongoing social supports like Clubhouses, as they ***enhance mental and physical health*** by reducing disconnectedness.[3]

[1]Source: Johnson and Hickey (1999).

[2]Source: Warner, Huxley and Berg (1999).

[3]Source: Leff and colleagues (2004).

Clubhouse as an Evidence Based Practice

A Submission to have the ICCD Clubhouse Model identified as an EBP has been accepted and is currently being reviewed.

We expect the review to be complete and ICCD Clubhouse to be identified as an EBP by September 2010.

United States Substance Abuse and Mental Health Services Administration's (SAMHSA) Registry of Evidence Based Practices: NREPP
http://www.nrepp.samhsa.gov/

The government in Finland where there are 16 ICCD Clubhouses
has completed their review and includes Clubhouses on their EBP registry.

STAKES Registry http://psitri.stakes.fi/EN/psitri.htm

Recent Research

There are many additional research articles available about the characteristics and effectiveness of Clubhouses

http://www.iccd.org/recent_research.html

About ICCD: Certification

- ***ICCD Certification*** is a ***symbol of quality*** and a clear demonstration of a Clubhouse's ***commitment to excellence***.
  - Certification is ***awarded for either one or three years***, subject to the degree of adherence by the Clubhouse to the ICCD International Standards.
  - The certification ***process is both evaluative and consultative***. It is conducted by members of the ICCD Faculty for Clubhouse Development (made up of veteran members and staff from certified ICCD Clubhouses from around the world).
- ***Certification components*** are:
  - A Clubhouse ***self study***
  - A site visit by members of the ICCD Faculty for Clubhouse Development
  - A ***findings presentation and dialogue*** with Clubhouse leadership focusing on improvement opportunities
  - A ***written findings report***
  - The award of ***certified status***
  - ***Ongoing consultation***

About ICCD: International Standards

- Membership
  - Ensures members that their participation is fully voluntary and that they can access all the opportunities available to them through Clubhouses.
- Relationships
  - Describes the unique collegial relationship between the Clubhouse staff and members.
- Space
  - Emphasizes the importance of creating a dignified, attractive environment where important work is accomplished.
- Work-Ordered Day
  - Describes the structure of the day-to-day activity within a Clubhouse, organized to help members develop self-esteem, confidence and friends which make up the foundation of the recovery process.

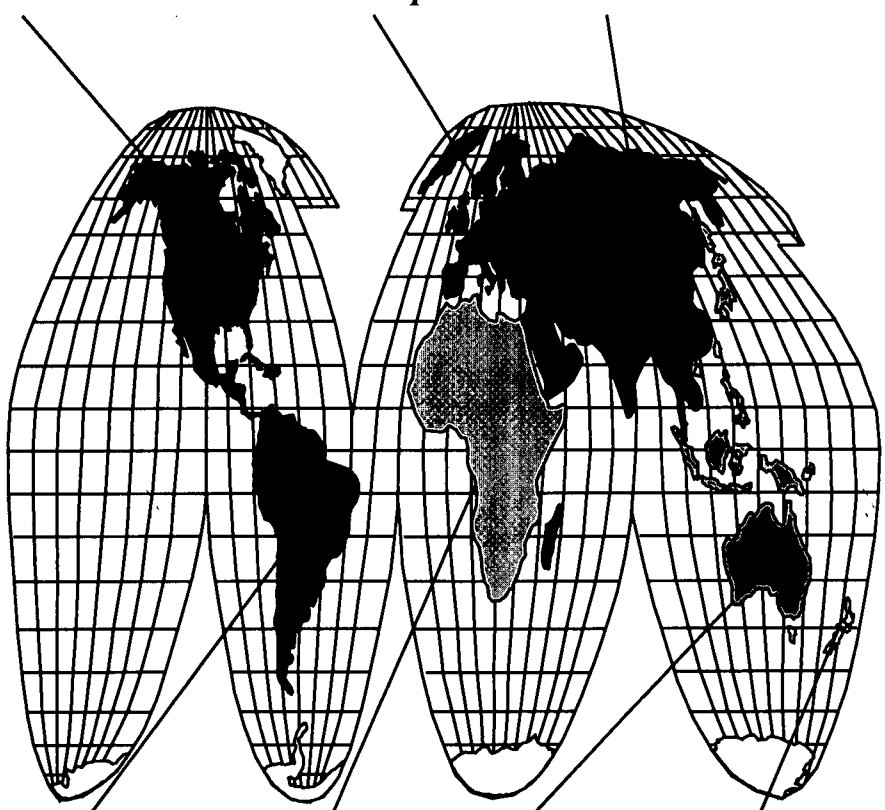
About ICCD: International Standards

- Employment
  - Ensures that Clubhouses offer members organized, effective strategies for moving into and maintaining gainful employment.
- Education
  - Ensures that Clubhouses offer members effective opportunities to complete their education.
- Functions Of The House
  - Addresses the basic requirements for meeting members' needs, with an emphasis on social and healthcare services.
- Funding, Governance And Administration
  - Describes requirements for overseeing and managing Clubhouses.

About ICCD: A Global Resource

There are 334 ICCD Clubhouses in 28 countries that serve over 55,000 people who have mental illness; about 15 new ICCD Clubhouses are opened each year.

North America: 226 Clubh***Europe***: 79Clubho***Asia***: 16 Clubhouses



South America: 0 Clubhouses ***Australia***: 10 Clubhouses

Africa: 2 Clubhouse ***New Zealand***: 1 Clubhouses

Joel Corcoran, M. Ed
International Center for Clubhouse Development
New York, New York, USA

Joel is the Executive Director of the International Center for Clubhouse Development (ICCD). The ICCD is a global network of individuals and organizations working to create opportunities for people living with mental illness to be respected members of society. The ICCD with its team of staff and Clubhouse members leads a worldwide alliance of Clubhouse programs coordinating training, quality assurance, and assistance with new Clubhouse development, technical assistance, research, information dissemination and advocacy. The ICCD today includes more than 350 Clubhouse programs and start-up groups operating in 32 countries.

Joel has worked in the field of community mental health and psychiatric rehabilitation since 1981. Before accepting his position at the ICCD in 1995 his career includes working at a large state psychiatric hospital, as a case manager, a residential director, a Clubhouse director and as an administrator in a multi state mental health agency. He has been involved as an advocate in state and national mental health services reform and promoting opportunities for people living with mental illness to have a role in the design and evaluation of those services.

He has traveled extensively throughout the world working to support the development and quality improvement of Clubhouse programs to be strong and enduring resource centers for people living with mental illness. He has been an active advocate for quality services, dignified opportunities and full citizenship for people living with mental illness. He has worked with local, state, national and international governments, public and private health agencies, advocacy groups and educational institutions. In his role as the Executive Director of the ICCD he has provided a system of training, accreditation, technical assistance and consultation on local, state and national levels to government, family member, provider and consumer organizations interested in Clubhouse development.

Presentation to the Legislative Oversight Committee
By: Charlene Lee
03/10/2010

My name is Charlene Lee. I am alive. And I am here today in large part because of a loving brother and a community called Club Nova. Club Nova is one of 8 ICCD Certified Clubhouse Models in North Carolina. The Clubhouse Model is one of the most comprehensive services/programs in the nation for people living with serious mental illness.

While my story has facets unique to me as an individual, I am one of many, many citizens across NC who live with serious mental illness. My hope is that every citizen who lives with mental illness will have access to membership in a Clubhouse with ICCD certification if they so choose. The Clubhouse Model must be a core service in our mental health system.

By all accounts, I should not even still be alive today. My life's journey began in January 1968, when I was born into a family with generations who suffered from mental illness. Several members of my dad's family were considered 'crazy', as we had not really named or acknowledged mental at that time. Ultimately, my dad and my granddad committed suicide via self-inflicted gun shots....my dad when I was two, my granddad when I was 12. Suffering from undiagnosed and untreated mental illness, I also I grew up in a home where abuse was the norm from age six until I was grown.

The fact that I suffered undiagnosed and untreated mental illness, along with many years of abuse, would eventually lead me down roads of self-destruction.

I had several hospitalizations and took prescribed medications that were not good fits/effective for me from my early 20's to early 30's. When those medications failed to work, I just began to go way off the deep end. I became involved in a destructive relationship that included drug use. I would eventually get into legal trouble that landed me in the Wake County jail from November 2002 until April 2003. I was released to sentencing services to go directly to UNC Psychiatric Hospital for treatment. I had been ordered an extensive mental health evaluation while in jail, and documentation was given that there were several issues going on with me, mentally, that required immediate attention.

My life continued to be shaky, with a couple of more hospitalizations, the last of which was April 2006. The day I was released from that hospital stay, I had to immediately go to my mother who was dying of cancer. I stayed with her 24/7 for two months, until her death.

I joined the Clubhouse in 2004. I attended for about 5 months and then disappeared. Despite repeated efforts, the Clubhouse could not locate me.

I had been evicted from my apartment in early 2006 because I was not able to work at all. My disability was repeatedly denied (four times to be exact). I was trying to get things together, but with every step I took forward, it seemed that there were two steps taken back. Financially broke, I began to write bad checks at the pharmacy just so I could get my prescribed medications, hoping that by staying on my meds that I could somehow get out of this hole. During this time, I faithfully attended my therapy and doctor appointments.

When my mom passed in May 2006, with no income and nowhere to live, I had to move in with my brother and his family in Wake County. We tried to get me set up with a doctor, but as my Medicaid had also been denied, I was told that it could be up to a year before I could get a permanent doctor without Medicaid. I contacted the agency in Orange County where I had previously received therapy and psychiatric services. My brother and I were told that I had to be a resident in that county to continue treatment. Therefore, I made the decision to move back to Orange County just so I could continue receiving my mental health treatment. I had no where to move to, and no money, and no job. Therefore, my brother had to take me to the women's shelter, where I would end up staying for three months, waiting for an apartment. I told my brother that if I could just get back to Club Nova, where I was a member, that I would be able to get back on my feet.

My brother took me to the women's shelter on Thursday, October 6, 2006. I got on a bus on Friday, October 7, 2006, and went straight to Club Nova. I walked in the door and announced, "I'm back. I'm homeless. I'm broke. I need help and I need a job." Staff at Club Nova immediately took me in and set down and talked with me about what was going on.

The Clubhouse offered assistance and support I needed when I needed it. Members in the International Clubhouse Community have guaranteed rights. One of those is "A guaranteed right to a place to return with immediate re-entry into the Clubhouse after any length of absence . . . . . ." re-entry was seamless. Barrier free. No weeks or months of securing the required Community Support that would complete a person centered plan, to then be signed by a doctor I have yet to see. I did not have to wait until Value Options authorized me to receive services. For those of us out here living with mental illness, we don't always have the time for person-centered plan development, doctor signatures, and responses from Value Options.

There was a Transitional Employment job available through Club Nova at Staples. It did not matter to me that it was scrubbing toilets and cleaning, I just needed a job. I went to work through the Transitional Employment program on October 10, 2006, and have been at Staples since then. I was hired on permanently after my nine month transitional period, and was promoted to the front of the store as a cashier, and have since moved on up to a lead position in customer service.

During this time, I was repeatedly denied my Medicaid and my disability. My worker at Club Nova helped me to schedule a hearing so that I could go before the Medicaid judge

in hopes of getting help to pay for my medications. After three failed attempts, I was finally approved for my Medicaid in December 2006. I would never have known how to get it had it not been for Club Nova staff working to get my hearing.

Housing was a big issue for me. I was on the section 8 waiting list, but nothing was coming available. Karen Dunn and other Club Nova staff began working with the section 8 people to try and get me out of the shelter and into an apartment. It took three months before I was finally in my apartment at Club Nova, and it was only then that I was able to move out of the shelter. I had no clue how to continue trying to get my Section 8 for housing, and Club Nova worked me through it.

As stated earlier, I had been denied my disability for a total of four times. I was finally granted a hearing for January 2009. Catherine Tiller, a staff at Club Nova, helped me to prepare for that hearing and drove me to Raleigh at the appointed time. The judge that I went before was very harsh and brutal, and I ended up breaking down in tears during his questioning, and what I felt like, his harassment. At one point during the hearing, I was crying so uncontrollably and so visibly shaken that the judge asked Mrs. Tiller and my attorney to assist me to the reception area to gather myself. Catherine walked me through things that would help me to get through this ordeal. Without her having been there, I probably would have just given up. As a result of this hearing, however, I was finally approved for my full disability.

In all my years at Club Nova, I have found that the Clubhouse is the one place in the mental health system that is consistent and the one place I have been able to count on. I have been caught up in the chaos of our mental health system .....lost community support, lost my therapist, and lost my doctor. Yet, Club Nova was still there through all of this. The staff has gone above and beyond in helping me, as well as many others, through this terrible time of mental health reconstruction. I would not be where I am in my life today had it not been for Club Nova.

I have no desire to go back to my former days before Club Nova. I have a strong desire to move forward.

I don't know where I'd be without CN . . . We need Clubhouses across NC . . .

Where am I today? The outcomes for me and many of our citizens participating in Clubhouses:

- First and foremost I am alive.
- I have gone from being homeless to having safe, decent, affordable house with support from Club Nova. I continue to live independently.
- With the support and assistance of the Clubhouse, I have the benefits I am entitled to including Medicaid and disability. I can now afford my medication.
- I am not considered a burden to society because I have stayed out of trouble. My involvement in the legal system is now a thing in the past. I am out of the legal system.

- I am a well respected requested speaker on mental illness and our mental health system, as well as an advocate.
- My relationships with family and friends have been repaired. I have new friendships and relationships.
- My family recognizes whole-heartedly the difference that Club Nova has made in my life.
- I participate and contribute in the fabric of the community.
- And I have been employed for 3 ½ years at Staples. I have been awarded three Associate of the Month certificates; I have received the highest honor that can be awarded for my employment status, that being "All Star" for our entire region; and, I am considered a very valuable part of our store's team. My last evaluation was 4.7 out of 5. Now, that is an awesome score for someone who battles depression and mania on a regular basis.
- I have not been hospitalized since April 2006.

As you can see, rather than being a burden to society, I am fully engaged, participating in, and contributing to the life of the community. I am an integral part of the social and economic fabric of the community. I think this is what is referred to as full community integration.

Mental illness is a life threatening illness. So I ask that you support the existing Clubhouses in NC as well as Clubhouse Development throughout the state of NC. Our lives depend on it. Clubhouses are effective for those of us living with mental illness. Clubhouses are cost effective and a wise investment of public funds.

Rather than eight, we need 108 in North Carolina.

CLUBHOUSES AND COMMUNITY SUPPORT SERVICES: COMPARISONS

CONVERGENCES, DIVERGENCE AND THE NEED FOR A CLUBHOUSE SERVICE DEFINITION

LOC PRESENTED BY SUE E. ESTROFF, PH.D.
10 MARCH, 2010

CONVERGENCE

COMMUNITY SUPPORT SERVICES

- Assist recipients in acquiring mental health and/or substance abuse recovery skills necessary for self management and to address successfully vocational, housing, and educational needs.
- Facilitation of the Person Centered Planning process which includes the active involvement of the recipient and people identified as important in the recipient's life (e.g., family, friends, and providers).

CLUBHOUSE STANDARDS AND SERVICES

- Helping people with mental illness to stay out of hospitals while achieving social, financial and vocational goals.
- Members at their choice are involved in the writing of all records reflecting their participation in the Clubhouse. All such records are to be signed by both member and staff.
- All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.

CONVERGENCE

COMMUNITY SUPPORT

- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Use natural and social supports
- Utilize functional skills to live independently
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that
- interfere with the recipient's daily living

CLUBHOUSE

- The work-ordered day engages members and staff together, side-by-side, in the running of the Clubhouse. The Clubhouse focuses on strengths, talents and abilities
- All work in the Clubhouse is designed to help members regain self worth, purpose and confidence...
- The Clubhouse has recreational and social programs during evenings and on Weekends. Holidays are celebrated on the actual day they are observed.
- The level of support increases or decreases in response to the changing needs of the member.

CONVERGENCE

COMMUNITY SUPPORT

- Community Support staff also inform the recipient about benefits, community resources, and services; and assist the recipient in accessing benefits and services. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

CLUBHOUSE

- Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse.
- They include helping with entitlements, housing and advocacy, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the community.

CONVERGENCE

COMMUNITY SUPPORT

- Relapse prevention and disease management strategies.
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers).
- • Assistance for the recipient and natural supports in implementing preventive and therapeutic intervention
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement

CLUBHOUSE

- Members and staff actively reach out to help members keep their housing, especially during periods of hospitalization.
- The Clubhouse provides an effective reach out system to members who are not attending, becoming isolated in the community or hospitalized.

CONVERGENCE

COMMUNITY SUPPORT

- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living

CLUBHOUSE

- The Clubhouse is committed to securing a range of choices of safe, decent and affordable housing for all members. The Clubhouse has access to housing opportunities that meet these criteria, or if unavailable, the Clubhouse develops its own housing program.
- The Clubhouse assists and supports members to secure, sustain and subsequently, to better their employment.
- The Clubhouse assists members to further their vocational and educational goals by helping them take advantage of adult education opportunities in the community. When the Clubhouse also provides an in-house educational program, it significantly utilizes the teaching and tutoring skills of members.

CONVERGENCE

COMMUNITY SUPPORT

- **Utilize functional skills to live independently**

CLUBHOUSE

- The Clubhouse offers its own Transitional Employment program, which provides as a right of membership opportunities for members to work on job placements in business and industry.
- Members who are working independently continue to have available all Clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs.
- Members have the opportunity to participate in all the work of the Clubhouse, including administration, research, intake and orientation, reach out, hiring, training and evaluation of staff, public relation, advocacy and evaluation of Clubhouse effectiveness.

CONVERGENCE

COMMUNITY SUPPORT

- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients;

CLUBHOUSE

- Community support activities are centered in the work unit structure of the Clubhouse. [FACE TO FACE]
- Clubhouse staff have generalist roles. All staff share employment, housing, evening and weekend, holiday and unit responsibilities. Clubhouse staff do not divide their time between Clubhouse and other major work responsibilities. [FACE TO FACE]

ADDITIONAL CONVERGENCES WITH COMMUNITY SUPPORT TEAMS

assist individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. Services offered by the CST shall be documented in a Person Centered Plan and must include: assistance and support for the individuals in crisis situations; service coordination; psycho-education and support for individuals and their families; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; monitoring medication; and self medication.

Individuals will experience decreased crisis episodes, and increased community tenure, time working, in school or with social contacts, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process.

DIVERGENCES THAT REQUIRE A CLUBHOUSE SPECIFIC SERVICE DEFINITION

COMMUNITY SUPPORT

- PRESCRIPTIVE TIME LIMITS FOR SERVICES, DISCHARGE
- PCP PLAN REPORTING SCHEDULE
- LIMITS ON HOURS OF SERVICE/ATTENDANCE
- STAFF CREDENTIALS
- ADMISSION PATHWAYS AND REQUIREMENTS
- GROUP SIZE LIMITS (8)

CLUBHOUSE

- Membership is voluntary and without time limits.
- Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community.
- Members who are working independently continue to have available all Clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs.

With the huge changes to our state's mental health system being proposed, including CABHA's and statewide Medicaid Waivers, Clubhouses need to have a voice at the table to protect our programs, and more importantly our Members, from being adversely affected.

Please work with us, through legislation if necessary, to ensure that we have that voice.

North Carolina Clubhouse Coalition Academic Partnerships

- Asheville Buncombe Technical College
- Belmont Abbey
- Blue Ridge Community College
- Brevard College
- Catawba College
- Cleveland Community College
- Duke University
- Durham Technical Community College
- East Carolina University
- Gaston College
- Gardner Webb University
- Greensboro College
- Guilford Technical Community College
- Isothermal Community College
- Limestone College
- Mars Hill College
- Meredith College
- NC A&T State University
- NC State University
- Peace College
- UNC-Chapel Hill
- UNC-Charlotte
- UNC-Greensboro
- UNC- Asheville
- Wake Technical Community College
- Webster University

Certified Clubhouses work with schools and departments within these academic settings

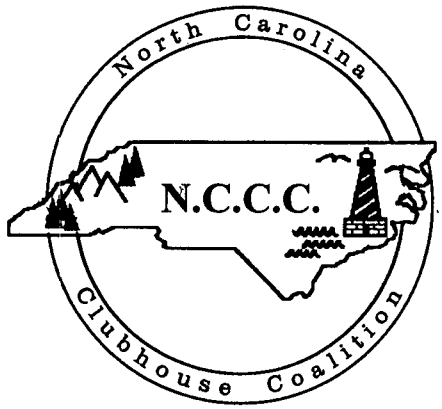
- School of Nursing
- School of Social Work
- Psychology Department
- Medical Anthropology
- Fuqua School of Business
- Occupational Therapy
- Journalism
- Art
- Sports Medicine
- Navy ROTC
- Nursing
- School of Public Health
- School of Medicine – Psychiatry, Social Medicine
- School of Dentistry
- School of Law – Including Poverty Center
- APPLES Service Learning

Additional North Carolina Clubhouse Coalition Educational Affiliations

- AHEC
- Center for Creative Leadership
- Discovery Learning
- Durham Literacy Center
- MAHEC

Sue E. Estroff, Ph.D. is Professor in the Department of Social Medicine, School of Medicine, and research professor in the departments of Anthropology and Psychiatry, University of North Carolina at Chapel Hill. B.A., Duke University, magna cum laude, 1972; Ph.D., University of Wisconsin-Madison, 1978 (Anthropology); Post Doctoral Fellow in Psychiatry, University of Wisconsin-Madison 1978-1981. She joined the UNC faculty in 1982, and was Chair of the Faculty from 2000-03. In 1984, she received the Margaret Mead award from the American Anthropological Association and Society for Applied Anthropology. She is past president of the Society for Medical Anthropology, and has been a visiting professor/lecturer at the University of Ulm, Germany, University of Toronto, and Tokyo University. Research areas: individuals with chronic illness and disabilities; cultural approaches to psychosis; sociocultural factors that influence the course of psychiatric disorders; disability income policy and practice; illness narratives; moral reasoning and the production of knowledge in qualitative scholarship; reconsidering the association of violence with persons with psychiatric disorders; and complexities of consent in maternal fetal surgery. Estroff teaches medical students, supervises dissertators in the Department of Anthropology, serves on thesis committees across campus, and teaches graduate seminars in methods and ethics. She is a co-editor of *The Social Medicine Reader* and the second edition of the *Reader*. Other recent publications include: *Ironic Interventions? Balancing Risks and Rewards in First Episode Psychosis via Qualitative Inquiry (in press), 'No Other Way to Go' Pathways to Disability Income Among Persons with Severe, Persistent Mental Illness; Whose Story Is It Anyway: Authority, Voice, and Responsibility in Narratives of Chronic Illness; and, The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness; Risk Reconsidered: targets of violence in the social networks of people with serious psychiatric disorders; The Cultural Calculus of Consent in Experimental Maternal Fetal Surger, Recognizing and Responding To Early Psychosis: A Qualitative Analysis Of Individual Narratives, and From Stigma to Discrimination: An Analysis of CommunityEfforts to Reduce the Negative Consequences of a Psychiatric Disorder and Label.* Estroff has served as a consultant to the Carter Center's Mental Health Stigma program, The Hogg Foundation Scientific Advisory Board, the Ohio and Pennsyvania Department of Mental Health, and is a member of the mental health services in specialty mental health settings review committee at NIMH.

Attachment 8



RECOMMENDED ACTION STEPS

LEGISLATIVE OVERSIGHT COMMITTEE
MARCH 10, 2010

1. Immediate restoration of the PSR rate to $12.12 per hour given the heavy work demands DHHS has placed on PSR programs with the closing of Community Support programs.

2. A service definition specific to ICCD Clubhouses should be developed and implemented.

3. In FY 10-11, ICCD Clubhouses require a reimbursement rate that accurately reflects the intensity, amount and quality of the services provided.

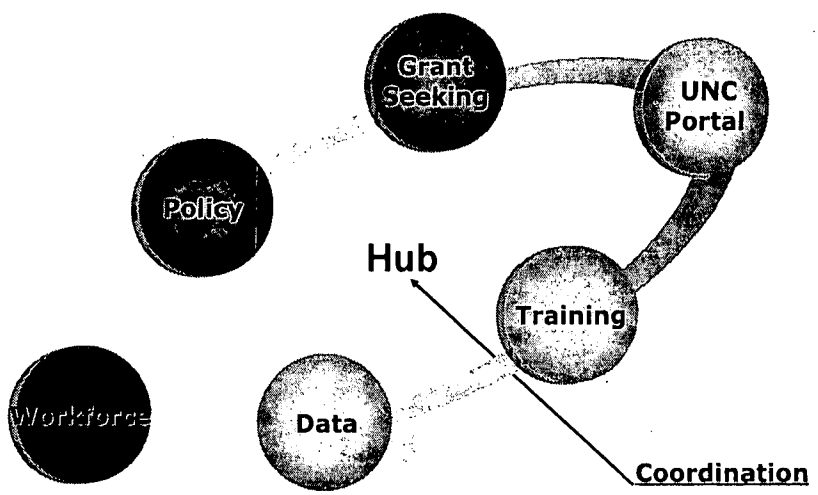
4. Funding for Piedmont Pioneer House, an ICCD Clubhouse in Gaston County, is now critical. DHHS should immediately identify emergency funding to prevent the closure of this Clubhouse.

We stand ready to work with you to accomplish these goals within a working group that needs to be established before the committee adjourns today.

North Carolina Mental Health Policy and Practice Hub

Legislative Oversight Committee
March 10, 2010

Hub Functions



Where did the Hub concept come from?

- MHLA Recommendations
- MH/DD/SAS Service Gaps Analysis
- Key Conversations
- Other Models

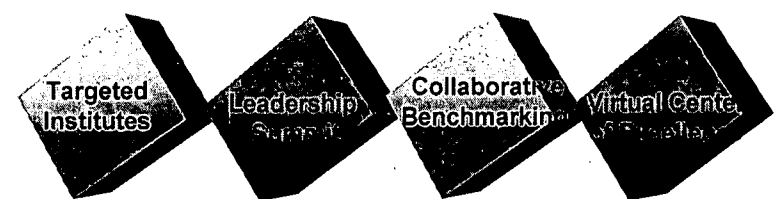
Mental Health Leadership Academy Overview

The purpose of the MHLA was:

- To develop the capacity of participants to apply skills and practices essential for enhancing organizational performance of North Carolina's LMEs.
- To improve skills by providing information and tools to LME senior staff to support them in sustaining a process of improvement that drives North Carolina's mental health reform movement forward.

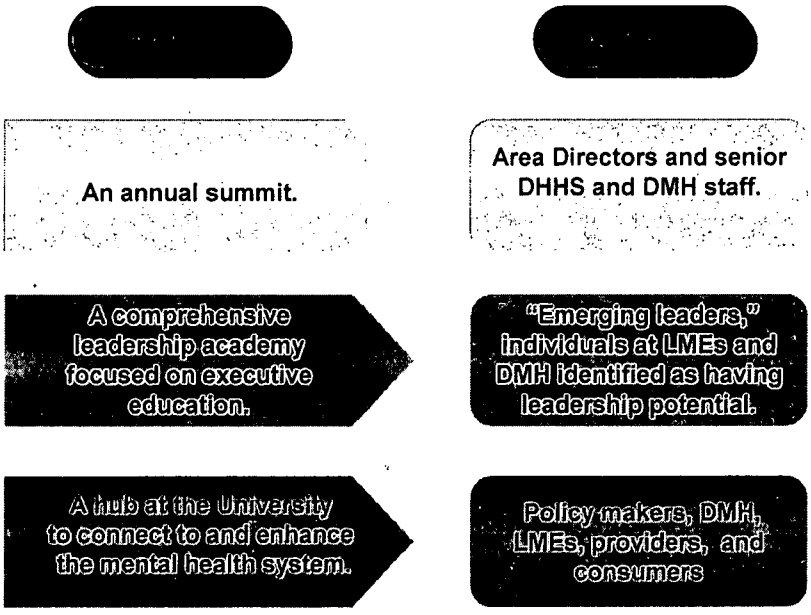
Participant Teams
Executives: Area Directors
CFOs, COOs and other managers
Clinical Directors and Directors of Care Management
Directors of Provider Relations, Directors of Community Relations

MHLA Y2 Program Components



Targeted Institutes	Leadership	Collaborative Benchmarking	Virtual Center
Focused training targeted by participant job responsibility	Topics related to leadership development, team building, and performance management	Facilitated dialogues for comparing how individual LMEs perform specific mission critical tasks	Interactive membership website to facilitate cross LME collaboration and extend core class work

MHLA Recommendations



MH/DD/SAS Service Gaps Analysis

This analysis found gaps in the areas listed below (among others):

- Quality and Accountability
- Workforce Development
- Leadership and System Management

The conclusion states that: *The need for more stability, better quality, and strategic use of existing resources must be the paramount concerns that drive policy direction for the immediate future.*

Key Conversations

Division leadership

Selected University leaders

Key policy makers

Other Models

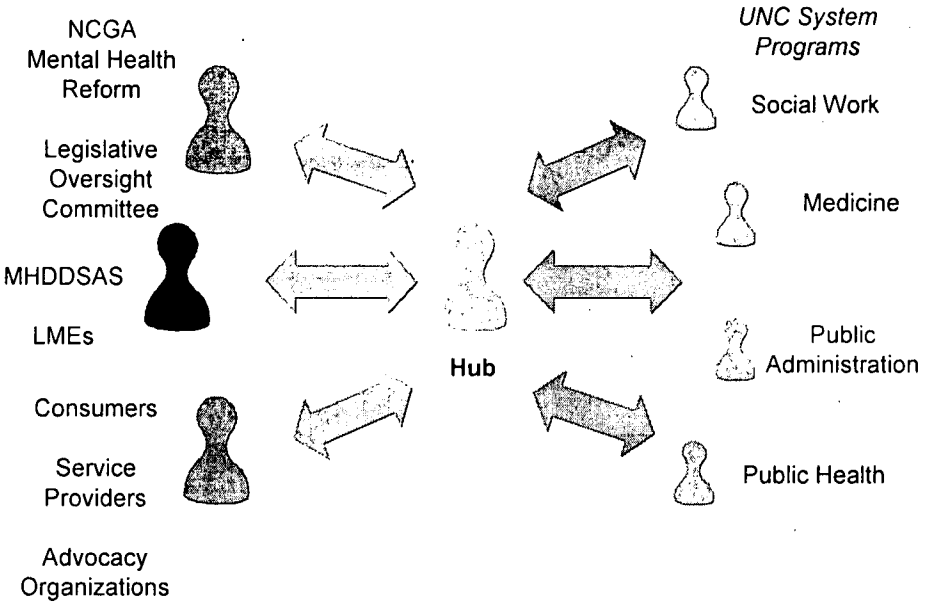
The Missouri Institute of Mental Health (MIMH) provides a variety of services to the Missouri Department of Mental Health and other state agencies and organizations. These services include:

- research,
- evaluation,
- policy, and
- training.

MIMH:

- Is funded through a line-item appropriation from the Missouri Legislature.
- Generated $24,454,277 in **new** funding brought to the state of Missouri in 2008.

NC MH Policy and Practice Hub



"Blending the DHHS leadership with LME leadership and the University's excellent minds can produce very positive and powerful results."

MHLA participant

CASE MANAGEMENT

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
March 10, 2010

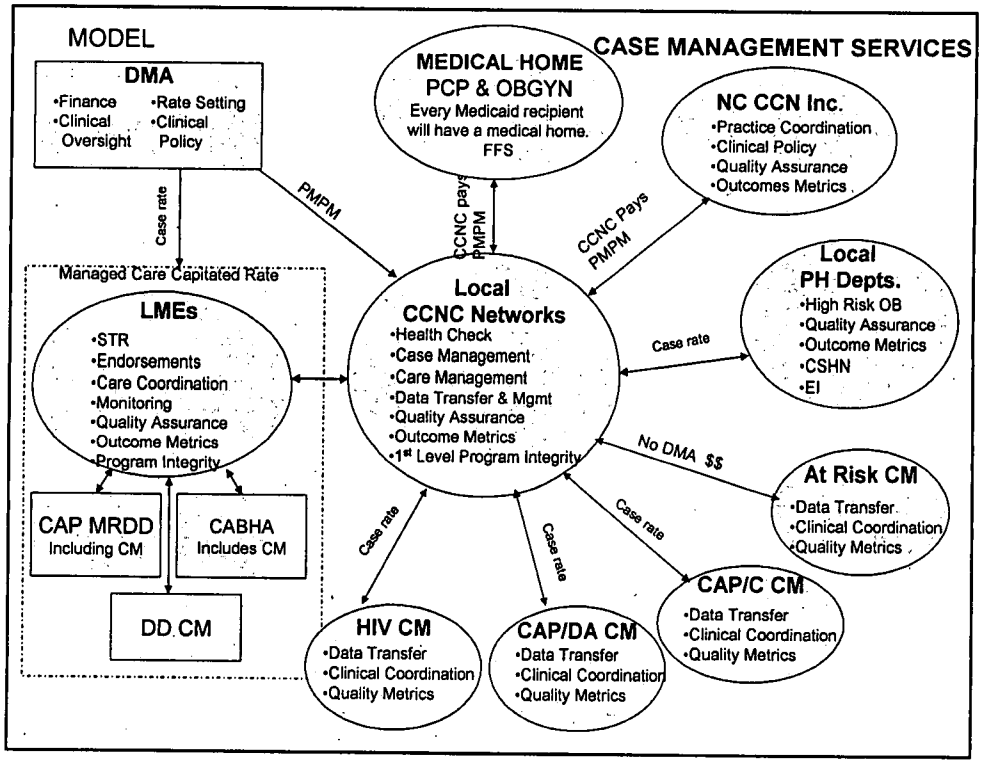
Tara Larson
Chief Clinical Operating Officer
DHHS, DMA

Legislation

- As required by **Section 10.68A (a) (10)** DHHS has undertaken a review of all case management services reimbursed by Medicaid in order to develop a plan for consolidation.
  - $40 million reduction associated with the consolidation plan

Highlights of Previous Presentations

- Previous presentations made in October and November, 2009 and covered:
  - An overview of the case management and care management definition and the 4 functions of case management
  - The current target populations covered
  - Data regarding program recipients and costs
  - Cost savings estimated if implemented January 1
    - $10-13 m for unit limitation
    - $2.5 m for single case manager
  - The work of the Steering Committee
    - Desired Outcomes/Goals
    - The short and long term goals
    - The diagram of the organizational structure
    - Next steps



Short Term Goals

- Unit Limits on case management – effective 3/1/10 (3hrs per month, 6 hrs "pool" per year)
  - Children are eligible for EPSDT reviews
  - PAG notification was January, 2009
  - Publication in Implementation Memo and Medicaid Bulletin January and Feb, 2009
  - Notification to recipients January 25, 2009
  - Prior authorized units were allowed to continue until time for next authorization or renewal
- Eliminate prior authorizations on CAP-MRDD case management – effective 3/1/10 (administrative reduction)
- Reduce prior authorizations on non waiver DD case management from quarterly to annually – effective 4/1/10 (administrative reduction). Will be closely monitored

Short Term Goals

- Allow direct billing for CAP DME waiver supplies – effective 7/1/10 (administrative reduction)
- Eliminate duplication – effective 4/1/10
  - *Place audits in system where possible to prevent billing by more than one CM provider in the same month*
- ***Also reported that DHHS would continue to involve stakeholders in the implementation/operations of the next steps and long term planning***

Operations and Implementation

- Stakeholder involvement in operations and implementation – have been meeting weekly since 1/19/10 with regular debriefing with DMA Management
- Representatives from providers, advocacy groups, consumers, DHHS division staff
- Four workgroups created to work on long term strategies and action steps: Service definition, CAP Waiver Standardization, CCNC Linkages, Form Standardization
  - Implementation strategy and plan
  - Timeline for implementation
  - Transition plan for current recipients and providers
  - Training plan
- Final Deliverables due 3/26/10

Service Definition Workgroup

As of January 2006, there is one federal definition for targeted case management which consists of 4 functions. However, today NC CM programs have different policies and procedures. This workgroup is charged with creating one standard policy.

- Target Populations
- Entrance, Continued Stay and Exit Criteria – there will be similarities and differences among disability areas
- Case Manager Qualifications for staff
- Provider Qualifications
- Outcomes

- **As long as targeted case management is the service billed, administrative functions MAY NOT be billed as TCM – only the 4 functions.**

Steering Committee Goals/Outcomes Addressed

- Ensure timely and accurate needs assessment
- Implement client specific outcomes
- Maintain disability/need specific expertise
- Prevention of substandard service delivery
- Develop professional standards for case managers
- Simplify the maze of various types of case management services and systems
- Develop a payment structure to promote outcomes
- Coordinate with programs such as Part C of IDEA or Title V and other DHHS funding sources.

CAP Waiver Standardization

CAP Waiver programs (1915c) are all regulated by the same federal guidelines yet their policies and procedures are different. This workgroup is charged with identifying areas that the three waivers can be made consistent. In addition they are looking at ways to simplify administration of the waivers.

- Identification of any Waiver requirements that may not be covered as allowed in direct TCM

Steering Committee Goals/Outcomes Addressed

- Simplify and eliminate ineffective administrative processes where allowed by regulation
- Simplify the maze of various types of case management services and systems
- Maintain disability/need specific expertise
- Prevention of substandard service delivery

CCNC Linkages

Data sharing is critical for coordinating clinical care. This workgroup is charged with developing processes and agreements that allow for key medical and behavioral information to be provided for all Medicaid recipients at the point of care. This data is needed to provide analytical support to prevent service duplication and optimize coordination of care.

- Which agency assumes primary responsibility and accountability – MH/DD/SA triggers such as:
  - Inpatient state or private
  - Use of Crisis services
  - History of 3 or more ED visits as well as prevention/diversion
  - Pharmacy/medication issues
  - NCQA standards for complex case management
- Communication linkages –data agreements
  - CCNC and LMEs for MH/DD/SA – meeting regularly with representation of LMEs, CCNC and DMA/DMH staff
  - CCNC and DPH for pregnancy home
  - CCNC and other waivers and medical

Steering Committee Goals/Outcomes Addressed

- Ensure appropriate linkages and follow up to services
- Eliminate duplication of functions and increase coordination /integration
- Support development of interoperable medical record systems
- Data sharing with providers

Forms Standardization

Since each case management program today has its own policies and procedures, they also have their own unique set of forms. This workgroup is charged with creating a standard set of forms/elements to be used by case managers.

- Coordination with initiatives for standardization

Steering Committee Goals/Outcomes Addressed

- Simplify and eliminate ineffective administrative processes
- Support the development of interoperable medical record system

Next Steps

- DD TCM submitted in 2005 approved by CMS 2/27/10. Still waiting on approval of the HIV SPA.
- CMS would not allow NC to submit the integrated CM SPA until the 2005 DD TCM was approved and the HIV SPA is approved
- CMS is requiring that the new SPA address all outstanding compliance issues such as cost reports for public agencies, comparability of TCM services and rates among various programs, and adherence to TCM SPA template requirements
- Revise payment structure – Case rate is under actuarial review by Mercer. The MH/SA case rate includes CABHA requirements as currently written. Other case rate includes waiver and non MH/SA TCM. Until actuarially certified and approved by CMS, the rates will not be valid.
  - Explanation of case rate
- SPA submission is scheduled in March
- Policy is more detailed and actually addresses more of the day to day operations. Draft policy posted 3/8/09. Draft is scheduled for the March/April Physician's Advisory Group (PAG)

Next Steps

- Submit CAP waiver revisions to CMS to make program policies more consistent
- Coordinate the MH/SA/DD implementation with other activities such as CABHA roll out, DD TCM direct enrollment since 05 SPA is approved, RFP submission and review for 1915b/c waiver
- Coordinate Community Support Phase Out
  - As of January 1, only Q (the case management function) of CS could be provided for new admissions and as a means to continue the needed CM for existing recipients.

Hello, you all know that as a codified body the State CFAC has several statutes to which we are obliged. Other Task Teams created within our SCFAC have been introduced to you. My name is Andrea Stevens and today I introduce you to the. SERVICES TASK TEAM our efforts focus on

SERVICE GAPS AND UNDERSERVED POPULATIONS MAKING RECOMMENDATIONS REGARDING THE SERVICE ARRAY AND MONITOR THE DEVELOPMENT OF ADDITIONAL SERVICES. PARTICIPATE IN ALL QUALITY IMPROVEMENT MEASURES AND PERFORMANCES.

All of which are taken directly from the statutes that have been created for us. With this outlined following is our advice:

WE URGE THE SYSTEM TO UTILIZE THE SCFAC BY SOLICITING OUR ADVICE AT THE ELEMENTARY STAGE NOT BY SEEKING OUR INPUT FOLLOWING DECISIONS ALREADY MADE.WE AIM TO BE PRO ACTIVE AND DELIBERATE .....NOT REACTIVE.

BE WARY WHEN YOU READ ABOUT A TOPIC THAT HAS 'BEEN PRESENTED TO THE SCFAC'. THIS DOES NOT EQUAL ACCEPTANCE OR A SOLICITATION FOR ADVICE. PLEASE BE REMINDED THAT WE ARE AN ADVISORY BODY, NOT AN ADVOCACY GROUP. Nor are we the only conduit to state wide consumer opinion.

REFERRING TO THE B/C WAIVERS THE SCFAC DOES INDEED BELIEVE THEM TO HAVE PROMISING QUALITIES. WE NEED TO BE ACTIVE PARTICIPANTS IN THE DECISIONS MAKING PROCESS AS THIS ENDEAVOR MOVES FORWARD. Personally, I reside in the Pbh catchment area and have a son who utilizes the b/c waiver with significant outcomes.

OUT OF NO WHERE CABHA IS LAUNCHED.WITH HASTE AND IN WHAT WE BELIEVE TO BE A RECKLESS MANNER. SUDDENLY THE B/C WAIVERS ARE SHADOWED BY CABHA.

Conversely to the Secretary's words WE BELIEVE THIS EFFORT IS MOVING FORWARD MUCH TOO FAST AND FOR THE WRONG REASONS. Causing the grave concerns expressed here today.

IF THIS PROCESS DOES NOT SLOW DOWN..THE DELIBERATE EFFORTS FOR SUCCESS WILL BE SUPERCEDED BY RECKLESS DECSIONS PRODUCING MONUMENTAL PROBLEMS INCREASING GAPS IN SERVICES INCREASING UNDERSERVED/ILLSERVED POPULATIONS AND HAS THE POTENTIAL TO CREATE A CASH COW SIMILAR TO COMMUNITY SUPPORT SERVICES.

The direction is not the concern- -the speed in which we are is too fast.

THIS BEHAVIOR will Produce DECADES OF LIABILITY AND UNPLANNED OUTCOMES.

VS A WELL THOUGHT OUT PLAN THAT HAS CONTROLLED OUTCOMES.

CARL NOYES IS AN INTEGRAL PART OF OUR SCFAC AND I WOULD LIKE YOU TO HEAR MORE FROM HIM ABOUT CABHA CARL...

Presented to LOC March 10, 2010 by Andrea Stevens State CFAC Services Task Team

a. Division of MH/DD/SAS and other DHHS staff should cease using language and statements that imply the inclusion of consumers as stakeholders, when there are no verifiable facts to support this. Furthermore, accurate records of those attending meetings in which policy matters are discussed and the affiliation of participants should be kept and be part of the public record of those meetings.

b. We feel that mental health consumers representing the largest stakeholder group should have a representation of 35% on workgroups and committees working on policy issues (whether Medicaid definitions, proposed rules or other issues) with other representation being 25% family members, 25% providers and 15% members of DHHS or Local LME Staff. These percentages for providers and staff will likely need to be adjusted to include psychiatrists, researchers or others with particular expertise.

c. We have heard the words "consumer driven" for years. Now is the time to make that a reality in our policy making. Persons with a disability or consumers (whatever the label to which we are referred) share some perspectives with their family members or the family constituency as a whole, but there are many, many issues on which we have very different perspectives.

   This perspective must be respected and valued if we want to have a more effective, efficient system of service delivery. "Nothing about us without us" is not the same as "let our parents or family members speak for us."

d. A procedure to identify and recommend consumers and family members from across the state for participation on committees and work groups needs to be developed. There will be a number of thoughts on this issue posted soon at ncmentnalhope.org/ inclusion.

e. A process by which consumers are involved in helping to create or to suggest MH/DD/SA rules, DMA definitions, and the like needs to be developed, rather than asking us to help fine-tune these after they have been developed essentially behind closed doors by staff and other "stakeholders."

f. The Legislative Oversight Committee is requested to include on its agenda regular reports on issues suggested by consumer-led organizations (in addition to those requested or submitted by the State CFAC.)

g. A number of issues to facilitate open and transparent communication to and from consumers and MH/DD/SAS, DMA and other state agencies need to be resolved. (This is a partial list of talking points only)

Submitted by:
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President, Board of Directors
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President, Board of Directors, North Carolina Mental Hope
jennifertheadvocate04@gmail.com, 252-373-9888 (cell)

Please visit ncmentalhope.org/inclusion (under development but expected to be available by Friday, March 12) for iinformation on the benefits of inclusion as exhibited by programs and policies in other states, as well as other information on the issue.

north carolina mental hope℠
... a little bit of hope is a powerful thing

Board of Directors

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Nicholas Stratus
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Martha Brock

Executive Director
David Cornwell

Note: The following is the original text of North Carolina Mental Hope's March 10 presentation to the LOC, but does not include extraneous remarks made during the actual presentation. During that presentation, two factual errors were made. A report on local CFACs was attributed to a state employee rather than a State CFAC member and provider organizations were incorrectly attributed as appointing some State CFAC members instead of Local Management Entities.

My name is David Cornwell. I'm executive director of North Carolina Mental Hope, a consumer-driven advocacy organization. I also serve on the board of Disability Rights North Carolina, chairing its Protection and Advocacy for the Mentally Ill Committee, better known as PAIMI. While I'm honored to serve on Disability Rights and PAIMI, I speak only for North Carolina Mental Hope today.

First, I thank the committee for this opportunity to update it on the first small steps toward inclusion of the largest contingency of stakeholders in the state's Mental Health, Developmental Disability, and Substance Abuse services into the actual planning of those services. I thank Secretary Cansler and Assistant Secretary Watson for their comments acknowledging the need for more consumer input. I thank Sen. Nesbitt for his remarks acknowledging not enough has been heard from consumers.

The small steps of which I speak are meetings that have begun between the Division and a growing collaborative of independent consumer-driven organizations representing a cross-section of the disability community. While time constrains me from acknowledging each of those groups, their directors and contact information are listed on the handout provided.

In January, we sat down with Mr. Watson, Leza Wainwright and Stuart Berde, from the division, to discuss, among other things, better communication, increased inclusion, and avenues for consumer empowerment. Some of the points we hope to discuss are also on your handouts.

The meetings in no way imply the journey toward inclusion has moved far down the path nor does it assure it will be completed. The Division, however, has committed to these meetings through October, for which we are grateful. And it's a dialogue in which we would also hope to engage the Division of Medical Assistance.

What is inclusion? First of all, as I discovered at dictionary.com last night while putting these comments together, it's not a very good word for what the grassroots advocacy collaborative or consumers are seeking. Inclusion can simply mean containing. The word that might better be used is "equality." Or "democracy."

In the present context, I see inclusion as representation of individuals from independent consumer driven organizations or unaffiliated individuals on all planning bodies at all levels dealing with decisions that affect services, representation on at least equal footing with other parties.

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north carolina mental hope SM
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To be more specific, it's just common sense that you don't ask the waiter if a customer's food is satisfactory. You ask the customer.

What other contingency is going to be more interested in providing the best services, with the best outcomes, most efficiently, and within the given budget? NAMI's "Grading the States" report and President Bush's "New Freedom Commission" each reached the same conclusion with regard to mental health systems, that systems that work the best are those that are consumer and family driven. New ideas, new perspectives. Inclusion saves money with better outcomes. The Colorado system is a case in point. It and other examples will soon be listed at ncmentalhope.org/inclusion.

I need to clarify that stakeholder inclusion is not necessarily synonymous with consumer inclusion. Providers, psychiatrists, employees of DHHS and its divisions are all stakeholders. But there has been very little independent consumer input. And that's from the Division's own documentation of meetings, such as the one from which CABHA sprang. Documented inclusion at those committee meetings, as far as I've been able to determine, was 1.5%.

Trust is the bedrock upon which any enduring system will be built. And trust needs to be built on truth. But I've listened to meeting after meeting this year, where truth has taken a beating. It has been stated and implied that stakeholder inclusion has been synonymous with consumer inclusion. Truth is one of the easiest things that can be done to heal our system. Truth costs no money and can be instituted immediately.

Another reason for inclusion was given more than 200 years ago in the Bill of Rights: "equality." Recognizing those with disabilities as equals is morally right. Democracy is the foundation upon which our country was built. And there is nothing democratic about mental health planning as it now stands, despite the spin some try to give it.

My own advocacy began with the conviction that my child wasn't going to grow up as a second class citizen with a second class illness. But when you advocate for one, you advocate for all.

What does exclusion say to my child? What does it say to him when only one individual with a mental health diagnosis serves on an Outpatient Commitment Work Group, a committee whose work goes to the heart of democracy, the stripping of a citizen's civil rights. What does it say to the state's consumers to have the state's mandated committee that serves as the voice for consumers and family members be one that is politically and LME appointed? What equality do this and other rules and statutes that entrench exclusion convey? Again, these are issues of civil rights and democracy. And they don't set standards for a world I want my child to grow up in.

So much money has been spent on so many studies on services and outcomes, but none that I know on the actual process of developing the definitions, policies and rules that guide our system. Could the process from which the product comes not be a part of the problem? To me, undoubtedly yes. For many, a side effect of mental illness is brilliance. Why not incorporate that brilliance into product development?

I respect the sincerity of this committee's efforts and as a citizen appreciate your public service, a role that carries few rewards. Just as respectfully, however, I need to point out that the consumer voice has been rarely asked for or heard in these proceedings. Agendas since last September have included an update on CFACs and today's presentation on Clubhouses. And while I can't say enough good things about Clubhouses, the security and warmth felt just stepping through their doors and the need to preserve them, the voice of the general grassroots consumer community has not been sought nor heard at any significant level by any level of government.

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From the public, stigma grows from the ground up. But it also filters down from public officials. And the present process only entrenches that stigma. I urge this committee to take a stand against stigma and for equality by adding the consumer voice to each of its meetings. Again, it's common sense to ask the diner how his service was and how it could be improved rather than always asking the waiter.

I understand there's no magic wand that can be waved to fix things. Now's not the time, some might say. We're in crisis. But we're always going to be in a crisis. And I would suggest that crisis is a time you most want everyone on the same page, working together.

I'll end with Einstein's three rules of work: "Out of clutter find simplicity, from discord find harmony; in the middle of difficulty lies opportunity." All are apropos, but perhaps none more so than the opportunity the state has, the opportunity to recognize the equality of all citizens, the opportunity to work together for a better system. I pray it is an opportunity that is seized.

David Cornwell
Executive Director
North Carolina Mental Hope

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
April 14, 2010 10:00 A.M.; Room 643, Legislative Office Building
Senator Martin Nesbitt, Co-Chair, Presiding

Welcome and Opening Comments *Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*	5 minutes *10:00-10:05*
Secretary's Remarks *Lanier Cansler, Secretary, DHHS*	10 minutes *10:05-10:15*
CABHAs Update *Michael Watson, Assistant Secretary for* *Mental Health, Developmental Disabilities* *Substance Abuse Services Development, DHHS*	45 minutes *10:15-11:00*
Expenditures and Utilization Tracking Update *Tara Larson, Chief Clinical Operating Officer, DMA*	15 minutes *11:00-11:15*
Medicaid Appeals *Tara Larson, DMA* *Julian Mann III, Director and Chief Administrative Law Judge* *Office of Administrative Hearings*	30 minutes *11:15-11:45*
Lunch	*11:45-1:00*
Three-Way Contracts *Michael Watson, DHHS*	15 minutes *1:00-1:15*
Psycho-social Rehabilitation Centers *Leza Wainwright, Director* *Division of Mental Health, Developmental Disabilities, and* *Substance Abuse Services*	20 minutes *1:15-1:35*
Innovations Wavier *Leza Wainwright, DMH/DD/SAS*	15 minutes *1:35-1:50*
UNC Center for Excellence in Community Mental Health *John Gilmore, MD; Director* *Barbara B. Smith, LCSW, Co-Director*	15 minutes *1:50-2:05*
Recommendations *Staff*	30 minutes *2:05-2:35*
Committee Discussion	
Adjourn	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	4/14/10																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	X																
Senator Bob Atwater	X																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	X																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson	X																
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	X																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

April 14, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, April 14, 2010 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Doug Berger, Jim Forrester, Charlie Dannelly, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw and Representative William Brisson were present. Also in attendance were Senator John Snow and Representative Pat Hurley.

Lisa Hollowell, Shawn Parker, Joyce Jones, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the March 10, 2010 meeting. The motion was made by Representative England and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS), advised that this will be a particularly difficult time with difficult decisions due to the budget shortfall. He said that DHHS would try to keep the efforts regarding mental health on course and continue to build a strong base operation for the delivery of mental health services. The Secretary stated that he remains convinced that implementation of the Critical Assess Behavioral Health Agency (CABHA) model is the correct path toward a system that has a solid clinical base, focusing on outcomes and quality. He said that DHHS had been in discussion with the Center for Medicaid and Medicare Services (CMS) to allow a six month transition period in order for those organizations ready to become CABHAs by July 1 to begin operation, and allow others the opportunity to have additional time to meet the requirements to become a CABHA. Secretary Cansler added that DHHS has received over 500 letters from providers interested in becoming CABHAs and that DHHS had discussed the possibility of authorizing CABHAs to contract with small providers to provide certain services. He added that follow up conversations would continue next week. Finally, the Secretary reported that the Department continues to explore ways to receive input from consumers, families, local Consumer and Family Advisory Committees (CFACs) and the State Consumer and Family Advisory Committee (SCFAC).

Mike Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS, provided an update on the new category of provider agency, the Critical Access Behavior Health Agency (CABHA). (See Attachment No. 2) Mr. Watson briefly reminded members of CABHA implementation goals, basic service delivery requirements, the history leading to the development of the CABHA model, and then discussed the certification process and the planned efforts to monitor the CABHAs post-certification. His presentation addressed the following items:

- The CABHA model is a response to very serious past issues in our mental health system with respect to quality of services and medical oversight and is intended to restore confidence in the system.
- Vast majority of CABHA providers will be in the 50% FTE/8 hour certification requirement.
- Six hundred letters of attestation have been received for consideration of certification by July 1.
- There is concern with CMS and providers that there may be liability issues regarding providers subcontracting with CABHA.
- LMEs are working with providers who want to become CABHAs and working with providers who need endorsement for a second service.
- The cost of national accreditation for a large provider is approximately $80,000 and $5,000 - $10,000 for smaller agencies.
- The cost for the Medical Director working only 8 hours is built into the proposed case management rate giving the provider more flexibility in how to deliver other medication management services.
- It is estimated that CABHAs through quality care will generate savings of approximately $7M in total dollars and $2.5M - $3M in State dollars.

Some members expressed concern that the bar had been set too high for the small providers and that they were being forced out of business. There was also concern that only 13% of the 300 providers who had applied to become a CABHA had qualified and that CABHA did not address the issue of self-referral. There were several complaints by providers to LOC members regarding the application itself. Members requested a map or list of eligible CABHAs by LME in order to see the distribution. It was suggested that the Committee had the responsibility to work to see what could be done to boost the number of qualified providers in psychiatry and psychology; to look at schools and medical schools to increase the number of qualified professionals in the field to offer services, especially in the rural areas.

Dr. Craigan Gray, Director of the Division of Medical Assistance (DMA), along with Julian Mann, Director and Chief Administrative Law Judge, summarized the Medicaid recipient hearing appeals process. (See Attachment No. 3) Dr. Gray explained in detail the recipient right to a hearing after receipt of an advance notice of an adverse termination and noted the importance of the Mediation Network. Dr. Gray reviewed the successful changes to the process to implement the statutory standards. He said it was a very streamlined, time driven process which saved an estimated $25M over the review period. The effectiveness of the process is indicated by noting that 83% of the cases that

have come up for potential appeal have been resolved through mediation alone. He recommended that the appeals process continue.

Judge Mann recognized the coordination and cooperation of different agencies in developing a process that is working successfully. He credited mediation with giving those without representation an opportunity to have resolution and said this was accomplished within 25 days. Judge Mann said that in 2007, there were 2, 291 total cases; in 2008 there were 3,717 cases; and in 2009 there were 6,693 cases.

Senator Nesbitt reminded members that the appeals process was a recommendation from the LOC that was put into Session Law rather than the General Statutes, in order to try it for two years. This year, the Committee needs to determine whether to put it in Session Law for another two years or place it permanently in the General Statutes. It was suggested that OAH make information available on their website indicating how cases are settled and how cases are resolved that go to hearing. It was indicated that a large number of cases going to final decision are being reversed by DHHS. . Dr. Gray said he would get the actual figures on the number of overturned cases to Committee members.

Steve Owen, Chief Financial Operating Officer, DMA, provided an update on expenditures and utilization tracking for enhanced services. (See Attachment No. 4) The first page of graphs indicate recipients moving out of Community Support services and moving into Community Support Team. The number of recipients continues to rise but the expenditures have leveled out. Regarding Targeted Case Management, the rate reduction put in place in November dropped the expenditure level this year and there has been an increase in the number of recipients beyond the enrollment growth this year. Mr. Owen said that recipients moving out of Community Support were affecting Intensive In-Home with expenditures increasing about $8M more per month this year compared to last year. He said the combination of Community Support, Community Support Team, and Intensive In-Home services were about $10M a month less in total expenditures this year as compared to 2009.

Mike Watson, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS, provided information on the 3 way contracts between DHHS, community hospitals and the LMEs. He explained that the contracts would expand Inpatient Psychiatric care (See Attachment No. 5) and provided the following information:

- In FY 09-10 there were 14,492 bed days delivered compared to 6,500 last year.
- Contract Summary chart – Cape Fear and Moses Cone have billings that have yet to be reflected on the chart and Western Highlands has twice as many bed days as what appears on the chart.
- Issue down the road – whether to continue to build on existing hospitals or add beds at new hospitals when they want to come online.
- As psychiatric beds are added to the community coupled with CABHA, it creates a demand for people with clinical skills which in turn encourages psychiatrists to move back into the scenario.

- There is concern from hospitals that have not expanded beds but do a significant amount of indigent inpatient psychiatric care. Data indicates indigent care has risen from 25% to 35%. Consumers with a substance abuse diagnosis are higher at 40% to 50%.
- Through contracting, Community hospitals are willing to get back into the inpatient psychiatric business and work with the State in accepting a more assertive role for short-term treatment of patients.

Leza Wainwright, Director of the Division on Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS, explained the difference between the Psycho-Social Rehabilitation Centers (PSR) and Clubhouses. (See Attachment No. 6) She stated that the PSR program and the Clubhouses have the same main goals but the Clubhouses stress consumer ownership of the program. There are four LMEs that do not have at least one program that follows the clubhouse model: Cumberland, Eastpointe, Five County, and Onslow Carteret Behavioral Healthcare.

Ms. Wainwright was asked if the populations served by PSR, Clubhouses, or the International Center for Clubhouse Development (ICCD) was different and if there were any outcomes available. She responded that there was not a clinical profile on the individuals served in any of the 3 models. She also said that at this time, there were no noticeable differences in outcomes but North Carolina clubhouses and ICCD certified programs are billing Medicaid. They have to conform to the Medicaid service definition if they are going to bill Medicaid. Ms. Wainwright was also asked why Clubhouses, but not PSR's, are complaining that they are about to go out of business. She responded that the PSRs are also experiencing serious financial difficulty.

Next, Ms. Wainwright compared the CAP- MR/DD waiver, the PBH Innovations waiver and the new NC Innovations waiver (1915 b/c). (See Attachment No. 7) Ms. Wainwright explained the background of waivers and how they build off of the approved Medicaid State Plan. The Structure of Waivers chart depicts the current waivers: the CAP-MR/DD waiver, the way PBH operates now and what the proposal is for new participants coming into an expansion of the PBH waiver. PBH will make these same changes in their waiver at the time LMEs are added. She reviewed the criteria for participants and explained the differences in services. The final chart compared the financial components of the waivers. She informed LOC members that CMS would be doing a mid cycle review of the CAP-MR/DD waiver next week. She added that the chart did not include the fact that CMS requirements regarding consumer rights, protections, and appeals, apply to all the waivers also. One to two LMEs will be selected from those that have applied and will become operational January 2011.

Dr. John Gilmore, Director of the UNC Center for Excellence in Community Mental Health and Barbara Smith, Co-Director, explained how the Center came to be established and described the services they provide. (See Attachment No. 8) Ms. Smith reviewed the strong partnerships the Center has throughout the community. Besides treating those with severe mental illness, Dr. Gilmore provided insight into the different treatment programs offered such as STEP and OASIS. He said the Center and CCNC were in collaboration

regarding the integration of medical and psychiatric care. Dr. Gilmore said that the Center had been involved with many workgroups bringing their clinical expertise to help inform State policy. He described training and current research being conducted to improve the care of those with mental illness.

Dr. Patricia Porter, consultant to the LOC, explained that in support of and cooperation with DHHS in an effort to streamline reports, the leadership of the LOC directed a review of reports requested and submitted to the committee. (See Attachment No. 9) The purpose of the review was to ensure that reports continue to be submitted which are necessary to adequately provide oversight, to ensure that reports are in compliance with statutes and Session Laws and to eliminate outdated reportage. With the approval of the Committee, the recommendations will be made a part of the LOC report to the General Assembly.

Representative Insko advised that LOC members would receive a draft of the recommendations report for review. She requested that members contact staff with any changes to the report. The report will be reviewed at the next meeting on May 6th.

There being no further business, the meeting adjourned at 3:15 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Anne Carter	Sanctuary House 518 N. Elm St. Greensboro, NC
Celeste Smith	" "
Ellen Stovall	" "
ALEXANDER DUDA	NCCPPR
Erin McLaughlin	MHANC
Mary Powell	NCDA Federation
Clarissa Goodlett	NCSA Federation
Annalicia Ralph	DRNC
Tracy Kimbrell	Parker Poe
Pete Smith	UNC Center for Excellence in Community Mental Health
Jane Vernetti	Institute for Family Centered Services

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	MHM Services
Bregga Rutherford	MHM Svcs
Jody K. Minor	Mediation Network
William K Moore	Healing Interventions, Inc 1100 Navaho Dr Raleigh NC 27609
Martha Wardrance	YAIO DOA
	OAH
Don OVERBY	OAH
Dawn Seagle	CDSS
Dawn Bryant	CDSS
Kate Caldwell	Wake Co
Sally Camera	NC Psychological

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Dan Bell	The Arc
Elizabeth Taylor	Kochanek Law Group
Will Woodell	Value Options
Kelly Kenoff	NAMI NC
Vincent STEPHENS	CMS
Victoria White	Sandhills Center
Kathy Baker	Southeastern Regional LME
HOWER	
Laurie Hickey	Community Partnerships Inc.
Judy Truitt	OPC Area Program
Cin Brailer	OPC Area Program

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
-Ryan Hemmasiand	JOHNSON & JOHNSON 14453 Adair Hawn Ct. Charlotte, NC 28277
marilyn michaux	Club Horizon 101-B forest Dr, Knightdale
Oswald Nwogbo	Carolina Comm. Supp. 520 S. Duke St Dunlap NC. 27701
MARTY WEEMS	e-daptivity Learning & Performance Solutions 31 Parks Glen Pl. Durham NC
Carmen Burton	OAH
Daphne Lyon	OAH
Ethel M. Benjamin	Club Nova
Kathryn M. Peck	919-360-6227 kpeck@clubnova.org; Carrboro
Collin Lee, Erin Spence Homer Morrow, Elena Fowler with Owen, Karen Dunn	Club Nova 103-D W Main St Carrboro NC 27510
Don Wade, Larry Grant	THRESHOLDS, DURHAM

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Anna MacDonald Dobbs	The Arc of NC 3433 E Six Forks Rd Raleigh
Tom Meece	Evergreen
Teresa Carter	NuDay, NC Providerland
Margaret Weller-Stargell	Coastal Horizons Center 615 Shipyard Blvd. Wilmington, N.C. 28412
[illegible]	"
TAD CLODFELTER	SOUTHLIGHT, INC / NC Substance Abuse Federation
Rebecca H. Judge	Eastpointe LME Board Mbr.
A. Terrell Midgett	Excel Therapeutic Services, Inc.
Adele Foscher	NC DAP
BRIAN SHANK	ASTRAZENECA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Martin	Lighthouse Counseling - 2800 Breezewood Fayetteville NC 28303
John Tuttle	MWC
W. Gary Cuffee	Personal Interest
Yumekco Little-Singletary	Family Legacy Mental Health Services, Inc. 204 N. Person St., Raleigh, NC 27601
Lisa Stacey, CEO	Family Legacy Mental Health 204 N. Person Street Ral. NC. 27601
Bernadette Carter	Family Legacy Mental Health Services, Inc 204 N. Person St Raleigh, NC 27601
Lon Wilson	NCALTCF
Lu-Ann Thompson	NCPA
John Bowdish	Astra Zeneca
Tracy Hunter	Feeding America Food Bank
Mark Seagle	MHM

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brad Bannister	DJJDP
Lesley Dover	Eastern Carolina Case Management LLC
Sean Kenny	Eastern Carolina Case Mgt
Michael Cottingham	CenterPoint Human Services
Tara Fields	CFSA-NC
Khalil Nassar	PDA Healthcare, Inc 701 South Main street, Dobson, NC 27017
Lindy Feigenbaum	HPM, SPH, UNC
Peggy Brewer	The Arc of NC
Fred Waddell	Eastern Seals UCP
Eric Gabriel	RHA - Howell's
Gene Rodgers	Universal Mental Health

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAN CAUGHRAN	PBH - CONCORD
PAM SHUPMAN	" "
Valerie Hennicke	Five Co. Mental Health A.
David Swann	Crossroads Behavioral Healthcare
Steve Day	TAC
C Graham	CHC
Ann Rodriguez	NC Council of Community Programs
Janet Schaufler	Duke
Pam Andrews	New River Behavioral Healthcare
Amanda Cheney	LA: Rep. Hugh Blackwell
John Vanderzalm	B&D Behavioral Health - Durham

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andrew Meehan	Capstrat
Doug Miskiew	Capstrat
Annie Smith	Youth Villages
[illegible]	NCACC
Daniel Brown	Monarch
[illegible]	[illegible]
Joe Donovan	Self
Larry Swabe	NACDD
Sarah Truluck	NACDD
Treva Johnson	Omni Visions Inc
Crystal Nunnemaker	Omni Visions Inc

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS April 14, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Terry Mutter	Parent
Janelle Albany	daughter CAPMR-DD
Jodi Lorenzo Stubley	Sanctuary House Greensboro

Critical Access Behavioral Health Agency (CABHA) UPDATE

Joint Legislative Oversight Committee on MH/DD/SAS
April 14, 2010

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

GOALS:
CABHA IMPLEMENTATION

- To ensure that mental health and substance abuse services are delivered within a clinically sound provider organization with appropriate medical oversight.
- Move the system over time to a more comprehensive and coherent service delivery model
- Increase economies of scale and efficiencies in the service system
- Increase consumer/family/stakeholder confidence in our provider network

GOALS:
CABHA IMPLEMENTATION CONT'D

- Reduce clinical fragmentation—Reduction of "Stand Alone" service delivery
- Increase provider "1st Responder" capacity
- Embed case management in comprehensive clinical provider
- Insure that consumers have access to an array of appropriate clinical services
- Increase accountability within the MH/SA service system—monitor service and referral patterns
- Provide a competent clinical platform on which to implement best practice service models

Basic CABHA Service Requirements

- **Services that must be delivered within the CABHA structure:**
  - Community Support Team (CST), Intensive In-Home (IIH), Day Treatment (Effective July 1, 2010) **NOTE: CMS Approved CABHA as a Provider Qualification for the above services**
  - New Services: Case Management/Peer Support – Pending CMS Approval

CABHA Certification Requirements

- Must provide the **core** services of:
  - Comprehensive Clinical Assessment
  - Medication Management
  - Outpatient Therapy
- Must deliver at least two enhanced services
  - In the same location where it provides the three core services to create a continuum of care

CABHA Certification Requirements Cont'd

- Active National Accreditation of at least 3 years
- Medical Director
  - 100% FTE for providers serving more than 750 consumers – 60% billing
  - 50% FTE for providers serving less than 376 – 749 consumers – 60% billing
  - 8 hours per week – 0 – 375 consumers – no billing *
- Clinical Director 100% FTE
- Quality Management/Staff Training Director 100% FTE

* Represents additional effort to scale Medical Director requirements for smaller providers – Implementation Update #71

Note: All providers must provide core services regardless of their size/Medical Director requirements

CABHA Certification Overview

- Attestation letter w/documentation
- Desk reviews conducted by DMH/DD/SAS
  - DMA/DHSR Collaboration
- Verification conducted by LME
  - Findings submitted to DMH/DD/SAS
- Interviews conducted by
  - DMH/DD/SAS Staff
  - DMA Staff
  - LME Staff

Desk Review

- Independent reviewers determine complete or incomplete
  - If discrepancy between reviewers LME Team leader and/or designee will review and make determination
- In addition to the desk review DMH/DD/SAS contacts the following agencies to determine "good standing"
  - DMA
  - DMH/DD/SAS Accountability and Consumer Services
  - DHSR

Verification

- Purpose
  - Verifies the components of the Letter of Attestation
  - LME confirms evidence of a provider's compliance with CABHA policy prior to an interview being scheduled

Interview - Staffing

CABHA Regional Certification Team

- Must be peer to peer (age, disability, education)
- Two staff from DHHS
  - One from LME Systems Performance Team
  - One from DMA
  - At least one of the above will be licensed
- Two staff from LMEs within the region
  - At least one must be licensed
- Medical Director from an LME in the region

Interview

- LME Systems Performance staff will serve as the team leader and be responsible for:
  - Identify/notify DMA and LME staff that will participate on the review committee
  - Coordinate interview
  - Track activities related to interview
  - Document results of interview
  - Send provider of decision in writing

CABHA Attestation Letters

- As of April 1, 2010, 550+ attestation letters received
- Providers submitting attestation letters by April 1 will be considered for CABHA certification by July 1.
- Tracking system established for attestation letters
- 300 providers have gone through desk review process
  - Providers notified of missing/deficient items
  - May resubmit as often as necessary to pass desk review
- 40 (13%) passed desk review and moved to "good standing" review
- 7 cleared for LME verification

Common Reasons for Not Meeting Desk Review Criteria

- Provider does not provide core services
  - Medication management, clinical assessment, outpatient therapy
- Provider does not have 3 year national accreditation
- Provider does not have 2 enhanced services providing a continuum
- Unable to verify credentials of licensed staff
- Not in "good standing" with DHHS
  - Outstanding paybacks, unresolved Type A licensure violations, etc.

DHHS Requests to CMS

- CMS has already approved CABHA requirements for Intensive In-Home, Day Treatment, and Community Support Team.
- Pending CMS request regarding CABHA and Case Management/Peer Support
- DHHS has requested CMS consider:
  - Begin CABHA implementation July 1, but allow 6 month transition period for existing providers, from July 1 to December 31, 2010
  - Permit CABHA agencies to subcontract with other providers for CABHA services
- No formal response yet from CMS

CABHA Monitoring

- Monitoring Goals
  - Quality Services
  - Implementation of Best Practice Care
  - Access
  - Choice
  - Referral to Appropriate Services
  - Primary Care Integration
  - Post-Discharge Continuity of Care
  - 1st Responder Capacity

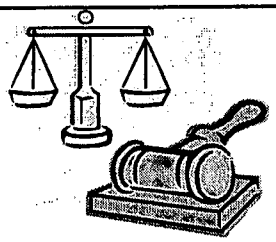
CABHA Monitoring Cont'd

- CABHA Monitoring Workgroup
  - Consumers
  - DHHS Staff
  - LME Representatives
  - Providers
- Monitoring Work Plan
  - Review CABHA Policy & Procedures
  - Review Current Provider Monitoring Efforts
  - Develop Standardized CABHA Report Card

CABHA Monitoring Cont'd

- Monitoring Tools
  - Paid Claims Data (e.g. referral patterns, service utilization)
  - Consumer/Family Complaints
  - Consumer Satisfaction Data
  - NC Treatment Outcome and Program Performance System (NC-TOPPS) data
  - LME Provider Risk Assessment & Monitoring
  - Service Endorsement Results
  - Review of High Cost/High Risk Consumers
  - 1st Responder Survey Data
  - DMA Program Integrity Data
  - Tracking of ED Use and Post-Discharge Follow Up

Questions?



REPORT TO THE
NORTH CAROLINA GENERAL ASSEMBLY

MEDICAID RECIPIENT
APPEAL PROCESS

PRESENTED BY
OFFICE OF ADMINISTRATIVE HEARINGS (OAH)
DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

APRIL 14, 2010

1

OVERVIEW OF RECIPIENT APPEAL PROCESS

- C.F.R. § 431.206 requires that the State inform every applicant or recipient of an adverse determination in writing—
  (1) of his right to a hearing;
  (2) of the method by which he may obtain a hearing; and
  (3) that he may represent himself or use legal counsel, a relative, a friend, or other spokesman.
- S.L. 2008-118 s. 3.13(a)(2) effective July 01, 2008 requires written notification to the applicant or recipient, and the provider, if applicable, of the determination and of the applicant's or recipient's right to appeal the determination 30 days before the effective date of an adverse determination.
- S.L. 2009-526, s. 2. effective August 26, 2009 amends the effective date from 30 days to 10 days.

2

OVERVIEW OF RECIPIENT APPEAL PROCESS

- Written notice must be provided by DHHS to the recipient/applicant, the legal representative, and service provider.
- The notice includes a clear statement of the decision, citation that supports the decision made, and appeal rights for a fair and formal hearing before OAH.
- Effective October 01, 2008, S.L. 2008-118, s. 3.13 eliminated the Medicaid *informal* appeal process or reconsideration review before the DHHS Hearing Office.
- A *fair and formal hearing* before OAH is required for adverse decisions made about a Medicaid recipient's or applicant's medical, dental, or behavioral health service requests.

OVERVIEW OF RECIPIENT APPEAL PROCESS

- S.L. 2008-118 s. 3.13(a) and (b) effective July 01, 2008 specified deadlines throughout the formal hearing process that must be met by OAH and DHHS/DMA.
  - The recipient has 30 days from the date the notice is mailed to file an appeal with OAH.
  - Immediate notification by OAH to the Mediation Network that a request for appeal has been received is required.
  - The Network has 25 days from the date the appeal is filed with OAH to complete the mediation.
  - OAH has 45 days from the date the appeal is filed (and that includes the 25 days for mediation) to schedule and hear the case.
  - OAH must issue decision and forward case to DHHS within 20 days of conclusion of hearing.
  - DHHS has 20 days from the date the OAH decision is received by DHHS to make the final agency decision and mail it to the petitioners.
  - The administrative law judge may allow brief extensions of the time limits for good cause and to ensure the record is complete.
  - The recipient has 30 days from the date the final agency decision is mailed to appeal the decision to Superior Court.

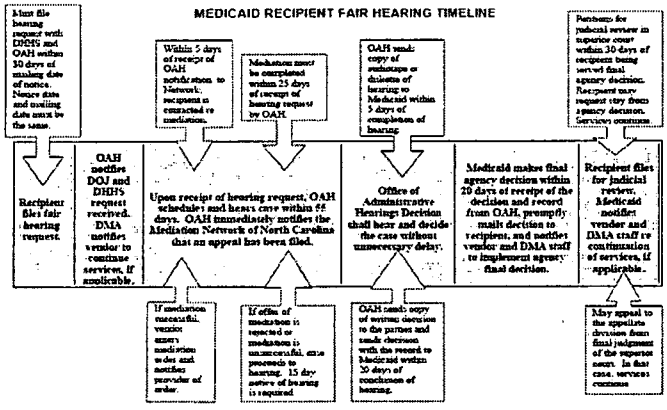
OVERVIEW OF RECIPIENT APPEAL PROCESS

- Effective August 26, 2009, Session Law 2009-526, s. 2.(a)(b) made clarifying changes to S.L. 2008-118, s. 3.13(b).
  - Changed 30 day effective date to 10 days.
  - Clarified reinstatement of services upon timely filing of appeal request.
  - Added 10 days (45 to 55) for OAH to schedule and hear the case.
  - Stated brief extensions along the timeline could be granted by the administrative law judge for good cause and to ensure the record is complete.
  - Specified that hearings could be held telephonically, or by video conferencing, or in person (in Wake County and, for good cause, in the recipient's county of residence).
  - Allowed continuances on the day of the hearing for good cause and allowed hearings to be dismissed if the petitioner failed to make an appearance when the hearing was properly noticed.

OVERVIEW OF RECIPIENT APPEAL PROCESS

- Clarified that a hearing would not be held unless the mediation was unsuccessful, the mediation offer was rejected, or the petitioner failed to appear for a scheduled mediation.
- Specified that the hearing would be dismissed if the parties resolved the issues in mediation.
- Stated the mediator must notify OAH and DHHS of mediation results within 24 hours of completion of the mediation.
- Added that new evidence could be submitted and that DHHS had 15-30 days to review the evidence.
- Specified the hearing would determine if DHHS:
  - Exceeded its authority or jurisdiction
  - Acted erroneously
  - Failed to use proper procedure
  - Acted arbitrarily or capriciously or
  - Failed to act as required by law or rule

OVERVIEW OF RECIPIENT APPEAL PROCESS



7

ACTIVITIES AND PROGRESS TO IMPLEMENT S.L. 2008-118, s. 3.13 and S.L. 2009-256, s. 2.(A) AND (B)

- Developed a DHHS electronic document management system.
- Developed DHHS revised due process notices and appeal request form. (Additional modifications will be made).
- Developed an OAH revised Notice of Hearing.
- Executed Memorandum of Agreement between OAH and DHHS on 09/01/09. (Required by the Centers for Medicare and Medicaid Services in order for DHHS to draw down federal monies for the hearing process).
- Developed internal policies and procedures by OAH, DHHS, and the Mediation Network of North Carolina to coordinate responsibilities.

8

ACTIVITIES AND PROGRESS TO IMPLEMENT S.L. 2008-118, s. 3.13 and S.L. 2009-256,s. 2.(A) AND (B)

- Executed amendments to DHHS vendor contracts to implement the new hearing process.
- Developed training and conducted presentations by DHHS and the Carolina Dispute Settlement Center for DHHS and vendors.
- Developed and provided training by OAH for mediators in conjunction with the Carolina Dispute Settlement Center and DHHS.
- Conducted ongoing DHHS training for providers, recipients, vendors, and other DHHS agencies.
- Developed an OAH Medicaid recipient appeals page found on the OAH website specified below.

  http://www.oah.state.nc.us/hearings/medicaid.html
- Developing a DHHS Medicaid prior approval page and to be found on the DHHS website specified below.

  http://www.dhhs.state.nc.us/dma/

ANALYSIS OF MEDICAID RECIPIENT APPEAL PROCESS

- Compliance with statutory standards set forth in S.L. 2008-118, s. 3.13 and Session Law 2009-526, s. 2.(a)(b) were met for the period October 01, 2008-March 31, 2010, is an indication of effecting legislative intent.

ANALYSIS OF MEDICAID RECIPIENT APPEAL PROCESS

- **Effectiveness of the Appeal Process (Maintenance of Services – MOS)**
  - If adverse action is taken on a **continuing** request for services and a hearing request is submitted within 30 days of the date the notice was mailed, the recipient is entitled to receive services during the pendency of the appeal in compliance with S.L. 2009-526, s. 1.1(a)(3). The service will be provided in accordance with federal and state requirements.
  - With the new hearing process and utilization of the document management system, an estimated $25 m has been saved for the period of October 1, 2008 - March 31, 2010.

ANALYSIS OF MEDICAID RECIPIENT APPEAL PROCESS

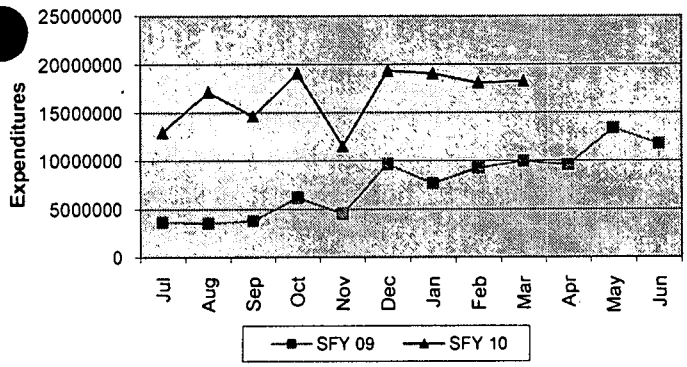
- An additional way to determine **effectiveness** of the process is by analyzing the number of requests for hearings resolved through mediations and hearings for the period July 01, 2009-March 31, 2010.
  - Resolved successfully through mediation – 83%
  - Referred for fair and formal hearing before OAH – 17%

RECOMMENDATIONS FOR RECIPIENT APPEAL PROCESS

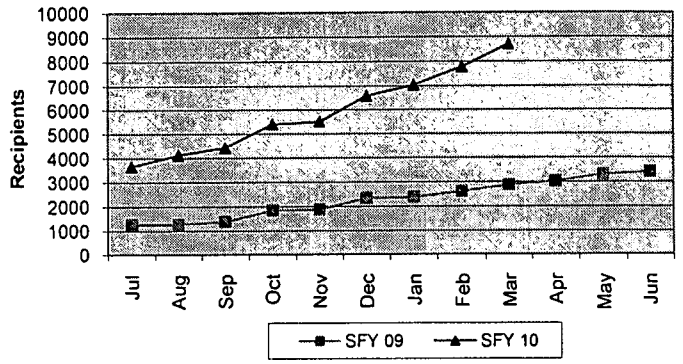
- Assess OAH and DHHS/DMA current staffing needs to insure that appropriate numbers of staff at all levels of the hearing process are in place.
- Develop policies regarding how hearings fraudulently requested by providers on behalf of recipients and applicants without their knowledge are to be handled.
- Monitor the appeals process and analyze data to assess progress towards objectives, cost effectiveness, and efficiency of the revised process.
- Continue the appeals process as set forth in S.L. 2008-118, s. 3.13 and S.L. 2009-526, s. 2.(a) and (b).

Attachment 4

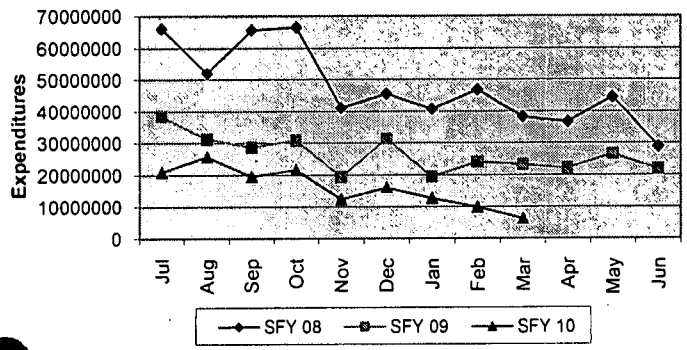
Community Support Team Expenditures



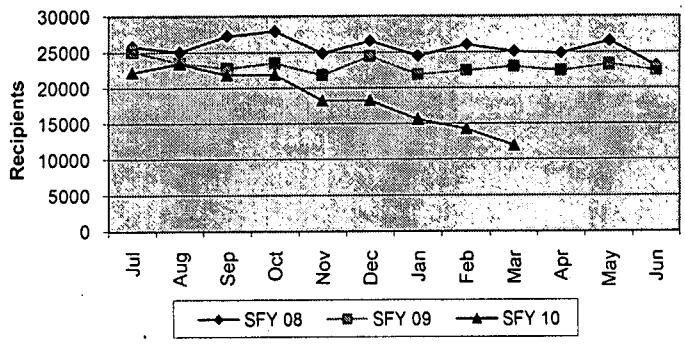
Community Support Team Recipients



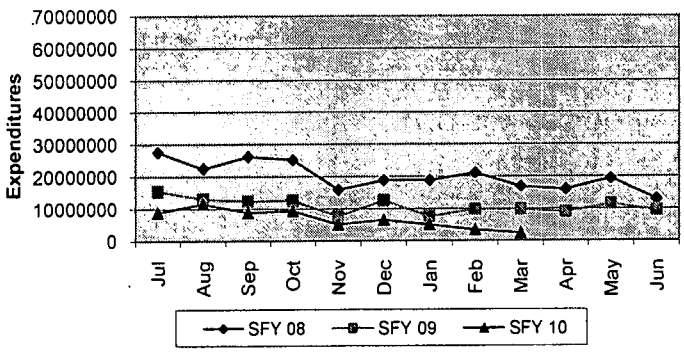
Community Support - Individual Child Expenditures



Community Support - Individual Child Recipients



Community Support - Individual Adult Expenditures



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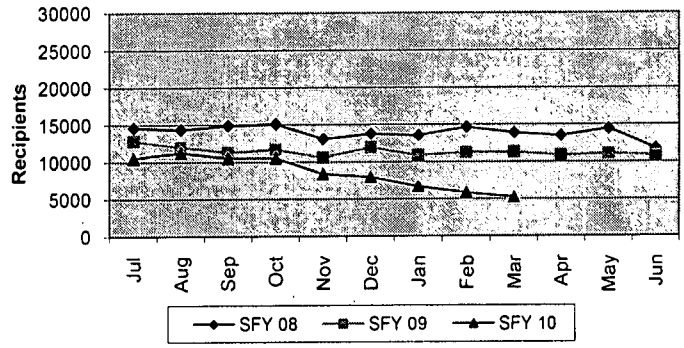
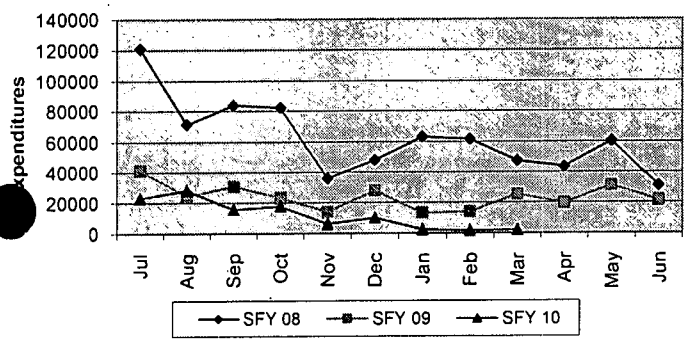


Community Support - Group Expenditures



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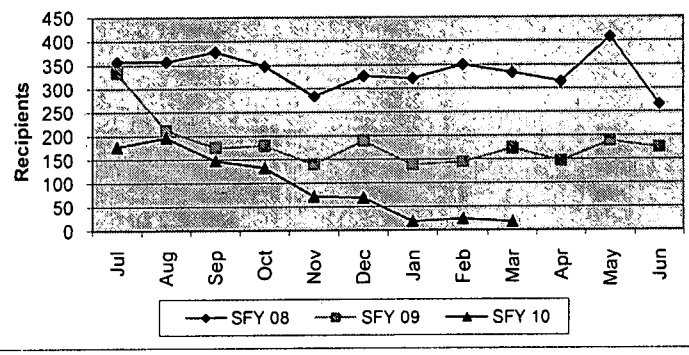

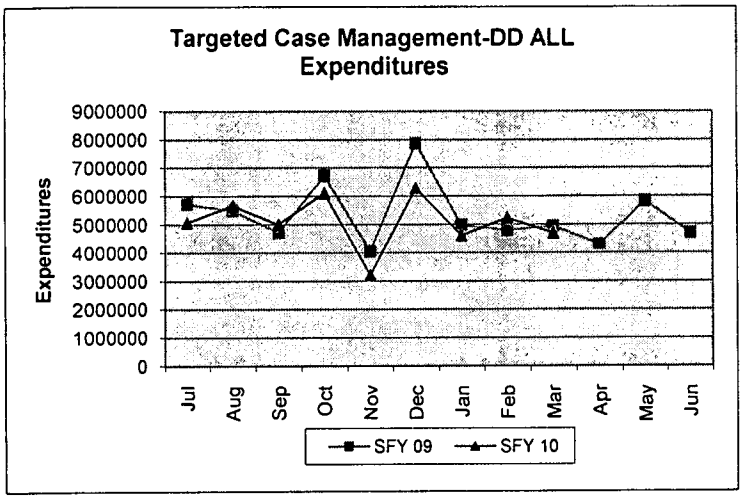
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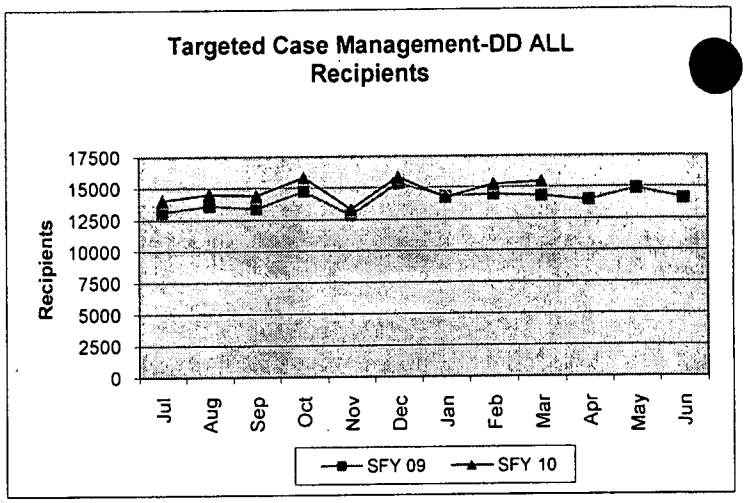
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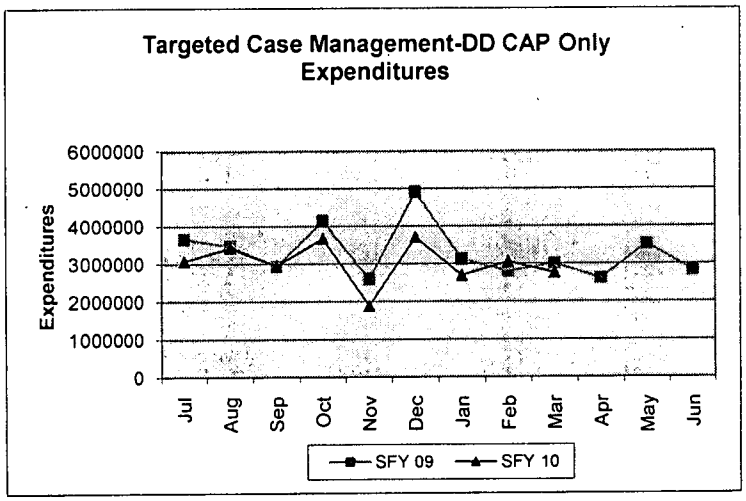
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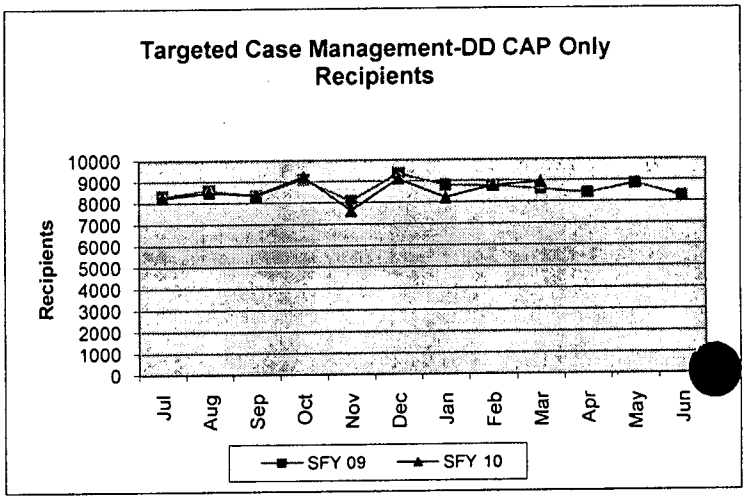
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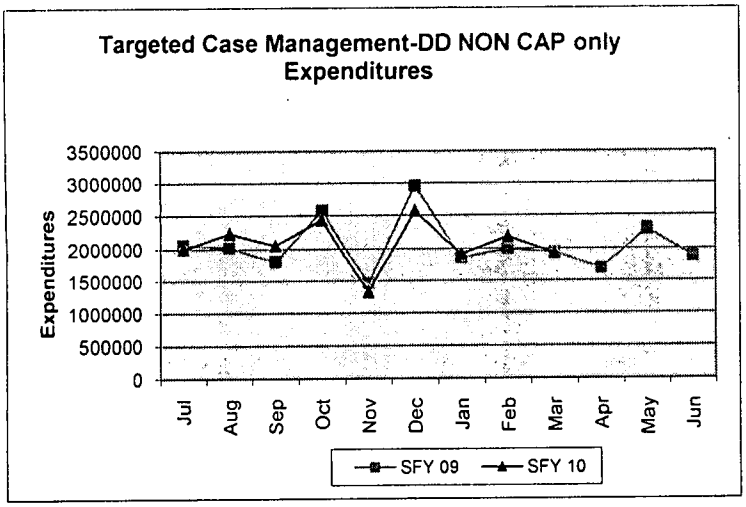
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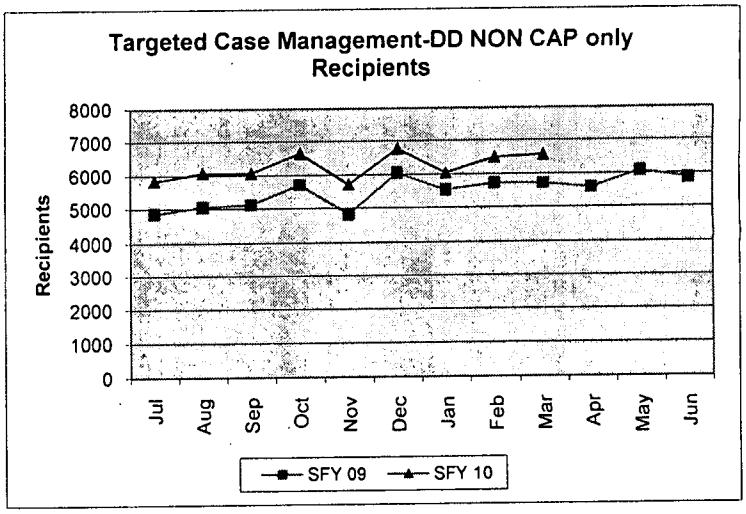
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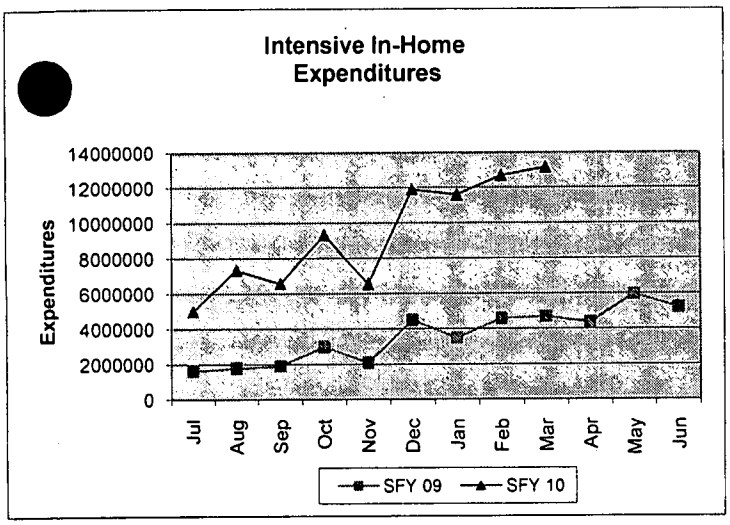
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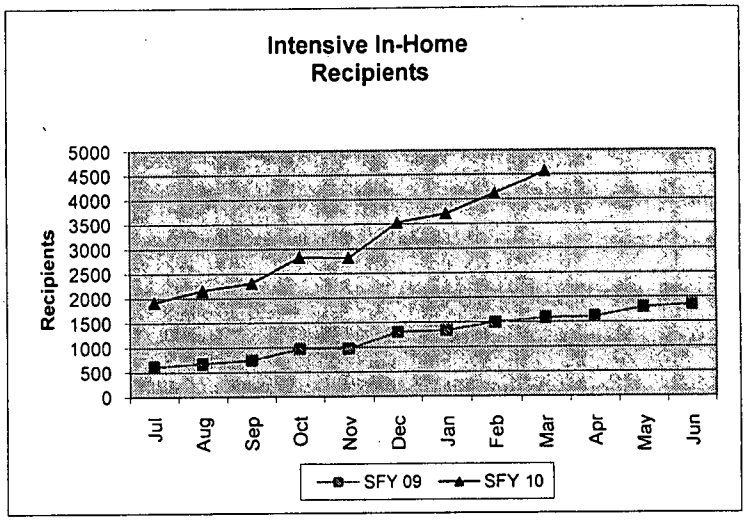
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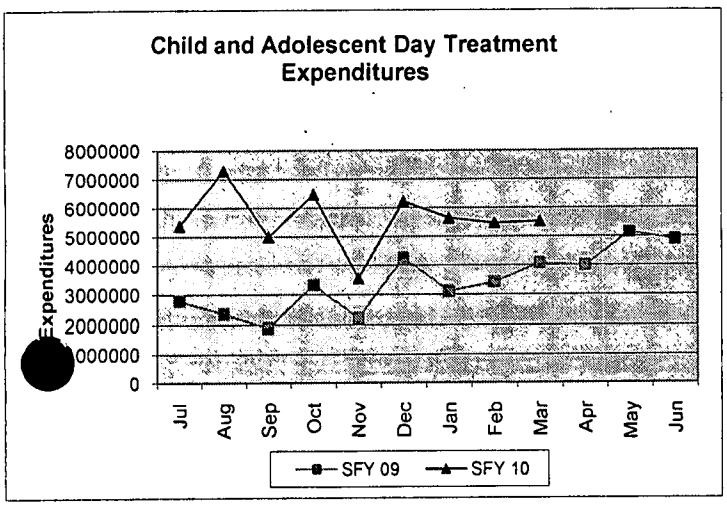
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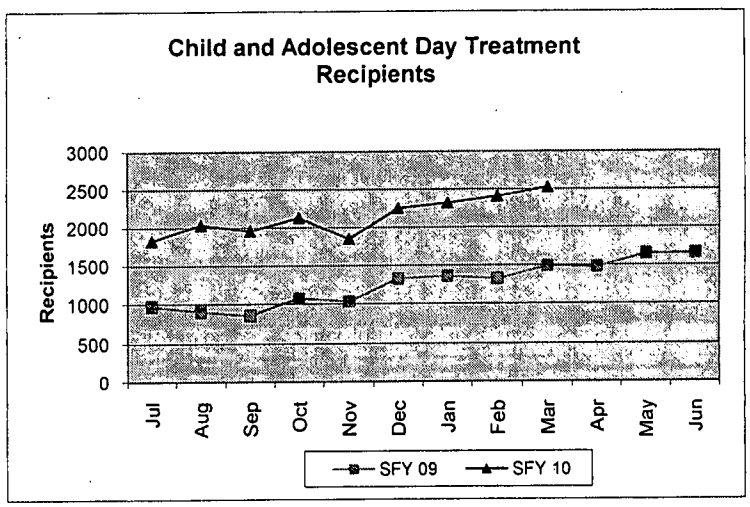
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DHHS REPORT ON LOCAL INPATIENT COMMUNITY HOSPITAL CONTRACTS (3 WAY CONTRACTS) UPDATE

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
April 14, 2010

Michael Watson
Assistant Secretary for MH/DD/SAS Development
Department of Health and Human Services

3 Way Contracts Basic Information

- Contract between a Community Hospital, DHHS and an LME to purchase **expanded** Inpatient Psychiatric Capacity
- Expanded Beds =
  - Opening New Beds (CON or State Hospital Bed Transfer)
  - Staffing Up Unused Capacity (Licensed but not staffed)
  - Opening Existing Bed Capacity to Involuntary Commitments

3 Way Contracts
Basic Information

- Payment Rate = $750 per day (Hospital Daily Rate + Psychiatric Care + Discharge Medications)
- Contract gives participating Hospitals priority in transfers to State Hospitals—Encourage taking difficult patients

3 Way Contracts
Basic Information

- Contract requires effective discharge efforts
- Available Funding = $20,121,644
  (FY 08-09 $8,121,644 + FY 09-10 $12,000,000)
- Phase-In issues associated with new funding/new contracts

3 Way Contract Goals

- Increase Community Psychiatric Inpatient Capacity
- Treat Consumers Closer to Home—Improve Hospital Transitions
- Reduce Short-term Admissions (7 days or less) to State Hospitals
- Decrease Emergency Room Wait Times & Impact on Law Enforcement
- Stop Trend toward Closure of Community Inpatient Beds

LME Contract Responsibilities

- Authorization of Admissions
- Collecting Patient Data
- Facilitating Discharge Planning (Follow Up Appointment with in 7 days)
- Coordinating Discharge Planning with Other LMEs
- Submit Hospital Claims to DMH/DD/SAS
- Pay Hospitals Within 10 working Day of Receipt of State Payment – **NOTE: State cash flow concerns**

FY 08-09 Contract Utilization

- Contracts were initiated with 11 Community Hospitals
- Contracts were Phased In throughout the year as increased Capacity came on Line
- Increased Capacity = 67 Beds
- Participating Hospitals Served an additional 1,453 patients over FY 07-08 Actual Admissions
- Paid for 6,316 Days of Care

Experience: FY 2009-2010 (July – February)

- Planned to add an additional 47 beds in 11 hospitals – Actual = 41 Beds
  - Halifax Regional Hospital (5 beds) declined offer due to staffing issues
  - Moses Cone Hospital Contract reduced from 5 beds to 4 beds
- 2 hospitals still planning to contract, but delayed
  - Davis Regional – construction and up fitting
  - Wayne Memorial – staffing issues
- 8 hospitals are operational
  - Note: Cape Fear Valley and Moses Cone are operational, but have not yet submitted billings

Experience: FY 2009-2010 (July – February)

- Funding is being reallocated on one time basis among Hospital Contracts
- Total Contracts = 21
- Total Beds Funded = 108
- FY 09-10 Bed Day to Date = 14, 492
- Contracts available in 15 of 24 LMEs
- Hospital Start Up Issues

3-Way Contract Summary

LME	2008-2009			2009-2010		
	Hospital	# of New Beds	2009 Actual Bed Days Purchased	Hospital	# of New Beds	2010 Bed Days Purchased February YTD
Alamance-Caswell	Alamance Regional	8	539			962
Beacon Center	Nash General	8	1,140			2,259
CenterPoint	Forsyth Memorial	8	519			1,909
Crossroads				Davis Regional	5	0
Cumberland				Cape Fear Valley	5	0
Durham	Duke	2	390			408
East Carolina	Beaufort Memorial	6	311			600
				Roanoke-Chowan	5	424
Eastpointe				Duplin General	5	79
				Wayne Memorial	5	0
Guilford				Moses Cone	4	0
Mental Health Partners	Catawba Valley	12	1,277			2,490
Pathways	King's Mountain	5	368			741
Sandhills	First Health	6	626			1,519
Smoky Mountain	Charles Canon	3	642			934
	Haywood Regional	4	504			777
Southeastern	New Hanover Memorial	5	0			1,188
Western Highlands				Margaret Pardee	4	86
				Mission/St. Joseph's	5	7
				Rutherford Memorial	2	17
				St. Luke's	1	92
Grand Total		67	6,316		41	14,492

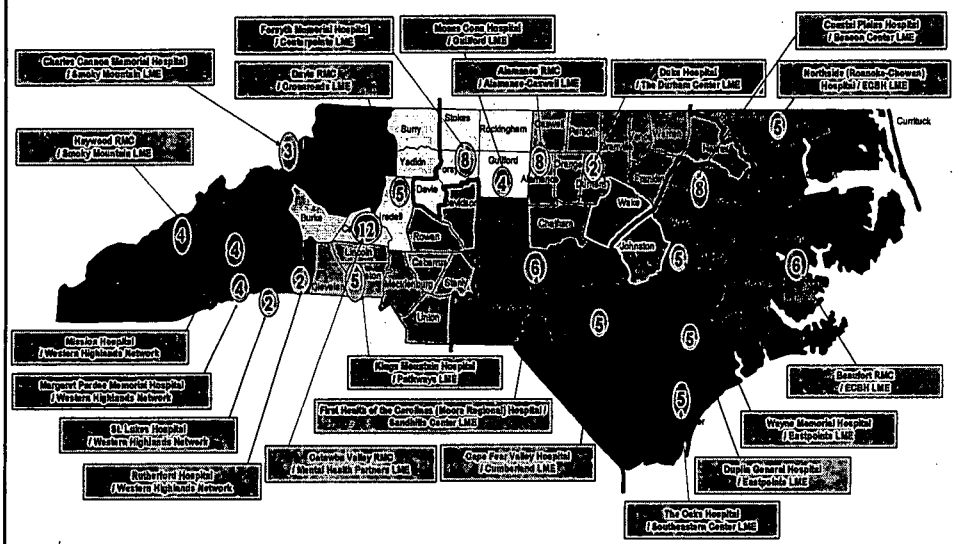
Bed Allocation Strategies

- # of Short Term Admissions to State Hospitals
- Geographic Coverage
- Support for Community Emergency Rooms

3-Way Contract Beds By Region

- Central Region: 23 Beds
- Eastern Region: 44 Beds
- Western Region: 41 Beds
- Total: 108 Beds

3-Way Contract Community Hospital Beds
(As of 4-7-10)



Currently 21 Three Way Contracts in 2010 with 108 designated beds

Initial Outcomes

- Readmission Rates

	State Hospitals	3-Way Contracts
30 Days	10%	6.2%
180 Days	20%	11.2%

- Clinical Capacity Building
  3-Way Contract + CABHA = Increased Psychiatric Capacity
- State Hospital Admissions – 7 Days or Less
  - FY 07 – 08 = 6,306 (46% of total)
  - FY 08 – 09 = 3,499 (40% of total)
  - FY 09 – 10 (July to Dec.) = 987 (28% of total)

NOTE: **Decreases also a function of State Hospital bed reductions and admission delays**

Future Funding

- Annualized Cost FY 09-10 Beds = $3.2 Million
- FY 10-11 Bed Expansion: 65 Beds = $13.3 Million
- Existing Bed Retention
  - Current Indigent Care Rate = 35% +
  - Loss of Existing Capacity

Contract Tracking Requirements

- Separate State Billing Code
- Admissions
- Hospital Denials
- Bed Utilization
- Transfers to State Hospitals
- Billing/ Expenditure Data

3-Way Contract Summary

LME	2008-2009			2009-2010		
	Hospital	# of New Beds	2009 Actual Bed Days Purchased	Hospital	# of New Beds	2010 Bed Days Purchased February YTD
Alamance-Caswell	Alamance Regional	8	539			962
Beacon Center	Nash General	8	1,140			2,259
CenterPoint	Forsyth Memorial	8	519			1,909
Crossroads				Davis Regional	5	0
Cumberland				Cape Fear Valley	5	0
Durham	Duke	2	390			408
East Carolina	Beaufort Memorial	6	311			600
				Roanoke-Chowan	5	424
Eastpointe				Duplin General	5	79
				Wayne Memorial	5	0
Guilford				Moses Cone	4	0
Mental Health Partners	Catawba Valley	12	1,277			2,490
Pathways	King's Mountain	5	368			741
Sandhills	First Health	6	626			1,519
Smoky Mountain	Charles Canon	3	642			934
	Haywood Regional	4	504			777
Southeastern	New Hanover Memorial	5	0			1,188
Western Highlands				Margaret Pardee	4	86
				Mission/St. Joseph's	5	7
				Rutherford Memorial	2	17
				St. Luke's	1	92
Grand Total		67	6,316		41	14,492

Psycho-Social Rehabilitation Services and the Clubhouse Model

Joint Legislative Oversight Committee on MH/DD/SAS

Leza Wainwright, Director, DMH/DD/SAS

April 14, 2010

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Historical Context

- Idea of psychosocial rehabilitation (PSR) gained prominence through the deinstitutionalization movement of the last century
- Medication and therapeutic interventions allowed individuals to successfully leave facilities, but did not adequately prepare some for community living and social interaction.

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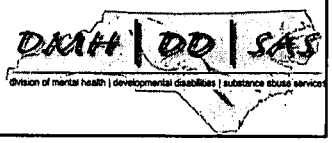
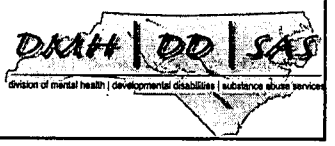
PSR Programs Developed

- To address these issues, PSR programs focus on 5 main areas:
  - Psychiatric and physical healthcare symptom self-management
  - Socialization skills – family and community relationships, use of leisure time
  - Prevocational and educational skills
  - Basic living skills – personal care, meals, safety
  - Financial skills



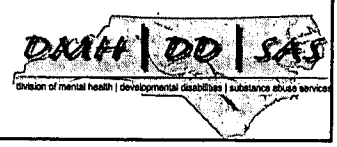
Clubhouses

- The clubhouse movement began with the creation of Fountain House in New York in 1944
- Focused on the same goals and activities as "traditional" PSR programs, but stress consumer ownership of the program



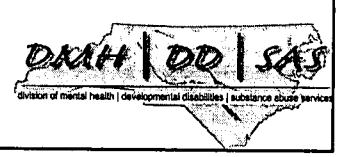
PSR in NC

- NC has covered PSR as a Medicaid-reimbursable service for over 20 years.
- Programs are licensed under rules promulgated by the Commission on MH/DD/SAS
- Must operate at least 5 hours/day, 5 days/week
- Current bundled rate is $2.74/15 minute unit



Numbers

- Currently 85 licensed PSR programs in NC
  - Every LME has at least 1 program; average is approximately 4 per catchment area
- 44 programs, 52%, follow the clubhouse model
  - All but 4 LMEs have at least one program that follows the clubhouse model
- 8 NC clubhouses are member of the International Center for Clubhouse Development (ICCD)
- 2,300 consumers, on average, receive PSR/clubhouse services each month



Comparison

Component	NC Psychosocial Rehabilitation Service Definition (Approved by CMS)	"Generic" Clubhouse Model	ICCD Certification Requirements
Focus	Recovery	Same	Same
Goal	Community Integration	Same	Same
Eligibility Criteria	Specified Axis I or II diagnosis and impairment in level of functioning. Must meet medical necessity criteria	Open to anyone with a history of mental illness	Open to anyone with a history of mental illness
Clinical /treatment options	Designed to be a clinical intervention. Lead staff must meet Qualified Professional requirements. Licensed professional must attest to medical necessity	Philosophical basis that the program is not clinical; staff do no have to meet any professional credentials or experience.	Philosophical basis that the program is not clinical; staff do no have to meet any professional credentials or experience.
Activities interventions	Community living (housekeeping, shopping, cooking, transportation, money management)	Same	Same
	Personal care (health care, medication self-management; grooming)	Same	Same
	Social skills building	Same	Same
	Use of leisure time	Same	Same
	Educational activities	Same	Same
	Pre-vocational activities Supported/Transitional employment optional * Not Medicaid covered	Pre-vocational activities Transitional employment	Pre-vocational activities Tiered employment – transitional employment, supported employment, independent employment
	Housing support not mentioned	Housing support not mentioned	Housing support
Words for recipient	Client, consumer, patient	Participant, member	Participant, member, partner, colleague
Duration	Time-limited	No time limitation	No time limitation

Note: In order to receive Medicaid reimbursement, clubhouse models, including ICCD certified programs, must adhere to the components of the PSR service definition

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Other States

- National Association of State Mental Health Program Directors conducted a survey of clubhouse programs earlier this year:
- 22 states responded, 20 had clubhouses
- Of those 20:
  - 4 receive no government funding
  - 6 receive state-funding only for unbundled services, i.e. WRAP, case management, Peer Support
  - 10, including NC, receive state grant funding or bundled state rate
  - 12 receive no Medicaid funding
  - 3 receive Medicaid funding only for unbundled services, i.e. case management and Peer Support
  - 5, including NC, receive a bundled Medicaid rate
  - 4 states require ICCD membership for reimbursement

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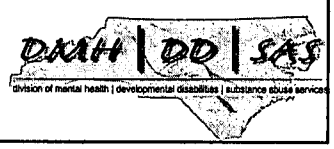
Questions?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Comparison of Current NC CAP-MR/DD Waivers, PBH Innovations Waiver, and New NC Innovations Waiver (1915 b/c)

Joint Legislative Oversight Committee
on MH/DD/SAS
Leza Wainwright, Director, DMH/DD/SAS

April 14, 2010

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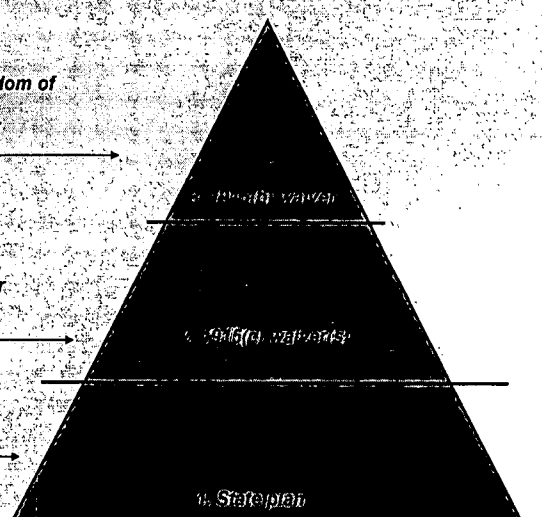
CMS 1915 b/c Waiver Structure

1915(b) waiver for freedom of choice and additional services paid for out of savings

1915(c) Home and Community Based Services (HCBS) waiver for additional services and eligibility, statewideness and comparability

State plan services and eligibility



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Structure of Waivers

KEY FEATURES	State CAP – MR / DD Tiered Waiver	Current PBH Innovations Waiver	NEW CMS-Approved NC Innovations Waiver
Waiver Structure	Currently 2 Waivers – Comprehensive and Supports Waivers. Ultimately, will have 3 waivers	Comprehensive Independence Plus concurrent with B Waiver	Comprehensive Independence Plus concurrent with B Waiver
Management of Waiver	Managed by DHHS.	Managed by LME; monitoring oversight by DHHS	Same as PBH
Annual Cost Limits	Comprehensive - $135,000 Supports: $17,500	Limited by Individual Budget and consumer needs; no upper limit	Limited by Individual Budget and consumer needs, upper limit of $135,000
Geographic Limitations	95 counties	PBH 5-county catchment area	Approved waiver entities, including PBH
Limitations on numbers of participants	Waiver participation limited by 1) state matching funds appropriated by the General Assembly and 2) number of participants approved by CMS.	Same	Same
Allocation of Waiver Funding	Slots are distributed on a per capita basis based upon funding availability	Same	Same
Reserved Capacity	Deinstitutionalization, transfer to/from other waivers, emergencies	Same	Same

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Participants and Services

KEY FEATURES	State CAP – MR / DD Tiered Waiver	Current PBH Innovations Waiver	NEW CMS-Approved NC Innovations Waiver
Entrance Criteria	Federal ICF-MR Criteria	Same	Same
Prioritization Process	NC uniform prioritization tool used by LMEs: balances severity of need with time on the waiting list	Criteria in waiver; use of Supports Intensity Scale (SIS)	Prioritization within Innovations is based upon "first come, first served" with reserve slots for emergency situations balanced across the waiver region.
Participant Self-Direction	Supports Waiver provides the option of the agency with choice mode.	Provides both the agency with choice model and Employer of Record Model	Provides both the agency with choice model and Employer of Record Model
Revision to existing waiver service definitions	Transition between both type of waivers addressed	Transition between both type of waivers addressed	• Renamed or revised plan for Behavioral Consultation and Non-Medical Transportation • Long Term Vocational Support from CAP included under Day Supports in Innovations • Home and Community Supports in CAP replaced with new Innovations service Intensive In-Home/Skill Building Individual Caregiver Training in CAP crosswalks to Natural Supports in NC Innovations. • Added Personal Care to Innovations; currently in CAP, but not PBH Innovations • Home Supports in CAP replaced with new Innovations service Intensive In-Home/Skill Building
B-3 Services	Not applicable.	Additional, alternatives services can be developed based upon savings realized. Can be offered to all Medicaid eligible individuals, whether or not they are participating on the waiver.	Same as PBH

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Financial Components

KEY FEATURES	State CAP – MR / DD Tiered Waiver	Current PBH Innovations Waiver	NEW CMS-Approved NC Innovations Waiver
Utilization Management	ValueOptions authorizes services based upon medical necessity criteria of service definitions and PCP	Plans authorized by LME based upon habilitation and support needed identified via SIS as well as limits set forth within the service definitions.	Same as PBH.
Provider Network	Required to meet endorsement and enrollment criteria; any willing qualified provider directly enrolled with DMA.	Allows for closed network; however, requires annual capacity study to ensure an adequate capacity and provider choice for consumers. Providers enrolled with LME.	Same as PBH. With new MMIS System, providers will also be credentialed by and enrolled with DHHS.
Rate Setting	Rates are standard across the State based upon actual cost per provider cost reports.	Allows rates to be adjusted according to needs of local community. Can provide rate incentives to develop needed services.	Same as PBH.
Payment Structure	Fee-for-service reimbursement; no cost saving incentives.	Flexibility around payment methodologies: fee-for-service, subcapitation, performance-based incentive payments, etc.	Same as PBH
Risk Management	State assumes all risk.	PBH assumes risk; mandatory risk pool funded by 2% of capitation payments and savings.	Same as PBH
CMS Monitoring and Accountability	Subject to quarterly reporting to CMS, on-site monitoring, renewal evaluations.	Same	Same

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On-line Waiver Information

DMHDDSAS

http://www.ncdhhs.gov/mhddsas/waiver/index.htm

DMA

http://www.ncdhhs.gov/dma/lme/MHWaiver.htm

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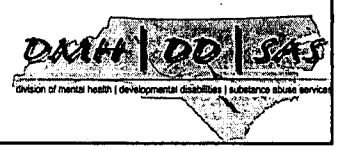
Questions?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UNC Center for Excellence in Community Mental Health

Helping the State Improve Mental Health Services

The University of North Carolina at Chapel Hill

UNC SCHOOL OF MEDICINE
Department of Psychiatry

UNC Center for Excellence in Community Mental Health

In 2007, the UNC Tomorrow Report
identified one of the greatest needs facing 21st century North Carolinians: access to health care services and information

And, the University system committed itself to "Develop an organized, University-based program or institute to assist government officials and concerned citizens improve our mental and behavioral services in the State."

http://www.northcarolina.edu/nctomorrow/reports/commission/Final_Report.pdf

UNC-Chapel Hill's Response

The Department of Psychiatry, in collaboration with other departments and schools, established the **UNC Center for Excellence in Community Mental Health.**

The mission of the Center is to address quality of care and workforce development issues in North Carolina's public mental health system by creating partnerships between existing state, academic, and community programs.

The Center grew out of our well-established Schizophrenia Treatment and Evaluation Program (STEP), a clinical program in operation since 1993

UNC Center for Excellence in Community Mental Health

Goals

- Treat those with psychotic disorders and other severe mental illnesses
- Train mental health professionals
- Conduct research
- Inform state and local policy

Leadership

- Dr. John Gilmore, Professor and Chair for Research and Scientific Affairs, Department of Psychiatry
- Barbara Smith, Director of Outpatient Services, STEP Program, Department of Psychiatry

Current Funding

- Three-year grant from The Duke Endowment
- Cross Area Services Program (CASP) funds from the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, appropriated by the Legislature.

UNC Center for Excellence in Community Mental Health

UNC System Partners

UNC-Chapel Hill Schools of:

- Social Work
- Nursing
- Medicine (Psychiatry, Family Medicine, Social Medicine, Rehabilitation Counseling and Psychology, Occupational Therapy)
- Public Health (SHEPS Center)
- Pharmacy

UNC System Partners

UNC-Chapel Hill College of Arts and Sciences, Department of Psychology

NC-Area Health Education Center (AHEC)

NC State University Department of Social Work

UNC Center for Excellence in Community Mental Health

Regional and Local Partners

Regional Partners

- Central Regional Hospital
- Dorothea Dix Hospital
- Duke University
- NAMI: North Carolina
- NAMI: Wake County

UNC Center for Excellence in Community Mental Health

Regional and Local Partners

Local Partners
- Orange-Person-Chatham LME
- Club Nova
- XDS, Inc. (ACT)
- Caramore Community
- Piedmont Health Care
- MHA of Orange County
- NAMI: Orange County
- Orange County Community Resource Court

UNC Center for Excellence in Community Mental Health

Providing Treatment

Comprehensive, multidisciplinary care for over 400 outpatients at UNC Hospitals and our new community clinic in Carrboro.

Core Treatment Programs
- STEP: Treatment & recovery for those with an established diagnoses
- OASIS: An early intervention program

Recovery Projects
- Book Project: **Our Voices: First Person Accounts of Schizophrenia**
- Brushes With Life: Supervised creative arts program

Providing Treatment: Integrating Medical and Psychiatric Care

Train psychiatrists and primary care physicians in the integration of medical and psychiatric care

Community Collaborations
Case management for Medicare/Medicaid dual eligible patients with CCNC – Demonstration project

Integrated care in our community with Piedmont Health Care (a CCNC provider)

UNC Center for Excellence in Community Mental Health

Training Mental Health Professionals

Multi-faceted learning opportunities for current and future service providers

- Psychiatry and pharmacy residents, and interns from social work, nursing, psychology, rehabilitation counseling psychology, occupational therapy, and public health
- Two-year Community Psychiatry Fellowship – First fellow to begin in July 2010
- Visiting scholars from around the world

Training Mental Health Professionals

Multi-faceted learning opportunities for current and future service providers

- Group home workers – In planning stages with NAMI Wake County
- ACT teams – Clinical supervision of local team
- Other mental health providers – Statewide AHEC workshops on schizophrenia

UNC Center for Excellence in Community Mental Health

Informing State Policy

State Level Workgroups

- Behavioral Health Medicine (MH/SA/DD)
- Physician's Advisory Group (DMA) Pharmacy and Therapeutics Committee, Behavioral Health Subcommittee
- Case Management (DMA)
- Community Support Transition (MH/SA/DD)
- Advisor to the Mobile Crisis Team Service Definition (MH/SA/DD)

Informing State Policy

Other State Involvement

- Developed a quality initiative to improve reduce costs and improve utilization of antipsychotics (DMA, MH/DD/SS, CCNC) Under review
- Trans-institutionalization study of patient movement between state psychiatric hospitals and prisons study (Department of Correction)
- iCareBoard

UNC Center for [illegible] Community Mental Health

Serving Our Local Community / Informing Local Policy

- NAMI Orange County Board
- Orange-Person-Chatham LME Providers Council
- Chapel Hill Mayor's Task Force on Mental Health

Conducting Research

Current Studies

Improving the quality of clozapine prescribing in the state (Duke University and DMH)

Trans-institutionalization -- patient movement -- between state psychiatric hospitals and prisons (Department of Corrections)

Methods to improve physician prescribing in accordance with evidence-based practices (UNC-Chapel Hill SHEPS Center/School of Public Health and CCNC)

UNC Center for Excellence in Community Mental Health

Conducting Research

Current Studies

Comprehensive inpatient consultations and study outcomes for patients referred by community providers with persistent symptoms, polypharmacy, and/or poor functioning (Dorothea Dix Hospital)

Impact of an inpatient illness management and recovery program on prescribing practices (UNC Hospitals Psychotic Disorders Unit and UNC-Chapel Hill School of Pharmacy)

Photo-voice study on community experience (UNC-Chapel Hill Occupational Therapy)

Conducting Research

Current Studies

Crisis services impact on state hospital admissions (UNC-Chapel Hill SHEPS Center/School of Public Health and Duke University)

Schizophrenia Trials Network (Member) – Sponsored by the National Institutes of Mental Health to study new treatments

Outcomes of model of early identification and treatment of psychosis, similar to our OASIS program – Nationwide study sponsored by the National Institutes of Mental Health

UNC Center for Excellence in Community Mental Health

What We Do

Use existing resources and private funds to advance mental health services and policy in North Carolina.

- Treat those who struggle with severe mental illness
- Train current and future service providers (best-practice)
- Partner with others to promote and provide affordable services
- Inform policy at state and local levels
- Add to our understanding of severe mental illness and through scholarly research and meaningful patient outcomes

We are unique...and already up and running, integrating UNC expertise and serving the citizens of North Carolina

We provide quality, multidisciplinary care in a community setting and use our experience on the "frontline" of mental health care to inform our training, our research, and our service to State policy makers.

UNC Center for Excellence in Community Mental Health

UNC Center for Excellence in Community Mental Health

For More Information

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Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

REPORTS REVIEW

April 14, 2010

The complete catalog of reports required to be submitted to the LOC from 2006-2010 was reviewed to cull out the reports that were directed to be submitted on a continuing basis as well as those pending submission.

A review was made of the Session Law that provided the source of the direction for these reports. In addition, each of the reports was reviewed for the purpose of determination of the need for:

- ✓ **Continuation or end of the report**
- ✓ **Change in the frequency of the periodic reportage or**
- ✓ **Need for new request for reportage**

The criteria for recommendations included:

1. **Current status of legislation**
2. **System changes (e.g. elimination of the Community Supports-Individual service definition)**
3. **Resolution or continuation of the issue that prompted the report request**
4. **Status of information needed to adequately provide MH-DD-SAS oversight**
5. **Consistency with the recommendations found in the Legislative Oversight Committee's Session Reports**

Each of the *165* reports requested and provided from 2006-2010 was reviewed. Of these, *22* reports were selected as either directed for future periodic reportage, having currently pending report dates or as provided would assist the LOC to have an additional summary report.

Table one represents a summary of the recommendations for these 22 reports along with the action needed by the LOC to address the recommendation.

Subsequent Tables list each of the reports by description, session law chapter reference, current report requirement and recommendation.

RECOMMENDATION	Number	Action
End	4	None
Continue As Is (periodic or one time report)	7	None
New Request for One Time Report	6	New Provision
Request Continuation of Periodic Report with New Language	5	New Provision
TOTAL	22	

Table One – Summary of Recommendations

REVIEWED REPORTS

1	**Due Date:** **From:** **Description:** **Chapter:**	January 1, 2008 DHHS Monthly report to ensure appropriate utilization of **community supports**. S.L. 2007-323, Sec. 10.49.(ee)(10) HB 1473	**DUE MONTHLY ENDED 7-1-09**	**REC. NEW REQUEST FOR FINAL SUMMARY 1-1-11**
2	**Due Date:** **From:** **Description:** **Chapter:**	May 1, 2008 DHHS Monthly report on **Community Support Services.** S.L. 2007-323, Sec. 10.49.(ee)(10) HB 1473	**DUE MONTHLY ENDED 7-1-09**	**REC. NEW REQUEST FOR FINAL SUMMARY 1-1-11**
3	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2008 DHHS Report on the implementation and status of each of the **community supports** activities listed in subsection 10.49 (ee). S.L. 2007-323, Sec. 10.49.(ee) HB 1473	**DUE MONTHLY ENDED 7-1-09**	**REC. NEW REQUEST FOR FINAL SUMMARY 1-1-11**
4	**Due Date:** **From:** **Description:** **Chapter:**	November 1, 2008 Commission for MHDDSAS Report on the current **death reporting** requirements under GS 122C-26(5)c and the need for any additional reporting requirements. S.L. 2008-131, Sec. 3 (S.B. 1770)	**DUE ONE TIME REPORT**	**REC. NEW LANGUAGE ON CURRENT STATUS OF DEATH REPORTING ONE TIME REPORT 9-1-10**

5	**Due Date:** **From:** **Description:** **Chapter:**	April 1, 2008 Task Force on Coordination of Children's Services Report on recommendations to improve collaboration and **coordination among agencies that provide services to children and families** with multiple service needs. S.L. 2007-323, Sec. 10.10.(i) HB 1473	**DUE ANNUAL**	**REC. ANNUAL 4-1-10**
6	**Due Date:** **From:** **Description:** **Chapter:**	July 1, 2007 DHHS Annual report on expenditures from preceding year from **MHTF** S.L. 2007-323, Sec. 10.49.(w1) HB 1473	**DUE** **ENDED 7-1-08**	**REC. NEW REQUEST FOR ANNUAL REPORT**
7	**Due Date:** **From:** **Description:** **Chapter:**	October 1, 2008 DHHS Report on **restraint and seclusion** including level of compliance of each facility, number of deaths and report on use of restraints. S.L. 2003-58, Sec. 1, G.S. 122C-5 (H.B.80)	**DUE ANNUAL**	**REC. ANNUAL 10-1-10**
8	**Due Date:** **From:** **Description:** **Chapter:**	July 1,2010 DHHS Recommendations based on data obtained annually from the **DD Waiting Lists** submitted to the Dept from each LME S.L. 2009-186, Sec. 2 GS 122-C-112.1(a) (35) (H.B.673)	**DUE ANNUAL**	**REC. ANNUAL 7-1-11**
9	**Due Date:** **From:** **Description:** **Chapter:**	April 1, 2008 DHHS **Statewide System Performance Report** S.L. 2006-142, Sec. 2(a)(c) (H.B. 2077)	**DUE BIANN. APRIL 2010**	**REC. UPDATE CRITERIA-BIANNUAL BEGINNING 1-1-11**
10	**Due Date:** **From:** **Description:** **Chapter:**	December 2009 DHHS Outcomes Evaluation Study on Services for People with **DWI Offenses** S.L. 2005-312, GS 122C-142.1	**DUE EVERY 2 YRS. TO GOV OPS**	**REC. CONTINUE BIANNUAL COPY TO LOC**

11	**Due Date:** **From:** **Description:** **Chapter:**	July 1, 2010 DHHS Report on **strategic plan** re: how State and local resources shall be organized and used to provide services. S.L. 2006-66, Sec. 10.26(f) (S.B. 1741)	**DUE EVERY THREE YEARS REPORT REQUIRE-MENTS ENDED 7-08**	**REC. NEW REPORT WITH UPDATED CRITERIA**
12	**Due Date:** **From:** **Description:** **Chapter:**	January 15, 2010 Institute of Medicine Interim report to include recommendations and proposed leg. on study of availability of Medicaid and State funded **MHDDSA services to military**; issues related to cost, quality, access to health care for all NC; strategies to address issues within adult care homes. S.L. 2009-451 S.B. 10.78.(ff) 202	**INTERIM RECEIVED**	**REC. FINAL REPORT DUE 1-15-11**
13	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2010 DHHS & Office of Adm. Hearings Report on costs, effectiveness, and efficiency of the **appeals process** for Medicaid applicants and recipients and make recommendations regarding continuation process. Sec. 3.13(b) S.L. 2008-118, Sec. 10.15A.(h6) HB 2438	**DUE FINAL**	**REC. NEW REQUEST ONE TIME REPORT TBD**
14	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2010 DHHS Review services funded through Division received by individuals w/**DD currently not served by CAP-MR/DD waiver** to see if they could be better served by Tier 1 waiver. S.L. 2009-451, Sec. 10.65A.(b) S.B. 202	**DUE FINAL EXT – APRIL 1**	**REC. END**
15	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2010 DHHS Report on a **uniform system of beds or bed days purchased** (i) w/Local funds; (ii) from existing St. appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under subsection. S.L. 2009-451, Sec. 10.12.(b) S.B. 202	**DUE ONE TIME RENEWED EXT –APRIL 1**	**REC. NEW REQUEST SEMI-ANNUAL 9-1-10 AND 4-1-11**

16	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2010 DHHS Report on the feasibility and efficacy of applying **Medicaid waivers** from CMS. S.L. 2009-451, Sec. S.B. 10.72A.(b) 202	**DUE** **FINAL** **EXT –APRIL 1**	**REC.** **END**
17	**Due Date:** **From:** **Description:** **Chapter:**	March 1, 2010 DHHS Report on the status of **the Total Quality Management Program,** including any activities associated w/its implementation within State facilities. S.L. 2009-451, Sec. 10.16 S.B. 202	**RECEIVED** **FINAL**	**REC.** **END**
18	**Due Date:** **From:** **Description:** **Chapter:**	April 1, 2010 DHHS Report on a plan for the implementation of **Tiers 1-4 of the CAP-MR/DD** program. S.L. 2009-451, Sec. 10.65A.(a) S.B. 202	**DUE** **ONE TIME** **EXT.** **JUNE 1,2010**	**REC.** **NEW** **REQUEST** **1-1-11** **ONE TIME** **STATUS OF** **IMPLEMENT-** **ATION**
19	**Due Date:** **From:** **Description:** **Chapter:**	May 1, 2010 DHHS Report on the progress **of Supports Intensity Scale (SIS) assessment tool pilot** project. S.L. 2009-451, Sec. 10.12.(f) S.B. 202	**DUE** **PROGRESS**	**REC.** **END**
20	**Due Date:** **From:** **Description:** **Chapter:**	May 1, 2010 DHHS Report on the results from **the LME fund balance reports.** S.L. 2009-451, Sec. 10.19A.(c) S.B. 202	**DUE** **TO DHHS** **QUARTERLYF** **ROM LME** **FINAL FROM** **DHHS 5-1**	**REC.** **NEW** **REQUEST** **ANNUAL** **5-1-11**
21	**Due Date:** **From:** **Description:** **Chapter:**	May 1, 2010 NCIOM Report on study of mhddsa services funded by Medicaid & State funds to determine what **services are currently available to military** and the need for increased services. Part XVI, Sec. 16.1, H.B. 945	**DUE** **FINAL** **BEFORE** **CONVENING**	**REC.** **FINAL** **REPORT DUE** **PRIOR TO 2010** **SESSION**
22	**Due Date:** **From:** **Description:** **Chapter:**	May 1, 2010 NCIOM Report on study of **mhddsa services to current and former members of the armed forces and their families.** Part XIX, Sec. 19.1, H.B. 945	**DUE** **FINAL** **BEFORE** **CONVENING**	**REC.** **FINAL** **REPORT DUE** **ON OR PRIOR** **TO 2010** **SESSION**

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA

May 6, 2010; 10:00 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair Presiding

I. Welcome and Chair's Opening Comments

5 minutes
10:00-10:05

- *Representative Verla Insko, Co-Chair*
- *Senator Martin Nesbitt, Co-Chair*

II. Secretary's Remarks

10 minutes
10:05-10:15

- *Lanier Cansler, Secretary, DHHS*

III. Update on DD Residential Services

45 minutes
10:15-11:00

"Where Does NC Stand? A Comparison of Medicaid-Funded Residential Service Trends, National and in North Carolina for People with Intellectual and Developmental Disabilities, 1998-2008."

- *John Agosta, Ph.D., Vice President, Human Services Research Institute*

IV. Terms of Area Board Members

15 minutes
11:00-11:15

- *Shawn Parker, LOC Research Division Staff*

V. Draft Interim Task Force Report

45 minutes
11:15-12:00

- *LOC Staff*

Final Remarks & Adjournment

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	5/6/10																
Senator Martin Nesbitt, Co-Chair	X																
Senator Austin Allran	X																
Senator Bob Atwater	X																
Senator Doug Berger	X																
Senator Charlie Dannelly	X																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	X																
Representative Beverly Earle	X																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson																	
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	X																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

May 6, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Thursday, May 6, 2010 in Room 643 of the Legislative Office Building. Members present were: Representative Verla Insko, Co-Chair; Senators Jim Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw and Representative William Brisson were present.

Lisa Hollowell, Shawn Parker, Joyce Jones, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the April 14, 2010 meeting. The motion was made by Representative Farmer-Butterfield and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS) made general remarks about the budget for the mental health system. He asked that members be aware of the three proposals by the Governor relating to the area of mental health when considering budget negotiations. The first proposal was to reinstate the $40M deduction of the community service funds; the second proposal was to continue to expand three-way contracts for crisis beds in community hospitals; and the third proposal was a request for $500,000 to be used for staff training in the mental health facilities. Secretary Cansler provided a detailed accounting of a recent incident at Cherry Hospital which emphasized the importance of having knowledgeable staff trained to deal with violent patients. He said that in order to continue to improve facilities there must be adequate staff training as well as staff accountability for proper use of the training. Secretary Cansler also advised that DHHS is still working on obtaining permission for a six-month transition period so that providers have every opportunity to meet the requirements for becoming a CABHA.

Representative Insko suggested that it would be beneficial for the Committee to hear a presentation on restraints and seclusions. She added that some states do not use restraints at all due to the way staff has been trained. It was suggested that those in supervisory positions should be held accountable for properly training staff in this area. Secretary

Cansler added that everyone working in the facilities from top to bottom should know the proper protocol and have proper training.

Dr. John Agosta, Vice President of the Human Services Research Institute, provided a comparison of Medicaid-funded residential service trends in North Carolina using data from 1998 to 2008 for people with intellectual and developmental disabilities. (See Attachment No. 2) Dr. Agosta provided the following additional information:

- Nationally, Medicaid accounts for approximately 26% of the average state budget.
- New human services ideas are layered on top of inefficient systems without subtracting from the system's old ideas.
- North Carolina is ranked 17th in the country in Medicaid dollars spent per person.
- Fewer people receive Medicaid funded services in North Carolina due to the fact that there are too many people being served in ICFs/MR which is more costly than a waiver.
- States choose to have an ICF/MR centered system. It is not a system that is really needed or necessary; states choose that option.
- North Carolina would have to serve almost 5,000 more people in order to reach the national average. Adding 1,000 Tier 1 slots in 2010 still leaves North Carolina 80% short of meeting the national average.
- Families are the backbone of the system. More than half of the people being supported in the system are living at home with family. What can be done to knit these families together to build an infrastructure around them for support?

Staff to the Oversight Committee reviewed the draft report explaining each of the recommendations referencing proposed legislation when appropriate. (See Attachments No. 3 and No. 4) After discussion and debate, Representative Insko requested a motion to approve the report and to authorize staff to make the Committee directed changes as well as any technical corrections. Senator Kinnaird made the motion and the Committee approved the report.

There being no further business, the meeting adjourned at 12:35 PM.

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erin McLaughlin	NHAMC
Annalisse Dolph	DRNC
AISANDER DUDA	NCCPPR
William Moore	Hardy Law Group
Kenneth Sparks	Carolina Outreach
Jen Mahan	MHA/NC
Sally Cameron	NC Psychological
Janet Scharrenbach	Indigo Consulting
Yvonne Copeland	NC Council of Community Programs
Pam Shipman	PBH LME
Valerie Hennike	Five Co. MHA LME

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andrew Meehan	Capstrat
Jennifer Rothman for Deby Dinoff	NAMI NC
Steve Metcalf	The Pacific Group
Bob Fitzgerald	Duke Med
Pam P. Andrews	New River Behavioral Healthcare
Joe Fenimore	Meridian Behavioral Health Care
Joe Lanier	Nelson Mullins
Evelyn Hawthorne	CHBR
Bob Feldbruch	NCPC
Ron Mitchell	NMRS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Martin	Lighthouse Counseling Center Fayetteville, NC
John Blue, M.D.	"
Misty Martin	"
Martha W Lawrence	VA ID / DDA
Jill Rushing	NC COUNCIL ON DD
Holly Riddle	NCCDD
[illegible]	[illegible]
Julia Adams	The Arc of NC
[illegible]	DD~~FA~~
Stan JORDAN	NCPC
Stephanie Alexander	DHSR
Peggy Balak	The Sagaman Grp.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Mayer	CRA 102 W. Ruffin, Mebane, NC 27302
ERIC GABRIER	RHA Howell 4700 Horewad Ct. Raleigh 27609
Vicki Smith	Disability Rights NC 2626 Glenwood ste 550 Raleigh, NC
Maureen Morrell	Autism Society of NC
Jill Hinton	
John Bordish	Astra Zeneca
	NCPA
Lan Wilson	NCLTCF
Erica Nelson	Office of Rep. Insko

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W. Gordon Pilgrim	Personal Interest
DAVID BARNES	Payne Scarnell
JIM PARSUE	RALPH SCOTT LIFESERVICES, INC.
Bennie Kidd	Ralph Scott Lifeservices, Inc
Crystal Nunnemaker	Omni Visions Inc
Treva Johnson	Omni Visions Inc
Margaret Stacy	Covenant w/ NC's Children
Julie Ewing	Parent Advocate
Curtis Buss	NC Assoc. of ICF/MR Providers
Mary Ann Ard	NC. Housing Finance Agency
Gena Pugh	Turning Point Services, Inc.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Clarissa Goodlett	GIASA
Colleen Kochanek	KLG
Dave Sprout	FOMS
Erica Weaver	Threshold
Don Wade	Threshold
Deborah A. Fike	Federation
Gina Price	NC DVRS
Angie Barther	SA Federation
Tony Beatty	SA Federation

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Tillery, MSW, LCSW	Club Nova Community Inc 103-D West main St. Conover, NC 28613
Jacki Pattisale	"
Collin Lee	"
Ethel Benjamin	"
Jeffery Ruffin	"
Barbara Richards	NAMI Pres. Hickory Area
Ben Richards	Client - CAP MR/DD
JACK REGISTER	National Assoc Social Workers-NC Chap

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS May 6, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wes Stewart	Coastal Horizons Center, Inc. TASC
Tom Champlin	" " "
Margaret Slaughter	" " "
Paula Cox Fishman	Volunteer advocate/family member DD
Louise G. Fisher	" " for Mentally Ill
Robin Huffman	NC Psychiatric Assoc / The Coalition
Judy Truitt	OPC MHC
Cim Brailer	OPC LME

WHERE DOES NORTH CAROLINA STAND?

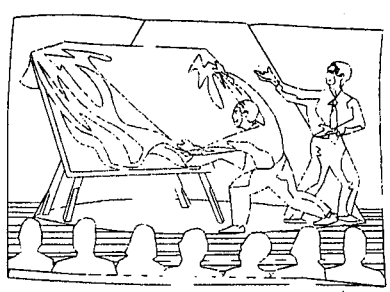
A Comparison Of Medicaid-funded Residential Service Trends, Nationally and in North Carolina, For People With Intellectual and Developmental Disabilities

May 6, 2010

John Agosta, Drew Smith & Kerri Melda
Human Services Research Institute
7690 SW Mohawk Street
Tualatin, OR 97062
503-924-3783
jagosta@hsri.org

Agenda

- Purpose
- Methods
- Bottom Line Findings
- Selected Graphics
- Recommendations
- Concluding Remarks



Definitions

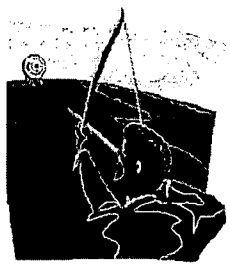
- ICF-MR -- facility

  An ICF-MR facility serves 4 or more individuals. For a facility to be certified as ICF/MR and thereby become eligible for Medicaid payments, it must comply with an extensive set of federal regulations and requirements.

- HCBS - waiver

  The home and community-based services (HCBS) waiver program waiver was established in 1981. It allows states to waive specified requirements of Section 1915 of the Social Security Act so that states may develop community-based alternatives to ICFs/MR. (For example, the CAP-MR/DD and Innovations are I/DD HCBS waivers.)

Purpose

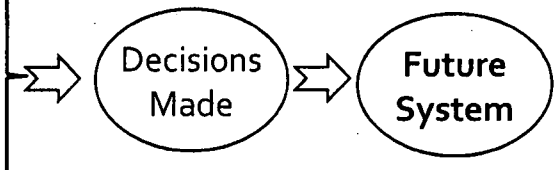


- This is the fourth edition of *Where Does North Carolina Stand?*
- The inquiry is funded by the North Carolina Council on Developmental Disabilities
- This paper provides a review of the trends in Medicaid-funded residential service utilization, residential living arrangements and service expenditures over the past decade (1998 – 2008), both nationally and within North Carolina.
- The findings can be used to guide policy decisions regarding services for people with intellectual and developmental disabilities (I/DD).

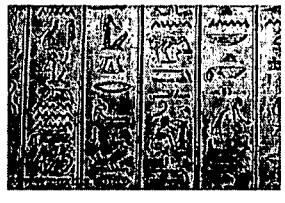
Why is the report important?

Think of the Challenges Faced By Policy Makers...

- Budget stress
- Accelerating service demand and waiting lists
- Reliance on legacy and inefficient systems
- Workforce shortages
- Continued push for community integration, participation, contribution... self direction.



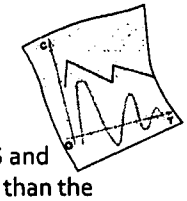
Methods



The statistics contained in the report are drawn from two national data sets.

- University of Minnesota's Research and Training Center on Community Living (RTCCL). Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2008 (Lakin et al.)
- The Coleman Institute for Cognitive Disabilities at the University of Colorado. The State of the States in Developmental Disabilities 2008. (Braddock et al.)

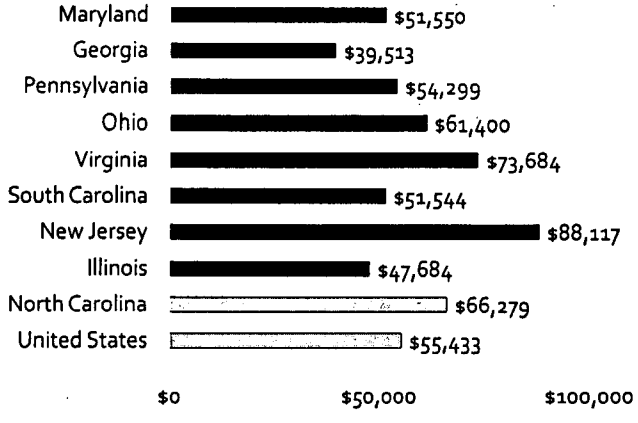
Bottom Line Findings



1. North Carolina **spends more per person** than the national average with overall Medicaid-funded (HCBS and ICF/MR) expenditures for services in 2008 16% higher than the national average ($66,279 vs. $55,433 per person annually);
2. The number of individuals who received Medicaid-funded (HCBS and ICF/MR) services in North Carolina in 1998 and 2008 was **markedly lower** than nationwide levels after controlling for population differences;
3. Along several dimensions, the **state's reliance on large (16+) state facilities and community ICFs/MR** as a chief service option endures; and
4. The state system is changing in ways consistent with national trends, but generally at a **much slower pace**.

1. *North Carolina Spends More Per Person...*

Medicaid ICF-MR and HCBS Combined Per Person Expenditures (FY 2008)



Lakin et al. (2009)

Chart 4: Percent of Individuals Receiving ICF/MR Services Compared to Percentage of Total I/DD Medicaid Expenditures (2008)

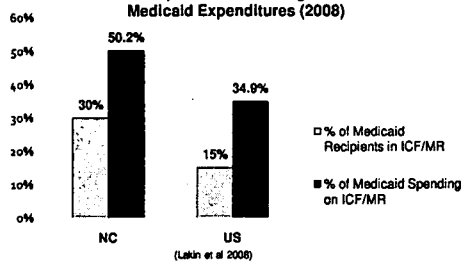


Chart 5: Percent of Individuals Receiving HCBS Services Compared to Percentage of Total I/DD Medicaid Expenditures (2008)

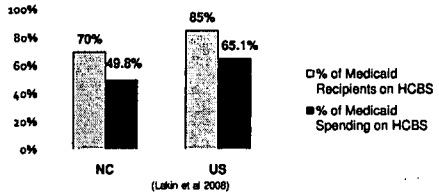
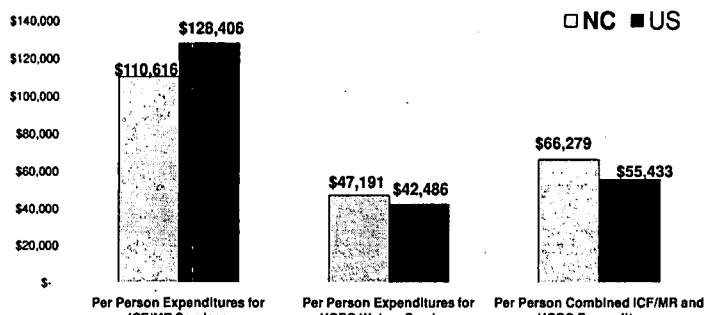
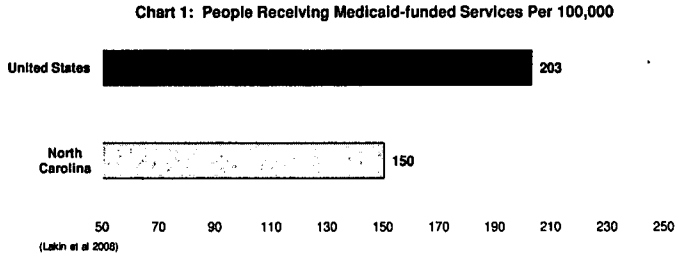


Chart 6: Comparison of Per Person ICF/MR, HCBS Waiver and Total Medicaid Expenditures: North Carolina and the United States (2008)



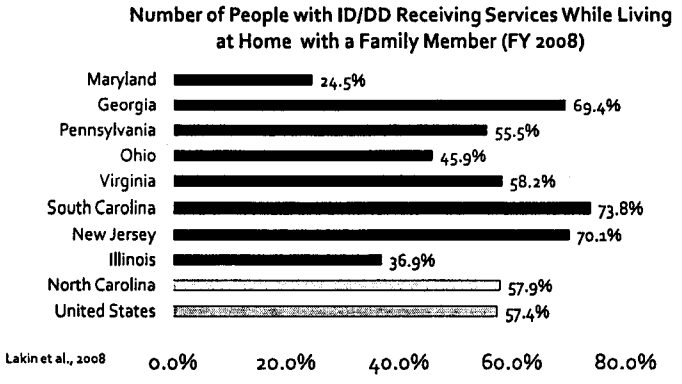
(Lakin et al 2008)

2. The number of individuals who receive Medicaid-funded services is markedly lower...



- From 2000 to 2008, North Carolina added 3,992 people receiving Medicaid-funded services to its developmental disabilities service system, or about 499 per year.
- This equals 40.4% growth over the 8-year period, but lags behind the average growth in other states (51.7%) by approximately 11%.
- Just as for any other state, this count does not include individuals receiving supports in the home of a family member, or individuals receiving state-only dollars. *(MHDDSAS reported that overall 25,106 individuals received services in residential or family home settings in 2008.)*

3. The state's reliance on large state facilities and community ICFs/MR endures...



- States furnish in-home services and supports to more individuals who live with their families than are provided in specialized "out-of-the-family-home" residential facilities.
- In 2008, North Carolina reported that these in-the-family-home services were furnished to about 58% of the service population, or 14,525 individuals living with their families

Reliance on Large Congregate Settings

2008 Utilization of all Residential Settings

	North Carolina		National
Residences 1 < 6	**7,852**	74%	75%
Residences 7 < 15	528*	5%	12%
Residences of 16+	2,201	**21%**	**13%**
Total	10.581	100%	100%

* State staff reported after reviewing a draft of this report that only 171 individuals resided in 7-15 bed homes.

Lakin et al., 2008

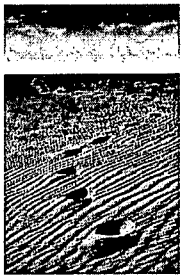
- Of the 7,852 living in 1-6 bed residences, 1,702 live in ICFs-MR, totaling 21.7%.
- Nationally, of those living in 1-6 residences, 5.6% live in ICFs-MR.

Reliance on Legacy Systems... It's A Living Museum ... Can this be efficient?

1956... 1962... 1972 ... !976...1983... 1987.. .1992... 1997.. 2000... 2003...2006...2010

4. *The state system is changing in ways consistent with national trends, but at a much slower pace.*

- North Carolina serves more people now than in 1998, adding 3,392 to Medicaid services between 1998 and 2008 -- a 40.4% increase. The national percent increase was 51.7%.
- North Carolina increased its capacity to serve people in out- of-home residential options between 1998 and 2008 - faster than the nation, but still lags behind (115 vs. 144 people served per 100k population).
- Between 1998 and 2008, North Carolina reduced its census of people living in state developmental centers by 20% (406 people). The national census fell by 32%.
- Between 1998 and 2008, North Carolina decreased the number of people living in 16+ facilities by 16%. The national average fell by 36%.



Human Services Research institute 15

Recommendations

1. Ask what people with developmental disabilities want... Consider... "Where are we headed?"
2. Make the system more efficient and equitable... lower the cost per person for delivering services.
3. Build capacity within the community to deliver high quality services and supports
4. Address the wait list.

Human Services Research institute 16

1. Is What We Are Doing What People Want?

People want to live life in the community with the support they need. Just like anyone else.

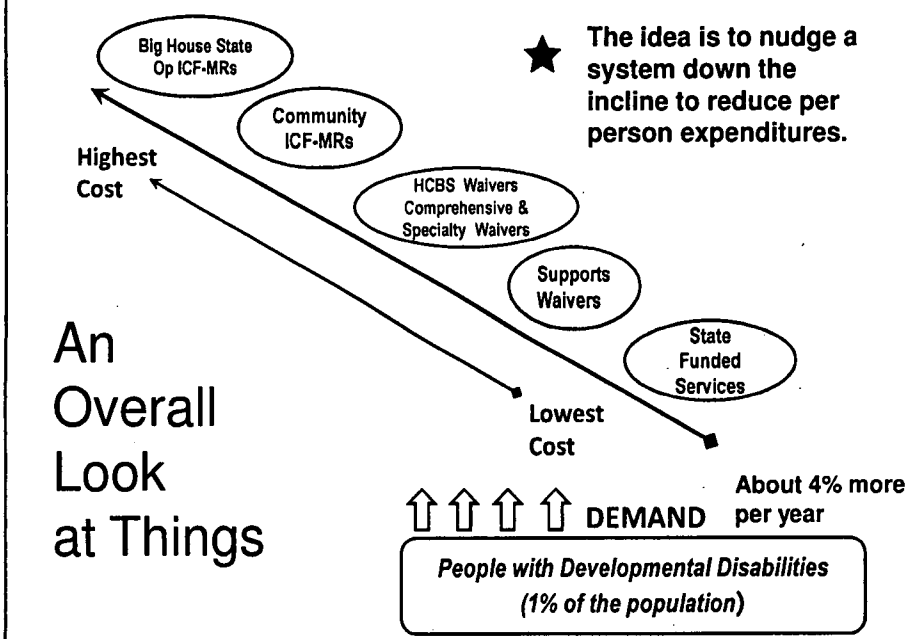
"Thank you for everything that you've done ... for all the services that there are... but what you built, we don't want. "

-Rebecca Cokley

Rebecca Cokley
National Consortium on Leadership and Disability
Institute for Educational Leadership

2. Make the system more efficient and equitable...

- Disinvest from high cost options in favor of lower cost community centered alternatives... this means accelerating relocation of individuals from Developmental Centers and community ICFs-MR into HCBS funded alternatives.
  - Utilize the Money Follows the Person initiative to help achieve this objective.
  - Assist service providers who are willing to transition from ICF-MR to HCBS waiver funding
- Invest in means for allocating resources per individual that are fair and in a accordance with personal needs.



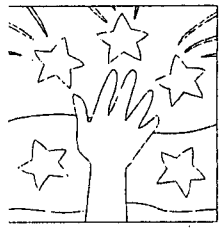
States with No State Developmental Centers or Fewer than 150 People in Census

States with No Developmental Centers	States with Census of 125 or Fewer in Developmental Centers	
Alaska	Colorado	Nevada
District of Columbia	Delaware	Montana
Hawaii	Idaho	Minnesota
Maine	North Dakota	Oregon*
New Hampshire	Wyoming	
New Mexico		
Vermont		
West Virginia		

* In 2010 Oregon became the first state to have no state developmental Center and no Oregon citizen living in an ICF-MR anywhere.

3. Build capacity within the community to deliver high quality services and supports

- Create opportunity within the community to build support structures that are not exclusively reliant on Medicaid.

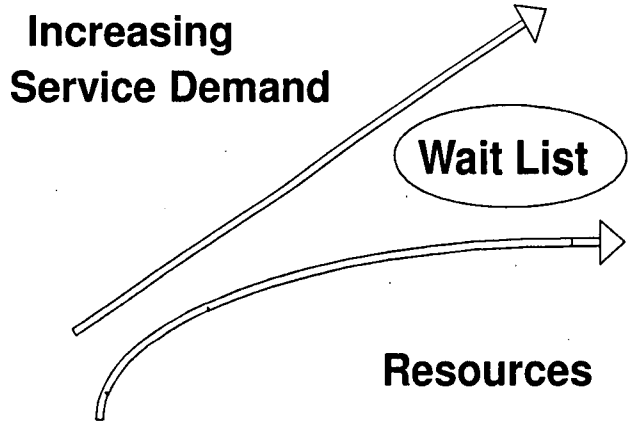


- Invest in building community capacity for addressing complex needs and for building staff competencies.

4. Address the wait list.

- In 2008, North Carolina furnished Medicaid-funded (HCBS and ICF/MR) services to 13,876 people.
- Given a state population of 9.2million this totals 150 people per 100,000 general population. The national average is 203 per 100,000.
- North Carolina's performance is 26% below this national marker.
- To reach the national average, North Carolina would have to serve 53 people per 100,000 more than it does, or 4,887 people.
- North Carolina should establish and implement a plan for eliminating the service waitlist over 7-10 years.

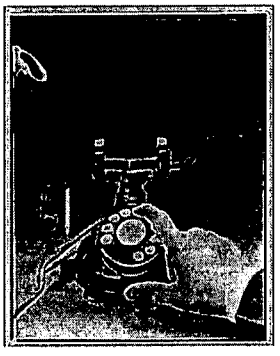
States Face a Big Problem...



Gary Smith, HSRI

Need and Opportunity

"A service system for [people with disabilities] and others in need of support will have to be a system in constant change. It has to be continuously developed, if the 'customers' are not to be left behind and to become hostages of an outdated way of doing things."



Alfred Dam
Denmark

Where Does North Carolina Stand?

1998-2008

A COMPARISON OF MEDICAID-FUNDED RESIDENTIAL SERVICE TRENDS, NATIONALLY AND IN NORTH CAROLINA, FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

PREPARED FOR THE NORTH CAROLINA COUNCIL ON DEVELOPMENTAL DISABILITIES

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April 2010

Prepared for:

THE NORTH CAROLINA COUNCIL ON DEVELOPMENTAL DISABILITIES

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All opinions expressed herein are solely those of the authors and do not reflect the position or policy of the North Carolina Council on Developmental Disabilities. The authors would like to acknowledge the contributions of Michael Mayer and Charlie Lakin.

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INTRODUCTION

This is the fourth edition of *Where Does North Carolina Stand?* This paper provides a review of the trends in Medicaid-funded residential service utilization, residential living arrangements and service expenditures over the past decade (1998 – 2008), both nationally and within North Carolina.

The original version of this report was prepared by Gary Smith, and released in 1997 as an appendix to a report entitled, *Choice, Change and Community*. In 1998 and 1999, updates were prepared on behalf of the North Carolina Council on Developmental Disabilities, which also sponsored the preparation of *Choice, Change and Community*.

The statistics contained in this report are drawn from two national data sets.

- The first is data compiled by the University of Minnesota's Research and Training Center on Community Living (RTCCL). Each year RTCCL researchers conduct an in-depth survey to compile both nationwide and state-by-state data concerning residential and other related services for people with developmental disabilities. The RTCCL data contained here is from the Center's most recent report: K. Charlie Lakin, Sheryl Larson, Pat Salmi & Naomi Scott (Eds.) (2009). Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2008[1]. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. (Cited in this report as Lakin et al., 2008).
- The second source of data is the biennial survey of state expenditures for developmental disabilities services that is conducted by the Department of Psychiatry and the Coleman Institute for Cognitive Disabilities at the University of Colorado. This information is contained in: David Braddock, Richard Hemp and Mary C. Rizzolo (2008). The State of the States in Developmental Disabilities 2008. Washington DC: American Association on Intellectual and Developmental Disabilities.

"Where Does North Carolina Stand?" provides updated information concerning the scope of publicly-funded services for the state's citizens with intellectual and developmental disabilities (I/DD)[2]. To lend perspective to this information, comparisons are made between North Carolina and the nation as a whole. The report's aim is to provide stakeholders a picture of North Carolina's developmental disabilities service system to inform their discussions concerning the direction the service system might take in the future.

The report begins by looking at utilization patterns for developmental disabilities services in North Carolina and the United States as a whole. Next, information is furnished concerning residential services. Attention then turns to how Medicaid dollars are used to pay for services and supports.

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[1] Information pertaining to the Piedmont Behavioral Health Local Management Entity was not included in this data set. As a result, about 1,000 individuals receiving services are not accounted for in tabulations presented in this report.

[2] Intellectual and Developmental Disabilities (I/DD) are disabilities characterized by significant limitations both in intellectual functioning and in adaptive behavior, which cover many everyday social and practical skills. Federal and state definitions vary slightly. The federal and North Carolina definitions can be found at the following site: http://www.nc-ddc.org/home/definition.html.

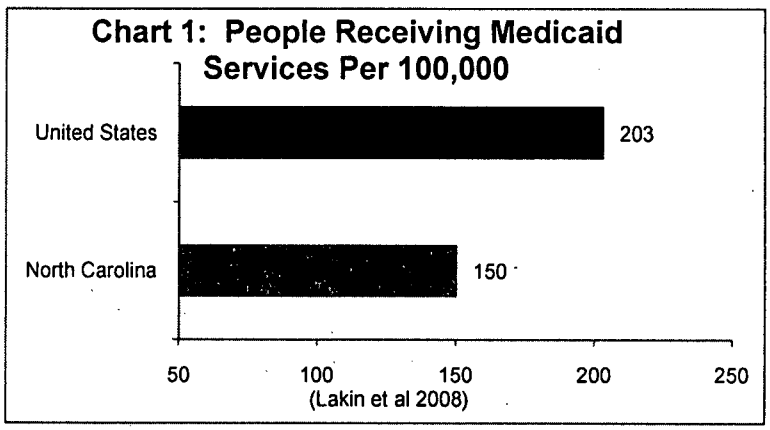
SERVICE UTILIZATION PATTERNS

From 2000 to 2008, North Carolina added 3,992 people receiving Medicaid-funded services to its developmental disabilities service system, or about 499 per year. As shown in **Table 1**, this equals 40.4% growth over the 8-year period, but lags behind the average growth in other states (51.7%) by approximately 11%.

Table 1
Medicaid-funded Services Growth: North Carolina and the United States (2000-2008) (Lakin et al 2008)

	North Carolina			United States		
Year	Total Service Recipients	# of People Added to Service System	Percent Change	Total Service Recipients	# of People Added to Service System	Percent Change
2000	9,884	N/A	N/A	407,696	N/A	N/A
2001	10,634	750	7.6%	441,839	34,143	8.4%
2002	10,658	24	0.2%	484,818	42,979	9.7%
2003	10,192	-466	-4.4%	508,969	24,151	5.0%
2004	9,886	-306	-3.0%	526,921	17,952	3.5%
2005	11,059	1,173	11.9%	545,429	18,508	3.5%
2006	11,922	863	7.8%	577,656	32,227	5.9%
2007	13,433	1,511	12.7%	597,916	20,260	3.5%
2008	13,876	443	3.3%	618,283	20,367	3.4%
Difference from 2000-2008	3,992		40.4%	210,587		51.7%

Service use patterns can also be viewed in terms of how many individuals receive services per 100,000 (100K) in population. North Carolina furnished Medicaid-funded services (i.e., Home and Community Based Service (HCBS) waivers and Intermediate Care Facilities for People with Mental Retardation (ICFs/MR)) to 13,876 individuals in 2008[3,4]. Given a state population of 9,222,414, this totals 150 people per 100,000 general population. The national average is 203 per 100,000 (**Chart 1**), leaving North Carolina 26% below this national marker. To reach the national average, North Carolina would have to serve 53 people per 100,000 more than it does, or 4,887 people. One may note that our experience shows that states serving about 300 people/100,000 come closest to having no wait-list for services.



[3] An ICF/MR is a facility that serves 4 or more individuals. For a facility to be certified as ICF/MR and thereby become eligible for Medicaid payments, it must comply with an extensive set of federal regulations and requirements. The home and community-based services (HCBS) waiver program waiver was established in 1981. It allows states to waive specified requirements of Section 1915 of the Social Security Act so that states may develop community-based alternatives to ICFs/MR.

[4] Note, this count does not include individuals receiving supports in the home of a family member, or individuals receiving state-only dollars. MHDDSAS reported that overall 25,106 individuals received services in residential or family home settings in 2008.

RESIDENTIAL PATTERNS

Residential services claim the majority of state expenditures for developmental disabilities services. In 1982, the majority of residential services in the United States were furnished in large, state-operated residential facilities. Since then, states have been shifting residential services away from larger congregate settings to smaller living arrangements in the community. Nationwide, in 2008, states provided residential services to 436,866 individuals. Of this total, 47,389 (11%) were in facilities of 16 or more people with most (35,035) living in large state-operated facilities. Complementing this trend, states have fostered the provision of services in living arrangements that are owned or rented by people with intellectual and developmental disabilities rather than in facilities or sites that are controlled by provider agencies. In fact, nationally 27% of those receiving residential services own or lease their own home, compared to 16% in North Carolina.

Residential Services - Overall

Residential services include not only large state-operated facilities but also other Medicaid-funded "community" ICFs/MR, Alternate Family Living, other group-living arrangements, and supports furnished to an individual who lives in his or her own home. **Table 2** shows the number of North Carolinians with intellectual and developmental disabilities who received publicly funded residential services (including North Carolina's institutional settings referred to as "State Developmental Centers" and "Neuro-Medical Treatment Centers,"[5] from now on referred to as "Centers" in this report) on June 30 of each year during the period 1998 - 2008 and comparable figures for the nation as a whole.

Table 2
Utilization of Out-of-Home Residential Services (1998 – 2008) (Lakin et al 2008)

Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1998	7,485	99	348,264	129
1999	7,753	101	361,172	132
2000	11,329	141	374,595	133
2001	11,857	145	387,745	136
2002	12,188	147	392,740	136
2003	12,466	154	402,281	143
2004	11,861	139	420,202	143
2005	11,932	137	411,215	139
2006	12,058	136	424,462	142
2007	11,834	131	437,707	145
2008	10,581	115	436,866	144
% Change 1998-2000	**+ 41.3%[6]**	**+16.2%**	**+25.4%**	**+11.6%**

[5] North Carolina's five large state-operated facilities are the Black Mountain and O'Berry Neuro-Medical Treatment Centers and the Caswell, Murdoch, and J. Iverson Riddle Developmental Centers.

[6] Between 1998 and 2003 North Carolina's out-of-home placement utilization increased quickly, peaking at 154 per 100K in 2003. Since then, it has cycled down, reaching 115 per 100K in 2008.

The figure shows that the number of individuals who received out-of-home residential services in North Carolina grew considerably over this period and at a brisker rate than the nation as a whole (i.e., 41.3% growth in NC compared to 25.4% nationally). The table also indexes these services to population (i.e., the number of people receiving these services per 100,000 general population) and also reveals growth at a quicker pace than nationally (16.2% to 11.6%).

Waiting for Residential Services

Like elsewhere, over a ten year period, North Carolina achieved a net increase in the availability of residential services relative to population. Yet, despite such growth, as illustrated above, North Carolina furnishes residential services per 100,000 in population to fewer individuals than nationally (i.e., 115 per 100,000 population in North Carolina to 144 nationally). We note, however, that between 1999 and 2003, the expansion of residential services in North Carolina exceeded the rate of state population growth, and surpassed the nation's average service rate. Since then, North Carolina has slowed its pace of growth so that by 2008, the gap per 100,000 population in residential services between North Carolina and the nation was unchanged from 1998 and 2008. The nation serves about 30 people more per 100,000 population than does North Carolina. Given the state population of 9.2 million, to reach the national average in residential service use in 2008 about 2,675 additional individuals would need to be provided such services.

More specific to expressed service demand in North Carolina, in 2007, the State provided an estimate to the University of Minnesota that 1,350 people with intellectual and developmental disabilities had been identified as needing residential services but had been "wait-listed" because such services were not available[7]. Given that North Carolina provided residential services to 10,581 people in 2008, the need to serve these additional 1,360 people amounts to a shortfall in capacity of about 13%. Nationwide, the shortfall in residential service capacity was 26.0%.

There are North Carolinians with intellectual and developmental disabilities waiting for other types of services as well. According to the Arc of North Carolina, approximately 5,000 individuals are waiting for developmental disability services, residential or otherwise.

To gather more accurate waiting list data, the North Carolina Legislature passed legislation in 2009 requiring Local Management Entities (LMEs) to

> "develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services...[and] report this data annually to the Department. The data collected should include numbers of persons who are:
>
> a. Waiting for residential services.
> b. Potentially eligible for CAP-MRDD.
> c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD."

[7] Note, the state did not furnish waitlist data for 2008.

Large State-Operated Centers

The number of individuals served in large, state-operated facilities has been declining in the United States for more than 30 years. These facilities are routinely operated as ICFs/MR. In 2008, eight states (AK, HI, ME, NH, NM, RI, VT, WV) and the District of Columbia had no large (16+) state-operated facilities, with several other states approaching this mark. In fact, in 2010 Oregon joined these states and became the first with none of its citizens residing in ICFs/MR of any size. Typically, these services are the most costly that a state provides, averaging in 2008 over $500/day/resident nationally and $481 in North Carolina.

Table 3 shows the number of individuals served in North Carolina's Centers over the period 1998 - 2008 and comparable nationwide figures. As shown, the number of individuals served in North Carolina's Centers declined steadily between 1998 and 2008. Nationally, over this period the number dropped by 32%. However, in North Carolina, the decline was 20%. Additionally, over the past several years, the Center population has remained constant at about 1,650 people.

Table 3
Individuals Served in Large, State-Operated Facilities: North Carolina and the United States (1998-2008)
(Lakin et al 2008)

Year	North Carolina	Percent Change	United States	Percent Change
1998	2,057	N/A	52,469	N/A
1999	1,995	-3.0%	50,094	-4.5%
2000	1,939	-2.8%	47,592	-5.0%
2001	1,893	-2.4%	46,236	-2.8%
2002	1,885	-0.4%	44,236	-4.3%
2003	1,863	-1.2%	43,289	-2.1%
2004	1,801	-3.3%	42,120	-2.7%
2005	1,736	-3.6%	40,532	-3.8%
2006	1,675	-3.5%	38,810	-4.2%
2007	1,663	-0.7%	37,172	-4.2%
2008	1,651	-0.7%	35,741	-3.8%
1998-2008	**-406**	**-20%**	**-16,728**	**-32%**

Shown another way, **Table 4** illustrates utilization rates of these facilities in terms of the number served per 100,000 population in 1998 and 2008. The table reveals that the rate in North Carolina decreased by 33% during the period (27.3 to 18.1 people/100,000). Nationally, the rate dropped by 41% (19.4 to 11.5 people/100,000). Overall, then, it is apparent that while North Carolina has steadily reduced its census, it has done so at a pace slower than the national average and maintains a significant number of people in large, state-operated facilities.

Table 4 Individuals Served in Large, State-Operated Facilities per 100,000 of population (Lakin et al 2008)			
Year	North Carolina	United States	North Carolina's Difference in Utilization
1998	27.3	19.4	+40%
2008	18.1	11.5	+57%

Children in Large, State-Operated Facilities

Nationwide, the population of children ages 0-21 in state centers has remained virtually constant since 1998 at 4%- 5% of the overall census (see **Table 5**). In North Carolina, while the percentages are lower than the national average, the trend shows growth – from 0% to 3% - over the past decade. In 2008 about 46 individuals aged 0-21 years resided in large state-operated facilities. Some, if not all, of this growth may have resulted from reclassifying a facility for children as an ICF/MR and placing it within the auspices of Murdoch Developmental Center[8].

Table 5 Individuals under the age of 21 Living in State-Operated Institutions (Lakin et al 2008)		
Year	North Carolina	United States
1998	0%	5%
2000	1%	4%
2002	2%	5%
2004	2%	4%
2006	2%	4%
2008	3%	5%

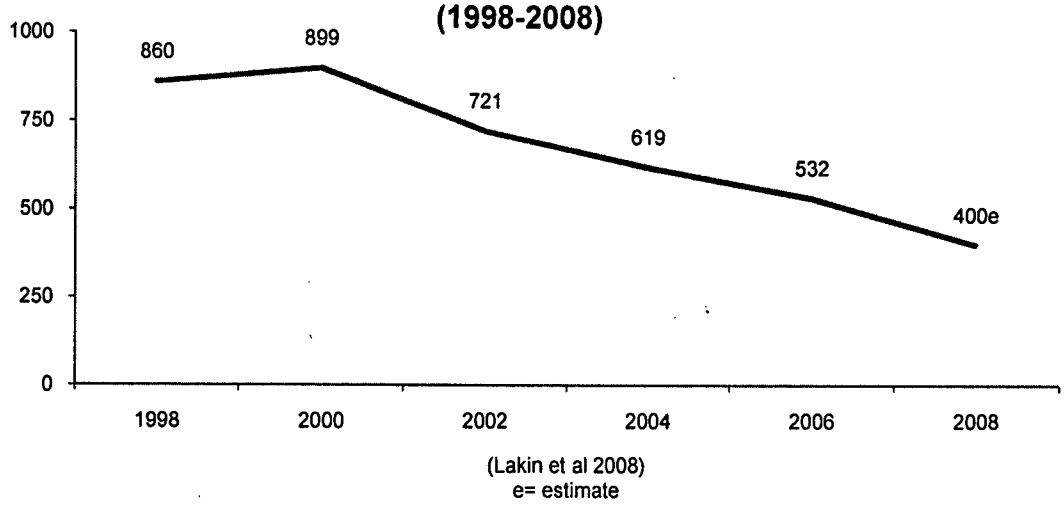
Nursing Home Facilities

The foregoing statistics do not include people with intellectual and developmental disabilities who reside in nursing facilities. Nursing home facilities provide long-term care and assistance with activities of daily living; patients in nursing homes do not require skilled nursing care on a daily basis. Medicaid or private insurance pays for nursing home stays with no statutory limits on duration. Over the past decade, utilization of nursing facilities has decreased at a quicker pace than in other states. In 2008, an estimated 400 people with intellectual and developmental disabilities were served in nursing facilities in North Carolina. It was about half as likely that a person with a developmental disability will be served in a nursing facility in North Carolina than in other states. When nursing facility and developmental disabilities residential services are

[8] MHDDSAS staff supplied the following information regarding children in large, state operated facilities. "In 2008, about 46 individuals aged 0-21 received services in state-operated developmental centers. Most of these individuals received services in the two, statewide, time-limited specialty programs at Murdoch Developmental Center. The Partners in Autism Treatment and Habilitation (PATH) program serves children with autism spectrum disorders and severe behavioral challenges. The Specialized Treatment for Adolescents in a Residential Setting (STARS) program serves adolescents who have a dual diagnose (developmental disabilities and mental illness) and demonstrate extreme behaviors. In keeping with its goal of short-term therapeutic treatment, the length of stay in PATH is two years while the length of stay in STARS is one year."

combined, a lesser percentage (about 3.6%) of North Carolinians with intellectual and developmental disabilities who receive a residential service of any type are served in nursing facilities than nationwide, where the percentage is 5.6%. This shows improvement over 1998, when North Carolina had a higher percentage (about 10%) to the nation's 6.7% average. [9]

Chart 2: Utilization of Nursing Home Residential Placements for Individuals with Developmental Disabilities in North Carolina (1998-2008)



(Lakin et al 2008)
e= estimate

Community Residential Services

There is a particularly wide difference between North Carolina and the rest of the nation in terms of the availability of Medicaid-funded community residential services outside large state-operated facilities. Nationwide in 2008, residential services outside large state-operated facilities were furnished at the rate of 144 individuals per 100,000 population. In North Carolina the rate was 115 people per 100,000 population or roughly 20% less.

Over the past three decades, there has been a major shift in the provision of residential services away from larger congregate settings to smaller living arrangements. In 1977 nationwide, the average residential setting served 22.5 individuals; by 1998, the average had dropped to 3.3 individuals per site; and by 2008; the average had dropped further to 2.5. **Table 6** shows the distribution in North Carolina and nationwide of individuals receiving Medicaid-funded residential services by size of the facility or living arrangement in 1998 and 2008:

In 2008, the proportion of individuals receiving residential services in smaller (1-6 person) living arrangements was the same in North Carolina as the nation as a whole (74%). We note, however, that 21.7% of these residents live in ICFs/MR compared to 5.4% nationally.

[9] The data pertaining to nursing home facilities reflects aggregate figures offered to the University of Minnesota by state developmental disabilities staff. At this time, it is unclear if these numbers are inclusive of individuals residing in the neuro-medical centers, or receiving adult care home services.

North Carolina also served a considerably larger proportion of individuals in large congregate (16+ people) facilities. Overall, North Carolina followed the general national trend of shifting residential services to smaller, community living arrangements. However, in 2008, it was more common for North Carolinians with intellectual and developmental disabilities to be served in larger living arrangements than their counterparts in other states.

Table 6
Distribution of Individuals Receiving Residential Services
by Size of Living Arrangement (1998 and 2008)
(Lakin et al 2008)

Year/Setting	North Carolina	Percentage of Total	United States	Percentage of Total
1998				
1-6 Beds	4,393	58.7%	204,571	58.7%
7-15 Beds	484	6.5%	54,474	15.6%
16+ Beds	2,608	34.8%	89,234	25.6%
2008				
1-6 Beds	7,852	74.2%	325,425	74.6%
7-15 Beds	528 [10]	5.0%	53,424	12.2%
16+ Beds[11]	2,201	20.8%	57,462	13.2%
% Change 1998-2008				
1-6 Beds	78.7%		59.1%	
7-15 Beds	9.1%		-1.9%	
16+ Beds	-15.6%		-35.6%	
Average Number of People Per Setting - 2008	DNF		2.5	

ICF/MR Services

One avenue for securing federal Medicaid funding of specialized residences for people with intellectual and developmental disabilities is to certify such facilities as Intermediate Care Facilities for People with Mental Retardation (ICFs/MR). Starting in 1993, the utilization of ICF/MR services nationwide began to decline. This decline reflected both the ongoing downsizing and closure of large state-operated facilities (most of which are certified as ICFs/MR) and more recently the conversion of a growing number of private ICF/MR facilities to

[10] The University of Minnesota published that 528 individuals received Medicaid-funded residential services in homes with between 7-15 beds. State staff, however, report after reviewing a draft of this report that only 171 individuals resided in 7-15 bed homes.

[11] The numbers in this table differ from the numbers presented in Table 3 of this report, with these numbers being higher. In this table the numbers represent individuals living in both private and public large residential facilities. In North Carolina this difference is represented by an additional 550 individuals living in private large (16+) ICFs/MR.

funding under the HCBS waiver program. Due to both cost and programmatic considerations, most states have been reducing the role that ICFs/MR play in their service systems.

Table 7 below shows the number of individuals who received Medicaid-funded ICF/MR services in North Carolina and nationwide during the period 1998 - 2008 as well as utilization indexed to population.

As shown, during this period the number of people served in ICFs/MR in North Carolina fell by 11% overall and 28% with respect to state population. This decline in ICFs/MR use is consistent with the trend nationwide. However, in 2008, about 45% more individuals were served in ICFs/MR in North Carolina relative to population than nationwide[12].

Table 7
Individuals Receiving ICF/MR Services: North Carolina and the United State
(1998-2008)
(Lakin et al 2008)

Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1998	4,705	62	124,258	46
1999	4,616	60	117,917	43
2000	4,520	56	116,441	41
2001	4,493	55	113,907	40
2002	4,645	56	110,572	38
2003	4,500	56	107,065	38
2004	3,875	45	104,526	36
2005	4,306	50	101,821	34
2006	4,091	46	98,411	33
2007	4,124	46	96,427	32
2008	4,176	45	93,164	31
Percent Change	-11%	-28%	-25%	-32%

HCBS Waiver Services

The second major avenue available to states to secure federal Medicaid funding for specialized developmental services is the home and community-based services (HCBS) waiver program. Individuals who are eligible for ICF/MR services may instead be offered HCBS waiver alternative services. The eligibility criteria are the same. The HCBS services may be provided to individuals who are served in licensed residences, live in their own homes, or live with their

[12] Note that these data do not represent children receiving out-of-home placement options in private community ICF/MR facilities. Children ages 0-21 are only counted in the University of Minnesota's database in regard to state-operated institutional settings.

families. North Carolina first gained federal approval in 1983 to operate an HCBS waiver program for people with intellectual and developmental disabilities. The HCBS program offers a wide array of services.

Table 8 shows the number of individuals with intellectual and developmental disabilities who participated in the HCBS program each year between 1998 and 2008 as well as the nationwide total number of participants in similar waiver programs. In each case, the table also shows the number of participants indexed relative to population.

As can be seen from the table, between 1998 and 2008, the number of individuals receiving HCBS waiver services in both North Carolina and nationwide more than doubled. The rate of growth in the number of people served through North Carolina's HCBS program has been slightly greater than the rate of growth in HCBS waiver programs nationwide.

Relative to population, however, North Carolina provided HCBS waiver services to 105 people per/100,000 population compared to 173/100,000 nationally, or 39% fewer individuals. To reach the national average, North Carolina would have needed to serve 6,255 additional individuals through the HCBS waiver program.

Table 8
Individuals Receiving HCBS Services: North Carolina and the United State (1998-2008)
(Lakin et al 2008)

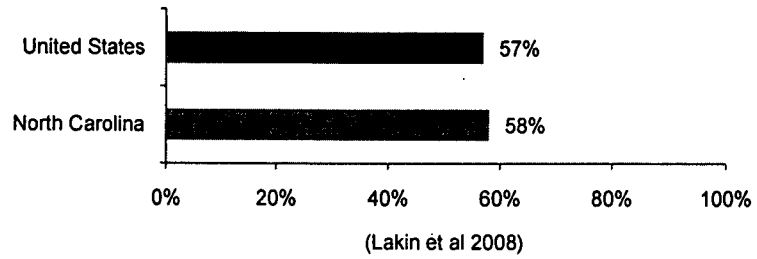
Year	North Carolina	Per 100,000 Population	United States	Per 100,000 Population
1998	3,986	53	239,077	89
1999	4,974	65	261,930	96
2000	5,364	67	291,255	103
2001	6,141	75	327,932	115
2002	6,013	72	374,246	131
2003	5,692	71	401,904	143
2004	6,011	70	422,395	145
2005	6,753	78	443,608	150
2006	7,831	88	479,245	160
2007	9,309	103	501,489	166
2008	9,700	105	525,119	173
Percent Change	143%	99%	120%	95%

Individuals Living at Home

Nationwide, states furnish in-home services and supports to more individuals who live with their families than are provided in specialized "out-of-the-family-home" residential facilities. In 2008, North Carolina officials reported that these in-the-family-home services were furnished to about 58% of the service population, or 14,525 individuals living with their families.

This compares to a smaller 10,581 individuals (42%) who received any residential services outside the family home in North Carolina. These percentages are consistent with what is happening in other states.

Chart 3: Percent of Individuals Living at Home with a Family Member (2008)



(Lakin et al 2008)

EXPENDITURE PATTERNS

Medicaid Funded Services

Nationwide, the single most important source of federal funding for the specialized services and supports that states furnish or purchase on behalf of people with intellectual and developmental disabilities is the Medicaid program. Through the Medicaid program, the federal government financially shares in meeting the costs of various types of services. In the case of North Carolina, the 2008 federal financial participation rate in Medicaid-reimbursable services is 64.05%[13]. In other words, for each $1 spent on a Medicaid qualified service, about 64¢ is paid by federal Medicaid funds and 36¢ by the State of North Carolina.

In 2008, state-federal Medicaid payments accounted for roughly 78% of all dollars spent nationwide on developmental disabilities services (Coleman Institute). In North Carolina, the proportion was about the same - about 77%.

The two main Medicaid program categories used by North Carolina (and other states) to secure Medicaid funding for specialized developmental disabilities services are the ICF/MR and HCBS programs. In 2008, North Carolina's spending for these two programs in combination totaled $919.8 million; federal payments to the state for these services came to $588.7 million. Clearly the Medicaid programs play a critical role in underwriting developmental disabilities services in North Carolina. In the following sections, information is furnished concerning each of these programs individually and in combination.

ICF/MR and HCBS Waiver Services in Combination

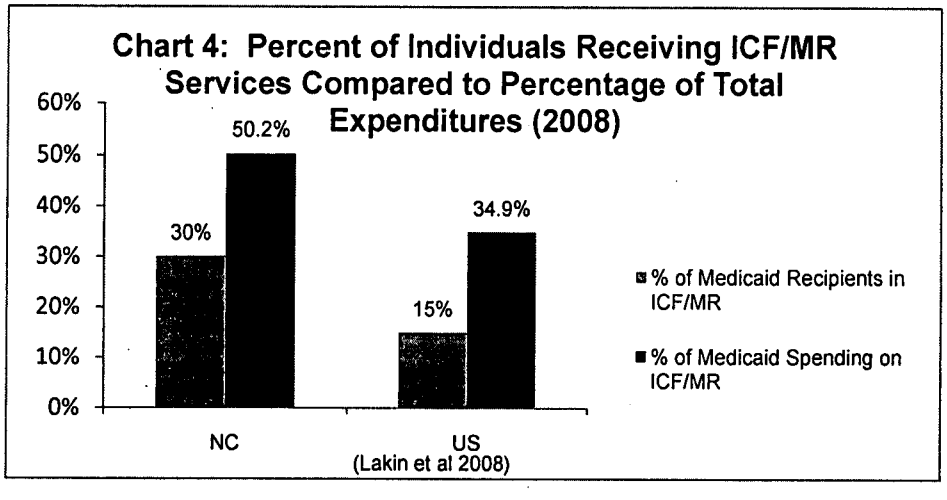
The same eligibility criteria apply in determining the eligibility of an individual for either ICF/MR or HCBS waiver services. In other words, both programs are intended to serve the same population. Therefore, in examining how Medicaid dollars are used in support of individuals with intellectual and developmental disabilities, it is useful to examine both programs in combination.

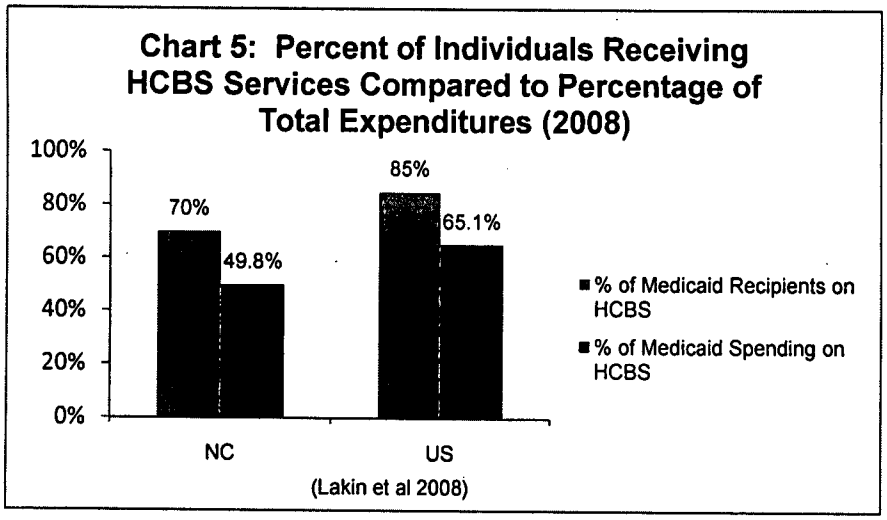
[13] Note that the Federal reimbursement rates were increased beginning in October 2009 to reflect additional Medicaid funding available under Section 5001 of the American Recovery and Re-investment Act of 2009. In 2010 the NC reimbursement rate is 71.33%

Table 9 and **Charts 4 and 5** illustrate information concerning HCBS waiver and ICF/MR services in North Carolina and nationwide. These graphics show that between 1998 and 2008, North Carolina's spending for Medicaid services for people with intellectual and developmental disabilities grew 79%, increasing at a rate 24% slower than the nation as a whole. The number of individuals who received either ICF/MR or HCBS services grew by 60% during this period. Nationwide, the increase was greater at 70%. In 2008, nationwide, nearly 85% of individuals who received Medicaid funded services were served through the HCBS waiver program. In North Carolina, the proportion was significantly lower - about 70%.

Table 9
ICF/MR & HCBS Waiver Services
(Lakin et al 2008)

	North Carolina	% of Total	United States	% of Total
Recipients - 1998	8,691		363,335	
ICF/MR	4,705	54%	124,258	34%
HCBS	3,986	46%	239,077	66%
Recipients - 2008	13,876		618,283	
ICF/MR	4,176	30%	93,164	15%
HCBS	9,700	70%	525,119	85%
Spending - 1998	$514.4 Million		$16.9 Billion	
ICF/MR	$380.2 Million	77.4%	$9.8 Billion	58%
HCBS	$134.2 Million	22.6%	$7.1 Billion	42%
Spending - 2008	$919.8 Million		$34.3 Billion	
ICF/MR	$462 Million	50.2%	$12 Billion	35.0%
HCBS	$457.8 Million	49.8%	$22.3 Billion	65.0%





As was the case nationwide, North Carolina directed a significantly greater percentage of its Medicaid dollars to purchase home and community-based (HCBS) services in 2008 than it did in 1998. However, the proportion of dollars earmarked for HCBS waiver services was substantially lower in North Carolina than was the case nationwide. Both in North Carolina and nationwide, the percentage of Medicaid dollars spent on ICF/MR services was disproportionate to the proportion that ICF/MR residents represent of the total of all individuals who received Medicaid funded services (e.g., nationwide, 15% of Medicaid recipients were served in ICFs/MR in 1998, but spending for these services accounted for nearly 35% of the total).

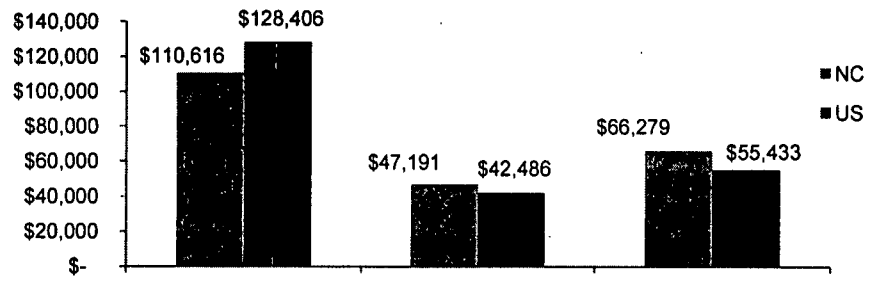
Table 10
Additional Indicators of Medicaid Utilization and Spending (2008)
(Lakin et al 2008)

	North Carolina	United States
Total ICF/MR & HCBS Waiver Recipients	13,876	618,283
Recipients per 100,000 Population	150	203
Total Outlays	$919.8 Million	$34.3 Billion
Outlays Per Citizen	$99.72	$112.72
Average Annual Expenditures Per Recipient	$66,279	$55,433

Table 10 (above) and **Chart 6** furnish additional 2008 comparisons between North Carolina and the nation as a whole with regard to Medicaid-funded services for people with intellectual and developmental disabilities. Relative to population, North Carolina provided Medicaid-funded services to about 26% fewer individuals than was the case nationwide. When Medicaid spending is expressed on a per citizen basis, North Carolina's Medicaid spending for developmental disabilities services was approximately 12% lower than the nationwide level. There was a relatively large difference in the annual expenditures per Medicaid recipient in North Carolina compared to the remainder of the nation. Overall, in 2008 North Carolina spent $919.8 million combined for ICF/MR and HCBS waiver services to support 14,362 people. This amounts to $66,279 per person annually. The national average was $55,433, or 17% less.

This difference stemmed in large part from North Carolina's heavier use of more costly ICF/MR services to meet the needs of individuals.

Chart 6: Comparison of Per Person ICF/MR, HCBS Waiver and Total Medicaid Expenditures: North Carolina and the United States (2008)



(Lakin et al 2008)

CONCLUDING REMARKS

The following observations may be made concerning North Carolina's services for people with intellectual and developmental disabilities:

- In 1998 and 2008, relative to population, fewer North Carolinians with intellectual and developmental disabilities received Medicaid-funded long-term services (via the ICF/MR and HCBS waiver programs in combination) than nationwide. North Carolina would need to serve 26% more people to reach the average national utilization rate of 203 people/100,000 in population.

- In 1998 and 2008, Medicaid-funded out-of-home residential services overall (both ICF/MR and HCBS) were notably less available in North Carolina than nationally. While the number of people in the USA and North Carolina has risen, North Carolina continues to serve about 30 people/100,000 population fewer than the national average.

- North Carolina continues to serve more people with intellectual and developmental disabilities in its large state-operated Centers than the nationwide norm. While the numbers of individuals served in the Centers decreased by 406 people from 1998-2008, the rate of decline was slower than the nationwide rate and the North Carolina census has stabilized at about 1,650 people since 2006.

- In 1998, North Carolina furnished residential services in settings that were larger than was typical elsewhere in the country. By 2008, however, North Carolina served as many people proportionately in residences of 1-6 beds as the national average. Still, this finding is tempered by the state's high use of ICFs/MR for this size setting and high use of large (16+) state operated facilities.

- In 1998, North Carolina reported that it served no children aged 0-21 years in its large state-run residential facilities. By 2008, however, even as the overall census was reduced in the ten year period, the state reports serving about 46 children in these facilities, or 3% of the population living in large, state-run institutions.

- In 1998, a greater proportion of North Carolina's residential services for people with intellectual and developmental disabilities were provided in ICFs/MR than was the norm nationwide. This is still the case. While the HCBS program continues to expand, the state has not reduced its reliance on public and private ICFs/MR at the same brisk pace as the nation.

- In 1998 and 2008, the total Medicaid dollars available for ICF/MR and HCBS services was greater than in other states. In 2008 this amounted to $66,279 per service recipient annually compared to $55,433/person nationally. This is explained primarily by the state's enduring reliance on costly public and private ICFs/MR services relative to other states' greater use of less expensive HCBS waivers.

In summary, four primary observations about services for people with intellectual and developmental disabilities in North Carolina include:

1. North Carolina spends more per person than the national average with overall Medicaid expenditures for services in 2008 16% higher than the national average ($66,249 vs. $56,433 per person annually);

2. The number of individuals who received Medicaid-funded services in North Carolina in 1998 and 2008 was markedly lower than nationwide levels after controlling for population differences;

3. Along several dimensions, the state's reliance on large state facilities and community ICFs/MR as a chief service option endures; and

4. The state system is changing in ways consistent with national trends, but generally at a much slower pace.

Rennie Hobby (Mental Health CA)

From: David T [nampman@msn.com]
Sent: Friday, April 30, 2010 11:24 PM
To: Rep. Verla Insko
Cc: Rennie Hobby (Mental Health CA); Gina Insko (Rep. Insko)
Subject: RE: #273 - David Thompson April 9 email

Derar Verla,

Thank you very much! I actually heard from Pani Tademeti at OSP and we met Wednesday. He was helpful and clarified that they did not submit the claim to Ameritas. However, AON Consulting, the contractor that processes the claims for the Medical Spending Accounts still insists that I provide them with an EOB and will not accept that IRS does not require one even though I gave them the precide regulation the IRS agent quoted to me. I am in the process of getting a written ruling from IRS to see if that helps but I am rather disappointed in the level of service from AON. I will give Rennie a call Monday with the details.

Thank you again for your assistance.

Sincerely,

David

Subject: RE: April 9
Date: Fri, 30 Apr 2010 22:59:07 -0400
From: Verla.Insko@ncleg.net
To: nampman@msn.com
CC: Mentalhealthca@ncleg.net; Inskola@ncleg.net

David:

Please call Rennie Hobby at 919-733-5639. She is clerk to the MHDDSA oversight committee and will get details from you on what is going on. She will discuss with me and we will see what we can do to get thsi cleared up.

Rennie: This may be for Pat Porter but if you could start on it, I would appreciate it. Check my contact list; I may have David's phone number. Or you can hook up by email. Please keep gina in hte loop.
Thanks

Verla

Verla Insko
House District 56
Orange County

From: David T [mailto:nampman@msn.com]
Sent: Thursday, April 22, 2010 9:39 AM
To: margaret.b.jordan@osp.nc.gov; Governor Office; nancy.phillips@osp.nc.gov; Sen. Ellie Kinnaird; Rep. Verla Insko; John Stewart
Subject: April 9

Dear Ms. Jordan:

To date, I have not received a response to my email of April 9, nor has the call center manager's supervisor contacted me (remember that he promised this would happen). I would ask that you address the issues raised in my April 9 email at your earliest convenience.

In particular, please identify the person or persons who submitted my claim to Ameritas without my permission. If this did not happen, please indicate why the call center manager indicated to me that he had received an email form you stating that my claim to Ameritas had been submitted and denied.

Sincerely,

Donald David Thompson

Summary of Recommendations

1. Restoration of LME Community Service Funds

   The LOC recommends the General Assembly appropriate $40 million for community services for FY2010-11 and that these funds be allocated to LMEs based on the amount of reduction LMEs received resulting from the $40 million nonrecurring reduction planned for FY2010-11.

2. Support Initiatives to Strengthen LMEs

   - The Department is encouraged to continue to expand the number of LMEs implementing 1915(b)(c) Medicaid waivers.
   - The Department is encouraged to return Utilization Management functions to LMEs.
   - The Department is encouraged to promote Single Stream funding for LMEs

3. Fund a Leadership Academy for LME Managers

   The LOC recommends that of the funds appropriated to the Division for the 2010-2011 fiscal year, up to five hundred thousand dollars ($500,000) should be used to support development of a mental health leadership academy that provides professional development to local management entities.

4. LME Independent Assessment Pilot

   The LOC recommends the Department establish a pilot project within 4 local management entities for the purpose of evaluating the cost and program efficacy of the independent assessment of individuals in or applying for service for the purpose of determination of their eligibility and need for IPRS enhanced services.

5. Funds for Local Hospital Three Way Contracts

   The LOC recommends the General Assembly appropriate an additional $12 million for the expansion of local inpatient psychiatric beds to allow purchase of an additional 50 beds out in the community.

6. Implementation of the Tiered CAP/MR-DD Waiver Program

   The LOC encourages the Department to continue to implement the tiered CAP-MR/DD waiver system.

7. Supports Intensity Scale Evaluations

   The LOC recommends requiring all DD consumers within the 7 region pilot catchment areas to undergo a Supports Intensity Scale (SIS) evaluation and directing the Department to develop and utilize a mechanism to employ the results of the SIS as the basis for assigning those individuals to CAP waiver

tiers and other services according to each individual's relative intensity of need.

8. CABHA Implementation and Certification Process

The LOC recommends the Department consider and seek approval for a three to six month extension of the transition period for full implementation of the CABHA model in order to ensure that client access to an array of appropriate clinical services is not disrupted, and to provide additional time for small providers to gain CABHA accreditation.

In addition, the LOC recommends that the General Assembly direct the Division to develop a plan for modifying the CABHA certification process in order to ensure that newly-certified CABHA providers are able to enter and participate in the CABHA network. The Division should submit a report on the modification plan to the LOC and the Fiscal Research Division not later than October 1, 2010.

9. Club House Model Study Rates

The LOC recommends the General Assembly direct DMA, in conjunction with the Division, to examine and, as the Divisions deem necessary, adjust the rates for community support services provided through the clubhouse model of psychosocial rehabilitation.

10. NCIOM Study Childhood Mental Health Services in North Carolina

The LOC recommends that the General Assembly continue recurring funds to the NCIOM in order to continue the work of the Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group.

In addition, the LOC recommends that the General Assembly direct the NCIOM to conduct a study of the needs of children from birth to age five and their families. The NCIOM may submit an interim report of its findings and recommendations to the LOC by January 15, 2012, and shall submit a final report of its findings and any recommended legislation to the LOC on or before the convening of the 2013 General Assembly.

11. Support Regionally-Purchased Locally-Hosted Substance Abuse Services

The LOC recommends that the General Assembly direct the Department to continue allocating substance abuse funds for regionally-purchased, locally-hosted substance abuse programs at the same level.

12. Expand and Extend the First Commitment Pilot Program

The LOC recommends the General Assembly authorize the Secretary to extend and expand the first commitment pilot program, direct the Department to establish continued training for current certified providers, direct the Department to utilize the Stakeholder group to examine the participation rates by each "waived" masters level health care professionals area, and determine if this should be expanded or reduced based on scope of practice and report any findings to the LOC.

13. Medicaid Appeals Process Changes

The LOC recommends the General Assembly make the temporary Medicaid appeals process for Medicaid applicants and recipients permanent and codify the process in Chapter 108 of the General Statutes. The LOC further recommends the General Assembly direct the Office of Administrative Hearings (OAH) to continue to collect statistics on these appeals and to provide more information as to the outcome of settled and withdrawn cases as well as incidences of DMA reversing an Administrative Law Judge's decision and report the results and any recommendations to the LOC on or before October 1, 2011.

14. County Managers Term Limits on Area Mental Health Boards

The LOC recommends the General Assembly exempt county managers who serve on area mental health boards from term limits while employed in that capacity.

15. Implement Report Review Recommendations

The LOC recommends the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports:

- By January 1, 2011, the Department shall report on the status of Community Support Services.
- By September 1,2010, the Department shall report on deaths that have occurred within in state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning 10-1-10, the Department shall provide status report on the expenditures and balance in the Mental Health Trust Fund
- Annually, beginning January 1, 2011, the Department shall report on the strategic plan regarding how state and local resources shall be organized and used to provide services.
- Annually, beginning May 1,2011, the department shall collect and report on LME fund balances.

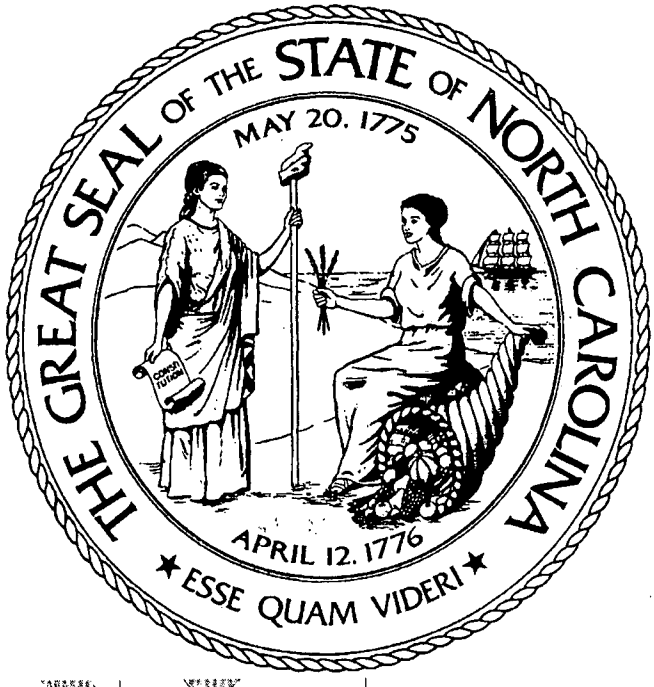
Summary of Recommendations

- By January 1, 2011, the Department shall report on the status of the implementation of the CAP-MR/DD Tiered Waiver to include mechanism for determination of assignment into each of the tiers for both new and current CAP recipients, movement from one tier to another, and cost impact.
- Biannual report beginning January 1, 2011, the Department shall report on Statewide System Performance to include the following criteria:
    - Access to Services
    - Individualized Planning and Supports
    - Promotion of Best Practices
    - Consumer-Friendly Outcomes
    - Quality Management Systems
    - System Efficiency and Effectiveness
    - Equitable Allocation of Resources
    - Prevention and Early Intervention
    - Statewide System of Crisis Response for Adults and Children
    - Management of the Utilization of State Facilities
- Semi-Annual report due on September 1 and April 1, beginning September 1,2010, the Department shall report on the uniform system of beds or bed days purchased (i) with local funds;(ii) from existing state appropriations,(iii) under the hospital utilization pilot, and (iv)under three-way contracts

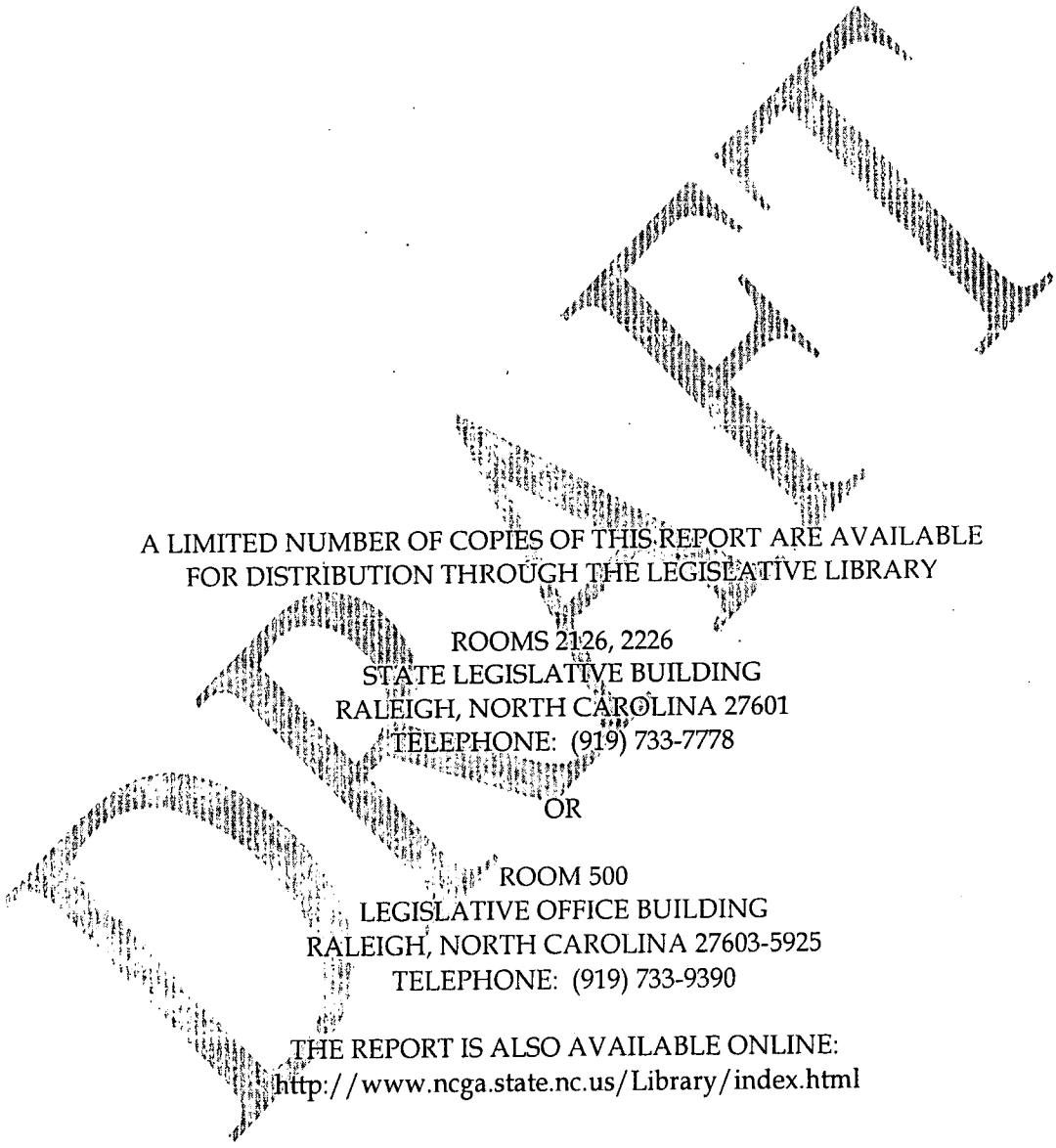
16. **Implement NC Council on Developmental Disabilities Recommendations on Residential Services for People with Intellectual/Developmental Disabilities.**

Attachment 4

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES



REPORT TO THE 2010 REGULAR SESSION OF THE 2009 GENERAL ASSEMBLY



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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27601

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

May 6, 2010

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, Co-Chair

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DRAFT

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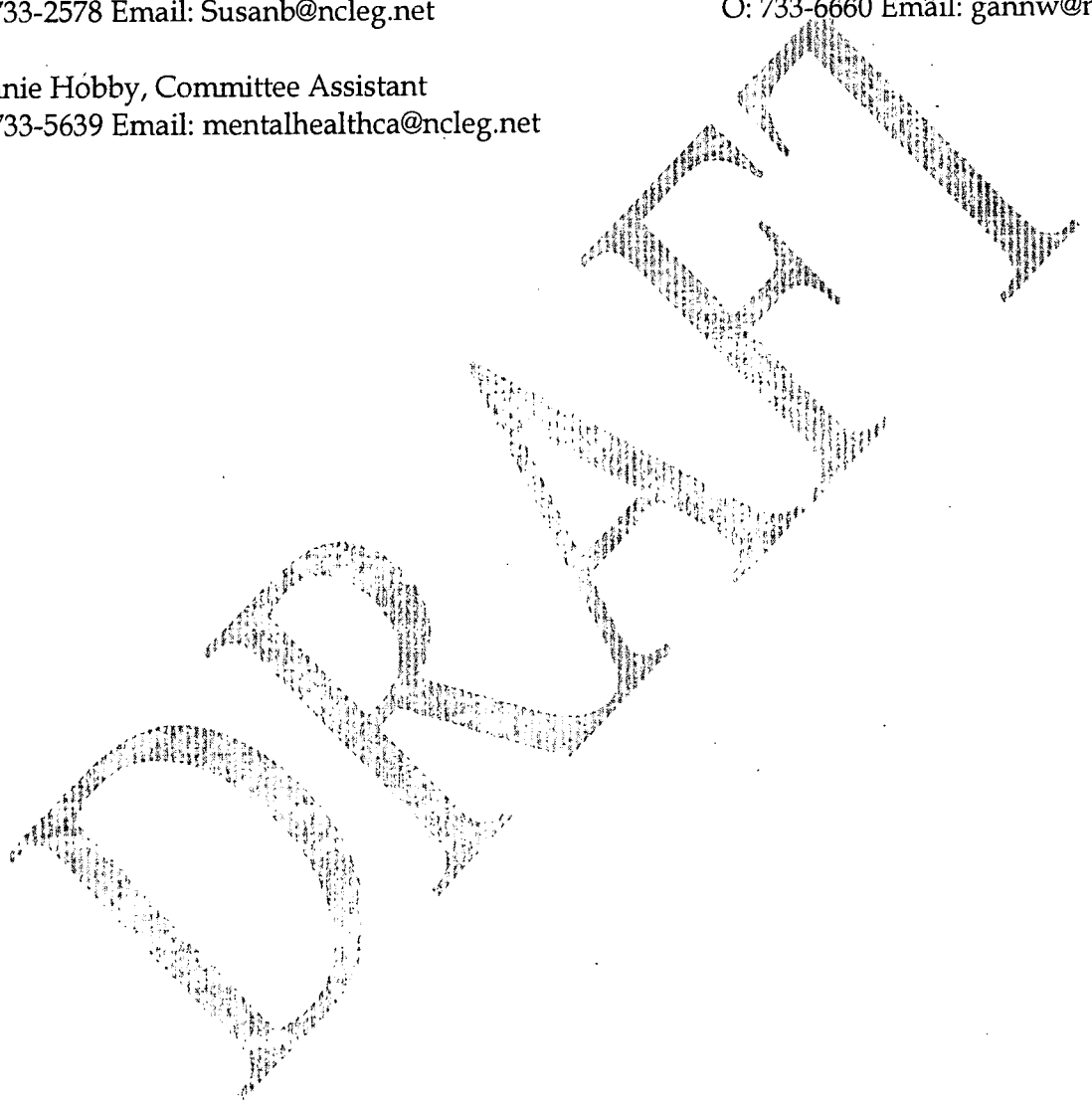

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The LOC consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the LOC. The Co-Chairs for 2009-2010 are Senator Martin Nesbitt and Representative Verla Insko.

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DRAFT

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met nine times during the 2009-2010 interim. The LOC heard from the individuals listed below during the specified meeting dates. Detailed minutes and information from each LOC meeting are available in the Legislative Library.

September 23, 2009

- Lisa Hollowell, Fiscal Analyst, Fiscal Research Division and Shawn Parker, Legislative Analyst, Research Division provided an overview of 2009 legislative actions.

- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services response to budget cuts and enacted legislation from the 2009 Session.

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, discussed the status of community support services.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented an overview for the transition of community support services.

- Lanier Cansler, Secretary, Department of Health and Human Services spoke briefly on the Department's organizational structure.

October 14, 2009

- Lanier Cansler, Secretary, Department of Health and Human Services provided an update on the budget reductions to the health care system required by the Legislature.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the transition of Level III and Level IV group homes across the State.

- Grace Crockett, Director, Mecklenburg Area Mental Health, discussed the impact on Local Management Entities (LMEs) of the Level III and Level IV group home transition.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, responded to concerns over Community Supports and discussed alternative services.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed the expenditures of Community Supports as well as other mental health services within the Medicaid budget.

- Dr. Melissa Johnson, Ph.D., Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative, requested that the LOC consider funding a study by the North Carolina Institute of Medicine to determine mental health needs for young children and effective strategies for serving this population.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the status of the Community Alternatives Program Supports and Comprehensive Waivers.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, discussed the consolidation of Case Management as directed by the General Assembly.

November 10, 2009

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the Department's perspective on the Local Management Entities (LMEs) funding reductions.

- Rhett Melton, Director of Pathways LME, gave a presentation on budget reductions at the community level.

- Lanier Cansler, Secretary, Department of Health and Human Services, discussed Critical Access Behavioral Health Agencies ability to ensure flexibility for providers while still controlling costs.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented information about former Thomas S. class members including funding and services offered.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the funding changes for Community Alternatives Program waivers.

- Curtis Venable, Pisgah Legal Services, discussed concerns about the mental health system.

- Kathy Crocker, State Consumer and Family Advisory Committee, presented the results of a survey sent to Local Consumer and Family Advisory Committees as well as recommendations for the Secretary of Health and Human Services and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, discussed the organizational structure of the new Division and the State psychiatric hospitals.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, gave an update on local inpatient psychiatric community hospital contracts.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed follow-up questions on Case Management from the October LOC meeting.

December 9, 2009

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, provided an update on Medicaid utilization and expenditures.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed the Critical Access Behavioral Health Agency (CABHA) and the changes to provider qualifications.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided a report on Community Support services with other enhanced services.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, responded to questions from the last LOC meeting regarding Case Management for people with developmental disabilities.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided an update on Residential Level III and Level IV Group Homes and Private Psychiatric Residential Treatment Facilities (PRTF).

- Flo Stein, Chief, Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, gave an update on substance abuse treatment and recovery – Cross Area Service Program (CASP).

January 13, 2010

- Barry Boardman, Fiscal Analyst, Fiscal Research Division, presented an overview of revenue projections.

- Lee Dixon, Fiscal Analyst, Fiscal Research Division, provided an update on the Medicaid budget shortfall.

- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill, discussed the Critical Access Behavioral Health Agencies model from the perspective of a psychiatrist.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the system vision for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the next two years.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed follow-up questions on Critical Access Behavioral Health Agencies from the December LOC meeting.

- Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project.

- Members of the audience were recognized for a period of public comment.

February 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on various mental health issues.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Supports Services, Targeted Case Management, Community Supports Team, and Intensive In-Home Services.

- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, addressed plans for implementation of the Community Alternatives Program Supports and Comprehensive Waivers.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the establishment of the developmental disabilities waiting list.

- Dr. Graigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided information on the demographics of recipients and providers participating in the Medicaid program.

- Michael Lancaster, Chief of Clinical Policy, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on telemedicine, the outpatient commitment process, and mobile crisis teams.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the North Carolina

Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC-START).

- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, provided an update on Alcohol and Drug Abuse Treatment Centers (ADATCs).

March 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on current issues related to funding programs within the Department.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided details on expanding the 1915(b)(c) Medicaid Waiver to other LMEs.

- Dan Coughlin, Area Director/CEO, PBH and Pam Shipman, Chief Operations Officer, PBH, gave a presentation on the 1915(b)(c) Medicaid Waiver from the LMEs perspective.

- Arthur Carder, CEO, Western Highlands Network; Jennifer Webe, Executive Director, Access II Care of Western North Carolina; and Dr. Richard Hudspeth, Medical Director, Access II Care of Western North Carolina, gave a presentation on Community Care of North Carolina (CCNC) and LME integrated care.

- Joel Corcoran, Director of the International Center for Clubhouse Development (ICCD), discussed the structure and services the Clubhouse model provides.

- Charlene Lee, Club Nova member, discussed the positive effect that Club Nova, an ICCD Certified Clubhouse model, has had on her life.

- Sue Estroff, Ph.D., Department of Social Medicine, School of Medicine, University of North Carolina at Chapel Hill, explained the need for a Clubhouse specific service definition.

- Rob Lamme, Consultant, former Director of Government Relations, Department of Health and Human Services, presented a proposal for the North Carolina Mental Health Policy and Practice Hub.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, reported on Case Management consolidation.

- Andrea Stevens, Services Task Team, State Consumer Family and Advisory Committee (SCFAC), discussed efforts focused on service gaps and underserved populations.

- Carl Noyes, State Consumer Family and Advisory Committee representative, expressed concern that services provided by Critical Access Behavioral Health Agencies would not be available in less populated areas of the State.

- David Cornwell, Executive Director, North Carolina Mental Hope, discussed the need for collaboration between consumers and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

April 14, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on various Department goals for the upcoming fiscal year.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on implementation and monitoring of the Critical Access Behavioral Health Agency model, including pending requests to CMS regarding a six-month transition period for existing providers.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Support Team, Individual and Group Community Support Services for Children and Adults, Targeted Case Management, Intensive In-Home Services, and Child and Adolescent Day Treatment Expenditures.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, and Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings, presented an overview of the Medicaid recipient appeal process;

reported on the activities, progress, and effectiveness of the appeal process; and made recommendations concerning the appeal process.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on three-way local inpatient psychiatric community hospital contracts.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, provided information on Psycho-social Rehabilitation and Clubhouse Services in North Carolina and gave a brief comparative overview of clubhouse programs in other states.

- Ms. Wainwright also reviewed and compared the structure, services and financial components of current North Carolina CAP-MR/DD Waivers, the PBH Innovations Waiver, and the new NC Innovations Waiver.

- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill,

- Dr. Patricia Porter, Consultant to the LOC, reviewed reports currently submitted to the LOC and made recommendations about requiring new reports and modifying or eliminating existing reports.

May 6, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on ...

- John Agosta, Ph.D., Vice President, Human Services Research Institute, reviewed a report on DD Residential Services entitled "Where Does NC Stand? A Comparison of Medicaid-Funded Residential Service Trends, National and in North Carolina for People with Intellectual and Developmental Disabilities, 1998-2008."

- Shawn Parker, Legislative Analyst, Research Division, provided information about term limits for county managers serving on area boards.

- LOC staff presented a review of the LOC's draft report; the LOC adopted the report as amended.

INTRODUCTION

The basic tenant of Mental Health Reform, enacted in S.L. 2001-437, is that consumers are best and most effectively served when the services they need are delivered in a community setting. Moreover, the system must be:

- participant-driven
- prevention-focused
- recovery-oriented
- State directed and locally managed
- cost-effective
- based on recognized best practice treatments, and self-determination of outcomes.

Every year since 2001, the General Assembly has enacted legislation to support the reform and restructuring of the State's system for delivering MH/DD/SAS services. These reform efforts have aimed to increase local management of the system, decrease reliance on State institutions, encourage the use of community-based best practice treatments, increase consumer involvement in the system, allow access to a range of qualified providers, and hold system providers and managers accountable to both State and local government. Through provisions it has enacted, the General Assembly has directed the Secretary of the Department of Health and Human Services (Department) and the Division of MH/DD/SAS (Division) to administer the system's reform. Oversight of reform efforts has been provided by the General Assembly and its Joint Legislative Oversight Committee on MH/DD/SAS (LOC).

The General Assembly of the 2009 session faced decreased revenues and was forced to make significant reductions to state agencies' budgets, including the Division and Division of Medical Assistance (DMA) that resulted in less services for individuals. Significant budget reductions included:

- -$40 million in state funded services nonrecurring for each year of the biennium,
- Elimination of Community Supports services,
- -$16 million of state funds that was used to supplement the Community Alternatives Program waiver, and
- Reduction in size for children's group homes; no more than 16 children may be served at any one group home for level III and level IV care.

However, the General Assembly honored an LOC recommendation and increased the funding for the State, Local Management Entity, and community hospital "Three-Way Contracts" by $12 million, raising the total funds in this initiative to $20 million.

At LOC meetings, members heard from the Division and local entities on how the reductions impacted their agency and local services. Within this report, the 2010 LOC has recommended restoring some funding for services.

The LOC also focused a great deal of its attention this interim on Critical Access Behavioral Health Agencies (CABHAs). CABHAs are a new designation of provider agency which the Department has begun to implement with the goal of ensuring that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services, and with an effort to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment. The federal Centers for Medicare and Medicaid Services has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA). Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

Reform of the State's public system for individuals in need of mental health, developmental disabilities, and substance abuse services is a monumental undertaking. It has requires enormous effort at the State and local levels with support and input by consumers, families, and providers. While the target is dynamic, significant mechanisms of reform are in place and others are scheduled for implementation in the very near future. The LOC continues to monitor reform implementation and reports its findings and recommendations to the General Assembly.

COMMITTEE FINDINGS AND RECOMMENDATIONS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) makes the following recommendations presented in this section to the 2010 session of the 2009-2010 General Assembly. Many recommendations are followed by additional background information. Corresponding legislative proposals appear in the appendix of this report.

Restoration of LME Community Service Funds

The LOC recommends the General Assembly appropriate $40 million for community services for FY2010-11 and that these funds be allocated to LMEs based on the amount of reduction LMEs received resulting from the $40 million nonrecurring reduction planned for FY2010-11.

The total reduction made by the General Assembly for the services managed through the LMEs was $60M for FY 2009-2010 and FY 2010-2011. A $40M reduction for the non-disability specific general service fund; a $16M reduction of services supplementing the CAP-MR/DD waiver package; and a $4M reduction of services identified as "non-core" to the mission of the Division of MH/DD/SAS. There was an additional 5% reduction ($15M) of the services administered through the LMEs but that money was reinstated by the Governor.

On November 10, 2009, Mike Watson reviewed, for the LOC, last year's LME budget reductions, including how funds were allocated to LMEs, how LMEs reduced their budgets, the effect of the reductions on fund balances, and the impact on services. Rhett Melton, Director of Pathways LME, discussed budget reductions at the community level. Pathways experienced a net loss of $4.6M, which is equal to a 26% reduction of State funds for the LME. Expressed concern over gaps that already exist and the impact of the elimination of additional services, and noted that there was no way to continue same level of care as in the past with 26% less funding.

Support Initiatives to Strengthen LMEs

The Department is encouraged to continue to expand the number of LMEs implementing 1915(b)(c) Medicaid waivers.

During the FY2009-10 interim, the LOC heard from Piedmont Behavioral Health and its success with the Medicaid waiver. The Department has received approval from CMS to add additional LMEs; the Department issued an RFP for interested

LMEs and is currently evaluating those applications. The tentative start up for adding LMEs in the waiver program is January 1, 2011.

The Department is encouraged to return Utilization Management functions to LMEs.

LMEs' core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor, which is Value Options. The 2008 General Assembly directed the Department to return utilization management to LMEs representing at least 30% of the State's population. Currently, there are two LMEs (Durham and East Point) willing to take on this responsibility. Beginning in September 2010, it is expected that these two LMEs will assume utilization management of Medicaid services.

The Department is encouraged to promote Single Stream funding for LMEs

There are currently 17 single stream funded LMEs of the 23 total programs. The use of single stream funding allows LMEs to set and fund community priorities. With single stream funding, the designated streams of funding lose their identity and may be used for any mental health, developmental disabilities, and substance abuse services as needed. In addition, the LMEs receive advance funding for purchase of services, negotiation of contracts, pay providers, and then file "shadow claims" to the Division.

Fund a Leadership Academy for LME Managers

The LOC recommends that of the funds appropriated to the Division for the 2010-2011 fiscal year, up to five hundred thousand dollars ($500,000) should be used to support development of a mental health leadership academy that provides professional development to local management entities

In FY2008-09, the Division funded a leadership academy at UNC's Kenan Flagler Business School. This initiative utilized the Business School's statewide initiative to train senior LME staff, Division staff, and community partners. The training provided resources and expertise to the LMEs to help manage money, people, information, and partnerships. In FY2009-10, there was not funding to continue the program. The LOC recommends funding the program for FY2010-11.

LME Independent Assessment Pilot

The LOC recommends the Department establish a pilot project within 4 local management entities for the purpose of evaluating the cost and program efficacy of the independent assessment of individuals in or applying for service for the purpose of determination of their eligibility and need for IPRS enhanced services.

The Department shall select at least one LME with UM responsibility and at least one without will be selected and these programs will establish a process for the assessment of individuals which is independent of the delivery of these services. Two additional LMEs, one with UM responsibility and one without shall be selected to serve as matches for the pilot sites for population size, rural/urban, numbers of persons currently in IPRS enhanced services. These LMEs will continue to provide these assessments without regard to the independent status of the assessor. All assessment delivery activities should be as close to identical as possible except for the independence of the assessment professional. The Division shall provide the LOC with a plan for the implementation of this pilot on or before October 1, 2010 and shall report its findings on or before October 1, 2011.

Data from the pilot shall include, for each site:

- numbers of persons assessed per site,
- numbers of persons recommended for enhanced services with a listing of those services,
- any costs associated with independent assessment,
- changes in utilization of IPRS enhanced services in pilot sites from non-independent

Funds for Local Hospital Three Way Contracts

The LOC recommends the General Assembly appropriate an additional $12 million for the expansion of local inpatient psychiatric beds to allow purchase of an additional 50 beds out in the community.

General Assembly appropriations over the past few years have increased the resources available for in-patient community care to $20 million. There are many benefits of community-based care including ameliorating the demand on expensive State hospital usage. Because Medicaid will not pay for inpatient care at a stand-alone psychiatric hospital for consumers aged 18-64, research by the North Carolina General Assembly's Program Evaluation Division indicates that the State pays 81% of the cost of care for adults in State hospitals, but only 41% of the cost of community-based care.

It is the State's policy that beds in the three State-run psychiatric hospitals are intended for longer-term admissions for consumers who cannot be adequately or safely treated in the community, including in community general hospitals with psychiatric beds. With the increase of community-based beds, the shorter term needs can now be handled within the communities.

Implementation of the Tiered CAP/MR-DD Waiver Program

The LOC encourages the Department to continue to implement the tiered CAP-MR/DD waiver system.

The 2008 General Assembly directed the Department to develop and implement four CAP-MR/DD tiers. The primary purpose of a tiered CAP-MR/DD waiver system is to assure that individuals receive the services they need at the intensity level required to fully participate in everyday activities. The Department reported to the LOC that it has developed and implemented Tier 1 and Tier 4 and a plan to develop and implement a third tier containing two levels. Each tier represents an array of services reflecting intensity and complexity of service need. There has been no plan provided by the Department on the critical formula or tool to be used to determine how waiver recipients will be deemed eligible for each of these tiers/levels.

Supports Intensity Scale Evaluations

The LOC recommends requiring all DD consumers within the 7 region pilot catchment areas to undergo a Supports Intensity Scale (SIS) evaluation and directing the Department to develop and utilize a mechanism to employ the results of the SIS as the basis for assigning those individuals to CAP waiver tiers and other services according to each individual's relative intensity of need.

The Department began implementation of a pilot project in 2008 to administer the Supports Intensity Scale (SIS) to a set of individuals with developmental disabilities residing within seven (7) local management entities. The purpose of the SIS is to measure the intensity of an individual's needs in critical areas resulting in specific information that can assist in identifying the unique strengths and support needs of that individual. The SIS was specifically designed to assess support needs, determine the intensity of needed supports, monitor progress, and evaluate outcomes of adults with intellectual and developmental disabilities

The SIS is not yet being administered to all persons with DD in the pilot LMEs and there is no data reported on its use in determining level of needs, particularly in the CAP-MR/DD waiver program and other services.

CABHA Implementation and Certification Process

The LOC recommends the Department consider and seek approval for a three to six month extension of the transition period for full implementation of the CABHA model in order to ensure that client access to an array of appropriate clinical services is not disrupted, and to provide additional time for small providers to gain CABHA accreditation.

In addition, the LOC recommends that the General Assembly direct the Division to develop a plan for modifying the CABHA certification process in order to ensure that newly-certified CABHA providers are able to enter and participate in the CABHA network. The Division should submit a report on the modification plan to the LOC and the Fiscal Research Division not later than October 1, 2010.

The Department reported to the LOC that it has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA). Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

The main implementation goals of the CABHA model, as expressed by Mr. Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, are to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services; and to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.

At the December, January, and April LOC meetings, Mr. Watson explained the three-step CABHA certification process. First, a provider must submit an attestation letter with documentation evidencing the provider's ability to meet basic certification requirements, namely:

- Delivery of three core services: comprehensive clinical assessment, medication management, and outpatient therapy;
- Delivery of at least two enhanced services in the same location where it provides the three core services to create a continuum of care;
- Active National Accreditation of at least 3 years;
- A Full-Time or Part-Time Medical Director, depending upon the number of consumers served (100% FTE for providers serving more than 750 consumers - 60% billing; 50% FTE for providers serving less than 376 - 749 consumers - 60% billing; 8 hours per week - 0 - 375 consumers - no billing)
- A Full-Time Clinical Director
- A Full-Time Quality Management/Staff Training Director

Second, the provider must undergo a desk review of the letter of attestation and supporting documentation, which is conducted by DMH/DD/SAS, in collaboration with DMA and DHSR staff, and verified by an LME. Third, the provider must undergo an onsite review conducted by DMH/DD/SAS, DMA, and LME staff. The onsite review includes staff interviews of the Medical Director, Clinical Director, Quality Improvement/Training Director, and other provider agency staff as deemed appropriate.

The most controversial aspects of the CABHA model are the requirements that the provider must (i) have active national accreditation for at least three years prior to applying for CABHA certification and (ii) hire or contract a medical director who has education and experience with the population being served. LOC members questioned DHHS about how new professionals could enter the system and provide the array of services offered within the CABHA model if CABHA certification requires three years of accreditation. The Department anticipates that providers will enter the system and become accredited with non-CABHA services and then have an opportunity to become nationally accredited in order to move into CABHA services. LOC members and providers also expressed concern that providers with fewer than 750 cases annually will have difficulty achieving CABHA certification due to the costs associated with hiring or contracting a medical director. While the Department has scaled down the Medical Director requirement for smaller providers, it is still unclear how this requirement will impact the ability of smaller providers to achieve CABHA certification.

Providers that do not achieve CABHA certification will be required to transfer their clients to certified CABHA providers for the five key services that must be delivered within the CABHA structure. LOC members expressed a sense of responsibility for ensuring that the transfer of clients and their medical records to certified CABHA providers is accomplished with minimal disruption to service

delivery and that there are a sufficient number of providers within the CABHA network to give clients State-wide access to key services.

Club House Model Study Rates

The LOC recommends the General Assembly direct DMA, in conjunction with the Division, to examine and, as the Divisions deem necessary, adjust the rates for community support services provided through the clubhouse model of psychosocial rehabilitation.

The Clubhouse Model is a type of psychosocial rehabilitation designed to address the needs of the whole person in his/her recovery from serious mental illness. Supporting psychiatric and healthcare symptom management, the Clubhouses offer vocational supports, community-based employment, education, housing, outreach, advocacy and access to health care and substance abuse services as well as social and recreational opportunities. Using a membership concept, the Clubhouses are founded on the importance of "consumer ownership". Each member shares in the operation of the community center. The Clubhouse model is outcome based and in North Carolina, the Clubhouses work closely with Universities to provide internship sites, collaborative research projects and service integration.

There are currently 85 licensed Psychosocial Rehabilitation providers in the state and 44 of these follow the Clubhouse model. Eight N.C. Clubhouses have received national certification by the International Center for Clubhouse Development having met the ICCD standards.

Psychosocial rehabilitation programs are licensed by the state and must operate 5 days per week for at least 5 hours per day. All PSR programs, including Clubhouses receive funding via Medicaid, receive the same PSR rate which is $2.74 for each 15 minute unit of service.

The NC ICCD Clubhouse Coalition presented to the LOC in March and noted that they were sustainable with the additional delivery of Community Support Services. With the elimination of the opportunity to draw down funding for Community Support services, these programs report that they are in jeopardy of closure due to the very low rate for the expansive services they provide. Members of the LOC noted that they support the Clubhouses and acknowledge the importance of the services they provide.

NCIOM Study Childhood Mental Health Services in North Carolina

The LOC recommends that the General Assembly continue recurring funds to the NCIOM in order to continue the work of the Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group.

In addition, the LOC recommends that the General Assembly direct the NCIOM to conduct a study of the needs of children from birth to age five and their families. The NCIOM may submit an interim report of its findings and recommendations to the LOC by January 15, 2012, and shall submit a final report of its findings and any recommended legislation to the LOC on or before the convening of the 2013 General Assembly.

In Section 10.78.(ff) of S.L. 2009-451, the General Assembly appropriated $250,000 from the Substance Abuse Prevention and Treatment Block Grant to the Division for the 2009-2010 fiscal year for the NCIOM to do all of the following:

- Study the availability of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds that are currently available to active duty, reserve, and veteran members of the military and National Guard. NCIOM was also directed to determine any gaps in services. The Task Force provided an interim report to the 2010 Session of the General Assembly. A final report is due from this Task Force to the General Assembly during the 2011 Session. Section 10.78.(ff)(1).

- Continue the work of the Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and also to monitor federal health-related legislation to determine how the legislation will impact costs, quality, and access to health care. Section 10.78.(ff)(2).

- Study short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness. Section 10.78ff(3) of S.L. 2009-451. In its Interim Report, the Task Force reported that its main focus will be on: (1) The problems created by the co-location of different populations in adult care homes; (2) how to appropriately identify/screen people for behavioral health disorders; (3) the training of adult care home staff; and (4) other options to ensure those with mental illness, behavioral health problems, the frail elderly, and others with disabilities are receiving appropriate care. Section 10.78.(ff)(3).

The Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group have all issued Interim Reports on the above-referenced studies. However, additional funding is necessary in order for the Task Forces to complete their work and, at the direction of the General Assembly, issue final reports with findings, recommendations, and suggested legislation to the 2011 General Assembly upon its convening.

During the LOC meeting on October 14, 2001, the LOC was made aware of one additional area of study for the NCIOM. Ms. Sarah Sabornie, Coordinator of the Young Child Mental Health Collaborative of Wake County, presented information concerning the unique needs of children from birth to age five with mental health issues. Ms. Sabornie stressed the need for early identification and intervention in order to accomplish cost-effective treatment and remediation of mental health issues in this population. In addition, she emphasized the need to integrate, collaborate, and support the resources of each State agency or system to address the mental health needs of those children. Toward that end, she requested, on behalf of the Young Child Mental Health Collaborative, that the NCIOM conduct a study to examine the needs, strengths, and resources of the service systems throughout the State as they affect the mental health of our birth to five population; to evaluate potential use of research-based interventions; and to make recommendations for moving forward with limited resources.

Support Regionally-Purchased Locally-Hosted Substance Abuse Services

The LOC recommends that the General Assembly direct the Department to continue allocating substance abuse funds for regionally-purchased, locally-hosted substance abuse programs at the same level.

The budget for the 2009-2010 fiscal year did not appropriate any additional funds for regionally-purchased, locally-hosted substance abuse services (often called Cross Area Service Programs, or CASP). However, CASP was one of the few areas spared from budget reductions and, according to information provided by the Department, received about $40.8 million for services. During the LOC meeting of December 9, 2001, Ms. Flo Stein, Chief of the Community Policy Management Section in the Division, reported to the LOC that CASP funds were used to establish new programs to (i) increase adult substance abuse comprehensive community treatment capacity and supportive housing services; (ii) increase adolescent substance abuse comprehensive community treatment capacity and residential program services; (iii) increase community capacity for substance

abuse prevention coalitions; (iv) increase community capacity for substance abuse services specific to pregnant women or women with children utilizing gender-specific treatment; and (v) develop expanded residential substance abuse programs. As further evidence that CASP is an appropriate and effective use of substance abuse dollars, the Division reported that a model CASP piloted in North Carolina has been identified as a national model in versions of health reform regarding how to provide addiction services.

Expand and Extend the First Commitment Pilot Program

The LOC recommends the General Assembly authorize the Secretary to extend and expand the first commitment pilot program, direct the Department to establish continued training for current certified providers, direct the Department to utilize the Stakeholder group to examine the participation rates by each "waived" masters level health care professionals area, and determine if this should be expanded or reduced based on scope of practice and report any findings to the LOC.

Pursuant to Section 1.1(b) of S.L. 2007-504, the LOC recommends extending the First Commitment Pilot Program through October 1, 2012 and to authorize the Secretary to grant a waiver to up to 20 LMEs. The LOC further recommends directing the Department to expand its standardized training program to include refresher training for all certified providers, and to study participation rates by provider practice area and determine how the services are within each professional's scope of practice and whether this group should be expanded or reduced, and report any findings to the LOC not later than April 1, 2012.

In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation allowed the Secretary to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. Under the Pilot Program, the Secretary could grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs, "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary." The Appropriations Act of 2006 extended the pilot by 1 year. In the Fall of 2006, the Department made a presentation and report to the LOC on the pilot in which it recommended that it be made permanent and extended Statewide. The LOC recommended and the General Assembly enacted in S.L. 2007-504 a three-year extension and authorized up to five more LMEs. In 2009, the Secretary was authorized in S.L. 2009-340 to expand the program to 15 LMES.

On January 13, 2010, Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project. The Division's recommendation to the LOC was that the waiver be continued and expanded statewide, since the pilot project indicates that licensed clinical social workers and licensed clinical addictions specialists who are properly trained, tested and certified, would make decisions similar to those made by psychologists, physicians, and psychiatrists.

Questions were raised after the report relating to whether the program can be expanded to include other properly trained health care professionals and to what extent the current "waived" professionals participate at the first evaluation stage, and whether there are training needs of currently certified evaluators.

Medicaid Appeals Process Changes

The LOC recommends the General Assembly make the temporary Medicaid appeals process for Medicaid applicants and recipients permanent and codify the process in Chapter 108 of the General Statutes. The LOC further recommends the General Assembly direct the Office of Administrative Hearings (OAH) to continue to collect statistics on these appeals and to provide more information as to the outcome of settled and withdrawn cases as well as incidences of DMA reversing an Administrative Law Judge's decision and report the results and any recommendations to the LOC on or before October 1, 2011.

The Office of Administrative Hearings (OAH) processes all appeals of contested Medicaid cases commenced by Medicaid applicants or recipients. OAH began to experience a significant backlog of cases due in part to adverse actions consumers and provider experienced relating to changes to Community Support services. As reported to the LOC in 2007, there were 2, 291 total cases; in 2008 there were 3,717 cases; and in 2009 there were 6,693 cases. The Department and OAH were directed by S.L. 2008-107 to work together to streamline the process for hearing Medicaid recipient appeals.

SL. 2008 -107, as amended by S.L. 2008-118 and S.L. 2009-526, established a temporary appeals process for Medicaid applicants and recipients who have been denied, terminated, suspended, or have had benefits reduced. Some of the major tenants of the temporary process are as follows:

- 10 days prior to the effective date of an adverse action, the Department shall provide proper notice and notice shall be as "user friendly" as possible.
- During the appeal an appellant has a right to services at the level or manner prior to the appeal.
- OAH must hear cases with 55 days of appeal.
- Hearings shall be conducted telephonically or by video conference, unless the appellant requests an in-person hearing. In-person hearings are to be in Wake County, but can be moved to the appellant's county of residence upon good show of cause.
- Prior to the hearing before the administrative law judge, mediation must be offered to the recipient. If mediation is successful, the mediator must indicate this outcome to the administrative law judge. If mediation is unsuccessful, the administrative law judge must hear the case and make a determination.
- The petitioner may submit evidence obtained prior to and subsequent to the Department's action.
- Provides that in each adverse action the hearing shall determine if the Department substantially prejudiced the rights of the appellant by exceeding its authority, acting erroneously, failing to use proper procedure, acting arbitrarily or capriciously, or failing to act as required by law.

On April 14, 2010, Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings (OAH), presented an overview of the Medicaid recipient appeal process. Judge Mann recognized the coordination and cooperation of different agencies in developing a process that is working successfully. He credited mediation with giving those without representation an opportunity to have resolution with 80% of the mediated cases being settled and said this was accomplished within 25 days. As of March 1, it was reported that OAH expended $1,409,201 in personnel, mediation services and operational costs at the same time the savings for the State as result of the process was almost twenty times the amount. OAH recommended to the LOC that the process should become permanent as it has been successful in achieving a desired result of having individuals able to file their appeal, receive the opportunity for mediation, and have their appeal heard and decided in an efficient and timely manner. OAH also requested funding to continue the mediation process and funding for additional personnel.

County Managers Term Limits on Area Mental Health Boards

The LOC recommends the General Assembly exempt county managers who serve on area mental health boards from term limits while employed in that capacity.

G.S. 122C-117(b) provides that the governing unit of the area authority (LME) is the area board. All powers, duties, functions, rights, privileges, or immunities conferred on the area authority may be exercised by the area board.

S.L. 2006-142 made changes to the structure of an area board by requiring at least 2 of the members have financial expertise and not more than 50% of the members can be consumers, family members, or advocates. It also limits board terms to members other than county commissioners to 3 years and 2 consecutive terms. A rationale for exempting county commissioners from term limits was the concern over replacing a county commissioner whose term in elected office exceeds the term limit on Area Board Members. Since county managers work at the pleasure of the county commissioners, the same concern could be found for county managers who serve on area boards.

On May 6, Shawn Parker made a brief presentation to the LOC on the last major change to the structure of area boards and offered an option of statutory change for the LOC to consider addressing the concerns of county managers who serve on area boards.

Implement Report Review Recommendations

The LOC recommends the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports:

- By January 1, 2011, the Department shall report on the status of Community Support Services to include numbers of individuals no longer receiving any service, numbers moved to other services with a list of those services and numbers for each, cost increases and decreases and projected cost savings. Status of new service definitions (e.g. peer supports)
- By September 1,2010, the Department shall report on deaths that have occurred within in state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning 10-1-10, the Department shall provide status report on the expenditures and balance in the Mental Health Trust Fund

- Annually, beginning January 1, 2011, the Department shall report on the strategic plan regarding how state and local resources shall be organized and used to provide services. Included will be criteria for the allocation of dollars, restrictions on how these dollars may be used, guidelines for utilization of funds and list of expenditures.
- Annually, beginning May 1,2011, the department shall collect and report on LME fund balances.
- By January 1, 2011, the Department shall report on the status of the implementation of the CAP-MR/DD Tiered Waiver to include mechanism for determination of assignment into each of the tiers for both new and current CAP recipients, movement from one tier to another, and cost impact.
- Biannual report beginning January 1, 2011, the Department shall report on Statewide System Performance to include the following criteria:
    - Access to Services
    - Individualized Planning and Supports
    - Promotion of Best Practices
    - Consumer-Friendly Outcomes
    - Quality Management Systems
    - System Efficiency and Effectiveness
    - Equitable Allocation of Resources
    - Prevention and Early Intervention
    - Statewide System of Crisis Response for Adults and Children
    - Management of the Utilization of State Facilities
- Semi-Annual report due on September 1 and April 1, beginning September 1,2010, the Department shall report on the uniform system of beds or bed days purchased (i) with local funds;(ii) from existing state appropriations,(iii) under the hospital utilization pilot, and (iv)under three-way contracts

In support of and cooperation with the Department of Health and Human Services in their efforts to streamline reporting, a review was conducted of the complete catalog of reports required to be submitted to the LOC from 2006-2010. A review was made of the Session Law that provided the source of the direction for these reports and determination was made for each of these reports of the need for continuation, end, change in frequency of periodic reportage or requirement for a new report request.

A total of 165 reports were reviewed and 22 of these were discovered to be in need of some change. These recommendations were provided to the members of the LOC for review and comment. The Recommendation above reflects the list of reports in need of new and/or revised language.

Implement NC Council on Developmental Disabilities Recommendations on Residential Services for People with Intellectual/Developmental Disabilities.

On May 6th, Dr. John Agosta made a presentation to the LOC on the provision of Medicaid-funded residential services for people with intellectual and developmental disabilities in the State, along with comparisons to the national trends. Major findings of the report are as follows:

North Carolina furnished Medicaid-funded services (Home and Community Based Services - HCBS and Intermediate Care Facilities for People with Mental Retardation - ICFs/MR) to 13,876 individuals in 2008. This equates to 150 people per 100,000 in the general population, which is below the national average of 203 per 100,000.

The number of individuals served in large, state-operated facilities, which are routinely operated as ICFs/MR, has been declining for the past several decades. In the decade 1998-2008, the rate of decline was 32% nationally, and 20% in North Carolina. Typically, these services are the most costly that a state provides, averaging over $500/day/resident nationally, and $481 in North Carolina.

While North Carolina has reduced the number of individuals in these facilities, it has done so at a slower pace than the national average, and continues to have a significant number of people living in them (approximately 1,650 people for the past several years).

In this time period, the number of people in ICFs/MR in North Carolina fell by 11% overall and 28% with respect to the State population, which is consistent with the nationwide trend. In 2008, however, about 45% more people were served in ICFs/MR in North Carolina relative to population than nationwide (45 per 100,000 in North Carolina compared to 31 per 100,000 nationwide).

In 2008, North Carolina spent $919.8 million (of which $588.7 million was paid to the State by the federal government, for the provision of these services) for ICF/MR and HCBS waiver services. Support was provided to 14,362 people at an average annual cost of $66,279 per person served (compared to the national average of $55,433 per person), with the difference in cost possibly attributable partly to North Carolina's heavier use of more costly ICF/MR services.

APPENDIX

Copies of the proposed legislation begin on the following page.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-106 [v.5] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 1:31:20 PM

Short Title:	Restore State-Funded LME Services.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RESTORE STATE-FUNDED SERVICES PROVIDED THROUGH LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of forty million dollars ($40,000,000) for the 2010-2011 fiscal year. These funds shall be used to increase the amount of State service dollars allocated for State-funded services provided through local management entities (LMEs). The amount of State service dollars allocated to an LME pursuant to this section shall be (i) identical to the amount by which State service dollars were reduced on a non-recurring basis for that LME during the 2009-2010 fiscal year, and (ii) used by the LME only to restore State-funded services provided by the LME prior to enactment of the budget reductions for the 2009-2010 fiscal year.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

BILL DRAFT 2009-MGz-107 [v.8] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 12:55:30 PM

Short Title:	Develop MH Leadership Academy for LMEs/Funds.	(Public)
Sponsors:	Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR DEVELOPMENT OF A MENTAL HEALTH LEADERSHIP ACADEMY TO PROVIDE PROFESSIONAL DEVELOPMENT OPPORTUNITIES FOR LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the 2010-2011 fiscal year, up to five hundred thousand dollars ($500,000) may be used to support development of a mental health leadership academy that provides professional development to local management entities, enabling senior LME staff to enhance their leadership and management skills.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-114 [v.1] (05/05)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/5/2010 12:28:03 PM

Short Title:	Pilot Independent Assessments by LMEs.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO IMPLEMENT A PILOT PROJECT TO EVALUATE THE COST AND PROGRAM EFFICACY OF INDEPENDENT ASSESSMENTS FOR INTEGRATED PROGRAM AND REPORTING SYSTEM ENHANCED SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a pilot project within four local management entities (LMEs) for the purpose of evaluating the cost and program efficacy of conducting independent assessments of individuals seeking or receiving services provided through LMEs, in order to determine their eligibility and need for Integrated Program and Reporting System (IPRS) enhanced services. The Department shall select the four participating LMEs as follows:

(1) The Department shall select at least one LME with utilization management responsibilities and at least one LME without utilization management responsibilities. The two LMEs selected pursuant to this subdivision shall establish a process for assessing individuals seeking or receiving services provided through the LMEs that is independent of the delivery of those services.

(2) The Department shall select two additional LMEs, one with utilization management responsibilities and one without utilization management responsibilities, that are comparable to the first two LMEs selected pursuant to subdivision (1) of this subsection in population, demographics, location, and number of individuals currently enrolled in IPRS enhanced services. The LMEs selected pursuant to this subdivision shall assess individuals seeking or receiving services provided through the LMEs without regard to whether the professional conducting the assessment is independent from the delivery of those services.

All assessments conducted by LMEs participating in the pilot project should be as close to identical as possible, except for the independence of the professional conducting the assessment.

SECTION 1.(b) The Department shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services an interim report on the implementation plan for the pilot project authorized by Section 1.(a) of this act by October 1, 2010, and a final report on the pilot project by October 1, 2011. In addition to the Department's findings and recommendations, the final report shall include all of the following information:

(1) The number of clients assessed at each pilot site.

(2) The number of persons recommended for enhanced services at each pilot site, along with a listing of those services.

(3) Any costs associated with independent assessment, broken down by each pilot site.

(4) Comparative data on utilization of IPRS enhanced services in pilot sites conducting independent assessments and pilot sites conducting non-independent assessments.

(5) Comparative costs among the four pilot sites.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-113 [v.2] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 2:50:37 PM

Short Title:	Expand Inpatient Psych. Bed Capacity/Funds.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE EXPANSION OF LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.12.(b) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.12.(b)** Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of twenty million one hundred twenty-one thousand six hundred forty-four dollars ($20,121,644) for the 2009-2010 fiscal year and the sum of ~~twenty million one hundred twenty-one thousand six hundred forty-four dollars ($20,121,644)~~ thirty-two million one hundred twenty-one thousand six hundred forty-four dollars($32,121,644) for the 2010-2011 fiscal year shall be allocated for the purchase of local inpatient psychiatric beds or bed days. ~~These beds or bed days shall be distributed across the State according to need as determined by the Department.~~ The Department shall work to ensure that these beds or bed days are distributed equitably across the State. The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the

purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient services under contract with community hospitals, including beds or bed days being purchased through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. ~~Not later than March 1, 2010, the~~ Beginning September 1, 2010, the Department shall report semiannually to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection."

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-105 [v.7] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/5/2010 1:21:09 PM

Short Title:	Modify CABHA Certification Process.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON A PLAN FOR MODIFYING THE CERTIFICATION PROCESS FOR CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall develop a plan for modifying the current certification process for Critical Access Behavioral Health Agencies (CABHAs) in a manner that will ensure new provider agencies are able to enter and participate in the CABHA network. The Division shall submit a report of the modification plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division not later than October 1, 2010.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

BILL DRAFT 2009-MGz-110A [v.3] (05/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 12:04:41 PM

Short Title:	Examine And Adjust Rates/Clubhouses.	(Public)
Sponsors:	Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, IN CONSULTATION WITH THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, TO EXAMINE AND ADJUST THE RATES FOR SERVICES PROVIDED THROUGH THE CLUBHOUSE MODEL OF PSYCHOSOCIAL REHABILITATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall examine and, as the Divisions deem necessary, adjust the rates for community support services provided through the clubhouse model of psychosocial rehabilitation. The Department shall report on any adjustment in rates to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than October 1, 2010.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

BILL DRAFT 2009-MGz-86 [v.5] (01/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 7:24:00 PM

Short Title:	NCIOM Studies/Funds.	(Public)
Sponsors:	Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE NORTH CAROLINA INSTITUTE OF MEDICINE TO COMPLETE ITS CURRENT STUDIES AND TO ESTABLISH A TASK FORCE TO STUDY THE NEEDS OF YOUNG CHILDREN WITH MENTAL HEALTH PROBLEMS AND THEIR FAMILIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the North Carolina Institute of Medicine (NCIOM) the sum of two hundred fifty thousand dollars ($250,000) in recurring funds for the 2010-2011 fiscal year. These funds shall be used by NCIOM to complete the following Task Force studies authorized in Section 10.78.(ff) of S.L. 2009-451:

(1) The availability of Medicaid and State-funded mental health, developmental disabilities, and substance abuse services to active duty, reserve, and veteran members of the military and National Guard. The study should discuss the current availability of services, the extent of use, and any gaps in services.

(2) The Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and the impact of federal health-related legislation on costs, quality, and access to health care.

(3) Short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness.

SECTION 2.(a) There is appropriated from the General Fund to the North Carolina Institute of Medicine the sum of one hundred fifty thousand dollars ($150,000) for the 2010-2011 fiscal year. These funds shall be used to convene a Task Force to study the needs of young children with mental health problems and their families. The Task Force shall:

(1) Examine the current mental health needs of young children, defined as children from birth to age five.

(2) Examine existing public and private systems of mental health care that are currently available to families of young children with mental health problems.

(3) Identify evidence-based and promising universal, selective and indicated prevention strategies to promote the emotional well-being of young children.

(4) Identify strategies for early screening and identification of young children with mental health risk factors or mental health problems. The screening and identification strategies shall address the impact of parents' behavioral health problems on the mental health of their young children.

(5) Review evidence-based and promising interventions and systems to promote the positive mental health and emotional well-being of young children and their families.

(6) Identify strategies to ensure that children who are at high risk of developing mental health problems and their families have access to a comprehensive range of treatments and services, coordinated across agencies and service systems that are (i) culturally, linguistically, and developmentally sensitive; (ii) individualized; (iii) family-centered; (iv) home, school, and community-based; and (v) evidence-based.

(7) Examine workforce adequacy and training needs of mental health professionals and other professionals who provide services to young children and their families.

(8) Examine the adequacy of state and other funding to support a comprehensive array of evidence-based services.

(9) Recommend strategies to develop, evaluate, and disseminate treatment and service delivery models to meet young children's mental health needs.

(10) Examine any other issue that the NCIOM deems relevant to the study.

SECTION 2.(b) The NCIOM shall make an interim report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than January 15, 2012, which may include legislative and other recommendations, and shall issue its final report with findings, recommendations, and any proposed legislation to the 2013 General Assembly upon its convening.

SECTION 3. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U D

BILL DRAFT 2009-SQz-28 [v.1] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 12:14:09 PM

Short Title:	Extend and Expand First Commit Pilot.	(Public)
Sponsors:		
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, as amended by Section 1.1(a)(5) of S.L. 2007-504, and as further amended by Section 3 of S.L. 2009- 340 reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283, pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the LME shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, 2010.

(5) The Secretary may grant a waiver under this section to up to ~~15~~20 LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires ~~October 1, 2010.~~October 1, 2012.".

SECTION 2. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand it standardized certification training program to include refresher training for all certified providers and shall report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the participation rate of licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist in the pilot program and whether the program should include other licensed or certified health care professionals.

SECTION 3. This act is effective when it becomes law.

DRAFT

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

BILL DRAFT 2009-MGz-108B [v.2] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/5/2010 10:54:55 AM

Short Title:	Establish Medicaid Appeals Process.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PERMANENT APPEALS PROCESS FOR MEDICAID APPLICANTS OR RECIPIENTS AND TO REQUIRE A REPORT ON THE TEMPORARY APPEALS PROCESS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 108A of the General Statutes is amended by adding two new sections to read:

"**§ 108A-70.6A. Appeals commenced by Medicaid applicants or recipients.**

(a) Definitions. – The following definitions apply in this section, unless the context clearly requires otherwise:

(1) "Adverse determination." – A determination by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(2) "Applicant" or "recipient". – This term includes an applicant's or recipient's parent, guardian, or legal representative.

(b) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid applicant or recipient to appeal a determination made by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the applicant or recipient, and the provider, if applicable, in writing of the adverse determination and of the applicant's or recipient's right to appeal the adverse determination. The Department shall not be required to notify an applicant's or recipient's parent, guardian, or legal representative unless the parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the applicant or recipient whose services are being affected by the adverse determination, including full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the applicant's or recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the applicant or recipient can request a hearing and a statement that the applicant or recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the applicant or recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination, or the amount requested by the applicant or recipient, whichever is less, if the applicant or recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the applicant's or recipient's questions.

(9) The telephone number by which the applicant or recipient may contact a Legal Aid/Legal Services office.

(10) The appeal request form described in subsection (e) of this section that the applicant or recipient may use to request a hearing.

(d) Appeals. – Except as provided by this section and section 108A-70.6B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The applicant or recipient must request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by sending an appeal request form to the Office of Administrative Hearings and the Department. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department shall immediately forward a copy of the notice to the Office of Administrative Hearings electronically. The information contained in the notice is confidential unless the recipient appeals. The Office of Administrative Hearings may dispose of the records after one year. The Department may not influence, limit, or interfere with the applicant's or recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the applicant or recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that in order to request an appeal, the applicant or recipient must send the form by mail or fax to the address or fax number listed on the form within 30 days of mailing of the notice.

(2) The applicant's or recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the applicant or recipient would like to appeal the specific adverse determination of which the applicant or recipient was notified in the notice.

(4) A statement informing the applicant or recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the applicant's or recipient's signature and date.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision and record to the Department in accordance with section 108A-70.6B. The Department shall make a final decision in the case within 20 days of receipt of the decision and record from the administrative law judge and promptly notify the applicant or recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes.

(g) Nothing in this section shall prevent the Department of Health and Human Services from engaging in an informal review of the case with the applicant or recipient prior to issuing a notice of adverse determination as provided by subsection (c) of this section.

(h) All informal appeals by Medicaid applicants or recipients under the informal appeals process that was discontinued pursuant to section 10.15A.(h4) of S.L. 2008-118 which are still pending and for which a hearing has not been held shall be discontinued and the applicant or recipient offered an opportunity to appeal to the Office of Administrative Hearings in accordance with the provisions of section 108A-70.6A. The Department shall make every effort to resolve or settle all of the backlogged cases prior to the effective date of this act.

"**§ 108A-70.6B. Contested Medicaid cases.**

(a) Application. – This subsection applies only to contested Medicaid cases commenced by Medicaid applicants or recipients under section 108A-70.6A. Except as otherwise provided by section 108A-70.6A and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid applicant or recipient is subject to the provisions of Article 3 of Chapter 150B. To the extent any provision in this section or section 108A-70.6A of this act conflicts with another provision in Article 3 of Chapter 150B, this section and section 108A-70.6A controls.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid applicant or recipient in order to complete the case as quickly as possible. To the extent possible, the Hearings Division shall schedule and hear contested Medicaid cases within 45 days of submission of a request for appeal. The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid applicant or recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing. The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(c) Mediation. – Upon receipt of an appeal request form as provided by section 108A-70.6A(d) or other clear request for a hearing by a Medicaid applicant or recipient, the chief administrative law judge shall immediately notify the Mediation Network of North Carolina which shall within five days contact the petitioner to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. If mediation is successful, the mediator shall inform the Hearings Division, which shall confirm with the agency that a settlement has been achieved, and the case shall be dismissed. If the petitioner rejects the offer of mediation or the mediation

is unsuccessful, the mediator shall notify the Hearings Division that the case will proceed to hearing. Nothing in this subdivision shall restrict the right to a contested case hearing.

(d) Burden of Proof. – The petitioner has the burden of proof to show entitlement to a requested benefit or the propriety of requested agency action when the agency has denied the benefit or refused to take the particular action. The agency has the burden of proof when the appeal is from an agency determination to impose a penalty or reduce, terminate, or suspend a benefit previously granted. The party with the burden of proof on any issue has the burden of going forward, and the administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(e) Decision. – The administrative law judge assigned to a contested Medicaid case shall hear and decide the case without unnecessary delay. The Hearings Division shall send a copy of the audiotape or diskette of the hearing to the agency within five days of completion of the hearing. The judge shall prepare a written decision and send it to the parties. The decision must be sent together with the record to the agency within 20 days of the conclusion of the hearing.

SECTION 2. Not later than October 1, 2011, the Office of Administrative Hearings shall submit a report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the number, status, and outcome of contested Medicaid cases handled by the Office pursuant to the appeals process established in section 1 of this act. The report shall include information on the number of contested Medicaid cases resolved through mediations and through formal hearings, the outcome of settled and withdrawn cases, and the number of incidences in which the Division of Medical Assistance reverses the decision of an administrative law judge.

SECTION 3. There is appropriated from the General Fund to the Office of Administrative Hearings the sum of ___ dollars ($) for the 2010-2011 fiscal year. These funds shall be used as follows:

(1) ___ dollars ($) shall be used to establish additional positions within the Hearings Division to conduct hearings for contested Medicaid cases under the appeals process established in G.S. 108A-70.6B.

(2) ___ dollars ($) shall be used for mediation services provided for Medicaid applicant and recipient appeals and contracted services necessary to conduct the appeals process established in G.S. 108A-70.6B.

SECTION 4. Section 3 of this act is effective July 1, 2010. The remaining sections are effective when this act becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U D

BILL DRAFT 2009-SQz-29 [v.2] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/5/2010 3:09:28 PM

Short Title: Term limits on Area MH Boards- County Mgrs. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AMEND THE STRUCTURE OF AN AREA BOARD TO ALLOW COUNTY MANAGERS TO SERVE MORE THAN TWO CONSECUTIVE TERMS AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-118.1(d) reads as rewritten:

"(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity. The terms of county commissioners on an area board are concurrent with their terms as county commissioners. The terms of county managers on an area board may be for the duration of their employment as a county manager. The terms of the other members on the area board shall be for three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members~~Members, other than county managers, shall not be appointed for more than two consecutive terms. Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section."

SECTION 2. This act is effective when it becomes law.

DRAFT

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

REPORT TO THE 2010 REGULAR SESSION OF THE 2009 GENERAL ASSEMBLY

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27601

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

May 6, 2010

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, Co-Chair

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES MEMBERS, 2009-2010

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The LOC consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the LOC. The Co-Chairs for 2009-2010 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met nine times during the 2009-2010 interim. The LOC heard from the individuals listed below during the specified meeting dates. Detailed minutes and information from each LOC meeting are available in the Legislative Library.

September 23, 2009

- Lisa Hollowell, Fiscal Analyst, Fiscal Research Division and Shawn Parker, Legislative Analyst, Research Division provided an overview of 2009 legislative actions.

- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services response to budget cuts and enacted legislation from the 2009 Session.

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, discussed the status of community support services.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented an overview for the transition of community support services.

- Lanier Cansler, Secretary, Department of Health and Human Services spoke briefly on the Department's organizational structure.

October 14, 2009

- Lanier Cansler, Secretary, Department of Health and Human Services provided an update on the budget reductions to the health care system required by the Legislature.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the transition of Level III and Level IV group homes across the State.

- Grace Crockett, Director, Mecklenburg Area Mental Health, discussed the impact on Local Management Entities (LMEs) of the Level III and Level IV group home transition.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, responded to concerns over Community Supports and discussed alternative services.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed the expenditures of Community Supports as well as other mental health services within the Medicaid budget.

- Dr. Melissa Johnson, Ph.D., Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative, requested that the LOC consider funding a study by the North Carolina Institute of Medicine to determine mental health needs for young children and effective strategies for serving this population.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the status of the Community Alternatives Program Supports and Comprehensive Waivers.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, discussed the consolidation of Case Management as directed by the General Assembly.

November 10, 2009

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the Department's perspective on the Local Management Entities (LMEs) funding reductions.

- Rhett Melton, Director of Pathways LME, gave a presentation on budget reductions at the community level.

- Lanier Cansler, Secretary, Department of Health and Human Services, discussed Critical Access Behavioral Health Agencies ability to ensure flexibility for providers while still controlling costs.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented information about former Thomas S. class members including funding and services offered.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the funding changes for Community Alternatives Program waivers.

- Curtis Venable, Pisgah Legal Services, discussed concerns about the mental health system.

- Kathy Crocker, State Consumer and Family Advisory Committee, presented the results of a survey sent to Local Consumer and Family Advisory Committees as well as recommendations for the Secretary of Health and Human Services and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, discussed the organizational structure of the new Division and the State psychiatric hospitals.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, gave an update on local inpatient psychiatric community hospital contracts.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed follow-up questions on Case Management from the October LOC meeting.

December 9, 2009

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, provided an update on Medicaid utilization and expenditures.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed the Critical Access Behavioral Health Agency (CABHA) and the changes to provider qualifications.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided a report on Community Support services with other enhanced services.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, responded to questions from the last LOC meeting regarding Case Management for people with developmental disabilities.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided an update on Residential Level III and Level IV Group Homes and Private Psychiatric Residential Treatment Facilities (PRTF).

- Flo Stein, Chief, Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, gave an update on substance abuse treatment and recovery - Cross Area Service Program (CASP).

<u>January 13, 2010</u>

- Barry Boardman, Fiscal Analyst, Fiscal Research Division, presented an overview of revenue projections.

- Lee Dixon, Fiscal Analyst, Fiscal Research Division, provided an update on the Medicaid budget shortfall.

- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill, discussed the Critical Access Behavioral Health Agencies model from the perspective of a psychiatrist.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the system vision for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the next two years.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed follow-up questions on Critical Access Behavioral Health Agencies from the December LOC meeting.

- Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project.

- Members of the audience were recognized for a period of public comment.

February 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on various mental health issues.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Supports Services, Targeted Case Management, Community Supports Team, and Intensive In-Home Services.

- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, addressed plans for implementation of the Community Alternatives Program Supports and Comprehensive Waivers.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the establishment of the developmental disabilities waiting list.

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided information on the demographics of recipients and providers participating in the Medicaid program.

- Michael Lancaster, Chief of Clinical Policy, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on telemedicine, the outpatient commitment process, and mobile crisis teams.

- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the North Carolina

Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC-START).

- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, provided an update on Alcohol and Drug Abuse Treatment Centers (ADATCs).

March 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on current issues related to funding programs within the Department.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided details on expanding the 1915(b)(c) Medicaid Waiver to other LMEs.

- Dan Coughlin, Area Director/CEO, PBH and Pam Shipman, Chief Operations Officer, PBH, gave a presentation on the 1915(b)(c) Medicaid Waiver from the LMEs perspective.

- Arthur Carder, CEO, Western Highlands Network; Jennifer Webe, Executive Director, Access II Care of Western North Carolina; and Dr. Richard Hudspeth, Medical Director, Access II Care of Western North Carolina, gave a presentation on Community Care of North Carolina (CCNC) and LME integrated care.

- Joel Corcoran, Director of the International Center for Clubhouse Development (ICCD), discussed the structure and services the Clubhouse model provides.

- Charlene Lee, Club Nova member, discussed the positive effect that Club Nova, an ICCD Certified Clubhouse model, has had on her life.

- Sue Estroff, Ph.D., Department of Social Medicine, School of Medicine, University of North Carolina at Chapel Hill, explained the need for a Clubhouse specific service definition.

- Rob Lamme, Consultant, former Director of Government Relations, Department of Health and Human Services, presented a proposal for the North Carolina Mental Health Policy and Practice Hub.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, reported on Case Management consolidation.

- Andrea Stevens, Services Task Team, State Consumer Family and Advisory Committee (SCFAC), discussed efforts focused on service gaps and underserved populations.

- Carl Noyes, State Consumer Family and Advisory Committee representative, expressed concern that services provided by Critical Access Behavioral Health Agencies would not be available in less populated areas of the State.

- David Cornwell, Executive Director, North Carolina Mental Hope, discussed the need for collaboration between consumers and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

April 14, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on various Department goals for the upcoming fiscal year.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on implementation and monitoring of the Critical Access Behavioral Health Agency model, including pending requests to CMS regarding a six-month transition period for existing providers.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Support Team, Individual and Group Community Support Services for Children and Adults, Targeted Case Management, Intensive In-Home Services, and Child and Adolescent Day Treatment Expenditures.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, and Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings, presented an overview of the Medicaid recipient appeal process;

reported on the activities, progress, and effectiveness of the appeal process; and made recommendations concerning the appeal process.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on three-way local inpatient psychiatric community hospital contracts.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, provided information on Psycho-social Rehabilitation and Clubhouse Services in North Carolina and gave a brief comparative overview of clubhouse programs in other states.

- Ms. Wainwright also reviewed and compared the structure, services and financial components of current North Carolina CAP-MR/DD Waivers, the PBH Innovations Waiver, and the new NC Innovations Waiver.

- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill,

- Dr. Patricia Porter, Consultant to the LOC, reviewed reports currently submitted to the LOC and made recommendations about requiring new reports and modifying or eliminating existing reports.

May 6, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on the Department's response to a recent incident in a State-Operated Healthcare Facility including plans for improved employee training.

- John Agosta, Ph.D., Vice President, Human Services Research Institute, reviewed a report on DD Residential Services entitled "Where Does NC Stand? A Comparison of Medicaid-Funded Residential Service Trends, National and in North Carolina for People with Intellectual and Developmental Disabilities, 1998-2008."

- Shawn Parker, Legislative Analyst, Research Division, provided information about term limits for county managers serving on area boards.

- LOC staff presented a review of the LOC's draft report; the LOC adopted the report as amended.

INTRODUCTION

The basic tenant of Mental Health Reform, enacted in S.L. 2001-437, is that consumers are best and most effectively served when the services they need are delivered in a community setting. Moreover, the system must be:

- participant-driven
- prevention-focused
- recovery-oriented
- State directed and locally managed
- cost-effective
- based on recognized best practice treatments, and self-determination of outcomes.

Every year since 2001, the General Assembly has enacted legislation to support the reform and restructuring of the State's system for delivering MH/DD/SAS services. These reform efforts have aimed to increase local management of the system, decrease reliance on State institutions, encourage the use of community-based best practice treatments, increase consumer involvement in the system, allow access to a range of qualified providers, and hold system providers and managers accountable to both State and local government. Through provisions it has enacted, the General Assembly has directed the Secretary of the Department of Health and Human Services (Department) and the Division of MH/DD/SAS (Division) to administer the system's reform. Oversight of reform efforts has been provided by the General Assembly and its Joint Legislative Oversight Committee on MH/DD/SAS (LOC).

The General Assembly of the 2009 session faced decreased revenues and was forced to make significant reductions to state agencies' budgets, including the Division and Division of Medical Assistance (DMA) that resulted in less services for individuals. Significant budget reductions included:

- -$40 million in state funded services nonrecurring for each year of the biennium,
- Elimination of Community Supports services,
- -$16 million of state funds that was used to supplement the Community Alternatives Program waiver, and
- Reduction in size for children's group homes; no more than 16 children may be served at any one group home for level III and level IV care.

However, the General Assembly honored an LOC recommendation and increased the funding for the State, Local Management Entity, and community hospital "Three-Way Contracts" by $12 million, raising the total funds in this initiative to $20 million.

At LOC meetings, members heard from the Division and local entities on how the reductions impacted their agency and local services. Within this report, the 2010 LOC has recommended restoring some funding for services.

The LOC also focused a great deal of its attention this interim on Critical Access Behavioral Health Agencies (CABHAs). CABHAs are a new federally approved designation of provider agency which the Department has begun to implement with the goal of ensuring that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services, and with an effort to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment. Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

Reform of the State's public system for individuals in need of mental health, developmental disabilities, and substance abuse services is a monumental undertaking. It has requires enormous effort at the State and local levels with support and input by consumers, families, and providers. While the target of reform has not changed, the system has been dynamic. Thus, while significant mechanisms of reform are in place, there needs to be flexibility in future implementations. The LOC continues to monitor reform implementation and reports its findings and recommendations to the General Assembly.

COMMITTEE FINDINGS AND RECOMMENDATIONS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) makes the following recommendations presented in this section to the 2010 session of the 2009-2010 General Assembly. Many recommendations are followed by additional background information. Corresponding legislative proposals appear in the appendix of this report.

Restoration of LME Community Service Funds

The LOC recommends the General Assembly appropriate $40 million for community services for FY2010-11 and that these funds be allocated to LMEs based on the amount of reduction LMEs received resulting from the $40 million nonrecurring reduction planned for FY2010-11.

The total reduction made by the General Assembly for the services managed through the LMEs was $60M for FY 2009-2010 and FY 2010-2011. A $40M reduction for the non-disability specific general service fund; a $16M reduction of services supplementing the CAP-MR/DD waiver package; and a $4M reduction of services identified as "non-core" to the mission of the Division of MH/DD/SAS. There was an additional 5% reduction ($15M) of the services administered through the LMEs but that money was reinstated by the Governor.

On November 10, 2009, Mike Watson reviewed, for the LOC, last year's LME budget reductions, including how funds were allocated to LMEs, how LMEs reduced their budgets, the effect of the reductions on fund balances, and the impact on services. Rhett Melton, Director of Pathways LME, discussed budget reductions at the community level. Pathways experienced a net loss of $4.6M, which is equal to a 26% reduction of State funds for the LME. Expressed concern over gaps that already exist and the impact of the elimination of additional services, and noted that there was no way to continue same level of care as in the past with 26% less funding.

Support Initiatives to Strengthen LMEs

The Department is encouraged to continue to expand the number of LMEs implementing 1915(b)(c) Medicaid waivers.

During the FY2009-10 interim, the LOC heard from Piedmont Behavioral Health and its success with the Medicaid waiver. The Department has received approval from CMS to add additional LMEs; the Department issued an RFP for interested

LMEs and is currently evaluating those applications. The tentative start up for adding LMEs in the waiver program is January 1, 2011.

The Department is encouraged to return Utilization Management functions to LMEs.

LMEs' core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor, which is Value Options. The 2008 General Assembly directed the Department to return utilization management to LMEs representing at least 30% of the State's population. Currently, there are two LMEs (Durham and East Point) willing to take on this responsibility. Beginning in September 2010, it is expected that these two LMEs will assume utilization management of Medicaid services.

The Department is encouraged to promote Single Stream funding for LMEs

There are currently 17 single stream funded LMEs of the 23 total programs. The use of single stream funding allows LMEs to set and fund community priorities. With single stream funding, the designated streams of funding lose their identity and may be used for any mental health, developmental disabilities, and substance abuse services as needed. In addition, the LMEs receive advance funding for purchase of services, negotiation of contracts, pay providers, and then file "shadow claims" to the Division.

Fund a Leadership Academy for LME Managers

The LOC recommends that of the funds appropriated to the Division for the 2010-2011 fiscal year, up to five hundred thousand dollars ($500,000) should be used to support development of a mental health leadership academy that provides professional development to local management entities

In FY2008-09, the Division funded a leadership academy at UNC's Kenan Flagler Business School. This initiative utilized the Business School's statewide initiative to train senior LME staff, Division staff, and community partners. The training provided resources and expertise to the LMEs to help manage money, people, information, and partnerships. In FY2009-10, there was not funding to continue the program. The LOC recommends funding the program for FY2010-11.

LME Independent Assessment Pilot

The LOC recommends the Department establish a pilot project within 4 local management entities for the purpose of evaluating the cost and program efficacy of independent assessments to determine eligibility and need for IPRS enhanced services and certain Medicaid enhanced services (Personal Care Services and Private Duty Nursing).

The Department shall select at least one LME with utilization management responsibilities and at least one LME without such responsibilities. Those two LMEs will establish a process for assessing individuals seeking or receiving services provided through the LMEs that is independent of the delivery of those services. The Department shall select two additional LMEs, one with utilization management responsibilities and one without, that are comparable to the first two LMEs selected to participate in the pilot. The two "matchining" LMEs shall be comparable in population, demographics, location, numbers of persons currently enrolled in IPRS enhanced services, and numbers of persons currently enrolled in Medicaid enhanced services. The "matching" LMEs will continue to provide client assessments without regard to whether the professional conducting the assessment is independent from the delivery of those services. All assessments administered by LMEs participating in the pilot project should be as close to identical as possible, except for the independence of the assessment professional. The Division shall provide the LOC with a plan for implementing this pilot by October 1, 2010, and shall report its findings and recommendations to the LOC by October 1, 2011.

Data from the pilot shall include:

- numbers of persons assessed per site,
- numbers of persons recommended for IPRS enhanced services or Medicaid enhanced services at each site, along with a listing of those services,
- any costs associated with independent assessment, broken down by each site,
- comparative data on utilization of IPRS enhanced services and Medicaid enhanced services at sites conducting independent assessments versus sites conducting non-independent assessments, and
- comparative costs among the four sites.

Funds for Local Hospital Three Way Contracts

The LOC recommends the General Assembly appropriate an additional $12 million for the expansion of local inpatient psychiatric beds to allow purchase of an additional 50 beds out in the community.

General Assembly appropriations over the past few years have increased the resources available for in-patient community care to $20 million. There are many benefits of community-based care including ameliorating the demand on expensive State hospital usage. Because Medicaid will not pay for inpatient care at a stand-alone psychiatric hospital for consumers aged 18-64, research by the North Carolina General Assembly's Program Evaluation Division indicates that the State pays 81% of the cost of care for adults in State hospitals, but only 41% of the cost of community-based care.

It is the State's policy that beds in the three State-run psychiatric hospitals are intended for longer-term admissions for consumers who cannot be adequately or safely treated in the community, including in community general hospitals with psychiatric beds. With the increase of community-based beds, the shorter term needs can now be handled within the communities.

Implementation of the Tiered CAP/MR-DD Waiver Program

The LOC encourages the Department to continue to implement the tiered CAP-MR/DD waiver system.

The 2008 General Assembly directed the Department to develop and implement four CAP-MR/DD tiers. The primary purpose of a tiered CAP-MR/DD waiver system is to assure that individuals receive the services they need at the intensity level required to fully participate in everyday activities. The Department reported to the LOC that it has developed and implemented Tier 1 and Tier 4 and a plan to develop and implement a third tier containing two levels. Each tier represents an array of services reflecting intensity and complexity of service need. There has been no plan provided by the Department on the critical formula or tool to be used to determine how waiver recipients will be deemed eligible for each of these tiers/levels.

Supports Intensity Scale Evaluations

The LOC recommends requiring all DD consumers within the 7 region pilot catchment areas to undergo a Supports Intensity Scale (SIS) evaluation and directing the Department to develop and utilize a mechanism to employ the

results of the SIS as the basis for assigning those individuals to CAP waiver tiers and other services according to each individual's relative intensity of need.

The Department began implementation of a pilot project in 2008 to administer the Supports Intensity Scale (SIS) to a set of individuals with developmental disabilities residing within seven (7) local management entities. The purpose of the SIS is to measure the intensity of an individual's needs in critical areas resulting in specific information that can assist in identifying the unique strengths and support needs of that individual. The SIS was specifically designed to assess support needs, determine the intensity of needed supports, monitor progress, and evaluate outcomes of adults with intellectual and developmental disabilities

The SIS is not yet being administered to all persons with DD in the pilot LMEs and there is no data reported on its use in determining level of needs, particularly in the CAP-MR/DD waiver program and other services.

CABHA Implementation and Certification Process

The LOC recommends the Department consider and seek approval for a three to six month extension of the transition period for full implementation of the CABHA model in order to ensure that client access to an array of appropriate clinical services is not disrupted, and to provide additional time for small providers to gain CABHA accreditation.

In addition, the LOC recommends that the General Assembly direct the Division to develop a plan for modifying the CABHA certification process in order to ensure that new providers are eligible to qualify to participate in the CABHA network. The Division should submit a report on the modification plan to the LOC and the Fiscal Research Division not later than October 1, 2010.

The Department reported to the LOC that it has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA). Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

The main implementation goals of the CABHA model, as expressed by Mr. Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, are to ensure that critical

services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services; and to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.

At the December, January, and April LOC meetings, Mr. Watson explained the three-step CABHA certification process. First, a provider must submit an attestation letter with documentation evidencing the provider's ability to meet basic certification requirements, namely:

- Delivery of three core services: comprehensive clinical assessment, medication management, and outpatient therapy;
- Delivery of at least two enhanced services in the same location where it provides the three core services to create a continuum of care;
- Active National Accreditation of at least 3 years;
- A Full-Time or Part-Time Medical Director, depending upon the number of consumers served (100% FTE for providers serving more than 750 consumers - 60% billing; 50% FTE for providers serving less than 376 - 749 consumers - 60% billing; 8 hours per week - 0 - 375 consumers - no billing)
- A Full-Time Clinical Director
- A Full-Time Quality Management/Staff Training Director

Second, the provider must undergo a desk review of the letter of attestation and supporting documentation, which is conducted by DMH/DD/SAS, in collaboration with DMA and DHSR staff, and verified by an LME. Third, the provider must undergo an onsite review conducted by DMH/DD/SAS, DMA, and LME staff. The onsite review includes staff interviews of the Medical Director, Clinical Director, Quality Improvement/Training Director, and other provider agency staff as deemed appropriate.

The most controversial aspects of the CABHA model are the requirements that the provider must (i) have active three-year national accreditation at the time of application and (ii) hire or contract a medical director who has education and experience with the population being served. LOC members questioned DHHS about how new professionals could enter the system and provide the array of services offered within the CABHA model if CABHA certification requires applicants to obtain three-year national accreditation. The Department anticipates that providers will enter the system and become accredited with non-CABHA services and then have an opportunity to become nationally accredited in order to move into CABHA services. LOC members and providers also expressed concern that providers with fewer than 750 cases annually will have difficulty achieving

CABHA certification due to the costs associated with hiring or contracting a medical director. While the Department has scaled down the Medical Director requirement for smaller providers, it is still unclear how this requirement will impact the ability of smaller providers to achieve CABHA certification.

Providers that do not achieve CABHA certification will be required to transfer their clients to certified CABHA providers for the five key services that must be delivered within the CABHA structure. LOC members expressed a sense of responsibility for ensuring that the transfer of clients and their medical records to certified CABHA providers is accomplished with minimal disruption to service delivery and that there are a sufficient number of providers within the CABHA network to give clients State-wide access to key services.

Club House Model Study Rates

The LOC recommends the General Assembly direct DMA, in conjunction with the Division, to examine and, as the Divisions deem necessary, adjust the rates for community support services provided through International Center for Clubhouse Development clubhouse models of psychosocial rehabilitation.

The Clubhouse Model is a type of psychosocial rehabilitation designed to address the needs of the whole person in his/her recovery from serious mental illness. Supporting psychiatric and healthcare symptom management, the Clubhouses offer vocational supports, community-based employment, education, housing, outreach, advocacy and access to health care and substance abuse services as well as social and recreational opportunities. Using a membership concept, the Clubhouses are founded on the importance of "consumer ownership". Each member shares in the operation of the community center. The Clubhouse model is outcome based and in North Carolina, the Clubhouses work closely with Universities to provide internship sites, collaborative research projects and service integration.

There are currently 85 licensed Psychosocial Rehabilitation providers in the state and 44 of these follow the Clubhouse model. Eight N.C. Clubhouses have received national certification by the International Center for Clubhouse Development having met the ICCD standards.

Psychosocial rehabilitation programs are licensed by the state and must operate 5 days per week for at least 5 hours per day. All PSR programs, including Clubhouses receive funding via Medicaid, receive the same PSR rate which is $2.74 for each 15 minute unit of service.

The NC ICCD Clubhouse Coalition presented to the LOC in March and noted that they were sustainable with the additional delivery of Community Support Services. With the elimination of the opportunity to draw down funding for Community Support services, these programs report that they are in jeopardy of closure due to the very low rate for the expansive services they provide. Members of the LOC noted that they support the Clubhouses and acknowledge the importance of the services they provide.

NCIOM Study Childhood Mental Health Services in North Carolina

The LOC recommends that the General Assembly continue recurring funds to the NCIOM in order to continue the work of the Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group.

In addition, the LOC recommends that the General Assembly direct the NCIOM to conduct a study of the needs of children from birth to age five and their families. The NCIOM may submit an interim report of its findings and recommendations to the LOC by January 15, 2012, and shall submit a final report of its findings and any recommended legislation to the LOC on or before the convening of the 2013 General Assembly.

In Section 10.78.(ff) of S.L. 2009-451, the General Assembly appropriated $250,000 from the Substance Abuse Prevention and Treatment Block Grant to the Division for the 2009-2010 fiscal year for the NCIOM to do all of the following:

- Study the availability of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds that are currently available to active duty, reserve, and veteran members of the military and National Guard. NCIOM was also directed to determine any gaps in services. The Task Force provided an interim report to the 2010 Session of the General Assembly. A final report is due from this Task Force to the General Assembly during the 2011 Session. Section 10.78.(ff)(1).

- Continue the work of the Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and also to monitor federal health-related legislation to determine how the legislation will impact costs, quality, and access to health care. Section 10.78.(ff)(2).

- Study short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness. Section 10.78ff(3) of S.L. 2009-451. In its Interim Report, the Task Force reported that its main focus will be on: (1) The problems created by the co-location of different populations in adult care homes; (2) how to appropriately identify/screen people for behavioral health disorders; (3) the training of adult care home staff; and (4) other options to ensure those with mental illness, behavioral health problems, the frail elderly, and others with disabilities are receiving appropriate care. Section 10.78.(ff)(3).

The Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group have all issued Interim Reports on the above-referenced studies. However, additional funding is necessary in order for the Task Forces to complete their work and, at the direction of the General Assembly, issue final reports with findings, recommendations, and suggested legislation to the 2011 General Assembly upon its convening.

During the LOC meeting on October 14, 2001, the LOC was made aware of one additional area of study for the NCIOM. Ms. Sarah Sabornie, Coordinator of the Young Child Mental Health Collaborative of Wake County, presented information concerning the unique needs of children from birth to age five with mental health issues. Ms. Sabornie stressed the need for early identification and intervention in order to accomplish cost-effective treatment and remediation of mental health issues in this population. In addition, she emphasized the need to integrate, collaborate, and support the resources of each State agency or system to address the mental health needs of those children. Toward that end, she requested, on behalf of the Young Child Mental Health Collaborative, that the NCIOM conduct a study to examine the needs, strengths, and resources of the service systems throughout the State as they affect the mental health of our birth to five population; to evaluate potential use of research-based interventions; and to make recommendations for moving forward with limited resources.

Support Regionally-Purchased Locally-Hosted Substance Abuse Services

The LOC recommends that the General Assembly direct the Department to continue allocating substance abuse funds for regionally-purchased, locally-hosted substance abuse programs at the same level.

The budget for the 2009-2010 fiscal year did not appropriate any additional funds for regionally-purchased, locally-hosted substance abuse services (often called Cross Area Service Programs, or CASP). During the LOC meeting of December 9, 2010, Ms. Flo Stein, Chief of the Community Policy Management Section in the Division, reported to the LOC that CASP funds were used to establish new programs to (i) increase adult substance abuse comprehensive community treatment capacity and supportive housing services; (ii) increase adolescent substance abuse comprehensive community treatment capacity and residential program services; (iii) increase community capacity for substance abuse prevention coalitions; (iv) increase community capacity for substance abuse services specific to pregnant women or women with children utilizing gender-specific treatment; and (v) develop expanded residential substance abuse programs. As further evidence that CASP is an appropriate and effective use of substance abuse dollars, the Division reported that a model CASP piloted in North Carolina has been identified as a national model in versions of health reform regarding how to provide addiction services.

Expand and Extend the First Commitment Pilot Program

The LOC recommends the General Assembly authorize the Secretary to extend and expand the first commitment pilot program, direct the Department to establish continued training for current certified providers, direct the Department to utilize the Stakeholder group to examine the participation rates by each "waived" masters level health care professionals area, and determine if this should be expanded or reduced based on scope of practice and report any findings to the LOC.

Pursuant to Section 1.1(b) of S.L. 2007-504, the LOC recommends extending the First Commitment Pilot Program through October 1, 2012 and to authorize the Secretary to grant a waiver to up to 20 LMEs. The LOC further recommends directing the Department to expand its standardized training program to include refresher training for all certified providers, and to study participation rates by provider practice area and determine how the services are within each professional's scope of practice and whether this group should be expanded or reduced, and report any findings to the LOC not later than April 1, 2012.

In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation allowed the Secretary to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. Under the Pilot Program, the Secretary could grant waivers to up to five LMEs for periods of time

not to exceed three years and required that participating LMEs, "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary." The Appropriations Act of 2006 extended the pilot by 1 year. In the Fall of 2006, the Department made a presentation and report to the LOC on the pilot in which it recommended that it be made permanent and extended Statewide. The LOC recommended and the General Assembly enacted in S.L. 2007-504 a three-year extension and authorized up to five more LMEs. In 2009, the Secretary was authorized in S.L. 2009-340 to expand the program to 15 LMES.

On January 13, 2010, Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project. The Division's recommendation to the LOC was that the waiver be continued and expanded statewide, since the pilot project indicates that licensed clinical social workers and licensed clinical addictions specialists who are properly trained, tested and certified, would make decisions similar to those made by psychologists, physicians, and psychiatrists.

Questions were raised after the report relating to whether the program can be expanded to include other properly trained health care professionals and to what extent the current "waived" professionals participate at the first evaluation stage, and whether there are training needs of currently certified evaluators.

Medicaid Appeals Process Changes

The LOC recommends the General Assembly make the temporary Medicaid appeals process for Medicaid applicants and recipients permanent and codify the process in Chapter 108 of the General Statutes.

The Office of Administrative Hearings (OAH) processes all appeals of contested Medicaid cases commenced by Medicaid applicants or recipients. OAH began to experience a significant backlog of cases due in part to adverse actions consumers and provider experienced relating to changes to Community Support services. As reported to the LOC in 2007, there were 2, 291 total cases; in 2008 there were 3,717 cases; and in 2009 there were 6,693 cases. The Department and OAH were directed by S.L. 2008-107 to work together to streamline the process for hearing Medicaid recipient appeals.

SL. 2008 -107, as amended by S.L. 2008-118 and S.L. 2009-526, established a temporary appeals process for Medicaid applicants and recipients who have been

denied, terminated, suspended, or have had benefits reduced. Some of the major tenants of the temporary process are as follows:

- 10 days prior to the effective date of an adverse action, the Department shall provide proper notice and notice shall be as "user friendly" as possible.
- During the appeal an appellant has a right to services at the level or manner prior to the appeal.
- OAH must hear cases with 55 days of appeal.
- Hearings shall be conducted telephonically or by video conference, unless the appellant requests an in-person hearing. In-person hearings are to be in Wake County, but can be moved to the appellant's county of residence upon good show of cause.
- Prior to the hearing before the administrative law judge, mediation must be offered to the recipient. If mediation is successful, the mediator must indicate this outcome to the administrative law judge. If mediation is unsuccessful, the administrative law judge must hear the case and make a determination.
- The petitioner may submit evidence obtained prior to and subsequent to the Department's action.
- Provides that in each adverse action the hearing shall determine if the Department substantially prejudiced the rights of the appellant by exceeding its authority, acting erroneously, failing to use proper procedure, acting arbitrarily or capriciously, or failing to act as required by law.

On April 14, 2010, Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings (OAH), presented an overview of the Medicaid recipient appeal process. Judge Mann recognized the coordination and cooperation of different agencies in developing a process that is working successfully. He credited mediation with giving those without representation an opportunity to have resolution with 80% of the mediated cases being settled and said this was accomplished within 25 days. As of March 1, it was reported that OAH expended $1,409,201 in personnel, mediation services and operational costs at the same time the savings for the State as result of the process was almost twenty times the amount. OAH recommended to the LOC that the process should become permanent as it has been successful in achieving a desired result of having individuals able to file their appeal, receive the opportunity for mediation, and have their appeal heard and decided in an efficient and timely manner. OAH also requested funding to continue the mediation process and funding for additional personnel.

Agency Reversal of Administrative Law Judge Decisions

The LOC recommends the General Assembly authorize Joint Legislative Program Evaluation Oversight Committee shall include in 2010 Work Plan for the Program Evaluation Division of the General Assembly a study of Chapter 150B contested cases. The Division shall study the number of decisions rendered by administrative law judges that are overturned as a final agency decision. For these cases the Division shall evaluate the nature of the case, the basis of the reversal, the number of cases appealed to Superior Court and the results of those appeals.

Implement Report Review Recommendations

The LOC recommends the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports:

- By January 1, 2011, the Department shall report on the status of Community Support Services to include numbers of individuals no longer receiving any service, numbers moved to other services with a list of those services and numbers for each, cost increases and decreases and projected cost savings. Status of new service definitions (e.g. peer supports)
- By September 1,2010, the Department shall report on deaths that have occurred within in state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning 10-1-10, the Department shall provide status report on the expenditures and balance in the Mental Health Trust Fund
- Annually, beginning January 1, 2011, the Department shall report on the strategic plan regarding how state and local resources shall be organized and used to provide services. Included will be criteria for the allocation of dollars, restrictions on how these dollars may be used, guidelines for utilization of funds and list of expenditures.
- Annually, beginning May 1,2011, the department shall collect and report on LME fund balances.
- By January 1, 2011, the Department shall report on the status of the implementation of the CAP-MR/DD Tiered Waiver to include mechanism for determination of assignment into each of the tiers for both new and current CAP recipients, movement from one tier to another, and cost impact.
- Biannual report beginning January 1, 2011, the Department shall report on Statewide System Performance to include the following criteria:

- Access to Services
- Individualized Planning and Supports
- Promotion of Best Practices
- Consumer-Friendly Outcomes
- Quality Management Systems
- System Efficiency and Effectiveness
- Equitable Allocation of Resources
- Prevention and Early Intervention
- Statewide System of Crisis Response for Adults and Children
- Management of the Utilization of State Facilities

- Semi-Annual report due on September 1 and April 1, beginning September 1,2010, the Department shall report on the uniform system of beds or bed days purchased (i) with local funds;(ii) from existing state appropriations,(iii) under the hospital utilization pilot, and (iv)under three-way contracts

In support of and cooperation with the Department of Health and Human Services in their efforts to streamline reporting, a review was conducted of the complete catalog of reports required to be submitted to the LOC from 2006-2010. A review was made of the Session Law that provided the source of the direction for these reports and determination was made for each of these reports of the need for continuation, end, change in frequency of periodic reportage or requirement for a new report request.

A total of 165 reports were reviewed and 22 of these were discovered to be in need of some change. These recommendations were provided to the members of the LOC for review and comment. The Recommendation above reflects the list of reports in need of new and/or revised language.

APPENDIX

Copies of the proposed legislation begin on the following page.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H D

BILL DRAFT 2009-MGz-106* [v.6] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:46:14 PM

Short Title:	Restore State-Funded LME Services.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RESTORE STATE-FUNDED SERVICES PROVIDED THROUGH LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of forty million dollars ($40,000,000) for the 2010-2011 fiscal year. These funds shall be used to increase the amount of State service dollars allocated for State-funded services provided through local management entities (LMEs). The amount of State service dollars allocated to an LME pursuant to this section shall be (i) identical to the amount by which State service dollars were reduced on a non-recurring basis for that LME during the 2009-2010 fiscal year, and (ii) used by the LME only to restore State-funded services provided by the LME prior to enactment of the budget reductions for the 2009-2010 fiscal year.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S D

BILL DRAFT 2009-MGz-107* [v.9] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:47:17 PM

Short Title:	Develop MH Leadership Academy for LMEs/Funds.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR DEVELOPMENT OF A MENTAL HEALTH LEADERSHIP ACADEMY TO PROVIDE PROFESSIONAL DEVELOPMENT OPPORTUNITIES FOR LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the 2010-2011 fiscal year, up to five hundred thousand dollars ($500,000) may be used to support development of a mental health leadership academy that provides professional development to local management entities, enabling senior LME staff to enhance their leadership and management skills.

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S D

BILL DRAFT 2009-MGz-114* [v.5] (05/05)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:55:09 PM

Short Title:	Pilot Independent Assessments by LMEs.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO IMPLEMENT A PILOT PROJECT TO EVALUATE THE COST AND PROGRAM EFFICACY OF INDEPENDENT ASSESSMENTS FOR INTEGRATED PROGRAM AND REPORTING SYSTEM ENHANCED SERVICES AND MEDICAID ENHANCED SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a pilot project within four local management entities (LMEs) for the purpose of evaluating the cost and program efficacy of conducting independent assessments of individuals seeking or receiving services provided through LMEs, in order to determine their eligibility and need for Integrated Program and Reporting System (IPRS) enhanced services and Medicaid enhanced services. The Department shall select the four participating LMEs as follows:

(1) The Department shall select at least one LME with utilization management responsibilities and at least one LME without utilization management responsibilities. The two LMEs selected pursuant to this subdivision shall establish a process for assessing individuals seeking or receiving IPRS enhanced services or Medicaid enhanced services provided through the LMEs that is independent of the delivery of those services.

(2) The Department shall select two additional LMEs, one with utilization management responsibilities and one without utilization management responsibilities, that are comparable to the first two LMEs selected pursuant to subdivision (1) of this subsection in population, demographics, location, and number of individuals currently enrolled in IPRS enhanced services or Medicaid services. The LMEs selected pursuant to this subdivision shall assess individuals seeking or receiving IPRS enhanced services or Medicaid enhanced services provided through the LMEs without regard to whether the professional conducting the assessment is independent from the delivery of those services.

All assessments conducted by LMEs participating in the pilot project should be as close to identical as possible, except for the independence of the professional conducting the assessment.

SECTION 1.(b) The Department shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services an interim report on the implementation plan for the pilot project authorized by Section 1.(a) of this act by October 1, 2010, and a final report on the pilot project by October 1, 2011. In addition to the Department's findings and recommendations, the final report shall include all of the following information:

(1) The number of clients assessed at each project site.

(2) The number of persons recommended for IPRS enhanced services or Medicaid enhanced services at each project site, along with a listing of those services.

(3) Any costs associated with independent assessment, broken down by each project site.

(4) Comparative data on utilization of IPRS enhanced services and Medicaid enhanced services at project sites conducting independent assessments and project sites conducting non-independent assessments.

(5) Comparative costs among the four project sites.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H D

BILL DRAFT 2009-MGz-113* [v.3] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:54:23 PM

Short Title:	Expand Inpatient Psych. Bed Capacity/Funds.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE EXPANSION OF LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.12.(b) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.12.(b)** Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of twenty million one hundred twenty-one thousand six hundred forty-four dollars ($20,121,644) for the 2009-2010 fiscal year and the sum of ~~twenty million one hundred twenty one thousand six hundred forty four dollars ($20,121,644)~~ thirty-two million one hundred twenty-one thousand six hundred forty-four dollars($32.121,644) for the 2010-2011 fiscal year shall be allocated for the purchase of local inpatient psychiatric beds or bed days. ~~These beds or bed days shall be distributed across the State according to need as determined by the Department.~~ The Department shall work to ensure that these beds or bed days are distributed equitably across the State. The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the

purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient services under contract with community hospitals, including beds or bed days being purchased through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. ~~Not later than March 1, 2010, the~~ Beginning September 1, 2010, the Department shall report semiannually to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection."

SECTION 2. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S D

BILL DRAFT 2009-MGz-118* [v.2] (5/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:55:55 PM

Short Title:	Expand Use Of SIS Assessment Tool.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE LOCAL MANAGEMENT ENTITIES PARTICIPATING IN THE SUPPORTS INTENSITY SCALE ASSESSMENT PILOT PROJECT TO USE THE ASSESSMENT FOR EVALUATION AND DETERMINATION OF SERVICES FOR CLIENTS WITH DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall require the seven LMEs participating in the current Supports Intensity Scale (SIS) assessment tool pilot project to administer a SIS assessment to all clients with developmental disabilities. The participating LMEs shall use the results of the SIS assessment to assign clients with developmental disabilities to one of the Tiers within the CAP-MR/DD Waiver and to other needed services, according to their relative intensity of need.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H D

BILL DRAFT 2009-MGz-105* [v.9] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:44:52 PM

Short Title:	Modify CABHA Certification Process.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON A PLAN FOR MODIFYING THE CERTIFICATION PROCESS FOR CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall develop a plan for modifying the current certification process for Critical Access Behavioral Health Agencies (CABHAs) in a manner that will ensure new provider agencies are able to qualify for participation in the CABHA network. The Division shall submit a report of the modification plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division not later than October 1, 2010.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S D

BILL DRAFT 2009-MGz-110A* [v.6] (05/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/12/2010 9:55:39 AM

Short Title:	Examine And Adjust Rates/Clubhouses.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, IN CONSULTATION WITH THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, TO EXAMINE AND ADJUST THE RATES FOR SERVICES PROVIDED THROUGH THE INTERNATIONAL CENTER FOR CLUBHOUSE DEVELOPMENT CLUBHOUSE MODEL OF PSYCHOSOCIAL REHABILITATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall examine and, as the Divisions deem necessary, adjust the rates for community support services provided through the International Center for Clubhouse Development (ICCD) clubhouse model of psychosocial rehabilitation. The Department shall report on any adjustment in rates to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than October 1, 2010.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

BILL DRAFT 2009-MGz-86 [v.5] (01/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 7:24:00 PM

Short Title:	NCIOM Studies/Funds.	(Public)
Sponsors:	Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE NORTH CAROLINA INSTITUTE OF MEDICINE TO COMPLETE ITS CURRENT STUDIES AND TO ESTABLISH A TASK FORCE TO STUDY THE NEEDS OF YOUNG CHILDREN WITH MENTAL HEALTH PROBLEMS AND THEIR FAMILIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the North Carolina Institute of Medicine (NCIOM) the sum of two hundred fifty thousand dollars ($250,000) in recurring funds for the 2010-2011 fiscal year. These funds shall be used by NCIOM to complete the following Task Force studies authorized in Section 10.78.(ff) of S.L. 2009-451:

(1) The availability of Medicaid and State-funded mental health, developmental disabilities, and substance abuse services to active duty, reserve, and veteran members of the military and National Guard. The study should discuss the current availability of services, the extent of use, and any gaps in services.

(2) The Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and the impact of federal health-related legislation on costs, quality, and access to health care.

(3) Short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness.

SECTION 2.(a) There is appropriated from the General Fund to the North Carolina Institute of Medicine the sum of one hundred fifty thousand dollars ($150,000) for the 2010-2011 fiscal year. These funds shall be used to convene a Task Force to study the needs of young children with mental health problems and their families. The Task Force shall:

(1) Examine the current mental health needs of young children, defined as children from birth to age five.

(2) Examine existing public and private systems of mental health care that are currently available to families of young children with mental health problems.

(3) Identify evidence-based and promising universal, selective and indicated prevention strategies to promote the emotional well-being of young children.

(4) Identify strategies for early screening and identification of young children with mental health risk factors or mental health problems. The screening and identification strategies shall address the impact of parents' behavioral health problems on the mental health of their young children.

(5) Review evidence-based and promising interventions and systems to promote the positive mental health and emotional well-being of young children and their families.

(6) Identify strategies to ensure that children who are at high risk of developing mental health problems and their families have access to a comprehensive range of treatments and services, coordinated across agencies and service systems that are (i) culturally, linguistically, and developmentally sensitive; (ii) individualized; (iii) family-centered; (iv) home, school, and community-based; and (v) evidence-based.

(7) Examine workforce adequacy and training needs of mental health professionals and other professionals who provide services to young children and their families.

(8) Examine the adequacy of state and other funding to support a comprehensive array of evidence-based services.

(9) Recommend strategies to develop, evaluate, and disseminate treatment and service delivery models to meet young children's mental health needs.

(10) Examine any other issue that the NCIOM deems relevant to the study.

SECTION 2.(b) The NCIOM shall make an interim report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than January 15, 2012, which may include legislative and other recommendations, and shall issue its final report with findings, recommendations, and any proposed legislation to the 2013 General Assembly upon its convening.

SECTION 3. This act becomes effective July 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U D

BILL DRAFT 2009-SQz-28 [v.1] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 12:14:09 PM

Short Title: Extend and Expand First Commit Pilot. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, as amended by Section 1.1(a)(5) of S.L. 2007-504, and as further amended by Section 3 of S.L. 2009- 340 reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the LME shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, 2010.

(5) The Secretary may grant a waiver under this section to up to ~~15~~20 LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires ~~October 1, 2010.~~October 1, 2012.".

SECTION 2. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand it standardized certification training program to include refresher training for all certified providers and shall report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the participation rate of licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist in the pilot program and whether the program should include other licensed or certified health care professionals.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H D

BILL DRAFT 2009-MGz-108C* [v.2] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:48:30 PM

Short Title:	Establish Medicaid Appeals Process.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PERMANENT APPEALS PROCESS FOR MEDICAID APPLICANTS OR RECIPIENTS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 108A of the General Statutes is amended by adding two new sections to read:

"**§ 108A-70.6A. Appeals commenced by Medicaid applicants or recipients.**

(a) Definitions. – The following definitions apply in this section, unless the context clearly requires otherwise:

(1) "Adverse determination." – A determination by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(2) "Applicant" or "recipient". – This term includes an applicant's or recipient's parent, guardian, or legal representative.

(b) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid applicant or recipient to appeal a determination made by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the applicant or recipient, and the provider, if applicable, in writing of the adverse determination and of the applicant's or recipient's right to appeal the adverse determination. The Department shall not be required to notify an applicant's or recipient's parent, guardian, or legal representative unless the parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the applicant or recipient whose services are being affected by the adverse determination, including full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the applicant's or recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the applicant or recipient can request a hearing and a statement that the applicant or recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the applicant or recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the applicant or recipient, whichever is less, if the applicant or recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the applicant's or recipient's questions.

(9) The telephone number by which the applicant or recipient may contact a Legal Aid/Legal Services office.

(10) The appeal request form described in subsection (e) of this section that the applicant or recipient may use to request a hearing.

(d) Appeals. – Except as provided by this section and section 108A-70.6B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The applicant or recipient must request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by sending an appeal request form to the Office of Administrative Hearings and the Department. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department shall immediately forward a copy of the notice to the Office of Administrative Hearings electronically. The information contained in the notice is confidential unless the recipient appeals. The Office of Administrative Hearings may dispose of the records after one year. The Department may not influence, limit, or interfere with the applicant's or recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the applicant or recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that in order to request an appeal, the applicant or recipient must send the form by mail or fax to the address or fax number listed on the form within 30 days of mailing of the notice.

(2) The applicant's or recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the applicant or recipient would like to appeal the specific adverse determination of which the applicant or recipient was notified in the notice.

(4) A statement informing the applicant or recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the applicant's or recipient's signature and date.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision and record to the Department in accordance with section 108A-70.6B. The Department shall make a final decision in the case within 20 days of receipt of the decision and record from the administrative law judge and promptly notify the applicant or recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes.

(g) Nothing in this section shall prevent the Department of Health and Human Services from engaging in an informal review of the case with the applicant or recipient prior to issuing a notice of adverse determination as provided by subsection (c) of this section.

(h) All informal appeals by Medicaid applicants or recipients under the informal appeals process that was discontinued pursuant to section 10.15A.(h4) of S.L. 2008-118 which are still pending and for which a hearing has not been held shall be discontinued and the applicant or recipient offered an opportunity to appeal to the Office of Administrative Hearings in accordance with the provisions of section 108A-70.6A. The Department shall make every effort to resolve or settle all of the backlogged cases prior to the effective date of this act.

"**§ 108A-70.6B. Contested Medicaid cases.**

(a) Application. – This subsection applies only to contested Medicaid cases commenced by Medicaid applicants or recipients under section 108A-70.6A. Except as otherwise provided by section 108A-70.6A and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid applicant or recipient is subject to the provisions of Article 3 of Chapter 150B. To the extent any provision in this section or section 108A-70.6A of this act conflicts with another provision in Article 3 of Chapter 150B, this section and section 108A-70.6A controls.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid applicant or recipient in order to complete the case as quickly as possible. To the extent possible, the Hearings Division shall schedule and hear contested Medicaid cases within 45 days of submission of a request for appeal. The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid applicant or recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing. The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(c) Mediation. – Upon receipt of an appeal request form as provided by section 108A-70.6A(d) or other clear request for a hearing by a Medicaid applicant or recipient, the chief administrative law judge shall immediately notify the Mediation Network of North Carolina which shall within five days contact the petitioner to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. If mediation is successful, the mediator shall inform the Hearings Division, which shall confirm with the agency that a settlement has been achieved, and the case shall be dismissed. If the petitioner rejects the offer of mediation or the mediation

is unsuccessful, the mediator shall notify the Hearings Division that the case will proceed to hearing. Nothing in this subdivision shall restrict the right to a contested case hearing.

(d) Burden of Proof. – The petitioner has the burden of proof to show entitlement to a requested benefit or the propriety of requested agency action when the agency has denied the benefit or refused to take the particular action. The agency has the burden of proof when the appeal is from an agency determination to impose a penalty or reduce, terminate, or suspend a benefit previously granted. The party with the burden of proof on any issue has the burden of going forward, and the administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(e) Decision. – The administrative law judge assigned to a contested Medicaid case shall hear and decide the case without unnecessary delay. The Hearings Division shall send a copy of the audiotape or diskette of the hearing to the agency within five days of completion of the hearing. The judge shall prepare a written decision and send it to the parties. The decision must be sent together with the record to the agency within 20 days of the conclusion of the hearing."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U D

BILL DRAFT 2009-SQz-31 [v.2] (05/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 2:09:44 PM

Short Title:	Prgm Eval Study Agency reversal ALJ decision.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY AGENCY REVERSAL OF ADMINISTRATIVE LAW JUDGE DECISIONS IN CHAPTER 150B CONTESTED CASES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Joint Legislative Program Evaluation Oversight Committee shall include in the 2010 Work Plan for the Program Evaluation Division of the General Assembly a study of Chapter 150B contested cases. The Division shall study the number of decisions rendered by administrative law judges that are overturned as a final agency decision. For these cases the Division shall evaluate the nature of the case, the basis of the reversal, the number of cases appealed to Superior Court and the results of those appeals.

SECTION 1.(b) The Program Evaluation Division shall submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Joint Legislative Administrative Procedure Oversight Committee at a date to be determined by the Joint Legislative Program Evaluation Oversight Committee.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S D

BILL DRAFT 2009-MGz-111* [v.8] (5/1)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:53:27 PM

Short Title:	Modify MHDDSAS Reporting Requirements.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODIFY REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Not later than January 1, 2011, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall provide a final report on community support services to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The final report shall include a summary of the following information with respect to former recipients of community support services:

(1) The number of individuals no longer receiving any services.

(2) The number of individuals transferred to other mental health services, broken down by the specific type of service and the number of individuals transferred to each service.

(3) The amount of any cost increase or cost savings resulting from the transfer of those individuals to other mental health services.

(4) The status of any new service definitions developed in response to the elimination of community support services.

SECTION 1.(b) By September 1, 2010, and annually thereafter, the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall submit a report summarizing all deaths subject to the reporting requirements set forth in G.S. 122C-31 that occurred during the one-year period preceding the date of the report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 1.(c) Section 143C-9-2(d) reads as rewritten:

"(d) Beginning ~~July 1, 2007,~~ July 1, 2010, the Secretary of the Department of Health and Human Services shall report annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on the expenditures made during the preceding fiscal year from the Trust Fund. The report shall identify each expenditure by recipient and purpose and shall indicate the authority under subsection (b) of this section for the expenditure."

SECTION 1.(d) Beginning January 1, 2011, and annually thereafter, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a strategic plan for organizing State and local resources to fund services provided through local management entities. The report shall include criteria for the allocation of funds, guidelines for utilization of funds, restrictions on use of funds, and a list of expenditures.

SECTION 1.(e) Section 10.19A.(c) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.19A.(c)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall require quarterly reporting from LMEs in the format required under subsection (a) of this section. The Department of Health and Human Services shall report the results of the quarterly reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on or before ~~May 1, 2010.~~May 1, 2011, and annually thereafter."

SECTION 1.(f) Section 10.65A.(a) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.65A.(a)** ~~For the purposes of improving efficiency in the expenditure of available funds and effectively identifying and meeting the needs of CAP-MR/DD eligible individuals, on or before April 1, 2010, the~~ By January 1, 2011, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services a ~~plan for~~ status report on the implementation ~~of Tiers 1 through 4 of~~plan for the CAP-MR/DD ~~program.~~Tiered Waiver. The plan shall describe the implementation of each of the Tiers ~~1 and 4 and the proposed implementation of Tiers 2 and 3, and revisions of Tier 4,~~ and shall include detail on each of the following:

(1) The array and intensity level of services that will be available under each of the ~~four~~ Tiers.~~;~~

(2) The range of costs for the array and intensity level of services under each of the ~~four~~ Tiers.~~;~~

(3) How the relative intensity of need for each current and future CAP-MR/DD eligible individual will be reliably determined.~~; and~~

(4) How the determination of intensity of need will be used to assign current and future CAP-MR/DD eligible individuals appropriately into one of the ~~four~~ Tiers.

(5) The criteria for moving individuals from one Tier to another and any costs associated with that movement.

~~The Department may develop an application to the Centers for Medicare and Medicaid services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program. The Department shall not submit the application until after it has submitted the plan required under this subdivision.~~ Nothing in this subdivision obligates the General Assembly to appropriate additional funds for the CAP-MR/DD waiver."

SECTION 1.(g) Section 122C-102(c) reads as rewritten:

"(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, ~~and prevention and early intervention. Beginning October 1, 2006,~~ equitable allocation of resources, prevention and early intervention, State-wide system of crisis response for adults and children, and management of the utilization of State facilities. Beginning January 1, 2011, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

SECTION 2. This act is effective when it becomes law.

NORTH CAROLINA PROVIDERS COUNCIL

North Carolina Providers Council
4700 Homewood Court • Suite 320 • Raleigh, NC 27609
Phone: 919-784-0230 • Fax: 919-784-0231
www.ncproviderscouncil.org

Legislative Oversight Committee
Comments on "Where Does NC Stand"
May 6, 2010

- Page 4 – North Carolina keeps as many people at home as possible.

- Page 5, Paragraph 1 – Large State-Operated Centers – North Carolina continues to use large state centers to a greater degree than the rest of the nation and these are our most expensive settings (state centers average of $481 per day).

- Page 7, Paragraph 1 – It is good that North Carolina supports people outside large state-operated centers (our most expensive settings) 20% less than the rest of the nation.

- Page 8, Paragraph 1 – **Community** ICF-MR services cost an average of only $269 per day. Though other states have been using HCBS waiver program programs to increase residential options, Medicaid does not pay for room and board in these settings and North Carolina has not adequately funded the costs of other community based residential options, like room and board, that Medicaid does not pay for.

- Page 9, Paragraph 1 - ICF-MR Services – People with complex medical and behavioral needs live in our state operated and community-based ICF-MR settings, which the federal government during our current budget crisis is paying $3 of every $4 for the cost of these services (this is covered on page 11, paragraph 1, Medicaid Funded Services). **And thank you Medicaid because as a state, we are not adequately funding people with complex needs with state dollars – instead we have cut many of these state funded services this year and have put people's health and safety at risk.**

- Page 9, Paragraph 2, HCBS Waiver Services - As stated above, since Medicaid does not pay for room and board in HCBS Waiver settings, and since North Carolina is not adequately funding the costs of other community based residential options (like room and board), North Carolina is not developing adequate residential options to meet the needs of people with intellectual and developmental disabilities in North Carolina.

5/5/10 Request to make this brief introduction personally On 5/6/10

IM BEN RICHARDS, ADVOCATE FOR THE NEXT GENERATION.

I HAVE THE RIGHT TO LIVE MY LIFE FREELY.

CAP HAS HELPED ME DO THIS SINCE I WAS 8 YEARS OLD.

PLEASE DON'T TAKE ANYMORE OF MY SERVICES FROM ME,

THAT MAY KEEP ME FROM WORKING, GOING TO SCHOOL

OR HAVING A CHOICE WHERE OF TO LIVE.

I MATTER.

THANK YOU,

BEN RICHARDS

Crisis Plan	Benjamin Richards	Record #	382848

CRISIS PREVENTION / INTERVENTION / RESPONSE PLAN

CLIENT DEMOGRAPHICS

CLIENT RECORD #:	[redacted]	UNIQUE ID:	[redacted]
MEDICAID #:	[redacted]	ORIGINAL PLAN DATE:	1/26/06
DATE OF BIRTH:	2/19/91	UPDATED:	01/09/07
CUSTOMER NAME:	Benjamin Richards	AGE:	15
ADDRESS:	[redacted]		
TELEPHONE#:	(828)464-2417		
GUARDIAN:	[redacted]		
ADDRESS:	[redacted]		
TELEPHONE#:	(828)464-2417		
CASE MANAGER:	Jimmy L. Bradley		
TELEPHONE#:	(828)695-8880		
PRIMARY CAREGIVER:	Gordon & Barbara Richards		
ADDRESS:	Same as above		
TELEPHONE#:	Same as above		

DIAGNOSIS

AXIS	CODE	DESC
I	300.3	Obsessive Compulsive Disorder
	299.80	Asperger's Disorder
	296.90	Mood Disorder
	300.02	Anxiety Disorder
II	345.50	Partial Complex Seizure Disorder
III	228.09	Cerebral Venous Angioma
	519.8	Upper Airway Resistance Syndrome
	995.3	Allergies
	Q85.8	Bannayan's Syndrome
	388.42	Severe Hyperacusis
	780.52	Insomnia
		Hypotonic Cerebral Palsy
		Encephalopathy
IV		
V	GAF	40 (current and highest in past year)

RUN DATE: 01/22/09
RUN TIME: 0732
RUN USER: NUR.CTURNE

Catawba Valley Medical EDM **LIVE**
EDM Assessments

Meds Ben Richards

Patient V001918704 RICHARDS,BENJAMIN GORDON

Discharge Home Med List

Date 01/22/09 Time 0730 User TURNEY,CHERIE M

DISCHARGE HOME MEDICATIONS LIST

Name of Medication	Dose/Route	How Often	Doses Taken Today	Take Next Dose at	RT GIVEN	Drug Notes Given
1. LORATADINE	- 10MG	- DAILY				
2. DIAZEPAM	- 5MG	- DAILY 1/2 TA				
3. TRAZADONE	- 150MG	- DAILY BEDTIM				
4. SYNTHROID	- 175MCG	- DAILY				
5. OMEPRAZOLE	- 20MG	- DAILY				
6. LUVOX	- 100MG	- 3-4 DA				
7. TOPAMAX	- 50MG	- 1 IN A 2 IN P				
8. LEVOCARNITINE	- 330MG	- 2 TABS TIMES				
9. FISH OIL	- BY MOUTH	- DAILY				
10. MVI	- BY MOUTH	- DAILY				
11. T B COMPLEX	- BY MOUTH	- DAILY				
12. CALCIUM	- BY MOUTH	- DAILY	-	-	-	-
13. VIT D	- BY MOUTH	- DAILY	-	-	-	-

7.4.10

To whom it may concern-

Barbara Richards has my consent and is authorized by me to disclose any past, present, and future information about my son, Timothy Borowski. This includes any medical information, and information concerning this plan of care and goals.

Darcy M Borowski

.5/5/2010 (This is a 3 minute comment that I would like to present in person following my Son)

MY SON BEN RICHARDS HAS ALREADY ATTENDED TWO CONFERENCES, ONE WHERE HE SAID "I KNOW I HAVE PROBLEMS BUT COULD YOU DO SOMETHING ABOUT MY LITTLE BROTHER". JUST LAST YEAR AT SOCIAL SECURITY HE SAID TO THE LADY AT THE COUNTER "IM NOT DISABLED IM NEUROLOGICALY IMPAIRED".

HE'S SWEET, HE'S FUNNY... A FINE YOUNG MAN AMOUNG MEN THAT LIVES THE MISERY OF 10 MEN EACH DAY. BUT ONLY LOOKS FOR WHAT TOMORROW HOLDS. ALL HE WANTS FROM YOU TODAY IS TO SIGN HIS PETITION TO GET THE "JAKE LONG SERIES" BACK ON THE DISNEY CHANNEL.

BEN KINDLY GIVE THEN YOUR BEST IRISH BROUGH, JACK SPARROW OR THREE STOOGES IMITATION AND HAVE A SEAT JUST OUTSIDE, MY SON BEN.., THANK YOU BEN, I LOVE YOU. (DITTO is how he always responds).

FREELY I GIVE YOU COPIES OF HIS DIAGNOSIS AND HIS MEDICATION.
AS HE AGES HIS HEALTH WILL DETERIORATE. HIS MEDS ALONE HAVE TOPPED OVER 2 GRAND A MONTH HE CAN'T COUNT;
HIS FORT'E IS LANGAUGE. HE COULD READ AT THREE, AND JUST LIKE THE RAIN MAN WITH JUDGE WOPNER HE CANT MISS THE THREE STOOGES. HE RECORDS THEM ALL AND REWINDS FOR A HOUR TO REPLAY THE FUNNY PARTS OVER AND OVER.

ALTHOUGH BEN IS 6'6 AND 19 HE IS A KID AT HEART. EMOTIONALLY AGE 10-12 AND HIS HEALTH PROBLEMS ARE MY A FULL TIME JOB.

CAN YOU EVEN IMAGINE HIM IN A GROUP HOME?

BEING OCD HIS ROUTINE TORN APART AND WITH GERMAPHOBIA HAVING TO HAVE POSSIBLY A UNSANITARY ROOMATE, OR THE NOISE WITH HYPERACCUSIS (hearing at 10 times the level you and I do) AND BEHAVIOR PROBLEMS OF OTHERS, WHEN HE HAS NONE. (He will even ask permission to spell out a bad word)

MY SON WOULD HAVE TO POSITIVELY BE PUT INTO A CHEMICAL LABOTOMY, SEDATED TO SUCH AN EXTREME THAT THE YOUNG MAN YOU SEE TODAY, WOULD NO LONGER EXIST. SO I ASK YOU. COULD YOU CARE FOR HIM AS WELL AS I CAN? WOULD IT BE RIGHT TO"THEORETICALLY" AS BEN WOULD SAY TAKE HIS LIFE?
STOP THE CUTS TO FUNDING OF CAP/MR/DD.

(My husband and I also care for in the afternoons) TIMMY NOW 14; HIS HOURS CUT IN HALF IS NOW REGRESSING. I TAUGHT HIM TO WALK, TALK, PLAY, WAVE, HUG, LAUGH AND ENJOY LIFE HE UNDERSTANDS WHAT'S GOING ON AROUND HIM AND HIS 1ST WORD WAS MY NAME BARBA.

I HAVE SPENT OVER 25 YEARS NOW IN HEALTH CARE ADVOCACY. I'VE WORKED IN THE SYSTEM, I LIVE IN THE SYSTEM AND DON'T TAKE IT LIGHTLY. I NOW HOLD THE SEAT AS PRESIDENT OF THE HICKORY GREATER AREA NAMI, IN THE PAST 5 YEARS I HAVE DIRECTLY SERVED OVER 200 CLIENTS IN OBTAINING SERVICES AND MAINTAINING THEIR WELLNESS AND CONTINUE TO WORK FOR THEM EACH DAY, FOR FREE.

YOU WILL RECEIVE HARD COPIES OF THIS MATERIAL AND THE CAP PRESENTATION I GAVE TO THE STATE CFAC WHILE SITTING ON THAT COMMITTEE IN 2002-2006; AND THE TAXATION ISSUE ON HOME SUPPORTS FOR DIFFICULTY OF CARE THAT FALLS UNDER THE FOSTER CARE RULE FOR ADULT CLIENTS. SOME AGENCIES RECOGNIZE IT WHILE OTHERS DON'T. THIS IS DISCRIMINATION THAT MENTAL HEALTH HAS CREATED BY SEPERATING AFL AND HOME SUPPORT SERVICES, WHICH ARE WORD FOR WORD THE SAME.

ONE LAST THING... RESTRUCTURE VALUE OPTIONS - 4 MONTHS FOR APPROVAL IS UNEXCEPTABLE, THEY DON'T UNDERSTAND THE NEEDS OF THESE INDIVIDUALES, AND TURN EVERYTHING DOWN. UNLESS CLIENTS OR FAMILY KNOW THE SERVICES AND HOW THEY WORK THE CLIENTS NEEDS MAY NOT BE MET. WHEN VALUE OPTIONS DOESN'T EVEN KNOW SERVICE DELIVERY THEMSELVES.

THANK YOU FOR YOUR TIME AND FOR ALL YOU DO!

BARBARA RICHARDS

828-464-2417

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
September 8, 2010 10:00 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair, Presiding

Welcome and Opening Comments	*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*
Secretary's Remarks	*Lanier Cansler, Secretary, Department of Health and Human Services*
Overview of 2010 Legislative Actions	*Lisa Hollowell, LOC Staff* *Joyce Jones, LOC Staff*
Expenditures and Utilization Tracking Update	*Craigan Gray, MD, Medical Director, Division of Medical Assistance, DHHS*
Community Supports Information	*Michael Watson, Deputy Secretary, DHHS*
CABHAs Update	*Michael Watson, DHHS*
Lunch	
Status Report on the Changes to Level III and IV Facilities for Children	*Mark O'Donnell, Program Manager DMHDDSAS, DHHS*
Second Mile Project – LME Presentation	*Roy Wilson, Director, East Carolina Behavioral Health (ECBH)* *Lisa Bonnett, Executive Director of the Recovery Education Unit, ECBH*
Wrap Up and Discussions	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	9/8/10																
Senator Martin Nesbitt, Co-Chair	X																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	X																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	√																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker																	
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson																	
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	√																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

September 8, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, September 8, 2010 in Room 643 of the Legislative Office Building. Members present were Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, Jim Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representative Van Braxton and Representative William Brisson were present.

Lisa Hollowell, Joyce Jones, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the May 6, 2010 meeting. The motion was made by Representative Earle and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services (DHHS), introduced Beth Melcher and Steve Jordan. Dr. Melcher replaces Michael Watson (now Deputy Secretary for Health Services) as the new Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development. Steve Jordan will serve as Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, replacing Leza Wainwright, who retired the first of September. He added that a new medical director and deputy director for the Division of MH/DD/SAS would be hired soon. The Secretary then provided a brief update on current issues. Regarding the budget, he stated that surprisingly DHHS has only spent 5.6% of its total budget on personnel costs and a total of 7.9% when all other administrative costs are added. The remainder of the budget is being used to purchase services. He noted that cutting all administrative costs would still not be sufficient to address the current budget shortfall. Accordingly, he said that with the pending budget shortfall, services will need to be eliminated. With respect to personnel, there would be approximately ten vacant positions per each of the MH/DD/SA facilities which does not give these facilities much flexibility.

Secretary Cansler announced the groundbreaking ceremony for the new Cherry Hospital on October 1 and said that the groundbreaking for the new Broughton Hospital would

occur next spring. He said that with the opening of Central Regional there have been no appropriations for Dorothea Dix Hospital. The operational cost of the 100 beds at Dorothea Dix for the last two years has been $30M per year. However, with budget cuts DHHS can no longer cover those costs. Pending action from the Legislature next year, the Secretary plans to officially close Dix Hospital. Mr. Cansler said that some Dix patients are moving to Central Regional; 30 beds are opening at Cherry Hospital for long-term patients; and 19 beds are opening at Broughton Hospital for acute short-term patients. By December 31 the operation of Dorothea Dix will be scaled down to a 26 bed minimum forensic unit that will operate for the foreseeable future. Across the State there will be approximately the same number of total beds or a few more but costs would be reduced by about $16M per year. He said that $14M of cost was still not budgeted but was coming from community funds. He added that the Wake community facility should be opening around the first of the year. Secretary Cansler also mentioned that the children's outpatient psychiatric program would continue on the Dix campus and any inpatient programs would continue at Central Regional. The Secretary was asked to provide a list of all the inpatient beds across the State and where they are located.

Senator Dannelly announced that Representative William Brisson was given the Legislative Leadership Award by the Arc of North Carolina last month in Wilmington.

Lisa Hollowell from Fiscal Research and Joyce Jones from the Bill Drafting Division provided an overview of the 2010 Legislative actions related to mental health, developmental disabilities and substance abuse services. Points of interest made by Ms. Hollowell included:

- The $40M reinstated brings the total service funds back up to $375M. In addition the LMEs received administrative funds making a total of $500M.
- The LOC will receive a report on the expansion project for community beds within local hospitals for psychiatric inpatient services.
- Two special provisions under #7 - a report will be made on the expansion of the Support Intensity Scale within the seven pilot sites; and a report will be made on the hospital emergency department usage for psychiatric crises, reviewing the LME catchment areas, crisis services available, ED usage, and a review of the 1915 (bc) site.
- A report to the LOC will come during the interim on the Capitated Behavior Health Pilot Program which adds the Mecklenburg LME to the1915 (bc) wavier program. This inclusion has been delayed from January 1, 2011 to July, 2011.
- Reports will also come on Enhanced Mental Health Changes and Independent Assessments for enhanced Mental Health Services.

Joyce Jones reviewed legislation that did not appear in the budget. Items of interest included:

- Extension of the sunset on the First Commitment Pilot Program to October 1, 2012, and expansion of the program to up to 20 LMEs. (S.L. 2010-119)
- The Studies Act of 2010: Section 9.2 is of particular interest to the LOC since it calls for a process to evaluate contested Medicaid cases; and-

- Section 16.1 authorizes the NCIOM to study the needs of children from birth to age 5 with mental health problems. (S.L. 2010-152)

Dr. Craigan Gray, Medical Director for the Division of Medical Assistance provided an expenditures and utilization tracking update for selected aspects of mental health, developmental disability and substance abuse services. (See Attachment No. 3) His presentation included the following points of interest:

- Expenditures have increased due to the number of recipients receiving services; however, the numbers will decrease as recipients transition out of Community Support Individual and into other services once this service ends December 31, 2010. Expenditures are also expected to level out for Community Support Team based upon the newly imposed limit of 32 hours in 60 days.
- The cost for Community Support Team at an 18 hour per week level was 2 to 3 times greater than the monthly cost for ACTT. The changes bring the cost per consumer of Community Support Team more in line with the cost of ACTT. Data on monthly cost per case is now available for Community Support Team showing how it now relates to ACTT.
- Children coming out of residential facilities and those transitioning from Community Support reflect the increase in numbers for Intensive In-Home.

Regarding Day Treatment, Representative Insko mentioned that DHHS is monitoring clinical outcomes but not education outcomes. She suggested that she would like to see the local school systems monitoring those outcomes as well.

Michael Watson, Deputy Secretary for Health Services provided a follow-up to questions from the Committee regarding Community Support. (See Attachment No. 4) Mr. Watson said DHHS had tracked the movement of consumers in the system since July 2009 using Medicaid and State paid claims data. Points of interest included:

- Data of consumers receiving Community Support Service (CSS) includes adults and children, with approximately 75% consisting of children. The service cost about $20M per month.
- Of those consumers no longer receiving CSS, some have completed treatment; for others service could not be justified; and some may be receiving service in a primary care setting which is not indicated in the data.
- Those consumers that moved into basic benefits moved into lower cost programs. Those consumers that went into enhanced services moved into services that cost approximately the same or slightly more.
- Of the 800 provider sites still endorsed, only 450 are billing for CSS. (They may be billing for other services but not CSS.) As of December 31st, all endorsements for Community Support Individual will end.
- As for the 9,000 consumers currently receiving CSS, between now and December they will be evaluated, and may be transitioned based on medical necessity to the new targeted case management for mental health and substance abuse or if the need is greater they would move into one of the other services.

Mr. Watson was asked what kind of savings occurred from April 2006, when 901 separate provider organizations submitted Community Support claims to now when only 300 provider organizations are submitting CS claims. He responded that he would have to get the data but at the peek of CS spending was probably $20M - $25M per month down to $3M - $4M per month now.

Next, Mr. Watson provided an update on Critical Access Behavioral Health Agencies (CABHAs). He explained the reasoning behind CABHAs, the goals, the CABHA certification process and where that stands, and what DHHS sees happening with CABHAs and the transition between now and December 31. (See Attachment No. 5) Items of interest included:

- The four counties that currently do not have a CABHA serving consumers are: Washington, Hyde, Tyrrell, and Gates.
- Of the 208 applicants currently in the certification process, the Department expects 25%-30% to become certified CABHAs.

Mr. Watson was asked to identify the two governmental entities that had been certified as CABHAs. He responded that in Catawba County the DSS assumed child services from the LME and became a CABHA, and New River became a provider under a 160A agreement where the county assumed the provider role. He then retracted the information about Catawba and said he would check to see if a private non-profit took over in that County. Mr. Watson was asked to provide a list of the CABHA providers and the counties they support to date.

Members discussed at length whether or not DHHS should set guidelines as to the number of CABHAs there should be in an area. There was concern that there should be some diversity in the provider network in order to eliminate abuse. For additional information on CABHAs see the website for DHHS: http://www.dhhs.state.nc.us/mhddsas/.

Mark O'Donnell, Program Manager from DHHS provided a status report on Level III and Level IV group homes for children. (See Attachment No. 6) In addition to his handout, Mr. O'Donnell's comments included these:

- A comprehensive list was made of youths that various agencies were responsible for in a Level III or IV setting. A comprehensive System of Care approach focusing on the needs of children and their families was established to review and respond to the needs of those children.
- The signature of the LME System of Care Coordinator had to be on the discharge forms for all admissions in order for Value Options to authorize the services. This was used as a quality check to ensure that the planning by the Child and Family Team was appropriate and that discharges were planned.
- An independent psychiatric assessment for each admission was administered as opposed to one done by the provider agency. This process aided in the integrity of the review and placement.
- A significant number of children, through very thorough and careful review, were discharged into much more appropriate settings.

Mr. O'Donnell was asked to provide the percentage of children in the system that have also been in the court system.

Roy Wilson, Director of East Carolina Behavioral Health (ECBH), Lisa Bonnett, Executive Director of the Recovery Education Unit at ECBH, and Cindy Ehlers, Assistant Area Director for Clinical Services, addressed the Second Mile Project written by Ms. Ehlers. (See Attachment No. 7) Ms. Ehlers addressed the issue mentioned by Mr. Watson of the gap in CABHAs in the ECBH area. She said that there were currently 10 different RFP's posted by ECBH to expand the service capacity in the area for CABHAs and listed several other ways ECBH was trying to fill the gap. She said that ECBH had considered the following solutions: providing school based mental health clinics, and offering co-located recovery oriented systems of care for adults and children with mental health and substance abuse issues in the health departments, federally qualified health clinics, and community care clinics. Ms. Ehlers said that ECBH looked forward to solution based conversations with DHHS to address the gaps.

Ms. Ehlers explained that Second Mile was a philosophy consistent with the mission at ECBH to meet the needs of consumers looking for support with mental health or substance abuse issues. She said that Second Mile was a comprehensive approach that integrates hope, empowerment, education, support, advocacy, and supportive services for all the populations that ECBH is required to work with. Comments regarding the project included:

- Part of Second Mile, ECBH funds two wellness cities – Hope Station in Greenville and Wellness City in New Bern. They are peer run education centers staffed by peers that have been involved in mental health or substance abuse struggles.
- In the other 17 rural counties, Outreach and Wellness classes are offered in health departments, Departments of Social Services, churches, and schools.
- The mobile crisis providers offer education and outreach to magistrates, law enforcement providers and volunteer first responders.
- There are 3 facility based detox centers with analysis suggesting that 1 additional site should be added to the catchment area.

Lisa Bonnett addressed how Second Mile has impacted individuals at Cherry Hospital.

- Classroom facilitators in the Wellness Recovery Action Plan (WRAP) program are trained individuals who have had problems with addiction or mental health issues.
- WRAP helps people determine how they got in the hospital to begin with, what triggered them to become unwell, what kind of old responses they had to those triggers, and the sort of new response they can have in the future to help them stay well for longer periods of time.
- WRAP helps people determine what their early warning signs are in order to get intervention earlier.
- A survey taken of people served at Cherry Hospital who have completed the WRAP class indicates that people have an overwhelming sense of empowerment

and hope that they can be well. Staff to Second Mile shares their own story to recovery creating an infectious atmosphere for those participating in the WRAP class.

- Second Mile is totally funded by county dollars and has received national recognition.
- Once a level of recovery is established, Second Mile helps transition people into permanent supportive housing.
- Second Mile is available to any consumer at Cherry Hospital. It is not limited to ECBH residents.

Ms. Ehlers said that outcome data indicated that for the original 9 counties of ECBH, before the Albemarle merger, from 2009-2010 there was a 60% reduction in hospitalization for the entire catchment area.

Members emphasized the importance of having enough critical care beds in the facilities across the State for our growing population. It was suggested that the General Assembly look at the issue very carefully during the upcoming year to see that the "safety net" is in place.

There being no further business, the meeting adjourned at 2:30 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elizabeth Taylor	Cochanek Law Group
Ashley Perkinson	Perkinson Law Firm
Teri Herrman	IFCS
Dave Scott	United Way of Forsyth
ANTHONY AUTRY	NCACC
Maray Guater	Club Horizon, Inc.
Clarissa Goodlett	Governors Institute on Alcohol & Substance Abuse
Robert S. Wall	R. Clark Wall & Assoc.
Jillaine VanEssen	The Arc of NC
Pam Shipman	PBH, Concord NC
NANCY BLACK	SCFAC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nilda Brown	Mental Retardation Ass. of NC.
James S. Wells, MD	Center For Creative Balance
Katherine Ross	PPAS
Judy Truitt	OPC Mental Health
Betty Taylor	CenterPoint Human Services
Will Woodell	Voice Options
Anna Marshall	Capstrat
Amanda Cheney	Rep. Hugh A. Blackwell - Leg. Assistant.
Erica Nelson	NCCCP
Teresa Canady	Team Daniel LLC. 3037F Boone Trail Ext, Suite 2 Fayetteville, NC 28304

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	MHM
Fred Wedel	Earth Tech URS
Vicki Smith	Disability Rights NC
Robin Huffman	NC Psychiatric Assoc
	NMRS
	"
	MWC
	The Arc of NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Holly Whiteside	Office of Indigent Defense Services
Barry Peterson	Haven House
Martha W Lowrance	YA IDDA
Lin Wilson	NCALTCF
Jesse Goodman	DHHS/DAAS
Chester Martin	Lighthouse Counseling Center - Fay., NC
Misty Martin	" " "
John Boerdesh	Astra Zeneca
Fred Boyce	Boyce & Asso.
Sara Fields	CFSA-NC
Karen McLeod	CFSA-NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angie Barthes	SA Federation
Abby Ahoff	NAMI NC
Treva Johnson	Omni Visions
Crystal Nunemaker	Omni Visions
Emily Carmody	NC Coalition to End Homelessness
Roy Wilson	ECBH
Pam Chapple	Coastal Horizons Center / SA Federation
TAD CLODFELTER	SAFederation / SouthLight, Inc.
Tom Meece	Meece Consulting
Curtis Bass	NC Assoc. of IC F/MR Providers
Kate Walton	NC Division of Aging & Adult Services/DHHS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS September 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hedrick	NCPC
Peggy Magan	
Sam Hedrick	RHA Howell
Jean Gibson	private practice Psych therapist
Kent Earnhardt	Wake County Human Svcs
Hank Debnam	CC Mental Health
Richard Anderson	Footprints Carolina NCPC
LuAnn Poyner	DLC

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Joint Conference Committee Report on Continuation, Expansion and Capital Budgets

Major Budget Actions - FY2010-11, *Session Law 2010-31, Senate Bill 897*

1. **Community Service Funds $40 million non-recurring**
   - This budget item reinstates the $40 million reduction taken in SL 2009-451

2. **Crisis Services $9 million Recurring expansion**
   - Special Provision 10.12 Provides a total of $29 million recurring funds for the purchase of community beds within local hospitals for psychiatric inpatient services. Sec. 10.6

3. **Leadership Academy $250,000 non-recurring**

4. **Training in Facilities $534,795 recurring**
   - Training of direct care staff and front line leaders in patient care.

5. **UNC Department of Psychiatry $200,000 non-recurring**
   - Outreach and Support Intervention Services Program (OASIS)

6. **Conversion of Whitaker School to a Psychiatric Residential Treatment Facility ($1.9 million Recurring reduction)**
   - Allows cost-sharing with Medicaid and reduces State appropriations.

7. **Reduce Management Funding ($7.2)Non-recurring**
   - Reduces unobligated funding at the division level and eliminates two positions. These funds are not used for services.

Medicaid Mental Health

8. **Mental Health Drug Savings ($10 million) Recurring**
   - Savings from adding mental health drugs to the Preferred Drug List (PDL) and requiring prior authorization for off-label prescribing of mental health drugs. Sec. 10.22 (a)

9. **Capitated Behavior Health Pilot Programs ($1.6 million) Recurring**
   - Savings from expanding the 1915 (bc) waiver program to one additional LME. Sec. 10.24 (a)

10. **Prior Authorization from Children's Outpatient Mental Health Services ($933K)** Recurring
    - Savings from changing the visits prior authorized from 26 to 16. Sec. 10.35

11. **Enhanced Mental Health Changes ($41 million) Recurring**
    - Savings from better management of utilization and a rate reduction.

12. **Independent Assessments on Mental Health Services ($7.7 million) Recurring**
    - Savings from independent assessment prior to the delivery of services, to ensure proper utilization of services. Sec. 10.36 (a)

1. **Extend & Expand First Commitment Pilot Program, S.L. 2010-119 (SB 1309)**
   - Extends the sunset on the First Commitment Pilot Program to October 1, 2012, and authorizes HHS Secretary to expand the program to up to 20 LMEs.
   - Directs the Division of MHDDSAS to expand its standardized certification training program to include refresher training for all certified providers, to report to the LOC on the participation rate of providers eligible to conduct first-level examinations under the pilot program waiver, and to report to the LOC on whether the program should include other licensed or certified health care professionals.

   This act became effective July 20, 2010

2. **Studies Act of 2010, S.L. 2010-152 (SB 900)**
   - Sec. 9.2: Authorizes the Program Evaluation Oversight Committee to include in its 2010 Work Plan for the Program Evaluation Division ***a study of Chapter 150B contested cases***. The study may include the number of decisions rendered by ALJs that are overturned as a final agency decision. For these overturned cases, the Program Evaluation Division may evaluate the nature of the case, the basis of the reversal, the number of cases appealed to superior court, and the results of those appeals.

   - Sec. 16.1: Authorizes the NCIOM to convene a Task Force to ***study the needs of young children with mental health problems and the needs of their families***. NCIOM is to make an interim report to the LOC by January 15, 2012, and a final report with findings, recommendations, and any proposed legislation to the 2013 General Assembly.

   - Sec. 18.1 to 18.6: Directs HHS Secretary to appoint a Task Force to ***study and propose recommendations*** by January 31, 2011, ***regarding the cost-effectiveness of supportive housing*** as an alternative to the institutionalization of members of the MHDDSA population who are frequent users of psychiatric beds and emergency departments.

   The Studies Act became effective July 22, 2010.

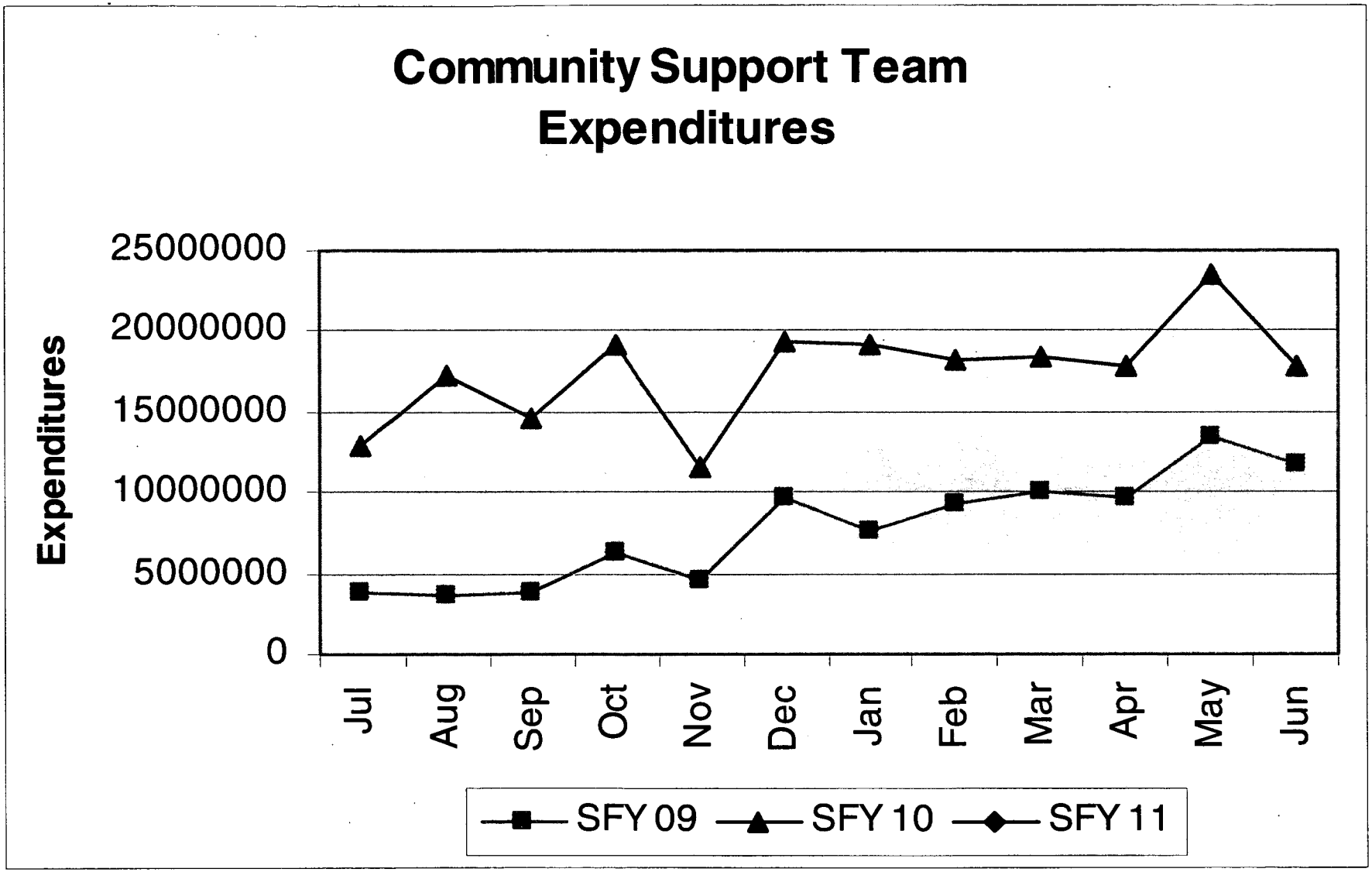
3. **Commission on Children with Special Needs – Dentist, S.L. 2010-12 (HB 1694)**
   - Adds a member to the Commission on Children with Special Health Care Needs. This additional member will be recommended by the North Carolina Dental Society, appointed by the Governor, and must be a licensed dentist who provides services to children with special needs.

   This act became effective June 23, 2010

Expenditures and Utilization Tracking Update

Joint Legislative Oversight Committee on MH/DD/SAS
September 8, 2010

Craigan Gray, MD, MBA, JD
Medical Director, Division of Medical Assistance, DHHS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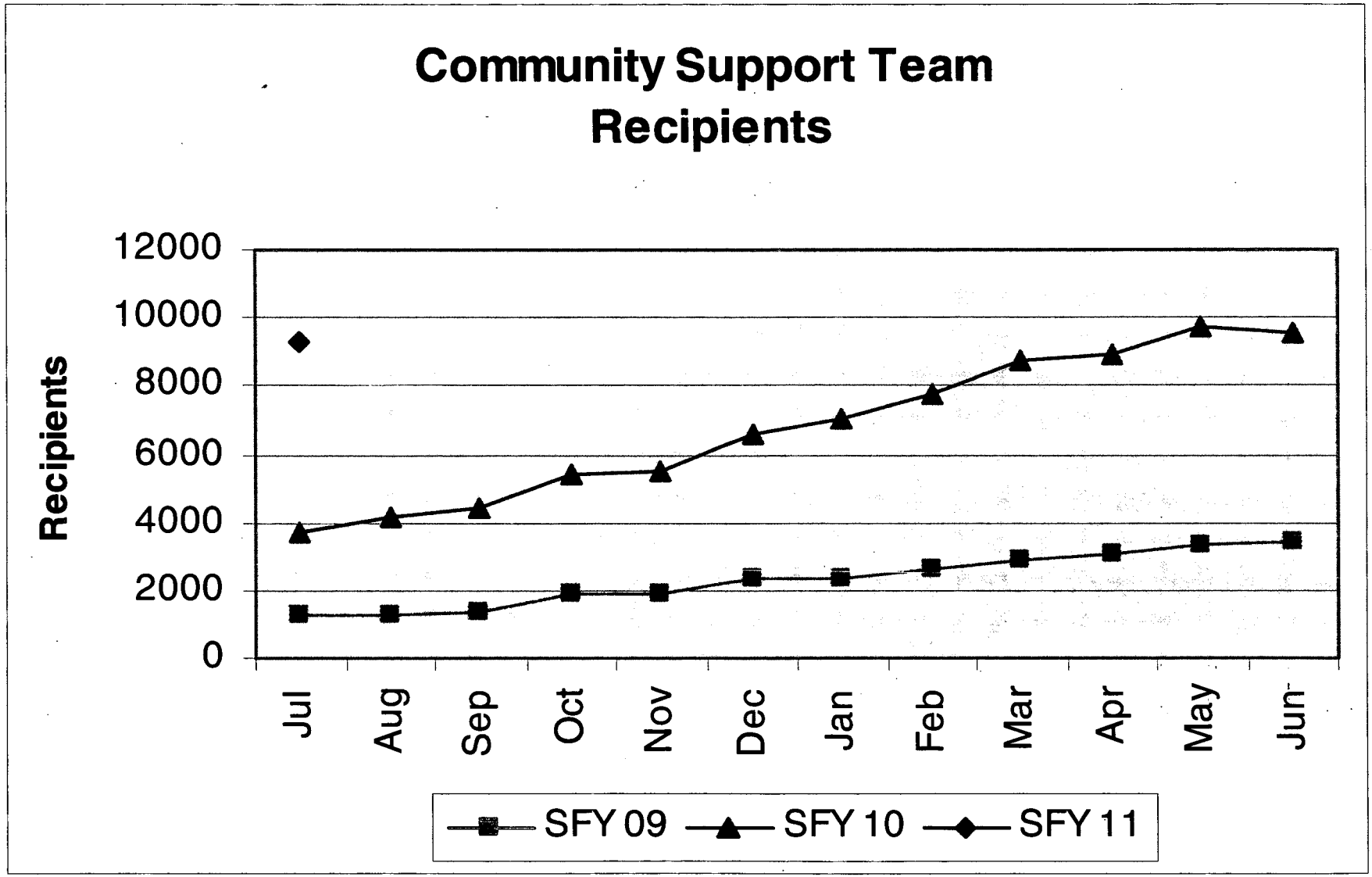
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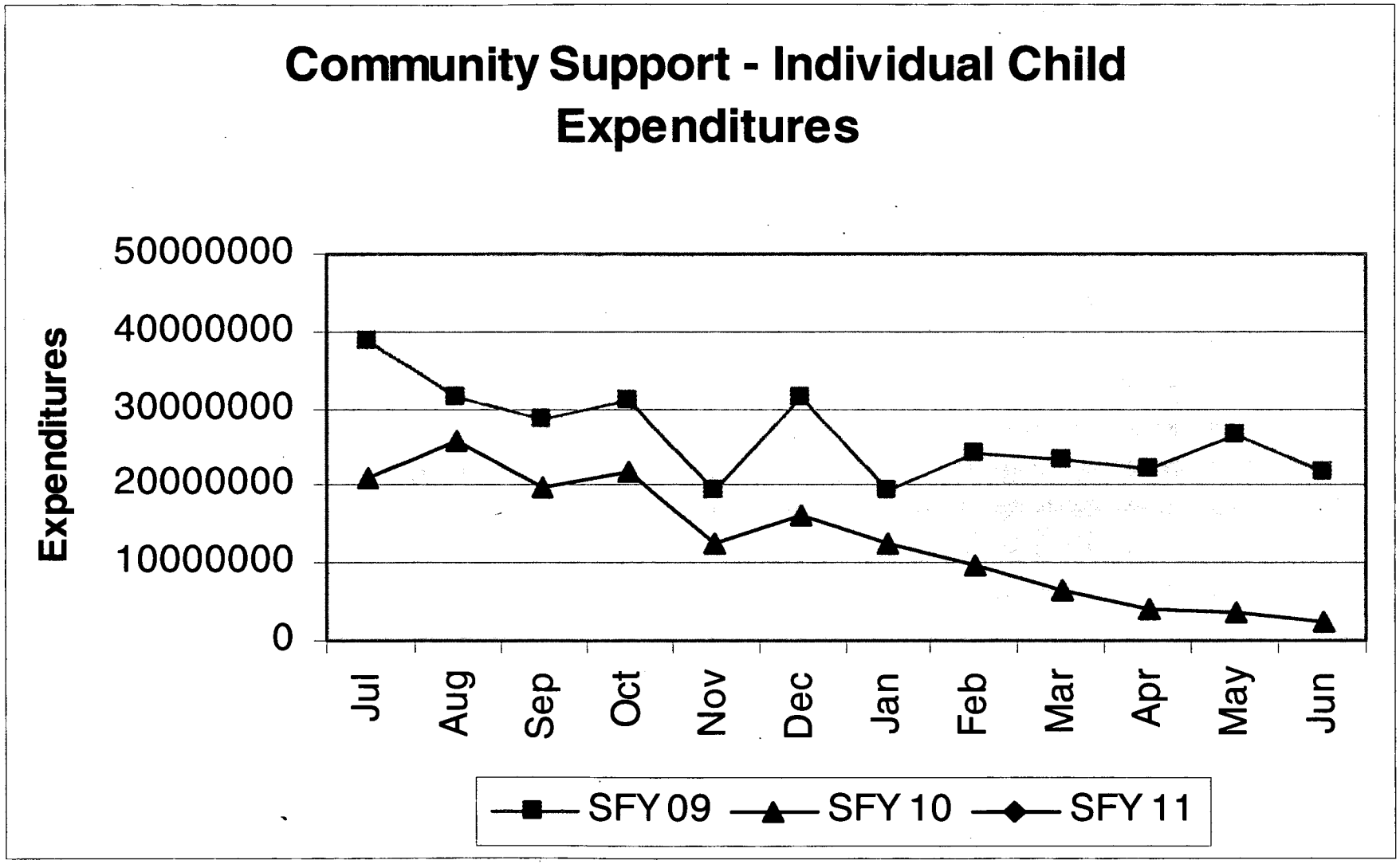
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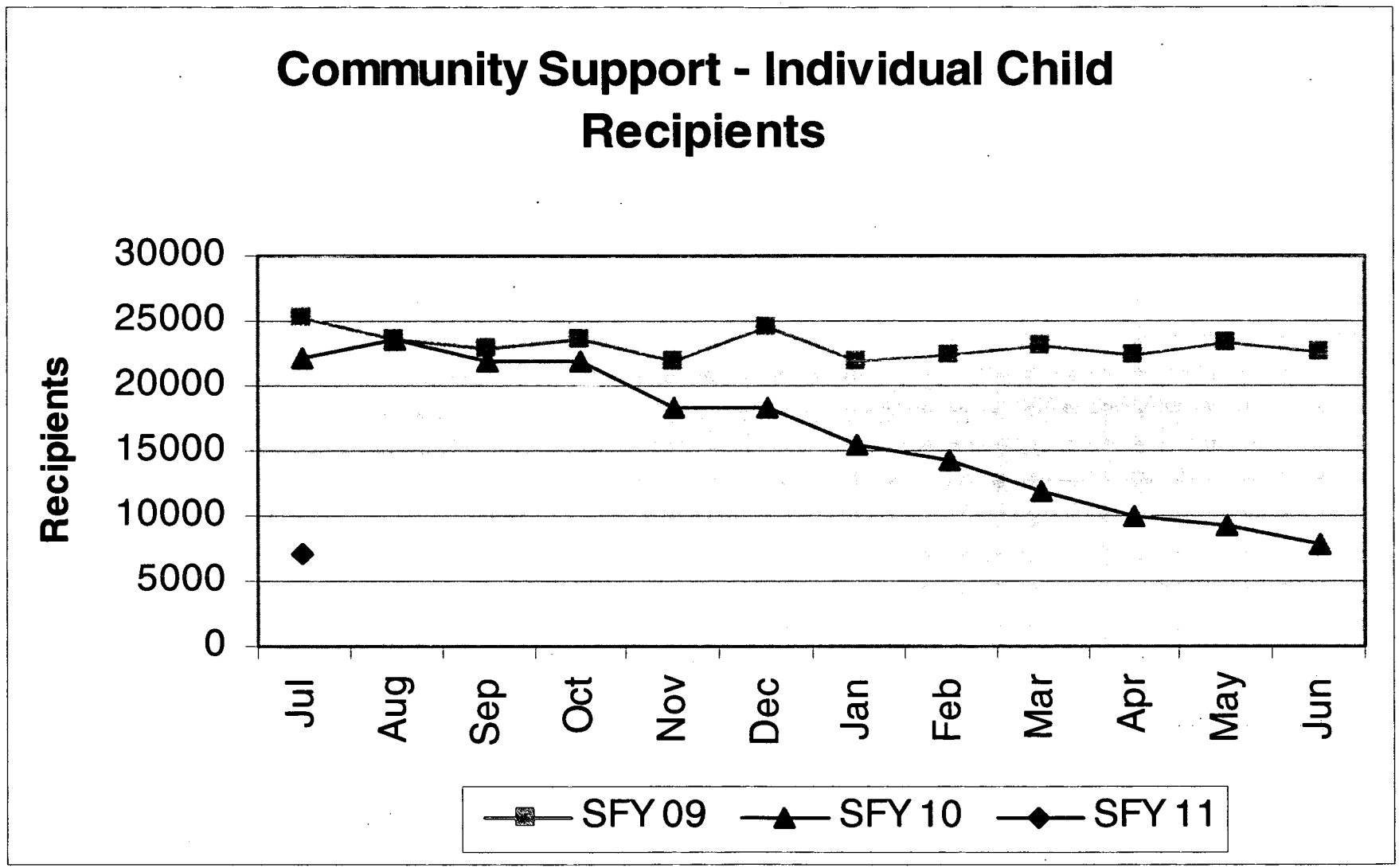
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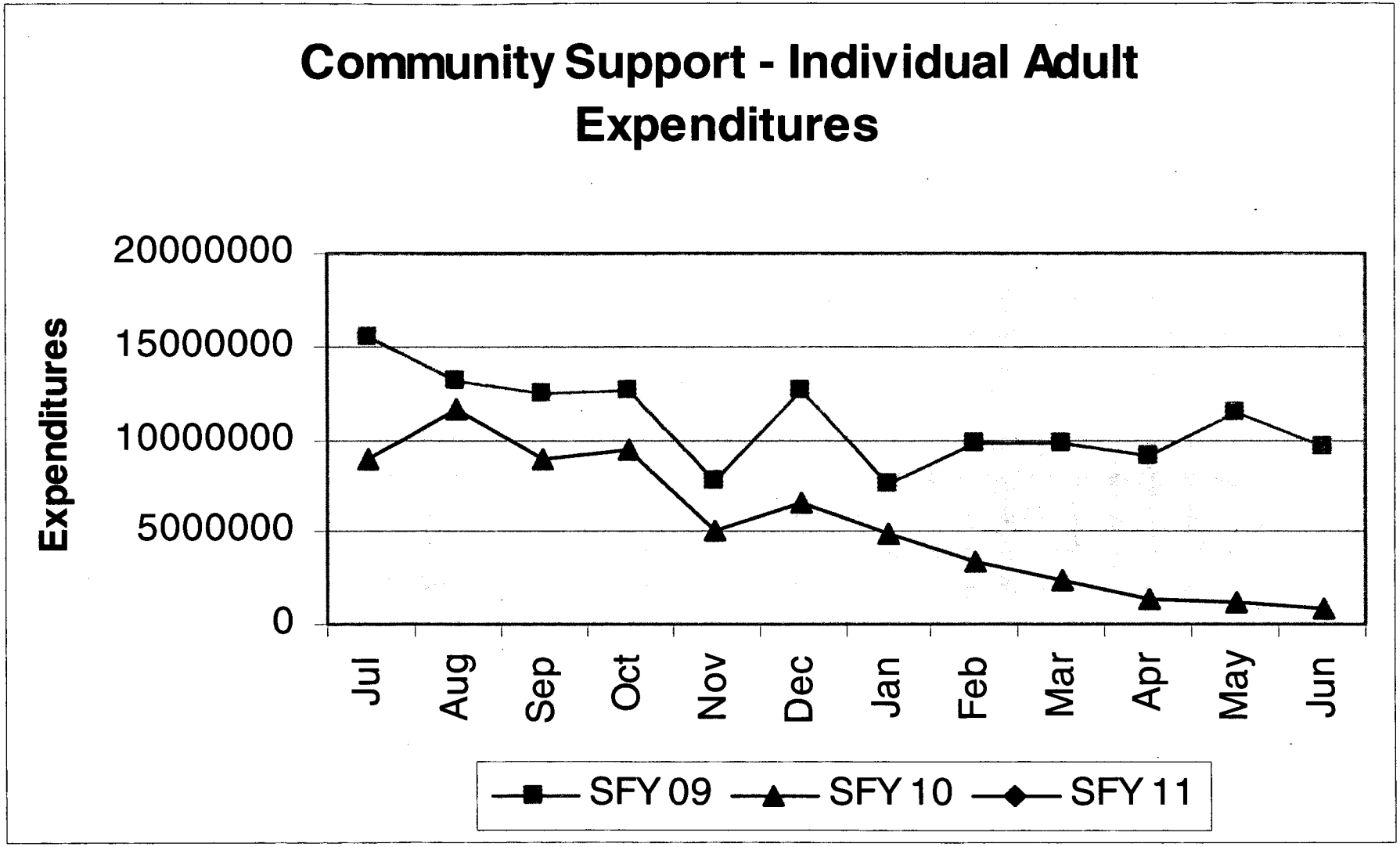
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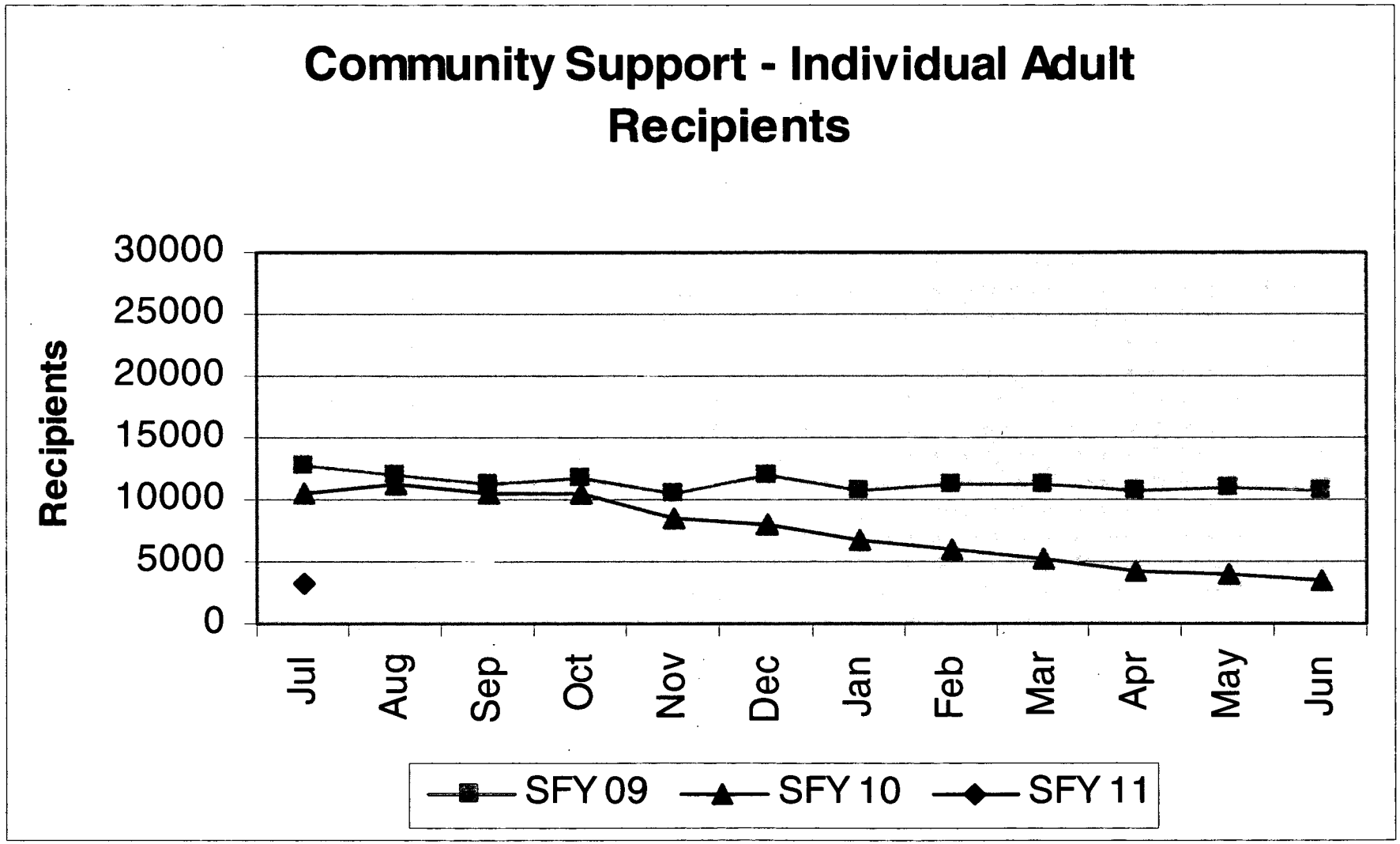
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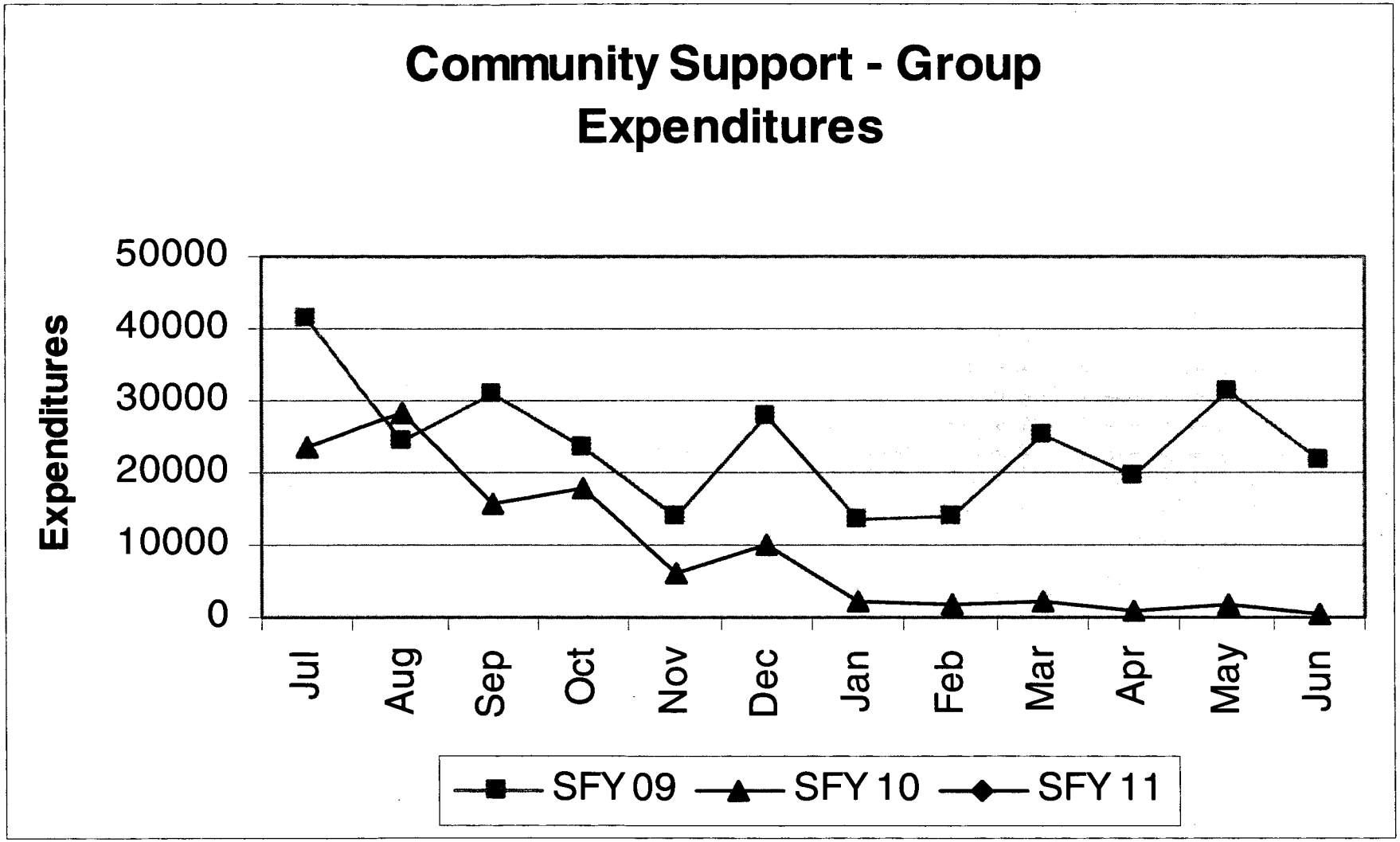
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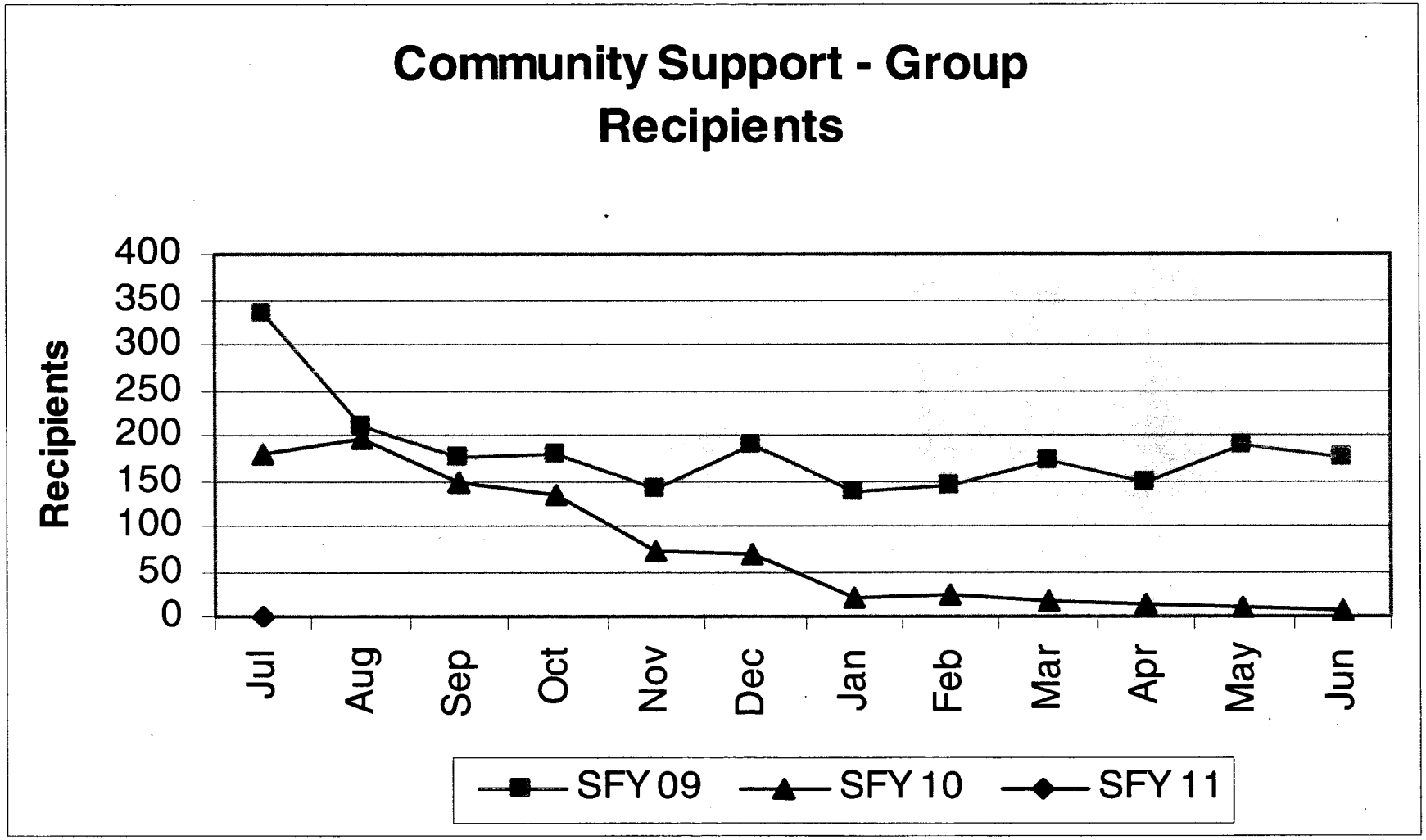
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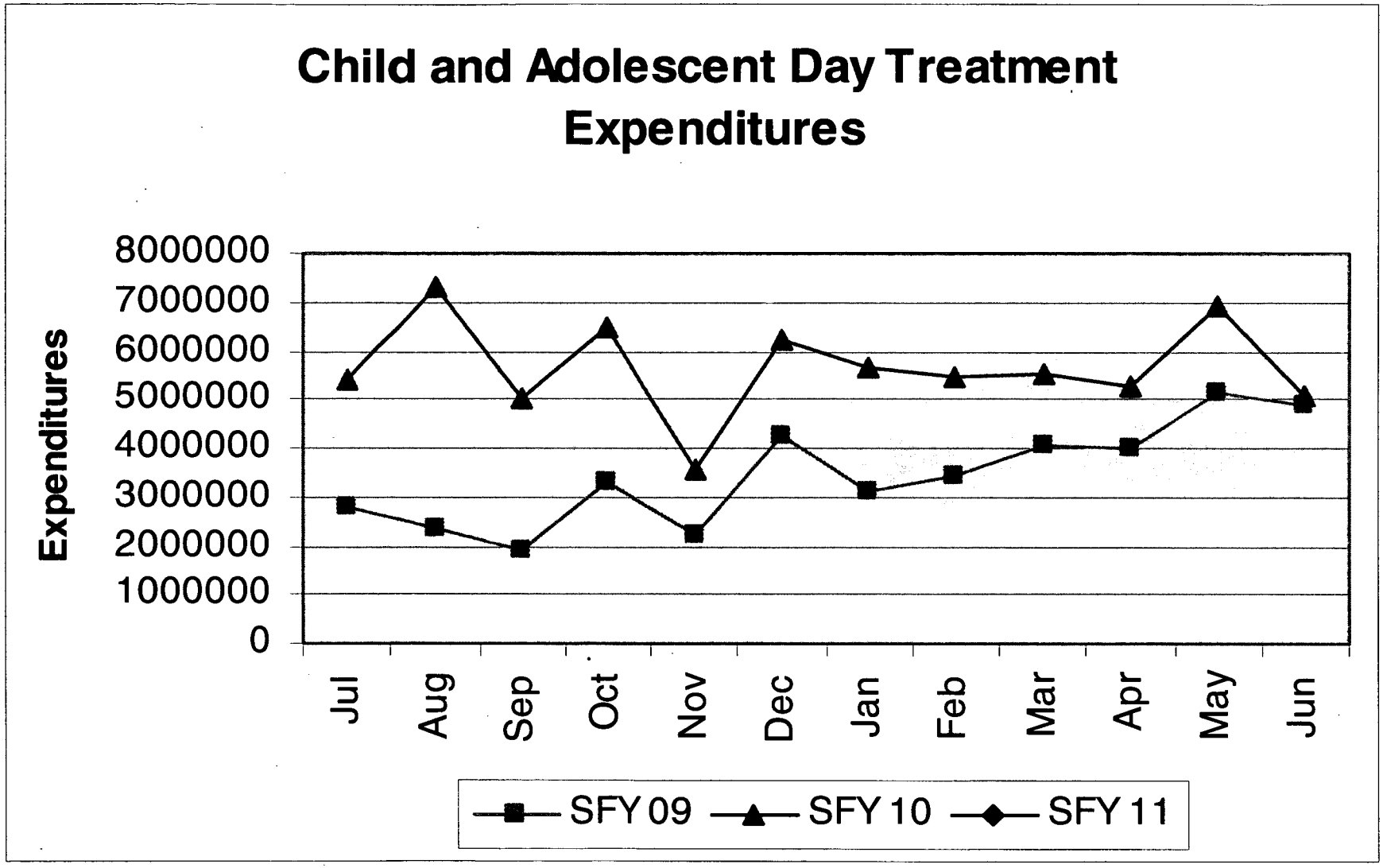
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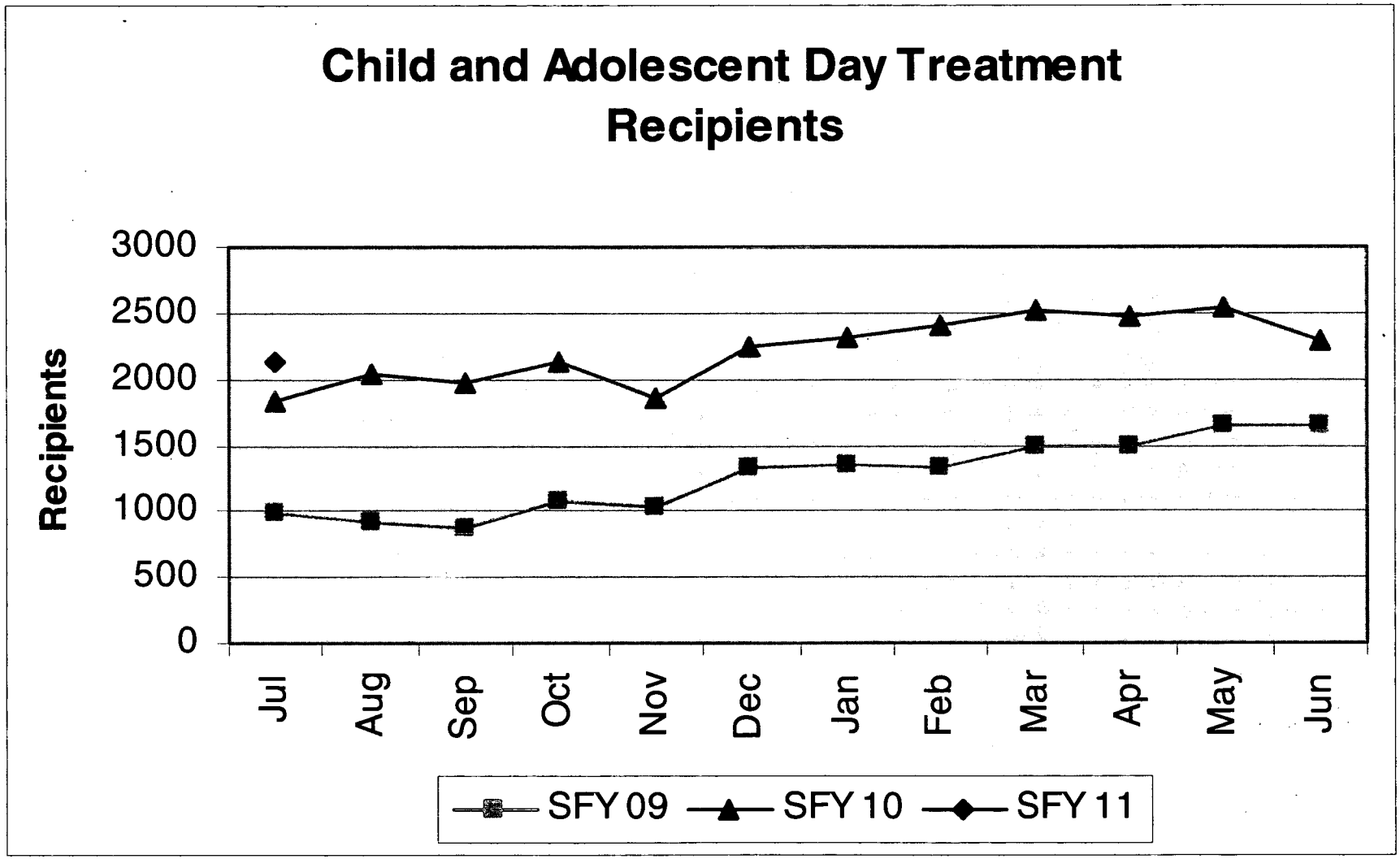
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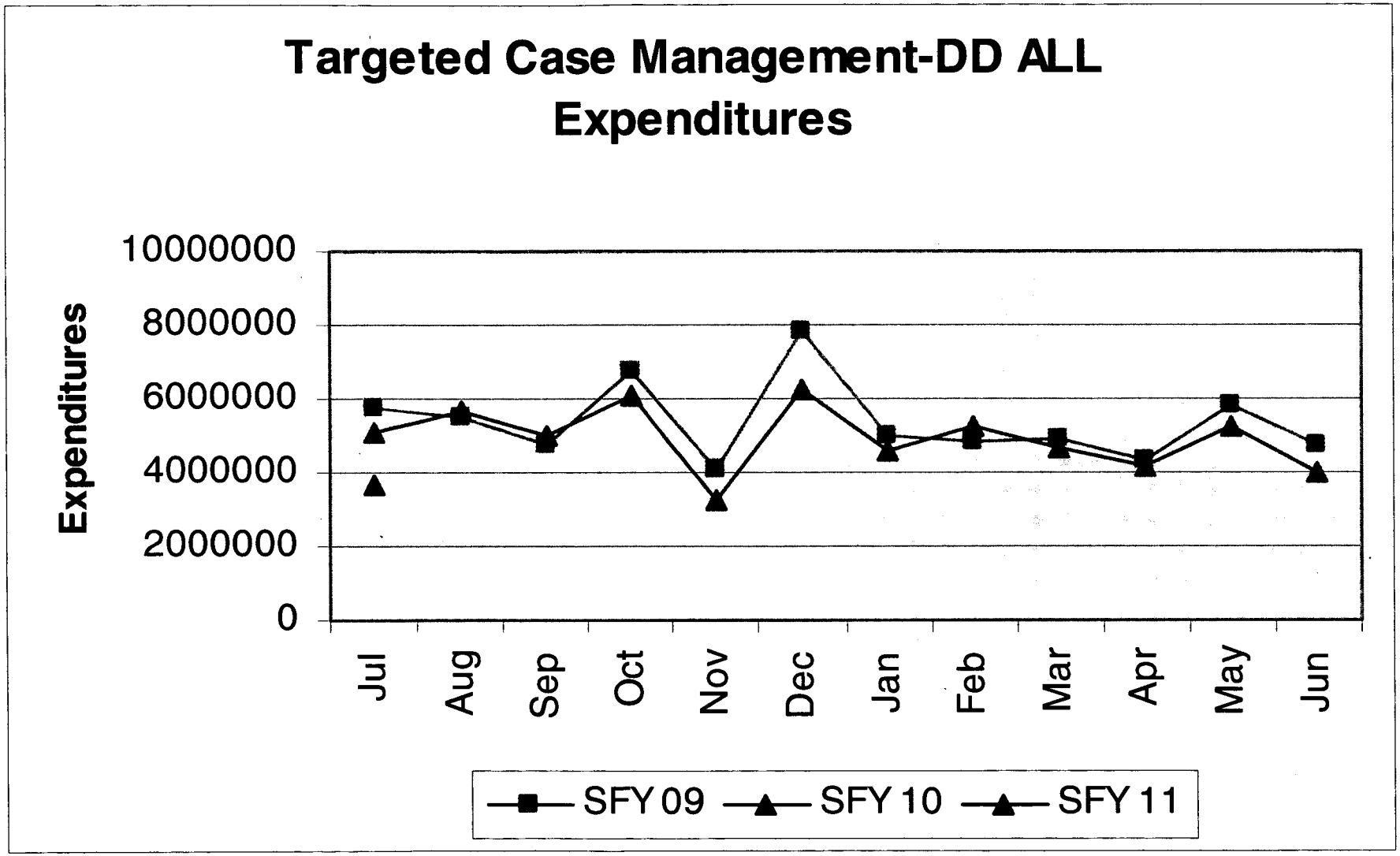
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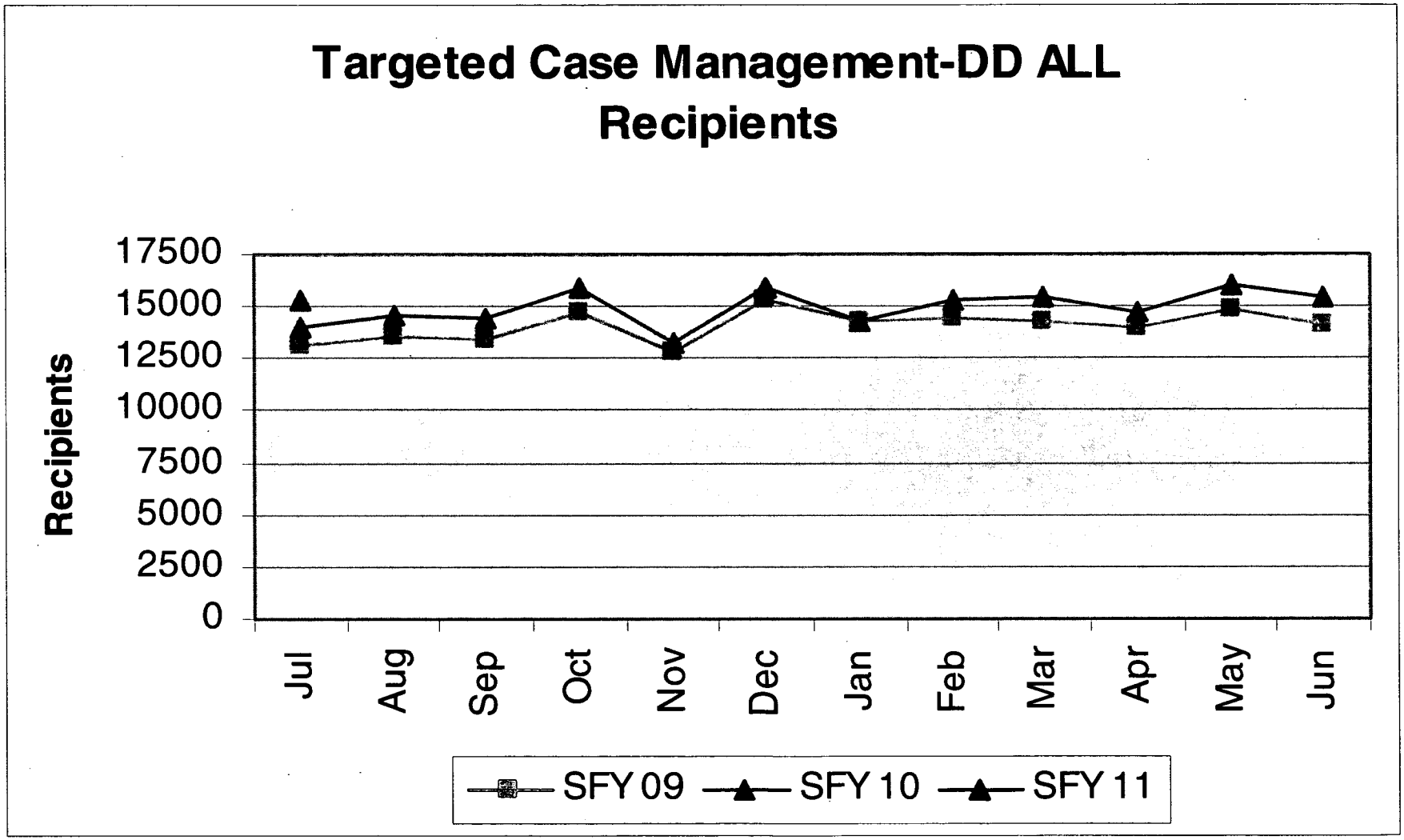
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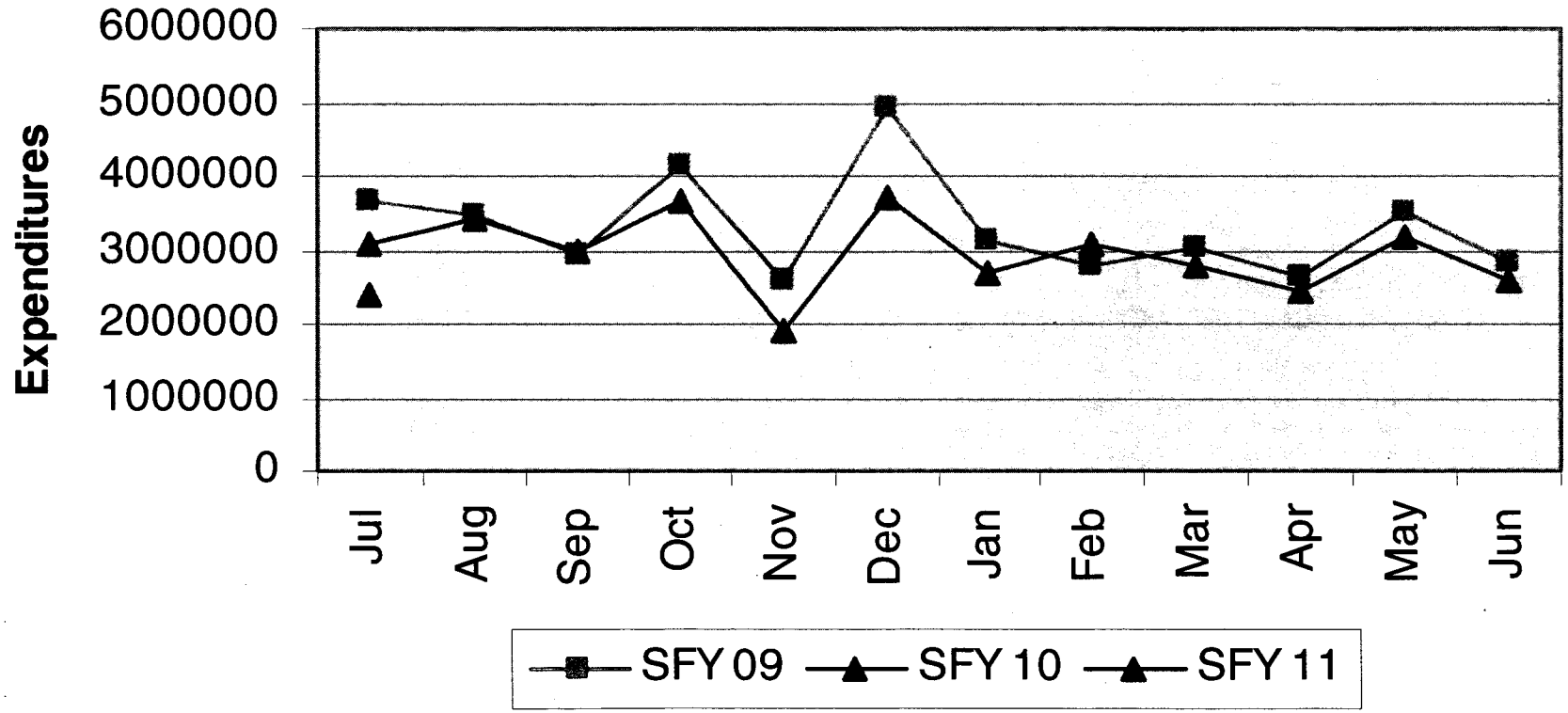

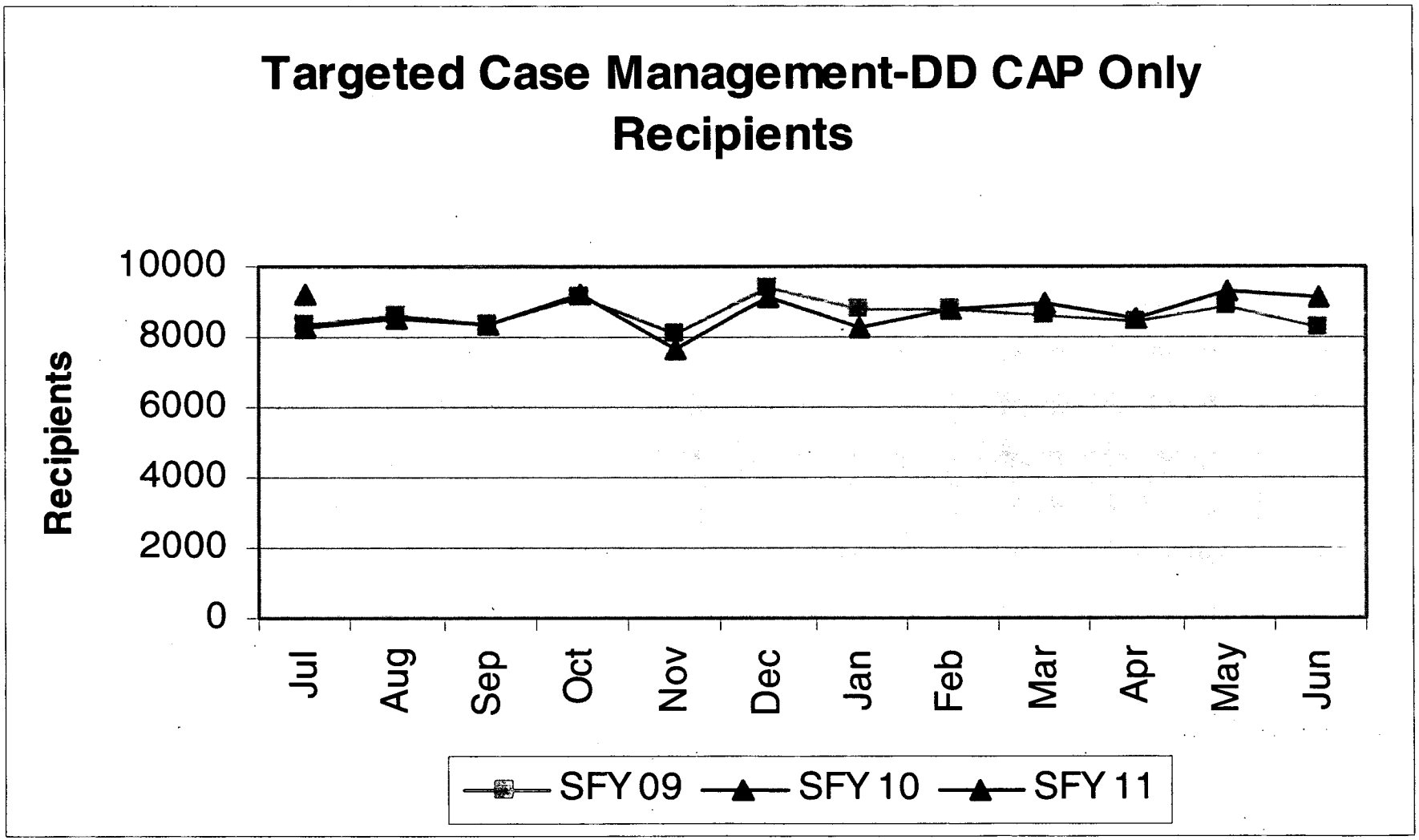
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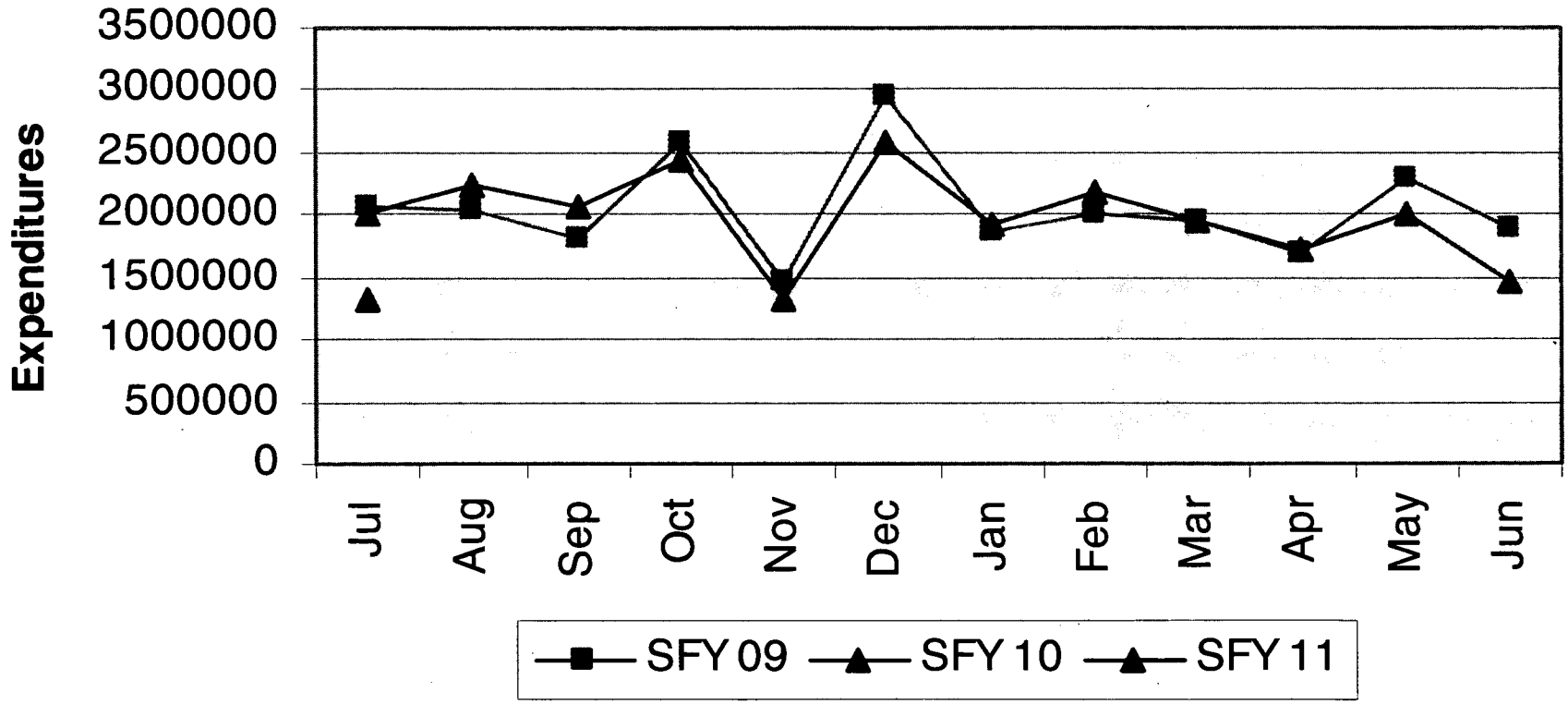

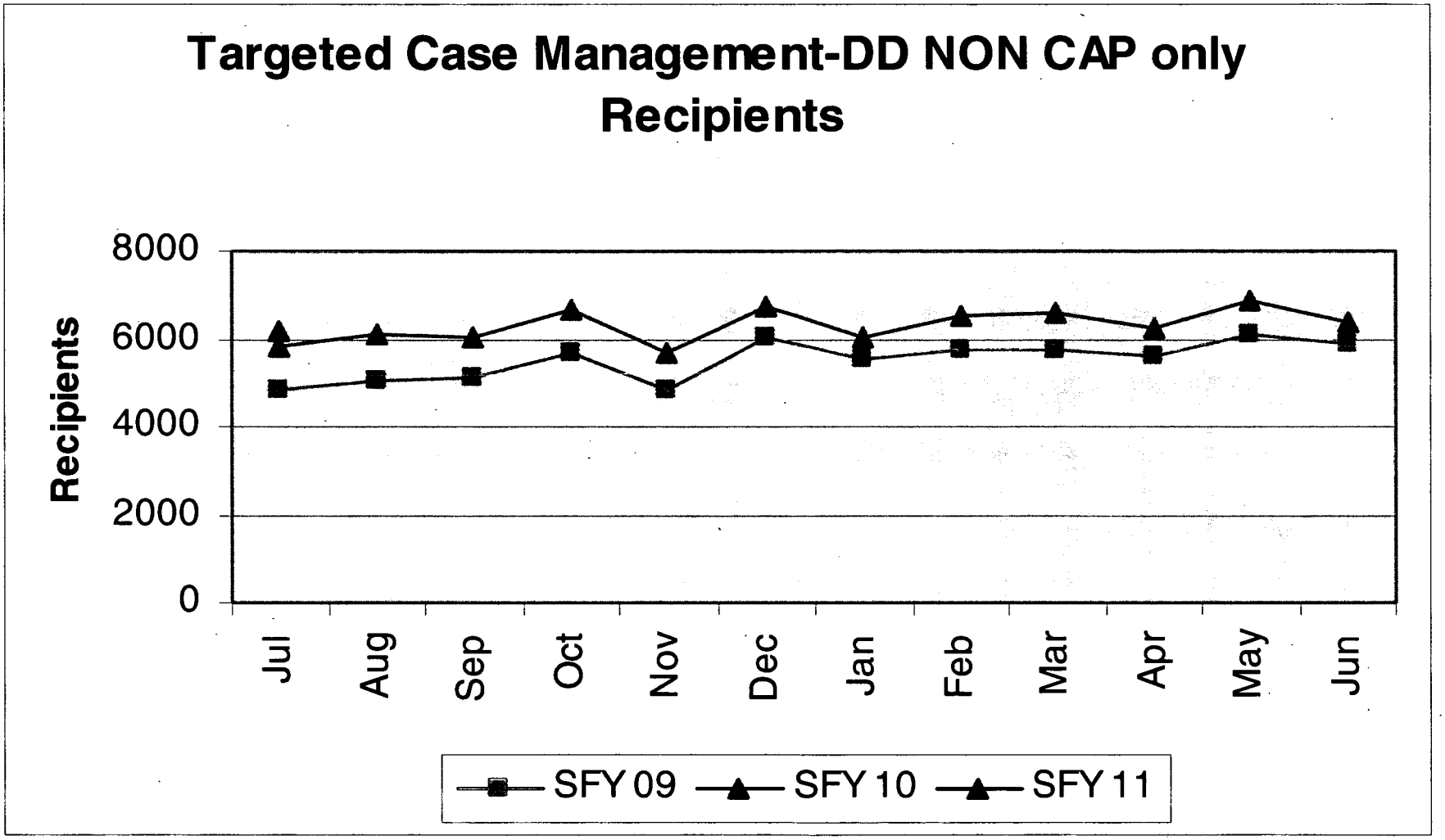
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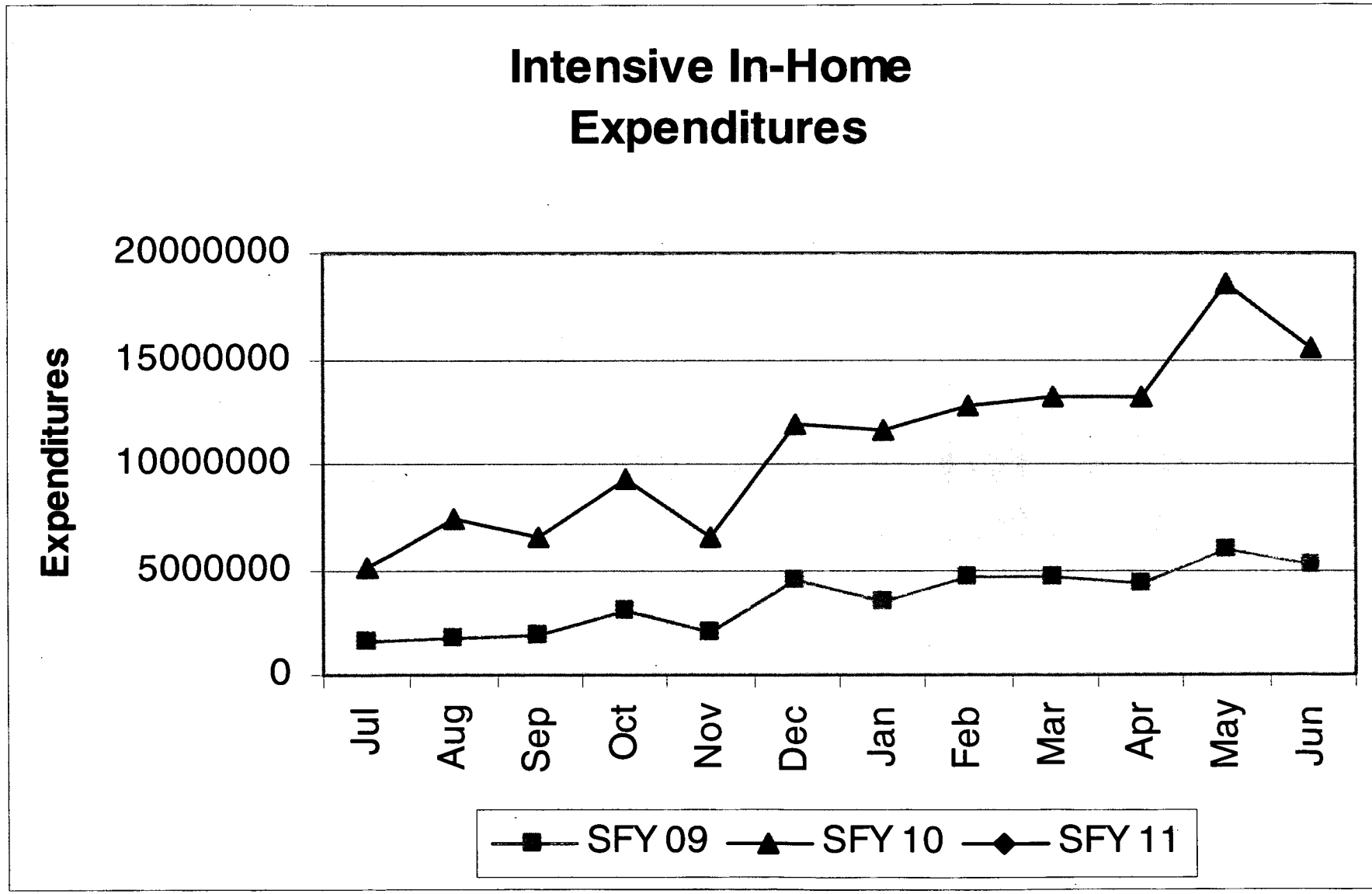
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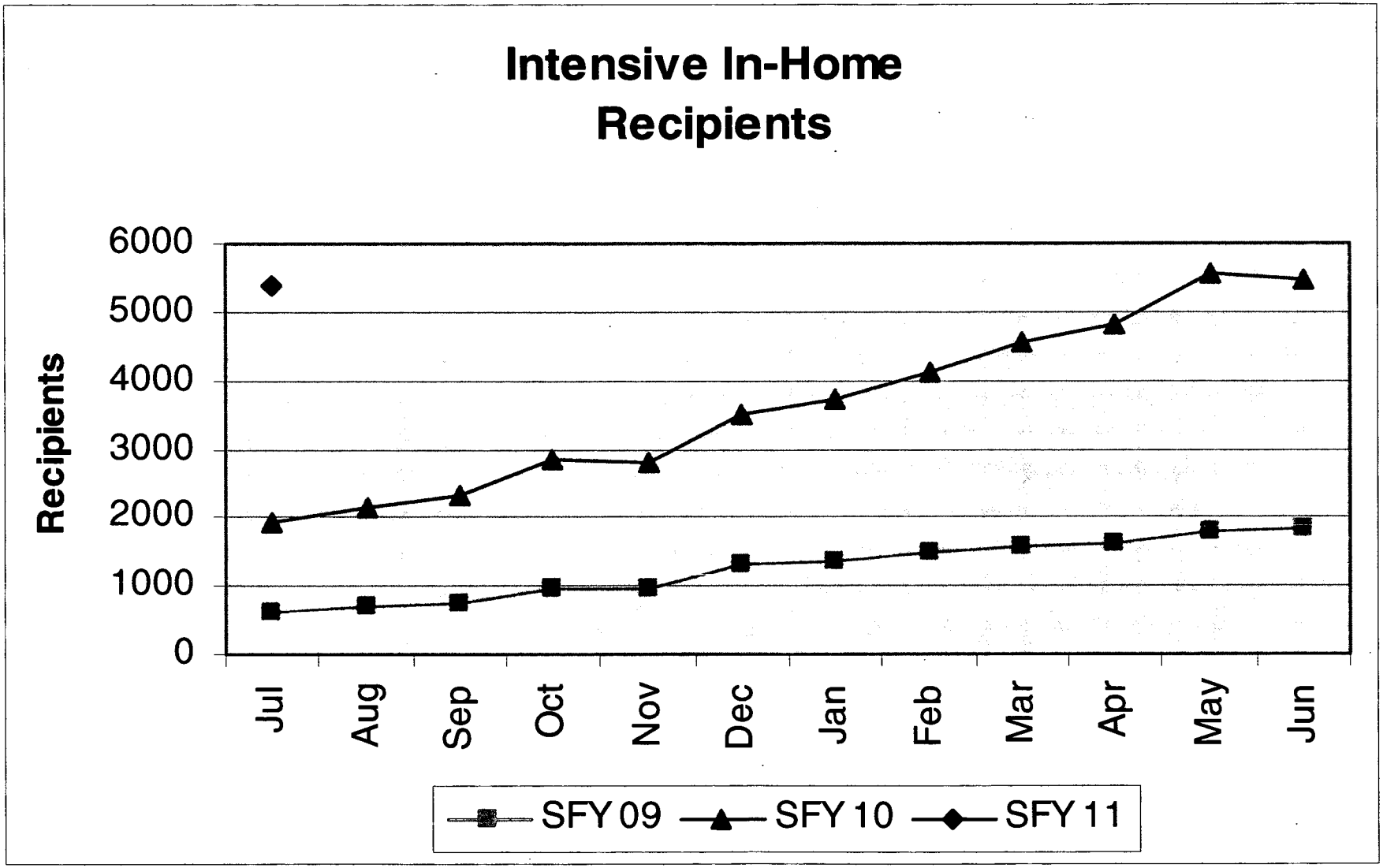
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COMMUNITY SUPPORT SERVICES (CSS) QUESTIONS/ PEER SUPPORT UPDATE

Joint Legislative Oversight Committee on MH/DD/SAS
September 8, 2010

Michael Watson
Deputy Secretary for Health Services
Department of Health & Human Services

Community Support Service (CSS) Questions

- Clinical Disposition for Consumers Who Received CSS
- Subsequent Services Received by CSS Consumers
- Movement From Higher to Lower Cost Services
- Changes in the # of CSS Providers

Note: CSS data generated from Medicaid/ State Funded Paid Claims. Due to billing lags (up to 18 months) it is difficult to track consumer movement.

2

Community Support Service (CSS) Profile

- Total # of Consumers Receiving CSS (July 2009 forward) = 49,052
- # Current Receiving CSS as of August 2010 = 9,107 (CSS-Professional = MH/SA Case Management)

Note: These consumers will transition to Targeted MH/SAS Case Management

- 39,945 Consumers No Longer Receiving CSS
  Note: Reduction resulting from Rate/UM/Program Changes

3

Community Support Service (CSS) Profile

- Disposition of Consumers No longer receiving CSS:
  - No further Medicaid/State Funded Services = 16,598 (42%)
  - Receiving Enhanced MH/SA Services = 12,726 (32%)
  - Receiving Basic Benefit (lower cost services) = 10,621 (26%)

4

Community Support Service (CSS) Profile

Note #1: The number of consumers (16,598) no longer receiving services reflect post payment review data that indicates that 25%-40% of consumers did not qualify for CSS. A portion of these consumers may be receiving basic benefit services in a primary care setting.

Note # 2: Movement of consumers from CSS to other services was based on a clinical assessment and a service authorization (based on medical necessity) by DHHS Vendor or a Local Management Entity.

5

Community Support Service (CSS) Profile

Note #3: The enhanced services that received the highest number of CSS transitions included: Day Treatment, Community Support Team (CST), Intensive In-Home (IIH) and Psycho-Social Rehabilitation.

Note #4: The cost of any service (regardless of rate) is directly associated with the frequency and intensity of its delivery.

6

CSS Provider Update

- Site/Service Endorsements:
  - Since April 2006, 1,644 Site/Service Endorsements have been issued for CSS
  - Currently, 800 Sites are still enrolled with DMA for CSS
  - Note: Only 450 (+/-) are billing

7

CSS Provider Update

- Provider Organizations:
  - Since April 2006, 901 different Provider Organizations have submitted claims for CSS
  - Currently, 300 (+/-) are submitting CSS claims

Note: This represents a 73% reduction in CSS billing sites and a 67% reduction in the # of providers submitting CSS claims

8

Peer Support Update

- Planned Implementation Date = January, 2011
- Responding to CMS requests for additional information regarding service model
- Awaiting CMS approval
- Grant to six LMEs for Peer Support training

9

CRITICAL ACCESS BEHAVIORAL HEALTH AGENCY (CABHA) UPDATE

Joint Legislative Oversight Committee on MH/DD/SAS
September 8, 2010

Michael Watson
Deputy Secretary for Health Services
Department of Health & Human Services

1

GOALS: CABHA IMPLEMENTATION

- To ensure that mental health and substance abuse services are delivered within a clinically sound provider organization with appropriate medical oversight
- Move the system over time to a more comprehensive and coherent service delivery model
- Increase economies of scale and efficiencies in the service system
- Increase consumer family/stakeholder confidence in our provider network

2

GOALS: CABHA IMPLEMENTATION CONT'D

- Reduce clinical fragmentation – Reduction of "Stand Alone" service delivery
- Increase provider "1st Responder" capacity
- Embed case management in comprehensive clinical provider
- Insure that consumers have access to an array of appropriate clinical services
- Increase accountability within the MH/SA service system – monitor service and referral patterns
- Provide a competent clinical platform on which to implement best practice service models

3

BASIC CABHA SERVICE REQUIREMENTS

- Services that must be delivered within the CABHA structure:
  - Community Support Team (CST), Intensive In-Home (IIH), Day Treatment, MH/SA Case Management, (Effective January 1, 2011).

    NOTE: CMS approved CABHA as a Provider Qualification for the above services.

    NOTE: Service transition period = July – December, 2010
  - New Service: Peer Support – Pending CMS Approval. Proposed implementation date = January 1, 2011

4

CABHA CERTIFICATION REQUREMENTS

- Must provide the core services of:
  - Comprehensive Clinical Assessment
  - Medication Management
  - Outpatient Therapy
- Must deliver at least two enhanced services in the same location where it provides the three core services to create a continuum of care

5

CABHA CERTIFICATION REQUREMENTS CONT'D

- Active National Accreditation of at least 3 years
- Medical Director
  - 100% FTE for providers serving more than 750 consumers – 60% billing
  - 50% FTE for providers serving less than 376-749 consumers – 60% billing
  - 8 hours per week – 0 – 375 consumers – no billing*
  - Clinical Director 100% FTE
  - Quality Management/Staff Training Director 100% FTE

NOTE: **All providers must provide core services regardless of their size/Medical Director requirements**

6

CABHA CERTIFICATION PROCESS

- Attestation letter with documentation
- Desk reviews conducted by DMH/DD/SAS
  - DMA/DHSR Collaboration ("good standing")
- Interviews conducted by
  - DMH/DD/SAS Staff
  - DMA Staff
  - LME Staff
- Verification conducted by LME
  - Findings submitted to DMH/DD/SAS

7

CABHA CERTIFICATION

- Certified CABHAs = 67 (67% = For Profit)
- CABHAs completing Medicaid enrollment process = 30 Note: Additional 14 CABHAs in enrollment process
- CABHA applications in certification process = 208

NOTE: Received 170 applications in last few days of August

8

CABHA TRAINING

- August – 3 Regional CABHA training events – (100+ providers attended each session)
- Topics
  - Enrollment
  - Service Authorization
  - Billing
- Presentations by:
  - DMA
  - DMH/DD/SAS
  - CSC – Provider Enrollment
  - Value Options

9

CABHA TRAINING CONT'D

- Additional training sessions planned
- Active Joint DMA/DMH/DD/SAS CABHA Website

10

DISTRIBUTION OF CABHA REQUIRED SERVICES*

- # of CABHAs servicing consumers by county
  - 5 Counties = 1 CABHA
  - 50 Counties = 2 – 5 CABHAs
  - 36 Counties = 6 – 10 CABHAs
  - 2 Counties = 11 – 15 CABHAs
  - 3 Counties = 16+ CABHAs

NOTE: 4 Counties do not currently have consumers receiving CABHA required services

*Day Treatment, Community Support Team (CST) and/or Intensive In-Home

11

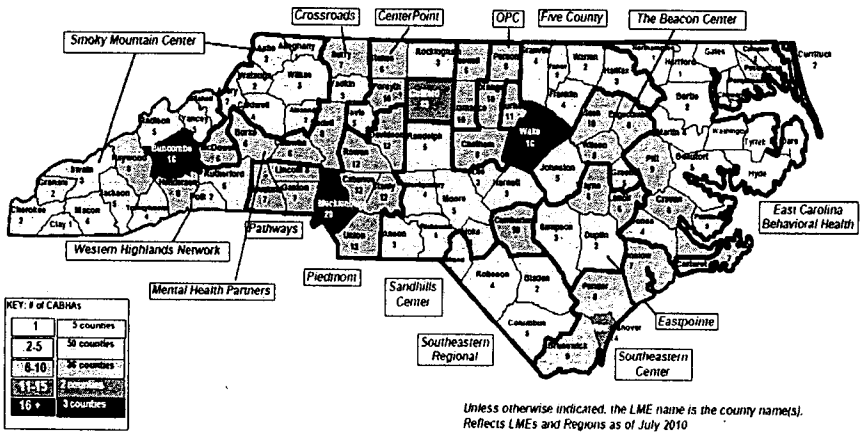
DISTRIBUTION OF CABHA REQUIRED SERVICES CONT'D

- Ensuring Access:
  - Monitor access/choice issues
  - LME Network Develop Role
  - CABHA/Non-CABHA Transition
  - Continued CABHA Certification

NOTE: Consumers must transition to MH/SA Case Management prior to December 31, 2010

12

Home Counties of Individuals Served by Fully Certified CABHAs with Community Support Team (CST), Day Treatment and/or Intensive In-Home (IIH) Services as of July 30, 2010



Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs and Regions as of July 2010

13

CABHA TRANSITION ISSUES

- Service Transition Period July 1, 2010 – December 31, 2010
- Goal: Smooth consumer transition based on clinical need
- Transitions Required:
  - Community Support - Professional to CABHA Targeted MH/SA Case Management
  - Non-CABHA Day Treatment to CABHA Day Treatment
  - Non-CABHA Community Support Team to CABHA CST
  - Non-CABHA Intensive In-Home to CABHA IIH

NOTE: All Transitions based on the clinical needs of the consumer

14

CABHA TRANSITION ISSUES CONT'D

- Transition Benchmarks:
  - Complete CABHA applications to DMH/DD/SAS by August 31st for processing by December 31st Note: Continue to accept applications
  - Upon CABHA Certification, provider must submit complete application to Medicaid provider enrollment to be enrolled by December 31st - Tracking Progress
  - Providers not passing desk review by Sept. 30th – submit transition plan for CABHA services by October 15th

  Note: No Authorization for Intensive In-Home/Day Treatment after Nov. 1st

15

CABHA TRANSITION ISSUES CONT'D

- Providers not passing Interview/Verification stage by Oct. 31st – submit transition plan by Nov. 15th for CABHA services

  Note: No Authorization for CST after December 1st

- Failure to submit transition plans by deadline = Termination of Medicaid Provider Agreement on IIH, DT and CST

16

PROVIDER TRANSITION PLAN REQUIREMENT

- Contact with LMEs regarding available CABHA options
- Consumer Choice in transition options
- Provisions for transfer of consumers most recent clinical information to new provider
- Transition Plan submitted to /approved by LME
- No Approved Plan = Medicaid Provider Agreement Termination

17

PROVIDER TRANSITION PLAN REQUIREMENT CONT'D

NOTE #1:Providers must address record retention responsibilities

NOTE #2: Approximately 12, 000 – 16,000 consumers will:

- Transition to CABHA services;
- Move to basic benefit services; or
- Transition out of services

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CABHA MONITORING

- CABHA Monitoring Workgroup
  - Consumers
  - DHHS Staff
  - LME Representatives
  - Providers

19

CABHA MONITORING CONT'D

- Monitoring Goals
  - Quality Services
  - Implementation of Best Practice Care
  - Consumer Access
  - Referral to Appropriate Services
  - Primary Care Integration
  - Post-Discharge Continuity of Care
  - 1st Responder Capacity/Crisis Services

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CABHA MONITORING CONT'D

- Monitoring Areas
  - Consumer outcomes
  - Leadership Roles in CABHAs
  - 1st Responder Performance/Crisis Utilization
  - Referral Patterns
  - QM Plan Implementation
  - Primary Care Integration
  - Core Service Delivery
  - Regulatory Compliance

21

CABHA MONITORING CONT'D

- Monitoring Tools
  - Paid Claims Data (e.g. referral patterns, service utilization)
  - Consumer/Family Complaints
  - Consumer Satisfaction Data/Interviews
  - NC Treatment Outcome and Program Performance System (NC-TOPPS) data
  - LME Provider Risk Assessment & Monitoring

22

CABHA MONITORING CONT'D

- Service Endorsement Results
- Review of High Cost/High Risk Consumers
- 1st Responder Survey Data
- DMA Program Integrity Data
- Tracking of ED Use and Post-Discharge Follow Up
- Monitoring Consequences:
  - Plan of Correction
  - DMA/PI
  - DMH/DD/SAS Investigations
  - Suspension of CABHA Certifications
  - Termination of CABHA Certifications

NOTE: Need to develop specific monitoring tool/CABHA Report Card

23

CABHA COMMUNICATION PLAN

- Create Effective CABHA Communication & Feedback Mechanism
- Peer Groups
  - Medical Directors
  - Clinical Directors
  - QM/Training Staff

24

CONCLUSION

- CABHA Certification Progressing Well
- CABHA Policies into Rules
- Monitor/Address Access Issues
- Monitor/Manage July – December Transition
- CABHA = Significant Provider invested + commitment
- CABHAs are in their infancy and will need support and system stability through the transition
- CABHAs as Partners
- CABHA = Critical Step toward Quality

25

Residential Level Transitions: Levels III and IV

Joint Legislative Oversight Committee on MH/DD/SAS
September 8, 2010

Mark J. O'Donnell, M.P.H.
DMH/DD/SAS

1

Why Changes Were Made?

- FY 2009-10 budget greatly reduces funding levels (42%) for Child Residential Level III and Level IV services for both Medicaid and state funded consumers. FY 2010-11 reduces funding another 18%.
- Many of these children were inappropriately placed in these LIII or LIV residential facilities, with medical necessity and clinical applications being in question.

2

What Did We Do?
System of Care Response

- By mutual agreement, the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction and the Administrative Office of the Courts embraced a System of Care (SOC) approach to providing services to children, youth and families.

3

What Did We Do?
LME Role: Triage

- The LME has been the lead agency coordinating and overseeing the transition. LME System of Care Coordinators and other LME care coordination staff triaged the initial list of currently placed youth based on severity of need and authorization timelines.
- SOC coordinators, LME care coordinators, or Community Support providers gathered clinical information from the most recent ITR, the current person centered plan (PCP), and the Risk Questionnaire along with other helpful information to assist in the triage and Child and Family Team meetings processes.

4

What Did We Do?
LME Role: Best Practice

- LME System of Care Coordinators and/or other LME care coordination staff attend all Child and Family Team meetings for youth in their catchment areas. In cases when this is not possible, a care coordinator is in close contact with the Community Support Qualified Professional convening the team.

- LME System of Care Coordinators ensure that the Child and Family Team process that occurs for each child/youth follows the best practice principles of the System of Care model.

5

State Guidance

Before a child can be admitted to Level III or Level IV placement the following shall apply:

- 1. Placement may be a transition from a Psychiatric Residential Treatment Facility (PRTF) or inpatient setting

OR

- 2. Multisystemic Therapy (MST) or Intensive In-Home (IIH) services did not meet the youth's treatment needs within the last six months and severe functional impairments persist;

AND

- 3. The CFT has reviewed all other alternatives and recommendations and recommends Level III or IV residential placement due to maintaining the health and safety of the child.

6

State Guidance Cont'd

- For all new admissions to child residential services, length of stay is limited to no more than 120 days. All requests for a new admission must include a discharge plan **signed by the SOC Coordinator** in order for the request to be considered complete.

7

State Guidance Cont'd

- The psychiatric assessment justifying the request and a revised discharge plan must be submitted to DHHS Vendor with the ITR and Person Centered Plan revision including documentation of the review of the CFT.

- Requests for Level III and Level IV residential services for children must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements.

8

What Happened?
Residential III and IV Results:

Recipients In Level III and Level IV Residential Services

		9/7/10	9/7/10
Recipients in Level III residential services. 2532	Recipients in Level IV residential services. 133	Recipients in Level III residential services 620 Difference of 2608	Recipients in Level IV residential services 29 Difference of 160

9

What Happened?
Residential III and IV Results:

Recipients who have been Paper Triaged 2538 Discharge Percentage 80%	Recipients who have had an initial Child and Family Team (CFT) 2546 Discharge Percentage 81%	Recipients who have had a follow-up Child and Family Team (CFT) meeting 2866 Discharge Percentage 91%	Recipients who have been discharged from Level III residential services 2321 Discharge Percentage 78%	Recipients who have been discharged from Level IV residential services 155 Discharge Percentage 92%

10

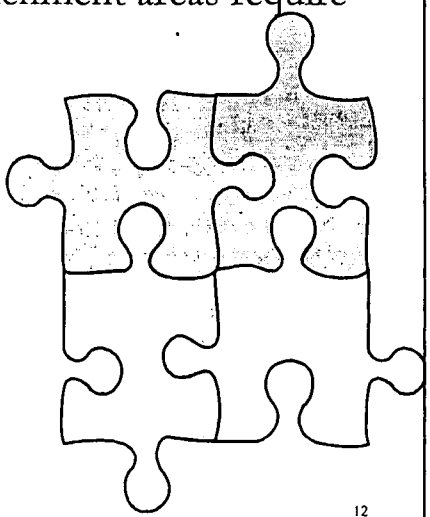
What Happened?
Residential III and IV Results:

- **Where CFTs are referring children (in order of need):**
  - Medication Management
  - Outpatient Individual Therapy
  - Outpatient Family Therapy
  - Intensive In Home
  - Natural Supports
  - Therapeutic Foster Care
  - PRTF
  - Day Tx
  - Residential Level II
  - MST
  - Residential Level III
  - Residential Level IV
  - SAIOP
  - Outpatient Group
  - Respite

11

What Happened?
Residential III and IV Results:

- Services in which some catchment areas require expansion:
  - Respite
  - Intensive In Home
  - MST
  - SAIOP
  - Day Tx
  - Therapeutic Foster Care
  - PRTF



12

What Happened?
Residential III and IV Results:

Level III beds as of August 1, 2009	Level III beds in catchment areas as of the date of this report	Level IV beds as of August 1, 2009	Level IV beds as of the date of this report
2369	1124 Percentage Remaining: 47%	132	12 Percentage Remaining: 9%

13

What Happened?

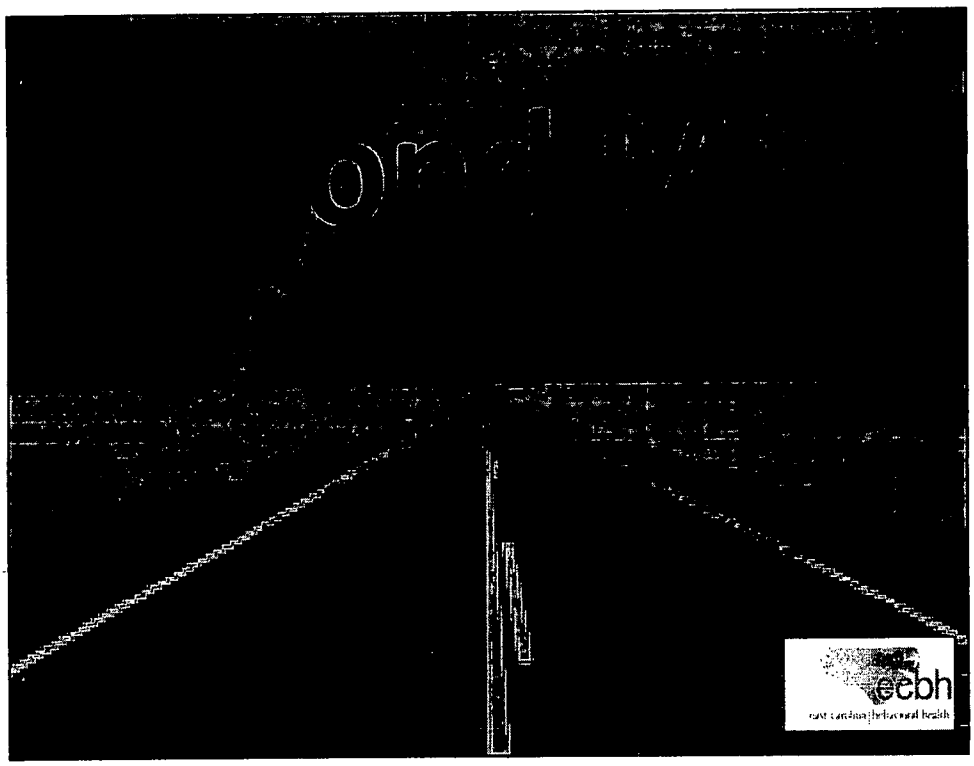
- DMH, working with the UNC Behavioral Health Research Program and Dr. Barbara Burns of Duke University, is conducting a follow-up study to determine the status of the children thus far discharged.

14

What Happened Cont'd?

- Working with Paid Claims data, 91% of the children discharged have remained stable in their discharge placement.
- 9% have returned to a LIII or LIV placement. Some of these have subsequently returned to their community placements.
- Children have been safe in their discharge placement.

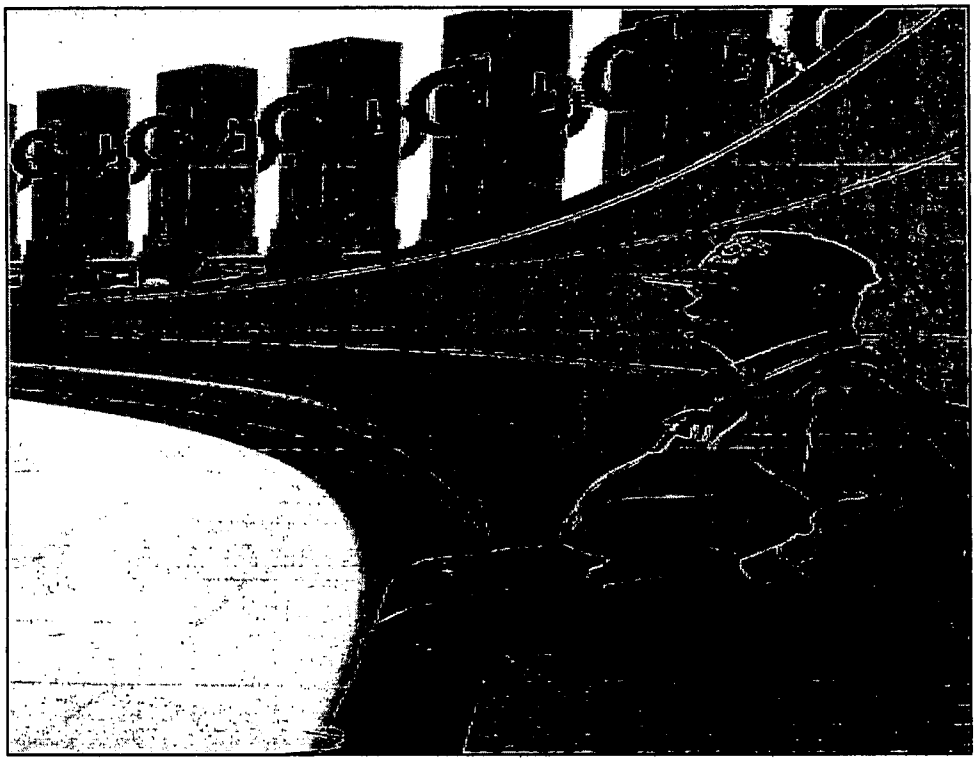
15

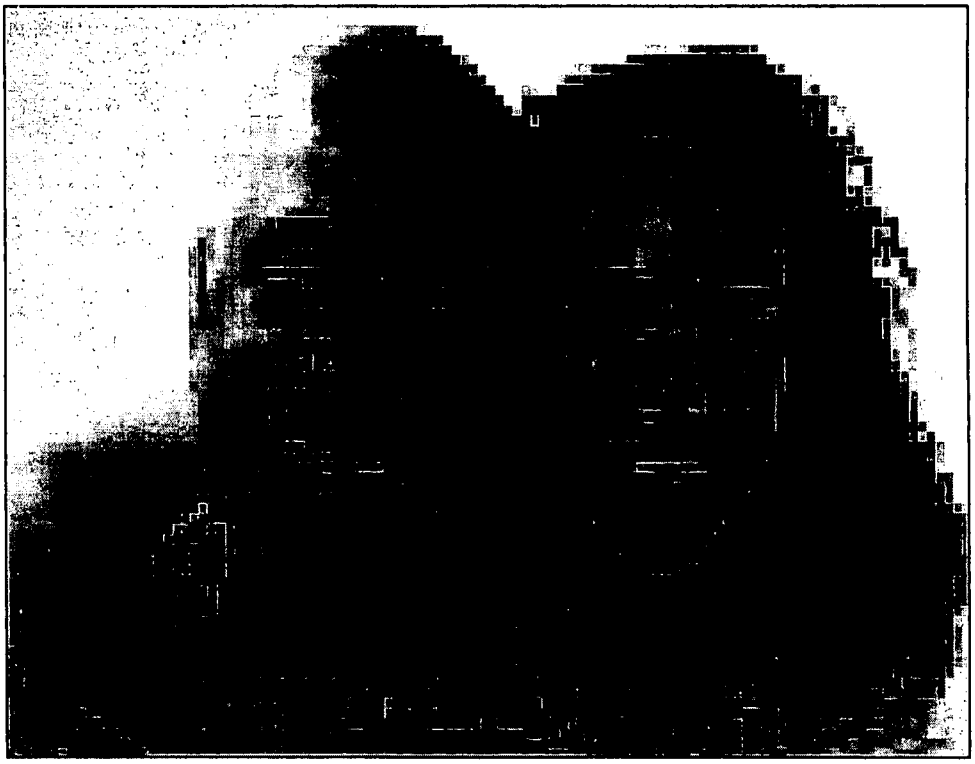


ecbh
east carolina behavioral health

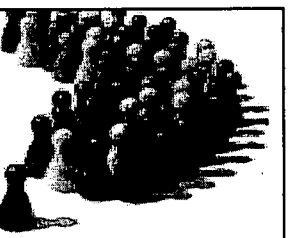
ECBH is a Local Management Entity (LME) for nineteen counties:

- Beaufort
- Bertie
- Camden
- Chowan
- Craven
- Currituck
- Dare
- Gates
- Hertford
- Hyde
- Jones
- Martin
- Northampton
- Pamlico
- Pasquotank
- Perquimans
- Pitt
- Tyrrell
- Washington





What is Second Mile?



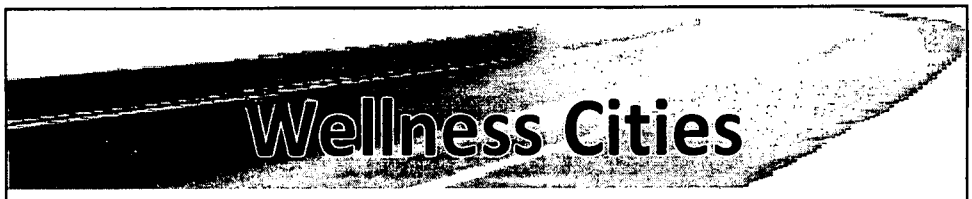
- Comprehensive approach

- Integrates hope, empowerment, education, support , advocacy and supportive services

What Does Second Mile Do?

- Gives people and their families hope that they can overcome mental illness or addiction.
- Empowers a person to approach their illness from a place of strength not defeat.
- Educates people about their illness or addiction and about the reality that Recovery is possible.
- Provides support to walk the extra mile with someone who has already walked it and understands the journey.
- Advocates through action to change old paradigms and create new ones, one person at time, one day at a time.

Second Mile is a part of everything that ECBH does to partner with people.



- ECBH funds two wellness cities operated by Recovery Innovations, Inc.
- Funded with local county dollars

Rural Outreach

- Outreach and wellness, peer support and self-management classes also offered by Recovery Innovations, Inc.
- Funded with local county dollars

Crisis Intervention Training

- Crisis Intervention Training (CIT) for law enforcement in all 19 counties
- A new program also for dispatchers as part of a "system" approach
- Funded by local county dollars and in partnership between ECBH, Pitt County Sheriff's Department and Recovery Innovations, Inc.

Mobile Crisis

- Mobile crisis in all 19 counties.
- ECBH Mobile crisis vendors respond in the community where people live, not in the hospital.
- ECBH and our Mobile Crisis providers also do education within the "system."
- ECBH, through funding from the DMH/DD/SA, subsidizes the Mobile Crisis providers.

Facility Based Crisis and Detox

- Facility Based Crisis and Detox for SA
- ECBH has three FBC and Detox centers within our 19 counties.

Inpatient Care

- ECBH purchases private public partnership beds from two hospitals and has a 3 way contract with 3 other facilities.
- State hospital for the ECBH area is Cherry hospital.
- Second Mile project includes changing the model at Cherry Hospital from a Medical Model to a Recovery Model of treatment.
- ECBH Second Mile Staff have been on campus at Cherry hospital since 2008 laying down the foundation. Trainings began in the summer of 2009.
- Staff are all people who have lived experience with psychiatric struggles or struggles with addiction.

- Classes offered by Second Mile staff have become a part of the choices people can make to participate in while inpatient at Cherry hospital.
- Many people have had the opportunity to learn about Mental Health Recovery through staff outreach and through attending classes.

Cherry Hospital is a 274-bed inpatient psychiatric hospital serving the citizens of 36 eastern North Carolina counties.

They are operated by the state of North Carolina, the Department of Health and Human Services.

Second Mile
Recovery Education Staff

- **NC Certified Peer Support Specialists**
- **WRAP Facilitators**
- **NCI Training**
- **Clients Rights Training**
- **Cherry Hospital New Employee Orientation**
- **Cultural Competence Training**

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NC Certified Peer Support Specialists

- **self-identify** as having personal experience with psychiatric and/or addiction struggles and are in recovery
- are **living examples** that recovery is possible and they **model recovery** in their lives
- have completed a state approved training program and received **state certification**

http://pss-sowo.unc.edu

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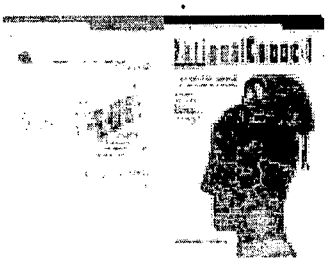
NATIONAL COUNCIL MAGAZINE 2009, ISSUE 2

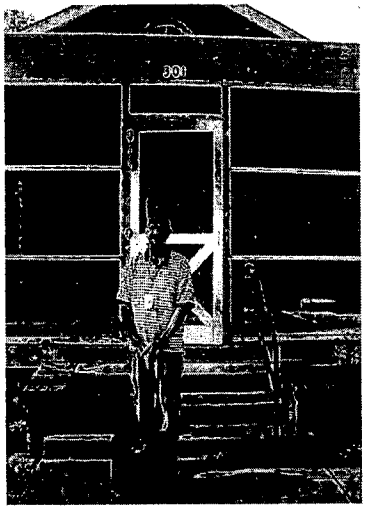


From the Field

Second Mile Offers Peer Support to Prevent Rehospitalization

www.thenationalcouncil.org

North Carolina Council Program of Excellence Award for 2009 - 2010



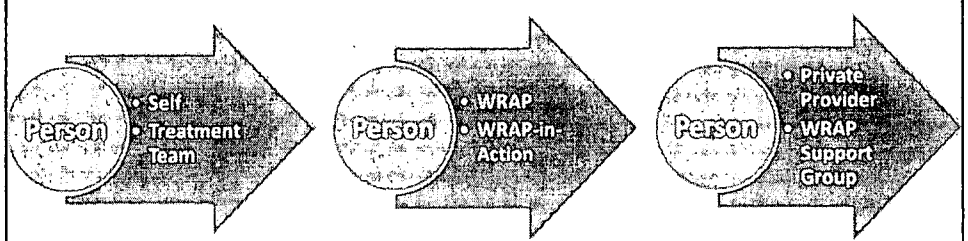
Mile Recovery Education Trainings

- People Served
- Professional Staff
- Health Care Techs
- Private Providers/Community Partners

Referral Process

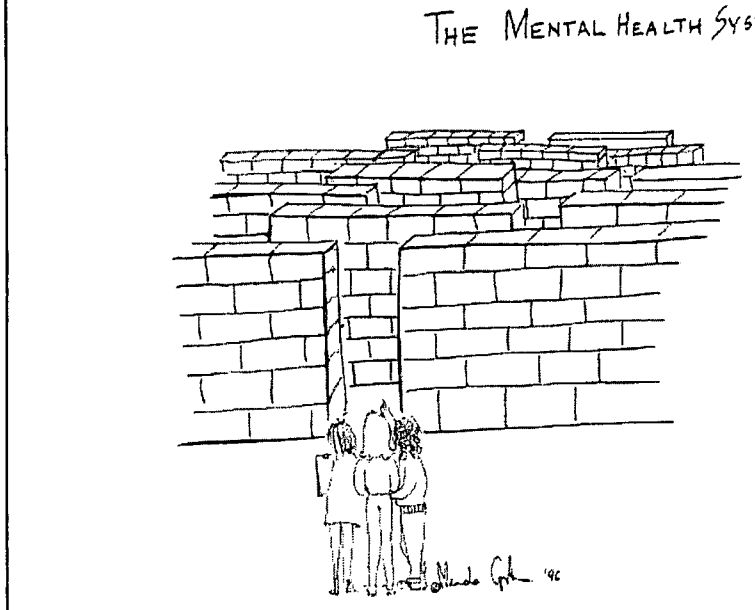
Treatment Mall

Discharge



Science has shown that having **hope** plays an integral role in an individual's recovery.

New Freedom Commission, 2003



After Care

- ECBH has developed two approaches to after care.

- One is transitional housing which gives an individual a place to go to learn and practice skills for Recovery in a Recovery oriented environment.

- The second approach has to do with engagement. Many times the first engagement or appointment after hospitalization can be the most critical time for the person.

25

Support Services

- We connect people to needed traditional services.

- ECBH LME staff and Second Mile staff attempt to link individuals to support services and classes within the community.

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Thank you

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
October 13, 2010 9:30 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair, Presiding

9:30 **Welcome and Opening Remarks**	*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*
9:30-10:00 **Secretary's Remarks**	*Lanier Cansler, Secretary* *Department of Health and Human Services*
10:00-10:15 **Expenditures & Utilization Tracking Update**	*Craigan Gray, M.D., State Medicaid Director* *Division of Medical Assistance*
10:15-11:00 **SIS Assessment Tool Pilot Project** *(Implementation of Sec. 10.6 of Budget Bill)*	*Rose Burnett* *DD Project Manager, DMH/DD/SAS*
11:00-11:30 **Independent Assessments/MH Services** *(Implementation of Sec. 10.36 of Budget Bill)*	*Beth Melcher, Ph.D.* *Asst. Secretary for MHDDSA Services Development*
11:30-11:45 **Update on Dorothea Dix Hospital & Report on Operating Budget** *(Sec. 10.10 of Budget Bill)*	*Luckey Welsh* *Director of State Operated Healthcare Facilities*
11:45-12:45 Lunch	
1:00-1:45 **National Health Reform: Overview and Impact on MH/DD/SA Services**	*Pam Silberman, JD, DrPH* *President & CEO, NC Institute of Medicine* *Publisher, NC Medical Journal*
1:45-2:15 **Implementation Update on CAP-MR/DD Tiered Waiver**	*Rose Burnette* *DD Project Manager, DMH/DD/SAS*
2:15-2:45 **LME Presentation on Youth Villages Transitional Living Program**	*Sabrina Russell-Holloman, Utilization Management Supervisor, Guilford Center Behavioral Health and Disability Services* *Mary Lee, Business Development Specialist, Transitional Living, Youth Villages* *Annie Smith, State Director, Youth Villages*
2:45-3:00 **Analysis of Effectiveness of Single Stream Funding** *(S.L. 2009-191, Sec. 2)*	*Steve Jordan* *Director, DMH/DD/SAS*
3:00 **Closing Comments & Adjournment**	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	10/13/10																
Senator Martin Nesbitt, Co-Chair	X																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	X																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	√																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	X																
Representative Bob England	X																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin	√																
Lisa Hollowell	√																
Gann Watson																	
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	√																
Representative William Brisson	X																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

October 13, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, October 13, 2010 in Room 643 of the Legislative Office Building. Members present were Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, Jim Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Jean Farmer-Butterfield, and Fred Steen. Advisory members Senator Larry Shaw and Representative Van Braxton were present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff member Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the September 8, 2010 meeting. The motion was made by Senator Purcell and the minutes were approved. She also announced that Secretary Lanier Cansler would not be able to address the Committee today.

Dr. Craigan Gray, State Medical Director for the Division of Medical Assistance provided an update on expenditures and utilization tracking. (See Attachment No. 2) Points of interest made by Dr. Gray included these:

- All graphs are created on the basis of date of payment which is affected by provider billing patterns and check writing schedules. The charts depict quarter to quarter rather than month to month.
- Community Support Child expenditures are down by 41%. Community Support ends on December 31, 2010.
- Intensive In-Home expenditures are up by 5.4% with an increase of approximately 350 children per month. This is a medical model, clinically driven.
- Child and Adolescent Day Treatment expenditures are down 18% and the number of children is down to approximately 400 per month due to a stricter criteria policy.
- Multisystemic Therapy expenditures were up 7.5% corresponding with 20 more children per month on average.
- Community Support Adult expenditures are down 33% with an average of 652 adults receiving this service every month with a total of 3,200 still receiving this service with the trend turning downward. Individuals receiving this service now are primarily those getting the case management component.

- Community Support Team expenditures are down 22.4% with 240 fewer adults receiving the service. Value Options reports a 25% - 40% denial rate for requests each month for those who do not meet the medical necessity criteria.
- Substance Abuse Intensive Outpatient expenditures are up 11% with approximately 40 new participants receiving services the first quarter of this fiscal year.
- Mobile Crisis Management expenditures increased by 24% with an average of 100 recipients receiving service per month. The hope is that the numbers reflect a decrease in the Emergency Room utilization. (This information was requested.)
- Targeted Case Management DD (All) waiver and non-waiver participants, expenditures are down 19.8% corresponding with the new service limits of 3 hours per month. CAP waiver recipients have increased by 7%, about 500 more CAP recipients each month. Non-waiver recipients have decreased by 5%, about 300 less recipients each month.
- Expenditures will be watched with providers beginning to bill at a weekly rate.

Joyce Jones from the Bill Drafting Division provided an introduction to the Supports Intensity Scale Assessment Tool Pilot Project (SIS) presented by Rose Burnette, DD Project Manager for DMH/DD/SAS. Ms. Jones stated that Special Provision Section 10.6 of the Budget Bill directed DHHS to expand the SIS Pilot Project initiated in April 2008, by requiring the 7 LME's currently participating in the pilot project to implement exclusive utilization of the SIS for evaluating and assigning all clients with developmental disabilities to the CAP-MR/DD Tiered Waiver and to other needed services. No additional funds were appropriated to the Department to implement this new requirement. She said that the LOC had asked the Department to review the pilot project and the SIS, and to present their implementation plan for exclusive use of the SIS within the pilot for clients with DD, including how SIS results will be used to determine intensity level of support needs and placement within the CAP-MR/DD Tiered Waiver and other needed services.

Ms. Burnette gave an update on the Supports Intensity Scale Project within the seven LME pilot sites. (See Attachment No. 3) She explained that SIS is a standardized assessment tool designed specifically for individuals with intellectual and developmental disabilities and is designed to determine the actual support needs for that individual. Additional points in her presentation included:

- SIS focuses on what a person can do rather that what they are not able to do. SIS is user friendly and engages the individual and family members as a part of the process.
- There is a full-time staff person who coordinates the SIS project through a contract with the Developmental Disabilities Training Institute within the School of Social Work at UNC.
- The state has trained 20 licensed professionals, mostly in the private sector, to administer the SIS. These professionals are able to charge Medicaid for the administration of the SIS. In addition, the state pays for their licensure and for their training.

- The total number of adolescent and adult SIS assessments within the seven pilot LMEs as of October 11, 2010 was 895. She noted that although not normed for children, 125 children had been administered the SIS in the pilot sites. These data as well as all other data are being sent to the owner of the SIS Assessment protocol, the American Association on Intellectual and Developmental Disability.
- Preliminary statistics from Human Services Research Institute (HSRI) indicates that North Carolina has higher support needs than other states examined.
- The Plan is to have HSRI identify a research sample in the 7 sites. These people will be tested and when these data are available, a request will be made to CMS for a technical amendment to the CAP-MR/DD waiver so that the test can be administered statewide for purposes of resource allocation. Until that time, people will have resource allocation based on the NC-SNAP, other tests and the person's current individual budget.

There were a number of questions posed by members of the LOC following this presentation. Representative Insko noted that this was not really a research pilot at all because the subjects in the study did not represent a randomized sample of adults with DD in the 7 LMEs. Ms. Burnette confirmed that only those who volunteered to be given the test were included in the data pool. Accordingly, the point was made that these data cannot be used for any comparative purpose in NC. They cannot be used to compare NC to other states in terms of extent of support needs. Representative Insko noted that the source of the directive to use the SIS to measure intensity of service need emerged from a study in an NC LME in which there was no correlation between the costs of services that any individual received and the intensity of need of that individual. People with low support needs received very high cost services and vice versa. In addition, recommendations were included in reports to the LOC from the Institute of Medicine Study of DD Transition and in the DD Consortium component of the DMH-DD-SAS Gap Analysis report for the use of a standardized intensity of need measure for the purpose of fair allocation of resources.

Members questioned why this pilot had not been designed to be able to provide the basic data to be used to move the pilot statewide. Senator Dannelly remarked that this should have been done a long time ago and that the state was just "treading time". Some questioned the reasoning behind payment of the assessors' training and licensure fees if they are allowed to charge for the testing. Representative Insko indicated that further directives about use of the SIS and resource allocation could be included in the LOC report to the General Assembly.

Lisa Hollowell from Fiscal Research provided an introduction for Dr. Beth Melcher, Assistant Secretary for MH/DD/SAS Development on Independent Assessments. She stated that there was a reduction taken in the budget of $7.7M to be achieved by savings from implementing enhanced mental health service independent assessments. She reminded members that an item in the proposed Governor's budget last year would have taken a $20M reduction for independent assessments but the General Assembly scaled back the reduction. The General Assembly also gave DHHS flexibility in achieving the savings. Ms. Hollowell said DHHS was asked to present plans to achieve the savings, to

explain the process of how it will fit into the CABHA model, and how the savings will be measured for tracking.

Dr. Melcher provided a brief update on the Special Provision to Independent Assessment. (See Attachment No. 4) Points of interest included:

- Fiscal Year 2010 had 40,000 Medicaid and State funded individuals request new services. To avoid the confusion of setting up two separate systems, independent assessments will be done on everyone which would number 108,000 individuals for the entire year.
- A multi-stakeholder group made up of an external advisory team that advises the Department and the Division of MHDDSAS, was tasked with determining how to move forward to accomplish the intent of the provision.
- Attention targeted on providers requesting services beyond a person's needs.
- It is unclear how this will result in the projected cost savings directed by the Special Provision.

Mr. Lucky Welsh, Director of State Operated Healthcare Facilities, provided an update on Dorothea Dix Hospital and a report on the operating budget. (See Attachment No. 5) Mr. Welsh recapped Secretary Cansler's comments from the September meeting regarding the funding shortfall at Dorothea Dix. Additional items of interest included these items:

- An emphasis was placed on the fact that there would be no reduction in bed capacity. Overall, there will be an additional 19 Adult Admission beds at Broughton Hospital.
- Very careful preparation and planning has gone into the transfer of patients. The number one priority is the safety and care of the patients.
- UNC Department of Psychiatry has requested that the Clinical Research Unit be operated on an Outpatient rather than the current in-patient basis. This move is supported by the pharmaceutical companies. If approved, there would be two UNC programs operated on the Dix campus in the same building – the Child Outpatient Program and Clinical Research.
- DDH employees – As many as 45 - 50 may transfer to Cherry Hospital to fill vacant positions. For employees opting to transfer to Butner, a "park and ride" service from the Dix campus will be offered.
- Dr. Jim Mayo, Clinical Director at Dorothea Dix will become the new Clinical Director at Cherry Hospital.
- Total budget calculations for Dix Hospital of $9,223,620 do not include Clinical Research costs which are now included in the Central Regional Hospital budget.
- A number of steps must be in place in order to close Dorothea Dix. The Secretary must present a plan to the General Assembly regarding the closure; if a bill has not been filed within 30 days after the next session starts, the hospital can be closed. If a bill has been introduced but is not acted upon, the hospital would close after adjournment.

It was noted that the solutions to some of the budgetary problems are not always easy. Mr. Welsh noted that the number of state hospital beds has not been decreased, money

has been saved, Central Hospital had already been built, and local hospital beds have been added. Representative Braxton suggested that the Dix facility should be kept for future needs as our State grows in population to be used as a safety net. Mr. Welsh responded that the new Cherry Hospital would have an additional 60 beds and the new Broughton Hospital would have about 100 more beds available for future growth. Wake County also has a facility opening 24 beds soon with plans to expand to 60 beds. Mr. Welsh was asked to provide detailed information regarding the cost to maintain patient care at Dix Hospital.

Dr. Pam Silberman, President and CEO of the N.C. Institute of Medicine and Publisher of the N.C. Medical Journal provided an overview and explained the impact of the National Health Reform on MH/DD/SA services. (See Attachment No. 6) She provided a brief description of the Patient Protection and Affordable Care Act with a focus on the provisions targeting mental health and substance abuse. Points of interest included:

- Data published on September 16, 2010 indicates that approximately 1.7 million people (non-elderly) or 20% of the State's population are uninsured.
- Some studies suggest that people who lack health insurance coverage are 25% more likely to die prematurely than those with insurance.
- North Carolina's median income is well below the 400% federal poverty guideline. Those individuals without access to affordable employer based coverage or who do not have access or qualify for public coverage will be eligible for subsidies to purchase health insurance coverage through the Health Insurance Exchange (HBE).
- HBE information will be available online. The different types of plans can be compared; the costs will be listed; quality ratings will be available; check to see if your provider is in the plan; and you can apply online. Insight to the plan can be viewed at: (www.healthcare.gov).
- Provisions in the Bill focus on investing in prevention in order to help manage a condition before it exacerbates into a crisis.
- Under the Health Reform Bill, State Medicaid dollars would now be available to pay for non-public institutions for individuals with mental illness.
- By 2019, there will be 23 million nonelderly residents uninsured. That population consists of the undocumented, those with incomes too low to buy health insurance coverage or those who would prefer to pay the penalty rather than buy the coverage.
- For people who were eligible for Medicaid but never enrolled who now come into the plan, the federal government wants states to pick up the current 1/3 of the cost.

Sabrina Russell, Utilization Management Supervisor with the Guilford Center addressed the Youth Villages Transitional Living Program. (See Attachment No. 7) She explained that the program targets individuals from ages 16 to 21 that are transitioning out of the foster care system. Youth Villages came to the attention of the Guilford Center through the Children's Mental Health Collaborative which is a part of the Center. Ms. Russell explained the mission of the program, the makeup and the responsibilities of the Collaborative, and the success of the program.

Annie Smith, State Director of Youth Villages provided an overview and addressed the outcome data for the project. Comments regarding the program included:

- Youth Villages was established 24 years ago as a non-profit with offices in 12 states.
- Through the assistance of the Day Foundation, Youth Villages was able to help fill the gap for children most at need by creating the program in 1999.
- The program uses a community based approach targeting youth in their natural environment. Participants are followed for 2 years after discharge.
- Specific to Transitional Living in North Carolina, approximately 100 youth have been served to date with an average of 55 daily at a cost of $51 per day.
- Approximately 400 children age out of foster care per year. Ideally, Youth Villages would like to target more of this population as they age out of foster care.
-

Mary Lee, Business Development Specialist for Youth Villages shared her experiences of living in a foster home as a youth, her adoption at the age of 17, and the support she received. She emphasized the importance of a family life and how difficult the journey was from childhood to adulthood. Ms. Lee provided statistical information comparing foster-care youth to the general population. Statistics indicated that foster-care youth were more likely to experience hardships and challenges through life.

Representative Insko then recognized members of the audience, who had signed up previously, to come forward for the public comment period. Concerns expressed by the audience included:

- Dix workers concerned that fundamental human rights have been denied; want the hospital to remain open; have collected over 1,000 signatures over the past 3 weeks to show support; In November, DHHS will hold "Mental Health Bill of Rights Speak Out" in Raleigh, Butner and Goldsboro for workers, advocates, patients and family members to address conditions. Workers requested that LOC members be present.
- Location of hospital is critical in terms of getting immediate service; patients need family close by and social support; the bulk of the population who need this service are in the Raleigh area.
- Concern for patients waiting in hospital Emergency Rooms for hours or days; 100 people move into Wake County per day but bed space is lacking; too much money being spent to build new hospitals in Goldsboro and Morganton but not enough to provide adequate staffing in the existing hospitals.
- Quality health care for those with mental illness must be number one priority; the first six months of 2010, there were 3,000 people waiting for state hospital beds in North Carolina; the average wait for a bed is 2.6 days; more money needed for additional beds until community supports can be in place.
- Concern was expressed for law enforcement officers being tied up with patients waiting for admittance to a hospital; Cherry Hospital and CRH do not have the equivalent long-term care facility that Dix Hospital has; some patients may require treatment for more than a year in order to stabilize them sufficiently to function in the community.

Due to time constraints, Representative Insko was only able to call on out-of-town speakers. She said that all others would be allowed to address the Committee at the November meeting.

Next, Steve Jordan, Director of DMH/DD/SAS provided an analysis of the effectiveness of Single Stream funding. (See Attachment No. 8) Mr. Jordan explained how Single Stream funding works, the benefits and concerns, and how the effectiveness of Single Stream funding was measured. He reviewed the allocations and expenditures of the 13 LMEs for SFY 2009. Mr. Jordan said that the amount of service actually provided was more than the State budgeted. The additional $7M services were created through the leveraging of the flexibility of the services to qualify for grants and other resources. He said that substance abuse services had increased by 184% across the 13 LMEs participating in Single Stream funding.

There being no further business, the meeting adjourned at 2:45 PM.

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Annie Smith	Youth Villages
NANCY BLACK	SCFAC
Deanna Jarvis	Pride in NC
Susie Doty	Threshold - 609 Gary St. Durham
David Barnett	Threshold
Larry Grant	Threshold
Peyton Maynard	SC
Brandon McPherson	Rep. Alexander's Office
Ken Melton	KMA
MIKE VICARIO	NCHA
Martha Lawrence	NAMI/NCA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Eric Hunley	SAS
Treva Johnson	Omni Visions Inc
Yonatan (Jonathan Neal)	L-d Willing Dorthea Speaking on Dix which will L-d Willing remain open
Gene Rodgers	Universal MH
Billy West	Dynamic Recovery Services
Julia Adams	The Arc of NC
Del Hannard	GPM; ASSOC
Lou Wilson	NCALTCF
John Bowdish	AstraZeneca
Wendy Koch	Policy Group
TARA FIELDS	CFSA-NC
[illegible]	MH/M - B+D Solutions

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TAD CLODFELTER	NC Substance Abuse Federation / SouthLight
Louise G. Fisher	Volunteer Advocate for Mentally Ill
Ashley Perkins	Perkins Law
ARTHUR CARTER	WHN - LME
Rhett Melton	Pathways LME
DAVID SWANN	Crossroads LME
Sandra Pierce	Institute for Family Centered Services
Vicki Smith	Disability Rights NC
Louise Jordan	Nami Wake
Jan Allen	NAMI Wake
William W Stanley	NAMI-WAKE

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS October 13, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kent Earnhardt	Wake Human Services Board

VISITOR REGISTRATION SHEET

SPEAKER SIGN-IN SHEET

Joint Legislative Oversight Committee on MHDDSAS — October 13, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
~~Jamie Johnson~~ Dante Stallings	UE150
~~Yonatan Jonathan~~ Neal	Speaking on Petition (Hillsborough St. Businesses), NCSU student bill, etc about DIX
Louise Jordan	Wake - Nami
~~Ann Akland~~	~~Nami-Wake Advocacy~~
~~[illegible]~~	~~RHA Health~~
TAD Clodfelter	NC Substance Abuse Federation
~~Robin Huffman~~	~~NC Psychiatric Assoc~~
~~William W Stanley~~	~~NAMI-WAKE ADVOCACY~~
Hope Turlington	Advocate - DIX
~~Barbara Moriarity~~	DIX employee - Union

VISITOR REGISTRATION SHEET

SPEAKER SIGN-IN SHEET

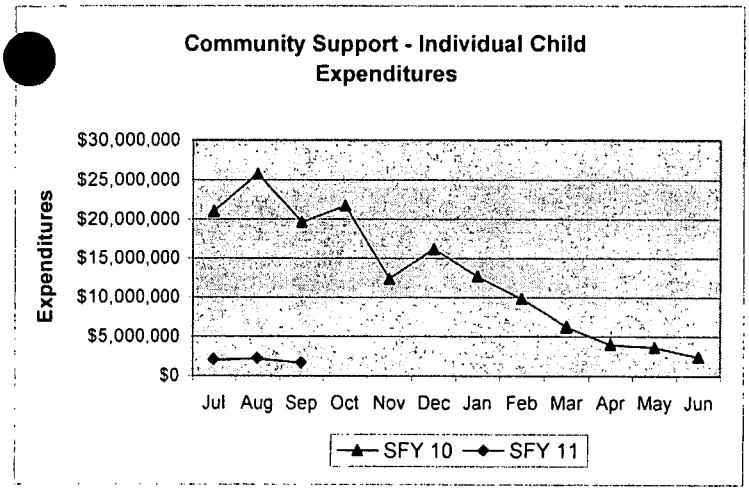
Joint Legislative Oversight Committee on MHDDSAS — October 13, 2010

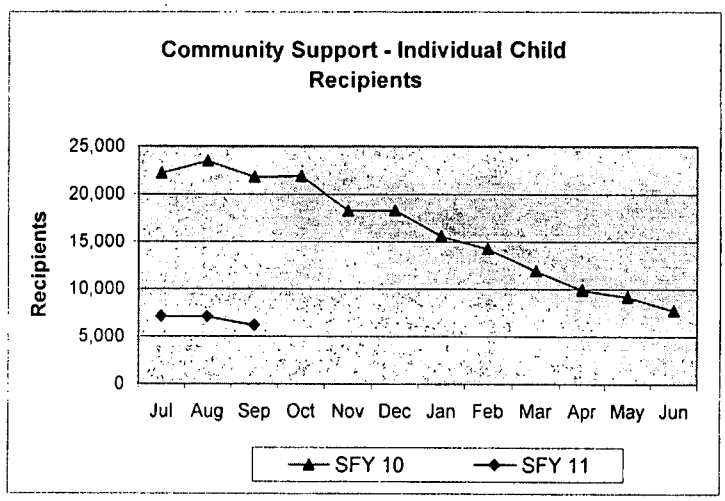
Name of Committee — **Date**

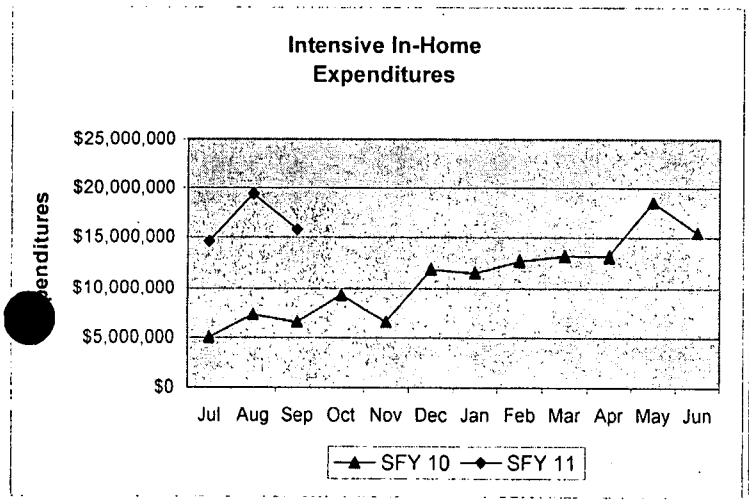
VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

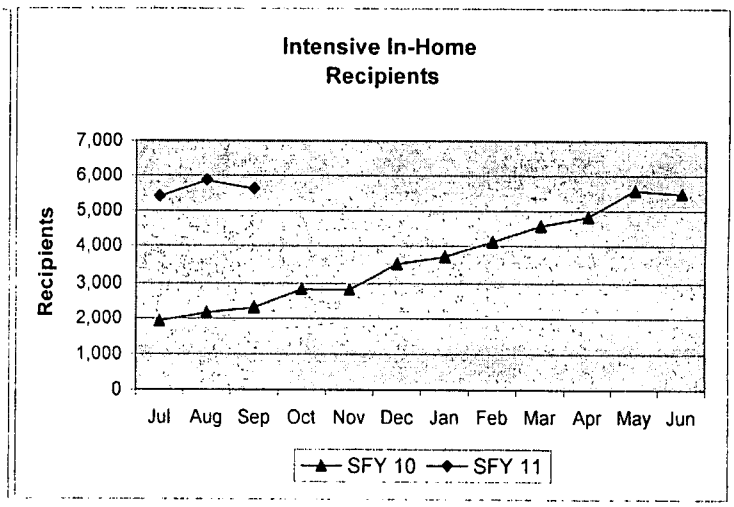
NAME	FIRM OR AGENCY AND ADDRESS
Louise Fisher	Volunteer Advocate for Mentally Ill
~~Hope Darlington~~	~~Dix - Attorney~~
~~Beverly Bennett~~	~~Dix - Nurse~~
Charles Perry	Dix Hospital nurse
~~Jim Wells~~	

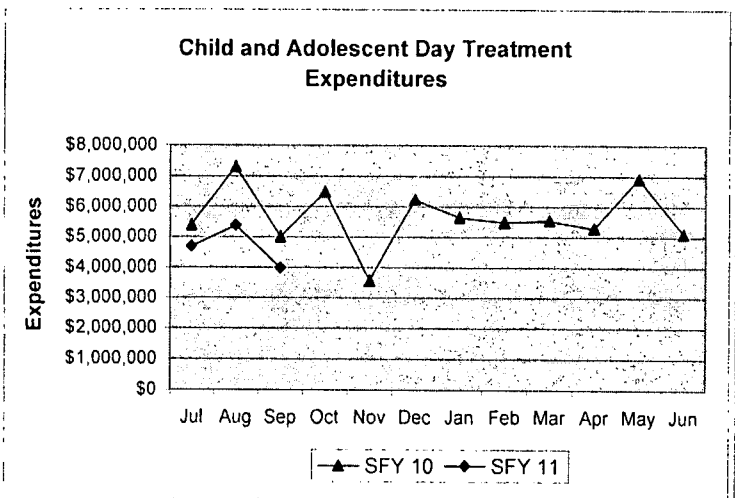
NC MEDICAID BEHAVIORAL HEALTH ENHANCED SERVICES
DATE OF PAYMENT - THROUGH SEPTEMBER 2010

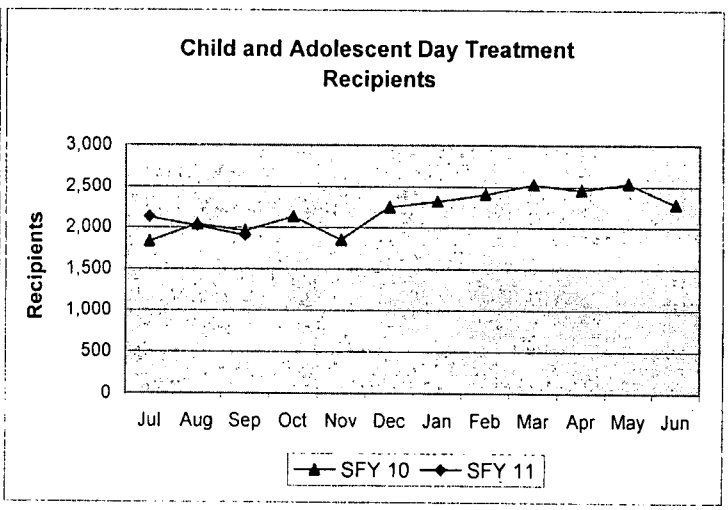


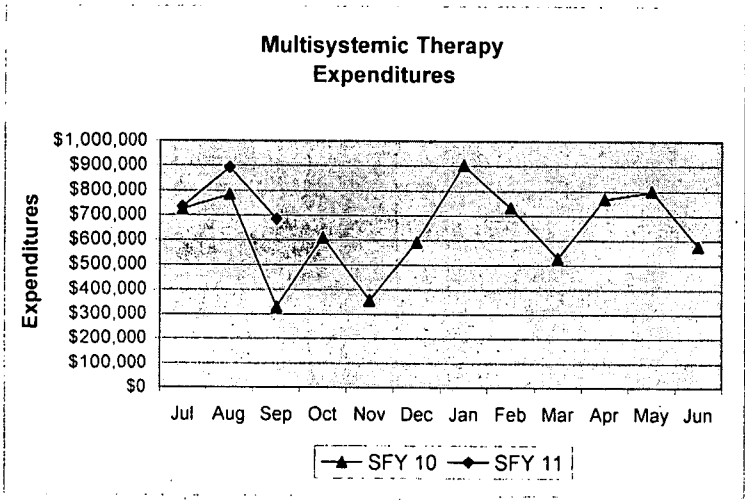








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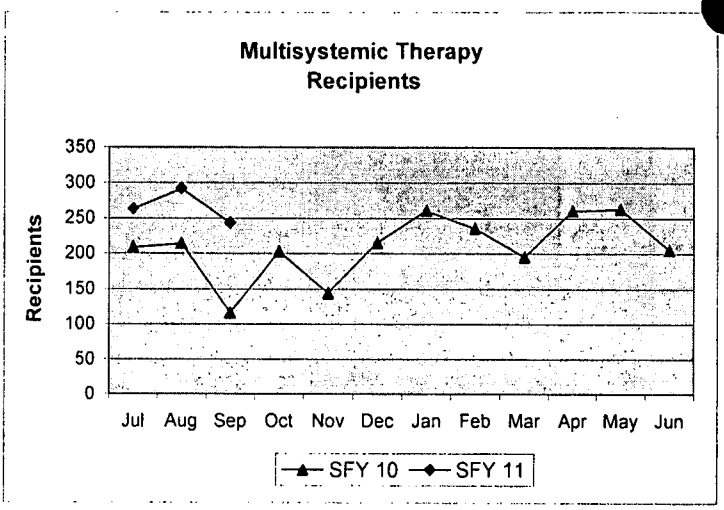
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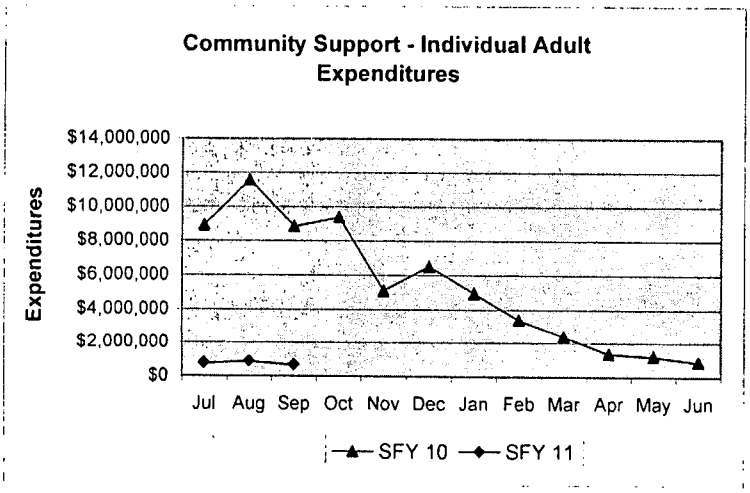
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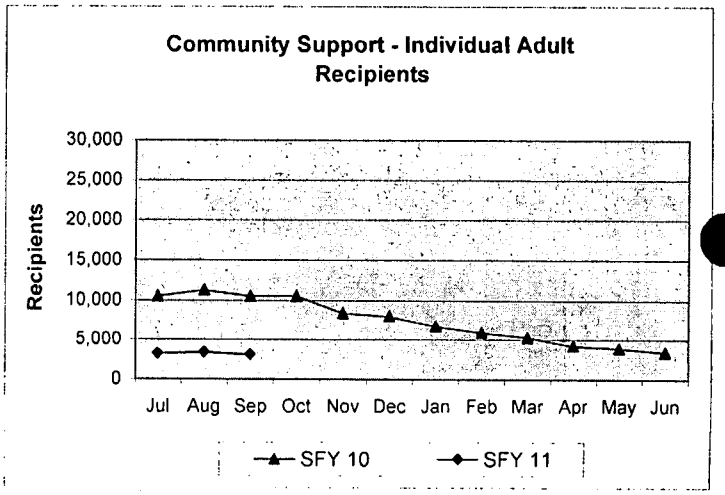
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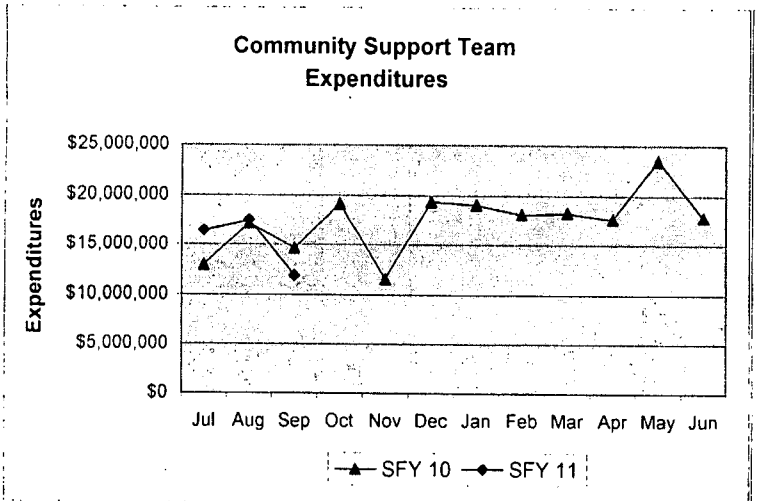
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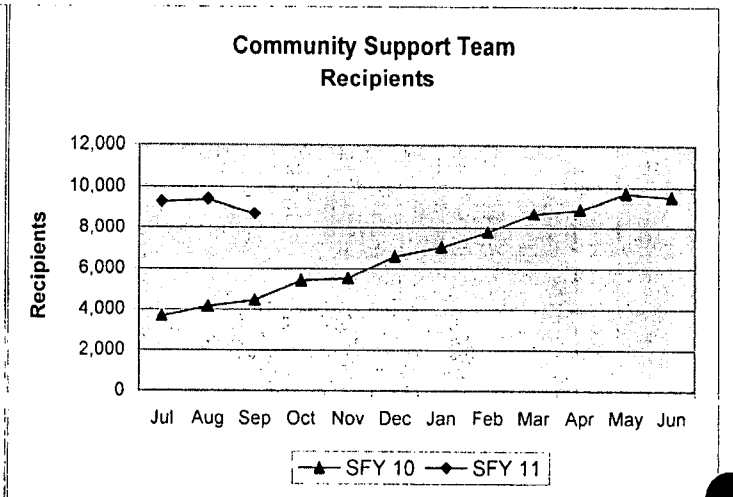
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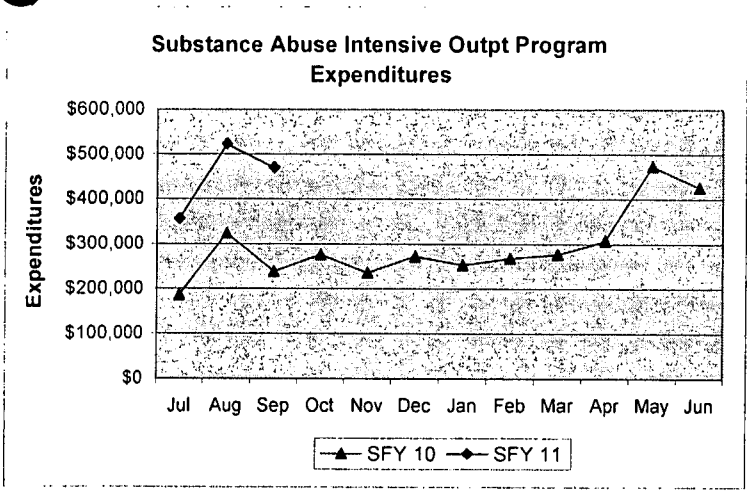
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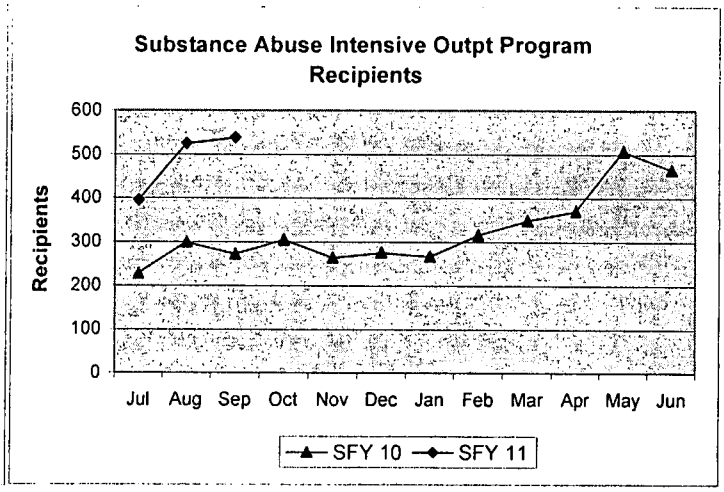
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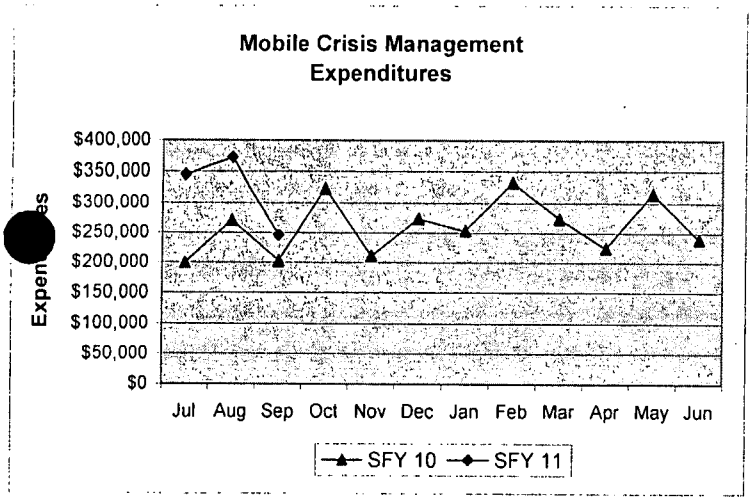
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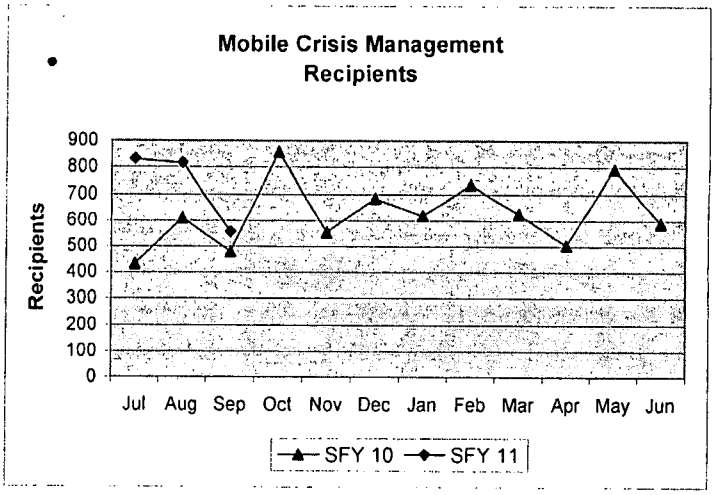
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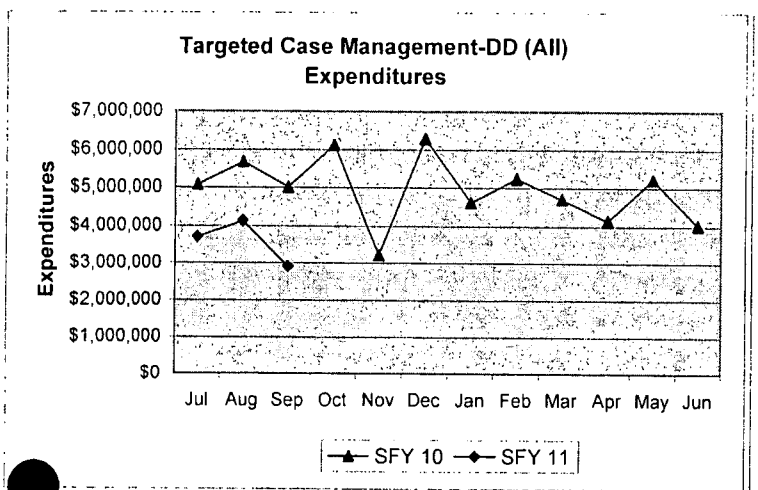
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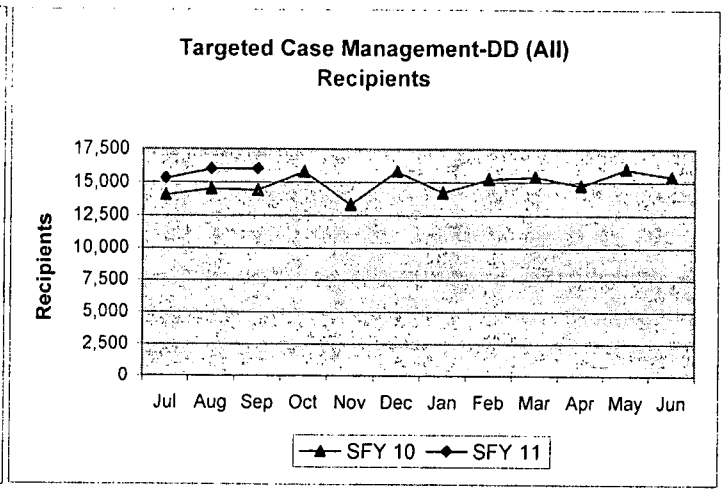
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Supports Intensity Scale™ Pilot Project

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, & Substance Abuse Services

Rose Burnette
NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

10/13/10

Supports Intensity Scale (SIS)

- A standardized assessment that focuses on what supports are needed by an individual along several dimensions of everyday life
- Information gathered is used to help the team in developing the supports for a person to live successfully

Why is North Carolina using the Supports Intensity Scale?

Because the SIS is:

- positive and supports oriented
- engaging (i.e., the interview includes the consumer, family, case manager, and others familiar with the consumer)
- a reliable and valid instrument that is currently being used in 10 other states
- quantifiable, SIS yields solid information about support needs that can be used in building funding applications

Supports Intensity Scale™ (SIS) Pilot Project

- Implementation of the Supports Intensity Scale™ (SIS) Pilot Project in April of 2008.
- First year of the pilot was planning, building examiner capacity and infrastructure within the LME(s).
- The second year has been to implement the use of the SIS within the 7 pilot LME(s).

SIS Pilot Objectives

The objectives of this effort include:

- improving the assessment of individual service and support needs
- to more reliably inform the person centered planning process
- collecting data to begin planning for a systematic process for determining distribution of funding based on intensity of need

SIS Pilot LME(s)

- The seven LME(s) involved in the SIS Pilot Project include;
  - Durham,
  - East Carolina Behavioral Health,
  - Five County,
  - Guilford,
  - Mecklenburg,
  - Sandhills
  - Smoky Mountain Center

Development and Expansion of the Project

- Recruitment and training of 20 SIS assessors;
- Development of an effective supervision model for use with the SIS assessors;
- Development of curricula and provision of SIS overview training to the pilot LME(s), case managers and other provider staff;
- Development of an informational packet and distribution plan about the SIS instrument for use by the pilot LME(s);
- Development of a SIS specific web page on the DMH-DD-SAS website;

Development and Expansion of the Project

- Maintenance of an active working relationship with the American Association on Intellectual and Developmental Disabilities (AAIDD, the sponsoring organization of the SIS)
- Review and analyze the AAIDD database maintained on NC SIS assessments completed;
- Provision of information and reports regarding the completion of SIS assessments within the pilot LME(s);
- Consultation with DMH-DD-SAS staff and stakeholders regarding the SIS tool and the SIS Pilot project; and
- Expansion of the use of the SIS assessment tool beyond the seven pilot LME(s) to include all LME(s) and individuals on the Support Waiver.

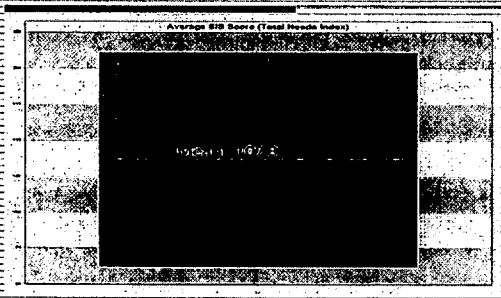
Development and Expansion of the Project

- Total of adolescent and adult SIS assessments completed as of October 1, 2010 is **860.**
- Age range of the sample is 16 through 72 years of age .
- The number of children assessed is 175 although not included in the 860 or data analysis

SIS Data Across States

- Human Services Research Institute (HSRI) has begun to observe common characteristics across multiple state data sets.
- The SIS Support Needs Index has an average score of 100
  - NC 107.3,
  - VA 101.74,
  - CO 99.89,
  - GA 98.23

North Carolina: Average Total Needs Index Score (SNI)



Total Number of Assessments: N = 860

Implementation of SL 2010-31, Section 10.12. (f)(2)

Requires the seven LME(s) participating in the current Supports Intensity Scale (SIS) assessment tool pilot project to administer a SIS assessment to all clients with developmental disabilities no later than October 1, 2010

- Currently there are 20 SIS practitioners and about 1778 individuals within the CAP-MR/DD waivers remaining to be assessed.
- Adequate time is needed to increase the numbers of SIS practitioners and complete the assessments.
- Currently the use of the SIS is not required within the waivers.

Implementation of SL 2010-31, Section 10.12. (f)(2)

The participating LME(s) shall use the results of the SIS assessment to assign clients with developmental disabilities to one of the tiers within the CAP-MR/DD Waiver and to other needed services, according to their relative intensity of need.

- DMH-DD-SAS and DMA are the only agencies that have the authority to allocate slots for the waivers, not the LME(s).

Distribution of Funding Based On Intensity of Need

- DHHS needs to determine next steps to create a systematic process for distribution of funding based on intensity of need;
  - Specific types of information is required that includes SIS data with other information about people who receive services.
  - The use of the SIS in isolation is not best practice and jeopardizes the integrity of any process/system for determining service costs.
  - Adequate time is needed to complete the necessary work to define the specific parameters of the proposed sample.
  - Stakeholder input is CRITICAL!!

Distribution of Funding Based On Intensity of Need

DMH-DD-SAS is engaged in a variety of exploratory activities:

- Discussions with other states
- Discussions with Jon Fortune and John Agosta, of the Human Services Research Institute (HSRI) regarding specific data requirements and information gathered from completed NC SIS assessments
- Discussions with PBH regarding the the PBH Support Needs Matrix

Implementation of SL 2010-31, Section 10.12. (f)(2)

Implementation Plan:

- Focus on gathering data generated from the standardized version Adult SIS.
- NC-SNAP will continue for children and adults until such a time that the SIS is implemented statewide

Implementation of SL 2010-31, Section 10.12. (f)(2)

Implementation Plan:

- First priority for completion of assessments is for adults on the CAP-MR/DD Waivers.
- Assessments based on the individual's annual Person-Centered Plan (based on the individual's birthday).
- Assessments to occur at least 60 days prior to the completion of the Person-Centered Plan

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Waiver Technical Amendment (TA)
  - To *require* individuals to participate in the completion of the SIS
  - Complete and review by Physician's Advisory Group (PAG)
  - Submission to CMS.
  - **Target date for completion: 1/30/11**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Implementation of the policy change (to require individuals to participate in the completion of the SIS) after CMS approval.
- **Target date for completion: 4/30/11**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Recruitment and training of SIS practitioners through establishment of two NC mentor level trainers.
- **Target date for completion: 10/30/10**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- To increase practitioner capacity, secure commitment from inactive practitioners (formerly trained) to determine interest/recruit back to active status.
- **Target date for completion: 10/30/10**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Finalize SIS training plan and establish schedule;
  - Develop training plan for new practitioners
  - Establish internal capacity for ongoing (reliable) training
  - **Target date for completion: 11/30/10**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Continue work with Jon Fortune and John Agosta (HSRI) regarding data collection related to completed SIS assessments and decisions regarding the specific parameters of the proposed sample.
- **Target date for completion: 11/30/10**

Implementation of SL 2010-31, Section 10.12. (f)(2)

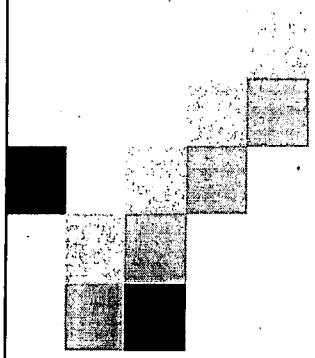
- Determine next steps for formal planning for the creation of a systematic process for determining distribution of funding based on intensity of need.
- **Target date for completion: 1/31/11**

Implementation of SL 2010-31, Section 10.12. (f)(2)

- Determine resource requirements for the creation of a systematic process for determining distribution of funding based on intensity of need.
- Resource needs include specific funding needed for qualified staff and costs associated with the complete implementation of the SIS for all adults who receive waiver funding.
- **Target date for completion: 1/31/11**

Supports Intensity Scale™ Pilot Project

- Thank you for your attention!
- Questions???



Independent Assessment

Presentation to the Legislative Oversight Committee

October 13, 2010

1

Summary of the Special Provision to Implement Independent Assessment on Mental Health Services 10.36(a-c)

- Start October 1, 2010
- Require that an independent assessment be conducted prior to delivery of Medicaid enhanced services
  - An initial assessment or continuing need assessment performed by independent entity not providing services in question
  - The independent assessment entity recommends the type and amount of services based on health condition and need of individual

2

Summary of the Special Provision to Implement Independent Assessment on Mental Health Services 10.36(a-c)

- Anticipated savings of $7.7 million
- If savings not achieved, also require targeted independent assessments for:
  - Individuals exiting inpatient facilities
  - High-cost/ high-risk individuals with high behavioral health or medical needs
  - Individuals for whom additional continuing care authorizations are being requested
  - Individuals moving to a higher, more intensive level of care
- Report of saving generated and other findings April 1, 2011

3

Goals of Implementation

- Meet requirements and intent of provision
- Ensure don't create barriers to service access
- Use existing resources instead of creating a new infrastructure
- Integrate into current authorization process
- Ensure do not undermine role of CABHAs

4

Challenges to Implementation

- FY10 had over 40,000 new service recipients for enhanced MH/SA (Medicaid/IPRS) services. Served total of over 108,000 Medicaid MH/SA.
- Have placed assessment within the CABHA core services. Do not have established infrastructure of independent licensed individuals who can do assessment outside of CABHA.
- Questions about how to
  - Identify independent licensed practitioners
  - Refer
  - Ensure sufficient awareness of community treatment/ support
  - Minimize conflict of interest or competition issues among CABHAs
- How to ensure that service participants would engage in this assessment. Concerns that transition to another provider following and assessment could create barrier for entering services and many would simply drop out of service
- Aggressive timeline to implement by October

5

Approach to Implementation

Need to evaluate whether referral to enhanced services is appropriate. For referral to occur licensed individual needs to sign off on PCP and service order.

- Specifically target the quality of the referral process at the point of the Service Order/PCP sign off.
- By using quality of care reports from utilization vendors and by identifying providers with high rates of denials/appeals, can conduct targeted independent reviews using psychiatrists/ psychologists to review records to see if services being requested are needed based on assessment and best practice.
- Do same type of independent assessment on random sample of providers who have not been identified in quality of care reports.
- Will help identify trends between the groups as well as whether using quality of care reports is a reliable way to trigger an independent review.

6

Current Status

- Continue to work on implementation of targeted independent review at point of service order
- Recognizing the complexity of implementing independent assessment have moved to put in place targeted independent assessments for individuals with high service needs to achieve as much of anticipated savings as possible. Can implement this process in a more timely manner
- Draft plan focuses on independent assessment when individual exceeds certain level service duration or frequency for ACTT, CST, PSR, IIH, Day Treatment, inpatient or crisis services. E.g. individuals receiving ACTT for greater than 18 months
- Would be completed by independent licensed practitioner and submitted with re-authorization request as information and recommendations for authorizing entity to consider in making a re-authorization decision

7

Next Steps

- Because the assessment impacts service type, frequency, and duration the plan needs to be reviewed by Physicians Advisory Group (PAG).
  - It was submitted to PAG on August 24,2010
  - Is being reviewed by MH subcommittee.
  - Expect PAG to take action at October meeting
  - Following review will be posted for 45 day comment period
- Will work with multi-stakeholder group to develop implementation strategies
- Collect data on cost savings, referrals, and outcomes

8

Dorothea Dix Hospital Cost Reduction Measures

Presentation to the LOC for Mental Health, Developmental Disabilities and Substance Abuse Services,

October 13, 2010

Luckey Welsh, Director
Division of State Operated Healthcare Facilities

Legislative Oversight Committee Meeting September 8, 2010

- Secretary Cansler shared information on the budget deficit at DDH and described the need for additional beds
- Secretary's Directive to:
  - Implement Cost Reduction Measures at DDH
  - Increase Acute Bed Capacity at Broughton Hospital

2

Legislative Oversight Committee Meeting September 8, 2010 (cont.)

- Dorothea Dix Hospital (FY2010/2011):
  - Required State Appropriations $57,936,998
  - Current State Appropriations $28,986,359
  - Net Unfunded Shortfall $28,950,638

3

- Cost Reduction Plan
- Timeline for Patient Transfers
- DDH Employee Placement and Transfers
- Budget

4

The Cost Reduction Plan

- Transfer To CRH:
  - 60 Adult Admission Beds
  - 11 Adult Long Term Beds
  - 54 Forensic Med/Max and Pre-Trial Beds
  - Clinical Research Unit
- Transfer to Cherry Hospital:
  - 30 Adult Long Term Beds
- Remaining on Dix Campus:
  - 30 Forensic Minimum Beds
  - Child Outpatient Program

- **No Reduction in Bed Capacity**

5

Timeline for Patient Transfers

Completed

- Move Patients in Adult Long Term to CRH

October/November

- Move Patients in Adult Long Term to Cherry
- Move Clinical Research Unit
- Stop Admissions to Inpatient Pre-Trial Evaluation (continue outpatient evaluations)

6

Timeline for Patient Transfers (Cont.)

December

- Move Patients in Forensic Maximum
- Stop Admissions to DDH
- Move Pre-Trial Evaluation Services
- Move Patients in Forensic Medium
- Move Remaining Patients in Adult Admission

7

DDH Employees

On August 24, Secretary Cansler met with DDH staff in 2 Town Hall Meetings to directly share with them the budget situation, the need to take significant cost reduction measures at DDH and to answer questions.

8

DDH Employees (cont.)

- 99% have been offered positions at CRH
- Have priority for any vacancies at DSOHF facilities, including expedited hiring
- Cherry Hospital has facilitated hiring for DDH employees who are interested in transferring to Cherry

9

Budget

- The Cost to Operate Units Remaining on Dix Campus (State Appropriations Only):
  - Child Outpatient: $1,661,558
  - Forensic Minimum: $7,562,062
  - Total: $9,223,620
- The cost to open 19 additional Adult Admission Beds at Broughton Hospital is $2,857,583 (State Appropriations Only)

10

Budget (cont.)

Net Outcome of Cost Reduction Measures

- Current Operations Cost
  Dix Hospital Shortfall $28.9M
- Less:
  - Cost to Operate Forensic-Minimum and Child Outpatient at Dix Hospital = $9.2M (State Appropriations Only)
  - Broughton Hospital cost to add 19 Additional AAU Patients = $2.8M Shortfall
- Division's savings after cost reduction measures = $16.9M (State Appropriations Only) with an increase in bed capacity in the system

11

Understanding National Health Reform

Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services

Presentation by:
Pam Silberman, JD, DrPH
North Carolina Institute of Medicine
October 13, 2010

NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

A Word About the NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

NCGS §90-470

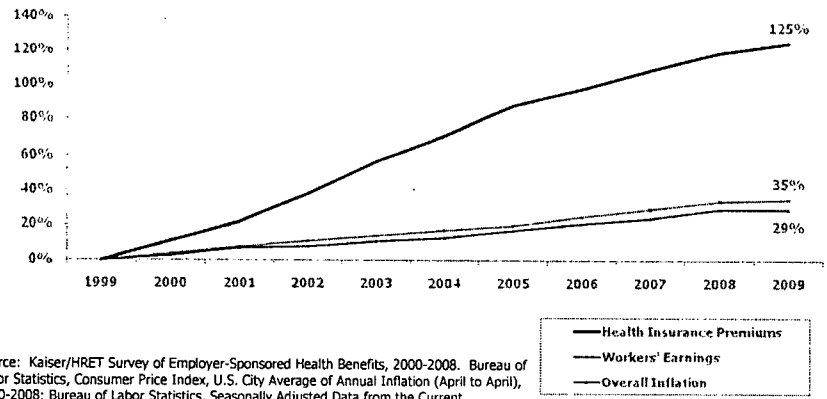
NCIOM

Background

- Estimates of the uninsured:
  - Recent Census numbers showed approximately 1.7 million non-elderly uninsured in NC (2009)
- Lack of health insurance impacts on a person's health
  - People who are uninsured are less likely to receive preventive services, more likely to end up in the hospital for preventable conditions or late stage cancer, and more likely to die prematurely
  - Lack of insurance coverage affects a family's financial security

NCIOM Source: US Census. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65. Table HIA-6:

US Health Insurance Premiums Increasing More Rapidly Than Inflation or Earnings (1999-2009)



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April). Claxton G. et. al. Job-Based Health Insurance: Costs Climb at a Moderate Rate. Health Affairs. Sept. 15, 2009.

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National Health Reform Legislation

- Patient Protection and Affordable Care Act (HR 3590) (signed into law March 23, 2010)
- Health Care and Education Affordability Act of 2010 (HR 4872)

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- CBO estimates
- North Carolina planning efforts
- Impact on people with MH/DD/SA

Basics of National Health Reform--Overview

- **Overview of health reform legislation**
- Changes in public coverage
- Private coverage
- Other provisions
- CBO estimates
- North Carolina planning efforts
- Impact on people with MH/DD/SA

Overview of Health Reform

- By 2014, the bill requires most people to have health insurance and large employers (50+ employees) to provide health insurance--or pay a penalty.
  - Builds on our current system of public coverage, employer-sponsored insurance, and individual (non-group) coverage
- New funding for prevention, expansion of the health workforce, long-term care services, increasing the healthcare safety net, and improving quality

Basics of National Health Reform--Overview

- Overview of health reform legislation
- **Changes in public coverage**
  - **Medicaid, CHIP and Medicare**
- Private coverage
- Other provisions
- CBO estimates
- NC planning efforts
- Impact on people with MH/DD/SA

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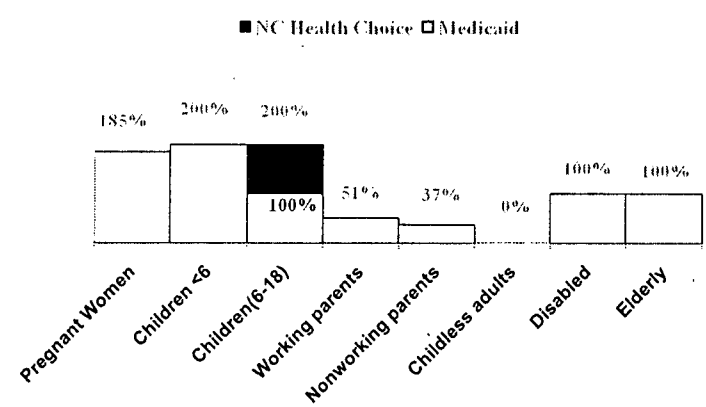
Existing NC Medicaid Income Eligibility (2010)

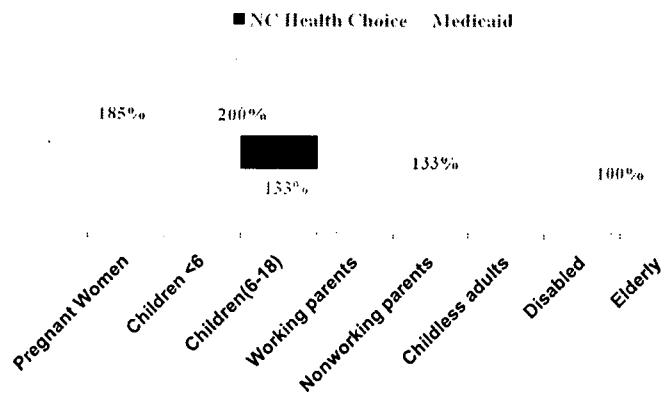


Currently, childless, non-disabled, non-elderly adults can not qualify for Medicaid

NCIOM

KFF. State Health Facts. Calculations for parents based on a family of three.

Existing NC Medicaid Income Eligibility (2014)



Beginning in 2014, adults can qualify for Medicaid if their income is no greater than 133% FPL, or $29,327 for a family of four

NCIOM

Source: Affordable Care Act (Sec. 2001, 2002).

Expansion of Public Programs

- Expands Medicaid to cover all low-income people under age 65 (including childless adults) with incomes up to 133% FPL (begins FY 2014) (Secs. 2001, 2002)
  - States must maintain current income eligibility for children in Medicaid and CHIP until 2019 (Sec. 2101(b), 10203).
  - Beginning 2014, special outreach requirements to vulnerable populations, including people with mental illness or substance use disorders (Sec 2201).

NCIOM

Medicare

- Enhances preventive services, beginning Jan. 2011 (Sec. 4103-4105, 10402, 10406)
- Phases out the gap in the Part D "donut hole" by 2020 (Sec. 3315, as amended by1101 Reconciliation)
  - $250 rebate in 2010
  - 50% discount on brand-name drugs in 2011 (Sec. 3301)
- Strengthens the financial solvency of the Medicare program
  - Extends the life of the Medicare trust fund by 12 years

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- **Private coverage**
  - **Standardized benefit package**
  - **Individual mandate and subsidies**
  - **Employer responsibilities**
  - **Health insurance "exchanges" and insurance reform**
- Other provisions
- CBO estimates
- NC planning efforts

Essential Benefits Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302; Sec. 2713 of Public Health Service Act, amended in Sec. 1001)
  - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; and maternity care
  - More extensive services for children under age 21 (Sec. 1001, 1302)
  - Recommended preventive services with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
  - **Mental health parity law applies to qualified health plans** (Sec. 1311(j))

Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
  - Bronze (minimum creditable coverage): must cover 60% of the benefit costs of the plan
  - ***Silver: 70% of the benefits costs****
  - Gold: 80% of the benefit costs
  - Platinum: 90% of the benefit costs

Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance, unless exempt. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
  - Penalties: Must pay the greater of: $95/person or 1% taxable income (2014); $325 or 2.0% (2015); or $695 or 2.5% (2016), increased by cost-of living adjustment*
  - Some of the exemptions include people who are not required to file taxes, and those for whom the lowest cost plan exceeds 8% of an individual's income (Sec. 1501(d)(2)-(4),(e))

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*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount. The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).

Subsidies to Individuals

- Refundable, advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis ($43,320/yr. for one person, $58,280 for two, $73,240 for three, $88,200 for a family of four in 2010).* (Sec. 1401, as amended by Sec. 1001 of Reconciliation)
  - Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare (Sec. 1401(c)(2)(B)(C), 1501)
  - In comparison: North Carolina's median household income in 2008 was $46,574 (avg. household = 2.5 people).

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*2010 Federal Poverty Levels are: $10,830 for an individual, $14,570 for a family of two, $18,310 for a family of three, or $22,050 for a family of four. US Census Bureau. North Carolina. Quick Facts. http://quickfacts.census.gov/qfd/states/37000.html

Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
- Employers with less than 50 full-time employees exempt from penalties. (Sec. 1513(d)(2))
  - Employers with 25 or fewer employees and average annual wages of less than $50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)

Health Insurance Exchange

- States will create a Health Insurance Exchange for individuals and small businesses. (Sec. 1311, 1321)
  - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees. (Sec. 1312(f))
- Exchanges will:
  - Provide standardized information (including quality and costs) to help consumers choose between plans
  - Determine eligibility for the subsidy

Health Insurance Exchange (HBE)

- "No wrong door approach" between Medicaid and HBE (Sec. 1311, 1411, 1413)
  - Individuals who apply for health insurance through the HBE will have their eligibility determined for Medicaid; those who apply for Medicaid will have their eligibility determined for HBE subsidies
- Patient navigators to help link individuals to Medicaid or private insurance through HBEs

NCIOM

Immediate Insurance Reform

- The ACA included immediate changes in insurance laws which may help some people with MH/DD/SA conditions
  - Funding for a federal high risk pool that provides more affordable coverage to people with preexisting health problems (Effective July 1, 2010, Sec. 1101)
  - Insurers cannot exclude children based on their preexisting health problems (effective for plans renewed or purchased after September 23, 2010)
  - Insurers cannot impose lifetime limits on health coverage, and must limit annual limits, and cannot rescind policies (effective for plans renewed or purchased after September 23, 2010, Sec. 2711 , 2712, of the Public Health Service Act as amended by Sec. 1001 of ACA)

Insurance Reform: 2014

- Insurers are prohibited from:
  - Discriminating against people based on preexisting health problems (Effective 2014; Sec. 1201)
  - Including annual or lifetime limits for essential benefits (Sec. 1001, 10101)
- Insurers are required to:
  - Limit the differences in premiums charged to different people based on age (3:1 variation allowed), and certain other rating factors (Effective 2014; Sec. 1201)

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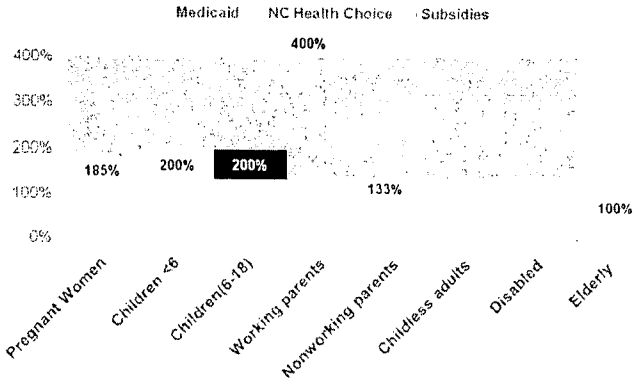
After Health Reform Fully Implemented (Beginning 2014)



Beginning 2014, most people with incomes ≤400% FPL who do not have Medicaid, Medicare, Health Choice, TRICARE, or access to employer-based coverage can qualify for subsidies to purchase insurance in the Exchange

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Income Eligibility for Subsidized Insurance (2010, 2014)

Annual income eligibility based on family size of four (based on 2010 federal poverty levels)

	Current: Eligibility for Medicaid or NC Health Choice (2010)	*New:* Eligibility for Medicaid or NC Health Choice (2014)	*New:* Eligibility for Subsidy in the Health Benefit Exchange (2014)
Child	≤$44,100	≤$44,100	$44,100-$88,200
Parent of dependent child	≤$11,246	≤$29,327	$29,327-$88,200
All other adults (non-disabled, non-elderly)	Not eligible	≤$29,327	$29,327-$88,200

NCIOM

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- **Other provisions**
  - **Prevention and Wellness; Workforce; Quality and New Models of Care; Safety Net; Long-Term Care; Other Provisions; States' Roles**
- CBO estimates
- NC planning efforts
- Impact on people with MH/DD/SA

NCIOM

Prevention: Mental Health & Substance Abuse

- Appropriates funds for a Prevention and Public Health Fund ($500M FY 2010-$2B FY 2015) to invest in prevention, wellness, and public health activities (Sec. 4002)
  - Priority areas for the national public health agenda includes health promotion and disease prevention to address lifestyle behavior modification (including smoking cessation, proper nutrition, exercise, **mental health**, **behavioral health, substance use disorder,** and domestic violence screenings) (Sec. 4001)
  - Half of the public health trust fund used to help support workforce initiatives in 2010

Workforce Overview

- Increased efforts to expand and promote better training for the health professional workforce
  - Includes loan forgiveness and scholarships to train primary care, pediatrics, geriatrics, nursing, dental health, public health, ***mental health/substance abuse,*** allied health and direct care workforce
  - Increased emphasis on increasing the supply of health professionals in underserved areas
  - Enhanced training in prevention, quality initiatives, interdisciplinary care, community based education, and diversity

Workforce: Underserved Areas

- National Health Service Corps: appropriates a total of $1.5B over 5 years (FY 2011-2015) (Sec. 5207, 10503)
  - Loan forgiveness for agreeing to serve in health professional shortage areas (HPSAs)
  - Eligible providers include: primary care, dental, **psychiatric (physician and mid-level providers),** plus **psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, and licensed professional counselors**

Quality

- HHS Secretary will establish national strategy to improve health care quality (Sec. 3011, 3012)
  - Funding to CMS to develop quality measures (i.e., health outcomes, functional status, transitions, consumer decision making, meaningful use of HIT, safety, efficiency, equity and health disparities, patient experience) (Authorizes $75M for each FY 2010-2014; Sec. 3013-3014)
  - Plan for the collection and public reporting of quality data (Sec. 3015, 10305, 10331)
  - Funding to support comparative effectiveness research

New Models Overview

- Efforts to test new models of care to improve quality and efficiency (Sec. 3021, 10306)
  - Some of the new models include: payment and practice reform in primary care, **reverse co-location (primary care in community mental health agencies), care coordination and community-based teams for chronically ill individuals including people with mental illness, emergency psychiatric coverage in institutions for mental diseases**, payment reform
  - Appropriates $5 million (FY 2010) for design and implementation of models and $10 billion to implement those models (FY 2011-2019)

Safety Net

- New funding to expand federally qualified health centers (also called community health centers) (Sec. 10503, Sec. 2303 of Reconciliation)
  - Appropriates a total of $9B over five years for operations ($1B in FY 2011 increasing to $3.6B in FY 2015); and $1.5B over five years for construction and renovation of community health centers (FY 2011-2015) (Sec. 10503, Sec. 2303 of Reconciliation)
- Other support for safety net organizations, but nothing in the bill directly targeted to community mental health agencies

Long-Term Care

- Establishes a national voluntary insurance program to purchase community living assistance services and supports (CLASS) financed through payroll deduction. (Sec. 8001-8002, 10801)
- New Medicaid state options to expand home and community-based services
  - Federal government provides an enhanced federal match rate to expand home and community based services to people who would otherwise need to be institutionalized (including ICF-MRs)

Long-Term Services and Supports

- Community First Choice option (Sec. 2401):
  - States can receive an increase in the FMAP rate by 6 percentage points (Effective 10-1-2011)
  - Will help pay for home and community based *attendant services and supports* for individuals with incomes <150% FPG who would otherwise need institutionalization (nursing home, hospitalization, **ICF-MR, or institution for mental disease**)
- State Balancing Initiative (Sec. 10202):
  - NC can receive an increase in its FMAP rate by 2 percentage points
  - NC would need to ensure that at least 50% of LTC Medicaid funds were spent on home and community based services

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- **Congressional Budget Office estimates**
- North Carolina planning efforts
- Impact on people with MH/DD/SA

Congressional Budget Office (CBO) Projections

- Covers 92% of all nonelderly residents (94% of legal, nonelderly residents)
  - Would cover an additional 32 million people (leaving 23 million nonelderly residents uninsured by 2019)
- Expansion of insurance coverage and new appropriations included in PPACA will cost $938 billion over 10 years.
  - However, with new revenues and other spending cuts, PPACA is estimated to reduce the federal deficit by $124 billion over 10 years.*

* More recent CBO estimate suggests that costs would increase by $115 billion over 10 years *if* Congress funds all the provisions that are authorized at certain levels but not yet appropriated. Sources: CBO letter dated March 20, 2010, May 11, 2010.

Basics of National Health Reform--Overview

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Health Reform Workgroups

- Public-private workgroups convened to how to best implement health reform in North Carolina
- *Overall Advisory Committee:*
  Co-Chairs: Secretary Lanier Cansler, CPA; Insurance Commissioner Wayne Goodwin, JD
- *Eight work groups:*
  Health Benefit Exchange and Insurance Oversight; Health Professional Workforce; Medicaid Provisions and Elder Law; New Models of Care; Prevention; Quality; Safety Net; Fraud and Abuse

Health Reform Workgroups

- The overall goal is to ensure the decisions made in implementing the federal health reform legislation serves the best interests of the state as a whole. To do this, the workgroups will:
  - Identify the decisions the state must make in implementing the national legislation.
  - Identify potential funding opportunities
  - Make recommendations to the legislature and executive agencies about options to help North Carolina improve population health, access to care, and health care quality, while slowing health care costs.

Basics of National Health Reform--Overview

- Overview of health reform legislation
- Changes in public coverage
- Private coverage
- Other provisions
- Cost containment and financing
- CBO estimates
- North Carolina planning efforts
- **Impact on people with MH/DD/SA**

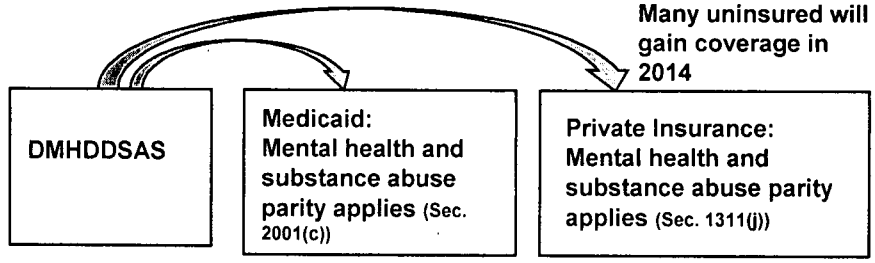
Summary: Impact on People with MH/DD/SA Conditions

- Insurance coverage will be expanded
  - All qualified health plans sold in the health benefit exchange must provide treatment for **mental health and substance use disorders in parity** to other physical illnesses
  - Preventive services recommended by the US Preventive Services Task Force must be offered with no cost sharing. This includes: **screening and counseling to reduce alcohol misuse in adults, and screening for depression in adults and adolescents**
  - No lifetime or annual limits for essential health benefits

Summary: Impact on People with Behavioral Health Conditions

- Many people who are currently uninsured and receive services through LMEs will be eligible for Medicaid or private insurance coverage
  - This means that fewer people will need to access clinical treatment services for mental health and substance use disorders through LMEs
  - LMEs will still have a major role to play in authorizing services to people who continue to lack insurance coverage, authorizing wrap-around services not covered through Medicaid or traditional insurance (such as recovery supports), and in utilization management

Potential Impact on MHDDSAS Delivery System



LMEs provide access to:
- Prevention
- Treatment
- Recovery supports
- Long term services and supports

Medicaid recipients can obtain many services directly from providers. Medicaid helps pay for:
- Clinical preventive services
- Treatment
- Some long term services and supports

Privately insured individuals can obtain services directly from private providers. Private insurance will pay for:
- Clinical preventive services
- Treatment

NCIOM

ACA Potential Impact on MHDDSAS Delivery System

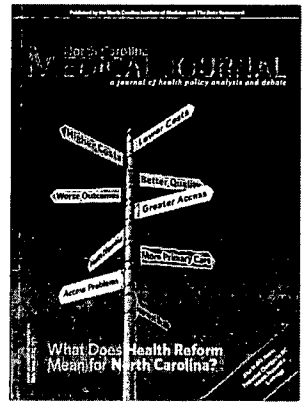
- Outstanding questions:
  - 1) What proportion of the LME clients will gain Medicaid or private insurance coverage?
  - 2) What gaps will remain in mental health, developmental disabilities or substance abuse services that will not be covered by Medicaid or private insurance?
  - 3) Will some of the current state IPRS dollars be "freed up" to fill gaps in services not covered through Medicaid or private insurance coverage?
  - 4) What is the role of the LME in the new system?

NCIOM

Questions

NCIOM Health Reform Resources

- What Does Health Reform Mean for North Carolina?
  North Carolina Medical Journal, May/June 2010;71:3
- NCIOM: North Carolina data on the uninsured
  http://www.nciom.org/data/uninsured.shtml
- Other resources on health reform are available at:
  www.nciom.org/data/healthreform.php



Structure of the Health Reform Workgroups

- The NC Department of Health and Human Services and the NC Department of Insurance is taking the lead in establishing these workgroups.
- The effort will be led by an overall advisory group, led by:
  - **Lanier Cansler, CPA**
    Secretary
    North Carolina Department of Health and Human Services
  - **Wayne Goodwin, JD**
    Insurance Commissioner
    North Carolina Department of Insurance

Health Benefit Exchange and Insurance Oversight

- Co-Chairs:
  - Louis Belo
    Chief Deputy Commissioner
    North Carolina Department of Insurance
  - Allen Feezor
    North Carolina Department of Health and Human Services
- Charge:
  - Development of the Health Benefit Exchange
  - Provide guidance on insurance oversight
  - Coordinate enrollment between Medicaid and the Exchange
  - Provide guidance on the new insurance ombuds program, and the creation of patient navigator programs

Health Professional Workforce

- Co-Chairs:
  - Tom Bacon, DrPH
    Director
    North Carolina Area Health Education Centers Program
  - Kennon Briggs
    Executive Vice President and Chief of Staff
    North Carolina Community College System
  - Alan Mabe, PhD
    Vice President for Academic Planning
    UNC General Administration
  - John Price
    Director, NC Office of Rural Health and Community Care
    NC Department of Health and Human Services

Health Professional Workforce

- Charge:
  - Examine funding opportunities for workforce development, including but not limited to: primary care, nursing, allied health, behavioral health, dentistry, public health, direct care workforce
  - Outreach about loan repayment opportunities
  - Identify best models for quality improvement and interdisciplinary training in workforce development programs
  - Fostering collaboration and coordinating implementation

Medicaid and Elder Services

- Co-Chairs:
  - Craigan Gray, MD, JD, MBA
    Director, NC Division of Medical Assistance
    NC Department of Health and Human Services
- Charge:
  - Identify implementation steps for Medicaid expansion
  - Coordinate enrollment between Medicaid and the Exchange
  - Explore Medicaid state options to expand services, including but not limited to: prevention, home and community-based services
  - Examine funding opportunities for Elder Justice Act

New Models of Care

- Co-Chairs:
  - Allen Dobson, MD
    Vice President, Clinical Practice Development
    Carolinas HealthCare System
  - Craigan Gray, MD, MBA, JD
    Director, Division of Medical Assistance
    NC Department of Health and Human Services
- Charge:
  - Explore new methods of financing care, including accountable care organizations, bundled payment, global payment
  - Explore new methods of delivering care, including patient centered medical home, coordinated care for chronic illness, medication management

Prevention

- Co-Chairs:
  - Jeffrey Engel, MD
    State Health Director
    Division of Public Health
    NC Department of Health and Human Services
  - Laura Gerald, MD, MPH
    Executive Director
    Health and Wellness Trust Fund
- Charge:
  - Identify funding opportunities for prevention and wellness programs
  - Identify communities of greatest need
  - Encourage collaboration in funding opportunities

Quality

- Co-Chairs:
  - Alan Hirsch, JD
    Executive Director
    NC Healthcare Quality Alliance
  - Sam Cykert, MD
    Associate Director for Medical Education
    NC Area Health Education Centers Program
- Charge:
  - Understand federal guidelines for patient outcome quality measures and reporting requirements
  - Identify strategies to improve quality of care provided to meet the new quality requirements
  - Build on existing state quality initiatives

Safety Net

- Co-Chairs:
  - Chris Collins
    Deputy Director, Office of Rural Health and Community Care
    Assistant Director, NC Division of Medical Assistance
    NC Department of Health and Human Services
  - Ben Money, MPH
    Executive Director
    NC Community Health Center Association
- Charge:
  - Explore new opportunities for community-based collaborative networks of care
  - Examine new requirements for safety net providers
  - Identify areas of the state with greatest unmet need, and encourage collaboration in funding opportunities

Fraud and Abuse

- Co-chairs:
  - Al Koehler
    Chief Investigator
    NC Department of Insurance
  - Tara Larson, MAEd
    Chief Clinical Operations Officer
    NC Division of Medical Assistance
    NC Department of Health and Human Services
- Charge:
  - Examine new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance
  - Identify implementation steps to meet new federal requirements
  - Understand and educate providers on financial integrity and fraud and abuse reporting requirements

"The Children's Collaborative"

Mission

To advise the Guilford Center LME of system barriers and gaps in services for children under the age of 18 years, and families with significant mental health needs across multiple human service systems such as child welfare, juvenile justice, education, health and mental health.

Mission

To engage in problem solving to address these needs and build local community capacity to provide effective, community-based, family and youth-driven services that are delivered within a System of Care philosophy on the behalf of children and families with significant mental health needs.

Mission

To promote public awareness of System of Care Principles and Values as a best practice guideline.

To serve in an advisory capacity to the Guilford Center with recommendations for service needs to be incorporated into the Children's Mental Health Community Collaborative Advisory Committee's annual budget.

Members

The voting members of the Children's Mental Health Collaborative include representatives from the Department of Social Services, Department of Juvenile Justice and Delinquency Prevention, Guilford County Schools, Department of Public Health, local universities, parents, and community mental health provider agencies serving youth with mental health and substance abuse issues. There are Memoranda of Agreement with the child serving systems that are involved.

Partnership

Youth Villages' New Day Transitional Living Program

- Youth Villages' Multi-Systemic Therapy (MST) program was well established in Guilford County prior to this contract with New Day Program.

- A benefactor wanted to expand the Tennessee program into North Carolina and would match Collaborative funding.

Partnership

Youth Villages' New Day Transitional Living Program

- The Collaborative identified transitional youth ages 16 to 18 as a service gap that needed additional services and recommended funding for this population.

- Traditional service billing codes often limit time-intensive services such as client engagement and the case management activities this population requires for success.

Partnership

Youth Villages' New Day Transitional Living Program

- Department of Social Services (DSS) and the Guilford Center often "shared" youth involved in both systems.

- Negotiations with local system Directors, the LME Contracts Unit, supervisors, the System of Care Coordinator, and Youth Villages Administration resulted in a viable partnership plan.

Partnership

Youth Villages' New Day Transitional Living Program

Benefits:

- The Collaborative was able to fund services for youth ages 16 through 17 years, 11 months.

- Benefactor matched funding, with no restrictions on the funding stream and can serve youth 18 to 21 years old.

Funding Streams

- The Collaborative funded the first seven months of services for $118,000 from Dec. 1, 2008 through June 30, 2009.
- The Department of Social Services (DSS) funded the second year of contract from July 1, 2009 through June 30, 2010.
- Benefactor from Tennessee provided matching dollars both years.

First Years Overview

- Collaborative funded 12 slots for youth ages 16 years to 17 years, 11 months.
- Matching revenue from benefactor and Youth Villages carries no age restriction on funding stream and served youth 16 to 21 years for the remaining slots.
- 25 total slots for youth were funded.
- Close monitoring of the program ensured operation at full capacity and included development of a waiting list.

Issues at Referral

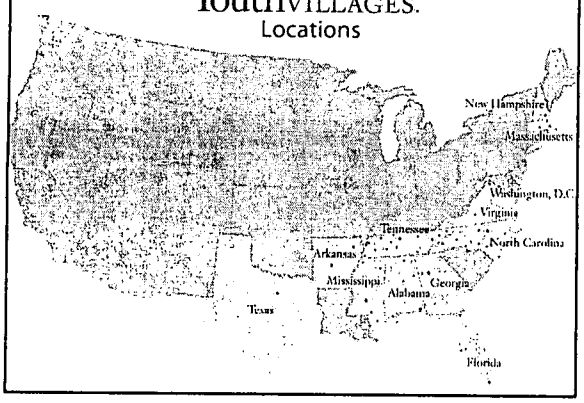
First year referral issues included:

- Unstable housing
- Needed employment
- Dropped out of school and was homeless
- Family conflict
- Needed basic assistance (food stamps, Medicaid, etc)
- Pregnant and in a violent relationship
- Resided with abusive parent
- Was failing school
- Legal issues
- Off psychotropic medications and unstable
- Suspended from school
- Experienced significant grief issues
- Needed help in accessing adult living facility
- Needed help with employability skills.

Transitional Living Program

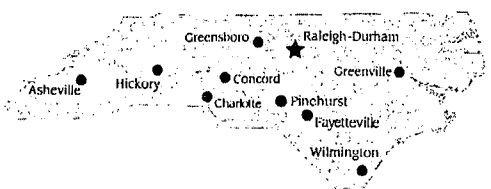
www.youthvillages.org

YouthVILLAGES. Locations



Youth Villages North Carolina

- The first Youth Villages offices in North Carolina opened in 2005 and provides Multi-Systemic Therapy to children and families, with Transitional Living starting in the state in December of 2008.
- The Youth Villages Transitional Living program is currently serving young people in Durham, Wake, Guilford and Catawba Counties.



www.youthvillages.org

Transitional Living Program History

- Created in 1999 with a grant from The Day Foundation
- Designed to help youth between the ages of 17 and 22 who are making the transition out of state custody into an independent life
- Systemic approach that incorporates multiple aspects of the youth's natural ecology (community, peers, family, school in addition to their personal characteristics)
- Strength-based approach to treatment

www.youthvillages.org

Program Key Components

- Transitional Living Specialists have extremely high levels of training and supervision
- Caseloads of only 8-10 young adults per TL Specialist
- 1 to 2 sessions per week conducted in the community or as intensity dictates.
- 24/7 on call support to clients
- Average 6-9 months per case

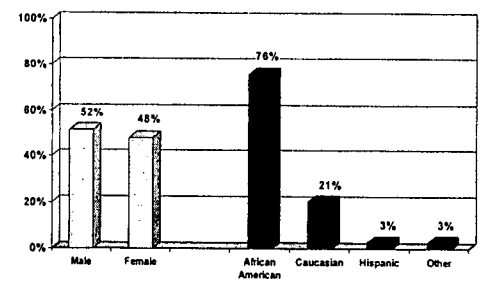
www.youthvillages.org

Greensboro Transitional Living Program

Demographics

Youth served through September 2010

N = 68



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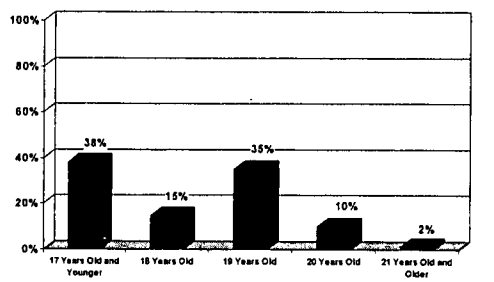
Greensboro Transitional Living Program

Age Group

Youth served through September 2010

N = 68



www.youthvillages.org

Program Objectives

The program focuses on the following areas:

- Permanency
- Education
- Employment
- Housing
- Independent Living Skills
- Pregnancy Prevention

www.youthvillages.org

Transitional Living Program Evaluation

After discharge, follow-up surveys are conducted at 6, 12 and 24 months to collect data in the following areas:

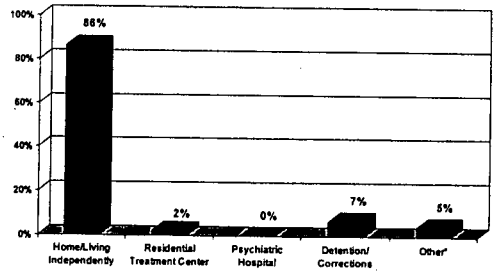
- Maintenance of stable housing
- Criminal/legal involvement
- Employment
- Social Support/Basic Life Skills

www.youthvillages.org

Greensboro Transitional Living Program

Discharge Location

Youth discharged October 2008 through September 2010
N = 38



*Other includes placements such as group homes, runaway, foster care and rehab centers

Benefits to Youths and the State

Overview

In comparison with their peers, foster youth are, on average:

- less likely to have a high school diploma,
- less likely to be pursuing higher education,
- less likely to be earning a living wage,
- more likely to have experienced economic hardships,
- more likely to have had a child outside of wedlock, and
- more likely to become involved with the criminal justice system.[1]

[1] Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21 Mark E. Courtney et al. Chapin Hall Center for Children.

The Challenge

	Secondary Education	Post-Secondary Education	Early Pregnancy	Crime
Foster Youth	25% have not obtained a HS diploma or GED by 21	10%-30% enroll in college	71% of female foster youth have been pregnant by age 21	66% of the foster care population had been arrested by the age of 21
General Population	13% of 20-24 yrs old have not graduated	60% attend college	33% of females had ever been pregnant by age 21	12% of the general population had been arrested by the age of 21

Example of costs

- Over a lifetime, an 18 yr old who does not complete high school earns approximately $260,000 less than an individual with a high school diploma and contributes about $60,000 less in lifetime federal and state taxes.[3]

[3] The Labor Market Consequences of an Inadequate Education. Rouse September 2005

All benchmarks on the previous slides come from the Chapin Hall study cited below.

Courtney, M., Dworsky, A., Cusick, G., Havlicek, J, Perez, A., & Keller, T. (2007) Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 21. Chicago: Chapin Hall at the University of Chicago.

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ANALYSIS OF THE EFFECTIVENESS OF SINGLE STREAM FUNDING

Presentation before the Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services

October 13, 2010

Steve Jordan, Director
DMH/DD/SAS

WHY THE REPORT

- The Special Provision outlined in Session Law, 2009-191, House Bill 672 Section 2,states:

"The Department of Health and Human Services shall analyze the effectiveness of single stream funding in the expenditure of State funds and review the allocation of service dollars to specific disabilities of LMEs that utilize single stream funding for a year or more and report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by June 1, 2010."

WHAT IS SINGLE STREAM FUNDING?

A funding method to provide Local Management Entities (LMEs) with greater flexibility to manage limited state funding for services. Under Single Stream funding, LMEs have the flexibility to determine, based upon the unique needs in the catchment area served, how to allocate state resources across the three disabilities.

SINGLE STREAM FUNDING BENEFITS

- Single Stream funding provides the LMEs greater flexibility in the use of limited state resources but also requires more accountability from the LME in determining and prioritizing the needs of consumers in its catchment area.
- The Division reimburses Single Stream LMEs one twelfth of their allocation each month and must then report the use of those funds after the fact.

CONCERNS WITH SINGLE STREAM

- Need to monitor earnings and utilization
- Too much movement of dollars among disabilities
- Maintenance of effort for individual disability services

NUMBER OF LME'S ON SINGLE STREAM

- As of July 1, 2010, sixteen (16) of the twenty-three (23) LMEs are operating under Single Stream funding protocols.
- Seven (7) LMEs have thus far failed to meet the approval criteria to convert to Single Stream funding

CRITERIA FOR SINGLE STREAM FUNDING

- LME has shown consistent compliance with the states performance contract
- The LME CFAC supports and has a role in establishing funding goals and monitoring
- Maintenance of effort requirements for continued services

HOW TO MEASURE EFFECTIVENESS

- Timely consumer access to services;
- Effective identification of services to persons in need;
- Timely initiation and engagement of consumers in services;
- Effective use of state psychiatric hospitals;
- Reduction in state psychiatric hospital readmissions;
- Timely follow-up after inpatient care in state psychiatric hospitals and state Alcohol and Drug Abuse Treatment Centers (ADATCs); and
- Reduction in the number of children in out-of-home placements for services

Expenditure-Based Reporting by Single Stream LMEs

- Types of Services
  - Gero Teams
  - Prevention
  - Veterans and Families
  - Traumatic Brain Injury
  - Mobile Crisis Team
  - START Team
  - Walk-in Crisis /Psychiatric Aftercare
  - TASC
  - Treatment Alternatives for Woman
  - Majors

SFY 2009 ALLOCATIONS AND EXPENDITURES

	Local Management Entity	Single Stream Funding Effective Date	All Disability Funding prior to Single Stream	SFY09 Actual Budget	SFY09 LME Shadow Claim/Non-UCR Expenditure Reporting for all Disabilities	Percent of Allocation
1	Centerpoint	7/1/2008	11,456,296	18,919,349	19,033,731	100.60%
2	Crossroads	1/1/2008	7,987,652	10,492,742	11,405,963	108.70%
3	Durham	11/1/2007	8,511,425	13,092,950	14,465,417	110.48%
4	ECBH	10/1/2007	11,455,915	25,729,910	25,807,935	100.30%
5	Five County	7/1/2007	10,911,126	12,777,273	13,391,260	104.81%
6	Guilford	4/1/2007	13,099,085	15,843,020	15,333,921	96.79%
7	Mecklenburg	4/1/2007	18,741,872	22,839,929	26,295,632	115.13%
8	Pathways	4/1/2008	15,998,776	18,737,582	18,797,922	100.32%
9	Piedmont	7/1/2003	15,988,814	28,198,057	24,678,253	87.52%
10	Sandhills	7/1/2007	20,009,752	23,790,503	27,878,867	117.18%
11	Smoky Mountain	7/1/2004	19,315,154	27,977,244	26,434,711	94.49%
12	Southeastern Regional	10/1/2008	9,350,732	14,161,568	14,538,183	102.66%
13	Western Highlands	7/1/2008	17,148,335	31,740,861	33,120,993	104.35%
			179,974,934	264,300,988	271,182,789	

* Note summary of all disabilities

SUBSTANCE ABUSE SERVICES

	Local Management Entity	Single Stream Funding Effective Date	Substance Abuse Services Funding Prior to Single Stream	Substance Abuse Services Value of SFY09 Shadow Claims
1	Centerpoint	7/1/2008	1,743,326	3,251,596
2	Crossroads	1/1/2008	413,568	706,338
3	Durham	11/1/2007	1,052,288	3,096,054
4	ECBH	10/1/2007	1,752,518	2,722,012
5	Five County	7/1/2007	720,605	1,259,364
6	Guilford	4/1/2007	1,315,228	3,444,476
7	Mecklenburg	4/1/2007	2,287,163	6,879,704
8	Pathways	4/1/2008	606,037	1,410,161
9	Piedmont	7/1/2003	1,127,980	2,627,480
10	Sandhills	7/1/2007	2,191,753	3,679,469
11	Smoky Mountain	7/1/2004	1,839,057	2,484,190
12	Southeastern Reg	10/1/2008	906,821	1,405,226
13	Western Highlands	7/1/2008	3,843,349	3,654,560
			19,799,693	36,620,630

* Note large increase in substance abuse services

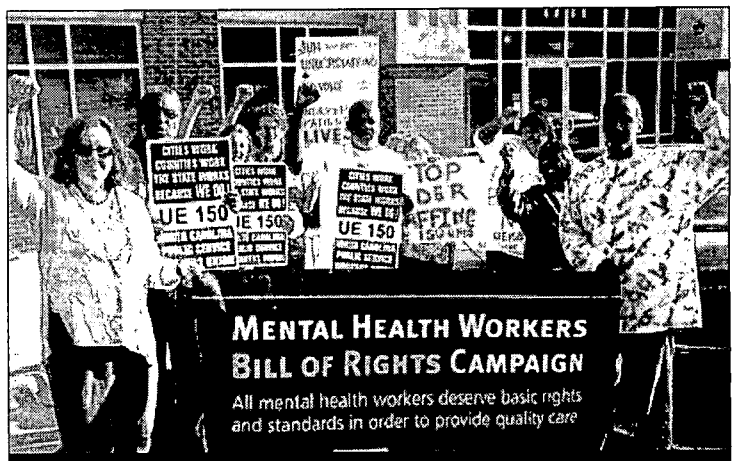
CONCLUSIONS

- LME's have used Single Stream funding to improve their performance
- Distribution of service dollars has remained relatively constant for MH and DD services
- Substance Abuse services has increased significantly
- Shadow claims data tracking has shown improvements in service access, appropriateness, quality and effectiveness

UE150 Union Helps Fired CRH Workers Win Justice!

Mental Health workers demand a Bill of Rights including: More staffing, better training, fair grievance procedure

On Monday, September 20, Judge Beecher Gray of the Office of Administrative Hearings ruled that Central Regional Hospital and DHHS failed to find just cause to terminate Pat Swann, Fred Gooch and John Long. The judge's complete findings of fact will come out in a written order in a few weeks. **The remedy order will include reinstatement of all three workers with back pay.** This ruling overturns the decision by DHHS Sec. Cansler and CRH Director Mike Hennike to fire three CRH workers for incident from November 2008.



UE150 DHHS Council members rally with community supporters at OAH before hearing on Thursday, Sept 17th. Pictured (from right): Cornell Hendrick, Ernestine Smythe, Dorothy Williams, Suzanne Bailey, Bernell Terry, Ben Carroll, Brigid Flaherty (Pushback Network), Ajamu Dillahunt and Dani Martinez-Moore from the NC Justice Center.

The judge found no patient abuse, and ruled that the workers did the best they could under the "exigent circumstances," which included complying with CRH's doctor's order for a forced blood draw on an aggressive, fighting patient. The three workers along with two other workers were unfairly fired while working on wards that were **understaffed and without receiving proper training** to deal with aggressive patients. Workers throughout the various DHHS psych hospitals and mental retardation centers are being victimized and disciplined for patient abuse because they are forced to work under these conditions. Instead of addressing the conditions, one-sided policies like Zero Tolerence were put in place by the Governor. The UE150 union has been fighting these battles at the various DHHS facilities by filing grievances, holding rallies, public hearings, meeting with the Mental Health Legislative Oversight Committee and meeting directly with Secretary Cansler. We will not stop demanding changes that benefit workers and the clients.

DHHS workers should continue to report conditions of understaffing, forced overtime and those that make conditions unsafe for patients/clients and workers to union stewards. Meetings will be organized so workers can hear more about the victory of the CRH workers and the issues presented by DHHS and the workers. We call on all workers to join in the struggle for the state of NC to pass a **Mental Health Workers Bill of Rights** to guarantee adequate and fair standards for mental health workers to provide quality care.

JOIN THE UE150 UNION MENTAL HEALTH WORKERS BILL OF RIGHTS CAMPAIGN!
CALL UE150 DHHS COUNCIL CHAIR PERSON, LARSENE TAYLOR AT 919-580-9618 FOR MORE INFO

Mental Health Worker and Statewide UE150 Union Representative Speaks to Legislative Oversight Committee for MH/DD/SAS

CRH3 reinstatement and downsizing of Dix represent failures of Reform Plan,

Pass a Mental Health Workers Bill of Rights! Keep Dix Open!

10/13/10

Hello. My name is James Johnson, a health care tech at Dorothea Dix. I am president of Dix chapter of the UE Local 150, the NC Public Service Workers Union and representative of UE150 DHHS Council. The Sept 20 ruling by Office of Administrative Hearings Judge Gray that Central Regional Hospital and DHHS failed to find just cause to terminate Pat Swann, Fred Gooch and John Long for alleged patient abuse points to the systemic flaws in NC's mental health system and the 2001 mental health reform plan. Workers are forced to perform their jobs in conditions of understaffing, forced overtime and lack of adequate training. They are then fired for poor job performance and patient abuse which are caused by the lack of investment in worker and patient safety.

Now you are seeking to continue on this same mental health reform plan as you attempt to downsize Dorothea Dix hospital. This hospital is vitally needed for the entire central region of the state. The mentally ill are forced to be stranded in an emergency room or risk being yet another inmate in the states overcrowded prisons. This is not the quality care patients deserve!

The closing of Dix also will have a disproportionate effect on the Black community and Black workers and on the poor. As you well know, 85% of Dix frontline workers are Black and over half of the patients are people of color and overwhelmingly poor. Closing this hospital is an injustice!

We have circulated petitions and collected over 1,000 petitions to keep Dix open in just the past 3 weeks and we will continue to collect more.

We call on Governor Perdue, DHHS Sec Cansler and this Legislative Oversight Committee to pass a Mental Health Workers Bill of Rights and keep Dorothea Dix hospital fully open. Until the state decides to invest adequate resources in mental health patients and workers will continue to have fundamental human rights denied them and we will continue to fight.

See attachments: 1) Petitions, 2) CRH3 Victory flier, 3) NAMI report on minority admissions in NC psych hospitals.

TABLE 1: STATE PSYCHIATRIC ADMISSIONS
PERCENT MINORITY BY FISCAL YEAR

FISCAL YEAR	08/09[1]	07/08	06/07	05/06	04/05	03/04	02/03	01/02
ALL MINORITIES	45.0	46.4	43.0	X	42.0	40.5	40.4	39.5
BLACKS	39.8	41.4	38.3	X	38.0	36.3	36.7	35.7
% BLACKS OVER [2]	84.2	91.7	77.3	X	75.9	67.3	69.1	64.5

[1] Fiscal year 08/09 marks change in policy of admission resulting in a major decrease of admissions.
[2] Percent Blacks Admitted divided by Percent Blacks in NC Population (Table 2)

TABLE 2: STATE NON-WHITE POPULATION
PERCENT OF TOTAL POPULATION

YEAR	2009	2008	2007	2006	2005	2004	2003	2002
ALL MINORITIES	33.2	32.2	31.9	31.6	31.6	31.6	31.6	31.6
BLACKS[3]	21.6	21.6	21.7	21.7	21.7	21.7	21.7	21.7

[3] Other than 2009, numbers shown are 5 year averages.

Discussion: The information of the combined two tables clearly shows that there has been an increasing percentage of minorities who have had to depend on the State psychiatric hospital system to provide them with treatment of their mental illness. Furthermore, the percentage of Blacks needing treatment, also increasing, is over-represented, almost 2 to 1 over the past two fiscal years for which there are data. The question is why? The following are hypotheses that require further attention.

1. **Education/stigma:** The community mental health systems are not adequately reaching the minority population. The incidence of mental illness is uniformly represented across race, so factors such as education and stigma may be accounting for some of the over-representation of the Black population. (refer to item #3 below) Early treatment which has been shown to be the most effective evidenced based practice, is probably not available to them.

2. **Economic Factors:** Blacks, and other minorities, may not be able to afford treatment in the community, and only when they are seriously ill do they seek treatment, usually in a hospital. Once there, if they do not have insurance or other means of payment, the hospital seeks admission to a state facility.

3. **Racial Bias:** Minorities may be intentionally, or unintentionally, discriminated against by the mental health system and the supports available to them to get through a crisis or know how to engage the

system that could offer them support. Once left to fend for themselves, they may give up until hospitalization is required, usually as an involuntary commitment.

Impact of closing Dix on the minority community: Because the population of minorities represents over half those being admitted to Dix (50.6% in the most recent report, and 52.4% in the previous report), any displacement of patients to other state hospitals will be most heavily felt by the minority community. Many of the family supports will have to travel further and will not have public transportation to visit their loved one as he/she recuperates.

Furthermore, as recently reported (www.nami-wake.org), these helplessly ill individuals on average had to wait 2.6 days in a hospital Emergency Department for a psychiatric hospital bed to become available for treatment. Forty two individuals (at least 21 minority) had to wait over 7 days before a bed became available. Some people are waiting for a state hospital bed for weeks in our community ERs and are then released with no treatment because there are no available beds. This puts them and the community in potential danger leading to crimes that do not have to happen.

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
November 9, 2010 10:00 A.M.; Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair, Presiding

10:00 **Welcome and Opening Remarks**	*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*
10:00-10:30 **Secretary's Remarks** ➢ **Dorothea Dix Closure**	*Lanier Cansler, Secretary* *Department of Health and Human Services*
10:30-10:45 **Expenditures & Utilization Tracking Update**	*Kelly Crosbie, LCSW* *Behavioral Health Manager* *Division of Medical Assistance, DHHS*
10:45-11:15 **LME Presentation/TASC**	*Mr. Mike Kupecki, Assistant Area Director* *East Carolina Behavioral Health* *Michael Gray the Vice President of Region 3* *TASC, Partnership for Drug Free NC and* *Vice President of National TASC* *Karen V. Chapple, Executive Vice President of* *Coastal Horizons Center and Immediate Past* *President of National TASC.*
11:15-11:45 **Three-Way Contracts Update**	*Mr. Mike Watson, Deputy Secretary for Health Services, DHHS*
11:45-12:45 **Lunch**	
12:45-1:45 **ICF-MR Cost Analysis and Comparison w/ CAP/MRDD Services**	*Steve Jordan, Director,* *Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, DHHS*
1:45-2:15 **Overview of the DD Waiting List**	*Rose Burnette, DD Project Manager* *Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, DHHS*
2:15-2:45 **Update on CAP-MR/DD Tiered Waivers**	*Rose Burnette, DD Project Manager,* *Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, DHHS*
2:45-3:00 **Public Comments**	
3:00 **Closing Comments & Adjournment**	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	11/9/10																
Senator Martin Nesbitt, Co-Chair	X																
Senator Austin Allran	X																
Senator Bob Atwater	√																
Senator Doug Berger	X																
Senator Charlie Dannelly	√																
Senator Jim Forrester	X																
Senator Ellie Kinnaird	√																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	X																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	X																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin																	
Lisa Hollowell	√																
Gann Watson																	
ADVISORY MEMBERS																	
Senator Larry Shaw	√																
Representative Van Braxton	X																
Representative William Brisson	√																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

November 9, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, November 9, 2010 in Room 643 of the Legislative Office Building. Members present were Representative Verla Insko, Co-Chair; Senators Bob Atwater, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Jean Farmer-Butterfield, Beverly Earle, and Fred Steen. Advisory members Senator Larry Shaw and Representative William Brisson were present. Also in attendance were: Representatives Hugh Blackwell, Pat Hurley and Deborah Ross.

Lisa Hollowell, Joyce Jones, Shawn Parker, Jan Paul, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the October 13, 2010 meeting. The motion was made by Senator Dannelly and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services provided an overview of the budget for DHHS for FY 2010-2011 and explained the challenges faced by the Department. (See Attachment No. 2) Points of interest included:

- DHHS is currently spending $20M more than is budgeted to operate the State facilities. Increasing costs to operate the facilities over time caused a larger deficit. Funds from other budget lines were used to cover these costs.
- Reducing the overall cost in the facilities will still leave DHHS $15M above budget. Right now, those additional funds are coming out of funds that would normally go to community mental health services.
- Administrative cost equals 7% of the overall budget.
- Optional services for adults have the most flexibility to make changes in Medicaid.
- Almost 80% of the budget consists of Federal funds. Seventy-nine percent of the DHHS appropriation is used to draw down those Federal funds.

Secretary Cansler introduced Dr. Nena Lekwauwa as the new Medical Director for DMH/DD/SAS.

Secretary Cansler then addressed the plan for the closure of Dorothea Dix Hospital. (See Attachment No. 3) He noted that DHHS was following the statutory requirements for

providing a plan of closure for the upcoming legislative session. He said the goal was to minimize the negative impact on the mental health system. The savings from the closure should be about $16M. Secretary Cansler emphasized the fact that the number of beds would not be reduced; the beds would be moved to other locations and Broughton Hospital would have 12 additional beds. Comments regarding the closing of Dorothea Dix included:

- The more difficult patients will be housed at Central Regional Hospital (CRH).
- The report describes what is being done regarding cost reduction measures; the plan for moving forward in the future; the plan to maintain services; and opportunities offered to the employees at the facilities.
- If legislation reverses the plan for the closure of Dix Hospital, an appropriation would be needed in order to not have the money come from community services.

Secretary Cansler said the expansion of the b-c waiver program was moving slowly due to the difficult, complex process. Two areas interested are Mecklenburg County, which has requested a delay for one year and Western Highlands. Smoky Mountain Center is interested and there are other LMEs that wish to work with PBH.

Kelly Crosbie, Behavioral Health Manager with DHHS provided the expenditures and utilization tracking update. (See Attachment No. 4) She reviewed data collected regarding children's services (community support, intensive in-home and multisystemic therapy and day treatment), adult services (community support, community support team, assertive community treatment team and psychosocial rehabilitation), and children and adult services (substance abuse intensive outpatient, mobile crisis and I/DD targeted case management). All community support service data shows a reduction in expenditures and service recipients in anticipation of the phase out of this service. Ms. Crosbie was asked what would happen to the appeals for those receiving services under Community Support-Child. She responded that there were appeals that would have to be finished but as of January 1, 2011, there would no longer be an appealable service.

Mike Kupecki, Assistant Area Director of East Coast Behavioral Health opened the presentation on Treatment Accountability for Safer Communities (TASC) by providing a brief history of the organization. (See Attachment No. 5)

- TASC first began in North Carolina in 1978. By 1993, TASC was in 10 of the old area programs that served 20 counties. By 1998, TASC had expanded to 23 of the 44 area programs serving 44 counties. In 2000, four area service programs were established across the State to provide economies of scale and statewide access to services.
- Services are available in all 100 counties and organized into 4 regions. TASC is administered through two LMEs; East Coast Behavioral Health administers Regions 1 and 2 through a contract with Coastal Horizons Center, and Western Highlands administers Regions 3 and 4 through a contract with Partnership for a Drug Free NC.
- The role of the LME is to prepare and disseminate the RFP, select providers, develop and administer the contract, to provide financial and programmatic oversight of the program and to be the liaison with the other 23 LMEs.

Michael Gray, Vice President of Region 3 TASC, Partnership for Drug Free NC, described what TASC is and what TASC does. Comments of interest included:

- The TASC mission is to work with individuals with behavioral health issues involved in the criminal justice system. TASC is the link between the courts and the treatment agencies to help individuals access treatment.
- After developing a person-centered plan, TASC works with community agencies and LMEs to develop a network of services appropriate for the clients.
- A standard Memorandum of Agreement ensures that all the agencies involved are working together with the offender with one plan and one common goal to make that individual successful throughout the program.

Next, Karen Chapple, Executive Vice President of Coastal Horizons Center, provided an overview of the demographics of the clients served, and their risks and needs. She said that Coastal Horizons operates TASC services in 53 counties in North Carolina. Items of interest included:

- Statistics indicate that 68% of probationers in North Carolina have a substance abuse disorder which is in keeping with the national average.
- Over the last 10 years, TASC went from serving 8,000 clients in 2001-2002, to over 17,000 in 2008-2009. Statistics shows that 88% of clients are either divorced, widowed, or have never married. In recovery, relationships are very important. TASC received 22,000 referrals from either probation or the court systems. Those that do not have a substance abuse disorder or mental health issue are screened and sent to another service.
- The number one drug used is marijuana. However, most of the clients are poly drug users.

A TASC client, by the name of Rose provided her personal story and described how TASC was a critical part of her recovery. She said that she had been drug free for 8 years, had completed school, and was working to become a councilor herself.

Lisa Hollowell from Fiscal Research provided an introduction to the 3 Way contracts update by Mike Watson, Deputy Secretary for DHHS. The Contracts with local hospitals, LME's, and DHHS for the purchase of the community psychiatric beds have been funded for three years; with the legislature increasing the current year's funding by $9M in the budget bill for a total appropriation of $29.1 million.

Today's presentation is a report to the Committee on the number of bed contracts, the cost, the location of these community beds, and methodology for determining the allocation of beds. The direction provided by the legislature is that the "The Department shall work to ensure that these contracts are awarded equitably around all regions of the State". For the past two years this Committee has supported this effort and has included in its report proposed increases.

Mr. Watson said the 3 way contract was in its third year and had been extraordinarily successful in the effort to increase capacity for inpatient psychiatric treatment. (See Attachment No. 6) Points made by Mr. Watson included these:

- The bundled rate paid to the hospitals of $750 per day includes: the daily charge - generally the Medicaid rate; the cost of psychiatric care; and the cost of medication upon the discharge of the patient. The State hospitals charge $1100-$1200 per day. (Note: Not always exactly the same patients.)
- The total available funding for FY 09-10 were State dollars designated towards non-Medicaid consumers. Children are billed through Medicaid and Medicare is billed for older adults.
- With the requirement for CABHAs to have medical directors and the expansion of the contracts across the State there has become a joint demand for psychiatric service. Therefore, there has been an increase in the number of psychiatrists coming back into the State and into the communities.
- 3 Way contracts support consumers by getting treatment closer to home, helping individuals to transition back into the community, help the ERs function better, and help law enforcement deal with seriously mentally ill adults.

Mr. Watson said there was still concern across the State regarding the waiting time in the ERs. Representative Insko said that before the State was paying for local psychiatric beds, there were 22 LMEs that had arrangements with their local hospitals to take psychiatric patients. Those hospitals now want to be paid as the others creating the danger of those beds being lost if the State does not pay. Mr. Watson said that a number of LMEs put their own state dollars into local in-patient contracts in addition to the 3 Way contracts. So, there is an additional $13-$14M going into those contracts. Representative Insko asked with the reduced number of short-term admissions at the State hospitals, how many of those people are now going to the ERs that are not admitted to local beds? Mr. Watson responded that the information would be difficult to find but that Mobile Crisis Teams go into the ER and where people are stable, try to move them back into the community.

Representative Insko then recognized members of the audience, who had signed up previously, to come forward for the public comment period. Concerns expressed by the audience included:

- Legislators need to prepare a bill to save Dorothea Dix Hospital so it can continue to serve those with mental illness.
- People should be carefully diagnosed to see if they really need to be hospitalized. Access to the right service at the level of need would prevent the need for additional hospital beds. Look at ways to prevent hospitalization. Put more money into services and less money towards hospitals.
- Transporting patients is too time consuming and costly for law enforcement.

Steve Jordan, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services provided a cost analysis and comparison of the ICF-MR and CAP/MR-DD services. (See Attachment No. 7) Points of interest included:

- Developmental Center - If an individual accepts waiver services, they are waiving the right to enter an ICF-MR. The Murdoch Center does "need determination" on all ICF-MR recipients in the State.
- The services in the facilities are more comprehensive than in the community ICF-MR and in the CAP/MR-DD waiver.
- The 2 group homes for the PATH program (for children with autism and severe behavior disorders) are not housed on the Murdoch campus but rather are State facility- operated programs located in the community (Franklin County and Granville County.)
- People in the DD Centers are older and more disabled that those in community ICFs-MR and those served by CAP-MR/DD funds: – 70% are 45 years or older; over 70% have profound I/DD; 50% have seizure disorders; 65% require partial to total assistance with feeding – with 13% of those on feeding tubes; 75% need partial to total assistance with dressing; and 85% are non verbal and have limited ability to communicate.
- Community ICF/MR-DD: – In the 1990s there was established a moratorium on the development of new ICF-MR/DD beds. The moratorium is managed through the Certificate of Need process operated by the Division of Health Services Regulation; there must be a needs assessment approved to show that there is a need for more ICF-MR beds in the community, and letters of support are required from the DHHS, the Division and the LME.
- Pharmacy and dental services are covered by the regular Medicaid state plan dollars in the community ICFs-MR and CAP-MR/DD. The DD Centers offer both of these services as part of their ICF-MR daily rate.
- CAP-MR/DD – Home Supports are provided by a family member who is reimbursed for providing the treatment to their adult child while living in their home. Residential Services are 3-4 bed group homes which offer alternative family living. Room and board are covered by Social Security Disability and Supplemental Support. CAP-MR/DD funding is not available to cover room and board.
- 50% of the total Medicaid and State matched dollars in NC goes to funding support for ICF-MRs.
- Some states are closing large facilities moving to smaller facilities at the community level doing away with large 16 – 300 bed facilitiess. More information was requested on how the more seriously ill are managed by the states that have done away with ICFs-MR.
- All costs are covered by the rate at the DD Centers and most are covered in the community ICF-MRs. However, the DD Centers have a medical care unit. Those not residing in the DD Centers go to local hospitals but those costs are covered by the Medicaid state plan, not the ICF-MR rate.

Mr. Jordan was asked if there were any facilities in North Carolina with more than 100 beds. He replied that he did not believe so and would get the figures requested. Subsequently, Mr. Jordan acknowledged that there were such community ICF-MR facilities in the state and that several of these housed young children. Representative Insko asked when DHHS brings a proposal for self-direction and the addition of other

Tiers, would the appropriation request include the additional administrative costs that are a part of self-direction. Rose Burnette said the additional cost currently is through Medicaid administrative funds but she was not sure about where the funds would be located in the state budget in the future. She suggested that the question needed to be addressed to DMA regarding the proposal.

Joyce Jones from Bill Drafting provided an introduction to the overview of the DD Waiting List by Rose Burnette, DD Project Manager for DHHS. She reminded members that Session Law 2009-186 required the Department to improve supports for persons with developmental disabilities by creating a statewide data collection system containing waiting list information collected regularly and obtained annually from each LME. The Department is charged with establishing standardized criteria to be used by LMEs to ensure that the processes for collecting waiting list data are consistent across LMEs. Applying the standardized criteria, the LMEs are to develop and maintain a waiting list for persons with developmental disabilities who are:

- Waiting for residential services;
- Potentially eligible for CAP-MR/DD;
- In need of other State-funded services and supports for people with DD.

The Department was asked to update the Committee on the statewide DD waiting list data system.

Ms. Burnette explained that the presentation which was prepared for last month's meeting includes information on the DD Waiting List and the Tiered Waivers. (See Attachment No. 8) Additional points in her presentation included:

- The Supports Waiver is intended for those with a low level of need. The annual allowable expenditure is $17,500.
- The Comprehensive Waiver is intended for those with more extensive needs. The maximum cost limit currently is $17,501 - $135,000 per person, per year.
- For the Supports Waiver, one vendor was selected for the Financial Management Service Agency. The vendor will manage CAP- MR/DD; CAP-DA –a CAP Medicaid program for aging individuals with disabilities, and individuals who receive services within the aging and long-term care community. DMA will manage the contract.
- Major revisions to the Comprehensive Waiver will design services to meet the specific levels of intensity of need of individuals.
- The new Community Intensive Waiver is designed to meet the needs of those with the highest medical and behavioral supports needs.
- A survey of stakeholders regarding the CAP-MR/DD Waivers indicate that most are satisfied with the waiver and request that there not be any big changes.
- DHHS hopes to submit the waivers to CMS by March or April of next year. The current waivers expire 11/1/11.

Ms. Burnette was asked to provide members the cost per person, per month for Case Management. Comments were directed to DHHS regarding the extra cost in the use of SNAP and SIS for assessments. Evidence shows the current way the DD population is

measured does not correlate with each person's intensity of need. SIS would help bring the need in line with the cost. It was suggested that this may be a policy issue and it requires further review and consideration.

Continuing, Ms. Burnette made several points regarding the waiting list.

- Short Term solutions – spreadsheet was created with the LMEs, and the waiting list work group which included multiple stakeholders. Comprehensive data submitted the end of July suggests a substantial number of persons waiting for service are potentially eligible for CAP-MR/DD funding.
- Long Term solutions – look at other options beyond the spreadsheet. The spreadsheet can give duplicate information and count people multiple times-making it problematic if the results were to be used for program and budget planning.
- Residential Supports - Of the 5,481 waiting for Residential services, 669 are receiving some services. The other individuals are not receiving any services. There are 1,785 people waiting for support in order to work. Of those, 208 are receiving some other services, the other are receiving no services.
- A case manager can authorize emergency services in a crisis situation while the person centered plan is going through the authorization process.
- In January 2011, Value Options will not longer be doing the utilization review for CAP-MR/DD funded individuals. This responsibility is being transferred to the LMEs. Nine LMEs submitted applications indicating an interest in becoming a Utilization Review vendor for CAP-MR/DD. Of those nine, Eastpointe and Durham have been approved and 2 additional LMEs were selected, Pathways and Crossroads. The LMEs selected to provide UR for CAP-MR/DD will work with the 7 LMEs not selected to cover the service as well as the other LMEs who must depend on the 4 selected LMEs to manage utilization management for all CAP-MR/DD recipients. Ms. Burnette acknowledged that a great deal of training and support will be required of the Division prior to January, 2011.

There being no further business, the meeting adjourned at 2:35 PM.

Martin Nesbitt
Senator Martin Nesbitt, Co-Chair

Verla Insko
Representative Verla Insko, Co-Chair

Rennie Hobby
Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin Huffman	NC Psychiatric Assoc
Peggy Magnum	TJAM
Lou Wilson	TJAM
Julia Adams	The Arc of NC
[illegible]	PBH
Billy West	[illegible]
ERIC GABRIEL	RHA
Jean Rhodes	[illegible]
Wendy Kelly	Policy Groups
Lonnie Cohen	self-advocate, NC CANSO
Joe Donovan	Self

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peggy Baker	Jaguars Gap
Will Woodell	Value Options
Mike Kupec	ECBH
Kyle Wennerlyn	-
Sam Chapple	Coastal Horizons - NC TASC
Melissa Mann	POFNC - NC TASC
Bert Wood	" "
Keith McCoy	Wake Co. LME
Kelly Kemp	NAMI NC
Wes Stewart	Coastal Horizons - NC TASC
Angie Barthen	SA Federation - Path of Hope

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Alexander	DHSR
David Seann	Crossroads
Cin Brailer	opc
Treva Johnson	Omni Visions
Crystal Nunnemaker	Omni Visions
Katherine Ross	APAB
Bob Fitzgerald	Walmart
JESSE GOODMON	DHHS/DHSR
Rose Zavalney	DRC
Allison Jourdon	DOC/DCC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ALEXANDER DUDA	NCCPPR
[illegible]	MH/DD/SAS Trust
Michelle Kucerak	TROSA
Michelle Wilder-Baker	DHHS
ALBERT A. FISHER	COMMUNITY PARTNERSHIPS, INC.
[illegible]	DHHS / BCA Division
Christy Asher	DOA
JOE LANIER	NELSON MULLINS
Fred Aikens	The Aikens Group LLC
Tennss Richardson	Dana G Jones & Associates
Dana Jones	" "

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dante Strobino	UE150 union
Robin D. Henderson-Wiley	Courtlight, Inc. 305 Fayetteville St - Suite 203 Raleigh, NC
Jayne Shola	Liberty Healthcare
Louise G. Fisher	Volunteer Adv. for M.I.
Gerry Akland	NAMI - Wake Co
Hope Tenbrighton	Advocate - Dorothea Dix Hospital
Rebecca Tomlin	NCACC
Pam Shipman	PBH
Valerie Hunter	Fidelity MHA
Ann Word	Wake Co. Human Services
John McMillan	MH-DS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andrew Meehan	Cupstart
Daphne Lynn	OE RI
Clarissa Goodlett	Governors Institute on Alcohol & SA
Don Kaade	THRESHOLD, INC
Ellis Fields	mental Health Assoc-/Charlotte, NC
Cheryl Moon	SEARC
	Sandhills Center
Kathy S Baker	Southeastern Regional LME
Natalie Batten	Accenture
Kay Paksoy	National Association of Social Workers

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erica Nelson	NCCCP
Yvonne Copeland	NC Council of Community Programs
Michael Cottingham	CenterPoint Human Services
Kent Earnhardt	NAMI-Wake
Ashley Parker	Parker Law Firm
Bo Heath	McGuire Woods
Bob Hedrick	NCPC
John Bowdich	Astra Zeneca
Frank Wadale	Eastern Seals UCP NC & VA
Kim Mitchell	CFSA-NC
TARA FLESS	CFSA-NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS November 9, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Anna Marshall Gauss	Capitol
Robert Wilson	SOS
Pam Shipman	PBH

VISITOR REGISTRATION SHEET

SPEAKER SIGN-IN SHEET

Joint Legislative Oversight Committee on MHDDSAS — November 9, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tad Clodfelter	NC Substance Abuse Fed.
Hope Turlington	Advocate - Dix Thanks, Hope Turlington - present
Louise Fisher	Volunteer Advocate for Mentally Ill
Charles Perry	Dix Hospital Nurse, UE
~~Mike Kupecki~~	East Carolina Behavioral Health
MARTHA LOWRANCE	VAID / DOA
James Johnson	Dix hospital tech, UE150
Erin Byrd	NAACP - RIF for Dix Workers
Dr Kent Earnhardt	Volunteer on state and county committees concerning MH
Laurie Cohen	NC CANSO
Yonatan (Jonathan) Neill	Have Legislators of N.C. State meeting Dix to stay open Students Businesses on Hillsborough wanting it open

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Attachment 2

EXAMINING THE DEPARTMENT'S BUDGET (Fiscal Year 2010-2011)

	Total Budget	Percent of Total Budget	Federal/Other Funds	State Appropriations	Percent of State Appropriations
DHHS Budget - TOTAL	17,285,219,239		13,368,052,025	3,917,167,214	
State Operated Facilities	810,365,071	4.69%	548,409,799	261,955,272	6.69%
Remaining DHHS Budget	16,474,854,168	95.31%	12,819,642,226	3,655,211,942	93.31%
Personnel Costs (Exclusive of State Facilities)	383,716,844	2.22%	225,506,138	158,210,706	4.04%
Remaining DHHS Budget	16,091,137,324	93.09%	12,594,136,088	3,497,001,236	89.27%
Other Administrative / Overhead Costs (Exclusive of State Facilities)	270,264,586	1.56%	152,587,024	117,677,562	3.00%
Remaining DHHS Budget	15,820,872,738	91.53%	12,441,549,064	3,379,323,674	86.27%
Medicaid (Exclusive of Personnel and Administrative Costs)	11,768,274,967	68.08%	9,450,531,571	2,317,743,396	59.17%
Mandatory Services (54%)	*6,354,868,482*	*36.76%*	*5,103,287,048*	*1,251,581,434*	*31.95%*
Optional Services - Children (17%)	*2,000,606,744*	*11.57%*	*1,606,590,367*	*394,016,377*	*10.06%*
Optional Services - Adults (29%)	*3,412,799,740*	*19.74%*	*2,740,654,156*	*672,145,585*	*17.16%*
Remaining DHHS Budget	4,052,597,771	23.45%	2,991,017,493	1,061,580,278	27.10%
*MH/DD/SAS **	*545,549,304*	*3.16%*	*124,008,304*	*421,541,000*	*10.76%*
*Public Health **	*580,197,747*	*3.36%*	*499,679,596*	*80,518,151*	*2.06%*
*Other Health Divisions **	*400,133,800*	*2.31%*	*292,512,946*	*107,620,854*	*2.75%*
*Social Services **	*1,661,764,127*	*9.61%*	*1,493,388,523*	*168,375,604*	*4.30%*
*Child Development **	*589,352,119*	*3.41%*	*362,468,784*	*226,883,335*	*5.79%*
*Aging & Adult Services **	*85,110,641*	*0.49%*	*49,262,412*	*35,848,229*	*0.92%*
*Disability Divisions **	*79,869,401*	*0.46%*	*59,306,958*	*20,562,443*	*0.52%*
*All Other Offices / Divisions **	*110,620,632*	*0.64%*	*110,389,972*	*230,660*	*0.01%*

** Exclusive of Personnel and Administrative Costs*

Notes on NORTH CAROLINA MEDICAID:

Program enrollment as of 09/30/2010 was approximately 1.435 million.
Through 09/30/2010 the current year enrollment growth rate is 4.25%.
Enrollment growth this fiscal year through 09/30/2010 was approximately 42,750 less than originally projected.
Anticipated enrollment growth resulting from health care reform (2014) is 500,000 to 700,000 new enrollees.
Factors Impacting Medicaid Program Costs:
- Eligibility / Enrollment
- Services / Consumption
- Provider Rates
- Program Integrity / Fraud & Abuse

Other Notes:

The Total DHHS Budget is 77% Federal/Other Funds and 23% State Appropriations (Appropriations for match or maintenance of effort is generally required to gain access to the Federal funds)
Personnel Costs are paid with 61% Federal/Other Funds and 39% State Appropriations (The majority of positions within DHHS are at least partially funded with Federal/Other Funds)

Attachment 3

Plan for the Closure of Dorothea Dix Hospital

Presented to:

The Joint Legislative Committee on
Mental Health, Developmental Disabilities and
Substance Abuse Services,
The House of Representatives Appropriations
Subcommittee on Health and Human Services,
And
The Senate Appropriations Committee on Health and
Human Services

In accordance with G.S. § 122C-112.1a (30) (b)

Prepared By:
Department of Health and Human Services
Division of State Operated Healthcare Facilities

November 1, 2010

Plan for the Closure of Dorothea Dix Hospital

Outline of Contents

I. Cost Reduction Measures at Dorothea Dix Hospital to be Completed by December 31, 2010
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   b. No Reduction in Bed Capacity
   c. Clinical Research Unit
   d. Timeline for Implementation of Cost Reduction Measures
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II. Formal Closure of Dorothea Dix Hospital
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      1. Ensuring Comparable Care and Treatment After Transfer to CRH
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         2. Employment
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      2. Bed Capacity at Central Regional Hospital
   b. How Support Services to Community-Based Agencies and Outreach Services will be Continued
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   a. Community Linkages
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IV. Conclusion

Plan for the Closure of Dorothea Dix Hospital

This report, the *Plan for the Closure of Dorothea Dix Hospital*, will describe steps the Department of Health and Human Services (DHHS) will take to formally close Dorothea Dix Hospital (DDH) through the relocation of a 30-bed Forensic Minimum Security Unit, the only remaining inpatient psychiatric beds and service to be provided at the hospital.

Additionally, this report will outline earlier cost reduction measures implemented at DDH to minimize the impact of a projected budget deficit and will discuss other issues related to the closure of Dorothea Dix Hospital.

I. Cost Reduction Measures at Dorothea Dix Hospital To Be Completed by December 31, 2010

During Fiscal Year 2010-2011, Dorothea Dix Hospital is projected to operate at a budget deficit of $28,950,638. In recent years when the hospital had some State appropriations and operated at a smaller deficit, funding from community mental health services and other DHHS Divisions has been used to make up the deficits. As discussed during the past legislative session with legislative leadership, additional budget reductions of over $13 million in funds previously used to operate DDH, combined with additional budget reductions for the Department as a whole, made it virtually impossible for DHHS to continue past operations of DDH without further reallocation of funds currently allocated to sustain community mental health services. To realize a reduction in the current operating deficit at DDH, cost reduction measures are currently being implemented. The majority of patient services will be transferred to Central Regional Hospital (CRH) in Butner and Cherry Hospital in Goldsboro. Three patient service units will remain open on the Dix Campus under the administrative and operational oversight of CRH. The cost reduction measures currently being implemented at DDH are projected to reduce the budget deficit by $16.9M through reductions in administrative and other indirect expenses and include:

- Transfer to Central Regional Hospital
  - 60 Adult Admission Beds (Dec. 2010)
  - 11 Adult Long Term Beds (Sept. 2010)
  - 54 Forensic Medium/Maximum and Pre-Trial Beds (Dec. 2010)
- Transfer to Cherry Hospital
  - 30 Adult Long Term Beds (Oct./Nov. 2010)
- Remaining on Dix Campus
  - 30 Forensic Minimum Beds
  - Child Outpatient Program
  - Clinical Research Outpatient Unit

No Reduction in Bed Capacity. These cost reduction measures will result in no reduction in bed capacity in the system. All adult admission beds currently at DDH will be transferred to CRH, with Wake and Sandhills LMEs referring all

patients to CRH. Forensic beds will also be relocated. As identified above, 11 patients in the adult long term unit at DDH have been transferred to CRH and the CRH adult long term unit (called the community transition unit), has been increased by 11 beds.

Cherry Hospital will increase their current census by 30 beds on their adult long term unit, including 24 patients currently on the adult long term unit at DDH. These 30 beds are not "new" to the system. They have been non-operational for more than 2 years. By bringing 30 beds back on-line at Cherry, the system is effectively replacing beds from DDH with beds at Cherry. Additionally, this allows Cherry to increase their capacity using existing resources, further reducing the deficit in the Division of State Operated Facilities (DSOHF) system.

Clinical Research Unit Changes. At the request of the University of North Carolina Department of Psychiatry, changes were made to the Clinical Research Unit (CRU) model. Due in part to an increase in acuity of patients on the admissions unit who do not meet criteria for the CRU clinical protocols, it was determined that the outpatient component of the CRU would be expanded and the inpatient beds would be eliminated. To maintain access to the greatest number of individuals participating in outpatient clinical research, it was agreed that the unit would remain on the Dix Campus rather than relocating to Butner as previously planned.

Timeline for Implementation of Cost Reduction Measures. As of the writing of this report, late October, 2010, the cost reduction measures are in the process of being implemented. The patients from the adult long term unit at DDH have been transferred to CRH. The remaining patients on the adult-long term unit at DDH are currently transferring to Cherry Hospital, with a small number transferring each week until all have moved by mid-November.

In early December, admissions to the Inpatient Pre-Trial Evaluation Unit will be discontinued at DDH. Evaluations on any current individuals on the unit will be completed. The majority of pre-trial evaluations, 80-85%, are conducted on an outpatient basis. Outpatient evaluations will continue during the transition period.

During December, the Forensic Maximum and Medium and Pre-Trial Evaluation Units will be transferred to CRH. Inpatient Pre-Trial Evaluations will resume at CRH. The Adult Admissions Unit will also transfer from DDH to CRH during December. Admissions from Wake and Sandhills LMEs to the Adult Admissions Unit will cease at DDH and begin at CRH in early December. Individuals on the Adult Admissions Unit at DDH will continue to be served for approximately 2 weeks. Since the average length of stay on the unit is less than 2 weeks, it is anticipated that the majority of patients will be discharged during that time. Individuals remaining on the unit will be transferred to CRH.

Preparing Patients for Transition. Patients transferring to CRH or Cherry Hospital from DDH during the implementation of cost reduction measures have been prepared for the move in a variety of ways. Patients, their families and/or guardians and representatives from their LMEs have or will be notified of upcoming moves. Disability Rights North Carolina (DRNC) has also been notified and invited to attend person-centered treatment and transition planning

meetings related to the moves. Staff members from the receiving hospitals have met with patients and their families/guardians to begin to develop relationships, describe the facilities to which they were being transferred and answer any questions. Individuals transferring to Cherry Hospital and their families were offered the opportunity to visit Cherry prior to the move. Additionally, a group of patients from long-term units at DDH visited CRH to tour the facility and to ask questions about their relocation with the goal of sharing the experience with those not able to visit.

Staff Considerations During Transition. Dorothea Dix Hospital has a long and proud history of quality care and treatment for individuals served. This quality is due to the staff at DDH. Although cost reduction measures have been necessary due to the budget deficit, DHHS has implemented mechanisms to ensure that as many DDH employees as possible have job opportunities within the system of State-operated facilities. These mechanisms include:

1. Ninety-nine percent of DDH employees have been offered positions at CRH to ensure that there is sufficient staffing at CRH. As natural staff turnover occurs, some of these positions will not be replaced. This level of staffing during the cost reduction measures accomplishes 3 significant goals: 1) protecting employee jobs, 2) allowing for extra staffing during the transition, a time when additional support is needed for the patients, and 3) reducing costly recruitment and hiring for CRH.
2. The Division of State Operated Healthcare Facilities has established a hiring priority for DDH employees for any vacancies occurring at other DSOHF facilities. Some DDH employees are not able to commute to Butner; therefore, employment in facilities located in other areas is preferable.
3. Cherry Hospital has facilitated the hiring of DDH employees, typically those living east or south of Raleigh, who are not able to commute to Butner, but want to continue working in a psychiatric hospital.

These measures have been implemented to assist current DDH employees; however, they will also enhance quality staffing at other DSOHF facilities.

II. Formal Closure of Dorothea Dix Hospital

Once all statutory requirements have been met, and necessary preparations have been accomplished at CRH, the Forensic Minimum Unit will be transferred to CRH, eliminating all inpatient beds at the current DDH and formally closing all hospital operations. The specific timeline for this transfer has not been established. Until such transfer and closure is accomplished, the Forensic Minimum Unit will be managed by CRH. The Forensic Minimum Unit has remained strongly linked to the other Units on the Forensic Treatment Unit (FTU), Forensic Maximum and Forensic Medium, as well as, Pre-Trial Evaluation. These services are operated as one service unit with consistent philosophy, policies and practices. The co-location of all units of the FTU will enhance the ability of FTU staff to consistently manage the service unit.

How Patients Will Be Cared For After Closure

Ensuring Comparable Care and Treatment after Transfer to CRH. The overall goal of the Forensic Treatment Unit (FTU) is to provide psychiatric care and treatment to individuals who have been admitted due to a finding of Not Guilty by Reason of Insanity (NGRI) or who have been found Incapable to Proceed to Trial (ITP). As individuals on the FTU demonstrate increased psychiatric stability and the ability to observe established rules, they progress to forensic units with less security. As the individual is clinically able, the clinical focus becomes assisting the individual to reintegrate into the community. With clinical recommendation, the Court may grant individuals, typically on the Forensic Minimum Unit, increased privileges such as freedom to independently come and go from the unit, grounds or community passes for specific lengths of time and facility based or community based work privileges. This progression of increasing independence prepares the individual for success to the point that the Court orders that s/he be discharged. The philosophy and programming that prepares individuals in the Forensic Minimum Unit for community integration will continue when DDH closes and the Forensic Minimum Unit relocates to Butner.

Treatment. Currently, patients in the Forensic Minimum Unit receive treatment, education, skills training and support by participating in the treatment mall. For reference, the following brief description of a treatment mall is provided. A primary objective of the treatment mall is to make the hospital's full complement of treatment and rehabilitation services accessible to all patients. All on-unit functions, including medication administration, medical services, and meals, are transferred to the mall during its operating hours. On the treatment mall, group facilitation is provided by practitioners from various hospital clinical disciplines, such as rehabilitation services, nursing, psychology, and social work. The treatment mall provides physical and social environs in which participants are more likely to become actively engaged in rehabilitation and recovery than they would be in unit-based programs. After transfer to CRH, patients on the Forensic Minimum Unit will participate in the treatment mall located at CRH and will receive education, skills training and support services comparable to the services they received at DDH.

Employment. Currently, 4 of the approximately 30 patients on the Forensic Minimum Unit work in the community: two at the Raleigh Convention Center,

one at a service station and one at a large retailer. Other forensic minimum patients currently work on the DDH campus in the following areas: food service, library services, janitorial services and landscaping services. After transfer to CRH, the individuals currently working in the community will be able to seek comparable jobs in Butner, Creedmoor (approximately seven miles from Butner) and Durham (approximately 15 miles from Butner). Patients seeking jobs close to Butner will be able to contact, with the assistance of vocational specialists at CRH, the approximately eight convenience stores/gas stations and approximately 25 restaurants located within five miles of Butner and the large retailers located approximately 10 miles from Butner in northern Durham. CRH has several vans and will ensure that staff is available to transport Forensic Minimum patients to their job sites, as needed. The patients currently working on the DDH campus will be able to do comparable work at CRH since the same jobs available on the DDH campus will be available on the CRH campus. Examples of CRH campus jobs include, but are not limited to: working in the Grill (restaurant-like setting which employs patients), cleaning up break room tables, helping the audio-visual team, landscaping, helping Nutrition Services, window-washing, washing State vehicles, library work, newspaper and mail delivery, helping Volunteer Services, carpentry shop work, and helping in the linen room.

Socialization. Currently, the treatment plans for some clinically stable patients in the Forensic Minimum Unit allow them to leave and enter DDH at will and to walk unaccompanied on the hospital grounds. Additionally, when allowed by their treatment plan, Forensic Minimum patients are taken by staff on outings to libraries, churches, sporting events, restaurants, malls, cultural and educational events. After transfer to CRH, the individuals in the Forensic Minimum Unit will be housed on the former John Umstead Hospital campus and their housing unit will be configured to allow them the same hospital entry and exit privileges that they currently have at DDH. The Butner/Creedmoor/Durham/Chapel Hill area offers many cultural, leisure, spiritual and educational activities. Examples of places near CRH that provide cultural/leisure activities include, but are not limited to, libraries in Creedmoor, Durham and Chapel Hill; bowling alleys in Bahama and northern Durham; museums in Durham and Chapel Hill; movie theatres in Durham and Chapel Hill; State recreation areas; the Durham Bulls Athletic Park; and shopping malls in Durham and Chapel Hill. Additionally, 12 places of worship are located in the Butner/Creedmoor area and many more are located in the Durham/Chapel Hill area. Also, located near CRH are two community colleges, Vance-Granville Community College and Durham Technical Community College. Other schools near CRH are Duke University and North Carolina Central University located in Durham and the University of North Carolina at Chapel Hill. As noted in the Employment section of this report, CRH has several vans and will ensure that staff is available to transport patients on the Forensic Minimum Unit, as allowed by their treatment plans, to cultural, leisure, spiritual and educational activities.

Central Regional Hospital Bed Capacity. Once all patients on the Forensic Minimum Unit and those in the earlier cost reduction measures have transferred to CRH, the total bed capacity at CRH will be 396 beds.

CRH Bed Complement after Closure of DDH

Service	Number of Beds
Adult Admissions	140
Community Transitions (adult long term)	76
Geriatric Services Unit	32
Medical Services Unit	18
Forensic/Pre-Trial Services Unit	84
Child/Adolescent Services Unit	34
Special Population, under development (previously - inpatient CRU)	12
Total	396

As discussed previously, Cherry Hospital will bring back on-line 30 beds on the adult long term unit, including the transfer of 24 individuals from DDH as part of the cost reduction measures. The remaining 6 beds will serve patients from Cherry's Adult Admission Unit.

How Support Services to Community-Based Agencies and Outreach Services Will Be Continued

Ensuring that a System is in Place for the Continuation of Hearings for Patients in the Forensic Minimum Unit. All patients in the FTU, including those in the Forensic Minimum Unit, have specific legal requirements due to their forensic status. Planning for the transfer of patients in the FTU includes ensuring that court hearings and necessary supports such as transportation are arranged. Individuals in the Forensic Minimum Unit have either been found Not Guilty by Reason of Insanity (NGRI) or Incapable to Proceed to Trial (ITP). All NGRI hearings, including those for Forensic Minimum, are held in the county where the facility is located or the court where the criminal case was originally tried. There are currently two patients in Forensic Minimum who have their NGRI hearings in the county where they were criminally tried. The others have their NGRI hearings in Wake County.

An adjudication of NGRI by the criminal court results in an automatic commitment to a State hospital. The patient must have the first hearing on the automatic NGRI commitment within 50 days. At the first hearing, the court can commit the patient for a maximum of 90 days. Before that commitment expires, another hearing must be held to determine if the patient still meets NGRI commitment criteria. At this second hearing, the court can commit the patient for a maximum of 180 days. Thereafter, at all subsequent NGRI hearings, the court can commit up to 365 days.

The Clerk of Court coordinates the calendar with the designated person at the facility and the Attorney General's Office, which coordinates with the lawyers who represent the patients. Individuals can waive their court appearance and consent to the commitment recommendation or they can have a hearing. Doctors, social workers, psychologists, and other members of the treatment team are sometimes needed to testify in court.

Patients who were adjudicated NGRI in Superior Court have their re-hearings in Superior Court. Patients who were adjudicated NGRI in District Court have their

re-hearings in District Court. Superior Court Cases at DDH for those that are NGRI, are held in the Wake County Courthouse. NGRI re-hearings are conducted at District Court which is held on hospital grounds.

There are five patients in Forensic Minimum who are not NGRI acquittees; they are patients with serious charges but who have been found Incapable to Proceed (ITP) on those charges. Patients with ITP status are held on civil commitments and have the same District Court hearings as all other committed patients. These hearings will continue to be held on Dix Campus while the Forensic Minimum Unit is located there. Upon closure, the few remaining patients who have ITP status will transfer to CRH and their hearings will be conducted at CRH.

Except for the NGRI cases that are tried in the counties where the original criminal trial occurred, Superior Court Cases for those patients that are Not Guilty By Reason of Insanity after the transfer will be held in Granville County. They schedule one Superior Court session per month and the court system is responsible for appointing a judge for that district.

As mentioned above, patients that are Incapable to Proceed will have already integrated into the court system at Central Regional Hospital prior to the Forensic Minimum transfer from DDH.

Child Outpatient and Outpatient Clinical Research Units. Both the Child Outpatient and Clinical Research Outpatient Units will continue to be located on the Dix Campus after the Forensic Minimum Unit transfers to Butner. Central Regional Hospital will operate these programs in conjunction with the University of North Carolina, Department of Psychiatry, and will maintain operational and administrative oversight. Both Units are located in the Scott Building on Dix Campus and will continue to operate from this location indefinitely. The University of North Carolina, Department of Psychiatry has been actively involved with the planning for these units.

Impact on the Remaining State Facilities

The impact on other State facilities will be limited to CRH. Since the Forensic Minimum Unit has been located on the Dix Campus, but under the administrative and operational oversight of CRH, the impact will be limited to services being in closer proximity to FTU and hospital management. This is viewed positively by FTU and hospital management.

Although minimal, some positions have been reassigned to the Forensic Minimum Unit while located on Dix Campus since the unit did not have the infrastructure of co-located service units. For example, the Unit will require re-deployed staff to provide active treatment since there will not be an existing functional treatment mall available for the patients on the Forensic Minimum Unit when they are the only patients remaining on Dix Campus. These positions will return to CRH service areas that need additional staff or to replace contracted staff.

No impact from the relocation of Forensic Minimum is anticipated for any other State operated facilities.

III. Additional Issues Related to the Closure of Dorothea Dix Hospital

Community Linkages

The closing of DDH, through transferring Forensic Minimum services to CRH, plus the earlier cost reduction measures, will not result in a reduction in capacity to the system. In fact, with the addition of an Adult Admissions unit at Broughton Hospital, there will actually be a small increase in the number of available beds in the system. Even though there is no reduction in bed capacity, community linkage is still a critical issue for individuals being discharged from State hospitals. The issues related to community linkages will not change as a result of the closure of DDH or the earlier cost reduction measures. Below is a brief discussion of mechanisms and processes related to community linkages.

Admission Delays. Limited resources, both in psychiatric units in community hospitals and in State hospitals, have led to delays for individuals requiring inpatient admission. Currently, the State hospitals are consistently on delay for admissions. The average wait time for patients in community emergency departments referred to State hospitals ranges from approximately 46 hours at Cherry Hospital to over 95 hours at Broughton Hospital. Although 60 adult admission beds have transferred from DDH to CRH, the total number of admission beds remains the same. Without a reduction in the number of admission beds in the system, no negative impact upon admission delays is anticipated. Additionally, Broughton Hospital is currently planning the expansion of its adult admission unit by 19 beds. This will reduce admission delays in the Western Region.

Daily Admission and Discharge Reports. Each State hospital provides an LME-specific report on a daily basis listing individuals from the LME catchment area who have been admitted or discharged. Each report contains basic information including the patient's name, age, and home county. Additionally, each hospital has opted to include additional information based on the discussions with LMEs in their region. The reports meet current confidentiality and privacy requirements.

Hospital Liaisons. Each LME has one or more employees identified as their LME Liaison to the State hospital. The Hospital Liaison ensures that the LME and providers are working in conjunction with the hospital during an individual's inpatient hospitalization. The Liaison is intended to be, and in most cases is, on site at the hospital, directly communicating with the patient and the treatment team. The Liaison typically attends treatment planning meetings and assists with discharge planning by assisting with appointments and/or connecting with community providers to engage in discharge planning. The Liaison proves to be critical when the development and/or implementation of a discharge plan is difficult or complicated. For example, the Liaison is the critical link to the LME, if funding or services need to be braided to meet the unique needs of the individual.

Discharge Communication. To increase the quality and consistency of discharge information provided to the patient, the LME and providers upon discharge, DSOHF worked with community stakeholders and State hospital staff to develop the Continuing Care Plan (CCP). The person-centered CCP is sent to the involved parties at the time of discharge and replaces the previous aftercare plans. The CCP includes the following information:

- Basic patient information
- Outpatient appointments with dates, contact names, addresses, telephone numbers and purpose of appointment
- Psychosocial needs and recommendations for treatment approach
- Service recommendations
- Medical diagnoses, follow-up recommendations and education
- Patient Recovery Plan
- Diagnostic information and reason for admission
- Discharge medication information, and
- Signatures of individuals involved in the development of the CCP.

The CCP is intended to ensure that the LME and, most critically, all aftercare providers have the necessary information from the hospital to begin immediate assessment and treatment of the individual in the community.

All hospitals currently complete the CCP together with each patient that is discharged. Subsequently, there will be no change in this process due to the transfer of patients to CRH or Cherry Hospital.

Discharge to Homeless Shelters. The DHHS, DSOHF and the State hospitals have taken measures to reduce the number and percentage of individuals discharged to homeless shelters. In FY2009, all DSOHF facilities entered into agreements with their local HUD Continuums of Care that stated the facilities would not discharge patients to homeless shelters if they had not been admitted from homeless conditions or had been in the facility for greater than 30 days. These agreements were based on federal templates for facilities nation-wide that regularly discharge individuals to homeless shelters including jails, prisons, foster care, hospitals, etc.

Since the agreements have been signed, all State hospitals have followed the stipulated conditions. Rarely is a patient that does not meet the above criteria discharged to a homeless shelter. Approval by DSOHF is required before a patient is discharged to a homeless shelter if s/he was not homeless upon admission or has been hospitalized for more than 30 days. DSOHF staff review the case with the hospital social worker to ensure that all alternative placements have been pursued.

During FY09-10, less than 5% of all discharges, or a total of 342 individuals, were discharged from State hospitals to homeless shelters. By individual report, approximately 8% of all admissions were living in homeless situations; typically a homeless shelter or the streets, immediately prior to admission.

Discharges to Homeless Shelters, All Hospitals

	FY07-08	FY08-09	FY09-10
Total Discharged to Homeless Shelters, All State Hospitals	1070	493	342
Percent of Total Discharges	7.11%	4.75%	4.70%

Data extracted from the Healthcare Enterprise Accounts Retrievable Tracking System (HEARTS).

The closure of DDH and the earlier cost reduction measures are not expected to positively or negatively impact the percentage of individuals discharged to homeless shelters. Central Regional Hospital and Cherry Hospital social workers will continue to abide by the on-going HUD agreements. Liaisons will also continue to work with hospital staff, at CRH and Cherry rather than DDH, to identify and arrange appropriate discharge placements.

Community Services and Qualified Providers

Wake Human Services and Sandhills Center are the Local Management Entities (LMEs) which are affected by the DDH closure, the earlier cost reduction measures and the transfer of individuals served at DDH to CRH. Other catchment areas previously served by DDH have been redrawn to be served by Broughton Hospital or Cherry Hospital; only Wake and Sandhills directly served by DDH.

If community-based services are available for persons with mental health and/substance abuse needs at any point on the continuum of need, it is less likely that the individual will require intervention in a State facility such as CRH, or a facility for treating persons with substance use issues. Following are those services and supports established by the two LMEs to address the needs of persons who reside within their catchment areas, and who had been served by DDH, and are now ultimately served, when necessary, at CRH.

Sandhills Center Community Services. Sandhills Center, through its partnership and collaboration with consumers, families, providers, advocacy groups, state and community agencies and initiatives, participates in the provision of the following community service options. These options include crisis prevention, intervention and stabilization; step-down and diversion services; and ongoing treatment, support, and recovery activities.

- Hospital Liaison Services – 3 Liaisons
- Hospital Transition Team – 1 Team
- Mobile Crisis Services – 2 Teams
- Daytime Crisis Walk-in Services – 9 Clinics
- Assertive Community Treatment – 9 Teams
- Targeted Case Management – 19 providers
- Psychosocial Rehabilitation – 23 locations
- Community Support Team – 50 Providers

- Substance Abuse Intensive Outpatient – 18 Providers
- Intensive In-Home – 70 Providers
- Day Treatment – 27 Providers
- Multi-Systemic Therapy – 5 providers
- Residential Crisis Bed/Respite Services – 16 Beds
- Contracted Local Hospital Beds Available – 9 Beds
- Local Inpatient and Detoxifications Services – 7 Locations
- After-hours face to face assessment services – 3 Providers
- Local Emergency Room Evaluations
- Facility Based Crisis – 1 Provider
- Individual Consumer Support
- Crisis Intervention Training for Law Enforcement – 6 Law Enforcement Agencies

Sandhills Center Crisis Service Expenditures. The crisis intervention and crisis services identified above are critical to meeting the needs of individuals with mental health, intellectual/developmental or substance use issues prior to the need to seek intervention in the State Hospital Facility. The availability and provision of appropriate crisis services is important in order to ensure that the state hospitals are used only for those consumers whose needs can not be met locally. When the designation, "Non-UCR" is included, this means the service was reported without identifying the number of units provided. The number of units would tell us the number of individuals served. In such cases, only the amount expended for the service is reported. For Sandhills Center, the expenditures reported over the previous two (2) Fiscal years (FYs) are:

Sandhills:
FY 2009

Service	Persons Served	Billing Code	Expenditure
Crisis Intervention	43	H2011	$42,309
Mobile Crisis Team		Non-UCR	$200,000
Walk-In Crisis		Non-UCR	$110,000
Facility Based Crisis	108	YP485	$114,710

Sandhills:
FY 2010

Service	Persons Served	Billing Code	Expenditure
Crisis Intervention	471	H2011	$277,881
Mobile Crisis Team		Non-UCR	$372,803
Facility Based Crisis	57	YP485	$56,363

Wake Human Services Community Services
The Services, availability and options, for Wake LME are listed below:

- Community Support Child – 29 providers (this service will end January 1, 2011, except for those individuals who are allowed to receive it through EPSDT
- Community Support Adult – 23 Providers (this service will end January 1, 2011)
- Community Support Team – 32 Providers
- Diagnostic Assessment – 31 providers
- Mobile Crisis Team – 1 Team
- Intensive In-Home -- 37 Providers
- Multi-Systemic Therapy – 3 Providers
- Assertive Community Treatment Team – 4 Providers
- Psychosocial Rehabilitation – 5 Providers
- Substance Abuse Comprehensive Outpatient Treatment – 5 Providers
- DD Targeted Case Management – 26 Providers
- Child Day Treatment – 10 Providers
- Substance Abuse Intensive Outpatient Treatment – 9 Providers
- Opioid Treatment --1
- Community Alternatives Program -- 43 Providers
- Level III Residential for Children --14 Providers (25 facilities in Wake Co.)

Of these services listed above, two (2) are nationally identified as evidence-based practices: Multi-Systemic Services (MST) and Assertive Community Treatment Teams (ACTT). ACTT is a service overseen by a Psychiatrist and is considered the most intensive community-based service available. It is used as a step-down service from the hospital setting, or a service which, if successfully provided, limits or prevents hospital stays for individuals with substance use or mental health issues.

Residential Services for children (Level III) also serve as step-down from inpatient settings; or when appropriately provided, prevention or limitation of inpatient stays.

Wake Human Services Crisis Services Expenditures. For Wake Human Services, the expenditures reported over the previous two (2) Fiscal years (FYs) are:

Wake Human Services
FY 2009

Service	Persons Served	Billing Code	Expenditure
Mobile Crisis Team		Non-UCR	$267,199
Facility Based Crisis	562	YP485	$1,505,993

Wake Human Services
FY 2010

Service	Persons Served	Billing Code	Expenditure
Mobile Crisis Team		Non-UCR	$170,582
Crisis Intervention	21	H2011	$722
Adult Crisis Services		Non-UCR	$96,464
Child MH/DD/SA Crisis Services		Non-UCR	$8,430
Walk-In Crisis/Psychiatric Aftercare		Non-UCR	$59,494
Facility Based Crisis	445	YP485	$1,197,194

Additional Crisis Facility Options:
Wake Crisis Assessment Unit: (Wakebrook Campus). The Wake Crisis Assessment Unit will open January 2011, and will house the following Crisis Service Options for persons with mental health, intellectual/developmental or substance use crisis issues:

- 24/7 Crisis Assessment Services
- Wake Transition Team
- Sixteen (16) Short-Stay residential Crisis Beds
- Sixteen (16) Non-Hospital Medical Detoxification Beds
- One (1) Dually Licensed Unit of sixteen (16) beds to open March, 2011, and a second one later in 2011.
- After six (6) months of operation, certification for Involuntary Commitment will be sought.
- LME interface with the hospital to help facilitate discharge to appropriate placements.
- One FTE LME Care Coordination hospital liaison will cover all adult admission, long term and forensic units at CRH once DDH closes. The liaison will be on-site 20 hours per week (50%) and at other times at the LME office or traveling. Another 0.25 FTE will cover the geriatric unit and the RJ Blackley ADATC, once that person is hired. There are also two (2) full-time staff assigned to Holly Hill Hospital
- In March, 2011, the Wake Substance Abuse Unit is planned to open. It will provide sixteen (16) beds for the voluntary treatment of substance use disorders.

Statewide Initiatives

Three-Way Hospital Beds. Since FY 2008, the General Assembly has appropriated funds, even in years of scarce resources, for the purpose of the purchase of inpatient psychiatric beds or bed days in communities around the State. The purpose of the purchase of these beds and bed days is several-fold:
(1) to provide individuals who need inpatient psychiatric care an opportunity to locate treatment nearer to their homes and allow better contact and family care, and;

(2) to reduce wait times in State facilities and allow the State hospitals to focus on treatment of persons with the most intensive needs;
(3) to reduce short-term admissions (7 days or less) to State Hospitals;
(4) to decrease emergency room (ED) wait times and impact on law enforcement;
(5) Stop the trend toward closure of inpatient beds.

A standardized contract is signed by DMH/DD/SAS, the LME in whose catchment area the hospital is located, and the hospital itself, hence the designation, "three-way hospital beds." The contract provides for a rate per night per bed which allows the hospital to recover its cost in the provision of the bed, including psychiatric care. It also allows participating hospitals to receive priority in transferring individuals with more intensive needs to State hospitals.

The expansion of these beds is accomplished in three (3) ways:
(1) Opening new beds (CON or State hospital transfer);
(2) Staffing unused capacity;
(3) Opening Existing Bed Capacity to Involuntary Commitments.

In FY2008-2009, contracts were initiated with
- Eleven Community Hospitals, and;
- Phased In throughout the year as increased capacity came on-line;
- Capacity was increased by 67 Beds;
- Participating hospitals served an additional 1,453 patients over FY 07-08 Actual Admissions.
- The State paid for 6,316 Days of Care through the 3-Way Hospital initiative.

The following chart represents the current (FY2011) configuration of contracted 3-way hospital beds across the State.

Table. FY2011 3-Way Contract Hospitals and Beds (as of October 27, 2010)

LME Name	Hospital Name	Number of Beds in SFY11 Contract	2011 Contract Amount	Contracted Units	SFY 11 Units to -Date
Mental Health Partners	Catawba Valley	12	3,285,000	4,380	694
Pathways	Kings Mountain	5	1,026,563	1,369	280
Alamance-Caswell	Alamance Regional	4	821,250	1,095	201
Sandhills	Moore Regional	9	2,394,000	3,192	383
Durham	Duke University Health	4	1,048,500	1,398	
Centerpoint	Forsyth Memorial	11	2,941,500	3,922	510
Cumberland	Cape Fear Valley Hosp.	5	1,026,563	1,369	93
Eastpointe	Duplin General	5	1,095,000	1,460	140
Beacon Center	Nash Hospitals (Coastal Plain)	11	2,941,500	3,922	477
ECBH	Beaufort Regional Medical	3	615,938	821	136
ECBH	Northside @ Roanoke-Chowan	5	1,368,750	1,825	345
Smoky Mountain	Haywood Regional	4	1,095,000	1,460	151
Smoky Mountain	Charles A. Cannon Memorial	3	821,250	1,095	118
Southeastern Center	The Oaks	8	2,120,250	2,827	471
Western Highlands	Margaret Pardee Memorial	4	821,250	1,095	144
Crossroads	Davis Regional Med. Cntr	5	1,026,562	1,369	
Guilford	Moses Cone Hospital	4	821,250	1,095	
Western Highlands	Mission Hospital	5	1,026,563	1,369	130
Western Highlands	Rutherford Hospital	3	615,938	821	69
ECBH	Pitt Memorial	3	460,688	614	
Mecklenburg	Presbyterian	8	1,503,000	2,004	
Totals		**121**	**28,876,315**	**38,502**	**4,342**

Housing

HUD 811 Housing. There are currently group homes and apartments with a total of 489 operational beds that have been developed with federal Housing and Urban Development (HUD) funds and HOME funds in the service area that will be affected by the closure of Dix. For example, the Sandhills' catchment area has developed more than 90 residential beds including 8 group homes and apartments in 10 locations. Since the mid-1980's, significant amounts of housing have been developed in North Carolina and been funded by HUD. The HUD Section 811 program makes capital advances to finance the development of rental housing and group homes with the availability of supportive services for persons with disabilities. The advance is interest free and does not have to be repaid as long as the housing remains available for very low-income persons with disabilities for at least 40 years. Project-based rental assistance covers the difference between the HUD-approved operating cost of the project and the tenants' contributions toward rent and utilities (usually 30 percent of monthly adjusted income) in the rental housing units.

HUD 811 projects have had significant funding cuts in recent years. In the latest funding round only one new 811 project was funded in all of North Carolina. Stakeholders should be aware that existing projects are extremely valuable and provide a solid housing option for persons with disabilities, but the State should not count on any new projects if current federal funding trends continue.

Oxford House. In the service area that will be affected by the closure of Dix, Oxford Houses currently have more than 500 beds. North Carolina State Oxford Houses are a clean and sober housing option for individuals in recovery. The first North Carolina Oxford Houses were established in Durham, NC and Asheville, NC in the spring of 1991. As of August 2010, there are 139 houses in North Carolina, with locations in 28 cities. With an average of 8 beds per house, there are more than 1,000 Oxford House beds in the State. Individuals typically enter an Oxford House after completing a drug and alcohol treatment program. Individuals living in a house are expected to participate in a recovery program in the community during their residence. All Oxford House residents are required to pay monthly rent and their percentage of all household utilities, averaging approximately $350 - $500 per month.

Targeting and Key Programs. As part of this housing initiative, independent supportive housing rental units statewide will be developed and targeted to serve persons with disabilities. The Key Program provides an operating subsidy in the form of rental assistance for persons with disabilities in targeted Low-Income Housing Tax Credit units. The Key Program originally was jointly funded by the NCHFA HOME Match funds and the Mental Health Trust Fund. As of September 1, 2010, the Targeting Program includes a total of 2,243 funded units, in over 340 properties, covering 141 cities, in 70 counties. Communities have additional sources of subsidized housing for which persons with disabilities are eligible to apply. There is active LME involvement in the catchment areas impacted by the closure of Dix.

Local Public Housing Authorities: Public Housing and Section 8 Public Housing are both available in most communities across the state, operated by local public housing authorities in direct relationship with the U.S. Department of *Housing and Urban Development.* Most public housing authorities also administer the Section 8 Voucher Program which provides rental assistance for use in the private sector. Most communities have closed Section 8 intake lists and/or have had extensive waiting lists for multiple years. Almost as many communities have lengthy waiting lists for public housing assistance. However, in the majority of communities, one bedroom units for persons with disabilities and the elderly are the public housing units that become available most often. Potential tenants should be encouraged to apply whenever those waiting lists are opened.

HUD McKinney-Vento Homeless Assistance Projects: McKinney-Vento funds are available for communities to request through establishing a homeless Continuum of Care (CoC). Thirteen CoCs exist in North Carolina and cover all 100 counties. These volunteer associations coordinate the application process for two types of HUD funding: Shelter Plus Care and Supportive Housing Program. If an application is successful, the contract for services is between HUD and a local unit of government or nonprofit that will provide the housing resource. Both programs specifically target homeless persons who have documented disabilities. A person who enters an institution with a homeless status and exits that institution within 7 days is considered homeless by HUD's definition. In addition, persons who have been institutionalized for over 30 days, are going to be released within 7 days, and have no alternative place to go, also meet HUD's definition of homeless and are eligible for housing provided by these programs. These funds are not controlled by the State.

Shelter Plus Care provides rental assistance, similar to the Section 8 Voucher Program. Shelter Plus Care is always operated by a unit of local government which may include housing authorities, county governments, or LMEs. There are over 1,030 Shelter Plus Care vouchers in 19 communities across North Carolina. The Supportive Housing Program is site based, and provides construction, renovation, and operating or leasing assistance for a property that will provide transitional or permanent supportive housing to homeless persons with disabilities. Some Supportive Housing Programs serve homeless families that do not have disabilities. There are over 80 funded Supportive Housing Program units in North Carolina.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services Monitoring of Wake and Sandhills Center. Monitoring of services and functions of the LMEs by DMH/DD/SAS is implemented in several ways:

Monitoring of Critical Indicators:
The LMEs submit regular reports to the DMH/DD/SAS Quality Management Team, and the team compiles LME scores for critical indicators of service performance. These results are then published in the quarterly Community Systems Progress Report. Examples of indicators include:

1. Timely Access to Care (Routine Care)
2. Timely Initiation and Engagement of Individuals in Service (Mental Health)
3. Effective Use of State Psychiatric Hospitals

4. State Psychiatric Hospital Readmissions
5. Timely Follow-Up Care for Individuals After Inpatient Care (ADATCs)
6. Timely Follow-Up Care for Individuals After Inpatient Care (Psychiatric Hospitals)

For these services, statewide averages and baseline data are identified, and LMEs are reviewed according to their performance in comparison to all other LMEs (statewide averages) and against baseline data and goals established for each indicator. The results of these reviews have several consequences. For those 17 of the 23 LMEs who receive their funding for services and supports in an aggregate and are allowed to use them with flexibility based on the needs of the LME (Single-Stream Funding), certain percentages are required to be maintained in order to be allowed to continue to receive funding in a single-stream. Statute requires DMH/DD/SAS to assure that LMEs are meeting standards for required LME functions. When these data suggest that an LME is functioning considerably lower than other LMEs, or when one or more are functioning considerably under statewide averages or established goals, DMH/DD/SAS is required to intervene to bring the LME to acceptable performance standards. If those standards are not met within identified timeframes, DMH/DD/SAS is required to take action such as removing functions, to assure individuals are appropriate served. The most recent report may be found under the heading "Community Systems Progress Reports,": http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Geographical Considerations

Central Regional Hospital is located approximately 36 miles north of Dorothea Dix Hospital. The table below lists counties and county seats currently served by DDH and compares their proximity to CRH and to DDH.

Distances in Miles from County Seat to DDH and CRH

County	County Seat	Distance in Miles from County Seat to DDH (2108 Umstead Drive, Raleigh)	Distance in Miles from County Seat to CRH (300 Veazey Road, Butner)	Additional Distance in Miles (one way) to CRH
Anson	Wadesboro	116	145	**29**
Harnett	Lillington	32	66	**34**
Hoke	Raeford	87	116	**29**
Lee	Sanford	40	69	**29**
Montgomery	Troy	86	117	**31**
Moore	Carthage	57	86	**29**
Randolph	Asheboro	70	92	**22**
Richmond	Rockingham	96	125	**29**
Wake	Raleigh	0	36	**36**
Average		*65*	*95*	***30***

Analysis of averages distances from county seats to the other two State hospitals shows the following:

The average distance from county seats served by Broughton Hospital to Broughton Hospital is 73 miles. The average distance from county seats served by Cherry Hospital to Cherry Hospital is 91 miles. Once Wake and Sandhills LMEs admit to CRH, the average distance from county seats served by CRH to CRH will be 70 miles.

Additionally, of the counties served by Broughton Hospital, the most distant county seat from Broughton is Murphy in Cherokee County, 166 miles away. Of the counties served by Cherry Hospital, the most distant county seat from Cherry is Manteo in Dare County, 186 miles away.

Comparing another large metropolitan area, Charlotte, to Raleigh, reveals that Charlotte is 74 miles from Broughton Hospital; twice the distance Raleigh is from CRH.

The 30 additional miles, on average, it will take for law enforcement officers to patients to CRH, is not ideal, but reasonable, given the large geographic area covered by North Carolina and the fact that North Carolina is served by three State Hospitals strategically located across the State.

IV. Conclusion

Dorothea Dix Hospital has a long and proud history of service to North Carolinians who require inpatient psychiatric hospitalization. Although forced by a significant budget deficit to implement cost reduction measures and, ultimately close Dorothea Dix Hospital, the Department of Health and Human Services has effected the changes while working to ensure the safety, care and treatment of current patients, preserving employment opportunities for Dix staff and, without reducing State hospital bed capacity, actually increasing beds at Broughton Hospital. The on-going stabilization and expansion of community-based services in Wake and Sandhills Center LMEs will provide more comprehensive mental health services to individuals locally, requiring fewer referrals to Central Regional Hospital.

Expenditures & Utilization Tracking Update
Joint LOC on MH/DD/SAS
November 9, 2010

Division of Medical Assistance
Kelly Crosbie, LCSW
Behavioral Health Manager

1

SFY 2010
DMA Utilization & Expenditures Tracking

- Per LOC request: update on utilization/expenditures that exceed 5% (increase or decrease)
- Comparison of SFY10 Q4 to SFY11 YTD
- Request that report be given quarterly
  - Uneven monthly reports based on paid claims

2

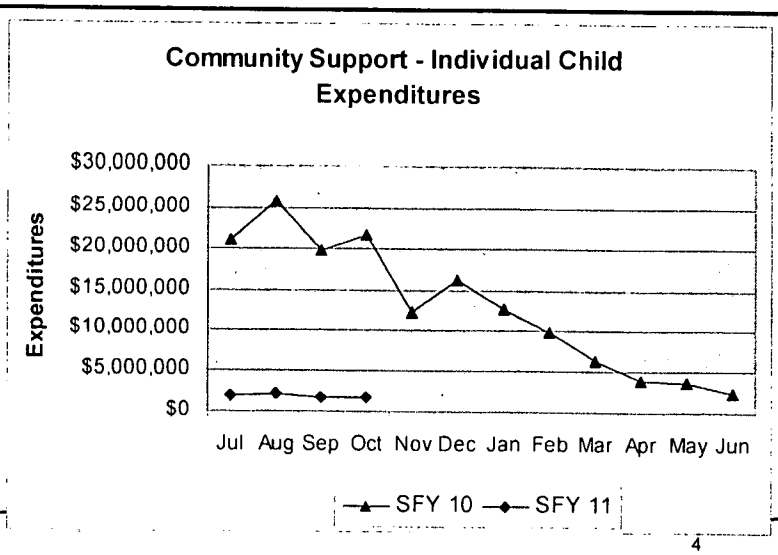
Children's Services

Community Support

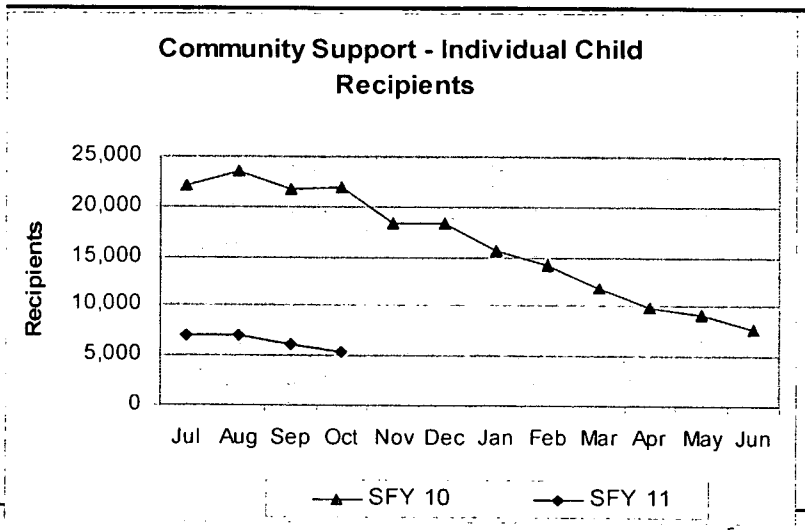
Intensive In-Home

Multisystemic Therapy (MST)

Community Support-Child Expenditures



Community Support-Child Recipients



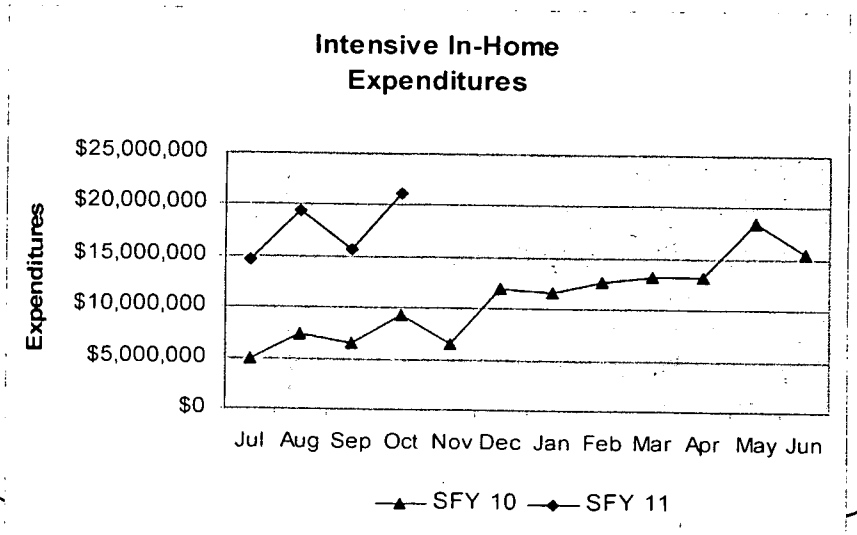
5

Community Support-Child

- Expenditures are down 43%
  - = $1.4 million/month (less)
- ~2500 fewer children per month
- ~ 6400 children still receive this service
- Service ends December 31, 2010

6

Intensive In-Home Expenditures



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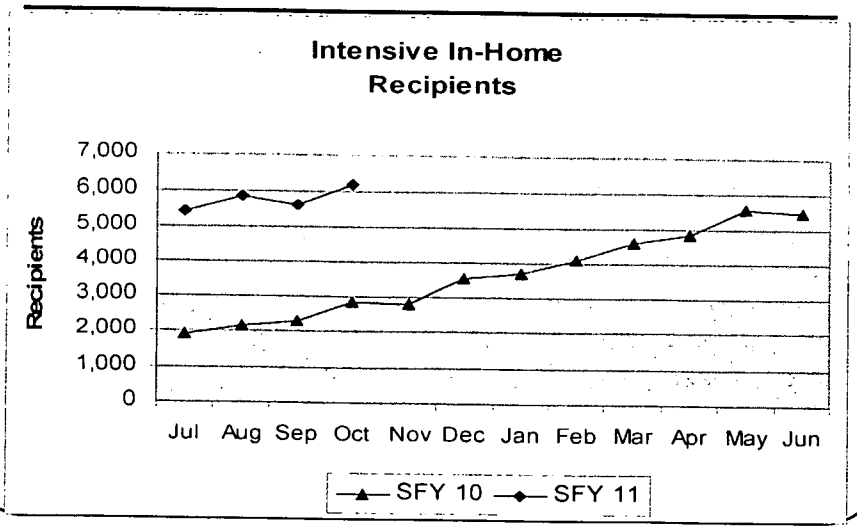
Intensive In-Home Recipients

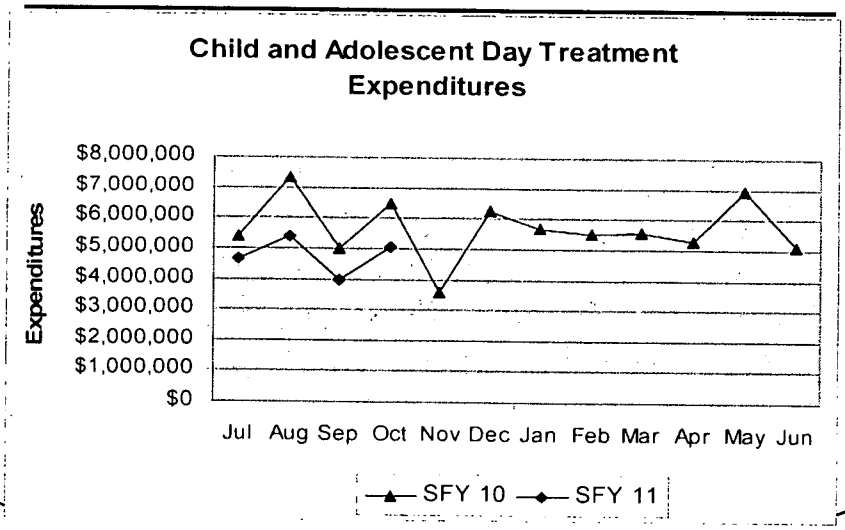


8

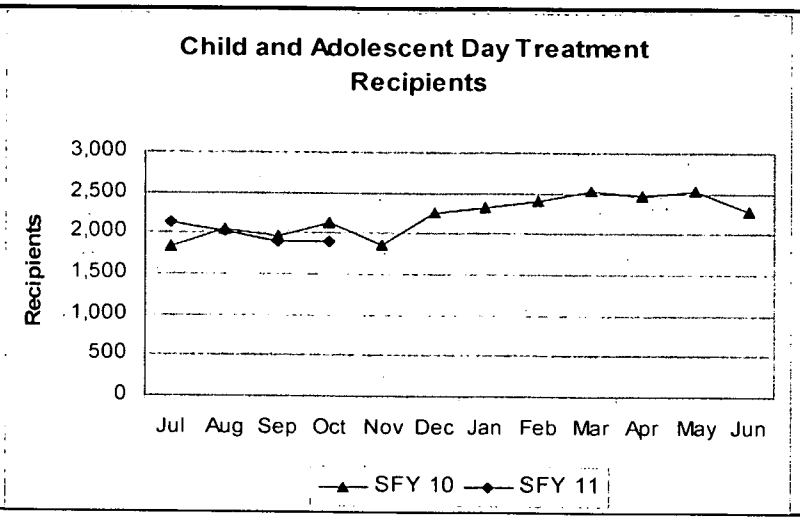
Intensive In-Home

- Expenditures are up 12.7%
  - = $2 million/month (more)
- Increase of ~700 children per month
- Clinically appropriate transfers from CS and Level III, IV

Day Treatment Expenditures



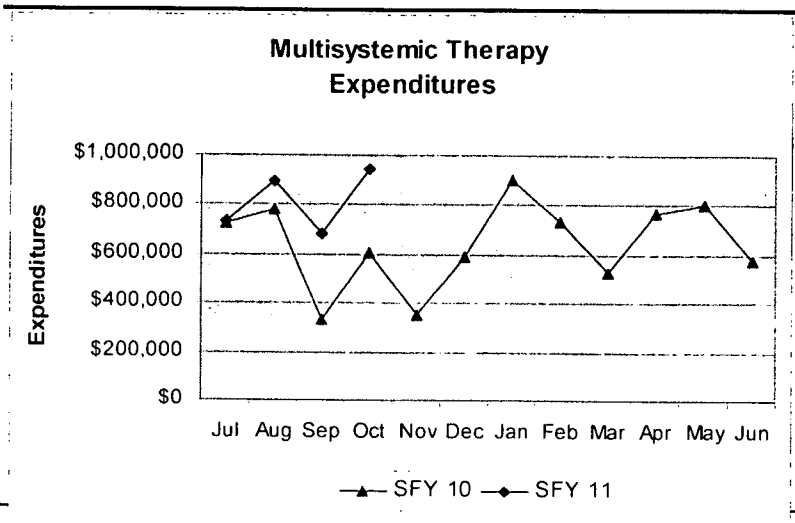
Day Treatment Recipients



Day Treatment

- Expenditures are down 17.3%
  - = $1 million/month (less)
- Less ~450 children/month
- Stricter policy criteria
  - updated eligibility guidelines
  - increased clinical staffing requirements

Multisystemic Therapy (MST) Expenditures



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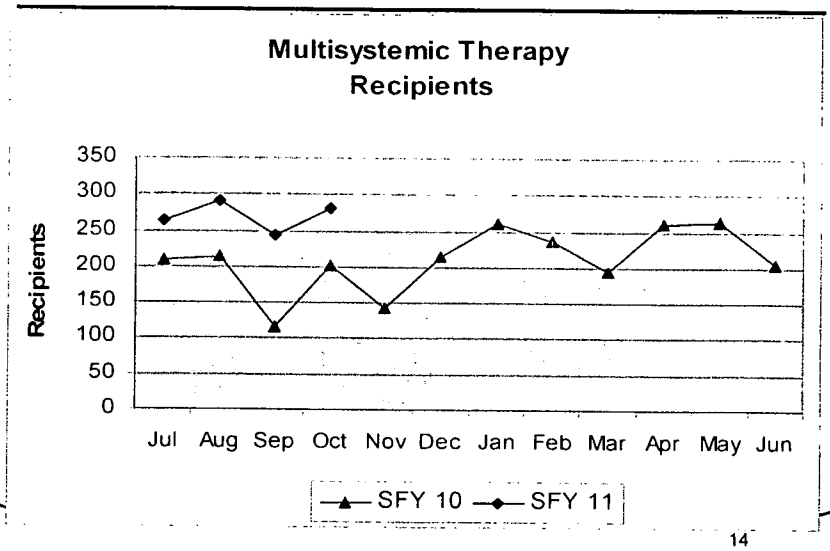
Multisystemic Therapy (MST) Recipients



14

Multisystemic Therapy (MST)

- Expenditures are up 13.7%
  - = $98,000/month (more)
- 30 more children/month
- **Growth is +**
- Evidence-based practice with outcome metrics

15

Adult Services

Community Support

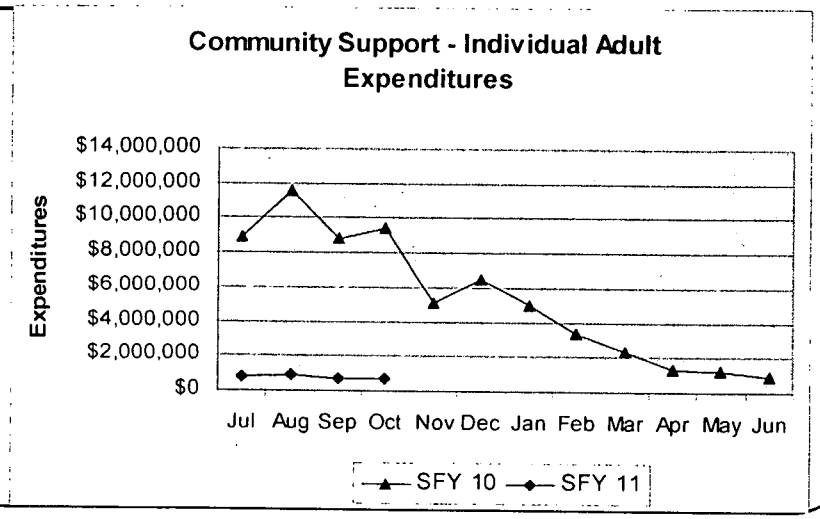
Community Support Team

Assertive Community Treatment Team (ACTT)

Psychosocial Rehabilitation (PSR)

16

Community Support—Adult Expenditures



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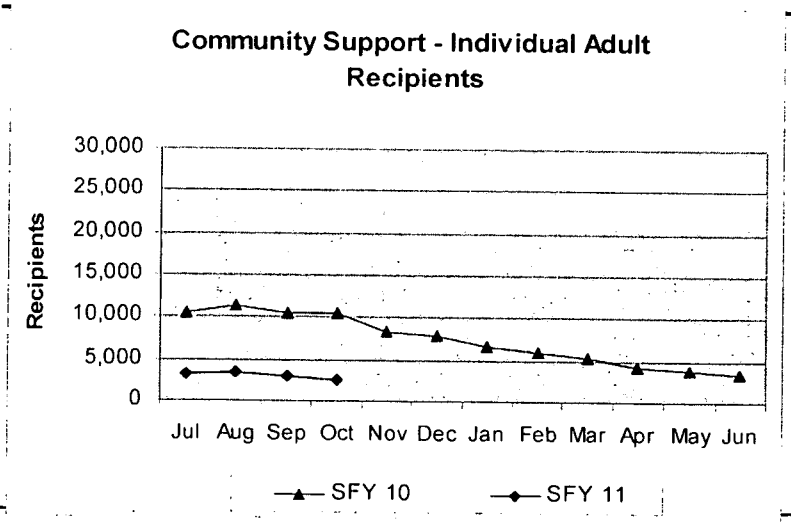
Community Support-Adults Recipients

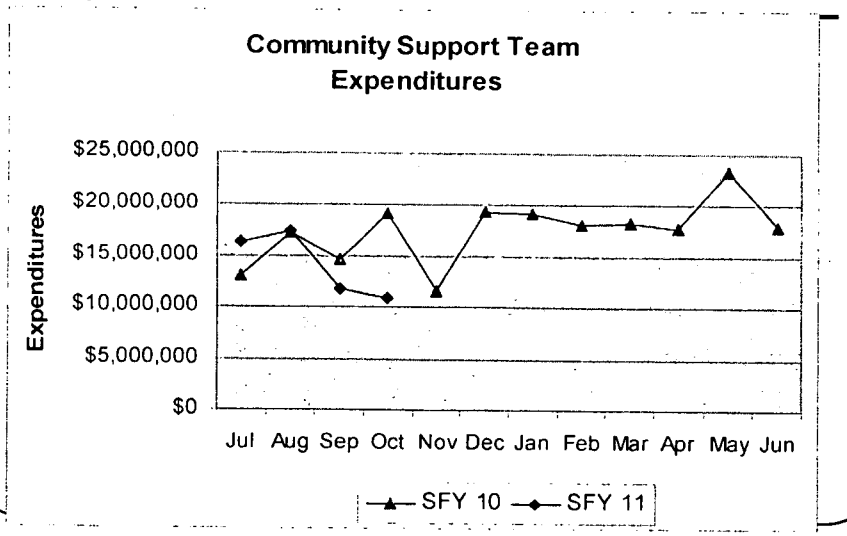


18

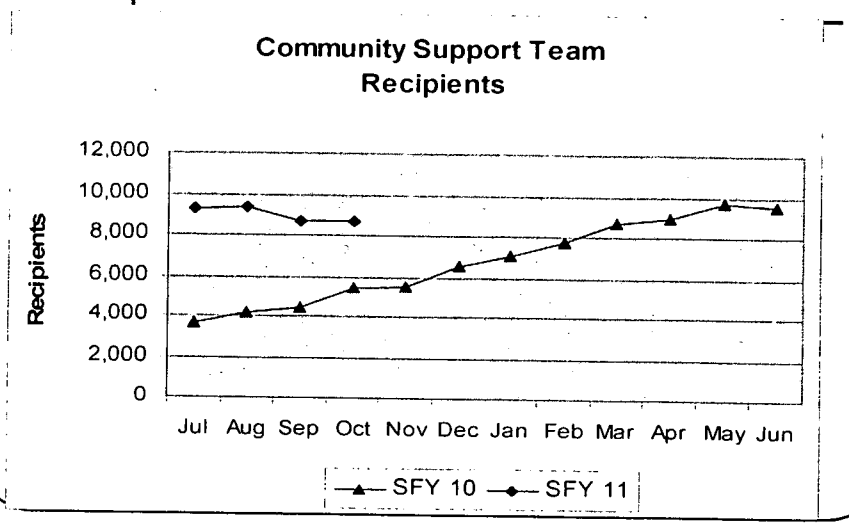
Community Support-Adults

- Expenditures are down 35%
  - = $407,000/month (less)
- ~800 fewer adults per month
- ~ 2600 adults still receive this service
- Trend continues downward
- Service ends December 31, 2010

Community Support Team (CST) Expenditures



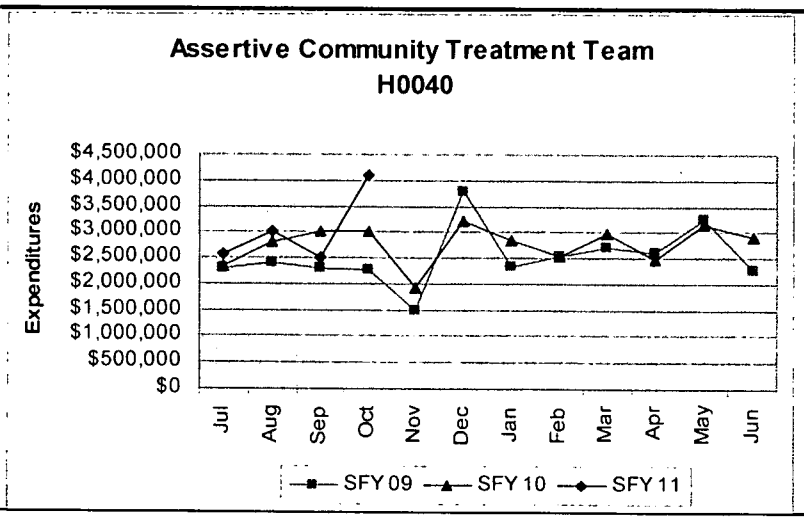
Community Support Team (CST) Recipients



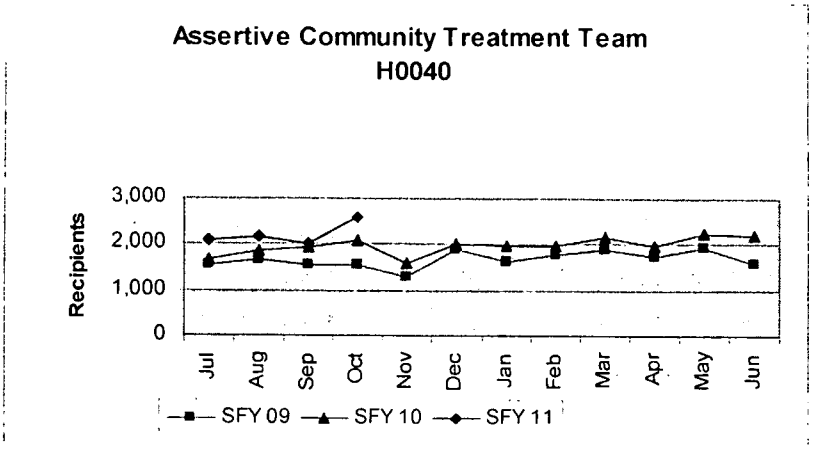
Community Support Team (CST)

- Expenditures are down 28%
  - = $5.5 million/month (less)
- ~ 390 fewer adults per month
- Trend continues downward
- New policy changes included: more clinical staffing, decrease in unit limits/month, rate decrease

Assertive Community Treatment Team (ACTT) Expenditures



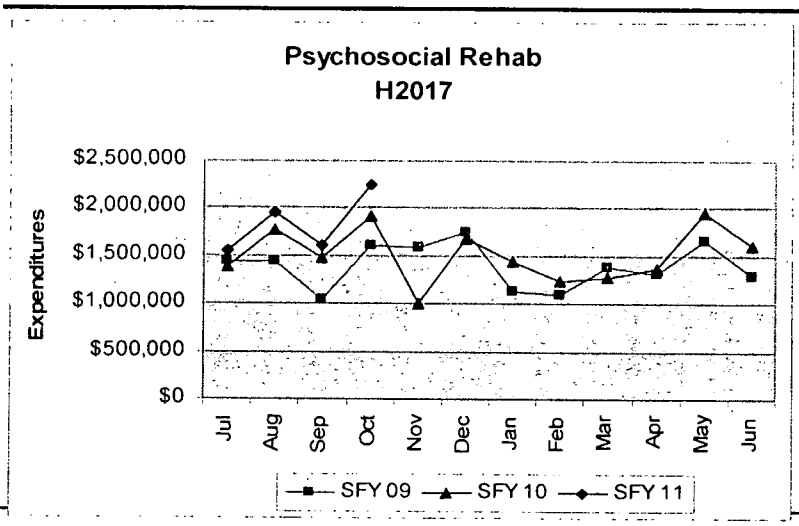
Assertive Community Treatment Team (ACTT) Recipients



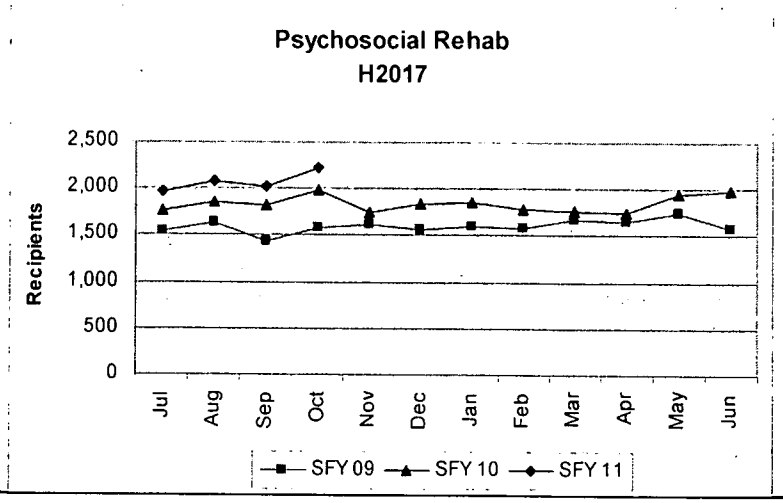
Assertive Community Treatment Team (ACTT)

- Expenditures have increased 7.4%
  - = $211,000/month (more)
- ~ 60 more adults per month
- **+ Growth**
- Evidence-based service

Psychosocial Rehabilitation (PSR) Expenditures



Psychosocial Rehabilitation (PSR) Recipients



Psychosocial Rehabilitation (PSR)

- Expenditures have increased 11.3%
  - =$187,000/month (more)
- ~200 more adults per month
- May be referrals from CS-Adult or CST
  - Clinically appropriate

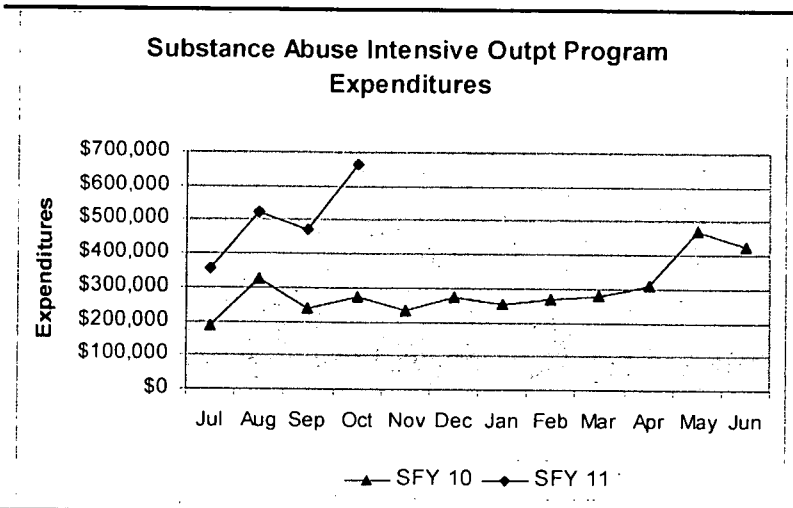
Children & Adult Services

Substance Abuse Intensive Outpatient (SAIOP)

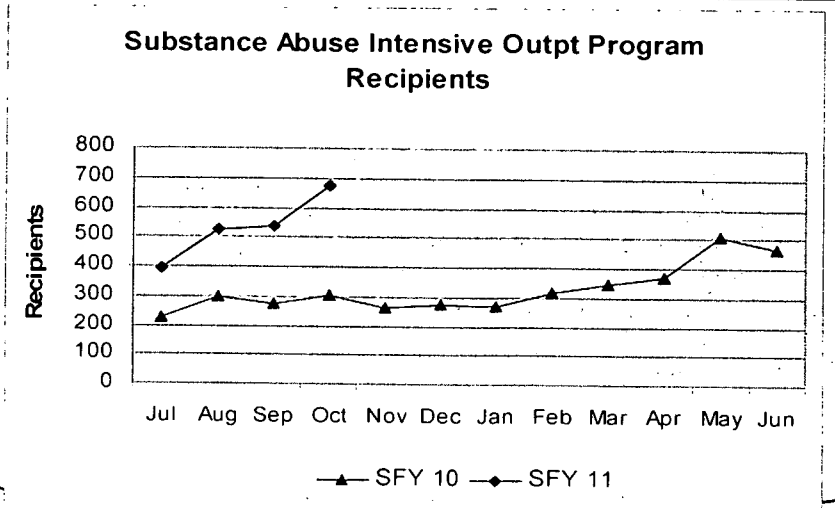
Mobile Crisis

I/DD Targeted Case Management (CAP waiver & non-waiver)

Substance Abuse Intensive Outpatient (SAIOP) Expenditures



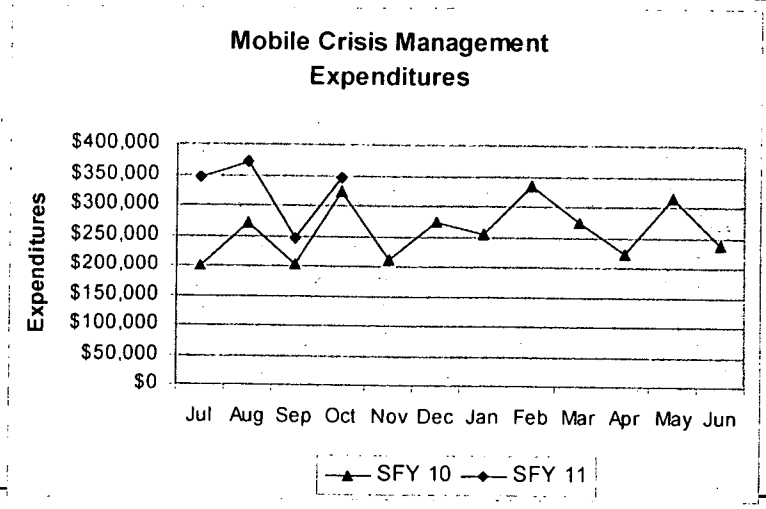
Substance Abuse Intensive Outpatient (SAIOP) Recipients



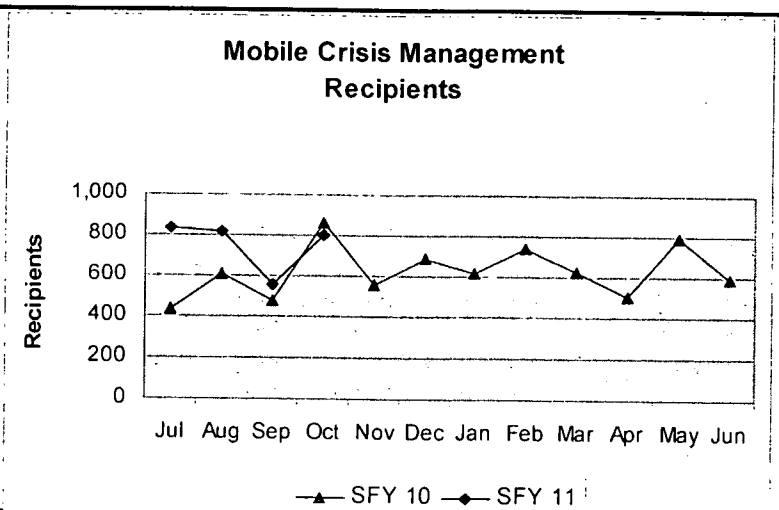
Substance Abuse Intensive Outpatient (SAIOP)

- Expenditures are up 25%
  - =$100,000/month (more)
- ~90 more recipients per month
- + Growth
- New policy guidelines allowed for a 30-day pass-through before prior authorization is required

Mobile Crisis Management Expenditures



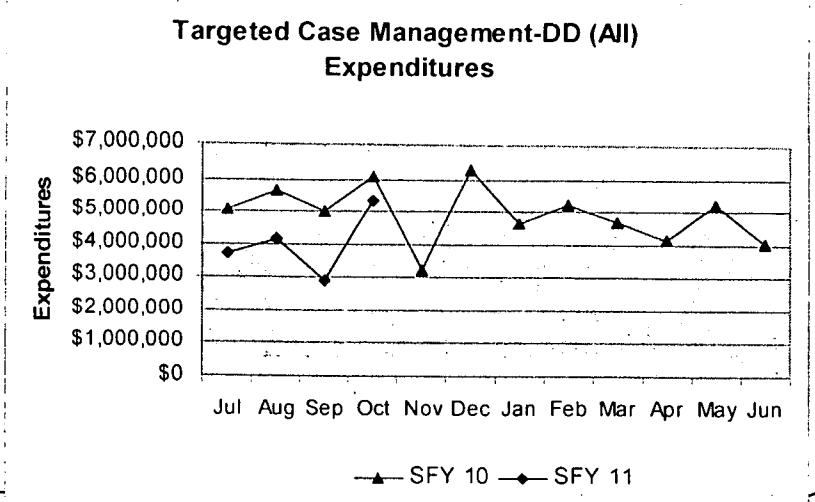
Mobile Crisis Management Recipients



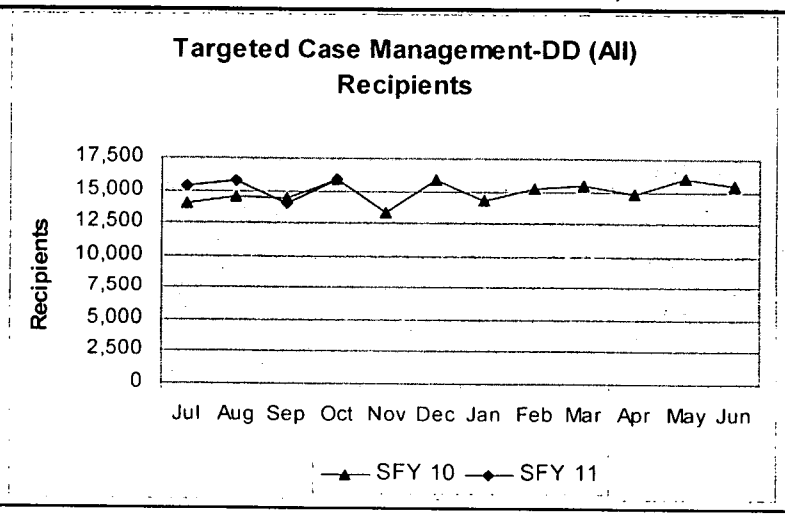
Mobile Crisis Management

- Expenditures have increased 26%
  - =$68,000/month (more)
- ~120 more recipients per month
- Should divert from emergency departments and inpatient

I/DD Targeted Case Management Expenditures (CAP & non-waiver)



I/DD Targeted Case Management Recipients (CAP and non-waiver)



I/DD Targeted Case Management (CAP & non-waiver)

- Expenditures are down 19.3%
  - =$334,000/month (less)
- CAP recipients (in case management) have increased 3%
  - ~150 more CAP recipients per month
- Non-waiver recipients (in case management) have decreased 7%
- ~170 less recipients per month
- # of I/DD case management recipients is fairly static
  - Decreased expenditures likely to 3 unit/month limit
  - Limit phases-out with weekly case rate

Questions

Treatment Accountability for Safer Communities

A Cross Area Service Program

Mike Kupecki
Assistant Area Director
East Carolina Behavioral Health

Michael E. Gray
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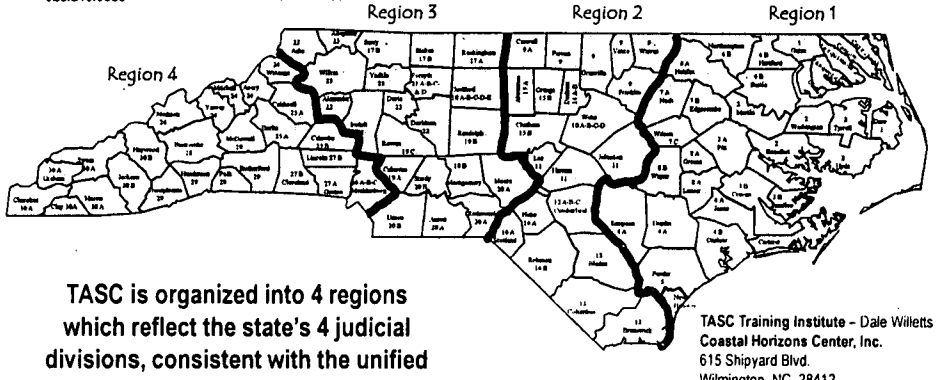

TASC is organized into 4 regions which reflect the state's 4 judicial divisions, consistent with the unified court & statewide probation systems.

TASC Training Institute – Dale Willetts
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What is TASC?

- A model that bridges two separate systems: justice & treatment
- Links treatment & justice goals of reduced drug use & criminal activity
- Uses processes that improve treatment access, engagement & retention

What TASC Does

- Assessing for treatment and recovery support needs;
- Matching clients with appropriate levels of care;
- Developing and adjusting person-centered plans;

What TASC Does...

- Referring clients to community-based resources for treatment and support services;
- Integrating service needs and supervision requirements; and
- Monitoring client progress and reporting to the criminal justice system.

DHHS-DOC-AOC MOA

Memorandum of Agreement
between the
North Carolina Department of Health and Human Services
and the
North Carolina Department of Correction
and the
Administrative Office of the Courts

I.

This Memorandum of Agreement (MOA) and Appendices are entered by and between the Department of Health and Human Services (DHHS), the Department of Correction (DOC) and the Administrative Office of the Courts (AOC) for the purpose of developing a comprehensive offender management model that ensures public safety while addressing the needs of offenders. The Division of Community Corrections (DCC) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) are the primary resources involved in community corrections. AOC manages the N.C. Drug Treatment Court Act Program and provides administrative support to the local courts that operate Adult Drug Treatment Courts (DTC). The Division of Alcoholism and Chemical Dependency Programs (DACDP) and Division of Prisons (DOP) impact community corrections through the release of offenders who have received services while in custody or while in a residential facility (DART-Cherry). The purpose of a comprehensive offender management model is to create a seamless system built on the ideals of integrated service delivery and coordination of resources that provide effective interventions for offenders.

NC Problem Statement

- Limited CJ & Tx Resources
- Complex Clients:
  - challenging behavioral health needs
  - serious consequences of failure
- Recidivism & Relapse are Common
- Service Availability & Effectiveness

The Right Service, At the Right Time, Any Place in NC

Care Management, Evidenced Based Treatment, Recovery Supports

Here's what we know about drugs & crime in NC

- SA is disproportionately represented in correctional populations
  - 80% of parolees
  - 67% of probationers

Report of the Re-Entry Policy Council, CSG, 2005

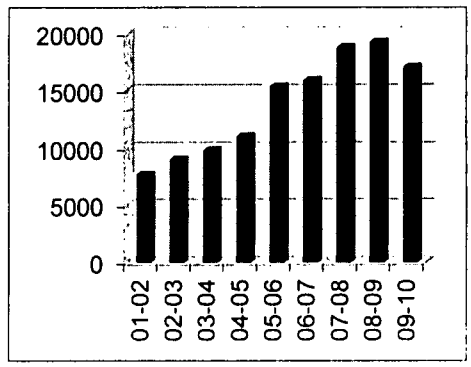
- 117,607 people on probation, parole or post-release
  - 79,347 need substance abuse services

NCDOC Research & Planning, June 30, 2007 populations

These are the people we serve

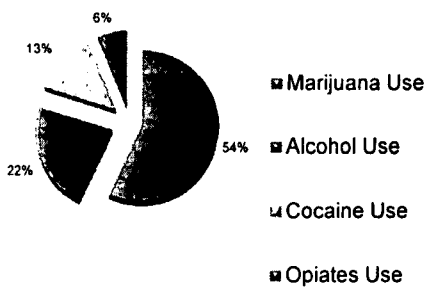
- TASC Served: 17,041
- 79% Male
- 53% Non-White
- 59% less than 31yo
  – 24% 16-21yo
- 68% Never Married
- 53% No HS Diploma
- 42% Unemployed

NC TASC ADMISSIONS



TASC Facts

DRUG OF CHOICE AT ADMISSION



- Diagnosis: 43% Abuse, 42% Dependence
- 83% Intermediate Punishment or Community Punishment Offenders at Risk of Revocation
- 51% Felony Offenders
- 50% Drug Offenses
- Avg. length of stay: 6 months
- 53% FY 09/10 Completion Rate
- $1.50 per client per day

Re-Arrests & Re-Convictions

2000 Recidivism Report to the General Assembly*

- 86% had at least 1 previous arrest (mean # 2.6)
- 61% were NOT re-arrested within 2 years of discharge

* NC Sentencing & Policy Advisory Commission

REGION 3 FY09-10

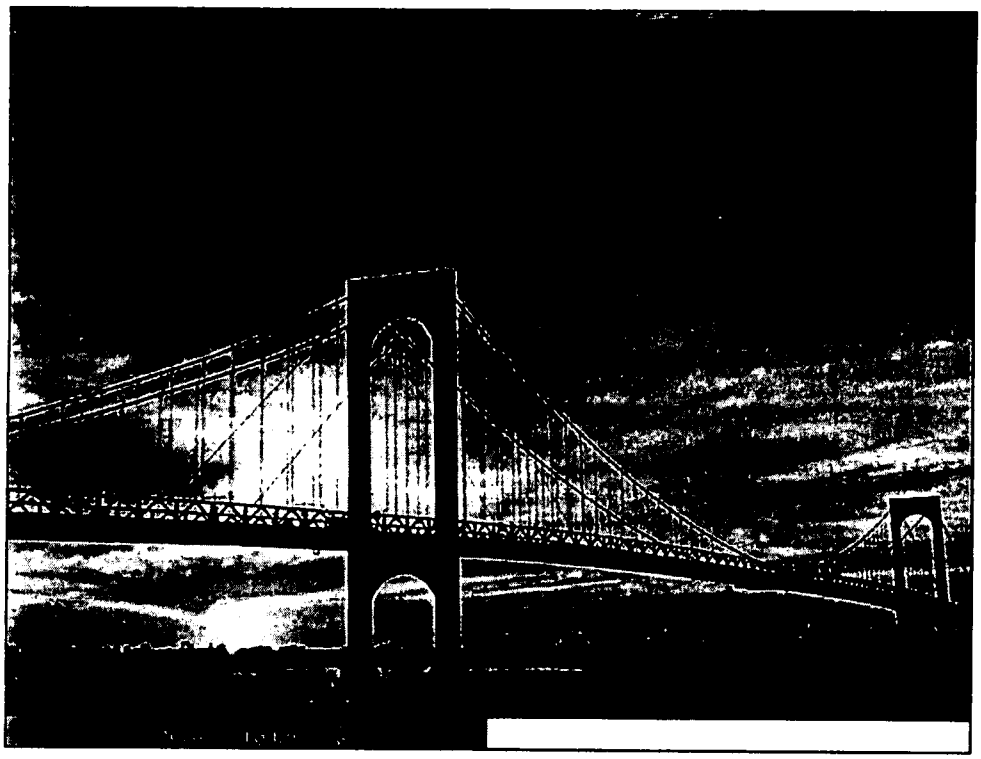
90 days following Successful Discharge

- 88% No Arrest

REGION 1 FY07-08

2 years following Successful Discharge

- 77% No Conviction

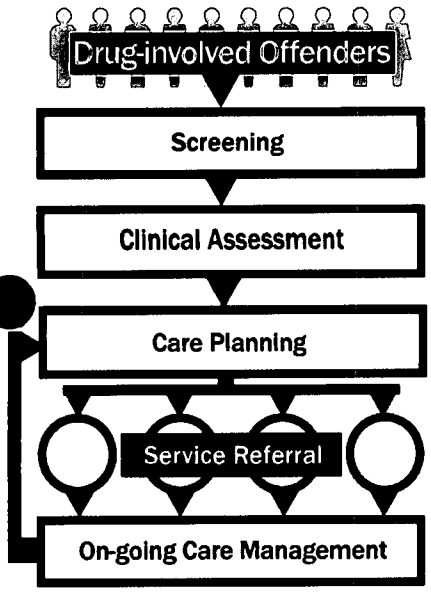


TASC in North Carolina

North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

The North Carolina TASC Network serves as a critical link between justice and treatment systems for offenders. By objectively balancing public safety with the need to restore individuals to health and self-sufficiency, and through access to an array of services, the TASC care management model reduces the burden and improves the outcomes of the justice and treatment systems. TASC operates within these systems by Memorandum of Agreement with the Department of Health and Human Services, the Department of Correction and the Administrative Office of the Courts.

The TASC Care Management Model



A National Perspective

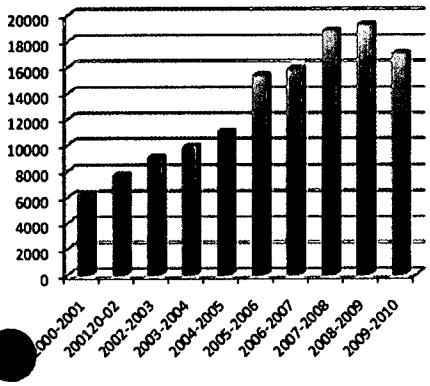
In 1962, the U.S. Supreme Court concluded that addiction is an illness, not a crime, and that states may compel addicts to submit to treatment, and also impose criminal sanctions for non-compliance. In the early 1970s, federal agencies began developing the concept of linking treatment and the judicial process for the specific purpose of interrupting the relationship between addictive behavior and criminal activity. The result was an initiative named Treatment Alternatives to Street Crime (TASC).

In 1972, the first TASC program opened in Wilmington, Delaware, and today there are TASC programs across the United States dedicated to the professional delivery of assessment and case management services to substance involved criminal justice and court populations. North Carolina is the only state in the country which has unified its TASC network under the central administration of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, ensuring that services delivered are of the same array and quality.

Structured Sentencing and TASC in North Carolina

In North Carolina, TASC operates as a component of a community mental health/substance abuse service provider maintaining close relationships with their local criminal justice system, which refers eligible clients to TASC. Eligible clients are those who demonstrate a need for addiction treatment and/or mental health services and have been charged with or convicted of crimes eligible for intermediate or community punishments. Referrals come from the criminal courts, as well as community corrections.

NC TASC ADMISSIONS

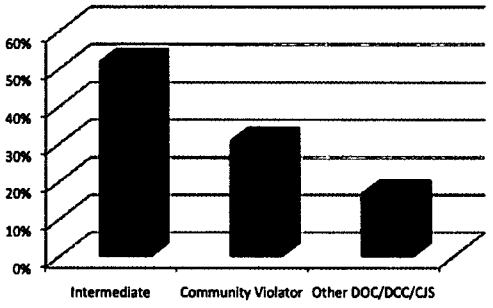


In 1994, North Carolina's Structured Sentencing Act (SSA) established truth-in-sentencing and expanded the community-based services available to drug-involved offenders. Designed to reduce recidivism and increase public safety by properly balancing punishment with rehabilitative options, SSA prioritized violent and career offenders for incarceration while offering judges a wide range of community-based sanctions for offenders remaining in and returning to the community. Among those options is participation in TASC, with serviceable populations prioritized by the intensity of services and supervision required and the likelihood of relapse and recidivism.

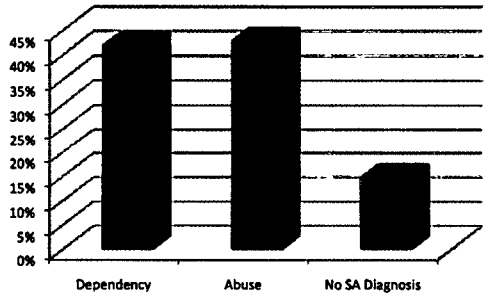
FISCAL YEAR 2009-2010 TASC STATISTICS

Referrals	21,745
Admissions	17,041
Male	79%
Non-White	53%
Average Age	30
Never Married	68%
No High School Diploma	53%
Drug Offense	50%
Average cost per client per day	$1.50

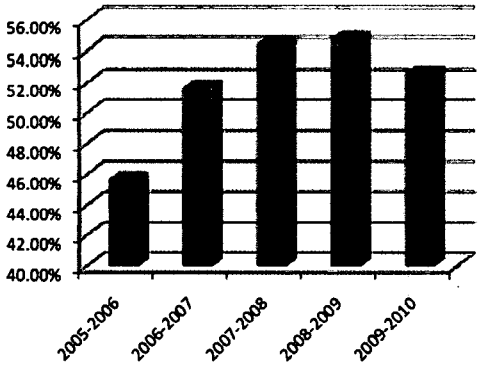
NC TASC PRIORITY POPULATIONS



PRIMARY DIAGNOSIS



TASC COMPLETION RATES



For more information contact:
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Division of Mental Health, Developmental
Disabilities and Substance Abuse Services
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Raleigh, NC 27603
(919) 715-2771
www.northcarolinatasc.org

The North Carolina Offender Management Model

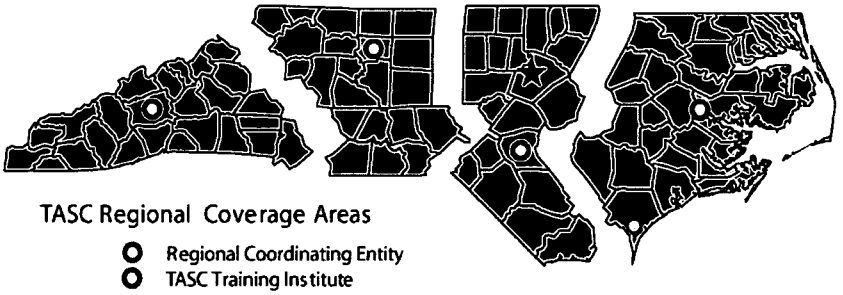
Prompted by a desire to manage limited community resources, DHHS partnered with the Department of Correction (DOC) to develop the North Carolina Offender Management Model (OMM). This model balances the intervention opportunities provided by DHHS with the controlled supervision of DOC to manage offenders effectively and efficiently.

Employing the TASC model and services in concert with the Division of Community Corrections, OMM presents a systemic method for assessing offenders, matching them to appropriate levels of care, and managing their case plans. Among the objectives of this partnership are:

- Creating a seamless continuum of services to offenders.
- Reducing the rate of technical and drug violations.
- Leveraging resources and preventing duplication of effort.
- Using the principles of effective interventions with offenders.

The Statewide TASC Service Delivery System

TASC services are available in every county in North Carolina and are organized into four regions that reflect the State's judicial districts and divisions. This structure facilitates communication across court, correctional and treatment systems. Each region is organized and managed via a TASC Regional Coordinating Entity (RCE), a key element of the standardized and integrated statewide network. The TASC RCEs serve as the management infrastructure for the effective delivery of treatment and recovery supports to the offender populations in each region. They are responsible for ensuring that TASC services are available throughout their respective regions, and serve as the administrative and accountability link between the TASC Network and the Division. To ensure that TASC staff and programs across the state are equipped to effectively deliver services to eligible populations, the TASC Training Institute was established to provide professional, state-of-the-art training on a wide range of issues related to offender management.



Managing Offender Care - A National Model

The North Carolina model for delivering TASC services to offenders is the first of its kind in the country, and replicable nationwide. Even as many states consider systemic approaches to the treatment needs of offenders, North Carolina has implemented a statewide infrastructure to meet those needs. Centralized oversight allows the state to efficiently leverage resources to ensure that offenders will return to their communities safely. The statewide nature of the TASC Network ensures that offenders across the state will have access to the same quality and types of services.

DHHS REPORT ON LOCAL INPATIENT COMMUNITY HOSPITAL CONTRACTS (3 WAY CONTRACTS) UPDATE

Joint Legislative Oversight Committee
On Mental Health, Developmental Disabilities and Substance Abuse Services
November 9, 2010

Michael Watson
Deputy Secretary for Health Services
Department of Health and Human Services

1

3 Way Contracts Basic Information

- Contract between a Community Hospital, DHHS and an LME to purchase **expanded** Inpatient Psychiatric Capacity
- Expanded Beds =
  - Opening New Beds (CON or State Hospital Bed Transfer)
  - Staffing Up Unused Capacity (Licensed but not staffed)
  - Opening Existing Bed Capacity to Involuntary Commitments

2

3 Way Contracts
Basic Information

- Payment Rate = $750 per day (Hospital Daily Rate + Psychiatric Care + Discharge Medications)
- Contract gives participating Hospitals priority in transfers to State Hospitals—Encourage taking difficult patients

3 Way Contracts
Basic Information

- Contract requires effective discharge efforts
- Available Funding = $29,121,644
- Phase-In issues associated with new funding/new contracts

3 Way Contract Goals

- Increase Community Psychiatric Inpatient Capacity
- Treat Consumers Closer to Home—Improve Hospital Transitions
- Reduce Short-term Admissions (7 days or less) to State Hospitals
- Decrease Emergency Room Wait Times & Impact on Law Enforcement
- Stop Trend toward Closure of Community Inpatient Beds

LME Contract Responsibilities

- Authorization of Admissions
- Collecting Patient Data
- Facilitating Discharge Planning (Follow Up Appointment with in 7 days)
- Coordinating Discharge Planning with Other LMEs
- Submit Hospital Claims to DMH/DD/SAS
- Pay Hospitals Within 10 working Day of Receipt of State Payment

FY 09-10 3-Way Hospital Contract Utilization

- Total Funding Available = $20, 121,644
- Total Expenditures = $20, 121,644
- # of Active 3-Way Hospital Contracts = 20
- # of Bed Days Purchased = 26,829
- # of Beds at 75% Utilization = 98 Beds

NOTE: Funding was moved between hospital contracts to achieve maximum utilization

FY 10 – 11 3-Way Hospital Contract Utilization

- Total Funding Available = 29, 121,644
- # of 3-Way Hospital Contracts = 20 (1 pending in Mecklenburg County)

NOTE: Added Pitt Memorial/WHN did not renew St. Lukes due to low utilization

- FY 10-11 Funding was increased/decreased among hospitals based on increased and FY 09-10 actual utilization

FY 10 – 11 3-Way Hospital Contract Utilization Cont'd

- Focus on supporting, expanding, annualizing existing contracts
- Fewer Start Up Issues
- Projected Bed Day Purchases = 38,829
- Projected Beds at 75% Utilization = 142

Bed Allocation Strategies

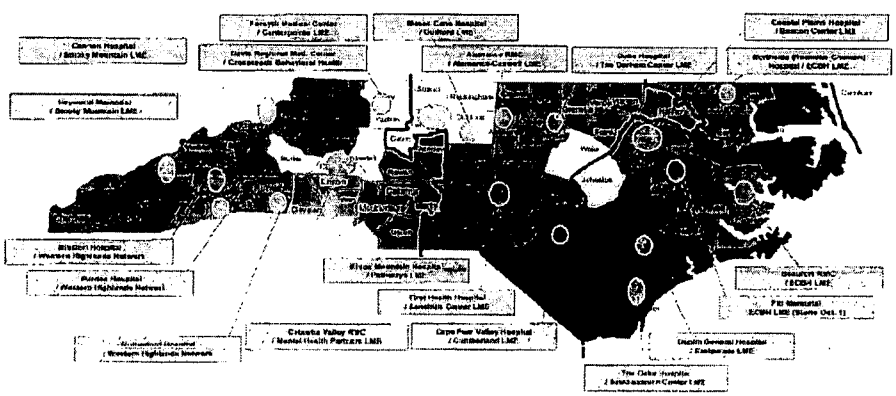
- # of Short Term Admissions to State Hospitals
- Geographic Coverage
- Support for Community Emergency Rooms
- Build on existing contracts

FY 10 – 11
3 Way Contract
Inpatient Hospital

LME Name	Hospital Name	2011 Contract Amount
Mental Health Partners	Catawba Valley	3,285,000
Pathways	Kings Mountain	1,026,563
Alamance-Caswell	Alamance Regional	821,250
Sandhills	Moore Regional	2,394,000
Durham	Duke University Health	1,048,500
Centerpoint	Forsyth Memorial	2,941,500
Cumberland	Cape Fear Valley Hosp.	1,026,563
Eastpointe	Duplin General	1,095,000
Beacon Center	Nash Hospitals (Coastal Plain)	2,941,500
ECBH	Beaufort Regional Medical	615,938
ECBH	Northside @ Roanoke-Chowan	1,368,750
Smoky Mountain	Haywood Regional	1,095,000
Smoky Mountain	Charles A. Cannon Memorial	821,250
Southeastern Center	The Oaks	2,120,250
Western Highlands	Margaret Pardee Memorial	821,250
Crossroads	Davis Regional Med. Cntr	1,026,562
Guilford	Moses Cone Hospital	821,250
Western Highlands	Mission Hospital	1,026,563
Western Highlands	Rutherford Hospital	615,938
ECBH	Pitt Memorial	460,688
Mecklenburg	Presbyterian (in progress - 8 beds)	1,503,000
Totals		28,876,315

NOTE: Beds funded at 75% - 100% based on anticipated utilization

Total 3-Way Contract Community Hospital Beds
(As of 10-25-10)



NOTE: One pending contract in Mecklenburg County not listed on map above

3-Way Contract Funding/Beds By Region

- Central Region: $8,026,500 = 39 Beds
- Eastern Region: $9,628,689 = 47 Beds
- Western Region: $11,221,126 = 55 Beds
- Total: $28,876,315 = 141 Beds*

* Assumes 75% utilization at $750 per day

Contract Tracking Requirements

- Separate State Billing Code
- Admissions
- Hospital Denials
- Bed Utilization
- Transfers to State Hospitals
- Billing/ Expenditure Data

Initial Outcomes

- Readmission Rates

	State Hospitals	3-Way Contracts
30 Days	10%	6.2%
180 Days	20%	11.2%

- Clinical Capacity Building
  3-Way Contract + CABHA = Increased Community Psychiatric Capacity
- State Hospital Admissions – 7 Days or Less
  - FY 07 – 08 = 6,306 (46% of total)
  - FY 08 – 09 = 3,499 (40% of total)
  - FY 09 – 10 = 1,733 (27% of total)

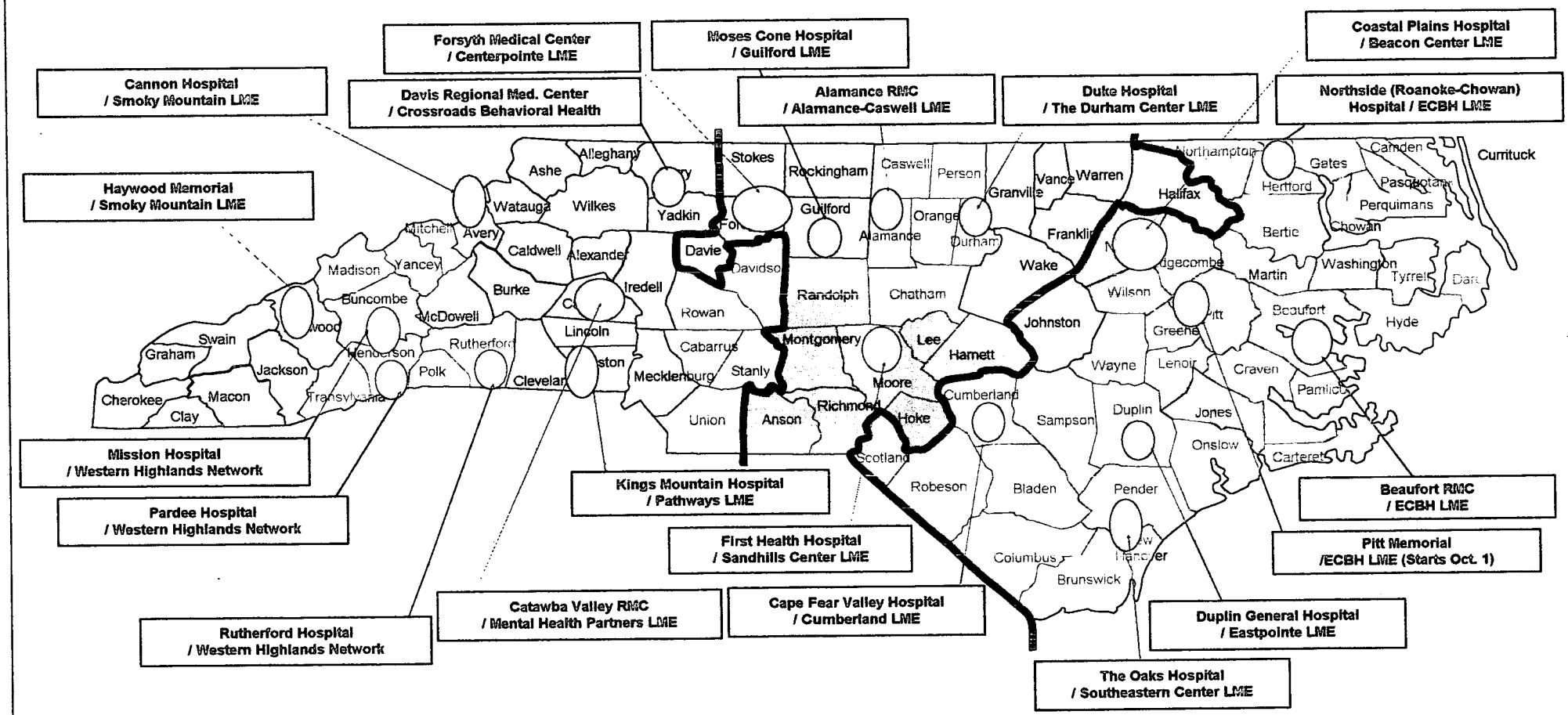
NOTE: **Decreases also a function of State Hospital bed reductions and admission delays**

Conclusion

- 3-Way Contracts = Effective Platform for supporting short term community psychiatric care
- 3-Way Contracts = Support for Consumers/ERs/Law Enforcement in serving seriously ill Mental Health patients
- Hospital Demands for Indigent Care exceeds available funding
- Existing Bed Retention – Potential Loss of Existing Capacity

Total 3-Way Contract Community Hospital Beds

(As of 10-25-10)



NOTE: One pending contract in Mecklenburg County not listed on map above

ICF-MR Cost Analysis and Comparison with CAP/MR-DD Services

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
November 9, 2010

Steve Jordan, Director
DMH/DD/SAS

1

System Components

- Developmental Centers
  - 3 State run regional facilities
- Community ICF's
  - 327 facilities
- CAP-MR Waiver
  - Statewide service
  - Private providers

2

ICF-MR Criteria

- To be Medicaid certified at the ICF-MR level of care, the individual shall require active treatment necessitating the ICF-MR level of care (42 CFR 435.1009; 42CFR 483.440) and shall have a diagnosis of mental retardation or a closely related condition.
- Intellectual and developmental disabilities (I/DD)
- Complex behavioral challenges and/or
- Medical conditions whose clinical treatment needs exceed the level of care available in the community.
- Individuals with I/DD needing comprehensive, 24 hour supports to maintain or improve the health and functioning
- Individuals considered for admission to a developmental center must be 18 years of age and older with a diagnosis of IDD * (with the exception of time-limited specialized programs for children and adolescents)
- The local management entity and the developmental center's admission committee work together to determine need.

3 Regional Developmental Centers

- West – J. I. Riddle Developmental Center
  Morganton
- Central – Murdoch Developmental Center
  Butner
- East – Caswell Developmental Center
  Kinston

Census

- Riddle 325
- Murdoch 568
  42 are children
- Caswell 430

- **Persons served: 1517**

5

Murdoch Center – TRACK

(Therapeutic Respite Addressing Crisis for Kids)

- In May 2010, Murdoch opened TRACK to divert children and adolescents with IDD and/or autism who are in a behavioral crisis from state psychiatric hospitals and local hospital emergency departments when appropriate community-based crisis services have been exhausted.

6

TRACK (continued)

- The 6-bed program serves individuals ages 5-17 from across the state.
- Primary focus is to stabilize the individual so they can return to their home as quickly as possible.
- Length of stay is 3-45 days, depending on the nature of the behavioral crisis.
- All referrals must go through the LME prior to admission.
- Funding sources include CAP-MR/DD Institutional Respite, ICF-MR reimbursement for admissions 30+ days, and self-pay ($8/day).

Specialized Residential Programs
Murdoch Center

PATH (*Partners in Autism Treatment and Habilitation*)

- Children, ages 6-16, with autism spectrum disorder and serious behavioral challenges
- Unit - coed, 8 beds, plus 2 respite beds
- 2 Group Homes - coed, 4 beds each, located
- Franklin County and Granville County
- Length of stay - up to 2 years
- Number of individuals served in fy 2008 –
- 17 on the unit, 6 in the group homes

Specialized Residential Programs
Murdoch Center

STARS (*Specialized Treatment for Adolescents in a Residential Setting*)

- Adolescents, ages 13-17, with dual diagnoses (developmental disability and mental illness)
- Who demonstrates extreme and dangerous forms of aberrant behavior
- 18 beds, coed
- Length of stay - up to 1 year
- Number of individuals served in fy 2008 = 29

9

Facility Services

- Medical- physician
- nursing, radiology
- pharmacy, etc.
- Dental
- Psychiatry
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chaplaincy
- Transition
- Advocacy
- Dietary/Nutrition
- Adaptive Equipment
- Residential
- Social Work
- Education
- Psychology
- Recreation Therapy
- Vocational
- Other

10

Community ICF

- 327 facilities
- 2692 consumers
- Owned and operated by private organizations (non-profit and for profit)
- Range in size from 5 consumers to 300+ consumers served
- CON required for construction (*Moratorium imposed in 1995)*
- Surveyed and monitored by DHSR

Community ICF Services

- Medical- physician & nursing,
- Psychiatry
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Transition
- Advocacy
- Case Management
- Dietary/Nutrition
- Adaptive Equipment
- Residential
- Social Work
- Education
- Psychology
- Recreation Therapy
- Vocational
- Other

CAP-MR/DD

- 10,771 consumers served
- Non institutional services
- All services are done in community or home settings
- Un- bundled and periodic in nature
- Residential services only cover treatment costs not facility, medical, pharmacy costs etc.

CAP-MR/DD Criteria

To be considered for CAP-MR/DD funding, an individual shall require the level of care provided by an ICF-MR. During the comprehensive clinical assessment process, the LME shall make an initial determination as to whether the individual potentially meets the ICF-MR level of care and provides it to the case manager for the person-centered planning process.

CAP-MR/DD Services

Periodic Services

- Adult Day Health
- Behavioral Consultant
- Crisis Respite
- Crisis Services
- Day Supports
- Home and Community Supports
- Individual Caregiver Training and Education
- Long-Term Vocational Supports
- Personal Care Services
- Respite Care—All Levels
- Specialized Consultative Services
- Supported Employment

CAP-MR/DD Services

Services Provided in a Person's Home by Family

- Home Supports

Residential Services

- Residential Support Services

CAP-MR/DD Services

Additional Supports:

- Augmentative Communication Devices
- Vehicle Adaptations
- Transportation
- Specialized Equipment and Supplies
- Home Modifications
- Personal Emergency Response System (PERS
- **Individual Goods and Services (Self-Direction Only)**

Facts

- According to Dr. Agostas'
  - *Where Does North Carolina Stand, Report May 6, 2010*
- 30% of recipients of service live in ICF-MR's
- 50% of our funding goes to support care
- 70% of our service recipients are using our waiver services
- 58% of service recipients live at home with family

Facts

- Nationally 15% of service recipients live in ICF-MR's
- 85 % of service recipients receive waiver services
- 58% of service recipients live home with family

19

Costs of Care

• State facilities	$244,833,405
• Community ICF	$232,706,020
• CAP-MR/DD	$468,945,001

20

Costs per Recipient

- State facilities $162,654
- Community ICF $92,906
- CAP-MR/DD* $61,291

* Include all cost

Other States

No state DD Centers

- Alaska, DC, Hawaii, Maine, New Hampshire, West Virginia

- These states Community waivers and ICF's
- Maine has 2 levels of ICF (Group and Nursing)

Other States

States with fewer than 125 State DD Centers

- **Colorado, Delaware, Idaho, North Dakota, Nevada, Oregon**
- **Oregon has no one in ICF or DD Center**
- **The other states have waiver and community ICF**

Conclusions

- North Carolina has a long history of reliance on DD Centers for the care of individuals with I/DD
- As centers downsize the cost per consumer goes up because the daily operational expense remains the same with fewer consumers to split cost
- Other states have similar use for community ICF services
- CAP-MR services are less expensive per person than both levels of ICF services
- DD Centers and Community ICF services have a more comprehensive service expectation than CAP-MR service

Conclusions

- CAP –MR services offer great flexibility to recipients of care
- For the community to be able to care for more complex needs investment is required

WHERE DOES NORTH CAROLINA STAND?

A Comparison Of Medicaid-funded Residential Service Trends, Nationally and in North Carolina, For People With Intellectual and Developmental Disabilities

May 6, 2010

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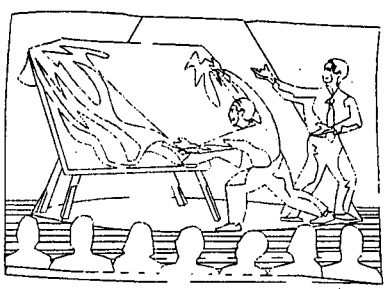
Agenda

- Purpose
- Methods
- Bottom Line Findings
- Selected Graphics
- Recommendations
- Concluding Remarks



Definitions

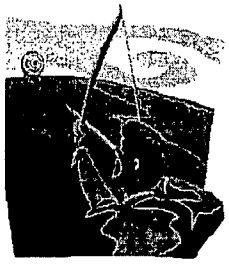
- ICF-MR -- facility

  An ICF-MR facility serves 4 or more individuals. For a facility to be certified as ICF/MR and thereby become eligible for Medicaid payments, it must comply with an extensive set of federal regulations and requirements.

- HCBS - waiver

  The home and community-based services (HCBS) waiver program waiver was established in 1981. It allows states to waive specified requirements of Section 1915 of the Social Security Act so that states may develop community-based alternatives to ICFs/MR. (For example, the CAP-MR/DD and Innovations are I/DD HCBS waivers.)

Purpose

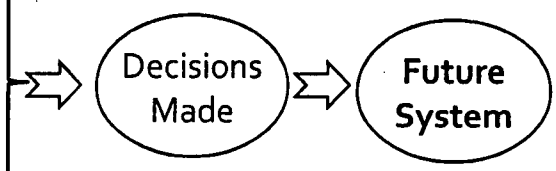


- This is the fourth edition of *Where Does North Carolina Stand?*
- The inquiry is funded by the North Carolina Council on Developmental Disabilities
- This paper provides a review of the trends in Medicaid-funded residential service utilization, residential living arrangements and service expenditures over the past decade (1998 – 2008), both nationally and within North Carolina.
- The findings can be used to guide policy decisions regarding services for people with intellectual and developmental disabilities (I/DD).

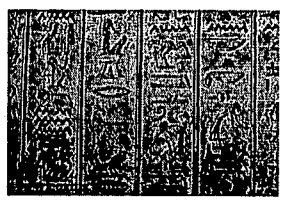
Why is the report important?

Think of the Challenges Faced By Policy Makers...

- Budget stress
- Accelerating service demand and waiting lists
- Reliance on legacy and inefficient systems
- Workforce shortages
- Continued push for community integration, participation, contribution... self direction.



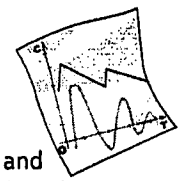
Methods



The statistics contained in the report are drawn from two national data sets.

- University of Minnesota's Research and Training Center on Community Living (RTCCL). Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2008 (Lakin et al.)
- The Coleman Institute for Cognitive Disabilities at the University of Colorado. The State of the States in Developmental Disabilities 2008. (Braddock et al.)

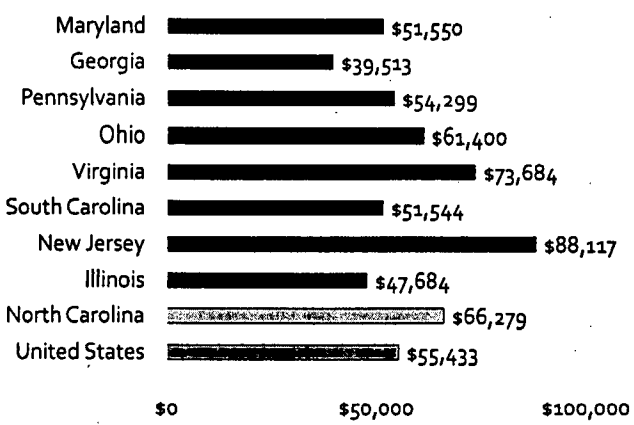
Bottom Line Findings



1. North Carolina **spends more per person** than the national average with overall Medicaid-funded (HCBS and ICF/MR) expenditures for services in 2008 16% higher than the national average ($66,279 vs. $55,433 per person annually);
2. The number of individuals who received Medicaid-funded (HCBS and ICF/MR) services in North Carolina in 1998 and 2008 was **markedly lower** than nationwide levels after controlling for population differences;
3. Along several dimensions, the **state's reliance on large (16+) state facilities and community ICFs/MR** as a chief service option endures; and
4. The state system is changing in ways consistent with national trends, but generally at a **much slower pace**.

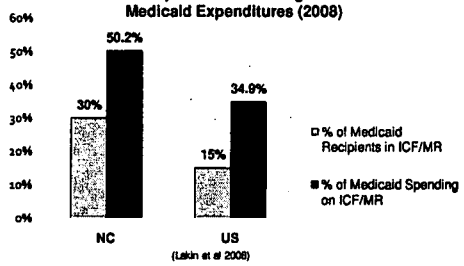
1. *North Carolina Spends More Per Person...*

Medicaid ICF-MR and HCBS Combined Per Person Expenditures (FY 2008)



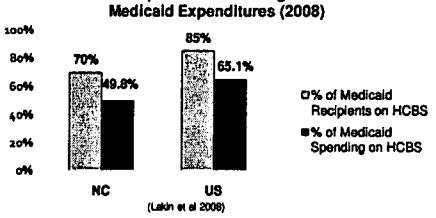
Lakin et al. (2009)

Chart 4: Percent of Individuals Receiving ICF/MR Services Compared to Percentage of Total I/DD Medicaid Expenditures (2008)



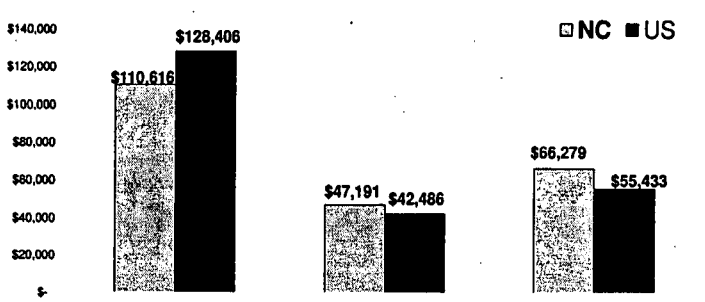
(Lakin et al 2008)

Chart 5: Percent of Individuals Receiving HCBS Services Compared to Percentage of Total I/DD Medicaid Expenditures (2008)



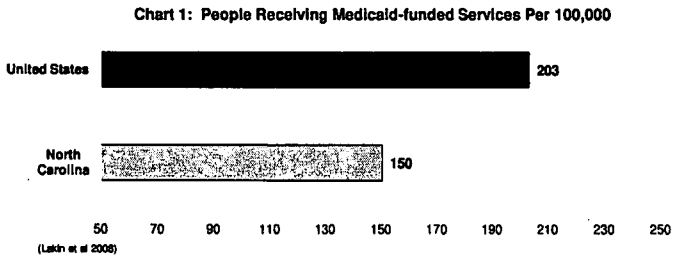
(Lakin et al 2008)

Chart 6: Comparison of Per Person ICF/MR, HCBS Waiver and Total Medicaid Expenditures: North Carolina and the United States (2008)



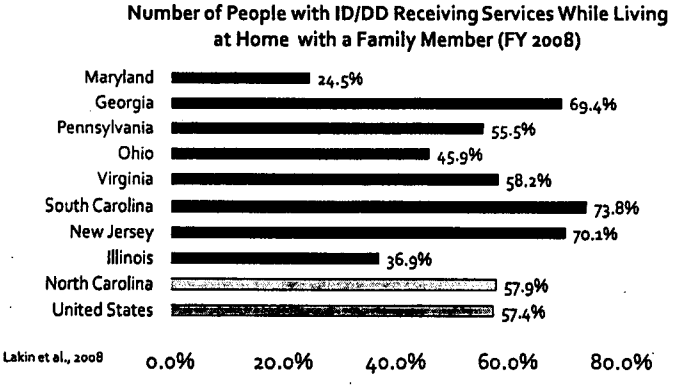
(Lakin et al 2008)

2. The number of individuals who receive Medicaid-funded services is markedly lower...



- From 2000 to 2008, North Carolina added 3,992 people receiving Medicaid-funded services to its developmental disabilities service system, or about 499 per year.
- This equals 40.4% growth over the 8-year period, but lags behind the average growth in other states (51.7%) by approximately 11%.
- Just as for any other state, this count does not include individuals receiving supports in the home of a family member, or individuals receiving state-only dollars. *(MHDDSAS reported that overall 25,106 individuals received services in residential or family home settings in 2008.)*

3. The state's reliance on large state facilities and community ICFs/MR endures...



- States furnish in-home services and supports to more individuals who live with their families than are provided in specialized "out-of-the-family-home" residential facilities.
- In 2008, North Carolina reported that these in-the-family-home services were furnished to about 58% of the service population, or 14,525 individuals living with their families

Reliance on Large Congregate Settings

2008 Utilization of all Residential Settings

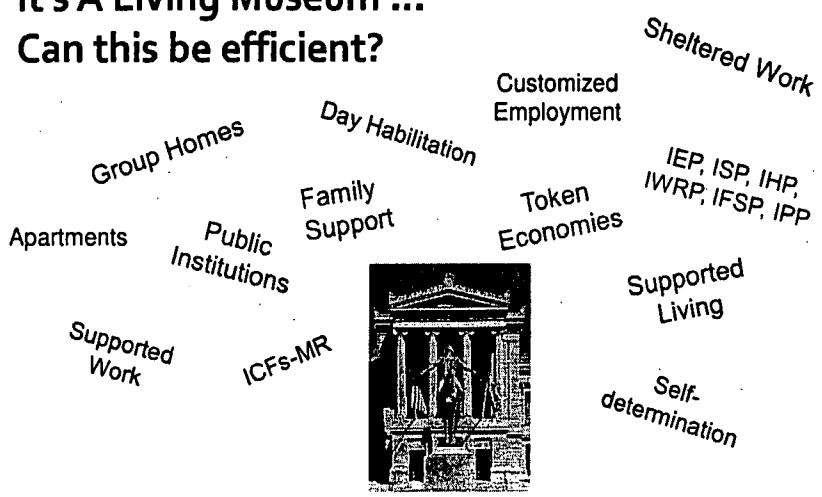
	North Carolina		National
Residences 1 < 6	**7,852**	74%	75%
Residences 7 < 15	528*	5%	12%
Residences of 16+	2,201	**21%**	**13%**
Total	10.581	100%	100%

* State staff reported after reviewing a draft of this report that only 171 individuals resided in 7-15 bed homes.

Lakin et al., 2008

- Of the 7,852 living in 1-6 bed residences, 1,702 live in ICFs-MR, totaling 21.7%.
- Nationally, of those living in 1-6 residences, 5.6% live in ICFs-MR.

Reliance on Legacy Systems... It's A Living Museum ... Can this be efficient?



1956... 1962... 1972 ... !976...1983... 1987.. .1992... 1997.. 2000... 2003...2006...2010

4. *The state system is changing in ways consistent with national trends, but at a much slower pace.*

- North Carolina serves more people now than in 1998, adding 3,392 to Medicaid services between 1998 and 2008 -- a 40.4% increase. The national percent increase was 51.7%.
- North Carolina increased its capacity to serve people in out- of-home residential options between 1998 and 2008 - faster than the nation, but still lags behind (115 vs. 144 people served per 100k population).
- Between 1998 and 2008, North Carolina reduced its census of people living in state developmental centers by 20% (406 people). The national census fell by 32%.
- Between 1998 and 2008, North Carolina decreased the number of people living in 16+ facilities by 16%. The national average fell by 36%.

Human Services Research Institute 15

Recommendations

1. Ask what people with developmental disabilities want... Consider... "Where are we headed?"
2. Make the system more efficient and equitable... lower the cost per person for delivering services.
3. Build capacity within the community to deliver high quality services and supports
4. Address the wait list.

Human Services Research Institute 16

1. Is What We Are Doing What People Want?

People want to live life in the community with the support they need. Just like anyone else.

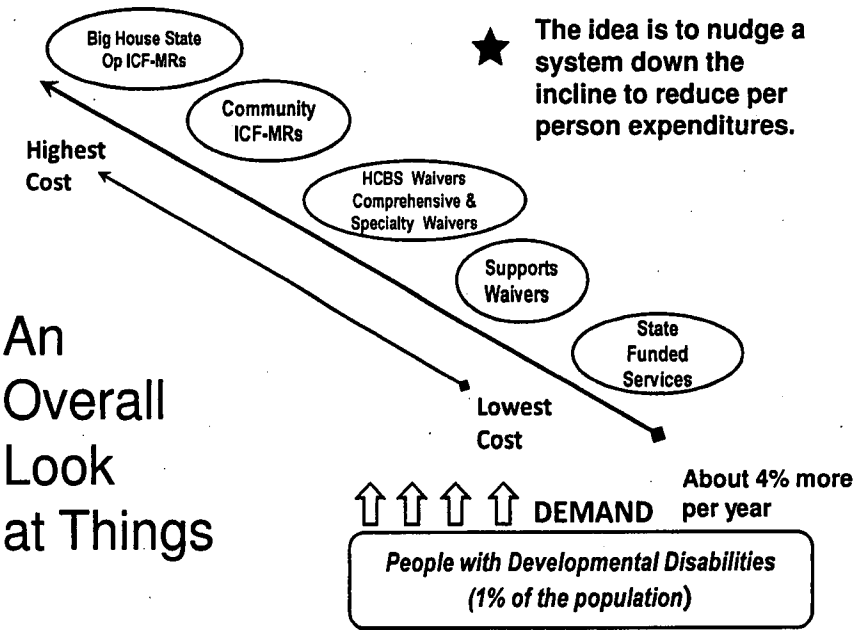
"Thank you for everything that you've done ... for all the services that there are... but what you built, we don't want. "

-Rebecca Cokley

Rebecca Cokley
National Consortium on Leadership and Disability
Institute for Educational Leadership

2. Make the system more efficient and equitable...

- Disinvest from high cost options in favor of lower cost community centered alternatives... this means accelerating relocation of individuals from Developmental Centers and community ICFs-MR into HCBS funded alternatives.
  - Utilize the Money Follows the Person initiative to help achieve this objective.
  - Assist service providers who are willing to transition from ICF-MR to HCBS waiver funding
- Invest in means for allocating resources per individual that are fair and in a accordance with personal needs.



An Overall Look at Things

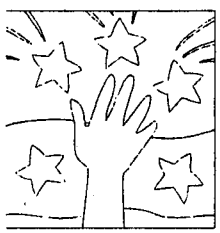
States with No State Developmental Centers or Fewer than 150 People in Census

States with No Developmental Centers	States with Census of 125 or Fewer in Developmental Centers	
Alaska	Colorado	Nevada
District of Columbia	Delaware	Montana
Hawaii	Idaho	Minnesota
Maine	North Dakota	Oregon*
New Hampshire	Wyoming	
New Mexico		
Vermont		
West Virginia		

* In 2010 Oregon became the first state to have no state developmental Center and no Oregon citizen living in an ICF-MR anywhere.

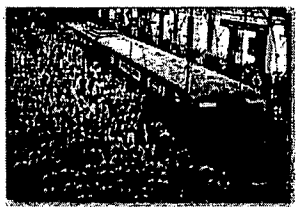
3. Build capacity within the community to deliver high quality services and supports

- Create opportunity within the community to build support structures that are not exclusively reliant on Medicaid.



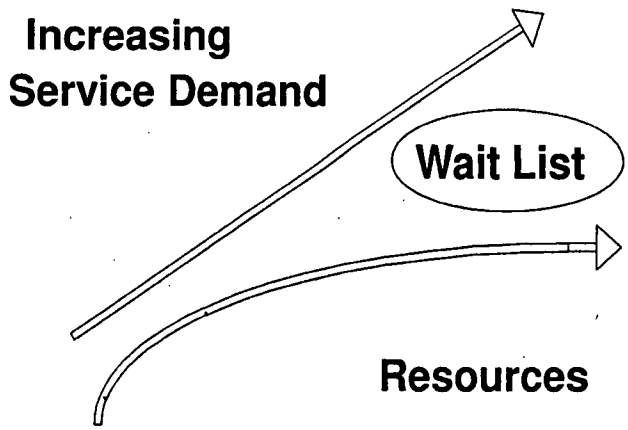
- Invest in building community capacity for addressing complex needs and for building staff competencies.

4. Address the wait list.



- In 2008, North Carolina furnished Medicaid-funded (HCBS and ICF/MR) services to 13,876 people.
- Given a state population of 9.2million this totals 150 people per 100,000 general population. The national average is 203 per 100,000.
- North Carolina's performance is 26% below this national marker.
- To reach the national average, North Carolina would have to serve 53 people per 100,000 more than it does, or 4,887 people.
- North Carolina should establish and implement a plan for eliminating the service waitlist over 7-10 years.

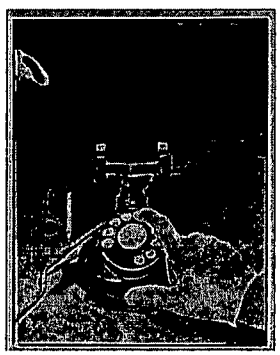
States Face a Big Problem...



Gary Smith, HSRI

Need and Opportunity

"A service system for [people with disabilities] and others in need of support will have to be a system in constant change. It has to be continuously developed, if the 'customers' are not to be left behind and to become hostages of an outdated way of doing things."



Alfred Dam
Denmark

Implementation Update of the CAP-MR/DD Tiered Waivers

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services

Rose Burnette
DMH-DD-SAS
10/13/10

Implementation Update of the CAP-MR/DD Tiered Waivers

Today's Presentation:

- ☐ Status of Current Waivers
- ☐ Self-Direction
- ☐ Summary of Planned Tiers
- ☐ Waiting List
- ☐ Residential Supports Level 5
- ☐ LME UR

2

Status of Current Waivers

Numbers of Individuals Served

- Comprehensive Waiver 9798
- Supports Waiver 853

3

Status of Current Waivers

Costs of Services

- **Comprehensive Waiver**-about $493 million of waiver services and about $112 million of other Medicaid services
- **Supports Waiver**-about $2.5 million of waiver services and about $2.5 million of other Medicaid services

4

Self-Direction-Supports Waiver

- Two required functions, the Financial Management Services Agency (FMS) and the Support Broker.
- The Support Broker function is called the Community Resource Consultant (CRC).
- DMH-DD-SAS has selected, through a RFA process, two vendors to provide the services of Community Resource Consultant (CRC).

5

Self-Direction-Supports Waiver

Community Resource Consultant (CRC) vendors

- *The Arc of North Carolina* and,
- *Central State of the Carolinas*
- Both vendors have many years of experience providing services and supports to individuals who receive CAP-MR/DD funding.
- Through the application process both vendors demonstrated the knowledge and ability to be successful in the role of Community Resource Consultant.

6

Self-Direction-Supports Waiver

- In collaboration with DMA an RFP process was conducted to select 1 vendor to perform the functions of a Financial Management Service (FMS).
- The Financial Management Service (FMS)
  - serves as the ***employer of record*** for the individual staff selected by the participant;
  - administers payroll, taxes, and insurance for staff selected by the participant; and
  - exercises budget authority for the participant.

7

Self-Direction-Supports Waiver

- The vendor selected as the Financial Management Service is *G.T. Financial Services.*
- *G.T. Financial Services*
  - owned and operated by individuals who have over 10 years of experience as financial administrators
  - have been operating as a family business providing fiscal intermediary services
  - for individuals participating in self-direction in Wisconsin and Michigan
  - Have served over 3000 people with disabilities

8

Self-Direction-Supports Waiver

- DMH-DD-SAS and DMA are working with the selected vendors, LME, CAP-MR/DD Supports Waiver participants, and other stakeholders to implement Self-Direction.
- Implementing formal Marketing Plan
  - Inform individuals of the Self-Direction option and provide information to all stakeholders.
  - Formal recruitment of participants

9

Self-Direction-Supports Waiver

Estimated Annual Cost for 126 CAP-MR/DD Participants

- Costs reflect both the Community Resource Consultant and the Financial Management Service
- Costs are not included in the participants annual budget

10

Self-Direction-Supports Waiver

Estimated Annual cost for 126 CAP-MR/DD Participants

- Annual cost for Financial Management Service for 126 participants=$58,560
- Annual cost for Community Resource Consultant for 126 participants=$460,320
- Total cost = $518,880
- About $4000 per person

11

Self-Direction-Supports Waiver

Benefits to the system:

- Offers flexibility, choice and control as a trade off for limited resources
- Research indicates when families are involved in the development of a budget they tend to spend less than families who receive what's typically on the menu.
- Cash and Counseling evaluation completed by Kevin Mahoney, researcher, found that individual control yielded lower costs.

12

Self-Direction-Supports Waiver

Benefits to the system:

- ☐ Less turnover in staff because of self selection
- ☐ Strengthens and sustains natural support networks that will reduce paid supports
- ☐ Reduces movement into facility based services

13

CAP-MR/DD Waivers
Summary of Planned Tiers

The Overall Goal of the Tiered waivers:

To improve efficiency in the expenditure of available funds and effectively identify and meet the needs of individuals who are eligible for CAP-MR/DD funding.

14

CAP-MR/DD Waivers
Summary of Planned Tiers

Each waiver provides for the specifically defined needs of intended participants based on intensity of need, financial limits, and services/supports.

The development of the Tiered waivers system is intended to; 1) assure that individuals receive the services/supports they need; and 2) Services are authorized equitably based on the individual's intensity of need.

15

Three Targeted Waivers

- ☐ Minor revisions to the Supports Waiver
- ☐ Major revisions to the Comprehensive Waiver
- ☐ Create new Community Intensive Waiver

16

Three Targeted Waivers

- ☐ Supports Waiver-Financial Range-up to $17,500 per year
- ☐ Comprehensive Waiver-Financial Range- $17,501 to $75,000
- ☐ Community Intensive-Financial Range-$75,001-$135,000 per year

17

Determination of Intensity of Need

Determination of intensity of need will be made by using information gathered through the use of the:

- NC-SNAP
- Supports Intensity Scale
- Other assessments
- Person Centered Planning process

18

Transition Into the New Waivers

Individuals in the Supports and Comprehensive waivers will transition into the revised and new waivers based on information gathered from the NC-SNAP, SIS and other assessment and support needs information contained in each Person Centered Plan.

19

Three Targeted Waivers

- Planning and development are underway
- Commitment to make as few changes as possible to reduce stress to the system
- Build in processes to support individuals during life transitions (early childhood to school, young adult and retirement)

20

CAP-MR/DD Waivers Summary of Planned Tiers

Progress to Date

- ☐ Stakeholder Survey
- ☐ Planning for Stakeholder workgroup meetings
- ☐ Planning for statewide Stakeholder Forums

21

Projected Timeline for Implementation of the Tiered Waivers

Development of the waivers with submission to CMS will occur by July 31, 2011 allowing adequate time for CMS approval and transition to the new waivers on 11-1-11.

22

Waiting List

- Each LME shall maintain a waiting list for:
  - Residential services
  - CAP-MR/DD Waiver services
  - Other
- Develop rules regarding waiting list data
- LME(s) to report waiting list information annually to DHHS

23

Waiting List

Short Term Solution

- LME spreadsheet to collect aggregate data
- LME(s) provided data-
  - identified 8191 persons potentially eligible for CAP-MR/DD

24

Waiting List

- **Long Term Solution**
  - Analyze effectiveness of spreadsheet effort
  - Evaluate feasibility of web-based solution or other alternatives

25

Residential Supports Level 5

- Residential Supports Level 5 is a 24 hour (per diem) service for the individual who has ***extreme behavioral support*** needs that require 24 hours per day one-on-one direct contact and supervision.
- Services are expected to be provided with a ***one to one staffing ratio for 24 hours per day***
- Staff qualifications require staff have specialized experience and supervision

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Residential Supports Level 5

- Authorization for Residential Supports Level 5 will be determined by a DMH-DD-SAS and DMA review committee:
  - clinical professionals with education and experience working with individuals with I/DD and related behavioral disorders, to include at a minimum;
  - consultation with professionals in the field of psychiatry, psychology, medicine, and pharmacy and other specialists as needed.

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Residential Supports Level 5

- October-PAG review
- 45 day posting
- Review of public comments and revisions as needed
- Implementation-2011

28

CAP-MR/DD UTILIZATION REVIEW

Effective January 20, 2011, the current Utilization review vendor will no longer be responsible for the utilization review for CAP-MR/DD waiver services.

29

CAP-MR/DD UTILIZATION REVIEW

- The LME(s) have received information regarding the requirements and must respond by October 18.
- All LME responses will be reviewed and selection letters will be mailed to the LME(s) November 1, 2010.

30

CAP-MR/DD UTILIZATION REVIEW

- Training with the selected LME(s)- December 6 through December 10, 2010.
- Transition Process-November 2010 through Implementation
- The Selected LME(s) will train providers- January 3 through January 14, 2011
- January 20, 2011, the selected LME(s) will begin utilization review for CAP-MR/DD waiver services

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Implementation Update of the CAP-MR/DD Tiered Waivers

- Thank you for your attention!
- Questions???

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Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
December 8, 2010 10:00 A.M.; Room 643, Legislative Office Building
Senator Martin Nesbitt, Co-Chair, Presiding

10:00 **Welcome and Opening Remarks**	*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*
10:00-10:15 **Secretary's Remarks**	*Lanier Cansler, Secretary* *Department of Health and Human Services*
10:15-10:45 **ICF-MR Cost Analysis and Comparison w/ CAP/MRDD Services**	*Steve Jordan, Director,* *Division of Mental Health, Developmental Disabilities, & Substance Abuse Services*
10:45-11:15 **State Operated Developmental Centers**	*Carol Donin, Team Leader, Developmental Centers, Division of State Operated Health Care Facilities, DHHS* *Dr. Aleck Myers, Director. Murdoch Center*
11:15-11:45 **Post-Hospitalization Continuity of Care**	*Peter E. Rives, Care Coordination Manager, CenterPointe Human Services LME*
11:45-12:00 **Overview of LOC Interim Presentations**	*LOC Staff*
LUNCH	
1:00-1:30 **Mobile Crisis- Service Gaps**	*Beth Melcher, Ph.D, Asst. Secretary for Mental Health, Developmental Disabilities, & Substance Abuse Service Development, DHHS*
1:30-2:00 **Transfer of Utilization Review to LMEs CAP/MRDD Services**	*Kelly Crosbie, LCSW, Behavioral Health Mgr.* *Division of Medical Assistance, DHHS*
2:00-2:30 **Update on Medicaid Waiver for Traumatic Brain Injury**	*Kelly Crosbie, LCSW, Behavioral Health Mgr.* *Division of Medical Assistance, DHHS*
2:30-2:45 **Residential Services for Children Ages 0-6 with DD**	*TBD*
2:45-3:00 **Committee Discussion & Adjournment**	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	12/8/10																
Senator Martin Nesbitt, Co-Chair	√																
Senator Austin Allran	√																
Senator Bob Atwater	√																
Senator Doug Berger	√																
Senator Charlie Dannelly	√																
Senator Jim Forrester	√																
Senator Ellie Kinnaird	X																
Senator William Purcell	√																
Representative Verla Insko – Co-Chair	√																
Representative Martha Alexander	X																
Representative Jeffrey Barnhart	√																
Representative Beverly Earle	√																
Representative Bob England	√																
Rep. Jean Farmer-Butterfield	√																
Representative Carolyn Justus	X																
Representative Fred Steen	√																
STAFF																	
Rennie Hobby	√																
Joyce Jones	√																
Shawn Parker	√																
Susan Barham	√																
Ben Popkin																	
Lisa Hollowell	√																
Gann Watson																	
Janice Paul	√																
ADVISORY MEMBERS																	
Senator Larry Shaw	X																
Representative Van Braxton	X																
Representative William Brisson	X																

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

December 8, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, December 8, 2010 in Room 643 of the Legislative Office Building. Members present were: Senator Martin Nesbitt and Representative Verla Insko, Co-Chairs; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, Jim Forrester, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Joyce Jones, Shawn Parker, Jan Paul, Susan Barham, and Rennie Hobby provided staff support to the meeting. Also in attendance was Dr. Patricia Porter, consultant to the LOC. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. He asked for a motion to approve the minutes from the November 9, 2010 meeting. The motion was made by Senator Purcell and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services explained that DHHS continues to try to identify ways to achieve budgetary savings and that the options would be provided to State Budget for consideration. Points of interest included:

- Policy decisions will need to be made regarding the b-c Medicaid waiver – should Local Management Entities who elect to partner with other LMEs in the operation of the b-c waiver be contiguous and what DD Services will be managed by LMEs operating the b-c waiver.
- All divisions throughout DHHS will now use the same budget codes in order to help coordinate and perhaps consolidate management in various programs and services.
- By the end of the year there will be 944 operating State psychiatric beds across the state. There will be a minimum of 30 forensic beds on the Dix campus. A Request for Information has been issued for a possible private contract for the operation of the forensic beds. If the information gathered is positive, DHHS will contact other states speaking with advocacy groups, district attorneys, and others before any decisions are made to issue a Request for Proposal.
- In an effort to cut costs as leases expire across the county for State offices, space may be made available on the Dix campus temporarily for those employees until a decision is made regarding all the employees housed on the campus by DHHS. (There are currently 1,300 employees on the campus.)

- There are currently very few vacant positions in the state operated facilities. Positions at Dix are not being eliminated but rather moved to Central Regional and Cherry hospitals. Carpooling will be made available to reduce the cost of travel to Central Regional Hospital.
- The cost to maintain 100 beds at Dix is approximately $30M per year. There have been no budgeted funds for Dix in several years and funding has come from other areas in DHHS in order to maintain the facility. DHHS is still $15M over budget in operation of the facilities. Funding will have to come from community services in order to maintain the facilities. A new financial accounting system in the hospitals that will be in place by the next fiscal year will better identify costs in the hospitals to help save money. There will be 20 more beds next year; there are 265 fewer beds this year than 5 years ago; 140 community and voluntary admission beds have been added to community hospitals.
- The average cost for a community hospital bed is $750 per day. The average cost to operate a State facility bed is $1100-$1300 per day. The focus is on building community capacity in order to keep consumers closer to home, getting the professionals in place, and getting the crisis beds established in the community.

Secretary Cansler gave a lengthy explanation of why mental health reform has struggled since implemented. He explained that the area programs were divested of the delivery of services before the reform infrastructure was in place. The hospitals were losing money on their psychiatric beds and closing those beds to reduce costs. Professionals started to leave because of the lack of community capacity and the reliance on the State hospitals increased but funding was reduced. All budgetary and funding decisions were based on having 3 regional hospitals with community capacity in place. He said the idea is to move the short-term patients, roughly 40% of admissions, into community beds at $750 per day thus creating focus on the long-term patients. The design of the hospitals allows for future growth if there is a demand.

Peter Rives, Care Coordination Manager for CenterPointe Human Services LME addressed post-hospitalization continuity of care. He explained that CenterPointe linked people with services needed in their recovery. (See Attachment No. 2) Items of interest included:

- Patients referenced in data are those discharged from State hospitals with the exclusion of those going to jail, a medical hospital, or transferred to a different MH or SA facility.
- In the past, when relying on the Sheriff's Department, budget constraints and staffing limitations within the Sheriff's Department often meant patients discharged from a facility could not leave because of a lack of transportation.
- Response to problems in the past included partnering with Daymark Recovery Services which eliminated the lag time between a patient's discharge and follow up appointment. Consumers receive 2 appointments upon discharge, one with Daymark as a "check-in" and the other with any provider within the system.
- CenterPointe contracted with a private provider to transport patients. County discretionary funds pay for transportation.

- Peer Support is used to help engage individuals and help them develop a *Wellness Recovery Action Plan* (WRAP) which is a plan the individual develops for the future.
- An indigent lab program is funded for those individuals needing medication upon discharge and need lab work but do not have the means to pay for the service.

Mr. Luckey Welsh, Director of State Operated Facilities, DHHS, and Dr. Jeff Holden, Special Services Director at the Murdoch Center provided an insightful presentation on State Operated Developmental Centers. (See Attachment No. 3) Points of interest included:

- The facilities provide services and supports to individuals with intellectual and developmental disabilities (I/DD) and complex behavioral challenges and/or medical conditions whose clinical treatment needs exceed the level of care available in the community. Many units are designed as individual homes and cottages. Medical, dental, special therapies as well as adapted technologists are located on campus to provide the individual services and supports needed for each individual.
- All of the Centers have been downsizing for years. Persons who now live in the Center are older and with more significant cognitive, physical, medical and behavioral disabilities. No children are admitted to the Centers for long-term care.
- The Centers are mostly federally funded (95%-98%) with State funds amounting to 2%-5%.

Dr. Holden addressed specific programs at the Murdoch Center. Items of interest included:

- The DD Centers each have special differences from region to region mostly due to the response to different populations and an effort to be responsive to the LMEs and the consumers in their particular areas.
- Murdoch has worked closely over the past 10-15 years with other programs, LMEs, providers, the Autism Society, TEACCH, and other partners to develop specialized programs not offered in the community. The four specialty programs developed at Murdoch are ICF-MR certified drawing down Medicaid dollars.

Shawn Parker from the Research Division provided members with an overview of the presentations from the last three LOC meetings for discussion in preparation of the interim report to the General Assembly in January. He said noteworthy topics from those meetings are highlighted, and the items listed as potential topics for recommendations were noted as being of particular interest by members during conversations at those meetings. (See Attachments No. 4A and 4B). Members were asked to review these lists and provide any comments they have about potential recommendations to be added to the report to the Committee Chairs or to LOC Staff. It was suggested that the Committee discuss and vote on whether or not b-c waiver LMEs should be contiguous. Another possible recommendation was to require a report annually on the progress being made on evidence based services that are available for delivery in our State institutions.

Dr. Beth Melcher, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Service Development, DHHS, addressed Mobile Crisis services. She explained that Mobile Crisis was one of the most critical services, responding to crisis needs in communities. (See Attachment No. 5) Points in Dr. Melcher's presentation included:

- Non-allocated non-UCR funds are State allocated dollars coming from the LMEs single stream funding which they designate for Mobile Crisis services. The allocation and the fee for service are not sufficient to support these services. The LMEs are needed for additional funding support.
- For those Hospital Emergency Departments that do not have psychiatric expertise, Crisis Teams collaboration helps offer structure and support to physicians with risk assessments, discharge and release plans for patients.
- Currently, there are Crisis Teams in all counties but in counties with a larger geographic area the response time can be longer. Additional response teams could reduce that wait.

Steve Jordan, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services provided a follow up to last month's cost analysis and comparison of the ICF-MR and CAP/MR-DD services. Mr. Jordan referenced the ICF-MR state operated DD facilities verses the ICF-MR private community services and compared the ICF-MR services within the community and in the facilities with CAP/MR services. (See Attachment No. 6) Additional points during his presentation included:

- There are approximately 1,565 individuals in the State ICF-MR facilities and approximately 2,236 individuals in the community ICFs in over 327 facilities.
- Community ICFs-MR range in size from 6 beds per facility to over 100 beds and house both children and adults
- Medicaid expenditures are roughly 33% State dollars and 66% Federal dollars for services for children and adults.
- The largest children's ICF-MR facility has 124 beds.
- The graph of CAP-MR/DD Children and Adults depicts children 18 years and younger representing 19% of the CAP recipients receiving services and 42% of the other health related Medicaid-supported services in the CAP program. The Unduplicated recipient counts represent 33% of the children on the CAP waiver who receive 19% of the funding and represent 42% of the average cost per day.
- One of the differences between ICF-MR public facilities and ICF-MR private community facilities is that for community ICFs-MR the individual's Social Security room and board is built into the rate. The Social Security for individuals on the CAP Waiver is not included in the average CAP-MR/DD cost per recipient.
- Provider assessments (a provider funded rate enhancement) changes the cost for the State in the community based ICFs-MR.

Kelly Crosbie, Behavioral Health Manager for the Division of Medical Assistance discussed the changes to Medicaid Utilization Review (UR). (See Attachment No. 7) Ms. Crosbie explained the legislative mandate directing the return of UR of Medicaid funded services to the LMEs "when they are ready". She described the current MH, SA, and

CAP services and said that Value Options would no longer be responsible for any CAP-MR/DD reviews effective January 20, 2011. Other items of interest were:

- An RFA packet was sent to all LMEs and Crossroads, Pathways, Durham and Eastpointe were chosen to be UR vendors. Durham and EastPointe are already doing UR for all MH-DD and SAS and they, along with the other two LMEs, will now be responsible for all CAP-MR/DD reviews. The CAP-MR/DD UR for all the other LME counties will be split among these 4 LMEs on January 20, 2011.
- An effort was made to see that there are an equal number of Medicaid CAP Waiver recipient reviews going to each of these LMEs.

Ms. Crosbie was asked to provide a cost comparison for providing UR by the LME and the amount paid to Value Options. She stated that she would get the information to the LOC members.

Next, Ms. Crosbie gave an update on the Medicaid Waiver for Traumatic Brain Injury (TBI). (See Attachment No. 8) She explained that legislation requested that DMA and the Division of MH/DD/SAS study and report on the feasibility and cost of a 1915(c) or a home and community-based services waiver for people with TBI. Ms. Crosbie reviewed the TBI report submitted to the General Assembly on December 1, 2010 going over the purpose of the waiver, describing the target population, the cost projections, and the suggested service array.

Ms. Crosbie was asked if the military was included and if federal dollars or services were available. She was uncertain about the eligibility for when one could obtain federal funding for services but military personnel would qualify for the 1915(c) waiver. Flo Stein, with DM/HDD/SAS, said that those with service related injuries in a combat zone had full VA benefits. It was stated that the Institute of Medicine was studying the military and broad mental health service needs to include TBI. Representative Insko recognized member of the Traumatic Brain Injury Advisory Committee for their hard work on the TBI waiver study.

It was suggested that the subject of DD residential services for children 0-6 be addressed at the January meeting.

There being no further business, the meeting adjourned at 2:25 PM.

Martin Nesbitt
Senator Martin Nesbitt, Co-Chair

Verla Insko
Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kate Snodgress	Caswell Developmental Center
[illegible]	Caswell Developmental Center
[illegible] Bone	Bone and Associates, LLC
W. Gardner Calloway III	NCNA
Tara Fields	CFSA-NC
Karen M. Ld	CFSA-NC
[illegible]	HAM Services, Inc
Brad Bannister	DJSDP
Andrew Meehan	CapStrat
Doug Miskew	PSG
[illegible]	NWC
[illegible]	NCMS
Yvonne Copeland	NCCCP

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin Huffman	NC Psychiatric Assoc.
Ru-Ann Chapman	NCPA
Lon S Cecil	NCALTCP
Sandy York	Hospitality Alliance
Kathline Ross	PPAB
Jennifer Mahorn	Autism Society of NC
Bob Hedrick	NCPC
Eric Gabriel	RHA
Julia Adams	The Arc of NC
Myron Press	Correct Health Svcs
JIM PARSUE	RALPH SCOTT LIFESERVICES
Erica Nelsen	NC CCP
Martha N Lowrance	YAIO/DDA
Ally Lumpp	NAMI NC

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bennie Kidd	Ralph Scott Lifeservices
Jennifer Helton	Ralph Scott Lifeservices Inc. 408 W Trade St Burlington
Annamese Ralph	DRNC
Gabrielle Martino	DRNC
Maryann Osorio	DRNC
KAREN GILLESPIE	BMS
Peter Rives	CenterPoint Human Services
Betty Taylor	" " "
Crystal Nunnemaker	Omni Visions Inc
Martha Brock	Examiner.com / media
Pat McInnis	Disability Rights PAIMI Member
TAD CLODFELTER	SOUTHLIGHT / SAFEDEMOCRATS
Joyce Munsieger	ECBH

Mary Freeman Tammy Lynn Center, NORCARR, & ICF/MR Association

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Truitt	OPC MHC
Cim Brailer	OPC MHC
Will Wordell	Value Options
Allison Jourdan	DOC/DCC
Rhett Melton	Pathways LME
DAVID Swann	Crossroads LME
Ellen Cochran	Mental Health Assoc.-Triad High Point, NC
Margaret Stanfield	Coastal Horizons Center
[illegible]	[illegible]
Ken Melton	K.M.A.
Bruce Sparrow	N.C. M.H.C.O.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
William Moore	Healing Interventions Inc 1100 Navaho Dr Raleigh NC 27609
Lawrie Cole	NC CANSD
Sally Cameron	NC Psychological Assoc
Jennifer Peed	6413 Valley Estates Dr Raleigh A Caring Heart Case Management
NANCY BLACK	SCFAC
DON KAADE	THRESHOLD, INC DURHAM
Louise Fisher	Volunteer Advocate for Mentally Ill
PAULA Cox Fishman	Volunteer Advocate MR/DD
Kathy S. Baker	Southeastern Regional LME
Mary Horne	B+A/OHHS
Valerie Hunnicke	Five Co Mental Health

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS December 8, 2010

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	3701 Latrobe Dr, Ste 140, Charlotte NC 28211
Kathryn Fallo-Woodson	Mental Health Assoc. of Central Carolinas
[illegible]	" " "
Mark Sullivan	MHA of the Triangle
Larry Swabe	NC Council on DD
ALBERT FISHER	COMMUNITY PARTNERSHIPS, INC
ALEXANDER DUDA	NCCPPR

Continuity of Care

Following State Hospital Discharge

CenterPoint
Human Services
People In Partnership Making A Difference

Care Coordination

Care Coordination is the art of working around barriers and developing ways of connecting people in need with services that can support them on their path to recovery.

Successful care coordination requires an intimate knowledge of several systems, problem solving skills, and an ability to engage interpersonally.

The role of Care Coordination has evolved to include Hospital Liaison, Homeless Shelter Liaison, Jail Liaison, Cost and Risk reduction, Medical/Behavioral Health Integration, and Peer Support.

Starting Points

DMH/DD/SAS Letter – Sept. 30, 2008

- Indicated a failure of CenterPoint to ensure follow-up care for State Hospital Discharges beyond a floating state average for SFY08 Qs 3&4
- Invoked provisions of G.S. 112C-115.4(d) which allow for
  - Focused Technical Assistance to the LME
  - Removal of Care Coordination from the LME
- Required a Plan of Action to be submitted to DMH by Oct. 10, 2008.

The Way We Were

- At the time of the letter (SFY09 Q1) The percentage of State Hospital discharges receiving aftercare within 7 days of discharge was 27% (51% within 30 days).

Understanding the Numbers

The Data:

- Based upon Medicaid and IPRS (indigent care state funds) paid claims data for MH/DD/SA services rendered.
- Population defined by indicated county of discharge from State Psychiatric Facilities for eligible discharge (excludes transfers, correctional, and medical discharges).
- Receiving county is responsible regardless of residence prior to admission to the hospital.

Understanding the Numbers

Limitations of the Data:

- "Paid Claims" data includes only what has been successfully billed and paid; not what was rendered.
- Medicaid claims are valid for submission for payment for up to 12 months from the date of service.
- State *Quarterly Progress Indicator Reports* are produced 60 days following the end of each quarter, thus not capturing all eligible claims.
- Some claims for services delivered will inevitably fail to become "paid claims" due to technical issues, authorization issues, and failure to submit for payment.

Aftercare Challenges

Consumer Choice

- Along with the right to choose one's provider of services comes the right to refuse services all together.

Transportation

- Transportation is not billable under any service definition, so getting people to their aftercare appointments is a challenge.

Access to Medications

- Indigent medication programs exist through pharmaceutical companies for some drugs, but the process is involved and takes time. Hospitals provide a limited supply at discharge.

Appointment Lag

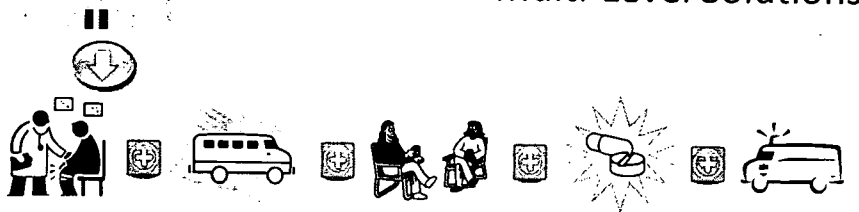
- Delays in scheduling results in a drop in adherence rates.

The Response

State Hospital Aftercare Restructured

CenterPoint
Human Services
People In Partnership Making A Difference

Multi-Level Solutions



CenterPoint has put into place an interactive, multi-level system to ensure continuity of care following hospitalization. In doing so we put resources at hand to work to empower consumers in their recovery process.

Multi-Level Solutions

clinic transport support meds crisis

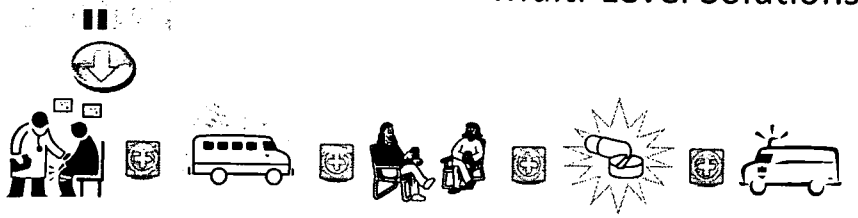
- Partnership with Daymark Recovery Services to provide a day-of-discharge clinic appointment.
- "Check-in" appointment assures connection with the system while preserving consumer choice of provider.

Multi-Level Solutions

clinic ***transport*** support meds crisis

- Developed alternate discharge transport to support Sheriffs' Departments.
- Transport automatically scheduled prior to discharge.
- Transport is direct to first appointment as well as "home" from the clinic.

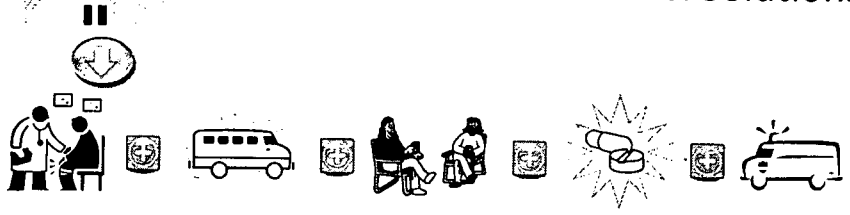
Multi-Level Solutions



clinic transport ***support*** meds crisis

- Developed alternative service definition for Peer Support.
- Funded Peer Support positions to "ride-along" with discharge transport as well as on-site at the discharge clinic.
- Provides support, guidance, WRAP planning upon discharge.

Multi-Level Solutions



clinic transport support ***meds*** crisis

- Developed Patient Assistance and Indigent Medications Program.
- Partnership with Forsyth County Public Health Pharmacy.
- Enrolls consumers in Patient Assistance Programs offered by drug manufacturers.
- Provides low-cost or free of charge medications for indigent care.
- Recaptures and redistributes sample and discarded medications.
- Provided $4.1 Million in free medications in SFY10.
- 3 FTE positions to support these programs.

Multi-Level Solutions

clinic transport support meds ***crisis***

- Developed a program for automatic dispatch of Mobile Crisis Management Team in response to any missed State Hospital Discharge Appointment.
- Allows for rapid response to prevent disruption of treatment.
- Seeks to re-engage individuals in community treatment.
- Supplemented with calls, letters and home visits from providers and LME staff.

Behind the Scenes

High Cost / High Risk Tracking

- Developed a system which automatically identifies and tracks consumers in the system who are High Cost and/or High Risk.
- Individual staff assigned for intensive monitoring and engagement.
- Integrated electronic documentation allows efforts to be automatically shared internally with LME Jail, Hospital and Shelter Liaisons as well as with ACCESS Line clinicians and Utilization Management Staff.
- Multi-Level clinical review processes to ensure that all possible strategies are being considered.

Behind The Scenes

State Hospital Peer Support

- Initiated a pilot program for incorporating LME Peer Support Specialist staff on-site at the State-Hospital Community Transition (Long-Term) Unit.
- Certified Peer Support Specialist is on-site 2 days weekly to provide face-to-face supports to Long-Term patients.
- PSS also teaches WRAP classes as part of the discharge readiness curriculum at the State Hospital.
- All efforts are documented electronically so that input can be used to supplement Care Coordination and Treatment Planning efforts.
- CPHS PSS Pilot recently recognized by CRH in quarterly publication.

Behind The Scenes

Care Coordination Staffing

- Care Coordination Manager
- Intellectual and Developmental Disabilities Care Coordinator
- Child and Adolescent Care Coordinator
- Substance Abuse and Homelessness Care Coordinator
- Adult MH/SA Hospital Liaison
- 2 RN Community Care Network BH/Medical Integration Staff
- 2 Certified Peer Support Specialists (part-time)

Plus

- 2 Law Enforcement / Jail Liaisons in the Community Relations Department.
- Support Staff

Results

Post-Discharge Continuity of Care

CenterPoint
Human Services
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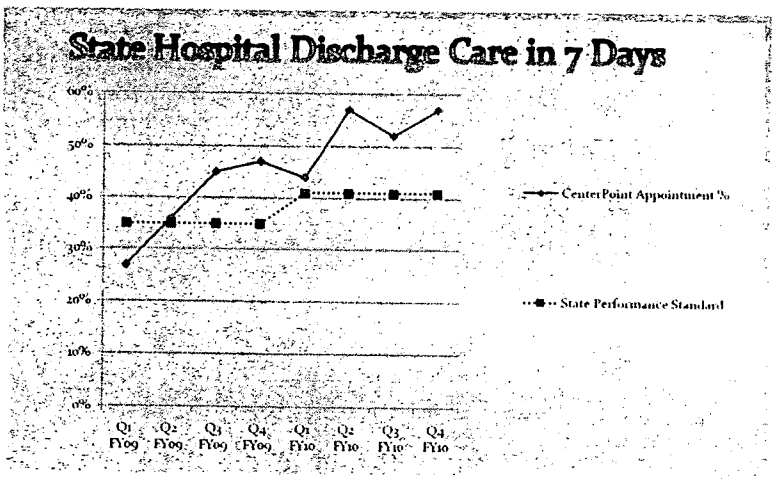
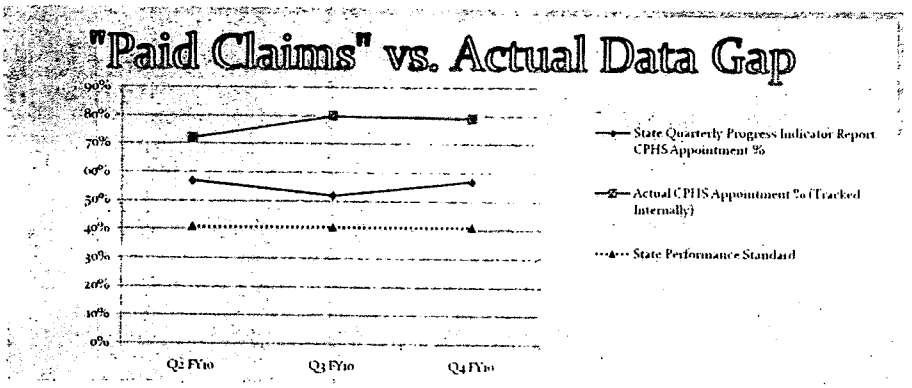
The Results



211% improvement over 2 years

The Results



The gap between "Paid Claims" data and actual percentages of individuals receiving aftercare (avg. 72% of actual).

* Continued improvement: October 2011 – Actual = 92.3%

CenterPoint
Human Services

Questions?

Presentation to the Legislative Oversight Committee

North Carolina's Developmental Centers

Carol Donin, Team Leader
Division of State Operated Healthcare Facilities

Alexander M. Myers, Ph.D., Director
Murdoch Developmental Center

December 8, 2010

1

NC DEVELOPMENTAL CENTERS

JIRDC *Murdoch* *Caswell*

Touching Lives. Enriching Futures.

2

North Carolina's Developmental Centers: Who We Support; What We Do

- NC's Developmental Centers provide services and supports to individuals with intellectual and developmental disabilities (I/DD) and complex behavioral challenges and/or medical conditions whose clinical treatment needs exceed the level of care available in the community.

- Services and supports include:
  - Residential, medical, habilitation (help in developing functional living skills) and training to promote independence and self-determination.
  - Facility-based therapeutic respite services to provide evaluations and assessments to individuals with specific medical and/or behavioral challenges.
  - Facility-based respite services to provide caregivers temporary relief.
  - Specialized programs that provide time-limited services to challenging target populations.

Location and Operating Capacity

East: Caswell Developmental Center, Kinston – 430

Central: Murdoch Dev. Center, Butner – 568

West: J. Iverson Riddle Dev. Center, Morganton – 325

Collaboration and Partnerships

- All admissions must be endorsed by the LME, with focus on return to community.
- New admissions to general population are authorized for one year. LMEs may request re-authorization prior to designated discharge date. Each specialty program has a designated length of stay.
- Families/guardians, LMEs, developmental center treatment teams collaborate for transition planning. Community provider agencies are included upon selection by family/guardian.
- Developmental Center staff and NC START partner for transition planning, post-discharge follow up and consultation in the community.

Admissions and Discharges from the three Developmental Centers

Fiscal Year	Number of Admissions General Population	Number of Discharges General Population	Number of Admissions Specialty Programs	Number of Discharges Specialty Programs
2008	23	7	29	25
2009	22	14	15	13
2010	12	13	26	27

The three state operated Developmental Centers are all:

- ICF/MR-certified facilities
- Operated by the Division of State Operated Healthcare Facilities (DSOHF) under the Department of Health and Human Services
- Federal Medicaid funded, covering almost all of the operating costs

All three Developmental Centers:

- Provide therapeutic homelike environments
- Offer specialized programs using their professional expertise, providing a vital safety net for the community.
  - Murdoch has 4 specialized, time-limited residential programs for persons with challenging behaviors
  - Caswell has a time-limited specialized DD/MI for adult males persons with challenging behaviors and mental health needs (in addition to DD needs)
  - JIRDC has created individualized and specialized residential treatment programs as needed, and offers a "Rapid Response" team to assist Broughton Hospital when challenging cases with I/DD arise

All three Developmental Centers:

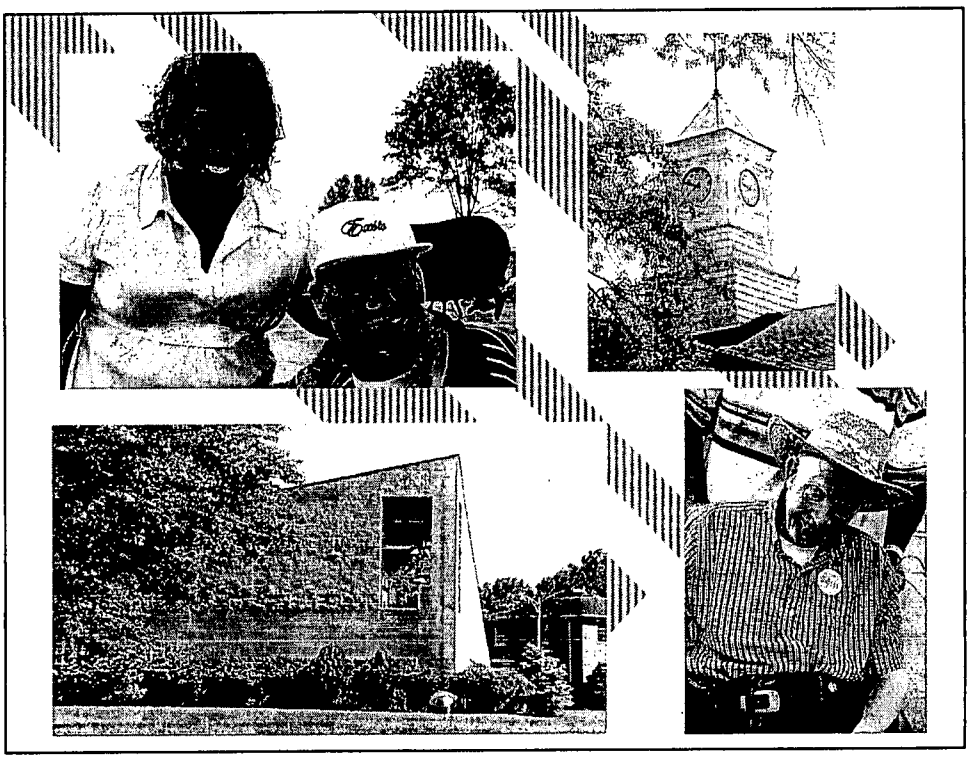
- Serve as a vital safety net for the community:
  - The centers are placements of last resort. Admission referrals are carefully screened to ensure that community options have been exhausted.
  - For an individual to be admitted to a developmental center, the community must clearly demonstrate that the individual needs the level of care and expertise offered in the center.
  - The centers work in partnership with the LMEs and families/guardians on both admissions and transitions back out to the community.

Murdoch Developmental Center currently serves 517 individuals; 463 in its general population and 54 in its specialized statewide programs.

11

All individuals receive comprehensive residential care and supports to address their specific needs. A team of professionals, along with the family and the individual, develops a comprehensive Person-Centered Plan which outlines an intensive treatment plan addressing the specific needs and wishes of the person.

12



Team members include representatives from Direct Care, Nursing, Social Work, Speech and Hearing, Education, Psychology, Physical and Occupational Therapy. Physicians, psychiatrists, recreation therapists, dentists, dieticians, pharmacists, and vocational instructors may also participate depending on the needs of the individual.

Interesting Facts:

- 245 individuals participate in our Vocational Enterprise program, earning wages for work performed on-campus and in the community. Jobs can be tailored to the person's abilities and challenges, allowing employment opportunities not typically available in the community. Schedules can be adjusted as needed (e.g., illness).

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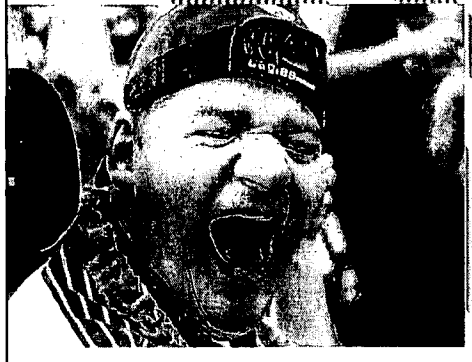
Interesting Facts:



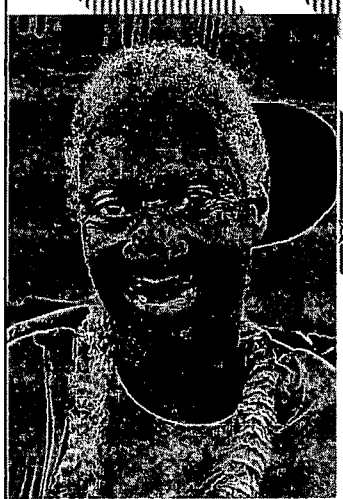
- Our Dental Clinic, in addition to meeting the needs of all of our individuals, provides **181** outpatient services per year; a vital community service, as there are few dentists willing to serve this population

16

Interesting Facts:

- Due to the special needs of our population, over 3,000,000 medications and treatments are administered annually. This is the equivalent of over 8200 per day.

17



Interesting Facts:

- Murdoch has an ICF-MR certified infirmary, providing close to hospital-level care for individuals when they need it.
- This facilitates faster return from the hospital and actually helps avoid hospital admissions. This is better for the person, and results in a considerable reduction in cost for the Center.

18

General Population

- Individuals residing in the general population have significant behavioral, medical, and/or daily living skills needs.
- They typically (95%) have severe-profound intellectual disabilities.

19

General Population (cont'd)

- Within the general population there are three primary categories:
  - Persons with increasing health needs
  - Persons with challenging behaviors
  - Persons aging in place (median age = 53+ years)

20

Specialized Statewide Programs

Murdoch Developmental Center also has four specialty programs that serve individuals from across the entire state.

All of these statewide programs are ICF-MR funded and serve individuals with intense behavioral challenges.

Specialized Statewide Programs

These four specialty programs all form the basis for our own Local Education Agency (LEA) serving school-age children and youth

The Center provides formal elementary, middle, and high school classes, as well as adult education

In addition, PATH has a classroom in the community, currently at Butner-Stem Middle School.

Specialized Statewide Programs

These four specialty programs all utilize an evidence-based behavioral treatment model. This is coordinated well with other models, such as TEACCH, as indicated by individual need.

All the developmental centers offer an integrated inter-disciplinary treatment program using person-centered philosophy and practice.

The **BART** (Behaviorally Advanced Residential Treatment) Program

- Serves young adult males
- Diagnosis of DD and very severe behavioral challenges
- History of multiple failed placements
- 10 beds (plus 2 therapeutic respite beds)

The **PATH** (Partners in Autism Treatment & Habilitation) Program

- Serves children ages 6 to 16 with Autism (ASD) and very severe behavioral challenges
- 10 beds on campus (+ 2 therapeutic respite beds)
- Two "step-down" community group homes (4 beds each); located in Oxford and Franklinton
- Maximum stay is 2 years

25

The **STARS** (Specialized Treatment For Adolescents in a Residential Setting) Program

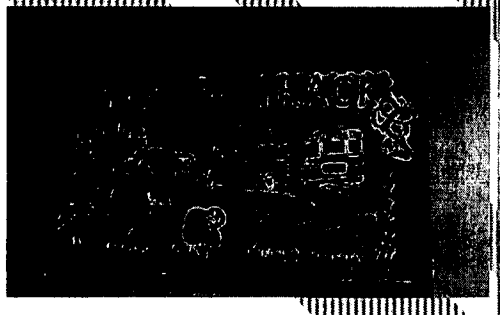
- Serves males and females aged 13-17
- Diagnoses of I/DD, MI and severe behavioral challenges; hx of residential/school failures
- 16 beds with a maximum of a one year stay
- Note: These individuals do extremely well during their time in STARS. However, it has been very difficult to find appropriate supports in the community upon re-entry. As a result, a troubling number of graduates are not maintaining their gains after discharge.

26

The **TRACK** (Therapeutic Respite Addressing Crisis for Kids) Program

- Serves males and females aged 5-17
- Diagnosis of I/DD and in behavioral crisis
- Safety net to avoid psychiatric hospitalization or emergency room stays
- Stays between 3 and 45 days
- Serves a maximum of 6 children at this time

27



28

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Overview of Substantive Committee Presentations – Fall 2010 Interim

SEPTEMBER 8, 2010

Community Supports Information

- DHHS had tracked the movement of consumers in the system since July 2009 using Medicaid and State paid claims data.
  - Of those consumers no longer receiving CSS, some have completed treatment; for others service could not be justified; and some may be receiving service in a primary care setting which is not indicated in the data.
  - As of December 31st, all endorsements for Community Support Individual will end

CABHAs Update

- Presentation explained the reasoning behind CABHAs, the goals, the CABHA certification process
  - Members discussed at length whether or not DHHS should set guidelines as to the number of CABHAs there should be in an area
  - There was concern that there should be some diversity in the provider network in order to eliminate abuse

Status Report on the Changes to Level III & IV Facilities for Children

- DHHS provided a status report on Level III and Level IV group homes for children
  - A comprehensive System of Care approach focusing on the needs of children and their families was established to review and respond to the needs of those children.
  - An independent psychiatric assessment for each admission was administered as opposed to one done by the provider agency
  - Question about percentage of children in the system that have also been in the court system.

Second Mile Project – (LME Presentation)

- Second Mile is an East Carolina Behavioral Health LME program that supports adults to transition successfully back to the community after a psychiatric hospitalization in a state operated facility.
  - funded by county dollars and has received national recognition.
  - once a level of recovery is established, Second Mile helps transition people into permanent supportive housing.
  - available to any consumer at Cherry Hospital. It is not limited to ECBH residents.
- Emphasized the importance of having enough critical care beds in the facilities across the State for our growing population

OCTOBER 13, 2010

SIS Assessment Tool Pilot Project

- DHHS provided an update on the Supports Intensity Scale Project within the seven LME pilot sites
  - SIS is a standardized assessment tool designed specifically for individuals with intellectual and developmental disabilities and is designed to determine the actual support needsl
  - Total of 895 adolescent and adult SIS assessments within the seven pilot LMEs.

Prepared by LOC staff
12/8/10

- a request will be made to CMS for a technical amendment to the CAP-MR/DD waiver so that the test can be administered statewide for purposes of resource allocation
- Concerns the pilot had not been designed to be able to provide the basic data to be used to statewide
- further directives about use of the SIS and resource allocation could be included in the LOC report

Independent Assessments/MH Services

- Special provision directed a report
  - Fiscal Year 2010 had 40,000 Medicaid and State funded individuals request new services.
  - independent assessments will be done on everyone which would number 108,000 individuals for the entire year.
  - A multi-stakeholder group made up of an external advisory team that advises the Department and the Division of MHDDSAS, was tasked with determining how to move forward to accomplish the intent of the provision.

Update on Dorothea Dix Hospital & Report on Operating Budget

- DHHS provided an update on Dorothea Dix Hospital and a report on the operating budget
  - noted that the number of state hospital beds has not been decreased, money has been saved, Central Hospital had been built and is operational, and local hospital beds have been added. Overall, there will be an additional 19 Adult Admission beds at Broughton Hospital.
  - DDH employees – As many as 45 - 50 may transfer to Cherry Hospital to fill vacant positions. For employees opting to transfer to Butner, a "park and ride" service from the Dix campus will be offered.

National Health Reform: Overview and Impact on MH/DD/SA Services

- N.C. Institute of Medicine provided an overview and explained the impact of the National Health Reform on MH/DD/SA services.
  - Under the Health Reform Bill, State Medicaid dollars would now be available to pay for non-public institutions for individuals with mental illness.
  - Provisions in the Bill focus on investing in prevention in order to help manage a condition before it exacerbates into a crisis.

Youth Villages Transitional Living Program(LME Presentation)

- Youth Villages Transitional Living Program targets individuals from ages 16 to 21 that are transitioning out of the foster care system.
  - program uses a community based approach targeting youth in their natural environment
  - Participants are followed for 2 years after discharge.
  - Approximately 100 youth have been served to date with an average of 55 daily at a cost of $51 per day.
  - Approximately 400 children age out of foster care per year

Analysis of Effectiveness of Single Stream Funding

- DHHS explained how Single Stream funding works, the benefits and concerns, and how the effectiveness of Single Stream funding was measured.

Prepared by LOC staff
12/8/10

- In review of the allocations and expenditures of the 13 LMEs for SFY 2009, the amount of service actually provided was more than the State budgeted
- additional $7M services were created through the leveraging of the flexibility of the services to qualify for grants and other resources
- substance abuse services had increased by 184% across the 13 LMEs participating in Single Stream funding.

NOVEMBER 9, 2010

TASC (LME Presentation)

- East Coast Behavioral Health opened the presentation on Treatment Accountability for Safer Communities
  - The TASC mission is to work with individuals with behavioral health issues involved in the criminal justice system
  - Services are available in all 100 counties and organized into 4 regions
  - TASC is administered through two LMEs
  - Statistics indicate that 68% of probationers in North Carolina have a substance abuse disorder which is in keeping with the national average.
  - Over the last 10 years, TASC went from serving 8,000 clients in 2001-2002, to over 17,000 in 2008-2009.

Three-Way Contracts Update

- DHHS reported to the Committee on the number of bed contracts, the cost, the location of these community beds, and methodology for determining the allocation of beds.
  - These contracts (local hospitals, LME's, and DHHS) for the purchase of the community psychiatric beds have been funded for three years; with the legislature increasing the current year's funding by $9M in the budget bill for a total appropriation of $29.1 million.
  - Program has been successful in the effort to increase capacity for inpatient psychiatric treatment
  - Still concerns across the State regarding the waiting time in the ERs.

ICF-MR Cost Analysis and Comparison w/ CAP/MRDD Services

- DHHS provided part I of a cost analysis and comparison of the ICF-MR and CAP/MR-DD services
  - The Murdoch Center does "need determination" on all ICF-MR recipients in the State.
  - The services in the facilities are more comprehensive than in the community ICF-MR and in the CAP/MR-DD waiver.
  - In the 1990s there was established a moratorium on the development of new ICF-MR/DD beds.
  - The moratorium is managed through the Certificate of Need process
  - 50% of the total Medicaid and State matched dollars in NC goes to funding support for ICF-MRs.
  - Some states are closing large facilities moving to smaller facilities at the community level doing away with large 16 – 300 bed facilities

Prepared by LOC staff
12/8/10

Update on CAP-MR/DD Tiered Waivers

- DHHS provided the update
    - The Supports Waiver is intended for those with a low level of need. The annual allowable expenditure is $17,500.
    - The Comprehensive Waiver is intended for those with more extensive needs. The maximum cost limit currently is $17,501 - $135,000 per person, per year.
    - The new Community Intensive Waiver is designed to meet the needs of those with the highest medical and behavioral supports needs.
    - A survey of stakeholders regarding the CAP-MR/DD Waivers indicate that most are satisfied with the waiver and request that there not be any big changes.
    - DHHS plan to submit the waivers to CMS by March or April of next year.
    - The current waivers expire 11/1/11.

Overview of the DD Waiting List

- Session Law 2009-186 required the Department to improve supports for persons with developmental disabilities by creating a statewide data collection system containing waiting list information collected regularly and obtained annually from each LME
    - Short Term solutions – spreadsheet was created with the LMEs, and the waiting list work group which included multiple stakeholders. Comprehensive data submitted the end of July suggests a substantial number of persons waiting for service are potentially eligible for CAP-MR/DD funding.
    - Long Term solutions – look at other options beyond the spreadsheet. The spreadsheet can give duplicate information and count people multiple times- making it problematic if the results were to be used for program and budget planning.
    - In January 2011, Value Options will not longer be doing the utilization review for CAP-MR/DD funded individuals. This responsibility is being transferred to the LMEs.

Prepared by LOC staff
12/8/10

Potential Topics for LOC Report Recommendations

1. Single Stream Funding – continue to expand?
2. Three Way Contracts – maintain and/or expand?
3. Continue Expansion of the B-C waiver – remove prohibition against sub-contracting with non-contiguous LMEs
4. Criteria-based report on the status of the implementation of the CABHAs: budget and program
5. Report on the Independent Assessment Study
6. Closure of Dix Hospital
7. Emergency Room Usage by persons with mental illness: statewide status report and comprehensive plan for reduction in length of stay
8. Mental Health services for military personnel
9. Develop a process to allow Day Treatment for children and youth to be provided by qualified schools
10. Comprehensive Plan for the fair and equitable allocation of resources for persons with developmental disability based on a reliable, statewide assessment of intensity of need and the development of a formula for use of this data to determine eligibility for type and array of services. Re-consider the need for revision of the Tiered Waiver if this Plan reveals that an additional tier is no longer needed.
11. Report on the status of LME Utilization Management for CAP-MR/DD: budget and program impact
12. Comprehensive report on the residential needs and options for children with DD aged 0-6. Include early intervention and education options for support in-home.
13. TBI waiver
14. Direct the DHHS to revise the DD Waiting List process to assure that there is a simple, non-duplicated list of children and adults waiting for state and federal funded DD services to include residential services. List should be research-based to assure that data collected are an accurate reflection of the need for classes of services currently available in NC. The data collected should reflect some indication of those who may potentially be eligible for CAP-MR/DD funding. DHHS should report on these data annually and use these data to determine geographic, age and disability service gaps and plans to address these gaps.
15. Implement LOC Report Review Recommendations supported by the LOC during the 2009-10 Interim.

Prepared by Pat Porter
12/08/2010

MOBILE CRISIS

Presentation to
Joint Legislative Oversight Committee
on Mental Health, Developmental Disabilities
and Substance Abuse Services

Beth Melcher, PhD
Assistant Secretary for MH/DD/SA Development
Department of Health and Human Services

December 8, 2010

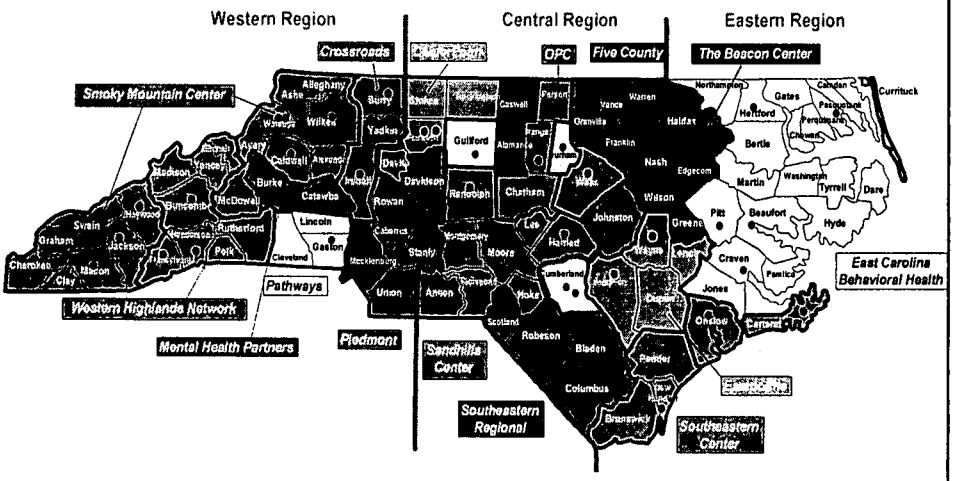
1

Mobile Crisis Team

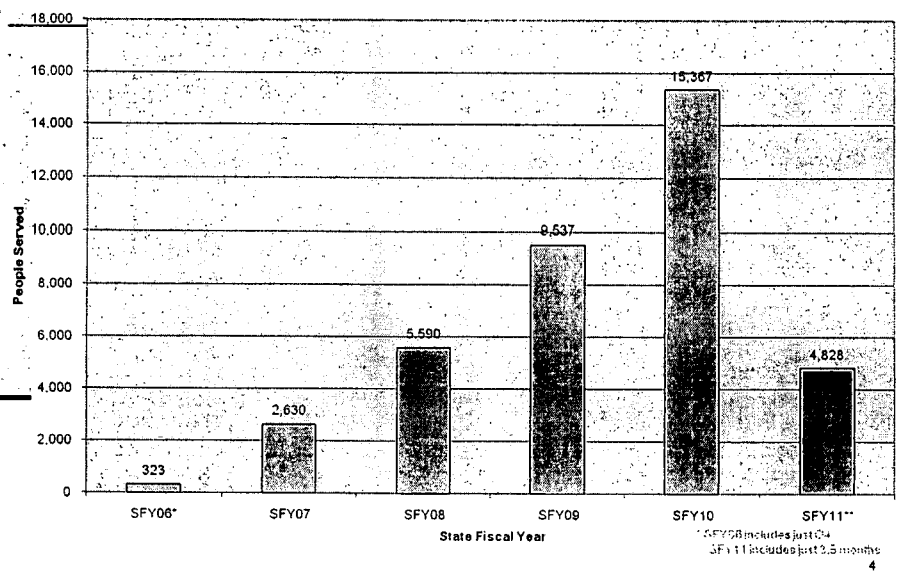
- Service Definition approved in 2006
- First state appropriation in 2008
- Funded by state funds and Medicaid fee for service
- Critical component in crisis service array
- Available 24/7/365
- Meet the individual where they are – as close to a persons home as possible
- Goal is to avoid Emergency Room or Inpatient admission
- Currently 41 Teams covering all counties

2

North Carolina Regional Mobile Crisis Teams



Mobile Crisis Management
Growth in People Served: Medicaid & IPRS Combined

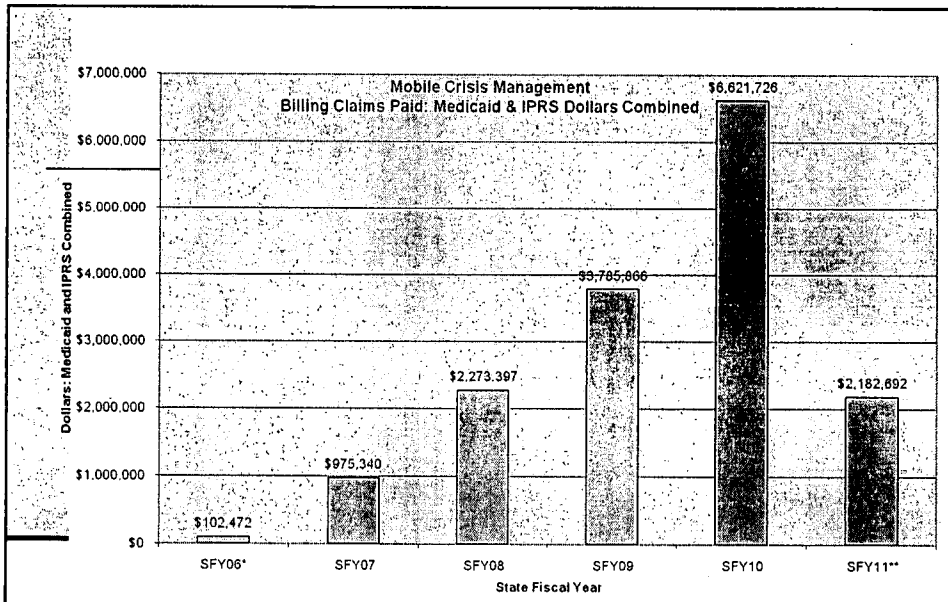


*SFY06 includes just Q4
**SFY11 includes just 3.5 months

Mobile Crisis Funding

- Recurring state allocations
  - $5.7 million
- Medicaid fee for service
  - $3.1 million
- IPRS
  - $3.6 million
- Non-allocated non-UCR funds
  - $3.8 million

  Cost per episode of care approximately $552



*SFY06 includes last Q4
**SFY11 includes just 2.5 months

Mobile Crisis Team Staffing

- Psychiatrist availability
- Substance Abuse staff (CCS,CSAC,CCAS)
- QP who is a Nurse, CSW, or Psychologist
- QP or AP with experience in Developmental Disabilities
- Other team members may be non-licensed qualified professionals and paraprofessionals

Accessing Mobile Crisis

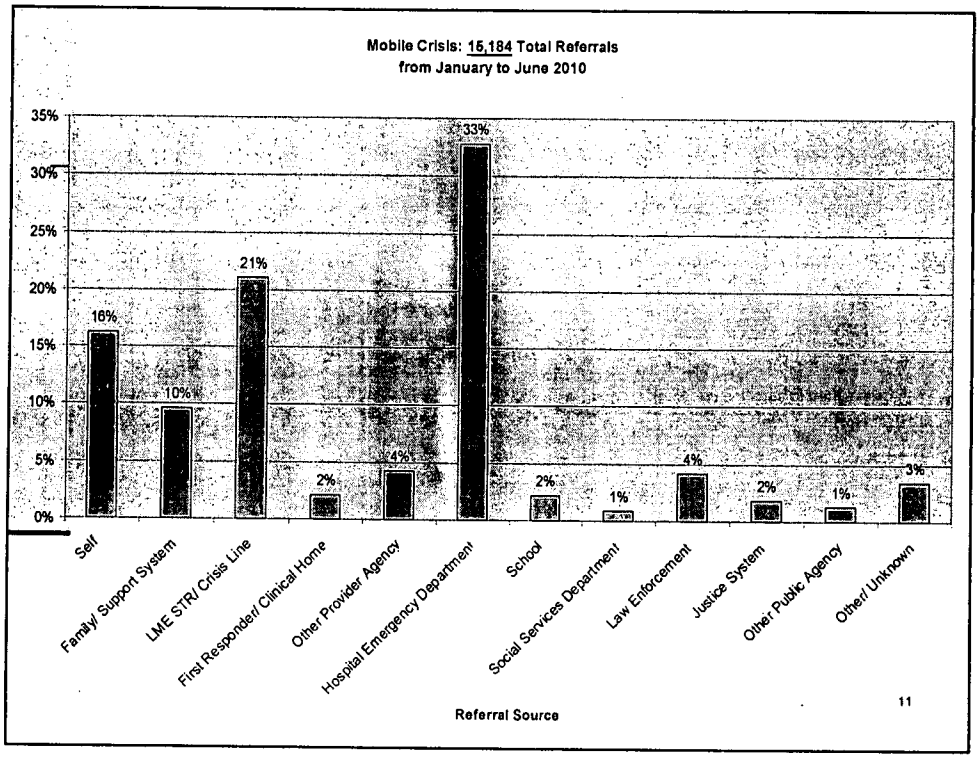
- Crisis Call to LME STR
- Direct Call From
  - Law Enforcement
  - Magistrates
  - Behavioral health providers
  - Non-behavioral health providers
  - Emergency Room

Mobile Crisis Activities

- Provide support to decrease crisis and allow individual to remain in their home
- Crisis Assessment (including assessment of appropriate setting for continued care of patient based on risk factors for danger to self or others
- Recommendations for behavioral management of disruptive behavior
- Coordinate with police Crisis Intervention Teams
- Help locating an inpatient psychiatric bed if needed
- Coordinate services required to discharge an individual from an Emergency Room to community based service
- Facilitate referrals to crisis stabilization resources, or other community intervention services or supports
- Brief Treatment/Intervention
- Development of a Crisis Plan

Response Location

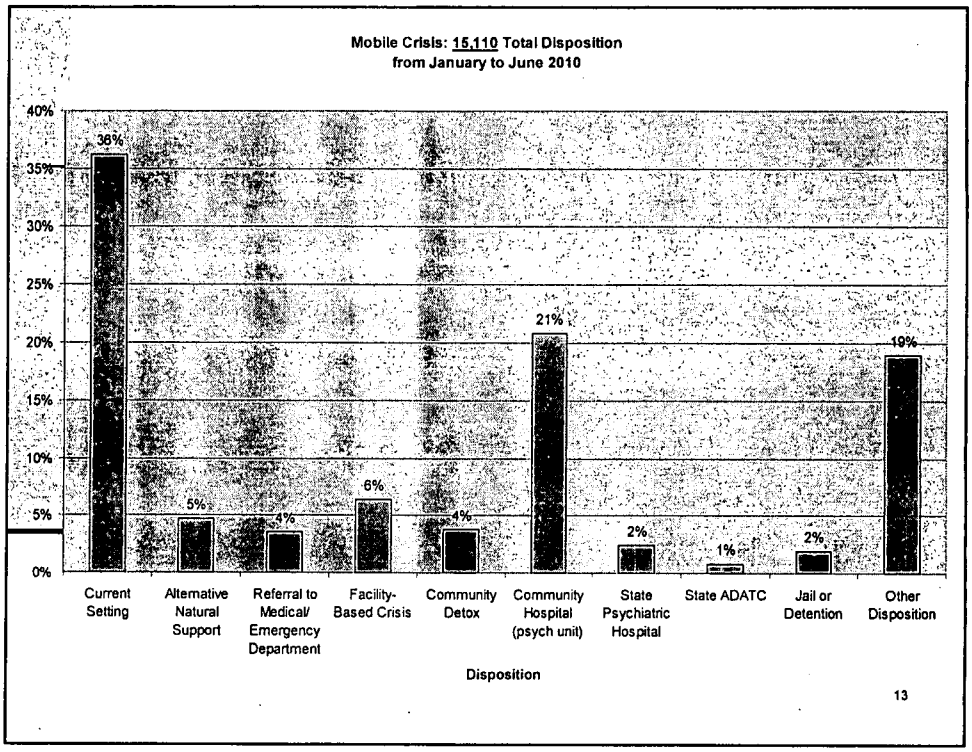
- Individual's home
- Schools
- Magistrate's offices
- Urgent care centers
- Group homes
- Consumer's Home
- Medical/primary care offices
- Emergency departments
- Police stations, jails, and other community sites

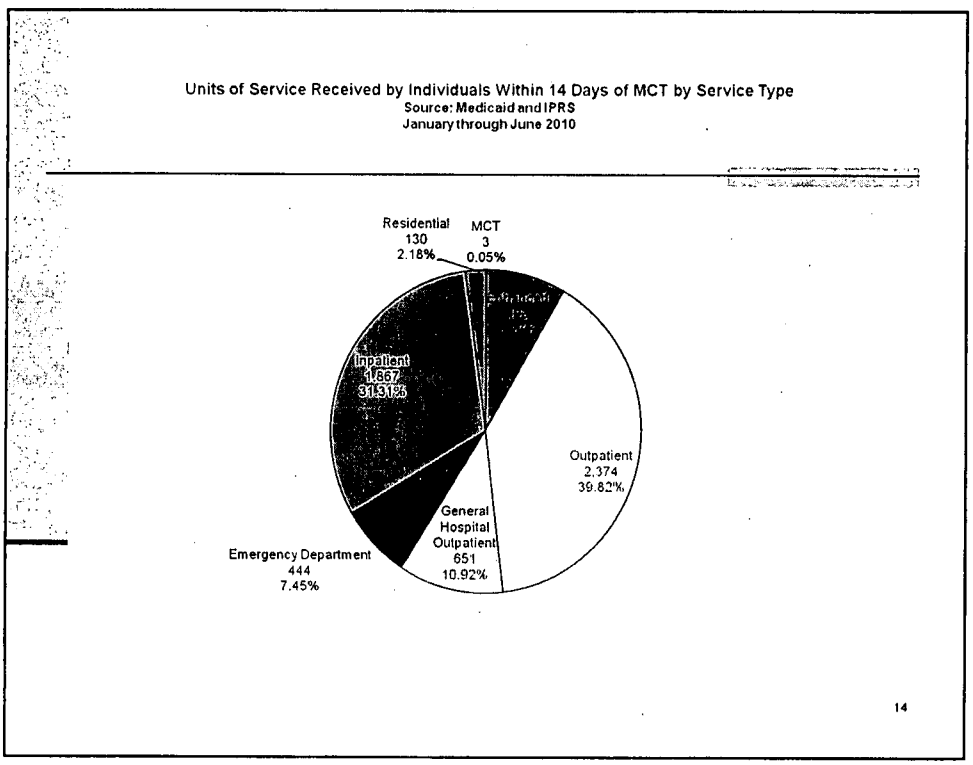


Results of Mobile Crisis Interventions

- 15,110 episodes of service Jan-June, 2010
- Increase from 13,335 episodes of service over the previous 6 months
- 77% of dispositions were to community and 23% to an inpatient setting
- Dispositions to Emergency Department decreased from 5% to 4% from the previous 6 months
- Dispositions to Facility Based Crisis increased to 6% from 5% over the previous 6 months
- Dispositions to Hospital inpatient setting decreased from 31% to 23%

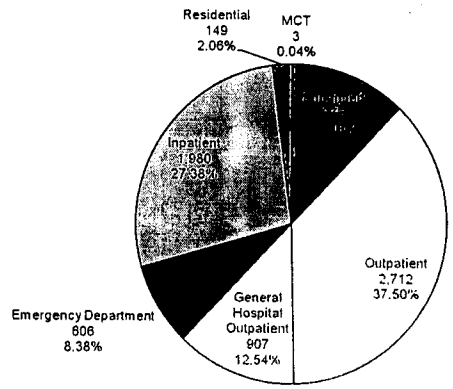
12


Mobile Crisis: 15,110 Total Disposition
from January to June 2010
40%
35%
30%
25%
20%
15%
10%
5%
0%
36%
5%
4%
6%
4%
21%
2%
1%
2%
19%
Current Setting
Alternative Natural Support
Referral to Medical/ Emergency Department
Facility-Based Crisis
Community Detox
Community Hospital (psych unit)
State Psychiatric Hospital
State ADATC
Jail or Detention
Other Disposition
Disposition
13


Units of Service Received by Individuals Within 14 Days of MCT by Service Type
Source: Medicaid and IPRS
January through June 2010
Residential
130
2.18%
MCT
3
0.05%
Inpatient
1,867
31.31%
Outpatient
2,374
39.82%
General Hospital Outpatient
651
10.92%
Emergency Department
444
7.45%
14

Units of Services Received by Individuals Within 30 Days of MCT by Service Type

Source: Medicaid and IPRS January through June 2010
N=8,373



Questions?

Attachment 6

ICF-MR Cost Analysis and Comparison with CAP/MRDD Services

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Steve Jordan, Director,
DMH/DD/SAS

December 08, 2010

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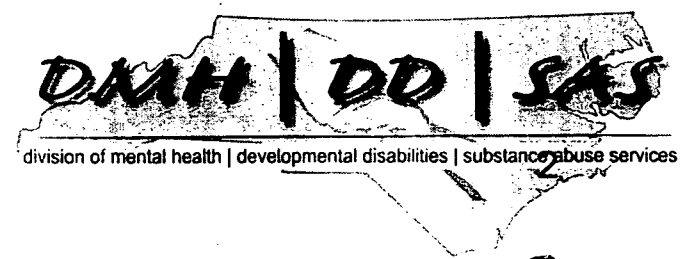
division of mental health | developmental disabilities | substance abuse services

FACILITY vs COMMUNITY SETTINGS COMPARED

- MR/DD
- ICF MR vs. CAP MR



FACTORS CONSIDERED

- State Owned compared to Non-State Owned facilities
- Services included in facility/basic rates plus those acquired outside the facility/basic service
- Impact of ICF MR provider assessments on costs – State vs. Federal

Adults
State Facilities & Community ICF-MR

Adults

ICF-MR Community Facilities	Number of Beds [2] (adult beds defined as 18 years and older)	Number of Unduplicated Medicaid Individuals Served (21 years and older) [3]	Total Medicaid Funds for State-Operated ICFs-MR	Community ICF-MR Rate [4,5]	Other health-care related costs	Total ICF-MR expenditures plus other health care related costs [6]	Total Reciepts (Federal & Other Funds) [7]	Total State Funds [8]	Average Cost Per Unduplicated Medicaid Recipant
State Operated -									
J Iverson Riddle	325	293	44,418,275	466.32	462,561	51,791,433	50,874,725	916,708	176,763
Murdoch Center	526	487	74,764,533	487.32	428,569	80,297,028	77,004,850	3,292,178	164,881
Caswell Center	430	417	77,127,639	566.32	782,006	81,552,804	77,434,387	4,118,417	195,570
O'Berry Center	284	265	42,225,075	509.64	540,710	52,570,030	50,982,415	1,587,615	198,377
Community ICFs-MR									
32 bed or larger	253	324	27,310,317	254.08	1,838,387	29,148,703	21,821,448	7,327,255	89,965
<31 beds	1,983	2,010	184,595,600	267.65	12,927,873	197,523,473	147,871,010	49,652,463	98,270
Medically Fragile	141	Included in above		N/A		Included in above			

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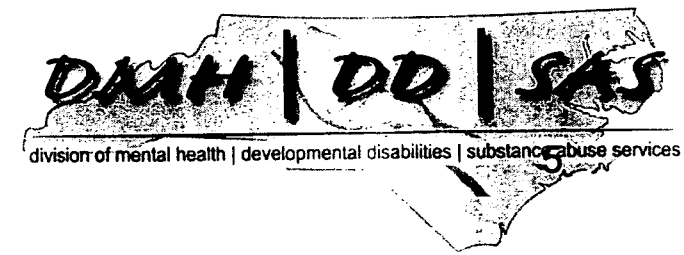
Children
State Facilities & Community ICF-MR

Children

ICF-MR Community Facilities	Number of Beds (children beds defined as less than 18 years)	Number of Unduplicated Medicaid Individuals Served (less than 21 years)	Total Medicaid Funds for State-Operated ICFs-MR		Community ICF-MR Rate	Other health-care related costs	Total ICF-MR expenditures plus other health care related costs [6]	Total Reciepts (Federal & Other Funds) [6]	Total State Funds	Average Cost Per Unduplicated Medicaid Recipant
State Operated -										
J Iverson Riddle - First In Families	0	7	787,177		466.32	5,140	1,790,841	1,759,143	31,698	255,834
Murdoch Center - BART & STARS	42	47	4,771,508		487.32	989,543	7,439,178	7,134,172	305,006	158,280
Community ICFs-MR										
32 bed or larger	73	130	12,340,559		254.08	1,873,124	14,213,683	10,640,718	3,572,965	109,336
< 31 beds	118	308	27,310,317		267.65	9,086,591	36,396,908	27,247,635	9,149,273	118,172
Medically Fragile	50	Included in above			N/A		Included in above			



CAP-MR/DD Children & Adults

CAP-MR/DD	All CAP Comprehensive Waiver Expenditures	All CAP Supports Waiver Expenditures	Allowable One-time Costs (above the capitated amount)		Other health-care related costs	State Service Funds suppporting room and board & other services for Non Thomas S 6	State Service Funds suppporting former Thomas S class members on CAP 6	Unduplicated Recipants	Average Cost per unduplicated CAP/MR/DD reciepient
Adults (18 years and older)	389,380,821	1,158,982	N/A		78065016	6081784	5782208	7142	67,274
Children (less than 18 years)	96,715,751	1,300,440	N/A		57380397	571614	0	3629	42,978

Data Source: Division of Medical Assistance DRIVE or Rate setting , unless otherwise noted

1 State Operated ICF/MR bed number source : Division of State Operated Healthcare Facilities

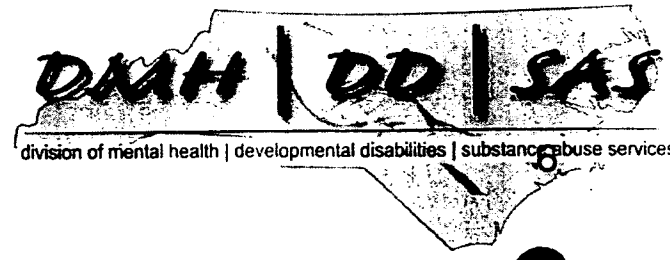
2 Community ICF/MR bed number source: Division of Health Services Regulations

3 Column B and Column C use different age groups; for instance there are recipitants classified as "children" - 21 years in Riddle and Caswell neither of which have children beds

4 Rates for Riddle, Murdoch and Caswell are the facility- specific rate effective 11/01/09; rates for the community facilities are an average of facility-specific rates

5 O'Berry rate is blended due to 3 rates for SFY 2010, current rate which was effective 11/01/09 is $523.32

6 Datasource: Division of Mental Health, Developmental Disabilities and Substance Abuse Services



CAP MR – ICF/MR

	CAP MR	ICF MR - NSO	ICF MR - SO **
Basic Services	$ 45,959	$ 90,149	$ 162,119
Medications	2,708	2,726	
Inpatient Hospital	764	2,237	478
Hospital Outpatient/ER	595	617	861
Physician	768	1,091	1,067
Case Management	3,422		
Nonphysician Practitioners	1,641		
Home Health/PCS	1,016		
DME	814	-	-
Annual Cost Per Recipient	$ 57,686	$ 96,821	$ 164,525
TOTAL RECIPIENTS	10,771	2,692	1,517

** - *STATE OWNED COST ESTIMATED*

Comparison based on Total dollars expended

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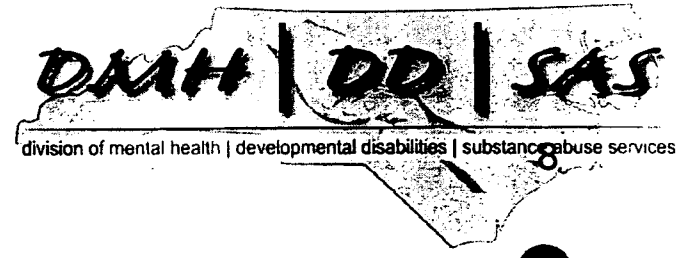
PROVIDER ASSESSMENTS

- Since 1991 CMS has allowed states to assessment/providers
- "Tests" must be met or fit within a "safe harbor" with a maximum assessment of 5 ½%
- Assessment on non-Medicare net patient revenue
- Assessments are allowed to be used to increase rates to providers – amounts leveraged by Federal match
- The result is a mechanism the increase payments to approved providers without raising cost to the state
- Currently Nursing Homes and ICF-MR's only providers with an assessment approved.



STATE DOLLAR COMPARISON

	CAP MR	*ICF MR - NSO*	*ICF MR - SO*
Basic Services - Total	$ 45,959	$ 90,149	$ 162,119
State Dollars	$ 16,086	$ 31,552	$ 56,742
Less Assessment	-	(1,008)	(3,645)
Net Cost to NC	$ 16,086	$ 27,544	$ 53,097
Other Costs	4,104	2,335	842
TOTAL NC COST	**$ 20,190**	**$ 29,879**	**$ 53,939**

State owned costs estimated

DMH | DD | SAS

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NC Department of Health and Human Services
Division of **Medical Assistance**

north carolina medicaid

Update on Medicaid Utilization Review (UR)
Joint Legislative Oversight Committee on MH/DD/SAS
December 8, 2010

Kelly Crosbie, LCSW
Behavioral Health Manager
Division of Medical Assistance

Division of **Medical Assistance**

north carolina medicaid

Utilization Review (UR) by LMEs

- Legislation mandate -General Assembly Session Law 2008-10 (HB 2436, Section 10.15(x))
- **Return Utilization Review to LMEs as they become ready**

Division of **Medical Assistance**

north carolina medicaid

Medicaid Utilization Review (UR) for Mental Health (MH), Substance Abuse (SA), and CAP services

CURRENT

Division of **Medical Assistance**

north carolina medicaid

UR for Mental Health, Substance Abuse, CAP services

September 20, 2010

- **The Durham Center**
- **Eastpointe LME**
  - UR for all recipients with eligibility in their respective county catchment areas
  - Also responsible for mediations
- **ValueOptions does UR for rest of the state** (excluding PBH)
- **DMA monitors all UR vendors**
  - VO—2 monitoring visits in Fall 2010
  - LMEs will have first monitoring visits in Jan 2011

Division of **Medical Assistance**

north carolina medicaid

Medicaid Utilization Review (UR) for CAP Waiver services

JANUARY 2010

Division of **Medical Assistance**

north carolina medicaid

UR for CAP Services

- Effective January 20, 2011, ValueOptions, will no longer be responsible for the UR for CAP-MR/DD waiver services
- *The Durham Center & Eastpointe will continue UR for CAP services in their catchment areas

Division of **Medical Assistance**

north carolina medicaid

UR for CAP Services—Selection of LME Vendors

- **DMA, in collaboration with DMHDDSAS, sent an RFA packet to all LMEs October 1, 2010**
  - requirements necessary to be a CAP UR vendor
  - Interested LMEs required to respond by October 18
  - If an LME chose to opt-out, they could choose the LME that would do the UR for their counties
  - 9 LMEs applied

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UR for CAP Services

- **DMA/DMHDDSAS evaluation team** reviewed applications received
  - Clinical & IT staff
- **Selection letters** were mailed in early November
- **Crossroads and Pathways were chosen**
  - In addition to Durham & Eastpointe
  - All LME counties split among 4 LMEs

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UR for CAP Services

- **All LME counties split among 4 LME UR Vendors**

- Crossroads: CenterPoint, WHN
- Durham: Guilford, Wake, A/C, Five County, OPC, Sandhills
- Eastpointe: Beacon Center, Cumberland, Johnston, SER, OCBHS, SEC, ECBH
- Pathways: Mecklenburg, Mental Health Partners, Smoky Mountain

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UR for CAP Services

- **DMA conducted IT training in November 2010**
- **DMA/DMHDDAS will conduct clinical and due process (mediation) trainings with the LMEs December 6-10**
- **IT testing: Dec 15-22**
  - Accept files from HP/transmit files to HP
- **Clinical testing: Dec 15-22**
  - Inter-rater reliability
- **Attend OAH hearings with DMA** in December
- **DMA/DMHDDSAS working with 4 LMEs & ValueOptions on a transition plan**

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UR for CAP Services

- **LMEs must develop a provider training package** and submit to DMA/DMHDDSAS for approval by December 28, 2010
  - LMEs will train providers the week of January 3-14, 2011
    - Face-to-face, webinars
  - **DMA/DMHDDSAS will publish Special IU** with directions for providers
  - **Only LMEs will provide CAP UR as of January 20, 2010**

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Questions

NC Department of Health and Human Services
Division of **Medical Assistance**

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Update on Traumatic Brain Injury (TBI) Waiver
Joint Legislative Oversight Committee on MH/DD/SAS
December 8, 2010

Kelly Crosbie, LCSW
Behavioral Health Manager
Division of Medical Assistance

Division of **Medical Assistance**

north carolina medicaid

TBI Waiver History

Session Law 2009-451, SECTION 10.72A.(a)

The Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report on the feasibility and efficacy of applying for Medicaid waivers from the Centers for Medicare and Medicaid Services. The report shall recommend whether the following waivers should be pursued and the reasons therefore:

- ....(3) A 1915(c) waiver to permit individuals who sustain traumatic brain injury after age 22 to access home and community-based Medicaid services. The report and recommendation shall include the estimated cost to implement the waiver.

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Development of TBI Waiver Study

- **Brain Injury Advisory Committee**
  - consumers, families, advocates, providers
- **DMA/DMHDDAS submitted report to General Assembly on 12/1/2010**
  - Brain Injury Advisory Committee reviewed report
- **Unanimous support to pursue 1915 (c) wavier for individuals with TBI**

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TBI Waiver Study

- **~160,000 survivors or TBI in NC**
- **Long term service needs:**
  - Financial support
  - Community services
  - Professional and agency knowledge of available TBI services
  - Education of professionals working with TBI
  - Housing
  - transportation

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TBI Waiver Study

TBI Waiver Purpose

- Community alternative for individuals with TBI who reside in nursing facilities or
- Individuals with TBI in community who are at risk for placement in a nursing facility
- Reintegrate & maintain individual in the community
- Receive targeted TBI services and supports

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TBI Waiver Study

Target Population

- TBI after age 22
- Meets nursing level of care criteria
- Cognitive, behavioral and physical deficits
- Rating of 5+ on Rancho Los Amigos Level of Cognitive Functioning Scale
- Function limitations in major life activities
- Care/treatment needs for extended duration

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TBI Waiver Study

TBI Waiver Cost Projections

- Maximum of 200 recipients served—gradual build-up of slots
- Maximum annual cost of $90,000
- Average annual cost of $67,000/recipient
- SFY 2010 $$612,000
- SFY 2011 $1.2 million
- SFY 2012 $2.4 million
- SFY 2013 $3.6 million
- SFY 2014 $4.8 million

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TBI Waiver Study

Suggested TBI Service Array (includes):

- Case Management
- Structured Day Programs
- Respite Care
- In-home/Residential Services
- Environmental & Vehicle Modifications
- Family & Caregiver Trainings
- Supported Employment
- PT, OT, MH/SA clinical services

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TBI Waiver Study

TBI Waiver Start-Date

- State Appropriation
- New MMIS system
- CMS approval of 1915(c) waiver
- Development of service array in community

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Questions

Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, & Substance Abuse Services
AGENDA
January 19, 2011
9:30A.M. Room 643, Legislative Office Building
Representative Verla Insko, Co-Chair, Presiding

9:30 **Welcome and Opening Remarks**	*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*
9:30-10:00 **CABHA Update**	*Beth Melcher, Ph.D., Assistant Secretary for Mental Health, Developmental Disabilities & Substance Abuse Services Development, DHHS*
10:00-10:30 **LME Medicaid Utilization Management**	*Anna North, Eastpointe* *Ellen S. Holliman, Area Director, The Durham Center*
10:30-11:00 **Residential Services for Children Ages 0-6 with Developmental Disabilities**	*Deborah Carroll, Ph.D., Head of Early Intervention Branch, Women & Children's Health Section, Division of Public Health* *Rose Burnett, DD Project Manager, Division of Mental Health, Developmental Disabilities & Substance Abuse Services*
11:00-11:30 **Draft Report & Committee Discussion**	
11:30 **Final Remarks & Adjournment**	

ATTENDANCE

Joint Legislative Committee on Mental Health, Developmental Disabilities and Substance Abuse

DATES / MEMBERSHIP	1/12/11															
Senator Martin Nesbitt, Co-Chair	√															
Senator Austin Allran	√															
Senator Bob Atwater	√															
Senator Doug Berger	X															
Senator Charlie Dannelly	√															
Senator Jim Forrester	X															
Senator Ellie Kinnaird	√															
Senator William Purcell	√															
Representative Verla Insko – Co-Chair	√															
Representative Martha Alexander	√															
Representative Jeffrey Barnhart	√															
Representative Beverly Earle	√															
Representative Bob England	X															
Rep. Jean Farmer-Butterfield	√															
Representative Carolyn Justus	X															
Representative Fred Steen	√															
STAFF																
Rennie Hobby	√															
Joyce Jones	√															
Shawn Parker	√															
Susan Barham	√															
Ben Popkin																
Lisa Hollowell	√															
Gann Watson																
Janice Paul	√															
ADVISORY MEMBERS																
Senator Larry Shaw	X															
Representative Van Braxton	X															
Representative William Brisson	√															

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

January 19, 2011
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, January 19, 2011 in Room 643 of the Legislative Office Building. Members present were: Senator Martin Nesbitt and Representative Verla Insko, Co-Chairs; Senators Austin Allran, Bob Atwater, Charlie Dannelly, Ellie Kinnaird and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Jean Farmer-Butterfield, and Fred Steen. Advisory member, William Brisson was present. Also in attendance were Representatives Pat Hurley and Justin Burr.

Lisa Hollowell, Joyce Jones, Shawn Parker, Jan Paul, Susan Barham, and Rennie Hobby provided staff support to the meeting. Also in attendance was Dr. Patricia Porter, consultant to the LOC. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. Representative Insko commented that this was the end of an era with a number of members having served on the committee for the past ten years. She stated that the system had gone through a number of transitions including moving from 41 area programs to 177 CABHAs across the State. She said that there was still a lot of hard work ahead but that direction had been set for the future. She asked for a motion to approve the minutes from the December 8, 2010 meeting. The motion was made by Senator Purcell and the minutes were approved.

Dr. Beth Melcher, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS, provided an update on the establishment of CABHAs across North Carolina. (See Attachment No. 2) She offered a quick reminder that CABHAs provided mental health and substance abuse services. Dr. Melcher said the bar was set high in order for agencies to be certified as CABHAs, requiring substantial clinical leadership and oversight in an effort to reduce service fragmentation, and to create agencies that could provide comprehensive services for those with complex needs. As of January 1, 2011, only CABHAs can provide Community Support Team, Intensive In-Home, Day Treatment Services, and Targeted Case Management. Other points of interest included:

- There are currently 177 agencies that have been certified as CABHAs. There is a list of those agencies on the DMH/DD/SAS website: http://www.ncdhhs.gov/mhddsas/
- Over 100 applications from agencies to become CABHAs were received after the August 31, 2010 deadline. Of those, 2/3 have had some sort of response. If an agency wants to upgrade and provide more comprehensive services and become a CABHA, they can apply at a later time.

- The map on page 4, indicates the actual number of service requests received for authorization for service, where services are being provided, and the number of CABHAs per county that are providing that service.
- As better daily billing data is available, perhaps in March, the maps will change to actual billing data to show where the services are provided.
- The map on page 5, is an under estimate of people per county where requests came in for services for Community Support Team from CABHAs since the data was collected before the transition of individuals from non-CABHA services to CABHAs.
- Additional maps in the future will depict services outside the CABHA in order to see the range of services provided across the State. This will also offer an opportunity for planning for communities to see how many CABHAs and agencies are providing what services in those communities.

Ellen Holloman, Area Director of The Durham Center provided an update on Medicaid Utilization Management responsibilities being transferred from statewide vendor Value Options to the LMEs. Anna North from Eastpointe was also available to address any questions. (See Attachment No. 3) Points of interest included:

- The transition from Value Options has been very transparent with very few complaints if any from consumers and providers.
- The Durham Center and Eastpointe authorize all funding sources, Medicaid, local, and State.
- Eastpointe and The Durham Center have partnered to develop an IT system that addresses the total need of the UR effort.

Dr. Deborah Carroll, Head of the Early Intervention Branch with the Division of Public Health explained that the Early Intervention Program included the State level offices for the Early Intervention Program and the Children's Developmental Services Agency.

- Families with children with disabilities often do not know where to turn before coming to the facility. They have said that they are thankful for the information provided to them and the state-of-the-art care.
- In 2006, restrictions for eligibility were placed on the program because there were more referrals than resources to serve.
- Service coordination develops a service plan, monitors services, and coordinates and integrates those services for families.
- Services must be provided in a natural environment, a setting that is typical for children age birth to three. Early intervention is imperative in order to provide services that will teach families how to work with their child and support the child's development.
- Many referrals to the Program come from hospitals and Neonatal Intensive Care Units. The Early Intervention Program works with local Health Departments, Child Service Coordination Programs or Home Visiting Programs.
- Families with children with delays not significant enough to be eligible for the program are often referred back to the Child Service Coordination Program at the local Health Department or other programs that serve young children.
- Since Early Intervention falls under Public Health there is a financial advantage. The Title Five Agency of the Social Security Act allows the program to access cost settlement

for services provided to the children. This year the amount is approximately $21M to the program.

Next, Rose Burnett, DD Project Manager with the Division of MH/DD/SAS provided information on residential options for children with intellectual/developmental disabilities ages birth through 6 years. (See Attachment No. 5) She provided the following additional points:

- When looking at the overall population for those in North Carolina with intellectual and developmental disabilities statistics indicate that 59% live with families or a family member or guardian followed by 14% who reside in group homes. The remainders are in different settings.
- Children age 0 to 6 living in ICF-MR facilities or private or State funded facilities have needs that are so extensive that families are not able to meet their needs. ICF-MR and State DD facilities are Medicaid eligible and monitoring is provided by the Division of Health Services Regulation.
- Data as of November 2010 showed that Horizon's Residential Center with a capacity of 30 was serving one child in the birth to 6 age group. RHA/Howells Care Centers have a capacity of 26 children (ages 0-6) living in their facilities. Of the RHA Homes, Walnut Creek has 5 children; Bear Creek has 1 child; River Bend has 2 children; and Tar River has 16 children.
- The cost for the 28 children in the ICF-MR facilities is approximately $4M per year.
- The Hill Top Home in Raleigh has a capacity for 22 children. They are a specialized community residential service serving children who are medically fragile and have severe to profound intellectual disabilities. The current facility is not ICF-MR but a new home is under construction that will meet the ICF-MR regulations. The new facility will accommodate the transfer of 22 beds from the O'Berry Developmental Center. Once the facility becomes ICF-MR eligible the children will be Medicaid funded.

Representative Insko reviewed each of the twelve 2010-2011 recommendations to be included in the LOC report to the General Assembly. (See Attachment No. 6) The Committee as a whole discussed each of the recommendations. Changes to the recommendations included:

#3) Representative Barnhart recommended the removal of "additional __ beds" and to insert "purchase additional beds."

#4) Change October 10, "2010" to October 10, "2011."

#8) Representative Farmer Butterfield recommended two additions to #8 –"People who directly allocate the resources will not be doing the assessments." And, "Upon the recommendation of the Department and with the approval of the General Assembly, the Department may add additional tiers."

Senator Kinnaird requested that the Committee insert an additional recommendation that DHHS submit a report by September 2011 on the Clubhouse model; including a description of the types of Clubhouse programs in North Carolina, the services available, the actual cost of services provided by the different Clubhouses, and the current reimbursement rate for those Clubhouses. The Committee voted to approve the recommendation.

Senator Atwater requested to have on record the recommendation that if the Dorothea Dix property were to be sold that the proceeds from the sale go to the existing State Mental Health Trust Fund. Several members of the Committee were concerned that there had not been a presentation on the issue to the LOC in order to make a recommendation. A motion was made by Senator Dannelly that the language be included in the report. The Committee voted on the motion and the motion failed with a vote of 6 to 5.

After discussion and debate, Representative Insko requested a motion to approve the draft report. Representative Earle made the motion, seconded by Representative Alexander and the Committee approved the draft report.

In closing, Senator Nesbitt expressed appreciation to the Committee for all of the hard work that has been done over the years. He stated that the LOC has made a lot of progress and that it will continue to be necessary to have oversight over a system that is still trying to be developed. He said that there are those that are constantly trying to change the system. He expressed concern that private vendors were trying to get into the b-c waiver and there is constant concern whether the DD population will be in the b-c waiver. He said that these and other issues needed to have oversight or the vested interest groups would pull the system apart and leave people in a system where their needs are not being met. Senator Nesbitt added that there was a proposal to put mental health under a committee for DHHS. He expressed concern that mental health would not get the attention that it deserves under those conditions. He anticipated that in a few years when the economy improved, the system could be a great system operating on its own without oversight.

There being no further business, the meeting adjourned at 11:25 A.M.

Martin Nesbitt
Senator Martin Nesbitt, Co-Chair

Verla Insko
Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

Attachment 1

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ellen Noel	Durham Center, Durham, NC
Gerry Akland	NAMI WAKE
Martha Brock	Examiner.com / Raleigh Cmedia
Billy West	DATAWAVE Recovery
Kristi Huff	NCHCFA
Paula Ortishman	Volunteer Advocate + Sister of Adult with DD
Kenneth L Yancey	Hearing Interpreters
PAIGE WORSHAM	Legislative Reporting Service
Bebe Smith	UNC Psychiatry Center for Excellence in Community MH
Jeanette Jordan-Hoffman	Southeastern Regional LME
Kathy S Baker	" " "

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kate Fraser	Club Nova Community, Inc Carrboro, NC
Ronnie P. Dobie	Threshold Durham, N.C.
[illegible]	Threshold
Tanya Pace	Club Nova Carrboro, NC
Jerome Galbreath	Club Nova Carr. NC.
Shannon [illegible]	Threshold Clubhouse
[illegible]	[illegible]
Mary Slade	Club Nova Carrboro, NC
LARRY LEE GRANT	Threshold/Durham, N.C.
Alex Harrison	Club Nova 1130 West Main St Carrboro 27510
Mary Powell	NC Substance Abuse Federation

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann McColl	State Bd. of Education
KATHLEEN HERR	Law Student
Clarissa Goodlett	Governor's Institute on Alcohol & Substance Abuse
Will Woodell	Value Options
Sarah Pfau	Disability Rights NC
Louise Jordan	Nami Wake
Daphne Lyon	OERI
Cim Brailer	OPC LME
Bill Hussey	Hammer-Burlington School System
JOE SIMMONS	Department of Public Instruction
VICTORIA WHITE	Sandhills Center

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin Huffman	NC Psychiatric Assoc.
Mike Vicario	NCHA
Lorraine Woodward	Woodward Communications
Adell Sanchez	advocate
Deborah Carroll	Dir. Public Health
Amy Funderburk	NC AOC
Jesse Goodman	DHHS
Bill Hussey	ABSS - Public Schools
Sally Cameron	NC Psychological Assoc
John Falk	Kate B. Reynolds Charitable Trust
James Wells	Citizen Advocate

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Wolfe	Parker Poe
John Burdick	Astra Zeneca
Joe Lanier	Nelson Mullins
[signature]	"
Nena Lekwauwa	DMH DD SAS
Gina Price	DVRS
Jesse Gudmon	DHHS
Tom Meece	Meece Consulting
Cynthia Williams	NCDOC - DCC
Treva Johnson	Omni Visions
Crystal Runnemaker	Omni Visions

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andrew Meehan	Capstrat
Michelle Fiorier	MFS
Jeff Engel	DHHS/Public Health
John McMillan	MFS
Patty Maguire	GR
BRIAN INGRAHAM	SMOOT
Myron Arscott	Crescent
Duncan Sawyer	Appalachian Community Services
Michelle Wilkie-Baker	DAAS
FRANK EDWARDS	SCFAC
Emily Carmody	NC Coalition to End Homelessness

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Parque	Ralph Scott Lifeservices Inc.
Bennie Kidd	Ralph Scott Lifeservices, Inc
Beth Stalvey	NC Council for Developmental Disabilities
Nelly Alemoff	NAMI NC
Erica Nelson	NCCCP
Julia Adams	The Arc of NC
Lyza Sammergon	ECBH
Ryan Wood	Wake Co
Bob Canupp	Eastpointe LME
Christal Wood	Eastpointe LME
Anna North	Eastpointe LME

VISITOR REGISTRATION SHEET

Name of Committee

1-19-11
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wilford B. Harris	General Assembly Intern
Don Kaade	Threshold, Inc
Allison Jourdan	DOC/DCL
Katherine Tiller	Club Nova Community Inc 105 N Columbia St Carrboro NC 27510
Erin Spence	Club Nova
Elena Fowler	Club Nova
Sam Sinclair	Durham Center
Rob Ingram	Durham Center

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jodi Mann	CAPM - Assoc
Dan Lawson	PBH
Lu-Ann C Brewer	NCPA
Lanni Cohen	NC CANSO - consumer
Stephanie Alexander	DHSR

VISITOR REGISTRATION SHEET

1-19-11

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emily Pierce	Club Nata 1030 W Main St, Carrboro, NC 27510
Gary Robertson	AP

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on MH/DD/SAS January 19, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Manay Gupta	Club Horizon, Inc. 101-B Forest Drive Knightdale NC 27545

CABHA Update

Legislative Oversight Committee on MH/DD/SAS
Beth Melcher, Ph.D.
January 19, 2011

CABHA Requirements

- Active National Accreditation of at least 3 years
- Medical Director
- Clinical Director
- Quality Management/Staff Training Director
- Continuum of care for population served

Must provide the core services of:

- Comprehensive Clinical Assessment
- Medication Management
- Outpatient Therapy

Must deliver at least two enhanced services in the same location where it provides the three core services to create a continuum of care

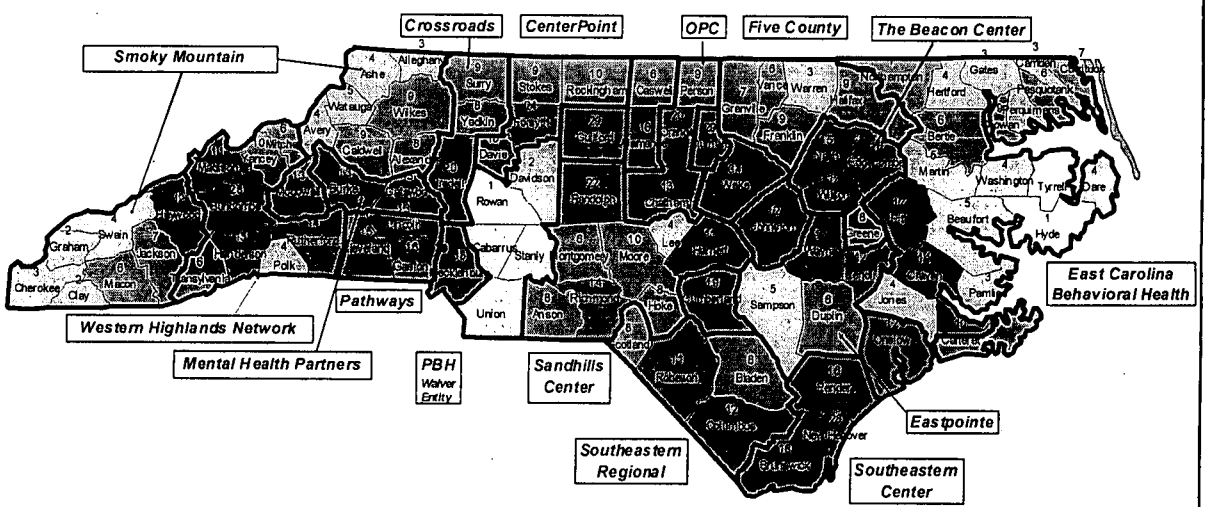
2

The Numbers

- 175 agencies have been certified as CABHAs. http://www.ncdhhs.gov/mhddsas/cabha/index.htm
- A total of 603 applications were received prior to August 31, 2010
- 104 applications came in after the deadline. 53 of those have had some sort of review/response and remainder will be processed based on date of submission

3

Home Counties of Individuals Served by Fully Certified CABHAs with Community Support Team, Day Treatment and/or Intensive In-Home Services as of December 3, 2010

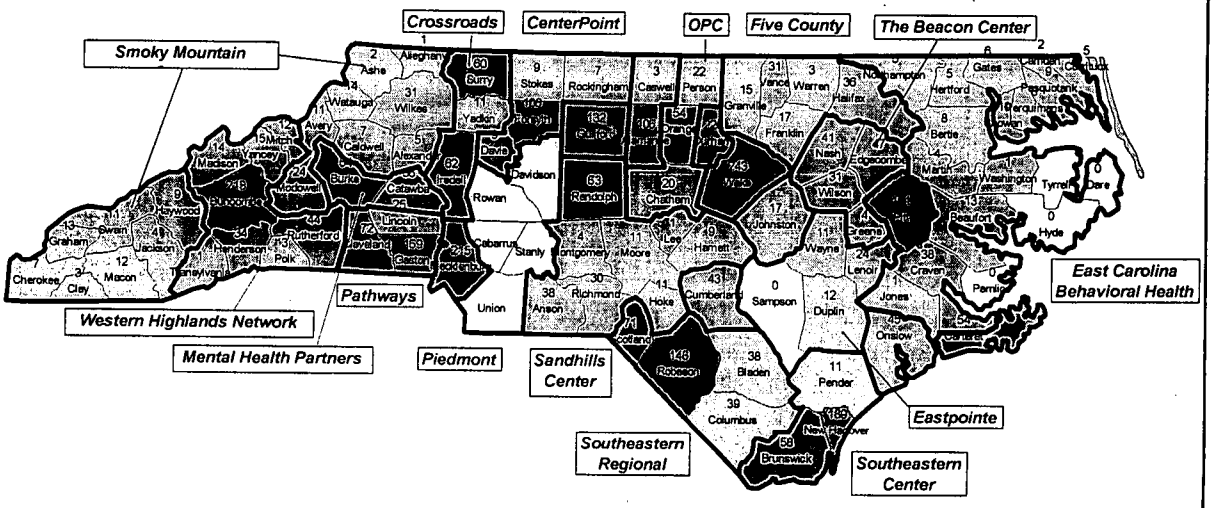


Number of CABHAs Serving Individuals	
0	1 county
1	2 counties
2 to 5	22 counties
6 to 10	34 counties
11 plus	38 counties
No data	3 counties

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010
Based on authorizations provided by ValueOptions, except for PBH.

4

Individuals Authorized to Receive Community Support Team Services in Home County by a Fully Certified CABHA during the month of November 2010



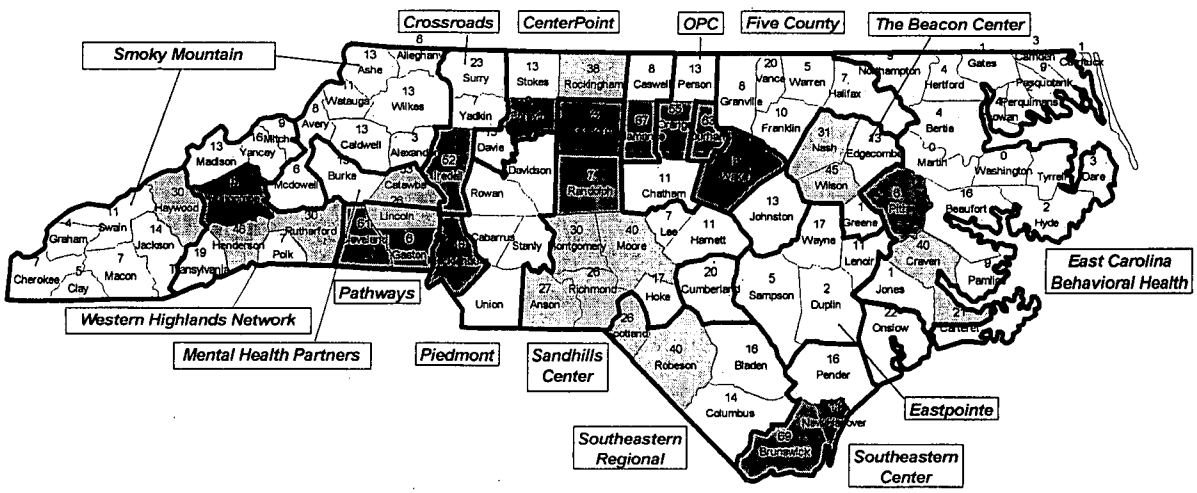
 # Individuals receiving CST from a CABHA

- ☐ 0 individuals, 4 counties 6.3%
- ☐ 1 to 25 individuals, 54 counties 56.3%
- ☐ 26 to 50 individuals, 16 counties 16.7%
- ■ 51 to 75 individuals, 9 counties 9.4%
- ■ 76 or more individuals, 11 counties 11.5%
- ☐ PBH - no data available

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010

5

Individuals Authorized to Receive Intensive In-Home Services in Home County by a Fully Certified CABHA during the month of November 2010



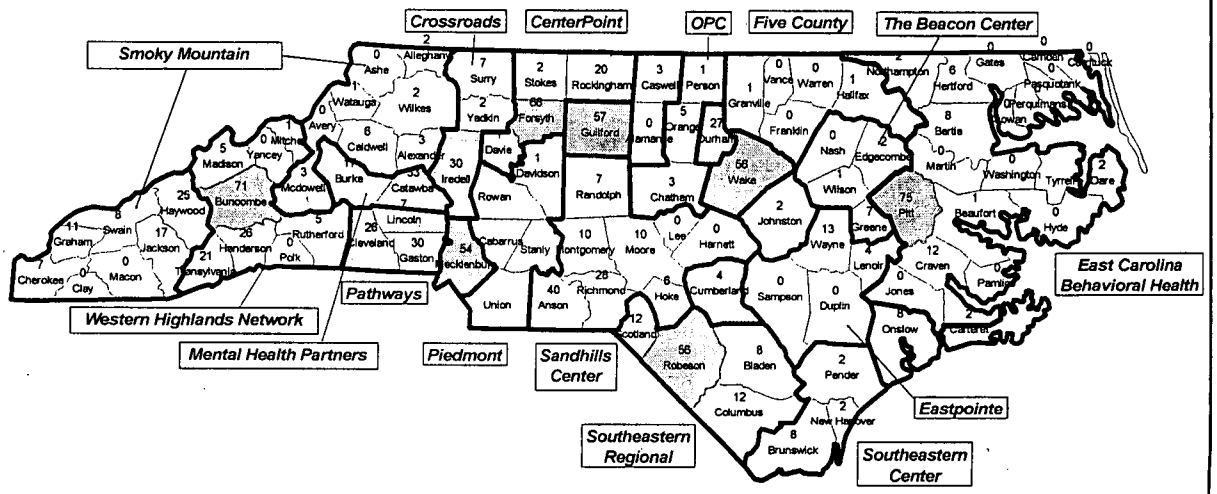
 # Individuals receiving IIH from a CABHA

- ☐ 0 individuals, 4 counties
- ☐ 1 to 25 individuals, 62 counties
- ▨ 26 to 50 individuals, 15 counties
- ■ 51 to 75 individuals, 6 counties
- ■ 76 or more individuals, 0 counties
- ☐ PBH - no data available

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010

6

Individuals Authorized to Receive Day Treatment Services in Home County by a Fully Certified CABHA during the month of November 2010



 # Individuals receiving Day Tx from a CABHA

- ☐ 0 individuals, 27 counties 28.4%
- ☐ 1 to 25 individuals, 53 counties 55.8%
- ☐ 26 to 50 individuals, 8 counties 8.4%
- ☐ 51 to 75 individuals, 7 counties 7.4%
- ■ 76 or more individuals, 0 counties 0.0%
- ☐ PBH - no data available

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010

7

Notes

- Information presented in the maps through November. Have increased numbers of CABHAs since then and anticipate increase in numbers of individuals served by CABHAs following January 1st
- Fewer day treatment providers as many agencies have found is more effective to offer in-home services

8

Next Steps

- In collaboration with the LMEs, follow transition of individuals to CABHAs to assure is successful and appropriate
- Expectation that will be fluctuation in number of CABHAs and services they offer as market responds to demand
- Review the CABHA cost model and regulatory requirements to support fiscal stability
- Regional meetings with CABHAs and LMEs

9

Next Steps

- CABHA Monitoring
  - Billing and authorization data
  - Quality reports from UM vendors
  - Program Integrity efforts
  - Monitoring Protocol review personal outcoms, leadership, referral patterns, quality management, integration with physical health care,. core services, regulatory compliance. Reviews to begin in Spring.

10

Questions?

11

THE DURHAM CENTER
Managing Behavioral Health & Disability Services

EASTPOINTE

LME Medicaid Utilization Review Project

A Presentation to the
Legislative Oversight Committee on MH/DD/SAS
January 19, 2011

Agenda

- Medicaid Utilization Review (UR) background
- Keys to success
- Benefits of local approval
- Cost of local approval
- CAP UR update
- Information technology update
- Future plans for Durham and Eastpointe

Background

- Legislation (NC Session Law 2008–107, Section 10.15(x)) mandated the return of Medicaid UR to the LMEs from a statewide vendor
- RFP issued, four LMEs selected
- DMA provided training and consultation
- LMEs did technical and clinical testing
- 9/20/10 – The Durham Center and Eastpointe resume all behavioral health UR for consumers in their catchment areas

Keys to Success

- Close working relationship between DMA and DMH and the LME vendors
- Standardization of LME functions
- Community buy-in
- Relationship with provider network
- Unification of LME functions
- Support from ValueOptions

Local Approval is Key

- Increased communication between LMEs and providers
- Authorization conducted for all funding sources
- Integration of System of Care and Care Coordination activities
- Allows more efficient tracking of consumers

Cost of Local Approval

- Rates for other Medicaid services the same as for the statewide vendor
- 15% savings in CAP UR cost conducted by Eastpointe and The Durham Center vs. rates paid to ValueOptions

CAP MR/DD UR

- The Durham Center and Eastpointe became two of four LMEs (Crossroads and Pathways) to conduct CAP MR/DD UR for entire state
- The Durham Center to serve serve 7 LMEs
- Eastpointe to serve 8 LMEs
- Preparations underway for a January 20, 2011 start

Information Technology

- Eastpointe and The Durham Center utilize Netsmart Avatar with ProviderConnect
- Netsmart serves 18,000+ health and human services organizations nationally
- 13 other LMEs currently employ Netsmart software (80% of population)
- Using a web-based system

Workplan for the Future

- Lay successful groundwork for being awarded a Medicaid Waiver contract
- Continue working with Netsmart to establish needed system updates to meet all additional waiver requirements

North Carolina Public Health

Early Intervention Program

Presentation to the Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services

January 19, 2011

Deborah E. Carroll, Ph.D.
Early Intervention Branch Head
DHHS, DPH
Women's and Children's Health Section

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North Carolina Public Health

Early Intervention Program

- **Serves infants and toddlers, birth to 3 years of age, with or at established risk for developmental disabilities or delays**
- **Serves all 100 counties**

2

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North Carolina Public Health

Early Intervention Program

- Entitlement under Part C of the federal Individuals with Disabilities Education Act
- Anyone can refer an infant or toddler who is thought to have a developmental delay

4

North Carolina Public Health

Early Intervention Program

- Pediatricians, families, and others refer to the Children's Developmental Services Agency (CDSA) for their county

5

North Carolina Public Health

Early Intervention Program

- Once a child is referred, CDSA must conduct a developmental evaluation
- Eligibility is based on a significant delay or on an established health condition
- CDSA is required to provide service coordination for each child referred and/or enrolled

6

North Carolina Public Health

Early Intervention Program

- Examples of services provided through EI program include speech-language therapy, physical therapy, assistive technology
- Services are referred to community based providers
- If a qualified provider is not available, the CDSA must provide the service

7

North Carolina Public Health

Early Intervention Program

- Services are provided at the child's home, or at the child's child care
- No residential services are provided or paid for under the Early Intervention program

8

North Carolina Public Health

Early Intervention Program

- CDSAs coordinate with other programs serving the child; no duplication or overlap
- CDSAs develop a transition plan for the child as he or she is leaving the program, often to public school preschool disability program
- Services are monitored at local and state levels; multiple federal requirements

9

North Carolina Public Health

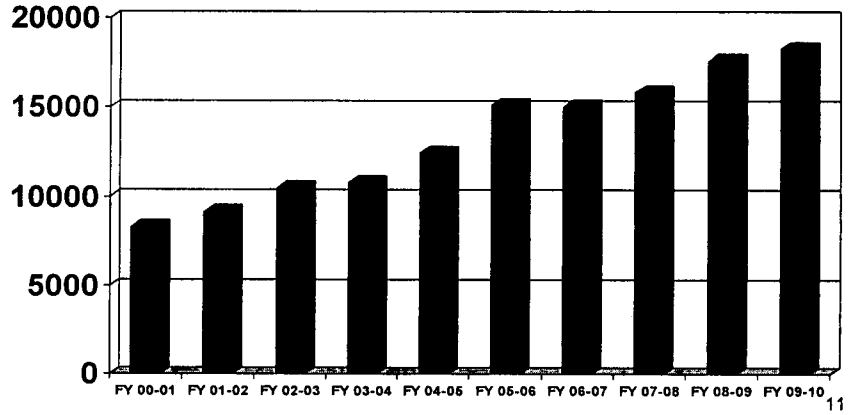
Early Intervention Program

- Focused on early identification and early intervention for infants and toddlers with disabilities
- Key to better results for children and their families

10

North Carolina Public Health

Children Enrolled by Fiscal Year



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North Carolina Public Health

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Residential Options for Children with Intellectual/Developmental Disabilities Ages Birth – 6 years

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Rose Burnette
January 19, 2011

Number of Individuals with Intellectual and Developmental Disabilities who Received Services in State Fiscal year 2010, by Age Groups

Age Groups	# Individuals	Percent
Birth through 6	1,115	4.9%
7 through 10	1,768	7.7%
11 through 13	1,322	5.8%
14 through 17	1,803	7.9%
18 through 24	3,885	16.9%
25 through 34	3,826	16.7%
35 through 44	3,286	14.3%
45 through 54	3,265	14.2%
55 through 64	1,940	8.5%
65 and up	724	3.2%
Total	22,934	100.0%

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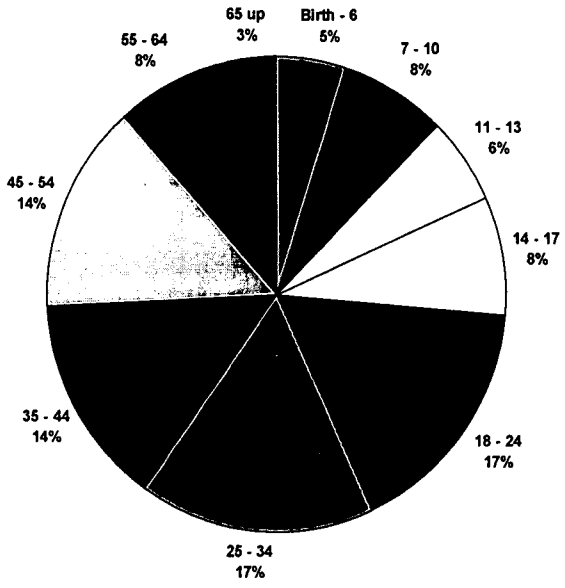
Number of Individuals with Intellectual and Developmental Disabilities who Received Services in State Fiscal year 2010, by Age Groups



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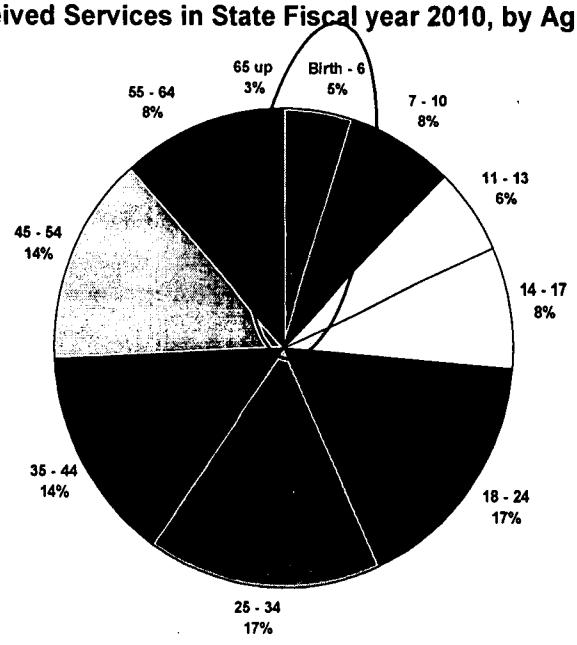
Number of Individuals with Intellectual and Developmental Disabilities who Received Services in State Fiscal year 2010, by Age Groups



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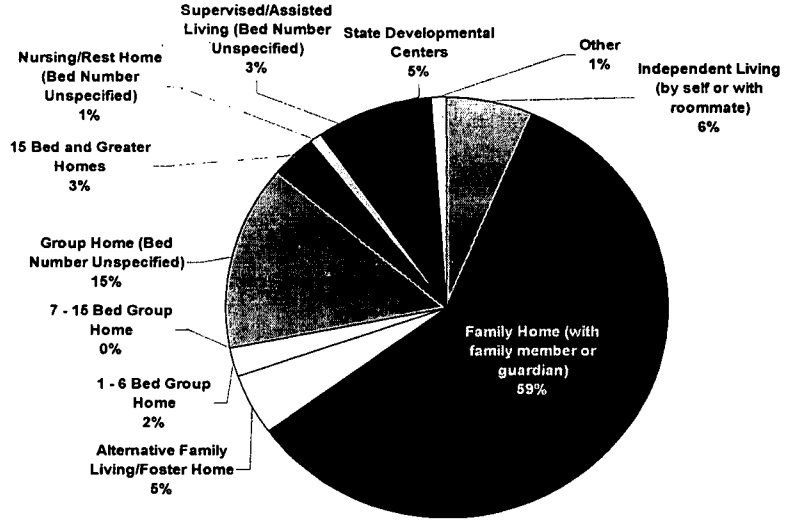
Residential Settings of Individuals with Intellectual and Developmental Disabilities who Received Services in State Fiscal year 2010

Type of Setting	# Individuals	Percent
Independent Living (by self or with roommate)	1,487	6.5%
Family Home (with family member or guardian)	13,395	58.4%
Alternative Family Living/Foster Home	1,128	4.9%
1 - 6 Bed Group Home	470	2.0%
7 - 15 Bed Group Home	27	0.1%
Group Home (Bed Number Unspecified)	3,250	14.2%
15 Bed and Greater Homes	770	3.4%
Nursing/Rest Home (Bed Number Unspecified)	198	0.9%
Supervised/Assisted Living (Bed Number Unspecified)	744	3.2%
State Developmental Centers	1,201	5.2%
Other	259	1.1%
System Missing	5	0.0%
Total	22,934	100.0%

5

Residential Settings of Individuals with Intellectual and Developmental Disabilities who Received Services in State Fiscal year 2010



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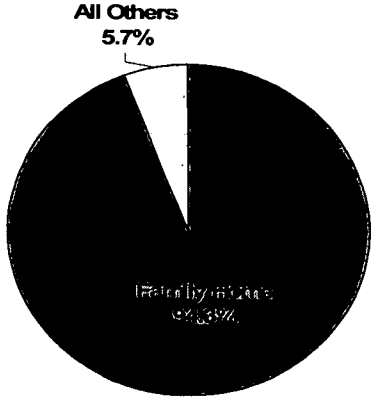
Residential Settings of Children with Intellectual/Developmental Disabilities, ages Birth through Six Who Received Services in SFY 2010

Types of Residential Settings and numbers of children served:

- Total of 1115 children
- Family Home-1051
  - 1 child receiving CAP-MR/DD Home Supports
- Community ICF-MR facilities-28
- State/Private Funded Residential facilities-9
- Other settings (Alternative Family, Foster Homes)-27

7

Residential Placements of Children with Intellectual/Developmental Disabilities, ages Birth through Six Who Received Services in SFY 2010



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What are the Needs of these Children?

- Needs are varied and require a variety of levels of services/support.
- Typically those children in ICF-MR facilities and group homes have the most significantly high and complex, chronic medical needs, in addition to intellectual disabilities.
  - Require intensive daily medical intervention and intensive support and supervision.

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ICF-MR Residential Settings

Serve Children with I/DD and co-occurring conditions:

- Horizon's Residential Center (Winston-Salem)-serve 1 child
- Tammy Lynn Center (Raleigh)-serve 1 child
- RHA/Howells Care Centers- (locations across the state)-serve 26 children

10

Other Residential Settings

State and Private Funding

- Funded primarily through LME(s) with some private funding
- SFY 2010-2011: 9 children
- Group Living High-state funded service provides-24 hour service and supervision

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Identification and Placement

- Local Depts of Social Services and community hospitals make referrals to facilities and LME(s)
- The LME(s) assist with the placement process
- LME(s) provide funding as available

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Monitoring Residential Settings

- LME(s) monitor facilities for whom they contract
- Division of Health Service Regulation monitors all licensed facilities

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Children with Intellectual/Developmental Disabilities, ages Birth through Six

Cost of Residential Services

- **ICF-MR**-$4 million/year
- **CAP-MR/DD**-1 child Home Support @ $50,000/yr
- **State Funded** -Group Living High @ $540,000/yr

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Residential Options for Children with Intellectual/Developmental Disabilities Ages Birth – 6 years

Summary

- Most are living at home
- Significantly high and complex, chronic medical needs, in addition to intellectual disabilities.
- 1 receiving CAP-MR/DD residential services
- Limited number of children in ICF-MR (28 total)
- Limited state funded residential services

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2010-2011 LOC RECOMMENDATIONS: DRAFT 1-13-11

1. DHHS shall provide a **report no later than September 2012 on the implementation of Utilization Review for the CAP-MR/DD waiver by four designated LMEs.** Report should contain a cost comparison between the external contract and the LMEs to include training, monitoring and operation of the UR. The report would also include numbers of persons served and description of accountability measures to assure the accuracy of UR decisions.

2. By October 2011, DHHS shall develop and submit to CMS an application to operate a **TBI Medicaid Waiver**. The development of this waiver should be in concert and with the advice and guidance of the NC TBI Advisory Council. Funds sufficient to provide the match for this waiver are to be identified prior to the development of the waiver application and from those already appropriated state funds earmarked to be used to serve persons with TBI. Attention should be paid to the slot formula with regard to the funds available for this waiver.

3. The LOC recommends the General Assembly appropriate an additional $10 million for the **expansion of local inpatient psychiatric beds** to allow purchase of an additional ___ beds out in the community. The DHHS shall report on the number, use and cost of these beds on a semi-annual basis beginning on October 1, 2012.

4. The DHHS shall report to the LOC by July 1, 2011 on the criteria and process being used to evaluate the fiscal, organizational and programmatic **efficacy of the implementation of the CABHA model. Beginning on October 1, 2010 and semi-annually thereafter, the DHHS shall report to the LOC on the results obtained from these measures.**

5. **The LOC recommends that the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports. All reports are to be provided to the LOC or any Committee that takes the place of the LOC:**

- By September 1,2011 the Department shall report on deaths that have occurred within state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning October 1, 2011, the Department shall provide a status report on the expenditures and balance in the Mental Health Trust Fund
- Annually, beginning July 1, 2011, the Department shall report on the strategic plan regarding how state and local resources shall be organized and used to provide services to persons with mental illness, developmental disabilities or substance abuse disease. Included will be criteria for the allocation of dollars, restrictions on how these dollars may be used, guidelines for utilization of funds and list of expenditures.

- Annually, beginning May 1, 2011, the department shall collect and report on LME fund balances.
- Biannual report beginning January 1, 2012 the Department shall report on Statewide System Performance to include the following criteria:
    - Access to Services
    - Individualized Planning and Supports
    - Promotion of Best Practices
    - Consumer-Friendly Outcomes
    - Quality Management Systems
    - System Efficiency and Effectiveness
    - Equitable Allocation of Resources
    - Prevention and Early Intervention
    - Statewide System of Crisis Response for Adults and Children
    - Management of the Utilization of State Facilities

6. In the continuing effort to manage care and costs, the DHHS shall continue **expansion of the B-C Medicaid waiver.** The structure and operation of the BC sites shall be those that are allowable within Medicaid regulations and that are determined to cost the state the least and provide outcomes equal to or better than those achieved via the current system.

7. By September 1, 2011, the DHHS shall provide to the LOC a comprehensive statewide report on the status of the use of **hospital emergency departments** by persons with mental illness. This report shall include numbers of persons, geographic location as well as average and range of length of stay. The report shall also contain a comprehensive plan for the reduction in length of stay.

8. The DHHS shall **provide a comprehensive plan for the fair and equitable allocation of resources for all persons with developmental disability by July 1, 2011.** The allocation model shall be based on a reliable and valid statewide assessment of intensity of need of each person. These assessments must be administered by those who are not engaged in the delivery of services. Included in this plan shall be a standardized formula for the use of these data to determine eligibility for type and degree and array of services to include DD Center and private ICF-MR facilities. The DHHS shall renew the CAP-MR/DD waiver with the two currently operational tiers. The plan for allocation of resources shall begin implementation by January 1, 2012 and be fully implemented across the state no later than July 1, 2013. The DHHS shall report to the LOC on the implementation process semi-annually beginning October 1, 2011.

9. By September 1, 2011 the DHHS shall report to the LOC on a comprehensive review of the current congregate **residential placements for children with developmental delay or intellectual and developmental disability aged 0-6 to** include the newly transferred DD Center ICF-MR beds. This report shall include an overview of all service options for this group of children now and as they move through school age.

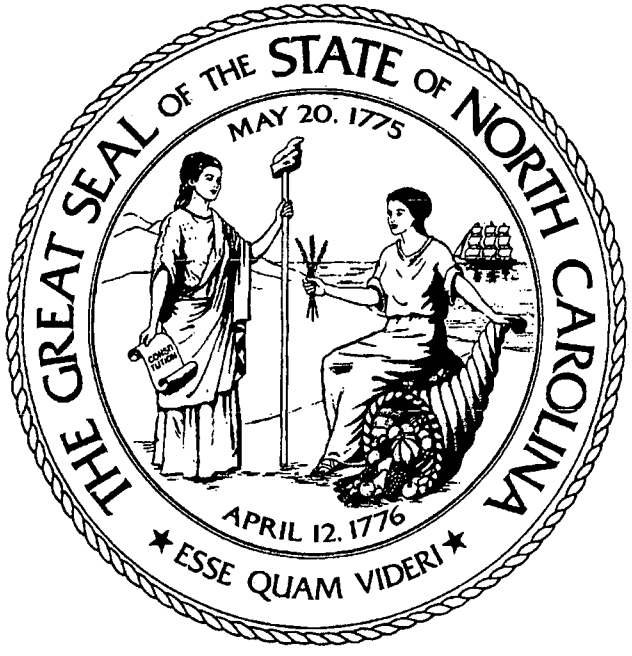
10. The DHHS shall revise the **DD Waiting List** process to assure that results of the process yield a simple, non-duplicated count of children and adults with I/DD across the state waiting for federally and state-funded services. The list shall be research-based to assure that the data collected reflect an accurate picture of those waiting for the categories of services currently available in NC. The collected data shall show the number of persons who are *potentially* eligible for the CAP-MR/DD waiver. DHHS shall report to the LOC on the revised process for collection of these data no later than September 1, 2011. The DHHS shall report these data to the LOC annually beginning September 30, 2012 and use these data to determine geographic, age and disability service gaps and plans to address these gaps.

11. The DHHS is directed to coordinate with the leadership of the Murdoch Developmental Center and its advisory committee to identify funding for the implementation of **a step-down unit for the BART program**. A report on the progress toward identifying funding and moving forward to develop this step-down unit shall be provided to the LOC on October 1, 2011 and quarterly thereafter until the unit is established.

12. By September 1, 2011 and annually thereafter, the DHHS shall report to the LOC on the progress in the **uniform use of evidence-based practices across all state operated psychiatric hospitals.**

Attachment 7

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES



REPORT TO THE 2011 REGULAR SESSION OF THE 2011 GENERAL ASSEMBLY

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27601

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

January 12, 2011

TO THE MEMBERS OF THE 2011 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, Co-Chair

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The LOC consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the LOC. The Co-Chairs for 2010-2011 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met five times during the 2010-2011 interim. The LOC heard from the individuals listed below during the specified meeting dates. Detailed minutes and information from each LOC meeting are available in the Legislative Library.

September 8, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services provided a brief update on current issues.

- Lisa Hollowell, Fiscal Research Division and Joyce Jones, Bill Drafting Division, provided an overview of 2010 Legislative actions related to mental health.

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided an update on expenditures and utilization tracking.

- Michael Watson, Deputy Secretary, Department of Health and Human Services, discussed community supports and gave an update on CABHAs.

- Mark O'Donnell, Program Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services gave a report on the status of the changes to Level III and IV facilities for children.

- Roy Wilson, Director, East Carolina Behavioral Health; Lisa Bonnett, Executive Director of the Recovery Education Unit, East Carolina Behavioral Health; and Cindy Ehlers, Assistant Area Director for Clinical Services provided information on the Second Mile Project.

October 13, 2010

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided an update on expenditures and utilization tracking.

- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services provided an overview of the SIS assessment tool pilot.

- Beth Melcher, Ph.D., Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services discussed independent assessments for mental health services.

- Luckey Welsh, Director of State Operated Services, Department of Health and Human Services provided an update on Dorothea Dix Hospital.

- Pam Silberman, JD, DrPH, President and CEO, Institute of Medicine Publisher, NC Medical Journal presented an overview of national health reform and the impact of reform on mental health, developmental disabilities, and substance abuse services.

- Sabrina Russell-Holloman, Guildford Center Behavioral Health and Disability Services; Mary Lee, Transitional Living, Youth Villages; and Annie Smith, State Director, Youth Villages discussed the benefits of Youth Villages Transitional Living Program.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services presented an analysis of the effectiveness of single stream funding.

November 9, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services discussed the closure of Dorothea Dix Hospital.

- Kelly Crosbie, LCSW, Behavioral Health Manager, Division of Medical Assistance, Department of Health and Human Services provided an update on expenditures and utilization tracking.

- Mr. Mike Kupecki, Assistant Area Director, East Carolina Behavioral Health provided a brief history of the Treatment Accountability for Safer Communities (TASC).

- Michael Gray the Vice President of Region 3 TASC, Partnership for Drug Free NC, and Vice President of National TASC described the organization's

work with individuals with behavioral health issues involved in the criminal justice system.

- Karen V. Chapple, Executive Vice President of Coastal Horizons Center and Immediate Past President of National TASC provided an overview of the demographics of the clients serviced, their risks and needs.

- Mr. Mike Watson, Deputy Secretary for Health Services, Department of Health and Human Services gave an update on the success of three-way contracts between local hospitals, LMEs, and the Department of Health and Human Services.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services presented an ICF-MR cost analysis and comparison with CAP/MRDD services.

- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services gave an overview of the DD Waiting List and an update on CAP-MR/DD Tiered Waivers.

December 8, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services discussed ways the Department could achieve budgetary savings.

- Peter E. Rives, Care Coordination Manager, CenterPointe Human Services LME addressed post-hospitalization continuity of care.

- Luckey Welsh, Director of State Operated Facilities, Department of Health and Human Services and Dr. Jeff Holden, Special Services Director, Murdoch Center provided a presentation on State Operated Developmental Centers.

- Shawn Parker, Legislative Analyst, Research Division, provided members with an overview of previous presentations in preparation of the report to the General Assembly in January.

- Beth Melcher, Ph.D, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Service Development, Department of Health and Human Services addressed Mobile Crisis services.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services presented a follow up presentation on the ICF-MR cost analysis and comparison with CAP/MRDD services.

- Kelly Crosbie, LCSW, Behavioral Health Manager, Division of Medical Assistance, Department of Health and Human Services discussed changes to Medicaid Utilization Review and presented an update on the Medicaid Waiver for Traumatic Brain Injury.

January 12, 2011

- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services provided a brief update on current issues.

- Beth Melcher, Ph.D., Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services provided an update on CABHAs.

- Ken Jones, Area Director, Eastpointe and Ellen S. Holliman, Area Director, Durham Center discussed LME Medicaid Utilization Management.

- Deborah Carroll, Ph.D., Head of Early Intervention Branch, Women & Children's Health Section, Division of Public Health and Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities & Substance Abuse Services presented an overview of residential services for children ages 0-6 with developmental disabilities.

- LOC staff presented a review of the LOC's draft report; the LOC adopted the report as amended.

COMMITTEE RECOMMENDATIONS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services makes the following recommendations to the 2011 Session of the 2011 General Assembly:

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APPENDIX

Copies of the proposed legislation begin on the following page.

State Psychiatric Hospital Admission Delays in North Carolina
Update for July-September 2010
www.nami-wake.org

Highlights:

1. More people are waiting and they are waiting for a longer time.
2. Over the 3 months, 1900 people were wait-listed and average of 2.8 days, an increase of 0.2 days over the previous 6 months.
3. Most delays occurred in the Central Region of the state.
4. There is some indication that the addition of community beds and implementation of the 7-day hold statute (G.S. 122C-263(d)(2)) are having some effect, although the effect is overshadowed by the increasing numbers of severe mentally ill patients needing hospitalization.

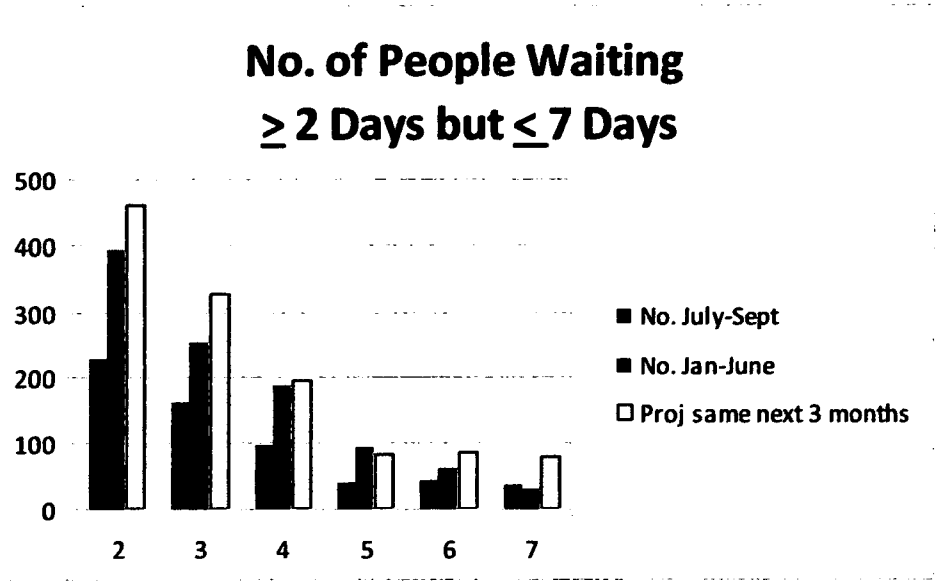


Table 2: EDs with at least four waits of 7 days or longer

Hospital	No. Patients	Region
WakeMed NBA	13	Central
CMC Randolph	11	Western
Mission/St. Joseph	8	Western
Guilford Center	7	Central
Forsyth Medical	5	Central
Betsy Johnson	4	Eastern
Duke	4	Central
Presbyterian	4	Western
Total	**56**	

No. Patients by Month

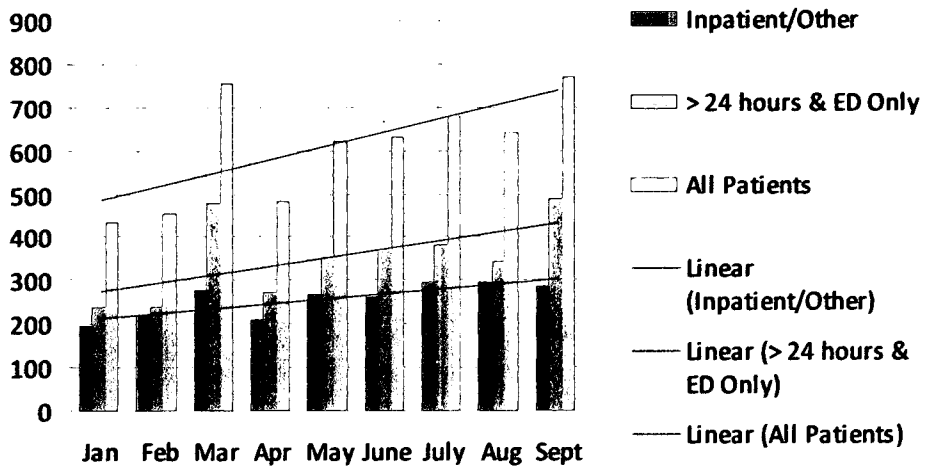
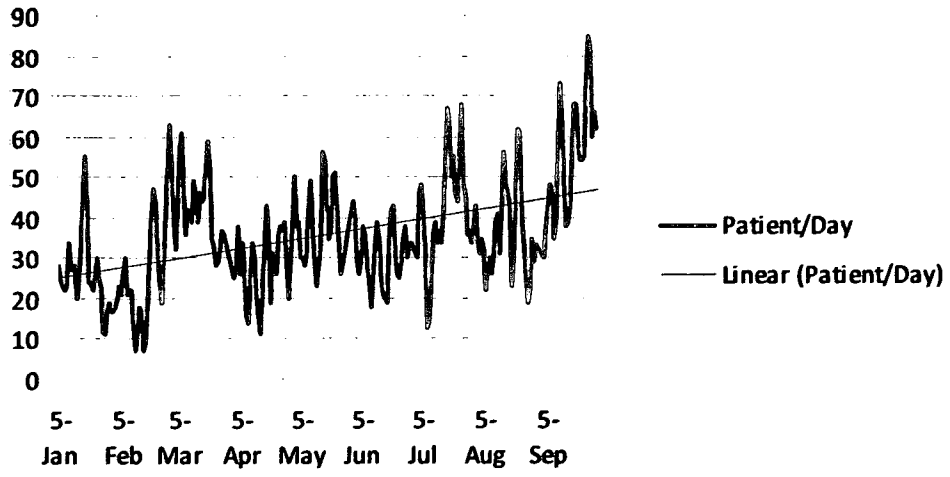


Table 3. Counties with largest number of delays (ranked highest to lowest)

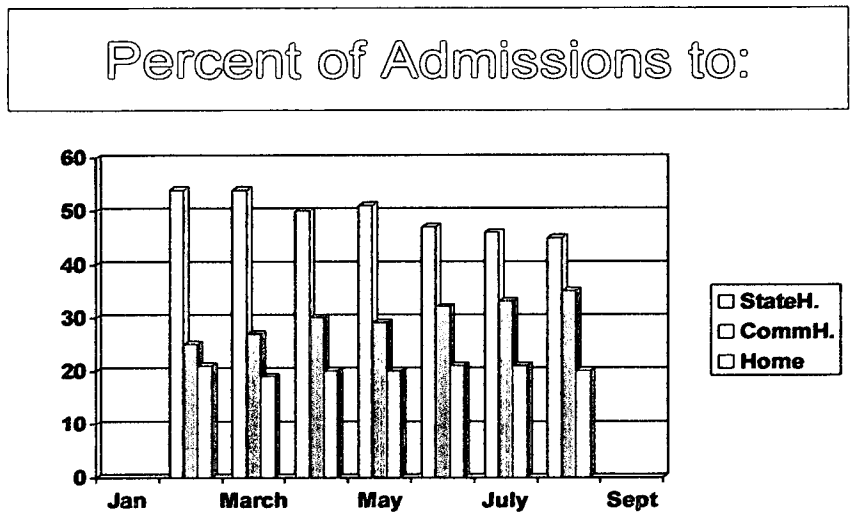
County	Number of Delays	Percent of Total	Cumulative Percent
Wake	314	16.5	16.5
Forsyth [1]	125	6.6	23.0
New Hanover *	124	6.5	29.6
Durham[2]	106	5.6	35.1
Nash[3] *	103	5.4	40.5
Guilford[4]	94	4.9	45.4
Randolph	85	4.9	50.0
Total	**951**		

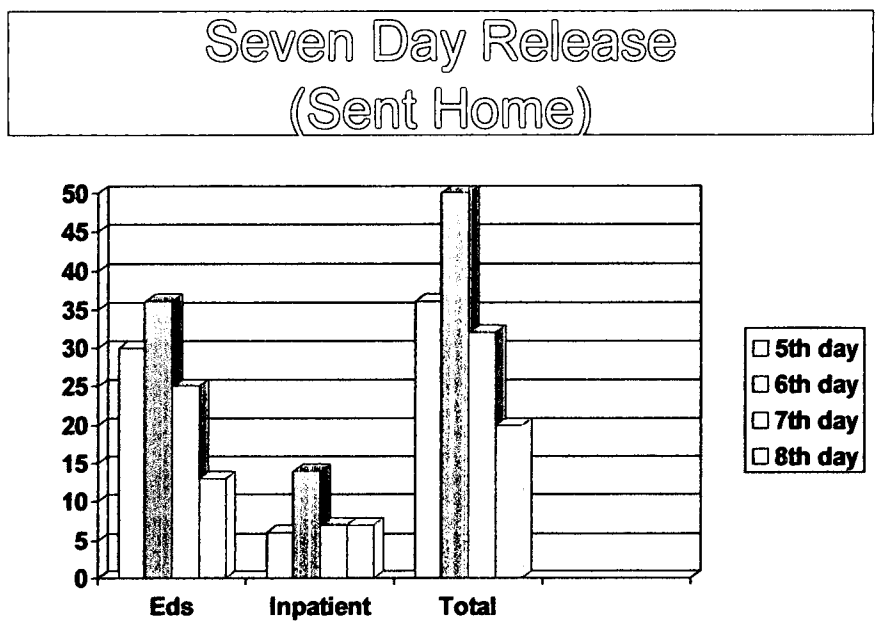
* not in central region; [1] 8 3-way contract beds; [2] 2 3-way contract beds; [3] 8 3-way contract beds; [4] 4 3-way contract beds.

Patients Waiting Each Day



Disposition of Patients to Hospitals or Returned Home by Month.





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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

REPORT TO THE 2011 REGULAR SESSION OF THE 2011 GENERAL ASSEMBLY

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JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27601

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

February 1, 2011

TO THE MEMBERS OF THE 2011 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, Co-Chair

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES MEMBERS, 2010-2011

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Appendix 11

PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The LOC consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the LOC. The Co-Chairs for 2010-2011 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met five times during the 2010-2011 interim. The LOC heard from the individuals listed below during the specified meeting dates. Detailed minutes and information from each LOC meeting are available in the Legislative Library.

September 8, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on current issues.

- Lisa Hollowell, Fiscal Research Division and Joyce Jones, Bill Drafting Division, provided an overview of 2010 Legislative actions related to mental health.

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided an update on expenditures and utilization tracking.

- Michael Watson, Deputy Secretary, Department of Health and Human Services, discussed community supports and gave an update on Critical Access Behavioral Health Agencies (CABHAs).

- Mark O'Donnell, Program Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services gave a report on the status of the changes to Level III and IV facilities for children.

- Roy Wilson, Director, East Carolina Behavioral Health; Lisa Bonnett, Executive Director of the Recovery Education Unit, East Carolina Behavioral Health; and Cindy Ehlers, Assistant Area Director for Clinical Services provided information on the Second Mile Project.

October 13, 2010

- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided an update on expenditures and utilization tracking.

- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services provided an overview of the Supports Intensity Scale (SIS) assessment tool pilot.

- Beth Melcher, Ph.D., Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services discussed independent assessments for mental health services.

- Luckey Welsh, Director of State Operated Services, Department of Health and Human Services provided an update on Dorothea Dix Hospital.

- Pam Silberman, JD, DrPH, President and CEO, Institute of Medicine, Publisher, NC Medical Journal presented an overview of national health reform and the impact of reform on mental health, developmental disabilities, and substance abuse services.

- Sabrina Russell-Holloman, Guilford Center Behavioral Health and Disability Services; Mary Lee, Transitional Living, Youth Villages; and Annie Smith, State Director, Youth Villages discussed the benefits of Youth Villages Transitional Living Program.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services presented an analysis of the effectiveness of single stream funding.

November 9, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services discussed the closure of Dorothea Dix Hospital.

- Kelly Crosbie, LCSW, Behavioral Health Manager, Division of Medical Assistance, Department of Health and Human Services provided an update on expenditures and utilization tracking.

- Mr. Mike Kupecki, Assistant Area Director, East Carolina Behavioral Health provided a brief history of the Treatment Accountability for Safer Communities (TASC).

- Michael Gray the Vice President of Region 3 TASC, Partnership for Drug Free NC, and Vice President of National TASC described the organization's

work with individuals with behavioral health issues involved in the criminal justice system.

- Karen V. Chapple, Executive Vice President of Coastal Horizons Center and Immediate Past President of National TASC provided an overview of the demographics of the clients served including their risks and needs.

- Mr. Mike Watson, Deputy Secretary for Health Services, Department of Health and Human Services gave an update on the success of three-way contracts between local hospitals, Local management entities (LMEs), and the Department of Health and Human Services.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services presented an ICF-MR cost analysis and comparison with CAP/MR-DD services.

- Rose Burnette, Developmental Disabilities (DD) Project Manager, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services gave an overview of the DD Waiting List and an update on CAP-MR/DD Tiered Waivers.

December 8, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services discussed ways the Department could achieve budgetary savings.

- Peter E. Rives, Care Coordination Manager, CenterPointe Human Services LME addressed post-hospitalization continuity of care.

- Luckey Welsh, Director of State Operated Facilities, Department of Health and Human Services and Dr. Jeff Holden, Special Services Director, Murdoch Center provided a presentation on State Operated Developmental Centers.

- Shawn Parker, Legislative Analyst, Research Division, provided members with an overview of previous presentations for their consideration in preparing the final report to the General Assembly in January.

- Beth Melcher, Ph.D, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Service Development, Department of Health and Human Services addressed Mobile Crisis services.

- Steve Jordan, Director, Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, Department of Health and Human Services presented a follow up presentation on the ICF-MR cost analysis and comparison with CAP/MRDD services.

- Kelly Crosbie, LCSW, Behavioral Health Manager, Division of Medical Assistance, Department of Health and Human Services discussed changes to Medicaid Utilization Review and presented an update on the Medicaid Waiver for Traumatic Brain Injury.

January 12, 2011

- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services provided a brief update on current issues.

- Beth Melcher, Ph.D., Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services provided an update on CABHAs.

- Ellen S. Holliman, Area Director, Durham Center discussed LME Medicaid Utilization Management.

- Deborah Carroll, Ph.D., Head of Early Intervention Branch, Women & Children's Health Section, Division of Public Health and Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities & Substance Abuse Services presented an overview of residential services for children ages 0-6 with developmental disabilities.

- LOC staff presented a review of the LOC's draft report; the LOC adopted the report as amended.

COMMITTEE RECOMMENDATIONS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services makes the following recommendations to the 2011 Session of the 2011 General Assembly:

1. Utilization Review by LME

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to provide a report, no later than September 2012, on the implementation of Utilization Review (UR) for the CAP-MR/DD waiver by four designated LMEs. The report must contain a cost comparison between the external contract and the LMEs to include training, monitoring and operation of the UR. The report must also include numbers of persons served and description of accountability measures to assure the accuracy of UR decisions.

2011-MGz-13

2. TBI Waiver

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services, by October 2011, to develop and submit to CMS an application to operate a TBI Medicaid Waiver. The development of this waiver should be in concert and with the advice and guidance of the NC TBI Advisory Council. Funds sufficient to provide the match for this waiver are to be identified prior to the development of the waiver application and from those already appropriated state funds earmarked to be used to serve persons with TBI. Attention should be paid to the slot formula with regard to the funds available for this waiver.

2011-MGz-14

3. Local Inpatient Psychiatric Beds

The LOC recommends the General Assembly appropriate an additional $10 million for the expansion of local inpatient psychiatric beds to allow purchase of additional beds out in the community. The Department of Health and Human Services must report on the number, use, and cost of these beds on a semi-annual basis beginning on October 1, 2012.

2011-MGz-15

4. Implementation of the CABHA Model

The LOC recommends the General Assembly enact legislation that requires Department of Health and Human Services to report to the LOC by July 1, 2011 on the criteria and process being used to evaluate the fiscal, organizational and programmatic efficacy of the implementation of the CABHA model. Beginning on October 1, 2011 and semi-annually thereafter, the Department of Health and Human Services must report to the LOC on the results obtained from these measures.

2011-MGz-16

5. Reports from the Department of Health and Human Services

The LOC recommends that the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports. All reports are to be provided to the LOC or any Committee that takes the place of the LOC:

- By September 1, 2011 the Department shall report on deaths that have occurred within state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning October 1, 2011, the Department must provide a status report on the expenditures and balance in the Mental Health Trust Fund
- Annually, beginning July 1, 2011, the Department must report on the strategic plan regarding how state and local resources shall be organized and used to provide services to persons with mental illness, developmental disabilities or substance abuse disease. The report must include criteria for the allocation of dollars, restrictions on how these dollars may be used, guidelines for utilization of funds and list of expenditures.
- Annually, beginning May 1, 2011, the Department shall collect and report on LME fund balances.
- Biannual report beginning January 1, 2012 the Department shall report on Statewide System Performance to include the following criteria:
    - Access to Services
    - Individualized Planning and Supports
    - Promotion of Best Practices
    - Consumer-Friendly Outcomes
    - Quality Management Systems
    - System Efficiency and Effectiveness
    - Equitable Allocation of Resources
    - Prevention and Early Intervention

- Statewide System of Crisis Response for Adults and Children
- Management of the Utilization of State Facilities

2011-MGz-19

6. Expansion of the 1915b/c Waiver

In the continuing effort to manage care and costs, the LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to continue the expansion of the B-C Medicaid waiver. The structure and operation of the waiver sites must be those that are allowable within Medicaid regulations and that are determined to cost the state the least and provide outcomes equal to or better than those achieved via the current system.

2011-MGz-18

7. Status and Use of Hospital Emergency Departments

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to provide to the LOC a comprehensive statewide report on the status of the use of hospital emergency departments by persons with mental illness no later than September 1, 2011. This report must include numbers of persons, geographic location, as well as average and range of length of stay. The report must also contain a comprehensive plan for the reduction in length of stay.

2011-MGz-17

8. Resource Allocation Plan for Persons with Developmental Disabilities

The LOC recommends that the General Assembly enact legislation to reuire the Department of Health and Human Services to provide a comprehensive plan for the fair and equitable allocation of resources for all persons with developmental disability by July 1, 2011. The allocation model shall be based on a reliable and valid statewide assessment of intensity of need of each person. These assessments must be administered by those who are not engaged in the delivery of services or who directly allocate resources. As part of the plan the Department shall include a standardized formula for the use of these data to determine eligibility for type and degree and array of services to include DD Center and private ICF-MR facilities. The Department shall renew the CAP-MR/DD waiver with the two currently operational tiers. The plan for allocation of resources shall begin implementation by January 1, 2012, and be fully implemented across the state no later than July 1, 2013. The Department

shall report to the LOC on the implementation process semi-annually beginning October 1, 2011.

2011-MGz-23

9. Residential Placements for Children with Developmental Delay or Intellectual and Developmental Disability Aged 0-6

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to report by September 1, 2011 to the LOC on a comprehensive review of the current congregate residential placements for children with developmental delay or intellectual and developmental disability aged 0-6 to include the newly transferred DD Center ICF-MR beds. This report must include an overview of all service options for this group of children now and as they move through school age.

2011-MGz-24

10. Revise Developmental Disabilities Waiting List Process

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to revise the Developmental Disabilities Waiting List process to assure that results of the process yield a simple, non-duplicated count of children and adults with ID/DD across the state waiting for federally and state-funded services. The list must be research-based to assure that the data collected reflect an accurate picture of those waiting for the categories of services currently available in NC. The collected data must show the number of persons who are *potentially* eligible for the CAP-MR/DD waiver. The Department of Health and Human Services must report to the LOC on the revised process for collection of this data no later than September 1, 2011. The Department of Health and Human Services must report annually to the LOC beginning September 30, 2012 using the data collected to determine geographic, age, and disability service gaps, and report on plans to address any gaps.

2011-MGz-25

11. Step-down Unit for the BART Program

The LOC recommends that the General Assembly enact legislation that directs the Department of Health and Human Services to coordinate with the leadership of the Murdoch Developmental Center and its advisory committee to identify funding for the implementation of a step-down unit for the BART program. A report on the progress toward identifying funding and moving

forward to develop this step-down unit shall be provided to the LOC on October 1, 2011 and quarterly thereafter until the unit is established.

2011-MGz-26

12. Uniform Use of Evidence-Based Practices Across All State Operated Psychiatric Hospitals

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to report by September 1, 2011, and annually thereafter, to the LOC on the progress in the uniform use of evidence-based practices across all state operated psychiatric hospitals.

2011-MGz-27

13. DHHS Report on Clubhouse Model

The LOC recommends that the General Assembly enact legislation that requires the Department of Health and Human Services to report on services provided by clubhouse program.

2011-MGz-29

APPENDIX

Copies of the proposed legislation begin on the following page.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-13* [v.5] (01/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2011 1:15:08 PM

Short Title:	Report on Transfer of CAP-MR/DD UR to LMEs.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REPORT ON THE IMPLEMENTATION OF UTILIZATION REVIEW BY DESIGNATED LOCAL MANAGEMENT ENTITIES FOR SERVICES PROVIDED UNDER THE COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. By September 1, 2012, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall submit a report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the implementation of utilization review by designated local management entities for services provided under the CAP-MR/DD Medicaid Waiver. The report shall include at least all of the following:

(1) A comparison of the training, monitoring, and operating costs associated with (i) transferring the utilization review function to Crossroads Behavioral Health Center, Eastpointe, The Durham Center, and Pathways LME (the four designated LMEs) and (ii) maintaining the statewide vendor contract in effect for utilization review prior to the transfer of this function to the four designated LMEs.

(2) Information on the number of CAP-MR/DD recipients who received utilization review services from the four designated LMEs between January 1, 2011, and January 1, 2012.

(3) A description of the accountability measures used by the four designated LMEs to ensure the accuracy of utilization review decisions.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-14* [v.3] (01/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2011 1:36:25 PM

Short Title:	Apply for TBI Medicaid Waiver.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A TRAUMATIC BRAIN INJURY MEDICAID WAIVER, AS RECOMMENDED BY THE LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, in consultation with the North Carolina Traumatic Brain Injury Advisory Council, shall develop and apply to the Centers for Medicare and Medicaid Services (CMS) for a 1915(c) waiver to permit persons who sustain traumatic brain injuries to access home and community-based Medicaid services. The Department shall not submit the application to CMS unless the General Assembly identifies a source of funding sufficient to provide the match for this proposed waiver from State appropriations earmarked for persons with traumatic brain injury. In determining the number of slots and the slot allocation formula for this proposed waiver, the Department shall consider the amount of funding identified by the General Assembly for this purpose.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-15* [v.3] (1/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2011 11:49:37 AM

Short Title:	Expand Inpatient Psychiatric Beds/Funds.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE EXPANSION OF LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS, AS RECOMMENDED BY THE LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, (Division) the sum of thirty-nine million one hundred twenty-one thousand six hundred forty-four dollars ($39,121,644) for the 2011-2012 fiscal year for the purchase of fifty additional local inpatient psychiatric beds or bed days. These beds or bed days shall be distributed across the State in LME catchment areas and according to need as determined by the Department. The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient

services under contract with community hospitals, including beds or bed days being purchased through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. Not later than March 1, 2011, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection.

SECTION 2. This act becomes effective July 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-16* [v.3] (1/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2011 2:37:23 PM

Short Title:	Evaluate Efficacy of CABHA Model.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EVALUATE AND REPORT SEMI-ANNUALLY ON THE EFFICACY OF THE CRITICAL ACCESS BEHAVIORAL HEALTH AGENCY MODEL, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) By July 1, 2011, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services (Division) shall report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the criteria and processes used by the Division to evaluate the fiscal, organizational and programmatic efficacy of implementing the Critical Access Behavioral Health Agency (CABHA) category of provider agency.

SECTION 1.(b) Beginning October 1, 2011, and every six months thereafter, the Division shall submit a report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services evaluating the fiscal, organizational, and programmatic efficacy of the CABHA category of provider agency using the criteria and processes identified by the Division in the report authorized by Section 1.(a) of this act.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-19* [v.3] (01/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2011 11:42:15 AM

Short Title:	Modify MHDDSAS Reporting Requirements.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODIFY DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall submit the following reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services:

(1) By September 1, 2011, a report summarizing for the one-year period preceding the date of the report, the deaths of clients of a State facility that primarily provides services for the care, treatment, habilitation, or rehabilitation of individuals with a mental illness, developmental disability, or substance abuse disorder (State facility) and, if known, the deaths of former clients of a State facility whose deaths occurred within fourteen days of discharge from the State facility.

(2) Beginning January 1, 2011, and annually thereafter, a report on a strategic plan for organizing State and local resources to fund services provided to individuals with a mental illness, developmental disability, or substance abuse disorder. The report shall include criteria for the allocation of funds, guidelines for utilization of funds, restrictions on use of funds, and a list of expenditures.

SECTION 1.(b) G.S. 143C-9-2(d) reads as rewritten:

"(d) Beginning ~~July 1, 2007,~~ October 1, 2011, the Secretary of the Department of Health and Human Services shall report annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on the balance of the Trust Fund and the expenditures made during the preceding fiscal year from the Trust Fund. The report shall identify each expenditure by recipient and purpose and shall indicate the authority under subsection (b) of this section for the expenditure."

SECTION 1.(c) G.S. 10.19A(c) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.19A.(d)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall require quarterly reporting from LMEs in the format required under subsection (a) of this section. The Department of Health and Human Services shall report the results of the quarterly reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on or before ~~May 1, 2010.~~May 1, 2011, and annually thereafter."

SECTION 1.(e) G. S. 122C-102(c) reads as rewritten:

"(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, ~~and prevention and early intervention. Beginning October 1, 2006,~~ equitable allocation of resources, prevention and early intervention, statewide system of crisis response for adults and children, and management of the utilization of State facilities. Beginning January 1, 2012, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-18* [v.5] (1/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/25/2011 10:01:01 AM

Short Title:	Allow Expansion of Capitated Waiver.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPAND THE CAPITATED 1915(B)/(C) MEDICAID WAIVER TO ADDITIONAL LOCAL MANAGEMENT ENTITY CATCHMENT AREAS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any law to the contrary, the Department of Health and Human Services may expand the capitated 1915(b)/(c) Medicaid waiver to any additional local management entity catchment area upon demonstrating to the satisfaction of the General Assembly that the expansion (i) is allowable under Medicaid (ii) will result in savings to the State and (iii) will provide outcomes equal to or better than those that could be achieved without the proposed expansion.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-17* [v.5] (1/18)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2011 5:29:14 PM

Short Title:	Report on MH Services Provided by Hosp. ER's.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REPORT ON THE UTILIZATION OF HOSPITAL EMERGENCY DEPARTMENTS BY INDIVIDUALS DIAGNOSED WITH MENTAL ILLNESS AND TO DEVELOP A COMPREHENSIVE PLAN FOR REDUCING THE LENGTH OF STAYS FOR INDIVIDUALS WITH MENTAL ILLNESS ADMITTED TO HOSPITAL EMERGENCY DEPARTMENTS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. By September 1, 2011, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall submit a report on the utilization of hospital emergency departments by individuals with mental illness to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include a comprehensive statewide analysis of the number of times between January 1, 2011, and June 30, 2011, individuals diagnosed with a mental illness utilized hospital emergency departments, broken down by geographic location, average length of stay, and range in lengths of stay. The report shall also include a comprehensive plan for reducing the length of stays for individuals with mental illness admitted to hospital emergency departments.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-23* [v.6] (01/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2011 3:00:46 PM

Short Title:	Develop Plan for Allocating DD Resources.	(Public)
Sponsors:	Representative Insko./Senator Nesbitt.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A COMPREHENSIVE STATEWIDE PLAN FOR THE FAIR AND EQUITABLE ALLOCATION OF RESOURCES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES; TO REPORT ON IMPLEMENTATION OF THE PLAN; AND TO APPLY FOR RENEWAL OF THE CAP-MR/DD WAIVER, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) By July 1, 2011, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop and submit to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services a comprehensive statewide plan for the fair and equitable allocation of resources for all individuals eligible for developmental disability services. The plan shall contain all of the following:

(1) A resource allocation model based on the results of the Supports Intensity Scale (SIS) or another standardized, reliable, and valid assessment tool for the determination of intensity of need. The plan for administration of the selected assessment tool must (i) require qualified persons who are not engaged in the delivery of any developmental disability services to administer the selected assessment tool and (ii) include operational guidelines for quality assurance and reliability in the administration of the assessment.

(2) A standardized formula for the use of the results of the SIS or other assessment tool data to determine eligibility for type, degree, and array of services, including services provided through State developmental centers and private ICF-MR facilities.

SECTION 1.(b) The Department shall begin implementing the comprehensive statewide plan developed pursuant to Section 1.(a) of this act by January 1, 2012, and shall achieve full implementation of the plan by July 1, 2013. Beginning October 1, 2011, and every

six months thereafter, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the implementation status of the comprehensive statewide plan developed pursuant to Section 1.(a) of this section.

SECTION 1.(c) The Department of Health and Human Services shall renew the CAP-MR/DD Waiver with the two tiers currently in operation. Subject to approval by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC), the Department may apply to the Centers for Medicare and Medicaid Services (CMS) to add additional tiers to the CAP-MR/DD Waiver.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-24* [v.3] (01/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2011 12:09:56 PM

Short Title:	Evaluate DD Residential Options for Children.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EVALUATE AND REPORT ON RESIDENTIAL PLACEMENT OPTIONS FOR YOUNG CHILDREN WITH DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall conduct a comprehensive review of current congregate residential placements for children from birth to six years of age who have a developmental delay, intellectual disability, or developmental disability. The review shall include newly transferred Developmental Day Center ICF-MR beds. By September 1, 2011, the Division shall submit a report of its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include an overview of all services available for this population of children (i) through age six and (ii) after age six.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H/S D

BILL DRAFT 2011-MGz-25* [v.5] (01/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/25/2011 4:18:56 PM

Short Title: Revise DD Waiting List Process. (Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT ON A REVISED PROCESS FOR COLLECTING DATA TO DEVELOP A WAITING LIST OF PERSONS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) By September 1, 2011, the Department of Health and Human Services (Department) shall study and submit a report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on a revised process for collecting data to develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The revised process shall ensure all of the following:

(1) A simple, non-duplicated count of children and adults with intellectual or developmental disabilities across the State who are waiting for federally and State-funded services.

(2) A research-based waiting list supported by data that accurately reflects the number of individuals waiting for categories of services currently available in this State.

(3) Data showing the number of individuals who are potentially eligible to receive services under the CAP-MR/DD Waiver.

SECTION 1.(b) Beginning September 30, 2012, and annually thereafter, the Department shall submit a report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the waiting list data collected from each local management entity (LME). The report shall include (i) an analysis of any service gaps revealed by the data, broken down by geographic location, age, and disability and (ii) plans to address these service gaps.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-26* [v.5] (01/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/27/2011 1:18:37 PM

Short Title:	Funds for Step-Down Unit for BART Program.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO IDENTIFY AND REPORT ON FUNDING AVAILABLE FOR THE ESTABLISHMENT OF A STEP-DOWN UNIT FOR THE BEHAVIORALLY ADVANCED RESIDENTIAL TREATMENT PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division), in consultation with the leadership and advisory committee of the Murdoch Developmental Center, shall identify funding sources available to establish a unit providing step down services from the Behaviorally Advanced Residential Treatment (BART) Program. By October 1, 2011, and quarterly thereafter until a BART step-down unit is established, the Division shall report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the progress towards identifying funding for, and establishing, the step-down unit.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-27* [v.3] (01/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/25/2011 4:18:05 PM

Short Title:	Evidence-Based Pract. in Psych. Hospitals.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REPORT ON THE PROGRESS TOWARDS IMPLEMENTING AND UTILIZING UNIFORM EVIDENCE-BASED PRACTICES ACROSS ALL STATE PSYCHIATRIC HOSPITALS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. By September 1, 2011, and annually thereafter, the Department of Health and Human Services shall report to the Senate Appropriations Subcommittee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the progress achieved in implementing and utilizing uniform evidence-based practices across all State psychiatric hospitals.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S/H D

BILL DRAFT 2011-MGz-29* [v.1] (01/25)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/25/2011 5:40:47 PM

Short Title:	Report on NC Clubhouse Programs.	(Public)
Sponsors:	Senator Nesbitt./Representative Insko.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REPORT ON THE SERVICES PROVIDED BY CLUBHOUSE PROGRAMS IN THIS STATE, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. By September 1, 2011, the Department of Health and Human Services shall submit a report on this State's Clubhouse Programs to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) A description of the types of Clubhouse Programs available in this State.

(2) The specific services available in each type of Clubhouse Program available in this State.

(3) The actual cost of services provided by each type of Clubhouse Program available in this State.

(4) The current reimbursement rate for services provided by Clubhouse Programs available in this State.

SECTION 2. This act is effective when it becomes law.