

OPC CFAC Meeting
February 9, 2006

In attendance: Dan Herr, Virginia Hill, Shira Belovicz, Ken Perry, Michael Bramwell, Gwyn Edgell, Megan Jones, Heather Nash, Cheryl Russ, Allen D., Rhonda Allen, Leslie Matthews, Marcus Matthews, Bradely Barnett, Edward Wright, Judi Hummel, Tiffany Johnson Chavis, Judy Batten, Bilie Guthrie, Sarah Lugar, Cheryl Moran, Lisa Lackman, Cim Brailer, Kent Earnhardt, Wolfgang Jacob Friderich, Kim Best

Dan welcomed the group and introductions were made. Dan reviewed the purpose of inviting the OPC Community Planners, which is to present on the new service definitions, discuss the impact they may have on consumers/family members and to answer questions of CFAC members. Billie will keep a list of any questions that the planners are unable to answer, so that they can follow up.

Cheryl Moran, Developmental Disability (DD) Community Planner began by discussing major changes in the DD service definitions. She explained that in December, LME's were informed that the service definition for Developmental Therapy, which would replace the current Community Based Services (CBS), was not approved by the Centers for Medicare and Medicaid Services (CMS). The Division subsequently sent a survey to LME's regarding their consumers who are currently receiving CBS. Cheryl referred to the handout, entitled CBS Fact Sheet, which indicates that there are currently 320 OPC consumers with DD receiving CBS. Of those 320 individuals, the following apply: 277 are receiving CBS based primarily on a DD diagnosis (may also have a co-occurring diagnosis); 20 are currently receiving CBS in a school setting; 185 live at home or with a legally responsible person; 245 are residing independently with supports or in a licensed facility where CBS is crucial to maintaining that placement; and 201 may meet ICF-MR criteria. At the end of January, the Division released a crosswalk plan for DD consumers currently receiving CBS. The plan is as follows: individuals with DD who may be eligible for the CAP-MR/DD waiver will receive waiver services (the Division has identified additional staff to expedite the process of adding people to the waiver); individuals who are eligible for the new mental health Community Support service (CS) will receive that service; individuals who are not eligible for either the waiver or CS and who would benefit from the Medicaid Personal Care Service (PCS) will receive that service (however, Cheryl noted that PCS is a very limited service that assists consumers with basic self-care needs and has a maximum of 60 hours per month. She indicated that if consumers were eligible for this service, in all likelihood, they would already be receiving it); and individuals who are unable to take advantage of any of the previously mentioned services will receive a new state funded service called Developmental Therapy. At OPC, case managers are working with each individual on their caseload in order to determine the most appropriate plan of action regarding services. Case managers are also diligently working to get the necessary paperwork submitted for consumers who may qualify for the waiver. Judi asked if the number of hours of CBS will be changed once a consumer is on the waiver? Cheryl answered that consumers will be receiving a similar set of services on the waiver and does not anticipate that hours will be decreased. Billie asked how a consumer will know if they qualify for the waiver? It was answered that case managers will work with consumers to identify who may be eligible. Medical forms, psychological evaluations and MR-2's must be submitted to Dr. Jeff Holden at the Murdoch Center, who will then be determining eligibility. Basic criteria include: DD diagnosis, meet ICF-MR level of care; functional limitations, qualifying cognitive functioning level and adaptive functioning level.

Sarah Lugar, Mental Health/Substance Abuse (MH/SA) Community Planner spoke next about service definitions that will affect the adult MH/SA population. She reviewed the handout entitled, New Medicaid Services Crosswalk. For people receiving services that will be changed or discontinued, as reflected in the handout, Person Centered Plans (PCP) will be amended to reflect

the change. For completely new services, new PCP's will be developed to reflect the new service definitions.

Sarah then explained several new/and or changed service definitions in detail. Community Support (CS) will be a bundling of services (case management, CBS and if necessary, psychiatry) with a maximum of 8 hours per day, 28 hours per week. An individual can receive CS from only one CS provider organization at one time. Some CS provider organizations may require that an individual receive all CS from that provider organization. CS cannot be provided during the same authorization period as Partial Hospitalization (PH), Substance Abuse Comprehensive Outpatient Treatment (SACOT), Substance Abuse Intensive Outpatient Program (SAIOP) or SA Non-Medical Community Residential Treatment (SA residential) except in order to facilitate admission or discharge to/from the service, in order to bridge services. Group CS cannot be billed on the same day as Psychosocial Rehabilitation (PSR). The consumer to staff ratio is 30:1. Shira inquired about how psychiatrists are fitting in with CS? For instance, can she continue to see her UNC psychiatrist and receive other CS services from a different provider? Sarah explained that face-to-face psychiatry visits must be made available. There are liability issues for the treating psychiatrist if CS is being provided by different provider, therefore the doctor may stipulate that CS be provided by their own provider organization. If a psychiatrist is willing, it is possible to receive outpatient treatment from a different provider than the one providing CS. It is the responsibility of the CS worker to connect consumers with outpatient treatment, such as psychiatry and therapy. Outpatient treatment must be clinically indicated and included in the PCP, with an order for service. Community Support Team (CST) is more intensive and intended for individuals needing more services and support than CS. CST may be provided no more than 8 hours per day, 35 hours a week. The consumer to staff ratio is 15:1. CST may not be provided to individuals who are receiving CS, Assertive Community Treatment Team (ACTT), SAIOP, SACOT or SA residential except for bridging services. Megan asked if a whole new PCP is required when a new service is added? Sarah specified that the PCP only needs to be amended in this circumstance. Megan also asked if it was allowable to see your representative payee and a CS provider in the same day. Sarah will follow up on this question, as she was unable to answer it at this time. Sarah briefly discussed Mobile Crisis Management, a very expensive service that has not previously been provided locally. She indicated that this is a much-needed service that includes supports and crisis prevention that are designed to reduce the incidence of recurring crisis. Partial Hospitalization (PH), which is also not currently offered in the OPC catchment area (though it has been in the past) is a short-term service that is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. Facility-Based Crisis (FBC) is also a service that provides an alternative to hospitalization. FBC necessitates a 24-hour residential facility with 16 beds or less. Individuals receiving FBC must be willing to contract for safety. Historically, FBC has been provided to our consumers by Residential Treatment Services in Burlington but now Freedom House provides this service locally. Allen asked if a consumer could go to Freedom House's FBC if they feel temporarily unsafe in the community to adjust to a medication change. Sarah confirmed that Freedom House's FBC would be an appropriate place for this. Sarah continued with an explanation of ACTT, which are services provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week. Individuals enrolled in ACTT will not be able to utilize PSR or PH. Sarah advised that if a consumer has been receiving both services in the past, it is essential to work with their current providers to make plans for the future and determine which service is most significant for recovery. Shira suggested that an ACTT or CST provider should develop PSR as an alternative to this exclusion. SA Intensive Outpatient Program (SAIOP) is structured individual or group addiction activities and services that are provided at an outpatient program. Services are delivered at least 3 hours a day, 3 days per week. SA Comprehensive Outpatient Treatment (SACOT) services are similar to SAIOP but more intensive, operating at least 20 hours a week and a minimum of 4 hours a day, 5 days a week. There is ready access to psychiatry with

SACOT. A consumer cannot receive SAIOP and SACOT simultaneously and currently there is no IPRS funding for either of these services.

Sarah reviewed some of the challenges of the new service definitions. She pointed out that some of the exclusions will be challenging for consumers who have traditionally had mixed services. There was general discussion of this point, including some of the purposes of the exclusions, such as the issue of double billing and the supposition that if a consumer is receiving an intensive level of service, such as ACTT, then their needs would be entirely met by this service. Sarah also pointed out the challenge of having enough staff to provide CS/ CST in time for implementation of new service definitions. She added that the clinics are working quickly and diligently to have enough CS/CST staff to adequately serve consumers. She mentioned that staffing SAIOP and SACOT will be also difficult as there is currently a lack of qualified substance abuse staff. Sarah recommended that consumers use their voice and lobbying power to inform the Division of personal issues that the new service definitions are posing for individuals. Judy also recommended that consumers contact OPC Customer Service for individual questions or concerns. Additionally, it was numerously stressed that consumers should work with their current providers to plan for future services.

Planners will provide Billie a revised new service definition cheat sheet with detailed information so that she may send it to CFAC members via email. Edward mentioned that it sounds as if the enhanced services, despite the many exclusion rules, are going to be more expensive. Judy explained that there has been ongoing discussion about whether the state can afford the new service definitions and mentioned that the General Assembly seems to understand the need for more adequate funding of the MH system. Michael pointed out that initially the services may be more expensive, but hopefully given the thoroughness of the services, there will be good long-term outcomes.

Lisa Lackman, Child and Family Community Planner discussed the new service definitions for children. She explained that there is generally a lot of good news for children, as the new service definitions provide more support and give providers more tools to serve children. Some of the challenges include limitations on stacked or combined services and less flexibility as advocates would have liked. An exclusion that will be particularly challenging is that consumers cannot simultaneously utilize residential services and day treatment. Currently there are about 12 children served by OPC that this will affect. Lisa stated that the exclusion puts more pressure on local communities to develop day treatment programs, in order to keep children in their community. She then reviewed the new continuum of services for children. Most children can be appropriately served by the basic benefits of outpatient treatment, including crisis services. If these services are not sufficient, then a child will receive a diagnostic assessment, which is the gateway to enhanced services. Child Community Support (CS) is similar to the adult CS service. Lisa explained that CS will provide improved coordination of services. If CS does not meet a child's needs, they will then receive Intensive In-Home (IIH) services, which is an intense family preservation service aimed to maintain a child in the home. A team of 3 people provides IIH services with the team leader being a licensed professional. The next level of service is Multisystemic Therapy (MT). MT is one of the most researched, evidenced-based services provided to children. It includes intensive work with family, school, and community for youth ages 7-17, by a team of 4 people. Another new service is day treatment for children, which we have not had in our community for many years. This service includes case management, skill training and symptom and behavior management for a minimum of 3 hours per day and 2 days per week. Substance Abuse Intensive Outpatient Program (IOP) is also a new service that has never been provided to children in our state. If none of the above services adequately addresses a child's needs, there continues to be Therapeutic Foster Care, Level III Group Homes, Level IV Group Homes, PRFT and Inpatient Hospitalization. Lisa explained that most children do have

Medicaid, with no caps as long as the service is medically necessary, which allows local communities to utilize state dollars to develop needed services, such as a day treatment.

The minutes were approved with one change. Leslie Matthews was added to the list of those in attendance.

Dan explained that the CSA RFP committee is hoping to reach closure by February 15 in order to make a recommendation to the Board by the end of the month. The discussion of NC TOPPS was deferred.

Billie reported that Elizabeth Vickery is currently serving on the Resident Selection Committee for the new Level III SPMI Group Home in Chapel Hill. Billie also provided details about the upcoming LOC meeting and encouraged members to attend. She prompted members to review the remainder of trainings and conferences (attached) for this fiscal year so that CFAC can budget accordingly. Thus far, despite much encouragement, she has received requests from only two CFAC members. If members are interested in attending a training or conference, they must come to the next meeting with a formal request. Michael advised CFAC members that if they are interested in serving on the planning committee for the upcoming Rights and Empowerment conference, they should contact him as soon as possible.

The vote on the budget was deferred until next month. In March, we will reach final closure on who will attend trainings and conferences and therefore also be able to take a final vote on the budget.

Judy provided an update on divestiture. Adult SPMI ACTT will be divested to Lutheran Family Services by a goal date of March 1. Cross Disabilities ACTT, which will be provided by a spin-off agency, will be divested by a goal date of May 1. Club Insight and Club Creative will be divested to the Chrysalis Foundation by a goal date of March 15. Club Nova will be divested to Club Nova, Inc. by a goal date of mid-March. OPC is hoping to divest DD and CAP case management, as well as the Supported Living Program by a goal date of late June. OPC is also currently looking for a provider to take over the Early Intervention program in Chatham County with the goal of doing this by late June. The CSA RFP committee plans to present a final recommendation to the Board during the February 28 meeting, with a goal of divesting the clinics by late June. Remaining programs include court services (TASC, CRC and DWI) and deaf services, which is a regional service currently provided by OPC.

Dan announced that the Board had a working group last Tuesday and it was recommended that CFAC write a letter to Division in support of OPC. Dan read a drafted letter, which was supported. A motion to approve the letter was made and seconded. There was brief discussion about the second paragraph. A small change was made and the letter was approved with no dissent.

CFAC spent the remainder of the meeting brainstorming about goals for the upcoming year. The following suggestions were made: gaps analysis/assessment; monitoring providers (including promoting easy and quick access to information regarding provider performance); reviewing reports, such as the NC TOPPS survey and best practices across the state; advocacy, including but not limited to insurance parity, housing, transportation; and community education (increasing awareness and reducing stigma). CFAC will spend the majority of the March meeting prioritizing goals for the next year.

Other agenda items for March include a presentation from Judy T. and Dave J. about OPC finances, an update from members taking the WRAP training and a report on PAI's progress.

The meeting was adjourned.