



## East Carolina Behavioral Health

*serving...Beaufort, Bertie, Craven, Gates, Hertford, Jones,  
Northampton, Pamlico, & Pitt counties*

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**ECBH Provider Forum  
February 10, 2010  
Agricultural Center, Greenville  
1:00-4:00**

Bland Baker:

- a. Had staff introduce themselves and state positions
- b. Reviewed the agenda
- c. Made providers aware of the comfort agreement

Bland Baker:

- a. Gave update that ECBH was awarded URAC certification for 3 years

Nancy Cleghorn: Community Support/Level III Transition Update/Sex Offender Training

Level 3 – 4 Transition:

We started with 222 in level 3 and now have 89 in level 3

We started with 15 in level 4 and now have 9 in level 4

So total youth in level 3 and 4 now is .....98

Level 3 Beds in our area: started with 231 and down to 195

Does your level 3 serve sex offenders or youth at risk for inappropriate sexual behavior? (let me know)

- Front line group home staff have been trained in all aspects of sex offender tx.
- Supervision is provided by an expert
- The expert is available 24/7 for consultation

(see Operations Manual page 104-105)

### TRAINING:

Here on Feb 19 from 1 to 4 Meeting the Challenge of Youth with Sexual Problems Within the Foster Care System. See our website to register

### CS Transition:

Continue to communicate with us through your spreadsheets. A Revision was suggested to spreadsheet to indicate total # transitioned.

If agencies that are ending the provision of CSS give less than a 30 day transition on their closing and this leads to disruption for consumers -- ECBH will report those agencies to the Division, then reported to DMA. Consumers should not be dropped from services.

Children that transition from Level III can receive Therapeutic Foster Care and Intensive In-Home at the same time.

SOC staff needs to be invited to CFT meetings

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Bland Baker:

Implementation Update # 67

- a. PSR Programs are “clinical homes”
- b. PCP must address all needs of the consumer eff. 2/01/10
- c. Annuals reviews after 2/1/10 must be on new PCP format
- d. Value Options will return PCPs if not in compliance with new rules eff. 2/1/10

Michelle Lewis:

Implementation Update # 68

- a. Record Retention / Disposal Plan has been addressed in the Provider Alerts
- b. Plan must be submitted to Shirley Harrell (Medical Records)at the LME
- c. ECBH held training but had low attendance
- d. Plan must state how records will be managed, stored etc if agency should close their agency

Day treatment service definition approved effective 4/01/10:

- a. Current providers are expected to meet service definition guidelines eff 4/01/10
- b. Providers should adhere to Evidence-based Practice and also which model is being used for clinical practices in policy and procedures
- c. If not adhering to service definition, then withdrawal of endorsement
- d. Definitions for Intensive In-Home and Community Support Team are forthcoming
- e. Definitions for CAP and Diagnostic Assessment are covered in Update 68

PCP Format:

- a. 3/811/10—providers may begin using the new PCP format for annual rewrites
- b. 3/1/10—will be no intro PCPs
- c. Providers should provide training for staff in completing PCPs to assure understanding of the new format guidelines. There is a new manual for this
- d. PCP must include all services if client only receives Basic Benefits—a comprehensive PCP is not required ( med mgt; outpatient therapy
- e. 7/01/10—all providers are mandated to use new PCP format.

Michelle Lewis: Endorsement Process Review: handout

- a. 2 tries to submit applications
- b. Extends timeframes
- c. After application approved—will have desk review; clinical review; on-site review
- d. Step by Step application documents also addressed in provider alert 2/05/10

Bland Baker: Business Verification/Re-endorsement Process

- a. Most agencies were endorsed in 2006/2007—they need to submit attestation letter to the LME for business verification to the attention of their lead coordinator.
- b. This will result in a new NEA letter that provider must submit to DMA
- c. If no letter of attestation is received by the LME, this may result in withdrawal of endorsement.
- d. The attestation letter should be submitted to the provider’s home LME—the LME that completed business verification

Bland Baker: Certificate of Insurance Review (samples given out)

- a. LME must have a current COI on file at all times
- b. Provider should not have lapse in coverage as this may result in withdrawal of endorsement.
- c. COI is not acceptable if all items are not listed on certificate
- d. Provider must communicate with insurance agency as ECBH’s policy is not to communicate with the insurance agencies.

Nancy Cleghorn / Michelle Lewis: Treatment of Co-morbid diagnosis

- a. Treatment of co-morbid diagnosis is moving toward use of evidence-based practice
- b. LME's philosophy is that provider agencies must be able to provide services to MH/SA diagnosed consumers.
- c. Clients must be receiving treatment for all services-services cannot be separated.

Handout has been updated to clarify:

**Clarification:**

In the Provider Forum on 2-10-2010, there was a handout referencing "supervision from a CCS or CSI that should be evidenced through employment of agency staff, or a contract or MOA with a CCS/CSI agency." Be aware: To have a contract with an agency (instead of an individual) would require written prior approval [from the LME](#).

**TREATMENT FOR CONSUMERS WITH SUBSTANCE USE/ABUSE/DEPENDENCE**

**Introduction**

All consumers should receive the most appropriate services based on their symptoms and diagnosis. Providers must have the capability to treat the individual consumer as a whole person. When a consumer has struggles with substance use/abuse or dependence, treatment should address these issues in a holistic manner. It is not acceptable to treat a consumer for a mental health (MH) diagnosis and refer the consumer out to another agency for treatment of a SA diagnosis. Treatment staff involved in the consumer's care must be trained and/or supervised to provide adequate treatment of the substance use/abuse or dependence. East Carolina Behavioral Health Local Management Entity (ECBH) monitors providers to ensure appropriate integrated treatment and ensures the health and safety of consumers.

**Standards**

If there is any indication of substance use and there is not a diagnosis, a referral for Substance Abuse evaluation should be made to a substance abuse qualified provider agency/practitioner to clarify diagnosis as needed.

If a consumer has a Substance Abuse (SA) diagnosis, (abuse, dependence or when applicable any of the specifiers, for example full sustained remission, etc) the provider must ensure that staff are either licensed/certified or appropriately supervised.

Licensed professionals provide treatment within their scope of practice.

Any provider agency staff who are not licensed or certified and deliver treatment services of any kind to a person with an SA diagnosis must be supervised by a Certified Clinical Supervisor (CCS) or Certified Clinical Supervisor-Intern (CSI).

Any provider agency staffs who are a Certified Substance Abuse Counselor (CSAC) must be supervised by a Licensed Clinical Addiction Specialist (LCAS) or CCS or CSI. The best evidence of adequate and appropriate supervision is the process that has to be followed when registered with the NC Substance Abuse Professional Practice Board. (<http://www.ncsappb.org/>) ECBH recommends this Board registration as the method to demonstrate compliance.

Adequate and appropriate supervision are requirements for endorsement.

The capacity to receive supervision from a CCS or CSI should be evidenced through employment of agency staff, or a contract or MOA with a CCS/CSI. (To have a contract with an agency instead of an individual would require prior written approval from the LME.) This would be further evidenced in staff supervision plans and supervision notes.

If consumer has an SA diagnosis and is treated by unlicensed/un-certified staff without the CCS/CSI supervision in place, ECBH staff then proceeds with recommendation to withdraw endorsement.

If an agency is providing a service that may be billed for a consumer with an SA diagnosis, the provider agency must adhere to these treatment standards. The co-morbidity should be addressed in the provider's program description and in job descriptions.

Provider's policies and procedures would address treating consumers with SA if an agency is providing a service that may be billed for a consumer with an SA diagnosis. Providers must ensure all staff is trained on policies and procedures.

Provider's policies and procedures should state if a provider does not serve consumers with SA. There should be procedures that are explicit about how these consumers are handled.

To ensure the health and safety of consumers, endorsement requires compliance with these review elements.

References:

**21 NCAC 68**, History Note: Authority G.S. 90-113.30; 90-113.39; 90-113.40; *Eff.* August 1, 1996.

2005: Senate Bill 705 which makes the substance abuse credential mandatory for all substance abuse professionals.

Michelle Lewis: CABHA update

- a. CABHA is still on track for implementation on 7/01/10
- b. State has begun desk review of letters of attestation
- c. Process mirrors the endorsement process for ECBH
- d. Only 2 providers under ECBH/AMHC have submitted letters of attestation at last review
- e. If not CABHA by 7/01/10 and provide Day Tx; IIH;CST, the provider will be out of business as it stands in rule today

Fonda Gonzales: Website update

- a. Provider choice list can be found on ecbhime.org by 2 search options
  1. location
  2. Service type
- b. Must complete CMHC user agreement at agency level to be granted access to the database
- c. Identified point person (for agency) will enter demographic information along with site specific data
- d. For counties served—remember to only indicate counties within geographic region of endorsement as well as those counties that can be reached within "First Responder Clinical home timelines.
- e. Remember that ECBH and AMHC are separate entities---unless you have an MOA with ECBH/AMHC appropriately—provider cannot list ECBH/AMHC as eligible counties.

Cham Trowell: Complaint Process Review

- a. Karen Ricks in STR will be overseeing the Compliant Process
- b. Complaints call access to care line which is 24/7-365
- c. Compliant can be phone call, fax or written letter sent
- d. Letter goes to provider, provider must respond back within time frames
- e. Send evidence to LME; re- resolution letter
- f. Send certified mail

Amy Modlin: Housing Update—handout

- a. ECBH has received \$2 million for 15 counties
- b. Hired 6 new staff—4 housing coordinators/ 2 housing locators
- c. Help people that are homeless or will be homeless

1. Rent
2. Utilities
3. No mortgage payments
4. Consumer must have some income or know income coming

Wanda Piland: ECBH & AMHC benefit plan for next year

- a. A Gaps and Needs analysis to be completed
- b. Family Living Moderate service will continue
- c. Increase long term vocational supports
- d. MST added to AMHC

Michelle Lewis: Evidenced based Practices (handout available)

- a. Outcome oriented
- b. Matrix model
- c. UNCSW training
- d. Providers encourage to visit websites to find resources

ECBH Initiatives and Future Opportunities

Waiver Updates:

- a. About economy of scale and scope
- b. How many providers are actually needed to provide services
- c. Similar to hospital certificate of need, but done locally versus at legislative level
- d. Similar to Piedmont Waiver
- e. Some differences—not a lot of providers
- f. Most TCM, Outpatient , etc was done by Area Program
- g. Piedmont close to ECBH & AMHC if merged in size
- h. Piedmont has only 3 comprehensive providers
- i. Difference is that ECBH has been moving forward with managing care versus providing care because they went from Area Program to managed care entity
- j. ECBH has also a decade of knowledge about how to manage versus Piedmont who did not have this advantage
- k. Advantage of waiver \$800 million includes everything in mental health
- l. If ECBH saves 1% , we can re-invest the money into whatever services needed—peer support,etc
- m. This allows the LME over time to buy what services the clients really needs not what is available in Medicaid service array.

RFPs & Grants:

- a. No RFPs in ECBH area—based on budget deficiency
- b. RFPs will be discussed in AMHC area at the next meeting
- c. Outpatient treatment using IPRS dollars contract must be 100% Evidence-based Practice model and demonstrate utilization of EBP prior to authorization of service
- d. Some LMEs are already doing this –Durham Center is example
- e. Reason is to help clients to benefit from services and treatment

CAP Waiver

- a. ECBH awarded 41 tier 1 slots and 5 comprehensive
- b. 270 consumers on wait list

Next meeting is March 3, 2010 at the Agricultural Center in Greenville.

Approved by Bland Baker—3/17/10

Recorded by Becky Smith