Medicaid Modernization or Transformation?

Modernization and transformation are the terms that are being used right now to distinguish between the House plan (Medicaid Modernization, HB372) and the Senate plan (Medicaid Transformation HB97) as passed by House, Section 12H.24.(a)) to restructure the entire Medicaid program into a capitated, at-risk managed care model. The differences between the House and the Senate plans go well beyond the titles they have given this restructuring.

Both include the LME/MCO management through the 1915(b)(c) waiver, but the timeline and expectation for transition varies in the proposals. The Senate gives the LME/MCOs up to three years with what has been characterized as a “pass-through” but the actual term in the provision is a “subcontract” that will go through the identified Managed Care Organization (MCO) or Provider-Led Entity (PLE). The capitation will be no lower than at the current capitation rate for the LME/MCOs. The House proposal excludes the MH/I-DD/SA services managed by LME/MCOs from most other Medicaid services that will be managed by the PLEs.

Both the House and Senate plans include PLEs, but the Senate also includes private, for-profit Managed Care Organizations. This is a key point of controversy as the House is promoting a “homegrown” model and the Senate is promoting competition between for profits and PLEs. As has been the case for the LME/MCOs and likely will be for the PLEs, any savings are used to reinvest in the service delivery system. For MCOs, savings are passed along to private shareholders. It is exactly these differences that cause the controversy. It is difficult to compete with one another when there are fundamental differences in the approach of the organizations.

The House proposal maintains Medicaid within the Department of Health and Human Services structure. The Senate proposal moves Medicaid out of DHHS into a new Health Benefits Authority. The Authority would be overseen by a private board of directors.

Finally, the timeline for implementation also varies between the two proposals. The House gives six years for implementation from the date the law becomes effective. The Senate proposal begins full capitation by August 1, 2017.

The two versions of the budget will be negotiated through a budget conference committee. HB372 has now passed the full House and will be considered by the Senate. It is not clear at this time which vehicle will be used to move North Carolina closer to Medicaid restructuring.
NC Council to Host Health Literacy Training with CDC Expert

If you are a communications staff member, care coordinator, cultural competency staff, community relations or training staff member at an LME/MCO or Provider organization, it is important that you communicate clearly with those you serve about their care. Being able to do this is called Health Literacy. As we move forward with managed care, care integration and toward health activation, where patients obtain the skills to manage their own health and improve their outcomes – health literacy will become even more important.

The Centers for Disease Control website says: “The Patient Protection and Affordable Care Act of 2010, Title V, defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.”

On July 9th the NC Council will host a one-day training, A Clear Approach to Health Literacy & Communications. This interactive presentation by the CDC will include a discussion and activities around the use of Plain Language; a Review the CDC Clear Communication Index Tools; and a “Walking Tour” of the CDC Health Literacy website and resources and more. Two websites will be the foundation of this training: CDC health literacy web site: www.cdc.gov/healthliteracy; and CDC Clear Communication Index: www.cdc.gov/ccindex

Trainer for the day Cynthia Baur, Ph.D., Senior Advisor, Health Literacy, Office of the Associate Director for Communication, Centers for Disease Control and Prevention describes her approach to health literacy saying,

“bring analysis, innovation, collaboration, and strategy to effective health communication with lay and professional audiences. Even the best science won't make a difference unless it is shared with others in ways they can understand and use. My passion for audience-driven communication leads me to focus on clear messages, appropriate channels, maximum reach, and dynamic feedback loops so that the communication process is interactive and self-correcting.”

- Dr. Cynthia Baur, Ph.D.

This one day training is $60 and will be held at the Royal Conference Center in Raleigh on July 9, 2015, from 9:30 – 2:00 p.m.. Register today!

For more information on the content of this training contact Joanna Linn at (919) 757-5608 or jlinn@nc-council.org.
Both the House and Senate have now passed their versions of the biennium budget for SFY15-16 and SFY16-17. The next step is for a budget conference committee, consisting of multiple Representatives and Senators, to meet and negotiate the points of contention or difference within the two budget proposals. If you have looked at the two budget proposals you already know that there are many of these! The House approach was to align fairly closely with the Governor’s budget proposal. The Senate approach was to add provisions related to large issues, one of which is Medicaid reform, presumably as negotiating chips during conference committee deliberations. Provisions related to MH/IDD/SA services that were in both or either budget include:

- $185.6 million Cut to Single Stream State funding to pay for Medicaid Transformation for each biennium year was included in only the Senate version (see story on page 4).
- Medicaid Reform/Transformation specifics were only included in the Senate budget (see story on cover).
- The House eliminates the State’s contribution of 2% to the LME/MCO Medicaid Risk Reserve by 2017. The Senate directs LME/MCOs to use their Medicaid Operating Budget for the Medicaid Risk Reserve and does not eliminate the State’s contribution of 2% until the LME/MCO has reached the 15% Medicaid Risk Reserve amount.
- LME/MCO Consolidation to five was only included in the House budget.
- A phased in transfer of ADATC funds to LME/MCOs is included in the Senate budget.
- Funding and Direction on Behavioral Health Crisis Services and building rural inpatient capacity is included in several provisions in the House budget.
- Additional State funding for the DOJ Settlement was included in both budgets.
- TBI funding and a new waiver was included in both budget proposals.
- Discontinuation of the CCNC contract for primary care case management was only included in the Senate budget.
- LME/MCO Out-of-Network Agreements are further specified in both the House and Senate budget proposals.
- Repeal of the Certificate of Need in a phased process is included in the Senate budget proposal.
- A report on the significance of national accreditation for 122C group home providers as it relates to monitoring requirements is included in the Senate budget proposal.

The General Assembly is expected to select the members of the Conference Committee to work out the difference in the budget proposals soon. Once those members have been chosen it will be important for stakeholders interested in these issues to contact their members and have their voice heard. To get a list of Conference Committee members and their contact information go to the General Assembly’s website.
Medicaid Should Not Be Used to Supplant State Funding

A provision in the Senate’s budget proposes to cut $185.6 million each year for the next two years ($371.2 million total) from LME/MCO State service funds to pay for the state’s Medicaid Healthcare Transformation. The Senate is assuming that the $185.6 million from State funded MH/I-DD/SA services will be made up by LME/MCOs using their “cash reserves.” The term is an umbrella that includes many categories of funding—most of which are reserved by statute or designated through a formal process by the Area Board. This makes the Senate’s proposal a very risky move that could result in cuts to existing services for the over 100,000 North Carolinians who are uninsured or underinsured. There are some key categories of funding that are required to remain intact by federal and State statute. The largest categories are related to Medicaid. The federal oversight agency, Center for Medicare and Medicaid Services (CMS), regulates the usage of Medicaid dollars through statute and regulation.

What Are Medicaid Cash Reserves?

Medicaid Risk Reserve (MRR): Every State is required (see 42 CFR 438.6) to have a means for insuring against catastrophic loss in a Medicaid waiver. That can be done through the MCO (public, non-profit or for-profit) purchasing stop-loss insurance, implementing risk corridors through which the MCO covers a certain part of the risk and then the State steps in to cover the rest (and profit is shared the same way) or a dedicated risk reserve. The requirement for the amount equal to 15% of the LME/MCOs annual Medicaid operating budget is written into the Medicaid 1915(b)(c) waiver agreement between North Carolina and CMS. Therefore, it would require a change to the 1915(b)(c) waiver if the Risk Reserve is no longer the way in which NC can insure against catastrophic loss.

Medicaid Operating Budget: Medicaid is an entitlement both in fee-for-service and managed care models, so approved/authorized medically necessary services have to be paid for. Within the 1915(b)(c) waiver, the services include mental health and substance abuse service and services for individuals with intellectual or developmental disabilities. Any risk of budget overrun lies with the LME/MCO. For CMS purposes LME/MCOs operate on a full accrual basis, meaning revenue is recorded in financial statements according to anticipated earning timeframes, and money that is owed to the LME/MCO is reflected as cash. At the same time, LME/MCOs record all liabilities at the time they are incurred which is reflected on the financial statement as “incurred but not reported liability” or IBNR. This is a critical point to recognize when reviewing financial statements because the Medicaid Operating Budget will include PMPM (earnings) as well as the IBNR (liabilities). It is by using both of these data points correctly that one can accurately reflect any Medicaid savings that have been achieved.

$275.5 Million = Average Annual Medicaid Operating Budget per each of 8 LME/MCOs

96% = Average Amount of the Medicaid Operating Budget that is spent on Medicaid services every month

4% = Average Amount that is Saved in the Medicaid Fund Balance and designated for Medicaid services

Medicaid Fund Balance: The intent of the Medicaid Fund Balance is to have dollars available to BUILD the service system. The Medicaid Fund Balance is made up of those dollars that the Medicaid managed care organization has been able to save due to making sure that people get the right service, at the right time, and in the right amount, thereby reducing the need for more expensive services. This is the part of the managed care model that provides support to the MCO to keep the population as healthy as possible. The LME/MCO will only approve a certain service because it is deemed by licensed professionals to be the BEST medically necessary service to meet the person’s needs. Sometimes that might require a more costly service than the one originally requested, and the LME-MCO ensures that this can happen. It further provides the incentive to treat the “whole person” because that consumer may have a health issue that has a ripple effect to cause them to need other services. The fund balance is also the first line of defense if there is a cost overrun in any given month, and it helps to ensure that providers do not experience problems when the State has cash flow or technology problems. When the waiver was expanded statewide through HB916, the intent expressed by the General Assembly and the Department of Health and Human Services was for the savings from Medicaid to be reinvested into the service system. LME/MCOs use their Gaps and Needs Analyses to determine the best ways to reinvest those savings.

Current Examples of How the Medicaid Fund Balance is reinvested into the Service System:

- Addition and expansion of MH/SA Integrated Care Teams and Hospital Transition Teams designed to work with consumers exiting psychiatric hospitals and EDs.
- ADATC consumer integration into LME/MCO population
- Assistance to a regional hospital’s Transitional Care Clinics
- Rapid Response for Children in Crisis
- Crisis Center Expansion in urban and rural parts of catchment areas as a part of the Governor’s Crisis Solutions Initiative
- Expansion of ACTT services to all counties
- Healing Transitions of Eastern North Carolina to build on the successful Healing Place model for substance abuse
- Pediatric Co-location projects
- Implementation of 5 integrated care projects with pediatric services, community health departments, a local hospital and a University School of Medicine
- Child Parent Psychotherapy (PSS)/Child First
- Building Overnight Respite Availability
- Specialized Child and Adolescent IDD Crisis Residential Service
- Accessible Playgrounds for Children with I-DD
- Specific projects like Rachel’s Challenge to Address Child Fatalities related to Suicide
- Expansion of availability of Behavioral Health Advanced Access/Urgent Care Centers
- Enhance Open Access Support
Leadership Changes at DHHS and Division of Medical Assistance

In May the Department of Health and Human Services announced several changes to their leadership. Robin Cummings, MD, Deputy Secretary for Health Services and Medicaid Director stepped down to become the Chancellor at the University of North Carolina at Pembroke.

Dave Richard has been named the new Deputy Secretary for Medical Assistance, taking on oversight of the Medicaid program. The role of Deputy Secretary for Behavioral Health and Developmental Disabilities has been given to Dale Armstrong, current Director for State Operated Healthcare Facilities. In addition to his new role, Armstrong will maintain his oversight of the state healthcare facilities. Courtney Cantrell, Ph.D., Director for the Division of MH/DD/SAS will have an increased role in supporting Armstrong with the oversight of the state facilities as well.

When asked about his new role and whether he thought the combined responsibility of oversight with the state facilities will benefit the system, Armstrong said, “The Deputy Secretary for Behavioral Health and Developmental Disabilities role offers a unique opportunity to coordinate both the hospital-facility and the community side of healthcare by working hand in hand with LME-MCO’s, community providers and consumer associations. Although I am new to the position of Deputy Secretary, I am not new to the issues. One of the benefits of working within North Carolina’s health and behavioral health system for 23 years is gaining necessary perspective. I see some of the challenges that we as a state, have been struggling with for years, but more importantly I see new, creative and effective solutions and a group of providers, consumers and healthcare leaders, committed to enhancing the array of behavioral health, developmental disability and substance use services for those we serve.”

“A key driver in successfully addressing the challenges we face is the coordination of services across a growing continuum. Developing a more seamless process of integrated care from the least restrictive, to when necessary, the most restrictive will be my primary goal. Doing this in a manner that involves all stakeholders and assures a system that provides high quality and is cost effective will be key.”

Division of Medical Assistance

There has been some minor staff restructuring to the clinical policy section at the Division of Medical Assistance. Since October, 2013, the Behavioral Health Assistance Director position has been vacant. That position was responsible for the day to day management and responsibly of the behavioral health unit. Sandy Terrell is the Director of Clinical Policy. Under the new structure, Terrell will have three Associate Directors. These Associate Directors will have less of a day to day programmatic role and more of a high level strategy role to help executive leadership meet DMA’s mission, vision and values.

Linda Rascoe was recently announced as the new Home and Community Associate Director. She will be responsible for the home care initiative unit, Personal Care Services, optical, speech and behavioral health. Rascoe is currently a program manager at the Department of Public Health and begins her new position with DMA on June 24th. Two additional associate directors are still to be named.

The behavioral health section will also have a new program manager (formerly known as chief). An announcement on this position will be forthcoming.
The NC Council has been honoring leaders in our system with its yearly Leadership Awards for over 20 years. This year was no different with an impressive slate of winners recognized during the Stronger Together - 2015 Spring Policy Forum on June 8th. Over 300 MH/DD/SA professionals and stakeholders were on hand to recognize some outstanding individuals.

Award Winner Group Photo (L to R): Gayle Mitchell, CFAC Leadership Award Winner (Partners); State Representative Leadership Winner, Rep. Susan Martin (Eastpointe); County Commissioner Leadership Winner, Commissioner Leon Inman, (CenterPoint); Lifetime Career Leadership Awards Winner, Patricia Porter, Ph.D. and Pam Shipman, Allan D. Spader Award Winner.

Thank You to Our Leadership Award Luncheon Sponsors:
Alexander Youth Network
AlphaCM, Inc.
Brynn Marr Hospital
Community Choices, Inc.
DDR, Inc.
The Echo Group
Frye Regional Medical Center
GHA Autism Supports
Holly Hill Hospital
Homecare Management Corporation
Lifespan Incorporated
Monarch
Nazareth Children’s Home
Netsmart
Old Vineyard Behavioral Services
Perkins+Will
Recovery Innovations
Southern Pharmacy Services
Therap Services

Consumer and Family Advisory Committee Leadership Award
Rhett Melton described CFAC Chair Gayle Mitchell’s leadership saying, “It is July 2012, Gayle Mitchell takes over as CFAC Chair. Three strong local management entities have joined to form Partners Behavioral Health Management. With all mergers, it is important to develop goals, a sense of direction, and most importantly, camaraderie within groups. With her leadership, Gayle Mitchell has helped pull together a diverse group of individuals into a proactive group. Today, Partners’ CFAC is a strong group of dedicated volunteers. Within the first few months of existence, they had developed their mission, identified goals and initiatives, and used measurable results to measure their success. However, Mrs. Mitchell wanted to make sure that the members of the group always had an opportunity to speak up, or let their voice be heard—which lead to the creation of “Our Voice,” a tool that ensures that members get the support they need while also celebrating personal accomplishments. Our Voice is shared with the Partners Executive Team monthly and is one of the examples of the many ways that Mrs. Mitchell’s leadership talents have benefited the CFAC.”

County Commissioner Leadership Award
County Commissioner Leon Inman was nominated by CenterPoint Human Services. Chief Administrative Officer Rhonda Outlaw presented his award saying, “Leon Inman understands people, their behaviors and motivations. Having worked for 33 years in the Stokes County School System, he worked as a teacher, counselor and administrator, giving him a broad and balanced viewpoint of youth issues, system challenges and the imperative need for community collaboration to build services and supports for those with MH/1-DD/SA problems.”

“At the NC Association of County Commissioners, Leon Inman is leading the charge to help County Commissioners stay informed about the MH/1-DD/SA system. He is the chair of a new Task Force of County Commissioners meeting to better understand the MH/1-DD/SA system in order to help their citizens navigate and obtain the care they need. Recommendations will be out in August and are expected to focus on helping counties find ways to assist their citizens to access and navigate care, as well as to ensure that county commissioners across the state understand the basics of how our system works.”

State Representative Leadership Award
Representative Leadership winner Rep. Susan Martin was nominated by Eastpointe, and her award was presented by CEO Ken Jones. He described Rep. Martin as “very committed and passionate about ensuring that there is availability of mental health crisis services geared toward children and adolescents. She understands the MH/1-DD/SA system in-depth, and has provided recommendations and insights to create reasonable approaches to crisis services that will help divert consumers from inappropriate emergency room visits. She is also very supportive of LME/MCOs and their management of services.” Jones went on to describe her legislative work impacting MH/1-DD/SA services, “She serves on several legislative committees, including Health, and the Joint Legislative Oversight Committee on Health and Human Services. She was the co-chair of the Subcommittee on Mental Health under the Joint Legislative Oversight Committee on Health and Human Services. It was that subcommittee which drafted the provisions included in the Report on Strategies for Improving Mental Health, Developmental Disabilities, and Substance Abuse Services. All these provisions were included in the 2014 budget bill and are now in progress, making our system better.”

Continued on page 7...
2015 Leadership Awards Presented

**Lifetime Career Leadership Award**

Lifetime Career Leadership Award winner Dr. Patricia Porter was nominated by former Cardinal CEO, Pamela Shipman. Shipman described Dr. Porter’s almost 40 year career in MH/I-DD/SA system saying, “Dr. Porter has served the North Carolina system of care for people with disabilities since she first arrived in 1977. She was recruited by the University of North Carolina Division for Disorders of Development and Learning (now the Carolina Institute for DD) due to her extensive work and piloting of techniques for non-verbal communication for people with disabilities. She served as both Clinician and Clinical Director at the Division for Disorders of Development and Learning. Dr. Porter later joined the faculty at UNC as Professor at The College of Allied Health. Dr. Porter has also served as the Chief of Developmental Disability Services for the North Carolina Division of MH/DD/SA fourteen years during a period of rapid growth and development of the community service system. She became a consultant for the NC General Assembly in the area of health and services for people across the range of disabilities at a critical time, and has served as a valuable resource to legislators ever since. In her role, Dr. Porter has assisted with numerous important pieces of legislation, including House Bill 916, which passed the General Assembly in 2011 and expanded the Medicaid waivers statewide. She has been immensely supportive of the community system of services and has worked tirelessly to preserve and improve critical aspects of the system.”

**Allan D. Spader Award**

This award recognizes an individual with strong leadership and collaboration skills. This year’s winner, Pam Shipman, was unanimously nominated by her LME/MCO CEO peers. The award was presented by Leza Wainwright, CEO of ECHB and NC Council President. Wainwright described Shipman’s accomplishments saying, “It is not an overstatement to say that Pam Shipman is the architect of the current behavioral health and intellectual and developmental disabilities public Medicaid managed care policy in NC. In 2003, Dan Coughlin (then CEO) and Pam persuaded Secretary Carmen Hooker Odom to support a waiver pilot at PBH. Pam came to Raleigh several days every week to work with workgroups of staff from DMH/DD/SAS, DMA, the DHHS Controller’s Office, and DHHS budget and analysis to craft the initial waiver and to identify the changes that would be needed to make the waiver successful.”

“The PBH experiment proved extremely successful and in 2011 Pam, who was then CEO of Cardinal Innovations, again stepped up to take the lead on the expansion of the waiver statewide. She worked tirelessly with DHHS leadership and Representatives Barnhart and Dollar to craft HB 916 and shepherd it to its ultimate passage. The result has been the conversion of our system to one that controls costs, ensures consumers care, is sustainable, and provides budget predictability. Pam’s efforts are based on her strong commitment to the consumers of services and their families. Before embarking on her 28 years of service to PBH/Cardinal she worked tirelessly in support of individuals with I-DD while with NC Developmental Evaluation Centers and a Developmental Daycare Center.”

---

**Be Our GHEST**

GHEST (Group Home Employee Skills Training) is a newly-revised training program for staff working in adult mental health group homes. The training was originally created in collaboration with NAMI Wake County and has been revised and updated at the UNC School of Social Work. The program provides face-to-face and online content about the basics of recovery, symptoms and treatment of common mental illnesses, effects and side effects of frequently used medications, ways to promote pro-social behavior, and many other relevant topics for adult group home staff.

Recently Wake County, Alliance Behavioral Health, and the Jordan Institute for Families at the UNC School of Social Work partnered to provide an overview of the GHEST curriculum to group home directors in Wake County. Because this was presented in a train-the-trainer approach the program will reach approximately forty-eight adult mental health group homes in Wake County.

One key to the success of the training has been the reliance on group home directors to help design and implement the training. Two Wake County group home directors were recruited to serve as co-trainer/resource people. These partners were extremely helpful in recruiting their colleagues to participate in the learning network and to keep the face-to-face training “real.”

An additional positive outcome of the training has been the enhanced communication and collaboration between the MCO and the adult mental health group home directors. The collaborative learning network created by this training program has the potential to be a vehicle for additional shared learning experiences in the future.

If you are interested in GHEST for the adult group homes in your community please contact Bebe Smith or Michael Owen at the Jordan Institute, UNC School of Social Work at owenmb@email.unc.edu or Besmith@med.unc.edu
Behavioral Health Leaders United in Support for Public Management at Spring Policy Forum

By Andrew Meehan

At the NC Council’s recent Spring Policy Forum in early June, prior to the NC Senate releasing its version of the state budget, a panel of behavioral health leaders closed the Forum with a united message -- public managed care is working well and stability is vital.

The closing panel, which took place on June 9, was moderated by Tim Boyum, host of Capital Tonight on News 14 Carolina. The panelists were:

- Karen McLeod, Executive Director of Benchmarks.
- Dave Richard, Deputy Secretary for Medical Assistance at DHHS
- Vicki Smith, Executive Director of Disability Rights North Carolina
- Leza Wainwright, Executive Director of East Carolina Behavioral Health (to be Trillium July 1)

There was concern among several panelists that the legislature might undo the state’s successful move to public managed care for behavioral health. Wainwright said she hoped behavioral health would not take “collateral damage” as part of a broader effort.

Legislative leaders on Medicaid have been discussing reform proposals for months. On Monday, June 15, the North Carolina Senate released a plan that would bring private managed care companies to the state and require them, in the short term, to contract with LME-MCOs.

McLeod acknowledged that this is a difficult time to be a provider. However, she was concerned that the hard work and innovation accomplished under public managed care could go away under a new Medicaid package. She also said that for some providers “the grass always looks greener.” But private managed care is not the same as dealing with private insurance companies. Medicaid has lots of regulation and requirements that private insurance does not, this will carry over even with private management.

Vicki Smith said the biggest concern for her group is ensuring that consumers have due process under Medicaid. She also stressed the need for policymakers to think long term, instead of just about short term savings. “Behavioral health cannot weather another major structural change. The MCOs have been kept off balance for many years. The real cost is borne by the recipients of services,” Smith said. “It’s a fallacy that just reducing dollars reduces the need. Those folks are not going away.”

The panelists also talked about the challenges of the “whole person care” concept that is attractive to legislators. Wainwright pointed out that most commercial managed care companies segment behavioral health. Also, very few states have managed care for the I/DD population.

In general, there was optimism that the legislature could reach a compromise that is good for the behavioral health system. Richard said that the House and Senate were fairly close on a solution, and he stressed the need for stability.

Wainwright said she was “very optimistic,” believing that the behavioral health and I/DD communities have made a strong case to the legislature that the public managed care system is working. McLeod said she also believed that the state will continue to keep the behavioral health system segmented and intact, but was unsure for how long that would be the case.

Andrew Meehan is the President of Meehan Strategy Group. He can be reached at andrew@meehanstrategy.com.
Small EMS Grants Could have Big Impact on Reducing ER Visits

A new grant distribution of $5,000 to LME/MCOs collaborating with their local EMS staff were recently granted. To be selected for this grant, LME/MCOs, providers and local emergency medical services agencies collaborated to identify how funds would be used to increase their community’s crisis service capacity. Grants were awarded to communities that had a crisis center provider willing to function as an alternative to the emergency room. Grants were awarded to the following LME/MCOs and counties:

- Partners – Lincoln
- Smoky - McDowell
- Alliance - Durham
- CoastalCare - Brunswick
- Sandhills - Guilford
- CenterPoint - Rockingham, Stokes, and Forsyth
- Cardinal - Orange, Franklin, and Halifax

According to DHHS, these counties, along with Onslow and Wake Counties which already have similar programs, will have the ability to divert more than 2,500 patients a year from the hospital ER to local crisis facilities.

There are many efforts underway to reduce the use of emergency room visits for MH/I-DD/SA needs and to increase crisis care in the community. The Division of MH/DD/SAS’s Crisis Solutions Initiative Coalition has been working to develop and implement new programs and services for the past year and a half, and LME/MCOs have been implementing several of them at the local level.

Earlier this year, the State awarded $2.2 million in recurring state funds and federal block grant dollars to fund four new facility-based crisis centers. The LME/MCOs receiving those funds are Cardinal Innovations, CenterPoint Human Services, Eastpointe, and Smoky Mountain LME/MCO. Each program is building a new crisis facility which will offer 24/7 local inpatient care, staffed by MH/I-DD/SA professionals 24/7 which will give LME/MCOs an important resource in their crisis care continuum and go a long way toward reduce usage of the hospital emergency rooms for MH/I-DD/SA individuals.

In addition, LME/MCOs have been working closely with their NAMI affiliates, local law enforcement, and other first responders to provide Critical Intervention Training (CIT). This training teaches officers, paramedics, and 911 operators to recognize when someone is experiencing a mental health crisis and how to diffuse the situation. CIT also educates these professionals about the services and supports available in their community. To date, hundreds of officers and first responders have been trained all over North Carolina - further reducing the possibility of harm to individuals and the use of hospital emergency rooms.

A number of years back the General Assembly provided additional funding to LME/MCOs to pay for additional hospital inpatient psychiatric beds to help replace beds lost due to the closing of Dorothea Dix Hospital. New funding has also been provided for the construction of two new state psychiatric hospitals at Cherry and Broughton. The new buildings are now under construction and will be equipped with the latest design to better care for consumers.

NC Council Launches New Online Registration Process

The NC Council is pleased to announce that on July 1, 2015 we will be launching a new website and on line registration process. The new more responsive website is designed to fit any browser and is more mobile friendly. It will provide visitors with easier and quicker access to information.

**Our new registration process will be as simple as ABC!**

To go along with our new website, we have also upgraded the training registration process. ABCSignup is the NC Council’s new online registration system. The headaches of creating an account, changing passwords, or just trying to get through the registration process are in the past.

Some highlights of the new process are:

- A username and password is still required but once you create an account, you are in control! You can change your information easily, automatically reset your own password if it is forgotten, and much more.
- There will be more detailed descriptions of trainings, conferences, presenters and trainers including travel directions and links to brochures and other important documents.
- Can’t remember when you attended a particular training? Want to track your CE credits? Your account history from this point forward will be accessible through your login.
- Anyone can register! Paying with a check? Register online and an invoice is automatically emailed to you.
- Confirmations, receipts and reminders will automatically be emailed upon submission of your registration.
- Certificates will be emailed to each participant upon completion of trainings.
- Want to sponsor or exhibit at a conference? This signup can now be done easily online.

NC Council Executive Director Mary Hooper said, “We are excited to improve the Council’s online communication tools for our members and all the stakeholders that regularly interact with us. We hope this is one more way we can serve the system at large.”
Transitions to Community Living – A New Life for Many

Can you imagine living years in an Adult Care Home (ACH) setting with restrictive rules about what you eat, where you go and with little access to the outside world and then having the opportunity to move into your own place? That is what has happened for hundreds of residents with severe mental illness in North Carolina as a result of the Transitions to Community Living Initiative (TCLI) settlement agreement in 2012.

“The TCLI staff I’ve met around the state are navigating a very complex system to assist individuals to exit institutions or to get the community supports and services they need to not be institutionalized, breaking down many barriers along the way. Most importantly they are instilling hope and optimism for recovery for so many individuals who have had so few choices and no hope for their future.” – Marti Knisley, Independent reviewer for TCLI

The settlement agreement was reached between the State of North Carolina and the U.S. Department of Justice in a lawsuit brought in 2010 by Disability Rights NC. The suit was on behalf of individuals with severe mental illness who resided in ACHs due to the lack of funding for and availability of appropriate housing and community supports in North Carolina.

The job of moving these individuals into a community setting and ensuring mental health services and supports was given to the LME/MCOs. With the hiring of new staff, LME/MCOs began the process of identifying these individuals in their catchment areas, but that was just the beginning. The In-Reach process of visiting these individuals and explaining their new living options in the community began. For many, this message was hard to believe, and in many cases, it took numerous visits for LME/MCOs to educate eligible individuals about their options. Additionally, there are family members to meet and assure that their loved ones will be safe in the community and will get the care they need. There are also a number of challenges to community placement such as educating landlords so they are willing to rent to these new residents and finding housing situations that meet the consumer’s budget while ensuring safety and proximity to transportation. Once housing has been found for an individual, there are additional challenges of stocking food cabinets and obtaining furniture. Residents get assistance with all of these from the LME/MCO and providers. Overall, each individual transition is a process and not always an easy one, but in the end, the ability to live in and be connected to a community is important for individuals living and recovering from severe mental illness.

LME/MCOs were tasked with building a network of providers equipped to serve this special population in the community. Some individuals require additional personal care, more focused high level community support and mental health services. Two services that have been a focus of the State are Assertive Community Treatment Teams and Supported Employment. Many of the providers have met the test of fidelity to a nationally-recognized, evidence-based model of providing these services. Many LME/MCOs have also developed their own plans for transitional care to assist the consumer in beginning the process of moving into the community even when the housing option has not yet been identified.

North Carolina was assigned an Independent Reviewer for the Transitions to Community Living Initiative to oversee the settlement agreement requirements for the U.S. Department of Justice. For North Carolina, Marti Knisley with the Technical Assistance Collaborative, was recently appointed to the position. Knisley has been getting acquainted with the program and meeting with LME/MCOs around the state. She says, “The TCLI staff I’ve met around the state are navigating a very complex system to assist individuals to exit institutions or to get the community supports and services they need to not be institutionalized, breaking down many barriers along the way. Most importantly they are instilling hope and optimism for recovery for so many individuals who have had so few choices and no hope for their future.”

Each LME/MCO has highlighted their TCLI experience either with a story of a consumer or the experience of the staff working to house and support these individuals.

**Alliance Behavioral Healthcare – Peer Support makes all the Difference**

Alliance Behavioral Healthcare has experienced the positive impact of Peer Support in assisting individuals through the transition process, connecting them to services and helping integrate them into the community.

In one case peer support was working with an individual to build rapport and provide assistance with developing coping mechanisms, to deal with stressors presented with the transition process. He has a long trauma history and an equally long list of triggers, and has had difficulty engaging with providers and support staff. The support of a peer specialist in serving as an ongoing advocate, translator, and mirror has helped this individual cope with these stressors. This has helped him to start and stay engaged in behavioral and physical healthcare services when in the past he may have simply “walked out.” He has repeatedly expressed appreciation for having someone in his life that “knows what it’s like” and has served as a steady presence to help him help himself. By his own admission he had been difficult to work with in the past, and he is grateful for a supporter with the willingness to walk with him during difficult times.

An Alliance Peer Support staff reports that “in working with individuals in the TCLI program I am sometimes reminded of some of the worst moments of my life and I am aware of how pivotal it was for me to have those few helpful and supportive professional resources and clinical supports. I am infinitely grateful that I, in turn, get to use the wisdom I gained from some of my own worst moments to be able to provide a sound, safe, and supportive space for someone else. They may have just needed someone to sit with them in their worst moments and not turn away from it. It is heart-warming to hear clients begin to express hope about the direction their life is going, and it is uplifting to walk side by side with them in their journey towards recovery.”

Alliance has been able to place a total of 45 individuals into community living situations. They have done this through approximately 600 in reach visits, testifying to the time and attention

Continued on page 11...
needed to successfully transition each individual.

**Cardinal – Staff Overcoming Barriers**

James - “There have been a lot of great experiences so far, but the one that stands out the most in my mind is the day I met William T. It was as if his prayers had been answered. He wanted out of that ACH so badly and was only 37 years old at the time. His dad had kicked him out of the house 3 months prior to me meeting him so he had only been in the ACH for 3 months but was so miserable there. He did end up moving out of the ACH and into his own apartment before planned and there were some issues with that. He is now in his own apartment through TCL and is doing very well. Every time I see him he tells me how grateful he is that I came out to see him that day and how grateful he is to Cardinal Innovations for helping him get his own apartment.”

Shaun - “I have had many uplifting experiences with TCL participants. Misty M. was a pleasure to work with. Misty had graduated from UNC with a degree in journalism and business administration. She had a breakdown and without any natural supports available she was placed in an ACH. Misty didn’t believe TCL or any other program was able to assist her and she would live in an ACH for the rest of her life. I’m very proud to say that she now has her place and even called to thank me the day she moved in.”

Ross - “As a Transitional Care Coordinator, the barrier I am most proud of overcoming is finding supportive housing for Thomas H, who has an extensive criminal background including a felony. The barrier is that many, many apartment owners have strict policies about criminal backgrounds, and several applications were submitted and denied for Thomas. The way the housing specialist and I have overcome this barrier is to find and develop relationships with several property managers in the Charlotte, NC area who are willing to work with our members like Thomas who have criminal backgrounds, especially when dealing with crimes that were committed years ago. Thomas’ property manager, Jessica Winters of JW Realty, is impressed with the supportive services that we are able to place around Thomas, the consistent payment of the housing subsidy, and Thomas’ ability to pay on time and keep his apartment in good condition. We are always on the look-out to develop relationships with other property managers/owners who are willing to work with our members, like Thomas, who have problems with their credit and/or credit backgrounds.

Cardinal has housed 85 individuals through the TCL program and an additional 39 individuals are actively in the process of transitioning to supportive housing.

**CenterPoint – Ron Reconnects with Family**

When staff first met “Ron,” he was a patient in the local hospital, where he had been for several weeks. His history of poor treatment compliance for his mental health issue resulted in periods of instability. Thus, a legal guardian had been appointed to make decisions for him. Although Ron was ready to be discharged, he had no home to which he could return. For the first time in his life, he faced the possibility of having to live in a residential facility. He had few family supports and strained relationships with his mother, his daughter and his daughter’s mother.

In working with Ron and helping him secure his own apartment, staff watched as his new independence became a starting point toward other goals. Ron re-established a relationship with his estranged family. They are now strong supports for him. Ron’s close connection with his young daughter includes regular phone calls and visits with her. Ron is now fully engaged in treatment, recognizes the positive impact of treatment on his life, and has recently stepped down from Assertive Community Treatment Team (ACTT) services. Additionally, Ron is his own guardian now.

Ron recognizes that his disability is a part of his life, but that it does not define him. He is determined to distance himself from public assistance and to return to the workforce. Ron leads an active life and has participated in many activities. He volunteered as a wrestling coach for a local high school; completed Peer Support Specialist training, Wellness Recovery Action Plan (WRAP) training and recently spoke at the North Carolina Guardianship Association’s Annual Conference. Ron is currently in the process of becoming a North Carolina Certified Peer Support Specialist.

Ron’s uplifting story is one example of how the Transition to Community Living Program can be the catalyst for success and positive life change.

To date, CenterPoint Human Services has successfully transitioned 41 clients to independent living through Transition to Community Living initiative.

**CoastalCare – Support During Transition Opens Doors to Recovery**

In November of 2014 CoastalCare was made aware that a local individual, “D,” was being evicted, and qualified for the Transition to Community Living program. D lives with a mental illness and substance use disorder, and was known as dangerous and very difficult to engage. CoastalCare’s In Reach Specialist, Angela Carrothers, NCCPSS, wasn’t sure what to expect, and on their initial meeting, a shopping trip, the conversation was scarce. Angela used the time together to build a rapport, and after a while D began to open up. Angela learned about D using drugs and other substances; she heard about symptoms of mental illness, about hearing voices, and about what led up to the eviction. As the opportunity presented itself, Angela was able to share her experience, strength and hope with D, and a trust to confide in her developed. D became engaged in treatment, and began inquiring about other supports.

When it came time to identify individuals to participate in a state-wide training, Angela recommended D. Others, familiar with D’s reputation before taking part in the TCL program, were apprehensive for fear of lack of participation, but D proved everyone wrong! D shared personal experiences, articulating what it was like to experience depression, hallucinations and coping with symptoms with substance use. D also shared about the transition to the new apartment and the support received through the TCL program. At the end of training D expressed interest in addressing the substance use. Angela gave D information about Narcotics Anonymous (NA) and other supports and offered taxi vouchers that were available through the TCL program. D attending his first NA meeting and is actively seeking recovery because of the engagement and compassion offered in the TCL program.

Continued on page 12...
D’s story is one of many people who have been given a new opportunity and the resources to support living independently. This fiscal year CoastalCare has been able to transition 33 individuals from institutional care to community living.

East Carolina Behavioral Health - Transforming Lives

At East Carolina Behavioral Health (ECBH), the Transitions to Community Living Initiative (TCLI) is bringing about opportunities, hope, and new beginnings for individuals with serious mental illness living in institution-like settings and to individuals who may be in or at risk of entry into adult care homes. From partnering with Recovery Innovations to bring peer support classes into adult care homes to In-Reach and Transition Coordinators wrapping individuals with natural supports and medical and behavioral health providers, the TCL staff does what it takes to ensure the individual is at the center of person-centered planning and supporting his or her dream to live independently.

As of June 5, 2015, ECBH has transitioned 17 individuals into supported housing during FY 2014-2015. We continue to support 10 more individuals who transitioned in FY 2013-2014 and remain in supported housing. ECBH has completed a total of 34 transitions since 2013. For FY 2014-2015, ECBH has provided in-reach to a total of 458 individuals living in adult care homes and State psychiatric hospitals.

It is inspiring to read what one man’s success through TCLI means to him. “I lived in an adult care home for 16 years, and I am proud to say that I moved into my own apartment on February 3, 2015. It is truly a dream come true for me! I have longed to be able to live on my own. I actually came to believe that living on my own wasn’t possible, but I am now doing it and it feels incredible!” These are the words of 59-year-old Benjamin Altenberger, a resident at a targeted apartment complex in Washington, NC where he feels right at home.

Like many of the individuals served within TCLI, Ben has a unique story and an event that contributed to his adult care home placement. After his mother passed away, he could no longer live in the community and was placed in an assisted living facility. With encouragement and guidance from his In-Reach Specialist Amy Corey and Transition Coordinator Tammy Askew at ECBH, Ben took a leap of faith to leave familiar surroundings after many years. He started a new chapter in his life and is now making his own decisions, developing new friendships with his neighbors and integrating into the community.

You can often find Ben helping other residents at his apartment complex, some of whom transitioned like him through TCLI. He is giving back to his community and becoming more comfortable living on his own each day. “At first it was a little difficult to get used to being alone and doing things for myself such as learning how to run a vacuum,” Ben admits. “Now, I can’t say that I am scared anymore. I believe once I became comfortable managing my own medications and tasks that had been done for me on a daily basis for so many years, I now feel successful on my own. It has been a new adventure every day for me, and I know I can continue doing this!” So whether he is offering an ear or a lending hand with his neighbor’s trash, Ben’s concern for others and appreciative spirit are contagious. Not only does he enjoy socializing with his neighbors and friends, Ben also enjoys attending church, cooking, and bargain shopping. He has an eye for just the right décor to personalize his new home. His transition team members cannot be more proud of Ben and what he has achieved. Visit www.ecbhlme.org for additional TCL success stories and click on the TCL webpage for more information.

This information was contributed by Lindsay K. Henson, MS, LMFT; TCL Director ECBH.

Eastpointe – New Freedom for Earnest

Earnest Perkins, a Transition to Community Living Initiative (TCLI) participant has been successfully housed since June of 2014 in his own apartment in Lumberton, NC. Earnest has made significant headways into reclaiming control over his circumstances and in displaying a new found freedom in assuming personal responsibilities for his life choices.

By Mr. Perkins’ own recounting, his life had been in disarray for many years until Eastpointe’s TCLI staff contacted him at an Adult Care Home (ACH) beginning in late April of 2014. He reports that he had been in an ACH on at least two occasions prior to the TCLI involvement and, when not in an ACH, he was living off and on with his estranged wife or other friends. He now reports that, outside the Adult Care Homes, this was a very uncomfortable, insecure, and unsafe experience with little to no personal control of the circumstances in which he found himself.

Even inside the ACH’s he was very limited as to his activities. For example, being a nonsmoker, he was forced to share outside time and space with heavy smokers which significantly reduced his enjoyment of the outdoors. Now Mr. Perkins reports that he has been blessed with a new found freedom and can relax or explore his own backyard and other natural surroundings, which he particularly enjoys.

While Earnest and his wife are still living separately, he is spending more time with her. His wife and his grandson have spent some weekends at his apartment. Moreover, he reported that “we are working on the issues that come between us” with the goal of resuming the full marriage relationship. Another social involvement that is meaningful and beneficial to Mr. Perkin’s is the involvement and support that he gets from his church. He relates to frequent and consistent participation in spiritual activities, including group meetings with fellow male members of the church who share in past experiences similar to his. He states that he draws strength and renewal from his church family. He volunteers for various functions of the church and is frequently at the church performing needed tasks.

The freedom to be able to independently engage in these activities has been greatly enhanced by his purchase of a Honda Accord of which he is very proud. He is seen to be significantly involved in his community.

The TCLI staff at Eastpointe Lumberton have had the opportunity to work with and witness the successful transition, of Mr. Perkins’s life before, during, and after his move into the supported living arrangement. The Transition to Community Initiative has enabled him to move from the darkness of institutional living into the marvelous light of a meaningful and purposeful life.

Continued on page 13...
Mary started getting ACTT, Home Care, and Services of the Blind. “I was an adult care home,” Mary said. “After I moved into my apartment, I now enjoy an independent life that includes taking college classes. Sandhills Center’s Transition to Community Living Initiative, and into her own apartment from an adult care home with the aid of Sandhills. – Mary Living Life and Going to College its TCLI since February, 2013.

“I just got Brownie back,” explains Louie as he offers me a cup of coffee. “My son had him while I was in the adult home, but now that I have my own place, he’s back with me.” Brownie finds a familiar spot at Louie’s feet. We begin talking about Louie’s days in the truck-driving business. A native of Indiana, Louie spent most of his career hauling grain to the South and transporting produce to his familiar spot at Louie’s feet. We begin talking about Louie’s days in the truck-driving business. A native of Indiana, Louie spent most of his career hauling grain to the South and transporting produce to the North.

While life took an unfortunate turn. His marriage failed. So did his business. He struggled with mental illness and eventually went to live in the adult care home.

“It’s taken time, but I’m better now,” nods Louie. He pats a plastic, color-coded box on the table next to him. “So long as I take my medication, I do well.”

Lonnie White, Mental Health/Substance Abuse Care Coordinator for Partners, is pleased with Louie’s progress. “I stop in to see him on a regular basis,” says Lonnie, “and so does Louie’s In-Reach Specialist, Marty Burton.” Louie is grateful for the help he receives from Partners. “They always treat me right,” he says simply.

As we wrap up our conversation, Louie tells me he has Meals on Wheels and he’s making friends at the senior living apartment complex. As he leans down to scratch Brownie’s ears affectionately, he glances up and says with a smile, “I’m much happier here, doing what I want when I want. It feels good to have my own place again.” Brownie wags his tail in agreement.

Partners has had in reach visits with 678 individuals as part of its TCLI since February, 2013.

Sandhills – Mary Living Life and Going to College

Fifty-three-year-old Mary, legally blind due to glaucoma, has been in and out of hospitals numerous times. Last July, she moved into her own apartment from an adult care home with the aid of Sandhills Center’s Transition to Community Living Initiative, and now enjoys an independent life that includes taking college classes.

“I was not getting any mental health services while I was in the adult care home,” Mary said. “After I moved into my apartment, I started getting ACTT, Home Care, and Services of the Blind. I was getting Services of the Blind for a few months but not anymore because I graduated. I pay my bills on time and bought new furniture that I have paid for on an account. I am very proud of my new things and have made friends at my apartment complex.”

Mary schedules all of her own appointments and utilizes public transportation for her visits. “I am proud of my bus pass that I wear around my neck,” she said. “I do not like to use the big bus because it has a rule of no more than two bags and I cannot go into a store and come out with only two bags. I am now taking college classes and I’m always ready for the bus; if not, the transportation aide will call my cell phone and I will have to let her know that I’m coming out. With taking college classes, I can say that I have a busy day.”

Under the Transitions to Community Living Initiative Sandhills Center has transitioned 67 individuals to the community with 60 individuals housed at this time. This was achieved with over 287 in reach visits by staff.

Smoky Mountain LME/MCO – Almost Too Good to Believe

My work as an in-reach specialist at Smoky Mountain LME/MCO has provided me with many wonderful experiences. To me, the entire Transitions to Community Living Initiative is based on lifting up people and giving them a new lease on life.

One memorable experience, though, stands out to me as truly inspirational.

I began working with a man living in an assisted living facility in Western North Carolina. When we first met, the man reported he had lived in the same facility for eight years and had come to expect nothing more. As I told him about TCL, he perked up, showed great interest and was eager to begin the process. For several weeks, I worked closely with this man as we completed required paperwork, secured housing and furnished his new apartment.

Today, this man is successfully integrated into the community. When I visit him for an update, he always seems to have company present, and his mood is upbeat and cheerful. I recently asked him about his TCL experience. He told me, “It has given me a lot more freedom and independence, and I am able to take care of myself now that I am out on my own. It has helped me a lot.” He also commented, “I never knew how institutionalized I was.”

If you meet this man today, it’s hard to imagine he spent eight years in a facility. To me, he’s a shining example that people do overcome obstacles, and people do recover.

Since February 2013, in-reach specialists at Smoky and Western Highlands Network, which merged in October 2013, have conducted in-reaches an estimated 62,000 times. As LME/MCOs were not required to keep full records on in-reach touches initially, this number was estimated based on several sources of information. Currently, Smoky completes an average of 450 in-reach touches per week.

To date, Smoky has housed 63 individuals through Transitions to Community Living, some of whom have lived in more than one residence.
In Case You Missed It...MH/I-DD/SA was Heard

Below are two important Op Eds supporting public management of our system that were printed in the Raleigh News and Observer during the month of May. The first piece is by Rob Robinson, Alliance CEO and the second by Jack Register, MSW, NAMI NC Executive Director.

May 29, 2015
The Managed Medicaid that’s Working Just Fine by Rob Robinson

A lot of conversation has come from Raleigh over the past months about the need to reform North Carolina’s “broken” Medicaid system, and much of that talk is about a “homegrown,” outcomes-based solution made up of health care providers already working in cities and towns across our state.

Here’s one homegrown success story that already supports that direction: our state’s public-sector behavioral health managed-care organizations. There are nine local management entities/managed care organizations, or LME/MCOs, responsible for managing the mental health, substance abuse and intellectual/developmental disability care for residents of our 100 counties.

As a system, these organizations are successfully meeting the mandates our General Assembly has set for the Medicaid program, providing budget predictability and generating savings in excess of $171 million in Medicaid costs over the past two years. The entire public behavioral health system operates on a capitated basis, meaning that the LME/MCOs receive a pre-determined amount of money per month for each individual eligible for Medicaid care. In turn, they bear full financial responsibility for providing an established level of care to some of the most vulnerable of our state’s Medicaid recipients.

While more can be done to continue to create efficiencies and improve consumer outcomes, the LME/MCOs are succeeding while bringing much-needed stability to North Carolinians exhausted by years of constant change in how public behavioral health care services are provided.

Conventional wisdom says that managed-care companies achieve cost savings by limiting access to care to people who need it. However, as the leader of the 400 outstanding professional employees of Alliance Behavioral Healthcare, I know there is another route to cost savings and efficient use of taxpayer dollars.

While managing the behavioral health care of 200,000 Medicaid-eligible residents of Wake, Durham, Cumberland and Johnston counties, 8 percent more individuals received Medicaid services in 2014 than in 2013. At the same time, during 2013 and 2014 Alliance saved over $39 million Medicaid service dollars compared with an unmanaged system, savings that are not paid out to shareholders as dividends. Some of those savings are in the form of budget cuts and some are available to Alliance for reinvestment in providing additional innovative, effective services to more people.

And those savings didn’t come from denying more services. Strategies geared toward improving treatment outcomes have allowed Alliance to maintain a very low service-denial rate while expanding the number of individuals served and reducing the overall cost of care.

Alliance has saved money through increased clinical oversight of high-cost services that have not been associated with positive outcomes. However, when people do need higher levels of care, we are proactive in matching their needs with the right services and facilities, which helps decrease the overall length of treatment.

Alliance leverages long-standing collaborations with an array of partner agencies and organizations to create a “system of care” approach – a network of community services and resources that work together to provide the comprehensive “wraparound” support that is most effective in meeting the needs of children and adults with serious and complex behavioral health concerns.

Moreover, Alliance and the other LME/MCOs are working proactively to move toward a more comprehensive, integrated model of care designed to better serve consumers with high levels of physical as well as behavioral needs. They are engaging with local hospitals and physician-driven organizations like Community Care of NC to provide the coordination that improves quality of life, saves money and often increases life expectancy.

As the discussion about refining the Medicaid system in North Carolina continues, we urge decision-makers to build upon the part of the our system with a history of delivering proven results – our community-based public behavioral health managed-care organizations.

Rob Robinson is chief executive officer for Alliance Behavioral Healthcare.

NAMI NC Op Ed, printed May 15, 2015
Why We Must Support the LME-MCO System

Medicaid reform has been the hot topic during this long session, and for good reason. It is time for North Carolina to move to an integrated care model that is whole person focused, fiscally responsible, accountable for quality outcomes, and most importantly, accountable for quality care. There have been numerous bills filed, and some proposals would change the delivery model for mental health services in our state. Health care reform is not a new idea for people with a mental illness in NC. Just look at the closure of hospital beds, the impending sale of Dorothea Dix, and the creation (and continued merging) of Local Management Entities-Managed Care Organizations (LME-MCOs.) To put it simply, people with mental illness have been subject to the throes and whims of “reform.”

What has reform given us? Less psychiatric hospital beds (which has us in a severe shortage per national reports), more use of our ERs, and a complex system for getting into the right type of care at the right time in the right setting. What are the consequences when just one factor is absent? Instead of sitting in front of a psychiatrist or therapist, people are waiting days in the ER, under bridges, or housed in jail or prison. We are just now starting to see the dust settle with the LME-MCOs and some sense of predictability and stability.

Do we think the LME-MCO system is perfect? Absolutely not. Do we think the LME-MCO system has demonstrated success managing the care of people with mental illness? Yes. Through capitation, the LME-MCO has given the General Assembly predictability in costs. People with mental illness in NC have been treated as guinea pigs. Now that we have settled on a model, let’s give it time to mature and build on the strengths and “lessons learned” from the LME-MCO system and move forward with meaningful integration.
NC Council Becomes a NBCC-Approved Continuing Education Provider (ACEP)

Providing access to high quality trainings in NC is vital to the success and continued growth of the MH/SA/I-DD system. As part of this effort, North Carolina Council of Community Programs has recently been approved by the National Board of Certified Counselors (NBCC) as an Approved Continuing Education Provider, ACEP No. 6731. This NBCC-approved provider status assures National Certified Counselors (NCCs) and other professionals that the activities offered by an approved provider have undergone rigorous review and have been found to meet the NBCC continuing education requirements.

Qualifying programs must be presented by qualified trainers and identified in one of the following categories: Counseling Theory/Practice and the Counseling Relationship; Human Growth and Development; Social and Cultural Foundations; Group Dynamics and Counseling; Career Development and Counseling; Assessment; Research and Program Evaluation; Counselor Professional Identity and Practice Issues; and Wellness and Prevention.

As a result of this new opportunity, NC Council looks forward to continuing to bring relevant, timely, and high quality trainings throughout North Carolina, as well as expanding our training efforts into areas of new interest and innovation.

Trainings so far in 2015 have included:
- Being and Becoming a Trauma Informed Agency
- The Ethics of Cultural Competency
- Corporate Culture and Turnover: How it Affects Your Bottom Line
- Documentation Training for Mental Health and Substance Abuse Providers
- ICD-10
- Clinical Supervision for the Recovering Professional
- Clinical Supervision (general)
- Implementing Evidence-Based Practices and Stages of Change in Co-Occurring Disorders
- Traumatic Brain Injury: Hidden in Plain Sight
- Identification and Referral for Children with Autism Spectrum Disorders: What is Your Role?

If you have a request for a specific training that you would like NC Council to offer, or questions about upcoming trainings, please contact Joanna Linn, Ph.D., LPCS, LCAS, CCS at jlinn@nc-council.org.

Please visit our website at www.nc-council.org/trainings/available-trainings/ to learn more about our current trainings and to register. We will be posting NEW trainings in upcoming weeks!

NC Council Upcoming Trainings

- July 9 - CDC: A Clear Approach to Health Literacy and Communications
- July 16 - Collaboration, Coordination, and Community: North Carolina’s Path towards Integrated Care for People with TBI and I-DD
- July 16 - Integrated Care in Mental Health Settings: Preparing for the Next Wave
- July 27-28 - LOCUS/CALOCUS Train the Trainer
- Introduction to Motivational Interviewing (Dates - TBD)
- Clinical Supervision (Dates - TBD)
**NC Celebrates May is Mental Health Month**

For over 65 years, the month of May has been recognized as Mental Health month, a time when communities work to raise awareness, educate, inform and offer information and services to the public about mental health treatment and services. Both the President and First Lady agree that seeking and obtaining treatment are key.

First Lady Michelle Obama at the launch of the Campaign to Change Direction said, “It’s time to tell everyone dealing with a mental health issue that they are not alone, and that getting support isn’t a sign of weakness, it’s a sign of strength.”

President Obama noted the importance of care when he spoke at the White House National Conference on Mental Health, saying, “Too many Americans who struggle with mental health illnesses are still suffering in silence rather than seeking help, and we need to see to it that men and women who would never hesitate to go see a doctor if they had a broken arm or came down with the flu, that they have that same attitude when it comes to their mental health.”

This May communities all over North Carolina hosted numerous activities and events to educate and inform children and adults alike. LME/MCOs, state and local advocacy groups and others community organizations collaborated to organize these events. Here are just a few of the events that went on around the state.

Mental Health First Aid trainings at several Cardinal Innovations communities provided the public with information on connecting with those who need mental health help. Attendees were taught the five steps to offering initial help to people with signs and symptoms of a mental illness or those experiencing a crisis. Cardinal also initiated an effective media campaign called “Say This/Not That” see flyer above. In addition, several film screening that looked at mental illness on a global scale of a film called “Hidden Pictures: A Personal Journey into Global Mental Health” were held. The filmmaker Delaney Ruston explores bipolar disorder, depression, schizophrenia and anxiety through poignant personal stories from around the world in India, South Africa, China, France and the United States.

NC Celebrates May is Mental Health Month

and Mental Health, a breakfast and awards program for the Making A Difference program where Heroes of Hope that go above and beyond in making a difference in the lives of Durham families were honored. A Youth on Fire Awards program also occurred to honor young people in Durham that give back to the community through service and outreach. There were also other numerous youth, teen and school activities that went on during the month.

CenterPoint collaborated on a number of activities and initiatives from providers and area schools children wearing commemorative green ribbons in support of Mental Health Month to distributing mental health awareness coloring books to pediatrician offices, to hosting a booth at Springfest where bookmarks with mental health tips were distributed along with other behavioral health information.

CoastalCare continued its partnership with Cucalorus Film Festival for Mental Health Awareness Month, hosting a family friendly film screening at Cucalorus headquarters, Jengo’s Playhouse. The Adventures of Elmo in Grouchland, followed by yard games, rock painting and dress-up allowed families and friends to enjoy time together, promoting some of the most important protective factors—social connections. Another activity was CoastalCare’s co-hosting the BeYOUtiful Me health expo with the Jacksonville Mall and NAMI-Coastal Division. Information was shared, and screenings and resources were provided throughout the day, in exchange for coupons and sales. NAMI also received a percentage of proceeds for future educational programs in the community.

All in all it was a busy and successful awareness month in our state.
**Mediware Acquires AlphaCM**

AlphaCM, the software vendor used by almost all LME/MCOs for management and billing was recently purchased by Mediware. Mediware acquired AlphaCM to expand its footprint across the continuum of care. “This acquisition broadens Mediware’s solution set and subject matter expertise in the mental health, developmentally disabled and substance abuse markets. AlphaCM’s expertise is a great complement to Harmony, our existing long term services and supports business unit,” said Thomas Mann, President and CEO of Mediware. Mediware is looking forward to expanding the success AlphaCM has already achieved with providers and MCOs. As the demand to provide care outside the hospital grows, MCOs will be able to turn to AlphaCM and Mediware’s complementary software solutions to meet their needs.

When asked about whether this merger would affect current services to LME/MCOs and providers, AlphaCM Director David B. Jones, MA, LPA said, "AlphaCM will continue to be dedicated to Customer Support and Product Management for our current products and customers, including LME/MCOs and Providers. I expect the combined AlphaCM and Mediware organization to be able to provide a broader set of software solutions required by states as they work to meet the growing demands in the community services area."

Since 1980, Mediware has provided software solutions to healthcare providers and has since expanded to serve many state and federal agencies. Mediware’s solutions are perfect for high-growth, complex patient care environments that remain underserved by existing vendors. The company employs more than 500 subject matter experts who deeply understand business and care processes in highly specialized acute, non-acute and community-based care settings and have years of experience integrating systems. Mediware’s portfolio of solutions currently includes long term services and supports, blood solutions, cellular therapy, home care, medication management, rehabilitation, and respiratory therapy.

**GLEANINGS from around the state**

- The North Carolina Council on Developmental Disabilities (NCCDD) is in the process of developing their next Five-Year State Plan. They are looking to hear from individuals with an I-DD, family members, providers and stakeholders. This plan is an opportunity for NCCDD to hear from the people they serve to shape their work to help improve the lives of individuals with I-DD and their families. There will be numerous listening sessions around the state through the end of July to gather feedback as well as an online survey.

- A deal between the State and the City of Raleigh was final agreed upon for the sale of Dorothea Dix property in May. The $52 million dollar deal will allow the city to turn the property into a destination park to attract tourism. Proceeds from the sale are to be used for mental health. Almost all of those funds were allocated for mental health related care in the Governor’s recent proposed budget. A lease-back agreement with the state to allow DHHS time to find new office space for 2,000 employees was also reached. The NC Council and several key state advocacy group leaders were invited to the property signing ceremony with the Governor on the Dix campus last month.
Major rule changes proposed in May by the Centers for Medicare and Medicaid (CMS) are focused on addressing the fact that Medicaid recipients are predominantly served by managed care plans. The new rules focus on service deliver and quality of care. An interesting change to the rules includes paying for IMD stays. The new rule would cover care to individuals between the ages of 21-64 receiving services in an IMD for up to 15 days as long as the consumer was receiving psychiatric, substance abuse or inpatient care or SUD crisis residential services. This would be a substantial change for Medicaid who has never allowed coverage of this service.

Other important provisions in the new rules include addressing network adequacy standards, medical loss ratios (MLR) and quality measures for Medicaid managed care plans. Under the rules Medicaid managed care plans will be required to use the same standards for their networks used by the Qualified Health Plans and Medicaid Advantage plans, states will be required to set these standards. Regarding MLR, CMS is proposing that all Medicaid managed care plans have a MLR of 85% or higher based in projected revenues and costs for a rate year. The new standard would take effect January 1, 2017. Quality measures are also addressed and the rules set three new standards for Medicaid managed care plans around clinical quality management, member experience and plan efficiency, affordability and management.

Details on the new rules can be found at “Proposed Rule For Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability.” Comments are being accepted through July 27, 2015.

A recent CMS press release reports that, “The Centers for Medicare & Medicaid Services (CMS) for the first time introduced star ratings on Hospital Compare, the agency’s public information website, to make it easier for consumers to choose a hospital and understand the quality of care they deliver…The Hospital Compare star ratings relate to patients’ experience of care at almost 3,500 Medicare-certified acute care hospitals. The ratings are based on data from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures that are included in Hospital Compare. HCAHPS has been in use since 2006 to measure patients’ perspectives of hospital care, and includes topics like: how well nurses and doctors communicated with patients; how responsive hospital staff were to patient needs; how clean and quiet hospital environments were; and how well patients were prepared for post-hospital settings.” Details on the rating system can be found on the CMS website.

CALL FOR PRESENTATIONS
CONFERENCE & EXHIBITION

DECEMBER 2-4, 2015
PINEHURST RESORT, PINEHURST, NC
SUBMISSIONS DUE BY AUGUST 7, 2015

Presentation Application at www.nc-council.org/trainings/conferences
Or contact jean@nc-council.org

Our mission is your mission: Improving the lives of the people of North Carolina
Netsmart is proud to be a friend of the Council.
www.NTST.com 1.800.472.5509
Diet May Be As Important To Mental Health As It Is To Physical Health

The following is an excerpt from the Huffington Post by Carolyn Gregoire, printed February 24, 2015 and is printed here with their permission.

by Carolyn Gregoire

We know that food affects the body -- but could it just as powerfully impact the mind?

While the role of diet and nutrition in our physical health is undeniable, the influence of dietary factors on mental health has been less considered. That may be starting to change.

For the first time, a report by a task force advising on new dietary guidelines, commissioned by the departments of Health and Human Services and Agriculture, included a point considering the possible role of diet in mental health outcomes. The USDA and HHS report notes, for example, that the American Psychiatric Association classifies omega-3 fatty acids (which are most commonly found in oily fish) as a complementary treatment for depression. However, the advisory panel concluded, for now, that the research was too limited to make policy suggestions.

Some psychiatrists, too, have recently launched a rallying cry for a more integrative approach to mental health care -- one that takes diet and other lifestyle factors into account in diagnosing, treating and preventing mental illness. In a paper recently published in The Lancet Psychiatry, an international group of scientists (all members of the International Society for Nutritional Psychiatry Research) argue that diet is "as important to psychiatry as it is to cardiology, endocrinology and gastroenterology."

With over 450 million people globally suffering from some form of mental disorder and a pharmacological approach having achieved only limited success in treating debilitating mental health conditions, the field of psychiatry may be reaching a sort of tipping point.

"We're now facing this huge epidemic of mental health disorders," one of the paper's authors Dr. Drew Ramsey, an integrative psychiatrist at Columbia University and author of Fifty Shades of Kale, told The Huffington Post. "Depression is the leading cause of disability in the world and soon it will be the leading cause of disability in America. So, as somebody who treats depression, it's of great interest when we see a data signal that suggests that we can treat depression by focusing on nutrition and what we eat."

Ramsey and colleagues' paper cites a number of studies attesting to the vital role of certain nutrients in brain health, including omega-3s, Vitamin D, B vitamins, zinc, iron and magnesium. The modern diet, while dense in calories, tends to be lacking in these important nutrients, which may be contributing to the rise in mental health conditions.

Many studies have linked depression with low levels of key B vitamins, for instance, while low maternal Vitamin D levels have been found to play a role in the child's risk of developing schizophrenia.

The research has been mounting in recent years, and has expanded from a focus on individual nutrients to dietary patterns more broadly. In 2011, a large study found the modern Western diet (which is high in processed, high-calorie and low-nutrient foods) to be linked with increased depression and anxiety, as compared to a traditional Norwegian diet. 2014 review of studies, too, linked unhealthy dietary patterns with poor mental health and children and adolescents.

"For a long time in psychiatry, we've known that individual vitamins can have a big impact on mental health -- vitamin B12, iron, magnesium -- but really in the past 10 years, studies have begun to look more at dietary patterns, and that's been quite revealing," said Ramsey.

Growing evidence of the brain-gut connection also lends support the hypothesis that when it comes to mental health, food matters. The idea that there might be a significant link between gut health and brain health -- and that gut bacteria imbalances in a number of neurological conditions, including anxiety, depression, autism, ADHD and schizophrenia -- has gained steam in the scientific community. A 2014 neuroscience symposium even called the investigation of gut microbes a "paradigm shift" in brain science.

"The idea that brain health depends on gut health... that's certainly the next wave of this," Ramsey noted.

However, up to this point, the traditional line of treatment for mental health problems has been pharmaceutical interventions or treatments like talk therapy, or some combination of the two. Diet and exercise are rarely taken into consideration, except by "alternative" practitioners. Bringing diet into the equation would represent a major shift in the field of mental health care, opening up new modes of treatment and low-cost, low side-effect interventions for individuals suffering from a range of mental health concerns.
Don’t Miss This Opportunity To Have MH/DD/SA Information at Your Finger Tips

The 2015-16 Directory includes:

- All MCO staff contacts, a list of 100 counties & corresponding LMEs.
- Service & Contact information for Private Providers and vendors that cater to MH/DD/SA services
- All state MH/DD/SA agencies - DHHS, Division of MH/DD/SAS, Medical Assistance, others
- State and National MH/DD/SA Advocacy Organizations
- All state psychiatric hospitals, Alcohol and Drug Treatment Centers, DD Centers and more
- Area Health Education Centers
- NC Legislators and much more...

Go to [WWW.NC-COUNCIL.ORG](http://WWW.NC-COUNCIL.ORG) to get your order form or order online!
Look under Advertising.

Economical Electronic Directory Available

An economical way to purchase the 2015-16 MH/DD/SA Directory for your entire staff will be electronically (searchable PDF format with live weblinks).
The electronic version is available for purchase at [www.nc-council.org](http://www.nc-council.org)