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February 8, 2010

Legislative Oversight Committee Co-chairs  
Senator Martin Nesbitt  
Representative Verla Insko

Dear Senator Nesbitt and Representative Insko,

NAMI North Carolina would like to give you both some feedback on the new CABHA concept, having carefully listened to many presentations on this subject around the state and at the capital.

First, we certainly recognize that a change is necessary in how we design our delivery system after the difficulties of the community support era. Certainly, lessons have been learned and must be applied or we are doomed to continue to experience instability and economic woes, without good health outcomes. We applaud the intent to improve quality and stabilize the system as one of the planned reasons for going with the change to CABHA requirements. NAMI NC does not want to take any public position against the CABHA concept as a whole; rather we'd like to examine some of the details that we think may cause a lot of hardship.

As with any sweeping change, we believe much time must be spent on the unintended consequences of that change. Perhaps the hardships that were endured with community support could have been avoided had more time been spent on things that might go wrong, and putting into place safeguards against that happening. We're hoping this feedback will allow you to make subtle changes that will constitute some of the safeguards to prevent further fragmentation and disruption to our beleaguered system.

We know you get a lot of feedback, and I'd like to start with thanking you for this opportunity to share the views of our constituents- families and individuals living with mental illnesses throughout the state.

Here are our ideas for changes to the CABHA program as currently outlined:

1. **Impact on clubhouses** – Psychosocial rehabilitation programs are incredibly inexpensive, yet effective. Reform has already taken a toll on this group of heroic providers- we've seen many close down across the state. The problem is that since the rate is so low- perhaps the lowest in the state- many have had to add additional services to just stay afloat- often times this is either CS or CSTeam. Of course the former is going away, and the latter can only be provided by a CABHA, which PSRs alone have no chance of becoming. This would be a tragic unintended consequence. I recently heard that all but two of the clubhouses belonging

to the clubhouse coalition in fact had other billable services and they would be adversely impacted by this rule.

**Action step recommended: Poll all clubhouses in the state to determine how many offer another billable service, which one, and determine the effect it would have. If it would result in a shut down, formulate an exception process**

2. **Assessments- Conflict of Interest** – We learned from community support (CS) that if the assessor is part of the same provider that also offers CS that generally the result of the assessment is that they must need CS. It has happened time and time again. Why not redesign our system to separate those who do the assessments and determination of what is needed from the providers of service? We would use independent assessment agencies. That way there will be no inherent conflicts of interest. A less invasive intervention would be to study referral practices to determine if it is weighted in the way that I think it will be.

**Action step: Redesign CABHA to eliminate assessment, or study referral patterns to determine if there is a problem, if assessment is kept within the CABHA**

3. **Possible Loss of Necessary Providers in Rural Areas** – Everyone is worried that the rural areas will not be able to make it- that they don't have providers who can be a CABHA, then, the rules will require a shut down of providers who have to become a CABHA, but can't. This is a genuine worry; the last thing needed right now is loss of treatment possibilities throughout our state.

**Action Step: Survey the rural areas systematically by claims data to determine the impact on small providers in those communities; as well as the plans of entities to become CABHAS, determining if there will be sufficient capacity to meet local treatment needs. A possible solution would be to allow more association agreements to sustain small, successful providers in rural areas who might otherwise lose their market. Develop a waiver/exemption process when it is clear that certain areas will lose vital services due to CABHA regulations**

4. **Concerns about conflicts of interest impeding referral flow between CABHA and other non CABHA providers** – We hear this one over and over again. People have trouble picturing the system once CABHAS are in place. What are the incentives to the CABHA to make referrals out of their sphere? Providers and clients need more guidance on referral flow, providers referral responsibilities, and someone needs to be studying referral patterns to see what's working, what's not.

**Action step: Design a document to describe actual referral flow based on sample scenario/clients with certain diagnostic conditions, changes in their condition, or an external crisis. Put safeguards into the system to perform care coordination activities if individuals are not getting referrals who obviously need them depending on their local condition. If a pattern exists within a CABHA to not appropriately refer, have this be reason for endorsement termination.**

5. **Outcomes** – NC requires outcome data on every single client in our system, but it is not woven into the requirements for endorsement. It is time to begin to fund our system based on who achieves outcomes. We feel that outcomes should be included in the endorsement process- and if outcomes fall below a certain level (to be defined) then the provider is put upon probation, or requires a plan of correction. Similarly, we'd like to see that providers who consistently surpass certain levels for outcomes should receive rate incentives (especially tied to institutional avoidance, stability, etc.)

**Action Step: Design a variable rate reimbursement system that is cost neutral: less to those not meeting the norm, more to those above the norm**

6. **Peer Support Concerns** – The new individual peer support (IPP) definition requires that IPP only be provided by a CABHA. Given the recent debacle of CS, it is understandable that any new definition coming out be very, very carefully framed. However, as we look to a future, more reasonable time when money is flowing and we are less worried about the “what ifs” – will we be happy with the system we've created? By limiting peer support to CABHAs, we eliminate the possibility that peer support can be connected most naturally to wellness and recovery education centers, consumer run businesses, and those who simply specialize in peer support. Other states have found that the growth naturally gravitates in that direction. In fact, a CMS report cites that freestanding peer support locations, such as drop in centers are one of the general locations of this service model. Yet it wouldn't be allowed according to this rule in NC. We hope to be a waiver environment one day; let's not define so narrowly where peer support can take place that we reduce the ability of this excellent new service to make a difference.

7. **Changes in Relationships** – Those with mental illnesses really do get better more quickly when they have a long term, trusting relationship with their clinician or helping person. If a clubhouse has provided case management, the service recipient will have to endure a change to another provider- and a setback to their recovery in the process.

**Action Step: Review the capacity of certified peer support individuals to meet the needs, considering removal of CABHA requirement over time, given budgetary constraints. Survey providers of recovery services, consumer run businesses to get their input into this conversation.**

8. **The right array of services** – Our organization believes that only grouping together two services that make sense (child array, adult array) is not really a continuum, so hardly meets the selling point of allowing one stop shopping, and less disruption to consumers whose needs change, but can still get their needs met within the same agency. A particular example of a future problem would be when our state includes IDDT (Integrated Dual Diagnosis Treatment) – where the integration is of SA and Mental Illness service arrays. How will a CABHA accommodate this? We need to look to the future while thinking of our CABHA design. While we don't have IDDT right now as a billable service, despite the fact that it is one of SAMSHAs evidence based practices, would a CABHA that specializes in adult mental health service array be allowed to provide IDDT?

**Action steps: Over time, require a larger array of service options by the CABHA (beyond the 2 enhanced benefit services). Study the policy implications of IDDT and determine the fit within the CABHA- preferably both on the MH and the SA side.**

North Carolina has just one change to get this big change right. We do believe that some change has to happen – NC cannot go on like we have in the past 4-5 years. Please listen to what consumers and family members have to say about some of these consequences that could be very devastating; perhaps with some system redesign, we can achieve the necessary clinical and quality improvement, as well as protect relationships, access to care in rural areas, and the rational growth of peer support. Please let me know if you agree with these suggestions, or if you don't. The dialogue as we enter another time of change is important.

Thank you both for your wonderful community service; we are thankful that you are sticking with mental health for the long run. We need you!

Sincerely,

A handwritten signature in purple ink that reads "Debra G. Dihoff". The signature is written in a cursive, flowing style.

Debra G. Dihoff, MA  
Executive Director  
NAMI NC