Capital Area Human Services District Board Meeting
Monday, January 10, 2011

Members Present: Sandi Record, Chairperson; Kay Andrews; Rev. Louis Askins; Christy Burnett; Dana Carpenter, Ph.D.; Kathy D'Albor; Gail Hurst; Becky Katz, Vice Chair; Vickie King; Kay Long; Gary Spillman; and Barbara Wilson

Members Absent: Amy Betts; Sue Bushey; Tandra Davison; Wayne Delapasse; and Jermaine Watson

CAHSD Executive Staff Members: Jan Kasofsky, Ph.D., Executive Director; Carol Nacoste, Deputy Director

ITEM	RESPONSIBLE PERSON	DISCUSSION	FOLLOW-UP TIMELINE
Consent Agenda • Approval of Agenda January 10, 2011 • Approval of December 6, 2010 Minutes	**Sandi Record, Chair**	The meeting was called to order at 3:09p.m. by Sandi Record, Chair. The agenda was amended to add a Pointe Coupee item to the Parish Updates report. Motion for approval of the December 6, 2010 minutes with the amended consent January agenda made by Kay Andrews, seconded by Rev. Askins and unanimously carried.	**Action taken, motion carried**
Reports from Executive Director • Communications: The Advocate Article • Letter to Deputy Keck • Presentation by DHH Deputy Secretary Tony Keck	**Dr. Kasofsky** **Deputy Keck**	Legislators were happy to see the article in the *Advocate* because they believe that the community needed to be aware of the budget situation. There has been a lot of community discussion about mental illness. The Board's letter to Deputy Keck was sent and he presented at today's Board meeting in response to that letter. Kathy Kliebert accompanied him as the new Deputy Secretary. Mr. Keck is going to lead South Carolina's DHH. Tony Keck: The vision for CAHSD and what should be focused on is in the strategic plan. Non-billable services will continue with CAHSD or community agencies. There will be an increase in community services and a decreased reliance on institutional services. The State is moving toward a coordinated care/ managed care network, but there is no clear path at this time. The Federal Government has set up parameters for healthcare reform, giving an opportunity for large expansion of the Medicaid population; which, in turn, will be an opportunity for behavioral healthcare agencies. There will be approximately 400,000 new Medicaid enrollees, which will give more people a choice of where they want to be treated. DHH does believe that people will continue to use public services. The new districts are in the position to start from scratch. Mr. Keck was asked what the role of a district is for people with health insurance; what role does CAHSD want to play in behavioral health with the available funding? He suggested that CAHSD pick business opportunities that	

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		are too unique or expensive for someone to copy – what is it that CAHSD can uniquely do that another entity would find very difficult or too expensive to copy? Research the competition. There is an interest for those to get into the private market because of healthcare reform. CAHSD has a lot of relationships that would make it difficult for others to take over; however, there are some companies that have a lot of startup money. This is an opportunity for districts that have those special relationships with the broader healthcare system to look at their mission to solve problems, not so much in terms of providing services, but such as keeping children out of foster care. Behavioral health (BH) issues are typically the root cause for people getting into the system and CAHSD has a unique role because the experience it has in BH. CAHSD has relationships with community leaderships and the authority to sit on an equal playing field as another governmental entity for common problem solving. A Board member posed the question of where CAHSD should invest its time and resources in explicit authority of the Governor. Mr. Keck replied that CAHSD will be more of a policy setter for care management functions in viewing clients as a whole person. The system won't be a one size fits all per parish because of parish capacity and new funding mechanisms. The market may not be flooded with providers. The State is making a bet based on analysis and how to attract clients and adjust moving forward. It is a very exciting time. The real implications will be with the growth of Medicaid. Healthcare reform has fundamentally changed the relationship between state and federal. There are only three years to prepare for the expansion. CAHSD will need to accept the expansion and do the best possible job of managing cost and getting clients into services. Currently there are too many kids in out of home placements. The State will revolve around a coordinated system of community care to prevent out of home placements. Best practice models are focused on "deep end kids", which consists of 2-3,000 kids in the state being provided intensive wrap around services where agencies are strict advocates for the children. There will be a conflict of interest if an agency provides services and coordinates the plans in getting kids in the best placement; i.e., should a wrap around agency be allowed to also provide services? The State does not want this to exist.	

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		However, in some areas it will be necessary because of the lack of providers. Agencies that provide both should have firewalls to prevent conflict and must have a high level of TA for data collection and a higher level of managed care delegates responsible for wrap around services. The State will be looking for those agencies that are separate for the first phase of the coordinated system of care. Community providers must agree on a set of principles to provide services in the community. There will be an application process for wrap around services and community providers. Agencies will be competing because there will be no client shortage. However, public agencies will no longer have State General Fund (SGF) guarantees and will have to self-generate funding and adjust services based on that level of funding. The SGF guarantee will go down as the Medicaid population increases. There will be some transition cushion built in for the first year or two. There should be an orderly transition for the new model with transition cost built in. The State will hand the keys over to the districts as much as possible. Kathy Kliebert: There will be a transition time for changes that will affect the delivery of services. The plan for transitions has many unknowns. The role of the collaborative agency will be to pull people together and fill niches based on community needs assessment. The new system will not happen overnight. Question and Answer Session: **Q:** It is important that the Board clearly understands CAHSD's role: Should CAHSD look more toward management or providing services? Can CAHSD do both and be careful in setting up what is being provided to fill service gaps? **A:** CAHSD should strategically look at what its major role will be and focus on more quality of and managing services. CAHSD should continue providing services and possibly move into more of a management role as more providers come into the community. **Q:** Does the State see the districts as competitors or will the districts be dissolving? **A:** Districts can't change portability through expansion. They must respond to competition and mental health parity. When considering their potential roles, districts can become more important when making the right decisions, but if they rely on strictly providing services, they may dissolve. They can be the only provider in specific areas, such as prevention services that are not covered by Medicaid. The districts can play very important roles and stay relevant where no one else will be able to provide services, such as crisis management or	

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		homelessness. CAHSD must position itself as an agency that will solve the community problems and focus on one role. It is a huge opportunity for districts to become stronger; to operate in a state cost structure that makes it difficult to compete with the private market. **Q:** What role does politics play? **A:** 90% of the changes are at the federal level flow of financing. The Medicaid reimbursement funding stream may not be able to avoid the services that we normally provide. The current Medicaid state structure is crumbling quickly. Agencies must have a referral network with law enforcement and courts to solve problems for them such as transitioning people out of institutional services or afterhours forensic care. Agencies may be overwhelmed by the choices of the clients. At the recent budget meeting with the Governor, 10 minutes was spent discussing districts and 1hour ½ spent on discussing the regions. Districts need to run themselves and know what they should be offering. The state can buy services or fund services. The districts' roles will play within the parameters of state statutes. Districts can respond to demands of community issues and redefine themselves once those issues are resolved. It comes down to funding and funding mechanisms. Dr. Kasofsky noted that managed care companies are interested in the things that CAHSD does well. OLOL is interested in being partners with CAHSD in the coordinated system of care. OLOL will be providing third year psychiatric rotations that would not happen without CAHSD. Until the budget is announced, we will not know what services CAHSD will be a part of; a lot will rely on the Medicaid plan. CAHSD managers will review productivity levels and the ability to collect for clinician time. Some services are almost a moral issue and should continue regardless of funding streams. **Q:** The concern is for those services that aren't billable – will there be funding for those entities that provide a service that no one else will do such as CIT training? **A:** There will still be items that the state will pay for and there will be more conversation on what those things are in regards to budget requests. There may be a broader view of where we collect the dollars. CAHSD can create different revenue streams for those roles that are not billable services. The direction of where the funding comes from will be different.	

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		Q: Where are all the providers going to come from? **A:** BH is taking a central role in the process and the market will be more favorable for BH staff (there will be a need for BH staff). There is a move from a state run system to a private Medicaid system. **Q:** Is DHH considering a state-wide electronic medical health record? **A:** No decision has been made yet regarding Anasazi. However, the decision will be the same across the regions, which will be made soon. <u>Summary</u>: CAHSD is strengthening ties with community providers and becoming more efficient. There are areas that CAHSD can let go to the community, but not necessarily in all parishes. CAHSD will focus on: what we do that no one else does; what we could do better and how; what the problems are with our current services; and, what service possibilities are there for the future? A mind change is necessary in that clinicians should make sure that productivity and billable services are up to standard. CAHSD may have to restructure services to make sure that clinicians can bill for 8 hours per day. When services and employees are cut, CAHSD services may not be competitive. The market will change, but CAHSD clients (chronically SMI) will not be seen by private providers because they can't bill for needed support services. Kay Andrews noted that Dr. Kasofsky's skill set will be the cause of CAHSD's survival through the changes.	
• Primary Care Services Collaborative	**Dr. Jan Kasofsky**	Dr. Kasofsky and Jamie Roques met with Kathy Viator, Earl K. Long Regional Medical Center (EKL) CEO. EKL has offered to set aside 30 appointments per month for indigent clients to be seen at EKL. OLOL will see clients up to three (3) times as they transition to EKL as their medical home. Hospitals will give CAHSD their decisions at the end of the month on if they will continue the indigent primary care services at no cost.	
• Infant, Child and Family Center Site Visit		The Infant, Child and Family Center (ICFC) is a program that has been partially funded through CAHSD escrow. It provides services to infants and young children exposed to prenatal substance abuse. DSS provides half of the funding for social workers' salaries. This program is not a mandated service for CAHSD, so Dr. Kasofsky is reaching out to two legislators to get a line item for the program in House Bill 1. All the kids are in foster care and have long-term problems, such as deficiencies in processing information and brain damage that cannot be reversed.	

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• Coordinated System of Care		CAHSD convened a meeting for the community on January 7th to give information regarding an application to be a pilot site for the new Coordinated System of Care (CSoC). Over 100 people came to the meeting. Meeting participants identified gaps in services and what it will take to fill those gaps. The next meeting is scheduled for January 28th to further the application process. Amy Traylor will send meeting details to the Board. (Note: Date changed to February 3rd.)	
• LINC		The Texas Two-Step has been renamed to Low Income Needy Communities (LINC). DHH has identified two (2) CAHSD LINC contracts. The ACT/FACT team will contract with the hospital entity. CAHSD will monitor the contracts and will keep 15% of the cost of the contracts, approximately $300,000. It is estimated that states will receive $5 to every $1 spent.	
• Medical Detoxification RFP		The Medical Detoxification RFP is out for bid.	
• MHERE Status		The MHERE continues to do well. Client hospitalization has decreased to 47%, which is a lot of money saved by the state. OLOL is attending the monthly MHERE team meetings. The team will identify root causes of utilization (one is housing) and the Interagency Service Coordination (ISC) team is handling the high users.	
• Ends Policies 2011		The Ends Policies are pended until the February meeting due to Dr. Kasofsky meeting with other executive directors to list services that are the role of government.	
Reports from Chair • Executive Director Performance Evaluation	**Sandi Record**	The Executive Director Performance Evaluation process was reviewed. Motion for approval of the Executive Director's Performance Review was made by Gary Spillman, seconded by Dr. Dana Carpenter and unanimously carried.	**Action taken, motion carried**
• Financial Planning/Budgeting Policy		Motion for approval of the Financial Planning/Budgeting Policy, with revision made to #3, made by Kay Andrews, seconded by Rev. Askins and unanimously carried.	**Action taken, motion carried**
• Financial Conditioning and Activities Policy		Motion for approval of the Financial Conditioning and Activities Policy made by Kay Andrews seconded by Rev. Askins and unanimously carried.	**Action taken, motion carried**
• Parish Updates		The Ascension Parish Mental Health Board meeting was attended by Becky Katz and Christy Burnett. The Parish will no longer provide Gonzales Mental Health Center with a fax machine or copier; both are now provided by CAHSD. Dr. Kasofsky will continue to monitor the MOU between the parish and CAHSD. Any changes to the MOU must be made with a 30- day notice to either party.	

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• Policy review Process	**Becky Katz**	Dr. Kasofsky will be scheduling parish council visits to explain the shift in culture. This will be discussed under Communication on February's Board agenda. Ms. Hurst noted that three behavioral health agencies have already presented to the Pointe Coupee Parish Council and local judges to request specific programs for their agencies. The Board Job Description Policy was reviewed by Becky Katz and it was found that the Board is in compliance with the policy. It was noted that the link between the District and the community is going to increase. The Agenda Planning Policy will be reviewed by Kathy D'Albor at the February Board meeting.	
Adjournment/ Next Meeting Date		The next meeting will be held on February 7, 2011 at 3:00 p.m. at 4615 Government Street, Building 2, Room 205.	