North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

January 13, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Thom Tillis
Speaker of the House
Room 2304, Legislative Building
Raleigh, NC 27601-2808

The Honorable Philip Berger
President Pro Tempore of the Senate
Room 2008, Legislative Building
Raleigh, NC 27601-1096

Denise G. Weeks
House Principal Clerk
16 West Jones St.
Raleigh, NC 27601

Sarah Lang
Senate Principal Clerk
16 West Jones St
Raleigh, NC 27601

Dear Speaker Tillis, President Pro Tempore Berger, Ms. Weeks, and Ms. Lang:

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services to study local management entity (LME) efforts and activities to help reduce the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder and the number of patients requiring three or more incidents of crisis services. Pursuant to NCGS §120-29.5, the Department is pleased to submit the attached report, which is the final in a series of five.

This report lays out the existing array of crisis services in the state, and the efforts by the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, its partners, and the LMEs to address the two priorities specified within the legislation.

Please contact Dave Richard, Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should you have any questions regarding this status report. Mr. Richard can be contacted at (919) 733-7011.

Sincerely,

Adam Sholar

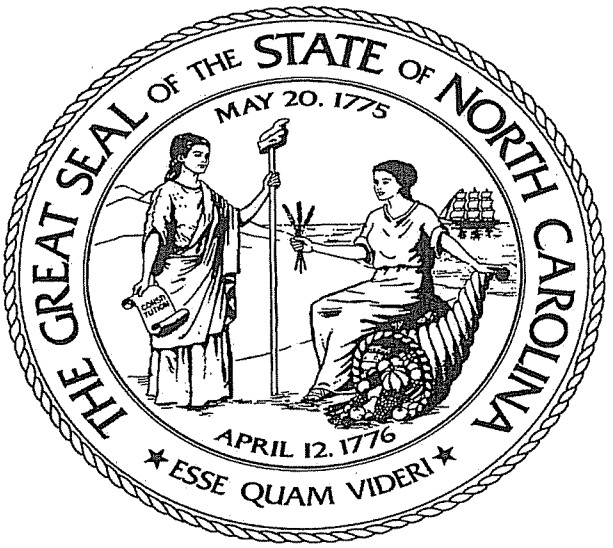
www.ncdhhs.gov
Tel 919-855-4800 • Fax 919-715-4645
Location: Adams Building/Dix Campus • 101 Blair Drive • Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001
An Equal Opportunity / Affirmative Action Employer

cc: Denise Thomas
Jim Slate
Dave Richard
Jim Jarrard
Pam Kilpatrick
Brandon Greife
Patricia Porter
Sarah Riser
Kristi Huff
Susan Jacobs
Rod Davis
Legislative Library (two hard copies)

Mental Health Crisis Management Report

June 2013 – August 2013: Status Report

Session Law 2012-128 (Section 2)



NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mental Health, Developmental Disabilities and Substance Abuse Services

Session Law 2012-128 (Section 2)
Mental Health Crisis Management Report

June 2013 – August 2013: Status Report

Report 5 in a series of 5

Executive Summary

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services to study Local Management Entity (LME) efforts and activities to help reduce:

- *the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder, and*
- *the number of patients requiring three or more incidents of crisis services.*

This report presents the existing array of crisis services in the state, the efforts and progress made by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS), its partners, and the Local Management Entity-Managed Care Organizations (LME-MCOs) to address the two legislative priorities.

As indicated in this report, the NC DMH/DD/SAS and LMEs have made and will continue to make significant efforts to address the high rates of inpatient and crisis services utilization for the persons served in North Carolina's publicly-funded system. It is believed that as LMEs evolve and mature in their role as MCOs, as relationships with emergency departments (EDs) and hospital inpatient are established or enhanced, and as non-crisis community-based services are expanded and the quality of those services improved, fewer people will need crisis services and fewer who do need crisis services will be directed to EDs and inpatient services.

Session Law 2012-128 (Section 2)

Mental Health Crisis Management Report

June 2013 – August 2013: Status Report

Report 5 in a series of 5

Introduction

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services (NC DHHS) to study Local Management Entity – Managed Care Organizations (LME-MCOs) efforts and activities to help reduce:

- *the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder, and*
- *the number of patients requiring three or more incidents of crisis services.*

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS) has produced a reporting template for the LME-MCOs to use to identify their efforts and activities pertinent to the two priorities that are bulleted above. The NC DMH/DD/SAS has also developed a crisis and inpatient database that will be used to track utilization trends by LME.

Three main sections comprise this report. The first section presents an overview of state level efforts and activities intended to address the crisis services issues and the crisis services needs of the public in North Carolina. The second section presents statewide data related to emergency department admissions and lengths of stay as well as use of bed days in state psychiatric hospitals. The third section summarizes the LME-MCOs' current and ongoing efforts and activities as well as the progress reported by those LME-MCOs pertinent to the two legislative priorities of Session Law 2012-128, Section 2. The individual LME-MCO reports of the June 2013 to August 2013 three month time period are available upon request.

Section One: State-level Efforts and Activities

Overview of the Community-based Crisis Services Continuum in North Carolina

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC DMH/DD/SAS), the North Carolina Division of Medical Assistance (NC DMA), and the Local Management Entities (LMEs) in the state have established an array of crisis services resources to address the crisis services needs of people living in the state. These resources are intended to reduce the need for emergency departments (ED) admissions and acute care inpatient hospitalization for people with mental health, developmental disabilities, and/or substance abuse disorders, who experience emergent and urgent crises.

Community-based Non-Hospital Services:

- 11 LME Call Centers
  Provides 24-hour telephonic crisis response and referral.

- 100 counties served by Mobile Crisis Management (MCM) teams
  Mobile, primarily face-to-face crisis assessment and response, with linkage to services/supports.

- 22 Facility Based Crisis (FBC) programs
  Alternative to hospitalization for adults who need brief, intensive, 24-hour crisis evaluation and treatment beds; eight of these are designated to treat involuntarily admitted individuals.
  http://www.ncdhhs.gov/dhsr/data/mhllist.pdf

- 18 Non-Hospital Medical Detox agencies
  Medically Monitored Detoxification delivered by medical and nursing professionals in 24-hour facility that provides medically supervised evaluation and withdrawal management services.
  http://www.ncdhhs.gov/dhsr/data/mhllist.pdf

- 5 Social Setting Detox agencies
  Clinically Managed Residential Detoxification delivered under clinical supervision of board-certified/licensed substance abuse professional in 24-hour facilities; characterized by peer and social support.
  http://www.ncdhhs.gov/dhsr/data/mhllist.pdf

- 91 Walk-In Crisis and Immediate Psychiatric Aftercare locations (WICs)

Serves adults, adolescents, and families who are in crisis or who need interim services following discharge from out-of-home services and prior to admission to routine services; primarily available during regular business hours; linkage to other services/supports.

- 6 NC START (Systematic, Therapeutic, Assessment, Respite and Treatment) teams, and twelve Crisis Respite beds.
  In-home crisis response and crisis respite for individuals who have intellectual/developmental disabilities and who are in crisis; providing ongoing training, consultation, and support to family members and providers.

- 4,923 Crisis Intervention Team (CIT) trained officers in North Carolina, with officers in each LME catchment area; As of 1/1/2013, CIT certified officers comprised 22% of all sworn law enforcement officers from the 307 law enforcement agencies participating in CIT in NC, and with 511 telecommunicators / dispatchers having received CIT training. *Pre-booking jail diversion program; law enforcement officers trained to de-escalate crises and assist individuals to access needed services rather than proceed to automatic incarceration.*

Through the Integrated Payment and Reporting System (IPRS) and appropriations from the North Carolina General Assembly, the North Carolina Department of Health and Human Services (NC DHHS) has provided access to inpatient hospital beds for indigent persons needing inpatient care.

Community-based Psychiatric Inpatient Services:

- 2,071 total psychiatric inpatient beds, excluding State Hospitals
  This total includes three-way contract psychiatric inpatient beds (see below) as well as all other community-based psychiatric inpatient beds.
  http://www.ncdhhs.gov/dhsr/ncsmfp/2014/proposed2014smfp.pdf

- Of the 2,071 total beds,135 are three-way contract psychiatric inpatient beds
  Inpatient service targeted specifically for individuals who are indigent. NC DMH/DD/SAS, LMEs, and 22 hospitals have contracted to provide this inpatient service.

The North Carolina Division of State Operated Healthcare Facilities (NC DSOHF) administers three state psychiatric inpatient hospitals and three Alcohol and Drug Abuse Treatment Centers (ADATCs) which are also certified hospitals that serve as the safety net in the continuum of crisis services.

State Operated Services in Crisis Services Continuum:

- 892 State Psychiatric Hospital beds in three state hospitals
  Provide crisis assessment, stabilization, and medical care in inpatient facilities; discharge planning to facilitate linkage to the community services and supports.

- 196 ADATC beds
  There are three ADATCs. The ADATCs are certified by the Centers for Medicare and Medicaid (CMS) Services as psychiatric hospitals. They provide an array of services including medical detoxification and psychiatric stabilization in addition to inpatient substance abuse treatment.

There are also 122 EDs in North Carolina, which are often used by people when they experience behavioral health emergencies. http://www.ncdetect.org/hospitalstatus.html Many hospital EDs have developed specialized areas to care for behavioral health patients requiring extended stays due to lack of inpatient capacity.

Emergency Department Length of Stay Action Plan

In November 2011, the NC DMH/DD/SAS published a set of recommendations (http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf) in the Emergency Department Length of Stay Action Plan that were developed by a large group of stakeholders and were intended to:

- reduce admissions of persons with mental health, developmental disabilities and/or substance abuse (MH/DD/SA) disorders to EDs;
- reduce the length of stay (also known as wait times or psychiatric boarding) for individuals with behavioral health issues in EDs; and
- link those persons to services, supports, and housing resources to avoid readmissions to EDs.

A total of 25 recommendations were made, which were organized according to and targeted at four timeframes related to an emergent crisis episode: pre-crisis, pre-admission to an ED, during an ED admission; and post-discharge from an ED. If implemented successfully, these recommendations would be expected to result in reduced admissions and re-admissions to EDs and shortening lengths of stay in the EDs, as well as reduced community inpatient hospital admissions.

The ED Length of Stay Action Plan was intended in part to provide guidance to the LMEs to assist in addressing the burgeoning problem with excessive ED admissions and extraordinarily lengthy wait times for persons needing psychiatric inpatient beds. The current LME Quarterly Reports, outlined in the third section of this report, reflect efforts and activities, many of which are in concert with or extensions of the Action Plan recommendations.

Efforts to Implement the ED Length of Stay Action Plan

The NC DMH/DD/SAS, in collaboration with several partners, has endeavored to implement a number of the recommendations of the ED Length of Stay Action Plan. Updates to the recommended activities are noted below:

- Working with NC DMA, NC DMH/DD/SAS has revised the service definition of FBC programs, which serves adults, so as to strengthen and increase the involvement of licensed professionals and the quality of clinical services, to increase 24/7 access to the service, and ensure that all of these facilities are capable of admitting and treating persons who are under involuntary commitment. The revised service definition awaits rate-setting and approval from NC DMA. This service definition revision is aimed at enhancing this service so that it will be a viable alternative to psychiatric inpatient hospitalization. NC DMA is currently analyzing the state plan and determining the feasibility of releasing the new definition, if it is cost-neutral.

- NC DMH/DD/SAS and NC DMA have also developed a new service definition, FBC for children and adolescents. This service definition has already been approved by CMS, and awaits state-level financial resources needed to fund the service. Similar to the revised FBC service for adults, this service is intended to provide a high quality alternative to inpatient hospitalization. NC DMA is currently analyzing the state plan and determining the feasibility of releasing the new definition, if it is cost-neutral.

- NC DMH/DD/SAS worked with multiple stakeholders, including LME-MCOs, NC DMA, and provider organizations to revise the elements of the individualized Crisis Plan, which is a component of the Person Centered Plan. The revised Crisis Plan is more robust than the previous Crisis Plan, with the addition of such essential information as diagnoses, current medications, medical concerns, contact information of the individuals who provide important support to the consumer, as well as a planning section for following-up with the consumer after

the crisis has been resolved. The Crisis Plan is designed to be used primarily to prevent the escalation or worsening of a crisis episode, allowing the resolution of a crisis before the need for an ED admission and/or psychiatric inpatient treatment. The revised Crisis Plan template, a training element, and the requirements for use have been published on the NC DMH/DD/SAS web site in September 2013.
http://www.ncdhhs.gov/mhddsas/communicationbulletins/2013/commbulletin139/cb139pcpcomprehensivecrisisplan.pdf

- NC DMH/DD/SAS has collaborated with the NC DHHS Office of Rural Health and Community Care, East Carolina University Center for Telepsychiatry and e-Behavioral Health, the University of North Carolina at Chapel Hill, the Albemarle Hospital Foundation, and the North Carolina Hospital Association to develop a statewide telepsychiatry consultation initiative in EDs. The report/plan for a statewide telepsychiatry program was submitted to the NC General Assembly in August 2013. There was a $4 million dollar appropriation for State Fiscal Years (SFYs) 2014 and 2015. First phase of this initiative will begin in January 2014. This initiative has been developed, using the very successful telepsychiatry model in South Carolina, and is intended to shorten length of stays in the ED and assist in guiding ED physicians in making disposition decisions, when appropriate, to less costly and less restrictive services than psychiatric inpatient hospitalization.
http://governor.nc.gov/sites/default/files/TelepsychiatryProgramPlan.pdf

- NC DSOHF has developed plans to add 124 beds at Cherry Hospital after its new facility opens in 2014. Currently, there are 892 operational beds in the three State psychiatric hospitals including that additional 19 bed unit Broughton Hospital opened in November 2013.

- NC DMH/DD/SAS has inserted draft language into its 2014 contract with the LME-MCOs with respect to strengthening care coordination activities for persons who seek crisis services. The draft contract specifies the broad priority populations for which care coordination activities shall be required, including children and adults with intellectual and development disabilities, mental health, or substance dependent disorders, and persons who have a combination of the former disorders. In addition, the contract would require the LME-MCOs to provide care coordination for persons who are at risk for crisis, including those who miss scheduled appointments and who are at risk for inpatient or emergency treatment, or who use a crisis service as the first service, or who are discharged from inpatient psychiatric hospitalization, a Psychiatric Residential Treatment

Facility, or FBC service. Care coordination activities would include linking the individuals to appropriate services, ensuring that they continue to be engaged with needed treatment and supports, monitoring hospital admissions, developing crisis plans for those individuals, and discharge planning to appropriate dispositions and coordinating access to follow-up services and supports.

- NC DMH/DD/SAS collaborated with the North Carolina chapter of the National Alliance for Mental Illness (NC NAMI) and several law enforcement agencies, to revise the Basic Law Enforcement Training (BLET) for law enforcement officer candidates and developed an inservice training for current law enforcement officers; both of which are mandated trainings and teach de-escalation techniques and encourage the law enforcement officer to utilize alternative crisis services, rather than unnecessarily transporting all persons with behavioral health crises to EDs. The BLET and the mental health inservice training have been implemented.

- In March 2012, at the request of NC DMH/DD/SAS Medical Director, LMEs identified LME points of contact for local EDs, and enlisted the NC Hospital Association to distribute that contact list to all EDs. This is intended to encourage increased collaboration between EDs and LMEs in order to facilitate appropriate dispositions of persons following discharge from the ED. Following the recent mergers of LMEs into LME-MCOs, the contact lists have been updated.

- Through August 2013, the number of three-way psychiatric inpatient hospital beds available in community hospitals was 135. The 2013-2015 State Budget appropriated an additional $9 million for three-way inpatient beds, $2 million of which will be used to pay a higher daily rate for persons with higher level acuity. Once contracts are finalized, an additional 30 three-way psychiatric inpatient beds will be available, six of which will be for more persons with more challenging needs.

- In SFY 2013, NC DMH/DD/SAS hired a Housing Administrator who provides state-level guidance to the LME Housing Coordinators. These positions all focus on helping homeless people, who receive or need mental health, developmental disabilities, or substance abuse services, to access desperately needed housing stock. The lack of housing has been identified as one major factor in driving high admission rates in EDs.

- LMEs are required, by the current contract with the NC MH/DD/SAS, to hire housing coordinators to increase access to housing and support services for the people receiving MH/DD/SA services.

Crisis Solutions Initiative

The NC DHHS has made a significant commitment to improving the system of publicly-funded mental health, developmental disabilities, and substance abuse services and is specifically addressing the critical needs around Crisis Services. On November 7, 2013, Secretary Aldona Wos announced the Crisis Solutions Initiative which will bring a renewed focus on these issues.

The initiative builds upon what is working in communities, targets specific new initiatives, measures outcomes and brings together community leaders from across the state to work on a Crisis Solution coalition. The Coalition is not established to publish another report but rather be an action group to bring focus on addressing these critical issues.

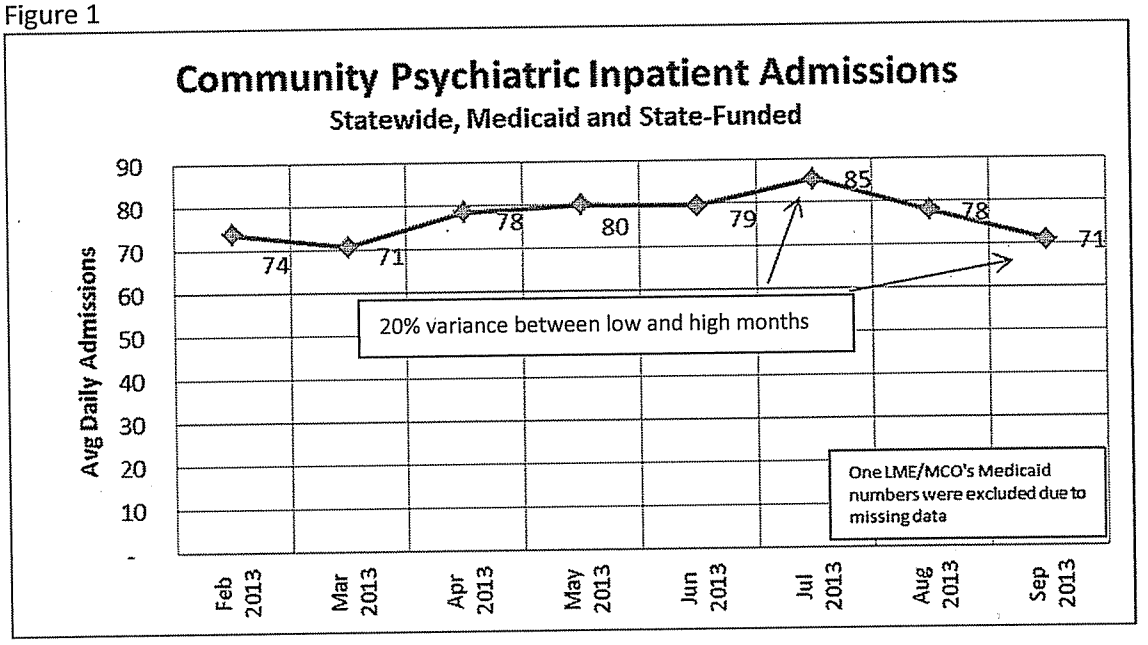
This effort will build upon many of the recommendations that have been identified in previous reports including the ED Length of Stay action Plan referenced in this document. The NC DHHS will work to align existing resources with the services and actions that we know to be effective, work with statewide and community partners on innovative approaches and identify service and policy changes that must be in place for a successful system.

Section Two: Statewide Data on Crisis System Performance Monitoring

As in prior quarterly reports, data on the statewide performance of the crisis system is limited, due to the lack of service specific data previously obtained from claims data. Plans are underway to ensure service data is accessible by January, 2014. Without claims data, reporting on trends regarding persons with three or more crisis events is not feasible.

Community psychiatric inpatient utilization is available only by self-report from the LME/MCOs, and is presented below. Complete data is missing from one LME/MCO and so has been excluded. The average number of admissions daily varies from 71 to 85 during the months reviewed, a variation of 20%. However, without multiple years of data, seasonal trends cannot be assessed, and the significance of this variance cannot be determined. The Department will continue to monitor these trends.

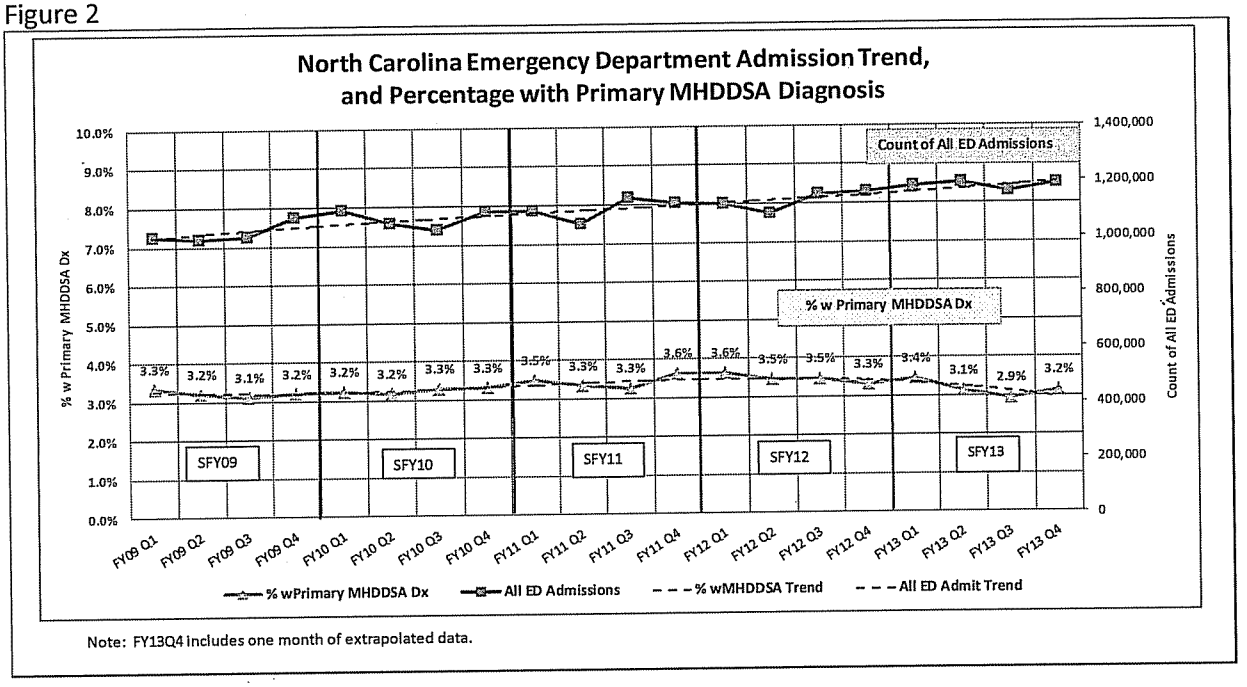
Figure 1



Emergency Department admissions for persons with a primary mental health, developmental disability, or substance abuse diagnoses has been a concern, as persons in the midst of a mental health crisis are not always best served in an Emergency Department. If the hospital has a psychiatric unit, then it can be a first step in the admission process. However, for persons referred for admission to State

Psychiatric Hospitals, or with the potential to be appropriately served with a less restrictive level of care, the ED is not the best place for a crisis assessment. Data shows that the rate of persons admitted to the ED with a primary MH/DD/SA diagnosis was increasing faster than overall ED admissions. However, FY 2013 has trended back down to levels seen in FY 2009 and FY 2010 (3.2% of overall admissions), after highs of 3.4-3.6% in FY 2011 and FY 2012. See Figure 2 below. While causality cannot be asserted, the downward trend of ED admissions in FY 2013 has coincided with intensive efforts and resources of the LME-MCOs to bring about lower ED admissions, decreased inappropriate use of inpatient services, and increased follow-up and linkage of frequent crisis service utilizers to non-crisis community based services and supports.

Figure 2



Note: FY13Q4 includes one month of extrapolated data.

Section Three: Summary of Efforts and Activities and Progress Made by LME-MCOs

In Section Three, an outline of the main activities of each LME-MCO is presented. These activities correspond to the two priorities, reducing inpatient utilization and repeated crisis services usage. All individual LME Quarterly Reports that were submitted to NC DMH/DD/SAS are available upon request.

Alliance Behavioral Healthcare

Alliance has been focusing its efforts on

- CIT training and a Community Paramedic Program to divert people in crisis away from EDs,
- care coordination in EDs and psychiatric inpatient settings,
- collaborating with CCNC to ensure integrated care for persons identified as being at high risk and high cost,
- use of critical case conferences and improved use of crisis plans,
- increasing use of FBC, MCM, and WICs,
- requiring providers to serve as first responders, and
- quality improvement activities to reduce ED readmissions.

Highlights of the reported progress by this LME-MCO include:

- Reduced admissions to EDs;
- Substantial reduction of admissions to EDs for "high utilizers," with estimated savings of $186,000 in a six-month period;
- Increase of utilization of MCM services.

Cardinal Innovations Healthcare Solutions

Cardinal Innovations has been focusing its efforts on

- care coordination to divert persons in EDs to alternative levels of care, instead of inpatient care,
- care coordination to expedite transition from inpatient settings to community based services,
- increasing CIT training to divert persons in crisis from admission to EDs,
- required use of crisis plans,
- critical case conferences for "top 20" consumers,
- use of peer supports and family advocates to prevent crises
- improved engagement in enhanced community based services,
- increasing use of MCM,
- requiring providers to serve as first responders, and
- quality improvement activities to track persons identified as being at high risk and high cost, crisis service system usage, and medication adherence.

Highlights of the reported progress by this LME-MCO include:

- 18 Law Enforcement Officers and 8 Magistrates trained in CIT;
- Behavioral Health Pharmacist conducted 64 medication reviews to ensure that persons who have used the crisis services continuum are prescribed and take appropriate medications.

<u>CenterPoint Human Services</u>

CenterPoint has been focusing its efforts on:

- care coordination in EDs and psychiatric inpatient settings,
- peer support specialists to guide persons who have been readmitted to inpatient care to prevent future readmissions,
- collaborating with CCNC to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost,

- increasing use of FBC,
- increasing effective use of community based services (non-crisis), and
- quality improvement activities to enhance outcomes of community based services (non-crisis).

Highlights of the reported progress by this LME-MCO include:

- Reduced number of readmissions to State Psychiatric Hospitals over 30 and 180 day periods;
- Use of Peer Care Coordinators to identify reasons for hospital readmission.

CoastalCare

CoastalCare has been focusing its efforts on:

- care coordination to divert persons who are admitted to EDs from being discharged to state hospital inpatient care,
- training peer support specialists and volunteers to function as alternative crisis response resources,
- collaborating with CCNC to promote wellness and to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost,
- collaborating with a local crisis consortium to divert persons in crisis from admission to EDs,
- use of clinical staffings and improved use of crisis plans to prevent crises,
- increasing use of crisis response centers within a comprehensive array of community based services,
- increasing community awareness of and effective use of a comprehensive array of community based services (crisis and non-crisis), and

- quality improvement activities to identify gaps in the services system to enable design of a comprehensive community based service system, and
- additional housing units for the homeless.

Highlights of the reported progress by this LME-MCO include:

- Increased utilization of MCM;
- 75 peer support specialists and 38 advocates trained;
- 36 additional housing units and 32 new employers; and
- 31 Law Enforcement Officers, twenty 911 telephone operators, and 9 private security guards trained in CIT.

East Carolina Behavioral Health (ECBH)

East Carolina Behavioral Health has been focusing its efforts on:

- care coordination to link persons, who are identified as having MH/DD/SA and physical health needs, to integrated care, in an effort to reduce admissions to inpatient care,
- care coordination to facilitate consumers' greater medication adherence (to take medications as prescribed),
- collaborating with individuals, providers, and CCNC to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost,
- increasing more effective use of MCM,
- increasing more effective use crisis plans, and
- developing a system of natural supports and recovery services.

Highlights of the reported progress by this LME-MCO include:

- 51% reduction in ED readmissions for persons served by providers with first responders;

- 18% reduction in ED admissions for persons served by providers with first responders;
- Non-adherence to prescribed anti-psychotic medications reduced by 35.5%;

Eastpointe

Eastpointe has been focusing its efforts on:

- care coordination to divert persons who are admitted to EDs from being discharged to hospital inpatient care,
- collaborating with CCNC to facilitate integrated care for persons identified as being at high risk and high cost,
- collaborating with providers, CCNC, and a local crisis collaborative to reduce readmissions,
- CIT training to divert persons in crisis from EDs,
- increasing use of FBC, MCM, WICs, NC START, and crisis respite beds,
- requiring providers to serve as first responders,
- increasing use of community based services, and
- quality improvement activities to reduce state psychiatric hospital readmissions.

Highlights of the reported progress by this LME-MCO include:

- implemented open access appointments pilot project;
- provided training to magistrates on behavioral healthcare resources; and
- established PROACT pilot project for high risk/high cost members.

MeckLINK Behavioral Healthcare

MeckLINK has been focusing its efforts on:

- care coordination to divert persons who are admitted to EDs from being discharged to hospital inpatient care,
- care coordination to link persons in inpatient care to community based services, including integrated care,
- collaborating with CCNC to facilitate integrated care for persons identified as being at high risk and high cost, and
- testing and requiring providers to serve as first responders.

Highlights of the reported progress by this LME-MCO include:

- timely and intensive behavioral healthcare follow-up with 88% of persons discharged from state hospital psychiatric inpatient care;
- timely and intensive behavioral healthcare follow-up with 70% of persons discharged from state ADATCs; and
- utilizing PROACT model to ensure effective transitional care to persons identified at high risk/high cost.

Partners Behavioral Health Management

Partners has been focusing its efforts on:

- care coordination to divert persons, who have repeatedly used crisis services, to other community based services,
- collaborating with CCNC and hospitals to facilitate transition of persons from inpatient care to community based services,
- CIT training to divert persons in crisis from EDs,
- increasing use of MCM in community settings, rather than in EDs,
- testing and requiring providers to serve as first responders,
- promotion of same day access to service model, and
- quality improvement activities to identify service gaps and increase awareness of community based services.

Highlights of the reported progress by this LME-MCO include:

- mapping access to resources;
- trained 43 Law Enforcement Officers in CIT;
- developing same day access model to appointments; and
- 50% increase in reported services in WIC provided to persons in crisis.

Sandhills Center for MH/DD/SAS

Sandhills has been focusing its efforts on:

- care coordination in EDs to divert from inpatient care,
- care coordination to link persons in psychiatric inpatient care to community based services,
- collaborating with CCNC to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost
- collaborating with EDs, hospital transition teams, a local crisis collaborative, and ACT teams to reduce readmissions to inpatient care,
- use of improved use of crisis plans,
- development of comprehensive plan for persons identified as being at high risk and high cost,
- increase use of MCM in community settings, rather than EDs,
- increase use of WICs and crisis centers, especially to assess persons who have been petitioned for involuntary commitment, and
- quality improvement activities to identify barriers to access and timeliness of access to services.

Highlights of the reported progress by this LME-MCO include:

- using CMT predictive modeling to identify members at high risk;
- provided timely access to urgent care for persons needing such care for 93% of the members; and
- provided timely access to routine care for persons needing such care for 78% of the members.

Smoky Mountain Center

Smoky Mountain Center has been focusing its efforts on:

- care coordination to link persons in psychiatric inpatient care to community based services,
- collaborating with CCNC to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost, or medically complex.
- collaborating with hospitals, local crisis committees, law enforcement, magistrates, local Departments of Social Services, public schools, CFACs and MCM providers to reduce readmissions to inpatient care,
- building awareness of MH/DD/SA, community based services, and involuntary commitment,
- use of interdisciplinary treatment team staffings to address needs of persons identified as being at high risk for readmissions,
- increase use of MCM in community settings, rather than EDs,
- increase and improvement of use of MCM and WICs,
- building community based service capacity and comprehensive service providers, and
- quality improvement activities to monitor trends in crisis services outcomes.

Highlights of the reported progress by this LME-MCO include:

- held Involuntary Commitment Symposium for over 500 Law Enforcement Officers, magistrates, clerks of court, and healthcare professionals; and

- trained 230 Law Enforcement Officers in CIT.

Western Highlands Network (WHN)

Western Highlands Network has been focusing its efforts on:

- care coordination to link persons in EDs and those who have repeated use of crisis services, to community based services,
- collaborating with CCNC and hospitals to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost,
- improved development of person centered plans and crisis plans to prevent crises,
- increase use of MCM in EDs,
- requiring providers who serve as first responders to improve responsiveness,
- improving access to a continuum of community based services,
- quality improvement activities to reduce repeated use of crisis services, and to identify homeless population, and
- increasing housing options for the "hard to house" individuals.

Highlights of the reported progress by this LME-MCO include:

- housing options being explored for 40 persons identified as "hard to house;"
- ED visits decreased by 43% for individuals with a current provider;
- ED visits decreased by 38% for individuals without a current provider; and
- 4% reduction in homeless persons receiving crisis services.

Conclusion

Crisis and inpatient services are an essential part of the behavioral health continuum of services, so even the most effective service system will include some level of utilization

of these intensive services. The objective is not to eliminate, but to "right-size" the utilization of these services. More study will be needed to determine if regions with very high utilization of these services have issues with the capacity, quality or robustness of the array of community services. That being said, all LME-MCOs reported that there are numerous and extensive efforts underway to improve access to community based services, both alternative crisis services and non-crisis services.

As indicated in this report, NC DMH/DD/SAS and the LME-MCOs have engaged in numerous activities that are intended to lower ED admissions, to decrease the use of unnecessary inpatient care, and to reduce the number of persons who have frequent crisis events, while focusing on the improvement and expansion of community based services. Much of the activities focus on

- Analyzing/establishing/enhancing the current continuum of non-crisis community based services (e.g., ACT, outpatient services)
- Bolstering the array of alternatives to crisis care in EDs and inpatient care (e.g., Mobile Crisis, Walk-In Crisis, Facility-Based Crisis services)
- Use of crisis prevention planning Care coordination efforts to provide transition care to people to appropriate levels of crisis services, and post-discharge community based services
- Education and training efforts extended to the local communities, providers, and partners (law enforcement, magistrates, hospitals, etc.)
- Accountability of providers to respond to the crises (e.g., first responders) of their consumers; and
- Identifying those people who are at high risk of repeated crisis episodes and applying intensive outreach via collaboration with CCNC, and follow-up to ensure more effective and appropriate care is utilized.

As mentioned earlier, the unavailability of inpatient claims data from the LME-MCOs prevents statewide reporting (other than the LME-MCO self-report data) of the use of community hospital psychiatric inpatient beds and individuals' repeated usage of crisis services. The available ED data show a downward trend beginning in SFY 2013 in ED admissions of persons with primary MH/DD/SA diagnoses.

While causality cannot be asserted, the downward trend of statewide ED admissions in SFY 2013 has coincided with intensive efforts of and resources brought to bear by the LME-MCOs to bring about lower ED admissions, decreased inappropriate use of inpatient services, and increased follow-up and linkage of frequent crisis service utilizers to non-crisis community based services and supports.

As claims data becomes increasingly available at the state-level, NC DMH/DD/SAS will conduct the additional following analyses:

1. A comparison will be done to determine if those utilizing the most crisis and inpatient services are receiving LME funded services.
2. DMH/DD/SAS can engage the LMEs in a discussion of the feasibility of reporting county-funded services through the IPRS system.
3. The new service, Psychotherapy for Crisis, will be included as it becomes available through the claims system.
4. DMH/DD/SAS will follow-up with LMEs that appear to be outliers with specific crises services and/or inpatient bed day utilization.

NC DMH/DD/SAS and LME-MCOs have made and will continue to make significant efforts to address the high rates of inpatient and crisis services utilization for the persons served in North Carolina's publicly-funded system. It is believed that as LME-MCOs mature in the management of care to persons served in their areas, as the LME-MCOs' relationships with EDs are enhanced, and as non-crisis community-based services are expanded and the quality of those services improved, fewer people will need crisis services and fewer who do need crisis services will be directed to EDs and inpatient services.

References

North Carolina Department of Health and Human Services, "Statewide Telepsychiatry Program Plan: Section 12A.2B of North Carolina Session Law 2013-360." (Raleigh, NC: 2013) [On-line]. Available at: http://governor.nc.gov/sites/default/files/TelepsychiatryProgramPlan.pdf [August 2013].

North Carolina Division of Health Services Regulation, "Hospitals By County." (Raleigh, NC: North Carolina Department of Health and Human Services, 2013) [On-line]. Available at: http://www.ncdhhs.gov/dhsr/data/hllistco.pdf [September 2011].

North Carolina Division of Health Services Regulation, "Mental Health Facilities (G.S. 122C)." (Raleigh, NC: North Carolina Department of Health and Human Services, 2013) [On-line]. Available at: http://www.ncdhhs.gov/dhsr/data/mhllist.pdf [October 2013].

North Carolina Division of Health Services Regulation, "North Carolina Proposed 2014 State Medical Facilities Plan." (Raleigh, NC: North Carolina Department of Health and Human Services, 2013) [On-line]. Available at: http://www.ncdhhs.gov/dhsr/ncsmfp/2014/proposed2014smfp.pdf [2013].

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Communication Bulletin #139." (Raleigh, NC: North Carolina Department of Health and Human Services, 2011). [On-line]. Available at: http://www.ncdhhs.gov/mhddsas/communicationbulletins/2013/commbulletin139/cb139pcpcomprehensivecrisisplan.pdf [September 2013].

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Emergency Department Length of Stay Action Plan." (Raleigh, NC: North Carolina Department of Health and Human Services, 2011). [On-line]. Available at: http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf [November 2011].

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. "Implementation Update #86." (Raleigh, NC: North Carolina Department of Health and Human Services, 2011). [On-line]. Available at: http://www.ncdhhs.gov/mhddsas/ImplementationUpdates/update086/iu86_april2011_final.pdf [April 2011].

University of North Carolina Department of Emergency Medicine, Carolina Center for Health Informatics. "Hospital Status Table & ED Data Completion Rates by Patient County of Residence." (Chapel Hill, NC: Carolina Center for Health Informatics, Department of Emergency Medicine, University of North Carolina at Chapel Hill; 2013). [On-line]. Available at: http://www.ncdetect.org/hospitalstatus.html [May 2013].