North Carolina Department of Health and Human Services

Pat McCrory
Governor

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

July 1, 2013

The Honorable Louis Pate, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1028, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Nelson Dollar, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307B1, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Pate and Representatives Burr and Dollar:

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 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,

Aldona Wos, M.D.
Secretary

Attachment

cc: Denise Thomas
Susan Jacobs
Patricia Porter
Sarah Riser
Kristi Huff
Brandon Greife
Pam Kilpatrick
Carol Steckel
Dave Richard
Jim Slate
Adam Sholar
Legislative Library (one hard copy)

Mental Health Crisis Management Report

December 2012 – February 2013: Status Report

Session Law 2012-128 (Section 2)

July 1, 2013

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

December 2012 – February 2013: Status Report

Due July 1, 2013

Report 3 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.*

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 identify efforts and activities pertinent to the two priorities established. The NC DMH/DD/SAS has also developed a crisis and inpatient database that will be used to track utilization trends by LME.

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 (LMC-MCOs) to address the two legislative priorities. This report also provides summarized data from 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 report encompasses individual LME-MCO reports of December 2012 to February 2013. Preliminary and background information supporting this report and LME-MCO activities can be found in the initial report submitted October 2012.

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 systems are established or enhanced, and as non-crisis community-based services are expanded and the quality of those services improved, even fewer people will need crisis services and fewer who do need crisis services will be directed to EDs and inpatient services.

Change from Previous Report

In previous reporting, data was included showing the SFY 2012 rates of psychiatric inpatient utilization and persons with repeated crisis events across LME-MCOs. This data was based on claims for services rendered for the twelve month period, paid by Medicaid and State DMH/DD/SAS funds. Extrapolation was used where Medicaid data was missing for two LME/MCOs that no longer submitted fee-for-service claims after they became MCOs. This information cannot be reported for this quarter's report. Medicaid claims data for the twelve months from October 2011 through September 2012 is missing for more LMEs, so extrapolation is no longer feasible.

As the LMEs becoming MCOs Medicaid claims are processed in local IT systems and reporting of these "encounter" claims to the State has not yet been accomplished successfully. The LME/MCOs are continuing to test the encounter claims submissions and progress is being made. It is hoped that complete data will be available for the next installment of this report.

Summary of Efforts and Activities and Progress Made by LME-MCOs Listed by Provider

Goals and progress reported by LME-MCOs, corresponding to the two priorities: reducing inpatient utilization and repeated crisis services usage. Please note that many of the identified efforts and activities to address one priority will likely impact the second priority as well.

Alliance Behavioral Healthcare

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Decrease use of Emergency Room admissions.
        i. Progress: University of North Carolina (UNC) has been contracted for the Wake county crisis and assessment facility. Crisis beds will be expanded in July of 2013 at the WakeBrook location. Alliance Quality Management (QM) staff is working with UNC staff to conduct a Quality Improvement Project in FY14 for a step-down service to determine if it would be cost and outcome effective. Meanwhile data elements are being shared with Alliance Behavioral Healthcare in order to better facilitate the meaning of the data collected (in addition to claims).
        ii. Progress: Co-location of care coordination staff has occurred at Duke, Johnston Memorial, Wake Med, and UNC hospitals. Alliance has begun extrapolation of ED and Inpatient data (for IPRS) via relationships with Utilization Review and Quality Improvement staff at each facility. Alliance staff is tracking high utilizers.
        iii. Progress: Care Coordination staff is able to "flag" consumers in the Alpha data system if identified by CCNC, and those are immediately followed up to ensure connection to outpatient and enhanced services. High utilizers are being tracked. Data regarding utilization changes will be available in the next quarter report.

    b. Goal: Meet with CIT partners to review policies, protocols, general orders, and anecdotal barriers and challenges (the completion date was January 1, 2013). Partners include county, city, and military law enforcement.
        i. Progress: The Community Paramedic Program is slated to begin in June of 2013.

ii. Progress: Crisis Intervention Team (CIT) training has been expanded in Cumberland, Wake and Johnston counties. One forty-hour training has been held: 28 law enforcement employees and one fire fighter trained.
iii. Progress: Three 16 hour CIT trainings have been held for City and County Telecommunicators.
iv. Progress: CIT curriculum has now been modified to include a module on responses to active duty military and veterans in the community.
v. Progress: CIT curriculum approved for refresher course for CIT trained officers.
vi. Progress: Advanced placement course developed that will require an additional 20 hours of CIT training that includes the trainee serving as a facilitator.

c. Goal: Increase utilization of facility based and mobile crisis services across the four counties.
i. Progress: To better integrate mobile crisis into the crisis continuum, Cape Fear Valley hospital is working on protocols to allow Mobile Crisis staff to gain access to the ED to provide assistance. Formal linkage agreements are being finalized.
ii. Progress: Alliance QM Staff is coordinating data extrapolation from crisis facilities, mobile crisis teams, and EDs for real time data since there are no authorizations for crisis services. Will have weekly crisis utilization report for the catchment area beginning April 1, 2013.
iii. Progress: Alliance QM staff will begin testing all network providers' first responder capabilities starting in April. Results, by provider, will be shared with Provider Network staff for technical assistance. First Responder Guidelines will be published on Alliance's website by early April 2013.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
a. Goal: Increase availability and use of alternative crisis assessment and referral.
i. Progress: High risk cases, including frequent ED admissions are staffed in monthly meetings with CCNC and the LME-MCO.

ii. Progress: All care coordinators are now participating in the monthly behavioral health integration meetings with CCNC.
iii. Progress: Cumberland County Commissioners have included establishment of a walk in assessment clinic at the Roxie Avenue Center. Final plans have not been adopted at this time.
iv. Progress: Hospital behavioral health staff is evaluating ways to increase direct screenings and evaluations for admission to the Roxie Avenue Center that will include use of physician assistants, associate level licensed clinicians and re-deployment of psychiatrists from the ED to provide services in the crisis center.
v. Progress: Alliance QM staff will begin testing all network providers' first responder capabilities starting in April. Results, by provider, will be shared with Provider Network staff for technical assistance. First Responder Guidelines will be published on Alliance's website by early April 2013.
vi. Progress: Outreach is being conducted in each county to reach out to other providers for appointments as needs are identified and the appointments are entered into the slot scheduler within 24 hours.

b. Goal: Increase utilization of first-responder activities of clinical home providers.
    i. Progress: Alliance QM staff will begin testing all network providers' first responder capabilities starting in April. Results, by provider, will be shared with Provider Network staff for technical assistance. First Responder Guidelines will be published on Alliance's website by early April 2013.

c. Goal: Reduce psychiatric hospital readmissions.
    i. Progress: High risk cases, including frequent ED admissions are staffed in monthly meetings with CCNC and the LME-MCO.
    ii. Progress: All care coordinators are now participating in the monthly behavioral health integration meetings with CCNC.

Cardinal Innovations Healthcare Solutions

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: To improve timeliness of linking consumers to necessary services and supports.
        i. Progress: Redesign of the inpatient UM team to collect discharge information during the review process.
        ii. Progress: Began educating acute inpatient providers by doing onsite visits; education includes emphasis on discharge procedures and completing discharge summaries with appointment information.
        iii. Progress: Discharge coordinator reviews all discharges and provides a 7 day follow up call post discharge to the provider to confirm appointment has occurred.
        iv. Progress: For individuals receiving transitional care visits following in-patient discharges, care coordinators confirm follow up appointment and identify / address any barriers to keeping the appointment.

    b. Goal: To improve quality of interactions between law enforcement and MH/DD/SA consumers in crisis and use of emergency behavioral health care services in lieu of ED.
        i. Progress: Five County meeting with District Court Judge and Magistrates as well as members of the CIT Partnership Committee held 2/21/13.
        ii. Progress: Orange-Person-Chatham (OPC) meeting of select CIT Partnership Committee Members to create a brief training for families with children on how to navigate the crisis system was held February 21, 2013.
        iii. Progress: OPC one hour training provided to Chatham County Magistrates was held on January 7, 10 and 14, 2013.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: To promote early interventions in Enhanced Benefit Services, which prevent crisis events.
        i. Progress: As part of the Treatment Authorization Request review process, care managers provide technical assistance and education to providers regarding engagement, crisis planning and prevention.

ii. Progress: Continue to have assigned dedicated emergency coordinator to contact emergency department daily and to work with ED staff and mobile crisis teams to divert admissions to crisis facilities.

b. Goal: To improve transitional care upon notification of discharge from local/state hospital for individuals with Medicaid and correct contact information.
    i. Progress: Upon telephonic review the Care Managers request updated address and phone information for the consumer.
    ii. Progress: During reporting period (December 2012 – February 2103) 15% of individuals received Transitional Care Visit within 72 hours with another 8% receiving the Transitional Care Visit but after the 72 hour timeframe.
    iii. Progress: Of the individuals receiving no Transitional Care Visit, correct contact information was not available for 37%.

CenterPoint Human Services

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Meet established readmission benchmarks for both State and local facilities. Identify precipitating factors that lead to admission and/or readmission to inform development of interventions.
        i. Progress: Protocol implemented to track precipitating factors for persons who have been re-admitted to inpatient hospitalization, and contacts made by care coordinators with consumers.
        ii. Progress: Peer Support staff is meeting with consumers who have been re-admitted and are documenting the reasons consumers are giving for re-admission.
        iii. Progress: ED care coordinators are in place and going to the two EDs which consistently serve the most individuals with behavioral health concerns. Additionally, the ED care coordinators are in daily contact with all other emergency departments in CenterPoint catchment area.
        iv. Progress: Care Coordinators follow-up with individuals who do not attend their hospital follow-up appointment. Care

coordinators inquire about reasons for non-compliance and assist with any barriers identified.

v. Progress: Exploring the addition of two 30-hour per week peer support specialist positions to increase hospital aftercare compliance efforts.
vi. Progress: Continue to collaborate with Northwest CCNC and local hospitals to identify trends in ED utilization of patients who use both the Wake Forest and Forsyth EDs, and overall ED utilization trends.
vii. Progress: Increased number of hospital liaisons from two to three. With increased staff, we were able to expand our efforts to hospitals outside CenterPoint's catchment area. Continue to collaborate with inpatient staff to assist with discharge planning.
viii. Progress: Care coordinators and integrated care specialists meet bi-weekly to collaborate on challenging cases. Additionally they meet on an as-needed basis, frequently daily, to address emergent concerns.

b. Goal: Determine feasibility of developing a local Facility-Based Crisis Center (FBCC) for ED diversion and provision of in-patient care in a community setting.
    i. Progress: Potential partners and supporters of the FBC service have been identified.
    ii. Progress: Meetings have been held approximately every 6 weeks with the major providers of emergency services, including Wake Forest University Baptist Medical Center and Forsyth Medical Center.
    iii. Progress: Current FBC providers are also contributing to the discussions with information about service delivery and utilization experience.
    iv. Progress: Three potential sites have been identified. Initial meeting with architecture firm has been held to determine feasibility of potential sites.
    v. Progress: Emergency Medical Treatment and Active Labor Act (EMTALA) and regulatory issues have been clarified.
    vi. Progress: Actively participating in the Forsyth County Behavioral Health Collaborative meetings involving the Northwest CCNC, Wake Forest University Baptist Medical Center and Forsyth Medical Center. These have produced

good dialogue leading to improved collaboration for care coordination, and dialogue about improved management of shared patients.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Utilize Care Management Technologies (CMT), a predictive modeling technology system, to assist in predicting crisis engagement based on patterns and trends in data specific to quality of care indicators.
        i. Progress: Care Coordination staff has implemented CMT, a predictive modeling technology system, into their daily workflow. Staff now utilizes CMT when receiving Care Coordination referrals to gain overall treatment knowledge of the consumer. Care Coordinators are using CMT to review hospitalizations, review medication history and identify prescriber information.
        ii. Progress: Consumers who are flagged as "high risk" by CMT's QI indicators are crosschecked against the top 20% high risk/high cost report to identify consumers who might not appear in traditional reporting methods.
        iii. Progress: Started monthly focus groups with CMT and other MCOs that are designed to address various functionality issues/utility of the CMT online analytics tool and identify additional reporting needs.

    b. Goal: Implement state-wide initiative to expand evidence-based, high-fidelity Assertive Community Treatment (ACT) Team services in collaboration with NC ACTT Coalition & Duke University.
        i. Progress: The NC ACTT Coalition is meeting regularly with participating teams from across the state (East, West & Central).
        ii. Progress: The ACTT fidelity instrument to be used has been identified. The ACTT service definition is out for public comment and fidelity reviews cannot be conducted until the definition is approved.
        iii. Progress: LME-MCO staff is registered to attend the Tool for Measurement of ACT (TMACT) training in March. The goal is to receive an overview of ACT implementation within the framework of the US Department of Justice settlement agreement, information on ACT fidelity screening plans and in-depth review of the TMACT fidelity scale.

CoastalCare

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Create and support alternative resources for persons to receive crisis response services instead of seeking care in the ED.
        i. Progress: CoastalCare discussed resuming the Crisis Consortium meetings which include community partners such as: magistrate, police, sheriff, EMS, hospital, primary health, and school representatives. This will begin after baseline data is collected and measurable goals can be determined.
        ii. Progress: Discussion regarding the creation of 24 hour crisis response centers will continue once more baseline data is collected and analyzed to better determine what additional crisis centers are needed at this time.

    b. Goal: Education of persons with MH/DD/SA regarding alternative and periodic services available to meet their behavioral health needs.
        i. Progress: Service gaps will be identified from the baseline data and will be discussed during the Root Cause Analysis scheduled for the April 1, 2013 meeting.
        ii. Progress: Signage and marketing for services will be determined after the baseline data is reviewed and service gaps are identified.

    c. Goal: Work with providers in the network to ensure that there is a continuum of care which is easily accessible/available for routine services including primary care physicians.
        i. Progress: Decisions regarding community training and certification and incentivizing of providers to ensure a seamless continuum of care will be determined once service gaps and provider sufficiency data is collected.
        ii. Progress: CCNC will be members in the QI Project and CoastalCare continues to partner with CCNC in meeting service and medical needs of consumers with MH/DD/SA diagnoses.

    d. Goal: Decrease recidivism rate in persons with MH/DD/SA.

i. Progress: Baseline data will be discussed at the March 4, 2013 meeting. A Consumer and Family Advisory Committee (CFAC) representative will be identified, as well as the team working to obtain a member from CCNC and hospital representatives to attend the QI Project meeting.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Linking high risk MH/SA/DD consumers with community based service providers in order to reduce overutilization of crisis services.
        i. Progress: At the initial QI Project meeting the team discussed a possible lack of initiation and engagement from consumers and providers. The question was raised as to whether or not persons who utilized a crisis service were being referred to a provider to assist them with their MH/SA/DD symptoms.
        ii. Progress: This goal will be discussed and assessed in further detail once a root-cause analysis is completed, which is scheduled for 4/1/13.

    b. Goal: Providing high risk MH/SA/DD consumers the tools needed to manage their MH/SA/DD symptoms through non-crisis services.
        i. Progress: QI Project team discussed the need to link consumers to routine services (outpatient therapy, primary health services, outpatient psychiatric services, etc.) as a diversion method from utilizing crisis services for routine needs.
        ii. Progress: More baseline data needs to be collected and analyzed (ongoing process) and a root-cause analysis (scheduled for 4/1/13) needs to be completed to determine applicable interventions to be implemented throughout the course of the QI Project.

    c. Goal: Work with providers in the network to ensure that there is a continuum of care and that routine services are easily accessible/available.
        i. Progress: QI Project team discussed the services that are available within the catchment area as well as identified service gaps.
        ii. Progress: Baseline data was discussed and one of the interventions that the QI Project team will focus on is developing services within the network to address consumers' needs, including peer supports.

d. Goal: Create a natural support and unfunded community resource network for persons with MH/SA/DD and educate those persons on how to access/use the supports to avoid crises.
    i. Progress: QI Project discussed the need for more peer supports in the provider network, and for providers to focus more on natural supports for their consumers to help meet the consumers' needs.
    ii. Progress: Baseline data was discussed and one of the interventions that the QI Project team will focus on is developing services within the network to address consumers' needs, including peer supports.

East Carolina Behavioral Health

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Decrease inpatient readmissions by scheduling hospital follow-up appointments and medication management appointments before discharge.
        i. Progress: State Hospital 30-Day Readmissions
            a. November 2012 (baseline) = 11.9%
            b. February 2013 (intervention) = 7.4%
        ii. Progress: Community Hospital 30-Day Readmissions
            a. November 2012 (baseline) = 8.78%
            b. February 2013 (intervention) = 5.7%

    b. Goal: Reduce ED admissions for consumers that are currently being served by our provider network.
        i. Progress: Two of the four providers with the highest ED admissions from April-Sept 2012 (37%) are no longer providing first responder services. Technical assistance was provided to the remaining two first responder providers with the highest percentage of ED admissions. The providers were asked to educate all of their consumers including those with the highest ED admissions from April-September 2012 (23%) to ensure the provider's crisis response protocol is followed.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:

a. Goal: Improve medication adherence for individuals at high risk.
    i. Progress: For the first data set, intervention occurred with 51 individuals who were non-compliant with antipsychotic medications; 22 individuals became compliant. Thus, antipsychotic medication non-compliance was reduced by 43%.
b. Goal: Link individuals at high risk to natural supports & Recovery services.
    i. Progress: Random sample of 120 individuals; records reflect that 98 of the 120 (81.67%) were linked to recovery services or natural supports.

Eastpointe

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Increase communication with hospitals, local authorities and providers to meet state average.
        i. Progress: Care coordinators telephone designated staff at emergency room for daily census.
        ii. Progress: Monthly face to face with three regional CCNC staff and one weekly phone conference within the network to discuss high risk/high cost enrollees.
        iii. Progress: Collaborate with providers regarding follow up activities for enrollees with three or more crisis events.
        iv. Progress: CIT Training conducted; graduated eleven officers in Rocky Mount area.
        v. Progress: Medical Director met with walk-in clinics throughout the catchment area.
        vi. Progress: Eastpointe personnel have been meeting with local hospitals to discuss individuals with high readmission rates.
        vii. Progress: Eastpointe personnel consulted with walk-in clinics regarding plans for reducing readmission rates.

    b. Goal: Increase community awareness of Mental Health, Intellectual/ Developmental Disability and Substance Abuse.
        i. Progress: Community Relations Staff provided education prevention forums throughout the twelve counties

ii. Progress: Provided education to enrollees and their families regarding MH/SA services

c. Goal: Ensure referral and transition to prevent readmission and maintain stabilization.
    i. Progress: Collaborate with providers regarding follow up activities for enrollees with three or more crises
    ii. Progress: Monthly meetings with CCNC and providers
    iii. Progress: Closed network effective January 1, 2013
    iv. Progress: Mobile Crisis Teams and Walk-in Clinics throughout the twelve counties.
    v. Progress: Talked with WIC regarding data.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Increase identification of members/enrollees with two crisis services in a thirty day period within a twelve month period.
        i. Progress: Collaborated with providers regarding follow up activities for enrollees with three or more crisis
        ii. Progress: Care coordinators have daily contact with the ED within the catchment area.
        iii. Progress: Care Management Technology training provided to MCO staff

    b. Goal: Ensure continuity of care for high cost/high risk members/enrollees post discharge monthly.
        i. Progress: Care coordinators provide follow up activities for consumers (who miss scheduled appointments, for whom a crisis services has been provided as the first service and to individuals discharged from 24 hour care, and with three or more crisis services.
        ii. Progress: Continued partnerships with Walk-in Crisis Clinics, hospitals throughout the twelve counties.

MeckLINK Behavioral Healthcare

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Timely follow-up with behavioral health practitioners after hospitalization decreases re-admission rates. The goal is to reduce

the number of readmissions by providing services within seven calendar days of a person's discharge from inpatient care.

i. Progress: Data for State Operated Psychiatric Facilities
    a. December 2012 - 100% (8/8)
    b. January 2013- 100% (7/7)
    c. February 2013 – 83% (10/12)
    d. Mental Health (MH) average for this time period = 93% (25/27)
ii. Progress: Data for State Operated Substance Abuse Facilities
    a. December 2012-100% (6/6)
    b. January 2012 – 88% (7/8)
    c. February 2013- 75% (9/12)
    d. Substance Abuse (SA) average for this time period =85% (22/26)
iii. Progress: Overall Average (MH & SA) = 89% (47/53)
iv. Progress: Goal Exceeded

b. Goal: Providers delivering certain outpatient services must implement an effective "first response" protocol in order to assist consumers during a crisis. One of the goals of 'first response' is to avoid emergency department admission and hospitalization.
    i. Progress: Baseline- 36% (4/11) of Providers had a functional first responder system in place at the time of the initial assessment in December 2006.
    ii. Progress: Recent Activity evaluated by CFAC members, who conducted test calls in March and April of 2012. The following data is shown by provider types, reflecting the percent of providers using a first response protocol:
        a. CABHAs = 60% (40/69)
        b. Intellectual/Developmentally Disabilities Targeted Case Management = 88% (7/8)
        c. Substance Abuse Intensive Outpatient Program = 62% (8/13)
        d. Substance Abuse Comprehensive Outpatient Treatment Program = 100% (2/2)
        e. ACTT =100% (1/1)
        f. Multisystemic Therapy = 100% (1/1)
        g. Total: = 63% (59/94)

iii. Progress: The 35 Providers that failed the test received a Plan of Correction and follow-up test calls from Provider Operations. Corrective Action Performance Data:
    a. 31 providers passed the follow-up test calls
    b. Three providers did not complete the Plan of Correction and are no longer in the network
    c. One provider left the network due to expired Business Verification.
iv. Progress: Preparations are underway for the 2013 test.
v. Progress: This goal has not yet been achieved but significant progress has been made since the initiation of the project; 63% of providers met the definition for having a Functional First Responder System.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Individuals who receive local psychiatric inpatient services, mobile crisis services, or psychiatric emergency department services will engage in treatment thereafter to avoid re-admission or further emergency interventions
        i. Progress: Initial metrics reflect baseline data and include IPRS consumers only for the period from 9/1/12 through 11/30/12:
            a. Total Episodes = 183
            b. Episodes with 4 follow up visits in 45 days = 1.6% (3/183)
        ii. Progress: Baseline data only = 1.6%

Partners Behavioral Health Management

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Require First Responder intervention prior to initiation/use of MCM for those consumers enrolled in enhanced services.
        i. Progress: Quality Improvement Plan on this topic is in place, has Medical Director oversight and is updated quarterly with reporting to Quality Improvement Coordinator. First responder baseline has been generated; data collection procedures have been improved.

ii. Progress: When crisis calls come to Customer Services, staff is trained to ask actively served consumers if they have attempted to reach their Provider.
iii. Progress: Mystery Shopper sampling of First Responders has been initiated.
iv. Progress: Clinical Director has developed Partners Strategic Crisis Services Plan; has met with key LME-MCO staff and communicated throughout the LME-MCO with the goal of optimal consumer crisis management.
v. Progress: Meeting with four Mobile Crisis Providers to be held on March 21, 2013, to review LME-MCO expectations of their responsiveness.
vi. Progress: Will address First Responder accountability with providers in April 9th Provider Form to enhance adherence of clinical practice.
vii. Progress: Have educated Emergency Department medical personnel of First Responder responsibilities to allow the EDs to have clear understandings of when First Responders should act.
viii. Progress: Clinical Director met twice with the four MCM providers between July and December, 2012. Discussion is underway to contract for a different rate when MCM is provided outside an ED location in FY 14. Goal is to increase use of MCM in community settings.

b. Goal: Increase the use of Community Based Services (CBS) for consumers in need of behavioral health services before crises arise.
i. Progress: Daily tracking of consumers in ED is reported to Medical Director for 13 EDs in eight counties; data broken down by age and disability. Information shared with clinical leadership.
ii. Progress: Quality Improvement Plan has been developed, with Medical Director and Quality Improvement Coordinator approval. New educational presentation and brochures have been designed for communication with Providers and consumers to use walk-in clinics instead of EDs.
iii. Progress: Locations of crisis service providers in newly configured eight county LME-MCO have been plotted on Geo-map.

iv. Progress: Expenditure by funding source has been calculated for five crisis codes (Inpatient Hospitalization, 3-way contract inpatient beds, Non-hospital Medical Detox, Mobile Crisis, and Facility Based Crisis beds), for July – December 2012 to establish the baseline usage of inpatient psychiatric hospitalization. Information is being used to further refine Network services through examination of crisis services current availability and identification of gaps.

c. Goal: CIT trainings for law enforcement, hospital personnel, local magistrates, and mobile crisis staff will continue to be offered across the eight-county LME/MCO. The purpose is to educate the community about options other than use of ED's and/or Involuntary Commitment (IVC) process.
   i. Progress: CIT has a strong foundation in the 8-county area; five of eight counties have CIT trained officers.
   ii. Progress: Sites where CIT training has occurred and where it is needed has been determined through the recent "Survey of CIT Programs In North Carolina." This review has shown areas to be prioritized in providing training so that gaps are minimized.
   iii. Progress: Three LME-MCO staff have completed CIT trainer training.
   iv. Progress: Three CIT classes are scheduled for May and June in Surry, Iredell, and Catawba Counties. A fourth class is being scheduled for Burke County.
   v. Progress: A new System of Care staff that will be on board in April will take CIT training in May and will offer at least one class by August.

d. Goal: Promote Walk In Crisis Service use in all LME/MCO counties.
   i. Progress: Baseline data taken from July- December 2012 was analyzed and determined that Walk-In Clinics were under-utilized compared with other crisis services.
   ii. Progress: Current QIP (noted above) is overseen by Medical Director. Purpose is to reinforce first responders to assist consumers to use walk-in clinic, as needed, along with appropriate intervention by first responders.
   iii. Progress: Clinical Director has developed LME-MCO work group to address crisis services gaps through Partners

BHM Strategic Crisis Services Plan. Work is underway to more closely partner with crisis providers in Network.

iv. Progress: Communication about the crisis service continuum and availability has begun with Gero-Adult Specialty Team staff; CFAC members; and brochures on crisis services have been designed and are ready for mailing to consumers and families.

v. Progress: QM Matters is a monthly column which communicates with community readers through Partners BHM weekly newsletter on a range of quality issues. Article on Walk-in Clinic is in preparation cross-departmentally.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Identify consumers at the time of a 2nd crisis intervention in a rolling twelve month period and notify Care Coordination (CC) for intervention to prevent additional use of crisis services.
        i. Progress: Clinical Director has identified CMT as resource for clinical staff to identify consumers who have specific risk factors. Contract has been signed which will allow clinical staff to access claims information to identify risk behaviors. Training is scheduled for April, 2013.

Sandhills Center for MH/DD/SAS

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Sandhills Center works to reduce state hospital readmission rate to less than 7% by ensuring that the highest risk/highest need members are connected with community based services designed to meet their needs in the least restricted environment.
        i. Progress: Members being readmitted to state hospitals within a 30 day period from Sandhills Center's Guilford county was at 4% during the past quarter. The readmission rate was at 12% for members being readmitted to state hospitals within a 180 day period.
        ii. Progress: Sandhills Center works to standardize the interventions used across the merged nine county catchment area and to decrease the 180 day readmission rate to less than 15% over the next several quarters and to ultimately decrease the 180 day readmission rate to less than 7%.

    b. Goal: Sandhills Center works to reduce community hospital readmission rate to less than 10% by ensuring that the highest risk/highest need members are appropriately connected with community based services designed to meet their needs in the least restricted environment possible.
        i. Progress: Members being readmitted to community hospitals within a 30 day period from Sandhills Center's Guilford county was at 11.2% during the past quarter.

ii. Progress: Sandhills Center works to standardize the interventions used across the merged nine county catchment area and to decrease the 30 day readmission rate to less than 10% over the next several quarters. The primary focus at this time is to continue to develop and implement standard methods of connecting the high risk/high need members with community based services.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Sandhills Center will increase access to services for persons with mental health and/or substance abuse service needs by 85%.
        i. Progress: Sandhills Center provided timely access to urgent care for 89 % of members determined to be in need of such care in the 2nd quarter.
        ii. Progress: Sandhills Center provided timely access to routine care for 84% of members determined to be in need of routine care during the same period.
        iii. Progress: Access to urgent and routine care were not measured in the Guilford County area for the same period.
        iv. Progress: Sandhills Center processes, develops, and implements technical standards so that the merged nine county area can make consistent decisions for reaching and maintaining goals across the service area.

    b. Goal: Sandhills Center will work to ensure that members with the highest need/highest risks have clinically sound Person Centered Plans in place that are being implemented under best practice guidelines by their chosen provider.
        i. Progress: Sandhills Center processes, develops, and implements technical standards so that the merged nine county area can make consistent decisions for reaching and maintaining goals across the service area.

Smoky Mountain Center

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: The LME-MCO shall work with local CCNC networks to manage the enrollees with unstable medical and MH/DD/SAS

diagnoses to reduce inappropriate use of acute care inpatient admissions.

i. Progress: Current minutes of meetings with CCNC Networks to staff high risk cases are housed internally.
ii. Progress: Audit forms are in production for use by Quality Management.

b. Goal: The LME-MCO shall create a process for reviewing trends and incorporating input from providers, stakeholders, consumers, families and other stakeholders into its decisions.
   i. A data tracking matrix system has been started. A workgroup has been initiated with our three comprehensive providers and will continue through the end of April. The goals of the workgroup are to create flexible data, meaningful reports, education for staff, and to use the data to guide business processes throughout the provider network and within the Smoky Mountain Center. Ultimately, we want to review the flow of MCM/Walk-In work and educate our stakeholders about the agreed upon processes.

c. Goal: The LME-MCO shall build community capacity and awareness relative to mental health promotion, prevention, early intervention and crisis management.
   i. Progress: Marketing plan is in development.
   ii. Progress: Community Training Library completed.
   iii. Progress: Two CIT classes completed this quarter – 201 certified CIT officers across 15 counties.
   iv. Progress: Two CIT Refreshers courses completed this quarter.
   v. Progress: Training records have been updated to reflect the number of trainings, participants, and certifications awarded.
   vi. Progress: The Smoky Mountain Center co-sponsored an IVC Symposium with 14 remote sites and 456 participants.
   vii. Progress: The Smoky Mountain Center has established 11 local crisis/ED committees covering 13 of our 15 counties.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:

a. Goal: The LME-MCO shall identify and provide care coordination services for high cost and/or high risk consumers who do not qualify for Medicaid including but not limited to Medicaid recipients.
    i. Progress: Report on frequent users of crisis services is still in development.
    ii. Progress: Audit forms are in production for use by Quality Management.

b. Goal: The LME-MCO will provide appropriate levels of community based crisis services (MCM and WIC).
    i. Progress: Current workgroup with WIC will include LME-MCO access to provider internal data. Workgroup will also stream line data and validate semi-annual WIC report.

Western Highlands Network (WHN)

Western Highlands Network provided no information for this report. WHN is in the process of merging with Smoky Mountain Center.

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. All LMEs indicated that there are 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 on-going activities that are intended to lower ED admissions, the use of unnecessary inpatient care, and to reduce the number of persons who have frequent crisis events. Much of the activities focus on:

- Analyzing/establishing/enhancing the current continuum of non-crisis community based services (e.g., ACT, outpatient services) (50% of reporting LME-MCOs);

- Bolstering the array of alternatives to crisis care in EDs and inpatient care (e.g., Mobile Crisis, Walk-In Crisis, Facility-Based Crisis services) (70% of reporting LME-MCOs);
- Care coordination efforts to provide transition care to people to appropriate levels of crisis services, and post-discharge community based services (80% of reporting LME-MCOs);
- Education and training efforts extended to the local community, providers, and partners (law enforcement, hospitals, etc.) (60% of reporting LME-MCOs);
- Accountability of providers to respond to the crises of their consumers (40% of reporting LME-MCOs);
- Identifying those people who are at high risk of repeated crisis episodes and applying intensive outreach, collaboration, and follow-up to ensure more effective and appropriate care is utilized (100% of reporting LME-MCOs).

For future reports, additional analyses will be conducted as encounter claims data becomes increasingly available at the state-level:

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.

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 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.