Crisis Services Update

Update to the Joint Legislative Oversight Committee on MH/DD/SAS

August 26, 2008

Goal of Crisis System

Provide prompt response to emergency situations including a high quality assessment capacity to determine the full extent of emergency, and appropriate disposition of emergency situations in the least disruptive setting possible closest to the consumer's home and family.

All components of the crisis system must work together – and with the existing "regular" provider network – to be effective. Prompt care following an emergency and efforts to improve crisis planning in advance are necessary to stop cycle of repeated emergencies.

New Components

- Emergency response and assessment:
  - Mobile Crisis Teams
  - Walk-In Crisis and Immediate Aftercare Clinics
  - DD START
- Emergency disposition in the community:
  - Inpatient psychiatric beds in community hospitals
  - Respite beds for DD
- Follow-up care and enhanced crisis planning:
  - Mobile Crisis Team
  - Walk-In Crisis and Immediate Aftercare Clinics
  - DD START

Mobile Crisis Teams

- Mobile Crisis Team – Typically 5+ person teams. Not all members of team respond to every call. Must have a nurse, LCSW or psychologist; a licensed clinical substance abuse professional; a developmental disabilities professional; and have access to a psychiatrist 24/7/365 by phone or face-to-face. Must serve all ages and all 3 disability populations.
- Key component is for Mobile Crisis Team to 1) suggest to LME components of crisis plan for each consumer served by team not previously in service or 2) review with consumer's primary service provider actions to improve the consumer's crisis plan to avoid the need for Mobile Crisis involvement in the future.
- Have thoroughly reviewed, with LMEs, the existing Mobile Crisis Teams to determine if they meet the full requirements or if they are willing and able to meet the full requirements and if they are willing to potentially expand their geographic territory.

Mobile Crisis

- Have plotted the prime location of the 30 teams to balance population density with geography with goal of having access to mobile crisis services within no more than 2 hours. Have also taken into consideration the number of emergency departments in the proposed catchment area.
- Identifying potential providers to start-up teams in underserved areas or to replace existing teams not willing to come into compliance with definition or proposed service area. Must pledge to have service running w/in 60 days of funding commitment.
- Will have all decisions finalized by Sept. 15.
- Management and oversight of the 30 teams will be vested in the LME in whose catchment area the team is based. Service will operate as a "cross area service program" or CASP.

DD START

- START – Systemic, Therapeutic, Assessment, Respite and Treatment. Evidence-based practice developed by Joan Beasley, Ph.D. in 1989.
- Dr. Beasley has provided 4 days of training in the model to NC providers, LMEs, advocates.
- Model requires both hands-on intervention with consumers with especially difficult behavioral challenges and well as working with community DD service providers to train the consumer's "regular" provider in more effective techniques.
- Team includes psychologists and other DD professionals and must have 24/7/365 access to a psychiatrist. Immediate availability of respite beds also a critical component to success of the model.

DD START

- Working with 3 LMEs – 1 per region – to host DD START teams.
- One provider will staff two teams in each region.
- Optimal locations for teams identified by geography, population density, and number of individuals with DD being admitted to state psychiatric hospitals.
- Final decisions on provider agencies to be made September 1. Providers must pledge to be up and running in both locations in each region within 60 days.
- Selected providers will work with Division and LME to develop respite capacity.

Walk-In Crisis and Aftercare

- Working with LMEs to finalize inventory of current psychiatrists serving public sector consumers and other existing walk-in services.
- Location of new psychiatrists will be determined based upon lack of current resources and projected demand.
- Developing recruitment plans for psychiatrists. Engaged in discussions with academic centers to pursue option for physicians to be associated with medical schools.
- Will be able to offer student loan repayment options through the Office of Rural Health.

Walk-In Crisis and Aftercare

- New positions to be based in 1) Federally Qualified Health Centers, 2) Public Health Departments, 3) existing MH/SA provider agencies, 4) primary care physician offices.
- Critical component is to ensure new physicians integrate with existing services. Working with LMEs to identify optimal location for that reason.
- Through the use of technology, each new psychiatrist will be able to serve at least two different locations.
- Will not be a 24/7/365 service, but will stagger hours to be available on some days after hours.

Community Inpatient Beds

- Funds appropriated by the General Assembly should cover cost of indigent care in 76 new community psychiatric inpatient beds.
- Focusing on 4 LMEs per region with the highest use* of state hospitals for 7 day or less lengths of stay:
  - Western: Crossroads, PBH, Smoky Mountain, Western Highlands
  - Central: Alamance-Caswell-Rockingham, CenterPoint, Durham, Guilford
  - East: Beacon Center, East Carolina Behavioral Health, Eastpointe, Southeastern Regional.

* Did not include Wake since CRH: Dix unit designed to handle that demand.

Inpatient Beds

6 hospitals that are currently designated to accept involuntarily committed patients (IVC) in the catchment areas of 4 of those LMEs currently have CON approval for 77 more beds than they are operating.

- 6 other hospitals in 4 LMEs currently operate 109 inpatient psych beds but are not designated to accept involuntary patients.
- 2 other hospitals without IVC designation in 2 LMEs currently have 56 non-operational CON beds.
- Potential of 242 new beds for involuntarily committed patients without need for CON process.
- Can also transfer "book beds" from state hospitals under State Medical Facilities Plan if a hospital without CON wishes to operate new beds.

Inpatient Beds

- Will have 3-way contract between hospital, LME, and the Division. Division involved to assure expedited admission to state hospital for consumers projected to have a length of 7+ days or particularly challenging issues.
- Will approach all hospitals in the targeted LME catchment area and solicit interest and proposals.

Inpatient Beds

- Contract will coordinate use of existing LME/hospital contracts, contract for these new beds, and state hospital diversion contracts.
  - Existing LME contracts used first
  - New contract $ next
  - State hospital diversion contract only as last resort.
- LME will authorize service and process payment for indigent care.
- DHHS developing reporting mechanism to track utilization of beds developed with this funding.