2011

HOUSE HEALTH & HUMAN SERVICES SUBCOMMITTEE ON MENTAL HEALTH

MINUTES

North Carolina General Assembly
2011-2012 Session
HHS Sub Committee on Mental Health

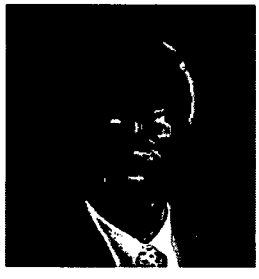
Rep. Pat B. Hurley
Chairman

Rep. Justin Burr
Vice Chairman

Rep. Tricia Cotham
Vice Chairman

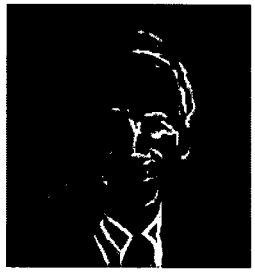
Rep. Shirley Randleman
Vice Chairman

Rep. Jeff Barnhart



Rep. Hugh Blackwell

Rep. William Brisson



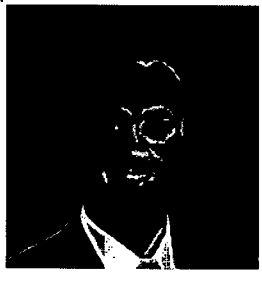
Rep. Jimmy Crawford

Rep. Bill Current

Rep. Nelson Dollar

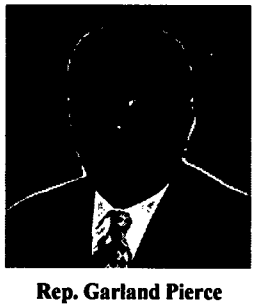
Rep. Beverly Earle

Rep. Verla Insko

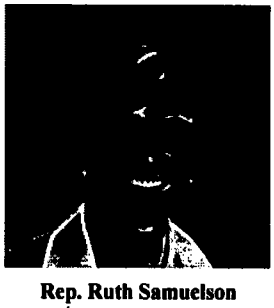


Rep. Darren Jackson

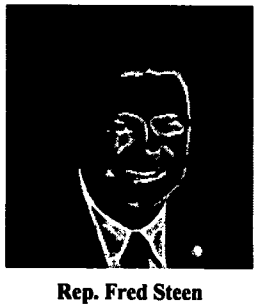
Rep. David Lewis



Rep. Garland Pierce



Rep. Ruth Samuelson



Rep. Fred Steen

Rep. Jennifer Weiss

HOUSE SUBCOMMITTEE ON MENTAL HEALTH

MEMBER	ASSISTANT	PHONE	OFFICE	SEAT
Rep. Pat Hurley Chairman	Susan Whitehead Committee Assistant	733-5865	532	44
Rep. Justin Burr Vice Chairman	Dina Long	733-5908	538	40
Rep. Tricia Cotham Vice Chairman	Rosa Kelly	715-0706	403	105
Rep. Shirley Randleman Vice Chairman	James White	733-5935	534	43
Rep. Jeff Barnhart	Joanna Hogg	715-2009	304	18
Rep. Hugh Blackwell	Dixie Riehm	733-5805	541	90
Rep. William Brisson	Caroline Stirling	733-5772	1325	23
Rep. Jim Crawford	Linda Winstead	733-5824	1321	24
Rep. William Current	Wendy Miller	733-5809	418B	42
Rep. Nelson Dollar	Candace Slate	715-0795	307B1	31
Rep. Beverly Earle	Ann Raeford	715-2530	610	83
Rep. Verla Insko	Gina Insko	733-7208	603	70
Rep. Darren Jackson	Angela McMillan	733-5974	1019	106
Rep. David Lewis	Grace Rogers	715-3015	534	20
Rep. Garland Pierce	Mildred Alston	733-5803	1204	46
Rep. Ruth Samuelson	Susan Phillips	715-3009	419B	55
Rep. Fred Steen	Chris Floyd	733-5881	305	27
Rep. Jennifer Weiss	Cindy Douglas	715-3010	1109	103

NORTH CAROLINA GENERAL ASSEMBLY
Legislative Services Office

George R. Hall, Legislative Services Officer

Research Division
300 N. Salisbury Street, Suite 545
Raleigh, NC 27603-5925
Tel. 919-733-2578 Fax 919-715-5460

O. Walker Reagan
Director

February 8, 2011

The Honorable Pat B. Hurley, Chair
Health & Human Services Subcommittee
on Mental Health
North Carolina House of Representatives
300 North Salisbury Street, Room 532
Raleigh, NC 27603-5925

Dear Representative Hurley:

I have asked Mr. Shawn Parker, Ms. Jan Paul, and Ms. Susan Barham, with the Research Division, to serve as staff/counsel to the House Health & Human Services Subcommittee on Mental Health, which you chair. They will attend the meetings of the Subcommittee when it convenes on Tuesdays at 10:00 a.m. In accordance with the Subcommittee's directions as expressed through the Chair, they will aid in analyzing proposed legislation and drafting amendments and committee substitutes. They will staff several other committees, as well.

I have asked Mr. Shawn Parker to serve as the coordinating staff person (point person) for the Subcommittee staff's efforts. I would ask that you and your Subcommittee clerk consider Mr. Parker as your initial contact for staffing needs and questions for the committee. The role of the coordinating staff will be to serve as the primary contact for the committee chairs and committee clerks to use in arranging committee meetings and identifying bills to be considered. Coordinating staff also will coordinate the assignment of bills among the committee staff. Most of the members of the Research Division have been asked to assume this role for one or more committees this session. If you are unable to reach Mr. Parker at any time, you should feel free to contact any of the other Subcommittee staff for assistance.

My best wishes to you and the Subcommittee in its work. If I can be of any service to you or the Subcommittee, please contact me.

Yours truly,

O. Walker Reagan

O. Walker Reagan
Director of Research

OWR/lba

cc: Hon. Thom Tillis, Speaker
Hon. Philip Berger, President Pro Tempore
Mr. George Hall
Mr. Shawn Parker
Ms. Jan Paul
Ms. Susan Barham
Mr. Brian Peck
Ms. Becky Cook

ATTENDANCE

Health and Human Services Subcommittee on Mental Health

(Name of Committee)

DATES	03-15-11	05-10-11													
Rep. Pat Hurley, Chair	✓	✓													
Rep. Justin Burr, Vice Chair	✓														
Rep. Tricia Cotham, Vice Chair		✓													
Rep. Shirley Randleman, Vice Chair	✓	✓													
Rep. Jeff Barnhart		✓													
Rep. Hugh Blackwell	✓														
Rep. William Brisson		✓													
Rep. Larry Brown															
Rep. Jim Crawford		✓													
Rep. William Current	✓	✓													
Rep. Nelson Dollar	✓	✓													
Rep. Beverly Earle	✓														
Rep. Verla Insko	✓	✓													
Rep. Darren Jackson	✓	✓													
Rep. David Lewis															
Rep. Garland Pierce															
Rep. Ruth Samuelson	✓	✓													
Rep. Fred Steen	✓	✓													
Rep. Jennifer Weiss	✓	✓													
STAFF:															
Shawn Parker	✓	✓													
Jan Paul	✓	✓													
Susan Barham	✓	✓													
Susan Whitehead, Committee Clerk	✓	✓													
Isabel Villa-Garcia, Intern	✓	✓													

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

March 15, 2011

House HHS Subcommittee on Mental Health

The Health and Human Services Subcommittee on Mental Health was called to order on Tuesday, March 15, 2011, at 10:00am in Room 544 Legislative Office Building. The following members were present: Representative Pat Hurley, Chair, Representatives Randleman, Burr, Vice Chairs, Representatives Blackwell, Current, Dollar, Earle, Insko, Jackson, Samuelson, Steen, and Weiss.

Representative Hurley called the meeting to order. She recognized the pages and thanked the staff and Sergeant-at-Arms for their services. A copy of the visitor's registration sheet is attached.

Representative Hurley told the committee there would be three presentations on Critical Access Behavioral Health Agencies (CABHAs) and to please hold all questions until the end of the programs.

The following speakers made PowerPoint presentations which are attached.

- Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse
- Kenny Burrow, CEO Therapeutic Alternatives, Inc.
- Richard Edwards Vice President Service Lines/Quality Improvement and Dr. Erica Arlington, Medical Director Easter Seals UCP.

Representative Hurley opened the floor for questions.

Representative Weiss stated that NC continues to have mental health patients backing up in emergency rooms and would like to know how this CABHA model is addressing this problem. Dr. Melcher answered by saying that one of the expectations of the CABHAs is that they be first responders, so CABHAs must develop crisis plans and be able to implement the plan when people do go into a crisis. The State's expectation is that the CABHAs are able to resolve many of those crises before someone has to go into

an emergency department. The State knows that from reviewing the data many of the people who end up in the emergency departments are able to transition back to their communities. There are also a more challenging group of people who need to go to the State hospitals. What needs to happen over time is the implementation of a process for the more challenging group of people that will enable the CABHA to move more quickly or to provide more support before they end up in the emergency department. Representative Weiss followed up by stating that she recognizes the State is always looking to reduce "red tape" on providers, but she wants to remind people that one of the reasons that more regulations were made was that a few years ago there was a community support program that lacked oversight and got out of control. Representative Weiss would also like to make the committee aware that there is an extreme gap in child substance abuse services. The NC General Assembly just took action to criminalize some additional drugs for policy reasons. The State needs to recognize that these young people will need a place to get treatment.

Representative Hurley commented that in Randolph County they have noticed that the CABHAs that are supposed to provide 24-hour assistance are calling the local police after 5:30pm and sending people with mental crisis needs to hospitals with emergency rooms. This practice has created some real problems.

Representative Hurley recognized Representative Samuelson who asked for a brief explanation of "targeted case management" vs. any other kind of case management. Dr. Melcher stated that service definition was to help people get connected into supports within the community. Initially when someone comes into the system there will be more work with that person to connect them with entitlements, service supports within that community. Representative Samuelson followed up by asking if targeted case management could be called intake/initialization case management. Dr. Melcher stated that there are no other billing codes for a different kind of case management for mental health and substance abuse. We do have case management kinds of services embedded into some of the comprehensive services such as community treatment teams or community support teams. They receive case management within the system that is longer term and comprehensive for the needs of individuals who have more significant needs. Representative Samuelson asked why Directors are prohibited from providing services. Dr. Melcher stated that the expectation was that Directors would be providing clinical oversight, directing programs and providing supervision. In some agencies where fewer people are served, some of those Directors provide care for a portion of their time, but there still is an expectation for Directors to provide clinical oversight to staff people and programs for which they are responsible.

Representative Hurley stated that she would invite the presenters to the next meeting and continue this discussion. There being no further time, the meeting was adjourned.

Respectfully submitted,

Pat Hurley

Representative Pat Hurley, Chairman

Susan H. Whitehead

Susan H. Whitehead, Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2011-2012 SESSION

You are hereby notified that the Committee on **Health and Human Services Subcommittee on Mental Health** will meet as follows:

DAY & DATE: Tuesday, March 15, 2011
TIME: 10:00 am
LOCATION: 544 LOB
COMMENTS: There will be a presentation on Critical Access Behavioral Health Agency (CABHA). Please make every effort to be on time.

The following bills will be considered:

None

Respectfully,
Representative Hurley, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **12 PM** o'clock on **March 09, 2011.**

☐ Principal Clerk
☐ Reading Clerk – House Chamber

Susan Whitehead (Committee Assistant)

Agenda

House HHS Subcommittee on Mental Health
March 15, 2011

I. Call Meeting to Order

II. Welcome

III. Presentations

- Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse
- Kenny Burrow, CEO Therapeutic Alternatives, Inc.
- Richard Edwards Vice President Service Lines/Quality Improvement and Dr. Erica Arlington, Medical Director Easter Seals UCP.

IV. Questions and Answers

V. Adjourn

CRITICAL ACCESS BEHAVIORAL HEALTH AGENCY (CABHA) UPDATE

House HHS/Subcommittee on Mental Health

March 15, 2011

Beth Melcher, Ph.D.
Assistant Secretary for MH/DD/SA Service Development
Department of Health & Human Services

CABHA Implementation Goals

- To ensure that mental health and substance abuse services are delivered within a clinically sound provider organization with appropriate medical oversight
- Move the system over time to a more comprehensive and coherent service delivery model
- Increase economies of scale and efficiencies in the service system
- Increase consumer family/stakeholder confidence in our provider network

2

CABHA Implementation Goals (con't)

- Reduce clinical fragmentation – Reduction of "Stand Alone" service delivery
- Increase provider "1st Responder" capacity
- Embed case management in comprehensive clinical provider
- Insure that consumers have access to an array of appropriate clinical services
- Increase accountability within the MH/SA service system – monitor service and referral patterns
- Provide a competent clinical platform on which to implement best practice service models

3

CABHA Requirements

- Active National Accreditation of at least 3 years
- Medical Director
- Clinical Director
- Quality Management/Staff Training Director
- Continuum of care for population served

4

CABHA Requirements (con't)

- Must provide the core services of:
  - Comprehensive Clinical Assessment
  - Medication Management
  - Outpatient Therapy
- Must deliver at least two enhanced services within a 35 miles radius of location where it provides the three core services to create a continuum of care

5

CABHA Requirements (con't)

Services that must be delivered within the CABHA structure:

- Community Support Team (CST)
- Intensive In-Home (IIH)
- Day Treatment
- MH/SA Case Management
- New Service: Peer Support- Proposed implementation date = July 1, 2011

Service transition complete December, 2010

6

CABHA Certification Process

- Attestation letter with documentation
- Desk reviews conducted by DMH/DD/SAS
  - Documentation of staff and program requirements
  - DMA/DHSR/DMH Collaboration ("good standing")
- Interviews conducted by
  - DMH/DD/SAS Staff
  - DMA Staff
  - LME Staff
- Verification conducted by LME and DMH/DD/SAS staff

7

CABHA Monitoring

Monitoring Areas

- Personal Outcomes
- Leadership Roles: Medical, Clinical, QM, Training Directors
- Use of Community Based Treatment to Address Urgent, Emergent, and Routine Needs
- Referral Patterns
- Quality Management Plan
- Integration with Physical Health Care
- Core Service Delivery
- Regulatory Compliance

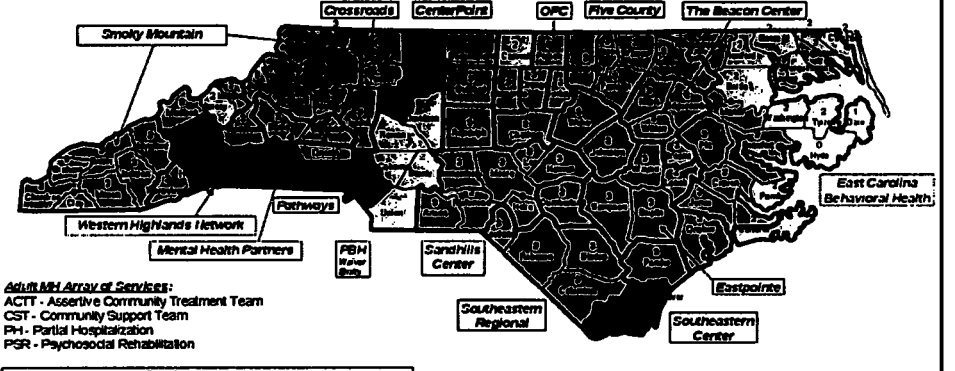
8

CABHA Numbers

- 603 applications processed
- 195 CABHAs certified
- 65 CABHAs went through reconsideration; 51 were subsequently approved, 8 denied and 6 were forwarded to the certification process
- Expect market forces to realign CABHAs
- Adequate service coverage across all counties providing a continuum of child and adult mental health and substance abuse services.
- Identified gaps in child substance abuse continuum. Work with LMEs to further develop these services.

9

Access to Adult Mental Health Array of Services by County during Oct-Dec 2010



Adult MH Array of Services:
ACTT - Assertive Community Treatment Team
CST - Community Support Team
PH - Partial Hospitalization
PSR - Psychosocial Rehabilitation

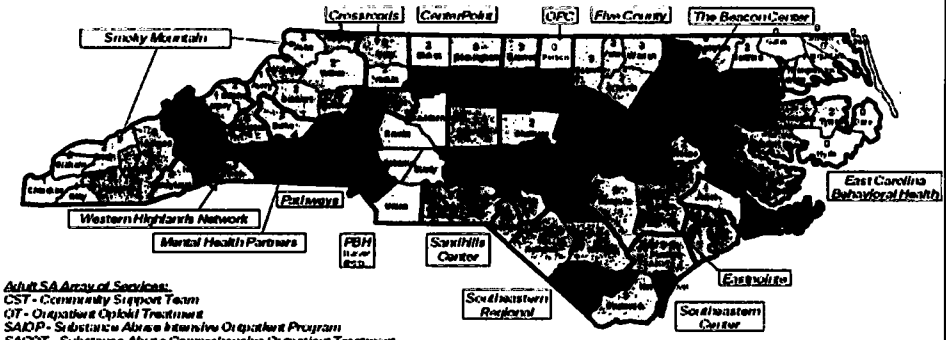
Extent of Access to Services	
☐ No services in the array	1 county
☐ 1 of the services in the array	1 county
☐ 2 of the services in the array	12 counties
■ 3 of the services in the array	69 counties
■ All 4 services in the array	12 counties
☐ No data from PBH LME	5 counties

Notes:
Based on Medicaid and IPRS/State claims paid through January 31, 2011.

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010.

10

Access to Adult Substance Abuse Array of Services by County during Oct-Dec 2010



Adult SA Array of Services:
CST - Community Support Team
OT - Outpatient Opioid Treatment
SAOP - Substance Abuse Intensive Outpatient Program
SAOOT - Substance Abuse Comprehensive Outpatient Treatment
CRT - Community Residential Treatment

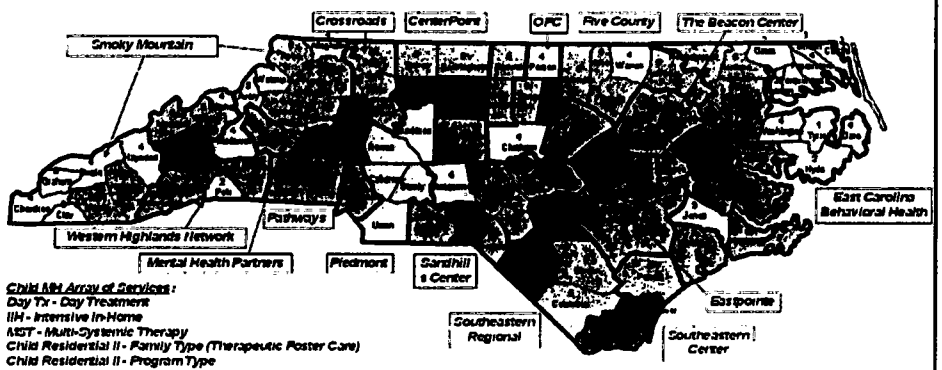
Extent of Access to Services	
☐ No services in the array	7 counties
☐ 1 of the services in the array	6 counties
☐ 2 of the services in the array	16 counties
☐ 3 of the services in the array	32 counties
■ 4 - 5 of the services in the array	34 counties
☐ No data from PBH LME	5 counties

Notes:
Based on Medicaid and IPRS/State claims paid through January 31, 2011.

Unless otherwise indicated, the LME name is the county name(s).
Reflects LMEs as of July 2010.

11

by County during Oct-Dec 2010



Child MH Array of Services:
Day Tx - Day Treatment
IIH - Intensive In-Home
MST - Multi-Systemic Therapy
Child Residential II - Family Type (Therapeutic Foster Care)
Child Residential II - Program Type
Child Residential III
Child Residential IV

Extent of Access to Services	
☐ No services in the array	7 counties
☐ 1 - 2 services in the array	6 counties
☐ 3 - 4 services in the array	16 counties
☐ 5 - 6 services in the array	32 counties
■ All 7 services in the array	34 counties
☐ No data from PBH LME	5 counties

Notes:
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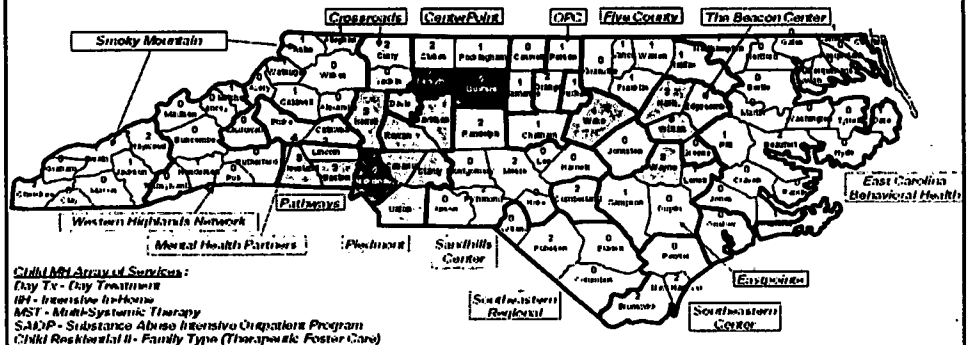
Reflects LMEs as of July 2010

12

Access to Child Substance Abuse Array of Services by County during Oct-Dec 2010



Child MH Array of Services:
Day Tx - Day Treatment
IIH - Intensive In-Home
MST - Multi-Systemic Therapy
SADP - Substance Abuse Intensive Outpatient Program
Child Residential II - Family Type (Therapeutic Foster Care)
Child Residential II - Program Type
Child Residential III
Child Residential IV

Extent of Access to Services	
No services in the array	44 counties
1 - 2 of the services in the array	41 counties
3 - 4 of the services in the array	7 counties
5 - 6 of the services in the array	2 counties
7 - 8 of the services in the array	1 county
No data from PBH LME	5 counties

Notes:
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Reflects LMEs as of July 2010

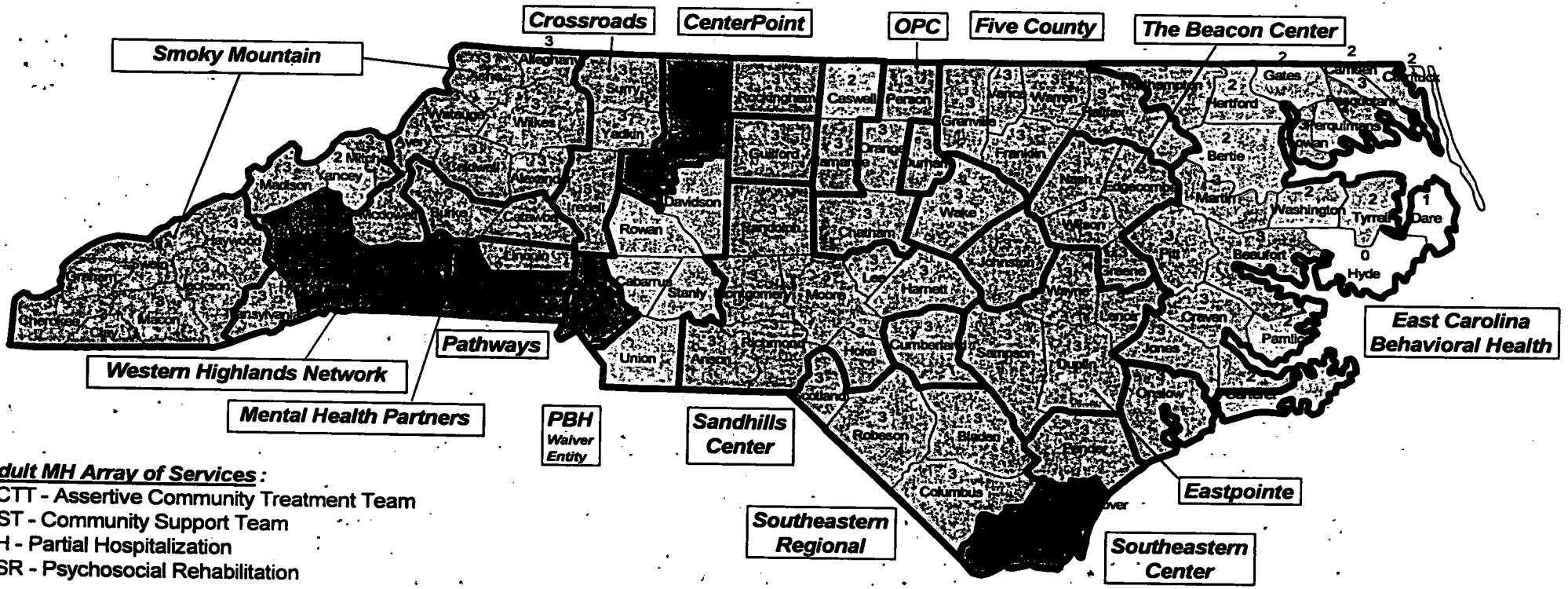
13

Supporting CABHAs

- Regional meetings with CABHAs
- Review of CABHA cost model
- Review and discussion of rules
- Process to review for duplication in rules, monitoring, etc. toward reducing redundancy and streamlining process
- CABHA monitoring will begin in spring
- Ongoing review of access to continuum of services across state

14

Access to Adult Mental Health Array of Services by County during Oct-Dec 2010



***Adult MH Array of Services*:**
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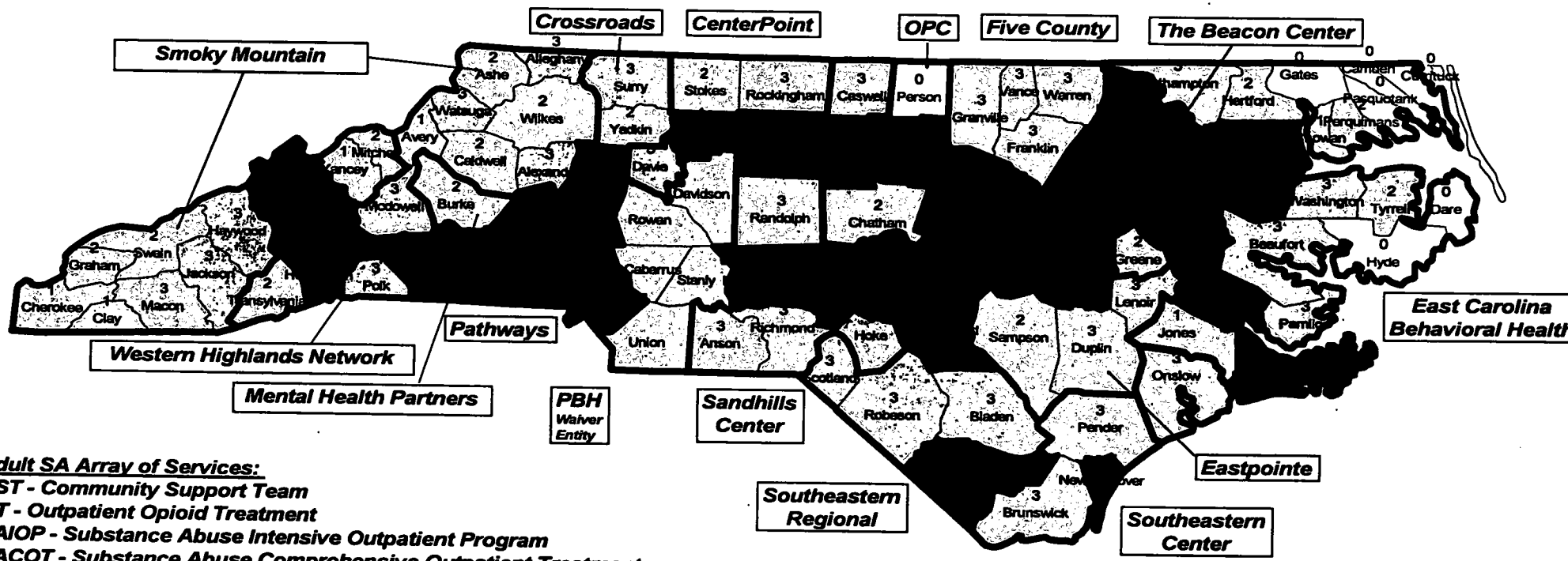
Access to Adult Substance Abuse Array of Services by County during Oct-Dec 2010



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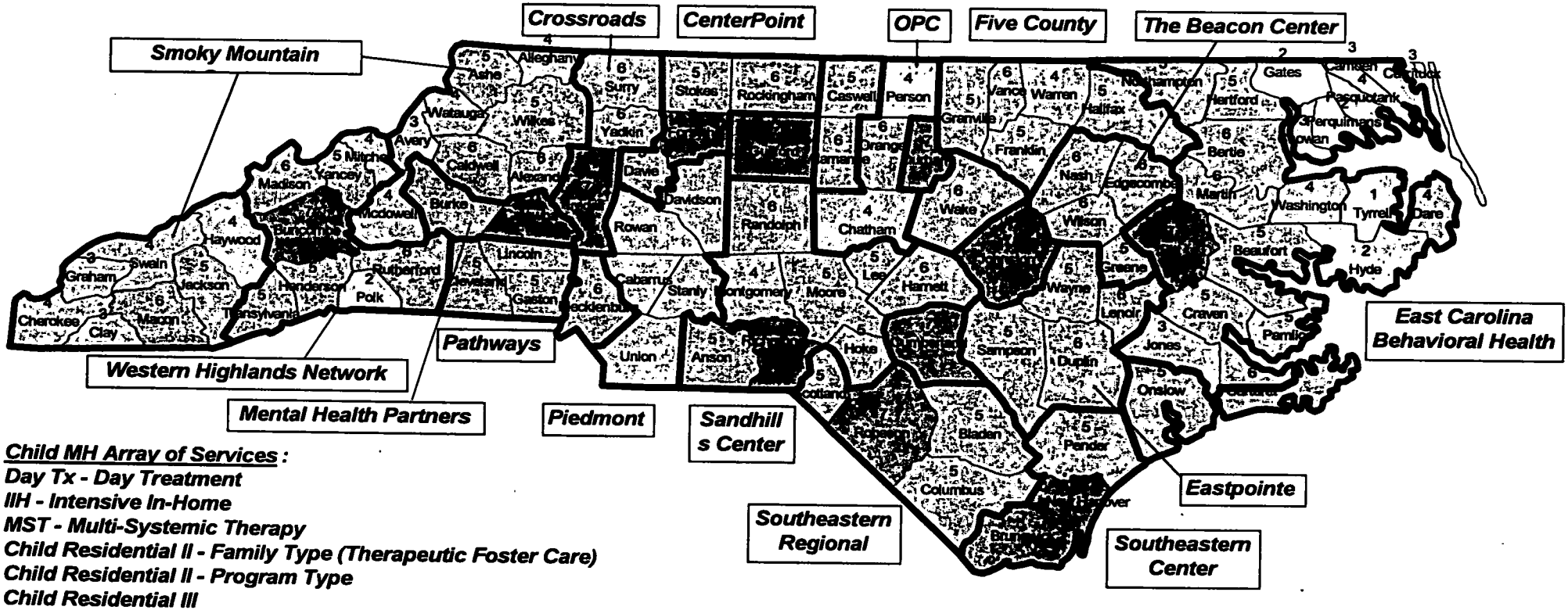
Child Mental Health Services
by County ing Oct-Dec 2010



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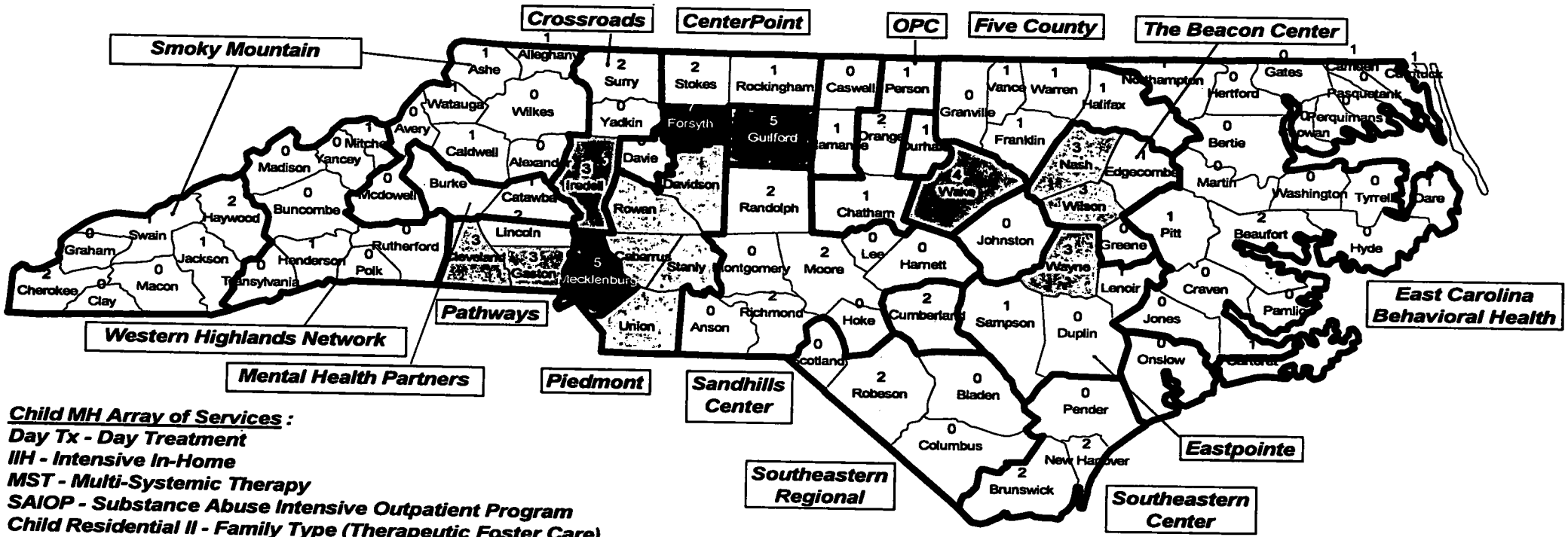
Access to Child Substance Abuse Array of Services by County during Oct-Dec 2010



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Child Residential II - Program Type
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7 - 8 of the services in the array	1 county
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CABHA Roadblocks from a Provider's Perspective

Kenny Burrow, CEO
Therapeutic Alternatives, Inc.
March 15, 2011

1

CABHA Staffing Requirements

- Each CABHA is required to have the following staff members:
  - Medical Director (may be part-time based on the number of consumers served and the individual is limited to the amount of time he/she can provide/bill for direct services)
  - Clinical Director (cannot bill for *any* direct services)
  - Quality Management Director
  - Training Director (required CABHA expectations leave little time for actual training of employees, which means other individuals must be hired/contracted for this purpose)
    - Medical Director and Clinical Director can be combined but the CABHA must show that he/she is a full-time employee and performing each position's required elements.
    - According to the state the Quality Management Director and Training Director positions may be filled by one person but with the expectations of the state there is no way one person can fulfill both roles.
    - This list does not include staff members who are needed to fulfill the other basic functions of being a CABHA.
  - The revenues to pay for all of these positions and the other administrative tasks that are involved with being a CABHA must come from direct services that the agency provides, more specifically, from Targeted Case Management.

2

Targeted Case Management (TCM)

- TCM was originally designed by DHHS as the way for CABHAs to generate the income necessary to support the salaries of the staff members listed on the previous slide, as well as all other administrative positions and functions, which include, but are not limited to, maintaining the following:
  - Authorization procedures and monitoring through Value Options (VO) and LMEs
  - Accounting systems
  - National Accreditation
  - Endorsements
  - Carrying out audits with LMEs and DMA
  - Comprehensive medical records system
  - Quality Management system
  - Training of staff
  - Clinical oversight of staff
  - Support staff who can carry out the functions of maintaining a clinical office

3

Targeted Case Management (continued)

- The reality is:
  - CABHAs do not support the quantity of TCM consumers that are necessary to pay for all of the costs of being a CABHA.
  - Authorizations are short-term meaning if you don't have new consumers coming in the door as authorizations run out, you have no way to pay for being a CABHA.
  - Rate is $81.25 per unit/week whether you provide 15 minutes or 30 hours.
  - What TCM was supposed to do for CABHAs and what it actually *does* simply do not match. There is no way to generate the TCM income that is needed to support a CABHA as the state designed it to work.

4

Economies of Scale

- As of 3/7/11 there were 193 CABHAs in the state.
- As of 3/4/11 there were 10,201 people authorized for Targeted Case Management (MH/SA).
- As previously mentioned, TCM was supposed to be the foundation that supports CABHAs; however, DMA has put measures in place to make it a short-term service.
- DHHS determined that 27% of the rate for TCM would be needed for CABHA costs.
- Current average number of TCM consumers per CABHA = 52
- Current average annual income per CABHA to pay for CABHA costs = $60,000 (52 consumers x $81.25 x 4.3 weeks per month x 12 months x 27%), BUT
  - This would be the amount if CABHAs could bill every single week for every consumer, which we cannot. A more realistic estimate would be billing for ½ to ¾ of the weeks in the year, bringing the CABHA revenues generated from providing TCM to $30,000 - $45,000 annually.
- More consumers for a single CABHA to serve = additional resources/funds with which to fulfill the state's expectations = a more financially and clinically sound CABHA = consumers receiving appropriate services.
- There is less money in the system today than when Area Programs delivered care and there were approximately 30 Area Programs when divestiture began. Now we have 193 agencies providing care.
- Bottom line, there are too many CABHAs which means the economies of scale principle is nearly impossible to achieve.

5

Lack of Licensed Staff

- There is a tremendous shortage of licensed staff members, including physicians.
- If you multiply the CABHAs by 1, you get the number of experienced clinicians (CLINICAL DIRECTORS) in NC who are now prohibited from providing direct clinical services.
- Add to that the number of psychiatrists (MEDICAL DIRECTORS) who are now limited in the number of hours of direct services they provide and you have a pool of qualified, seasoned, and experienced providers who are not allowed to provide patient care.
- Add to that the number of psychiatrists with the CABHA consultant group (the CCNC psychiatrists) who also cannot provide direct services and you have a larger pool of highly trained professionals who are banned from treating patients.
- Put another way, if an agency wants to provide services, it is *required* to hire the most experienced (and expensive) professionals, who cannot provide services, so that the agency can provide services.
- We can and do employ newly graduated and provisionally licensed individuals who, by and large, are eager to provide high-quality services but require previous experience for the specific service and supervision by a fully licensed clinician.
- Many seasoned mental health professionals have gotten out of the field or have gone into private practice.

6

Heavily Over-monitored

- CABHAs are required to:
  - Maintain National Accreditation (In 2008 we received nationally accredited for three years. The amount we paid to the accrediting body was $49,448. This does not include any staff time, which was enormous.) We are due another visit this year.
  - Obtain service endorsements through the LMEs for each enhanced benefit service the CABHA provides. Must have follow-up reviews.
  - Obtain licenses for certain services, and undergo monitoring by DHHS.
  - Participate in FREQUENCY & EXTENT OF MONITORING (FEM) TOOL that is performed by LMEs. This is a form of intense monitoring that the state requires and it is extremely time-consuming. It is also redundant since a lot of the same areas that National Accreditation covers are involved. We receive FEM tool monitoring by more than one LME.
  - Have continual state required audits conducted by LMEs. This is extremely costly and takes an extraordinary amount of staff time.
  - Have DMA audits that can occur frequently. Our agency will have completed three DMA audits within a six-month period by the end of March. On our most recent one, 59 consumer and staff records were requested and mailed to DMA (26 pounds of paper). Preparing for these audits is extremely time-consuming.
- Obviously, more money is not always the answer. If the regulations and monitoring were reduced, our agency could better operate with the current reimbursement rates for enhanced benefit services.

7

Other Issues

- Out of 193 CABHAs about half are child MH providers with a continuum of IIH and day treatment. Statistically, half of the CABHAs only treat children with Medicaid.
- The end result of the well meaning requirements are continuums that foster CABHAs that treat a predominantly Medicaid population. When this happens it is the adult substance abuse and indigent population that is left behind. This is the same group that statistically ends up in EDs and psychiatric hospital beds, including the state hospitals.
- Endorsement process recently changed. All staff must be on board and providing service before we can actually become endorsed or BILL for the service.
- Outpatient services funded by Medicaid and IPRS funding are traditionally treating the most complex and challenging patients with mental illnesses. These outpatient services are high risk, high acuity, time consuming for the individual clinicians and require an expensive infrastructure just to run/manage the business part of the service. The funding and payments for these services make it nearly impossible financially for CABHAS to meet these staffing and clinical requirements.
- All the training requirements are meaningful but costly.
  - CST and IIH team members are required to complete a tremendous amount of training (CST leaders approximately 70 hours, CST QPs approximately 58 hours, IIH team leader approximately 81 hours, IIH QPs approximately 69 hours. An additional 10 hours of training is required annually for all of these positions. This does not include the basic training that all staff must complete, such as First Aid, CPR, OSHA, Consumer Rights, etc).

8

Potential Solutions

- *Decrease* the number of CABHAs
- *Reduce* the amount of monitoring
- *Cut* the amount of paperwork that is required of clinicians, Qualified Professionals and the CABHA in general
- *Accept* National Accreditation as proof of an agency's willingness and ability to provide high-quality services
- *Allow* Clinical Directors to bill for *some* services
- *Consolidate* and trim the amount of required training
- *Increase* period of time an individual can receive TCM
- *Increase* rates for outpatient services (a required component of being a CABHA)

9

Critical Access Behavioral Healthcare Agency **One Year Later**

Richard Edwards
Erica Arrington, MD
Easter Seals UCP

North Carolina & Virginia

Easter Seals UCP

- Serves 17,000 people annually across NC and VA
- Certified as a CABHA providing child-specific mental health services, but also provide MH services to adults
- Certified as a CABHA in Wake County, but meet the service array qualifications in six NC communities
- Erica Arrington, MD—Medical Director
- Jill Hinton, PhD—Clinical Director

North Carolina & Virginia

CABHA Successes

- Enhanced clinical and medical support for programs
- Enhanced engagement among physicians and nurses
- Stronger clinical and medical engagement at senior leadership level of the organization
- Enhanced clinical and medical support for individuals with urgent needs
- Grant funding to support reverse co-location of behavioral health and medical services in two NC communities

Easter Seals UCP North Carolina & Virginia

CABHA Challenges

- Medicaid rate reductions in 2009 of 9.5%
- Required CABHA services (Outpatient Therapy & Psychiatric Services) have rates below private market
- Targeted Case Management – MH/SA has not covered costs as originally intended
- Significantly increased travel time for key personnel—taking away from primary duties
- No additional funding to support increased personnel costs for Medical & Clinical Directors

Easter Seals UCP North Carolina & Virginia

CABHA Transition

* CABHA implementation began for us in January, 2010 with the official transition date of January 1, 2011
* CABHA transition has significantly reduced the number of providers of specific services
* However, January 1 implementation did not result in large numbers of referrals
* Questions remain about stability given large number of CABHAs (~200) and insufficient funding

Easter Seals UCP
North Carolina & Virginia

CABHA—One Year Later

* Easter Seals UCP has clearly seen a positive impact the CABHA concept has had on our agency and our services
* However, without additional support, the CABHA model is not sustainable
* We appreciate Sec. Cansler's commitment to finding a solution to assure continuity and availability of services that are clinically sound and create positive impact for the individuals, families and communities we serve
* CABHA transition is still in process

Easter Seals UCP
North Carolina & Virginia

HOUSE PAGES

NAME OF COMMITTEE Health & Human Services DATE 3/15/11

1. Name: Kristopher Faheem
   County: Wake
   Sponsor: Rosa Gill
2. Name: Tah-leel Minnigan
   County: Robeson
   Sponsor: Thom Tillis
3. Name: Shanthini McNeill
   County: Scotland
   Sponsor: G.L Pridgen
4. Name:
   County:
   Sponsor:
5. Name:
   County:
   Sponsor:

Committee Sergeants at Arms

NAME OF COMMITTEE Health and Human Services

DATE: 3/15/11 **Room:** 544

House Sgt-At Arms:

1. **Name:** Reggie Sills
2. **Name:** Ken Kirby
3. **Name:** Garland Shepheard
4. **Name:**
5. **Name:**

Senate Sgt-At Arms:

1. **Name:**
2. **Name:**
3. **Name:**
4. **Name:**
5. **Name:**

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — March 15, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Fisher	John Locke Foundation
Richard Edwards	Easter Seals UCP NC & VA. Inc.
Erica Armenton, MD	Easter Seals UCP NC and Va, Inc
Frank Welch	Easter Seals UCP NC & Va.
C.L Calhoun	ESUCP.
Mason Hill	Smith Anderson
Jodi Mynard	GPM + ASSOC.
Gene Rodgers	Universal Mental Health
John Mirack	Policy Group
Janet Schanzenbach	NCAITCF
Karen M. Ld	Benchmarks

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — March 15, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Flo Stein	DMHDDSAS
Lisa Jackson	DMH/DD/SAS
Ken Marsh	DMH/DD/SAS
David Barnes	Poyner Spruill
[illegible]	Carolina State Strategies
Karen [illegible]	Bristol-Myers Squibb
Barbara Canslev	[illegible]
[illegible]	MWC
[illegible] Davis	Electricities of NC
Cameron Hardy	Electricities of NC

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — March 15, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TARA FIELDS	Benchmarks
MARTHA LOWRANCE	NAMI/DMA
Alex Miller	KLG
Joyce Peters	APASSE
Julia Adams	The Arc of NC
	DHHS
Steve JORDAN	DMH DD SAS
Kelly Crosbie	DMA
Michael Watkins	DHHS
Bill Scott	DMH/DD/SAS
Kenny Burrow	Therapeutic Alternatives

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — March 15, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emily Grimm	MWC
Kay Paksoy	NASW-NC
Matt Wolfe	Parker Poe
JOE LANIER	NELSON MULLINS
Chris Valauri	Takeda Pharmaceuticals of America
TINA GORDON	NC Nurses
Amy Whited	NC Medical Society
Jackie Bazargan Cone	Carolina
Pam Shipman	PBH
Mary Bode	AARP - NC

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — March 15, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	SEANC
[signature]	NMSS-NC
[signature]	NCSA
Fred Aikens	The Aikens' Group LLC
Erica Nelson	NCCCP

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

May 10, 2011

House HHS Subcommittee on Mental Health

The Health and Human Services Subcommittee on Mental Health was called to order on Tuesday, May 10, 2011, at 10:00am in Room 1228 Legislative Building. The following members were present: Representative Pat Hurley, Chair, Representatives Cotham, Randleman, Vice Chairs, Representatives Barnhart, Brisson, Crawford, Current, Dollar, Insko, Jackson, Samuelson, Steen, and Weiss.

Representative Hurley called the meeting to order. She recognized the pages and thanked the staff and Sergeant-at-Arms for their services. A copy of the visitor's registration sheet is attached.

Representative Hurley recognized Representative Randleman and asked that she preside as Chairman of the meeting during discussion of *H423 First Evaluation Program* which Representative Hurley is the Primary Sponsor.

Representative Randleman recognized Representative Hurley who introduced *H423 First Evaluation Program PCS #1*. A proposed committee substitute #2 was presented by Representative Hurley and Representative Steen moved to approve it for consideration. Motion passed. Representative Hurley began by offering a perfecting amendment to the PCS #2 which clarified the General Statute reference. Representative Cotham moved and Representative Insko seconded this amendment be approved. Motion passed. Representative Hurley asked Shawn Parker to explain the PCS #2. Mr. Parker stated the PCS #2 incorporated changes offered by Representatives Blackwell and Insko. Representative Insko made a motion to give a favorable report to PCS #2 as amended unfavorable to the PCS #1. This was seconded by Representative Jackson and the motion passed.

Representative Randleman returned the gavel to Representative Hurley.

Representative Hurley told the committee there would be four presentations, two on Hospital Emergency Room Waits and two on Three-Way Contracts. There would be a question and answer period between each topic.

The following speakers made PowerPoint presentations on Hospital Emergency Room Waits which are attached.

- Robert E. Morrison, President, Randolph Hospital
- Katherine Haddix-Hill, RN, MSN, Vice President, Emergency and Trauma Services, Moses Cone Health System

Dr. John Bednar, Medical Director at Moses Cone Heath System added to Ms. Haddix-Hill presentation with statistics. Emergency medicine is the nation's healthcare safety net. Emergency Room doctors specialize in acute, unscheduled, episodic medical care. The following statistics dispel the myth that emergency room departments are crowded/overcrowded not because of the patients waiting to be seen but because of the patients waiting to be admitted to either medical floors or mental health patients. Moses Cone ED sees approximately 200,000 per year and the average is 3-4 hours per emergency patient. Two percent of patients leave the ED without being seen. One out of 20 patients who think they have a "non-emergency" condition actually has a serious life-threatening complaint. ED doctors do not want to miss these patients. ED's need help getting the mental health patients admitted to a proper therapeutic environment. Approximately 4,000 psychiatric patients are admitted to Moses Cone Behavioral Health Center, and they have a 10-hour wait in the ED. Approximately 300 psychiatric patients are admitted to Central Regional Hospital and they have a 5.5 days or 132-hour wait in the ED. Therefore, Moses Cone spends about 40,000 ED hours for the 4,000 patients admitted to their Behavioral Health Center and 39,600 ED hours for the 300 patients admitted to Central Regional. If the ED Wait time for Central Regional Hospital patients were lessened, more patients could be seen and Moses Cone would perhaps not miss 2% of ED patients who leave and lives could be saved and approximately $1 million of health care costs could be made. When psychiatric patients are brought to the ED, two law enforcement officers accompany the patient. These officers must stay with the patient for the 5.5 days. There have been as many as 20 involuntary committed psychiatric patients waiting to be admitted to Central Regional which means 40 law enforcement officers. This causes a strain not only on the hospital, but the law enforcement agency as well.

Representative Hurley asked if there were questions from the committee.

Representative Samuelson re-visited Mr. Morrison's statement that because Randolph Hospital does not have a psychiatric doctor on staff, the main issues are holding psychiatric patients until they could be transferred for inpatient treatment and psychiatric patients can not be treated by the local LME psychiatric doctors while they were waiting for transfer. Therefore, many of the patient's problems become worse. If Randolph Hospital could treat the patients (i.e. adjust medicine and find a disposition) many of these patients could be released earlier. Does Moses Cone also have this problem? Dr. Bednar stated that they have psychiatric doctors on staff who make rounds and are able to immediately assist with medication management and find a disposition. It is not the therapeutic holistic approach mental patients require. Representative Samuelson asked Mr. Morrison to elaborate on the prohibition of LME psychiatric doctors treating patients in Randolph Hospital. Mr. Morrison stated that

Randolph Hospital does not have its own inpatient Behavioral Health Center and staff psychiatric doctors like Moses Cone and it would cost easily $15 million to create these services. Randolph Hospital has asked the LME psychiatrists that are already treating the patients to be involved in making hospital rounds so that Randolph Hospital could have the consultation. Randolph Hospital ED physicians believe they can do the great majority of diagnosing whether a patient needs a referral to Central Regional, but in the case of judgment calls they go the conservative course which is inpatient admission. Randolph Hospital has created a holding area space for mental patients and LME psychiatrists could see them in this holding space. Medications could be adjusted in this holding space and eventually many patients could be released without admission to Central Regional. Randolph Hospital would like to keep the patients in the community and not send them away to Central Regional.

Representative Weiss commented that it is criminal the way mental patients are being treated. The example she reiterated from one of the presenters was if you were in a hospital having a heart attack, it would be criminal to be told it would be a 5.5 day wait before you could see a cardiologist. Representative Weiss asked why the 300 patients who are referred to Central Regional Hospital can't be treated at Moses Cone's own Behavioral Health Center. Ms. Haddix-Hill stated those patients did not meet the admission criteria at Moses Cone and mostly that is due to them being too violent or need long term care that can not be provided. Dr. Bednar stated another reason is that the patient may have already exhausted the resources at the Behavioral Health Center. The patient may have been discharged multiple times and they are no longer considered candidates. Representative Weiss asked if there were resources in the community or state for these patients. Ms. Haddix-Hill stated that Moses Cone was aware of most of these patients and were working with the Behavioral Health Center to put an action plan into place for these patients. There comes a time when the Behavioral Health Center can not provide all that these patients need. Representative Weiss asked for a description of the process ED physicians must go through to try to place the patients who need extended care. Ms. Haddix-Hill stated that an Action Assessment Team consisting of licensed social workers and registered mental health technicians begins to make phone calls every shift. State facilities are not able to take patients on weekends and there is usually a waiting list on Monday. Representative Weiss stated that in addition to the lack of access by LME psychiatric doctors, it is obvious the state does not have adequate capacity. Mr. Morrison stated the outpatient support/wraparound services in a community are critical if you want to prevent hospitalizations. A lot of the psychiatric cases are indigent homeless people who have no way of regularly receiving services. The ED staff knows most of these patients by name because they return time and again.

Representative Insko asked what percent of the people seen in ED with mental health issues have private insurance or are eligible for Medicaid? Ms. Haddix-Hill stated very few have private insurance. Representative Insko stated that was the problem and that the legislature does not allocate enough money to solve this problem. Ms. Haddix-Hill stated that many of the recent news stories like Gabriel Giffords could easily happen in NC and that is why ED physicians are hesitant to discharge these patients.

Representative Insko asked that once the National Health Plan takes effect in 2014, do they believe this problem would be solved? Ms. Haddix-Hill stated she did not know.

Representative Dollar stated he knew the need for beds has been a problem for a long time. The House Budget did not close any beds and there are a couple of provisions that may create more beds. Leadership is working on a different model to move 60 forensic beds at Central Regional to Dix that will free up some beds at Central Regional. We need to continue to look at creatively making more beds available.

Representative Randleman stated that her District, Wilkes County, is mostly rural. There was a 27-year old patient who had been in an assisted living facility and had to stay 18 days in the hospital. This man was not medicated during this time, tried to set the hospital on fire twice. Rural areas also need to be addressed.

Representative Insko stated that if NC had more community services that are paid for with state dollars, we would be able to keep a lot of these patients out of hospitals. Most mentally ill patients are able to live on their own if sufficient wraparound services are available. Dr. Bednar stated that they even see patients from out-of-state because these patients have exhausted their resources in their home state.

Representative Hurley stated the meeting would be moving to the next topic. The following speaker made a PowerPoint presentation on Three-Way Contract which is attached.

- Glenn M. Simpson, MBA, MA, NCC, Administrator, Behavioral Health Services Pitt County Memorial Hospital

Representative Hurley introduced Jo Haubenreiser, Vice President, Novant Health, Forsyth Medical Center. Ms. Haubenreiser stated that Forsyth Medical Center adopted the Three-Way Contract over three years ago and were an early user. The dynamic around mental health has changed every year due to the economy, attempted solutions to problems, and this has put a lot of tension in the system. Initially, Forsyth Medical Center started with 7 beds and has grown to 11 beds. These beds are constantly full and are funded at 75%, therefore Forsyth Medical Center is not paid for total care. The patients are 75% mental health and 25% substance abuse or a combination. 80% are within their cachement center and the other 20% come from Guilford, Piedmont Behavioral Health, the Waiver program, or Crossroads. All of the patients come to Forsyth Medical Center in crisis (i.e. through the ED). At the beginning of the Three-Way contract, we averaged a 5.5 day stay and it is now a 6.5 day stay. Wraparound services are a barrier for discharge. NC needs to figure out how to get these wraparound services to the mental health patient. Homeless patients are the majority. The typical mental patient who has to go back into community, the homeless shelter, in order to continue to receive their wraparound care is a challenge. For the patient who does not have a medical co-morbidity a Behavioral Healthcare Center will find it difficult to make it on the $750 per deim. Most patients have medical co-morbidity like diabetes, high blood pressure. Ms. Haubenreiser stated that Forsyth Medical Center sees about 350 psychiatric cases per month and approximately 40% of those only need out-patient

admission, 60% need in-patient admission and of that 20% go to Central Regional. The out-patient admission people come through the ED because there are no 24-hour services available and the ED is the only place for 24-hour services. Forsyth Medical Center has a difficult time placing adolescents and developmentally disabled patients. There are very few facilities around the state that can accept these types of patient. Many of the developmentally disabled psychiatric patients could be handled on an out-patient basis if there were wraparound services available. No community hospital is able to accept violent patients. The Forsyth Medical Center has a good relationship with their LME's. Their doctors are not able to come to Forsyth Medical Center, but their counselor's do. Forsyth Medial Center has Access Staff who are in the ED 24/7/365 in order to access these patients after the patient has received medical clearance. Forsyth Medical Center also has 12-18 hour/7 day per week behavioral mental health mid-levels who work on the mental health patient while they wait. This is a resource that the hospital funds; the state does not. Forsyth Medical Center can call a mental patient's counselor who will come and work out a plan in order to find the right place and/or level of service. Forsyth Medical Center and the LME meet regularly, share data where the patient has been, talk about the patient's needs, look at the recidivism rates and decide to change and improve the plan of care, look at how to change the next disposition. The key for success is quick authorization, timeliness and responsiveness, sharing information, and making sure documentation expectations are consistent. LME's are not standardized across the state. Forsyth Medical Center has 4 LME's they interface with and each one has a different process. Community hospitals are there to stabilize the patient and move them back into the community. Community hospitals want to keep psychiatric patients local. Long term management needs to be with state facilities. Community hospitals can not access the psychiatric physicians or the clinical specialty resources, so the contract LME's has to be designed to support smaller hospital settings. Special populations need to be looked at individually because there are different specialty needs the different groups have. Ms. Haubenreiser's recommendations include the state needs to move from crisis to proactive management and care of the patient. If the patient is indigent, we need to make sure the wraparound services are robust. The counselor may need to go to the homeless shelter. Medical management for patients and housing need to also be addressed. There needs to be a sliding scale for costs of a patient at community hospitals that are considering three-way contracts. Construction, renovation, and specialty services will never be covered by the $750 per deim that also has to cover patient care, physician payments, medications, discharge and discharge services that are called for in the contract.

Representative Hurley opened the floor for questions.

Representative Insko stated that this is one of the times where the least expensive cost for service needs to be used and that is within the community. If the community is not able to do it, the public sector needs to take care of this.

Representative Weiss stated that she has heard over an over community hospitals are not set up to take care of special populations such as violent, developmentally disabled, and adolescent. How many hospitals are set up across the state are set up for these

special populations? Mr. Simpson stated that hospitals that are in a Three-Way Contract are not set up to accept these special populations.

Representative Hurley introduced Michael Watson, Deputy Secretary of the NC Department of Health and Human Services. The department knows there are excessive wait times in emergency rooms. Over the last 10 years there has been a reduction of hundreds of patient beds. In response DHHS has started the Three-Way Contract program. DHHS currently funds 145 new beds and this has increased capacity because in order for hospitals to get these funds hospitals had to agree to open new beds, staff up beds that weren't being used, or switch beds over so that hospitals could start taking involuntary commitments. This is a whole different certification process. DHHS has 20 different contracts this year buying around 40,000 bed days. This is additional capacity. The re-admission rates are lower and reducing short term stays at state hospitals. There is a demand for more beds and we have a number of hospitals who want to expand or add new beds and want to discuss contracts. There are mobile crisis teams that come into ED to work with physicians around dispositions and come in to do assessments of patients. The idea that there can be a psychiatrist in every rural emergency room is difficult to turn into reality. DHHS is trying to create an acceptable community system and accountability with the new CABHAs. One of the strategies in the 1915(b)(c) waiver is to create financial incentives, one of the things LME's will be doing is paying for ED visits. This creates incentive to keep people out of EDs. LME's will have incentive to do more effective plans for care for frequent ED users. There is a significant waiting time at our state hospitals for the special population mental patient. The issue that confronts DHHS is expanding Three-Way Contracts and to do a better job managing patients with wraparound services in the community so they do not end up in ED.

Representative Hurley thanked the presenters for coming. There being no further time, the meeting was adjourned.

Respectfully submitted,

Pat Hurley

Representative Pat Hurley, Chairman

Susan H. Whitehead

Susan H. Whitehead, Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES
COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2011-2012 SESSION

You are hereby notified that the Committee on **Health and Human Services Subcommittee on Mental Health** will meet as follows:

DAY & DATE: Tuesday, May 10, 2011
TIME: 10:00am – 11:50am
LOCATION: Rm .1228 LB
COMMENTS: There will be presentations and discussions regarding Hospital Emergency Room Waits and Three-Way Contracts. Please make every effort to arrive on time.

The following bills will be considered:

Respectfully,
Representative Hurley, Chair

I hereby certify this notice was filed by the committee assistant at the following offices at **11 AM** o'clock on **May 05, 2011**.

☒ Principal Clerk
☒ Reading Clerk – House Chamber

Susan Whitehead (Committee Assistant)

Agenda

House HHS Subcommittee on Mental Health
May 10, 2011

I. Call Meeting to Order

II. Welcome

III. H423 Enact First Evaluation Program
PCS: Yes
Serial Committee Referral: None

IV. Presentations on Hospital Emergency Room Waits
- Robert E. Morrison, President, Randolph Hospital
- Katherine Haddix-Hill, RN, MSN, Vice President, Emergency and Trauma Services, Moses Cone Health System
  John Bednar, MD, Medical Director, Moses Cone Health System

V. Questions and Answers

VI. Presentation on Three-Way Contracts
- Glenn M. Simpson, MBA, MA, NCC, Administrator, Behavioral Health Services, Pitt County Memorial Hospital
- Jo Haubenreiser, Vice President, Novant Health, Forsyth Medical Center

VII. Questions and Answers

VIII. Adjourn

HOUSE BILL 423
Committee Substitute Favorable 4/20/11

Short Title: Enact First Evaluation Program. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-263A. Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.**

(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding all of the following:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) A waiver granted by the Secretary under this section shall be in effect for a period of three years.

(5) In no event shall the substitution of a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist.

(6) The Department shall assure that staff performing the duties have successfully completed the Department's standardized training program and examination and are properly trained and privileged to perform the functions identified in the waiver.

(7) The LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

(8) A master's level certified clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers performing first examinations pursuant to subsection (a) of this section."

SECTION 2. This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
PROPOSED COMMITTEE SUBSTITUTE H423-CSSQ-24 [v.2]

5/9/2011 1:42:43 PM

Short Title: Enact First Evaluation Program. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-263A. Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.**

(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding all of the following:
a. The request meets the requirements of this section.
b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.
c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) A waiver granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the LME has failed to meet the requirements of this section.

(5) In no event shall the substitution of a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist.

(6) The Department shall require individuals performing initial examinations under the waiver have successfully completed the Department's standardized training program and examination. The Department shall maintain a list of these individuals on its Website.

(7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.

(8) A master's level certified clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 2. Beginning January 1, 2012, each 24-hour residential facility that (i) falls under the category of non-hospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C.0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.

(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.

(3) The reason for referring the individuals described in subdivision (2) to a different facility or program, including the need for more intensive medical supervision.

SECTION 3. This act becomes effective October 1, 2011.

HOUSE BILL 423:
Enact First Evaluation Program

2011-2012 General Assembly

Committee:	House Health and Human Services Subcommittee on Mental Health	**Date:**	May 9, 2011
Introduced by:	Rep. Hurley	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Second Edition H423-CSSQ-24		

SUMMARY: ***House Bill 423 codifies a current pilot program* which allowed certain trained Master's level professionals to conduct the initial examination of a person as part of the involuntary commitment process. The Proposed Committee Substitute provides the Secretary authority to limit or revoke granted waivers and directs a report on involuntary commitments from certain 24 hour residential facilities to the Department.***

CURRENT LAW: *The process for inpatient involuntary commitment requires a number of steps:*

Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a magistrate or clerk and execute an Affidavit and Petition for Involuntary Commitment.

If the magistrate or clerk finds reasonable grounds to believe the facts alleged in the affidavit, the magistrate or clerk must issue an order for law enforcement to take the respondent (person who is the subject to the petition) into custody for an examination by a *physician or eligible psychologist.* [1] This is the first examination in the commitment process.

The first examination must occur within 24 hours after the respondent is presented for examination.[2] Under Session Law 2010-119 "First Evaluation Pilot Program" the Secretary is authorized to approve up to 20 LME requests to substitute appropriately trained *licensed clinical social workers, masters level psychiatric nurses*, or *masters level certified clinical addictions specialists* to conduct first-level examinations.[3] The pilot program expires October 1, 2012.

BILL ANALYSIS:

House Bill 423 authorizes the Secretary of Health and Human Services to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. The bill sets the standards for which the Secretary will make his or her decision including requiring the LME to provide an adequate description on how, under the waiver, service delivery will improve while maintaining or improving the purpose and safeguards of the current statutory requirements.

The bill limits substitution to licensed staff specifically trained to perform the evaluation (and *requires the Department to maintain on its Website a list of such individuals*) and requires an LME as part of its waiver request to document that a physician is available at all times to provide support. The bill directs

[1] G.S. 122C-261
[2] G.S. 122C-263(c)
[3] SL 2003-178, as amended by SL 2006-66, SL 2007-504, SL 2009-304, and SL 2010-119

the Division of MH/DD/SAS to expand its standardized training program to include refresher training and limits the waiver to *a revocable time period of up to three years.*

The PCS *adds a reporting requirement* for certain 24-hour residential facilities designated to serve as facilities for the custody and treatment of involuntary clients. These facilities are directed to report to the Department on the first of January and July beginning January 1, 2012, on the number and primary presenting conditions of individuals being served under a petition of involuntary commitment, the number of individuals referred to different facilities or programs, and the reason for the referral.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

BACKGROUND: In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation allowed the Secretary to approve LME requests to substitute appropriately trained *licensed clinical social workers, masters level psychiatric nurses*, or *masters level certified clinical addictions specialists* to conduct first-level examinations. Under the Pilot Program, the Secretary could grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary."

The Appropriations Act of 2006 extended the pilot by 1 year. That Fall of 2006, the Department made a presentation and report on the pilot to the Legislative Oversight Committee on MH/DD/SAS (LOC) in which it recommended that the pilot be made permanent and extended State wide. The General Assembly enacted SL 2007-504 which provided a three year extension and authorized up to five more LMEs. The Secretary was authorized in SL 2009-340 to expand the program to 15 LMES and in SL 2010-113 to expand the program to 20 LMEs (there are currently 23 LMEs statewide).

The bill limits the substitution of clinical addiction specialist to involuntary commitments of substance abusers under G.S. 122C-281.

H423-SMSQ-24(CSSQ-24) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 423

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H423-AMG-34 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2011

Representative Hurley

moves to amend the bill on Page 1, Line 10,
by replacing "122C-263A." with "122C-263.1."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

2011 PERMANENT SUBCOMMITTEE REPORT
HOUSE OF REPRESENTATIVES

FOR RECOMMENDING BILLS TO STANDING COMMITTEE OR TO THE FLOOR OF THE HOUSE
The following report(s) from permanent sub committee(s) is/are presented:
By Representative(s) Hurley (Chair) for the Health and Human Services Subcommittee on Mental Health.

☐Committee Substitute for
HB 423 A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

WITH APPROVAL OF STANDING COMMITTEE CHAIR(S) FOR REPORT TO BE MADE DIRECTLY TO THE FLOOR OF THE HOUSE:
Representative Hurley (Chair) for the Standing Committee on Health and Human Services.

s/ William A. Current Sr.

/ Mark W. Hollo

/

☒With a favorable report as to the committee substitute bill 2, unfavorable as to Committee Substitute Bill 1.

(FOR JOURNAL USE ONLY)

_____ Pursuant to Rule 32(a), the bill/resolution is re-referred to the Committee on _____.

_____ Pursuant to Rule 36(b), the (House/Senate) committee substitute bill/(joint) resolution (No._____) is placed on the Calendar of _____. (The original bill resolution No._____) is placed on the Unfavorable Calendar.

_____ The (House) committee substitute bill/(joint) resolution (No. ____) is re-referred to the Committee on _____. (The original bill/resolution) (House/Senate Committee Substitute Bill/(Joint) resolution No. ___) is placed on the Unfavorable Calendar.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
PROPOSED COMMITTEE SUBSTITUTE H423-PCS80220-SQ-24

Short Title: Enact First Evaluation Program. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-263.1 Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.**

(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding all of the following:
a. The request meets the requirements of this section.
b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.
c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) A waiver granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the LME has failed to meet the requirements of this section.

(5) In no event shall the substitution of a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist.

(6) The Department shall require that individuals performing initial examinations under the waiver have successfully completed the Department's standardized training program and examination. The Department shall maintain a list of these individuals on its Web site.

(7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.

(8) A master's level certified clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 2. Beginning January 1, 2012, each 24-hour residential facility that (i) falls under the category of non-hospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.

(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.

(3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision.

SECTION 3. This act becomes effective October 1, 2011.

RANDOLPH HOSPITAL

Mission Statement

Randolph Hospital's mission is to provide quality healthcare and to promote health and wellness.

RANDOLPH HOSPITAL

Emergency Patient Needs

1) Medical and mental evaluation

2) Diagnosis

3) Emergency medical and mental treatment

4) Referral for outpatient follow-up or transfer to inpatient psychiatric hospital

RANDOLPH HOSPITAL

Problems for Patients

1) No psychiatric consultation to support emergency physician's diagnosis and treatment
2) Inadequate staff and facilities to provide psychiatric treatment during waits for admission
3) Long waits for transfer

KANDOLPH HOSPITAL

Results for Patients

1) Emergency Physicians estimate that 25% to 30% of patients admitted to inpatient care could have been discharged to outpatient follow-up if psychiatric consultation had been available. If there is any question of danger to self or others, an Emergency Physician acting without specialty consultation will generally take the conservative course (inpatient admission). *In Randolph County, this is the only way to get an emergency patient seen by a psychiatrist.*

KANDOLPH HOSPITAL

Results for Patients, continued:

2) The patient may be held *against his will* for days awaiting involuntary commitment.

3) The extended wait in an Emergency Department holding area may agitate patients and compound their problems.

4) The hospital admission may have been unnecessary.

KANDOLPH HOSPITAL

Results for Patients, continued:

5) "Patients who experience this are reluctant to seek subsequent care for fear of repeating the experience."
(Quote from emergency physician)

RANDOLPH HOSPITAL

Results for Randolph Hospital

1) 20-25% of Emergency Department capacity was used for Mental Health holding. This caused excessive waits by other patients, creating risk for those patients and lower patient satisfaction for those experiencing long waits.

KANDOLPH HOSPITAL

Results for Randolph Hospital, continued:

2) The hospital has incurred the cost of creating and staffing a mental health holding area *(nurses, security guards, attendants, medications, and support services)* at an approximate cost of $1,000,000 annually for a service that is little more than a waiting room for those in need of transfer.

3) Staff dissatisfaction and turnover related to the work environment

KANDOLPH HOSPITAL

Results for Randolph Hospital, continued:

4) Exposure of other patients, visitors and staff to violence, and extreme behavior problems during their own emergencies. *(On several occasions we have needed multiple law enforcement officers to control patients who were in the midst of long waits for transfer. There was no psychiatrist to offer advice or assistance in management of these extreme cases.)*

RANDOLPH HOSPITAL

Randolph Hospital Statistics

Annual ER Visits	40,000
ER Bed Capacity	24
Mental Health Holding	0-14
April 2011 Average Holding	6.2
April 2011 Police Visits for Mental Health Patients	9

KANDOLPH HOSPITAL

Fundamental Problems

1) Inadequate outpatient service

- High recidivism rate implies that outpatient service should be re-evaluated.
- Patients report being encouraged by LME contract agents to go to the hospital Emergency Department and bypass the mental health emergency service.

RANDOLPH HOSPITAL

Fundamental Problems, continued:

- Psychiatrists and other clinicians treating mental outpatients are not available to see patients during emergencies. Once the patient has arrived at the hospital ER, he essentially loses all access to the mental health system unless/until he is admitted to an inpatient psychiatric hospital. (*This is a contributing factor to "unnecessary" admissions. They become "necessary" because there is no other way to see a psychiatrist without being discharged.)*

KANDOLPH HOSPITAL

Fundamental Problems, continued:

2) Lack of inpatient psychiatric capacity

- State Hospital closures
- This problem could be lessened if the LME would contract for its psychiatric staff to continue serving their patients after arrival at the ED.

RANDOLPH HOSPITAL

Fundamental Problems, continued:

- Inadequate reimbursement to support hospital investment in adding psychiatric service. *(Note that hospitals and doctors compete aggressively for the opportunity to create other kinds of services.)*

KANDOLPH HOSPITAL

Some Facts from Randolph County

1) The Required mental health emergency center operates a Monday-Friday day shift.

2) At closing time, patients with mental health emergencies are directed by that center to the hospital Emergency Department. Some are sent by patrol car.

RANDOLPH HOSPITAL

Some Facts from Randolph County, continued:

3) Psychiatrists *(MDs)* who diagnose and treat the patients under contract to the LME cease all service to the patient when they arrive at the ED and will not resume until the patient is discharged from the ED or from an inpatient psychiatric hospital.

4) The only way to get a specialty *(psychiatric)* consultation is an inpatient admission *(generally at the expense of the State of North Carolina).*

RANDOLPH HOSPITAL

Some Facts from Randolph County, continued:

5) The LME's "crisis team" which is supposed to respond to mental health emergencies after hours has no base of operations. There is no place for a mental health emergency patient to go after hours besides the Emergency Room.

6) The personnel that the LME contracts with can assist with patient interviews and can call state facilities to get beds. They cannot diagnose or treat patients.

RANDOLPH HOSPITAL

Real World Examples

Case #1

The Emergency Center under contract to the LME sent the patient to the Randolph Hospital Emergency Department with an Involuntary Commitment Affidavit and petition stating, "This 20 year-old man with a history of PTSD and depression reports that he is experiencing overwhelming homicidal ideation towards another resident at the shelter where he lives and that if he goes back there or sees the man he will slam his head into a concrete wall. He has a previous history of gang involvement and violent behavior directed toward others." This statement is signed by the psychiatrist working at the Emergency Center.

RANDOLPH HOSPITAL

Real World Examples

<u>Case #1, continued:</u>

This patient waited for six days for transfer from Randolph Hospital to a psychiatric hospital.

1) He was known to be dangerous.
2) Private Facilities under contract to the LME refused him because he was dangerous and too difficult to manage *so he remained at Randolph Hospital waiting for a bed at a state hospital.*

RANDOLPH HOSPITAL

Real World Examples

Case #1, continued:

3) While the patient waited, the only service provided by the LME and the Emergency Mental Health Service was to make calls looking for available beds. No health care or consultation was provided.

The ER is not the place for this patient to wait. We are very fortunate that no one was injured.

We need an alternative and so did this patient.

KANDOLPH HOSPITAL

Real World Examples

Case #2 *A voice mail message for the Hospital President*

Good morning, Doctor _____ here. Just a mental health update for you. I have a patient (in the hospital) with adverse effects from her haldol that she is getting from Daymark/Therapeutic Alternatives. I asked for a mental health consult and they didn't come. I asked for another one and they said they would not come until she was medically cleared to go to a mental health hospital which she doesn't need. I just need to make sure they set up a follow-up plan before I let her go home. So we are in of the midst of they refuse to come see their patient while they are in the hospital unless they are going to be discharged to a mental hospital which leaves a big gap which means she will probably bounce when she goes home. So, just kind of a new twist on the unavailability, even for their own patient who is in the hospital because of their own failure to follow properly. Just thought I'd share this in case you want to look into it. We are trying to get her out of here, but it will probably require a couple of extra days to iron out all of their stuff will add to the expense on your part.

RANDOLPH HOSPITAL

Real World Examples

Case #2, continued:

In this case, a primary care physician has a patient who is also a patient of the LME's contract agency. The patient is admitted through the ER with side effects of a psychiatric medication prescribed by the LME's psychiatrist. Neither the psychiatrist nor any contract staff will see the patient except to help admit her to a psychiatric hospital. The primary care physician does not think she needs inpatient care. She just needs a psychiatrist to help adjust her medications.

RANDOLPH HOSPITAL

Real World Examples

Case #3

(Name) MSW, PLCSW, TACT was dispatched to Randolph Hospital ED to assess *(Patient Name)*. Patient was brought to ED by Archdale police because she stabbed her husband 8 times with a pair of scissors. Patient reported she hurt her husband's twin brother because her husband's twin brother was trying to hurt patient's son and had already killed another son. PLCSW was unable to determine if the son patient claims is deceased exists or is part of hallucination. Patient reported her husband has over 4,000 twin brothers and all of them have had their legs cut off and blames patient for it. Patient does not realize she stabbed her husband, patient consistently claims she stabbed her husband's twin brother.

RANDOLPH HOSPITAL

Real World Examples

Case #3, continued:

Patient reported she thinks her husband is missing and wanted to know if the police had found him yet. When PLCSW asked patient if she had a psychiatrist her response was God was her psychiatrist. During assessment patient became increasingly agitated and was rocking back and forth while holding her head. In addition, during assessment patient was talking to someone but there was no one else in the room except patient, PLCSW, and officer. PLCSW was unable to complete the assessment because patient refused to answer any more questions. PLCSW spoke with Dr. _____ regarding patient and Dr. _____ informed PLCSW that involuntary commitment paperwork was in place for patient.

RANDOLPH HOSPITAL

Real World Examples

Case #3, continued:

Like case #1, this is a potentially dangerous patient who was rejected by 3-way contract hospitals as too dangerous. She spent six days waiting in our ER without a psychiatrist. It is a pattern that dangerous patients have longer waits because they are harder to place.

Hospital staff tried to have her transferred to Central Prison's psychiatric service, but could not because no charges had been filed.

RANDOLPH HOSPITAL

These Cases Have This in Common:

The North Carolina Mental Health System seems to operate on the assumption that its responsibility ends when a patient arrives at a hospital Emergency Room.

RANDOLPH HOSPITAL

Closing Thought

- There are many possible long term scenarios.
- There is one immediate priority:
  - It should be made clear that the LME's obligation to provide mental health service including psychiatric diagnosis and treatment continues while patients await transfer to inpatient psychiatric facilities.

DOCUMENTS TO ACCOMPANY TESTIMONY

Subcommittee on Mental Health
May 10, 2011

Robert E. Morrison
President, Randolph Hospital

rrison Robert

From: Morrison Robert
Sent: Wednesday, September 15, 2010 11:35 AM
To: steve.jordan@dhhs.nc.gov
Cc: Victoria Whitt (victoriw@sandhillscenter.org); Griffith Devin L.; Allen Sandra; Crawford Tremonteo
Subject: meeting follow-up

Thank you for arranging our meeting yesterday. It was good to be able to hear some of Victoria's plans and I was particularly glad to hear that Sandhills will be publishing a flow chart showing how referrals should proceed. By handling psychiatric emergencies at the contract crisis facility and in patients' homes, we can avoid unnecessary ED visits. Your agreement that the primary mental health caregiver and/or their on-call backup will be involved prior to referral to the ED will also be helpful. We will look forward to receiving clinical referral which will help us understand the reason for the ED visit. We are very willing to continue working with Sandhills and DHHS on improvements of this kind.

We are also interested in pursuing the idea that we presented for your consideration. To summarize:

1. Sandhills provides or contracts with RH to provide twice daily psychiatric consultation on site at RH. The psychiatrist would evaluate and provide recommendations regarding ED mental health patients, and patients awaiting transfer who are in inpatient or observation status.
2. RH would have a contract with Sandhills or DHHS, possibly similar to the 3-way contracts for psych facilities, to be paid for inpatient and observation services while awaiting transfers.
3. RH and our Emergency physicians and hospitalists would work with the psychiatrists to begin evaluation and medication management during the period that the patient is awaiting transfer.
4. It is our belief that through this program we can reduce the state's overall mental health spending. With psychiatric evaluation in the ED, the number of psychiatric admissions may decline by 25-30%. By actively managing patients awaiting transfer, some of those awaiting transfer may improve enough to avoid the need for the transfer.
5. We propose developing a plan to this effect in partnership with Sandhills and DHHS as a one year pilot project. The three parties would collaborate to evaluate both patient outcomes and costs as compared to prior years.
6. We would cooperate with DHHS and Sandhills to seek partial grant funding to offset the cost of this pilot project.
7. If the project succeeds, it might serve as a model for other communities.

We believe that this idea would improve care, reduce costs, and that it would also be more fair to RH which is now receiving no payment for holding and observing mental health patients which Sandhills is obligated to transfer to inpatient facilities which would be paid.

We await your response to the idea.

After you left the meeting, our conversation continued briefly. At your suggestion, we not go into our difference of opinion as to the requirements on Sandhills imposed by

North Carolina laws and regulations during most of the meeting. After your departure I did raise this concern again and I want you to know what was said. I pointed out to Victoria that we still strongly believe that the interpretation of the law provided in our position statement is correct. I asked her if Sandhills has ever asked independent legal counsel to provide an opinion on the matter. By independent, I mean an attorney who is familiar with these laws and who is being asked for an independent opinion, and who is not being asked to represent any particular point of view. She told me that Sandhills has not done that and I encouraged her strongly to do it. I hope that you will do the same if you have not already done it.

RH will continue to cooperate with Sandhills and DHHS to improve patient care and to reduce costs regardless of whether Sandhills is in compliance with the law but our position statement, provided previously, is still our viewpoint. We would also like to work with you to bring services into compliance with what we believe the law requires.

Again, thank you for initiating the meeting. We will look forward to succeeding in partnership with DHHS and with Sandhills.

Bob Morrison

Robert E. Morrison (Bob)
President/CEO
Randolph Hospital
364 White Oak St.
Asheboro, NC 27203
PHONE: 336.633.7730
: 336.626.7664

EXCERPTS FROM NC LAW AND ADMINISTRATIVE CODE
EMPHASIS ADDED

§ 122C-3. Definitions.
The following definitions apply in this Chapter:

31) "Qualified professional" means any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, **including physicians**, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors.

10A NCAC 27G .0104 STAFF DEFINITIONS
The following credentials and qualifications apply to staff described in this Subchapter:

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Each area program shall employ or contract for the services of a:
(1) psychiatrist;

§ 122C-115.4. Functions of local management entities.

LME CAN DELEGATE ONLY BY CONTRACT

(b) **The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity** under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(5) Care coordination and quality management. **This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results.**

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(2) Emergency for Individuals of all Disability Groups;

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SECTION .6100 - EMERGENCY SERVICES OR INDIVIDUALS OF ALL DISABILITY GROUPS

10A NCAC 27G .6101 SCOPE

Each area program shall make provisions for emergency services on a 24-hour non-scheduled basis to individuals of all ages and disability groups and their families, for immediate screening or assessment of presenting problems including emotional or behavioral problems or problems resulting from the abuse of alcohol or other drugs.

10A NCAC 27G .6102 STAFF

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THIS CAN BE A PSYCHIATRIST AS NEEDED BY ED PHYSICIAN

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DHHS Response to Randolph Hospital Letter to Sandhills LME

Robert Morrison, President of Randolph Hospital, has written to Victoria Whitt, Director of the Sandhills Center Local Management Entity (LME) outlining several concerns regarding patients being seen the Randolph Hospital Emergency Department (ED) who are in need of psychiatric and/or substance abuse services. In his letter, Mr. Morrison has made several assertions regarding the responsibilities of LMEs. The following information is intended to set the record straight from the perspective of the Department of Health and Human Services, the state agency responsible for managing and overseeing the activities of LMEs and for assuring those entities of local government are meeting their statutory responsibilities.

First, it is important to note that we share Mr. Morrison's concern about consumers waiting for appropriate mental health and/or substance abuse services for long period of time in community hospital EDs. We continue to work with the NC Hospital Association, NC Sheriff's Association, Association of County Commissioners, NC Council of Community Programs and the Office of the Attorney General to address those complicated issues. We have also worked with the NC General Assembly to secure additional financial resources to enhance LME's crisis response system. To that point, though Mr. Morrison's letter focuses on areas in which he believes Sandhills is not fulfilling its responsibilities, it is important to note the services that Sandhills does provide on behalf of patients seen in the Randolph Hospital ED. Sandhills contracts for psychiatric first commitment evaluations to be performed by the physicians' group that staffs the Randolph Hospital ED. The LME also pays for after-hours assessments by qualified professionals in the ED by staff of a provider agency, Therapeutic Alternatives and offers Mobile Crisis services to all residents of Randolph County through another contract with Therapeutic Alternatives. All Mobile Crisis Teams, including the ones operated by Therapeutic Alternatives, have access to a psychiatrist for appropriate consultation. In addition to these efforts, Sandhills operates a 24/7/365 screening, triage and referral/emergency services telephonic operation staffed by licensed clinicians and contracts for walk-in crisis centers staff by psychiatrists and other licensed professionals throughout its 8 county catchment area. There are two such walk-in crisis centers in Randolph County: one in Asheboro and one in Archdale.

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THE DOCUMENT DOES NOT SAY THIS.

2. Psychiatry Services: Mr. Morrison is correct that the NC Administrative Code at 10A NCAC 27G.6102 requires the LME to provide a "qualified professional, as appropriate to the client's needs" to provide emergency services through consultation and direct face-to-face contact. However, Mr. Morrison errs in assuming that the "qualified professional" must be a psychiatrist or that "emergency services' as required by the rule refers to psychiatric treatment. "Qualified professional," as defined in the NC Administrative Code at 10A NCAC 27G.0104, is: a licensed mental health professional (social worker, professional counselor, etc.); or a person with a Master's degree in a human service field

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WHAT ELSE WOULD IT MEAN?

and one year experience with the population to be served; or a person with a Bachelor's degree in a human service field with two years experience with the population to be served; or a person with a Bachelor's degree in any field and four years experience with the population to be served. In addition, "emergency services," as defined within the same group of rules (10A NCAC 27G.6100) is an "immediate screening or assessment of presenting problems." Sandhills LME fulfills the requirements of these rules by contracting for Mobile Crisis Team services and after-hours assessment services for individuals in the Randolph Hospital ED who require a psychiatric assessment. As noted earlier, the Mobile Crisis Team does have access to consultation by a psychiatrist.

3. Provision of Emergency Psychiatric Services: We agree with Mr. Morrison that it is the responsibility of the LME to provide for timely transfer of patients to an inpatient facility. That, of course, requires that an appropriate bed be available in an inpatient facility. Sandhills LME has contracts for inpatient services with First Health in Moore County, Sandhills Regional in Richmond County, High Point Regional and Moses Cone in Guilford County, Holly Hill in Wake County, Dorothea Dix Hospital and Central Regional Hospital state hospitals and with Freedom House in Orange County for substance abuse inpatient services. If an appropriate bed cannot be located for a patient within 24 hours the LME's clinical care coordinators become involved and if the wait stretches to 48 hours the LME director becomes personally involved in trying to locate a bed. If a bed is not located within 72 hours, the DMH/DD/SAS becomes involved in searching for a bed. Unfortunately, there are times when with all due diligence, an appropriate bed cannot be located for longer than anyone would wish. For that reason, DHHS has recommended and the General Assembly has supported funding to expand the number of inpatient psychiatric beds available in community hospitals through the "3-way hospital" initiative. Mr. Morrison's letter indicates that Ms. Whitt has discussed the possibility of Randolph Hospital opening an inpatient psychiatric unit through those 3-way hospital funds, but Randolph Hospital has not been interested in pursuing that opportunity.

THIS DOES NOT JUSTIFY ENDING PSYCHIATRIC SERVICE WHEN THE PATIENT ARRIVES AT THE ER.

Mr. Morrison is incorrect in his interpretation of NC Administrative Code at 10A NCAC 27G.0502. That rule does not require "each area program to develop written agreements between the area program and general or private hospitals." Rather, the rule requires each area program to "make provisions for inpatient services" and states that this may be accomplished by the area program directly providing the service, through written agreements or though a written referral procedure. The rule also does not require the LME to have agreements with every hospital in its catchment area. As noted above, Sandhills does have contracts with many hospitals to serve patients in its 8 county catchment area.

4. DHHS/Sandhills Center Three-Way Inpatient Contracts: As noted above, Mr. Morrison indicates that Randolph Hospital is not interested in pursing a 3-way contract for inpatient services. He does, however, recommend re-opening the Walker Treatment Center. Although this would be a local issue and a decision to be made by the Sandhills Board and management, it is our understanding that the Walker Treatment Center was closed early in this decade because it was not financially viable. Given that history, the idea that it might be operated on a "break-even basis" would appear to be remote.

THIS DOCUMENT WAS SENT TO THE PRESS AND RANDOLPH HOSPITAL, UNSIGNED, ON JULY 29, 2010 IT CAME FROM THE LME.

rrison Robert

From: Morrison Robert
Sent: Wednesday, September 15, 2010 11:35 AM
To: steve.jordan@dhhs.nc.gov
Cc: Victoria Whitt (victoriw@sandhillscenter.org); Griffith Devin L.; Allen Sandra; Crawford Tremonteo
Subject: meeting follow-up

Thank you for arranging our meeting yesterday. It was good to be able to hear some of Victoria's plans and I was particularly glad to hear that Sandhills will be publishing a flow chart showing how referrals should proceed. By handling psychiatric emergencies at the contract crisis facility and in patients' homes, we can avoid unnecessary ED visits. Your agreement that the primary mental health caregiver and/or their on-call backup will be involved prior to referral to the ED will also be helpful. We will look forward to receiving clinical referral which will help us understand the reason for the ED visit. We are very willing to continue working with Sandhills and DHHS on improvements of this kind.

We are also interested in pursuing the idea that we presented for your consideration. To summarize:

1. Sandhills provides or contracts with RH to provide twice daily psychiatric consultation on site at RH. The psychiatrist would evaluate and provide recommendations regarding ED mental health patients, and patients awaiting transfer who are in inpatient or observation status.
2. RH would have a contract with Sandhills or DHHS, possibly similar to the 3-way contracts for psych facilities, to be paid for inpatient and observation services while awaiting transfers.
3. RH and our Emergency physicians and hospitalists would work with the psychiatrists to begin evaluation and medication management during the period that the patient is awaiting transfer.
4. It is our belief that through this program we can reduce the state's overall mental health spending. With psychiatric evaluation in the ED, the number of psychiatric admissions may decline by 25-30%. By actively managing patients awaiting transfer, some of those awaiting transfer may improve enough to avoid the need for the transfer.
5. We propose developing a plan to this effect in partnership with Sandhills and DHHS as a one year pilot project. The three parties would collaborate to evaluate both patient outcomes and costs as compared to prior years.
6. We would cooperate with DHHS and Sandhills to seek partial grant funding to offset the cost of this pilot project.
7. If the project succeeds, it might serve as a model for other communities.

We believe that this idea would improve care, reduce costs, and that it would also be more fair to RH which is now receiving no payment for holding and observing mental health patients which Sandhills is obligated to transfer to inpatient facilities which would be paid.

We await your response to the idea.

r you left the meeting, our conversation continued briefly. At your suggestion, we did not go into our difference of opinion as to the requirements on Sandhills imposed by

rth Carolina laws and regulations during most of the meeting. After your departure I did raise this concern again and I want you to know what was said. I pointed out to Victoria that we still strongly believe that the interpretation of the law provided in our position statement is correct. I asked her if Sandhills has ever asked independent legal counsel to provide an opinion on the matter. By independent, I mean an attorney who is familiar with these laws and who is being asked for an independent opinion, and who is not being asked to represent any particular point of view. She told me that Sandhills has not done that and I encouraged her strongly to do it. I hope that you will do the same if you have not already done it.

RH will continue to cooperate with Sandhills and DHHS to improve patient care and to reduce costs regardless of whether Sandhills is in compliance with the law but our position statement, provided previously, is still our viewpoint. We would also like to work with you to bring services into compliance with what we believe the law requires.

Again, thank you for initiating the meeting. We will look forward to succeeding in partnership with DHHS and with Sandhills.

Bob Morrison

Robert E. Morrison **(Bob)**
President/CEO
Randolph Hospital
/hite Oak St.
)oro, NC 27203
ONE: 336.633.7730
X: 336.626.7664

EXCERPTS FROM NC LAW AND ADMINISTRATIVE CODE
EMPHASIS ADDED

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WHAT ELSE WOULD IT MEAN?

Comments?

Contact:

Glenn Simpson

252.847.5095

glenn.simpson@pcmh.com

THANK YOU

Q. Are Most Services "Crisis" or "Treatment"

A.

- The goal of hospitalization is to stabilize the "crisis" and "treat" the reason for admission.
- Psychiatric hospitalization stays should be short.
- Post-inpatient care is as important, if not more important, than inpatient care.

Three Way Contract Q&A

- PCMH provides special programs/units including geri-psych, psych-med, and intensive care/acute.
- Costs associated with these services are well above the per diem.
- The Three Way Bed Workgroup has discussed the concept of tiered-rates.
- Community hospitals serve many unfunded patients with mental illness.

UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital

Q. Does $750 per day cover hospital costs?

A.

- At PCMH, the funds do not cover the actual cost of care. The $750 is all inclusive.
- PCMH provides needed medical care in-house.
- Three Way Bed patients often have co-morbid medical disorders.

Q. How are Current Beds Used? What is the Utilization?

A.

- At PCMH, more beds than funded are used.
- Most Three Way Contract patients at PCMH are from the local LME catchment area.
- At PCMH, there are more patients that qualify for Three Way beds than the funding supports.

Q. What are the barriers to hospitals using Three Way Beds?

A.

- Three Way Bed patients often require more resources than other patients.
- Many hospitals are unable to provide such resources.

Q. Are Three Way Beds a Cost-Effective Solution?

A.

•Inpatient psychiatric units are the most restrictive and expensive healthcare environment but provide safe alternatives for those seeking to hurt self or others as a result of a mental illness.

•Within the context of the current delivery system, Three Way Beds provide a needed service at a pre-determined daily expense to the State. However, robust community resources designed to prevent or provide alternatives to inpatient level of care would be preferred.

Q. Are More Three Way Beds needed?

A.

- If community hospitals had the capacity and resources to admit more patients, the State Hospital delays could be reduced.

- Without funding, hospitals can have difficulty maintaining "open" beds.

UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital

Three Way Contract Q&A

However,

- The goal of ED's are to stabilize patients and transfer to the next level of care as quickly as possible.

- If more Three Way funded beds were available, ED wait times could be shortened.

- Three Way Contract success needs to be measured by reduced wait times in ED's, improved patient outcomes, and sustainability of community beds.

Q. Is the Three Way Contract Working?

A.

- PCMH/UHS is dedicated to serving the citizens of eastern North Carolina who suffer from mental illness.
- PCMH appreciates the opportunity for Three Way Bed funding.
- Since the contract is new for PCMH, it is premature to determine the success.

Three Way Contract at PCMH

- PCMH was awarded a Three Way Contract in October 2010.
- The first Three Way Contract patient was admitted in November 2010.
- The PCMH Three Way Contract is funded for 75% of Three Beds per day (=2.25 beds/day).

In the ED

- During SFY 09, 135,536 persons were seen in NC Emergency Departments in mental health crises. (NC DETECT)
- In November 2010, 8,608 patients were seen in 78 NC ED's for mental health crises. (DMH/DD/SA Study)
- Average Length of Stay (ALOS) in the ED's in November 2010 was 9.62 hours. For those patients transferred to state facilities, the ALOS was 26.33 hours. (DMH/DD/SA Study)

Behavioral Health Patients and the ED

- "Behavioral Health Patients in ED's is a widespread problem causing serious disruption of the service delivery system."

  (A Literature Review: Psychiatric Boarding; U.S. Department of Health and Human Services; October 2008)

- The Agency for Healthcare Research and Quality released a report on emergency department utilization and found that in 2007, 12.5 percent of ED admissions were caused by or related to behavioral health issues or substance abuse. Of the expenditures related to these visits, 30 percent were billed to Medicare and nearly 20 percent were billed to Medicaid. According to the report, which was released in July 2010, behavioral health-related ED visits were two and a half times more likely to result in a hospital admission than other causes. A total of 41 percent of all behavioral health-related ED visits resulted in a hospital admission.

  (Dorland Health, Case in Point Newsletter, September 2010)

Mentally Health in the US

- About one in four adults in the United States suffers from a mental disorder in a given year, with about 6 percent suffering from a serious mental illness.
- Mental health disorders were one of the five most costly conditions in the United States in 2006, with expenditures at over $57.5 billion.
- People with psychotic disorders and bipolar disorders are 45 percent and 26 percent less likely, respectively, to have a primary care doctor than those without mental disorders.

(AHRQ Mental Health Research Findings, November 2009)

Behavioral Health Services

Pitt County Memorial Hospital Behavioral Health Services includes:

- General Adult Psychiatric Inpatient Treatment (23 beds).
- Geriatric/Psychiatric-Medicine Inpatient Treatment (14 beds)
- MI/MR (aka: MR/MI; IDD; DD; Diversion) Inpatient Treatment (10 beds).
- Acute (aka: Psychiatric Intensive Care) Inpatient Treatment (10 beds).
- Electroconvulsive Therapy Inpatient & Outpatient Treatment.

Pitt County Memorial Hospital

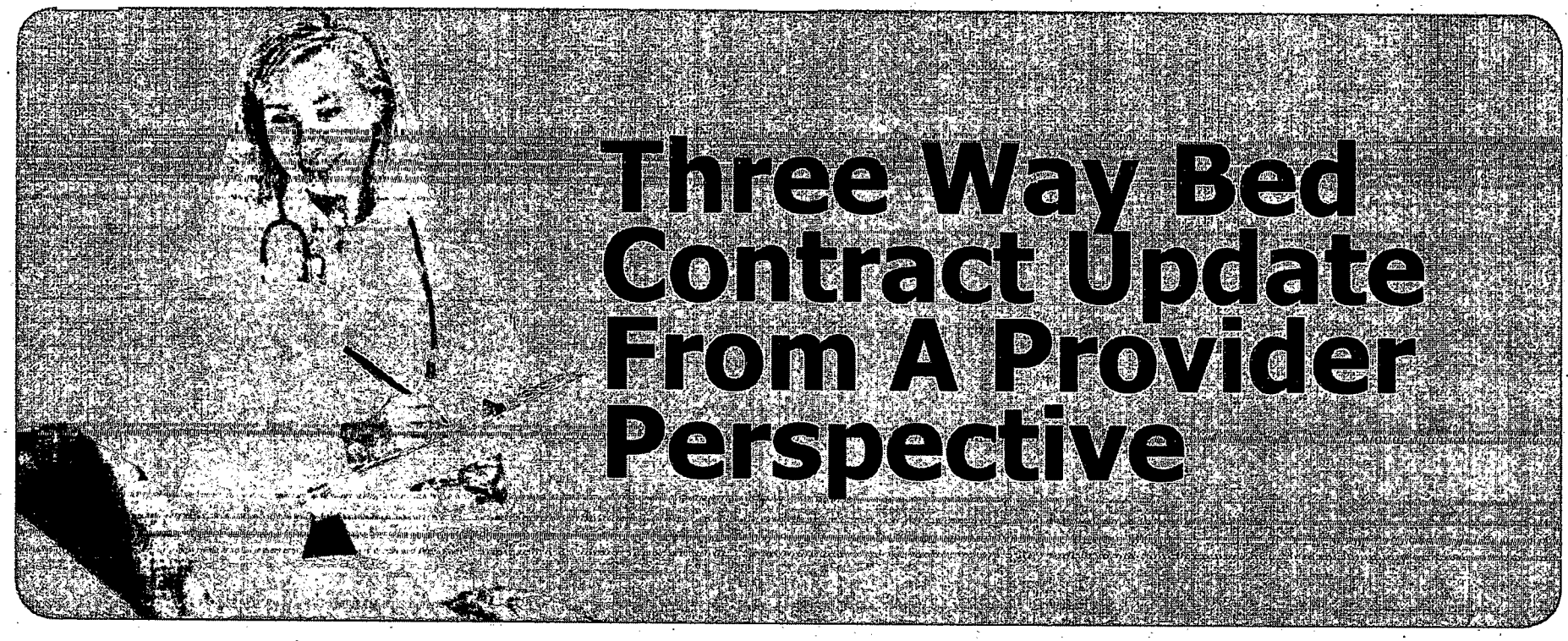
- Third largest hospital in the State.
- One of four North Carolina academic medical centers.
- Partnered with the East Carolina University Brody School of Medicine.
- Flagship hospital of the not-for-profit University Health Systems of Eastern North Carolina.
- Serves over 1.3 million North Carolinians.

UNIVERSITY HEALTH SYSTEMS
Pitt County Memorial Hospital

Presenter

Glenn Simpson
Administrator
Behavioral Health Services

University Health Systems
Pitt County Memorial Hospital



Three Way Bed Contract Update From A Provider Perspective

UNIVERSITY HEALTH SYSTEMS

Pitt County Memorial Hospital

Take Away

The ED is not an effective milieu for psychiatric treatment

MOSES CONE
HEALTH SYSTEM

- Increase in number of inpatients holding for admission to inpatient psychiatric hospitals
- Increased overall LOS for hospital admissions
- Increased personnel costs
- Creates delays for ED patients requiring admissions

MOSES CONE
HEALTH SYSTEM

Patient Care Area

- Seven Bays
- A Quiet Room
- White noise devises
- Monitoring by cameras that feed to the nurses station and security.
- Advanced nurse call system.

MOSES CONE
HEALTH SYSTEM

Not enough, some days have 19 MH patients in department

MCHS ED volumes increase in correlation with every retraction of state services, such as:

- Closure of state facilities
- Elimination of Community Support
- Retraction of Community Support Teams

The EDs see an increase in Mental Health patients in 10-14 days.

MOSES CONE
HEALTH SYSTEM

How MH Patient Delays Impact ED

- Strain on resources
  - Staff / sitters / beds / security / off duty law enforcement / social workers / case managers
- Delays for patients with medical emergencies
- Left without being seen rate increases when holding MH patients
- Disrupts entire ED
  - Uncomfortable for staff and other patients
  - Decrease in satisfaction (employee and patient)

MOSES CONE HEALTH SYSTEM

Trends

- 7% increase in total MH patients in EDs over previous year
- 5% increase in overall average length of stay (LOS) for all MH patients in ED
- Huge increase in ED LOS for patients going to Central Regional Hospital
  - Average time spent in ED for CRH waiting for placement: 5 1/2 days.
  - Longest -13 days

MOSES CONE
HEALTH SYSTEM

- 50 Adult beds
- 30 Child & Adolescent
- Adult Unit at 99% capacity for last 10 months except for 18 days

MOSES CONE
HEALTH SYSTEM

Dispositions

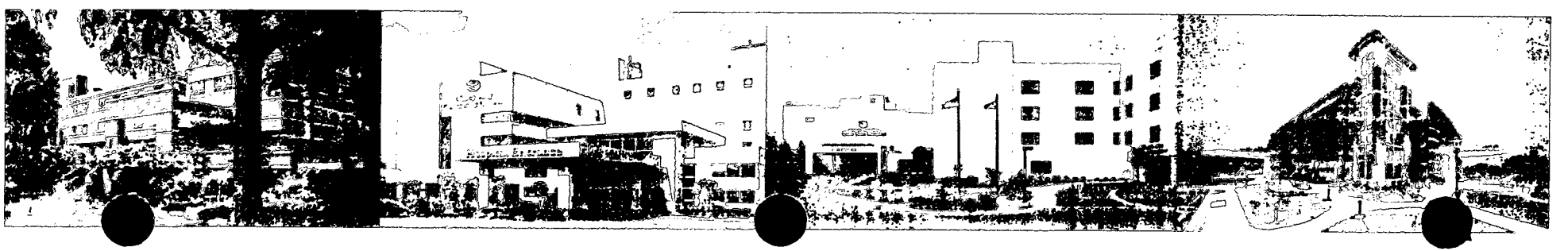
- 40% transferred to MC BHC
- 3% Central Regional Hospital
  - No admissions over weekends
  - High volume days for EDs
- 57% Discharged or transferred to other facilities

MOSES CONE
HEALTH SYSTEM

Emergency Services
Moses Cone Health System

MCHS total mental health assessments: 10,502

- Moses Cone Hospital (1206)
- Behavioral Health Center (5866)
- Wesley Long Community Hospital (2408)
- Annie Penn Hospital (734)
- Med Center High Point (288)



Impact of Mental Health Patients on Moses Cone Health System Emergency Departments

Katherine Haddix-Hill, RN, MSN

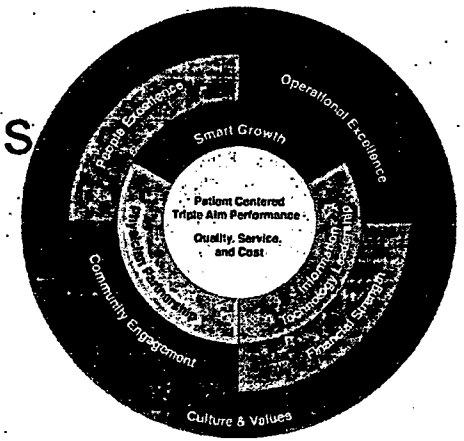
Vice President, Emergency & Trauma Services

John Bednar, MD

Medical Director, Emergency Services

MOSES CONE

HEALTH SYSTEM



TAR Heel Challenge Students

House Committee Pages / Sergeants at Arms

NAME OF COMMITTEE HEALTH & HUMAN SERVICE

DATE: 5-10-11 **Room:** 1228

*Name: JARED RAUSCHER
County: WAKE
Sponsor: SPEAKER TILLIS

*Name: TIAWANA MUNNIEALYN
County: LENOIR
Sponsor: SPEAKER TILLIS

*Name: ALESHA SATTERWHITE
County: WAKE
Sponsor: SPEAKER TILLIS

*Name: VICTORIA BISHOP
County: SAMPSON
Sponsor: SPEAKER TILLIS

*Name: DANIEL HOOD
County: MOORE
Sponsor: SPEAKER TILLIS

House Sgt-At Arms:

1. Name: BILL BASS
2. Name: EARL COKER
3. Name:
4. Name:
5. Name:
6. Name:

VISITOR REGISTRATION SHEET

HHS Subcommittee on Mental Health — May 10, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Loss	PPAB
[illegible]	NCAFP
[illegible]	Life Span
Janice Cantor	Lifespan
Steve Mitchell	ASTEIAS
[illegible]	[illegible]
[illegible]	CYPC
Annaliese Dalyn	DRNC
[illegible]	NMSS - NC

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HHS Subcommittee on Mental Health — May 10, 2011

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NAME	FIRM OR AGENCY AND ADDRESS
Rita Lord	Rowan Salisbury School System
Sara Trexler	Rowan-Salisbury School System
Patty Overcash	Rowan Salisbury School System
Ann Christian	Atty
Paula Fishman	Volunteer Advocate for I/DD
Joyce Ivey	JPDesoc
Lavine Foster	Volunteer Advocate for M.T.
Lay Wilson	NCALTCF
Angie Harris	WM

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NAME	FIRM OR AGENCY AND ADDRESS
Lydia Dickens	Easter Seals UCP North Carolina
Trish Eure Hussey	Freedom House Recovery Center and Addiction Prof. of NC
KURTIS TAYLOR	OXFORD HOUSES OF NC
Mary Powell	NC Substance Abuse Federation
Elizabeth Taylor	Kochanek Law Group
Holly Safi	DRNC
Corye Dunn	DRNC
M. Wilson	DHHS
[illegible]	DHHS
Marc Jacques	NAMI Wake & Mental Health Advocacy Inc.
Amy Whited	NCMS

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NAME	FIRM OR AGENCY AND ADDRESS
Lucky Walsh	DHHS
Laura White	DHHS
Kelly Woodall	ASA-NC
BJ Miller	Moses Cone
Mari Waldron	Novant
Hugh Tilson	NCHA
Eric Gabriel	RHA
Allison Waller	Nelson Mullins
Matt Wolfe	Parker Poe
John Dunn	Governor's Office
Mary Broughton	ESUCP

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NAME	FIRM OR AGENCY AND ADDRESS
Gerry Akland	NAMI-Wake 1112 Old Faircloth Rd Knightdale NC 27545
Chris Kiricopkes	BCDC DD ADVOCATE & PROVIDER
LARRY BROWN	STEPS academy 704 493-3848
Paul Peters	Covenant Case management Services
Sally Cameron	NC Psychological Assoc
JACK REGISTER	Coalition - National Assoc. of Social Workers
Jennifer Mahan	ASNC
JILL HINTON	EASTERSEALS UCP
RICK CHAPPELL	RESIDENTIAL SUPPORT SERVICES - RAL, NC
Melanie Rash	NCCPPR
Robert Morrow	Raleigh Hospital

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NAME	FIRM OR AGENCY AND ADDRESS
Michael Ramsey PCC	Allied Behavioral Mgmt 608 Pecan Lane Whiteville 28472 N.C.
GARY HARDY	NAMI-ORANGE COUNTY, CHAIRMAN ORANGE COUNTY, NC
Kris Horton	DHHS
Nicole Fisher	John Locke Foundation
Steve Jordan	DMHDDSAS
Beth Melcher	DHHS
Bill Scott	DHHS
George Cowan MD	N. Raleigh Psychiatry
Tim Patterson	The Arc of NC 217 N Main St Ste 100 Tarboro NC 27886
Nina Kalleh	The Arc of NC 946 X West Andrews Ave Henderson, NC 27536
Cyndy Grant	NCMS