North Carolina Department of Health and Human Services

Pat McCrory
Governor

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

October 1, 2013

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601

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

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Session Law 2012-128, Section 2, requires the North Carolina Department of Health and Human Services to study local management entity (LME) efforts and activities to help reduce the need for acute care inpatient admissions for patients with a primary diagnosis of a mental health, developmental disability or substance abuse disorder and the number of patients requiring three or more incidents of crisis services. Pursuant to the provisions of law, the Department is pleased to submit the attached report. This quarterly reporting requirement is due to the Joint Legislative Oversight Committee on Health and Human Services on October 1, 2013.

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

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

Sincerely,

Aldona Wos, M.D.
Secretary

AW:mth

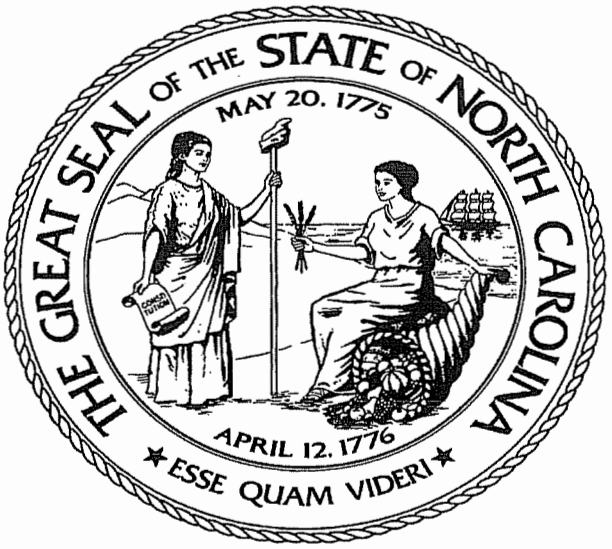
Attachment

cc: Adam Sholar
Matt McKillip
Dave Richard
Courtney Cantrell
Pam Kilpatrick
Legislative Library (one hard copy)
Denise Thomas
Patricia Porter
Sarah Riser
Kristi Huff
Susan Jacobs
Brandon Greife

Mental Health Crisis Management Report

March 2013 – May 2013: Status Report

Session Law 2012-128 (Section 2)



October 1, 2013

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

Session Law 2012-128 (Section 2)

Mental Health Crisis Management Report

March 2013 – May 2013: Status Report

October 1, 2013

Report 4 in a series of 5

Introduction

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

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

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

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

Section One: State-level Efforts and Activities

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

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

Community-based Non-Hospital Services:

- 11 LME 24-hour crisis response Call Centers
- 48 Mobile Crisis Management (MCM) teams
- 26 Facility Based Crisis (FBC) programs
- 16 Non-Hospital Medical Detox agencies
- 6 Social Setting Detox agencies.
- 78 Walk-In Crisis and Immediate Psychiatric Aftercare clinics (WICs
- 6 NC START (Systematic, Therapeutic, Assessment, Respite and Treatment) teams and twelve Crisis Respite beds.
- Crisis Intervention Team (CIT) trained officers in each LME catchment area;

Community-based Psychiatric Inpatient Services:

- Psychiatric inpatient beds total 2,022
  - Including 135 three-way contract psychiatric inpatient beds.

State Operated Services in Crisis Services Continuum:

- 873 State Psychiatric Hospital beds in three state hospitals
- 240 ADATC beds

Emergency Departments- 120 EDs serving behavioral health emergencies. Many EDs have developed specialized areas to care for behavioral health patients requiring extended stays due to lack of inpatient capacity.

Emergency Department Length of Stay Action Plan

In November 2011, the NC DMH/DD/SAS published a set of recommendations (http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf) in the

Emergency Department Length of Stay Action Plan that were developed by a large group of stakeholders and were intended to:

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

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

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

Efforts to Implement the ED Length of Stay Action Plan

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

- Working with NC DMA, NC DMH/DD/SAS has revised the service definition of FBC programs (see recommendation #7 on page 7), which serves adults, so as to strengthen and increase the involvement of licensed professionals and the quality of clinical services, to increase 24/7 access to the service, and ensure that all of these facilities are capable of admitting and treating persons who are under involuntary commitment. UPDATE: NC DMA is currently analyzing the state plan and determining the feasibility of releasing the new definition, if it is cost-neutral.

- NC DMH/DD/SAS and NC DMA have also developed a new service definition, FBC for children and adolescents (see recommendation #7 on page 7).

UPDATE: NC DMA is currently analyzing the state plan and determining the feasibility of releasing the new definition, if it is cost-neutral.

- NC DMH/DD/SAS has worked with multiple stakeholders, including LMEs and NC DMA, to revise the elements of the individualized Crisis Plan (see recommendation #2 on page 6), which is a component of the Person Centered Plan. UPDATE: The revised Crisis Plan template was released as Communication Bulletin # 139: Person-Centered Crisis Prevention and Intervention Plan and Crisis Plan on September 23, 2013 and went into effect on October 1, 2013.

- NC DMH/DD/SAS, with NC DHHS leadership and involvement of East Carolina University, the University of North Carolina at Chapel Hill, the Albemarle Hospital Foundation, and the North Carolina Hospital Association, has been pursuing the development of an expanded telepsychiatry consultation initiative in EDs (see recommendation #19 on page 7). UPDATE: A draft plan for a statewide telepsychiatry program has been prepared for submission to the NC General Assembly by August 15, 2013.

- NC DSOHF has developed plans to add 124 beds at Cherry Hospital after its new facility opens in 2013, and an additional 19 beds at Broughton Hospital, which are pending approval by the North Carolina Office of Budget and Management (OSBM) (see recommendation #19 on page 7). UPDATE: Cherry Hospital is expected to be completed in the summer of 2013. OSBM has not released the funds for the additional beds at Broughton Hospital.

- NC DMH/DD/SAS has inserted draft language into its 2014 contract with the LME-MCOs with respect to strengthening care coordination activities for persons who seek contract would require the LME-MCOs to provide care coordination for persons who are at risk for crisis, including those who miss scheduled appointments and who are at risk for inpatient or emergency treatment, or who use a crisis service as the first service, or who are discharged from inpatient psychiatric hospitalization, a Psychiatric Residential Treatment Facility, or FBC service. Care coordination activities would include linking the individuals to appropriate services, ensuring that they continue to be engaged with needed treatment and supports, monitoring hospital admissions, developing crisis plans for those individuals, and discharge planning to appropriate dispositions and coordinating access to follow-up services and supports.

- NC DMH/DD/SAS collaborated with the North Carolina chapter of the National Alliance for Mental Illness (NC NAMI) and several law enforcement agencies, to revise the Basic Law Enforcement Training (BLET) for law enforcement officer candidates and developed an in-service training for current law enforcement officers (see recommendation #8 on page 7); UPDATE: The BLET and the mental health in-service training have been implemented.

- NC DMH/DD/SAS has developed a protocol for the MCM team's role in the EDs, which would require the teams' licensed professionals and the psychiatrists to take an active role in providing consultation to the ED physicians regarding disposition (i.e., whether the individual requires inpatient hospitalization or referral to a less restrictive service in the community) (see recommendation #6 on page 7). This protocol could be inserted into the MCM service definition in a future revision.

- In March 2012, at the request of NC DMH/DD/SAS Medical Director, LMEs identified LME points of contact for local EDs, and enlisted the NC Hospital Association to distribute that contact list to all EDs (see recommendation #17 on page 7). UPDATE: Following the recent mergers of LMEs into LME-MCOs, the contact lists have been updated.

- In calendar year 2012, with funding appropriated by the NC General Assembly, NC DMH/DD/SAS increased the number of three-way inpatient hospital beds available in community hospitals from 121 to 135 and extended a contract to one additional hospital (see recommendation #19 on page 7). UPDATE: 2013-2015 State Budget appropriated an additional $9 million for three-way inpatient beds, $2 million of which will be used to pay a higher daily rate for persons with higher level acuity.

- In SFY 2013, NC DMH/DD/SAS hired a Housing Administrator who provides state-level guidance to the LME Housing Coordinators (see recommendation #21 on page 7). These positions all focus on helping homeless people, who receive or need mh/dd/sas, to access desperately needed housing stock. The lack of housing has been identified as one major factor in driving high admission rates in EDs.

- LMEs are required, by the current contract with the NC MH/DD/SAS, to hire housing coordinators to increase access to housing and support services for the people receiving MH/DD/SA services (see recommendation #21 on page 7).

Section Two: Statewide Data on Crisis System Performance Monitoring

Information currently accessible that is related to the health of the crisis system for persons with MHDDSA diagnoses indicates that it is unclear whether efforts to improve the system have begun to pay off. Wait times for persons needing admission to State Hospitals and community psychiatric hospitals continue to be high. Proportions of hospital Emergency Department (ED) admits with a primary MH, DD or SA diagnosis have shown some fluctuation, with an increase from SFY 2009 through SFY 2012, but a possible downward trend beginning in SFY 2013. State Hospital bed days utilized overall remain steady, and rates of State Hospital bed day utilization continue to vary by LME/MCO.

The NC Hospital Association (NCHA) collected information from about 40% of NC hospital Emergency Departments on persons with mental health and substance abuse disorders in 2012, including wait times by disposition. The NCHA data for 2012 shows an average wait time in EDs for persons admitted to community hospital psychiatric beds as 24.5 hours, a 73% increase over a one month study done in the November 2010 study which showed an average of 14.2 hours. The average wait time for persons subsequently admitted to State Hospitals was just over 78 hours, or 3 ¼ days (n=350). This was almost a threefold increase over the November 2010 study, which had a State Hospital average wait time of 26.6 hours (n=227). The 2012 wait times are corroborated by data kept by the State Hospitals, which showed an average wait time to admission for referrals from EDs of 77.7 hours (n=2,025). The State Hospital database is available through half of 2013, and the average wait times show an increase to almost 85 hours. Wait times for persons referred from Crisis Centers (as opposed to EDs) is similar – almost 80 hours for both 2012 and the first half of 2013.

The total number of persons presenting to EDs with MHDDSA diagnoses is available from the NC DETECT system. This data is inclusive of all persons, regardless of diagnosis or payer. Analysis of persons presenting with a primary MH, DD or SA diagnosis relative to total numbers of persons admitted to the ED are conducted quarterly. Between SFY 2009 and SFY 2012 there was an increase of 9.8% in total numbers of persons admitted to the EDs (see Table 1 on page 13). The percent of these individuals who presented with a primary diagnosis of MH, DD or SA varies between 3.2% and 3.5%. SFY 2012 shows an increase of 8% in the proportion of overall admission or admits that had a primary MHDDSA diagnoses; however, the first half of SFY 2013 displays a slight decrease. **If the SFY 2013 rate of primary MHDDSA admits as a percent of overall admits continues as it did the first half of the year (3.3%), then this will reflect a slight downward trend from SFY 2012, and be more in line with SFY 2009 and SFY 2010 (3.2%).**

Table 1
Statewide ED Admission Trends

Number of Admissions for Individuals with Primary MH/DD/SA Diagnosis

		SFY					
Disability	AgeGroup	FY09	FY10	FY11	FY12	FY13 (partial)	FY12 % Change from FY09
⊟Developmental Disabilities	Adult	445	649	667	657	325	47.6%
	Child	303	531	510	598	308	97.4%
Developmental Disabilities Total		**748**	**1,180**	**1,177**	**1,255**	**633**	67.8%
⊟Mental Health	Adult	87,553	92,104	99,124	101,549	50,641	16.0%
	Child	10,585	11,357	11,989	12,865	6,155	21.5%
Mental Health Total		**98,138**	**103,461**	**111,113**	**114,414**	**56,796**	16.6%
⊟Substance Abuse	Adult	32,464	34,102	38,266	39,976	20,058	23.1%
	Child	864	892	966	1,016	537	17.6%
Substance Abuse Total		**33,328**	**34,994**	**39,232**	**40,992**	**20,595**	23.0%
Total MHDDSA ED Admits		**132,214**	**139,635**	**151,522**	**156,661**	**78,024**	18.5%

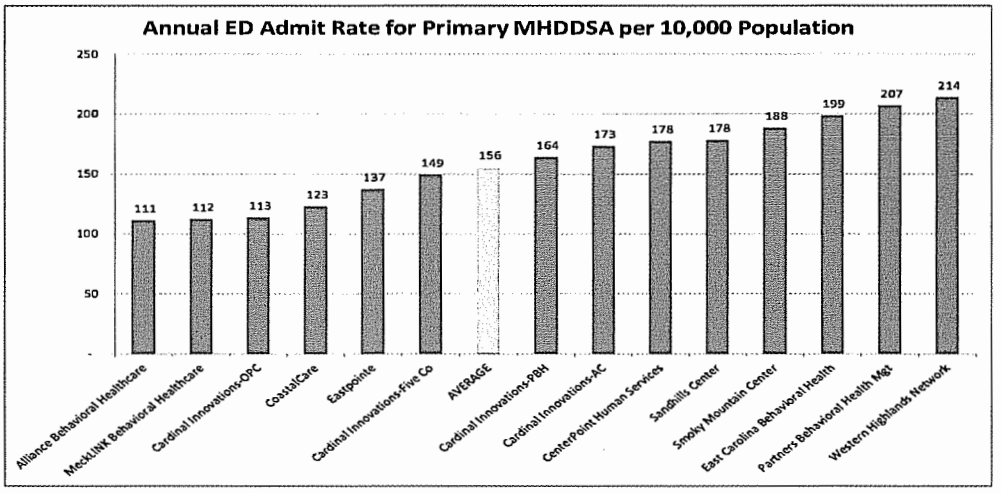
All ED Admissions (Any Diagnosis)

	Sum of Visits SFY						
	AgeGroup	FY09	FY10	FY11	FY12	FY13	FY12 % Change from FY09
All ED Admissions (Any Diagnosis)	Adult	3,313,760	3,456,566	3,607,885	3,709,988	1,931,784	12.0%
	Child	805,497	841,638	810,008	811,435	441,587	0.7%
	Grand Total	4,119,257	4,298,204	4,417,893	4,521,423	2,373,371	**9.8%**
Primary MHDDSA as % of All ED Admissions		**3.2%**	**3.2%**	**3.4%**	**3.5%**	**3.3%**	**8.0%**

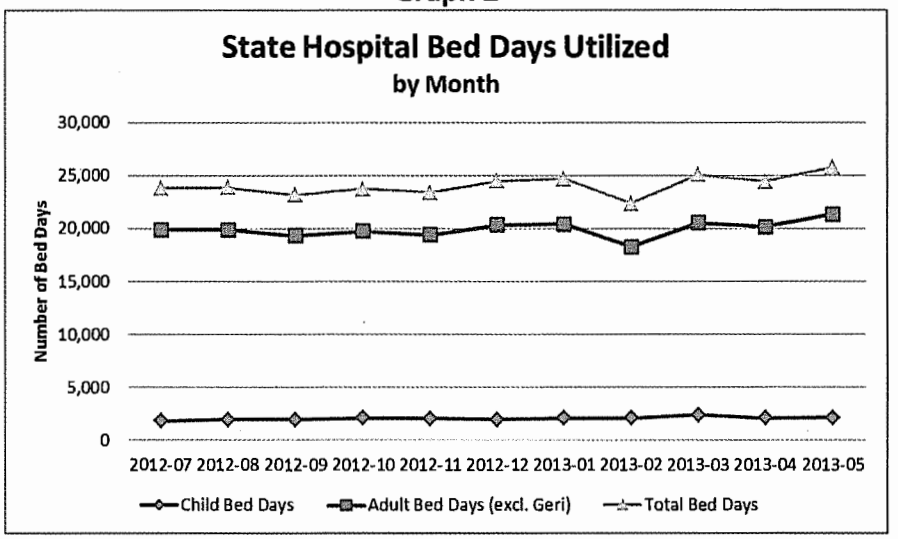
Source: NC DETECT

The ED Admit rate by LME/MCO catchment area varies significantly. Graph 1 (on the next page) displays the ED admit rate for persons with a primary MH, DD or SA diagnosis. Those with the highest rates are almost double the LME/MCO catchment areas with the lowest rates. LME/MCO influence on the numbers of persons with MHDDSA diagnoses who present in EDs may vary depending on the accessibility of walk-in crisis centers relative to EDs, and the public's and law enforcement's knowledge of these resources.

Graph 1

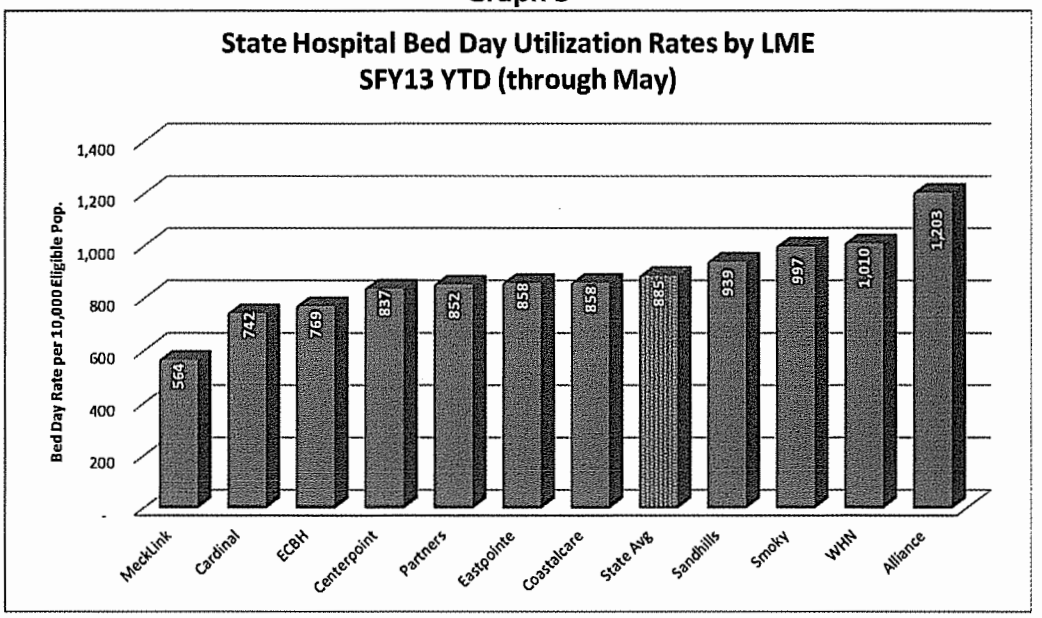


Graph 2



The utilization of State Hospital beds over SFY 2013 has stayed relatively steady (see Graph 2, above). Complete data on community hospital bed day utilization is not available due to the issues described on the next page, so overall utilization of psychiatric inpatient care cannot be currently shown.

Graph 3



State Hospital bed day utilization rates by LME/MCO vary considerably across the state (see Graph 3). When reviewing the State Hospital inpatient psychiatric bed day utilizations rates, it is important to consider that LME/MCO catchment areas differ in the amount they expend for community hospital psychiatric inpatient services, which is not

shown here. Also, LME/MCO catchment areas differ considerably in the amount of local dollars available for inpatient services, with Mecklenburg and Wake (Alliance Behavioral Healthcare) counties making significant contributions. There has historically been a higher utilization of State Hospitals in the counties directly surrounding the State Hospital locations. An additional consideration is that Cardinal Innovations Healthcare Solution's PBH region State Hospital funding is managed directly by the LME/MCO; funding for all other State Hospital catchment areas is managed by the State Hospital, not the LME/MCO.

The data presented above only gives a partial picture of the status of the crisis service system in North Carolina. Monitoring statewide and LME/MCO success at reducing repeated crises and utilization of inpatient level of care requires full and accurate reporting of crisis and inpatient service events. This has historically been achieved through the claims reporting systems for Medicaid and State-funded MHDDSAS services. However, with the transition of LMEs to Medicaid Waiver Managed Care Organizations (MCOs), mergers between LME/MCOs, and implementation of new IT claims systems at the LME/MCOs, the claims data currently available to the State is too incomplete for accurate reporting. Once LME/MCOs have been able to work through IT system issues with reporting to the new NC TRACKS system, data to support this monitoring will become available again. With claims data, rates of persons with three or more crisis events will be available by LME/MCO and statewide, both comparative and trends over time. Additionally, claims data will provide community psychiatric inpatient unit utilization rates and trends, which will allow for a more robust and comprehensive report on the crisis system.

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

The Section follows with the LME-MCO reported progress made with respect to the goals of the efforts and activities.

A short outline of the main activities of each LME-MCO is presented, followed by the goals and progress of the main activities as reported by the LME-MCOs. These activities correspond to the two priorities, reducing inpatient utilization and repeated crisis services usage. All individual LME Quarterly Reports that were submitted are also attached to this report. Please note that many of the identified efforts and activities to address one priority will likely impact the second priority as well.

Alliance Behavioral Healthcare

Alliance has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Decrease use of Emergency Room Admissions by co-locating Care Coordinators in EDs and implemented at least two other quality improvement action steps.
        i. Progress: Progress between 4/1/13 and 6/25/13 is still minimal, with Alliance preparing to merge with Cumberland County on July 8th. With a 6 month lag in data report claims from the hospitals, data received thus far show a slight increase. There were

approximately 13 less ED admissions for primary MH/DD/SA diagnoses in FY12,Q1 (5097) than (5110) in FY13,Q1.

ii. Progress: As the new contractor for the Wake Crisis and Assessment Facility, UNC opened WakeBrook Recovery Center on May 8th; scheduled to open 16-inpatient bed unit July 1st. Crisis beds expanding: adding 2 patients to overflow area. Alliance Care Coordination and QM staff is working with UNC to track aftercare and follow-ups. Meanwhile data elements are being streamlined and standardized for Alliance in order to improve the utilization of data collected (in addition to claims).

iii. Progress: Co-location of care coordination staff at Duke, Johnston Memorial, Wake Med, and UNC has proven effective. Via collaboration there has been a noticeable reduction in ER use of high utilizers. Data regarding high utilizers "pilot" program will be available in the next quarter report.

iv. Progress: Care Coordination staff receive daily alerts from EDs and utilize to update and/or add "flags" (i.e., Jail, Hospitalized, ED pilot, Care Coordination; High Risk MH/SA) to consumers in the Alpha data system. (Ex: 24 out of 25 of Durham's Top 25 high utilizers receive Intensive Care Coordination thru Alliance). Data from Informatics System allows breakdown of ED visits to show Medicaid and Quadrant 2 (i.e., high MH/DD/SA complexity or risk and low physical health complexity or risk) consumers.

b. Goal: Meet with CIT partners to review policies, protocols, general orders, and anecdotal barriers and challenges (the completion date was January 1, 2013). Partners include county, city, and military law enforcement. Expand CIT training modules, and the number of CIT trainings, and implement a Community Paramedic Program to divert people from EDs.
    i. Progress: The Community Paramedic Program is having substantial success. In one year, CPP increased ED diversions resulting in 139 diversions out of 258 interactions; 14 hr. avg. at Wakebrook Crisis and Assessment Services (Wakebrook CAS) giving back 2200 bed hrs. to hospitals. Next step: CMS Innovations grant proposal.

ii. Progress: CIT training continually expanding in Cumberland, Wake and Johnston counties. Twenty-three percent of the sheriff's office, 61% of the police dept., 32% of county EMS telecommunicators, 100% of city telecommunicators, and 52% School Resource officers have been trained in Cumberland County.

iii. Progress: Durham County has three MH 101 classes scheduled for the Department of Social Services 7/13-8/13. Future courses will be offered to foster care and public school system.

iv. Progress: Specialized curriculum developed for Fire Department and EMS personnel.

v. Progress: All of patrol division in Cumberland County is mandated to be CIT trained.

vi. Progress: Trainings offered include: MH/SA; PTSD; trauma; I/DD; meds; and Overall Consumers' Interactions with the Criminal Justice System.

c. Goal: Increase utilization of facility based and mobile crisis services across the four counties to divert people from inpatient care.
   i. Progress: To better integrate mobile crisis into the crisis continuum, Cape Fear Valley hospital is working on protocols to allow them access to the ED for assistance. Formal linkage agreements are being finalized.

   ii. Progress: Durham Center Access (DCA) monthly admissions have decreased from 169 in FY12 to 150 in FY13. There were 159 less consumers presenting at DCA in FY13 Q3 in comparison to 3rd Qtr. FY12. STS utilization has also decreased from 100% in FY12 to 76% in FY13. Alliance QM is researching and addressing issues related to lower utilization.

   iii. Progress: Wake's MCM provider has expanded to 5 staff in addition to assist WakeBrook CAS with the reduction of diversions. MCM provider reported total of 306 requests for 1st and 2nd Qtr. of FY13.

   iv. Progress: Cumberland County is increasing utilization of both MCM teams and integrating effectively with first responders and CIT

officers. Linkage agreements have been signed with MCM teams and staff is in process of obtaining ID badges from hospital HR department.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Increase availability and use of alternative crisis assessment and referral by using a critical case conference model, care coordination for persons identified as high risk/high cost, and developing a walk-in assessment center in Cumberland County.
        i. Progress: Inter-disciplinary staffing occur a minimum of monthly with CCNC. Specific cases may be reviewed in smaller settings as necessary. CCNC has been incorporated into the staffing of cases approved for the community housing initiative of the DOJ Settlement Agreement. This has been instrumental in ensuring true integration of behavioral and primary health occurs prior to a patient leaving an ACH.

        ii. Progress: Cumberland County Management and Commissioners have a tentative time period of operation as October 2013 for the walk in assessment clinic at Roxie Avenue Center.

    b. Goal: Increase utilization of first-responder activities of clinical home providers to de-escalate crises before they require higher cost crisis services.
        i. Progress: Alliance QM staff will begin testing all network providers' first responder capabilities starting in July. Results, by provider, will be shared with Provider Network staff for technical assistance. First Responder Guidelines were published on Alliance's website and emailed to Provider Listserv in early April.

    c. Goal: Reduce psychiatric hospital readmissions via care coordination.
        i. Progress: For first quarter of FY13 three of four counties have met the goal of 7% or less for state psychiatric readmissions within 30 days; None have met the 17% or less goal for state psychiatric readmissions within 180 days; and all four are below or near the state average of 11% for community psychiatric readmissions within 30 days.

Cardinal Innovations Healthcare Solutions

Cardinal Innovations has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: To improve timeliness of linking consumers to necessary services and supports.
        i. Progress: Redesign of the inpatient UM team to collect discharge information during the review process.

        ii. Progress: Began educating acute inpatient providers by doing onsite visits and our education includes emphasis on discharge procedures. Procedures include: completing discharge summaries with appointment information.

        iii. Progress: During this reporting period, consumer transportation was another focus of the CI Team. Enhancing some rates for the Comprehensive Community Clinics (CCCs) in order to cover the

cost of transportation for high risk/high use consumers is being considered.

iv. Progress: The CI Team is moving on increasing the use of peer supports/family advocates in pre-crisis situations.

v. Progress: CI continues monitoring medication adherence. A series of pharmacy utilization reports, based on CCNC as well as CI data, is provided by Care Management Technologies (CMT) are used to identify non-adherence patterns. This analysis is shared with Care Coordination and/or provider(s), as indicated.

b. Goal: To improve quality of interactions between law enforcement and MH/IDD/SA consumers in crisis and use of emergency behavioral health care services in lieu of ED.
   i. Progress: CIT TRAININGS:
      a. Five County:
         i. April 29-May 3, 2013 (9 trained)
         ii. CIT Partnership Meetings: April 23 and May 14, 2013

      b. Orange, Person, & Chatham (OPC):
         i. April 3rd-Community Relations Specialist attended the state meeting related to orienting new individuals to CIT
         ii. April 16th-Community Relations Specialist led the quarterly CIT Partnership implementation committee meeting at the OPC office

      c. Piedmont:
         i. April 22-26, 2013 (26 trained)
         ii. May 13-17, 2013 (28 trained)

      d. April 3rd-Community Relations Manager attended the state meeting related to orienting new individuals to CIT and reviewing policy and procedures

      e. The CIT Steering committee met on April 9th

f. June 27th-Community Relations Manager will attend the NC CIT Committee Meeting in Raleigh.

Data on hospital admissions in Cardinal areas, March 2013 - May 2013

	March - May 2013
Admits	938
Eligible Population	583,058
Admits per 10,000	16.1

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

        ii. Progress: The dedicated Emergency Services Coordinator continues to contact emergency departments daily and to work with ED staff and mobile crisis teams to propose alternative levels of care as opposed to admission to IP or crisis facilities.

        iii. Progress: During this reporting period, the Cardinal Innovations (CI) team decided to expand the availability of Crisis Intervention Training (CIT) to Magistrates, 911 personnel and first responders such as Fire, Emergency Medical Services, etc. Another training that will be offered is 'Mental Health First Aid'.

        iv. Progress: The CI team will also continue to monitor and track, in conjunction with Care Coordination as well as Utilization Management, high risk/high use consumers across the service continuum.

v. Progress: Additionally, an automated report, capturing all consumers with 3 or more crisis episodes in a 12 month period, is being tested and will be in production as soon as possible. This will reduce system search time and target those specific consumers requiring more focused Care Coordination and /or provider monitoring.

vi. Progress: Another initiative that will soon be implemented is the Critical Case Conference. This very focused case review methodology, involving UM, Care Coordination, providers, Mobile Crisis Teams and Quality Management among others, will specifically target the 'top 20' consumers involved with crisis services (ED, IP, MCM, FBC, Walk-in Crisis Unit, etc.) and assure service linkages and coordination. The intervention will then be examined for reductions in crisis usage.

vii. Progress: The CI Quality Improvement Department is developing a provider performance report card that will feature crisis system usage as an element.

b. Goal: To improve transitional care upon notification of discharge from local/state hospital for individuals with Medicaid and correct contact information.
    i. Progress: Upon telephonic review the Care Managers request updated address and phone information for the consumer. Reporting Period: March 2013 – May 2013
        a. 15% of individuals received Transitional Care Visit within 72 hours with another 8% receiving the Transitional Care Visit but after the 72 hrs. timeframe.

    ii. Of the individuals receiving no Transitional Care Visit, correct contact information was not available for 37%

    iii. Note: This goal is being deleted since an internal work group has re-assessed, and criteria for both Medication Reconciliation and Care Coordination referrals are being re-evaluated.

Data on 3+ crises in the Cardinal areas during 12 months preceding May 2013

Catchment	Total Population	Estimated Uninsured Population	Medicaid Eligible	Estimated Eligible Population (Medicaid + Estimated Uninsured Population)	# Clients with 3+ Crisis Events/Year	3+ Crisis Events per 10,000 Population	3+ Crisis Event rate per 10,000 Eligible Population
PBH	753,566	126,174	221,976	348,150	434	5.8	12.5
AC	176,521	31,491	33,845	65,336	58	3.3	8.9
OPC	244,317	41,939	28,181	70,120	92	3.8	13.1
FC	239,029	44,513	54,939	99,452	198	8.3	19.9
Total	1,413,433	244,117	338,941	583,058	782	5.5	13.4

CenterPoint Human Services

CenterPoint has been focusing its efforts on

- care coordination in EDs and psychiatric inpatient settings,
- peer support specialists to guide persons who have been readmitted to inpatient care to prevent future readmissions,
- collaborating with CCNC to facilitate integrated care and effective transitional care from inpatient settings, for persons identified as being at high risk and high cost
- increasing use of FBC,
- increasing effective use of community based services (non-crisis), and
- quality improvement activities to enhance outcomes of community based services (non-crisis).

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Via care coordination, use of peer support to identify reasons for hospital readmission, and collaboration with CCNC, LME-MCO will meet established readmission benchmarks for both State and local facilities. Identify precipitating factors that lead to admission and/or readmission to inform development of interventions.

i. Progress: Protocol implemented to track precipitating factors for persons who have been re-admitted to inpatient hospitalization, and contacts made by care coordinators with consumers.

ii. Progress: Peer Support staff and hospital liaison staff are continuing to meet with consumers who are readmitted and are tracking reasons for readmission. We are analyzing trends in reasons given for readmission.

iii. Progress: ED care coordinators continue to visit two largest EDs in catchment area on a daily basis. The ED care coordinators are working on ways to increase the communication between the two major EDs in Forsyth County. The ED care coordinators continue to have daily contact with all other ED departments in the CPHS catchment area.

iv. Progress: Care Coordinators continue to follow up with individuals who do not attend their aftercare appointment. For individuals who do not have working phone numbers care coordination staff will send letters and make "cold call" home visits. Care coordination is tracking reasons given for non-compliance with aftercare appointments and working to remove barriers.

v. Progress: Continue to collaborate with Northwest CCNC and local hospitals to identify trends in ED utilization. Tracking patients who use both the Wake Forest and Forsyth EDs, and overall ED utilization trends. Working with both local CCNC networks on possibly implementing the ProAct model.

vi. Progress: The increased number (three) of hospital liaisons has improved our ability to assist with discharge planning with hospitals outside our catchment area. Increased the number of days hospital liaisons visit Central Regional Hospital and a local substance abuse treatment facility.

vii. Progress: Care coordinators and integrated care specialists continue to meet bi-weekly to collaborate on challenging cases. The CCNC network which covers Rockingham County (P4CC) expressed an interest in providing funding for a CCNC nurse to be

imbedded in the care coordination department. The efforts to hire a nurse are currently underway.

viii. Progress: Two of three measures for this goal were met in FY13,Q2. The percent of persons discharged from a state psychiatric hospital who are readmitted within 30 days of discharge equaled 5%. The percent of persons whose inpatient care was paid by Medicaid and who discharged from a community hospital psychiatric bed, who are readmitted to any community hospital psychiatric bed within 30 days following discharge equaled 7%. Both measures were met. The percent readmitted within 180 days of discharge equaled 18% and was 1% higher than the stated target of 17%.

b. Goal: Determine feasibility of developing a local Facility-Based Crisis Center (FBCC) for ED diversion and provision of in-patient care in a community setting.
   i. Progress: Potential partners and supporters of the FBC have been identified.

   ii. Progress: Meetings have been held approximately every 6 weeks with the major providers of emergency services, including Wake Forest University Baptist Medical Center and Forsyth Medical Center.

   iii. Progress: Current FBC providers are also contributing to the discussions with information about service delivery and utilization experience.

   iv. Progress: Three potential sites have been identified. Initial meeting with architecture firm has been held to determine feasibility of potential sites.

   v. Progress: EMTALA and regulatory issues have been clarified.

   vi. Progress: Actively participating in the Forsyth County Behavioral Health Collaborative meetings involving the NW CCNC, Wake Forest University Baptists Medical Center (WFUBMC) and Forsyth Medical Center. These have produced good dialogue

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

vii. Progress: Further evaluation demonstrates that one of the three potential sites is suitable. This site is owned by Forsyth County. We have approached the county about the long term use of this building and requested that it continue to be used for the provision of behavioral health services. We have contacted a behavioral health planning and consulting company to assist in the next business planning stages. We expect to contact potential grant funding agencies over the next two quarters, with submission of grant requests by the first grant application cycle in 2014. Once a site and start-up funding are secured we will proceed with construction bids and a RFP to providers.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Utilize Care Management Technologies (CMT), a predictive modeling technology system, to assist in predicting crisis engagement based on patterns and trends in data specific to quality of care indicators.
        i. Progress: Care coordination staff continues to utilize CMT when receiving Care coordination referrals to gain overall treatment knowledge of the consumer. For active care coordination consumers, care coordinators are using CMT to check medication and prescriber history.

        ii. Progress: Care coordination continues to crosscheck consumers flagged as "high risk" by CMT's QI indicators against the top 20% high risk/high cost report.

        iii. Progress: We are utilizing CMT to help with the identification of consumers who fit criteria for PROACT, a proposed collaboration with CCNC for enhanced transitional care coordination. This is helping us review the frequency and intensity of services and the capacity CPHS has for the program. The PROACT priority list creates a watch list of patients with behavioral health diagnoses who may benefit from high intensity care coordination when they do engage with crisis services. CMT has been helpful in clarifying some of the population characteristics and the resources that will be required to make a significant impact on quality of life and

decrease unnecessary utilization of inpatient and emergency services. It is hoped that this will result in decreased utilization of both medical and behavioral emergency service utilization. CMT has also developed a report listing patients who have been prescribed an antipsychotic medication and who are likely to have a SMI and/or be at risk for metabolic consequences of antipsychotic use. This includes patients being seen by behavioral or medical providers. In collaboration with CCNC we are developing an integrated care approach to improving the medical monitoring and care of this population at high risk for medical complications.

b. Goal: Implement state-wide initiative to expand evidence-based, high-fidelity Assertive Community Treatment (ACT) Team services in collaboration with NC ACTT Coalition & Duke University.
    i. Progress: The NC ACTT Coalition is meeting regularly with teams from across the state (East, West & Central) participating.

    ii. Progress: The ACTT fidelity instrument to be used has been identified. The ACTT service definition is out for public comment and fidelity reviews cannot be conducted until the definition is approved.

    iii. Progress: MCO staff is registered to attend the Tool for Measurement of ACT (TMACT) training in March. The goal is to receive an overview of ACT implementation within the framework of the USDOJ settlement agreement, information on ACT fidelity screening plans and in-depth review of the TMACT fidelity scale.

    iv. Progress: Quality Management staff has identified ACT and CST providers in the network to track specific consumer outcomes. These outcomes are focused on quality and recovery, e.g. adult hospital readmission rates and the average length of stay in each specific service.

    v. Progress: Quality Management staff will provide training and technical assistance regarding the tracking of these outcomes. The collected outcomes will be compiled to create an annual report to be shared with stakeholders to assist in developing future benchmarks and targets.

CoastalCare

CoastalCare has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:

    a. Goal: Via training and education efforts for the community and consumers, LME-MCO will enhance access to and utilization of alternative resources for persons seeking crisis response services instead of receiving care in the Emergency Department.
        i. Progress: The Crisis Consortium meetings have resumed during the fourth quarter, which include community partners such as: magistrate, police, sheriff, EMS, hospital, primary health, and school representatives. The purpose of these meetings is to ensure up to date communication sharing about community resources and to improve services in the catchment area.

ii. Progress: Community Development Department completed the following as of May 2013: trained 17 new peer support specialists, provided volunteer support services to 99 consumers, created 6 peer lead disability support networks, provided Free Life Skills classes to 85 individuals, facilitated participation in NAMI classes for 90 individuals, developed relationships with 4 new employers that will be utilized to hire consumers, added 26 housing units, and trained 22 advocates.

iii. Progress: The team has identified potential crisis response center locations that would be the highest priority in our catchment area. This will be assessed in further detail once more ongoing data is collected and analyzed and the root cause analysis is completed to better determine what additional crisis centers are needed at this time. See the attached document (CoastalCare Provider Location Maps)

iv. Progress: Marketing strategies have been identified and potential strategies will be implemented during the first quarter of fiscal year 2014 once service gaps are identified as a result of the Root Cause Analysis.

b. Goal: Using health promotion education, LME-MCO will increase linkages to primary care physicians for persons with a primary diagnosis of MH/DD/SA.
    i. Progress: According to the Community Systems Progress Report FY 12-13 Q2 CoastalCare was at 92% and FY 12-13 Q1 CoastalCare was at 91% in the category of medical care coordination, which surpassed the state average. CoastalCare received training on the ProAct Model and is currently working with CCNC on integrated care.

c. Goal: Develop a comprehensive, routine and crisis services continuum of care which is easily accessible/available for persons with a primary diagnosis of MH/DD/SA.
    i. Progress: QIP team has identified the services that are available within the catchment area as well as service gaps. See the attached document (CoastalCare Provider Location Maps)
    ii. Progress: CoastalCare is actively recruiting CCNC representatives for membership in the QIP and CoastalCare continues to partner

with CCNC in meeting behavioral health and medical needs of consumers with a primary diagnosis of MH/IDD/SUD. CoastalCare has been holding High Risk/High Cost meetings monthly which serve as clinical staffings for specific consumers. These meeting include CCNC, service provider, Care Coordinator, and Medical Director.

d. Goal: Using care coordination and collaborating with CCNC and other partners to develop protocols for ED diversion, LME-MCO will decrease inpatient readmission rates for persons with a primary diagnosis of MH/DD/SA who are admitted to the Emergency Department and State Psychiatric Hospitals.
    i. Progress: Ongoing data is being collected for Inpatient Readmissions for persons with MH/IDD/SUD who were admitted to the Emergency Department and State Psychiatric Hospitals. CoastalCare is working closely with hospitals in the network to link consumers that are discharged from the Emergency Department and State Psychiatric Hospitals with a Care Coordinator upon discharge.

    ii. Progress: CoastalCare has been holding High Risk/High Cost meetings monthly which serve as clinical staffings for specific consumers. These meeting include CCNC, service provider, Care Coordinator, and Medical Director.

    iii. Progress: QIP team now includes a CFAC representative, two representatives from hospitals in the network, a service provider representative, and the QIP team continues to work towards including a representative from CCNC.

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

    a. Goal: Linking high risk persons with MH/DD/SA to community based service providers in order to reduce inappropriate utilization of crisis services.
        i. Progress: CoastalCare identified the number of persons with MH/IDD who received 3 or more crisis services within a 12 month period that are currently receiving Care Coordination. (SUD

consumers are unable to be tracked due to confidentiality laws-data from Medicaid Paid Claims 1/12-12/12)

ii. Progress: CoastalCare is currently working toward linking 100% of consumers utilizing crisis services with Care Coordination.

iii. Progress: CoastalCare has been holding High Risk/High Cost meetings monthly which serve as clinical staffings for specific consumers. These meeting include CCNC, service provider, Care Coordinator, and Medical Director.

iv. Progress: CoastalCare also holds monthly Crisis Consortium meetings with community stakeholders to ensure up to date communication sharing about community resources and to improve services in the catchment area.

b. Goal: Providing high risk persons with MH/SA/DD the resources needed (care coordination, access to evidence-based and evidence-informed practices) to manage their MH/DD/SA symptoms through non-crisis services.

i. Progress: CoastalCare has been holding High Risk/High Cost meetings monthly which serve as clinical staffings for specific consumers. These meeting include CCNC, service provider, Care Coordinator, and Medical Director. CoastalCare also holds monthly Crisis Consortium meetings with community stakeholders to ensure up to date communication sharing about community resources and to improve services in the catchment area.

ii. Progress: QIP team analyzed the data and a result was the team determined gaps in the reporting. There was a question about the reliability of the data, the QIP team is assessing data collection methods, and will validate the data against Paid Claims once the information is available and complete. (See CoastalCare Provider Location Maps.)

iii. Progress: Community Development Department completed the following as of May 2013: trained 17 new peer support specialists, provided volunteer support services to 99 consumers, created 6 peer lead disability support networks, provided Free Life Skills classes to 85 individuals, facilitated participation in NAMI classes

for 90 individuals, developed relationships with 4 new employers that will be utilized to hire consumers, added 26 housing units, and trained 22 advocates.

c. Goal: Work with providers, using incentives, training, certification, recruitment and retention efforts, to ensure that there is a continuum of care and that adequate non-crisis services are easily accessible/available.
    i. Progress: QIP team reviewed maps of the catchment area and identified service gaps. (See CoastalCare Provider Location Maps).

    ii. Progress: Community Development Department completed the following as of May 2013: trained 17 new peer support specialists, provided volunteer support services to 99 consumers, created 6 peer lead disability support networks, provided Free Life Skills classes to 85 individuals, facilitated participation in NAMI classes for 90 individuals, developed relationships with 4 new employers that will be utilized to hire consumers, added 26 housing units, and trained 22 advocates.

d. Goal: Create and enhance community resources/natural support network for persons with MH/DD/SA.
    i. Progress: Community Development Department completed the following as of May 2013: trained 17 new peer support specialists, provided volunteer support services to 99 consumers, created 6 peer lead disability support networks, provided Free Life Skills classes to 85 individuals, facilitated participation in NAMI classes for 90 individuals, developed relationships with 4 new employers that will be utilized to hire consumers, added 26 housing units, and trained 22 advocates.

    ii. Progress: CoastalCare is actively developing services within the network to address consumers' needs, including peer supports. QIP team is discussing the possible need to build reports to track data.

e. Goal: By ensuring that providers develop detailed, person-specific crisis plans, LME-MCO will decrease the number of times that persons with MH/DD/SA who have crisis plans utilize crisis services.
    i. Progress: Goal will begin during the first quarter of fiscal year 2014.

East Carolina Behavioral Health

East Carolina Behavioral Health has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:

    a. Goal: Reduce ED admissions for consumers that are currently being served by our provider network by providing technical assistance to providers on first responder requirements and accessing MCM.
        i. Progress: The number of ED Admissions (duplicated count) decreased by 35% from the previous quarter. There was one provider that accounted for 25% of the total ED admissions during this quarter (and for high numbers last quarter). Technical assistance was provided for this provider. The barriers of the consumers who contributed to the ED admissions were discussed. The provider was also asked to continue educating all consumers to ensure the providers' crisis response protocol is followed. *(FOR THIS GOAL ONLY) The data provided is for the months of January through March to allow for the 90 day lag time that hospitals have to bill.*

    b. Goal: Care coordinators will review care alerts and/or Individual Health Profiles to ensure that individuals at high risk receive integrated care. [Goal to *Decrease inpatient readmissions by scheduling hospital follow-up appointments and medication management appointments before discharge* was changed this quarter due to difficulty with gathering the input. ECBH

Leadership and Executive Management along with front line staff and the Data Cross Functional Team spent significant time researching the trends of the Crisis Data and brainstorming additional interventions to reduce admissions. As a result, ECBH will continue our focus on integrated care with the addition of this new Goal.]

i. Progress: Report on progress will be provided next quarter, due September 30, 2013.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
   a. Goal: Care coordinators will utilize CMT Quality Indicators to improve medication adherence for individuals at high risk.
      i. Progress: For the second data set, intervention occurred with 82 individuals who were non-compliant with antipsychotic medications; 36 individuals became compliant. Thus, antipsychotic medication non-compliance was reduced by 44%.

      ii. Progress: It is well proven that medication is a very effective treatment to manage significant mental illness yet between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended. The costs are both personal and economic when someone not taking their medication goes into crisis and their health deteriorates necessitating emergency room and hospital involvement. Licensed clinicians at ECBH take a patient centered approach and explore with the person served the barriers and benefits to taking their medicine. Collaboration also occurs between the LME/MCO and the providers to encourage individuals to manage their mental illness. As a result, a significant impact is being made with individuals at high risk.

   b. Goal: Care coordinators will link individuals at high risk to natural supports & recovery services.
      i. Progress: Random sample of 150 individuals served; records reflect that 105 of the 150 (70%) were linked to recovery services and/or natural/community supports. ECBH values the real world connections for individuals and the benefit to being involved with our natural/community supports. Recovery principles such as hope and empowerment are emphasized as we connect individuals at high risk to others with lived experience so they can learn to manage their wellness.

ii. Progress: Strategies to increase the linking even further will be implemented this next quarter during clinical staffings, team meetings and in supervision with staff.

Eastpointe

Eastpointe has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Increase communication with hospitals, local authorities and providers and CIT training to increase use of MCM, WIC, FBC, NC START and crisis respite beds.
        i. Progress: Care Coordinators continue to telephone staff at local emergency room for daily census within the 12 counties.

        ii. Progress: Continue to meet monthly with three regional CCNC staff and one weekly phone conference within the network to discuss High Risk/High Cost enrollees.

iii. Progress: Continued collaboration with providers regarding follow up activities for enrollees with 3 or more crisis.

iv. Progress: Four CIT Trainings conducted throughout the catchment area for a total of 46 officers.

v. Progress: MCO Medical Director met with walk- in clinics throughout the catchment area.

vi. Progress: MCO personnel continue to meet with local hospitals to discuss individuals with high readmission rates.

vii. Progress: MCO personnel consulted with walk-in clinics regarding plans for reducing readmission rates.

viii. Progress: Maintain current Performance Improvement Project (PIP) to decrease state psychiatric hospital 30 day readmissions for high risk members.

b. Goal: Increase community awareness of Mental Health, Intellectual/ Developmental Disability and Substance Abuse services (including crisis services) and supports via use of educational resources (webinar, brochures, advertisements) and crisis collaborative forums.
    i. Progress: Community Relations Specialists provided education prevention to over 10,108 members, family members, community stakeholders and providers throughout the twelve counties.

    ii. Progress: MCO Medical Director along with Chief of Clinical Services met with walk in crisis clinics within catchment area to explore ways to reduce hospital readmission rates.

c. Goal: Care coordinators, in collaboration with CCNC, will ensure referral and transition to prevent readmission and maintain stabilization.
    i. Progress: Continue to collaborate with providers regarding follow up activities for enrollees with three or more crises.

    ii. Progress: Monthly meetings with CCNC and providers.

iii. Progress: Community Relations staff hold Community Crisis Collaborative meetings with the Hospitals, Medical Director, ED, Mobile Crisis Teams and Walk-in Clinics and providers.

iv. Progress: Call Center Staff follow up on all members who access service. Follow up includes: telephone members and enrollee packet mailed which provide information.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Care coordinators, with the assistance of CMT, will increase identification of members/enrollees with two crisis services in a thirty day period within a twelve month period to assist with transition from inpatient care.
        i. Progress: Collaborated with providers regarding follow up activities for enrollees with 3 or more crisis.

        ii. Progress: Care Coordinators have daily contact with the ED within the catchment area.

        iii. Progress: Care Management Training (CMT) provided to MCO staff.

        iv. Progress: Internal process that alerts Care Coordination when a member is considered high risk who access services through member call center.

        v. Progress: Distribute enrollee packets to all members who access services.

    b. Goal: Care coordinators will follow-up monthly with high cost/high risk members/enrollees to ensure continuity of care post discharge.
        i. Progress: Care Coordinators provide follow up activities for consumers who miss scheduled appointments, for whom a crisis services has been provided as the first service and to individuals discharged from 24 hour care, and with 3 or more crisis.

        ii. Progress: Continued partnerships with Walk-in Crisis Clinics, hospitals throughout the twelve counties.

iii. Progress: Monitor first responder activities through routine monitoring, when Quality of Care concerns arise, through complaints and care coordination. Provide technical assistance or issue plan of correction when deficiency is noted.

MeckLINK Behavioral Healthcare

MeckLINK has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: LME-MCO will ensure that consumers receive timely and intensive follow-up with behavioral health practitioners after hospitalization to decrease re-admission rates. The goal is to reduce the number of readmissions by providing services within seven calendar days of a person's discharge from inpatient care.
        i. Progress: Data for State Operated Psychiatric Facilities:
            a. March 2013 - 80% (8/10)
            b. April 2013- 87% (13/15)
            c. May 2013 –82% (9/11)
            d. Compliance with measurement goal (MH): 83% (30/36)

        ii. Progress: Data for State Operated Substance Abuse Facilities:
            a. March 2013 - 63% (5/8)
            b. April 2013- 67% (6/9)
            c. May 2013 –89% (8/9)
            d. Compliance with measurement goal: 73% (19/26)

        iii. Progress: Overall level of compliance: (MH & SA)= 79% (49/62)

iv. Progress: Goal Exceeded

b. Goal: Providers deemed a "clinical home" must implement an effective "first response" protocol in order to assist consumers during a crisis. One of the goals of 'first response' is to provide therapeutic interventions that will reduce the necessity for emergency department admission and hospitalization.
    i. Progress: Baseline- 36% (4/11) of Providers had a functional first responder system in place at the time of the initial assessment in December 2006.

    ii. Progress: Activity evaluated by CFAC members, who conducted test calls in March and April of 2012. The following data is shown by provider types, reflecting the percent of providers using a first response protocol:
        a. CABHAs = 60% (40/69)
        b. Intellectual/Developmentally Disabilities Targeted Case Management = 88% (7/8)
        c. Substance Abuse Intensive Outpatient Program = 62% (8/13)
        d. Substance Abuse Comprehensive Outpatient Treatment Program = 100% (2/2)
        e. ACTT =100% (1/1)
        f. Multisystemic Therapy = 100% (1/1)
        g. Total: = 63% (59/94)

    iii. Progress: The 35 Providers that failed the test received a Plan of Correction and follow-up test calls from Provider Operations. Corrective Action Performance Data:
        a. 31 providers passed the follow-up test calls
        b. Three providers did not complete the Plan of Correction and are no longer in the network
        c. One provider left the network due to expired Business Verification.
    iv. Progress: CFAC calls did not begin as planned in 2013 because MeckLink was in the process of becoming an MCO. Calls began on July 1, 2013.

    v. Progress: This goal has not yet been achieved but significant progress has been made since the initiation of the project; 63% of

providers met the definition for having a Functional First Responder System.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Follow-up within 30 days immediately following a hospitalization or discharge from any acute inpatient setting (including acute care psychiatric facilities) for mental illness.
        i. Progress: Performance data (09/1/2012-11/30/2012):

            a. There were 211 visits and 13 of those had follow-ups within 30 days (6.16% compliance)

            b. In order to improve the rate of compliance with this measure, the MCO has formed a collaborative with Community Care Partners of North Carolina (CCPGM/ CCNC) called PROACT. In the PROACT project, Transitional Care Coordinators meet with Quadrant II and Quadrant IV consumers while they are receiving emergency or inpatient services in order to decrease the average length of an inpatient stay, avoid unnecessary hospitalization, and hospital readmission.

    b. Goal: LME-MCO, collaborating with CCNC, will utilize the PROACT model with persons identified as being High Risk/High Cost consumers to ensure that they receive focused, timely & effective transitional care from emergency and inpatient care, which is expected to reduce inpatient readmissions.
        i. Progress: Project is still in development stage.

<u>Partners Behavioral Health Management</u>

Partners has been focusing its efforts on

- care coordination to divert persons, who have repeatedly used crisis services, to other community based services,
- collaborating with CCNC and hospitals to facilitate transition of persons from inpatient care to community based services,
- CIT training to divert persons in crisis from EDs,

- increasing use of MCM in community settings, rather than in EDs,
- testing and requiring providers to serve as first responders,
- promotion of same day access to service model, and
- quality improvement activities to identify service gaps and increase awareness of community based services.

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Require First Responder intervention prior to initiation/use of MCM for those consumers enrolled in enhanced services.
        i. Progress: Quality Improvement Plan on effects of increasing awareness of Community Based Services is underway.

        ii. Progress: Mystery Shopper calls to providers continue monitoring of 1st responder activity.

        iii. Progress: Clinical Director and other Partners BHM staff met community stakeholders on May 29, 2013. One MCM provider indicates an increase in community contacts and a corresponding decrease in hospital ED visits by that staff.

        iv. Progress: Clinical Director has issued clear, measurable outcomes expectations for MCM providers effective July 1, 2013. Daily reports from MCM with demographic information will be required. Additional measurable outcome, as part of the Strategic Action Plan, is for Crisis providers to be connected with consumer on same day access basis.

        v. Progress: Medical Director and Clinical Director have met with hospitals in catchment areas to assist them in realigning expectations of MCM providers in ED; MCO expectations are explicitly that MCM services are provided in community, not in EDs. Emphasis in these meetings has been to connect with MCO's designated crisis specialists.

    b. Goal: Increase the use of Community Based Services (CBS) for consumers in need of behavioral health services before crises arise.

i. Progress: Daily census tracking continues. Medical Director and Utilization Management staff have increased contacts with inpatient providers.

ii. Progress: Partners BHM will conduct a Gap Analysis/Service Needs Assessment beginning in July 2013. One goal is to identify the services needed, with volume and geographic location identified, within the community to be most impactful in reducing crisis events.

c. Goal: CIT trainings for law enforcement, hospital personnel, local magistrates, and mobile crisis staff will continue to be offered across the eight-county LME/MCO. The purpose is to educate the community about options other than use of ED's and/or Involuntary Commitment (IVC) process.
    i. Progress: Two CIT classes were held during this reporting period, one is Surrey and one class In Iredale Counties. A total of twenty six officers attended and completed trainings. This means that Partners BHM has achieved one-third of the goal of 75 newly trained law enforcement

    ii. Progress: Two more CIT classes are planned for the next reporting period, for Catawba and Yadkin Counties.

d. Goal: Promote Same Day Access to care in all LME/MCO counties, building on the strength of the Walk-In Crisis centers in all eight counties.
    i. Progress: During this reporting period, with increased scrutiny of crisis services, Clinical staff have determined that focus should be on same day access to care rather than waiting until a consumer is in crisis. While there are few results to show at this time, Providers have begun to engage in the conversation about the importance of timely access to care. Partners BHM promotes this Performance measure at Provider Forums and has engaged in direct talks with Providers.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Identify consumers at the time of a 2nd crisis intervention in a rolling twelve month period, notify Care Coordinators, who will collaborate with providers and CCNC's care managers to prevent additional use of crisis services.

i. Progress: 289 consumers out of 1163 (25%) have had 2 or more crisis events since July 1, 2012. We are requesting a report to analyze this information. Our initial work involves determining if CC is involved with those with 2+ events. We are also one hospital at a time looking at ways to assist each hospital to care coordinate across the transition.

Sandhills Center for MH/DD/SAS

Sandhills has been focusing its efforts on

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Through the use of MCM, collaboration with partners (hospital EDs, hospital transition teams, ACT providers, CCNC), care coordination, and crisis plans, Sandhills Center works to reduce state hospital readmission rate to less than 7% by ensuring that the highest risk/highest need

members are connected with community based services designed to meet their needs in the least restricted environment.

i. Progress: Members being readmitted to state hospitals within a 30 day period from Sandhills Center's pre-Guilford merger service area was at 4% during the past quarter. The readmission rate was at 12% for members being readmitted to state hospitals within a 180 day period.

ii. Progress: Sandhills Center works to standardize the interventions used across the merged nine county catchment area and to decrease the 180 day readmission rate to less than 15% over the next several quarters and to ultimately decrease the 180 day readmission rate to less than 7%.

iii. Progress: Sandhills Center establishes Guilford Crisis Collaborative to address standardization across the merged nine county area. The Crisis Collaborative is an intervention strategy used in the original eight county Sandhills Center area. The Collaborative is comprised of default crisis walk-in providers and a Mobile Crisis Contract provider. Sandhills Center works with the providers to create protocols to ensure that crisis interventions are offered in the community as appropriate.

iv. Progress: The Collaborative enlists the input and involvement of local magistrates and a local law enforcement agency.

v. Progress: The Collaborative establishes protocols related to involving Mobile Crisis management to de-escalate crisis situations in the community whenever possible.

vi. Progress: Sandhills Center works with the Collaborative to meet objectives related to Involuntary Commitments being routed through the default crisis centers as appropriate versus automatic involvement with hospital emergency departments.

b. Goal: Through the use of MCM, collaboration with partners (hospital EDs, hospital transition teams, ACT providers, CCNC), and care coordination, Sandhills Center works to reduce community hospital readmission rate to less than 10% by ensuring that the highest risk/highest need members are

appropriately connected with community based services designed to meet their needs in the least restricted environment possible.

i. Progress: Members being readmitted to community hospitals within a 30 day period from Sandhills Center's pre-Guilford merger service area was at 11.2% during the past quarter.

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

iii. Progress: Sandhills Center establishes Guilford Crisis Collaborative to address standardization across the merged nine county area. The Crisis Collaborative is an intervention strategy used in the original eight county Sandhills Center area.

iv. Progress: The Collaborative is comprised of default crisis walk-in providers and the Mobile Crisis Contract provider. Sandhills Center works with the providers to create protocols that ensure that crisis interventions are offered in the community as appropriate.

v. Progress: The Collaborative establishes protocols related to involving Mobile Crisis management to de-escalate crisis situations in the community whenever possible.

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

   a. Goal: Sandhills Center will identify barriers to accessing services and develop plans to increase access to services for persons with mental health and/or substance abuse service needs by 85%.

      i. Progress: Sandhills Center provided timely access to urgent care for 89 % of members determined to be in need of such care in the 2nd quarter.

ii. Progress: Sandhills Center provided timely access to routine care for 84% of members determined to be in need of routine care during the same period.

iii. Progress: Access to urgent and routine care were not measured in the Guilford County area for the same period.

iv. Progress: Sandhills Center processes, develops, and implements technical standards so that the merged nine county area can make consistent decisions for reaching and maintaining goals across the service area.

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

Smoky Mountain Center

Smoky Mountain Center has been focusing its efforts on

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

- increase use of MCM in community settings, rather than EDs,
- increase and improvement use of MCM and WICs,
- building community based service capacity and comprehensive service providers, and
- quality improvement activities to monitor trends in crisis services outcomes.

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: The LME-MCO shall work with local CCNC networks and primary care providers to manage the enrollees with unstable medical and MH/DD/SAS diagnoses to reduce inappropriate use of acute care inpatient admissions.
        i. Progress: Current meeting minutes are housed internally. Continue to meet at least monthly to staff high risk/high need consumers within care coordination.

        ii. Progress: Currently SMC partners with the following CCNC Networks:
            a. AccessCare (Ashe, Alleghany, Avery, Watauga, Alexander, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, and Swain Counties);
            b. Community Care of Western North Carolina (McDowell County); and
            c. Northwest Community Care (Wilkes County)

        iii. Progress: Data sharing includes CCNC informatics as well as CMT data to identify correctible clinical areas of concern that present a financial risk

        iv. Progress: MCO Chief Medical Officer provides clinical consultation and meetings with CCNC psychiatrists for Quadrant II and IV consumers.

        v. Progress: Cases where an individual is medically complex, utilizing a high number of medications (8+) or has been referred by CCNC are staffed either in person or through secure email depending on the individual's potential acuity. In scenarios where a member is

not enrolled with CCNC or is not a Medicaid consumer, Care Coordinators refer for medication reconciliation and consultation with SMC's Chief Medical Officer.

vi. Progress: At a minimum, SMC Regional Care Coordination Managers and regional Geriatric and Adult Mental Health Specialty Team RNs meet with each CCNC Network to staff high risk/high cost cases. Staffing may include other providers and community partners depending on who is involved with the individual. SMC has continued to participate in the quarterly CCNC Steering Committees across SMC's catchment.

vii. Progress: Care Coordinators collaborate with CCNC Nurse Care Managers in managing transitional care, after a behavioral health hospitalization, to consumers who have both medical and mental health needs.

viii. Progress: SMC and CCNC care coordinators/care managers share information on assigned caseloads to prevent duplication and to coordinate activities.

ix. Progress: Consumers with behavioral health or I/DD needs that are identified by the CCNC TREO system as high risk are reviewed by SMC Care Coordination to determine if behavioral health services and/or ongoing SMC Care Coordination intervention is needed.

x. Progress: Information from the Care Alerts provided in the CCNC Provider Portal identify physical health needs and allow either agency staff assigned to follow up to ensure integrated care. Examples include blood tests or labs needed for chronic physical illnesses, yearly physicals for children.

xi. Progress: SMC Care Coordinators and CCNC Care Managers participate in Interdisciplinary Treatment Team staffing on high risk consumers who have multiple Emergency Room and Inpatient hospitalizations.

xii. Progress: Audit forms are in production.

b. Goal: The LME-MCO shall create a process for reviewing trends in prevention, early intervention, and crisis management outcomes and incorporating input from providers, stakeholders, consumers, families and other stakeholders into its decisions.
    i. Progress: Matrix has been completed. Metrics Work Group has finished their work with comprehensive providers which includes two new forms that will be completed by both MCM and WIC providers. This information will help SMC create flexible data, meaningful reports, education for staff, and to use the data throughout each provider and SMC to guide business processes. The first due date is July 1st for June data. Semi-annual reports will be created and sent to providers and other stakeholders based on the information provided.

c. Goal: Via marketing, education, training modules, technical assistance, CIT trainings, and stakeholder meetings, the LME-MCO shall build community capacity and awareness relative to mental health promotion, prevention, early intervention and crisis management.
    i. Progress: Marketing plan implemented; Consumer Crisis Brochure and IVC Consumer Handbook created. Brochure distributed widely.

    ii. Progress: Community Training Library completed. Trainings provided in a variety of settings including community based programs, hospital EDs, DSSs, etc.

    iii. Progress: Annual goal to increase CIT classes by 50% was exceeded. CIT Two Day Refresher Course refined and offered in two additional counties. Smoky now has 220 certified CIT officers across 15 counties.

    iv. Progress: Training records updated to reflect the number of trainings, participants, and certifications awarded.

    v. Progress: SMC has established local crisis/ED committees covering all 15 counties. Committees have representation from hospitals, MCM providers, law enforcement, magistrates, DSSs, public schools, CFAC and other stakeholders.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: The LME-MCO shall identify and provide care coordination services for high cost and/or high risk consumers who do not qualify for Medicaid including but not limited to Medicaid recipients.
        i. Progress: Report on frequent users of crisis services is complete. SMC Care Coordination receives referrals from a variety of external and internal agency sources. SMC Care Coordination Managers also review and prioritize the Top 20%, 3+ Emergency Services and MCM Emergency Department reports to proactively identify consumers who may benefit from CCNC Care Management or CCNC enrollment.
        ii. Progress: Peer Record review is complete and ongoing.
        iii. Progress: Audit forms are being reviewed and updated.

    b. Goal: Providing technical assistance to and using performance management with providers, the LME-MCO will ensure that appropriate levels of community based crisis services (MCM and WIC) are available.
        i. Progress: Metrics Work Group has finished their work with comprehensive providers, which includes new forms that will be completed by WIC providers. This information will help SMC create flexible data, meaningful reports, education for staff, and to use the data throughout each provider and SMC to guide business processes. The first due date is July 1st for June data. Semi-annual reports will be created and sent to providers and other stakeholders based on the information provided.

        ii. Progress: Monthly contract performance meetings are held with comprehensive providers to focus on evidence based practices in prevention and crisis management.

<u>Western Highlands Network (WHN)</u>

Western Highlands Network has been focusing its efforts on

- care coordination to link persons in EDs and those who have repeated use of crisis services, to community based services,

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

1. Efforts to reduce the need for acute care inpatient admissions for persons with primary diagnoses of MH/DD/SA:
    a. Goal: Increase housing options for the "hard to house" individuals that have been identified by the Asheville City/Buncombe County Homeless initiative advisory committee.
        i. Progress: Hard to house committee meeting minutes (6.24.13). Meeting is scheduled to occur the fourth Monday of each month.
        ii. Progress: About forty individuals have been identified as "Hard to House" as a result of eviction, criminal background, and conflicting behaviors.
        iii. Progress: During most recent meeting, June 24, 2013, outcome measures were presented by Housing programs. The purpose of tracking relevant information will assist in determining reasons and possible services to support individuals in maintaining housing.
        iv. Progress: Upon receiving consumer health information, identify individuals within WHN database.

2. Efforts to reduce the number of consumers needing three or more crisis services in a twelve month period:
    a. Goal: Reduce ED Visits for target population, who have a provider, in WHN by improving Person Centered Plans, Crisis Plans, responsiveness

of first responders; increase use of MCM in EDs, increase access to continuum of services in CABHAs; and collaboration with community hospitals and CCNC to focus resources on persons with frequent use of EDs.

i. Progress: Crisis Events According to WHN Claims Per Consumers "With a Provider" Jan'12-June'13:
    a. Two thousand, four hundred, and forty seven crisis events were captured using claims data during January 2012 thru June 2013. Including specified duplicate events per consumer, this is an increase of 486 events following WHN's submission in April of 2013. The increase of crisis events is due to delay in processing claims and additional months following the previous submission. The emergency room (2305), ER Visit- Low Severity (5), and ER Visit-Moderate Severity (137) were the leading service codes in this data extraction. This total (2,447) of crisis events is associated with consumers identified as having a provider. Consumers "with a provider" is defined as whether the client received a service within 30-days prior to the crisis event.
    b. One thousand, four hundred, and forty-five consumers utilized 2,447 crisis events over an eighteen month period (Jan12-May13). Of the total number of individuals with a provider receiving a crisis service (1,445), sixty-nine percent received a single event, seventeen percent received two events, and fourteen percent received three or more crisis events.
    c. See attachment: ED Visits_By Provider_June2013

b. Goal: Reduce ED Visits for target population, who do not have a provider, in WHN by improving Person Centered Plans, Crisis Plans, responsiveness of first responders; increase use of MCM in EDs, increase access to continuum of services in CABHAs; and collaboration with community hospitals and CCNC to focus resources on persons with frequent use of EDs.

ii. Progress: Crisis Events According to WHN Claims Per Consumers "Without a Provider": Jan'12-June'13
    a. Claims data indicates that crisis events associated with consumers without a provider total 2,448. Consumers without a provider are defined as the individual had no paid

service claims 30-days preceding the crisis event. According to this data, the emergency room (2325), ER Visit-Low Severity (4), ER Visit-Moderate Severity (118), and ER Visit-Minor (1) were the prominent service providers. The number of crisis services identified with consumers not having a provider increased by 501 events following submission in April, 2013.

b. Two thousand, one hundred, and sixty-five consumers without a provider utilized 2, 448 crisis events. Of this total (2,165): eighty-nine percent account for a single crisis event, ten percent for two events, and the remaining two percent of individuals received three crisis events or more.
c. See attachment: ED Visits_By Provider_June2013

c. Goal: Increase follow-up of people with 2 crisis events or more (maximum number to follow at one time = 40) via Western Highland Network's Care Coordination and CCNC's Care Management.
    i. Progress: WHN IS/QM will collect data for review of trends.

    ii. Progress: Identify consumers with 2 crisis events considered to be at risk/high risk of needing additional crisis services.

    iii. Progress: In comparison to previous submissions, monitoring of data sources has indicated a correction in extraction of information. This correction is illustrated in the totals displayed in this quarter's attachment.

    iv. See attachment: 3 Crisis Events or More

d. Goal: Identify the number of homeless people using 24 hour services.
    i. Progress: -WHN IT will compile aggregate data specific to unduplicated homeless consumers who have received 24 hour crisis services by month. Between January '12 and May '13, 506 unduplicated individuals receiving crisis services were identified as homeless.
    ii. See attachment: June 2013 Homeless

e. Goal: Improve access to primary care treatment through innovative initiatives, such as the Drop-In Group Medical Appointments model, Lazarus public health model, and collaborative efforts with CCWNC.

i. Progress: Identifying resources available to recognize consumers with a primary care provider in place: specifically CCNC regional databases.
ii. Progress: WHN staff attended CCWNC informatics and provider portal training on June 12, 2013. Staff participants included representation from Care Coordination, Utilization Management, Access/Call Center, and Quality Management.
iii. Progress: Upon completion of merging data resources with identified MCO partnership organization, community hospital participation will become more recognizable.
iv. Progress: The incorporation of WHN data into CCNC database will increase opportunities to identify WHN Medicaid recipients receiving primary care services.

Conclusion

Crisis and inpatient services are an essential part of the behavioral health continuum of services, so even the most effective service system will include some level of utilization of these intensive services. The objective is not to eliminate, but to "right-size" the utilization of these services. More study will be needed to determine if regions with very high utilization of these services have issues with the capacity, quality or robustness of the array of community services. That being said, all LMEs indicated that there are efforts underway to improve access to community based services, both alternative crisis services and non-crisis services.

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

- Analyzing/establishing/enhancing the current continuum of non-crisis community based services (e.g., ACT, outpatient services) (73% of LME-MCOs);
- Bolstering the array of alternatives to crisis care in EDs and inpatient care (e.g., Mobile Crisis, Walk-In Crisis, Facility-Based Crisis services) (91% of LME-MCOs);
- Use of crisis prevention planning (55% of LME-MCOs)
- Care coordination efforts to provide transition care to people to appropriate levels of crisis services, and post-discharge community based services (100% of LME-MCOs);

- Education and training efforts extended to the local communities, providers, and partners (law enforcement, magistrates, hospitals, etc.) (64% of LME-MCOs);
- Accountability of providers to respond to the crises (e.g., first responders) of their consumers (64% of LME-MCOs); and
- Identifying those people who are at high risk of repeated crisis episodes and applying intensive outreach via collaboration with CCNC, and follow-up to ensure more effective and appropriate care is utilized (100% of LME-MCOs).

While the unavailability of claims data from the LME-MCOs prevents statewide reporting of the use of community hospital psychiatric inpatient beds and individuals' repeated usage of crisis services, the available data show increases in lengths of stay in EDs, steady utilization of state psychiatric hospital beds, but a possible downward trend beginning in SFY 2013 in ED admissions of persons with primary mh/dd/sa diagnoses.

As claims data becomes increasingly available at the state-level, future reports will provide the additional following analyses:

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

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

Reference

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