2014 Annual Report

NC Department of Health and Human Services
Transitions to Community Living Initiative

5/15/2015

Vision Statement

North Carolina supports serving individuals with disabilities in the least restrictive and most integrated settings possible, based on what is clinically appropriate as defined by the individual's person centered planning process. Through the planning process, the Department believes that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards. These settings will vary depending upon the individual's preferences and supports needed to live in the community.

The Department of Health and Human Services is pleased to present the Second Annual Report for the Transitions to Community Living Initiative. Implementation of a comprehensive services system inclusive of the Transitions to Community Living Initiative continues to be the main focus for meeting the requirements of the settlement. Over the last year we've seen major successes for the individuals we serve. Some of these accomplishments include:

- Providing housing and services to 375 individuals since the beginning of Transitions to Community Living Initiative.

- Providing fidelity supported employment services to 460 individuals and specifically providing those services to 62 individuals that meet the requirements of the settlement.

- Conducting Person Centered Planning Trainings which included training sessions conducted by individuals who had participated in the Transitions to Community Living Initiative.

- Having 13 Individual Placement and Support – Supportive Employment (IPS-SE) Teams that meet fidelity.

- Having 77 Assertive Community Treatment teams that meet TMACT fidelity serving (number) individuals. These 77 teams provide services to 5,054 individuals.

Lives Transformed: Comments from some who participated in the Transitions to Community Living Initiative

"At first I had hope - now I have faith"

"I know what I want and am focused on getting it"

"I am now gaining acceptance and support from my family"

"I used to be lost in the system"

"Staff gave me hope that I might be able to do something outside of a facility- this was the first glimmer of hope I had in 25 years. Everyone listened to me."

"So much of the outcome is how you officially approach the person. They gave me hope and inspiration and then trust opened doors for me. Depression does not eat at me every day. I get out of the house. I can plan ahead even days in advance"

"It is hope and being able to look forward."

"You're never too old to gain knowledge"

"Small dreams are meaningful- remember any dream is a dream"

"What people need to know to support me: Just listen to me."

"I'm in my dream environment: you walk in, see a picture of my family and see my colors. Everything matches all over the house."

1. LME/MCO Totals for Start of 2014

LME/MCO	In-Reach Planning	Transition Planning	Housed	PASRR Screenings Processed	S.E. Total/ In or At Risk/ Teams	ACT Total/ Teams
Alliance Behavioral Healthcare	255	26	18	371	0/0	109/1
Cardinal Innovations	123	9	25	543	24/3/1	0/0
CenterPoint Human Services	116	15	20	143	0/0	0/0
Coastal Care	94	15	16	144	0/0	117/1
East Carolina Behavioral Health	278	27	9	344	0/0	0/0
Eastpointe	140	10	21	191	0/0	41/1
Partners Behavioral Health Mgmt.	209	5	12	269	0/0	72/1
Sandhills Center	109	19	22	180	0/0	158/2
Smoky Mountain Center	211	23	29	443	0/0	113/2
Total	**1650**	**158**	**172**	**2628**	**24/3/1**	610/8

Data entered in the table above reflects fidelity reviews done from September 2013-December 2013.

2. LME/MCO Totals for End of 2014

LME/MCO	In-Reach Planning	Transition Planning	Housed	PASRR Screenings Processed	S.E. Total/ In or At Risk/ Teams[2]	ACT Total/ Teams[3]
Alliance Behavioral Healthcare	324	41	29	654	124/9/2	856/10
Cardinal Innovations	501	41	61	938	79/8/2	796/15
CenterPoint Human Services	169	6	33	245	15/0/0	274/4
Coastal Care	137	33	46	227	43/11/1	433/5
East Carolina Behavioral Health	426	19	25	334	119/4/1	59/2
Eastpointe	157	21	47	573	88/20/2	434/7
Partners Behavioral Health mgmt.	304	17	28	493	0/0/0	678/10
Sandhills Center	251	16	56	353	0/0/0	416/6
Smoky Mountain Center	451	28	48	728	63/10/1	1108/18
Total	**2720**	**222**	**375**	**4545**	**460/62/9**	**5054/77**

Note. Supported Employment and ACTT numbers may partially duplicate other totals.

1- Total includes consumers no longer in housing.

2- Total includes consumers served by fidelity providers, regardless of at-risk status. Teams includes fidelity providers only.

3- Total includes consumers served by fidelity providers. Teams includes fidelity providers only.

Community Based Mental Health Services

Summary

As we approach the 25th anniversary of the Americans with Disabilities Act (ADA), it is important to note the significant strides North Carolina has made in fulfilling the promise of the Transitions to Community Living Initiative (TCLI). Our focus continues to be ensuring that our adult mental health service array is person centered, infused with recovery oriented practices and a community focus. We will continue to broaden our efforts to re-shape the adult mental health service array. Our goal is that all levels of service delivery (from providers, to LME/MCO staff, to state agencies) provide adults with serious mental illness (SMI) access to services that support them in living, working, and thriving in the community of their choice.

Assertive Community Treatment (ACT)

To date, 88 Tools for Measurement of Assertive Community Treatment (TMACTs) have been completed across North Carolina. As if March, 2015 all teams have completed their baseline TMACT review. 47 Teams have scored above a 3.6, 33 teams scored in the 3.0-3.6 range. Common areas of technical assistance and training needs include:

- Implementation of evidence based practices (which includes: Integrated Dual Disorders Treatment, Individual Placement Support-Supported Employment, Wellness Recovery Action Planning, Psychiatric Rehabilitation, Family Psychoeducational and Wellness Management and Recovery)
- Person Centered Planning
- Organization and Structure (which includes: daily team meeting organization, team scheduling and linking the person centered plan to scheduling)
- Assertive Engagement
- Assessments (which includes: integrating mental health and substance use, being comprehensive and ongoing, and directly influencing the treatment provided)

The Department has sponsored and/or facilitated multiple trainings during 2014 that focused on quality improvement. In February and March 2014 our contractor, t3 (Think, Teach, Transform) conducted four two-day Tenancy Supports Trainings. These trainings were provided in Raleigh, Wilmington, Asheville and Greensboro, and focused on improving ACT staff's ability to assist individuals with housing related supports. This training was trauma informed, as it discussed the high frequency of trauma histories in adults with severe mental illness, and also utilized evidence based practices in the application and provision of tenancy supports. Trainers taught motivational interviewing techniques designed to better engage with individuals and build rapport. This training series was followed up by three webinars that addressed: motivational interviewing, trauma informed care, and psychiatric rehabilitation.

In June 2014 emotional CPR (eCPR) training was conducted for peer support specialists. eCPR is a Commission on Accreditation of Rehabilitation Facilities (CARF) endorsed training that focuses on providing support staff skills and tools to support individuals experiencing crisis in a way that is holistic, empowering, and person centered. The 24 training participants learned about the eCPR model and

participated in dynamic role plays that allowed them to practice the skills they had been taught under the guidance and assistance of the trainers.

The ACT training audit tool has been developed to ensure that ACT trainings required by policy meet NC DHHS standards in that they provide information that supports the implementation of high fidelity ACT services. The ACT Training Audit Tool has been reviewed and an implementation plan is in development.

Our focus for 2015 will address both completion of second TMACT fidelity reviews and ensuring that ACT teams have access to training, technical assistance, and learning communities/collaboratives that provide them the resources needed to continue to improve quality and improve their fidelity to the model, support recovery, and facilitate community integration for adults with severe mental illness.

Supported Employment (SE)

NC continues to make significant strides in the area of SE and is focusing on the work that still needs to be done. We now have two teams that have scored a 99 or higher on their first fidelity review, with one team scoring in the exemplary range on their first fidelity review (score: 115.) These teams demonstrate that the Individual Placement and Support- Supported Employment (IPS-SE) model can successfully be implemented in NC and that it is a highly effective way to support adults with SMI in finding and maintaining employment. The State is continuing to work through policy revisions that support the provision of high fidelity, recovery focused IPS-SE across the state.

At this time, 35 teams have expressed their intent to provide fidelity IPS-SE, with a state-wide capacity of roughly 5,600 individuals (assuming each team pushes to reach the currently identified maximum of 160 individuals receiving services.) Most providers are running far below capacity and have had difficulty growing their programs. Data shows that LME/MCO staff, along with providers, continue to need and benefit from systematic training addressing conversations around employment. The State will continue to identify and provide training and technical support that addresses readiness criteria and that will shift the concept of work from an exception to the expectation for adults with mental illness.

In 2014 trainings for Supported Employment included:

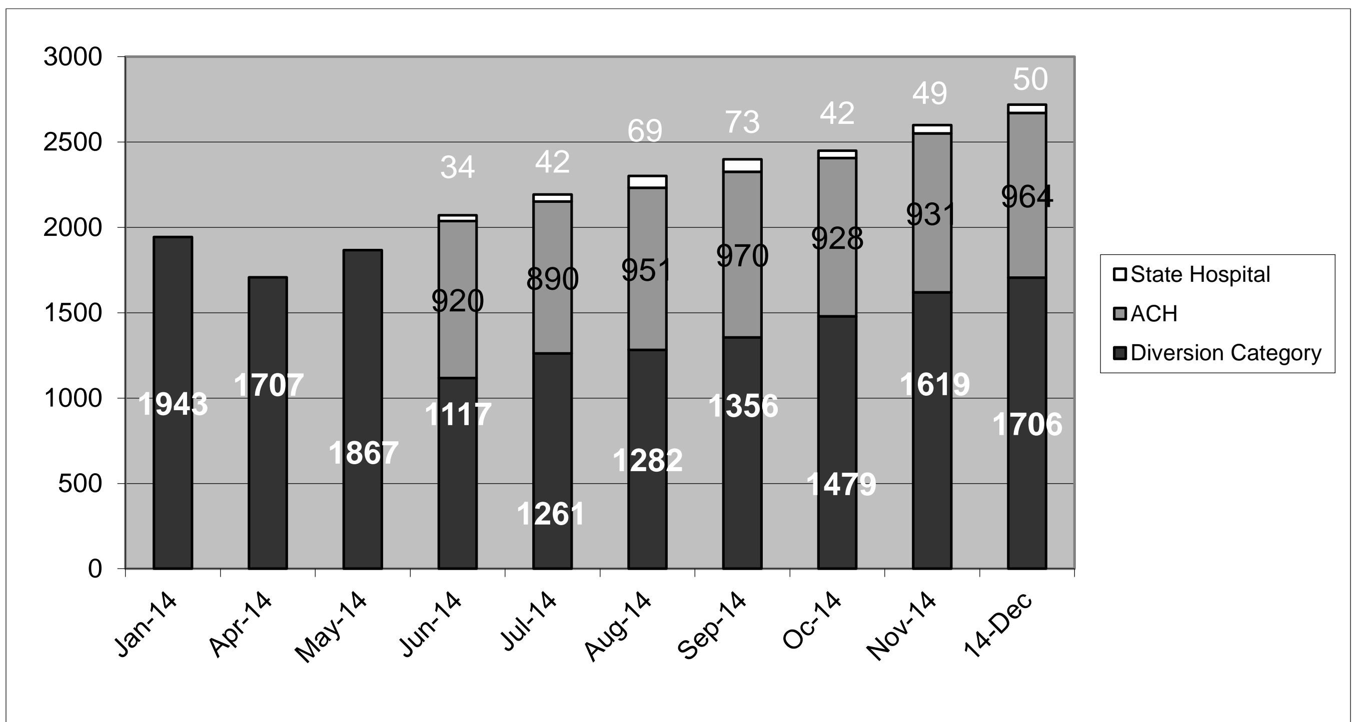
- Foundations of SE and Recovery
- Employment Peer Mentor
- Benefits Counseling for Recovery
- Job Development
- Motivational Interviewing and Vocational Supports

North Carolina will continue to collaborate with the Dartmouth Psychiatric Research Center, and participate in the Dartmouth Learning Collaborative. This collaboration will continue to provide funding, training and technical assistance to support the State in developing a sustainable infrastructure for the IPS-SE model. The North Carolina Division of Vocational Rehabilitation (DVR) will partner with other divisions within the Department in this endeavor. The State currently has three Dartmouth sites: University of North Carolina Center of Excellence in Community Mental Health in Carrboro/Pittsboro (Cardinal Innovations LME/MCO), Meridian Behavioral Health in Sylva (Smoky

Mountain LME/MCO), and Easter Seals UCP in Wake (Alliance LME/MCO). We will be releasing a Request for Proposals to add at least two new Dartmouth sites to the collaborative in the upcoming year.

The implementation of IPS-SE is truly a system change, as this specific evidence based practice was not provided prior to the Transitions to Community Living Initiative. The State continues to support a significant number of individuals in supported employment through ACT teams with a supported employment specialist, clubhouses that link individuals to competitive employment, and Vocational Rehabilitation services with the outcomes focused on competitive employment.

Figure A: December, 2014 Monthly Totals of Individuals in In-Reach Status by Population Category



2014									
Jan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1943	1707	1867	2071	2193	2302	2399	2449	2576	2720

Notes. Bar chart totals for months prior to June 2014 are combined totals. Diversion category includes individuals who were screened for ACH admission and may or may not have been diverted from ACH admission.

In 2014 we made individuals who met the TCLI eligibility criteria who were being discharged from state psychiatric hospitals a high priority for receiving in-reach services. The DHHS Division of State Operated Healthcare Facilities (DSOHF) convened a workgroup to focus on increasing the number of individuals receiving in-reach. The group looked at what processes

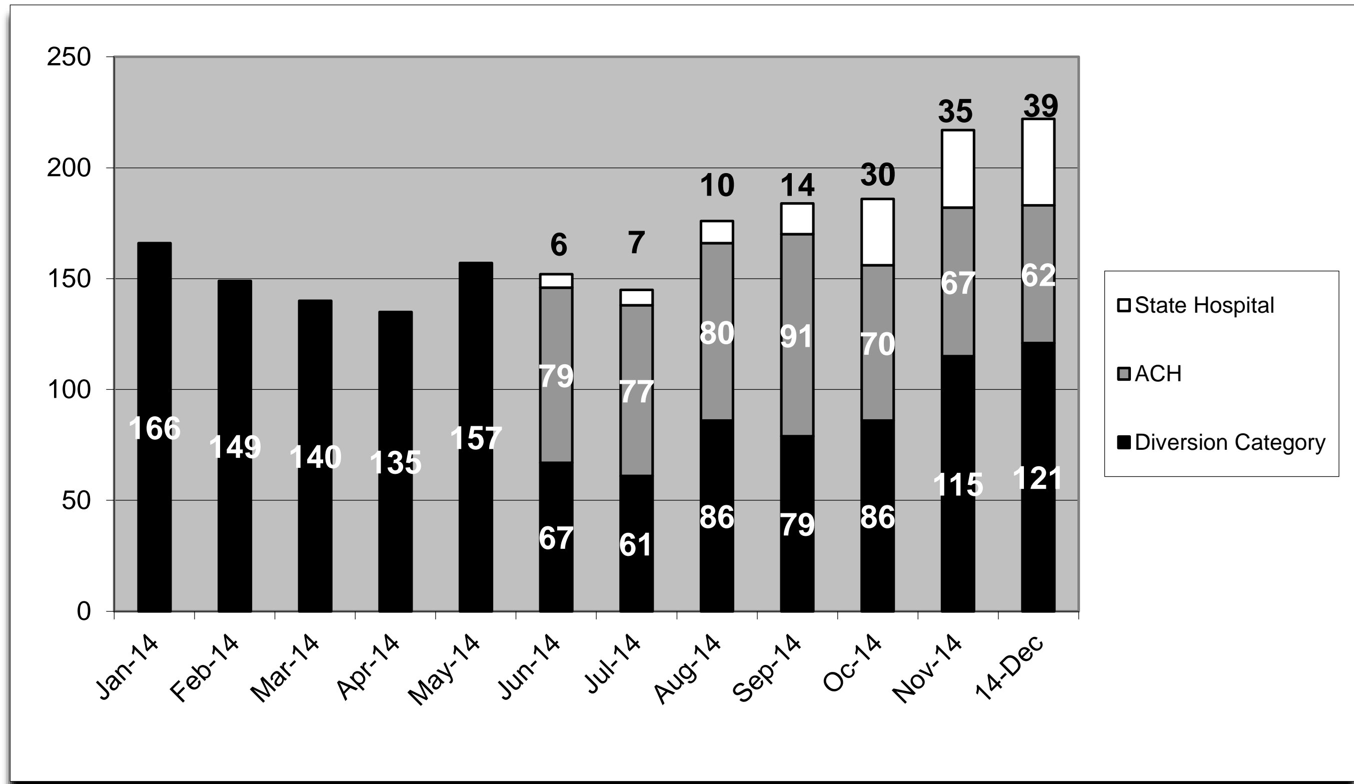
were operating well and also what barriers were being encountered by the LME/MCO in-reach staff. The workgroup continues to meet on a bi- monthly basis. As a result of this workgroup, the internal and external communications between the state hospital staff and the LME/MCO staff have been significantly streamlined and become more collaborative. The improved communications has led to earlier access to eligible individuals and a significant increase in the number of eligible individuals in state psychiatric hospitals receiving in-reach services compared to the previous year.

Also in 2014 a revised and streamlined in-reach tool developed by a workgroup of state and LME/MCO representatives was implemented. This new tool replaced three other somewhat redundant and cumbersome in-reach/transition tools and also incorporated a more comprehensive person centered process.

Another focus by the State TCLI for improving the in-reach process was to offer trainings about the TCLI and the Person Centered approach to other DHHS divisions, local agencies and LME/MCO's. The State in-reach and transition leads conducted TCLI trainings for three groups of new adult protective services social workers across the state. They also conducted a TCLI state-wide training for all of the state ombudsmen and a TCLI training at the statewide Social Services Institute which is attended by the state directors of county social services and their social worker staff. Additional training initiatives provided in-depth and hands on person centered trainings and provided consultation to all nine LME/MCO in-reach and transition staff.

All of the above activities have resulted in a consistent and growing number of TCLI eligible individuals receiving in-reach services and moving onto and completing the transition process to living in community settings.

Figure B: December, 2014 Monthly Totals of Individuals in Transition Status by Population Category



2014											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
166	149	140	135	157	152	145	176	184	186	217	222

Notes. Numbers for months prior to June 2014 are combined totals. Diversion category includes individuals who were screened for ACH admission and may or may not have been diverted from ACH admission.

In 2014, LME/MCO staff made a significant effort to increase the number of individuals engaged in the transition process. This was occurring while the same staff were assisting a great number of individuals leaving transition for placement in the community in supportive housing.

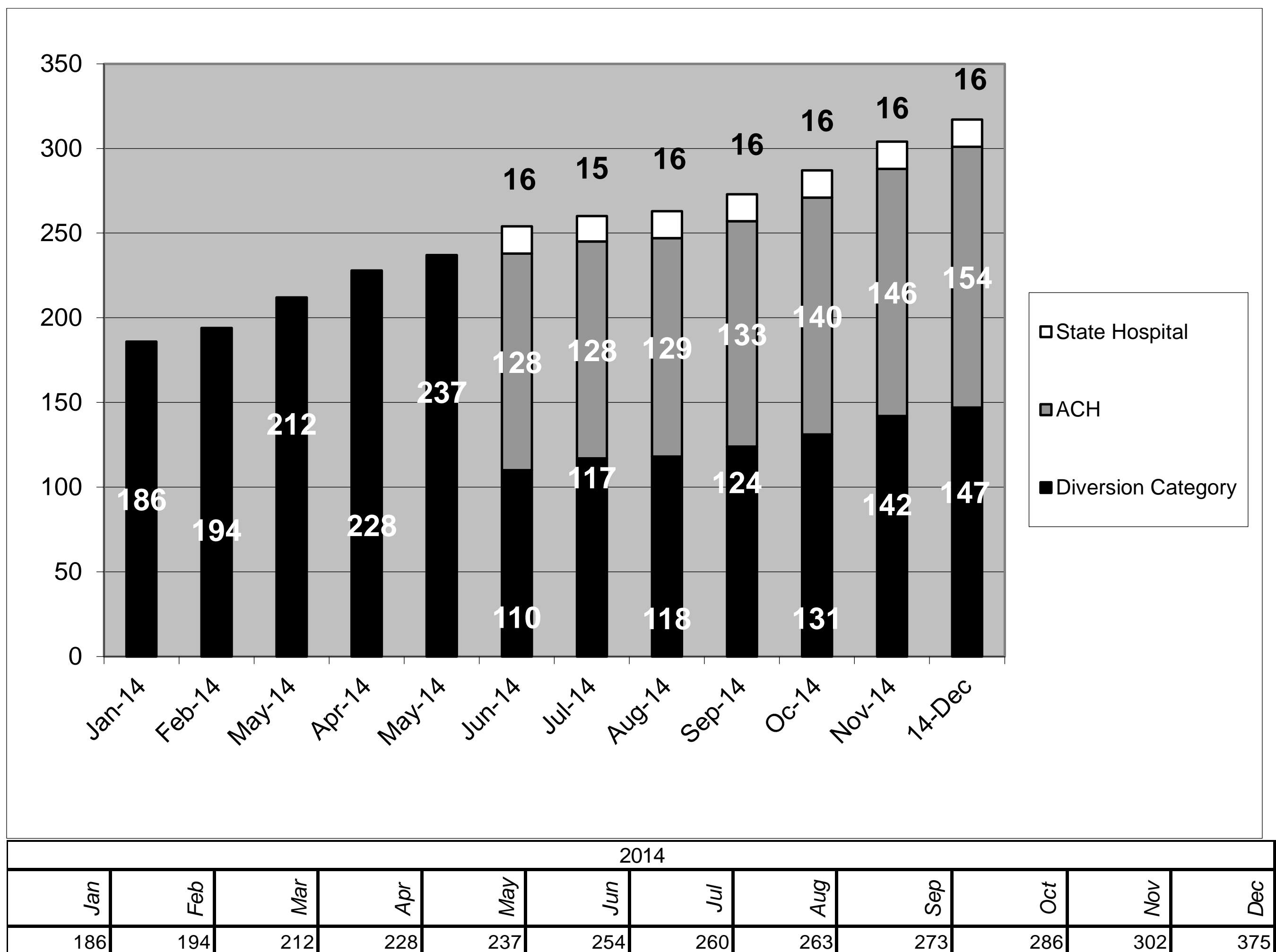
Transition efforts have been increased in two key areas. The first is within the Adult Care Home facilities. A significant effort has been made to improve in reach and education for individuals residing in ACHs to allow more individuals to become educated about the opportunity of choices in the community for housing and for services. The second area was within the State psychiatric hospitals. This year saw the largest number of individuals in the state hospital system become involved with the transition process due to the close collaboration between LME/MCO staff and hospital social workers. Working together, the two staff were able to identify many new eligible participants.

A new process of reviewing Person Centered Plans (PCPs) was implemented. Prior to the award of a housing slot and final transition, each PCP is reviewed and must receive approval. This has resulted into key achievements. First, LME/MCO staff are working with consumers to develop stronger PCPs.

Second, the system has put safeguards in place to ensure services are in place prior to the transition, and individuals are not waiting for important support services after arriving in their new home.

In 2014 we focused on identifying, examining and resolving barriers experienced in the transition process. LMC/MCOs with difficulties would share a potential barrier with staff on the DHHS transition team. Those barriers were reviewed and examples of possible solutions shared with the larger group as a whole. To date over 22 barriers have been identified and resolved through this process. A committee has been established which will continue to review barriers and offer support to LME/MCO staff.

Figure C: December, 2014 Monthly Totals of Individuals in Housing by Population Category



2014											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
186	194	212	228	237	254	260	263	273	286	302	375

Notes: Bar chart totals for months prior to June 2014 are combined totals. Diversion category includes individuals who were screened for ACH admission and may or may not have been diverted from ACH admission.

In calendar year 2014 the number of individuals moved in Supportive Housing more than doubled. Most of these placements were people who came to the LME/MCO's attention through

the TCLI Diversion process, which includes a Preadmission Screening and Resident Review (PASRR).

Housing Units are all inspected using HUD Quality Standards. The State will continue inspections of units, and re-inspections at times to make sure all housing provided is of sufficient quality.

Steps were taken in 2014 to make more housing units available. Individuals with approved housing slots for Transitions to Community Living are given top priority on the wait list for Targeted/Key Housing Units. This has allowed individuals to utilize more Targeted/Key units.

Planning and contracting for two pilot programs occurred in 2014. Each of these pilots began operations in 2015. One pilot program allows a specific LME/MCO to place individuals in an extended stay hotel after they leave a facility to provide the individual time to ensure choice of permanent housing in the community. The second pilot allows a specific urban LME/MCO to authorize higher Tenant Based Rental Assistance payments (the norm is a maximum of $360), to provide access to a wider choice of available housing.

A key realization in 2014 was that the LME/MCOs need more resources to assist with the housing search for persons in the Transitions to Community Living Initiative. The need for additional available housing units was also identified in early 2015. All options for meeting these needs are currently being discussed.

As part of the review of housing options, the State hopes that an agreement will be possible with the local HUD offices to make Section 8 and other tenant based housing vouchers available to Transitions to Community Living Initiative in the future. The North Carolina Housing Finance Agency (HFA) is aggressively working to expand the Targeted/Key program. They are approaching landlords that have filled units, and are offering to allow for Key Housing funding in up to 20% of a property's units instead of 10%. This makes more housing available. The State is considering all options at this point for streamlining the Housing Search phase, and getting people into housing in urban areas that where housing should be more readily available. Finally, in 2015, after the Independent Reviewer's baseline report is released, the State will synthesize the information, and write a housing plan to achieve future benchmarks.

2. LME/MCO Totals of Individuals in Housing by Population Category, Start of and End of 2014

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	0	10	0	2	6	**18**
Cardinal Innovations	2	4	0	1	6	**13**
CenterPoint Human Services	15	0	0	0	5	**20**
Coastal Care	7	5	0	0	4	**16**
East Carolina Behavioral Health	2	0	1	0	6	**9**
Eastpointe	0	10	2	4	5	**21**
Partners Behavioral Health mgmt.	4	0	2	2	4	**12**
Sandhills Center	1	12	2	1	6	**22**
Smoky Mountain Center	8	3	5	2	11	**29**
Total	**39**	**49**	**12**	**12**	**60**	**172**

LME/MCO	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Total
Alliance Behavioral Healthcare	0	11	0	2	13	**26**
Cardinal Innovations	5	19	1	1	28	**54**
CenterPoint Human Services	11	7	0	0	12	**30**
Coastal Care	19	0	0	2	18	**39**
East Carolina Behavioral Health	3	3	3	1	10	**20**
Eastpointe	0	16	2	3	17	**38**
Partners Behavioral Health mgmt.	4	0	3	3	8	**18**
Sandhills Center	0	20	5	2	20	**47**
Smoky Mountain Center	11	6	4	2	19	**42**
Total	**53**	**82**	**18**	**16**	**145**	**314**

Note. Population categories are defined as follows:

1- Individuals with SMI who reside in an ACH determined by the State to be an IMD;
2- Individuals with SPMI who are residing in ACHs licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness;
3- Individuals with SPMI who are residing in ACHs licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness;
4- Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and
5- Individuals being considered for admission to an ACH and determined through preadmission screening to have SMI.

3. Diversion Status of Individuals with PASRR Screenings Processed for end of December, 2014

LME/MCO	Diverted	Not Diverted	In Process*	Total PASRR Screenings Processed
Alliance Behavioral Healthcare	194	308	152	**654**
Cardinal Innovations	177	467	294	**938**
CenterPoint Human Services	29	146	70	**245**
Coastal Care	31	147	49	**227**
East Carolina Behavioral Health	83	232	19	**334**
Eastpointe	197	343	33	**573**
Partners Behavioral Health mgmt.	93	332	68	**493**
Sandhills Center	60	234	59	**353**
Smoky Mountain Center	130	507	91	**728**
Total	**994**	**2716**	**835**	**4545**

* PASRR has been sent to the LME/MCO and the LME/MCO is working to divert the individual.

Exclusions: Out of State, Deceased, Dementia, IDD, Not SMI, Not Stable, Private Pay, Re-Routed

Beginning in August 2014, monthly, (or more often as requested) onsite Diversion technical assistance was provided to each LME/MCO. Technical assistance focused on data compliance within the Diversion area of the TransITions database as well as providing responses to questions regarding Diversion and Community Integration Plans (CIP's). Prior to this effort, there was a large amount of missing and/or incorrect data that was entered into the TransITions database pertaining to Diversion. By the end of December 2014, there was a drastic increase in data compliance within the Diversion portion of the TransITions database which in return allowed for more accurate and meaningful data to be available for reporting.

We will continue to monitor and provide technical assistance to LME/MCOs regarding the Diversion process. We will also continue to monitor and review CIPs. The Department contracted with a vendor, Earthmark, in early 2015 to complete all Community Integration Plans as part of the PASRR Level II Comprehensive Clinical Assessment and screening process. The CIP and Guidelines have been updated and revised to meet the needs of the new Level II screening process for Earthmark. Training on the revised/updated CIP form and guidelines has been conducted with the Earthmark screeners/evaluators. The PASRR manual has been revised to include the revised and updated CIP form and guidelines. A consent form has been drafted and has been included as part of PASRR Level II screening process that will be conducted by Earthmark.

Quality Management

In 2014 the State took steps to improve Quality Management, both of the work being done by the LME/MCOs, as well as DHHS TCLI program administration. These steps include a formalized Root Cause Analysis process to help make sure LME/MCOs and providers understand and learn from incidents, data compliance checks, reviewing Supported Employment files, working to improve the State's technical capabilities, providing hands on training to the LME/MCOs, reviewing the housing subsidy administrator's tenant files to ensure compliance with TCLI requirements, and documenting progress for the USDOJ on a monthly basis.

In April 2014 the State gained the ability to query the whole state to find out how many incidents had occurred, based on the individual's unique Common Name Data Service number (CNDS#). If the individual has Mediciad, this will match their CNDS#. Since then, the State has been tracking the numbers of incidents for TCLI individuals. From April – December 2014, 18 category 2 and 3 incidents were documented in the Department's Incident Response Improvement System (IRIS), or about 2.25 per month. Level 2 and 3 incidents are defined below.

Note. An "incident," as defined in 10A NCAC 27G .0103(b)(32), is "any happening which is not consistent with the routine operation of a facility or service or the routine care of a consumer and that is likely to lead to adverse effects upon a consumer."

- **Level II** includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior.
- **Level III** includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer, (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer, (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer, (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer or (5) a threat caused by a consumer to a person's safety.

Incident types:

- Death
- Restrictive Intervention
- Injury
- Medication Error
- Allegation of Abuse, Neglect, or Exploitation
- Consumer Behavior (including suicide attempt, inappropriate sexual, aggressive, destructive, illegal, unplanned absence)
- Suspension, Expulsion from services
- Fire

Early in 2015, Quality Management (QM) professionals reviewed the Settlement Agreement to develop a method of reporting compliance with each provision and to assign a person responsible for tracking compliance. This will allow the State to report on each provision as needed. It also empowered

individuals at the State level to monitor areas of the Settlement in a more refined and consistent manner than before.

In 2014 State employees began monitoring data compliance in the TransITions IT system by the LME/MCOs to make sure information is complete, and thus meaningful. State employees follow up with the LME/MCOs when information isn't included to get better data quality.

The State collects data on where individuals go when they leave Supportive Housing. By the end of 2014, 61 individuals had left Supportive Housing. The below table shows these destinations.

Where	Total #
Family	7
ACH	19
Mental Health Group Home	4
Deceased	9
Alternative Living Family	1
Skilled Nursing Facility	1
Jail	3
State Hospital	4
Unknown	3
Independent	10
Total	61

It should be noted that several of the people that were discharged to ACHs were again provided In-reach and were able to get placed back into Supportive Housing in community settings.

The State has worked with the Division of Information Resource Management (DIRM) to make reporting capabilities more robust for the TransITions system. Beginning in 2015 the State was able to track aggregate reports about numbers of people with repeat emergency room visits, time spent in congregate day settings, and time spent attending school. An area of opportunity in 2015 will be to improve the rate at which LME/MCOs comply with the requirement to update the person's quarterly status.

A review of the compiled information showed 10 people accounted for the 71 days in crisis beds, and 37 people accounted for 73 ER visits. There was some overlap, such that 41 Individuals accounted for these 144 total days in crisis, and ER Visits. This data will allow the LME/MCOs to focus on these individuals and work to identify needs to attempt to reduce the need for crisis and emergency services.

Community Engagement

Engagement	Activity
Activities/Hobbies	74
Volunteering	5
School	12
Working	8
Total	99

LME/MCOs have documented 99 different cases where someone has engaged in community activities. The majority are activities and hobbies with a group, but there are another 25 that are working, in school, or volunteering.

By the end of 2014 314 of the 375 individuals placed in Supportive Housing were still placed. This represents 83% of all people who were placed were able to keep their Supportive Housing.

A step to improve QM in 2015 will be the broadening of the reports that can be drawn out of TransITions, which will allow for automation of many of the compliance reports, and make it easier to discern whether an LME/MCO has simply failed to documents something, or if a service or crucial piece of the puzzle is missing. The State is working on monthly status report cards for each LME/MCO so that they can see how they are progressing in several key areas. This will allow each LME/MCOs track their progress towards their compliance goals and allocate their resources appropriately.

5. Hospital Census for 2014

Calendar Year 2014	Admits	Discharges	Average Daily Census
Broughton	**528**	**515**	**244.53**
Adult Admissions	478	433	104.71
Adult Long Term	3	34	84.6
Geriatric	6	16	36.93
Medical Unit	20	14	9.38
Deaf Unit	21	18	8.91
Cherry	**552**	**542**	**165.1**
Adult Admissions	486	442	60.68
Adult Long Term	7	43	82.11
Geriatric	45	43	19.63
Medical Unit	14	14	2.67
CRH	**871**	**881**	**332.73**
Adult Admissions	645	609	143.07
Adult Long Term	3	48	74.28
Geriatric	56	71	34.26
Medical Unit	62	48	3.83
Forensic Unit	105	105	77.28
Grand Total	**1951**	**1938**	**742.36**

Notes.

- Adult Admissions Units are acute care units with typical length of stays around 30 -60 days. Length of stay on the adult admissions units may be less than 1 month. Adult admissions units admit people 24/7/365, taking many individuals waiting in community emergency departments for psychiatric hospitalization.
- Adult Long Term units are for individuals who need longer term care at the hospital level. Often individuals on long term units have serious mental illness complicated by legal problems, poor response to treatment, co-occurring intellectual/developmental disabilities, chronic illness and cognitive deficits.
- Geriatric units typically serve people 64 and older but may include people in younger age ranges who have needs similar to the older individuals.
- Individuals in need of care for a medical condition that can be treated at the State hospital are admitted to the medical units.
- All of these units may have individuals who qualify for TCLI therefore individuals on all units are referred to the MCO for In Reach.

6. Hospital Discharge Data for 2014

Calendar Year 2014 Discharge Destination 2014	Broughton	Cherry	CRH	Grand Total
2014				
Adult Care Home	71	49	46	**166**
Alcohol/Drug Abuse Treat Center	10	15	27	**52**
Alternative Family Living	13	0	1	**14**
Apartment With Supports	13	0	3	**16**
Boarding House	4	0	5	**9**
Community Hospital (referred for inpatient medical treatment)	1	1	3	**5**
Community Respite	1	0	0	**1**
Correctional Facility	35	54	103	**192**
Developmental Disability Center	2	0	1	**3**
Expired	0	1	2	**3**
Forensic Evaluation	0	0	1	**1**
Group Home 5600	35	47	119	**201**
Halfway House	4	14	4	**22**
Homeless Shelter	25	15	33	**73**
Hotel	3	11	6	**20**
Neuro Medical Center	0	11	17	**28**
Nursing Facility	3	0	10	**13**
Private Residence	258	282	370	**910**
Psychiatric Hospital	10	4	35	**49**
Referred for Inpatient Medical Treatment	23	29	49	**101**
TCLI Private Residence	3	6	3	**12**
Therapeutic Home (under 21 only)	1	0	0	**1**
Transfer within Same Facility	0	0	17	**17**
Veteran Admin. Hospital	0	1	0	**1**
Group Home – ICF/MR	0	0	1	**1**
Grand Total	**508**	**541**	**867**	**1916**

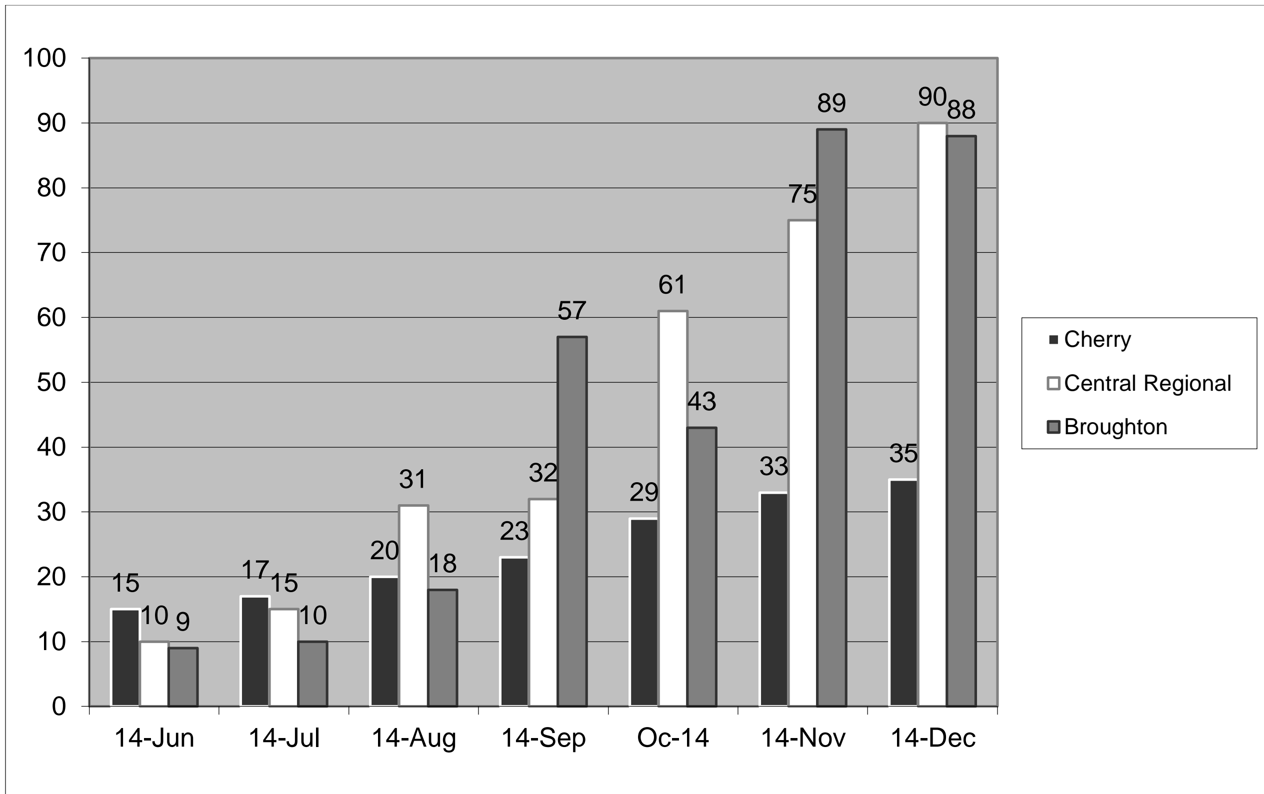
Of the one thousand nine hundred and sixteen people discharged from State hospitals in 2014, 47% were discharged to a private residence, currently defined as any private home in the community. Adult Care Homes (ACH) accounted for 8 % of the discharge locations. In all cases (with the exception of individuals with a primary dementia diagnosis or who are returning to an ACH) the hospitals must follow the PASRR process, provide housing options to consider and explain the Transitions to Community Living Initiative. All individuals are referred to the LME/MCO for In-Reach prior to discharge.

Figures E and F: Individuals who started In Reach in a State Hospitals

The Division of State Operated Healthcare Facilities (DSOHF) started collecting In-Reach data from the three State psychiatric hospitals in June 2014. Since then, a total of 179 individuals started In-Reach services while in a State psychiatric hospital. Starting In-Reach for individuals in the State hospital was defined as the LME/MCO staff going to the State hospital to meet with the individual or the LME/MCO making contact with the individual's legal guardian to provide in-reach. Contact with a guardian typically happens outside the State hospital.

Efforts to increase Transitions to Community Living Initiative in the State psychiatric hospitals began in June 2014 and continued with regional collaborative meetings with the LME/MCO TCLI staff and State hospital social workers. The LME/MCOs have been provided with a monthly list of people from their catchment areas who are in the State hospitals and meet the Transitions to Community Living Initiative eligibility requirements. The list provides details about the individuals, including if discharged, the location, to assist the LME/MCO staff in following up.

Figure E: Number of Individuals that have started In-Reach while in a State Hospital, by State Hospital



*Includes 83 individuals who have been discharged since beginning In-Reach in a State psychiatric hospital.

Figure F: Number of Individuals that have started In-Reach while in a State Hospital, by LME/MCO

	June	July	August	September	October	November	December
Alliance	7	8	13	17	23	31	39
Cardinal	5	6	9	10	15	20	23
CPHS	0	1	8	17	22	27	30
Coastal	3	3	4	6	10	10	12
ECBH	6	8	8	9	10	11	12
Eastpointe	6	7	8	8	10	12	11
PBHM	3	3	5	10	13	16	16
Sandhills	3	4	9	9	14	16	18
Smoky	1	2	5	10	16	54	52
Total	34	42	69	96	133	197	213

Note. Totals are cumulative. Current total includes 83 individuals who have been discharged since beginning In-Reach in a State psychiatric hospital.

External Quality Review

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity and prepare an annual technical report that describes the manner in which data for activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. To comply with these regulations, the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) contracted with The Carolinas Center for Medical Excellence (CCME), an External Quality Review Organization, to aggregate and analyze the data and prepare an annual technical report. The contract between CCME and DMA stipulates that a compliance review be conducted for the PIHPs every year.

The process used for each of the review activities was based on the protocols for external quality review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans developed by the Centers for Medicare & Medicaid Services (CMS). The review included a desk review of documents submitted by the health plan, a two-day onsite visit for the compliance review, a teleconference to discuss the validation findings, and a review of any corrective action plans submitted.

All nine Managed Care Organizations have been reviewed by CCME and the Mercer Group (a contractor employed by the Department's Division of Medical Assistance to perform audits of the LME/MCOs) for compliance with the required TCLI areas as listed below. ,.

Marketing—Verified by CCME and Mercer
Information to beneficiaries—Verified by CCME and Mercer
Grievances—Verified by CCME and Mercer
Timely access to services—Verified by CCME and Mercer
Primary Care Provider/Specialist Capacity—Verified by CCME and Mercer
Coordination/Continuum of Care —Verified by CCME and Mercer
Coverage/Authorization—Verified by CCME and Mercer
Provider Selection—Verified by CCME and Mercer
Quality of Care—Verified by CCME and Mercer

Findings

To determine the state's PIHP's compliance with state and federal requirements, CCME developed and DMA approved a set of standards which address access, quality, and the timeliness of the care and services received by enrollees for LME/MCO. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Evaluated, or Not Applicable. The findings for each MCO, as will be outlined in the compliance findings, are listed as follows:

1. **Alliance**--has developed desk procedures addressing requirements for the Transitions to Community Living Initiative. Review of the desk procedures and client files confirmed that overall, appropriate processes are being followed and documented for each client.

2. **Cardinal Innovations--**has not developed policies to address requirements. Cardinal has, however, developed a very detailed task list for use by staff, which addresses requirements, timeframes, pre-requisites, forms needed, etc. This task list addresses all functions and tasks required to meet the requirements of the USDOJ settlement. In addition, a reference binder containing detailed documentation of the specifics of the settlement was created as a central source of information for staff.

3. **CenterPoint--**has developed procedures to address requirements for the Transitions to Community Living Initiative. However, the requirements for Quality of Life survey completion at 11 and 24 months post-transition to community living were not addressed in the procedures. Onsite review of the TCLI files confirmed that appropriate processes are being followed and documented for each client.

4. **CoastalCare--**has developed 2 policies relating to In Reach activities for Transition to Community Living. Detailed case management/care coordination processes and eligibility requirements are found in policy 1001, Care Coordination, and in the PowerPoint presentation titled Care Coordination.

5. **ECBH--**All of the files contained appropriate documentation that included; Person Centered Plans, completed Quality of Life surveys, In Reach tool completion, transition meetings, and progress notes following transition. ECBH demonstrated their dedication to these individuals by remaining involved several months following transition. Individuals received Peer Support, Tenancy Support, ACT, Community Support, and Medication Management services when indicated. ECBH has several policies which guide the provision of care coordination for ECBH enrollees that include those with complex health needs and high-risk behavioral health conditions.

6. **Eastpointe:** Descriptions are found for Case Management /Care Coordination programs related to I/DD and MH/SA. Eastpointe included the Transition to Community Living Initiative state initiative in their 2013-2016 Business Plan and has formulated goals and a strategy for meeting those goals related to this initiative. Three policies that address the Transition to Community Living Initiative services were presented onsite. All three policies were still in draft form. It was also noted that Eastpointe had not developed a program description that describes how these services will be handled for this population.

7. **Partners** has developed internal processes to comply with requirements of Transitions to Community Living Initiative. However, no formal policy or procedure has been developed. CCME recommended that a policy that addresses all requirements, as well as Partner's processes to ensure compliance, should be developed. Currently, some of the requirements and processes are found in the Care Coordination Program Description. Review of the selected TCLI files onsite confirmed that activities are being performed to meet the requirements. Crisis plans and person centered plans are being developed as required, and members are contacted frequently during the transition process.

8. **Smoky Mountain Center** has developed detailed and thorough policies to guide staff through the Transitions to Community Living Initiative requirements. Review of files for three enrollees in the Transition to Community Living initiative confirmed that SMC is following appropriate processes for pre-transition, transition, and post-transition for these enrollees. The files confirmed that contacts with these members, both in person and by telephone, exceed the frequency requirements of the Transitions to Community Living Initiative and are well-documented.

9. **Sandhills Center** has developed a Care Coordination Departmental Operations and Procedures document which includes a summary of the activities required for this population.

   •Files demonstrated face to face contact met or exceeded that required by the contract.
   •Sandhills Center has a large number of TCLI members who remain successfully transitioned.
   •Sandhills has staff dedicated to serving this population.
   Areas for Improvement include:
   •One file did not contain a person-centered plan.
   •Three files did not include a pre-transition Quality of Life Survey.
   • One file was lacking an 11 month Quality of Life Survey.
   During the onsite visit Sandhills Center submitted three policies and procedures related to the TCLI. Generally speaking these policies addressed most of the requirements. However, they did not address the requirement of pre-transition, and 11-month and 24-month Quality of Life Survey completion. TCLI members should be identified as a new required "Special Healthcare Population" in policies.

Monitoring of Service Gaps

LME/MCOs are required on an annual basis to conduct and submit Provider Capacity, Community Needs Assessment and Gaps Analyses ("Gaps Analyses") in accordance with their DHHS Performance Contracts. The Gaps Analyses are part of a continuous assessment and action process that drives development of and updates to LME/MCO local business plans and network development plans, and implementation of strategic plans through quality improvement projects and actions.

The DHHS distributed Gaps Analyses process and report guidelines in January 2014 for LME/MCO state fiscal year 2013 reports to be submitted in April 2014. LME/MCOs were required to address the following in their gaps analyses:

1. Analyses by service type of the capacity and adequacy of the Provider Network to serve and offer consumers with a choice of providers;
2. Assessments of LME/MCO catchment area population needs;
3. Identification of service gaps, underserved populations, and unmet needs in the LME/MCO catchment area; and
4. Strategies to address identified service gaps.

LME/MCO reports were reviewed by three-person DHHS teams. Teams identified areas of concern and strength in each LME/MCO's gaps analyses and developed recommendations regarding approval of the

reports, requests for additional information, and areas for consideration in the implementation of strategies to address identified gaps and needs. Results of the final review and recommendations for future needs and gaps analyses were sent to LME/MCOs to inform ongoing activities and future needs and gaps analyses.

All LME/MCOs were required to evaluate the full service array in their assessments and gaps analyses. In doing so, most identified and described service gaps, priorities and initiatives of special relevance to the Transitions to Community Living Initiative. LME/MCO priorities and initiatives focused, for example, on the TCL initiative in particular (2 of 9 LME/MCOs), Crisis Services (6 of 9 LME/MCOs), Housing (2 of 9 LME/MCOs), and/or specific Community-Based Mental Health Services such as Supported Employment (4 of 9 LME/MCOs), Assertive Community Treatment Team (3 of 9 LME/MCOs), and Peer Support (2 of 9 LME/MCOs). Other areas for which LME/MCOs identified service gaps, priorities, and initiatives include and are not limited to the following: B3 services, bilingual staff, evidence based practices, integrated health care, prevention activities, provider outcomes, psychiatric capacity, smoking cessation, and substance use disorder and detox services.

LME/MCOs have described and implemented varied strategies to address identified service gaps. For example, strategies specifically related to the Transitions to Community Living Initiative include strengthening community collaboration to broker support for implementation; eliminating prior authorization requirements and modifying payment methodologies for certain services (i.e., Peer Support) that transitioning individuals choose to utilize; and providing education to all consumers approved for TCL housing slots regarding the benefits of Supported Employment. Additional strategies to address gaps related to Community-Based Mental Health Services include dedicating LME/MCO staff to develop services; issuing RFPs and contracting with additional providers in order to expand or add services to the continuum; increasing access and availability of fidelity teams; and exploring adjustments to service reimbursement rates.

LME/MCO measures to address gaps and weaknesses in Crisis Services include improving communications with stakeholders and creating county-based crisis collaboratives with wide stakeholder representation; promoting crisis prevention, early intervention, and crisis services to decrease the need for more restrictive interventions; developing/expanding facility-based crisis centers, “open access” and walk-in clinics, and hospital diversion programs; expanding basic benefit service provision and service providers; improving accessibility of walk in clinics and psychiatrists; reducing Emergency Department wait times and admissions; developing processes to improve timely follow-up after inpatient crisis care; reducing inappropriate inpatient psychiatric admissions and readmissions; and implementing a crisis facility/ACTT pilot to enhance engagement by arranging for ACTT teams to meet directly with consumers not yet linked with services before leaving an assessment center.

Two LME/MCOs also described local initiatives to collaborate with community partners to develop safe, affordable community-based Housing Solutions for consumers and to reduce institutional care. Plan components include identifying resources for transitioning individuals with sufficient supports to ensure successful retention; aggressively conducting continuing stay reviews for all types of institutional care and ensuring rapid and effective transitional care plans to support successful re-entry to community based care; and deploying care coordinators/care managers to intervene and engage individuals at high risk of moving to inpatient or institutional care to ensure sufficient community-based services are in place.

The State continues to monitor Crisis Services and Community-Based Mental Health services that are required to enable the successful transition of adults with severe mental illness (SMI) to supportive housing.   Services and identified gaps, as well as the implementation and success of LME/MCO strategies to address service gaps, are monitored by the DHHS through many activities, including the annual Gaps Analysis review process, review and monitoring of LME Local Business Plans, review of LME/MCO Network Development Plans and Quality and Performance Improvement Plans and Projects LME/MCO and Intradepartmental Monitoring Team (IMT) review of LME/MCO performance relative to contract requirements and performance standards.

Quality of Life Survey Update

The Community Living Quality of Life (CLQL) Surveys assess participant satisfaction and perceptions related to daily living, community supports, and services. The Initial (Pre-Transition) version of the survey is administered during the individual's transition planning period. Follow-Up surveys are administered 11 and 24 months after the individual has transitioned to the community.

As of December 31, 2014, Initial surveys of 316 TCL participants and 11-Month Follow-Up surveys of 94 individuals had been administered and submitted by the LME/MCOs. Survey responses to date point to most individuals' positive transition planning experiences, and to their greater experiences post-transition of choice and control, satisfaction with varied aspects of housing and community, well-being and recovery support, and service access and satisfaction.

- A majority (94%) of individuals reported positive perceptions about their participation in transition planning.
- More individuals reported satisfaction with their daily activities after transitioning to the community.
- More individuals reported satisfaction with specific aspects of their communities, including Shopping, Transportation, Church, Leisure and Recreation, Healthcare, Home Maintenance, and Neighbors, after transitioning.
- More individuals reported access to and satisfaction with mental/behavioral health services after transition.

Survey results, including areas of need and lower reported satisfaction, are described more fully in the attached Appendix, *N. C. Transitions to Community Living Quality of Life Survey Summary Results* (January 2015).

Crisis Services

The Department established priorities for improvement in crisis services and began the work on those priorities in 2014. The Crisis Solutions Initiative (CSI), established in November 2013, focuses on identifying and implementing the best known strategies for crisis care throughout the continuum of prevention, intervention, response, and stabilization. Initiative projects are intended to support the

development of appropriate levels of intervention for individuals in behavioral health crises and to reduce avoidable visits to emergency departments and involvement with the criminal justice system. The Initiative is built upon two key strategies:

(1) Work in partnership with all of the stakeholders in the crisis system; and
(2) Discover effective crisis intervention strategies in locations across the state and nation. Evaluate the potential for replication. Find ways to replicate and sustain successful models by eliminating barriers, and establishing policy and funding to support those models.

The Initiative is led by Dave Richard, Deputy Secretary of Behavioral Health and Developmental Disabilities and project managed by Crystal Farrow from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS).

The Crisis Solutions Coalition is a meeting for the diverse stakeholders involved in the crisis intervention continuum to gather. Held every 6 – 8 weeks, representatives from the LME/MCOs, providers, law enforcement, EMS, hospitals, advocates, DHHS staff, and others came together to hear presentations on innovative crisis intervention strategies, network and learn from each other, and to guide the Department's work on the priority areas they established early in the year. Briefly stated, those priorities are to:

(1) Fund, define, and monitor 24/7 Walk-in Crisis Centers as alternatives to divert unnecessary ED visits AND as jail diversion sites for CIT officers
(2) Provide training and support for all involved system partners – 911 responders, EDs, Providers, Consumers and Families, etc.
(3) Re-work Mobile Crisis Teams
(4) Fund the whole service continuum -- Peer Support, Case management, Jail in-reach, EMS diversion, etc.
(5) Recognize more inpatient beds are needed
(6) Utilize our collective data
(7) Treat the whole person in an integrated care approach
(8) Support emergency departments because they will continue to have a role in crisis response and should be well prepared to do so
(9) Focus on prevention strategies like Psychiatric Advance Directives and MH First Aid

Using this list, along with input obtained through the LME/MCO local business plan and gaps analyses materials, the Crisis Solutions Initiative structured its SFY2014 – 2015 project list. Funding in the total amount of $8,400,000 -- from federal mental health and substance abuse block grant funds and a new state appropriation of $2,200,000 – is dedicated to the project list. Educational and engagement oriented presentations and site visits to a variety of programs and stakeholder groups, in addition to topic focused workgroups and leveraged contributions from other partners, continue to build momentum and support for the development and improvement of crisis intervention services.

NEW DEVELOPMENTS

Three CSI Projects achieved significant progress in 2014:

1. **IMPLEMENT POLICY DIRECTION AND FUNDING FOR FOUR BEHAVIOR HEALTH URGENT CARE AND FACILITY-BASED CRISIS PROGRAMS.**

This CSI project addresses the #1 priority identified by the Coalition members. It also addresses the interest of the NC General Assembly which appropriated funds to build crisis responses services that will effectively divert individuals in behavioral health crisis from the unnecessary use of emergency departments into settings staffed with behavioral health specialists and more connected to other community-based services.

Policy: Requirements and guidance for 24/7 "walk-in crisis centers" was not previously well-defined. A "Behavioral Health Urgent Care Workgroup" was established in April 2014 with DMH/DD/SAS leadership and crisis provider agency representatives, and expanded to include representation from the LME/MCOs. The workgroup has begun the work of outlining guidance for existing and new Behavioral Health Urgent Care Centers.

The first workgroup product is a new description of four distinct Access to Care Center Tiers of service provided in sites formerly all known as "walk-in crisis". The Crisis Solutions Coalition endorsed the use of the new names and descriptions for the Tiers at its meeting on December 15, 2014. The DMH/DD/SAS will adopt the workgroup's recommendation and coalition's endorsement to use the new language and to recognize Tier III and Tier IV programs as Behavioral Health Urgent Care Centers.

- Tier I = Traditional Outpatient Service Centers
- Tier II = Same Day Access Centers
- Tier III = Behavioral Health Urgent Care Centers
- Tier IV = 24/7 Behavioral Health Urgent Care Centers

While all services have a place in the crisis continuum, the Tier III and Tier IV Behavioral Health Urgent Care Centers are the programs that truly have the necessary elements in place to function as alternatives to ED visits and as CIT jail diversion partners. Tier III and Tier IV programs are NOT licensed sites. They are outpatient clinic programs that are robust in facility design and staffing. They must function as a gateway to every level of care, not just as an admissions unit for a setting with bed. They are walk-in based, and designed for "urgent & emergent" needs. Individuals using the service will receive a Crisis Assessment and crisis intervention services, including medication management, may be initiated. BH Urgent Care Centers must serve as a community's designated site to receive consumers in need of a first examination in the Involuntary Commitment process, and the facility and staffing must be designed to manage the behavioral health, medical, and safety needs of consumers in the involuntary commitment process.

Historically, some walk-in programs - but not all – were required to do semi-annual expenditure and service reports. Single stream allocations of state dollars, local contributions of other funds toward the

walk-in programs, and the desirable growth of same day access models of service led to unreliable, inconsistent and incomplete data. The State is evaluating better options.

The second product created by the workgroup is a revised tool for service data reporting. The tool has been extensively vetted by the crisis providers, including live trials of data. The workgroup members also agreed that any sites which do not meet criteria for Tier III or Tier IV functions will not be included in reporting.

During November/December 2014, LME/MCOs and any existing providers of "walk-in crisis" services completed a review of each site for the previous month. Of the 102 sites that completed the review, 29 are currently identified as Tier III – Behavioral Health Urgent Care Centers, and eight are currently identified as Tier IV – 24/7 Behavioral Health Urgent Care Centers. These sites, and any sites that expand operations to Tier III or IV capacity in the future, will be required to resume quarterly service reporting using the new data reporting tool beginning for the quarter ending March 31, 2015.

The Behavioral Health Urgent Care workgroup will continue its work on defining and refining guidelines for Behavioral Health Urgent Care Centers for the foreseeable future.

Funding: The NC General Assembly appropriated $2,200,000 in recurring funds in SL 2014-100, Section 12F.5.(b)

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.
(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S.122C-252 and 10A NCAC 26C .0101. The Department shall give priority to areas of the State experiencing a shortage of these types of facilities.
(3) To provide reimbursement for services provided by facility-based crisis centers.
(4) To establish facility-based crisis centers for children and adolescents.

DMH/DD/SAS issued an Invitation to Apply for Funds to the LME/MCOs in November 2014 for this appropriation and block grant funding. Four programs and their provider partners have been selected to receive funds in the amount of just under $1,000,000 each for SFY 2015 and again for SFY 2016, and recurring funds of $550,000 into the future. The programs awarded funds are:

- Smoky Mountain Center, with RHA Behavioral Health, will develop a 24-hour Behavioral Health Urgent Care Center to serve adults and children, and a co-located 16-bed crisis unit for adults. An array of outpatient services and other community supports will also be provided in a comprehensive care center in Asheville.
- CenterPoint Human Services, with Monarch, will develop a 24-hour Behavioral Health Urgent Care Center for adults and children, and a co-located 16-bed crisis unit for adults in Winston-Salem.

- Eastpointe, with Monarch, will renovate and expand an existing 11-bed facility – adding five beds while increasing safety and security measures for adults, and develop a co-located Behavioral Health Urgent Care Center in Lumberton.
- Cardinal Innovations Healthcare Solutions, with Monarch, will develop the state's first 16-bed crisis facility for children and adolescents in Charlotte.

Each project generated partnerships and local contributions in addition to the state funding. All are sizeable projects involving construction and facility renovations in addition to program and operational planning. Once fully operational, each project is expected to reduce over-dependence on emergency departments for psychiatric care and decrease unnecessary inpatient care for individuals in a behavioral health crisis.

2. IMPLEMENT POLICY DIRECTION AND FUNDING TO PROVIDE CRITICAL TIME INTERVENTION IN FOUR SITES

Critical Time Intervention (CTI) is a time-limited intensive case management model designed to assist adults age 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. CTI promotes a focus on recovery, psychiatric rehabilitation, and full community inclusion.

Funding: In July 2012, the Kate B. Reynolds (KBR) Charitable Trust awarded a 3 year grant to the UNC Center for Excellence in Community Mental Health and the UNC School of Social Work to introduce CTI in Orange and Chatham Counties. A team funded through the KBR grant has been providing CTI to consumers who are homeless and/or who are at high risk for crisis relapse due to instability in their recovery plan and resources immediately following an Emergency Department visit, a brief psychiatric inpatient stay, or a release from jail.

Due to the successes of the grant funded program and because of the applicability of the CTI model to the TCLI population, DMH/DD/SAS allocated $1,460,000 for SFY 2015 and again for SFY 2016 to further pilot the model. Four LME/MCOs and their providers have been selected to receive funds to establish the CTI service teams. The programs are:

- Alliance Behavioral Healthcare will focus on individuals being released from jail in Cumberland County.
- CoastalCare will focus efforts in New Hanover and Onslow Counties on individuals who are frequently in crisis in emergency departments including individuals in the TCLI population.
- Partners Behavioral Health Management will focus primarily in Gaston County and on individuals who have serious mental illness with housing needs, including those in transition from adult care and other congregate settings.
- Cardinal Innovations Healthcare Solutions will focus on sustaining and expanding the existing KBR funded team with expansion targeted to the more rural communities in Alamance, Caswell, and Person Counties.

In addition, DMH/DD/SAS has contracted with UNC-Behavioral Healthcare Resources Program for training and technical assistance to assure new teams are implemented to fidelity. UNC-BHRP is

serving as the main link to the model developers. A full day kick-off conference will be held in May 2015, followed by training for the new provider teams and LME/MCOs. Service delivery is anticipated to begin in July 2015.

Policy: DMH/DD/SAS believes sustainability of CTI, and further development, will necessitate a stable source of reimbursement. A state-funded clinical policy/service definition will be added to the DMH/DD/SAS service array beginning in July 2015. Pilot sites will draw a portion of their awards using the definition. Other LME/MCOs will have the choice to use existing state or local funds to initiate CTI beyond the pilot sites. In SFY 2016, DMH/DD/SAS will partner with the Division of Medical Assistance (DMA) to begin the process of incorporating the CTI policy/definition into the Medicaid funded array.

3. EXPLORE AND PILOT COMMUNITY PARAMEDICINE BEHAVIORAL HEALTH CRISIS RESPONSE

DMH/DD/SAS and the Office of Emergency Medical Services (OEMS) are collaborating on an innovative strategy that will improve care for individuals in a behavioral health crisis.
Local Emergency Medical Services (EMS) personnel are frequently the first responders providing assessment and intervention for a person in a behavioral health crisis. EMS departments who have developed advanced training for their paramedics and partnerships with community providers that specialize in treating mental illness and substance use are able to successfully divert individuals in crisis from unnecessary visits to hospital emergency departments, especially when partnering with Behavioral Health Urgent Care Centers.
This model benefits everyone involved. The person in crisis is able to access specialized behavioral health services more quickly and easily, and the emergency department has more time available to assist patients requiring an acute level of medical attention. This has been successfully demonstrated in Wake County for the past five years and more recently implemented in Onslow County.
The DMH/DD/SAS and OEMS are using federal block grant funds to award up to 12 capacity building mini-grants for EMS departments to partner with LME/MCOs and crisis providers. A substantial community partnership is needed to implement this model. EMS agencies, crisis provider agencies and LME/MCOs are required to collaborate and identify how the funds will be used to increase the community's capacity to provide this service. Funds will be allocated to the LME/MCOs, who will reimburse local EMS agencies for advanced paramedic training in behavioral health crisis response or for equipment needed to support the project.
Early response to the grant application process has been strong. The projected impact for 12 – 14 counties, a mixture of large and small in population, could be diverting as many as 2500 behavioral health events in a year.
The existing programs and several of the start-ups are committed to operating with grant and local funds because they already see the clinical benefits to their patients and community stakeholders. Although block funds will be dedicated for partial reimbursement of service events to move the project forward in SFY 2016, the next goal for the DMH/DD/SAS and OEMS partnership is to identify a sustainable funding strategy as insurers typically do not cover this service. Payers typically reimburse only for trips to hospital emergency departments.
In the meantime, DMH/DD/SAS and OEMS are working with Wake and Onslow counties to develop clinical policies, which include standards and requirements for: agencies, individual paramedics, provision of the service, contracting strategies, reimbursement rates, and data collection tools.

CURRENT STATUS OF CRISIS SERVICES

North Carolina continues to have the foundational components in place for a crisis services system.

Call Centers: All LME/MCOs have 24/7 Access Centers that provide screening, triage, referral, and customer service functions. Some of the LME/MCOs designate the Access Center as the first line for crisis response. Others more broadly publicize direct lines to their primary crisis providers. All of the LME/MCO websites have improved the prominent placement of crisis information on their websites in the last year. All of the toll-free Access Center lines were answered within three rings during a random call survey in December 2014.

Mobile Crisis Teams: All 100 NC counties are served by Mobile Crisis Teams, contracted by the LME/MCOs. There are 13 agencies providing Mobile Crisis Management services. There continues to be wide variability in the utilization of this service across the LME/MCOs. There also continues to be wide variation in how much of the work is in response to community-based events vs. in response to hospital emergency departments.

Walk-in Crisis Centers: Please see the section above on the development of Behavioral Health Urgent Care. 83 counties continue to report some version of a walk-in crisis center. There have been gains in the number of those available for hospital and jail diversion services.

Community beds in Facility-Based Crisis Services Units: The number of units and beds remained the same. There are 22 facilities licensed in either or both categories of the community-based crisis categories of Facility-Based Crisis or Non-Hospital Detoxification. Three additional facilities applied for and achieved designation to treat individuals on an involuntary commitment basis – allowing for more individuals to avoid inpatient hospital admissions.
Site visits revealed significant variability in the role each unit plays in the local continuum. Please also see the above section of the development of Behavioral Health Urgent Care and Facility-Based Crisis Units.

Crisis Intervention Team Partnerships: All LME/MCOs continue to actively support law enforcement Crisis Intervention Team programs. An additional 1094 CIT officers became CIT certified in calendar year 2014, resulting in a 19% increase from the previous year, and totally more than 7000 certified officers. An additional 21 law enforcement agencies began participating in a CIT program in North Carolina in 2014 – a 6% increase from the previous year – for a total of 352 agencies.

Crisis Prevention Planning: The second version of the "Comprehensive Crisis Prevention and Intervention Plan" was released for implementation by providers on January 1, 2014.[1] This is a section of any person-centered plan that may be pulled out to be free-standing and distributed to any resource the individual allows.

CHALLENGES

[1] http://www.ncdhhs.gov/mhddsas/communicationbulletins/2013/commbulletin139/cb139pcpcomprehensivecrisisplan.pdf

Consistent collection and analysis of data has been the single biggest challenge for the Crisis Solutions Initiative. Local crisis intervention services have historically been funded with state or local sources for which no reporting format has been consistently defined. When encounter based data is available, there is usually no separate coding for a crisis event. A "crisis assessment" or instance will not usually be distinguishable from another outpatient assessment. . In addition and unlike in other services provided by the publicly funded systems, crisis intervention services must also be available to privately insured individuals. These data issues muddy the picture when attempting to analyze visit counts or wait times in emergency departments.

ON THE HORIZON

Other CSI projects that have funding and plans to be implemented in 2015 include:

Group Home Employee Skills Training (GHEST): DMH/DD/SAS will contract with UNC-BHRP to provide this 3-day seminar for employees of group homes. The training builds skills around crisis intervention, de-escalation, and community resource knowledge. Materials developed several years ago at the UNC-Center for Excellence in Community Mental Health have been secured and are under review. The first workshop will likely focus on the Alamance County area in partnership with Cardinal Innovations due to the high concentration of group homes in that area. Cardinal has done a data analysis related to the use of law enforcement and hospital EDs which will serve as some baseline data for this effort. Alliance Behavioral Healthcare is also investing in GHEST and will partner in this project.

Peer Operated Hospital Diversion: 11 other states have seen success in using a Peer Operated house as hospital diversion for adults with serious mental illness. DMH/DD/SAS is seeking Technical Assistance from SAMHSA to secure consulting services from a national expert (PEOPle) on the development of policies and guidance that will enhance the success of the start-up rather than create barriers or allow selected organizations to flounder. $700,000 of block grant funds have been allocated to pilot 2 sites once the guidance is developed.

Innovative Technologies: DMH/DD/SAS will issue an Invitation to Apply for Funds to receive awards of $41,000 each for LME/MCOs with plans to use innovative technology in crisis prevention strategies.

Promoting the Use of Psychiatric Advance Directives (PADs): DMH/DD/SAS will contract with NAMI-NC to gather key stakeholders to assess the baseline of the use of PADs in the state, and to plan a process to promote long-term strategies for increased awareness about PADs, their utilization, and a sustainability model for facilitators to assist individuals in the completion of a PAD. Plan will revolve around engaging NAMI affiliates, CFACs, and peer support specialists in various settings.

Mental Health First Aid: DHHS will maintain its commitment to this crisis prevention strategy by investing in instructor training workshops for both Adult and Youth Mental Health First Aid programs.

The following additional CSI projects have evolved throughout the year and will continue into 2015:

Statutory Changes recommended in Involuntary Commitment Statutes Workgroup:
Representatives from hospitals, law enforcement, and LME/MCO groups convened to discuss changes to streamline the involuntary commitment statutes for all involved. The recommendations here have

been presented and endorsed by the Crisis Solutions Coalition, and will be forwarded for consideration for legislative attention.

- Allow officers of the opposite sex to transport respondents when necessary.
- Allow magistrates/clerks of court to send custody orders to law enforcement via fax or electronic means.
- Promote best practice standards for transportation of respondents when the city or county contracts the responsibility, utilizing the CIT model.
- Provide clarity about each county's preferred location for first examinations. Establish a preferred site and provide for a well understood community-wide plan when the preferred site is unavailable or at capacity. Accomplish this through a plan developed by the area authority with input from all relevant stakeholders.

Provider Survey Results: A provider survey of both traditional MH/DD/SAS providers and non-traditional MH/DD/SAS (hospitals, EMS, law enforcement, DSS, etc.) was conduct in late 2014. The survey was well received with 1,161 responses. Results, particularly the free-text comments, are still being analyzed. Early analysis suggests that a focus on education for the general public and providers about alternatives other than hospital emergency departments for behavioral health crises will be essential.

Mobile Crisis Management: As noted above, "Rework Mobile Crisis" was a high priority for the Crisis Solutions Coalition. It is also the service in the crisis intervention continuum which seems to have the widest utilization and quality variability. DHHS intends to explore options for improvement in a thoughtful and methodical process inclusive of all stakeholders. The exploration of alternative models began on January 20, 2015 when the NC Practice Improvement Collaborative and the Crisis Solutions Initiative sponsored a one day conference on "The Future of Crisis Response In North Carolina". More than 160 participants heard four leaders in the field present. Speakers included David Covington, CEO and president of Recovery Innovations; Mary Smith, Executive Director, REAL Crisis Intervention, Inc.; Larry Villano, Chief Operations Officer of Terros and the Clinic Operations Director for the Choices Network of Arizona; and Becky Stoll; Vice President, Crisis and Disaster Management of Centerstone.

Closing Statement

DHHS continues to be committed to achieving the goals of the settlement agreement while building a system that assures the vision of a community based system is in place for people with Mental Illness. We are working closely with all of our partners and stakeholders adjusting our strategies as we identify opportunities to improve. We are confident that this approach will result in a successful implementation of the settlement.