



NC Department of Health and Human Services

Behavioral Health and Integrated Healthcare in North Carolina

Kody H. Kinsley

Deputy Secretary for Behavioral Health & IDD

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@KodyKinsley

Agenda

- **Big Picture**
- **Behavioral Health Structure and Delivery System in North Carolina**
- **Behavioral Health Strategic Plan**
- **Medicaid Transformation / Integrated Health**
- **Opioids**
- **Overview of the State Operated Healthcare Facilities**

Various sources.

BIG PICTURE

North Carolina by the Numbers:

- **With over 10 million people, North Carolina is the 10th fastest growing state in the nation.**
- **2.2 million** people have **Medicaid; 1 million** people are **uninsured**
- **1 in 20** people are living with a **serious mental illness**
- **1 in 20** people are living with an **opioid use** or **heroin use disorder**
- **2nd highest death rate in the nation from opioid misuse.**
- **Over 1400** people died by **suicide** in CY2017**. Five per week were Veterans.**
- **1** in **58** children has **autism**
- There are **128,000 adults and children** in NC with an **Intellectual Developmental Disability**
  - **Only 12,738** have a slot on the Innovations waiver
- **Nearly 80,000** people sustained a **traumatic brain injury** last year
- Over **16,000 kids** in **foster care**
- **25,000** people were **re-entered society** from prison last year
- **9,000** people **experiencing homelessness**; over **800 are veterans**

Various sources.

Our system faces key challenges:

- **Chronically underfunded mental healthcare system**
  - Over 1 million people are uninsured
  - Half of the opioid overdoses presenting in EDs are uninsured
  - 56% of adults with mental illness don't receive treatment
- **Stigma**
- **Bifurcated payment systems**
- **Imbalance of community-based services relative to inpatient and residential care**
  - ED boarding
  - Insufficient community-based resources
- **NC ranks 30th in US in ACEs prevalence**
- **Opioid Crisis –** straining an already stretched behavioral health system

Various sources.

History of Delivery

1963: Area Mental Health Programs
Local Management Entity (LME) Providing Service

2001-2003: Disinvestment & Privatization
Divest Staffing → Contractors

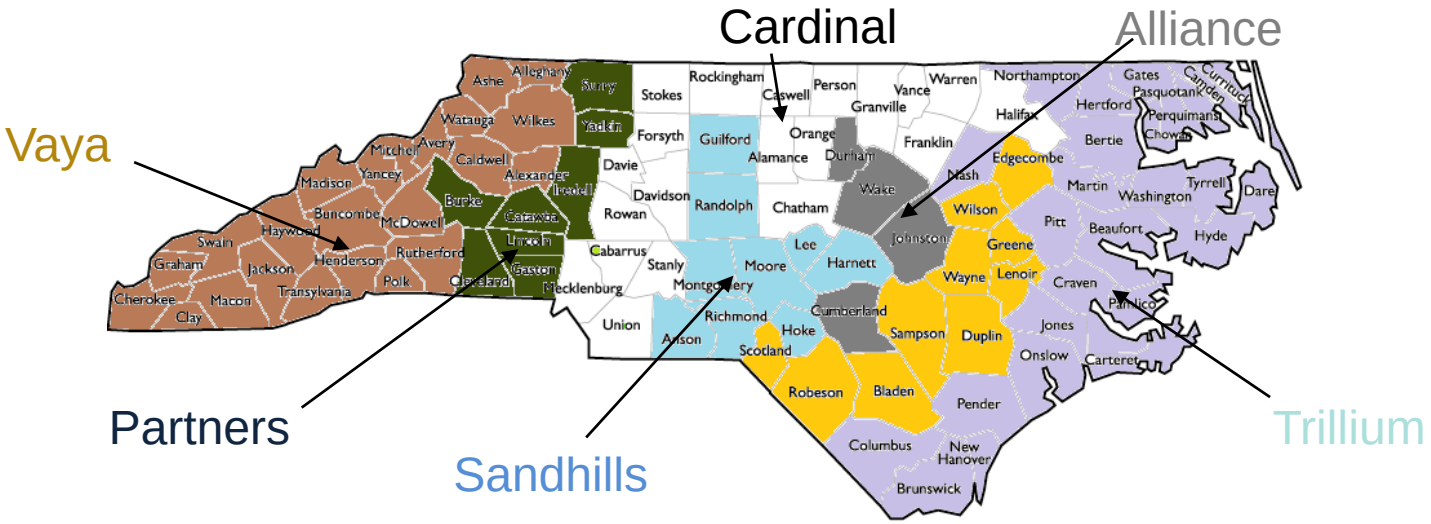
Period of LME Consolidation

2013: Behavioral Health MCOs implemented statewide

Today: Seven LME/MCOs

NC Behavioral Health System Structure

- **7 Local Management Entity/Managed Care Organizations currently manage the services for the State's covered populations across the State**
- **LME/MCO's manage services for both the uninsured and Medicaid**



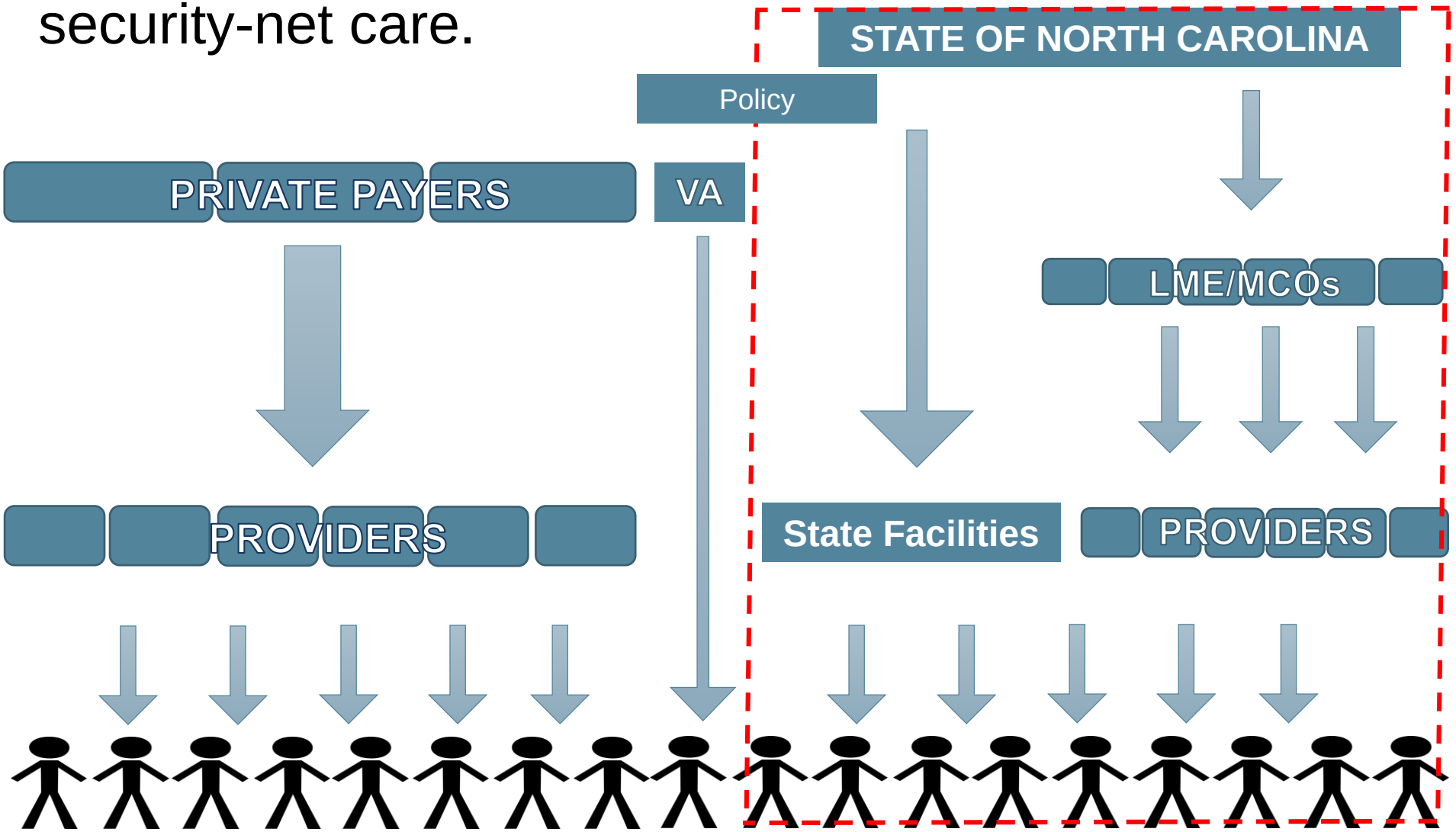
Behavioral health conditions, like physical health, vary in complexities and do treatment strategies, locations, and cost.

Mild	Moderate	Severe
Mental Health Condition		
Condition: Mild Depression Treatment: Medication treatment and brief counseling by primary care provider Cost: Individual able to work with minimal disruption to productivity or family responsibilities	Condition: Moderate Depression Treatment: Medication treatment by a psychiatrist and weekly individual counseling Cost: Individual maintains employment, but misses days of work and not always able to meet family responsibilities	Condition: Severe Depression Treatment: Inpatient psychiatric hospitalization followed by outpatient day programming Cost: Individual unable to maintain employment or meet family responsibilities for several months
Physical Health Condition		
Condition: Mild Diabetes Treatment: Medication treatment and nutritional counseling by primary care provider Cost: Individual able to work with minimal disruption to productivity or family responsibilities	Condition: Moderate Diabetes Treatment: Insulin treatment by an endocrinologist and ongoing counseling with a nutritionist Cost: Individual maintains employment, but misses days of work and not always able to meet family responsibilities	Condition: Severe Diabetes Treatment: Inpatient medical hospitalization followed by home health and physical therapy Cost: Individual unable to maintain employment or meet family responsibilities for several months

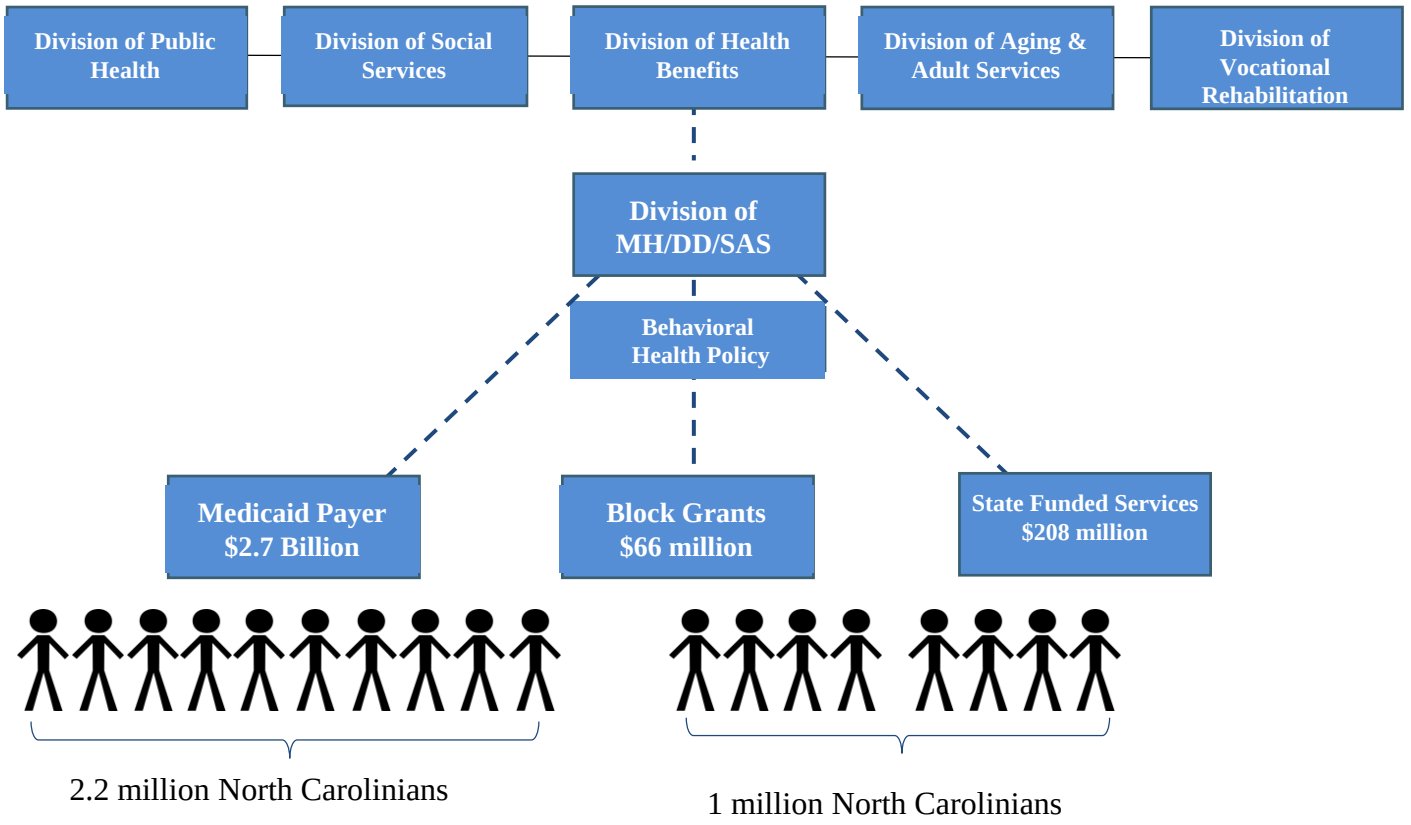
Examples of diagnoses, services, and supports in key domains of our behavioral health system (sampling).

Mental Health	Intellectual and Developmental Disability, Traumatic Brain Injury	Substance Use Disorder
Diagnosis		
- Mild Depression -Major Depression Disorder -Bipolar Disorder -Post traumatic stress disorder -Serious Emotional Disorder -Serious Mental Illness -Psychotic Disorders	-Autism Spectrum Disorder -Fetal alcohol syndrome -Developmental Disability -Down Syndrome -Fragile X -Traumatic Brain Injury with Behavioral	-Opioid or heroin use disorder -Alcohol use disorder, DWI -Cocaine use - Benzodiazepine use disorder - Polysubstance use disorder - Problem Gambling -Tobacco use, underage smoking
Treatment: No stigma, evidenced-based, high quality, community based, accessible		
-Outpatient Therapy -Supportive Employment -Intensive outpatient -Peer supports -In-patient residential treatment programs -Inpatient hospitalization	-Innovations Waiver -Natural supports, respite -Supportive employment -Intermediate care facility -Traumatic Brain Injury Demonstration Waiver -Home and Community Based Care	-Prevention -Medication assisted treatment -Intensive outpatient -Intensive residential treatment -Medical detox

Continuum: The state sets policy, manages health-care finance for the public system, and providers direct security-net care.



DMH/DD/SAS works collaboratively across divisions to create well-informed-policy that drives whole-person wellness.



Strategy: Vision, Mission, and Goals

In February 2017, the Department issued a behavioral health strategic plan, identifying two broad areas for strengthening the system: (1) integration and (2) access.

Vision for Behavioral Health in North Carolina: *North Carolinians will have access to integrated behavioral, developmental, and physical health services across their lifespan. We will increase the quality and capacity of services and supports in partnership with providers, clients, family members, and communities to promote hope and resilience and achieve wellness and recovery.*

The strategic plan grounds our efforts in data and key indicators of performance across our system.

DMH/DD/SAS Mission: *Through the lens of behavioral health, we aim to lead with our ideas to identify gaps, invest in promising interventions, and efficiently scale a system that promotes health and wellness for all North Carolinians across all payers, providers, and points of care.*

1. Access: Increase overall access to high-quality behavioral health services and IDD supports; right-care, right-time, and right-setting.
2. Integration: Integrate behavioral healthcare into routine primary care
3. Transformation: Radically realign the behavioral healthcare system to maximize access and integration of services
4. Operational excellence: Strive for operational excellence and continuous improvement in our internal operations and regulatory functions.
5. Maximize impact: Advance policies and narratives that reinforce the Division as competent thought leaders and service-oriented partners

Key system gaps and initiatives were outlined in the Behavioral Health Strategic Plan – work is underway implementing these efforts.

	Gaps	Initiatives
ACCESS	• Coverage gap – one million people in NC have no routine access to care; • Geographic imbalance to services, providers and inpatient beds • Emergency room “boarding” • Service-array imbalance or lack of evidence to services provided • Workforce - variations in provider capacities, training, and skills. • Service navigation and supports • Opioid treatment, especially in rural communities	• 1115 waiver as part of transformation – SUD amendment • Telehealth and telepsychiatry policy; UNC ECHO • Home and Community Based Services • Community collaboratives • Behavioral Health Crisis Referral System (BH-CRSys) • Peer Support • Step-down services; respite; pre/post inpatient care
INTEGRATION	• Physical and Behavioral Health • Continuum of Service • Criminal Justice System • Schools Services • Social Determinants of Health (healthy food, safe housing, transportation, etc.)	• Medicaid transformation • Transitions focused team • Jail-based MAT; ED-Induction; Jail Diversion/Re-Entry • School based interventions, training, CALM • Healthy Opportunities: NC Care 360 • Routine Screening of Children and Adults • Transitions to Community Living (TCLI) • Awareness, training • Robust communication between providers

MEDICAID TRANSFORMATION INTEGRATED HEALTH

Medicaid Transformation Goals = Buy Health

- Transforming from state run Medicaid program to a managed care administered system
- Using best practices from other states and building on the existing infrastructure in NC

1. **Behavioral Health Integration**
2. **Advanced Medical Homes**
3. **Value-Based Purchasing**
4. **Healthy Opportunities**

Physical and Behavioral Health Integration

- **Single point of accountability for care and outcomes; reduces clinical risk and gives beneficiaries <u>one insurance card</u>**
- **Standard Plans**
  - "Primary care" behavioral health spend included in PHP capitation rate
  - Beneficiaries benefit from integrated physical & behavioral health services
  - Phase 1 begins – November 2019
- **Tailored Plans**
  - Specialized managed care plans targeted toward populations with significant BH and I/DD needs
  - Access to expanded service array
  - Behavioral Health Homes
  - Delayed start

Promoting Quality, Value and Population Health

- **Statewide Quality Strategy**
  - PHPs will be monitored on 33 quality measures against national benchmarks and state targets
- **Advanced Medical Homes**
  - 4 tiers of participation, with practice requirements, payment models and performance incentive payment expectations differing by tier.
  - Sophisticated data capabilities needed across the state, the plans, and the practices/CINs
- **Value-Based Payment**
  - By the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either:
    - Increase by 20 percentage points, or
    - Represent at least 50% of total medical expenditures.

Key Upcoming Milestones

5 weeks	MAXIMUS Mails Welcome Packets (June 3, 2019)
9 weeks	PHP Call Centers will be open (July 2019) Phase 1 Open Enrollment Begins (July 2019)
22 weeks	Phase 2 Open Enrollment Begins (Oct. 2019)
26 weeks	Managed Care Go Live (Nov. 1 ,2019)
2+ years	**Tailored Plans Go Live (July 2021)**

*as of week 2/3/19

Medicaid Expansion

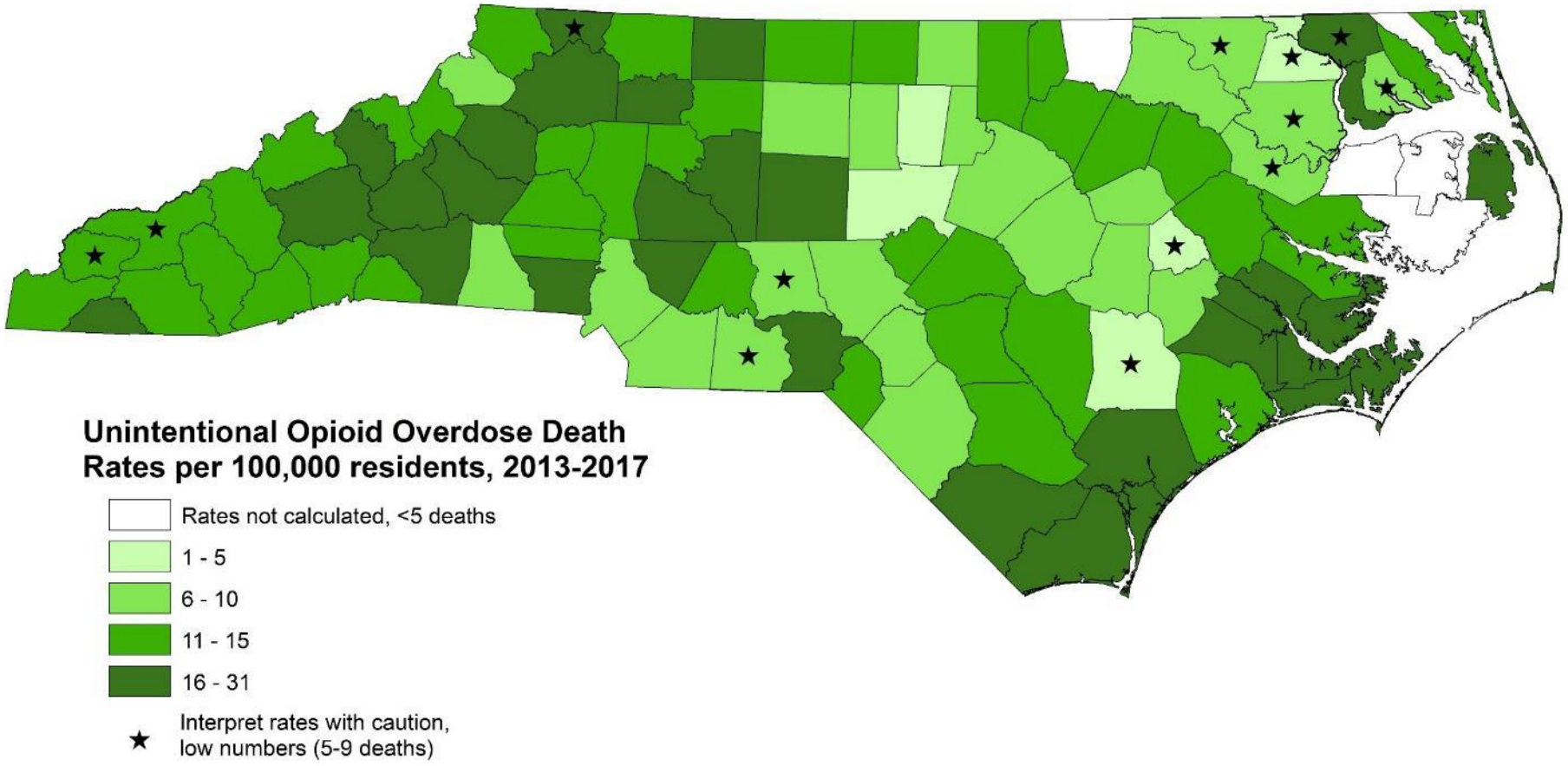
500,000	**New projected enrollees due to expansion, including a disproportionate number of rural North Carolinians**
$4 billion	**Annual federal dollars NC leaves on the table**
43,000+	**Jobs created in the first five years of expansion**
90%	**Share of costs paid by the federal government – no new state appropriation needed to fund the state share**

Now is the time to:

- **Improve overall health of NC (ranked 37th)**
- **Advance rural economic vitality, health**
- **Build sustainable infrastructure to combat the opioid epidemic**
- **Put downward pressure on everyone's premiums**

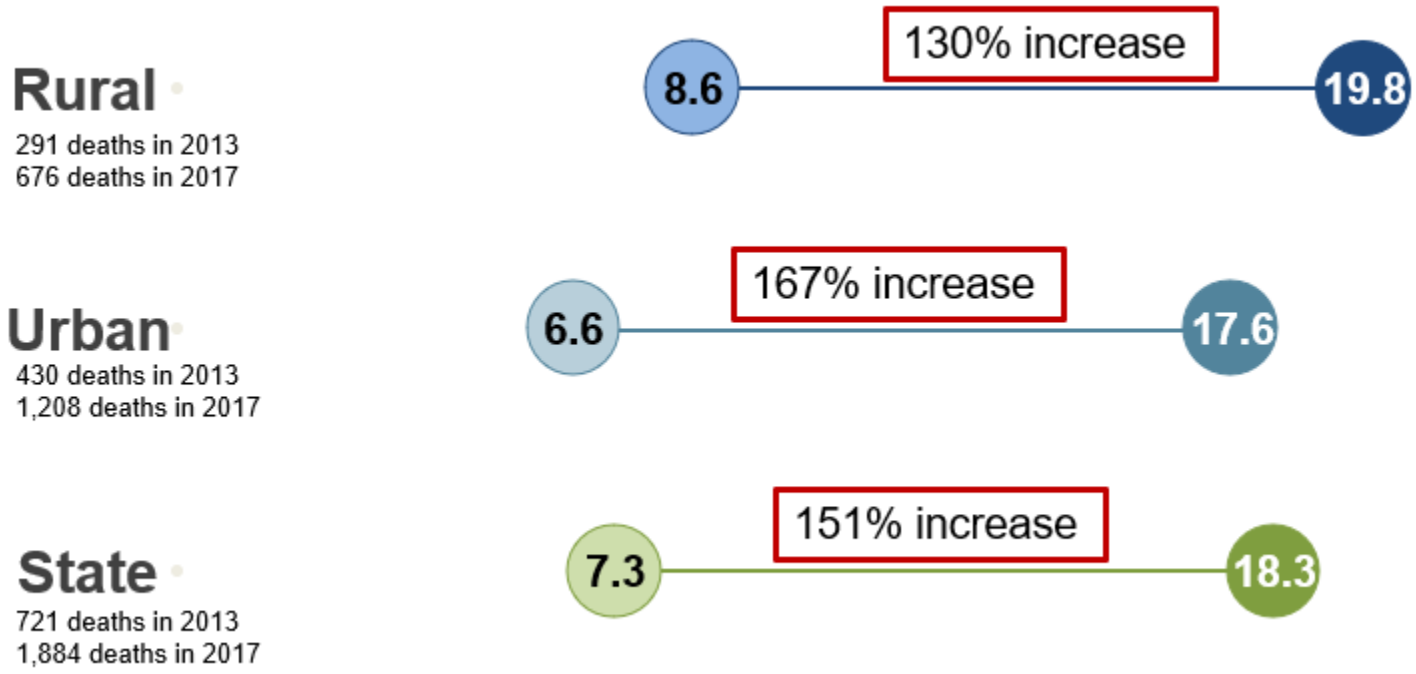
OPIOID USE DISORDER

Statewide, the unintentional opioid overdose death rate is 12.1 per 100,000 residents from 2013-2017



Technical Notes: Rates are per 100,000 N.C. residents, Unintentional medication and drug poisoning: X40-X44 and any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone),T40.4 (Other synthetic opioid) and/or T40.6 (Other/unspecified narcotics)
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2013-2017; Population-NCHS, 2013-2017
Analysis by Injury Epidemiology and Surveillance Unit

Urban counties have seen largest increase in unintentional opioid overdose death rates



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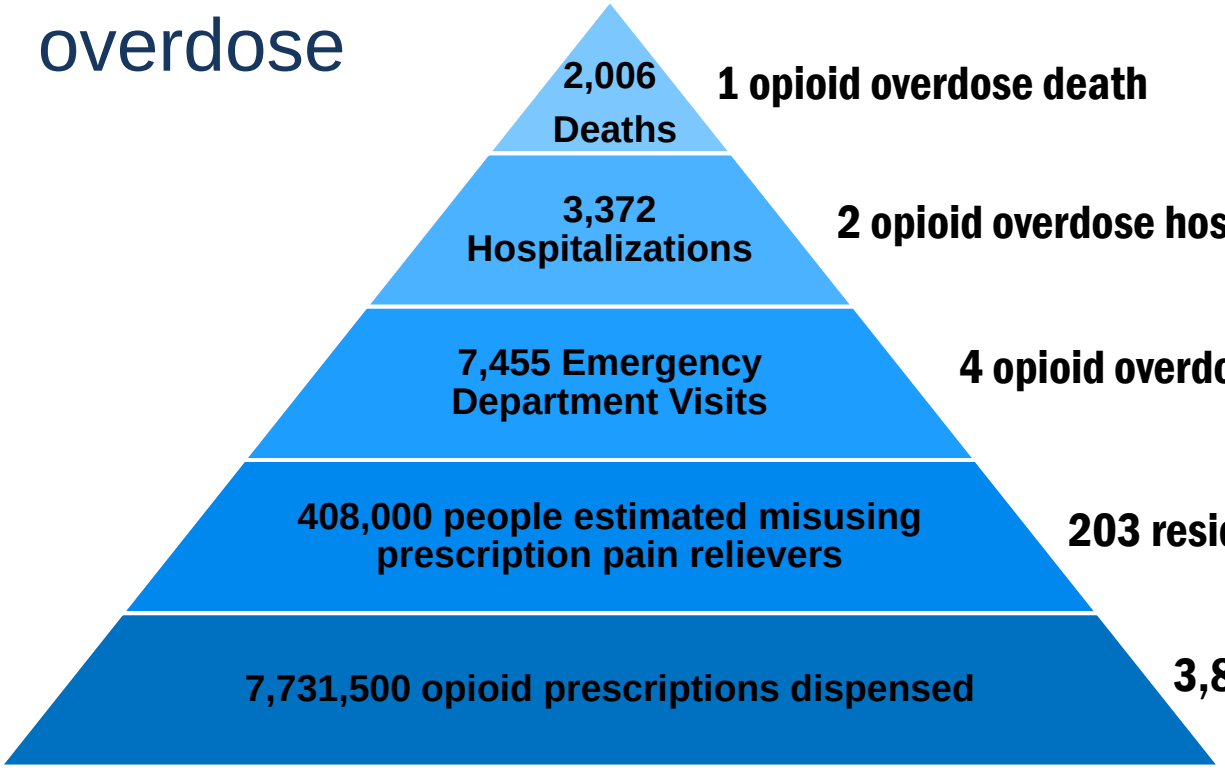
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2013-2017; Population-NCHS, 2013-2017; Primary Urban/Rural Designation definition consistent with N.C. Office of Rural Health
Analysis by Injury Epidemiology and Surveillance Unit

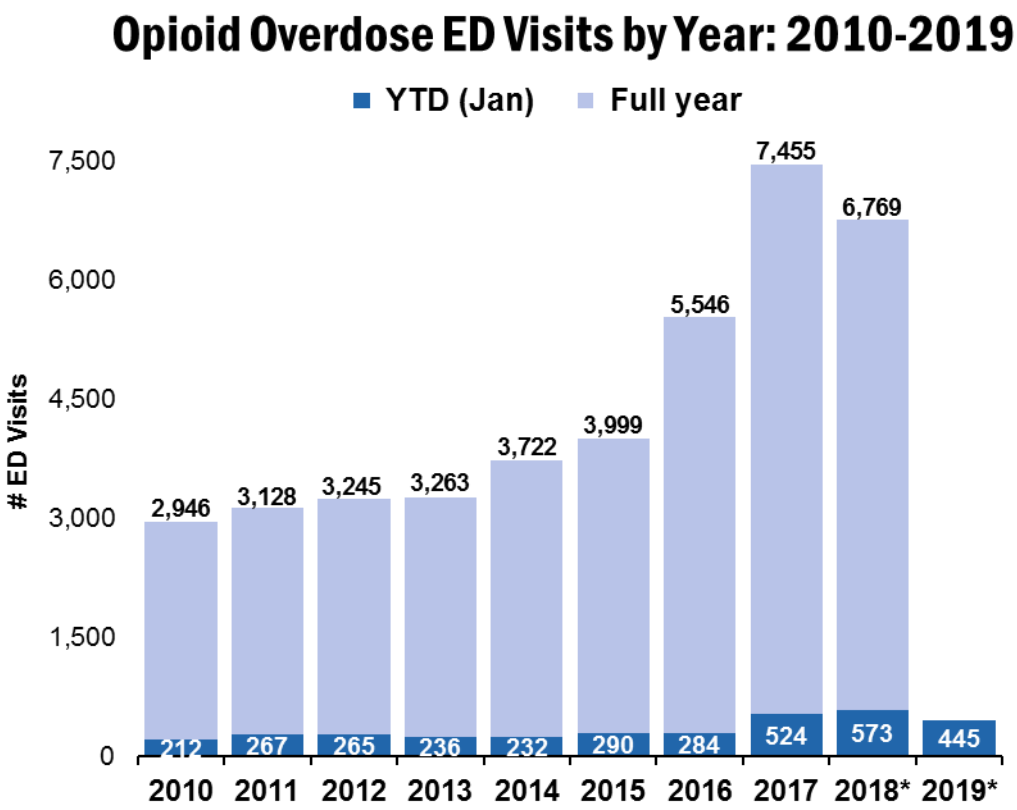
For every opioid overdose death, there were nearly 2 hospitalizations and 4 ED visits due to opioid overdose



N.C. Overdose Pyramid

Technical Notes: Deaths, hospitalizations, and ED data limited to N.C. residents; Includes all intents, not limited to unintentional
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2017/ Hospitalizations- North Carolina Healthcare Association, 2017/ED-NC DETECT, 2017/ Misuse-NSDUH, 2015-2016 applied to 2017 population data/Prescriptions-CSRS, 2017
Analysis by Injury Epidemiology and Surveillance Unit

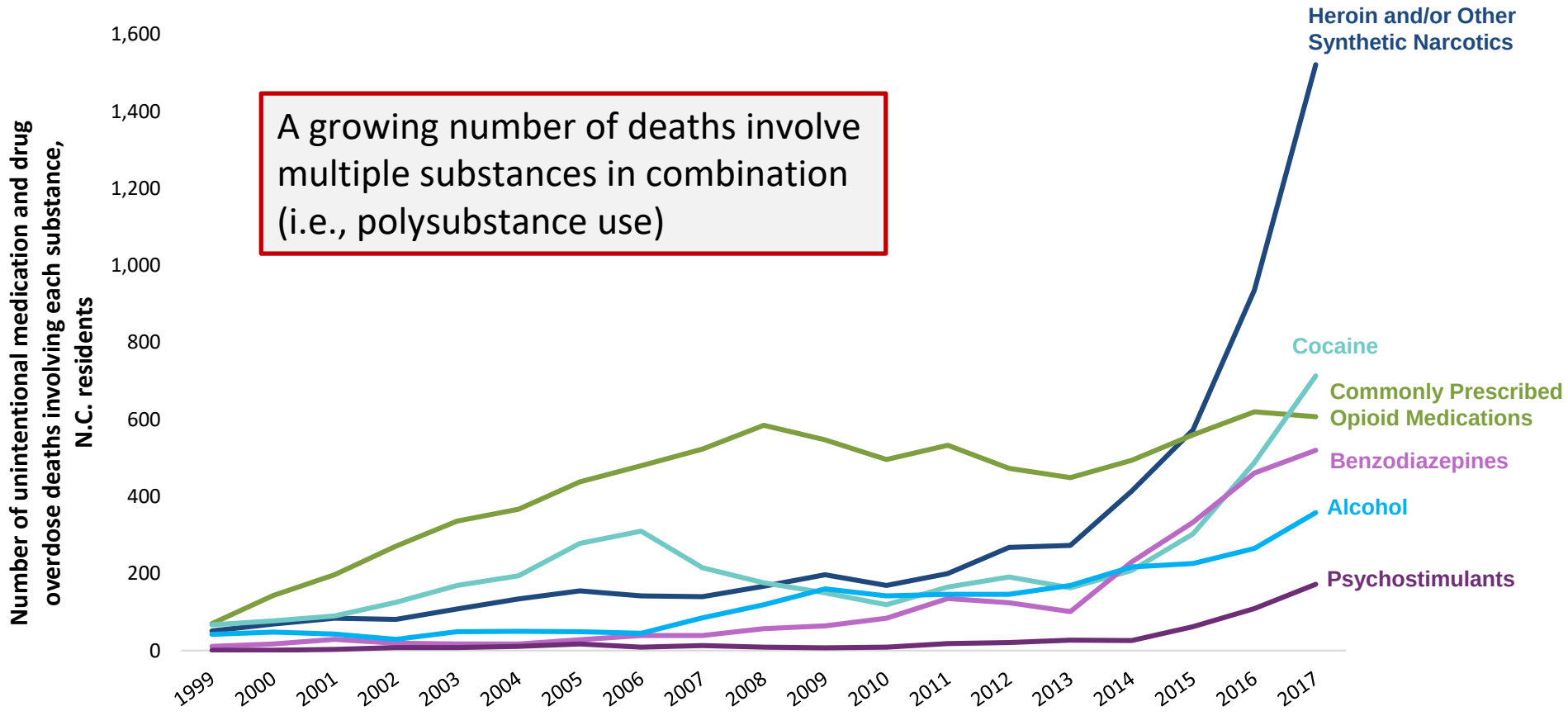
Opioid Overdose Emergency Department Visits: 2010-2019 YTD



Insurance Coverage: 2019 YTD	
Private insurance	14%
Medicaid or Medicare	29%
Uninsured/Self-pay	46%
Other/Unknown	11%

Data Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT), 2010-2019;
*2018-2019 data are provisional and subject to change; Data as of January 31, 2019.
Analysis by Injury Epidemiology and Surveillance Unit

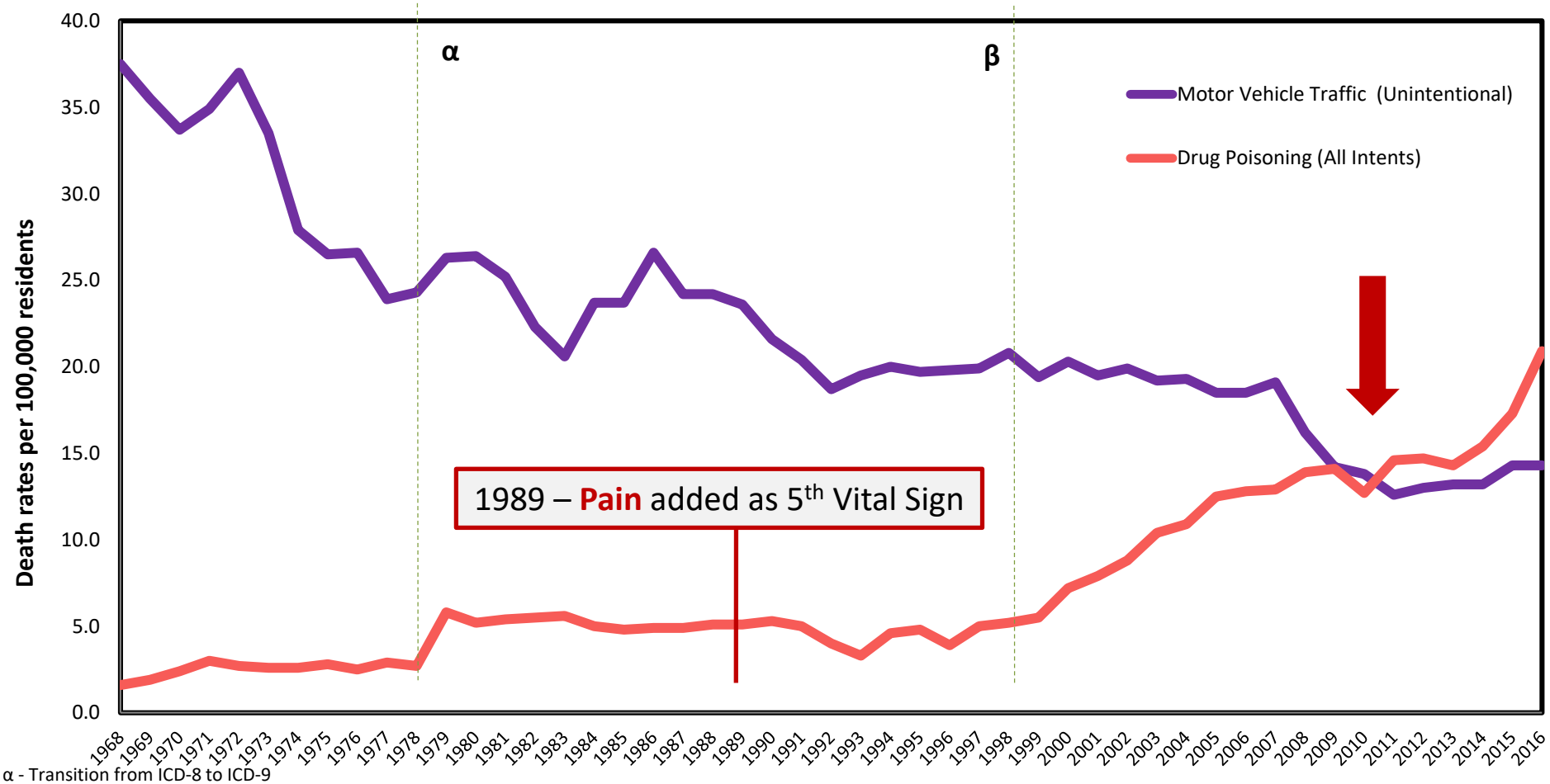
Broader: Unintentional overdose deaths involving illicit opioids* have drastically increased since 2013



*Heroin and/or Other Synthetic Narcotics (mainly illicitly manufactured fentanyl and fentanyl analogues)

Technical Notes: These counts are not mutually exclusive; If the death involved multiple substances it can be counted on multiple lines; Unintentional medication, drug, alcohol poisoning: X40-X45 with any mention of specific T-codes by drug type; limited to N.C. residents
Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 1999-2017
Analysis by Injury Epidemiology and Surveillance Unit

Poisoning death rates are higher than traffic crash death rates in N.C.



α - Transition from ICD-8 to ICD-9
β – Transition from ICD-9 to ICD-10

Technical Notes: Rates are per 100,000 residents, age-adjusted to the 2000 U.S. Standard Population
Source: Death files, 1968-2016, CDC WONDER
Analysis by Injury Epidemiology and Surveillance Unit

OPIOID ACTION PLAN

NC's Opioid Action Plan

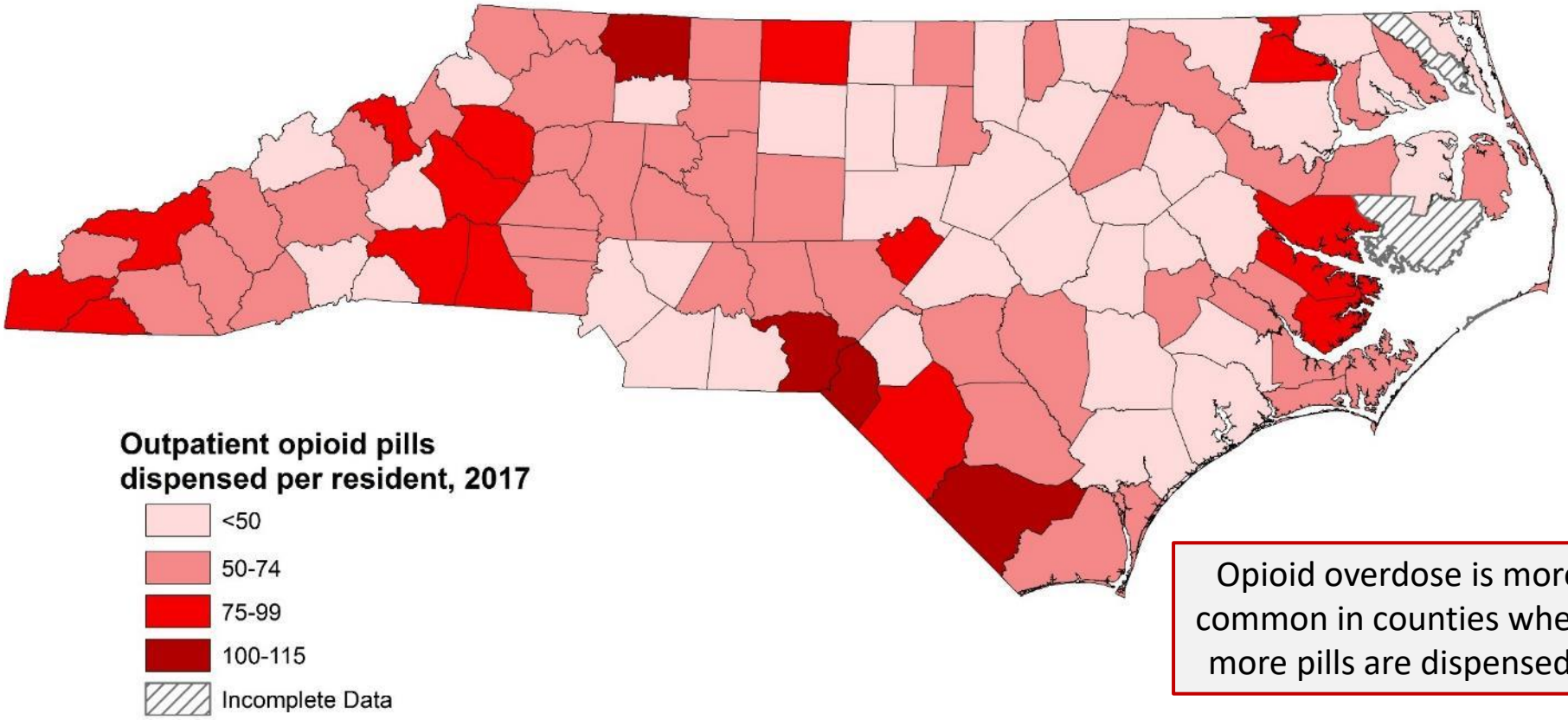
1. Coordinate the state's infrastructure to tackle opioid crisis.
2. Reduce the oversupply of prescription opioids.
3. Reduce diversion of prescription drugs and flow of illicit drugs.
4. Increase community awareness and prevention.
5. Make naloxone widely available.
6. Expand treatment and recovery systems of care.
7. Measure effectiveness of these strategies based on results.

We can do better with Medicaid expansion.

"If you're a state that does not have Medicaid expansion, you can't build a system for addressing this disease." – Dayton, OH Mayor Nan Whaley

Dayton more than halved its opioid death rate after Ohio expanded Medicaid.

Reduce oversupply of prescription opioids:
Statewide, 51 pills per resident dispensed in 2017

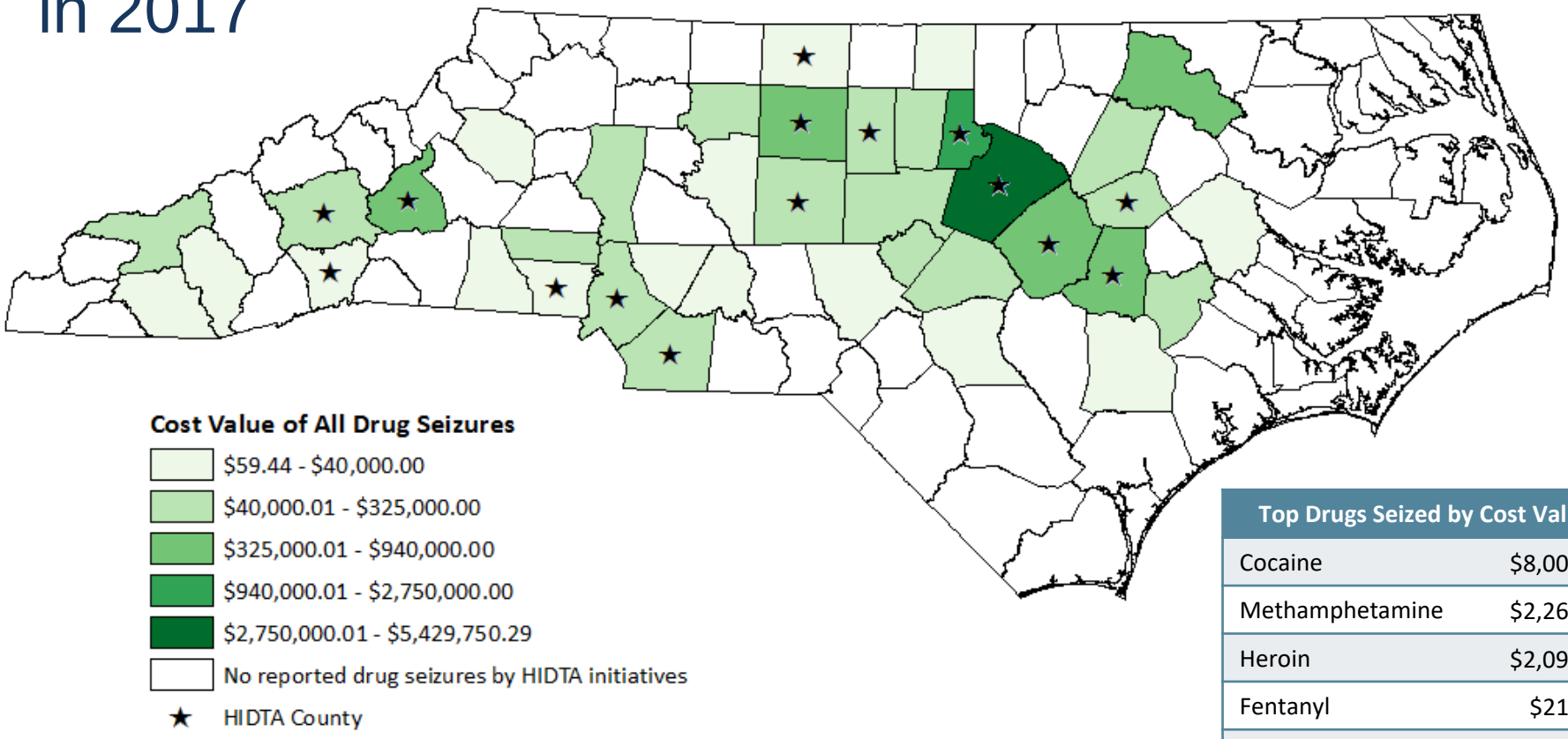


Opioid overdose is more common in counties where more pills are dispensed*

*Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics - 2011-2015; NCMJ 2017

Technical Notes: In 2017, CSRS data for Hyde and Camden counties are incomplete
Source: Opioid Dispensing – NC Division of Mental Health, Controlled Substance Reporting System, 2017; Population- NCHS, 2017
Analysis by Injury Epidemiology and Surveillance Unit

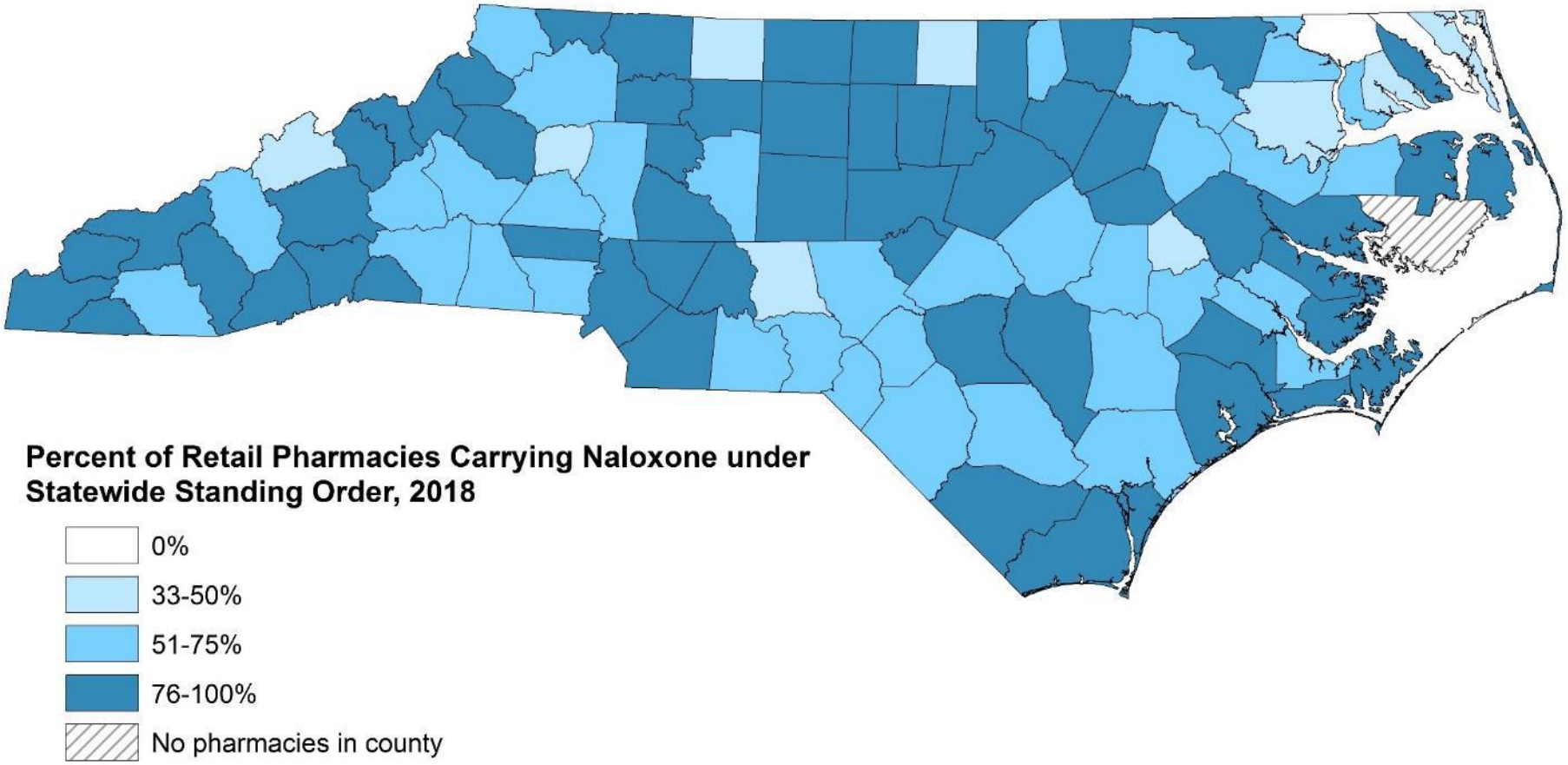
Reduce diversion of prescriptions and flow of illicit drugs: Over $12.5 million in drugs seized by HIDTA in 2017



Top Drugs Seized by Cost Value	
Cocaine	$8,007,106
Methamphetamine	$2,267,669
Heroin	$2,095,056
Fentanyl	$217,945
Prescription Opioids	$4,730

Technical Notes; Cost value of drug seizures excludes marijuana-related seizures; Cost value of drug seizures are provisional
Source: : Value of drug seizures reported by North Carolina HIDTA initiatives to Atlanta-Carolinas HIDTA in 2017
Analysis by Injury Epidemiology and Surveillance Unit

Increase community prevention: Over 85% of retail pharmacies dispense Naloxone under Standing Order

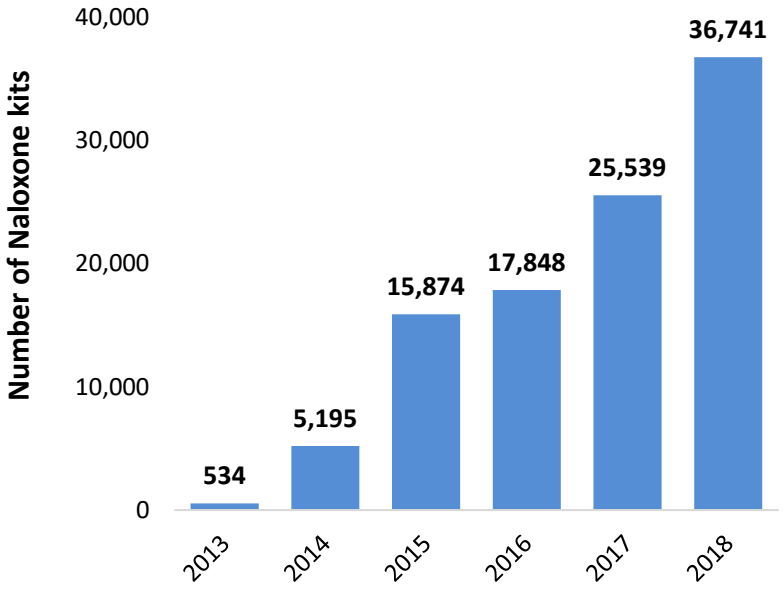


Source: Injury and Violence Prevention Branch, December 2018
Analysis by Injury Epidemiology and Surveillance Unit

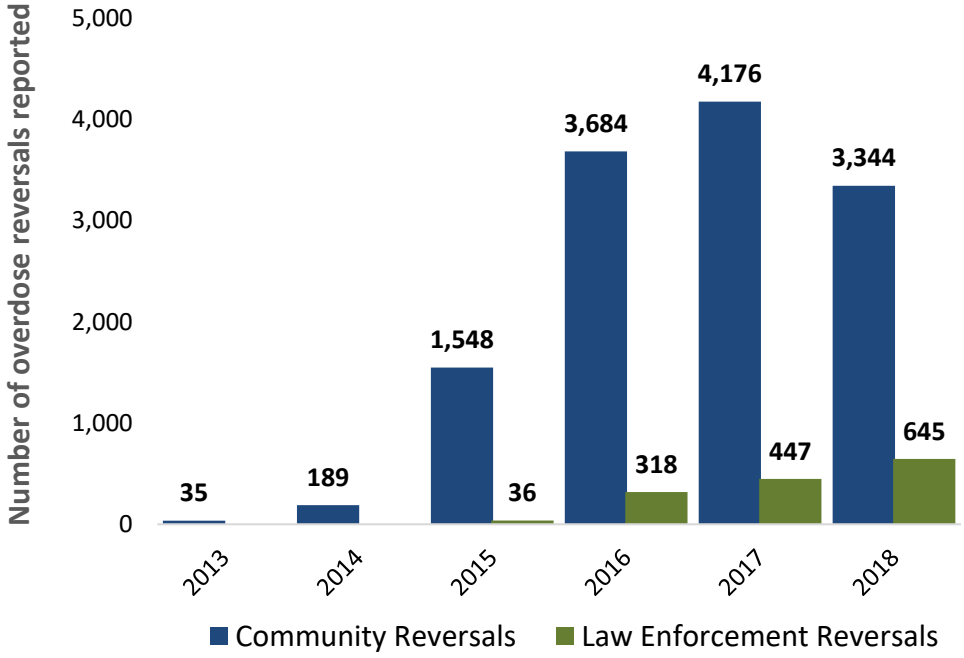
North Carolina Injury & Violence PREVENTION Branch

Make naloxone widely available: Over 101,000 naloxone kits distributed and over 14,000 reversals reported

Naloxone Kits Distributed by NCHRC

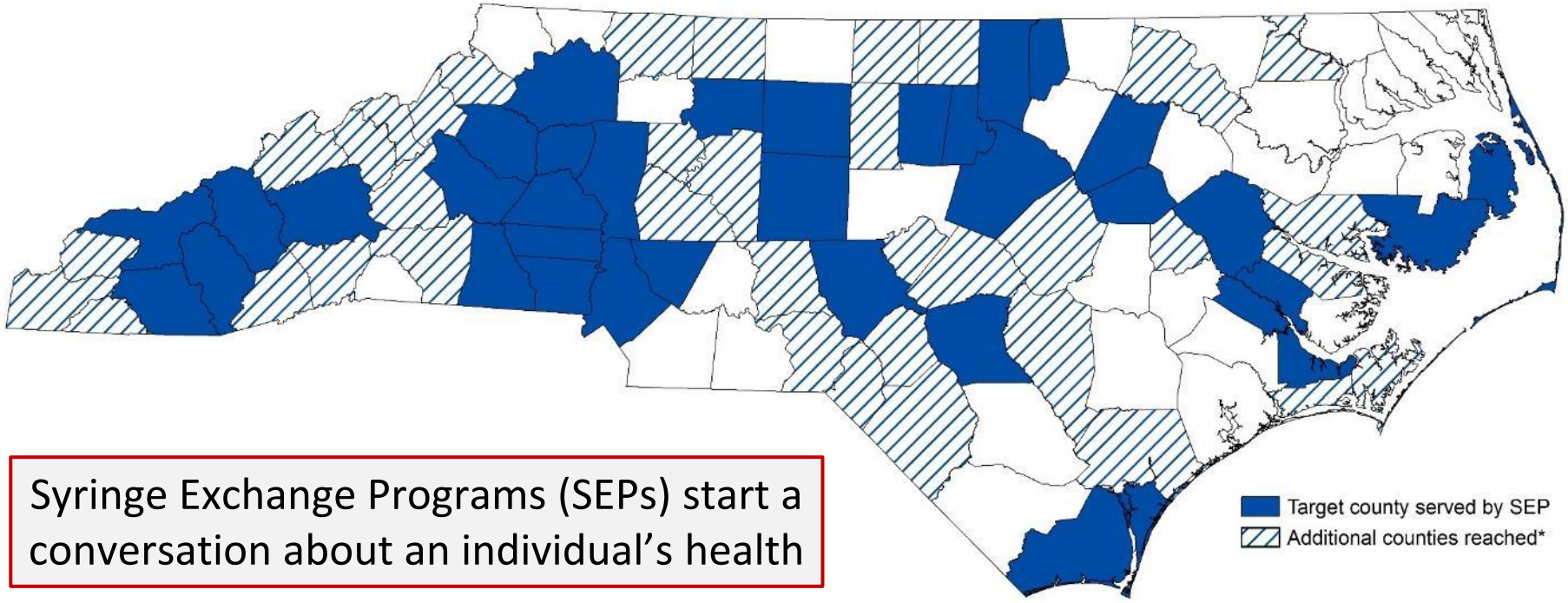


Opioid Overdose Reversals Reported to NCHRC



Technical Notes: Kit distribution and reversal reporting began in August 2013; Reversal data do not represent all reversals, just those reported to NCHRC
Source: North Carolina Harm Reduction Coalition (NCHRC)
Analysis by Injury Epidemiology and Surveillance Unit

Expand treatment and recovery:
After Year 2, 29 registered SEPs covering 34 counties



Syringe Exchange Programs (SEPs) start a conversation about an individual's health

*Residents from an additional 35 counties without SEP coverage (and out of state) traveled to receive services in a SEP target county in N.C.

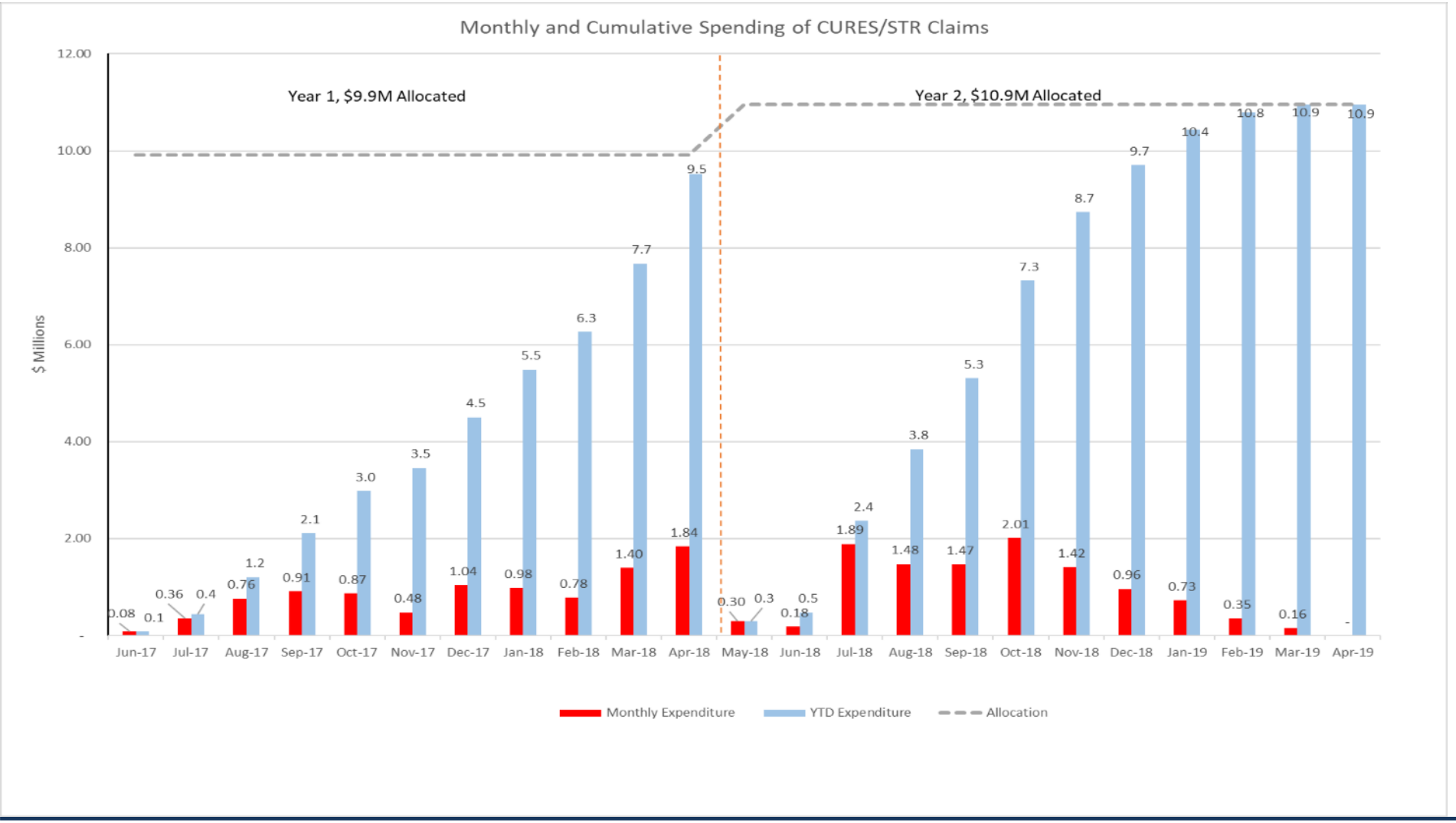
Technical Notes: There may be SEPs operating that are note represented on this map; in order to be counted as an active SEP, paperwork Must be submitted to the N.C. Division of Public Health
Source: N.C. Division of Public Health, Year 2 SEP Annual Reporting, June 2018
Analysis by Injury Epidemiology and Surveillance Unit

Federal Grants to Support Opioid Treatment

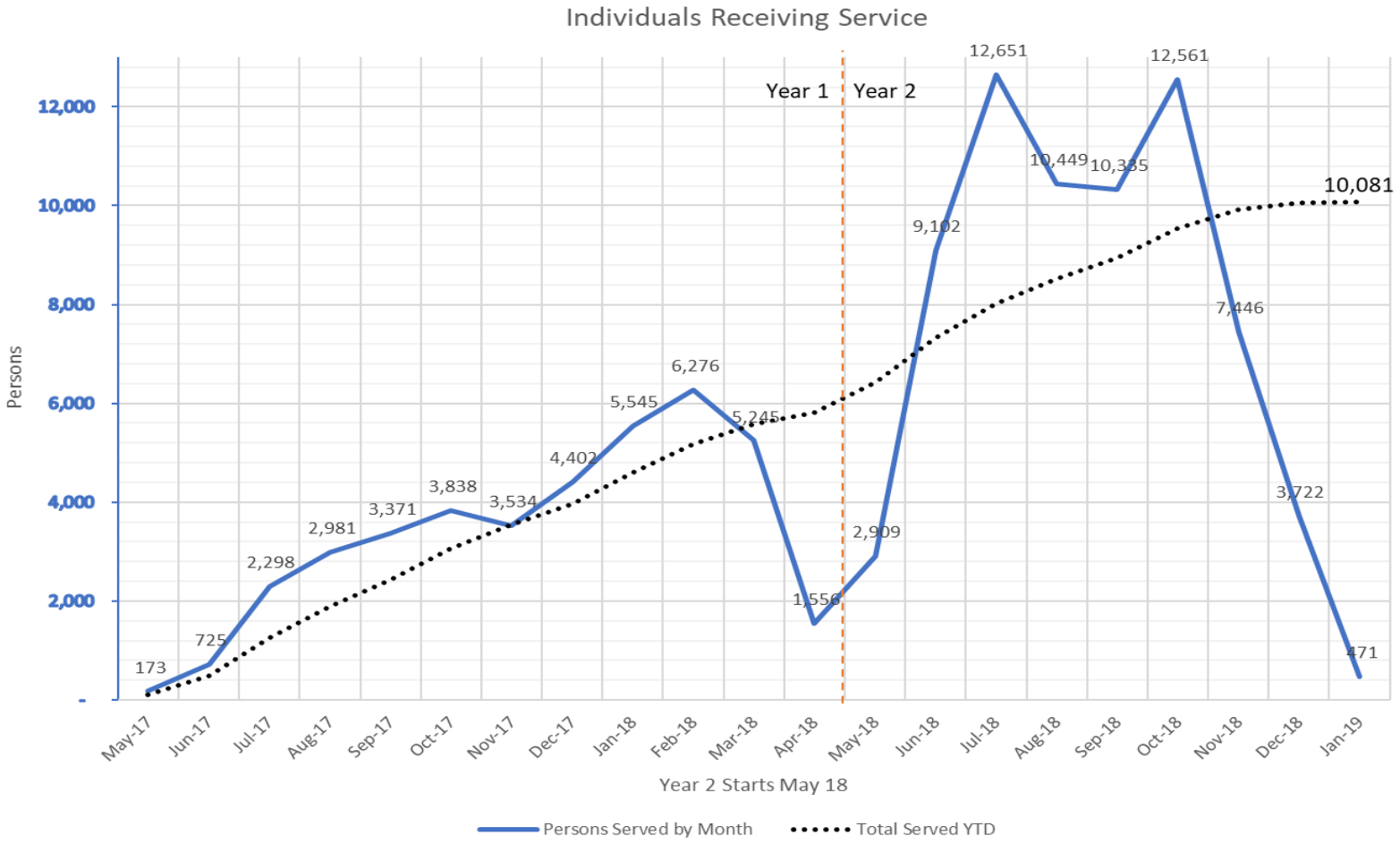
- **Cures/STR: May 1, 2017 – April 30, 2019**
  - **$15.5 M for 2 years: $31M**
  - **<u>Renewed</u> for two years, amount still unknown.**

- **SOR: October 1, 2018 – September 30, 2020**
  - **$23 M for 2 years: $46M**

Expand Treatment Federal CURES/STR grant:



About 10,000 individuals have received treatment from this funding:



Between May 1, 2017 and April 30, 2018, 33,234 individuals with an opioid use disorder received publicly-funded (Medicaid, state, federal) treatment services. Of these, 10,081 individuals received services through Cures/STR funds. 2,279 of these individuals received services in Year 1 and Year 2 of the Cures/STR grant.

State Operated Healthcare Facilities

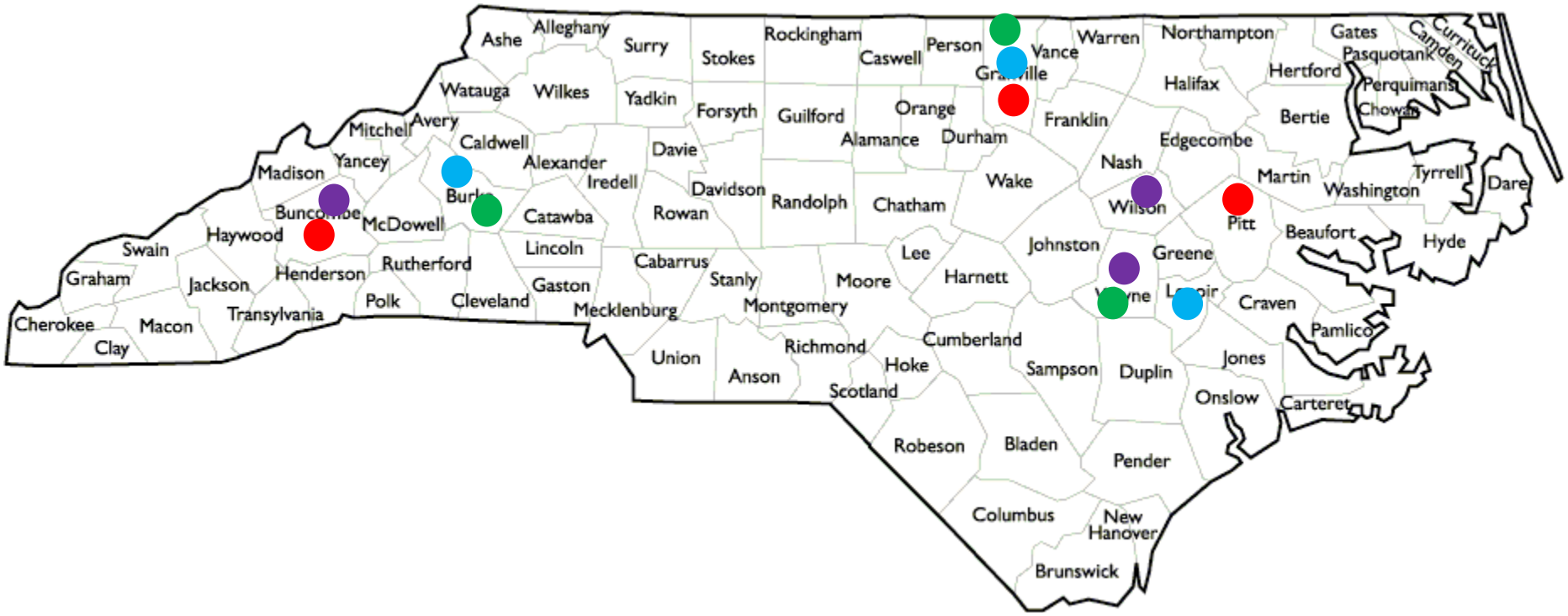
Overview of State Operated Facilities

- **Psychiatric Hospitals**
- **Alcohol and Drug Abuse Treatment Centers (ADATC)**
- **Developmental Centers**
- **Neuro-Medical Treatment Centers (NMTC)**
- **Children's Residential Programs – *Wright and Whitaker***

System Priorities

- **Ensure the protection and safety of the people we serve**
- **Create a high reliability and safety culture**
- **Provide evidence based best practices**
- **Maximize existing resources and fiscal efficiency**

Overview of State Operated Facilities



- Inpatient
- ADATC
- Neuro-Medical
- Developmental Centers

Psychiatric Hospitals

Psychiatric hospitals provide care and treatment for adults, children and adolescents who have psychiatric illnesses and whose needs cannot be met in the community. Inpatient services include crisis stabilization, assessment, medical care, psychiatric treatment, patient advocacy, social work services including counseling, discharge planning and linkages to the community.

- Broughton, Morganton
- Cherry Hospital, Goldsboro
- Central Regional Hospital, Butner

Children's Residential Programs

The residential programs are for children and adolescents who have severe emotional and behavioral needs. Both employ a re-education model which prepares the child/adolescent to successfully return to the community.

- Whitaker, Butner
- Wright School, Durham

Alcohol and Drug Abuse Treatment Centers

ADATCs are designed to treat persons with addictions and/or co-occurring disorders (addiction and mental health diagnoses). They provide crisis stabilization, detoxification services, substance abuse treatment and education, psychiatric services, rehabilitation therapy, social work, nursing, psychological and collateral treatment services for family members of consumers served.

- R.J. Blackley, Butner
- Walter B. Jones, Greenville
- Julian F. Keith, Black Mountain

Developmental Centers

The Developmental Centers provide comprehensive residential supports to maintain and improve the health and functioning of individuals with intellectual and/or developmental disabilities (IDD). The services may include time-limited, specialized programs for individuals in identified target populations (Autism, IDD/MI, etc.) with the goal of community reintegration. The types of admissions include general, therapeutic, respite and specialty programs.

- Caswell, Kinston
- Murdoch, Butner
- J. Iverson Riddle, Morganton

Neuro-Medical Treatment Centers

The Neuro-Medical Treatment Centers are specialized skilled nursing facilities serving individuals who have chronic, complex medical conditions that co-exist with neurological conditions often related to a diagnosis of severe and persistent mental illness, and intellectual and/or developmental disability.

- Black Mountain, Black Mountain
- Longleaf, Wilson
- O’Berry, Goldsboro