Medicaid in the Long Session

The 2015 long session officially began on January 14th. Legislative bills began to be introduced on January 28th, and true legislative activities will pick up once the Governor introduces his budget bill and the House begins its work on his proposed budget. That could happen sometime in February or March. The long session is officially scheduled to end June 30th, but this date will likely be impacted by budget negotiations and related controversy. The long session signals the beginning of legislative proposals that can conceivably stay in play through the short session of 2016. All bills that were introduced in previous sessions, but not acted upon can no longer be considered, but a number of topics that were introduced in past sessions are likely to arise again.

What many thought would be a high legislative priority for MH/DD/SA this session – the proposed restructuring of Medicaid and the reorganization of Medicaid with the Department of Health and Human Services - does not seem to be front and center at this time. Time will tell if the leadership of the House and Senate can come to some agreements on Medicaid. There are two issues tied into Medicaid restructuring that have taken two different tracks of consideration.

The first is the restructuring of the Medicaid program. During the legislative sessions of 2013 and 2014 there was considerable discussion about the possibility of shifting the fiscal structure of Medicaid for primary healthcare to a managed care system. The debate was heavy over whether this would be a home-grown model of Accountable Care Organizations or a model of private managed care companies. The debate also included the issue of how to incorporate the specialty population of consumers with MH/DD/SA issues. The NC Council and many of its partners continue to support having the specialty population funding separate and managed by the public LME-MCOs. Recently, the Joint Legislative Oversight Committee on Health and Human Services (a committee that is not authorized to meet during the legislative session) passed a proposal that incorporated the following principles into a Medicaid managed care system over the next three years (if feasible):

- Shared financial risk
- Defined, measurable goals for outcomes, quality of care, patient satisfaction and cost
- Accountability for coordinated care, positive health outcomes and controlling cost
- Regional access to care
- Administrative efficiencies

The second issue, the reorganization of the state’s Medicaid administration, was considered by a subcommittee of the Program Evaluation (PE) Legislative Oversight Committee. The subcommittee recommended to the full Program Evaluation LOC that Medicaid remain under DHHS with a separate oversight board and Medicaid Director who would not report directly to the DHHS Secretary. The PE LOC does have the authority to meet during the legislative session. At a January meeting it did include the proposal “for discussion only” on the agenda with no action taken. Co-Chair Senator Hartsell noted the many new members of the PE LOC and that they had not had an opportunity to participate in the debate. DMA Director Robin Cummings presented a statement from DHHS in opposition to the proposal.

Oversight of ADATCs

A proposal that was passed by the Program Evaluation LOC, and presented as a draft bill (not yet introduced into legislation), has to do with bringing all substance abuse services under the management of the LME/MCOs and moving the state’s Adult Drug Abuse Treatment Centers (ADATC) funding to LME/MCOs to manage. The draft legislation discusses transitioning these dollars to LME/MCOs and requires them to submit plans to the State describing how they will utilize the new funding to build community capacity, reduce service gaps, and purchase services from the ADATCs. The bill was amended during the LOC session to remove a prescriptive re-allocation of the ADATC dollars, but did not delete a corresponding section related to the LME/MCO management.

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**February**

**March**

**SAVE THE DATES**

**NC Council Upcoming Trainings**
- **February 19, 2015**, Cognitive Developmental Aspects of Substance Abuse and Personality Disorders, Royal Conference Center, Raleigh
- **February 23, 2015**, Clinical Supervision, Gastonia NC
- **February 26, 2015**, Corporate Culture & Turnover: How it Affects Your Bottom Line Royal Conference Center, Raleigh, NC
- **March 10, 2015**, Implementing Evidence-Based Practices and Stages of Change in Co-Occurring SA and MH Disorders, NC Council Office, Raleigh, NC
- **March 11-12, 2015**, Clinical Supervision, Raleigh, NC
- **March 13, 2015**, Cognitive Developmental Aspects of Substance Abuse and Personality Disorders, CoastalCare, Wilmington, NC
- **March 17, 2015**, DSM-5 Training, CoastalCare, Wilmington, NC
- **March 18, 2015**, The Ethics of Cultural Competency in Behavioral Health, Raleigh, NC
- **March 19, 2015**, Motivational Interviewing, Raleigh, NC
- **March 23-24, 2015**, LOCUS/CALOCUS Train-the-Trainer, Raleigh, NC
- **March 27, 2015**, Being and Becoming a Trauma Informed Agency / TBI: Hidden in Plain Sight, Raleigh, NC
- **March 30, 2015**, Advanced Motivational Interviewing, Raleigh, NC

For more information and to register online go to www.nc-council.org/trainings or contact Laura Ring, Training Coordinator at laura@nc-council.org.

Information at www.nc-council.org/trainings/conferences
NC Council takes Position on LME/MCO Consolidation

Recently, the NC Council clarified its position on the issue of LME-MCO consolidation. The following position statement was developed and approved by the NC Council Board of Directors in late 2014:

In December of 2013, in collaboration with DHHS leadership, the NC Council, on behalf of its membership, agreed to work towards consolidation of LME-MCOs, with a target of 4 regional LME-MCOs. This agreement was made in order to support the following set of principles and goals:

• Support the public management of the behavioral healthcare system
• Ensure that the unique needs of consumers are addressed thru a specialty system of care
• Establish a system which saves money, ensures cost predictability, and improves outcomes
• Eliminate the profit motive and its impact on scarce resources
• Increase statewide standardization and streamlining
• Advance the commitment to treating the whole person in community settings that also address environmental barriers such as housing and employment, and
• Recognize that the LME-MCO model with the Medicaid 1915(b)(c) waiver was built specifically for the needs of North Carolina and is demonstrated to be a responsive system.

North Carolina’s leadership continues to define the structure and goals for an integrated healthcare system for Medicaid recipients. We believe that this yet-to-be-defined architecture requires the LME-MCOs to maintain some flexibility in their structures. During this time, LME-MCOs continue to work on structural models:

• LME-MCOs are actively pursuing multiple structural options that include organizational consolidations and are working with community partners to explore opportunities.
• ALL LME-MCOs are continuing to work on standardization and streamlining of operations and business practices — both regionally and state-wide that enhance consumer outcomes and support a stable and qualified network of providers.
• ALL LME-MCOs continue to be active in developing partnerships and strategies to integrate care at the local level
• All of these efforts assist the State in building capacity to rapidly move toward the vision for Medicaid restructuring once it is determined, and
• ALL of these activities support the appropriate role and authority of the LME-MCOs as defined in the Medicaid 1915(b)(c) waiver.

Future Consolidations

In 2014, the General Assembly passed a law requiring that LME/MCOs consolidate into 7 entities by July 1, 2016.

ECBH and CoastalCare have announced their intent to consolidate their programs and form a new agency as of July 1, 2015. The new public agency will serve 24 counties in eastern North Carolina. “ECBH and CoastalCare have stayed true to our consumer-focused missions through these recent transitions and have met every expectation set by DHHS,” said CoastalCare CEO, Foster Norman. “As a new entity, this organization will continue the dedicated service offered by its predecessors. We are looking forward to continuing to serve the communities of eastern North Carolina.”

Maintaining a local presence and taking the least disruptive approach for consumers, families, providers, the community, and employees of the current agencies is paramount for the new organization. With a total population of 1,259,757—and an estimated 165,000 of those people eligible for Medicaid—the combined agency will have a budget of approximately $400 million annually.

In addition, to the consolidation, it was recently announced that ECBH and CoastalCare have formed a strategic partnership with Cardinal Innovations to bring the new entity onto Carinal Innovations information technology system and platform. "Business systems are the backbone of any managed care organization. With better systems, we have better data, better services and better outcomes for the individuals and families we serve. This partnership is one more step in the maturing of North Carolina’s public managed care system. Cardinal Innovations Enterprise is a cutting edge, integrated platform that meets the unique needs of North Carolina’s managed care environment and is easily expandable to meet the changing needs of consumers and providers in the future,” said Leza Wainwright, ECBH’s Chief Executive Officer.

ECBH and CoastalCare are in the process of working with their communities to choose a name for the new entity. The announcement should be made soon.
State Outlines Transition Plan to Comply with Federal HCBS Requirements

MH/DD/SA Stakeholders have 30 days (until February 20) to review and comment on the Department of Health and Human Services’ Transition Plan that outlines how NC will implement the new federal Home and Community Based Services (HCBS) Rules affecting those served on the 1915 (c) Innovations Waiver. The federal rules became effective in March, 2014. The State plan includes a tool to assess current provider settings, and includes strategies and implementation timelines for meeting the new requirements. The Centers for Medicare and Medicaid (CMS) has given states time to develop and implement these changes through 2018. The NC Transition Plan can be found at www.ncdhhs.gov/hcbs. Once feedback is received on the Transition Plan it will be submitted to CMS in March for approval.

Last spring, the DHHS began working with a Stakeholder Committee to develop the transition plan. The committee includes recipients and their families, I/DD representative organizations, provider associations, LME/MCOs, and local service providers. The state also initiated a statewide “listening tour” where DHHS officials held public meetings in order to receive feedback first hand from consumers, families and other stakeholders. Listening tours are also occurring this month on the transition plan.

The new rules are aimed at allowing individuals served under the waiver more control over decisions about where to live, work, and how they want to participate in their communities.

Rule Requirements

The Federal Rules for HCBS require providers to offer recipients full access to the individual’s community and services in the most integrated setting appropriate. Specifically HCBS settings are required to:

- Be integrated in and support full access to the community at large
- Offer opportunities for consumers to seek employment in competitive, integrated setting and engage with community and control their resources.
- Ensure individuals receive services in the community to the same degree those not on the waiver do.
- Be selected by the individual and include non-disability specific settings as an option or private unit in a residential setting (with financial consideration)
- Ensure individuals right to privacy, dignity, respect and freedom from coercion and restraint
- Optimize but not regiment individual initiative, autonomy and independence in making life choices; and facilitate choice regarding who provides services and supports.

Provider owned or controlled residential settings have several additional requirements to include the provision of privacy in sleeping or living unit; freedom for individuals to control schedules or activities, access to food, allowing visitors and physical accessibility.

Transition Plan

In order to ensure that providers are in compliance, the process will start with a self-assessment. A Provider Self-Assessment Tool has been drafted with input from the Stakeholder Committee, and feedback is being sought. In addition, a pilot of the Self-Assessment Tool will be completed before it is used statewide. The assessments will be submitted to DHHS and LME/MCOs for review and approval. Providers not meeting the rule requirements must submit a plan outlining changes they will implement in order to meet the requirements. Once statewide provider assessments are complete, the state will conduct education and training. If the current transition plan is adopted, the Provider Assessments will occur between now and May 31, 2015.

Administrative changes to the Innovations Waiver may include changes for LME-MCOs around care coordination and utilization management. LME/MCOs will be required to comply with the HCBS rules and will be asked to review their business practices and make the necessary changes to ensure compliance.
continued from cover... Medicaid in the Long Session

LME/MCO CEOs discussed the proposed legislation at a recent NC Council Forum meeting and are supportive of bringing ADATCs into their provider networks to manage as a part of the entire service system.

Medicaid Expansion

The Governor has indicated some willingness to consider expansion of Medicaid under the Affordable Care Act (ACA) with specific waivers that would make ours a “North Carolina Plan.” After a January meeting between a number of governors and President Obama, it was reported that Governor McCrory asked the President about the possibility of linking Medicaid eligibility to jobs or job training. While there was not agreement on this point, since that time, CMS and the state of Indiana have agreed on an expansion plan with several provisions that may be of interest to NC’s leadership. CMS did not approve a work requirement as was requested by Indiana for Medicaid eligibility as part of state’s expansion plan, but is allowing the state to encourage employment through a state-funded incentives plan. Other state specific elements in the Indiana plan that might be considered for North Carolina include the establishment of “health accounts” funded in part by beneficiaries to help pay for their care, incentives to receive preventative care, and a six month “lock-out” from Medicaid’s essential benefits for consumers who stop paying their health account premiums. The service lock-out would only apply to consumers above 100% of FPL (federal poverty level) who are not medically frail.

In the press release about the Indiana expansion, CMS Administrator Marilyn Tavenner said, “HHS and CMS are committed to working with states to design programs uniquely their own, while maintaining essential health benefits guaranteed under the Affordable Care Act and other key consumer protections consistent with the law.”

In his recently delivered State of the State speech, concerning Medicaid, expansion, McCrory said, “As we continue to review health care options for the uninsured, we are exploring North Carolina-based options that will help those who can’t help themselves, and encourage those who can. If we bring a proposal to cover the uninsured, it will protect North Carolina taxpayers. And any plan will require personal and financial responsibility from those who would be covered.”

In general, North Carolina’s General Assembly has not publicly supported a move to expand Medicaid under the ACA.

Track MH/I-DD/SA Legislation

All stakeholders are invited to use the NC Council’s legislative database to track legislation that is pertinent to MH/I-DD/SA services during this session. The database is accessible at ciclt.net/nc-council with the user name “nccouncil” and password “nccouncil123”. It is also accessible through the NC Council’s website at: www.nc-council.org. Look for the link under “policy.”

Staff Hired to Support LME/MCO Provider Stakeholder Work

In order to continue the progress of the LME/MCO Provider Stakeholder work being done by the Steering Committee and its subcommittees on business practices and information technology, a decision was made to hire a Program Specialist to provide support in driving forward implementation of shared policy/practice decisions by the groups. The new position is jointly funded by the NC Council of Community Programs, Benchmarks and the NC Provider’s Council.

The position was recently filled by Janet Schanzenbach, MPA. Schanzenbach has over 25 years of experience in the MH/DD/SA service system serving in a number of positions including Executive Director of NC Association of Rehabilitation Facilities, Deputy Director of the NC Council of Community Programs, and lobbyist for the NC Providers Council.

Schanzenbach’s role will be key to ensuring that information and communication flow between the committee and stakeholder groups via regular updates. She will also provide administrative support needed to assist in moving a variety of processes forward. “I am extremely proud that our three organizations have come together to so clearly support the critical work of the LME-MCO Provider Steering Committee,” stated Mary Hooper. “The support by our respective boards of directors for this shared position serves as proof positive of our awareness that the success of the public behavioral healthcare system in North Carolina requires a seamless interface between LME-MCOs and provider organizations. The LME-MCO Provider Steering Committee and its subcommittees is integral to this process.”
LME/MCOs and CCNCs Working Together to Integrate Care – A Snapshot

Did you know that North Carolina’s LME-MCOs and CCNC local networks have been involved in collaborations to create and maintain integrated care activities since 2009? Since that time, both at the state and local levels, organization representatives from LME-MCOs and CCNCs have committed time and staff to these efforts that improve care for Medicaid consumers/patients. A myriad of projects have been developed to address the needs of consumers and that reflect the unique needs of the communities in which they live.

Here is a snapshot of current LME/MCO and CCNC activities:

- 7 joint efforts around improving care to consumers in Emergency Rooms and reducing reliance on Emergency Rooms for care
- 3 Integrated Health Teams
- 7 projects to improve prescribing practices - ensuring the right medicines for consumers
- 6 BH/PCP Meet and Greets – Behavioral health and primary healthcare professionals have an opportunity for face-to-face interactions
- 5 joint efforts around managing chronic pain
- 6 projects to improve care for children and adolescents

In addition to service development projects, more recently LME-MCOs and CCNC have successfully entered into data agreements to ensure that critical information is shared and available. Data is key in communication between primary and behavioral healthcare, both at the individual consumer level and at the population level. Data sharing reports include: care coordination and population management; identification of high risk consumers; admission discharge data; and pharmacy information.

Other local efforts include: joint network meetings between LME/MCOs and their regional CCNC offices, programs with regional psychiatric hospitals; hosting joint teams at hospitals and reconciliation of pharmacy and medicine information.

LME/MCO Crisis Update: Four Facility Crisis Center Grants Awarded

Last year the General Assembly appropriated $2.2 million in recurring state funds and federal block grant dollars to fund the Division of MH/DD/SAS’s Crisis Solutions Initiative for four new facility-based crisis centers. LME/MCOs were given the opportunity to partner with providers and community stakeholders to develop proposals for these funds. Recently four LME/MCOs were awarded grants: Cardinal Innovations, CenterPoint Human Services, Eastpointe, and Smoky Mountain Center.

The new crisis facilities will provide focused community behavioral health care as an alternative to hospital emergency room treatment where consumers are not always served in a timely manner due to the complexity of their needs. Providing local inpatient care, staffed by MH/I-DD/SA professionals 24/7, will give LME/MCOs an important resource in their crisis care continuum.

In addition to the facility-based grant awards, all LME/MCOs have been working to build on and improve their crisis services continuum including training EMS workers, educating the community, and using Peer Support Specialists during crisis. An update on those activities is also provided below.

Facility-Based Crisis Grants
Cardinal Innovations – Partnering to Develop Child Adolescent Crisis Care

To address the unmet crisis needs of children and youth in their county, Cardinal Innovations’ Mecklenburg Community Operations Center partnered with Monarch to develop the grant proposal in collaboration with children’s advocates and stakeholders to address these needs. The center will provide crisis stabilization for youth who do not require an inpatient level of care, but who cannot be stabilized in the community. The facility will be staffed with RNs, MDs, licensed therapists and psychologists and is expected to begin operation in June.

Daniel Brown, Monarch’s Chief Clinical Officer said, “We are extremely excited about the opportunity to partner with Cardinal Innovations and others to develop North Carolina’s first child-adolescent Facility-Based Crisis program. This innovative facility will serve as a diversion point for children and adolescents away from emergency departments and inpatient hospitalization and is a critical addition to the system of care in Mecklenburg County. This partnership is an example of the way a community can work together to provide the necessary care for individuals with very complex needs.”

Nicole McKinney, Cardinal Innovations’ Vice President of Community Operations for the Mecklenburg Region, said, “We have spent the last few months extensively examining ways to strengthen our crisis continuum of care here in Mecklenburg County for both children and adults. We are so excited to be given the opportunity to pioneer the launch of a child and adolescent facility-based crisis center here in Mecklenburg County and in North Carolina. It will add a critical piece to our crisis continuum puzzle. We are very fortunate to partner with committed community stakeholders that have supported this effort with us. I especially commend Monarch... Continuous on page 7...
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**LME/MCO Crisis Update: Four Facility Crisis Center Grants Awarded**

for their leading efforts with the new center and look forward to fitting more community pieces into the puzzle that will support Cardinal Innovations’ purpose to enhance the health and well-being of individuals and their families.”

**CenterPoint Human Services - New Facility to Provide Whole Person Care**

CenterPoint Human Services, a recipient of the state grants, is moving forward with plans to build a facility-based crisis center and behavioral health urgent care center in the heart of Winston-Salem’s area of greatest need. The Center will be designed to promote three central principles of effective behavioral health care: whole person care; recovery-focused services and supports including Peer Support Specialists; and trauma-informed care.

CenterPoint recently submitted over 40 letters of support from law enforcement, first responders, hospitals, community advocates, providers, local government, advisory groups, Foundations and other stakeholders to the NC Department Health and Human Services in its application for funding assistance. The intended location has been rezoned to permit the new construction. Through a competitive Request for Qualifications process, an architectural firm was selected to oversee the project.

In addition to providing much-needed access to urgent/crisis care for residents with behavioral health challenges, the Center will bring community revitalization and employment opportunities to the area. The Center is expected to greatly reduce the usage of hospital emergency departments for behavioral health conditions.

**Eastpointe - Crisis an Opportunity to Serve**

President John F. Kennedy once said that, when written in Chinese, the word “crisis” is composed of two characters. One represents danger and the other represents opportunity. Eastpointe is dedicated to cultivating opportunities to serve the people of Eastern North Carolina, and to this end, enthusiastically supports Monarch in the expansion of a 9 bed facility-based Crisis Center (FBC) in Lumberton, NC. This facility will move toward the acceptance of individuals who are on Involuntary Commitment (FBC) in Lumberton, NC. This facility will move toward the acceptance of individuals who are on Involuntary Commitment (IVC) status and will be increasing to sixteen FBC beds. In addition, Monarch will be adding a level 4 behavioral health care urgent center capability to ITS current facility-based crisis center. This will offer an additional alternative to the community for meeting behavioral health needs in an emergency situation, thus shifting the current “front door flow” away from the hospital Emergency Department (ED) and towards a community program that can assess, petition and work on placement if necessary, hopefully with the result of bypassing the ED altogether. By adding the urgent care center, individuals will have a place they can walk into 24/7 when in crisis. This center will be able to complete comprehensive clinical assessments, petition for involuntary commitments, and process required paperwork for the magistrate’s office.

The focus on crisis interventions is not limited to one location, but has been the mission of Eastpointe in all 12 counties served through trainings in Mental Health First Aid (MHFA) and the CIT (Crisis Intervention Team) continuum. Toward this endeavor, Eastpointe provides Mental Health First Aid (Youth, Adult, and in the future Military focused) trainings designed to help individuals, families, and communities better understand mental illness and respond to psychiatric emergencies. The eight-hour course gives participants a 5-step action plan to use in crisis situations involving individuals with mental illness or substance use disorders. And with the understanding that no one succeeds alone, Eastpointe is committed to supporting community stakeholders and law enforcements through its CIT training for law enforcement, telecommunication staff, and Emergency Medical Staff who respond through 911 dispatch. Eastpointe continues to educate law enforcement, emergency management staff, and community stakeholders so that they are knowledgeable about community resources which enable them to direct members to alternate resources instead of higher-end services, jail or petitions to the court. Eastpointe is providing these training completely free of charge to all who are interested, as a demonstration of commitment to its mission, and with a focus on education to manage crisis issues and crisis services for families in its communities.

Eastpointe takes pride in its relationships in serving members (consumers) and collaborating with providers at the highest levels, and maintains an ongoing commitment to focus on the future of crisis prevention. Eastpointe’s strategic planning task force examines new evidenced-based crisis interventions with consideration toward sustainability, integration, technology, peer recovery, systems of care, and special populations. With both member and provider call centers exceeding state and national standards, its current information technology system conversion is another aim at improving a data driven system of checks and balances to cost effectively and objectively measure positive impacts of services for each member and each community. Eastpointe recognizes that to minimize crisis in the future, we have to succeed at wellness and prevention.

**Smoky Mountain LME/MCO – Expanding & Enhancing Crisis Services in Western NC**

Smoky Mountain LME/MCO is working with partners to increase access to and use of behavioral health crisis services. In January, Smoky helped secure nearly $2 million in grant funding from DHHS to open a regional comprehensive care center, which includes a 24-hour urgent care center and crisis facility, in Asheville. Project partners include Mission Health, Buncombe County, RHA Health Services, and Asheville Buncombe Community Christian Ministry. The funding was awarded through the state’s Crisis Solutions Initiative.

Also in January, Smoky and community partners were awarded a $5,000 Crisis Solutions Initiative Community Capacity grant to train McDowell County’s entire EMS staff in Crisis Intervention Team (CIT). The grant will improve the county’s behavioral health crisis response through this training and by promoting the use of mobile crisis teams, walk-in centers and the Caldwell County crisis facility. Smoky has trained more than 550 western North Carolina officers and first responders in CIT since 2008.

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Smoky was also instrumental in helping secure N.C. Housing Finance Agency funding in Caldwell County to establish a crisis facility in Lenoir. That facility is scheduled to open in January 2016.

These new initiatives will enhance a continuum of crisis services, which also includes inpatient facilities at community-based hospitals and existing crisis and detox facilities spread across the 23-county catchment area. Additionally, Smoky is involved in Community Crisis Education partnerships in Polk, McDowell and Watauga counties. These projects educate residents about what to do in a behavioral health crisis and about alternatives to the emergency department. In Polk County alone, the number of people calling Smoky to request services each quarter nearly doubled following implementation of the education project there.

**New Local Initiatives**

**Alliance Behavioral Healthcare – Strengthening the Crisis Continuum**

Alliance Behavioral Healthcare continues to strengthen its strong crisis continuum of services that ensure highly effective, community-based support and care for individuals in a crisis.

Alliance Crisis and Assessment Centers provide care to ensure individuals obtain the right care in the right place, when possible avoiding unnecessary use of emergency departments and jails. Enhancements to those facilities include:

- Durham Center Access has implemented the use of Care Navigators, frequently Peer Support Specialists, to welcome and assist consumers and families in accessing crisis services.
- UNC Health Care at WakeBrook in Raleigh recently opened a new 16-bed Alcohol and Drug Detox Unit designed to improve the flow of consumers through the five programs on the campus and ensure that programming and services better address the needs of individuals with substance use disorders. Additionally, a new integrated community health clinic is helping to ensure the delivery of whole person care to individuals with severe and persistent mental illness that have difficulty with co-morbidity.
- The Community Mental Health Center at Cape Fear Valley in Fayetteville now admits individuals brought to the Center by a CIT officer or Mobile Crisis Team 24 hours a day.

Alliance’s Durham Crisis Intervention Team is the only CIT program in North Carolina providing a second level review and follow-up on CIT calls, and is being featured in a national documentary film now in production. An embedded social worker and CIT officer work in tandem in the Durham Police Department to make house calls, visit individuals and families, help individuals access and engage services, and follow-up with individuals to ensure they obtain the support and care they need.

**CoastalCare – Collaborating and Responding to Local Needs**

CoastalCare currently supports a continuum of crisis services across its five county area. Walk-in crisis centers or Crisis Response Centers are located throughout the catchment area, as well as a 16 bed short term residential treatment facility, mobile crisis team, and telespsychiatry.

To enhance and support the crisis services offered, CoastalCare hosts monthly Crisis Consortium meetings in each county. These meetings allow stakeholders, including crisis services providers, emergency department personnel, school representatives, law enforcement and other first responders, to come together to discuss crisis services and outcomes in each community. Agenda topics at the Crisis Consortium meetings include current data of emergency department visits and state psychiatric hospital admissions, barriers to services, gaps in services and changes in the service system. Through these meetings several initiatives for the enhancement of crisis services have arisen.

In July 2014, hours were extended at the Crisis Response Center in Morehead City, allowing more opportunity for individuals to bypass the emergency department in times of crisis and more CIT officers to utilize this crisis service on shift.

In September, Onslow County Emergency Medical Services began using the Community Crisis Response Center for individuals experiencing a crisis related to MH/1-DD/SA disorders. Instead of going to the Emergency Department, EMS can now transport individuals experiencing a crisis, with no other medical complications, to the Community Crisis Response Center. Onslow EMS personnel have received additional training in MH/1-DD/SA, as well as verbal de-escalation techniques and community resources by way of Crisis Intervention Team training.

CoastalCare is also active in the North Carolina Harm Reduction Coalition’s voluntary harm reduction program to address the increase in overdose deaths in NC. In December of 2014, more than 50 local professionals and substance use treatment providers attended a training to learn how to safely distribute, as well as teach others how to safely administer, the opioid overdose reversing drug Naloxone. CoastalCare and the NCHRC have secured 1180 Naloxone rescue kits for distribution in the CoastalCare catchment area. The facility-based crisis service in Wilmington, operated by RHA Health Services, is the first facility based crisis provider in the state to distribute rescue kits upon discharge.

**East Carolina Behavioral Health (ECBH) - Homeless Recovery Care**

ECBH is partnering with the Healing Place of Wake County in Raleigh to develop Healing Transitions of Eastern North Carolina to address homelessness and support people ready to begin their recovery journey from addiction and substance use. The first site will be a 100-bed program for men in Greenville. Over the next three years the planning committee will form a board, purchase a site, and work on building designs for the program.

There are now three ECBH staff trained to present Mental Health First Aid, one of whom is also trained in Youth Mental Health First Aid. ECBH has conducted seven classes since May 2014 for provider staff, community groups, and the public. The number of individuals who have become certified in MHFA or YMHFA totals 125 people; these are people who are prepared to assist someone who may be having a mental health crisis.

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ECBH System of Care Coordinators have been organizing screenings of The Anonymous People throughout its catchment area since the inception of the initiative in April 2014. In response to the main message of Recovery, ECBH believes that, the more people are aware and understand that addiction is treatable, the fewer crises families will have in their lives. To date, 326 participants have viewed the film at 17 screenings in 12 counties.

**Partners Behavioral Health Management – New Service Hubs Offer Safe Place in Crisis**

Partners Behavioral Health Management has implemented a number of focused initiatives to better communicate with communities, to educate stakeholders, and to make sure that citizens know who to call, and where to go, when a crisis occurs.

Partners continues to work with its communities to ensure that citizens know where to turn when crisis services are needed. Recently, the first of Partners’ “service hubs” held its grand opening in Lincoln County. Four provider organizations have joined together to create Lincoln Wellness Center, located in the heart of Lincoln County. The center operates an open access model for individuals who need to be seen without an appointment; it is the operational basis for the local mobile crisis team, and offers access to the full continuum of care in one location. The facility has been well received by the community and is becoming known as the “safe place to present” when in crisis. Partners is working with community leaders and providers in Burke and Cleveland County to develop similar hubs focused on integrated healthcare. The Burke and Cleveland hubs are scheduled to open by June 2015.

Many times, law enforcement and emergency service personnel are contacted to assist someone in a crisis, simply because citizens did not know where else to turn. For a number of years, Partners has joined with local NAMI chapters, mental health advocacy groups and providers to conduct Crisis Intervention Team trainings throughout the eight-county area. Approximately 150 law enforcement officers, EMS staff and telecommunicators graduated from CIT training in 2014. The response to CIT training has been positive and has created stronger partnerships between the groups that impacts the care delivered to the individual in crisis.

Starting in March 2015, Mobile Crisis providers will no longer be able to be reimbursed by Medicaid or the State for MCM if provided in the hospital setting. Partners has worked closely with MCM and hospital providers to make sure they understand this change and planned appropriately. Many hospitals in the eight counties served by Partners have expanded their tele-psychiatry capabilities in response to this imminent change. Partners has worked with mobile crisis providers throughout its catchment area to serve individuals in community settings instead of the hospital ED. Over the past year, the three providers delivering Mobile Crisis Management have increase community-based service delivery, with one provider showing a 25% increase in service delivered in a community setting instead of the hospital.

**Sandhills - Committed to Expanding Care**

Sandhills Center has a commitment to strengthen, improve and expand crisis services. It also has a commitment to decrease Emergency Department wait times associated with psychiatric hospital admissions.

Sandhills Center’s efforts to this end are designed to promote early community based strategies and interventions. Improving pre-crisis and crisis services in the community decreases the need for more restrictive interventions. Reducing the number of admissions and the Emergency Department wait times will lessen the strain on Emergency Department resources.

Sandhills is achieving these goals by taking the following steps:

- Continuing to offer Crisis Intervention Team (CIT) training throughout the region to assist law enforcement officers and other first responders to understand and respond to members in mental health crisis situations
- Alleviating barriers to services by exploring and presenting data to our Quality Management program for analysis and program planning
- Collaboration with contract Mobile Crisis team to conduct crisis assessments in community hospitals and assisting in appropriate transitions
- Strengthening and standardizing an efficient process to ensure members receiving crisis services have adequate follow-up and to ensure transitions between crisis serving agencies are effective for members (consumers)
- Collaboration with magistrates, law enforcement, human services agencies and hospital personnel to ensure appropriate exchanges of information and that the pre-determined crisis plans of recidivistic members are consistently executed
- Improving review and identification of highest risk/highest need members to consistently assign high risk members to care coordination services
- Developing and providing crisis prevention training for the provider network such as the provider training offered in December 2014
- Having a Sandhills Center staff member trained to offer Mental Health First Aid

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**LME/MCO Crisis Update: Four Facility Crisis Center Grants Awarded**

Four Facility Crisis Center Grants Awarded

- Having a Sandhills Center staff member trained to offer Mental Health First Aid
It’s Fail First Again

This article appeared in the January 20, 2015 Open Minds electronic newsletter and is reprinted here (minus active links) with permission

by Monica E. Oss

Just when you think we’ve gotten over it, “fail first” policy pops up again. In this case, the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) has announced a new “fail first” policy for antipsychotic medications (see North Carolina Medicaid Implements Fail-First Policy For Non-Preferred Antipsychotic Medications). If you’re not familiar with the concept, essentially a consumer of health care must “fail” on a “preferred” (meaning less costly drug) in order to get payment for a different medication. In this case, as of January 1, 2015, consumers in the North Carolina Medicaid program must “fail” on an antipsychotic medication that is on the “preferred” list before prior authorization will be granted for a non-preferred antipsychotic medication.

I think “fail first” policies are bad policy for a number of reasons – the health economics, the science, and the ethics of the policy are questionable. At the macro level, these policies are put in place purportedly to save money for the health plan. But the whole notion is a symptom of our “siloed” approach to health care resources. Is it really cost effective system design to force a “health catastrophe” in order for a consumer to get access to health resources (see What to Make of Current Policies About Access to Antipsychotic Medications: Short-Term Gain for Long-Term Pain)? Probably not if you’re looking at total consumer health resource use over time – rather than just considering spending on medication. And then there is the benefits administration of this policy. What is the criteria for a treatment “failure?” How is that documented and how does authorization for another medication actually happen?

Then there are the scientific issues. First, there is the issue of “bioequivalence” among antipsychotic medications. There is certainly controversy about whether these medications are similar enough to form a “class” and are really interchangeable (except for the non-generic versions of the same medications). And while the North Carolina list of “preferred” medications is long – the policy ignores that issue altogether. And, there is the new evidence from genetic research that “schizophrenia” is more than one disease (see Genetic Research Finds Schizophrenia Is Eight Distinct Disorders) – a situation not anticipated in the development and testing of the current crop of antipsychotic medications.

And then there are the ethical issues. ¬¬There has been an emerging body of research that each “psychotic” episode (essentially the “failure” that is required) results in permanent damage to consumer brain functioning. (For more on this, see Does Drug Treatment Prevent Brain Damage In Early Psychosis Or Schizophrenia? and Schizophrenia in Translation: Is Active Psychosis Neurotoxic?) Is it ethical to require a “treatment default” that is so personally damaging to consumers? Can you imagine consumers for other types of health care services accepting care that operates under the premise that treatment failure with permanent long-term consequences is a requirement for access to some available treatments?

There is no doubt that policies like “fail first” policies have teeth. A recent review found that many health plans include “fail first” policies – policies that were cited a impeding consumer access to optimal treatment (see Medication Restrictions Significantly Affect Mental Health Treatment Outcomes; New Survey Cites Formulary Restrictions, Prior Authorization And “Fail-First” Rules As Obstacles). This is part of the mix of factors that contribute to a too-high proportion of people with mental illnesses not receiving treatment that reflect current thinking about best clinical practices (see For 39% Of Consumers With First-Episode Psychosis, Prescriptions Not Aligned With Best Practices).

When talking with my colleague, Jonathan Evans, the chief executive officer of Safe Harbor and a member of the OPEN MINDS advisory board, his perspective as a professional working directly with consumers brings an added perspective. “Fail first policies are a detriment to effective community treatment. I have many research papers demonstrating that “open” formulary designs improve treatment outcomes while saving health care dollars. But, in addition to the economics, I do wonder would we as a society permit “fail first” policies to apply to other major illnesses — heart disease, or kidney disease, or cancer? Could this be a parity issue? In addition, there is research indicating possible damage to brain tissue from the acute exacerbation of psychosis. Every time I see a health plan adopt this policy, I don’t see supporting data other than short-term financial gain.”

What is the solution to “managing” the cost of medications? I’m not saying that every consumer should have carte blanche selection of medications at the expense of the payer. First of all, I think the premise of managing medication costs is the wrong question. Payers shouldn’t be focused on the silos of medication costs – but rather should be focused on the total costs of a consumer disease state. But beyond that, consumers (and clinical professionals) need better tools for medication selection – about efficacy, side effects, and specificity which medications are truly clinically interchangeable. The selection guidelines shouldn’t be based only on the health plan’s price negotiations with pharmaceutical companies. Rather consumers should have access to selection guidelines that make use of the current state of genetic testing for medication matches, of the use of “big data” (practice-based evidence) on effectiveness in practice, and comparative effectiveness research.

I realize that every stakeholder in the U.S. health care system is struggling with improving their “value equation” and delivering more for the resources expended. But, I would argue that “fail first” policies are a crude tool in an era where other more effective approaches exist. In addition to some of the tools mentioned above, the notion of integrated care management (that includes an incentive for discretion in the use of total resources) may be part of the solution to this issue. What I do know is, increasing “fail first” policies is a step backward on many fronts.

Monica Oss is the Executive Director of Open Minds. The original article can be found at www.openminds.com-market-intelligence/executive-briefings/fail-first.htm/
2014 Conference Highlights
National Speakers, New Technology, 800 Attend and More...

Close to 800 MH/DD/SA professionals and stakeholders from around North Carolina and the country came out to participate in the NC Council’s 2014 Conference and Exhibition, “Pathways to Integration” on December 3-5, 2014 in Pinehurst, NC. Sessions ranged from presentations from some of North Carolina’s largest healthcare providers – Carolinas HealthCare System, the University of North Carolina - to our homegrown LME/MCO leaders and providers who are leading the way with innovative care integration and local collaboration. In addition, a full day track was offered on measuring quality and improving outcomes for individuals with intellectual/developmental disabilities.

This year’s conference was bookended with national experts: one in the MH/DD/SA field, Monica Oss, Chief Executive Officer, with Open Minds and the other from the larger world of healthcare and technology, futurist David Houle. “We really tried to push the envelope this year and worked to bring in keynote speakers who are forward thinkers, offered relevant information, and could inspire attendees to think about issues in new ways that will be critical for future success.” said Mary Hooper, NC Council Executive Director.

An overview of David Houle’s Closing Plenary remarks on societal shifts affecting healthcare, business and all of us, are highlighted on page 12.

Using Technology
This year’s event included the addition of ConfPlus, a new mobile app, that helped attendees instantly access the meeting agendas, maps, speaker information and more. “For the first time attendees could get information about sessions, speakers, exhibitors, do evaluation on line and learn about another one, all by using their cell phones. We got some great feedback on the product and plan to use it at future events” said Jean Overstreet, NC Council Conference Planner. Almost 200 attendees utilized the new app to enhance their conference experience.

“Another fun thing we did this year was hire a professional photographer to capture the event. We thought this would be of value to us, as well as to attendees and vendors interested in using the pictures on their social media sites and in marketing materials,” said Overstreet. All of the conference photos are still available for view and download at www.nc-council.org/trainings/conferences/. Just click on conference photos.

Consumers at Pinehurst
The NC Council has always encouraged consumer and family member participation and attendance at the Pinehurst conference. “In years past, we have been able to offer a limited number of consumer scholarships, said Mary Hooper. “This year the Council began offering 50% off the registration fee to MH/DD/SA consumers. We really feel it is important to have the participation of ALL MH/DD/SA stakeholders, especially those actually receiving services. We also recruit consumers to serve as session monitors. They do a great job with introductions, announcements, and assisting speakers; and they get to listen to and participate in sessions” stated Hooper.

For the about the past ten years, the NC Council has offered consumers and family members attending the conference an opportunity to get together and hold a caucus meeting. Each year the meeting outcome is a little different. This year the group developed a list of ten recommendations for the NC Council and Division of MH/DD/SAS to consider as ways to improve care. See recommendations on page 13.

If you did not get to attend the conference there is a photo montage on page 20 and a wall of pictures linked at www.nc-council.org/conferences. And if you did attend, go and find your pic today!
David Houle Reveals Future Change Drivers to Conference Attendees

by Andrew Meehan

At the closing plenary session of the NC Council’s Conference 2014, futurist David Houle led the crowd in a wide-ranging discussion on globalization, generational change, and landmark shifts in health care. For two hours, Houle challenged the audience to reconsider their vision for change … and even riled up a few attendees.

Houle contends that the current decade (2010 – 2020) will define this century, calling it the Transformation Decade and part of the Shift Age. “We are seeing the collapse of legacy thinking, and this is the first decade of 21st century thought.”

Houle cited three factors driving the unprecedented speed of change – globalization, individual explosion of choice, and accelerating electronic connectedness. He described the last factor as the most important.

Citing nearly ubiquitous cell phone ownership worldwide, Houle drove home just how technology has decreased geographic limitations. “The difference between 30 feet and 15,000 miles is now two seconds [the extra relay time to connect a cell phone call].”

He called on all organizations to completely re-examine their place in the world. “If you aren’t changing the form or nature of your organization, you might not be around in 2020,” Houle said.

The health care sector will feel the impact of this transformation even more acutely than other sectors. “The health care discussion is motivated by fear and misinformation, and it is manipulated by the politicians…Health care is the only part of the American economy that does not operate in the capitalist economy.”

One of the most important transformations for health care is the growing importance of big data. Houle called it the third age of human mapping, and the first opportunity to have real-time sociological and anthropological data. In a statement that caught the attention of the room, Houle said, “We are shifting from health care to health management.”

Houle also highlighted the health care sector’s steady move to outcomes-based thinking and prevention. The increasing power of the consumer, and the explosion of individual choice, will drive the change. “Just in the process of asking how much things cost, costs go down.”

Houle echoed many others in pointing out that the millennial generation will play an increasing role in driving this decade’s transformation. Houle is optimistic about the digital connectedness and social responsibility of the millennials. Part of the strength of millennials, and what Houle termed the “digital native” generation following them, is in their ability to manage two realities – the physical reality and the screen reality.

“The millennials are more like each other around the world than they are like their parents…They do not understand information overload…Everyone in this room is a digital immigrant,” he commented in a reference to the baby boomer generation in the audience.

During a sometimes rousing question and answer session, a few members of the audience wondered if the technological revolution was fully positive or leaving vulnerable groups behind. Houle remained steadfast – stating that it is incumbent upon individual businesses, associations, and non-profits to help bridge those divides.

NC Council Executive Director Mary Hooper said the attendees seemed to enjoy this departure from previous closing plenaries. “It was a great change of pace. After spending two packed days talking about our mission, I think people enjoyed taking a step back and being challenged to take a broader and actually global view.”

Comments from attendees…

“This was absolutely awesome -- pushed forward thinking and healthcare in the future. I will read his book.”

“The session was good. Opened my eyes to possibilities, realities, and the future. Very informative.”

“David Houle’s presentation was outstanding. The Council hit a homerun with this one. Great job!”

Andrew Meehan is the President of Meehan Strategy Group a public relations company. Andrew Meehan can be reached at andrew@meehanstrategy.com.
The NC Council is reprinting recommendations made by a group of advocates, consumers and family members that meet each year at the NC Council’s conference in Pinehurst. This group comes together to develop recommendations for NC Council, the Division of MH/DD/SAS and the system at large that they believe are important for improving care to the citizens we serve. NC Council Executive Director Mary Hooper referenced these recommendation during her remarks at the Closing Plenary Session. They are printed here in full for your consideration.

The following are the recommendations we hope you will value and utilize in the upcoming year:

1. Shift the focus of efforts from process development to what the system is actually achieving in the lives of those served. If we are to be able to sustain system efforts with limited public funds, then we must focus on purchasing value as system customers define value.

2. Ensure fairness of appeals processes. Create provisions which protect a customer from losing services during appeals processes, which can be very lengthy, lasting many months. Ensure that MCO Offices of Consumer Affairs are sufficiently developed to offer frequent training to the consumer community on the appeals process so they can become more empowered and prepared should they need to make an appeal. This improves system quality!

3. Value and utilize personal outcomes measures across all disability arenas as part of systemic quality improvement. Personal life outcomes are the actual substance of value in human services.

4. Ensure that all regions of our state have quality psychiatric rehabilitation services, which place a premium on recovery and on helping people become meaningfully employed. This includes the development of best practice model (International Center for Clubhouse Development).

5. Planning must ensure choice and respect self-determination as a fundamental human value. Personal choice implies personal responsibility and agency for system customers. They promote hope.

6. Create true, collaborative partnerships at the managed care level and at the state level with any agencies that can work together to solve old problems, anticipate and prevent new ones.

7. Develop with the assistance of consumers, service rating systems that help drive quality and ensure customer satisfaction.

8. Ensure that viable networks are developed to promote the employment of all who wish to work.

9. Please use more person first language. (As an example, it was shared that yesterday the term “frequent flyer” was used to speak of people using the EDs frequently. It over-characterizes individuals.)

10. Engage consumers to give input not so much as separate committees, but more as advisors or consultants integrated into work groups within MCOs and at the Division (we thank the Division for already taking much leadership in this in the past two years). We will have faster change by integrating input as it is gathered at higher levels.

This year’s Consumer Caucus was convened by Marc Jacques, Co-Director for Mental Health Advocacy Inc. “I totally enjoy the conference and have attended, more years than not, since 2009 - what was significant this year was the interaction between the consumer advocates and the NC Council. We observed a well-run, well attended consumer caucus with deep and intricate participation which produced a set of recommendations which were openly received. It was nice to see the lessons of the past consumer caucuses come to fruition. I look forward to building further on this year’s accomplishments.”

This list of recommendations was put together by Laurie Coker, Executive Director for NC CANSO, a statewide consumer advocacy group.
Excellence Awards Demonstrate Innovations Resulting from Public Managed Care Partnerships

2014 marks one full year of public managed care for seven LME/MCOs and 2 years of implementation for Smoky Mountain Center and East Carolina Behavioral Health. The 2014 Programs of Excellence Award winners were clearly the result of innovation, outreach, partnership and flexibility that has resulted from a system of public managed care in North Carolina.

This year's Programs of Excellence Reception was generously sponsored by:
Alexander Youth Network
AlphaCM
Brynn Marr Hospital
Community Choices, Inc.
Cornerstone Treatment Facility, Inc., Premier Healthcare Services, Inc. & CTFP, Inc.
Developmental Disabilities Resources, Inc.
The Echo Group
Frye Regional Medical Center
GHA Autism Supports
Holly Hill Hospital
Ingenuity Health
Lifespan Incorporated
Monarch
Netsmart
Old Vineyard Behavioral Health
Open Minds
Qualifacts Systems, Inc.
Recovery Innovations
ResCare
Southern Pharmacy Services
Strategic Behavioral Center
Universal Mental Health Services, Inc.

Excellence in Care Integration - Catawba Valley Behavioral Healthcare Integrated Care Program and Partners Behavioral Health Management

With an eye toward cultivating integrated care in the Partners provider network, in 2013, Catawba Valley Behavioral Healthcare (CVBH) Integrated Care Program began providing comprehensive whole person care at the Burke and Catawba County outpatient clinics through onsite assessments and counseling, psychiatric services and medication, a primary medical home, substance abuse treatment, and peer support services. The goal of CVBH was to “see” the whole person and put in place all of the services needed to support a consumer in the journey to better health.

Treatment planning done at the program recognizes the link between mental and physical health and involves the consumer, guardian, family members or personal supports, therapists, medical practitioner, peer support and any other enhanced services provider that might be needed. The program works in collaboration with area hospitals and other primary care providers, Community Care North Carolina, care homes and day programs, and receives referrals for consumers who need a holistic integrated approach to care that increases supports and removes barriers. CVBH also partners with an on-site pharmacy that provided $1.4 million in medication during the last program year.

Excellence in Best Practice Services - Monarch Open Access and Alliance Behavioral Healthcare

When Wake County Human Services transitioned away from behavioral healthcare service provision as part of the move toward managed care, Alliance needed to find a large provider to provide local services. Based on stakeholder feedback to Alliance regarding the need for greater and more immediate access to outpatient psychiatric services, Monarch’s Open Access Model program was chosen. Monarch’s Open Access Clinic provides people help when they need or request it. Open access means individuals who need mental health services and are new to Monarch can simply walk in – no appointments are necessary. They offer same day access to a prescriber. This concept makes services more available and prevents delays in connecting consumers with providers. The goal is to provide a comprehensive clinical assessment, a treatment plan, psychiatric evaluation with prescriptions as needed and referral to the proper level of care.

This collaboration with Alliance has resulted in a significant increase in accessibility and decreased strain on local emergency/crisis centers. Monarch receives additional financial support from Alliance to operate this model. The collaboration between Monarch and Alliance has assisted Monarch in offering this model in multiple locations in Wake County.
Excellence in Partnerships to Improve Services - Community Resource Database – NC 2-1-1 - East Carolina Behavioral Health

As a way to help the community better access all the resources in their area, East Carolina Behavioral Health implemented NC 2-1-1, a statewide database of community resources developed by the United Way of North Carolina for all 19 of their counties. Individuals, families and providers can use NC 2-1-1 to identify a variety of resources and natural supports as options to include in the person-centered plan. This gives the planning process a much more robust array of services and supports to consider while strengthening the person’s self-determination. ECBH collaborates with United Way-NC on database maintenance and technical assistance.

To help spread the word about the database and increase resources, ECBH is also collaborating with the child mental health community collaborative in each county to update and add community resource information to the database. They provide outreach to communities throughout their catchment area to raise awareness and increase usage of the system. Individual members representing Departments of Social Services, Health and Public School have been instrumental in updating the data in NC 211 for their respective organizations.

Excellence in Crisis Response - Crisis Intervention Team Continuum – Eastpointe

Crisis Intervention Team (CIT) continuum is a training program provided to law enforcement and other first responders to provide insight and instruction on how to best deal with individuals experiencing a mental health crisis. This training is key to avoiding unnecessary use of force, hospitalizations, jail, and other unwanted consequences. The Eastpointe CIT program is a direct result of input from magistrates, law enforcement and other community agencies participating in crisis collaboratives and other stakeholder meetings. The foundation is based on communications and collaborations with members and the community. Prior to each CIT training event, a planning team is developed for the purpose of collaborating and gaining input from agencies impacted by the training. Planning team members include, but are not limited to, police chiefs, sheriffs, police department training/support services managers, Emergency Management Services (EMS) directors, community college representatives, CIT facilitators, evaluators, clinical affairs officers, peer support specialists, telecommunicators, magistrates, Consumer and Family Advisory (CFAC) members and NAMI representatives.

Excellence in Prevention/Outreach and Wellness

Anti-Bullying Initiative – Eastpointe

Eastpointe’s mission is to work together with individuals, families, providers, and communities to achieve valued outcomes in the behavioral healthcare systems. One of the ways this has been accomplished is by addressing bullying behaviors and the resulting emotional impact on children in local schools. Eastpointe is partnering with a cross section of the community to make this happen. First, Eastpointe worked with local schools systems and stakeholders to design ‘Stop Bullying’ efforts that are student driven and research based. The focus of these efforts is to highlight programs that are already in existence, in order to increase community awareness and to foster inclusion of students when developing bullying programs.

Eastpointe also met with groups of students representing 6th and 7th grade to focus on bullying in the schools. Information was gathered and shared with school personnel. As a result, Eastpointe partnered with “Leading to Change”, to design a Youth Summit this past September. The Summit was attended by about 120 students and community leaders such as Sheriff Lemmie Smith of Greene County and State Senator Don Davis.

As a result of the anti-bullying campaign, Eastpointe has seen doors open to provide further education about mental health topics.
Excellence in Consumer Directed Supports - Health Improvement Peer Program - CenterPoint Human Services

PHOTO (left to right): Burch Johnson, CenterPoint Chief Operations Officer and Betty Taylor, CenterPoint CEO

CenterPoint’s Health Improvement Peer Program (HIPP) teaches whole-health (mind and body) wellness to individuals with mental health and substance abuse challenges. The program includes in-depth nutrition and stress management modules as well as guidance in partnering with health care providers and developing individualized smart goals and self-management plans. In developing and evaluating the curriculum, CenterPoint Human Services worked with local peer support specialists requesting their input as subject matter experts as well as educators. HIPP is taught by certified peer support specialists (PSS). Their lived experiences with mental health and substance abuse challenges gives them a uniquely personal perspective. PSS involvement in every phase of the program’s development helped identify missing information and uncovered cultural and language “barriers” that could have deterred full participation. Peer specialists serve on the HIPP program committee, which meets monthly. They continue to gather data and feedback from participants in an on-going quality improvement effort.

The CenterPoint HIPP program is based on similar, successful integrated health programs such as Stanford University’s chronic disease self-management program and the Whole Health Action Management (WHAM) program offered through the National Council for Behavioral Healthcare.

Public Awareness and Advocacy - Mental Health Month Cucolorus Film Festival Film Screenings – CoastalCare

PHOTO (left to right): Foster Norman, CoastalCare CEO and Kate Murphy, Public Information Officer

In May 2014, CoastalCare partnered with Cucalorus Film Festival to showcase films and open up dialogue about mental health. The events quickly gained pace, and resulted in successful events, and continued community conversations about mental health, access to services and recovery. Cucalorus is a non-competitive film festival focused on supporting innovative artists and encouraging creative exchange. The event brings about 10,000 filmmakers, film industry workers, fans and activists to the Cape Fear region every year. Cucalorus film festival is known for its support of the relationship between art and advocacy.

In December 2013, CoastalCare and Cucalorus began collaborating to create an event that would advocate for mental health, while celebrating recovery and advocacy. The design and implementation of the program involved a work group with representatives from CoastalCare, Cucalorus, NAMI Wilmington, local peer support specialists, and individuals living with a mental health condition and their loved ones. Organizations such as UNC-Wilmington, the Disability Resource Center and The Cape Fear Commission for Persons with Disabilities were also present, providing promotion and volunteers leading up to the film screenings as well as for the evening’s programs.

GLEANINGS
from around the NATION

- The U.S. Department of Health and Human Services has made a “historic announcement” to move Medicare and “the health system at large” toward paying for quality, rather than quantity. The goal is to tie 30% of Medicare payments to alternative payment methods that reimburse based on value using ACOs, bundled payment arrangements, etc. by the year 2016 and up to 50% of reimbursements based on quality by the end of 2018. The DHHS press release mentions Medicaid and HealthChoice in general, but it is clear that these new goals are aimed at the Medicare program. To help providers make this leap to valued based reimbursement, HHS has announced the creation of a Health Care Payment Learning and Action Network. Through this network, HHS will work with private payers, employers, consumers, providers and others to implement alternative payment methods in their states. To learn more go to www.hhs.gov/news/press/2015pres/01/20150126a.html.

- An interesting study done by Yale University found that children who received expanded Medicaid benefits in the 80s and 90s now pay more taxes as adults. It was also found that these children were more likely to go to college and less likely to die prematurely as adults. The study analyzed the tax returns of all children born between 1981-84 and compared the returns of those who received Medicaid with those who did not. The study found that by the time these children were 28, the federal government was recouping 14 cents for every dollar spent on Medicaid while they were children. Assuming this continued, the federal government would recoup 56 cents for each dollar they spent on Medicaid services by the time the child reached 60. It was found that children on Medicaid longer had higher incomes and females had higher wages.
Alliance Launches Two New Public Awareness Campaigns

by Doug Fuller

Alliance Behavioral Healthcare has recently unveiled two new public awareness campaigns. The first focuses on the concepts of recovery and self-determination. The campaign is titled “It’s Time to Re-Think” and is designed to help dispel several of the common misconceptions that can produce stigma and keep people with a mental illness, substance use disorder, or intellectual/developmental disability from seeking the help they need. The second campaign is a team effort with WakeMed on “Kids in Crisis” to create a public awareness project designed to direct the families of children and youth experiencing a behavioral health crisis to the most appropriate source of care.

“IT’S TIME TO RE-THINK” PUBLIC AWARENESS CAMPAIGN

Among the key messages of the campaign is that people can and do recover from mental illness and substance use disorders. There are more treatments, services, and community support systems than ever before, and they work. Recovery means people can live, work, learn and participate fully in their communities.

Self-determination is about people being empowered to speak out for their rights and achieve their goals and dreams. Most people with an intellectual/developmental disability can make their own choices about where they live and work, who they love, and what they want. They are as individual as people without disabilities, and all people deserve to have as much independence as possible.

“Recovery and self-determination are more than concepts at Alliance – they are principles that shape all of the work we do here,” said Rob Robinson, Alliance Chief Executive Officer. “We know that people can and do recover, and that everyone deserves to live the healthiest, most independent life possible. We hope this public awareness campaign will help combat the myths that place unfair and unnecessary barriers in their road to recovery.”

The Re-Think campaign includes some very informative videos about recovery that can be viewed on the Alliance website www.AllianceBHC.org.

The Community Relations teams at Alliance’s community offices in Durham, Wake, Cumberland and Johnston counties will take these messages to stakeholder groups across their communities, and their efforts will be supported by a media campaign utilizing multiple venues.

Commercials are airing on ESPN, USA Network and Discovery Channel, in multiplex theatres throughout the Alliance region, and on a variety of popular websites. Posters and other print materials have been produced and the Alliance website (AllianceBHC.org) hosts an “It’s Time to Re-Think” portal as well as a toolkit under the provider tab that helps stakeholders share campaign messaging and media using their own websites, email lists and social media.

“KIDS IN CRISIS” CAMPAIGN

The joint campaign with Alliance Behavioral Healthcare and WakeMed Health & Hospitals includes posters and other print materials created to encourage families to reach out first to Alliance’s 24-hour toll-free Access and Information Line at (800) 510-9132 rather than coming directly to a hospital emergency department. Although hospital emergency department providers can evaluate and stabilize patients with behavioral health issues, emergency departments are not designed to offer the kind of therapeutic services these patients need and deserve.

When an individual or family member calls the Access and Information Line a trained clinician can help evaluate the situation and if crisis response is needed, recommend the most appropriate kind of crisis help from the array of services available through Alliance. These include 24-hour behavioral health Crisis and Assessment Centers in Wake and Durham counties as well as mobile crisis teams that can come directly to an individual in crisis.

“Alliance appreciates WakeMed’s willingness to address a shared concern about getting young people in crisis to the right level of care, right away,” said Alliance CEO Rob Robinson. “We hope it serves as a model for additional public-private partnerships that provide collaborative, innovative responses to healthcare issues that impact our communities.”

Print materials also address the early warning signs that a child or teen may be developing a mental illness, with the goal of getting them the help they need before an illness can evolve into a crisis situation. “Early identification, assessment and treatment can change the trajectory of mental illness and prevent the onset of more serious mental health conditions, leading to recovery and better life outcomes,” said Sean Schreiber, Alliance Chief Clinical Officer.

Posters are being distributed throughout Wake and Durham counties to pediatric primary care and behavioral health providers as well as to public schools, libraries, faith communities and other locations that come in regular contact with children and their families.

Doug Fuller is the Director of Communications for Alliance Behavioral Healthcare. He can be reached at dfuller@AllianceBHC.org.
**GLEANINGS from around the state**

- **Alliance Behavioral Healthcare** will receive the prestigious **Advancing Evidence Based Practices** Award at the Southeast Region AHEC Clinical Update Conference in late February. The award was established to recognize an individual or agency that best exemplifies the advancement of evidence based practices in the mental health field in North Carolina. It works to identify the efforts made at research, training of staff, implementing evidence based practices, and establishing positive outcomes based on evidence based practices.

- According to a Cardinal press release, **“Cardinal Innovations Healthcare Solutions** has achieved compliance with the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) system more than a year before the Oct. 1, 2015, deadline set by the federal Centers for Medicare & Medicaid Services (CMS). Healthcare companies are required to upgrade the system of codes used to report medical diagnoses and inpatient procedures to increase the level of detail included in reports. The old system, ICD-9, used approximately 20,000 codes for reporting diagnoses and inpatient procedures. The new ICD-10 system has 80,000 codes. The change to ICD-10 will provide greater specificity and accuracy than the previous ICD-9 system allowed. Completing the upgrade before the CMS deadline will allow Cardinal Innovations to support the ICD-10 testing timeline that will be forthcoming from the North Carolina Department of Health and Human Services. “Upgrading our systems well in advance will help facilitate a smooth transition to ICD-10 across the state,” said Rick Pickett, Director of Information Technology for Cardinal Innovations.”

- North Carolina has been awarded $21 million from the U.S. Department of Housing and Urban Development to help end homelessness in our state. The awards breaks down in to many local awards for various housing, transitional living, rental assistance and homeless programs around the state.

- **Coastal Horizon’s Center**, an Affiliate Member of the NC Council, has received a $2 million grant over four years from the Substance Abuse Mental Health Services Administration (SAMHSA) for a minority AIDS Initiative that integrates HIV Medicaid care into behavioral health programs. The program known as Minority AIDS Initiative – Continuum of Care (MAI – CoC) will allow Coastal Horizons the funding to “offer coordinated, integrated care that will include behavioral health treatment, prevention, and HIV medical services for racial and ethnic minority populations at high risk for, or living with, HIV - through the co-location of behavioral health treatment and medical care,” stated President and CEO Margaret Weller-Stargell.

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**PEOPLE GLEANINGS**

- The NC Council was saddened by the passing of **Hugh D. Moon**, retired Smoky Mountain Center Area Director, who died last month at the age of 83. Moon served as Area Director at Smoky for over sixteen years and held various positions at the program starting in 1974. Moon was also the chair of the Western Region Management Team for over six years. He was very active in the MH/DD/SA community and known as a pioneer in the field. He was a founding member of the NC Council of Community Programs in 1983 and held numerous leadership roles in the Council. Moon was instrumental in mentoring a number of leaders in the MH/DD/SA system over the past 30 years, and was responsible for hiring many leaders in North Carolina’s mental health system. Among those are David Swann, who became the Area Director at Crossroads Behavioral Healthcare in 1994, Ron Yowell, who later became the Area Director of Smoky Mountain Center, Tom McDevitt who later became the Area Director of the Smoky Mountain Center, and Joe Ferrara who also became the Area Director of the Smoky Mountain Center. David Swann described Hugh in this way: “Hugh possessed great skills in assessing competencies, developing capable leaders and delegating to them. Hugh made great contributions to North Carolina’s Mental Health system in the early days of development between the 1970’s and 1980’s.”

- East Carolina Behavioral Health CEO **Leza Wainwright** took over as NC Council President in January, 2015. Leza was voted President-elect for the NC Council in 2014 and was scheduled to take over duties as President starting in July, 2015. Council President Ed Tarleton announced his resignation following the NC Council conference in December due to a relocation. Wainwright will serve as NC Council President though June, 2016, making her chair of the NC Council Board of Directors as well as Chair of the NC Council CEO Forum. “We are pleased that Leza agreed to step up to the plate early. Her leadership skills are well-recognized, and her years of experience provide her with a wealth of knowledge and information that strengthen the Council and all of its members. I so appreciate Leza’s willingness to take on these additional responsibilities, especially as she leads ECBH’s consolidation activities.” said Mary Hooper, NC Council Executive Director.

- **Jim Jarrard** retired from the Division of MH/DD/SAS at the end of December. Jarrard served the state over 20 years and the Division of MH/DD/SAS since 1994. He was Deputy Director for the Division of MH/DD/SAS and took over as Acting Director immediately following the tragic death of Division Director Steve Jordan in 2010. Other positions held by Jarrard include Chief of the Resource and Regulatory Management Section, which is responsible for fiscal monitoring, accountability, and regulatory compliance, support of information technology and contracts management. He was also Team Lead for Accountability.
DHHS Hires Key Staff Members

Several key positions are now filled at the Division of Medical Assistance and will support DHHS in the DMA reorganization announced late last year. **Trey Sutten** has been hired as the new Director of Finance. He has been acting as budget director under the contract with Alvarez & Marsal Consulting since March of 2014. According to Medicaid Director Dr. Robin Cummings, Sutten has more than 14 years of experience, “improving financial and operational performance in the health care field and public sector working for PricewaterhouseCoopers, PA Consulting Group, Fannie Mae, and Alvarez & Marsal.”

**Sandy Terrell,** MS, RN who served as DMA’s Acting Medicaid Director for a time, was named the Director of Clinical Policy for DMA, the position previously held by Tara Larson. Terrell has been with DMA since 2010. She will oversee clinical policies and procedures covered by Medicaid program, as well as contracts (such as LME/MCOs) for managed care.

**Steve Tedder** was named DMA’s Director of Business Information. Tedder has experience working for the state as a project management adviser to the state Information Technology Services “providing management oversight and risk assessment for large projects including NCTracks.” According to the hiring announcement, Tedder will oversee the development and implementation of the Medicaid office information strategy.

In the Fall of 2014, **Kendra Gerlach** was hired as the new DHHS Director of Communications. She is a native of NC and has fifteen years of experience working in the health care public relations field, as well as five years of experience as a newspaper journalist. Gerlach’s background includes work at two medical centers, Emory Healthcare in Atlanta and New Hanover Regional Medical Center in Wilmington, NC in marketing and public relations positions. She also has healthcare crisis experience having been trained by FEMA’s Center for Domestic Preparedness at the Department of Homeland Security.