

Crisis Services Work Group
Meeting Notes
February 5, 2008
Dorothea Dix Campus, Adams Building, Room 264

Members Present: Secretary Dempsey Benton, Amy Blackwell, Wendy Webster, Sarah Wiltgen, David Rubinow, Jack Naftel, Ellen Holliman, Mike Watson, Foster Norman, Barbara Beatty, John Tote, Robin Huffman, Marvin Swartz, Brent Myers, Carl Britton-Watkins, Walker Wilson.

Members Absent: Tara Larson, Peter Mumma, Tony Lindsay, Patrice Roesler, Darlene Menscer.

Executive Support Team Present: Mike Hennike, Linda Povlich (by phone), Leza Wainwright, Stuart Berde, Mike Lancaster, Michael Vicario, Yvonne Copeland, Jack St. Clair.

Others Present: Barbara Whitaker, Katherine Davis, Martha Are, Paula Graham, Rebecca Troutman, Scarlette Gardner, Pam Shipman, David Jones, Billy West.

Decision Making Process

Decisions will be made by consensus as much as possible. We intend to present the Secretary with a list, and we will rank the list based on preferences expressed by the group. If someone has a dissenting opinion they will be able to write that up and it will also be submitted to the Secretary.

The process we will use to make our decisions is

- 1) define the issue
- 2) gather information
- 3) build a list of alternatives
- 4) evaluate the alternatives including ways to measure their effectiveness

Outputs

Recommendations for what the outputs should include are

- A list of short and long term alternatives for what an LME crisis program should look like, the resources needed including staffing requirements
- Clarification of which of these alternatives are budgetary requests from the legislature, recommendations for spending of current funding, and which are systemic changes that do not require funding
- An impact statement clarifying the impact if a recommendation is or isn't adopted
- Strategies for evaluation
- Recommendations for follow up work this group will need to do

Secretary Benton clarified that the group should look at the state's capacity for crisis and short term care. We need to understand how the state hospitals work and who they serve and how we fully operationalize the community component so we can see it on the ground.

LME Presentations

Piedmont LME presented on their crisis services, naming that most of the people they see in crisis are IPRS, not Medicaid funded. Their hospital ED's have had a reduction in cases they see, down from an average of 8 a day to 1 a day. Piedmont has a DMH waiver and a Medicaid waiver that assists with their flexibility. The group received handouts that provide additional detail.

Sandhills LME presented on their crisis services strategies which have focused on reducing demand for crisis services, increasing crisis services capacity, and protecting the consumer's safety and welfare. This LME also has a funding waiver from DMH that help with things like medication, transportation and housing assistance. The LME focuses quite a bit on consumers coming out of the hospitals, and has seen a significant switch from state hospitals to community hospitals, and overall hospital admissions have gone down. Handouts provide additional details on goals, 18 strategies and progress to date.

State Crisis Funds Expenditures

Leza Wainwright shared a spreadsheet that shows what has been spent during the first six months of the year, looking only at the \$27.3M state dollars that are in the current budget and earmarked for crisis services. Other funds used for crisis services are not included in the spreadsheet. Some of these state funds were allocated by the general assembly using formulas, and others funds were put in at the discretion of the LMEs. The spreadsheet includes fee for services categories that are also eligible for Medicaid reimbursement, fee for services that aren't eligible for Medicaid reimbursement, and reimbursements for expenses that aren't fee for services. Some LMEs have not yet reported any spending in the fee for services categories. Beginning next year LMEs will also have to report how they spend their county funds.

Single stream funding waivers have been approved for 9 LMEs. Those funds were decategorized. The LME has one pot of money that is paid out in equal, monthly increments. Reports from these funds are not as specific about how the funds are used and their outcomes. Through Oct.1 of this year, it was a judgment call on the part of the division and the department about whether or not single stream funding waivers would be provided. The division/department approached LMEs known to be good at managing their dollars and that had been creative within the old funding stream system. Starting Oct. 1 there are published guidelines for past performance an LME must have

demonstrated to apply for the single stream waiver. Since then, only Crossroads has applied and been approved.

Hospital Association & NC Council on Community Programs Report

The NCHA and NCCCP, along with several LMEs, have been meeting to establish a common plan for MH crisis services. The plan was presented in the form of a charter, and uses a methodology from an April 2007 DMH/DD/SAS document that projects need for 187 additional inpatient crisis beds. The problem is that 50% of state psych hospital admissions have stays of 7 days or less, up from 30% only a few years ago. Our focus is on increasing community capacity by the number of beds needed to serve these short stay admissions.

We recommend that LMEs with high state hospital utilization and limited community capacity be identified for projects that include financing of inpatient capacity and of related capital costs. The model would require sequential exhausting of all efforts identified in the plan. NCHA indicated that a rate higher than the Medicaid rate was proposed to help cover costs of higher acuity, medical co-morbidity and physician care. He also reminded the group that the plan differed from the need in the State Medical Facilities Plan as it specifically identifies need for funded beds to serve indigent patients that would otherwise be admitted to state hospitals. The group commented that there are beds that are licensed, not utilized and possibly not practical to be counted as available beds. Additional details are provided in the project document distributed to the workgroup.

Survey Results

The survey document was distributed. Members are asked to review it and come prepared to make additional comments at the next meeting. Members can also continue to submit responses to Martha who will incorporate them into a revised document.

The next meeting

The group was asked to identify what additional information might be helpful to have at the next meeting. Ideas that the Executive Support Team will explore included

- Information on what each of the LMEs is doing with crisis services so we can compare services being offered.
- What does it cost to transfer someone from the community to a state hospital?
- Exploration of disproportionate share funding

- What do LMEs identify as the patient need and capacity? This is important for exploring the idea of clinical homes in the community.
- More information about licensed and in-use beds. Similarities and differences in admission criteria.

In our next meeting we'll review the survey responses and begin listing alternatives.