Clinical system interfaces (outpatient treatment providers – EDs and hospital inpatient units – EMS -- specialty crisis providers)

- Training, protocols, partnerships, and payment strategies for EMS to divert from EDs to MH/DD/SA providers
- Is there a way for Mobile Crisis, EMS, and telepsych to work together
- "Medical clearance" for psych inpatient admission
    - Guidelines already in use for state hospital admissions, and some local community hospitals use it
    - Can EMS provide a medical clearance
- Incentivize providers to keep consumers engaged, diverted from EDs, directed to appropriate levels of care earlier in a crisis episode
    - 1st responder role
    - Payment strategies
    - Education/training needs
- Starting treatment for those clients who are waiting in EDs
    - Meds
    - Meeting providers/alternative planning
    - Care coordination
        - Ask ED consumer what would have kept them out of ED, and use that information for crisis planning for next time
    - ED privileging and credentialing rules/barriers
    - Education for ED staff – many are not operating with good understanding of a changing mh/dd/sas system

IVC process interfaces with legal system

- Look at statutes, training needs, transportation options, easy access to consultation and alternatives
    - Magistrate training
        - Consultation for magistrate
            - IVC alternatives such as MCT, 1st responder, etc
    - Transportation options
        - Law Enforcement vs. privatized options
        - Family involvement
    - ED training – how to terminate petitions
        - Consultation for ED MD's (from whom)
            - IVC alternatives
    - Using Outpatient commitment properly
- Add judge and/or magistrate to this Coalition

Other legal/criminal justice system interfaces

- CIT expansion (cover all counties/all shifts, engage more partners like dispatch, EMS, etc)
- Improve partnerships with CIT and Mobile Crisis Teams
- Jail diversion options at multiple points beyond CIT
    - Mental health courts
    - Screening at or immediately after booking
    - Pre-trial release programs
    - Care Coordination strategies for jailed consumers
        - Ongoing provider involvement
        - Payment barriers

Enhancing roles for consumers, families, and advocates

- Peer support services
- Identifying and promoting free resources
- Peer to Peer training, WRAP planning, Advanced Directive education
- Providers need to try to include families in planning, don't hide behind HIPPA

Enhancing and developing the clinical continuum

- Same day access walk-in centers
    - Successfully meeting needs of many callers
    - Financial model OK, high productivity
    - Med initiation/management a must, can telepsych happen in a person's home for f/u?
    - Need to expand hours
    - Need to resolve payment/co-payment/deductibles issues across LME-MCOs
- Walk-in Crisis Centers
    - Need to expand hours
    - Safety and security concerns around IVC clients
        - Funding for enhanced safety, security, client monitoring
            - Facility modifications and staffing enhancements
- Mobile Crisis Teams
    - Perhaps need to provide treatment beyond the crisis response event – continuity
    - Ability to provide meds – different role for MD
- Facility Based Crisis
    - Not enough of them
    - EMTALA issues to use from EDs
    - May be advantages to having hospitals partner/manage FBCs
    - Private insurance and Medicare do not pay for FBC, so patients go to EDs
- Need more services for specific populations
    - NC START respite beds

  - Community (foster family) respite for children
  - Seasonal support and respite services
- Peer support/peer operated services
  - Try a trauma informed peer respite center
  - Utilize more peer support specialists throughout the continuum
  - More Healing Place type programs needed for non-medical detox
- Integrated care strategies
  - Enhance primary care physician's role in earlier intervention
  - View SA as a chronic long term disorder
    - Implement recovery supports, check-ins
    - Explore medical respite model for frequent mh/sa ED users
- Consolidate and regionalize crisis providers for more efficiency and specialized services
- Must not forget that ready access to ongoing outpatient services is essential or clients of crisis providers will be isolated from the rest of the system
- Inpatient units
  - We do not have enough inpatient beds. EDs can evaluate and although we can make improvements to divert from inpatient hospitalization for some, we still will not have enough beds. The ED Length of Stay is a big issue for those.
  - 3 Way beds
    - Working well overall
    - Should include in their contracts a requirement to be on a state-wide bed board

Data and Funding strategies

- Need a survey of who is currently using EDs to determine amount and types of feasible alternatives needed
- How can systems to collaborate on data sharing and analysis
- How can systems collaborate in resource sharing
- Need to know the payor breakout
- State can't absorb the cost of all non-medicaid covered individuals
  - What are good uses of county contributions
- Funding cuts and stigma are related. Educating legislators and others about treating mental illness and substance use like any other disease is essential.
- Maybe b3 services could be expanded under the Medicaid waiver
- Align incentives with desired behaviors
  - Need to look at current funding and get it aligned properly first.
  - And examples as noted above:
    - Pay EMS for right care/right setting
    - Provide necessary overhead funding for Walk-in clinics to manage IVC level of care, medical screenings, extended hours
    - Manage state hospital referrals within the LME-MCO array