NORTH CAROLINA

S.T.A.R.T.

Community MH Crisis Prevention and Intervention Model for Persons with Intellectual and Developmental Disabilities

Systemic, Therapeutic, Assessment, Respite, and Treatment

What is START?

- The START Model provides prevention and intervention services to individuals with developmental disabilities and complex behavioral needs through crisis response, training, consultation, and respite. The goal is to create a support network that is able to respond to crisis needs at the community level. Providing supports that enable an individual to remain in their home or community placement is the first priority.

- START does not replace existing services in the community. START provides training and technical assistance to enhance the ability of the community to support individuals with DD and co-occurring mental illness/complex behavioral needs.

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Role of START

- Provide support and technical assistance to community MH crisis and intervention supports
- Create and maintain linkages and relationships with community partners
- Coordinate support meetings and cross systems crisis plans for individuals
- Provide on-going consultation to providers and/or families
- Provide training and technical assistance to community partners
- Provide short-term respite – both emergency and planned

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History

- START Model was recommended by the DD-PIC to the Division of MH/DD/SA
- START Model was presented to the Legislative Oversight Committee in February 2008
- Funds were appropriated for community based crisis
- Division held a training with Joan Beasley on START for eligible providers and LME's
- Two providers were designated to implement this community based model

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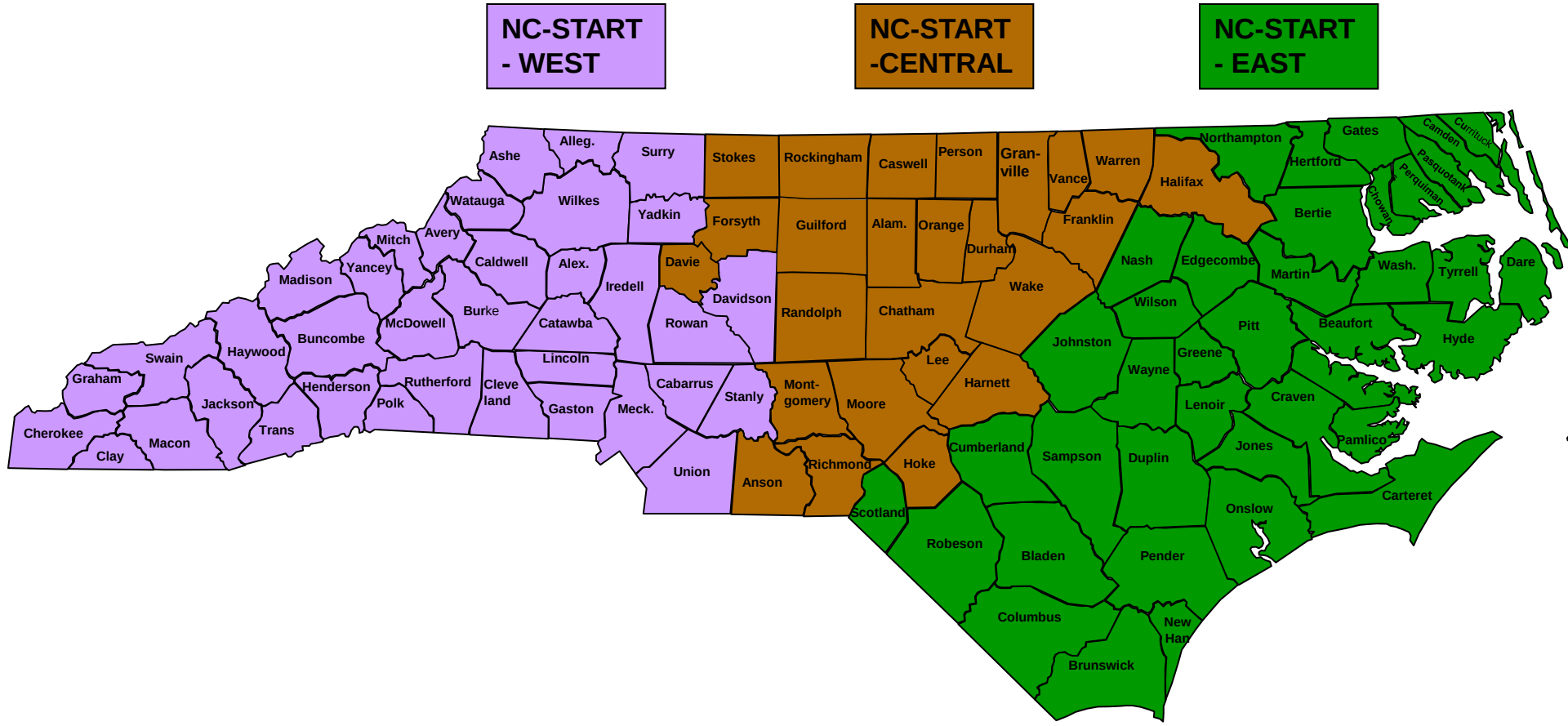
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NC-START - EAST
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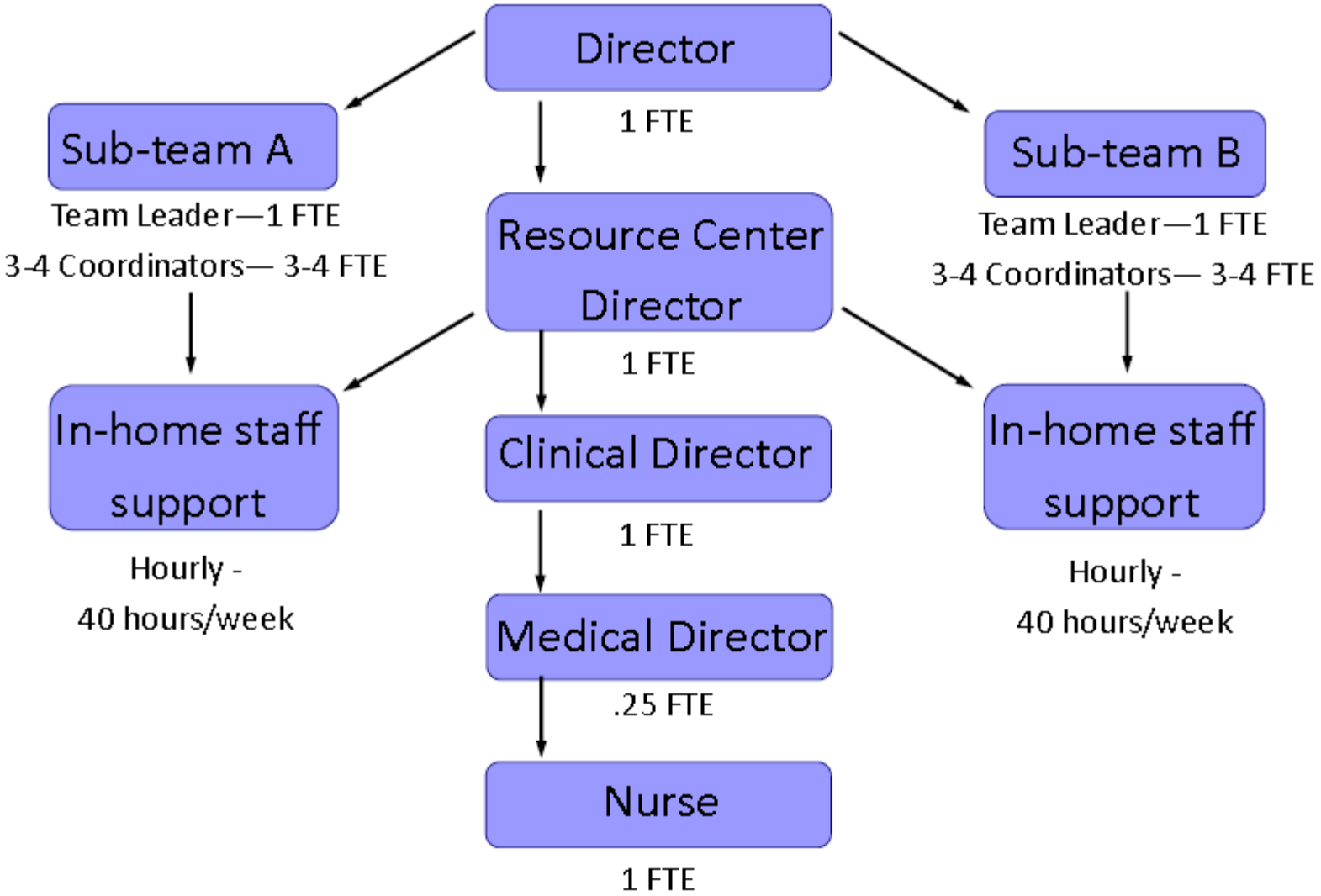
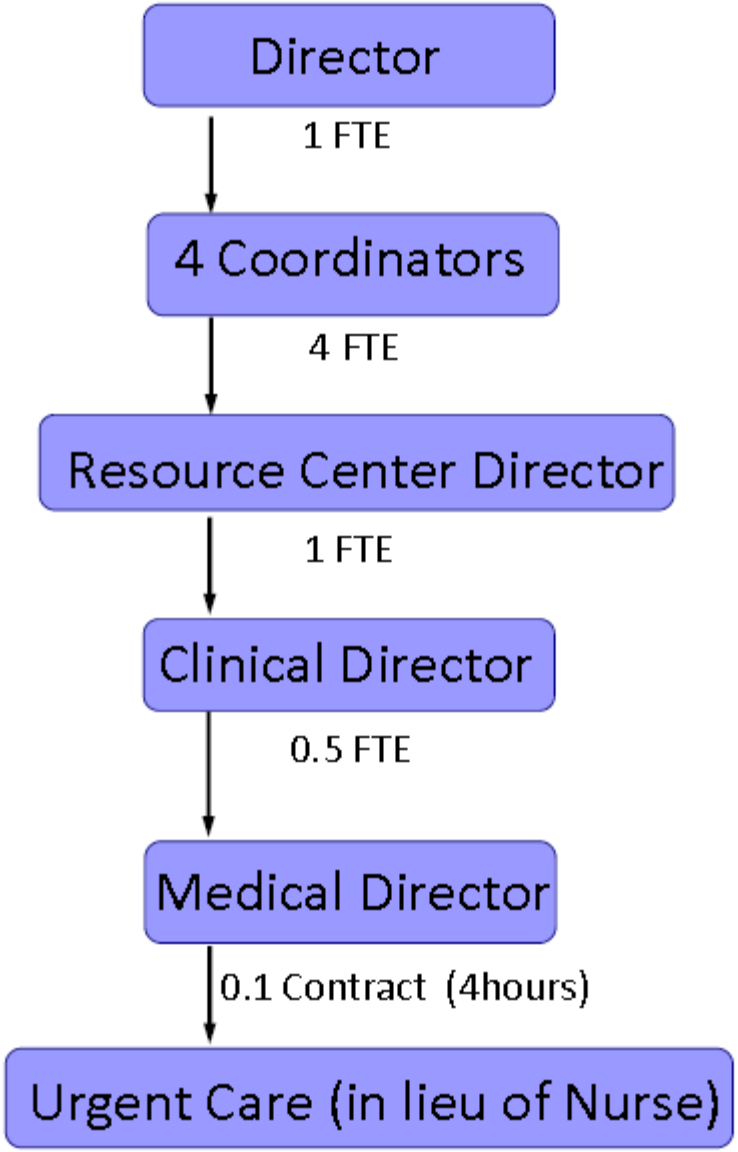
Planned Structure per Region Based on Gap Analysis



Current Structure per Region



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Who is eligible for NC START?

- Individual has confirmed developmental disability and is eighteen years of age or older
- Individual has significant behavioral challenges and/or a co-occurring mental illness
- Individual demonstrates significant behavioral challenges that require further psychological and/or psychiatric intervention
- Current treatment attempts are unsuccessful
- Prior to full admission, case manager/care coordinator is identified and participating

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Essential Components

- Linkages
- Expertise, training
- Family support and education
- Planned and emergency therapeutic resources (respite services)
- Crisis Response
- Cross-systems crisis prevention and intervention planning
- Employs evidence-informed practices and outcome measures (advisory council, clinical team, data analysis)
- Learning communities, local, regional, statewide, national

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Outcomes

- Maintain stable community residence
- Access and engage resources
- Decrease behavioral challenges
- Decrease mental health symptoms
- Decrease state facility and hospital utilization
- Increase community involvement
- Increase crisis expertise in community
- Implement and maintain community partnerships

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Caseloads

- -From 2011-2012 START had an 18% increase in caseload with another 18% increase from 2012-2013. From 2013 through the first quarter of FY14 there was an increase of 15%.

- -Overall, since 2010 the teams have seen a 41% increase in caseloads; all of this with no increase in resources for the teams and no solid mechanism for billing.

- Caseloads in the Central region have exceeded 50. The West is approaching this number also. *START Model is based on 25-30 cases per coordinator.*

- -The Central region has temporarily suspended acceptance of new cases due to the increased demand and the West has caught up to the Central region in the demand.

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From the data

- Average age – early 20's
- Psychiatric and medical complexity
- Approximately half have mild ID
- Increase in referrals from ED (most recent quarter 37%)
- Disposition for large majority of referrals continues to be avoiding higher level of care and higher costs.

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- Current active caseload is 560 with the average caseload per coordinator at about 46.
- Most individuals served (67%) are Medicaid/non-Innovations recipients with limited services and supports.
- Approximately 50 individuals were denied NC START services in the Central region due to capacity issues this most recent quarter.

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Recent Quarter Data

- Over 500 people supported
- 130 respite admissions: ALOS for planned - 4 days; and crisis respite at – 21 days.
- The number of denied respite requests has risen steadily this fiscal year with the current quarter reflecting 101. 53, or half, of all denials were due to the homes being at capacity. An additional 13 had no return address.
- 1814 hours of planned services (cross system crisis planning development, intake assessments, family support, and transition planning with our developmental centers and state hospitals).
- 140 hours of training was provided to the system including training to MCO staff, providers, family members, and police or emergency response. *This is the prevention work that the teams should focus on; but due to limited resources are unable to do so.*

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Trends

	FY 2010	FY 2011	FY 2012	FY2013	FY 2014 (est)
# Served	394	340	402	474	600
Funding Medicaid Non-waiver	52%	56%	64%	63%	67%
Predominant Referral Source	Clinical Home/Case Mgmt	Clinical Home/Case Mgmt	Clinical Home/Case Mgmt	Hospital ED 35%	Hospital ED
Referrals from ED	87	207	231	383	
Hours of training	1085	1057	1211	802	Less than half of previous year

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On-going Support to System

- Teams continue to support EDs, providers, and MCOs; and prevent unnecessary more intensive services
- CET – Clinical Education Team – case presentations and training in a community forum
- Quarterly regional Advisory Council meetings
- Transition planning supports to developmental centers for individuals transitioning to the community.
- Clinical collaborative meetings with state hospitals on a monthly basis to collaborate on the treatment needs and planning, including discharge planning, for individuals with an intellectual/developmental disability (IDD) in the state hospital.

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