Mental Health/Substance Use Disorder Central Assessment and Navigation System Pilot Program

Session Law 2017-57, Section 11F.7.(c)

Final Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

October 1, 2019

Reporting Requirements

Session Law 2017-57, Section 11F.7.(c) Reports. – *By July 1, 2019, the LME/MCO responsible for the management and provision of mental health, developmental disabilities, and substance abuse services in New Hanover County, in collaboration with New Hanover Regional Medical Center and Recovery Innovations, Inc., shall submit a final report of the program to the Division. By October 1, 2019, the Division shall then submit a final report of the program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report shall include the Division's recommendations with respect to sustaining or expanding the program.*

Program Requirements

Session Law 2017-57, Section 11F.7.(a) described the funding and the intended outcome of the Mental Health/Substance Use Disorder Central Assessment and Navigation System Pilot Program (MH/SU Central Assessment and Navigation pilot):

> Pilot Program Creation. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two hundred fifty thousand dollars ($250,000) in nonrecurring funds for the 2017-2018 fiscal year and the sum of two hundred fifty thousand dollars ($250,000) in nonrecurring funds for the 2018-2019 fiscal year shall be used to oversee, in consultation with the local management entity/managed care organization (LME/MCO) responsible for the management and provision of mental health, developmental disabilities, and substance use disorder services in New Hanover County under the 1915(b)/(c) Medicaid Waiver, the establishment of a two-year pilot program to focus on assessing and navigating individuals seeking mental health or substance use disorder services, or both, to appropriate community-based services or other community resources in order to reduce the utilization of hospital emergency department services for mental health and substance use disorder services.

Session Law 2017-57, Section 11F.7.(b) outlined some program requirements, including a general description of the activities to be performed to accomplish the intended outcome, as well as the team of individuals who would perform specific activities for this pilot program:

> Program Design and Location. – The pilot program shall be conducted at New Hanover Regional Medical Center (NHRMC) and at Wellness City, operated by Recovery Innovations, Inc., by a three-person centralized team. The three-person team shall consist of the following individuals:

> (1) A master's level, fully licensed clinician to perform comprehensive clinical assessments of NHRMC patients and other New Hanover County residents exhibiting symptoms of mental illness or substance use disorder who are referred to the pilot program.

(2)   A qualified professional to assist patients, particularly those with a completed comprehensive clinical assessment, with identifying and accessing appropriate community-based services or other community resources.

(3)   A North Carolina certified peer support specialist, with specialized training and personal experience in successfully managing his or her own serious mental illness or substance use disorder, to provide peer support services, including encouraging patients to take personal responsibility for managing their condition, assisting patients in establishing meaningful roles in society, and providing patients with transportation to and from appointments.

I.   Background

This project was conceptualized in a conversation between NHRMC and Recovery Innovations, Inc. (R.I.), to address repeated admissions by high-utilizer patients to the Emergency Department and/or in the Behavioral Health Unit at NHRMC. This was reportedly due to the lack of capacity and ability for the providers to complete comprehensive clinical assessments to determine the appropriate follow-up Outpatient Behavioral Health services, and then to facilitate the admissions of those individuals into the services that would meet their needs in a timely manner.

The purpose of the pilot was to:

1. Conduct comprehensive clinical assessments (CCAs) of eligible individuals who are

    o   admitted to New Hanover Regional Medical Center's Emergency Department with behavioral health emergencies;
    o   have recently been discharged from behavioral health inpatient care at New Hanover Regional Medical Center;
    o   other New Hanover county residents who have been referred to the pilot program because of symptoms of mental illness or substance use disorder.

2. Assist eligible individuals with identifying and accessing appropriate community-based services, at the appropriate level of care, or other community resources, including but not limited to referring individuals with behavioral health service needs who have received CCAs to an identified partner, Coastal Horizons.

3. Provide peer support services, to include

    o   encouraging individuals to learn to manage their behavioral health symptoms;
    o   assisting the individuals to seek out opportunities and work toward establishing meaningful roles in society; and
    o   providing transportation to and from appointments.

The program objectives were:

1. Reduce overall ED admissions at New Hanover Regional Medical Center ED.
2. Reduce re-admissions to New Hanover Regional Medical Center EDs within 30-days and 90-days of initial ED visits.
3. Reduce overall ED and inpatient spending and costs associated with ED boarding and utilization.
4. Increase the percentage of individuals who receive post discharge (from the ED and inpatient) care within 7 days of discharge.

After the centralized Peer Navigation Team was hired in April 2018, Trillium Health Resources (LME-MCO) met with NHRMC Emergency Department staff, hospital Social Workers, and Behavioral Health staff to educate them on this pilot program, sharing the goals and parameters of it.

By May 1, 2018, the Team, was ready to begin the program activities, and served the first individual on May 4, 2018.

II.   Peer Navigation Team Activities

In the first month of service provision (May 2018), all individuals referred to the R.I.'s Peer Navigation Team were offered face-to-face peer support and transportation to get to their next needed/scheduled appointments and/or services. Most individuals declined the assistance. In June, the Peer Support Specialist (or Qualified Professional) went to the referral source to complete the initial intake and brought the individuals to the Peer Navigation Team office for their Comprehensive Clinical Assessment if the individuals were available at that time. Otherwise, the Peer Support Specialist or Qualified Professional completed the intake and scheduled a Comprehensive Clinical Assessment with the Navigation Team, and offered to provide transportation for the scheduled time.

In the last week of June 2018, NHRMC and the Peer Navigation Team again met with community partners and other provider agencies. As a result of input received during this meeting, additional elements were inserted into the Comprehensive Clinical Assessment, and the group discussed the benefits of utilizing this team and accepting Comprehensive Clinical Assessments from Recovery Innovations, Inc. This process led to improved cooperation among the providers in New Hanover County.

Through the SFY 2018-19, the program has made strides in being able to improve collaboration between local service providers, connect individuals with needed services for their recovery, and identify community gaps and needs. The supports that were provided by R.I.'s Peer Navigation Team and/or by local supports organizations included: transportation, shelter, social services

(e.g., food stamps), Wellness City, facilitating access to primary care health appointments and medications, and assistance with employment applications.

III.   Results

A. Overview

From December 2018 through May 2019, the program made face to face contact with 446 individuals at the hospital. R.I. reported that the Peer Navigation Team served 61 of those individuals, and it further reported on the referral, assessment, and navigation activities that were accomplished by the Team, as well as the ED and inpatient readmissions to NHRMC's ED or inpatient services.

NHRMC reported on ED and inpatient readmissions of 52 persons, who were served by the Peer Navigation Team, and the dollars charged for the hospital's services. The discrepancy between the number of persons reported on by NHRMC and R.I. may be due to the different data systems used by the two partners with respect to identification of patients.

NHRMC separated ED from inpatient readmissions and reported on multiple measures used to track readmissions: number and percent of persons readmitted; number of readmissions within 30 days, and within 90 days, and over the life of the pilot project.

A total of 79 persons were referred to the Peer Navigation Team, according to R.I., and a total of 64 were referred from and identified as patients of NHRMC. The table below outlines the way in which pilot participants were served. See Table 1 below.

Table 1
R.I.'s Peer Navigation Team
Persons Referred/Served
May 2018 – May 2019

	Number Referred to Peer Navigation Team	**Number Served by Peer Navigation Team**	**Percent Served by Peer Navigation Team**
Activity	79	61	77%
Comprehensive Clinical Assessments		11	18%
Linked to Provider		49	80%
Linked to Supports		34	55%

Though there was a relatively low number of Comprehensive Clinical Assessments completed the Peer Navigation Team facilitated linking 49 of the 61 persons served to one or more behavioral health and integrated care (medical and behavioral health) providers and local support organizations. The reasons reported for the seven persons who were not linked to a provider and/or support organization included, "no show," "MIA" (missing in action), "no contact number," "disengaged," and "declined further services".

The behavioral health and integrated care providers to which the 49 persons were linked offer both substance use treatment and mental health services, and some offer medical care as well. While R.I.'s report did not consistently identify the actual services to which the persons were linked, the services that were identified included Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Detoxification Services, Community Support Team, Assertive Community Treatment Team, Mobile Crisis Management, and outpatient therapy.

More broadly, all of the people served were between the ages of 19 and 68. Approximately 43% were females and 57% were males. Finally, Table 2 below shows the behavioral health payer sources of the individuals who were served by R.I.'s Peer Navigation Team. See Table 2 below.

Table 2
R.I.'s Peer Navigation Team
Payer Source of Persons Served
May 2018 – May 2019

Payer	Number of Persons
Private Insurance	3
State-funded (IPRS)	43
Medicaid	15
Total	**61**

B. *Reduction in ED admissions at New Hanover Regional Medical Center ED*

NHRMC was able to track and report data from June 2018 through May 2019 about 52 of the 61 individuals who were served by R.I.'s Peer Navigation Team. It did not provide direct data on the impact of the pilot on overall ED admissions, nor the impact on readmit rates specifically at 30 or 90 days intervals. However, NHRMC did report on the number of ED and Inpatient admissions before (Pre-) and after (Post-) individuals received services from the Peer Navigation Team, by tracking the admissions for the same length of time before and after the first engagement with the Peer Navigation Team. For example, if three months has passed since a

person first received Peer Navigation Team services, NHRMC identified the number of admissions that occurred three months prior to, and three months after Peer Navigation Team services began.

The 52 individuals who were tracked visited the ED a total of 192 times before engagement with the Peer Navigation Team, and 154 times after engagement. Those same 52 persons were admitted a total of 57 times to NHRMC's inpatient unit before engagement with the team, and 45 times after. See Table 3 below.

Table 3
NHRMC Tracking of 52 Peer Navigation Team Participants
ED Admissions & Inpatient Admissions
June 2018 – May 2019

	Pre-Peer Navigation Team	Post-First Contact with Peer Navigation Team	Difference	Percent Change
ED Admissions	192	154	-38	-20%
Inpatient Admissions	57	45	-12	-21%
Total Inpatient Length of Stay (Hrs./Days)	13,007 hrs./542 days	7,875 hrs./328 days	-5,132 hrs./214 days	-39%
Average Inpatient Length of Stay (Hrs./Days)	228 hrs./9.5 days	175 hrs./7.3 days	-53 hrs./-2.2 days	-40%

Note: in this table and in the report "inpatient", unless otherwise specified, refers to acute medical inpatient and/or behavioral health inpatient services.

C. *Reduction in overall ED and inpatient spending and costs associated with ED boarding and utilization.*

NHRMC reported on the dollars charged for both ED admissions and Inpatient admissions for the 52 individuals before and after their first contact with the Peer Navigation Team. A total reduction of ED charges from before and after first contact was reported to be $445,001, while the total reduction of Inpatient charges was reported to be $515,515. See Table 4 below.

Table 4
NHRMC Tracking of 52 Peer Navigation Team Participants
Dollars Charged: ED & Inpatient Admissions
June 2018 – May 2019

	Pre-Peer Navigation Team	Post-First Contact with Peer Navigation Team	Difference	Percent Change
ED Admissions	$1,513,492	$1,068,491	-$445,001	-29%
Inpatient Admissions	$1,494,673	$979,158	-$515,515	-35%
Total	$3,008,165	$2,047,649	-$960,516	-32%

D. *Increase the percentage of individuals who receive post discharge (from the ED and inpatient) care within 7 days of discharge.*

While R.I. reported on the linkages made by the Peer Navigation Team, connecting the persons served by the Team to providers in the community for follow-up care, the Division did not receive data pertaining to how quickly the individuals actually received their first appointment with those local providers.

E. *Additional Impact of the Program*

The Peer Navigation Team experienced multiple successes during the past year that helped individuals who were served as well as the local community. Through this program, a local community mental health provider collaborative has been developed to improve communication among treatment providers and address identified gaps in services. The team has developed a network of service providers, identified which agencies provide what services, and developed local contacts with agencies to immediately begin connecting individuals with services. The Team also developed relationships with local social service providers to meet the additional needs of the individuals, such as food, housing and employment, to further improve an individual's success in recovery.

Team members also expressed that providing one-on-one time with each client, making sure needs are met personally and being able to get to know each person facilitated their paths to recovery. The vital service of a Peer Support Specialist team member helps the whole Team learn what methods best help the individual participant and build trust. They also expressed the view that the transportation services provided by the team also helped to ensure that individuals served were strongly connected to their provider agencies before discontinuation of services

through the pilot program, thus potentially improving the individual's likelihood for long-term treatment and recovery.

IV.   Challenges and Barriers

For four months early on in the pilot, the Peer Navigation Team did not have access to NHRMC, and therefore was limited with respect to the ability to engage with individuals that were at the hospital in order to recruit referrals for the Team's services. That challenge was resolved in November 2018, when the Peer Navigation Team members received badges from NHRMC allowing them to complete daily rounds in the different areas of the hospital.

From December 2018 through May 2019, the program made face to face contact with 446 individuals at the hospital. This data prompted the team to further improve on data captured to help understand what barriers were preventing individuals from engaging in the program.

From March 2019 through May 2019, the program recorded the number of people contacted for engagement with the Peer Navigation Team and barriers preventing engagement in the program. For instance, when an individual has been involuntarily committed (IVC) to psychiatric or substance use inpatient treatment (31% of 446 individuals contacted through the pilot), it can make it more difficult to engage with community providers.

Another challenge identified was that many individuals declined to participate in the program, with just 23% of individuals contacted who initially agreed to participate.

The Peer Navigation Team also experienced multiple staffing changes during the State Fiscal Year 2018-2019 that impacted how well the team functioned, including the absence of a licensed clinician for seven months of the last fiscal year. The program also discovered that many local mental health and substance use service providers did not want to accept Comprehensive Clinical Assessments from the pilot program, thus limiting the ability of these assessments to decrease the wait time that an individual has when being connected with a provider.

In addition, the Team has also identified community barriers that are impacting individuals' ability to access resources and engage in ongoing treatment to support recovery. The main barrier identified was lack of affordable housing in the area. A lack of reliable communication and disengagement by participants were also challenges.

V.   Conclusion

The purpose of the pilot program, as described in the Session Law 2017-57 was to help individuals access behavioral health services and other community resources in order to reduce those individuals' utilization of hospital ED services for behavioral health care. The data reported from R.I. and NHRMC reflect several measures used for monitoring the objectives of the project.

Pilot participants who were served by the Peer Navigation Team experienced approximately a 20% reduction in both ED and inpatient admissions and approximately 40% shorter inpatient stays when they were admitted. This also resulted in approximately a 32% decrease in costs to NHRMC for those individuals.

However, only a small number of the people the Peer Navigation Team reached out too were actually served by the program (approximately 14%). Moreover, only eleven CCAs were completed by the Team's licensed professional. As explained above, multiple barriers and challenges were encountered by the Team that limited these outputs. Regarding the CCA's specifically, there was a period of time in which the Team was without a licensed professional, some individuals being served by the Team refused to participate in the CCA, and some behavioral health providers would not accept CCAs from clinicians who were external to the provider organization.

VI.   Recommendations

Peer navigation, which can be described as a variety of case management, appear to offer potential benefits to persons who experience repeated hospital readmissions and debilitating social determinants. However, to adequately facilitate the benefits of peer navigation/case management, proactive discharge planning and sufficient levels of care and intensity of services and supports need to be available in the local community for the navigation/linking/case management activities to be efficacious.

Further, tracking the results of such efforts is essential, regardless of payer source of the persons served; and the use of claims-based data would enable LME-MCOs to monitor and verify the reported outcomes for the persons served, such as ensuring that the linkages made to local behavioral health providers were made in a timely manner. Claims-based data would also be helpful for the LME-MCOs to identify individuals who might benefit from higher intensity/higher level of care to reduce the occurrence of crises and the need for higher-cost emergency response and stabilization services.

DMHDDSAS and NC Medicaid have been working to develop a robust care management model as part of Medicaid Transformation. In addition, Peer Supports is now available as a service in the DMHDDSAS service array and can be billed by appropriate providers. NC Medicaid is in the process of promulgating a similar definition that will tentatively be available by October of 2019. Claims data will allow for better monitoring of the service and its outcomes, which can inform future amendments to the service, if needed, to ensure ongoing quality. Finally, as a definition in the service array, more people across North Carolina will have access to the service.