Welcome! and Introductions of Attendees

• Welcome!
  – Steve Mange
  – Susan Kansagra

• Introductions of Attendees
  – Your name
  – Your organization/affiliation
Post Reversal Response/ED to Treatment Connection

Action Learning, Continuation

Jai Kumar, NC Hospital Association
A Crisis in Crisis Care: Opioids and Behavioral Health in EDs

Jai Kumar, MPH
Julia Wacker, MSW, MSPH
North Carolina Hospital Association
<table>
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<tr>
<th>Care linkages</th>
<th>NCHA LME/MCOs</th>
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<td>Work with health systems to develop and adopt model overdose discharge plans to promote recovery services and link to treatment care</td>
<td>DMH, RCOs, APNC, CCNC, LME/MCOs, NCATOD</td>
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<td>Link patients receiving office-based opioid treatment to counseling services for SUD using case management or peer support specialists</td>
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<td>Treatment access</td>
<td>All</td>
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<td>Increase state and federal funding to serve greater numbers of North Carolinians who need treatment</td>
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Rates of Unintentional/Undetermined Prescription Opioid Overdose Deaths & Outpatient Opioid Analgesic Prescriptions Dispensed

- Average mortality rate: 6.4 per 100,000 persons
- Average dispensing rate: 82.9 Rx per 100 persons

Analysis: Injury and Epidemiology Surveillance Unit
Opioid Overdose ED Visits by Year: North Carolina, 2009-2017 YTD

Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT). Counts based on diagnosis (ICD-9/10-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose cases include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics. Analysis by Injury Epidemiology and Surveillance Unit

YTD: Year to Date
*Provisional Data: 2017 ED Visits
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### Opioid Overdose ED Visits by Insurance Coverage: 2017 YTD

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Peer Support Integrated Model
A Collaborative Approach

• Peer Support & Supports of Health are certified by LME/MCO and employed by the health system

• Hospital case management/social work to set up linkages in care while peer support act as health navigators & initiate **HOT Handoffs**

• Community Supporters of Health act as liaisons to ensure SUD patients make it to treatment
Problem Analysis

Is this the right model?
Action Learning and Problem Analysis

Involuntary Commitment

Julia Wacker, NC Hospital Association
Over the past decade, the number of patients seeking behavioral healthcare in NC emergency departments, and the length of time they wait for treatment, has increased 4-fold.
2015 ED Visits by Patient Zip

NC Patient Counts by Zip Code

NC Patient Counts:
- 0 - 33
- 34 - 76
- 77 - 134
- 135 - 221
- 222 - 328
- 329 - 482
- 483 - 659
- 660 - 875
- 876 - 1225
- 1226 - 2127

Miles
Average ED Wait Times in NC

Wait Time for Admission to a State Facility in Days

FY 2012: 3.03 days
FY 2013: 3.53 days
FY 2014: 4.18 days
FY 2015: 4.59 days
FY 2016: 4.95 days

Source: State Hospital Referral Database
NC’s Behavioral Health Crisis Response System

The Impact
System in Conflict with the Evidence

- 65-80% of patients in crisis can be more quickly stabilized outside of a hospital
- BH patients twice as likely to be admitted
- Involuntary = treatment outcomes
- Mixed evidence that short-term inpatient treatment is effective
Boarding of patients in emergency departments “often creates an environment in which a psychiatric condition slowly deteriorates”

NCHA Behavioral Health Agenda

Extended Boarding of Patients in NC EDs

**PRE-Hospitalization**
- IVC process is a mess
  - Revise statute for clarification
  - ED staff, magistrate education
- Crisis response ineffective
  - Fund additional crisis centers
- Staff and space ill-equipped
  - Change mobile crisis service definition
- Inability to transfer
  - Reimburse for per diem stay
  - Staff training, assessment protocols, space

**Emergency Department**
- Revise language in EMTALA
- Improve utility of bed registry

**POST-Hospitalization**
- Inadequate placement options
  - Post-acute recovery care pilot
  - LME/MCO ED visit data sharing
- No clear "process owner" at dx
  - Fund case management
  - Pilot Mobile Medication Program
Goal: Full Continuum of Care
SB 630: Involuntary Commitment

• Incentivize coordination of services
• Decriminalize behavioral health crises
• Maximize use of trained workforce
• Ensure protocols reflect best practices
• Address inefficiencies for timely treatment
A review of 18 SUD/IVC studies revealed treatment-oriented measures (referral, retention), showed benefits of compulsory treatment relative to non-compulsory treatment,

The majority of studies investigating criminal behavior and substance use showed no differences between the two types of treatment.

The benefits were only seen when treatment was for an extended period of involuntary commitment (30-90 days).
Problem Analysis

What are our next steps?
Action Plan Implementation and Reporting

- Need point of contact for every action item listed in the Opioid Action Plan
- Please sign up in a blank OR confirm you’re the right person listed
- Likely requests for quarterly updates for Legislative reports and Governor’s Office
- Updates consolidated and shared with OPDAAC Coordinating Workgroup
- To streamline the process, a brief reporting “form”
Reporting

• Progress update since last report
• Challenges?
• Immediate next steps
• Assistance needed?
Looking Ahead: 2018 Legislative Short Session
Wrap up, THANK YOU!, and What’s next

• Next Full OPDAAC Meeting
  – December 15 at Durham Regional Hospital
  – Registration OPEN

• Next OPDAAC Coordinating Meetings
  – January 11, 2018 at NC Hospital Association
  – February 8
  – April 12