Crisis External Advisory Committee Meeting

August 7th

9:00 – 10:00 AM

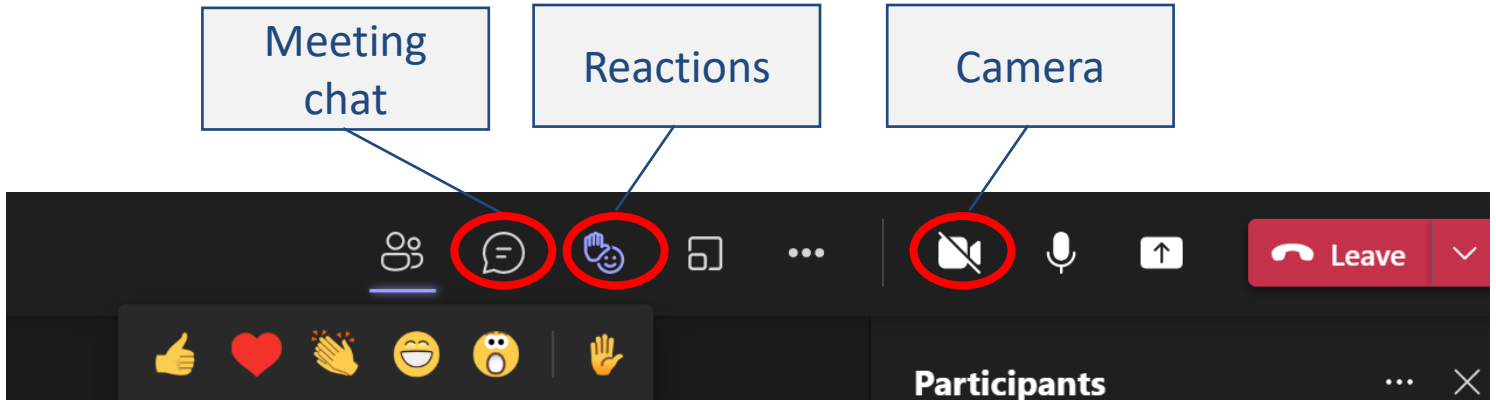
Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS)

Agenda

- Housekeeping and Community Collaboration Model
- Crisis Services Updates
- Discussion
  - Mobile Outreach, Response, Engagement and Stabilization (MORES)

Housekeeping

We encourage those who are able to turn on cameras use reactions in Teams to share opinions on topics discussed and share questions in the chat.



Guidelines for Engagement

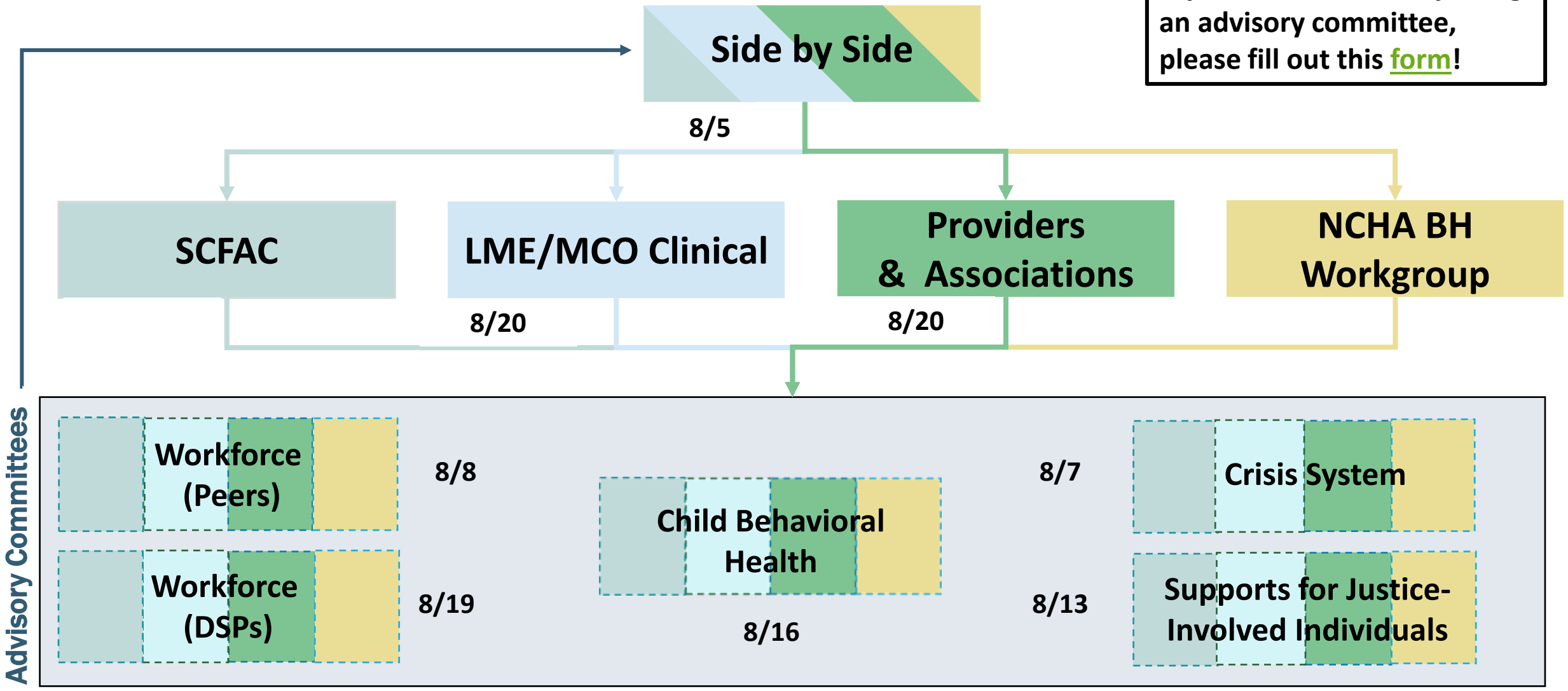
DMH/DD/SUS is committed to transparency in our work and creating shared spaces to engage in constructive dialogue.

We acknowledge that these topics may be difficult, based on personal experiences and identities, and we honor your willingness to share valuable insight.

- If you have a question, wish to express an idea, or share a concern, please use the raise hand feature or the chat function.
- We ask that you are mindful of time to ensure as many members as possible have a chance to provide input and share their thoughts.
- We may interrupt dialogue to keep the space constructive. One of our staff members will connect you with our DMHDDSUS team for additional conversation offline.

August Community Collaboration

If you're interested in joining an advisory committee, please fill out this form!



Crisis Services Updates

Back to School Materials

NCDHHS is providing free, printed 988 educational materials for non-profits, houses of worship, community organizations, NC schools and state and local governments to distribute in their communities.

Includes flyers, stickers, bookmarks and magnets for your back-to-school outreach and events.

988 Back-to-School Materials Order Form

NC Medicaid Back-to-School Materials Order Form

NCDHHS Celebrates Anniversary of 9-8-8 Suicide and Crisis Lifeline Number

On July 16, 2024, the North Carolina Department of Health and Human Services celebrated the second anniversary of 988, the three-digit suicide and crisis lifeline.

- 988 connects North Carolinians via **call, chat or text** to a trained counselor who will listen, offer support and provide community resources **24 hours a day, 7 days a week**.
- In June over 8,000 people **contacted the NC 988 call center**.
- Early indicators suggest 988 is highly effective, **showing 90% of individuals with thoughts of suicide reported improvement** in how they were feeling by the end of their call.
- NCDHHS also supports the **24/7 peer warm line** for individuals who contact 988 and prefer to speak to someone with lived experience.

***To read the press release, click here**

MORES Discussion

Mobile Outreach, Response, Engagement and Stabilization (MORES) Overview (1/2)

MORES is a team-based crisis response intervention for children and adolescents (ages 3-21) experiencing a behavioral health crisis.

MORES can provide the following supports:

- Access to a licensed clinician trained in child and adolescent interventions.
- Access to a Family Support Partner (an individual with lived experience of caring for a child with behavioral health challenges) who provides support and resources to the youth and family.
- Access to psychiatric consultation.
- Access to care management to provide connection to needed resources.
- Up to 4 weeks of follow-up care after the on-site crisis response to assist the family and youth in obtaining services and supports.

DHHS is working to expand the scope of MORES teams responsibilities and increase the number of MORES teams across the state to provide greater access to this service for youth and families.

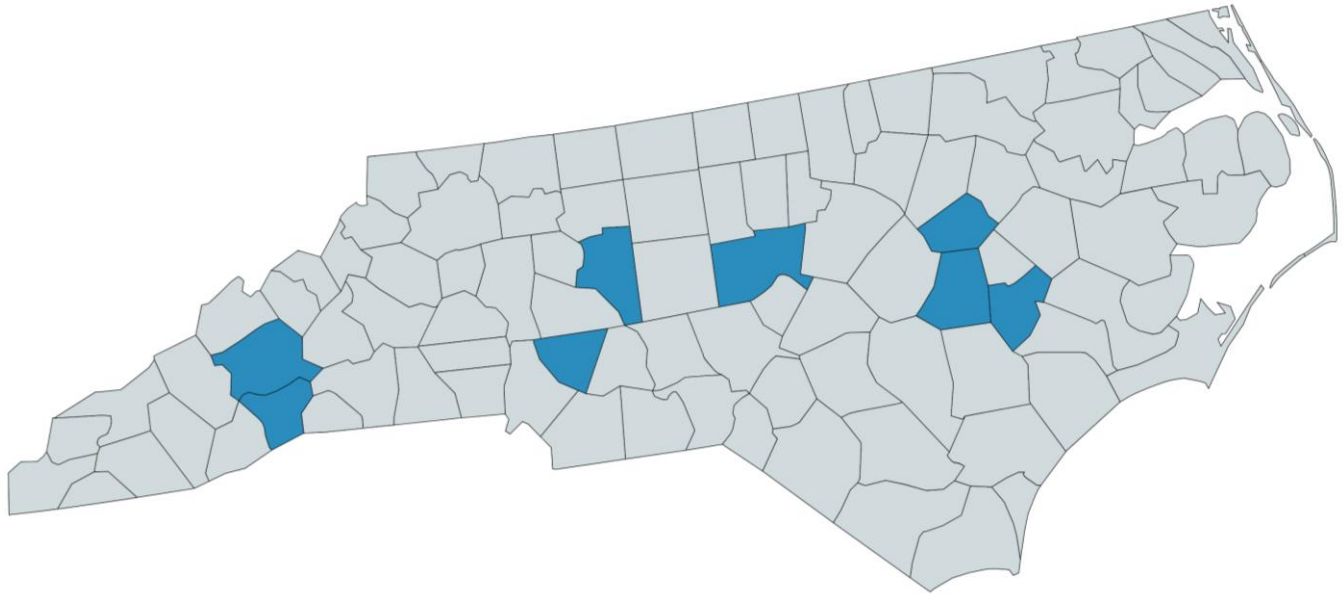
MORES Overview (2/2)

MORES teams provide resources and support to both the youth in crisis and their family in select counties.

What families can expect:

- Immediate support via telephone.
- Short-term crisis management until the crisis is resolved.
- Referral and connections to follow-up services.
- Support and advocacy to identify needs and crisis planning.
- Someone to walk with you and your family.

DMH/DD/SUS-Funded MORES Pilot Sites



- **DMH/DD/SUS is supporting MORES teams are using a combination of Duke Endowment, BH&R Investment, and Mental Health Block Grant funds. Alliance Health also supports MORES in several counties within their catchment area.**
- **DMH/DD/SUS-Funded MORES teams are currently available in the following counties:**
  - Buncombe, Henderson, Cabarrus, Davidson, Lenoir, Wayne, Wilson, and Chatham

Proposed Updates to MORES

NC DHHS seeks to ensure that youth ages 3-21 have access to a specialized mobile crisis response and follow-up stabilization service to meet their specific needs.

Goals for MORES Changes:

- Ensure all MORES teams can provide both mobile crisis and extended follow-up services.
- Improve mobile crisis response times and community stabilization rates.
- Expand MORES statewide and ensure sustainability of the service.
- Align services with evidence-based practices for serving children, youth and families like Mobile Response & Stabilization Services (MRSS).

Reminder: Proposed Mobile Crisis Management Changes

- **Hybrid Service Delivery Models.** Mobile crisis teams could deliver services using either one or two-person teams leveraging a variety of staffing models.
- **Transportation.** Mobile crisis providers would be reimbursed for transporting an individual to a crisis setting (e.g., BHUC, FBC, Crisis Respite).
- **Follow-up.** Within 72 hours of the initial response, mobile crisis teams would be required to conduct follow-up if an individual does not have an existing relationship with a behavioral health provider.
- **Staffing and Training.** Additional types of professionals would be eligible to work on mobile crisis teams, and DHHS will establish new training requirements.

Proposed Approach: Accessing MORES (1/4)

DHHS would require MORES teams to provide youth-specific mobile crisis response in addition to follow-up services.

Initial Mobile Crisis Response

- All MORES teams would provide initial mobile crisis response to children and youth ages 3-21.
- The in-person mobile crisis response could respond to crises in the home, school, or another community location.
- The initial mobile crisis response could last up to 72 hours (allowing for multiple in-person visits) and would be permitted for youth receiving enhanced services.
- MORES teams would be required to adhere to the new mobile crisis requirements (e.g., hybrid staffing models, optional transportation, etc.).

Pathways to Service

- Youth and families could access MORES through an initial mobile crisis response **or** as a follow-up service post-discharge from a crisis-receiving facility.

NC DHHS is considering development of a single clinical coverage policy for Mobile Crisis Management to include MORES.

Proposed Approach: Extended Follow-Up and Care Coordination (2/4)

MORES teams would be allowed to provide up to eight weeks of follow-up services through MORES, an increase from the current four weeks to align with evidence-based practice.

Follow-up Services and Care Coordination

- Following the initial mobile crisis response, MORES teams will provide a warm handoff to services and supports, including pre-existing care coordination entities and referrals to a higher level of care if needed.
- MORES teams will contact an individual's care manager within 24 hours of the initial response.
- When appropriate, MORES teams will provide extended follow-up services to the youth and family with the goal of establishing clear connections to treatment.
- Extended follow-up services are not intended for youth receiving Multisystemic Therapy (MST), Intensive In-Home (IIH).

Proposed Approach: Staffing and Training (3/4)

MORES teams would be required to follow a more prescriptive staffing model than traditional mobile crisis teams to meet the specific needs of youth and families.

Staffing

- MORES teams must include a team lead (qualified professional), clinician (licensed or associated professional), and a family support partner.
- MORES teams must have access to clinical staff who can complete crisis assessments, staff with SUD, I/DD, and TBI expertise, a staff member who is a certified first examiner for IVC, and a psychiatrist or psychiatric extender (child specialization preferred) who can provide clinical consultation.
- MORES teams must ensure their staff responding in-person to a crisis carry naloxone.

Training

- MORES must complete all training required for traditional mobile crisis teams.
- MORES staff must complete additional youth-specific training aligned with evidence-based practices (e.g., training for family support partners, training in family dynamics, child and family training).

Proposed Approach: Timely Response and Transportation (4/4)

DHHS is committed to ensuring that MORES teams provide timely access to care and can safely transport youth to other care settings when medically necessary.

Access Requirements

- DHHS will work to expand access to MORES so that its available 24/7 in urban areas and as widely available as possible in rural areas.
- BH&R investment dollars could be utilized to leverage MORES capacity building.

Transportation

- Like the proposal for MCM, MORES could provide transportation to individuals after completing the initial crisis assessment.
- This approach is utilized by other states providing youth-specific mobile crisis services.

Discussion Questions

- What feedback do you have about the proposed service delivery model we discussed today?
- To what extent will MORES teams be able to hire additional staff? What support would be needed for MORES teams to grow?
- How can we raise awareness of MORES in the communities where it is currently available?
- What support and resources will MORES teams need to comply with these proposed changes?
- Are there additional changes the state should consider that weren't discussed?
- Would there ever be a need for a MORES team to provide a delayed mobile crisis response (e.g., schedule a time for the mobile crisis team to come out)?

Appendix

Proposed Changes to Mobile Crisis and MORES

DHHS is interested in making changes to Mobile Crisis Management (which will include MORES) to improve quality, reduce response times, increase community stabilization rates, and financially sustain a firehouse model for the service.

Overview of Proposed Changes

- **Hybrid Service Delivery Models.** Mobile crisis teams could deliver services using either one or two-person teams leveraging a variety of staffing models.
- **Transportation.** Mobile crisis providers would be reimbursed for transporting an individual to a crisis setting (e.g., BHUC, FBC, Crisis Respite).
- **Follow-up.** Within 72 hours of the initial response, mobile crisis teams would be required to conduct follow-up if an individual does not have an existing relationship with a behavioral health provider.
- **Staffing and Training.** Additional types of professionals would be eligible to work on mobile crisis teams, and DHHS will establish new training requirements.
- **Reimbursement.** DHHS will explore changes to reimbursement to reflect these improvements and make mobile crisis services more sustainable.
- **Timeliness.** DHHS can work with Tailored and Standard Plans to build a network that provides in-person MCM within 30 minutes in urban areas and 60 minutes in rural areas.

Goals of Changes:

- ✓ Expand mobile crisis capacity by maximizing flexibility for multiple models
- ✓ Improve response times and community stabilization rates
- ✓ Maximize federal Medicaid funding through enhanced state match authorized by section 9813 of the American Rescue Plan Act.

Advisory Committee Members

Crisis System Advisory Committee Membership

Providers	
Name	**Organization**
Amanda Green	Atrium Health - Behavioral Health Charlotte
Amanda Johanson	Triangle Springs
Annette K. Gibbs	Carobell. Inc.
Ashley Sparks	Alexander Youth Network
Barbara-Ann Bybel	UNCH
Benjamin Horton	Veterans Services of the Carolinas - ABCCM
Brianne Winterton	Coastal Horizons
Brittney Peters-Barnes	NC START
Carson Ojamaa	Children's Hope Alliance
Christine Beck	North Carolina Children and Families Specialty Plan
Cindy Estes	Novant Health
Corie Passmore	Tammy Lynn Center
Corye Dunn	Disability Rights NC
Dave Jenkins	Cone Health
Eileen Slade	NC START Central
Elizabeth Barber	Threshold, Inc.
Erika Taylor	Brody School of Medicine at East Carolina University, Dept. of Family Medicine
Erin Jamieson Day	Community Impact NC
Glenn Simpson	ECU Health
Heather Hicks	Anuvia Prevention & Recovery Center
Jacob Schonberg	UNC Institute for Best Practice
Jade Neptune	Carolina Dunes Behavioral Health employee, student
Jill Hinton	Licensed Psychologist
Joel Maynard	NCPC
Joyce Harper	Freedom House Recovery Center, Inc.

Crisis System Advisory Committee Membership

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Karen McLeod	Benchmarks
Kelvin Barnhill SR	Flovi Services
Kerri Erb	Autism Society of NC
Kirsten Smith	Children's Hope Alliance
Laura McRae	Pinnacle Family Services
Lisa Goins	Addiction Recovery Care Association Inc.
Luke McDonald	Novant Health
Luwanda Smith Daniels	Alternative Behavioral Solutions Inc.
Lysha Best	RI
Marcie Boyes	Easterseals UCP
Margaret Hunt	Youth Villages
Micah Krempasky	WakeMed
Michelle Ivey	Daymark
Michelle Kluttz	NC START East/West
Mona Townes	Integrated Family Services, PLLC
Morgan Coyner	APNC
Natasha Holley	Integrated Family Services, PLLC
Nicholle Karim	NC Healthcare Association
Pablo Puente	ServiceSource
Paula Bird	Novant Health
Peggy Terhune	Monarch
Rachel Crouse	Coastal Horizons Center, Inc.
Rebecca Peacock	CriSyS
Robyn Codrington	CriSyS
Russell Rainear	Private EOR

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Ryan Estes	Coastal Horizons
Samuel Pullen	Novant Health
Sandy Feutz	RHA
Sarah Huffman	RHA
Sarah Roethlinger	Youth Focus, Inc.
Sherrell Gales	Abound Health
Tammy Margeson	The Hope Center for Youth and Family Crisis/Kidpeace
Teri Herrmann	SPARC Network
Therese Garrett	WellCare NC
Tisha Jackson	Abound Health
Trish Hobson	The Relatives
Venkata Ravi Chivukula	Novant Health

Crisis System Advisory Committee Membership

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Name	**Organization**
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Brian Perkins	Alliance Health
Melissa Payne	Alliance Health
Natalie Barnes	Alliance Health
Jay Patel	Alliance Health
Sandhya Gopal	Alliance Health
Liza Go-Harris	Partners Health Management
Doug Gallion	Partners Health Management
Tara Conrad	Partners Health Management
Michelle Stroebel	Partners Health Managment
Cindy Ehlers	Trillium Health Resources
Benita Hathaway	Trillium Health Resources
Hannah Coble	Trillium Health Resources
Laurie Whitson	Vaya Health
Lesley Jones	Vaya Health
Tina Weston	Vaya Health
Tracy Hayes	Vaya Health
Eric Harbour	WellCare NC

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Consumers and Family Members	
Name	**Organization**
April DeSelms	SCFAC
Bob Crayton	Vaya CFAC
Carol Conway	PACID
Church Wendy	Self
Crystal White	Easterseals UCP
Hannah Russell	Special Education Consultant
Jessica Aguilar	Grupo Poder y Esperanza
Johnnie Thomas	SCFAC and Wake NC 507 CoC
Michelle Laws	SCFAC
Nancy Johns	NAMI-Wake, Alliance CFAC, NCCPSS, HEYPEERS
Patricia-Kay Reyna	Center on Brain Injury Research and Training
Patty Schaeffer	SCFAC
Sharon O'Donnell	Self
Sherri McGimsey	NAMI

Crisis System Advisory Committee Membership

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Name	**Organization**
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Amber Howard	Appalachian District Health Department
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Ashley Barber	Alamance County Health Department
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Cait Fenhagen	Orange County Criminal Justice Resource Center
Chiquita Evans	Neighbors for Better Neighborhoods
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Dawn Koonce	Murdoch Development Center
Denise Foreman	Wake County
Denise, Price	Forsyth County Government
Desireé Gorbea-Finalet	Disability Rights North Carolina
Diane Coffey	Parent to Parent Family Support Network
Gayle Rose	UNCG - Center for Youth, Family and Community Partners
Jai Kumar	North Carolina Healthcare Assoication
Jeremy Fine	UNC
Johana Troccoli	Duke Health
Kristy LaLonde	Pride in NC
Marvin Swartz	Duke
Michele Chassner	The Hope Center for Youth and Family Crisis/Kidpeace
Naglaa Rashwan	UNCG
Nancy Keith	ECU Health
Philip Woodward	North Carolina Council on Developmental Disabilities (NCCDD)
Shagun Gaur	Autism Society of North Carolina

Crisis System Advisory Committee Membership

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Tracie Potee	Soar Parenting and Life Wellness Coaching Services Inc.
Troy Manns	CHPD/CHT Crisis Unit
Vicki Smith	Alliance of Disability Advocates
William Edwards	Transitional Services Center, inc

Crisis System Advisory Committee Membership

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Jessie Tenenbaum	DHHS
Renee Clark	DHHS Office of Rural Health
Kelsi Knick	NC Medicaid
Michelle Merritt	NC Medicaid
Sandy Terrell	NC Medicaid
Stephanie Wilson	NC Medicaid
Kelly Crosbie	DMHDDSUS
Erica Asbury	DMHDDSUS
Tanya Thacker	DMHDDSUS
Charles Rousseau	DMHDDSUS
Elliot Krause	DMHDDSUS
Kelly Crosbie	DMHDDSUS
Keith McCoy	DMHDDSUS
Lisa DeCiantis	DMHDDSUS
Saarah Waleed	DMHDDSUS
Essie Santillano	Accenture
Mary Ambrosino	Accenture
Jocelyn Guyer	Manatt
Ashley Traube	Manatt
Erica Brown	Manatt
Jacob Rains	Manatt