

Partnering to Drive Reform in Behavioral Healthcare

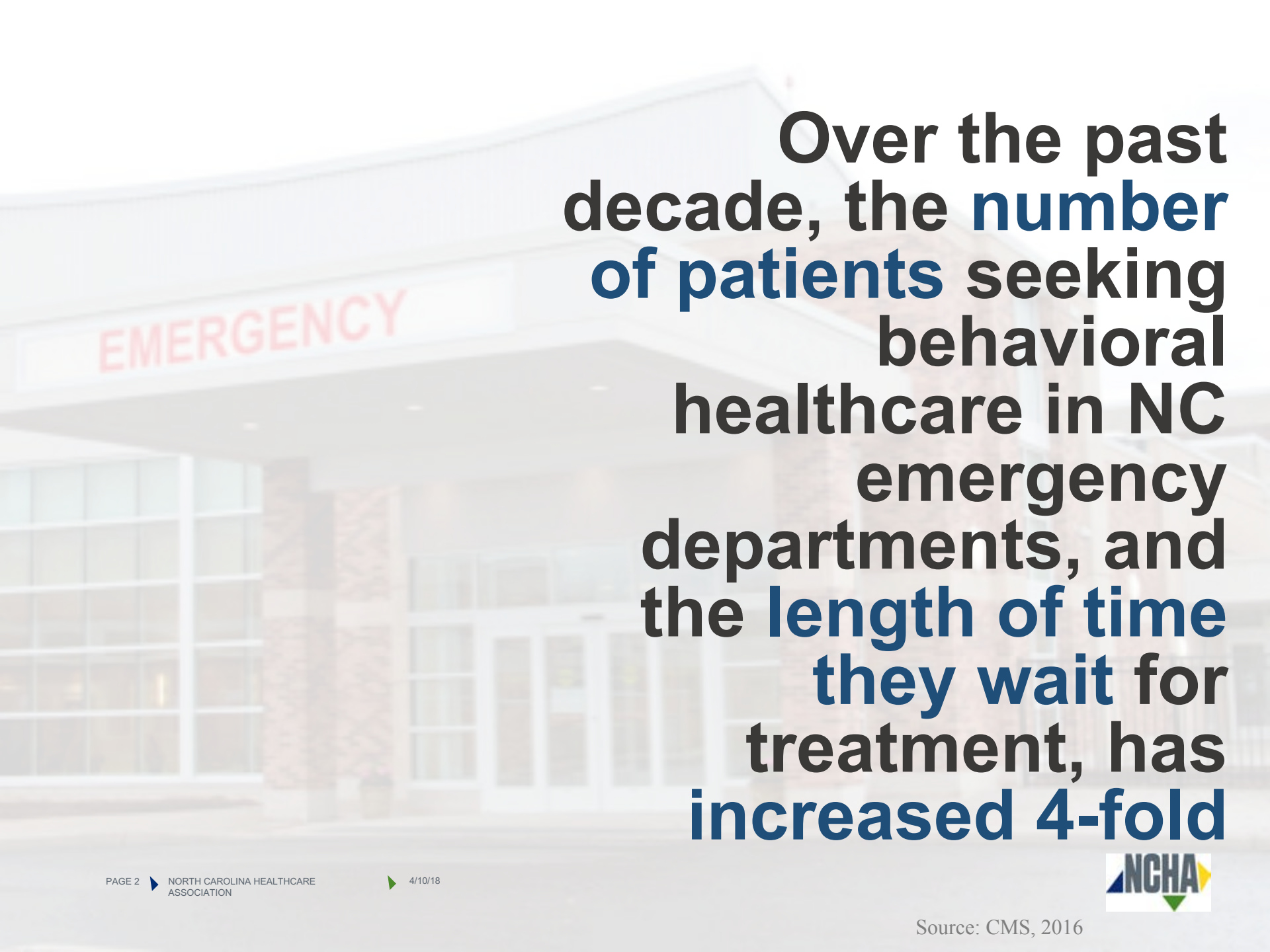
► Stories from North Carolina

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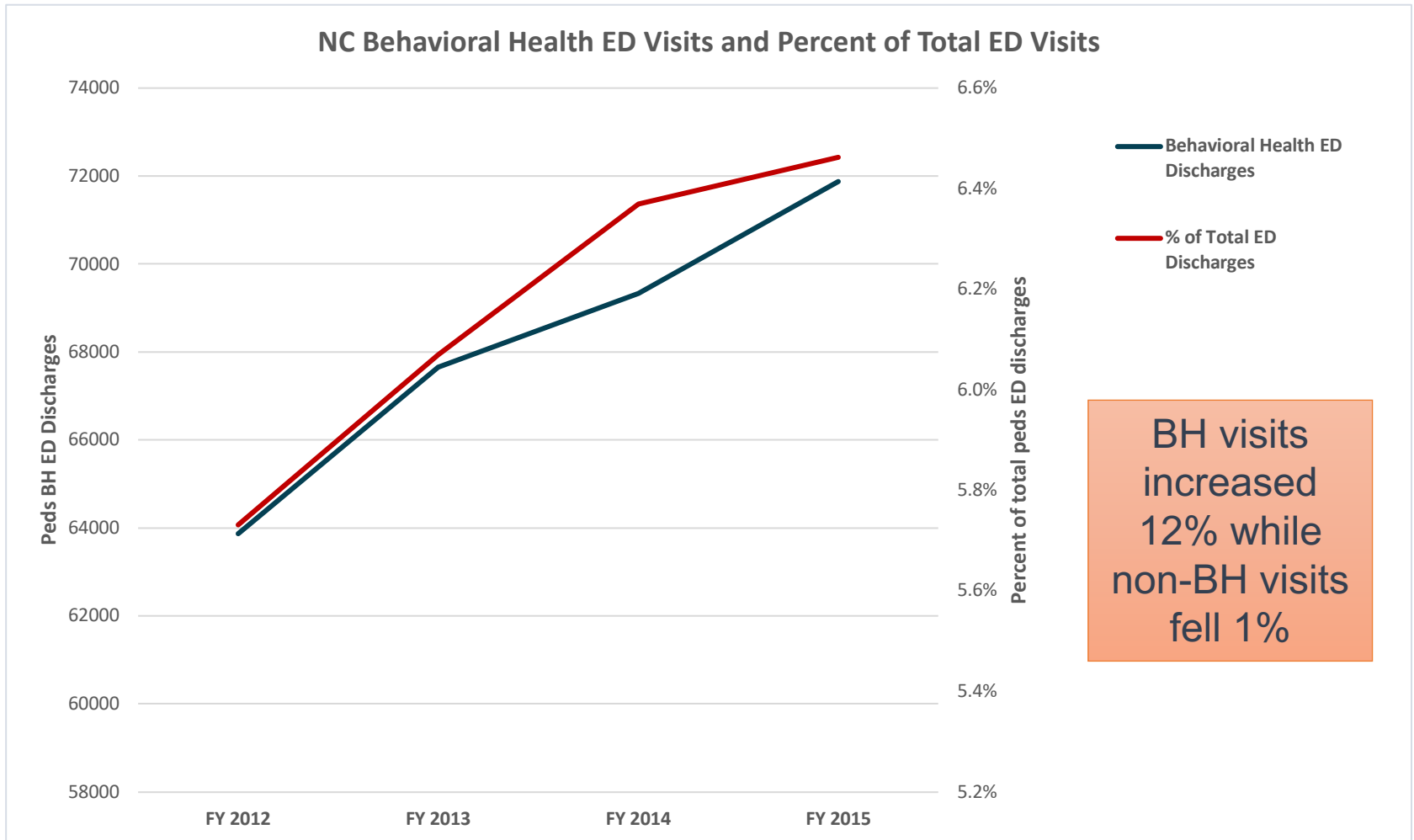
April 11, 2018

Uniting hospitals, health systems and care providers for healthier communities



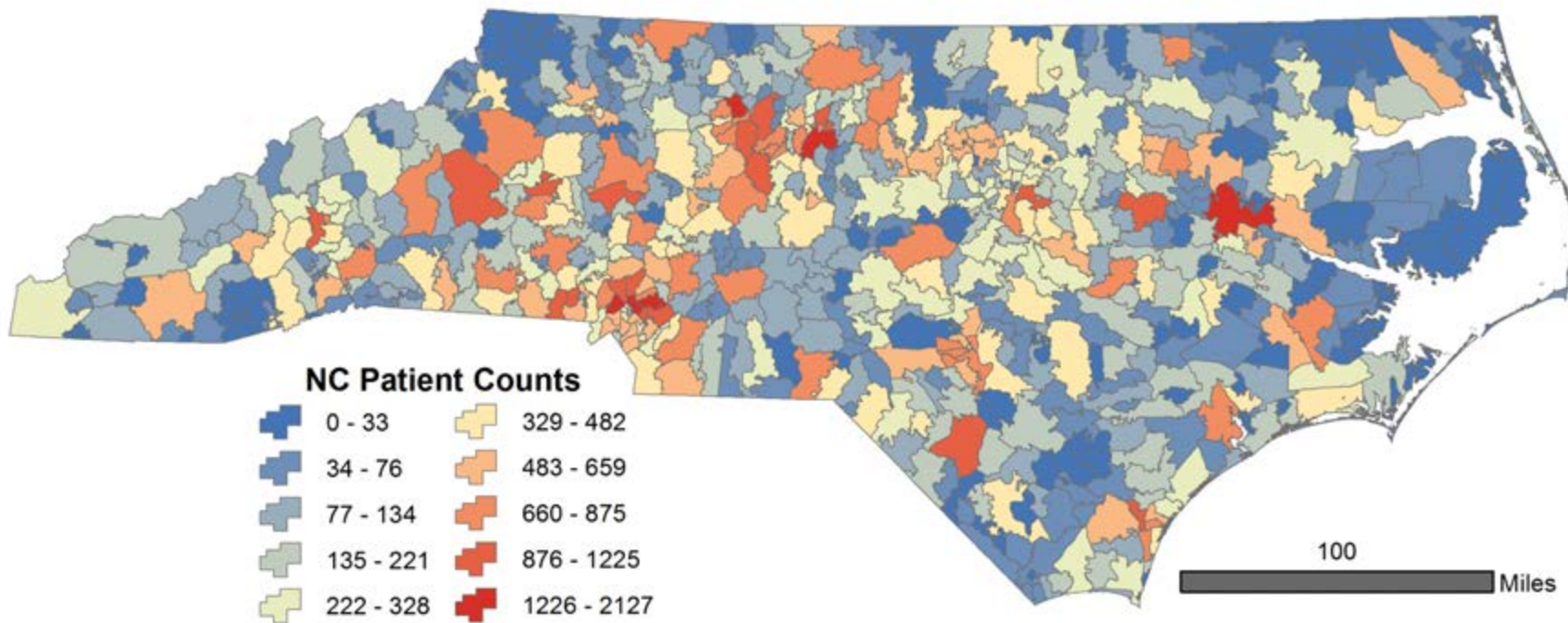
Over the past decade, the **number of patients** seeking behavioral healthcare in NC emergency departments, and the **length of time they wait** for treatment, has **increased 4-fold**

NC's Growing Emergency



Number of ED Visits by Zip Code, 2015

NC Patient Counts by Zip Code



**In NC, people with mental illness
are 3.5 times more likely to
go to jail than a hospital.**

“They’re serving a life sentence, 30 days at a time.”

**Up to 65% of people
incarcerated in NC have some
form of mental illness.**

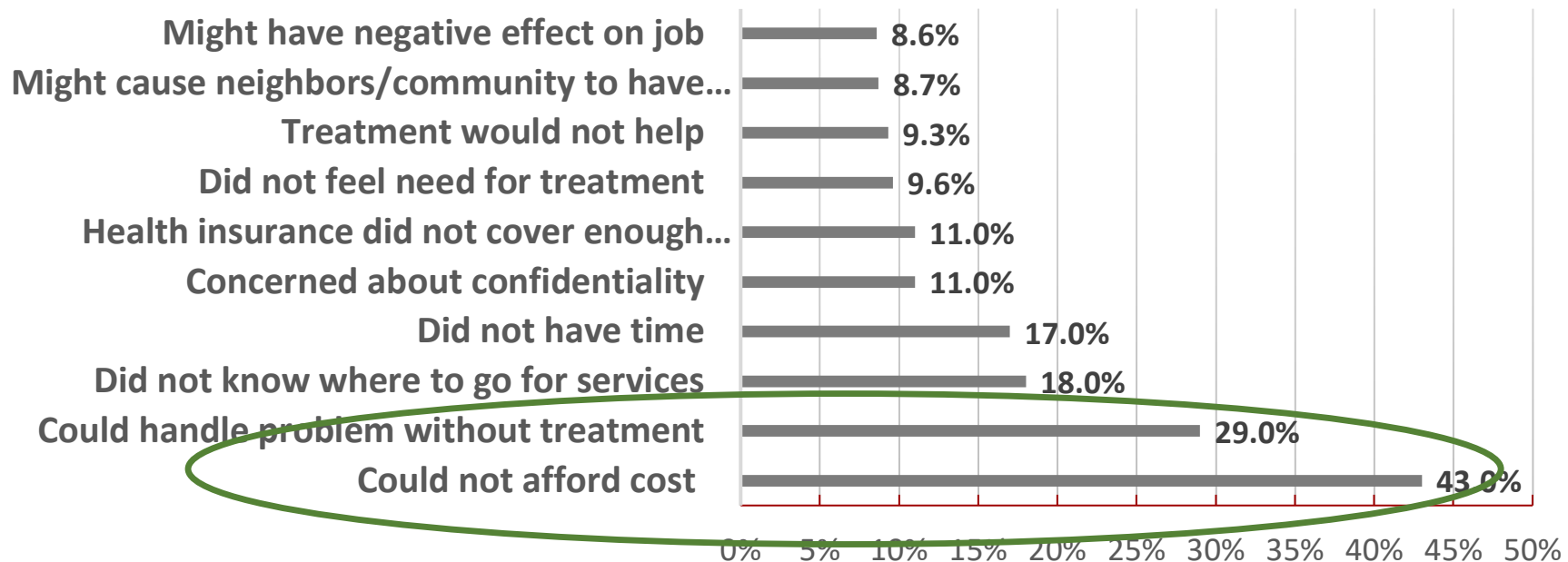
How Did We Get Here?

- 1) Separate and unequal systems for physical and behavioral health



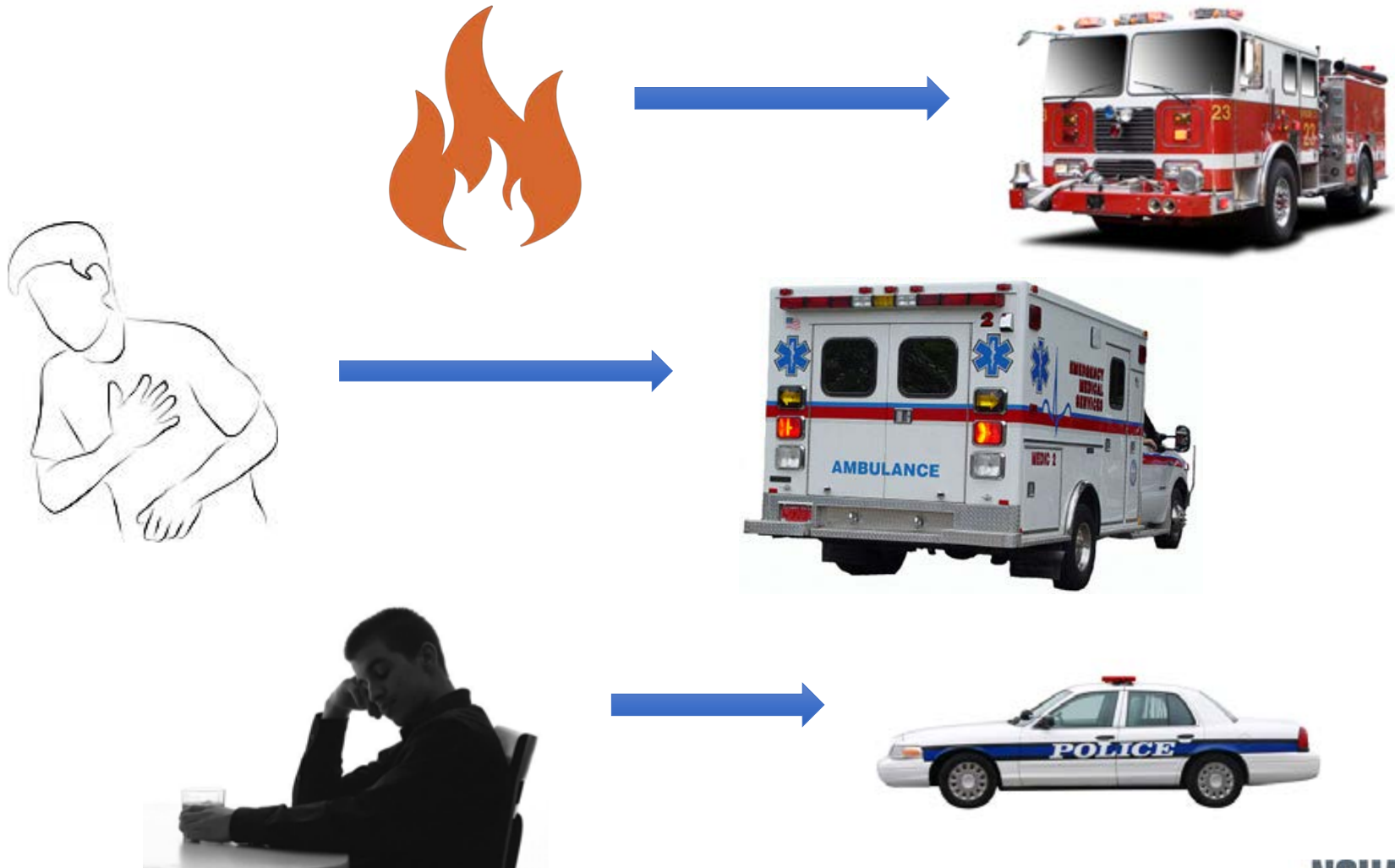
Prohibitive Cost of Preventative Care

REASONS FOR NOT SEEKING MENTAL HEALTH CARE (AGE 18+)



56% of adults with a mental health condition do not receive treatment

Disparities in Crisis Response



How Did We Get Here?

- 1) Separate and unequal systems for physical and behavioral health
- 2) Persistent assumption that low-no cost solutions will manage the problem

The LME/MCO Experience

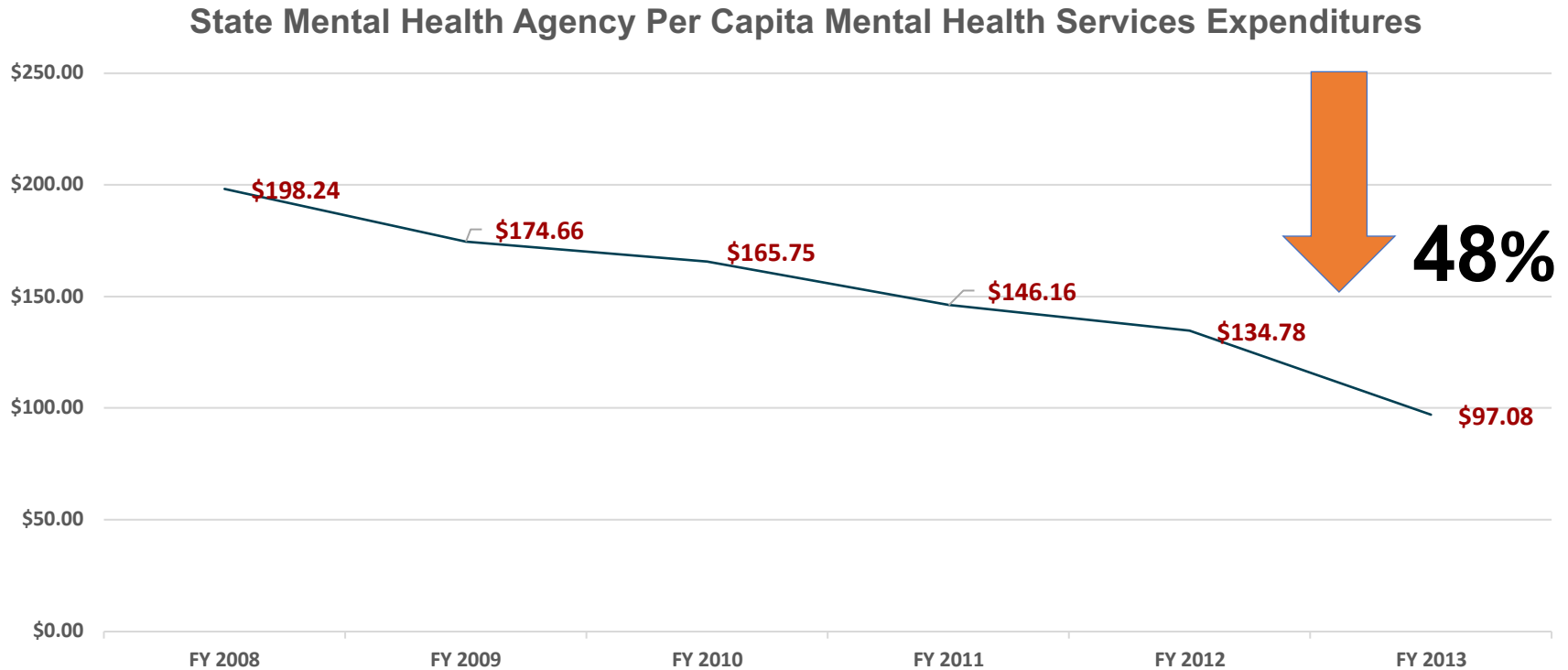
► Created by the NCGA to **control costs**

- Forced competition to test best models
- Incentive to save money, then reinvest
- Investment projects to meet identified need

► Unintended **consequences**

- Billable services and processes vary
- Variable governance/accountability structure
- Lack of transparency and accountability

Single Stream Funding Cuts

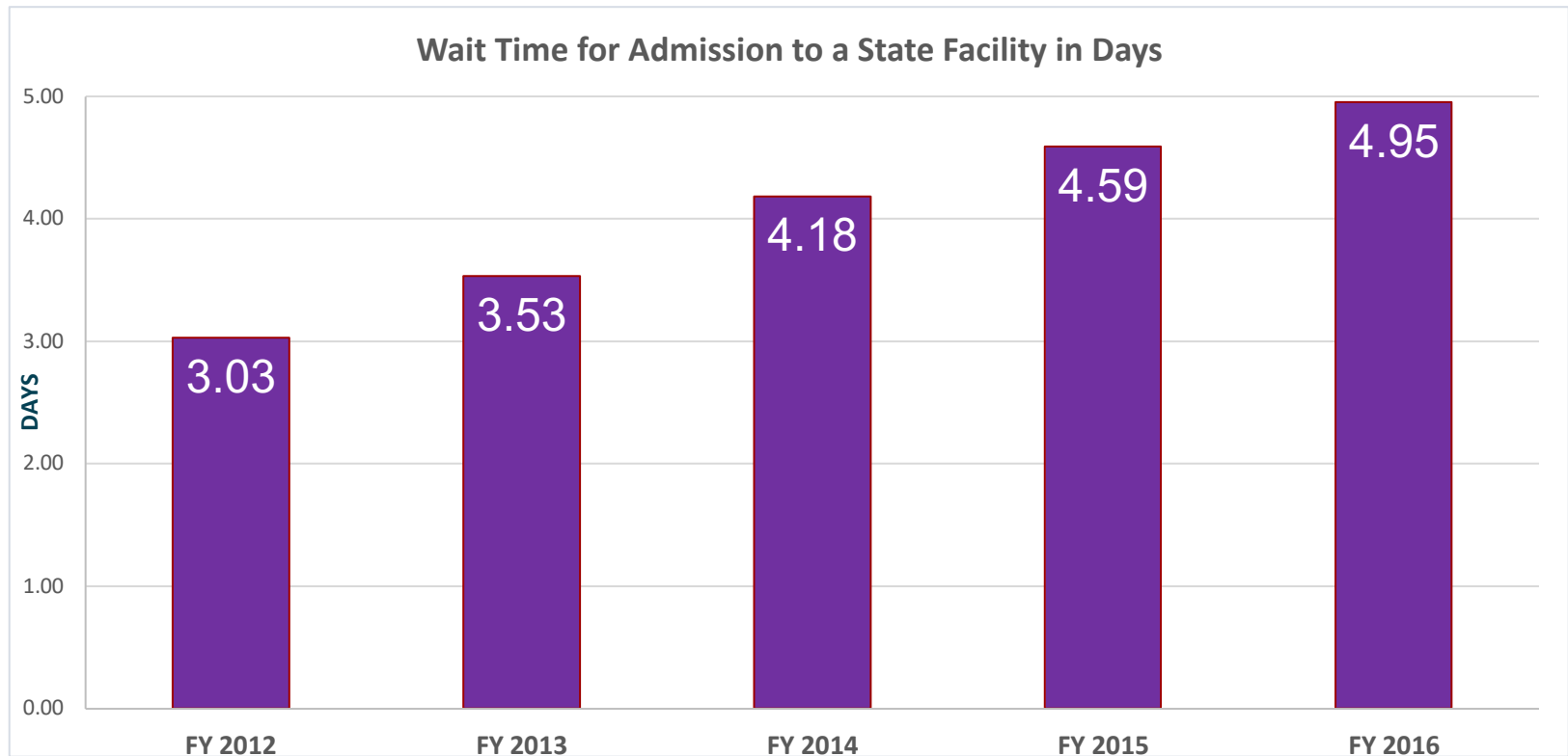


In the same period, NC lost 54,000 community providers

Cost Shifting to the Safety Net

- ▶ “**Boarding** is the practice of holding patients in the ED or a temporary location for 4 hours or more after the decision to admit or transfer.”
- ▶ 75% boarding > 24 hrs & 10% > one week
- ▶ NC fairs worse than national average

Average ED Wait Times in NC



Cost Shifts to Law Enforcement

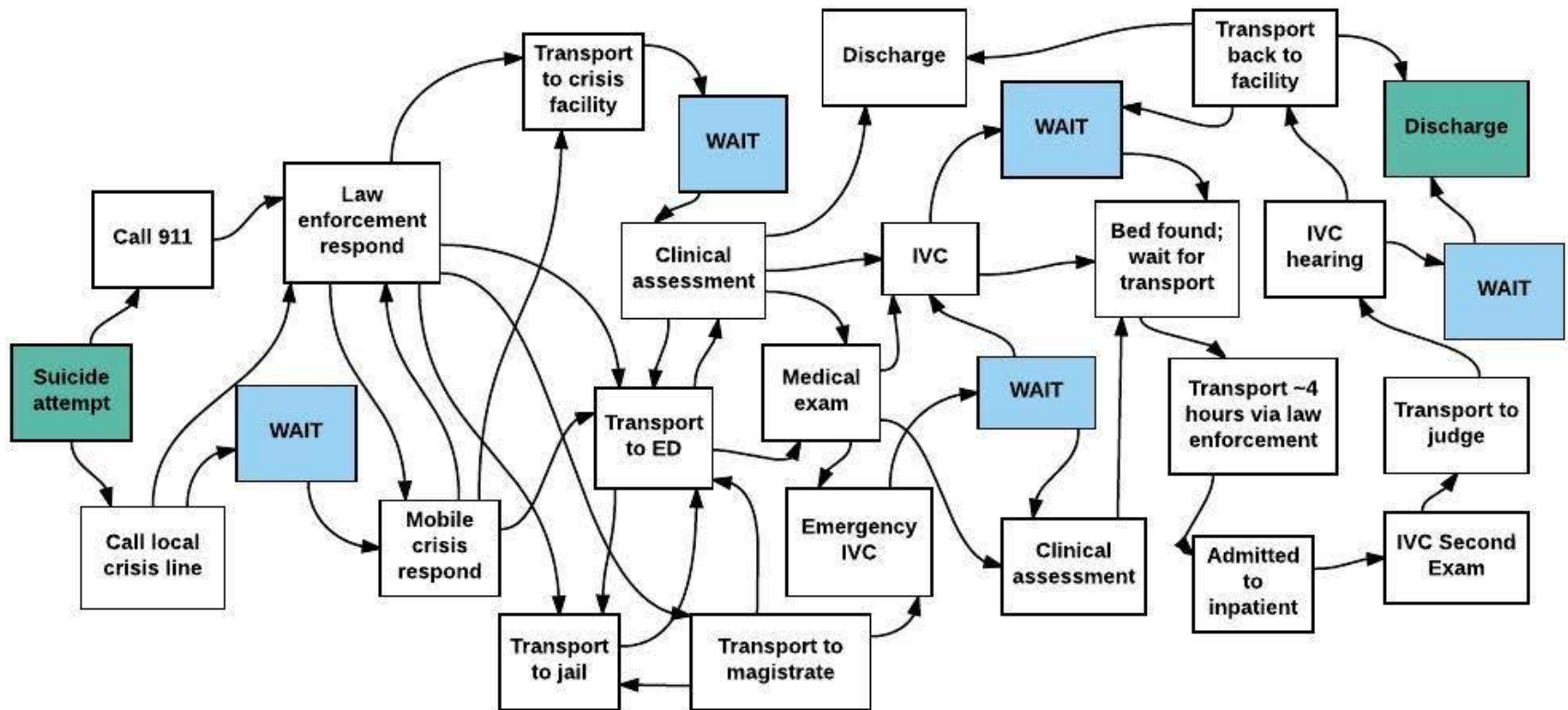


In half of NC counties, law enforcement make **200+ IVC trips annually** with the average trip taking **6-10 hours**

Costs to county departments average roughly **\$115,000** a year

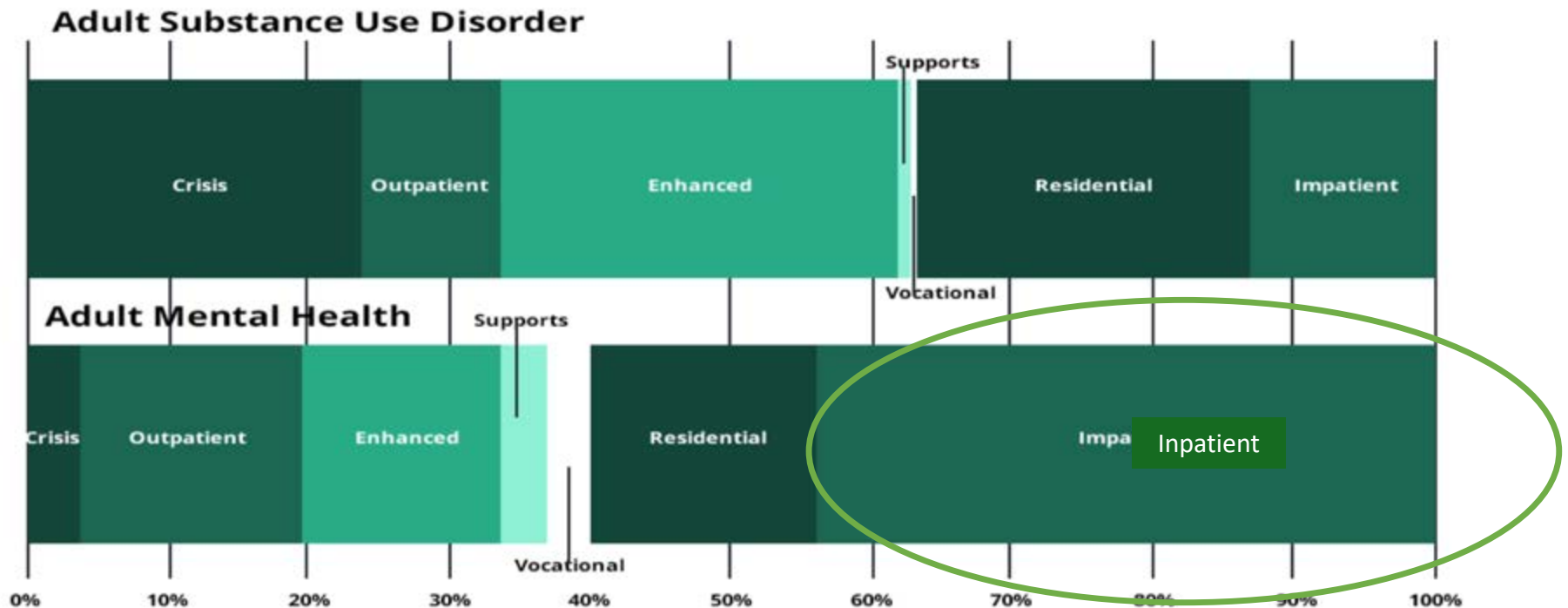
The Impact

NC's Behavioral Health Crisis Response System




How Public Funds are Spent

FY16 State Fund Expenditures by Age/Disbaility and Category of Service



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**”

- US
DHHS Report, 2007



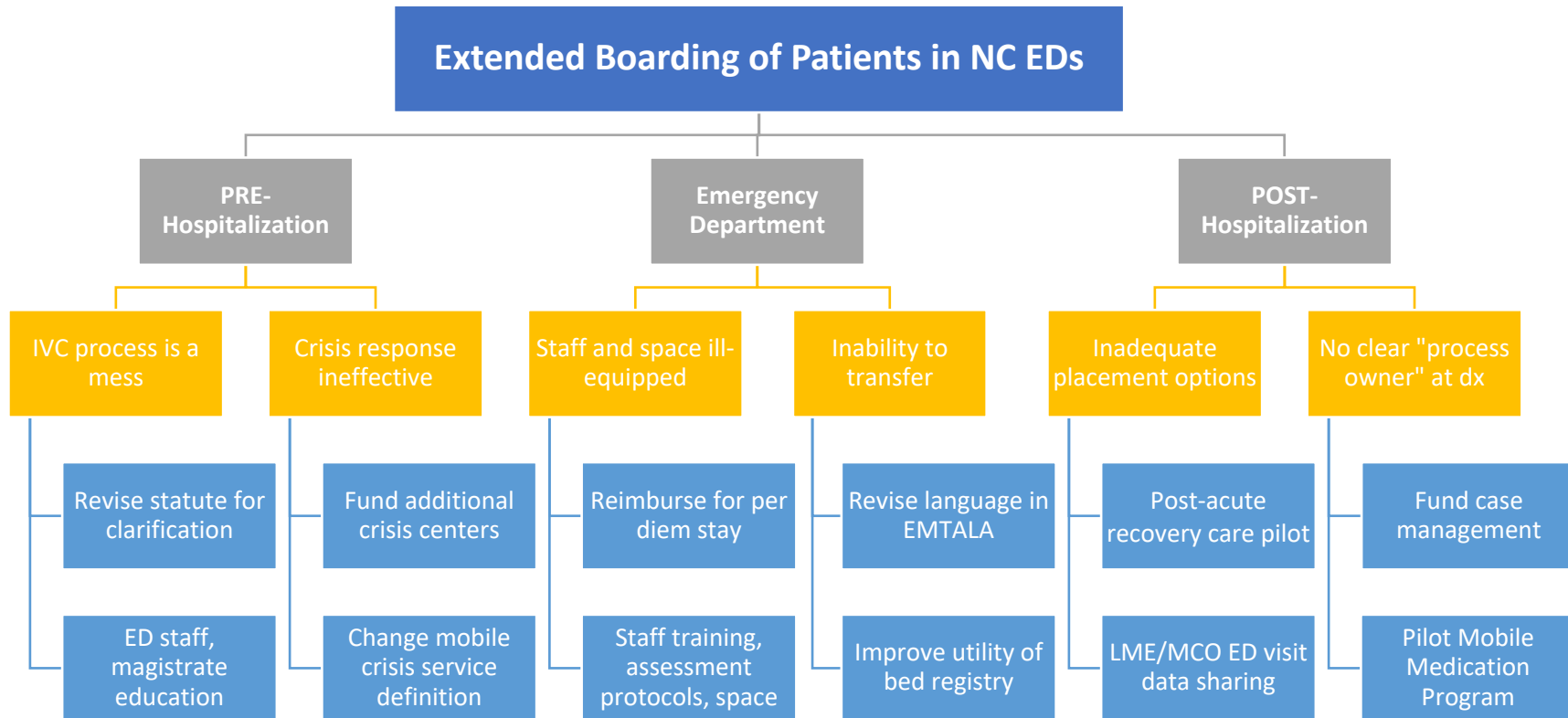
What Do We Do Now?

- ▶ NCHA Behavioral Health Workgroups: statewide multi-sector representation

Hospitals, DHHS, patient advocates, LME/MCOs, first responders, Department of Justice, Psychiatric Association, community providers, Disability Rights, NAMI NC

- ▶ Rebalance the system to invest in community prevention

NCHA Behavioral Health Agenda



Collaborative Goals

- 1) Preventative, fully integrated physical and behavioral, community-based care
- 2) Reimbursable and coordinated crisis response to prevent unnecessary ED visits

Robust & Integrated Crisis Response



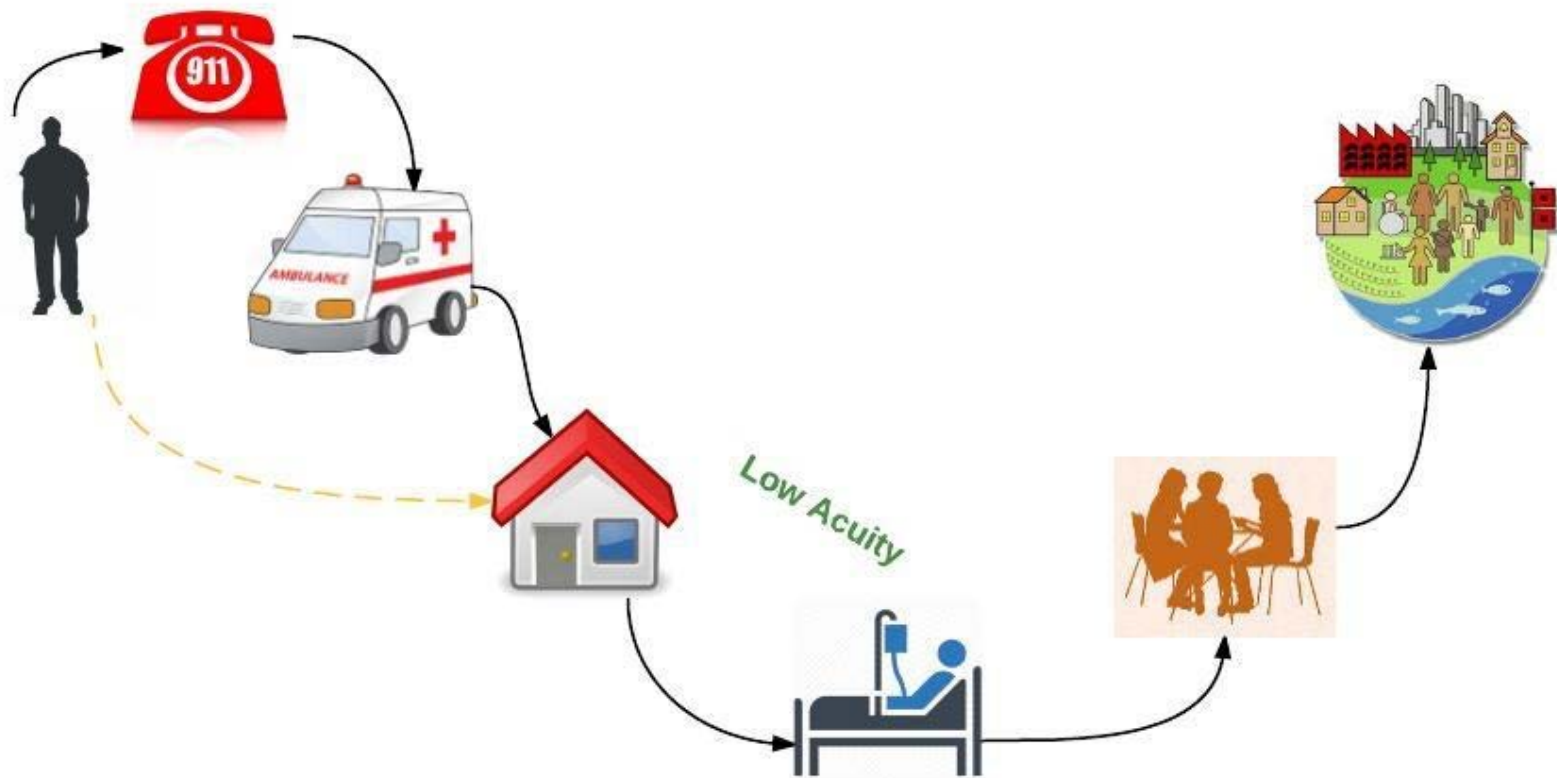
Single emergency
number

Embedded mental
health professional

Standard
assessments

\$2.16 return on
every \$1 invested

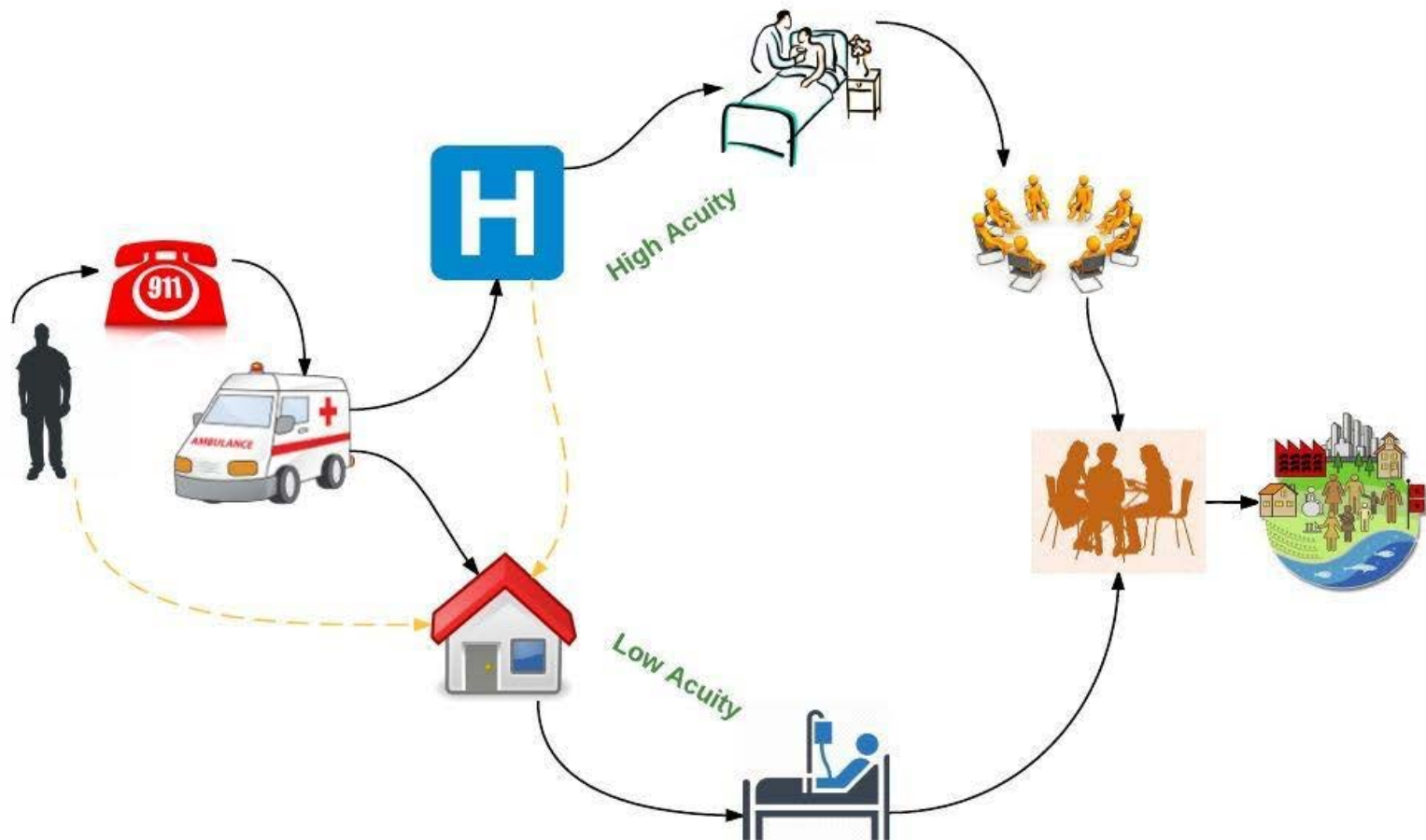
Appropriate Use of Crisis Facilities



Collaborative Goals

- 1) Fully integration care focusing on community-based preventative services
- 2) Reimbursable and coordinated crisis response to prevent unnecessary ED visits
- 3) Fair and equal payment for inpatient and outpatient BH treatment = enforcement of mental health parity in NC

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

Practice-Based Initiatives

