

**NC INSTITUTE OF MEDICINE  
TASK FORCE ON SUBSTANCE ABUSE SERVICES  
March 14, 2008  
10:00-3:00  
NC Hospital Association**

**Meeting Summary**

**Attendees:**

*Task Force/Steering Committee:* Patrice Alexander, Dewayne Book, Barbara Boyce, Sherry Bradsher, Carl Britton-Watkins, Anthony Burnett, Chris Collins, April Conner, Anne Doolen, Tony Foriest, David Friedman, Robert Gwyther, Paula Harrington, Carol Hoffman, Verla Insko, Larry Johnson, Michael Lancaster, Tara Larson, Kevin McDonald, Sara McEwen, Phillip Mooring, Paul Nagy, Will Neuman, Marguerite Peebles, Janice Petersen, Martin Pharr, William Purcell, James Ragan, Jane Schairer, Starleen Scott-Robbins, DeDe Severino, Flo Stein, Anne Thomas, Leza Wainwright, Cynthia Wiford

*Interested Persons:* Sheila Davies, Steve Day, Felissa Ferrell, Kathleen Gibson, Phillip Graham, Denise Harb, Kathy Heilig, Jessica Herrmann, Jeanette Jordan-Huffam, Sally Malek, Nidu Menon, Tim Moose, Bonnie Morrell, Joe Morrissey, Shawn Parker, Kevin Ryan, Kathleen Thomas, Mike Vicario, Helen Wolstenholme

*Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Pam Silberman, Berkeley Yorkery

**WELCOME AND INTRODUCTIONS**

**Representative Verla Insko**

NC House

Representative Insko welcomed the Task Force members to the meeting.

**CRISIS SERVICES**

Steve Day

Technical Assistance Collaborative

North Carolina has been working on improving crisis services for almost two years now, the goal is to have a complete crisis system that is integrated into the larger health care system. Often, crisis services are talked about as components, but individual components, such as mobile crisis and crisis stabilization units, will not work alone. To best serve people's needs, North Carolina must have a complete, well-functioning system. A well-functioning system is attained through sameness of purpose, clarity of roles, interconnectedness of communication, and leveraging resources.

The crisis system starts with prevention and early intervention, includes acute intervention and crisis treatment and ends with recovery and reintegration. Ensuring the first part of the system, that identifies people in crisis and at-risk for crisis, is operating smoothly helps subsequent parts of the system by reducing the number of people showing up in need of acute intervention.

Crisis planning being done around the state is based on seven principles of comprehensive crisis systems:

- Make crisis work routine.
- Strive for resource transparency.
- Incorporate crisis competencies across the network.
- Use data for planning, performance assessment, and quality management.
- Assess and strengthen essential partnerships.
- Seek upstream solutions.
- Address community expectations.

A variety of efforts are underway around the state to integrate these principles into the crisis system. A lot of what is being done is around improving early response to crisis. LMEs are working to identify gaps in the system and data that would be helpful for planning at the local level. One major hurdle is working with the broader community to address expectations and educate them about how the full crisis system works. Communities often expect hospitals to be their crisis center and may not be aware of, or trust, alternatives. There is a need for communication with both the medical community and the public about the variety of crisis services available within communities.

There are a number of services available across the system to respond to crisis, including mobile teams, crisis respite, crisis facilities, local detoxification, developmental disability competencies and resources (although still a great need for more), substance abuse competencies and resources, and family focused interventions. Although there are a wide variety of services, the substance use treatment gap remains quite large. In the past year, almost 200,000 people needed, but were not receiving, treatment for illicit drug use, and 425,000 needed, but were not receiving, treatment for alcohol use. There are a number of barriers preventing these people from accessing service, including a lack of problem recognition by users, under-identification by providers, a lack of access to or awareness of services, and stigma.

The barriers preventing people who need treatment from receiving it could be reduced by using non-traditional allies to identify people with substance abuse treatment needs. One idea to do this would involve a brief screening/intervention for patients coming through the emergency room, another would increase the awareness and competency of providers of other services to identify substance users. There are many options that would expand the safety net by looking beyond traditional services and providers to ensure that others are involved in improving services and treatment for those with substance abuse problems.

North Carolina must continue to strive towards a comprehensive crisis continuum that is integrated with and supported by the DMHDDSAS system and other parallel systems (ie, health, criminal, justice, housing). This integrated system must have clear clinical pathways and points of authority and accountability.

Comments/Questions:

If a patient presents at 2am in the ER and the doctors have their hands full, is it good or bad for the doctor to check them in and call in the crisis response team? Case-by-case

decisions are always appropriate. If the person can stay in the waiting room safely for a few hours then that response may be okay. There must always be good patient care based on individualized responses. The decision of the doctor needs to be made in full awareness of all options available within the community for crisis response. In turn, the system must provide reliable, safe options to ER doctors that are reliable.

## **CRISIS SERVICES**

Bonnie Morell  
Crisis Services  
NC MHDDSAS

In 2006, the NC General Assembly passed legislation appropriating funds for the planning and development of a continuum of crisis services for consumers of all ages who are in need of crisis services because of mental health, developmental disabilities, or substance abuse. The legislative requirement called for LMEs to develop plans to address 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite, 23-hour beds, facility-based crisis services, detoxification services, in-patient hospitalization, and transportation. Five million was appropriated in SFY 07 for start-up funds, \$7 million recurring funds for crisis services in SFY 07, and \$13.7 million in SFY 08 in recurring additional funds for implementation of crisis plans.

LMEs developed comprehensive crisis plans that looked at services available by age group, identified gaps, and set priorities, and submitted them by March 1, 2007. Plans were reviewed by the DMHDDSAS. The DMHDDSAS worked with LMEs on revisions, with some LMEs receiving technical assistance to improve their plans. All LMEs then received start-up funding. Currently, all LMEs have taken steps to implement their plans by identifying additional service providers and increasing the capacity and effectiveness of current services.

Data from state hospital admissions indicate that progress is being made at the local level. Hospital admissions, including those for substance abuse, are down in SFY 08 from SFY 07, which indicates something is happening in communities and it may be, in part, due to changes in the crisis response system.

Data from LMEs show that 6,699 people with substance abuse disorders received crisis services in SFY 07, which represents 11% of adults with substance abuse disorders who received services in the community. Social setting detoxification and non-hospital medically-monitored detoxification were the most widely used services. Others received services such as mobile crisis or facility-based services, or services from an Assertive Community Treatment Team. The data indicate that not many people are getting local detoxification services and the system needs more substance abuse-specific acute interventions.

The DMHDDSAS's strategic plan for 2007-2010 includes work to continue development of a comprehensive crisis services system that is integrated with existing community

medical and public safety emergency response system that provides an effective, clinically appropriate continuum of services.

Comments/Questions:

There was a discussion around LME plans and substance abuse services. It was pointed out that all LMEs had to address substance abuse separately in the plans submitted to DMHDDSAS.

There was a lengthy discussion of why the crisis continuum is not currently working for substance abuse. Reasons cited included: patients are not behaving because they are intoxicated; providers are not as well compensated for substance abuse services as they are for other chronic diseases; there is an unwillingness to provide any supports to someone who is in an active addiction stage; a continued belief that people are not going to get better until they hit bottom.

Many were concerned with how to better integrate people into their health care system early on. To ensure that people receive primary care and have a medical home so that prevention and early intervention part of the crisis continuum can work. If more people are tied in to the medical community from the beginning, the pre-crisis part of the continuum can work relieving pressure on parts of the system that must deal with acute crises. Additionally, there were concerns about how to get people presenting at emergency departments who are unknown to the system tied in to resources outside of the emergency department.

There was a lot of discussion around the need for short- and long-term services for substance abuse patients. Many cited a concern that the resources are just not available for substance abuse patients to receive the kind of care they need.

Health insurance came up in a number of questions and comments about ways to better integrate patients with substance abuse problems into the health care system before crisis. Although many acknowledged that universal health insurance would be beneficial to this population, they agreed the focus of this task force does not include solving the overall health care crisis.

## **SUBSTANCE ABUSE CARE IN THE HOSPITAL EMERGENCY DEPARTMENT**

Mike Vicario

Vice-President of Regulatory Affairs

North Carolina Hospital Association

The emergency department serves as the “front door” of the hospital to the general public, with 45% of all hospital admissions coming from emergency departments. A significant percentage (40%) of patients being seen in emergency departments are not classified as urgent or emergency. 62% of hospitals report their emergency departments are over capacity. In North Carolina, there are 436 emergency department visits per

1,000 people and the average wait time is 240 minutes (NC is close to the national average in both categories).

Hospitals are working to reduce the strain being put on emergency departments in a variety of ways. Hospitals are improving their information systems and improving triage to help better handle patients coming in to emergency departments. Hospitals are working with their communities to increase alternatives for people who come to the emergency room for primary care such as community clinics, drug store clinics, and urgent care clinics. These alternatives provide faster services and are preferred by insurers because services are provided at much lower costs. Some hospitals are working on redesigning or expanding their emergency departments—this is happening all over North Carolina. In some areas where the current systems are unable to handle the demand for emergency care, freestanding emergency departments are being built.

One growing concern is that boarding, or lengthy wait times in emergency departments, is on the rise. In North Carolina, a number of hospitals are reporting wait times of 12-14 hours. This is especially true for behavioral patients coming in through the emergency department. Sometimes waits are longer than 24 hours, especially when a patient is waiting for transfer to a state hospital.

In 2005, 1.4 million of 108 million emergency room visits were associated with drug misuse. About 1/3 of drug related visits involved alcohol combined with drugs (or alcohol alone for those under 21-years-old). The data from 2004 to 2005 show a 21% increase in the number of visits related to the non-medical use of pharmaceuticals, including prescription and over-the-counter drugs. These percentages likely underestimate the extent of alcohol and drug related emergency department visits.

A Washington state study showed that frequent aged and disabled emergency department patients have high rates of alcohol and drug disorders and mental illness. Fifty-six percent of those who visited the emergency department 31 or more times/year had both an alcohol or drug disorder and mental illness. There is increased interest in providing alcohol and other drug intervention services in emergency departments because multiple studies of screening, brief intervention, and referrals conducted in primary care, emergency departments and in-patient trauma centers have shown positive outcomes in decreasing or eliminating alcohol use, reducing injury rates and reducing costs.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals with emergency departments meet certain obligations. These obligations include providing a medical screening examination to all patients, providing necessary stabilizing treatment within the hospital's capability and capacity, providing an "appropriate transfer" to ensure safe transport, and providing care regardless of managed care plan or payer status. EMTALA raises some issues for handling alcohol and other drug disorder patients in emergency departments. One concern is whether an "appropriate transfer" must be another hospital or if it includes any facility that can provide appropriate care. Although there are an increasing number of facilities that can

treat substance abuse and mental health problems outside the hospital setting, if a patient presents at the hospital, EMTALA regulations must be followed.

In North Carolina, there were 3.5 million visits to the emergency department in 2006 and 402,000 patients were admitted from the emergency department. The emergency department payer mix of patients presenting was 24% self-pay, indigent or charity, 23% Medicaid, 21% commercial insurance, 20% Medicare, and 12% other. The payer mix for substance abuse patients in North Carolina for the 33,715 patients seen in the emergency department in 2006 shows that the vast majority (51%) are self-pay, indigent or charity followed by Medicaid (15%), commercial insurance (14%) and Medicare (12%). The payer mix for mental health patients presenting in emergency departments was 27% self-pay, indigent or charity, 25% Medicaid, 23% Medicare, and 16% commercial insurance. From 2004 to 2006, the number of uninsured patients visiting the emergency room grew approximately 7% each year. This growth signals an increasing access challenge for uninsured patients.

In 2007, the North Carolina Hospital Association convened the Emergency Care Services Task Force. As part of the work of this Task Force, the hospitals agreed that the primary purpose and core business of hospital emergency care should be driven by urgent and emergent needs of patients. This group felt that social issues (ie, dental care, domestic violence) and mental health could best be handled outside the emergency room. They cited mental health issues and substance and alcohol abuse treatment as two of the greatest diversions to the delivery of care to emergent patients. To solve this problem, the hospitals believe that they need to form stronger partnerships with community organizations and service providers.

#### Comments/Questions:

The comments and questions that followed this presentation were a continuation of the discussions that came up after the first two presentations.

### **DISCUSSION OF POTENTIAL RECOMMENDATIONS**

The Task Force discussed recommendations focused on prevention, primary care, continuum of services, and data. Each participant was given a copy of the recommendations incorporating comments from both the discussion at the February meeting and email communication following the meeting. The discussion will continue at the April meeting to finalize the recommendations for the interim report.