SCBHC
South Carolina Behavioral Health Coalition

Crisis Stabilization/Acute Care Management
Meeting Date: November 9, 2017
Chair: Geoff Mason, SCDMH
Co-Chair: Bill Lindsey, SC NAMI
Scribe: Amanda Gilchrist (DMH)

The workgroup has broken up into three priority subgroups:

A. Mapping

- Decisions: Statewide Mapping should include all behavioral health services and service providers both crisis and no-crisis services so that a service continuum can be developed to show what is missing based upon the area.
    - Idea: To have a behavioral health service directory created to show real-time information on inpatient beds available, services available as well as contact and/or referral information on how to access the services and supports
    - The database will need to be continuously updated with the new programs and correct information for existing programs
    - Will likely need dedicated staff to keep this running statewide
    - Providers should be able to be filtered by payor source to make referral process easier.

•Next Steps:

- Look at the compilation of a statewide survey to begin collecting information on all behavioral health services and providers statewide

B. Array of Services

•Guiding Question: What do we have in our communities that addresses crisis stabilization and works well?

Peer Living Room (Spartanburg):

space for non-urgent care from 10am-7pm. Purpose is to keep non-emergency patients from going to the emergency room.
*DMH – SR collaboration (Staffed with personnel from DMH)
*(cost) 190K
*Based Partially on Ashville
*(start date) January 2018 expected
*Expecting to have Reassurance Line and NAMI will be present.

Charleston

*Charleston uses “Intercept Model”; where people with mental health issues intersect with the criminal justice system.
*Mobile Crisis unit 24/7 (Anywhere except ED)
*They have embedded clinicians.
*Telehealth Link – assess the situation for EMS, and provides instructions on how to help the patient.
* ($?) 54% of these calls were diverted from ER

*Low tech infrastructure cost, they use existing equipment
*Crisis Stabilization Unit (Charleston)
*10 Beds/ Embedded in AOD Center
*Hwy to Hope RV 24/7
*Mobile Crisis Unit 24/7 (anywhere except ED)
*Deflects ED
(Co-located clinician for homeless outreach)
*CIT- Crisis Intervention Training (With NAMI)
*Trains law enforcement to address people with mental health issues.
*Mental Health First Aid (Preventative)
*Information provided to the community that trains citizens.
*Note-(FEP) First Episode Psychosis
*School based training services
(Charleston is in every school, they have a 100% participation)

<u>Greenville and Spartanburg have 80% participation.</u>

*Sobering Center (Charleston): 5 chairs and 5 beds. Paid by Charleston center in efforts to decrease the jail population.
•Greenville: (CIT with Law Enforcement)
*Developing Crisis Stabilization and Mental Health First Aid
*10 Bed Unit & anticipate 3 to 5 day stay
*Regional Collaboration with CSU
*1.2 mill? It is a shared cost (DHS $300k, St Francis $300k, DMH $ 300-500K)
* (Target Date Jan 18th)

<u>Columbia:</u>

*Have Clinicians in ER at Palmetto Health and Transitions shelter (Transition shelters also provide Homeless Court)
*Have the Mental Health Court (Also located in Rock Hill and Greenville)

<u>Pee Dee: McCloud</u>

*Monthly Event where numerous service providers participate along with Mercy Medical Clinic, Hope Health, and FMU professor with grad students that provide free mental health assessments along with alcohol/drug assessments.
*Process of commitments
*Misuse results in delay of care to move psychiatric acute cases
*Sobering Center in Chas. about to open
*Natl model
*No need to be licensed by DHEC (Part of the effort)
* ($3.6m) DMH Partnership with DHHS to fund Crisis Intervention and expand these services across the state.
*Pilot n Jan-March 18th

DMH/CAMH

*Clinicians in ER
*Clinicians in Transitions Shelters
*Mental Health court
** (Will expand via Duke Endowment) **
*DHHS – CCRI (Community Crisis Response and Intervention)
*Based on Charleston Crisis Response system
*Funding occurs outside medical

Tidelands Health (Georgetown)

*Have clinicians embedded in 2 Emergency Rooms
*Have Community Care Network (To prevent unnecessary ED visits)
*Shared FTE expense with DMH
*No behavioral health unit
*Have 5 Annex beds for persons waiting for mental health bed

Wish List

*Tidelands: CSU/MCS
Resources for treatment (Substance Abuse)
*Spartanburg: Resources for patients with intellectual disabilities (Networking effectively)
*State Wide: Uniformity of Process?
" " *Resources?
*Legislative Support?
*Cohesive across providers
*How to enlighten silent/ unaware stake holders
*More Resources across the state
*Questions about uniformity of processes and uniformity of our resources
*Networking is essential to making the connection to accomplish the programs established in Charleston
*Legislative support
*Cohesion across providers

C. Business/Fiscal Case

Business case will start will collecting information from local hospitals to determine cost for an individual with mental health services to frequent ER versus the cost for accessing services prior to escalating to a state of crisis.

- The business model will vary dramatically from one location to the next. There is no "one size fits all".

- The best source for business case information and development is the engaged stakeholders from each locality.
- The logical approach to gathering the engaged stakeholders is via The Community Mental Health Centers.

•This committee recommends

- Development of a broad scope template to be used by each community for developing the business and economic model.
- OSCHA would develop the template
- SCHA and DMH resources within our Behavioral Health Task Force will work directly with each CMH as the template is deployed.