

Smoky Mountain Center Community Development Plan 2008/2009

Table of Contents

Introduction	3
I The Smoky Mountain Center Catchment Area & Characteristics	3
II Methodology to Assess the Service Needs of the SMC Catchment Area	5
III Data Analysis	6
A) Analysis of Prevalence and Service Gaps	7
B) Performance Contract Standards	7
C) Analysis of Treated Prevalence	7
D) Summary of Treated Prevalence and Service Gaps	8
E) Analysis of Access to Care – Emergent, Urgent and Routine	8
F) Analysis of Survey and Anecdotal Data	9
IV Characteristics of the SMC Service Area which Present Challenges to Meeting Service Demand	14
V Results	14
VI Goals	15
A) Timely Access to Care	15
1. Goal	15
B) Workforce Expansion	16
1. Goal	16
C) Substance Abuse Services.....	16
1. Goal	16
D) Developmental Disabilities Services to Children and Adolescents	16
1. Goal	16
VII Achievements and Successes in Meeting Identified Community Needs	16
A) Assessment of Community Need and Provider Capacity for Children’s Services in the SMC Catchment Area.	17
B) Enhancing Service Delivery through Financing Methods	17
C) Emergency and Crisis Services Continuum	18

APPENDICES

- A. Map of SMC Catchment Area
- B.1 Population Demographics of the SMC Catchment Area
- B.2 Population Density of Each County in SMC Catchment Area
- C. Treated Prevalence Rates
- D.1 Timely Access to Care Graphs
- D.2 Timely Access to Care Data
- E.1a Consumer and Family Member Survey Data
- E.1b Consumer and Family Member Comments
- E.1c Consumer and Family Member Survey Sample

- E.2a Community Stakeholder Survey Data
- E.2b Community Stakeholder Survey Comments
- E.2c Community Stakeholder Survey Sample
- E.3a Provider Capacity Survey Comments
- E.3b Provider Capacity Survey Sample
- E.4a SMC Board of Directors Survey Data
- E.4b SMC Board of Directors Survey Comments
- E.4c SMC Board of Directors Survey Sample
- E.5a SMC Staff Survey Comments
- E.5b SMC Staff Survey Sample
- F. Definitions
- G. Capacity Analysis

Introduction

One of the key responsibilities of the Local Management Entity (LME) is to ensure access to a high quality continuum of care, which reflects best practices in the areas of Mental Health, Substance Abuse and Developmental Disabilities. In order to accomplish that responsibility, there are several important activities that Smoky Mountain Center (SMC) is concerned with. Perhaps the most significant is the ongoing evaluation and articulation of service need within the 15 county SMC catchment area. Smoky Mountain Center's Community Development Plan is the single document which encapsulates both broad based information about service need and also offers specific strategies and solutions to address identified service gaps. It is a working document that is updated on a quarterly basis as new information becomes available and as progress on meeting service goals is made.

I The Smoky Mountain Center Catchment Area & Characteristics

As referenced above, the SMC LME must ensure adequate access to a high quality continuum of care for all of the clients it serves in each of the fifteen counties that together form its service area. The provider community in each county should represent the unique populations and service needs of that area and region.

Initially SMC was comprised of only the seven most western counties of North Carolina (the counties of Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain). On July 1, 2007 the five Counties of the former New River Area Authority joined the SMC LME and are known as the Northern Region. These five counties are Alleghany, Ashe, Avery, Watauga, and Wilkes. On July 1, 2008 SMC added to its catchment area, the three counties that had been managed by the Foothills LME – Caldwell, Alexander and McDowell Counties. These three counties are known as the SMC "Central Region". This report describes the SMC Northern, Central and Southern Region counties.

The SMC catchment area includes individuals representing a wide array of socioeconomic, educational, and cultural circumstances in its large rural 15-county service area. This includes many local individuals and communities rich in Appalachian culture. There are also increasing numbers of more affluent retirees and other wealthy individuals moving into the area for the climate or to join the resort/vacation style communities that are developing. (Please see Appendix A for a map of the SMC Service area).

To serve these consumers of mental health, developmental disabilities services, and substance abuse services, Smoky Mountain Center works with a provider network of

- 89 contracted providers (for state-funded direct clinical contracts) both in and out of the 15-county catchment area to meet the needs of the community. In addition, SMC has another
- 142 Memoranda of Agreement's with agencies, some with the providers mentioned above, for the provision of enhanced services within its catchment area.

At this writing, and not counting CAP MR/DD services,

- 32 providers in the *Northern* Region have been endorsed for a total array of 30 services within the SMC catchment area,
- 19 providers in the *Central* Region have been endorsed for a total array of 38 services and
- 13 providers in the *Southern* Region have been endorsed for a total array of 43 services.

In addition, Smoky Mountain Center works with an array of out of network providers and community supports to provide additional therapeutic and wrap-around supports for the region. Further, SMC contracts with an interpreting agency for the SMC Call Center. This contract enables SMC Call Center staff to access interpretive services for virtually any language which a consumer may use.

Population, Demographics and Geographic Area

SMC obtains the population and demographic data from the Substance Abuse, Mental Health Services Administration (SAMHSA) and the US Census Bureau. This information is a starting point in our annual needs analysis and provides valuable information about the characteristics and changes in population and demography of our area. The following table shows the 2007 (most recent available data) breakdown of the percentages of SMC county population data according to the US Census Bureau estimates. The complete table showing raw number data can be viewed in Appendix B.1

Table #1.0 Population and Demographics of the Fifteen County SMC Service Area

County	Total Pop	Child Under 18	Adult	White	Black	American Indian	Latino Hispanic*	Foreign Born	Language other than English Spoken at Home
Alexander	7.2	22.5	77.5	91.6	6.2	0.3	3.3	0.9	3.8
Alleghany	2.1	19.0	81.0	96.9	1.6	0.3	8.5	1.0	5.8
Ashe	5.0	19.6	80.4	98.0	0.9	0.4	3.5	0.4	3.2
Avery	3.5	17.6	82.4	93.2	5.3	0.4	3.8	0.7	4.5
Caldwell	15.6	22.6	77.4	93.0	5.4	0.3	3.8	0.7	3.3
Cherokee	5.2	20.0	80.0	94.9	2.0	1.5	1.4	1.2	2.8
Clay	2.0	18.1	81.9	97.7	1.2	0.5	1.8	0.5	2.4
Graham	1.5	22.3	77.7	90.2	0.5	7.8	1.2	1.0	3.6
Haywood	11.1	20.3	79.7	96.8	1.5	0.6	1.9	0.7	3.1
Jackson	7.2	18.6	81.4	85.5	2.4	10.1	2.1	1.2	5.4
Macon	6.4	20.1	79.9	96.6	1.6	0.3	2.8	0.8	3.4
McDowell	8.6	22.1	77.9	93.8	4.1	0.3	4.4	0.7	4.2
Swain	2.7	22.7	77.3	69.6	2.4	26.0	2.1	1.9	5.0
Watauga	8.8	14.9	85.1	95.8	2.2	0.3	2.0	0.9	4.4
Wilkes	13.1	22.2	77.8	94.2	4.2	0.2	5.4	0.6	4.7
NR	32.5	19.1	80.9	95.3	3.1	0.3	4.2	0.7	4.4
CR	31.3	22.4	77.6	92.9	5.2	0.3	3.8	0.7	3.6
SR	36.2	20.0	80.0	92.0	1.8	4.8	2.0	1.0	3.7
SMC All	100.0	20.5	79.5	93.3	3.3	1.9	3.3	0.8	3.9

Source: US Census Bureau web site <http://quickfacts.census.gov>

** According to the US Census Bureau “Hispanics may be of any race, so also are included in applicable race categories.”

†NR = Northern Region: Alleghany, Ashe, Avery, Watauga, and Wilkes Counties

‡CR = Central Region: Alexander, Caldwell, and McDowell Counties

¶SR = Southern Region: Cherokee, Clay, Graham, Haywood, Jackson, and Swain Counties

§SMC = All fifteen counties of the Smoky Mountain Center catchment area

The data in the chart provide some important and useful planning information:

- The total population of the SMC service area is 509,021
- The most populous of the three regions is the Southern Region
- The least populous of the three regions is the Central Region
- The most populous counties are Caldwell, Wilkes and Haywood

- The least populous counties are Graham, Clay and Alleghany
- The county with the highest population of African-Americans persons is Caldwell
- The counties with the highest population of Hispanic/Latino persons are Wilkes and Caldwell
- The counties with the highest population of American Indian and Alaskan Native persons are Swain, Jackson and Graham.

The above population data informs SMC of important characteristics of the areas served. Information about county population density and scarcity is used to determine levels of service availability and number of providers of specific services (see Appendix B.2, Population Density Table). Providers may wish to locate service centers in densely populated areas for ease of access. Providers serving scarcely populated areas may need to investigate transportation services to help consumers obtain services. The data also verifies the need for culturally competent services in the area. In some counties a significant percentage of the population is foreign born and a language other than English is spoken in the home. In those counties Providers may need to utilize foreign language interpreter services to competently serve consumers. Also, in those areas with the highest non-Caucasian populations, SMC and its provider community will need to invest in the training appropriate to ensure sensitivity to the various cultural differences.

The remainder of this document will explore the issue of service need – how it is defined, identified and then addressed in a systematic manner.

II Methodology to Assess the Service Needs of the SMC Catchment Area

A) Terminology: Prevalence, Treated Prevalence, Capacity and Need

It is important to define some of the key terms in this discussion: Prevalence, Treated Prevalence, Capacity, and Need.

- Prevalence refers to the number of individuals in a given population (a state, region, or county) who are in the case of this discussion, in need of services because of problems associated with Mental Illness, Developmental Disabilities and or Substance Abuse.
- Treated Prevalence refers to the number of those identified as needing services who are actually receiving service.
- Capacity refers to the number of people that can be served, and
- Need simply refers to the difference between Prevalence and Capacity.

Simply put, need is the difference between what is expected or projected and what is actual. If the *Treated Prevalence* is less than the *Prevalence*, the difference is referred to as a service gap. Conversely, if there is more actual service being delivered (Treated Prevalence) compared to what is believed to be needed (Prevalence) that represents over utilization of services.

This document will look at the many relationships between these terms, and will calculate prevalence, treated prevalence, performance standards, current capacity, and the resulting unmet need and service gaps that are present.

B) Data Sources

This needs assessment draws from a number of data sources. The North Carolina Department of Health and Human Services (DHHS) has chosen to use data from the Center for Mental

Health Services (CMHS) to determine the prevalence of mental illness, development disabilities and substance abuse for its citizens. The CMHS methodology is applied to the US Census Bureau population data (Table 1.0) for the counties in the SMC service area to determine the prevalence of those in need of mental health, developmental disabilities and substance abuse services. These Federal Fiscal Year (FFY) 2005 CMHS calculations are intended to not only identify prevalence but to also estimate *those persons in the overall population needing MH/DD/SA services*. It should be noted here that the CMHS calculations are extrapolations of national data the validity of which has not been tested. Local factors such as socioeconomic status, population density, cultural and regional characteristics may distinguish the SMC catchment area from the broader populations used to determine national prevalence rates. It is not known if these local characteristics are accounted for in the CMHS methodology and national rates.

This prevalence and service need calculation then becomes the basis for the service penetration standards which are included in the DHHS/LME contracts. (See Appendix C, Prevalence Rates).

Another quantitative performance measure of the SMC service network is the responsiveness of providers to requests for services. The NCDHHS has set standards for timely access to care for consumers requesting services. This data is tracked by SMC for each county in the SMC service area.

The final category of data is the needs assessment activities conducted by SMC. These activities provide valuable, firsthand perspectives from a variety of sources. This data provides SMC with a direct local picture of available and needed services. Persons providing survey or anecdotal input are selected because they are consumers or family members of consumers of the services, are involved in their communities, are involved in the delivery of services, or are involved employees of SMC. The five groups are:

- Consumer and Family Input
- Stakeholder Input
- Provider Input
- Board of Directors
- Smoky Mountain Center Staff Input

III Data Analysis

This section of the report provides an analysis of both the quantitative data and the qualitative survey data. The most valuable portion of the analysis will be where those intersections between the qualitative data and the quantitative data occur. In other words, when these two sources positively correlate in their identification of service need, then we can assume a greater level of confidence than if an indicator is from only one source and is not positively correlated with the other source.

The data analysis will provide indicators of service capacity and service need levels for the 15-county area. The report then will go on to identify network development goals and strategies to address the identified service gaps.

The analysis below shows how well the SMC Provider Network achieved the treated prevalence goals and how well the SMC Provider Network achieved the Timely Access to Care goals.

A) Analysis of Prevalence and Service Gaps

The chart below uses the prevalence rates to calculate the incidence and treatment need for persons with mental illness, developmental disabilities, and substance abuse for the Northern, Central and Southern regions and SMC as a whole.

Table #3.1 Prevalence of Mental Illness/Developmental Disabilities/Substance Abuse

Region	U.S. Census Bureau General Population Totals	Adult	Child Under 18	Adult Mental Illness Prevalence	Child & Adolescent Mental Illness Prevalence	Adult Developmental Disability Prevalence	Child & Adolescent Developmental Disability Prevalence	Adult Substance Abuse Prevalence	Child & Adolescent Substance Abuse Prevalence
Prevalence Occurring Nationally	-----	-----	-----	5.4%	12%	0.79%	3.21%*	7.98%	7.24%
Northern Region	165,607	133,924	31,683	7,232	3,802	1,058	1,017	10,687	2,294
Central Region	159,387	123,619	35,768	6,675	4,292	977	1,148	9,865	2,590
Southern Region	184,027	147,180	36,847	7,948	4,422	1,163	1,183	11,745	2,668
Total Number Individuals in SMC Catchment	509,021	404,723	104,298	21,855	12,516	3,197	3,348	32,297	7,751

Source: 2007 US Census Bureau and the 2005 Center of Mental Health Services

- Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

The number of persons served in any given target population is only meaningful when compared to the prevalence of persons needing those services in that target population. Using data from the US Census Bureau and the CMHS Prevalence formula the table above shows, for instance, that we should expect approximately 5.4% of adults ages 18 and above or roughly 21,855 adults in the SMC catchment area to need mental health services. Likewise, we would expect approximately 12% of children ages 17 and under, or roughly 12,516 individuals, in the SMC catchment area to need mental health services.

B) Performance Contract Standards

For SFY 2008-09 the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has determined that each LME must "reach or exceed" a statewide minimum standard for a percentage of individuals receiving treatment who are in need. The standards are set via averaging the treated prevalence levels achieved by all LMEs in one quarter in the prior fiscal year.

C) Analysis of Treated Prevalence

Below is a table using the DMH/DD/SAS established goals and data drawn from the IPRS and Medicaid monthly paid claims files sent by the DMH/DD/SAS and Division of Medical Assistance (DMA) to SMC for calendar year 2008. The figures in the table provide a very important comparison of treated prevalence compared to the DMH/DD/SAS's goal.

Table 3.2 Comparison of Prevalence to Actual Treated Prevalence for calendar year 2008

Region	Adult Mental Illness	Child/Adolescent Mental Illness	Adult Developmental Disability	Child/Adolescent Developmental Disability	Adult Substance Abuse	Child/Adolescent Substance Abuse
SMC % of Individuals who Received Treatment Who are in Need	39%	45%	44%	18%	10%***	6%***
State FY, 2009 Established Minimum Standard for % of individuals Receiving Treatment Who are in Need*	38%	38%	36%	19%**	8%	7%

Source: IPRS and Medicaid monthly paid claims files sent by the Division and DMA to SMC for calendar year 2008 Year 2008

* Minimum standards are set by DHHS using the average performance of all LMEs in a single quarter in the prior fiscal year.

** Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

*** Medicaid and State Service Claims Data for the one year period: October 1, 2007 to September 30, 2008. This is a different date range than for the other groups in this table. It is the only available source of both Medicaid and IPRS claims data for these two SA populations.

D) Summary of Treated Prevalence and Service Gaps

The data in the above table shows that SMC meets or exceeds the State treated prevalence standards in each category of service except the Child/Adolescent DD group and the Child/Adolescent SA group. (See Appendix C, "Prevalence Table" for complete Treated Prevalence data).

While SMC is pleased and proud to have met or exceeded the Standard in the four other disability/age groups, we remain focused on the need to improve service levels to the Child/Adolescent DD group and the Child/Adolescent SA group. The strategies SMC will use to increase services to these two populations will be presented in the Goals section later in this report.

E) Analysis of Access to Care – Emergent, Urgent and Routine

A human service delivery network must be responsive to the needs of the persons accessing the services of the network. Timely and effective access to care is an important measure of the performance of the SMC provider service network.

The NCDHHS has established standards for acceptable access to care for emergent, urgent and routine assessments. The standards are:

- 100% of individuals determined to need *emergent* care were provided a face-to-face service (assessment and/or treatment) within two hours from the time of the request.
- 80% of individuals determined to need *urgent* care were provided a face-to-face service within 48 hours from the time of the request
- 80% of individuals determined to need *routine* care were provided a face-to-face service within 14 calendar days from the time of the request

The table below shows the standards and the performance of SMC in each of the four quarters of calendar year 2008.

Table 3.3 Timely Access to Care

Appt Type	State Standards	3 rd Qtr 07-08	4 th Qtr 07-08	1 st Qtr 08-09	2 nd Qtr 08-09
Emergent	100%	83%	100%	94%	76%
Urgent	80%	60%	69%	46%	54%
Routine	80%	72%	70%	54%	52%

Source: Community Systems Progress Indicators Reports for Calendar Yr 2008 (Third Quarter SFY 2007-2008 through Second Quarter SFY 2008-2009).

The data in the table shows that SMC met the State standard in only one quarter for only emergent access to care. Providing timely access to care is a significant problem and one SMC has been aware of and has taken steps to remedy. SMC has set the highest priority on improving the percentage of consumers having timely access to care in the upcoming year (for complete data on Timely Access to Care please see appendix D). The strategies SMC is using and will use to increase access to care will be presented in the Goals section later in this report.

F) Analysis of Survey and Anecdotal Data

1. Consumer and Family Member Surveys

Total Number of Surveys Tabulated in 2009 = 752

Total Number of Surveys Tabulated in 2008 = 414

The surveys are on file in the Provider Relations office of the Smoky Mountain Center. The complete tabulated survey results are found in Appendix E at the end of this document.

Methodology

- The surveys were disseminated through providers to consumers and family members in the 15-county SMC area in February and March 2009.

Data from 2009 and 2008

Comparison of 2009 to 2008 Consumer and Family Member Surveys

Based on your experiences, how would you rate each aspect of the services described below?

Rating is reported as an average based on a 4 point spread where

1=poor, 2=fair, 3=good, and 4=excellent, and *dark grey* is negative change, *white* is no change, and *light grey* is positive change in 2009 vs. 2008.

		Disability Population					
		MH		SA		DD	
Survey Items	Age Population	2009	2008	2009	2008	2009	2008
availability of providers	Child/Adol	3.1	3.2	3.3	3.2	3.1	3.1
	Adult	3.3	3.4	3.3	3.1	3.2	3.2
choice of providers	Child/Adol	2.9	3.1	3.3	3.1	3.1	3.0
	Adult	3.2	3.4	3.3	3.1	3.3	3.2
convenience of services	Child/Adol	3.1	3.2	3.2	3.0	3.1	3.1
	Adult	3.2	3.4	3.2	3.3	3.3	3.3
quality of services	Child/Adol	3.1	3.4	3.3	3.2	3.2	3.2
	Adult	3.3	3.5	3.3	3.2	3.4	3.4

Conclusions from Consumer and Family Surveys

There are several conclusions drawn from this data.

In comparison, the 2008 and 2009 consumer and family member comments show us two general things:

- A concern expressed repeatedly in both years is concerns for provider staffing adequacy in both quantity and training.
- Another common concern in both years is regarding the right service in the right amount from the right provider.

Overall, when the comments and the average ratings are examined together, one must use caution when drawing conclusions from this data.

- Findings may be generalized only at the aggregate level. Sample size from each provider or age/disability area needs to be sufficient to generalize at the provider or age/disability area.
- One conclusion to be drawn is that consumers are generally positive (generally 3 or better out of 4) about the services.

2. Stakeholder Surveys

Total Number of Surveys Tabulated = 58

Methodology

These surveys were distributed to staff at stakeholder agencies in all 15 counties. Surveys were distributed in the months of February and March, 2009 and collected from stakeholders over the same period. The surveys were distributed to the following categories of stakeholder agencies in their respective counties: Department of Social Services, Health Departments, Schools, Law Enforcement, Hospital Administration and Emergency Departments, Juvenile Services, Transportation Departments/ Agencies, Domestic Violence Agencies, Child Advocacy Centers/ Multi-disciplinary Teams, Healthy Carolinian Committees, Interagency Councils, District Attorneys, Probation and Parole, Treatment Alternatives for Safer Communities, Juvenile Crime Prevention Councils, Regional Interagency Collaborative Council, Partnership for Children Collaborative, System of Care Collaboratives, National Alliance for the Mentally Ill.

Conclusions from Stakeholder Surveys

Findings may be generalized only at the aggregate level. Sample size from each provider or age/disability area needs to be sufficient to generalize at the provider or age/disability area.

The ratings indicate:

- When compared to the consumer data directly preceding this, it is clear that the SMC stakeholders who responded are significantly less positive about the SMC services than are the consumers.
- The stakeholders appear to be most favorable about the services for consumers with DD symptoms, and least positive about the services for consumers with SA symptoms.
- The stakeholders provided more favorable ratings regarding the quality of services than for the quantity or location.

The comments indicate;

- Stakeholders express a broad viewpoint of services and may be compelled to express or experience shortcomings in the service delivery system.
 - There are problems with the process used for the surveys; in future the surveys will be coded to enable identification of the geographical area of the respondents
 - Questions in the survey tool need to be restated for clarification of meaning.
 - Also, there were no checks for duplicate entries although this seems unlikely to have occurred

3. Provider Surveys

Total Number of Surveys Tabulated = approximately 30

Methodology

Surveys were distributed through the SMC Communication distribution list to all providers in the SMC catchment area. Surveys were distributed in February and collected from providers in February and March.

Conclusions from Provider Surveys

There is at least one clear correlation between the services needed and the barriers to providing existing or additional services: a lack of financial resources. This theme permeates virtually all aspects of the Providers' responses.

- It is a major reason for the limited amounts of higher end services being available
- It is a reason Providers have difficulty recruiting professional and seasoned staff.
- It is a primary reason providers have such difficulty staying in business.
- It is a key reason providers are so concerned about administrative processes – those challenges “waste” their time and thus cost them money.

The pervasive tone that the Providers are feeling should not be overlooked. Their responses indicate a high level of stress regarding some fundamental components of the system:

- keeping up with changes to the system
- recruiting and keeping adequate staff
- documentation, billing and authorization processes
- maintaining financial solvency.

4. Board of Directors

Total Number of Surveys Tabulated = 9

Methodology

Surveys were distributed through the Community Relations Coordinator to the full Board of Directors in March of 2009. Responses could be emailed, faxed, or mailed back to the SMC Area Office in Sylva. Responses are sorted by region and can be seen in entirety in Appendix E.4

Conclusions from Board of Directors Surveys

Southern Region

- All services in mental health, substance abuse and developmental programs need to be in all areas, and for all age groups. The barrier is funding.

- Residential services are needed in the Southern Region, for child MH, for children/adults with SA issues, and for children/adults who are in the severe range of developmental disabilities.

Northern Region

- More beds in hospitals, more money to hire personnel; finding available people to hire is also a major problem.
- All accomplishments/concerns of SMC should be presented to the Board.

Central Region

- In-house rehab for adult substance abusers, more than one month.
- Adult Mental Health – need longer hours, easier access and more staff.
- Clients need to be seen more frequently; it is difficult to get MH services for clients who need them on an ongoing basis.
- DD CAP services for children are poor due to length of waiting required; lack of stability in DD .
- Convenience of service is poor because clients are often required to access services outside the county in order to be seen on a regular, consistent basis.
- Need services for indigent clients; need more choice in providers.
- More psychiatrists are needed for individual and family counseling.
- A lot of individuals who previously received services when providers changed were lost in the transition; need more hospital in-patient beds; need more community-based services.

Overall, the SMC Board of Directors respondents have a fair level of satisfaction regarding the SMC treatment service continuum.

Several concerns from individual Board members were expressed regarding specific services or groups of services. Several of the concerns reflect concerns shared by other survey groups mentioned above – concerns such as:

- needing more psychiatry,
- needing more staff,
- needing additional funding
- needing more residential services, and
- needing a fuller spectrum of service availability.

5. SMC Staff Surveys

Total Number of Surveys Tabulated = 33

Methodology

Surveys were distributed by email to a sub-group of key SMC staff members such as Access staff, Community Based Clinicians, Provider Relations staff who have first-hand knowledge of our provider network and service system. These surveys were distributed and gathered in February and March of 2009. Input was solicited from the Clinical Operations Director who submitted detailed comments.

The data was broken into the following region specific groups: All, Central, Northern, Southern. A detailed list of responses from SMC Staff by region is available in Attachment E5

Conclusions from SMC Staff

The responses from SMC Staff indicate many of the same barriers and challenges that the other survey response groups do, among them funding and staffing.

There are some common responses from staff regarding the unmet needs: psychiatric services, delay in getting into services (as noted above by the need for more assessment capacity), substance abuse services for all populations and levels of care, and the need for a mix of higher end services. In addition, SMC staff members assert a need for more accessible psychiatric services, more services for consumers with traumatic brain injuries, and a need for more housing of a variety of consumers including crisis or emergency housing. Also noted is the need for Spanish-speaking services, as there is a significant minority population of primarily Spanish-speaking immigrants in the SMC catchment area, but a paucity of Spanish-speaking MH/DD/SA service providers.

The SMC Clinical Operations Director is also intimately familiar with the service needs of the continuum of services in the SMC area. He notes the following additions to the list already mentioned, above:

Child:

- Child Crisis Stabilization services and Residential services in all SMC regions
- Services of all types for adolescents
 - while many providers work with younger children, fewer work with adolescents leaving this consumer age-group at higher risk;
- Appropriate services for aggressive and offending youth;

Adult:

- Domestic violence programs
- Supported employment and long term follow along for DD and MH populations;
- Supported living apartments for DD/MH/SA consumers;
- Recovery Education Centers (REC)
 - Currently available in eight of the SMC counties
- Traditional MH/SA services
 - While some of these services are available, they are not as prevalent as needed

Adult and Child:

- more evidence-based practices for many of the primary mental health disorders;

6. Conclusions from All Survey Input

There appears to be differences in the perceptions held by professionals and perceptions held by consumers regarding the services. The consumers tended to respond positively about the services, and the “professionals” in the field seem to hold a much more critical, less positive view.

Emergent themes in the comments from providers and SMC staff indicate that staffing shortages and lack of qualified staff in the area of substance abuse are conditions that persist and are difficult to remedy across all regions. Particularly there is a shortage of staff who perform assessment services in the Central region, this is one factor that contributes to the low percentage of persons obtaining timely access to care in that area.

IV Characteristics of the SMC Service Area which Present Challenges to Meeting Service Demand

Smoky Mountain Center's Service Management Dept and Provide Relations and System Performance (PRSP) Dept. have identified five major ongoing challenges to adequate services in all categories in its catchment area:

- Availability of workforce,
- Proximity standards and geography and population density,
- Transportation to services,
- Increasing capacity and limited state-funds for non-Medicaid services
- Quality Improvement and
- Impact of Reform and Change on the MH/SA/DD system.

V Results

In this section we will draw conclusions from the information provided in section III, the Data Analysis section. The results derived from that data provide indicators for areas of change or improvement.

As stated in the data analysis section the two areas needing improvement are services to children and adolescents in need of developmental disability services and, children and adolescents in need of substance abuse services.

In the Capacity Analysis Table (Appendix G) one can see a comprehensive picture of the services offered in the specific counties and regions. In this table, one can see that in any given county there are many services offered by multiple providers, some services only offered by one provider, and some not offered by any. This measure of level of capacity (and any increases) is not a perfect tool as it does not provide an indicator for the capacity of each provider, only the number of providers of a given service.

The Capacity Analysis shows an obvious dearth in substance abuse providers and explains the conclusions drawn from the treated prevalence data.

The other area of deficient "treated prevalence" is services to Developmentally Disabled children and adolescents. Using the data in both the Treated Prevalence Analysis and the Capacity Analysis seems to indicate a need for increased service delivery to this group but does not seem to be a problem of inadequate capacity.

A third area needing improvement is Timely Access to Care. This analysis (seen in Appendix D) clearly indicates a need to improve timely assessments to all disability/age groups. The geographic areas where the greatest need for improvement are in two Central Region counties (Alexander, Caldwell) and Northern region counties (Wilkes, Watauga). Improvements are needed to a lesser degree in the Southern region counties.

It is notable that there is consensus among SMC staff and providers that lack of available emergency psychiatric services is closely linked to the lack of timely access for emergency assessments. An adequate level of emergency psychiatric services will directly improve access to services in emergent situations. For the past four years SMC has been engaged in diligent efforts to increase availability and access to emergency psychiatric outpatient care for those who in need of that level of care.

Themes identified in the comments from providers and SMC staff indicates that staffing shortages and lack of qualified staff in the area of substance abuse are conditions that persist and are difficult to remedy across all regions. Particularly in the Central Region, staffing shortages are a factor contributing to the low percentage of persons obtaining timely access to care in that area.

The above results give focus to the work that must be done by SMC in the coming year to improve and strengthen the SMC provider network. In the next section goals are presented which address the four areas of;

- Increasing services to developmentally disabled children and adolescents
- Increasing capacity and services to children and adolescent who need substance abuse services
- Improving the timely access to care for emergent, urgent and routine care
- Increasing the workforce in the professional disciplines of Psychiatry and substance abuse.

VI Goals

Many parts of the SMC service continuum warrant development, yet the Data Analysis (section III) and the challenges to meeting service need (Section IV) in this report lead SMC to identify key, priority areas needing improvement. These are the areas that will make the most positive impact on SMC service network responsiveness and capacity in the near future. After careful evaluation of the above data, SMC has set goals and strategies for improvement in the following four areas.

A) Timely Access to Care

Provide Timely Access to Care

While there is a reasonably good array of MH, SA and DD services offered across SMC's catchment area, timely access to those services often does not meet established standards. One provider organization left the area; another provider has greatly reduced the services that it offers, now providing only basic benefit services in a restricted geographic area, and several other providers have reduced the number of enhanced services that they provide, especially Community Support.

1. Goal

Achieve the NCDHHS standards for timely access to care in the 15-county SMC area by October 1, 2009:

- 100% of individuals determined to need emergent care were provided a face-to-face service (assessment and/or treatment) within two hours from the time of the request.
- 80% of individuals determined to need urgent care were provided a face-to-face service within 48 hours from the time of the request
- 80% of individuals determined to need routine care were provided a face-to-face service within 14 calendar days from the time of the request

B) Workforce Expansion

1. Goal

Workforce expansion has been an identified need in the Community Development Plan for FY 07-08 and in years prior to that. Availability of mental health and substance abuse professionals in rural areas of North Carolina has been a persistent problem.

Two strategies have been developed and implemented by SMC to address this workforce shortage. An incentive program was implemented to expand the substance abuse workforce. SMC provides monetary incentives to providers to recruit, train and retain substance abuse professionals. The incentive implemented for the workforce expansion of psychiatrists is a salary subsidy to providers who add psychiatrist positions to their staffing patterns. A total of three providers are now participating in these incentive programs. A Quality Improvement Project is tracking the impact of the substance abuse professional workforce incentive program.

The other goals listed in this section pertaining to access to care and increased treated prevalence are also related to the issue of workforce shortage. As providers attain adequate staffing levels the access to care levels and the treated prevalence levels will increase. This means provider organizations which are fully staffed will have greater service capacity and can better serve the populations. Therefore, it seems prudent to also set a goal with a focus on the efficient use of the existing staff of provider organizations. The goal below reflects that focus.

1. Goal

By February 1, 2010 the level of service delivered by substance abuse professionals and psychiatrists will be increased by at least 10% via strategies which improve time efficiency of substance abuse professionals and psychiatrists.

C) Substance Abuse Services

1. Goal

By January 1, 2010 services to child/adolescents needing substance abuse services will have met or exceeded DHHS treated prevalence standards for at least three of the four quarters in calendar year 2009 for the overall SMC Catchment area.

D) Developmental Disabilities Services to Children and Adolescents

1. Goal

By January 1, 2010 the level of treated prevalence for the Child/Adolescent DD population will meet or exceed the NCDHHS standards in the overall SMC catchment area

VII Achievements and Successes in Meeting Identified Community Needs

Synopsis: This section describes SMC success in building a more comprehensive provider network, development of innovative programming with single stream funding, increasing community based psychiatric interventions leading to reduced psychiatric hospital admissions.

A) Assessment of Community Need and Provider Capacity for Children's Services in the SMC Catchment Area.

SMC has actively worked with providers to build and expand a continuum of child services aimed at maintaining or developing positive family and community connections.

In March of 2006 the General Assembly allocated recurring funds to support a System of Care (SOC) coordinator in each of the LME's. This position was to be dedicated to SOC coordination for child mental health and substance abuse services and increase collaboration across local agencies, ensure youth and family involvement, enhance the child and family team process, support activities of the community collaborative, and promote cultural competence throughout the system.

SMC had already created the CBC positions which performed the majority of these duties. The Smoky Mountain Center CBC's and Northern Region staff both have been integrally involved in the System of Care children's collaborative efforts.

Some of the SMC System of Care successes include:

- working with Cherokee and Graham County School Systems to develop peer review teams for academically at-risk children;
- working with local Department of Social Services (DSS), Department of Juvenile Justice (DJJ), and Local Education Authorities (LEA), to provide coordinated care for children and their families;

A child crisis stabilization program is being developed using therapeutic foster care Providers and Intensive In-Home services. These two services will be used to provide short term stabilization to children in emotional crisis and divert them from admission to psychiatric inpatient care. In calendar year 2008 more children were served in the community than in the previous year (Southern Region: 2008-2721 children served/2007-1618 children served).

B) Enhancing Service Delivery through Financing Methods

"Single stream funding" enables Smoky Mountain Center to be creative in partnering with providers to find the best ways of supporting its community given the reality of limited State funds. One of the most prominent examples of this are the fixed fee funding contracts with two of our primary providers, Meridian Behavioral Health Services (MBHS) and New River Behavioral HealthCare (NRBH), to serve the state-funded consumers in SMC's fifteen counties. These contracts eliminate most requirements for service authorizations and processing claims, and include services such as Assessments, SAIOP, PSR, ACTT, and Recovery Education Centers.

"The primary intent of the Recovery Education Program is to serve individuals who meet the state's target population criteria who do not have Medicaid. This includes individuals who fall at all Levels of Care. Individuals who do not fall into a target population will also be invited to participate in the Recovery Education Program. For state-funded individuals in need of more community-based or intensive services, Assertive Community Treatment, Psychosocial Rehabilitation Programs and Substance Abuse Intensive Outpatient Programs will continue to be offered as an alternative to the Recovery Education Program.

"The intention of a Recovery Education Center is to provide a supportive and empowering environment that facilitates wellness and skill-building through an educational model."

This arrangement with MBHS started approximately three years ago, and the arrangement with NRBH is in its second year. SMC is excited to be able to partner in efforts such as this to meet the needs of the community in creative and effective ways utilizing the limited state funds in as efficient a manner as possible.

C) Emergency and Crisis Services Continuum

It is critical to the SMC service continuum as a whole to have a strong undergirding of an array of emergency and crisis services. Crisis services are often the entry point to services for consumers. Crisis services provide the safety net for consumers working to cope with life and to make changes in their lives. Strong crisis and emergency services are the backbone of any successful implementation of a comprehensive mh/dd/sa service continuum.

Great strides have been made in developing crisis services in the SMC region over the past 12 months. Thanks to crisis expansion funding, Mobile Crisis Management services are now available throughout the 15 county service area. 26 adult psychiatric inpatient beds have been opened where none existed before. There are 28 licensed facility based crisis beds in the catchment area. Psychiatric walk-in centers are making psychiatric and medication management services more available. Broughton hospital referrals are declining significantly as individuals are served closer to home in less restrictive environments. A child crisis stabilization program is planned using Therapeutic foster care Providers and Intensive In-Home services. These two services will be used to provide short term stabilization to children in emotional crisis and divert them from admission to psychiatric inpatient care.

Regional reports:

Northern Region:

New River Behavioral Health provides mobile crisis management, emergency services and psychiatric walk-in services. NRBH has joined the involuntary commitment pilot program which allows social workers to complete the first exam for involuntary commitment. Synergy Recovery operates 16 facility based crisis beds serving the SMC catchment area and beyond. On 10/01/08 Cannon Memorial Hospital opened 10 new adult psychiatric inpatient beds in Avery County in partnership with SMC and the State.

Central Region:

New River Behavioral Health provides mobile crisis management, emergency services and psychiatric walk-in services.

Southern Region:

Smoky Operated Services (SOS) is the provider services arm of Smoky Mountain Center. SOS provides mobile crisis management services under a State approved waiver, expanding crisis services from the Balsam Center to the broader community. Meridian Behavioral Health is developing psychiatric walk-in services in collaboration with Smoky Operated Services. A 16 bed psychiatric inpatient unit was opened 11/17/08 at Haywood Regional Medical Center through a public private partnership with Smoky Operated Services. The Balsam Center Adult Recovery Unit, a 12 bed facility based crisis program, was temporarily closed on 12/12/08 due to an acute staff shortage related to staffing the new Behavioral Health Unit at Haywood Regional Medical Center. SMC is planning to reopen the Balsam Center Adult Recovery Unit by 05/01/09.

D) Implementation of a Crisis Services Plan

SMC has embarked on the implementation of a Crisis Services Plan for its Southern Region originally submitted to the Division in March, 2007. The Crisis Plan Update for 2009 can be seen below:

A great deal has occurred since the development of the original crisis plan, including the following major developments:

LME Expansion

Since SMC has expanded to cover the 5 counties of the former New River LME, and the 3 counties served by the Foothills LME, crisis planning now encompasses all 15 counties. To ensure adequate crisis planning and stakeholder relations in the larger catchment area, SMC created a North/Central Region Crisis Coordinator to oversee this region.

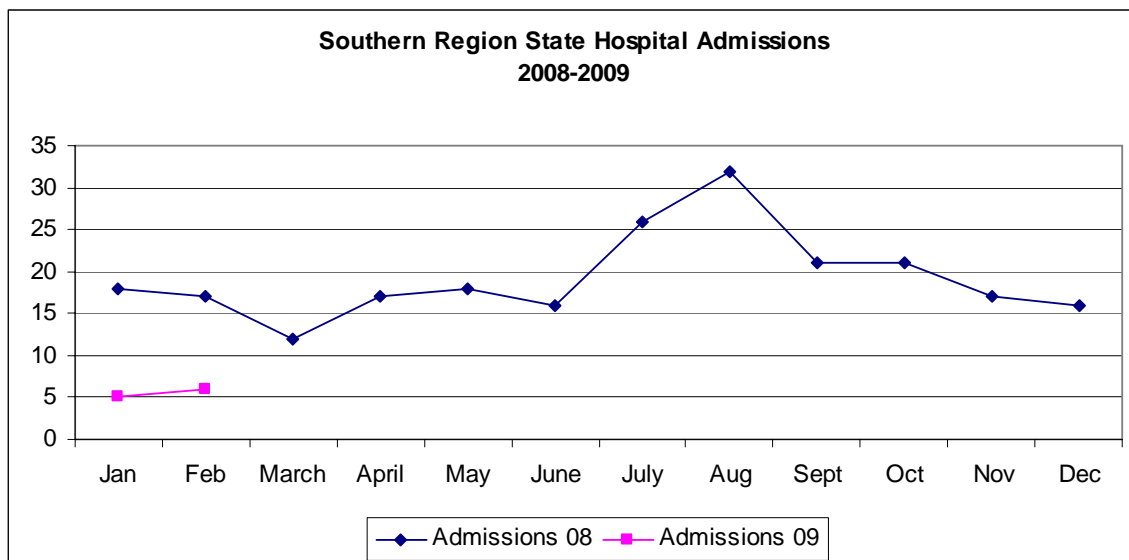
Mobile Crisis Management and Psychiatric Walk-in Funding

Funding was provided to expand MCM across the 15 counties, and SMC was granted a waiver to provide this service directly in the Southern Region through 2009. Consequently, the LME moved from “community based crisis intervention” to endorsed Mobile Crisis Management. In addition, the LME is funding psychiatric walk-in clinics in three locations in the Southern Region.

Hospital Diversion Pilot

In addition to the Crisis Services Plan discussed above, SMC in the hospital pilot program (HB1473 Reduction in State Psychiatric Hospital Utilization Pilot Project). This 18-month pilot has been approved by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, began January 1, 2008, and is targeted at reducing hospital use by holding an LME financially and clinically responsible for the cost of that use and by providing additional resources to build community capacity. This has resulted in the development of 26 new psychiatric inpatient beds serving the region, a crisis residential resource for children/adolescents, geriatric psychiatry specialist, and enhanced care coordination.

These initiatives in the Southern Region show some promising reductions in Broughton admissions as seen below:



E) Southern Region Divestiture

The LME has not been able to fully divest of services in the Southern Region due largely to the lack of a comprehensive service provider which can support psychiatric and high end crisis services. SMC is now working with county commissioners to explore the formation of a 160 intergovernmental service authority which would combine psychiatric, mobile crisis, emergency services, facility based crisis and inpatient services provided by SMC with other safety net services provided by Meridian Behavioral Health. This has the potential to re-integrate some critical services and provide a more stable system of care.

APPENDICES

- A. Map of SMC Catchment Area
- B.1. Population Demographics of the SMC Catchment Area
- B.2. Population Density of Each County in SMC Catchment Area
- C. Treated Prevalence Rates
- D.1. Timely Access to Care Graphs
- D.2. Timely Access to Care Data
- E. Survey Data
 - E.1. Consumer and Family Member: Survey Data/Comments, Sample Survey
 - E.2. Community Stakeholders: Survey Data/Comments, Sample Survey
 - E.3. Provider: Survey Comments, Sample Survey
 - E.4. SMC Board of Directors: Survey Data/Comments, Sample Survey
 - E.5. SMC Staff: Survey Comments, Sample Survey
- F. Definitions
- G. Capacity Analysis